IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

ABUKAR HASSAN AHMED,	:	CASE NO. 2:10-cv-00342
Plaintiff,	:	**Electronically Filed**
v.	:	District Judge: George C. Smith Magistrate Judge: Mark R. Abel
	:	
ABDI ADEN MAGAN,	:	**DECLARATION OF CHRISTINA GEORGIA HIOUREAS IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT OR, IN THE ALTERNATIVE , FOR DEFAULT JUDGMENT**
Defendant.	:	

State of New York)
) :ss.:
County of New York)

Pursuant to 28 U.S.C. § 1746, I, Christina Georgia Hioureas, declare the following:

1. I am over eighteen years of age and am otherwise qualified to testify to the facts set forth below. All of the facts rendered herein are based upon my personal knowledge.

2. I am an associate with the law firm of Latham & Watkins LLP, counsel for Plaintiff, Abukar Hassan Ahmed ("**Plaintiff**"). I submit this Declaration in Support of Plaintiff's Motion for Partial Summary Judgment or, in the Alternative for Default Judgment Against Defendant Abdi Aden Magan ("**Defendant**").

3. By the close of discovery, July 29, 2012, Plaintiff had fully complied with the Court's discovery orders and, excluding these protected materials, produced a

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ABDI ADEN MAGAN,	:	
Defendant.	:	

EXHIBITS IN SUPPORT OF
DECLARATION OF CHRISTINA GEORGIA HIOUREAS IN SUPPORT OF PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT OR, IN THE ALTERNATIVE, FOR DEFAULT JUDGMENT

Exhibit 1: 1989 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000749-55).

Exhibit 2: Amnesty International U.S.A. document titled Suleiman Nuh Ali (Bates Nos. P-000369-71).

Exhibit 3: Document titled *Background: The Human Rights Situation in the Somali Democratic Republic* (Bates Nos. P-000892-901).

Exhibit 4: October 1988 U.S. Department of State Cable No. 1988MOGADI12222 (Bates Nos. P-000997-1019).

Exhibit 5: June 1982 International Commission of Jurists Review document titled *Somalia* (Bates Nos. P-000881-83).

Exhibit 6: June 16, 1988 Amnesty International document titled *Fear of Torture/Legal Concern*, AI Index: AFR 52/17/88 (Bates Nos. P-000022-23).

Exhibit 7: July 14, 1988 Hearing Before the Subcomm. on Africa of the House Committee on Foreign Affairs, 100th Cong., titled *Reported Massacres and Indiscriminate Killings in Somalia*, (Bates Nos. P-000139-68).

Exhibit 8: May 1989 U.S. Department of State Cable No. 1989MOGADUI5258 (Bates Nos. P-000728-38).

Exhibit 9: January 1, 1990 *Human Rights Watch World Report 1989 – Somalia* (Bates Nos. P-000768-73).

Exhibit 10: 1990 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000756-62).

Exhibit 11: 1991 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000763-67).

Exhibit 12: November 17, 2010 Defendant's Responses to Plaintiff's First Set of Interrogatories.

Exhibit 13: December 1989 U.S. Department of State Cable No. 1989MOGADI14054 (P-000905-16)

Exhibit 14: May 24, 2012 Plaintiff's Second Set of Interrogatories to Defendant.

Exhibit 15: April 20, 2000 Amnesty International letter from Dr. M. Hill (Bates No. P-000917-20).

Exhibit 16: Photographs of Abukar Hassan Ahmed Scars (Bates Nos. P-000812-14).

Exhibit 17: March 5, 2012 email and letter from Plaintiff to Defendant attaching the Notice of Deposition.

Exhibit 18: March 22, 2012 email and letter from Plaintiff to Defendant attaching the subpoena.

Exhibit 19: April 3, 2012 email and letter from Plaintiff to Defendant reminding him about the Court's Discovery Order.

Exhibit 20: Medical Records of Abukar Hassan Ahmed submitted *in camera* (Bates Nos. P-000821-29, P-000833-80).

Exhibit 21: May 31, 2012 Expert Report of Dr. Coleen Kivlahan, M.D., MSPH submitted *in camera*.

Exhibit 22: May 29, 2012 Expert Report of Dr. Stuart Lorin Lustig, M.D., M.P.H. submitted *in camera*.

Exhibit 1: 1989 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000749-55).

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 4 of 49 PAGEID #: 1054

P-000749

[redacted]

101st Congress
2d Session

JOINT COMMITTEE PRINT

COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 1989

REPORT

SUBMITTED TO THE

COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES

AND THE

COMMITTEE ON FOREIGN RELATIONS
U.S. SENATE

BY THE

DEPARTMENT OF STATE

IN ACCORDANCE WITH SECTIONS 116(d) AND 502B(b) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

FEBRUARY 1990

Printed for the use of the Committees on Foreign Affairs and Foreign Relations of the House of Representatives and the Senate respectively

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 5 of 49 PAGEID #: 1055

SIERRA LEONE

c. Prohibition of Forced or Compulsory Labor

Forced or compulsory labor is prohibited by law and is not practiced. Since 1964 the ILO Committee of Experts (COE) has asked the Government to repeal or amend a section of the Chiefdom Councils Act under which compulsory labor may be imposed. The Government has indicated that the pertinent section of the Act is not enforceable, but it has not yet replied to COE requests for an official declaration to that effect.

d. Minimum Age for Employment of Children

The minimum age for employment of children is officially 18 years, but in practice, there is no minimum age. In the interior of the country, children at early ages work seasonally on subsistence family farms. Because the adult unemployment rate is as high as 60 percent, there are few children involved in the industrial sector. However, children often engage in street trading, and some children work with small fishing groups.

e. Acceptable Conditions of Work

Currently, there is no legislated minimum wage. In 1987 the Constance Davis Commission recommended the establishment of a mimimum wage and social security program, but to date, the Government has not passed implementing legislation. The standard legal workweek is 38 hours (8 hours on Monday through Thursday and 6 hours on Friday). There is no limit on overtime. The rate of overtime pay for public holidays is 2.5 times the basic rate. For other days the overtime rate is double the normal rate of pay.

Within the Ministry of Labor there is a moribund Health and Safety Division. Health and safety regulations are included in collective bargaining agreements negotiated by the trade unions. However, there is no evidence of systemic enforcement of these safety standards. Trade unions provide the only protection for workers who file complaints about hazardous working conditions. Initially, the unions make a formal complaint to the Ministry of Labor. When this fails, the unions can issue a 21 day strike notice. As a last resort the unions can strike to achieve their demands.

SOMALIA

Somalia is a one-party state ruled since 1969 by President Mohamed Siad Barre. He presides over the Somali Revolutionary Socialist Party (SRSP), the sole legal political party, and the Government through the presidentially appointed Council of Ministers. The President's clan, the Marehan, holds key positions, e.g., the President's eldest son, Abdurahman Mohamed Siad "Maslah", is Commander of the Armed Forces. A National People's Assembly, last elected on a single slate in 1984, is subordinate to the executive. Civil conflict continued during 1989, with an outbreak of rioting in the capital, Mogadishu, followed by official reprisals. Troops mutinied in the southern, central, and northern regions, and political ferment intensified.

The Somali Armed Forces (SAF) number over 35,000 troops. Internal security responsibilities, including for coping with the civil conflict, are shared by the National Army, the military police (MP), the Defense Intelligence Security Agency ("Hangaash"), the National Police, and the National Security Service (NSS). During 1989 army combat units and military police resorted to attacks on civilian villages, roundups, and summary executions as means of combating the antiregime Somali National Movement (SNM), other dissident groups, and rioters. Reformist groups made efforts during 1989 to curb the security services' arbitrary powers of detention, but were only partially successful.

Clans continued their age-old competition for waterholes and grazing lands, and at the national level the governing elite, based on the Marehan subclan, struggled with other clans for control of the country's few resources. Most of Somalia's estimated 8 million people manage a bare subsistence as herdsmen or farmers. The modern sector of the agricultural economy consists mainly of banana plantations located in the south. The chief exports are livestock and bananas. Mogadishu now has a population exceeding 1.5 million, many of whom are unemployed migrants from the countryside. Increasingly straitened conditions in the capital contributed to an increase in crime and to the potential for civil disorder, while life in the north has been severely disrupted by the civil conflict.

Despite some limited progress in the first half of the year, human rights in Somalia suffered sharp setbacks during 1989. A State Department-sponsored study (the Gersony report) documented massive human rights violations, committed by both government and, to a lesser extent, SNM forces in the 1988-89 fighting; the SAF murdered at least 5,000 unarmed civilians between May 1988 and March 1989. In the first half of 1989, the Government did release most political prisoners, including those whose cases had been publicized in the West, and strengthened the constitutional prohibition against arbitrary detention. However, on July 9, an unknown gunman shot and killed the Roman Catholic Bishop of Mogadishu. The Government detained for investigation several prominent Islamic leaders and other critics. On July 14, rioting broke out in Mogadishu as a result of the detentions, and several police officers were killed. The police and MP's responded to the killings by firing on the crowds. At least 100 people were killed and hundreds more injured in fighting throughout the city. (One human rights group claims 450 were killed.) On subsequent days and nights military units detained about 2,000 people, searched and looted houses, assaulted and sometimes shot

P-000750

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 6 of 49 PAGEID #: 1056

people in their homes, and summarily executed at least 46 young men, mainly Isaaks, at a nearby beach. In response to the growing political discontent, the President announced that multiple political parties would be allowed to organize and to contest elections to a new People's Assembly within 16 months. He offered to negotiate with dissident organizations, but his initial attempts had been rebuffed at year's end.

RESPECT FOR HUMAN RIGHTS

Section 1 Respect for the Integrity of the Person, Including Freedom from:

a. Political and Other Extrajudicial Killing

During 1989 extrajudicial killing was employed as a method of warfare in Somalia's civil conflict. Government forces were the worst though not the only offenders. While some incidents could be attributed to poor leadership and training, the pattern of raids on civilian villages, reprisal killings, and summary executions suggested that extrajudicial killing had official sanction (see Section 1.g., for details). Following the extensive July disorders and killings, the President formed an investigating committee, but at the end of 1989 the committee had not released its findings, and the Government had not brought those responsible to justice. There have been persistent reports that the perpetrators were members of the Marehan subclan (Rer Koshin) to which the President and his family belong.

b. Disappearance

Disappearances continued to occur in Somalia during 1989. They were hard to distinguish from arbitrary arrests and detentions (see Section 1.d.) and extrajudicial killings, because these are not acknowledged by the authorities. For example, an interpreter employed by the U.S. Office of Military Cooperation has been missing since July 17 and is presumed to have been among the victims of the shootings at the beach.

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment

Torture is forbidden by Article 27 of the Constitution. Senior government officials repeatedly deny that it is practiced as a government policy and, in fact, instances of torture appeared to decrease in response to a governmental reform effort and international pressure. Some recently released short-term detainees complained, however, that they were subjected to forms of torture such as the "Mig," in which their hands and feet were tied together behind their backs with a rope, which was pulled tight so that the body was arched backwards, to resemble the swept-back wings of a Mig aircraft. The Canadian Centre for Victims of Torture continued to report seeing torture victims from Somalia.

Harsh prison conditions do not provide sanitation, adequate water, or medical care. Prisoners receive the absolute minimum of food necessary for survival because it is customary for food to be supplied from outside by their families. Amnesty International (AI) stated that the conditions at the maximum security prisons of Lanta Bur and Labatan Jirow, where political prisoners are often held incommunicado, were particularly life-threatening.

Mistreatment of detainees sometimes results from negligence. In October, for example, at least 11 youths died of suffocation and dozens of others were hospitalized after police locked them in a steel shipping container. The authorities arrested the police official allegedly responsible for this incident.

d. Arbitrary Arrest, Detention, or Exile

Although Article 26 of the Constitution accords citizens the right to be formally charged and to receive a speedy trial, the Criminal Code was modified in 1970 to exempt crimes involving national security from time limits and rules of procedure. The Government has repeatedly shown an exceptionally broad interpretation of what constitutes national security and has used its powers in an arbitrary manner to detain, often incommunicado, suspected political opponents or critics. In the first half of 1989, in response to growing criticism of such abuses, the Government revised Article 26 of the Constitution to limit arbitrary detention. As a result, the security services in the early months of 1989 detained fewer persons and usually released them if evidence against them was lacking. (Normally, the National Security Court--see Section 1.e.--gives investigators a fixed time limit, with necessary extensions, to complete an investigation.)

Following the disturbances in July, however, mass detentions were resumed under a presidential decree (as provided for in Articles 82 and 83 of the Constitution) imposing emergency rule throughout the country. Many detentions seemed to have only an incidental investigative purpose, the main aim being to frighten possible opponents of the regime and silence criticism. Most of the detainees were released after a few weeks in military camps.

Prominent Somalis arrested in the investigation of the Bishop's assassination in July included the lawyer Dr. Ismail Jimale Ossoble, chief counsel for the defense in the February 1988 national security trial; Abdulkadir Aden Abdulle Osman, son of Somalia's first president; Sheikh Abdirahman Sheikh Ali Sufi, a senior religious leader; and three other imams. Dr. Jimale Ossoble and Mr. Osman were released in October 1989. The sheiks remained in detention at the end of the year. Also under detention were former cabinet ministers Aden Nur and Ba'adleh, who were arrested in July.

The number of detainees is difficult to estimate because the Government does not disclose such information, detainees are often held incommunicado, and at least 9 entities (National Police, NSS, Hangaash, military police, SRSP, the militia, the Custodial Corps, regional governors, and district commissioners) have the power to detain. The number probably fluctuated considerably during 1989, as the Government first released most detainees, then arrested about 2,000 people in July, and then released most of them after a few weeks. In conjunction with the October 21 national day celebrations, the President amnestied over 1,160 detainees and prisoners. Most of these detainees had been held on criminal charges, but some may have been detained for minor political offenses such as making "tribalistic" remarks.

The Somali security forces also practice the taking of hostages in interclan conflicts. In disputes between rival clans, the Government may order the arrest of senior members

P-000751

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 7 of 49 PAGEID #: 1057

of both clans in order to compel an end to the violence. The most recent example of this practice occurred in June when a minority Darod clan began attacking members of the Hawiya clan in and around Mogadishu. The Government arrested members of both clans and dictated peace terms between the parties; when peace was assured the hostages were released.

The Government does not practice exile as a means of political control. With regard to forced or compulsory labor, see Section 6.c.

e. Denial of Fair Public Trial

The Somali judicial system includes civil and criminal courts, and a separate National Security Court. Lawyers are permitted to represent suspects before the National Security Court, but proceedings are usually held in camera. Although nominally independent, the judiciary is in fact not distinguishable from the executive, which reviews and controls judicial decisions. All judges in the Supreme Court and lower courts are appointed by the President with the advice of the higher judicial council, of which the President is chairman. Judges of the National Security Court generally are military officers posted to the Court.

Law No. 54 of 1970 provides the death penalty for political offenses "against national security," defined as behavior "which may be considered prejudicial to the maintenance of peace, order and good government." Among the 20 offenses punishable by death are "organizing a subversive association" (Article 3), "exploiting religion for creating national disunity" (Article 12), and "publishing antistate propaganda" (Article 18).

In the civil and criminal courts, legal assistance is provided, and there are established rules of evidence. There are no religious courts in Somalia. In civil proceedings relating to family matters, such as marriage and inheritance, the judge may cite prevailing Islamic Shari'a law in rendering decisions. The right to appeal exists in criminal and civil cases but not in cases heard by the National Security Court. For persons convicted by the National Security Court, the only avenue for clemency is through the Politburo of the SRSP.

Only one trial before the National Security Court received publicity in 1989. This was the November conviction and sentencing to death of five persons accused of embezzling funds from the Commercial and Savings Bank. These were the first death sentences announced in Somalia in over a year. It appeared that some of those convicted were still at large. At year's end none of the death sentences had been carried out. By midyear most political prisoners had been released. Most of the thousands of persons detained in July were also released. Few if any detainees were tried and convicted of political offenses.

f. Arbitrary Interference With Privacy, Family, Home, or Correspondence

Under the umbrella of the National Security Act, the security forces routinely search the homes of citizens for weapons and printed material critical of the Government. These searches are carried out without a warrant or the consent of the searched. No probable cause is required (see Section 1.g.). The telephone conversations and mail of suspected persons are

monitored, and anyone in the country suspected of political activity is subject to surveillance.

g. Use of Excessive Force and Violations of Humanitarian Law in Internal Conflicts

About 500,000 people fled the outbreak of fighting in northern Somalia in 1988. A U.S. Government-sponsored 1989 study (the Gersony Report), based on 300 interviews with displaced persons and refugees (many of them eyewitnesses to killings), "conservatively estimated that at least 5,000 unarmed civilians were purposefully murdered by the SAF between May 1988 and March 1989," when the civilians no longer represented a threat to the Somali Armed Forces (SAF) forces. The study also found that the SNM combatants killed hundreds of unarmed civilians in similar indiscriminate fashion. Further, the study found that both sides systematically engaged in grave violations of the internationally protected status of Ethiopian refugees in the refugee camps administered by the United Nations in the area. The Government forcibly conscripted Ethiopian refugees from the camps into the SAF after May 1988. The SNM conducted systematic violent attacks against these camps, killing 400 or more refugees in the process (see also Section 2.d.).

Some of these abuses, apparently sanctioned by the opposing leaderships, were consistent with traditional patterns of clan warfare in an arid land. One of the basic tactics of Somali army forces, for example, was to control the waterholes and deny their use to the SNM. The SNM similarly prevented the Government from repairing the pumping station which once supplied water to Hargeisa. When combating rebels, mutineers, and bandits in the central regions of the country, Somali troops took reprisals against certain villages by driving off livestock and burning houses.

Documented incidents included:

SNM members of the Isaak clan, in fighting around the northern town of Erigavo in March, killed a number of unresisting civilians. Progovernment militias then drove the SNM out of Erigavo and killed about 200 Isaak civilian inhabitants of the town.

Marehan soldiers carried out reprisal killings of about 30 Isaak civilians after a landmine explosion on the Burao-Berbera road in May.

Reacting to rioting in Mogadishu on July 14, military police fired into crowds, killing bystanders as well as rioters. Some innocent persons were killed in their homes by stray rounds. During searches of Mogadishu neighborhoods on subsequent nights, security forces looted houses and assaulted--and occasionally shot--their inhabitants.

In retaliation for the killing of some of their comrades in the July 14 riots, members of the Armed Forces abducted 47 Somali men, took them to an isolated section of beach, and shot them. Reports from witnesses and one survivor indicate that the targets of this execution were members of the Isaak clan, randomly selected and identified by their accents.

In late September, when government forces attacked rebels of the Ogadeni clan near the Kenyan border, troops overran the village of Dobli and killed many of the inhabitants.

P-000752

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 8 of 49 PAGEID #: 1058

P-000753

In November, when government forces attacked several villages near Galkayo in central Somalia in reprisal for a mutiny there, troops reportedly killed a number of civilians outside of immediate combat zones.

There have been other unverified reports of summary executions of rebels in the northern and southwestern regions of the country and of massacres committed by SNM fighters against non-Isaak villages in the north.

The situation remained volatile at the end of 1989. According to the Gersony report, the Government has armed clan-based civilian militias which are not under the effective command of either the SAF or clan elders. These militias were an additional element of continuing instability and lawlessness. Information is lacking on the fate of prisoners taken in Somalia's civil conflict. In general, it seemed that few prisoners were taken. Rebel forces welcomed deserters from government ranks.

Section 2 Respect for Civil Liberties

a. Freedom of Speech and Press

Although freedom of speech is guaranteed by the Constitution, that right continued to be severely abridged in practice. NSS informants frequented public places listening for expressions of antigovernment sentiment; persons were sometimes held responsible for opinions expressed in personal conversations as well as in public forums.

The Government continued to own and operate the radio and television as well as the country's six newspapers. No publications other than those authorized by the Government were legally distributed, and possession of unauthorized newspapers and journals has brought prison sentences of from 5 to 15 years. All printed, taped, and filmed material entering Somalia must be approved by the National Censorship Board. The material is checked for "obscene" as well as politically objectionable content. Academic freedom was not permitted; a Somali law professor with an evident interest in the local human rights situation was detained for several months in 1988 and 1989.

Information on the situation in Somalia was difficult to obtain because throughout the first half of 1989 the Government refused to issue visas to foreign journalists. Several European journalists were permitted to enter the country in the latter part of 1989. An American journalist arrived in Mogadishu in December for a 1-week visit.

b. Freedom of Peaceful Assembly and Association

Although politics is a common topic at informal gatherings of Somalis, and although Article 24 of the Constitution guarantees the right to participate in or organize an assembly or demonstration, in practice the Government only permitted meetings which it sponsored to advance government purposes. Political protest meetings were not permitted.

Freedom of association, though not specifically mentioned, is implicitly provided for in the Constitution, which entitles every citizen to participate fully in political, economic, social, and cultural activities. In practice, however, there was no freedom of association in Somalia in 1989. Having a

business relationship with a person under suspicion was enough to attract the attention of the security services. In March a restaurant owner was detained by the NSS when his restaurant was host to a party for former political prisoners. The only organizations allowed to exist are those approved by the Government and the SRSP.

For a discussion of freedom of association as it applies to labor unions, see Section 6.a.

c. Freedom of Religion

Islam is the state religion and nearly 100 percent of the population is Muslim, predominantly of the Sunni sect. The Constitution states, however, that every person shall be entitled to profess any religion or creed. In practice this means that members of religions other than Islam may practice their faiths but may not proselytize. Mogadishu has a Roman Catholic community numbering about 2,000, which was established during the period of Italian colonial rule. Both Protestant and Catholic houses of worship operate openly. No other religious group has significant representation in Somalia. Christian charitable organizations operate in Somalia but confine their activities to technical assistance.

There is no evidence that the July 9 killing of the Catholic Bishop of Mogadishu was religiously motivated. Nevertheless, the assassination inflamed Muslim-Christian relations. Tension between the communities increased in the first half of 1989, as a revivalist spirit spread within the Muslim community, and some imams accused Christians of proselytizing. During the July disturbances in Mogadishu, there was some violence against Protestant medical missionaries and other persons perceived to be Christians.

Many in the Muslim community attribute Somalia's difficulties to lax observance of Islam. Such views, in addition to raising popular anxiety over Christian proselytizing, also tend to set the Islamic community in opposition to the Government, which has secular roots and a long history of antagonism toward religious leaders. The Government is sensitive to this trend, because it threatens to unite disparate opposition groups under the banner of Islam. Therefore, since 1985 the Government has licensed all mosques and Koranic schools, and since 1986 it has approved all imams and paid them a salary. Tensions between the Government and the Islamic community came to the fore in July, following the Catholic Bishop's assassination. In the investigation of that crime, security forces detained several outspoken imams. These acts provoked more antigovernment criticism within the mosques. The police, alerted to expect trouble on Friday, July 14, ringed the mosques, entered some, attempted to prevent antigovernment sermons, and tried to arrest additional imams. Widespread rioting and many deaths ensued.

Ethiopian Christian refugees sometimes claim that they face persecution in Somalia, but apparently that persecution is based more on nationality than religion.

d. Freedom of Movement Within the Country, Foreign Travel, Emigration, and Repatriation

Police and military checkpoints control travel between towns, in border areas, and in areas of interclan violence. There is, however, no requirement to report residence to the police

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 9 of 49 PAGEID #: 1059

or other government authority. Many Somalis are nomads, and the nomadic tradition remains strong. Travel within Somalia is a freely practiced right. In general, there are no restrictions on international travel for those who can afford it. Passports are available to all citizens and to ethnic Somalis who reside abroad; they generally are not denied on political grounds.

However, the Government restricted the travel of some former detainees and political prisoners by denying them passports or stopping them at the airport. Former political prisoners Suleiman Nuh Ali and Abdi Ismail Yunis were prevented from attending the Muslim pilgrimage. Their passports were confiscated when they tried to depart Somalia at Mogadishu airport. At the end of 1989 their passports had not been returned.

Somalis who have emigrated are generally permitted to return; in 1989 President Siad repeatedly promised amnesty to antigovernment Somalis returning from foreign countries. Nevertheless, based on the experience of previous years, some Somalis remained abroad because they feared possible imprisonment for opposition activity if they returned.

There have been massive displacements of persons as a result of the civil conflict. Many persons have fled to Mogadishu where the population has swollen to over 1.5 million. The Isaak population of northern Somalia has been driven into remote rural areas, and many hundreds of thousands are living in exile in Ethiopia and Djibouti, and fewer in Kenya. Within Hargeisa, about 90 percent of the Isaak homes, businesses, and property have been destroyed or severely damaged. The economic life of northern Somalia has been profoundly disrupted. At the end of 1989, the best estimates indicated that there were 324,000 displaced persons and refugees from Somalia (mainly Isaaks) in Ethiopia and 30,000 in Djibouti.

The Government reports that there are 837,000 Ethiopian refugees in Somalia, but outside observers, including from the United Nations, indicated that about half that number remained in refugee camps at the end of 1989. Conscription of refugees into the Somali army continued in 1989, in violation of international covenants. Spontaneous repatriation of refugees to Ethiopia continued throughout the year, and tripartite negotiations involving Somalia, Ethiopia, and the United Nations High Commissioner for Refugees (UNHCR) made progress on arrangements for officially sponsored voluntary repatriation. In addition to the UNHCR, the International Committee of the Red Cross (ICRC) agreed to participate.

Section 3 Respect for Political Rights: The Right of Citizens to Change Their Government

Citizens have neither the legal right nor the ability peacefully to change their government or the form of their government. The SRSP is the only legal party; opposition groups and criticism of the Government are illegal. However, in August President Siad Barre announced that multiple political parties would be allowed to contest elections to a new People's Assembly by the end of 1990. In November a committee of lawyers began drafting proposed changes in the Constitution that would remove the SRSP from its leading role in state and society, permit the operation of multiple parties, and allow operation of a free press and other institutions of an open society. At the end of 1989 no

practical steps had been taken to implement these proposals. In the present governmental structure, the National People's Assembly has very limited powers.

For many Somalis the traditional clan system is the accepted vehicle of political expression. President Siad Barre and other officials consult frequently with clan elders. Since 1982, however, President Siad has been widely perceived as relying on and furthering the interests of his family and his Marehan subclan by playing off other clans aginst one another. This reliance on the Marehan accelerated in 1989, as the President appointed his son as head of the Armed Forces, another family member as Chief of Police, and Marehan officers as commanders of most military units.

Section 4 Governmental Attitude Regarding International and Nongovernmental Investigation of Alleged Violations of Human Rights

During the first half of 1989, the Government showed a willingness to cooperate with international and other human rights organizations. A visit by Amnesty International, proposed by President Siad in 1988, took place from June 24 to July 2. Officials arranged the meetings requested by the two-man delegation, including with former political prisoners, Prime Minister Samantar, and President Siad. However, a week after the AI delegation's departure, the Bishop of Mogadishu was killed and civil unrest and summary executions followed; and AI has not been invited to return.

The Government has continued cooperation with the ICRC, which is now operating an emergency hospital in Berbera and making preparations to aid in refugee repatriation.

Although there are no human rights organizations as such in Somalia, the Association of Somali Lawyers concerns itself with human rights issues.

Section 5 Discrimination Based on Race, Sex, Religion, Language, or Social Status

Because Somalia is racially homogeneous, there is little racial discrimination as such. Animosities and rivalries based on bloodline and clan affiliation, however, are a fundamental problem at the root of the country's continuing civil conflict. Many persons have capitalized on their clan and family affiliations to gain economic advantage or privilege. The clan differences also have a north versus south aspect. Members of the Isaak clan, who form the bulk of SNM supporters, are increasingly discriminated against because most of them are perceived as opponents of the Government. Although not all Isaaks are persecuted, a disproportionate number of political detainees and victims of extrajudicial executions (e.g., almost all of the 46 in Mogadishu in July) were of that clan.

By tradition Somali women suffer discrimination in education, work, and family matters. Female enrollments in school remain far below those for males at all levels of education for traditional and cultural reasons. The payment of dowry and bride wealth are common marriage customs. Divorce laws and practices strongly favor the male partner.

P-000754

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-2 Filed: 08/09/12 Page: 10 of 49 PAGEID #: 1060

SOMALIA

The Siad Barre Government has historically supported women's rights. In the face of conservative opposition, it rewrote laws to increase women's rights to inherit and own property, made women the legal equals of men, and perhaps most importantly it outlawed female circumcision. The Government's campaign against female circumcision, led by the Somali Women's Democratic Organization of the SRSP, continued to make progress in 1989. Although the practice remained common, especially in rural areas, pharaonic circumcisions (the most extreme and dangerous form of female genital mutilation) became less common.

Domestic violence against women is not a significant social problem in Somalia. There are several interlocking cultural and economic reasons why such practices as wife beating are relatively uncommon. One is that Somalis, being Muslims, do not generally drink alcohol. A second reason is that Somali marriages are contractual, with the wife's relatives prepared to enforce the agreement that she will be treated with dignity. Wife beating carries a stigma which makes it difficult for divorced wife beating males to remarry. Finally economic conditions, which have made it increasingly difficult for men to have more than one or at most two wives, also tend to curtail violence against women. (A veteran police officer, asked whether wife beating was a problem, said that in the days before independence it was common for men to have three or four wives and to treat the less favored of them as beasts of burden, beating the ones who faltered or were lazy. He said that young men of the present generation cannot afford more than one wife, and therefore they are constrained to treat her with respect.)

The civil conflict has, however, had a profoundly negative impact, and it appears that rape by government forces and others has occurred fairly often.

Section 6 Worker Rights

a. The Right of Association

Workers are not free to form independent unions. There is a single labor confederation, the government-controlled General Federation of Somali Trade Unions (GFSTU), is run by government-appointed officials. The GFSTU's main function is to monitor the work force and provide a conduit for worker grievances. The GFSTU is a member of the Organization of African Trade Union Unity and the International Confederation of Arab Trade Unions. Somalia has been a member of the International Labor Organization (ILO) since 1960, but has ratified neither ILO Convention 87 regarding freedom of association nor Convention 98 on collective bargaining.

Strikes are outlawed, and organizing a strike is legally punishable by death. Nevertheless, there was a short transportation strike in 1987, and strikes by quarry workers in 1989. The Government took no action against the striking workers.

b. The Right to Organize and Bargain Collectively

The right to organize does not appear to be infringed by employers. Because the GFSTU speaks for the Government, its dealings with employers on wages, hours, and working

SOMALIA

conditions tend to resemble binding arbitration rather than collective bargaining. Some negotiation between employers and employees goes on outside the union framework. Given the official status of the GFSTU, antiunion discrimination appears to be a moot question. Labor courts adjudicate employer-employee disputes with relative impartiality. There are no export processing zones in Somalia.

c. Forced or Compulsory Labor

Forced or compulsory labor is prohibited by law, but the Government and party occasionally organize campaigns of "voluntary labor" to clean streets or boost production of state-owned factories.

d. Minimum Age for Employment of Children

The minimum age for the employment of children is 15, and persons under 18 are not permitted to work at night or in certain hazardous occupations. The law imposing the requirements, however, is not effectively implemented, and there is considerable child labor on the margins of the wage economy. Children sell cigarettes on the street, carry bags in the market, and watch and clean cars to support themselves and to supplement family incomes.

e. Acceptable Conditions of Work

Somalia has comprehensive labor legislation setting minimum safety and health standards for the workplace. These are applicable to the small, modern wage sector of an economy that is predominantly pastoral and agricultural and are not normally enforced. In theory the workday is 8 hours per day, 6 days per week, with limits on overtime hours. There is no legal minimum wage. Workers are entitled to paid holidays, annual leave, holiday bonuses, and a variety of fringe benefits. In reality, however, the salary scale is extremely low, especially in the public sector. The average salary of a civil servant is equivalent to about $10 per month and is not adequate to maintain a decent standard of living. Productivity in the public sector is correspondingly low, and many civil servants make only minimal appearances in their offices. Workers resort to second jobs, corruption, assistance from other family members, and remittances from abroad to support themselves and their families.

P-000755

Exhibit 2: Amnesty International U.S.A. document titled Suleiman Nuh Ali
(Bates Nos. P-000369-71)

AMNESTY INTERNATIONAL USA

Group 211, Washington, D.C.

National Office: 304 West 58th Street, New York, New York 10019 (212) 582-4440

SULEIMAN NUH ALI

Background

Suleiman Nuh Ali, a 49 year-old architect and civil engineer, has been imprisoned in Somalia since September 1982. He was educated at Allegheny College in Pennsylvania and at Howard University in Washington, D.C. in the late 1960s and 1970s, and then returned to Somalia to become a well-known architect. Nuh Ali was working for the U.S. Agency for International Development at the time of his arrest. Amnesty International believes that he was arrested because he is from the northern part of the country, where the Somali National Movement (SNM), a Somali opposition group seeking to overthrow the government, is based. Nuh Ali is also a member of the Issak tribe, many of whom support the SNM.

Nuh Ali was arrested at his home and imprisoned without charge for over five years. In the Fall of 1987, AI learned that Nuh Ali and several other Somali prisoners of conscience were to be brought to trial on charges of subversive activity that carry a mandatory death sentence.

Nuh Ali was brought to trial on February 1, 1988, and was sentenced to death on February 7, along with several other defendants. AI members, members of Congress, and other concerned people sent hundreds of letters and telegrams protesting the sentence and asking President Barre to commute the sentences. State Department officials met with Somali Ambassador Addou to discuss the cases, and U.S. Ambassador Frank Crigler met with President Barre to express the U.S. concerns about the human rights of the defendants.

A few days later AI members learned that President Barre had commuted all of the death sentences. However, Nuh Ali was sentenced to a long prison term of 24 years.

From testimony smuggled out of prison shortly before the trial, AI learned that Nuh Ali has been tortured in prison. He suffers from torture injuries and eye complaints.

Charges Against Nuh Ali

Nuh Ali, along with about a dozen others, was charged with violating articles 3 and 8 of Law No. 54 (1970), also known as the National Security Law. The charges were described as:

> "Between 1978 and 1982 the accused persons formed and put into operation a subversive group that was aimed at causing

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> chaos to the unity and security of the Somali nation. The accused persons also formed armed groups which on various occasions attacked various parts of the Somali Democratic Republic using lethal equipment. The armed group caused the deaths of several persons and also robbed and destroyed property belonging to people. The accused persons also attcked nomads, robbing them of their livestock." (BBC Summary of the World Broadcasts, 10 February 1988).

Amnesty International believes that Nuh Ali did not receive a fair trial. Although Somalia has not ratified the International Covenant on Civil and Political Rights, article 14(1) of the document states with respect to fair trial:

> ...In the determination of any criminal charges against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. ...

Nuh Ali was tried and sentenced under the provisions of the National Security Law of 1970 which, in AI's view, fails to provide the conditions necessary for a fair trial according to internationally recognized standards. For instance:

- the National Security Court does not appear to operate as an independent judicial body;

- those detained for investigation for an alleged offence under this law may be held indefinitely without being charged and have no right to counsel until formal charges are made;

- defendants have no right of appeal to a higher court, although death sentences require review by the head of the state.

- rules of procedure are arbitrarily applied.

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Prisoners in the February 1988 Trial who are rumored to be missing from Labatan Jirow Prison.

Please note that two men whose names are followed by an asterisk have specifically been named in the rumors; the International Secretariat has not been able to confirm or verify the rumors but remains very concerned about the prisoners listed below. . All of them had been transferred to the Labatan Jirow prison after the trial in February 1988.

Ismail Ali Abokor
Mohamed Abdi Aden
Suleiman Nuh Ali
Abdullahi Jama Ismail Gallal*
Omar Arteh Ghalib
Osman Arteh Ghalib
Osman Mohamed Ghelle
Ahmed Mohamed Halla*
Omar Haji Mohamed
Aden Mohamed Samakab
Abdullahi Jama Samantar
Mohamed Aden Sheikh
Mohamed Yusuf Weirah

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Exhibit 3: Document titled *Background: The Human Rights Situation in the Somali Democratic Republic*
(Bates Nos. P-000892-901)

BACKGROUND

The Human Rights Situation in the Somali Democratic Republic

1. The Somali Revolution

The Somali Armed Forces took power in a bloodless coup d'etat on 21 October 1969 and abolished the constitution and political parties. This followed considerable nationwide dissatisfaction over the corruption, inefficiency and political failures of the civilian government. By 1970 the new Supreme Revolutionary Council (SRC) led by Major General Mohammed Siyad Barre and composed of senior military and police officers, announced that it would adopt a policy of "scientific socialism" based on marxist-leninism but adapted to Somali conditions. The SRC aims were:

1. Honesty and hardwork through the nation, especially in government;

2. Full participation of all citizens (including nomads) in national development;

3. The elimination of "tribalism" (clan factionalism);

4. Removal of dependence on foreign powers or cultures;

5. A pragmatic adaptation of socialism to the Somali context, aimed at equitable economic development and reduction of differences between the elite and the masses, town and country, the employed and the nomads (who compose almost 75% of the population of over four million).

President Siyad Barre has made considerable achievements in these fields, through a blend of authoritarianism, personal charisma, dynamic and honest leadership, and masterful political strategies. Human rights have suffered, but progress has been made in political stability, the maintenance of Somali independence and economic development. Two major achievements were the handling of the effects of the terrible drought of 1974-75 when 200,000 destitute pastoralist nomads were resettled by a massive airlift; and the

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rural literacy and development campaign of July 1974 to March 1975, using the new romanized Somali script, when all students and teachers were sent out into the countryside.

The SRC ruled from 1969 to 1976 with the assistance of civilian ministers, and military control of the country's administration. The instruments of control were (and are):

1. legislation on political offences - see separate section below;

2. political surveillance by very active National Security Force (plain clothes intelligence police) with a network of informers throughout the country, and given powers of summary arrest and arbitrary search on suspicion of political offences. National Security agents have been known to operate outside the country too, often attached to embassies, to keep surveillance on certain Somali nationals;

3. compulsory political education courses for civil servants, military personnel, lecturers and teachers, school-leavers, etc, which includes para-military training; and regular attendance by everyone at "orientation centers";

4. strong control on press and radio through the Ministry of Information and National Guidance, which uses the media for ideological education;

5. the creation of a youth corps (Gulwadayasha - Victory Pioneers) with the task of implementing socialist policy in self-help development schemes - though they do not have supra-legal powers like the Malawi Youth Pioneers, for example.

(originally 21 members)

The SRC/was replaced on 1 July 1976 by the Somali Revolutionary Socialist Party (SRSP) after some years of promises of a political party. This has a central committee composed of all former SRC members, with civilian ministers responsible to it. Major policy-making is carried out by the President, (now Secretary General of the SRSP), his five-man Political Bureau, and the Office of the President (which includes the former Ministry of the Interior). The full Congress of the Party numbers 74 appointed members, and branches are being established in Mogadishu and the fifteen regions and 64 districts of Somalia. Eventually Congress will probably become mainly elective. There has been no change in ideology or policy during the change from the SRC to the SRSP, but a greater stress on national political mobilization may be expected during 1977 and 1978.

2. Somalia's International Relations

The Somali Democratic Republic is a member of the United Nations, the Organization of African Unity (OAU), the Arab League (1973), has signed a Treaty of Friendship and Cooperation with the USSR (July 1974 - following over a decade of Soviet assistance), is an associate member of the European Economic Community (EEC) and signatory of the Lomé Convention. Somalia has good relations with eastern bloc countries (especially USSR, German Democratic Republic and North Korea); the Socialist Republic of China; Arab League countries, (especially Saudi Arabia, Egypt, Sudan, Abu Dhabi); Cuba (receiving a visit from President Fidel Castro in 1977); several African countries, excluding Ethiopia and Libya with whom relations

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are not good.

Somalia's main military assistance has come from the USSR, with considerable assistance too in economic affairs and political control, such as the establishment of the National Security Service. There has never been a Russian naval base at the port of Berbera, but Russian ships have servicing facilities and there are reportedly missile handling facilities (not used) near Berbera. However, Somalia is not a "Soviet satellite" and President Siyad Barre has constantly stressed his pragmatic application of marxist-leninism, which has a Somali rather than Moscow tone, and his fervent pursuit of Somali nationalism and anti-imperialism. Somalia opposes the establishment of foreign bases in Africa, supports the demilitarization of the Indian Ocean, works for the liberation of southern Africa. During early 1977 there were evident strains in the relations with the USSR, following USSR assistance to Ethiopia as United States influence rapidly declined. Somalia has constantly been under pressure from Saudi Arabia and other Arab League countries to take an Arab nationalist (and partly pro-Western) position, and a re-alignment of international relations looks possible during 1977, with Somalia possibly turning more to the Arab world, the EEC and USA for trade, oil, military assistance and political relations. Somalia will however, certainly retain its nationalist policy and its socialist and anti-imperialist ideology. One major issue of 1977 will be the forthcoming independence from France, due to take place in June, of the Territory of the Afars and Issas (TAI - also known as Djibouti), which will affect all international relations in the Red Sea and Indian Ocean. The independence of Djibouti also concerns Somalia's "Greater Somalia" policy of reuniting Somali peoples and their nomadic territory in Djibouti, Ethiopia and Kenya, by peaceful means. Somalia supports secessionist guerrillas in eastern Ethiopia, but in Kenya a policy of detente seems to be fairly firm.

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3. Legislation concerning political offences

i. Preventive Detention Law, 1970

Persons may be detained by the order of a district or regional Revolutionary Council or the National Security Court. This law contains various legal safeguards: evidence has to be given on oath, and the matter has to be reported to the Supreme Revolutionary Council, with the reasons for detention stated. The grounds of detention are "... conducting himself in such a manner as to be dangerous to the peace, order or good government in the Republic, or is intriguing against the Supreme Revolutionary Council or by word or act against the aims or spirit of the revolution". No right of appeal exists and no judicial review is mentioned, though the SRC may revoke the order at any time. Detainees have no rights of legal representation. According to information received by Amnesty International, the legal safeguards in this law have now been removed, and detainees have no rights whatsoever.

ii. The National Security Law of 10 September 1970

This was issued by the Supreme Revolutionary Council with the assent of the President of the Somali Democratic Republic, and overrides civilian judicial and constitutional courts. It contains several articles under which persons can be tried for political offences, including treason and armed rebellion. Some examples are:

> "Any person who directly commits or participates in committing or assisting other people to commit offences adverse or damaging to the independence, unity and security of the Somali State will be liable to be punished with the death sentence and the confiscation of his property by the State." (Article 1)

> "Any person who uses religion for the purpose of breaking up the unity of the Somali people or weakening or damaging the authority of the Somali State shall be punishable by death." (Article 12)

> "Any person who organizes strikes or walkouts from work or similar behaviour aimed at reducing output will be liable to the death penalty." Life imprisonment is the penalty for participating in the organization of strikes, etc., and one to ten years for taking part in them. (Article 17)

> "Any person who spreads or takes out of the Somali Democratic Republic printed, reading, spoken or broadcast matter, or persons in the SDR who display, distribute or disseminate information aimed at damaging the sovereignty of the revolution of the Somali nation will be liable to death. Any person who writes in a newspaper or who has articles in a newspaper written in his name spreading matter described as hostile to the sovereignty of the Somali nation will be liable to a fine of not more than 10,000 shillings (approximately US $1,400), dismissal and confiscation of his property." (Article 18)

Many similar offences are accompanied by the penalty of confiscation of property, which leaves the family dependents destitute, thus extending the

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punishment for a man to his wife (or wives) and children, if not other dependent relatives. Confiscation of a man's property would appear to involve the violation of the rights of women and children in their husbands' and fathers' property.

Further National Security Laws have been passed, not all of which are known to Amnesty International. A "Law of 26 Articles" published around 1972 set long prison terms for offences of tribalism, nepotism, (i.e. favouritism), embezzlement and the peculiar crime of "afminshar-ism", which means approximately "having a mouth like a saw", i.e. spreading malicious gossip. These offences are extremely vague and undefined. *

Note on "Tribalism"

Somalis all belong to one ethnic group, culture, religion and have one language. "Tribe" refers to six major clan groupings and smaller lineages which persons belong to by patrilineal descent (father-to-son), and which are associated with particular regions in Somalia. Many traditional customs are associated with these clans, referring to legal and property rights, inheritance and marriage payemnts etc, but many of these customs have been prohibited by law by the SRC. President Barre opposes "tribalism" (i.e. clan factionalism) in politics, which became dominant in the former government and led to extreme corruption and nepotism. At the same time the traditional relationships are embedded in Somali life and impossible to erase suddenly. It is thought that many accusations of "encouraging tribalism" refer to ordinary non-subversive comments or political gossip, which are punished very harshly indeed.

iii. National Security Courts

These were set up under the National Security Legislation to try offences primarily under National Security Laws. They operate at national, regional and district levels, with a president or vice president (both military officers) and a panel of judges, usually most of whom are military officers with minority judicial representation. Military members of these tribunals rarely have legal training. Defendants in more serious cases are only allowed court appointed lawyers, but since all lawyers are registered in legal cooperatives and employed by the State, the independence of the legal profession is in doubt, even in cases where defendants are permitted a choice of lawyer. In one case known to Amnesty International a defendant's lawyer was not permitted to defend him according to his instructions. Internationally accepted norms of judicial process are not fully followed, for example adjournments are not accepted, there is no right of "privileged access to lawyer"(i.e. confidential communication between defendant and counsel), obstructions are placed in the way of cross-examination of prosecution witnesses, and many judgements have the appearance of being summary. Judges and judiciary members who fail to conform to the dictates of the revolution have also been dismissed or detained, such as the former Minister of Justice and Religious Affairs, detained in 1975, and adopted by Amnesty International as a prisoner of conscience. Trials take place in closed court and the proceedings are not published.

There is a right of appeal to higher security courts, and to the SRC, functioning as a final court of review. Death penalties require

*Addendum: a National Security Law of March 1975, retroactive to January 1975, imposed the death penalty for embezzlement of over 100,000 shillings (US $17,000), life imprisonment for over 50,000 shillings, and 10 to 20 .../ years for less.

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confirmation by the SRC, and effectively therefore by the President of the Republic.

Examples of sentences passed by National Security Courts are as follows:

- Ten Muslim sheikhs were executed by firing squad in public on 23 January 1975 under Article 12 of the National Security Law. They were accused of preaching against a new law of 11 January 1975 issued by the SRC, giving women equal inheritance rights to men, contrary to Somali custom. Twenty-three others were sentenced to long prison terms: 6 to 30 years, 17 to 20 years, for "exploiting religion to cause national disunity and subverting state authority". President Barre later declared, "The government is the representative of religion and is responsible for safeguarding it".

- The former Prime Minister, Mohamed Haji Ibrahim Egal, was sentenced in 1974 to 30 years' imprisonment, 50,000 shillings fine (US $7,000) and ordered to repay 36 million shillings (US $5 million) to the government for corruption while in office 5 years earlier. He had already been detained for 5 years. His property was also confiscated.

- In Togder region in 1974, 12 persons were sentenced to 20-30 years' imprisonment for "distributing anti-government leaflets". Thirteen teachers were sentenced to 7-10 years' imprisonment in April 1975 for striking and refusal to wear uniform while on a Halane political institute course. Twelve students were sentenced at the same time to 20 30 years for "anti-revolutionary activities".

- A sentence of four years for "encouraging tribalism" was passed on Abd -l Qadir Warsame Hersi in June 1976. Two other men were sentenced to 15 years and 30,000 shillings fine for "encouraging favouritism" in employment. The National Security Courts and even regional and district security courts have passed death sentences on persons accused of committing homicide. This represents an extension of security court powers into non-political cases, especially as regards homicide and any cases between the government or government employees and civilians.* The authority of the civil courts and the Supreme Court has been reduced to handling only smaller civil and criminal cases.

It must be mentioned though that the teachers and students mentioned above, and most of the sheikhs and persons sentenced to prison terms on religious charges, were amnestied in October 1975. Former Prime Minister Egal was also amnestied then, together with around 200 (or possibly more) political prisoners.** Death penalties on this anniversary of the revolutim were all commuted and long prison terms reduced. However, other death penalties have been carried out before then and since, and the number is not known. For example in April 1977, two persons were sentenced to death in Western Region and executed. In 1975 the sentences on the ten sheikhs were carried out, and two generals, General Ainanshe Guled, (Vice President of the Republic) and General Salad Gavere were executed in public on 3 July 1972 for attempting a coup d'etat in May 1971.

* There are reports of security courts even judging cases of theft of livestock.

** It was announced that these pardons were "clear proof that true socialist motivation upholds the good traditional character of our nation".

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iv. Penal Code amendments

There have been several amendments to the Somali Penal Code since the revolution, full details of which are not available to Amnesty International. As regards offences where there are political implications, certain charges such as corruption and embezzlement have become very vague and place a very wide category of people in liability of arrest and trial. A characteristic of many of these amendments and national security legislation is that offences as redefined or newly created are made retroactive to the beginning of the Revolution, 21 October 1969. Persons have been tried and convicted retroactively of offences which were not offences, or not so severely punishable, at the time when the offence was committed.

v. Many persons have also suffered violations of their rights in connection with suspicion of having committed a political offence, or being related to a political offender. Especially the wife of a political detainee or person sentenced by a National Security Court suffers, where family property is confiscated. Many persons released after serving their sentence, or amnestied, suffer loss of civil rights such as the right to obtain government employment or seek public office. In effect this bars very many persons from any possible chance of employment, since government is the major employer in Somalia. Furthermore persons have been prohibited from leaving the country, or returning to residence or studies abroad after they have visited Somalia for a short period, or taking up employment in the Middle East or elsewhere which has been offered to them. All persons in these positions are kept under political surveillance and are liable to harrassment by security agents. Somali citizens living abroad or working in international commerce have also been subject to political interference, and some have had their passports withdrawn. Somali authorities consider any contact with foreigners as potentially dangerous and suggestive that a political offence might be committed.

vi. Comments on this legislation

Amnesty International considers that certain aspects of detention and national security legislation violate the Universal Declaration of Human Rights and other international covenants. Defendants in political trials do not obtain fair trial, sentences are excessively harsh, charges are extremely vague and undefined, and detainees have no legal rights. Where offences or penalties are made retroactive, this violates the whole concept and principle of legality. Other fundamental freedoms are also severely restricted in Somalia, the right to travel or the right to free association. It should also be mentioned in this connection that gatherings of more than a very small number of people require government permits, and many social clubs and tea shops have been virtually closed because of surveillance and subsequent action by security agents. Civil servants and military personnel have been summarily dismissed for "failing to adhere to the country's revolutionary* The activity of security agents does not however affect the whole population, and hardly touches the nomads or poorer peasants. It cannot be said there is a "climate of terror" in Somalia, but clearly there is intimidation and systematic repression of political expression outside ideological conformity, which itself is not clearly defined. For example many left wing intellectuals, like Dr Mohammed Jamah Aden, have themselves been detained, though most have been subsequently released. Arrests are a frequent part of urban Somali life, and in their randomness they put a very

*policies". All publications are subject to censorship.

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large part of the educated elite at risk of arrest, detention, and punishment by security courts. There are no authenticated reports of torture, and beatings of those arrested are rare and isolated. However, in respect of fundamental human rights and individual freedoms, this widespread repression does amount to systematic violation of Article 19 of the United Nations Declaration of Human Rights referring to "the right to freedom of opinion and expression". Before the Revolution, freedom of expression was very wide.

It may be claimed by the government that economic rights are much more important than civil and political rights. Amnesty International takes the view that even in a military or one-party state, the protection of individual human rights is vital for full participation in national economic development. The atmosphere of insecurity, the secrecy of information on political trials and detentions, the harrassment of Somalis in their contacts with foreigners, the possibility of persons being persecuted for political reasons on account of personal enmities by security agents or political informers, and the persecution of families of alleged political offenders, all violate international concepts of civil liberties and propagate an atmosphere of distrust. The number of Somalis who have fled abroad because of political persecution, or who fear to return, may amount to several hundreds of persons, though AI has no exact figures.

4. Conditions of Political Imprisonment

Political detainees and those sentenced to prison terms on charges which are basically political, i.e. by security courts, probably number several hundred if not over a thousand. The vast majority are tried by security courts. So far as is known they are all men. The most prominent political prisoners are held in a maximum security prison specially designed for political prisoners, reportedly by German Democratic Republic experts, at Lanta Dur, 50 km south west of Mogadishu near Afgoi. Possibly the greatest number of political prisoners are held at Mogadishu general prison (which is not specifically designed for political offenders) but others are held in regional prisons. The general condition of prisoners (both political and non-political) is poor, and overcrowding, poor food, poor medical facilities are common. However, most prisoners are permitted visits from relatives once a fortnight, and moderate recreational facilities, such as reading material. Those who are detained or have not yet been tried by a security court are normally not allowed visits or correspondence. The position of detainees or those sentenced for political offences who are held at Lanta Dur prison, however, is radically different.

Lanta Dur is specifically designed to hold the most "feared" political prisoners. This is despite the fact that none have been known to have advocated or practised violence, none have a criminal record and none would be likely to attempt violence or escape from prison. The purpose of the mode of imprisonment is political - to change political beliefs and behaviour. This is to be effected by means of a "dehumanization" of the prisoner achieved by severing all contact with the outside world and with other persons. Prisoners are not treated brutally and it is thought no torture is practised

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there. There are 38 one-man cells, and all prisoners are in solitary confinement, forbidden to speak to each other, see each other, or speak to guards except with a single word (e.g. "match" -- request for a match). They are allowed no visitors and no correspondence, and no reading material (except possibly the Koran). They are permitted only a very short exercise period each day, a privilege which may be withdrawn. They do no work or other prison tasks. Food is poor, and it is not known if adequate medical treatment is available. The only relief to prisoners is meditation and prayer, which as Muslims they perform several times each day, praying aloud. Otherwise they would not have permission to use the voice, as conversation with guards beyond specific one-word requests is forbidden. To most prisoners this is a form of mental torture in the sense of deprivation of human contact calculated to destroy a person's nerves.

5. Amnesty International action taken on Somalia

AI has had several adoption and investigation cases since 1969. The largest group was that of members of the civilian government overthrown in 1969 most of whom were eventually amnestied in April 1973, and others in October 1975. Around the sixth anniversary of the October Revolution in 1975, President Barre announced pardon for many political offenders, but according to Amnesty's information, a few detainees were not released. Many others are still serving reduced prison sentences for offences with a political content. AI also adopted a group of teachers imprisoned for striking in 1974, and a number of other individuals imprisoned for various offences such as "encouraging tribalism", "making malicious statements against the government", "indulging in political activities against the principles of the revolution", etc. Only one Somali case was active in April 1977 when a new adoption program was started with twelve prisoners of conscience, two of whom were previous prisoners of conscience, later amnestied, then re-detained. Further cases of political prisoners held under the Detention Law and National Security Legislation will be taken up as further information is received.

AI has also protested against the use of the death penalty, as in the case of the ten Muslim sheikhs executed in January 1975. On the occasion of the amnesty of October 1975, AI wrote to President Barre congratulating him. An AI mission to Somalia has been planned since 1975, but in 1976 the Somali authorities replied that permission could not be received "for the moment" due to the preoccupation of the government with the massive work of resettling nomads affected by the 1975 drought. A further attempt will be made during 1977-78 to gain permission for this mission to take place.

Exhibit 4: October 1988 U.S. Department of State Cable No. 1988MOGADI12222
(Bates Nos. P-000997-1019)

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TO SECSTATE WASHDC PRIORITY 7714
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INFO AMEMBASSY ADDIS ABABA
AMEMBASSY DJIBOUTI
AMEMBASSY NAIROBI

Dept. of State, RPS/IPS, Margaret P. Grafeld, Dir.
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- (C) STATE 296006 (D) STATE 315046
- (E) STATE 336048

1. NOFORN - ENTIRE TEXT.

2. THE FOLLOWING IS POST'S SUBMISSION OF 1988 HUMAN RIGHTS REPORT FOR SOMALIA.

3. BEGIN TEXT:
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PAGE 02 MOGADI 12222 01 OF 09 171048Z

- SOMALIA

SOMALIA'S FORMAL GOVERNMENTAL STRUCTURE INCLUDES THE

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PRESIDENT, THE COUNCIL OF MINISTERS, AND THE NATIONAL PEOPLE'S ASSEMBLY. PRESIDENT MOHAMED SIAD BARRE, WHO SEIZED POWER IN A BLOODLESS COUP IN 1969, IS ALSO HEAD OF THE ARMED FORCES AND SECRETARY GENERAL OF THE SOMALI REVOLUTIONARY SOCIALIST PARTY (SRSP), THE SOLE LEGAL POLITICAL PARTY. IN 1986, PRESIDENT SIAD WAS ELECTED TO A 7-YEAR TERM IN SOMALIA'S FIRST DIRECT PRESIDENTIAL ELECTION, WITH 99.9 PERCENT OF THE VOTE. THE COUNCIL OF MINISTERS IS APPOINTED BY PRESIDENT SIAD. THE MEMBERS OF THE PEOPLE'S ASSEMBLY WERE LAST ELECTED ON A SINGLE SLATE IN 1984, WITH NO PROVISION FOR ALTERNATIVE OR DISSENTING VOTES. INFORMAL AND FORMAL CONSULTATIONS BETWEEN THE LEADERSHIP AND CLAN GROUPS ALSO HAVE A MAJOR IMPACT ON INTERNAL POLITICS.

CONFLICT AMONG SOMALIA'S FIVE MAJOR CLANS AND NUMEROUS SUBCLANS HAS BROKEN OUT REPEATEDLY OVER THE CENTURIES. THE ANTIREGIME SOMALI NATIONAL MOVEMENT (SNM), WHICH FINDS SUPPORT AMONG THE NORTHERN ISAAK CLAN, LAUNCHED ARMED ATTACKS IN NORTHERN SOMALIA IN MAY 1988, KILLING NON-ISAAKS AND SUSPECTED OPPONENTS AND DESTROYING THEIR PROPERTY. IN RESPONDING, THE SOMALI NATIONAL ARMY INFLICTED ADDITIONAL HEAVY DAMAGE ON HARGEISA, THE PRINCIPAL CITY OF THE NORTH, AND ON BURAO. THE MILITARY POLICE, THE UNIFORMED REGULAR POLICE, AND THE NATIONAL SECURITY SERVICE (NSS) BECAME INCREASINGLY ACTIVE IN THEIR PURSUIT OF REBELS AND SUSPECTED DISSIDENTS. THE NSS, CREATED IN 1970, HAS ESSENTIALLY UNLIMITED POWERS OF ARREST, DETENTION, SEARCH, AND CONFISCATION. OVER THE YEARS THE NSS HAS
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PAGE 03 MOGADI 12222 01 OF 09 171048Z

DETAINED THOUSANDS OF PEOPLE FOR POLITICAL OR UNSPECIFIED REASONS, OFTEN FOR YEARS WITHOUT TRIAL. THERE HAVE BEEN NUMEROUS ACCUSATIONS, AND CREDIBLE MEDICAL EVIDENCE, THAT THE NSS TORTURES MANY DETAINEES. SOLDIERS, POLICE, AND GOVERNMENT EMPLOYEES ARE POORLY PAID AND POORLY DISCIPLINED, AND THEREFORE PRONE TO TREAT CITIZENS HARSHLY AND SUBJECT THEM TO EXTORTION.

SOMALIA HAS FEW PROVEN NATURAL RESOURCES, AND MOST OF ITS ESTIMATED 7.7 MILLION PEOPLE MANAGE A BARE SUBSISTENCE AS HERDSMEN OR FARMERS. THE CAPITAL CITY, MOGADISHU, NOW HAS A POPULATION EXCEEDING A MILLION,

MANY OF WHOM ARE UNEMPLOYED MIGRANTS FROM THE COUNTRYSIDE. THE GOVERNMENT IN 1983 INTRODUCED POLICIES TO ENCOURAGE DEVELOPMENT OF THE SMALL PRIVATE SECTOR AND TO INITIATE ECONOMIC REFORMS. KEY FOREIGN EXCHANGE REFORMS WERE REVERSED IN SEPTEMBER 1987, SERIOUSLY WEAKENING THE EXPORT SECTOR WHILE DRYING UP ESSENTIAL IMPORTS AND FORCING UP PRICES IN URBAN MARKETS (INFLATION REACHED 13 PERCENT PER MONTH IN AUGUST 1988). HOWEVER, SINCE MID-1988, THE GOVERNMENT HAS RENEWED ITS COMMITMENT TO IMF-PROPOSED STRUCTURAL REFORMS, INCLUDING STEEP CURRENCY DEVALUATION.

THE HUMAN RIGHTS CONSEQUENCES OF THE WAR IN THE NORTH HAVE BEEN PROFOUND. THE SOMALI ARMED FORCES USED ARTILLERY EXTENSIVELY AGAINST INSURGENTS WHO BARRICADED THEMSELVES IN URBAN AREAS OF HARGEISA AND BURAO, AND BOMBED AND STRAFED ZONES POPULATED BY CIVILIANS. BOTH SIDES HAVE EXECUTED SUSPECTED OPPONENTS. ABOUT 400,000 SOMALIS HAVE FLED THE FIGHTING, INTO ETHIOPIA, DJIBOUTI, MOGADISHU OR THE SOMALI COUNTRYSIDE. THESE REFUGEES' INACCESSABILITY HAS MADE RELIEF WORK DIFFICULT OR IMPOSSIBLE. THE

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PAGE 04 MOGADI 12222 01 OF 09 171048Z

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PAGE 01 MOGADI 12222 02 OF 09 171049Z
ACTION HA-09

INFO	LOG-00	ADS-00	AID-00	INR-10	SS-00	OIC-02	AF-00
	CIAE-00	EB-00	DODE-00	H-01	IO-19	NSCE-00	NSAE-00
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TOWNS OF HARGEISA AND BURAO NOW HAVE LESS THAN A TENTH OF THEIR FORMER INHABITANTS.

THESE CALAMITIES OVERSHADOWED SEVERAL POSITIVE HUMAN RIGHTS DEVELOPMENTS IN SOMALIA DURING 1987-88, INCLUDING THE EXCHANGE AND REPATRIATION UNDER INTERNATIONAL RED CROSS (ICRC) AUSPICES OF SEVERAL THOUSAND ETHIOPIAN PRISONERS OF WAR HELD BY SOMALIA SINCE THE 1977-78 OGADEN WAR; THE TRIAL IN FEBRUARY 1988 AND COMMUTATION OF DEATH PENALTIES BY PRESIDENT SIAD OF 22 SOMALIS WHO HAD BEEN DETAINED WITHOUT
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PAGE 02 MOGADI 12222 02 OF 09 171049Z

CHARGE SINCE 1982; AND TWO GOVERNMENT-HOSTED INTERNATIONAL CONFERENCES DEALING WITH CULTURAL DISCRIMINATION AGAINST WOMEN (NOTABLY, CIRCUMCISION AND INFIBULATION) AND DEFINING GOVERNMENT POLICIES FOR CORRECTING ABUSES.

SECTION 1 RESPECT FOR THE INTEGRITY OF THE PERSON, INCLUDING FREEDOM FROM:

A. POLITICAL KILLING

WHEN THE SNM ATTACKED CITIES IN NORTHERN SOMALIA IN LATE MAY, IT EXECUTED GOVERNMENT OFFICIALS, SUSPECTED OPPONENTS, WAVERING SUPPORTERS, AND NON-ISAAKS. ONE MASS GRAVE IN BURAO CONTAINS THE BODIES OF 71 SUCH VICTIMS. FOREIGN AID WORKERS AND OTHER EYEWITNESSES TO THE FIGHTING IN NORTHERN SOMALIA HAVE STATED THAT WHEN THE GOVERNMENT COUNTERATTACKED, SOLDIERS AND SECURITY AGENTS LINED UP AND SHOT DOZENS AND PERHAPS HUNDREDS OF PERSONS, EITHER BECAUSE THEY WERE

SUSPECTED REBELS OR BECAUSE THEY WERE MEMBERS OF THE ISAAK CLAN WHO ENCOUNTERED GOVERNMENT PATROLS. PRIOR TO THE OUTBREAK OF FIGHTING THERE WERE OCCASIONAL SHOOTINGS BY SECURITY FORCES, PARTICULARLY CURFEW PATROLS.

THE ALLEGATIONS OF EXECUTIONS BY BOTH GOVERNMENT AND ANTI-GOVERNMENT FORCES ARE CREDIBLE, BUT NUMBERS ARE DIFFICULT TO ESTIMATE. POLITICAL KILLINGS OF THIS SORT PROBABLY FLUCTUATE IN DIRECT PROPORTION TO THE INTENSITY OF FIGHTING BETWEEN THE GOVERNMENT AND THE SNM. THERE ARE ALSO CHARGES OF RANDOM KILLINGS BY CURFEW PATROLS, THE MILITARY POLICE, AND THE NSS, BUT
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PAGE 03 MOGADI 12222 02 OF 09 171049Z

CORROBORATING EVIDENCE IS LACKING. BECAUSE NUMBERS OF PEOPLE DETAINED BY THE NSS OVER THE PAST 18 YEARS HAVE NEVER AGAIN BEEN HEARD FROM, IT IS ASSUMED THAT SOME OF THEM WERE KILLED. ON THE OTHER HAND, AMONG DETAINEES TRIED IN 1988 BEFORE THE NATIONAL SECURITY COURT AND SENTENCED TO DEATH, THERE IS NO EVIDENCE THAT ANY WERE ACTUALLY EXECUTED.

B. DISAPPEARANCE

THERE ARE NO RELIABLE FIGURES AS TO UNEXPLAINED DISAPPEARANCES. SUCH INCIDENTS HAVE PROBABLY INCREASED SINCE LATE MAY WHEN THE FIGHTING IN THE NORTH BROKE OUT. AS WITH POLITICAL KILLINGS, GOVERNMENT SECURITY FORCES AS WELL AS INSURGENTS WERE PROBABLY RESPONSIBLE FOR DISAPPEARANCES. MANY HUNDREDS OF CIVILIANS WERE FORCED TO LEAVE HARGEISA AND BURAO ALONG WITH THE INSURGENT FORCES -- AT LEAST SOME OF THEM INVOLUNTARILY -- WHEN THE INSURGENTS FLED THOSE TWO TOWNS; THERE ARE CREDIBLE REPORTS THAT THE REBELS ARE NOW FORCIBLY PREVENTING THEM FROM RETURNING HOME. DISAPPEARANCES ATTRIBUTABLE TO THE GOVERNMENT ARE HARD TO DISTINGUISH FROM ARBITRARY ARRESTS AND DETENTIONS (SECTION 1 D, BELOW) BECAUSE DETENTIONS ARE NOT EXPLAINED OR ACKNOWLEDGED BY THE AUTHORITIES.

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PAGE 01 MOGADI 12222 03 OF 09 171050Z
ACTION HA-09

INFO	LOG-00	ADS-00	AID-00	INR-10	SS-00	OIC-02	AF-00
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P 171026Z OCT 88
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C. TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING
- TREATMENT OR PUNISHMENT

RECURRING REPORTS, SOMETIMES SUPPORTED BY MEDICAL EXAMINATIONS, INDICATE THAT THE NSS AND THE MILITARY POLICE OFTEN TORTURE DETAINEES. METHODS OF TORTURE INCLUDE SUBMERSION IN WATER, ELECTRIC SHOCK, PLACING PRISONERS IN CONTORTED POSITIONS FOR EXTENDED PERIODS, SEVERE BEATING, WOUNDING WITH KNIVES, AND RAPE (OF MALES AND FEMALES). WOUNDS INFLICTED DURING TORTURE SOMETIMES FESTER BECAUSE OF UNSANITARY PRISON
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PAGE 02 MOGADI 12222 03 OF 09 171050Z

CONDITIONS AND DENIAL OF MEDICAL CARE, PERMANENTLY DAMAGING THE HEALTH OF DETAINEES. KIDNEY AILMENTS SEEM COMMON AMONG LONG-TERM PRISONERS. SOMALI OFFICIALS CONSISTENTLY DENY THAT TORTURE IS PRACTICED;

THE NATIONAL SECURITY COURT HAS REFUSED TO ADMIT INTO EVIDENCE ALLEGATIONS OF TORTURE.

SOME POLITICAL DETAINEES IN MAXIMUM SECURITY PRISONS ARE DENIED CONTACT WITH THEIR FAMILIES, AND IN SOME CASES KEPT IN SOLITARY CONFINEMENT IN CELLS AS SMALL AS TWO SQUARE METERS. MEDIUM SECURITY PRISONS HOUSING COMMON CRIMINALS ARE ALSO UNSANITARY AND OVERCROWDED, THOUGH FAMILY VISITS ARE ALLOWED.

D. ARBITRARY ARREST, DETENTION, OR EXILE

ALTHOUGH THE SOMALI CONSTITUTION ACCORDS CITIZENS THE RIGHT TO FORMAL CHARGES AND A SPEEDY TRIAL, THE CRIMINAL CODE WAS MODIFIED IN 1970 TO EXEMPT CRIMES INVOLVING NATIONAL SECURITY FROM TIME LIMITS AND RULES OF PROCEDURE. PERSONS SUSPECTED OF A SEDITIOUS INTENT, OR PERCEIVED AS A POLITICAL THREAT, MAY BE HELD INDEFINITELY WITHOUT BEING BROUGHT TO TRIAL. DETENTIONS BY THE SECURITY SERVICES MAY NOT BE REVIEWED OR OVERTURNED BY THE COURTS. PRECISE ESTIMATES OF THE NUMBER OF DETAINEES ARE IMPOSSIBLE, BECAUSE THE GOVERNMENT DOES NOT DISCLOSE SUCH INFORMATION, BUT THEY PROBABLY NUMBERED IN THE THOUSANDS AT THE HEIGHT OF THE CONFLICT IN THE NORTH; SOME HAVE BEEN RELEASED SINCE FIGHTING SUBSIDED. FOR A DISCUSSION OF FORCED OR COMPULSORY LABOR, SEE SECTION 6 C.

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PAGE 03 MOGADI 12222 03 OF 09 171050Z

THE GOVERNMENT DOES NOT PRACTICE EXILE. IN JULY AND SEPTEMBER 1988 PRESIDENT SIAD BARRE OFFERED AMNESTY TO DISSIDENTS ABROAD WHO WISHED TO RETURN TO SOMALIA.

E. DENIAL OF FAIR PUBLIC TRIAL

THE SOMALI JUDICIAL SYSTEM INCLUDES CIVIL AND CRIMINAL COURTS, HEADED BY THE SUPREME COURT, WHICH ARE OPEN TO THE PUBLIC. THERE IS A SEPARATE NATIONAL SECURITY COURT, AFFILIATED WITH THE NATIONAL SECURITY SERVICE, WHERE PROCEEDINGS ARE NOT USUALLY OPEN TO THE PUBLIC. IN SEPTEMBER 1988, A U.S. CONSUL FOR THE FIRST TIME WAS PERMITTED TO ATTEND A TRIAL OF THE NATIONAL SECURITY COURT. THE PROCEEDINGS WERE SYSTEMATIC;

ATTORNEYS FOR THE DEFENSE APPEARED COMPETENT AND THEY ARGUED THEIR CASE WITH VIGOR; WITNESSES DID NOT APPEAR UNDER DURESS. THE OFFENSE BEING TRIED, POSSESSION OF SEDITIOUS MATERIALS, WOULD NOT HOWEVER BE A CRIME IN THE U.S.

LAW NO. 54 OF 1970 PROVIDES THE DEATH PENALTY FOR POLITICAL OFFENSES "AGAINST NATIONAL SECURITY", DEFINED AS BEHAVIOR "WHICH MAY BE CONSIDERED PREJUDICIAL TO THE MAINTENANCE OF PEACE, ORDER AND GOOD GOVERNMENT". THE LAW DOES NOT DISTINGUISH BETWEEN VIOLENCE AND NON-VIOLENT CRITICISM OR OPPOSITION TO THE GOVERNMENT. IN ITS VERDICTS AND SENTENCES, HOWEVER, THE NATIONAL SECURITY COURT SOMETIMES APPEARS TO MAKE THIS DISTINCTION.

IN THE CIVIL AND CRIMINAL COURTS, LEGAL ASSISTANCE IS PROVIDED, AND THERE ARE ESTABLISHED RULES OF EVIDENCE. THERE ARE NO RELIGIOUS COURTS IN SOMALIA. IN CIVIL PROCEEDINGS RELATING TO FAMILY MATTERS, SUCH

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PAGE 01 MOGADI 12222 04 OF 09 171052Z
ACTION HA-09

INFO	LOG-00	ADS-00	AID-00	INR-10	SS-00	OIC-02	AF-00
	CIAE-00	EB-00	DODE-00	H-01	IO-19	NSCE-00	NSAE-00
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SUBJECT: 1988 HUMAN RIGHTS REPORT - SOMALIA

AS MARRIAGE AND INHERITANCE, THE JUDGE MAY CITE PREVAILING ISLAMIC SHARI'A LAW IN RENDERING DECISIONS.

ALTHOUGH NOMINALLY INDEPENDENT, THE JUDICIARY IS IN FACT NOT DISTINGUISHABLE FROM THE EXECUTIVE, WHICH REVIEWS AND CONTROLS JUDICIAL DECISIONS. ALL JUDGES IN THE SUPREME COURT AND LOWER COURTS ARE APPOINTED BY THE PRESIDENT WITH THE ADVICE OF THE HIGHER JUDICIAL COUNCIL, OF WHICH THE PRESIDENT IS THE CHAIRMAN. JUDGES OF THE NATIONAL SECURITY COURT GENERALLY ARE MILITARY OFFICERS POSTED TO THE COURT.
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PAGE 02 MOGADI 12222 04 OF 09 171052Z

THE RIGHT TO APPEAL EXISTS IN CRIMINAL AND CIVIL CASES, BUT NOT IN CASES HEARD BY THE NATIONAL SECURITY COURT. FOR PERSONS CONVICTED BY THE NATIONAL SECURITY COURT, THE ONLY AVENUE FOR CLEMENCY IS THROUGH THE POLITBURO OF THE SRSP.

F. ARBITRARY INTERFERENCE WITH PRIVACY, FAMILY, HOME OR CORRESPONDENCE

THE NATIONAL SECURITY SERVICE SEARCHES HOMES WITHOUT WARRANTS; THE NSS ALSO MONITORS COMMUNICATIONS AND OPENS MAIL, ALTHOUGH THERE IS NO EVIDENCE THAT SUCH PRACTICES ARE EXTENSIVE.

PRESS GANGS PROVIDE THE MILITARY WITH CONSCRIPTS. AFTER THE OUTBREAK OF FIGHTING IN THE NORTH, THE PRESS GANGS' ACTIVITIES INCREASED GREATLY. PRESS GANGS AND GROUPS POSING AS PRESS GANGS HAVE REPORTEDLY ABDUCTED PEOPLE IN ORDER TO EXTORT MONEY FROM THEIR FAMILIES.

THE SOMALI REVOLUTIONARY SOCIALIST PARTY IS NOT AS ACTIVE AS IT WAS IN ITS EARLY YEARS IN PROPAGANDIZING AND MOBILIZING THE POPULATION. MOBILIZATION CAMPAIGNS STILL TAKE PLACE, HOWEVER, ESPECIALLY DURING THE ANNUAL PREPARATIONS FOR NATIONAL DAY. MEMBERSHIP IN THE SRSP IS A REQUIREMENT FOR HIGHER RANKING OFFICIALS, BUT SEEMS TO BE A FORMALITY, NOT A

SIGNIFICANT IMPOSITION.

C., D., AND E. DETENTION, TORTURE, TRIAL AND IMPRISONMENT: SOME CASE HISTORIES

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PAGE 03 MOGADI 12222 04 OF 09 171052Z

INVESTIGATIONS BY A DELEGATION OF THE U.S. NATIONAL ACADEMY OF SCIENCES, THE CANADIAN CENTRE FOR INVESTIGATION AND PREVENTION OF TORTURE, AND AMNESTY INTERNATIONAL, AS WELL AS INFORMATION COLLECTED BY THE EMBASSY, REVEAL A NUMBER OF CASE HISTORIES OF POLITICAL PRISONERS. THE FOLLOWING HAVE BEEN SELECTED BECAUSE THEY HAVE SOME TIE WITH THE UNITED STATES.

A. SULEIMAN NUH ALI, AN ARCHITECT WHO GRADUATED IN 1971 FROM HOWARD UNIVERSITY IN WASHINGTON, DC. HE WAS ARRESTED ON SEPTEMBER 12, 1982, BY THE NSS, AND HELD UNDER THE PREVENTIVE DETENTION LAW, CHARGED UNDER LAW NO. 54 WITH "CREATING A SUBVERSIVE ORGANIZATION" AND "ESTABLISHING AN ARMED GROUP" WHICH CARRIED OUT AN ASSAULT ON A PRISON AND ATTEMPTED TO ASSASSINATE A MAJOR GENERAL OF THE SOMALI NATIONAL ARMY. ACCORDING TO THE NATIONAL ACADEMY OF SCIENCES, SULEIMAN NUH ALI "IS NOT KNOWN TO HAVE BEEN INVOLVED IN ANTI-GOVERNMENT POLITICAL ACTIVITIES NOR TO HAVE EVER PRACTICED OR ADVOCATED VIOLENCE". AT THE TIME OF HIS ARREST, HE WAS WORKING AS AN ENGINEER AND CONSULTANT FOR USAID. NUH ALI WAS REPORTEDLY MISTREATED DURING THE EARLY DAYS OF HIS DETENTION; HE HAS EYE PROBLEMS BECAUSE HE WAS KEPT CONTINUOUSLY IN ARTIFICIAL LIGHT; HIS CELL MEASURED 1.2 BY 1.8 METERS. IN FEBRUARY 1988, NUH ALI AND 21 OTHER DEFENDANTS WERE BROUGHT TO TRIAL BEFORE THE NATIONAL SECURITY COURT. NUH ALI WAS FOUND GUILTY UNDER LAW NO. 54 AND SENTENCED TO DEATH. THE SENTENCE WAS COMMUTED TO LIFE IMPRISONMENT BY PRESIDENT SIAD BARRE.

B. ABDI ISMAIL YUNIS, A MATHEMATICIAN WHO EARNED A MASTERS DEGREE IN 1972 FROM THE STATE UNIVERSITY OF NEW YORK (SUNY) AT NEW PALTZ. HE WAS ARRESTED IN

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PAGE 01 MOGADI 12222 05 OF 09 171053Z
ACTION HA-09

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	CIAE-00	EB-00	DODE-00	H-01	IO-19	NSCE-00	NSAE-00
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MARCH 1982 WHILE VISITING HIS PARENTS IN HARGEISA, AND LATER CHARGED WITH THE SAME CRIMES AS SULEIMAN NUH ALI UNDER LAW NO. 54. ABDI ISMAIL YUNIS WAS REPORTEDLY TORTURED DURING THE EARLY PERIOD OF HIS CONFINEMENT. TESTICULAR WOUNDS INFLICTED THEN LED TO INFECTIONS. HE IS REPORTED ALSO TO HAVE SUFFERED FROM SKIN IRRITATIONS CAUSED BY TICKS OR MITES, PROBABLE RHEUMATOID ARTHRITIS, AND SEVERE BACK PAIN. HE WAS HELD IN SOLITARY CONFINEMENT AT THE NSS PRISON IN MOGADISHU. THEN IN FEBRUARY 1988 HE WAS ONE OF THE DEFENDANTS BROUGHT TO TRIAL BEFORE THE NATIONAL
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PAGE 02 MOGADI 12222 05 OF 09 171053Z

SECURITY COURT, FOUND GUILTY, AND SENTENCED TO DEATH. THE SENTENCE WAS COMMUTED TO LIFE IMPRISONMENT BY PRESIDENT SIAD BARRE. ABDI ISMAIL YUNIS IS NOW REPORTEDLY IN LABAATAN-JIROW HIGH SECURITY PRISON. HE

IS PERMITTED NO VISITORS AND THERE IS NO NEWS OF HIS PRESENT CONDITION.

C. MOHAMMED BARUD ALI, A CHEMIST EDUCATED IN THE UNITED KINGDOM, WAS DIRECTOR OF THE PEPSI COLA PLANT IN HARGEISA AT THE TIME OF HIS ARREST ON NOVEMBER 4, 1981. BARUD ALI WAS CONVICTED OF ANTI-REVOLUTIONARY ACTIVITIES AND SENTENCED ON MARCH 6, 1982, TO LIFE IMPRISONMENT. HE IS BELIEVED TO BE HELD IN LABAATAN-JIROW PRISON, BUT HAS NOT BEEN SEEN BY HIS FAMILY OR OTHERS IN MORE THAN FIVE YEARS.

D. SAFIA HASHI MADAR, A BIOCHEMISTRY GRADUATE AND TEACHER, WAS WORKING WITH ETHIOPIAN REFUGEES FOR THE U.S.-BASED TRANS CENTURY FOUNDATION WHEN ARRESTED IN HARGEISA IN JULY 1985. NINE MONTHS PREGNANT AT THE TIME OF HER ARREST, SHE WENT INTO LABOR ON THE SECOND DAY OF HER DETENTION. TAKEN TO A HOSPITAL FOR DELIVERY, SHE WAS SEPARATED FROM HER INFANT SON, WAS RETURNED TO PRISON, AND FOR TWO MONTHS RECEIVED NO INFORMATION ABOUT HER CHILD, WHO HAD BEEN PLACED IN THE CARE OF HER FAMILY. SAFIA HASHI MADAR WAS REPORTEDLY BEATEN AND RAPED WHILE IN DETENTION. BROUGHT TO TRIAL IN MAY 1986 BEFORE THE NATIONAL SECURITY COURT, AND CHARGED WITH MEMBERSHIP IN A SUBVERSIVE ORGANIZATION (BELIEVED TO BE THE SNM), SHE WAS DENIED LEGAL REPRESENTATION, CONVICTED, AND SENTENCED TO LIFE IMPRISONMENT. AMNESTY INTERNATIONAL BELIEVES THAT SAFIA HASHI MADAR MAY HAVE BEEN CRITICAL
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PAGE 03 MOGADI 12222 05 OF 09 171053Z

OF THE GOVERNMENT, BUT THAT SHE WAS NOT INVOLVED IN ANY VIOLENT ACTIVITY; SOME OF HER RELATIVES ARE KNOWN TO OPPOSE THE GOVERNMENT AND HAVE ALSO BEEN DETAINED. SAFIA HASHI MADAR IS NOW IN THE CENTRAL PRISON IN MOGADISHU, AND IS REPORTED TO BE SUFFERING FROM A KIDNEY INFECTION, DEPRESSION AND MALNUTRITION.

E. (NOTE: PRIVACY ACT WAIVER NECESSARY BEFORE THIS ITEM MAY BE USED.)

NUR ABBY HUSSEIN, AN AMERICAN CITIZEN WHO WORKED AS A CONSULTANT FOR USAID AND CHEVRON OIL IN SOMALIA, WAS DETAINED FOR TWO MONTHS IN 1986 BY THE NSS, BUT RELEASED AFTER A HEARING BEFORE THE NATIONAL SECURITY

COURT. IN JUNE 1988 HE WAS REARRESTED, AND IN SEPTEMBER 1988 HE WAS TRIED AND CONVICTED BY THE NATIONAL SECURITY COURT ON A CHARGE OF POSSESSING SEDITIOUS MATERIALS -- THREE CASSETTES OF SOMALI POETRY CRITICAL OF THE GOVERNMENT. A U.S. CONSUL WAS PERMITTED TO ATTEND THE TRIAL. THE COURT SENTENCED NUR ABBY HUSSEIN TO FIVE YEARS IMPRISONMENT, AND HE IS NOW IN MOGADISHU CENTRAL PRISON. NUR ABBY HUSSEIN HAS APPARENTLY NOT BEEN ILL-TREATED. HE HAS ALLEGED, HOWEVER, THAT WITNESSES IMPORTANT TO HIS DEFENSE WERE EXCLUDED FROM HIS TRIAL. NUR ABBY HUSSEIN HAS A KIDNEY TRANSPLANT AND OTHER HEALTH PROBLEMS.

SECTION 2 RESPECT FOR CIVIL LIBERTIES, INCLUDING:

A. FREEDOM OF SPEECH AND PRESS

MOST SOMALIS GET THEIR NEWS BY WORD OF MOUTH OR -- CONSISTENT WITH SOMALIA'S STRONG ORAL TRADITION -- BY TRANSISTOR RADIO. EXCEPT FOR RADIO, THE MODERN MEDIA

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PAGE 01 MOGADI 12222 06 OF 09 171054Z
ACTION HA-09

INFO	LOG-00	ADS-00	AID-00	INR-10	SS-00	OIC-02	AF-00
	CIAE-00	EB-00	DODE-00	H-01	IO-19	NSCE-00	NSAE-00
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P 171026Z OCT 88
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ARE NOT IMPORTANT. THE GOVERNMENT DOES NOT ALLOW PUBLIC EXPRESSION OF DISSENTING VIEWS AND OWNS AND OPERATES THE RADIO AND TELEVISION, AS WELL AS THE COUNTRY'S SIX NEWSPAPERS. THE CENTRAL CENSORSHIP BOARD RETAINS CONTROL OVER ALL MEDIA (FOREIGN AND LOCAL), INCLUDING PUBLICATIONS CIRCULATED WITHIN THE COUNTRY -- FILMS, PLAYS, CONCERTS, LECTURES, AND OTHER MEANS OF COMMUNICATION, SUCH AS VIDEOTAPES, WHETHER IMPORTED OR PRODUCED IN SOMALIA. AN EDITOR WAS REPORTEDLY DETAINED IN 1988, AFTER HE RE-RAN AN ARTICLE NO LONGER IN LINE WITH GOVERNMENT POLICIES.
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PAGE 02 MOGADI 12222 06 OF 09 171054Z

IN THE PAST, SOME ITALIAN PUBLICATIONS HAVE BEEN BANNED, AS WELL AS THE QUARTERLY JOURNAL "HORN OF AFRICA" PUBLISHED IN NEW JERSEY BY EXPATRIATE SOMALI AND ETHIOPIAN INTELLECTUALS.

B. FREEDOM OF PEACEFUL ASSEMBLY AND ASSOCIATION

ALTHOUGH SOMALIS GATHER INFORMALLY AT TEAHOUSES AND GOSSIP INCESSANTLY ABOUT POLITICS, MORE FORMAL MEETINGS ARE PERMITTED ONLY WITH GOVERNMENT SPONSORSHIP, TO ADVANCE GOVERNMENT PURPOSES. POLITICAL PROTEST MEETINGS ARE NOT PERMITTED. PROFESSIONAL AND CIVIC ORGANIZATIONS MAY BE FORMED ONLY WITH GOVERNMENT SPONSORSHIP AND PARTICIPATION. THE SRSP IS THE ONLY LEGAL POLITICAL PARTY. UNDER LAW NO. 54, MEMBERSHIP IN AN OPPOSITION GROUP IS PUNISHABLE BY DEATH. FOR A DISCUSSION OF FREEDOM OF ASSOCIATION AS IT APPLIES TO LABOR UNIONS, SEE SECTION 6 A.

C. FREEDOM OF RELIGION

ISLAM IS THE STATE RELIGION OF SOMALIA, AND NEARLY 100 (#)
SOMALIS ARE PERMITTED TO UNDERTAKE
THE HAJJ, AND MANY DO. MEMBERS OF OTHER RELIGIONS MAY PRACTICE THEIR FAITHS FREELY, BUT MAY NOT PROSELYTIZE. MUSLIM CHARITABLE ORGANIZATIONS ARE

PERMITTED TO FUNCTION, AS ARE CHRISTIAN VOLUNTARY ORGANIZATIONS PROVIDED THAT THEY REFRAIN FROM PROSELYTIZING.

SINCE 1985 THE GOVERNMENT HAS LICENSED ALL MOSQUES AND
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PAGE 03 MOGADI 12222 06 OF 09 171054Z

KORANIC SCHOOLS, AND SINCE 1986 IT HAS APPOINTED ALL IMAMS. THE NSS MONITORS SERMONS AND OCCASIONALLY DETAINS RELIGIOUS LEADERS WHOM IT CONSIDERS TOO OUTSPOKEN. THE GOVERNMENT IS SUSPICIOUS OF SHI'ITES, WHETHER SOMALI OR FOREIGN, AND IS ANXIOUS TO PREVENT THE DEVELOPMENT OF RADICAL ISLAMIC MOVEMENTS. LAW NO. 54 PROVIDES THE DEATH PENALTY FOR "EXPLOITING RELIGION FOR CREATING NATIONAL DISUNITY OR SUBVERTING OR WEAKENING STATE AUTHORITY". IN 1987 THE DEATH SENTENCES OF NINE ISLAMIC TEACHERS CONVICTED BY THE NATIONAL SECURITY COURT WERE COMMUTED TO LIFE IMPRISONMENT. THOSE NINE AND SEVERAL OTHER RELIGIOUS PERSONS REMAIN IN PRISON.

D. FREEDOM OF MOVEMENT WITHIN THE COUNTRY, FOREIGN TRAVEL, EMIGRATION, AND REPATRIATION

POLICE AND MILITARY CHECKPOINTS CONTROL TRAVEL BETWEEN TOWNS, IN BORDER AREAS, AND IN AREAS OF INTERCLAN VIOLENCE. THE NORTHERN REGION HAS BEEN UNDER AN 8:00 P.M. TO 5:00 A.M. CURFEW SINCE 1986. IN MAY 1988, WHEN FIGHTING BROKE OUT IN THE NORTH, MASS MIGRATIONS OVERWHELMED THESE TRAVEL CONTROLS. SIGNIFICANT SHIFTS OF POPULATION CONTINUED, AS CITIES SUCH AS BERBERA LOST INHABITANTS WHILE MOGADISHU ABSORBED WAR VICTIMS AND ECONOMIC MIGRANTS IN INCREASING NUMBERS.

SOMALI CITIZENS BETWEEN THE AGES OF 15 AND 40, MALE AND FEMALE, ARE PROHIBITED FROM LEAVING SOMALIA WITHOUT OFFICIAL PERMISSION. THE U.S. EMBASSY CONTINUED THROUGHOUT 1988 TO ISSUE NON-IMMIGRANT AND IMMIGRANT VISAS.

SOMALIS WHO HAVE GONE ABROAD ARE PERMITTED TO RETURN.

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PAGE 04 MOGADI 12222 06 OF 09 171054Z

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PAGE 01 MOGADI 12222 07 OF 09 171056Z
ACTION HA-09

INFO	LOG-00	ADS-00	AID-00	INR-10	SS-00	OIC-02	AF-00
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E.O. 12356: N/A
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SUBJECT: 1988 HUMAN RIGHTS REPORT - SOMALIA

TWICE IN 1988 PRESIDENT SIAD BARRE PROMISED AMNESTY TO ANTI-GOVERNMENT SOMALIS RETURNING FROM FOREIGN COUNTRIES.

SOMALIA HOSTS AN UNKNOWN NUMBER OF REFUGEES FROM ETHIOPIA. THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES (UNHCR) PROVIDES FOODSTUFFS FOR 870,000, BUT MOST OBSERVERS AGREE THAT LITTLE MORE THAN 350,000 PERSONS ARE FULL-TIME RESIDENTS OF THE REFUGEE CAMPS. THE PROGRAM OF SUPPORTING REFUGEES FROM ETHIOPIA CONTINUES DESPITE THE WAR IN THE NORTH AND THE EXODUS
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PAGE 02 MOGADI 12222 07 OF 09 171056Z

OF SOMALIS INTO ETHIOPIA. THE GOVERNMENT HAS SUPPLIED ARMS TO AN UNDETERMINED NUMBER REFUGEES TO FIGHT THE SNM INSURGENTS IN THE NORTH. SOME REFUGEES HAVE BEEN CONSCRIPTED; OTHERS HAVE APPARENTLY JOINED THE GOVERNMENT SIDE VOLUNTARILY, AT LEAST IN PART BECAUSE OF LONGSTANDING ENMITY BETWEEN THE OGADENI (REFUGEE) AND ISAAK (SNM) CLANS.

THE GOVERNMENT IS APPEALING TO SOMALIS WHO FLED ACROSS THE BORDERS INTO ETHIOPIA AND DJIBOUTI TO RETURN TO THEIR HOMES. IT HAS ACCUSED THE SNM OF DRIVING THE POPULATION OUT OF THE NORTHERN TOWNS AND FORCING THEM TO STAY IN THE COUNTRYSIDE. ACCORDING TO WAR VICTIMS REACHING MOGADISHU FROM THE NORTH, THERE IS TRUTH TO THESE CHARGES.

SECTION 3 RESPECT FOR POLITICAL RIGHTS: THE RIGHTS OF CITIZENS TO CHANGE THEIR GOVERNMENT

SOMALIA HAS ONLY ONE INDIGENOUS ETHNIC GROUP, THE SOMALI, WHICH IS DIVIDED INTO CLANS AND SUBCLANS. CLAN IDENTIFICATION IS VERY STRONG, AND FOR MANY SOMALIS THE TRADITIONAL CLAN SYSTEM IS THE ACCEPTED VEHICLE OF POLITICAL EXPRESSION. PRESIDENT SIAD BARRE AND OTHER OFFICIALS CONSULT FREQUENTLY WITH CLAN LEADERS. SINCE 1982, HOWEVER, THE PRESIDENT HAS BEEN WIDELY PERCEIVED AS FURTHERING THE INTERESTS OF HIS FAMILY AND HIS MAREHAN SUBCLAN RATHER THAN BALANCING THE INTERESTS OF ALL CLANS. FACED WITH DIFFICULTIES IN PLACATING OTHER CLANS, THE PRESIDENT HAS FALLEN BACK INCREASINGLY ON HIS ROLE AS COMMANDER OF THE ARMED FORCES AND SECRETARY GENERAL OF THE SRSP TO MAINTAIN HIMSELF IN POWER.
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PAGE 03 MOGADI 12222 07 OF 09 171056Z

THE SRSP IS THE ONLY LEGAL PARTY; OPPOSITION GROUPS AND CRITICISM OF THE GOVERNMENT ARE ILLEGAL. THUS THE PEOPLE HAVE NEITHER THE LEGAL RIGHT NOR THE ABILITY PEACEFULLY TO CHANGE THEIR GOVERNMENT OR THE FORM OF THEIR GOVERNMENT. IT IS CONCEIVABLE, HOWEVER, THAT

OVERWHELMING CONSENSUS AND SUSTAINED PRESSURE FROM CLAN ELDERS COULD BRING ABOUT PEACEFUL CHANGES IN THE GOVERNMENT.

VOTING FOR THE 171-MEMBER PEOPLE'S ASSEMBLY ENTAILS ONLY A VOTE FOR OR AGAINST THE SRSP'S NATIONAL SLATE, ALTHOUGH CANDIDATES NEED NOT NECESSARILY BE PARTY MEMBERS TO BE INCLUDED ON THE SLATE. PRESIDENT SIAD BARRE WAS THE SOLE CANDIDATE FOR PRESIDENT IN 1986, AND WAS REELECTED TO A SEVEN-YEAR TERM WITH 99.9 PERCENT OF THE VOTE.

SOMALIA'S TRADITIONAL AND MODERN POLITICS ARE MALE DOMINATED. THERE ARE A FEW WOMEN MEMBERS OF THE PEOPLE'S ASSEMBLY AND PARTY CENTRAL COMMITTEE, TWO WOMEN VICE MINISTERS AND A WOMAN AMBASSADOR, BUT THEY EXERCISE LITTLE POWER. THE SOMALI WOMEN'S DEMOCRATIC ORGANIZATION, THOUGH SUBORDINATE TO THE PARTY, HAS ADVOCATED GREATER POLITICAL PARTICIPATION AND MOBILIZATION FOR WOMEN. IT HAS ALSO ATTEMPTED TO MOBILIZE PUBLIC OPINION AGAINST THE PRACTICE OF FEMALE CIRCUMCISION, AND HAS SUCCESSFULLY GENERATED THE SUPPORT OF THE GOVERNMENT, THE PARTY AND SOMALI RELIGIOUS LEADERS FOR PROHIBITION OF THIS PRACTICE.

SECTION 4 GOVERNMENTAL ATTITUDE REGARDING
- INTERNATIONAL AND NON-GOVERNMENTAL
- INVESTIGATION OF ALLEGED VIOLATIONS OF

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PAGE 01 MOGADI 12222 08 OF 09 171057Z
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SUBJECT: 1988 HUMAN RIGHTS REPORT - SOMALIA

- HUMAN RIGHTS

APPARENTLY AS A RESULT OF INTERNATIONAL PRESSURE, IN FEBRUARY 1988, THE GOVERNMENT BROUGHT TO TRIAL 22 PERSONS WHO HAD BEEN DETAINED WITHOUT CHARGES SINCE 1982. AFTER THE NATIONAL SECURITY COURT PRONOUNCED EIGHT DEATH SENTENCES IN THESE CASES, PRESIDENT SIAD BARRE COMMUTED THEM TO LIFE IMPRISONMENT.

ALTHOUGH THE GOVERNMENT HAS GENERALLY NOT REPLIED TO INQUIRIES BY HUMAN RIGHTS ORGANIZATIONS, IT DID PERMIT
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PAGE 02 MOGADI 12222 08 OF 09 171057Z

A VISIT OF INQUIRY IN 1987 BY THE COMMITTEE ON HUMAN RIGHTS OF THE U.S. NATIONAL ACADEMY OF SCIENCES. ONLY ONE OF THE DELEGATION'S REQUESTS WAS GRANTED FOR APPOINTMENTS WITH SOMALI GOVERNMENT OFFICIALS. THE NATIONAL ACADEMY'S REPORT, "SCIENTISTS AND HUMAN RIGHTS IN SOMALIA", WAS PUBLISHED IN JANUARY, 1988.

IN SEPTEMBER 1988, AFTER THE PUBLICATION BY AMNESTY INTERNATIONAL OF A REPORT ENTITLED "SOMALIA: A LONG-TERM HUMAN RIGHTS CRISIS," PRESIDENT SIAD INVITED AN AMNESTY INTERNATIONAL DELEGATION TO VISIT SOMALIA.

BETWEEN AUGUST 23 AND SEPTEMBER 1, 1988, THE INTERNATIONAL COMMITTEE OF THE RED CROSS (ICRC), MAKING TWENTY FLIGHTS IN A BOEING 707, REPATRIATED 3,543 ETHIOPIAN, 246 SOMALI, AND ONE CUBAN PRISONER OF WAR HELD SINCE THE 1977-78 OGADEN WAR. ALTHOUGH THERE IS A LIST OF MISSING PERSONS WHO MAY HAVE BEEN HELD PRISONER, THE ICRC'S PRISONER EXCHANGE HAS BEEN BASICALLY COMPLETED. ICRC REPRESENTATIVES HAVE NOT

BEEN PERMITTED TO MEET WITH SOMALI POLITICAL PRISONERS. ALTHOUGH THE ICRC HAS BEEN ALLOWED TO VISIT THE NORTH AS PART OF GOVERNMENT-ORGANIZED TRIPS FOR DONORS IN CONNECTION WITH EMERGENCY ASSISTANCE, IT HAS NOT YET BEEN GRANTED PERMISSION TO TRAVEL WITHOUT GOVERNMENT ESCORT.

THERE ARE NO SOMALI ORGANIZATIONS WHICH ADDRESS HUMAN RIGHTS ISSUES. IN TRIALS BEFORE THE NATIONAL SECURITY COURT, HOWEVER, INDIVIDUAL LAWYERS HAVE ARGUED THAT THEIR CLIENTS' HUMAN RIGHTS WERE VIOLATED.

SECTION 5 DISCRIMINATION BASED ON RACE, SEX,
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PAGE 03 MOGADI 12222 08 OF 09 171057Z

RELIGION, LANGUAGE OR SOCIAL STATUS

ESPECIALLY SINCE THE OUTBREAK OF FIGHTING IN MAY 1988, THERE HAVE BEEN ALLEGATIONS OF GOVERNMENT DISCRIMINATION AGAINST ISAAK BUSINESSMEN. ISAAKS' BANK ACCOUNTS AND OTHER ASSETS HAVE BEEN SEIZED ON SUSPICION THAT THEY WERE COLLABORATING WITH THE SNM. ISAAK BUSINESSMEN HAVE SUFFERED OTHER SETBACKS, BUT IT IS NOT CLEAR IF THESE ARE DISCRIMINATION-RELATED. FOR EXAMPLE, THE ANNUAL HAJJ-SEASON EXPORTS OF LIVESTOCK TO SAUDI ARABIA FROM BERBERA WERE DISRUPTED BECAUSE THEY COINCIDED WITH THE OUTBREAK OF THE FIGHTING.

NATION-WIDE, LIVESTOCK EXPORTS IN 1988 WERE ALSO SEVERELY CURTAILED DUE TO THE GOVERNMENT'S POLICY OF OVERVALUING THE SHILLING.

MEMBERS OF CERTAIN CLANS AND SOME INDIVIDUALS CAPITALIZE ON THEIR POLITICAL CONNECTIONS TO GAIN ECONOMIC ADVANTAGE OR PRIVILEGE, BUT THERE IS NO OVERT DISCRIMINATION AGAINST PEOPLE WHO LACK SUCH OPPORTUNITIES. THERE IS NO DISCRIMINATION IN ACCESS TO EDUCATION AND HEALTH SERVICES ON CLAN OR ETHNIC GROUNDS, BUT THESE SERVICES ARE AVAILABLE ONLY IN LARGER URBAN AREAS OF THE COUNTRY. THE FIGHTING IN THE NORTH HAS CLOSED SCHOOLS THERE AND MADE MEDICAL CARE MORE DIFFICULT TO OBTAIN. ALTHOUGH GIRLS ARE FREE TO ATTEND SCHOOLS, THEIR ENROLLMENTS REMAIN FAR BELOW THOSE FOR MALES AT ALL LEVELS OF EDUCATION FOR TRADITIONAL AND CULTURAL REASONS.

ALTHOUGH THEY HAVE CONSIDERABLE INHERITANCE AND OWNERSHIP RIGHTS, SOMALI WOMEN SUFFER FROM TRADITIONAL DISCRIMINATION IN WORK AND FAMILY MATTERS. PRACTICES

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PAGE 01 MOGADI 12222 09 OF 09 171058Z
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SUCH AS FEMALE CIRCUMCISION REMAIN PREVALENT DESPITE THE GOVERNMENT'S ADOPTION IN 1988 OF A POLICY PROHIBITING THIS PRACTICE. THE PAYMENT OF DOWRY AND BRIDE WEALTH ARE COMMON MARRIAGE CUSTOMS. DIVORCE LAWS AND PRACTICES STRONGLY FAVOR THE MALE PARTNER.

SECTION 6 WORKER RIGHTS

A. AND B. RIGHT OF ASSOCIATION; RIGHT TO ORGANIZE AND BARGAIN COLLECTIVELY

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PAGE 02 MOGADI 12222 09 OF 09 171058Z

WORKERS ARE NOT FREE TO ORGANIZE INDEPENDENT UNIONS. THERE IS A SINGLE LABOR CONFEDERATION, THE GENERAL FEDERATION OF SOMALI TRADE UNIONS (GFSTU), WHICH IS GOVERNMENT-CONTROLLED, WITH GOVERNMENT-APPOINTED OFFICIALS. THE GFSTU'S MAIN FUNCTION IS TO MONITOR THE WORK FORCE AND PROVIDE A CONDUIT FOR WORKER GRIEVANCES. THE GFSTU IS A MEMBER OF THE ORGANIZATION OF AFRICAN TRADE UNION UNITY AND THE INTERNATIONAL CONFEDERATION OF ARAB TRADE UNIONS. IT PARTICIPATES IN THE INTERNATIONAL LABOR ORGANIZATION. ORGANIZING A STRIKE IS PUNISHABLE BY DEATH. NEVERTHELESS THERE WAS A TRANSPORTATION STRIKE IN 1987; NO KNOWN DEATH SENTENCES RESULTED FROM IT.

C. FORCED OR COMPULSORY LABOR

PRISONERS MAY PERFORM LABOR AS PART OF THEIR PENAL SERVITUDE. IN OTHER RESPECTS COMPULSORY LABOR IS NOT PERMITTED. THE GOVERNMENT AND PARTY OCCASIONALLY ORGANIZE CAMPAIGNS, HOWEVER, OF "VOLUNTARY LABOR" TO CLEAN STREETS OR BOOST PRODUCTION OF STATE-OWNED FACTORIES.

D. MINIMUM AGE FOR EMPLOYMENT OF CHILDREN

THE MINIMUM AGE FOR EMPLOYMENT OF CHILDREN IS 15, AND PERSONS UNDER 18 ARE NOT PERMITTED TO WORK AT NIGHT OR IN CERTAIN HAZARDOUS OCCUPATIONS. THE LEGISLATION, HOWEVER, IS NOT EFFECTIVELY IMPLEMENTED AND THERE IS CONSIDERABLE CHILD LABOR ON THE MARGINS OF THE ECONOMY. CHILDREN SELL CIGARETTES ON THE STREET, CARRY BAGS IN THE MARKET, AND WATCH AND CLEAN CARS TO SUPPORT THEMSELVES AND/OR TO SUPPLEMENT FAMILY INCOMES.
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PAGE 03 MOGADI 12222 09 OF 09 171058Z

E. CONDITIONS OF WORK

SOMALIA HAS COMPREHENSIVE LABOR LEGISLATION SETTING MINIMUM SAFETY AND HEALTH STANDARDS FOR THE WORKPLACE. THESE ARE APPLICABLE TO THE SMALL MODERN SECTOR OF AN ECONOMY THAT IS PREDOMINANTLY PASTORAL

AND AGRICULTURAL. IN THEORY THE WORKDAY IS EIGHT HOURS PER DAY, 48 HOURS PER WEEK, WITH LIMITS ON OVERTIME HOURS. WORKERS ARE ALSO ENTITLED TO PAID HOLIDAYS, ANNUAL LEAVE, HOLIDAY BONUSES, AND A VARIETY OF FRINGE BENEFITS. IN REALITY, HOWEVER, THE SALARY SCALE IS EXTREMELY LOW, ESPECIALLY IN THE PUBLIC SECTOR. THE AVERAGE SALARY OF A CIVIL SERVANT IS ABOUT USD 10 PER MONTH. PRODUCTIVITY IN THE PUBLIC SECTOR IS CORRESPONDINGLY LOW, AND MANY CIVIL SERVANTS MA
E MINIMAL APPEARANCES IN THEIR OFFICES. WORKERS RESORT TO SECOND JOBS, CORRUPTION, ASSISTANCE FROM OTHER FAMILY MEMBERS, AND REMITTANCES FROM ABROAD TO SUPPORT THEMSELVES AND THEIR FAMILIES. A PROGRAM OF CIVIL SERVICE REFORM HAS MADE LITTLE HEADWAY BECAUSE INFLATION HAS NULLIFIED SALARY INCREASES.

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total of 962 pages of documentary evidence as well as the information for all potential experts and eye-witnesses.

4. Defendant has failed to comply with his discovery obligations and never once advised Plaintiff of his difficulty in doing so, most recently with the Court's July 9, 2012, Order on Protective Order Compliance.

5. To date Defendant has not produced a single document or provided any of the additional information required.

6. Attached as Exhibit 1 is a true and correct copy of the 1989 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. (P-000749-55).

7. Attached as Exhibit 2 is a true and correct copy of the Amnesty International U.S.A. document titled Suleiman Nuh Ali (Bates Nos. P-000369-71).

8. Attached as Exhibit 3 is a true and correct copy of the document titled *Background: The Human Rights Situation in the Somali Democratic Republic* (Bates Nos. P-000892-901).

9. Attached as Exhibit 4 is a true and correct copy of the October 1988 U.S. Department of State Cable No. 1988MOGADI12222 (Bates Nos. P-000997-1019).

10. Attached as Exhibit 5 is a true and correct copy of the June 1982 International Commission of Jurist Review document titled *Somalia* (Bates Nos. P-000881-83).

11. Attached as Exhibit 6 is a true and correct copy of the June 16, 1988, Amnesty International document titled *Fear of Torture/Legal Concern*, AI Index: AFR 52/17/88 (Bates Nos. P-000022-23).

12. Attached as Exhibit 7 is a true and correct copy of the July 14, 1988, Hearing Before the Subcomm. on Africa of the House Committee on Foreign Affairs, 100th Cong., titled *Reported Massacres and Indiscriminate Killings in Somalia*, (Bates Nos. P-000139-68).

13. Attached as Exhibit 8 is a true and correct copy of the May 1989 U.S. Department of State Cable No. 1989MOGADUI5258 (Bates Nos. P-000728-38).

14. Attached as Exhibit 9 is a true and correct copy of the January 1, 1990, *Human Rights Watch World Report 1989 – Somalia* (Bates Nos. P-000768-73).

15. Attached as Exhibit 10 is a true and correct copy of the 1990 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. (P-000756-62).

16. Attached as Exhibit 11 is a true and correct copy of the 1991 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. (P-000763-67).

17. Attached as Exhibit 12 is a true and correct copy of the November 17, 2010, Defendant's Responses to Plaintiff's First Set of Interrogatories.

18. Attached as Exhibit 13 is a true and correct copy of the December 1989 U.S. Department of State Cable No. 1989MOGADI14054 (Bates Nos. P-000905-16).

19. Attached as Exhibit 14 is a true and correct copy of the May 24, 2012, Plaintiff's Second Set of Interrogatories to Defendant.

20. Attached as Exhibit 15 is a true and correct copy of the April 20, 2000, Amnesty International letter from Dr. Martin Hill regarding Plaintiff Abukar Hassan Ahmed (Bates Nos. P-000917-20).

21. Attached as Exhibit 16 is a true and correct copy of the photographs of Plaintiff Abukar Hassan Ahmed's scars (Bates Nos. P-000812-14).

22. Attached as Exhibit 17 is a true and correct copy of the March 5, 2012, email and letter from Plaintiff to Defendant attaching the Notice of Deposition.

23. Attached as Exhibit 18 is a true and correct copy of the March 22, 2012, email and letter from Plaintiff to Defendant attaching the subpoena.

24. Attached as Exhibit 19 is a true and correct copy of the April 3, 2012, email and letter from Plaintiff to Defendant reminding him about the Court's Discovery Order.

25. Attached as Exhibit 20 is a true and correct copy of the medical records of the Abukar Hassan Ahmed submitted *in camera* (Bates Nos. P-000821-29, P-000833-80).

26. Attached as Exhibit 21 is a true and correct copy of the May 31, 2012, Expert Report of Dr. Coleen Kivlahan M.D., MSPH submitted *in camera* (Bates Nos. Kivlahan_0001-30).

27. Attached as Exhibit 22 is a true and correct copy of the May 31, 2012, Expert Report of Dr. Stuart Lorin Lustig, M.D., M.P.H. submitted *in camera* (Bates Nos. Lustig_0001-15).

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 6th day of August 2012

Christina Georgia Hioureas

DAWN M. DELROSSI
Notary Public, State of New York
No. 01DE4884120
Qualified in Nassau County
Commission Expires Jan. 26, 2015

Exhibit 5: June 1982 International Commission of Jurists Review document titled *Somalia*
(Bates Nos. P-000881-83)

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SOMALIA

INTERNATIONAL COMMISSION OF JURISTS REVIEW, JUNE 1982

In March 1982 the government of Somalia lifted the state of emergency which had been declared on October 21, 1980, at the height of the refugee flood from the Ogaden, and under which the constitution had been suspended. To follow the effects of this return to constitutional rule, it is necessary to review briefly some of the events and legislation since independence in 1960.

Between 1960 and 1969, Somalia enjoyed a parliamentary democracy and a good measure of political stability. Two general elections were held, three governments succeeded each other, and the first president of the Republic was replaced, all in keeping with the constitution and the democratic institutions of the country. There were no political prisoners in the country, and human rights violations were never reported.

However, a long-lasting and severe drought in the country, coupled with a hotly contested and controversial election in March 1969, and the assassination of the President of the Republic, gave the army leaders the opportunity to stage a coup. At first this was welcomed by those who were discontented with the record of the civilian administration, but their enthusiasm soon died down when they discovered the oppressive nature of the military rule, with mass detentions and executions, elimination of all civil and political rights, and the creation of a highly repressive security network.

The National Security Service

Immediately after the military take-over, the democratic constitution was abrogated, and all political and professional associations banned. A Supreme Revolutionary Council (SRC) governed the country by decree, exercising legislative, executive and judicial powers.

One of the first decrees issued by the SRC established a national security service (NSS) empowered to arrest, detain and imprison for an unlimited period of time any person "behaving in a manner which may be considered prejudicial to the maintenance of peace, good order and correct administration". The same measures may also be applied to anyone who "by word or by action acts against the objectives or the spirit of the Revolution" (Law No. 1 of January 10, 1970). The writ of *habeas corpus* was abolished by Presidential Decree No. 64 of October 10, 1970. The NSS is headed by the President's son-in-law, Brig. Gen. Ahmed S. Abdulle, who is also a member of the SRC, and is staffed by clansmen of the President.

Para-military groups were also created in each neighbourhood or district with power to arrest anyone suspected of 'counter-revolutionary' activities. These groups, known as the "Guulwadayal", have their own prisons in Mogadishu and in all provincial capitals. A detention order by the NSS or the Guulwadayal cannot be appealed from nor questioned in the courts. The two groups act with impunity, and hold thousands of individuals at any one time in detention camps and special prisons, carrying out torture, beatings and prolonged interrogations.

The chief of the "Guulwadayal" is another son-in-law of the President.

The National Security Court

The third arm of the special security system is constituted by the National Security Court. This court was established by Decree Law No. 3 of January 10, 1970, i.e. three months after the army take-over. The main seat of the Court is in Mogadishu, but regional sections have been created all over the country. All the judges of the Court are members of the armed forces appointed by the President. The procedure is that of military tribunals. No legal qualifications are required for such appointment, and none of the present judges has had a legal education. A few civilian advisers with legal education have occasionally been appointed to assist the military judges of the court.

The court has a special prosecutor known as the Attorney General of the Security Court, who is assisted by several prosecutors. All members of the prosecutor's office are either from the army, the police, or the national security service. The special prosecutor and his representatives enjoy an unlimited power of arrest, search, detention and sequestration, not only of property, but of persons as well. The sequestration of persons, causing their indefinite disappearance, or detention in unidentified places, is therefore legally sanctioned (Article 2(4) of Decree Law No. 3 of January 10, 1970).

The court has jurisdiction over offences provided for by Decree Law No. 1 of January 10, 1970 (see below 'power to detain'); Decree Law No. 54 of September 10, 1970, and Decree Law No. 67 of November 1, 1970, as well as the following crimes contained in the Somali Penal Code: crimes against 'the personality of the State', crimes against public order, and crimes against the public administration when committed by public officers.

The decree of September 10, 1970, containing 26 articles, provides for many security offensives. For example, Article 19 provides that "whoever possesses any seditious printed, typed, taped or written material against the State shall be punished with imprisonment for a term of five to fifteen years". Under Article 21, "whoever spreads any rumour against the Somali Democratic Republic, the authorities of the State or the State policies" is punishable with two to ten years imprisonment.

Decree Law No. 17 of April 7, 1970, has abolished the right of a detainee to consult or see upon arrest his defence lawyer. He is able to see a lawyer only "after the end of all investigations". Decree Law No. 8 of January 26, 1970, has amended article 151 of the criminal procedure code to read:

"No confession by any person shall be used as against such person unless the confession is made before a judge. This restriction on confession as evidence shall not, however, *be applicable in cases falling within the jurisdiction of the national security court*" (emphasis added).

It is alleged that the majority of the individuals brought up to now before the court have been prosecuted and judged on the basis of confessions extracted through torture. The decisions of the court are final and cannot be appealed, except in the form of an application for pardon.

Judgments of the regional and district sections of the Court are also final.

Power to Detain

Law No. 1 of 10 January 1970, aptly entitled "power to detain", provides that the Regional or District Revolutionary Councils have the power to detain any person in the territory of Somalia so long as they may consider it necessary, and whenever it is proved by evidence on oath to the satisfaction of such organs that such a person (a) is conducting himself so as to be dangerous to the peace, order or good government in the Democratic Republic of Somalia, (b) is intriguing against the Supreme Revolutionary Council, or (c) by word or by action, acts against the aims and spirit of the Revolution.

On the basis of this wide-ranging permission to arrest and detain, the above mentioned organs have imprisoned, deported and persecuted tens of thousands of Somalis in the last ten years.

Since 1977 a proliferation of the security services and other organs of repression has taken place. Thus, in addition to the NSS, the following authorities carry out arrests and detention:

1) the agents of the Party Control Committee;
2) the Guulwadayaal (Victory pioneers), which now form part of the national militia forces;
3) the agents of the security services of the First lady, Mme Khadija, and
4) the agents of the National Committee for the eradication of corrupt practices in the public administration, chaired by Gen. Mohamud Ghelle, President of the Security Court.

The first three organs have their own special prisons and "safe houses" in Mogadishu, while the fourth usually takes detainees to the Central prison of Mogadishu.

Since all these organs are assimilated by the regime to the national security service, and are practically considered as special but independent branches of this service, they enjoy the same powers and privileges. Consequently, they also have the right to arrest any person without warrant, and to detain him/her for an indefinite period of time, usually under the pretext that investigations are being carried out.

In addition to the power to detain, law No. 14 of 15 February 1970 on "the establishment of the national security service", confers upon these organs the right to search any person, property or house, and to sequester any property belonging to a person suspected of anti-revolutionary activities. The victims of repression are usually arrested at their homes in the early hours of the morning. Otherwise, they are invited to the offices of one of the above-mentioned organs and arrested there.

The 1979 Constitution

In 1979, a new Constitution was proclaimed, establishing a one-party state. The constitution contains many provisions purporting to protect human rights, but their effect is strictly limited as the legislation reviewed above remains in force.

As a prelude to the provisions on human rights, Article 19 of the constitution states that "the Somali Democratic Republic recognizes the Universal Declaration of Human Rights...". The rights protected by the constitution are then proclaimed in a detailed manner in chapter II of the constitution.

Some of the fundamental human rights recognized in the U.N. Covenants, and in most constitutions of the world, are not to be found in the Somali constitution. The right to association is not provided for, nor is the right to form independent trade unions recognized.

Article 7 of the constitution proclaims the Somali Revolutionary Socialist Party as the only legal party in the country and "no other party or political organization may be established". All political and professional associations were abolished soon after the military take-over of 1969, and the new constitution formally endorses their elimination from the life of the Somali people.

With respect to trade unions, Article 12 of the constitution prescribes that "the State shall allow the establishment of social organizations of the workers...". However, "the specific structure, statutes and programmes of the social organizations shall be in consonance with the... programme of the Somali Revolutionary Socialist Party", which means in practice that they are created and controlled by the party. Indeed, the only trade union organization which exists is affiliated to the party, and apart from its name it has little in common with a trade union.

Equally omitted from the constitution is the right to freedom of movement, and in particular the right to leave and to return to the country. Over a hundred thousand Somalis have fled the country in the last few years as a result of the repression practised by the regime. Most of these people had to leave without a passport, since this document is not delivered to suspected or supposed opponents of the regime inside or outside the country.

Article 24 provides for freedom of assembly, participation in demonstrations or processions and freedom of opinion, publication and speech. The exercise of these freedoms is however subject to the proviso that "they shall not contravene the constitution, the laws of the country, general morality and public order...".

This limitation makes the recognition of these rights meaningless in view of the numerous laws enacted by the military regime since 1969 which prohibit the exercise of these freedoms.

The 1979 constitution purports to protect personal liberty and guarantees the right to be informed of the grounds of arrest and to be brought before a judicial authority (art. 26). However no relief has been provided for infringement of this fundamental right by executive or administrative action since the abolition of the writ of *habeas corpus* in 1970. Also, the security services and the regional and district military administrators are still empowered to imprison and detain persons for an unlimited period of time.

Art. 27 of the constitution provides that a detained person shall not be subjected to physical or mental torture, and prohibits corporal punishment. Numerous instances of torture, corporal punishment and physical abuse have been reported in the prisons since the present regime came to power in 1969. In some cases, the victims who died as a result of torture were hurriedly buried, while their families were told that their demise was due to natural causes and denied the right to have their bodies examined by doctors.

State of Emergency

During the state of emergency the Constitution was suspended, an act which was not provided for in the Constitution. The military Supreme Revolutionary Council was revived, exercising legislative, executive and judicial functions. It would seem that the emergency was directed more to the internal than the external situation. Civil arrest, political uncertainty and a foundering economy, intensified by a severe drought, had further complicated the uneasy state of affairs in the country. The disappearance and imprisonment of suspects increased. In retaliation for alleged collaboration with the Somali Salvation Front, an opposition movement based in Ethiopia which made repeated attacks against the army in the border zone, many civilians were killed in the Mudug region, their livestock confiscated and their water-reservoirs destroyed. Recruitment into the army was intensified, and many draftees were reported to have been shot in January and February 1981 while trying to escape from their camps. Three members of the People's Assembly (the parliament) were arrested and detained without trial, notwithstanding their immunity under the Constitution.

Return to Constitutional Rule

The state of emergency was formally lifted on March 1, 1982. On this occasion, the President also announced the dissolution of the Supreme Revolutionary Council (SRC), and made a cabinet reshuffle. Almost all the members of the SRC have been given cabinet posts in the new government. A few political prisoners were released during the same week. Among them were the last civilian Prime Minister, Mr. Mohammed I. Egal, and a former chief of the police, Mohammed Abshir. Five members of the People's Assembly remain in detention.

President Barre adopted these measures two weeks before an official visit to the U.S. The U.S. Government had shown reluctance to entertain closer relations with the Somali Government owing to its domestic human rights record, which was further aggravated by the state of emergency, the totalitarian political system avowedly based on "scientific socialism", and the continuing conflict with neighbouring countries (Ethiopia and Kenya). On several occasions the U.S. government advised President Barre to release at least some political prisoners and to end the state of emergency. The U.S. demands for better relations were said to include also the liberalization of the economy, and the relaxation of the draconian security measures in force in the country.

Available evidence clearly suggests that, despite the ending of the state of emergency, the repression has not diminished. Rather it has spread to certain regions hitherto unaffected by the murders and property destruction which became widespread in 1981.

Demonstrations held in Hargeisa, the capital of the northern region, to protest against the trial of 42 political prisoners, were dispersed by the army with gun-fire, killing 15 persons and wounding about 100. The prisoners consisted mainly of civil servants, medical doctors and businessmen, who were accused of subversion because of their engagement in self-help schemes in the region to improve the living standards of the local population.

Subsequently over 200 persons were imprisoned in Hargeisa as a result of popular protest against their prosecution. At the trial the death sentence was demanded by the state attorney. The Security Court sentenced most of them to life imprisonment.

The situation of human rights violations

d s not, therefore, appear to have changed since the lifting of the emergency. All the repressive laws on national security are still in force. Because of increasing popular discontent, and a budding opposition movement, the regime has in fact become more xenophobic and repressive. The economy of the country is in disarray (see World Bank report on Somalia, 1981), and poverty has become more acute and wide-spread. Several members of the government have recently fled the country – among them, the former Minister for Industry, Ali Khalif, and former Minister to the Presidency, Mohamed Said Samanter, as they could no longer tolerate the excesses of the regime.

Opposition to government policies evidently exists at the highest levels within the Party. In June 1982, Ismail Ali Abuukar, a Vice-President and Assistant Secretary-General of the Party, and Osman Mohamed Jelle, a member of the Party Central Committee, and five other members of the parliament were arrested, deprived of their parliamentary immunity, removed from all offices they held, accused of committing treason against the nation and ordered to be detained 'until such time as they may be brought before the competent court'.

It is clear that the return to the Constitution will have little effect upon civil liberties unless and until the excesses committed by the various security services are brought to an end, and a return made to the rule of law.

Exhibit 6: June 16, 1988 Amnesty International document titled *Fear of Torture/Legal Concern*, AI Index: AFR 52/17/88 (Bates Nos. P-000022-23)

amnesty international

INTERNATIONAL SECRETARIAT
1 Easton Street London WC1X 8DJ
United Kingdom

URGENT ACTION

EXTERNAL (for general distribution)

AI Index: AFR 52/17/88
Distr: UA/SC

UA 154/88 Fear of torture/Legal Concern 16 June 1988

SOMALIA:

Nur ABBY, businessman, formerly resident in the United States of America
Ali Saeed ARALE, former general manager of the electricity agency
Ibrahim Elmi BULLALE, former deputy director of customs
Ahmed DUALE, employee of the Saudi Arabian embassy in Mogadishu
Hussein Mohamed EGEH, employee of the British embassy in Mogadishu
Jama Abdi FARAH ("Takroni"), businessman
Mohamed Mohamoud ISMAIL, flight engineer, Somali Airlines
Hali Ahmed SAHARDID ("Arab"), director of the pasta factory in Mogadishu

==========

The above eight prisoners were arrested in the capital of Mogadishu in the past week and are reportedly held in the custody of the National Security Service in Mogadishu. They were among large numbers (said to be several hundreds) of people from northern Somalia - all members of the Isaaq clan - who were arrested in Mogadishu after the recent attacks on government forces in the north by the opposition Somali National Movement (SNM). Many of those arrested in Mogadishu have been taken to Danane military camp, about 30 kilometres southwest of Mogadishu.

In addition, as fighting continues between government forces and the SNM in the northern port of Berbera, the following prisoners are reported to have been arrested in Berbera and transferred to prison in Mogadishu:

Haji Mohamed BURSADE, mayor of Berbera
Ali Mohamed DIRIE ("QOWDHAN"), businessman
Abdillahi Jirre DUALE, businessman
Ali Jirre DUALE, brother of the above, businessman
Mohamed KARSHE, owner of a restaurant

Amnesty International has received numerous reports of the routine torture of political prisoners by the National Security Service, particularly in its Benadir Region headquarters in Mogadishu, known as "Godka" (The Hole). Many such prisoners have been detained for indefinite and lengthy periods without charge or trial, incommunicado and in harsh conditions. Others have been tried by the National Security Court, where recognized international standards of fair trial are not applied.

There are fears for the safety of these prisoners, who appear to have been arrested in reprisal for the SNM attacks in the north, and because they belong to the Isaaq clan, from which the SNM draws most of its support.

BACKGROUND INFORMATION

Since late May 1988 there has been heavy fighting in Somalia's northwest region between government forces and the SNM. The SNM launched new attacks on the northwest region capital of Hargeisa and Berbera, and gained control of the smaller towns of Burao, Upper Sheikh, Mandera and Gebileh. There have been large-scale casualties as a result of the fighting in Hargeisa, which is still continuing. The capture of Mandera, Burao and Gebileh by the SNM led to the release of all political prisoners held there, including prisoners of concern to Amnesty International.

Amnesty International has received reports of summary and arbitrary executions of civilians in Hargeisa by members of the government security forces. These killings, which took place after the commencement of fighting in Hargeisa on 31 May 1988, were deliberate executions of arrested people, rather than casualties which occurred in the course of the fighting between government and opposition forces. Those killed are said to include people apprehended by military or security officers on suspicion of having links with the SNM and a large number of other people shot dead by the government's security forces during house-to-house searches for opponents.

RECOMMENDED ACTION: Telegrams/telexes/airmail letters etc -

- expressing concern at the detention of the above-named prisoners, who appear to have been arrested for political reasons and because of their membership of the Isaaq clan;

- appealing, in view of reports of the torture of political prisoners in Somalia, for their basic human rights to be protected while they are detained;

- urging that they be released if the are not to be promptly charged with a recognizably criminal offence and tried by a court which conforms to international standards of fair trial;

- urging that they be given access to legal counsel and relatives and to independent medical personnel.

Concern should also be expressed at reports of summary and arbitrary executions of civilians in Hargeisa by the security forces. Urge the government to investigate these reports and to take appropriate steps to prevent extrajudicial executions of civilians or captured members of opposition forces.

— Please take action as soon as you receive this Urgent Action appeal. Carefully read the recommended action. If possible, send a telegram or express letter immediately to one or more of the addresses given. Other letters can be sent afterwards.

— Telegrams and letters should be brief and courteous. Stress that your concern for human rights is not in any way politically partisan. Refer to relevant provisions in international law, such as the United Nations Universal Declaration of Human Rights:

Article 3 — "Everyone has the right to life, liberty and security of person."

Article 5 — "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or

— The name of Amnesty International may be used, although letters written in a private or personal capacity may be more effective.

— Copies of appeals should be sent to relevant diplomatic representatives in your country.

— In Urgent Action cases, Amnesty International has to act rapidly to prevent the ill-treatment of prisoners. An appeal is issued when Amnesty International believes it has received reliable and accurate information in such cases. It is not always possible to verify all details independently and in some instances the situation outlined in the appeal may change. Urgent Action participants are always notified of any significant new facts.

— Copies of any replies received from government authorities should be sent immediately to your section's Urgent Action

Exhibit 7: July 14, 1988 Hearing Before the Subcomm. on Africa of the House Committee on Foreign Affairs, 100th Cong., titled *Reported Massacres and Indiscriminate Killings in Somalia*, (Bates Nos. P-000139-68)

DOCUMENTS U.S. Congress. House Foreign affairs com.
STACKS

REPORTED MASSACRES AND INDISCRIMINATE KILLINGS IN SOMALIA

DOC Y 4.F 76/1:M 38

HEARING

BEFORE THE

SUBCOMMITTEE ON AFRICA

OF THE

COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

JULY 14, 1988

Printed for the use of the Committee on Foreign Affairs

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CONTENTS

Aryeh Neier, executive director, Human Rights Watch .....
Bruce Bradshaw, former AID contractor in Somalia .....
Kenneth Brown, Deputy Assistant Secretary for African Affairs, Department of State, accompanied by Mr. Brown: John Davison, Director, Office of East African Affairs and Margaret McKelvey, Director, Office of African Refugee Assistance .....

APPENDIX

1. A listing of international press accounts concerning the deteriorating situation in Somalia, submitted by Rep. Howard Wolpe, chairman, Subcommittee on Africa .....
2. Statement submitted by the Organization for Somali Affairs .....

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 10 of 50 PAGEID #: 1109

P-000140

REPORTED MASSACRES AND INDISCRIMINATE KILLINGS IN SOMALIA

THURSDAY, JULY 14, 1988

HOUSE OF REPRESENTATIVES,
COMMITTEE ON FOREIGN AFFAIRS,
SUBCOMMITTEE ON AFRICA,
Washington, DC.

The subcommittee met at 1:45 p.m., room 2172, Rayburn House Office Building, Hon. Howard Wolpe (chairman of the subcommittee) presiding.

Mr. WOLPE. The hearing will come to order.

We have scheduled today's hearing on rather short notice in response to reports of major clashes between rebel Somalia National Movement forces and government troops in Northern Somalia, and in response as well to numerous eyewitness accounts of gross human rights violations by the Government of Somalia.

These reports indicate that thousands of civilians from the Isaaq clan, the largest northern ethnic group, may have been killed or injured in mass executions and in the indiscriminate bombing of rebel-held towns and cities.

An estimated 175,000 refugees have entered Ethiopia in the last month, and many others have fled to rural areas of Somalia. Hundreds of Somalis from the northern region have been arrested in Mogadishu, the capital, largely, it seems, because of their clan affiliations.

Amnesty International and the National Academy of Science have recently issued reports documenting what they term routine torture of political prisoners in Somalia.

Finally, as a result of the fighting and its consequences, an estimated 250,000 Ethiopian refugees in northwest Somalia appear to be cut off from all supplies.

Since the late 1970s, the United States has been a major diplomatic and financial supporter of the formerly-Soviet-aided scientific socialist government of President Siad. Military assistance has been provided in return for military facilities at the Port of Berbera.

It appears the Somali aircraft are taking off for their bombing runs over Hargeisa and Burao from military facilities we also utilize at Berbera Airport.

We want to know what the United States Government has done during this crisis and what, if anything, it should do to try to curb or disassociate itself from the reported war against civilians in Northern Somalia.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 11 of 50 PAGEID #: 1110

P-000141

We also want to know what can be done immediately to meet the apparently vast emergency needs of the civilian population.

The increasing violence in Somalia raises still another issue for American policy. The current uprising in the north and the outcome of years of political repression and seven years of intermittent but bloody clashes in rural areas and cycles of urban unrest and repression, rebel forces have established—I should have indicated earlier that the current uprising in the north is the outcome of years of political repression and the clashes I have cited earlier.

Rebel forces have established significant positions and appear to produce considerable disaffection within the Somalia military. Accumulating political and economic problems and President Siad's advanced age and illness are affecting the political prospects of Somalia's longstanding regime.

The United States may be in a position to weigh in against military and repressive solutions to Somalia's difficult problems.

Our first witness today will be Mr. Aryeh Neier, Vice Chairman of the Human Rights Watch, a human rights monitoring organization comprised of America's Watch, Asia Watch and Helsinki Watch.

Our second witness will be Mr. Bruce Bradshaw, a former personal services contractor for AID, and, thirdly, we will be hearing from Mr. Kenneth Brown, the Deputy Assistant Secretary of State for African Affairs.

Before turning to our witnesses, I would like now to invite my distinguished ranking member, Mr. Burton of Indiana, to make any opening remarks he might care to make.

Mr. BURTON. Thank you, Mr. Chairman.

We are all concerned about human rights violations, and I share the concern of the Chairman regarding the fighting in northern Somalia.

While there have been numerous reports on the situation there, we have had trouble finding out exactly what has been going on.

I am encouraged by the announcement by the Somali Government that the foreign relief workers may remain in Mogadishu while arrangements are being made for their return to the north.

My understanding of the situation is that Somali rebels, the SNM, attacked two major towns and assassinated a number of Somali Government officials. The rebels have been armed primarily by the Communist Ethiopian Government next door.

Though Somalia and Ethiopia have reached an agreement not to interfere with each other's affairs, I am concerned that the Ethiopians may have assisted in this recent Somali National Movement (SNM) offensive.

I do not believe that we make a positive contribution to this situation by blaming this tragic conflict on the Government of Somalia. The SNM rebels with Ethiopian support have chosen to turn two Somali cities into a battleground and are probably hoping that the government will respond as brutally as possible.

I hope the Somali Government will exercise restraint and will not play into the rebels' hands by alienating the civilian population. I h[illegible] the SNM will not prolong the fighting in order to gain the [illegible]paganda victory resulting in more civilian deaths and

I hope that Ethiopia will attend to feeding the two million people still at risk of starvation in the north rather than continuing to stir up trouble next door, and, finally, I hope that this hearing process will be used to find the facts, not as a propaganda vehicle for the Ethiopian-backed Somali rebels.

I look forward to hearing our witnesses today, Mr. Chairman.

Thank you.

Mr. WOLPE. Thank you very much, Mr. Burton.

With that, we would like to turn to our witnesses.

I would like to make a very urgent request that all of the oral testimony be restricted to no more than ten minutes, shorter if possible, so we might have maximum time for questions, and I should indicate that the full written text of all the testimony that is to be presented today will be entered in the record in its entirety.

With that, let me invite as our first witness, Mr. Neier, and I hope I am pronouncing that correctly.

STATEMENT OF ARYEH NEIER, EXECUTIVE DIRECTOR, HUMAN RIGHTS WATCH

Mr. NEIER. Thank you, Mr. Chairman.

Mr. Chairman, I am very grateful for the opportunity to appear before this committee.

As you mentioned, the Human Rights Watch, which I direct, is composed of Helsinki Watch, America's Watch and Asia Watch. We are now in the process of forming an Africa Watch Committee to try to monitor human rights systematically in Africa in the fashion in which we have done in the other regions with which we are concerned, and in our establishment of an Africa Watch, we are particularly concerned with the very serious human rights situation in a number of countries in the Horn of Africa.

We are grateful for the opportunity to appear here, particularly because this committee has compiled a distinguished record of drawing attention to human rights abuses in Africa and thereby, I believe, has played a very important part in contributing to the protection of human rights in Africa.

Mr. Chairman, ordinarily, the Watch Committees that I direct like to present testimony and compile reports when we have been able to engage in systematic gathering of information directly in the regions affected.

We would very much like to have been in the position today to come to you with firsthand information that we collected. We have not done so on this occasion, and I recognize, therefore, that the testimony draws upon fragmentary information that is available and is not of the character that we ordinarily wish to present.

Unfortunately, the Somali Government has made it extremely difficult for groups to gather information in the direct fashion in which we would like to gather such information. Journalists are having difficulty or are finding it impossible to reach the regions that are affected by this conflict.

The employees of various relief organizations are essentially out of the region right now. We do not know of [illegible] observers who are in the region from whom we could gathe[illegible]atic information.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 12 of 50 PAGEID #: 1111

But the fragmentary accounts that have been available paint a very disturbing picture. It is a picture that I think has to be looked at in terms of what we do know about the human rights record of the Somali Government over a long period. That is, in the nineteen years that the Government of President Siad Barre has been in power, Somalia has evolved into what might be described as a combination of a totalitarian system of government with the worst features of the old-style despotic system of government.

A totalitarian system in the sense that it is a government which completely denies freedom of the press, freedom of expression, freedom of association, which has given short shrift to principles of due process of law and has tried people through military tribunals completely lacking any protection for the rights of the individuals and a sort of old-fashioned despotic system in the sense that it has practiced great cruelties in the manner in which it has treated detainees.

Reports of torture and reports emerging from Somalia of other forms of mistreatment are legion.

The current conflict is one in which we do not have a position. We take no sides. We do not endorse the position of the rebels who are fighting the Somali Government. We do not endorse the position of the Government.

Our concern is that those who are engaged in such conflicts must respect international norms that have been established to govern even the conduct of such conflicts. That is, there is a body of law variously known as the Laws of War or International Humanitarian Law, and it says that even when governments and guerrilla groups are engaged in military conflict, that there are certain rules they must observe, that they may not, no matter what the provocation, no matter what the excuse, they may never attack civilians.

They must limit their combat to combatants, they may not execute captured combatants once Combatants are rendered hors de combat, they must respect them, and it is clear to us from such reports as have been possible to gather that those Laws of War, that that body of International Humanitarian Law, is by no means being respected by the Somali Government.

There are statements that officials of the United Nations High Commissioner for Refugees have made indicating that at least 2,000 refugees per day are crossing into Ethiopia. We have heard even higher figures than that. We do not have the independent ability to confirm those figures or to say exactly what the figures are. We would very much like to be able to conduct the kind of investigation that we ordinarily conduct in the regions we monitor, but it has been rendered impossible in the current circumstances.

We do think that given the very serious reports of attacks on civilians, of bombings of civilians, of the destruction of wells on which the largely-nomadic population in northern Somalia is so dependent, of the systematic torture and execution of detainees, that it is extremely urgent that attempts be made to verify what can be verified, and we think that probably at this moment, the only body that is [illegible] of entering into this situation and conducting the kind of [illegible]gation that is required is the United States Government [illegible]ase the United States Government has far more influence with the Somali Government than anybody else outside the Somali Government.

The Somali Government has had the United States as its closest ally since the United States switched rolls with the Soviet Union when the Soviet Union became a backer of the Ethiopian Government and the United States adopted the Somali Government about ten years ago.

The Somali Government has been very much dependent upon various forms of assistance that it receives from the United States, and the United States, therefore, has the leverage to be able to insist upon the access in order to gather the kind of information that is required.

Recently, the United States Government confronted a terrible situation in another region of Africa, in Mozambique, where vast numbers of refugees were fleeing. Mozambique and the State Department sent an investigator into the area to compile a report on what the cause was of this flight of refugees, and we think that is a good example of what the State Department could do in the present circumstances.

We call upon this committee to call upon the Department of State to conduct that kind of investigation. If possible, the committee itself or the Congress itself could sponsor a fact-finding delegation in order to be able to look into these very serious abuses or the reports of these very serious abuses.

Then, I think it is extremely important given the reports that are emerging that the United States exercise whatever influence it has to make sure that international humanitarian bodies are able to enter into the region to provide assistance.

It is our understanding that the International Committee of the Red Cross is being substantially restricted today, unable to provide humanitarian assistance to civilian victims of the conflict, that the only role that the International Committee of the Red Cross is being permitted to play by the Somali Government at this moment is to deal with wounded members of the armed forces of the Government of Somali.

The International Committee of the Red Cross has compiled an extraordinary record of impartial service in situations of internal conflict and it is an agency that has the skill and the experience to deal with the humanitarian situation arising out of this conflict, and the United States should, we believe, put whatever strength it has behind an effort to make sure that the International Committee of the Red Cross is able to perform its humanitarian services in the region of conflict.

We also believe that the situation is such that the United States should exercise leverage by cutting off all arms shipments to the Government of Somali, and if the reports of the atrocities that are emerging about the practices of the Government of Somali are verified, then the United States should cut off all aid to the Government of Somali.

A government that engages in such gross abuses of human rights as are being reported today is not deserving of [illegible]aid. The United States law calls upon us to forbid such a [illegible]vernments practicing gross abuses of human rights, of the s[illegible]nat are being

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 13 of 50 PAGEID #: 1112

reported by various sources that are available on the situation in Somalia today.

This is an urgent situation. This committee, by holding this hearing, is putting the spotlight on this situation. We think it is very important for this committee to use whatever influence it has in order to make sure that the spotlight stays on Somalia and that the current situation is investigated to the degree possible, and that as reports are verified, that the United States take such action as it can take.

Thank you very much.

[Prepared statement of Mr. Neier follows:]

TESTIMONY OR ARYEH NEIER
VICE CHAIRMAN, HUMAN RIGHTS WATCH
before the Africa Subcommittee
on
HUMAN RIGHTS IN SOMALIA

July 14, 1988

Chairman Wolpe, thank you for holding this important hearing. We appreciate the Subcommittee's consistent attention to human rights issues in Africa and your willingness to investigate the recent sharp deterioration in human rights in Somalia. My name is Aryeh Neier, and I am Vice Chairman of Human Rights Watch, a human rights monitoring organization comprised of Americas Watch, Asia Watch and Helsinki Watch. Human Rights Watch is forming an "Africa Watch" to monitor human rights in Africa, and we have collected extensive information on the subject at hand today.

* * *

The fierce fighting in northern Somalia since May 26, 1988, between government troops and the armed rebel group, the Somali National Movement (SNM), has highlighted, once again, the dismal long-term human rights record of President Mohamed Siad Barre. The situation in Somalia is grave and has been ever since President Barre seized power in a military coup in

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Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 14 of 50 PAGEID #: 1113

P-000144

1969. The extraordinary level of state violence that has been used to suppress peaceful dissent and the wide range of official violations of basic rights was largely unreported for many years. Tightly controlled communication within Somalia and between Somalis and the outside world inhibited the collection of information. In recent years, however, as thousands of Somalis flee the country and those abroad have begun to publicize the cruelties of the regime, international human rights organizations have been receiving frequent and continuous reports of summary executions, torture, detentions without charge or trial of suspected political opponents as well as substantive violations of judicial procedure and political and civil rights.

The United States has been Somalia's principal ally since 1978 when Somalia lost the Ogaden War with Ethiopia. Somalia has been a recipient of U.S. aid and military assistance ever since. Somalia's strategic location, on the Gulf of Aden and the Indian Ocean, has been the prime concern of U.S. policy. The U.S. has a base for the use of the Rapid Deployment Force in the port of Berbera, on the Gulf of Aden. In spite of revelations by human rights organizations about the scope of atrocities, there has never been any public suggestion by successive U.S. Administrations that President Barre's practices might run afoul of U.S. laws imposing human rights conditions on military and economic assistance. Instead, U.S. policy has sought to consolidate the privileged position of a military regime engaged in a systematic pattern of gross violations. There has been

little public debate outside this Subcommittee about our bilateral relations with the Barre government. The U.S. role in providing aid to the military dictatorship of President Barre, in the view of many Somalis, makes us culpable for the abusive policies we do not condemn. The Administration has done nothing to dispel this view.

This is a critical moment in Somalia's history. The atrocities committed by the Somali government against unarmed civilians, particularly since the fighting at the end of May, are finally attracting international concern. They should be publicly and forcefully condemned by both the Administration and the Congress. The recent events provide an important opportunity to have an impact. Only the U.S., by virtue of its economic, military and political ties, can pressure President Barre to curb the abuses that have become the hallmark of his regime. Failure to act now would cost more lives and would encourage the regime to intensify the practices that have created political chaos, economic bankruptcy and brought the country to the edge of civil war.

Immediately upon seizing power in October 1969, under a program of "scientific socialism," the military government of President Mohamed Siad Barre introduced policies and enacted laws and regulations that seriously undermine the protection of human rights. The regime abolished the 1960 Constitution, disbanded political parties, prohibited professional and labor associations and brought civic organizations under the control of

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 15 of 50 PAGEID #: 1114

P-000145

the government. There is no free press. The media is owned, operated and tightly censored by the government. Every form of cultural expression is closely monitored. Foreign journalists have trouble obtaining visas. The proscription of political parties, professional, labor and civic organizations without the sponsorship and participation of the state is still in force.

Political power is concentrated in the hands of President Barre, his family and close military advisors. There is only one officially sanctioned Party, the Somali Revolutionary Socialist Party, of which the President is the Secretary-General and which is entirely subservient to him. President Barre was elected for a new seven-year term in December 1986 in an election in which he was the only candidate and obtained 99.9% of the vote.

One of the government's first priorities was the creation of a formidable security network. The principal security organ is the National Security Service (NSS). The unlimited powers of the NSS, in conjunction with those of the National Security Court, have provided for the detention, often without charge or trial, of tens of thousands of Somalis in the past eighteen years. Extensive legislation introduced in 1970 empowers the NSS to arrest, without a warrant, anyone suspected of a seditious intent or perceived as a political threat. It has power to detain suspects indefinitely, to search their homes and to confiscate their property.

The NSS soon acquired a reputation for terror and became associated with the constant intrusion of a police state in

people's lives. At public events, in government ministries, in schools, in mosques and in neighborhood centers, it is generally assumed that speakers are all under surveillance and may be subject to follow-up police action if their remarks are judged to be too disrespectful of the Head of State, critical of government policies or simply too controversial. The NSS has its own interrogation and detention centers. The NSS central prison in Mogadishu, known as "The Hole" ("Godka") is synonymous with torture, ill-treatment and harsh conditions. Other security agencies parallel the NSS. These include the Victory Pioneers ("Guulwadayal") who act as the government's watchdog at the community level and report directly to the President. The Control Committee of the Party is the security force of the ruling Party. The President's senior wife, Khadija, has her own secret service agency. The Military Police, known as "Dhabar Jabinta" (The Backbreakers) are particularly notorious for their brutal treatment of military personnel and civilians. All these agencies retain wide powers to arrest and detain those suspected of security-related offenses. No court can modify or revoke their detention orders. Detentions are not explained or acknowledged by the authorities. Names of detainees are not published. Families usually have to bribe an official in order to trace the whereabouts of a detainee.

The government also passed a series of legislative acts which have institutionalized the denial of fundamental human rights. In 1979, it introduced a new Constitution which

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 16 of 50 PAGEID #: 1115

P-000146

expressly provided that these laws override the political and civil rights guaranteed by the Constitution. The most important was Law No. 54 of September 10, 1970 which provides the death penalty for a wide range of political offenses that relate to "national security." Offenses against national security are defined as behavior "which may be considered prejudicial to the maintenance of peace, order and good government." This has been interpreted broadly to mean whatever the authorities want it to mean, both for individuals and groups. The law does not distinguish between violent and non-violent criticism or opposition to the government and thus does not adequately protect the right to hold, express and disseminate opinions, the right of association or of peaceful assembly. Not only the expression of political dissent, but also the possession of written material interpreted as "seditious" has been labelled as treason. Membership in opposition groups or in any organization not acceptable to the government, is a capital offense. The right to strike is not recognized and any attempt to organize a strike is punishable by death.

On April 8, 1987 nine teachers of religion were condemned to death in secret trials in Mogadishu under Article 12 of Law 54 which provides the death penalty for "exploiting religion for creating national disunity or subverting or weakening state authority." They had criticized the government's failure to respect freedom of worship. After a national outcry and intense pressure from Islamic governments, the sentences were commuted to

life imprisonment. Five others arrested at the same time were given long sentences. Mr. Chairman, members of this Committee expressed concern about the executions and contributed to the commutation of the sentences.

The vagueness of the allegations and charges and the often insubstantial evidence has resulted in the arrest, detention and execution of prisoners, on account of their political opinions, associations, non-violent activities or because of their clan affiliation. In 1982, 20 doctors, businessmen, teachers and civil servants, arrested in 1981 in Hargeisa, were sentenced to long prison terms, some of them to life imprisonment. They were accused of setting up a subversive organization: a self-help scheme to improve local facilities, including the hospital in Hargeisa. Most of them are still in prison. Safia Hashi Madar, an employee of an American relief agency, the Transcentury Foundation, was arrested in Hargeisa on July 14, 1985. Nine months pregnant at the time of her arrest, she has been subjected to torture and ill-treatment and sentenced to life imprisonment on May 31, 1986. She was convicted of membership in a subversive organization (SNM), which she has denied. It is believed that she was arrested because some of her relatives are known to oppose the government. She is reported to be seriously ill.

The architect, Suleiman Nuh Ali, a graduate of Howard University, and Abdi Ismail Yonis, a prominent educator, a graduate of the State University of New York, were arrested in 1982 on suspicion of having links with the SNM, which the

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 17 of 50 PAGEID #: 1116

P-000147

authorities have never proved. They were tried in 1988 and sentenced to death, which has been commuted to 24 years in prison. Both have been severely tortured.

These policies have led hundreds of thousands of Somalis to leave the country and to seek sanctuary elsewhere, in the Middle East, Africa, Europe and the U.S.

ARBITRARY ARREST, DETENTION, AND UNFAIR TRIALS All security-related offenses and crimes punishable by death are tried by the National Security Court (NSC) which is shielded from any independent scrutiny. The main seat of the NSC is in Mogadishu; regional sections are autonomous. The court tries both civilians and military officers. NSC courts are an arm of the executive branch and do not form a part of the regular judicial system. The President of the NSC, General Mohamed Ghelle, is an army officer, a Cabinet Minister and a member of the Central Committee of the Ruling Party. He has no legal training. The court is presided over by military or security officers with no legal training or experience, appointed by President Barre. It has its own Special Prosecutor and assistants to the Prosecutor, who are all from the armed forces, police or security forces, and who have the power to arrest and detain suspects, search homes and confiscate property.

There is a wholesale denial of due process in the summary proceedings of the NSC, which is more of a military tribunal than a court of justice. Human Rights Watch has noted a pattern that has emerged in most, if not all, of the trials before the NSC, of

which the following are the main elements. Criminal investigations and convictions rely heavily on oral confessions by the accused, obtained through physical torture or psychological intimidation, such as threats against family members. Confessions are legally admissible as evidence. Once a confession has been obtained, the authorities exert little effort, if any, to gather other evidence. There is no right to confront witnesses. Access to a defense attorney is prohibited until "all investigations have been completed." Even after that, detainees are permitted only nominal contact with a lawyer just before the beginning of their trial, and always in the presence of the Prosecutor of the NSC or his assistant. In practice, many prisoners have not been permitted access to a lawyer, even in cases involving the death penalty. Most trials take only a few days to complete and are not open to the public. Important political trials usually take place in great secrecy. Habeas corpus, the legal recourse in the case of illegal detentions, was abolished in 1970. There is no right of appeal to a higher court, even from the regional courts. Death sentences may be reviewed by the President, but only upon an appeal for clemency. In the past, executions have taken place immediately after trials that lasted a few days. No independent observer, diplomatic representative or foreign journalist has ever been allowed to follow a trial before the NSC. We believe that such substantive violations of judicial procedure and of fundamental human rights and the obvious lack of an independent judiciary, compromise

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 18 of 50 PAGEID #: 1117

P-000148

internationally recognized standards for a fair trial and justice. They also violate international agreements to which Somalia is a signatory.

THE TRIALS OF SIX FORMER MEMBERS OF PARLIAMENT AND OTHER POLITICAL DETAINEES IN FEBRUARY 1988 Six former members of Parliament (The National Assembly), including a former Vice President, Ismail Ali Abokor, a former Foreign Minister, Omar Arteh Galeb and sixteen others, all detained since 1982 without charge or trial, were tried by the NSC in Mogadishu on February 1, 1988. They were charged, shortly before the trial, with two principal offenses, "organizing a subversive organization" (SNM), and "organizing an armed band" (SNM). After a trial that lasted four days, eight of them were condemned to death and some of the others to long prison sentences. After numerous international appeals for clemency, President Barre commuted the death sentences. Ismail Ali Abokor and Omar Arteh Galeb were given an unspecified prison term to be served under house arrest and the other six were given a 24-year sentence. In spite of allegations of torture by at least 3 defendants -- Suleiman Nuh Ali, Abdi Ismail Yunis and Abdillahi Jama Galaal -- a request by the defense for an independent medical examination was denied. Most of the prosecution witnesses were from the army, police and security forces who had interrogated the defendants.

TORTURE Torture is reported to be widely used against suspects arrested on political grounds. Testimonies by former prisoners indicate a pattern of torture used to obtain a

confession of involvement in anti-government activities, especially of links with the SNM or to give incriminating evidence about others. Relatives of political detainees and prisoners have been tortured to force the detainee to confess. In 1984, the pregnant wife of a detainee, Abdillahi Jama Galaal, was beaten severely and her thigh broken, so as to coerce him to implicate Ismail Ali Abokor on charges of treason. Others have been detained and tortured for information about a relative who was wanted by the security forces. Some victims are reported to have died as a result of torture and ill-treatment or to have sustained permanent physical or mental damage as a result of their injuries. Warsame Ali Farah, a former member of parliament arrested in 1982, died in custody in November 1984, reportedly as a result of being denied medical treatment for a serious illness. In a report issued on June 30, 1988, Amnesty International accused the Somali government of the systematic torture of political detainees and prisoners. It detailed cases of torture at the hands of the NSS and the Military Police. Torture methods include severe beatings, especially the "mig" method (while victims are bent over double); prolonged immersion in the sea or a water tank until the victim, who has been placed in a sack, has nearly drowned; sexual assault of women and men; and knife cuts. Early in 1988, a testimony by Suleiman Nuh Ali, giving details of brutal methods of torture, was smuggled out of Somalia. Abdillahi Jama Galaal, a former army colonel, reportedly had to

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 19 of 50 PAGEID #: 1118

P-000149

have surgery to remove a testicle which had been damaged as a result of torture.

LONG-TERM VIOLATIONS IN THE NORTH Until 1978, there was no organized opposition in Somalia. However, in the wake of the defeat in the Ogaden War and a failed coup attempt in 1978 led by members of the Majerteen clan, the political context changed. From 1978-81, the Majerteen, from regions in central Somalia, were the main targets of arrests and detentions because, at that time, the principal organized opposition group, the Democratic Front for the Salvation of Somalia (DFSS), was supported mainly by them. The military implemented a scorched-earth policy in the central regions of Mudug and Bari. Since 1981, with the formation of the SNM, northern Somalia has seen the worst atrocities.

Serious human rights violations, including extra-judicial executions of unarmed civilians, detentions without trial, unfair trials, torture, rape, looting and extortion, have been a prominent feature of life in the towns and countryside in the northern region since 1981. In order to deprive the SNM of a civilian base of support in their area of operation, those living in rural areas between Hargeisa and the Ethiopian border have suffered particularly brutal treatment. A scorched earth policy that involves the burning of farms, the killing of livestock, the destruction of water-storage tanks and the deliberate poisoning of wells, has been pursued actively by the military. The principal towns have been subjected to a curfew for several

years; arbitrary restrictions on the extension of the curfew have facilitated extortion by soldiers and curfew patrols. Internal travel is controlled through military checkpoints.

The military, security forces and curfew patrols have become a law unto themselves and created a climate of unrestrained violence. The existence of the SNM has provided a pretext for President Barre and his military deputies in the north to wage a war against peaceful citizens and to enable them to consolidate their control of the country by terrorizing anyone who is suspected of not being wholeheartedly pro-government. Years of sustained state violence have created a serious level of political unrest in the region.

The atmosphere of lawlessness has enabled soldiers to harass civilians for the purposes of extortion. Many Somalis have reported that military and security officers only respond to inquiries by detainees' relatives with promises to secure their release in exchange for cash payments. Civilians living in Buroa and Hargeisa have frequently been forbidden to hold funerals for relatives shot dead by the military and curfew patrols until they have paid a ransom. Rape, of young and older women, is routine. They will only be released from detention centers, even after being raped, if the family pays a ransom. No soldier or member of the security forces has ever been disciplined or prosecuted for abuses, which highlights the general lack of accountability.

THE SITUATION IN NORTHERN SOMALIA SINCE FIGHTING BROKE OUT ON MAY 26, 1988 Fierce fighting broke out in northern Somalia

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 20 of 50 PAGEID #: 1119

P-000150

when the Somali National Movement (SNM) attacked Hargeisa, the provincial capital of the region, Buroa, and other towns. Fighting continues for the control of these towns. The SNM, which until recently had its bases inside Ethiopia, has been waging an insurgency against the government since 1981. Most of its support comes from the Isaaq clan, numerically the largest in northern Somalia. Reports reaching human rights organizations and coverage by the international press indicate that as many as 10,000 people may have been killed since fighting broke out some 7-8 weeks ago. (also see The Washington Post, July 2, 1988; The Economist, July 9, 1988). We believe that the government is using this as an opportunity to intensify a long-standing campaign against the Isaaq, in order to deprive the SNM of a political base of support and to punish Isaaq. The actions of the government have created a level of violence unprecedented in scope and duration in Somalia. Government troops have engaged in massacres, summary executions and indiscriminate killings of the local population. Foreign relief workers who were evacuated a few days after fighting broke out provided details of these atrocities. Jean Metenier, a French hospital technician in Hargeisa, told reporters at Nairobi airport that at least two dozen people were executed by firing squad against the wall of his house and the corpses later dumped on the streets to serve "as an example." (The Sunday Times (London), June 12, 1988; The Independent (London), June 9, 1988). Government troops continue to search the homes of suspected SNM sympathizers and to take

people away to be shot, interrogated, tortured and detained. As people flee in panic, many are missing and relatives are unable to trace the whereabouts of family members. Thousands of Somalis have fled into neighboring Ethiopia. The UNHCR has issued reports of a massive influx of Somali refugees into Ethiopia, at the rate of 2,000 a day, arriving destitute. The UNHCR reported 40,000 - 50,000 refugees at the border near Harshin alone (The Independent (London), July 7, 1988). According to the Ethiopian government, another 70,000 Somalis have entered Ethiopia at Aware, 370 miles east of Addis Ababa. According to a June 30 Reuters dispatch, Ethiopian officials put the total number of Somalis who had entered the country by that date at 110,000. We have not been able to verify these figures, but believe that the number is certainly in the tens of thousands. Thousands of others have fled into the countryside in Somalia itself. In an attempt to dislodge the SNM, the government is using artillery and air bombardment, especially Hargeisa and Buroa, on a daily basis, aiming particularly at civilian population targets. Reports from eye witnesses speak of the town of Hargeisa as mere rubble, devastated to the point that it is barely recognizable even to its inhabitants.

MEDICAL SITUATION In spite of the enormous number of civilian casualties, the government has refused the International Committee of the Red Cross (ICRC) access to civilians in the north. It will only allow the ICRC to treat wounded government soldiers. An evacuee, a West German doctor, told reporters that

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 21 of 50 PAGEID #: 1120

P-000151

he had been ordered to treat only military personnel and to leave civilians to die (The Observer (London), July 3, 1988). The need for the ICRC is all the more urgent since all 165 foreign aid workers, involved in government and United Nations relief operations in the region, have been evacuated by the United Nations. The government is not allowing food, medicines and other basic supplies to reach civilians. Power and water have also been cut. There are fears of an outbreak of a cholera epidemic. In addition, there are hundreds of thousands of refugees who had fled persecution and famine in Ethiopia living in camps inside northern Somalia, who have been cut off by government action from access to food and water.

In the midst of these developments, President Barre has appealed to the U.S. for armaments and medical supplies, the latter apparently intended to benefit only military casualties. According to our information, a ship arrived a few days ago at the port of Berbera, carrying U.S. rifles and grenade launchers, which has been justified as a consignment that was scheduled before the recent fighting broke out. We are not aware that any country, other than the United States, is currently supplying the Barre government with weapons and other warfare materials. In view of the peace treaty between Somalia and Ethiopia in April 1988, it is difficult to avoid the conclusion that such weapons are intended for internal use. In addition, we received reports that an American team is helping to maintain and run the

military's communications network in the war zone in the north, to boost the government's military capacity.

ARBITRARY ARRESTS AND DETENTIONS AS A CONSEQUENCE OF THE FIGHTING Since the fighting began, there has been a dramatic escalation of the arrest of northerners living in Mogadishu. Hundreds of Somalis from the Isaaq clan have been arrested in retaliation for SNM attacks. Scores of prominent businessmen, civil servants and technicians who were not known to be politically active have been arrested, interrogated and some of them released only upon the payment of a bribe. Some of those still in detention include:

Haji Jama Mohamed Miyateen, a businessman in his eighties;

Haji Ibrahim Osman (known as "Basbas"), a businessman in his seventies;

Mohamed Ahmed Aden (known as "Skeerse"), a businessman;

Ali Ahmed Hassan (known as "Ali Jinnah"), a businessman;

Mohamad Ahmed Hassan (known as "Surwaaleh"), a former veterinary surgeon, now a businessman (brother of the above);

Ismail Hashi Madar, a lecturer at a military academy;

Mohamad Hashi Madar (brother of the above), an accountant;

Faiza Ahmed Halla, a Somali Airlines stewardess;

Dahir Ahmed (known as "Burso"), a Somali Airlines catering officer.

Pilots, engineers and officials of Somali Airlines, which is being used to fly military equipment to the north, have been a special target.

Various security agencies and military officers have taken

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 22 of 50 PAGEID #: 1121

P-000152

advantage of the chaos to arrest people for the sole purpose of extortion from family members.

A number of prominent northerners living in Hargeisa and Berbera were also arrested and transferred to prison in Mogadishu. They include:

Haji Mohamed Bursade, Mayor of Berbera;

Ibrahim Urdoh, a businessman from Hargeisa;

Ismail Jibril, a businessman from Hargeisa.

Long-term abuses and the recent developments relating to the fighting in northern Somalia underscore the importance of demonstrating high level U.S. concern. We urge that these concerns be immediately communicated to President Barre and that they be the major focus of meetings between the U.S. and Somali governments in the weeks to come.

U.S. policies have tended to reinforce the government's own contention that it is the only alternative to chaos. On the contrary, unrest and disorder in Somalia stem directly from the policies of state violence which, during Barre's presidency, have divided the nation, destroyed its political fabric and social cohesion and brought the country to the edge of civil war.

It is time for the Administration and Congress to exercise the leverage of the United States by speaking out publicly against extrajudicial killings, arbitrary arrests, summary trials and unlawful detentions. We should call for the repeal of laws that have institutionalized the denial of basic rights. At a minimum, we should call on President Barre to stop the bombing of

cities and towns in the north, to rein in the army and security forces engaged in massacres in the north, to provide access to other international relief agencies, and to release all political prisoners. As a matter of urgency, Congress must call on President Barre to allow the ICRC to treat civilians wounded in the north and to give access to international human rights organizations and foreign journalists to report on the situation.

It is critical that there should be no further military assistance to the Somali government. We must ensure that any humanitarian and medical assistance by the U.S. benefits the civilian population and not just the army. To this end, Congress must insist that such assistance should be administered by the International Committee of the Red Cross. The Congress should call on the Department of State to conduct its own investigation of developments and to issue a public report, as the Department did several months ago with respect to Mozambique. If access to Northern Somalia is blocked, the State Department should attempt to interview refugees in Ethiopia. Lastly, we recommend that a Congressional delegation should conduct a fact-finding mission to Somalia. It is vital that in the months to come, we should use every opportunity to raise concerns for human rights publicly with the Somali government.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 23 of 50 PAGEID #: 1122

P-000153

Mr. WOLPE. Thank you very much, Mr. Neier, and I would like now to turn to Mr. Bradshaw for his testimony, and then we will open it up for questions.

STATEMENT OF BRUCE BRADSHAW, FORMER AID CONTRACTOR IN SOMALIA

Mr. BRADSHAW. I thank you for the opportunity to be here today.

As most of you know, I was the personal services contractor with US AID. I was in Hargeisa for eleven months, until it was attacked, from May 31st until I left. I was evacuated on June 4th.

On May 27th, it was a Friday, we were told that Burao was attacked by the SNM and some of us were quite surprised that they had taken the entire city and we wondered what was going to happen in Hargeisa.

I was running an auction at the time of excess US AID furniture and office equipment, and we thought one of the indications to know how the community is going to feel about Burao falling is how they are going to respond to our auction.

Well, on Saturday, Sunday and Monday, we collected over $4,000 on bids for this furniture, $4,000 equalled ten percent bids, and it seemed a good indication that the community was not terribly concerned about it. They were giving us checks equivalent to a 100,000 shillings. From Friday until Monday evening, there was intermittent fighting, but there seemed to be some sense of normalcy in the respect that people were going about their business. They were making bids on furniture, etc.

Then there was a curfew imposed about three o'clock in the afternoon, and, so, I went to visit some friends from a private voluntary organization who lived in another part of town and planned to spend the night there, and on the Monday night of May 30th, the fighting was a little heavier than we had expected.

At two o'clock on Tuesday morning, the fighting was as intense as we had ever had imagined, and from two o'clock Tuesday morning until about ten o'clock Tuesday morning, Hargeisa fell under seige, and the entire city was infiltrated with government soldiers as well as SNM, and that fighting went on until I was evacuated Saturday, June 4th.

The fighting seemed to have been everywhere at once. On Tuesday morning, we listened to the fighting and we had an idea of where it was, and not long after that, within a few hours, it was all over the city, and the fighting was done with armed soldiers, heavy artillery, and tanks.

It is really hard to know as not being a Somali. Well, we knew the SNM was fighting the Somali troops and vice-versa, but to see a Somali troop, it was difficult to know whether he was SNM or not, you know, who is fighting who?

For example, there was a battle right outside of our door, and we looked out there, and we saw the soldiers fighting and shooting at each other, but at that given moment, I could not tell who was on which side. I hope, though, that they could because they were shooting each other.

As far as results from the fighting went, there were a lot of casualties. A lot of uniformed soldiers were killed. Some were in the streets. Others were being picked up by their comrades, and there were some civilian casualties as well.

We had two women visit us, saying that two family members had been hit. We went over to their house and one woman was hit in the jaw. A bullet hit her and left her without a jaw. Another woman was hit in the chest and there was no medical care for her. We bandaged her up however, there was no access to medical care. There was no hospital to take her to. We just did not know where the fighting was going to break out, what part of town where it would erupt, and, so, she stayed there and we expect that she died.

And that was characteristic of the next four or five days. On Wednesday, the day after the fighting, there was a lull and I wanted to get back to my office. We went back and our staff had gathered on the US AID compound, and I opened the building and that became a command post for the evacuation, and there was continued fighting.

Just about every house was hit to some degree. Some houses, like ours, got hit with some bullets. Other houses were hit by an anti-tank gun, and tanks.

Fortunately, the international community had gathered around the houses within the US AID compound and that was not hit heavily. There were no casualties within the international community. There were a lot of civilian casualties, and those arguments about if they were caught in the crossfire, and they definitely were. No question that civilians were leaving their homes, the fighting was in their neighborhood, and they left.

There was talk that the government would be going through the houses to find SNM and SNM sympathizers, and people were anticipating that and were fleeing.

On the day before I left, I went out to find some of our staff and found that most of them had left the city.

We had about five or six guards, who happened to be on the AID compound when the fighting began they stayed on the compound with their families' expecting they would be safer there than they were in the villages where they lived.

There was a lot of talk about human rights abuses, summary executions, such as that. I cannot say that I saw that. I was not an eyewitness to any of that, but there certainly was enough talk about it and enough—there were enough testimonies that it is believable, but I cannot testify that I saw it. It was certainly not taking place around the US AID compound.

There was no food, water or electricity in the city from the day after the fighting started. We had a 5,000-liter cistern that was fortunately full when the fighting began. We had lots of supplies and two generators in the AID compound that enabled us to kept the international community reasonably comfortable until we were able to evacuate.

But the Somali community did suffer extensively during that time. The shops in the city had nothing in them. The Indian community, which were the primarily merchants for most of the Somali community evacuated themselves. This is a level of testimony as to how intense the fighting was.

Now, when the international community ev[illegible] it seemed like it was not such a serious issue because they [illegible] there tempo-

Case 2:10-cv-00342-GGS-MRA Doc # 97-3 Filed: 08/09/12 Page: 24 of 50 PAGEID # 1123

rarily. Most were there for one, two or three year-terms, and many were glad to get out of there early.

The Indian community, though, had been there for generations. They had businesses there. Their lives were there. Their families were there. Most of us expected they had left India and were permanent residents of Somalia, and they left everything there.

You know, when I left, I left nothing. I came back home, but they had no home to go to, and there was an incredible testimony to how threatened they felt by being there, and they were willing to leave generations of their heritage as well as their businesses, their livelihoods, to get out of Somalia and to go into something that was not known.

There has been some talk about the refugee situation, and again after the fighting, I could not visit any refugee camps. We stayed around Hargeisa or around the US AID compound and attended to the needs of the evacuating international community.

But during the fighting, traffic was virtually stopped. There was no utilities, such as food, water, electricity, etc. The ELU-CARE compound, which is the Emergency Logistics Unit for CARE, that supplied refugees, was on fire, and had been since Thursday or Friday night until the time we left. I understand that that compound was occupied by the SNM.

So, I can say that I would be very surprised that there was any aid to refugees during that time simply because the compound was burning, traffic had stopped, there were very little logistics to provide for them.

As far as the future of the refugee situation, in some ways, I would expect the refugees would be better off than the Hargeisa residents in the respect that they were out of the fighting. To my knowledge, there was no fighting in the refugee camps themselves, and, so, the refugees were out of the firing range, and they had connections over the border, if they had chosen to flee. Over the border meaning the Ethiopian border.

The Hargeisa residents, who went out into the bush, I expect, would have had less family connections there.

That is really all I have to say. I would like to welcome any questions, though.

Mr. WOLPE. Thank you very much, Mr. Bradshaw.

Thank you, both, for your testimony today.

I wonder, Mr. Neier, if you could provide some details of the evidence of the reports that have been advanced with respect to summary executions and massacres occurring inside Somalia.

What is the basis of those reports? How many people do we believe to have been subject to summary execution or to civilian massacre?

Mr. NEIER. Well, I think that using a figure is clearly a severe problem here because of the inability to monitor the situation.

I saw that the Washington Post, when it dealt with this on July 2nd, said that informed observers had reported that some 10,000 people had been killed. There have been stories in the British newspapers which have used comparable figures to that.

I do [illegible] a way of saying whether those figures are right, but the[illegible] individual testimonies which have emerged.

For example, in my testimony, I refer to one statement that was made by a French hospital technician in Hargeisa, a man named Jean Meteneir, who told reporters at Nairobi Airport, when he arrived there, that he had seen at least two dozen people who were executed by firing squad against the wall of his house and the corpses were later dumped on the street to serve as an example.

Other AID workers or relief workers who have been in the area have also given statements but have not always been willing to identify themselves, I suppose, because some of them have hopes of returning to their areas.

So, again, all of this is extremely fragmentary. The numbers are not numbers that I can stand by, but people do not flee in large numbers as they have apparently fled from northern Somalia unless there are terrible reasons to flee.

When Mr. Bradshaw spoke about the Indians who gave up everything, clearly the Somalis who have fled into Ethiopia are hardly fleeing into a paradise when they flee into Ethiopia.

I mean, imagine having to flee into Ethiopia of all places in the world. It has to be pretty bad if you are going to flee into Ethiopia, and the United Nations High Commissioner for Refugees is saying 2,000 people a day are coming across the border into Ethiopia. People have given up everything in order to get out of there and go into the terribly difficult circumstances that they would have in that part of Ethiopia.

So, they have had good reasons to do so. They do not flee casually and give up everything. They have to have good reason in order to be able to do so.

The Ethiopian Government had issued a statement at one point saying that the number of refugees that had crossed over the course of a few weeks was a 110,000. Again, I do not have a way of verifying the numbers that were used by the Ethiopian Government, but when you get the statements by that government, when you get the statements by the United Nations High Commissioner for Refugees, when other UN agencies are also indicating that there are large numbers fleeing, clearly, we have got a very serious problem on our hands, and it is necessary, I think, above all, to take all these fragmentary reports and do an absolutely thorough investigation in order to determine exactly what is going on.

Mr. WOLPE. My understanding is that the report of the UNHCR indicates that 175,000 people have already fled as refugees, and that the rate of refugee outflow continues at 2,000 a day.

Mr. NEIER. Well, again, I have heard figures of that sort. I have heard other figures as well. All we know, whether—I cannot stand behind one number or another. All we know is that the number is very large.

This is not a terribly populous area to begin with. We are talking about a very large percentage of the population, indeed, and a very short span of time, and, so, the situation is very drastic, indeed, for that many people to flee.

Mr. WOLPE. And can you tell us the basis of the reports with respect to the bombings of civilian targets and civilian populations?

Mr. NEIER. Well, there are a certain number [illegible]s who are out of the country, who have been able to get [illegible] contact with

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 25 of 50 PAGEID #: 1124

members of their families within the country. Some of the information that we get is coming out in that fashion.

Some of it is coming out because of relief workers who are in the region. Those are the essential sources of information that we have been able to draw on.

Mr. WOLPE. Thank you very much.

Mr. Burton.

Mr. BURTON. Thank you, Mr. Chairman.

I think you are absolutely right. A thorough investigation is necessary, but I think in a situation like this, deductive reasoning sometimes is flawed.

People flee war. Every news reel I have ever seen where a war was taking place, whether it was Korea, World War II or World War I, when there is bombings going on and fighting going on, house to house, in a city, people want to get out of there because they do not want to get shot.

A perfect example is Mr. Bradshaw and the AID people. I think they were anxious to get out of there with all that fighting going on, and I think that is justifiable. So, people do flee to get out of there.

I have a couple of questions.

Mr. NEIER. Congressman, could I respond to that?

Mr. BURTON. Sure.

Mr. NEIER. I have been engaged in a good deal of monitoring of various war situations through the organizations that I direct in places such as Afghanistan and places such as Central America and elsewhere, and I have seen situations in which wars take place in which there is a large flight of rural refugees, and I have seen situations where there is not a comparable flight. And in my experience, at least, when there is a large flight of rural people, it is because there is a deliberate effort by one side or another in such a conflict to drive out people who they think might provide a civilian population base for a guerrilla force or for a government force.

That is, when the Soviets bombed in the Afghan countryside, their purpose was to drive out the civilians who might have provided food and shelter and medical assistance for the Mujaheddin. It was not necessary for the civilian population in Afghanistan to flee to Pakistan just because of combat; it was a deliberate consequence of the Soviet military tactics in Afghanistan.

My experience is it is not an accidental consequence of war. It is when scorched earth tactics are used or when governments are deliberately trying to drive out the civilians who might aid a guerrilla group that you tend to get these enormous flights of refugees.

Mr. BURTON. Well, I will not argue with that, but I was making the point that the people who are fleeing the city probably want to get out of the war as quickly as possible to save their lives and their families.

Mr. NEIER. But bear in mind, Congressman, that we are not talking about just the people who have fled the City of Hargeisa or the City of Burao. When we are talking about that number of people, we are talking about an awful lot of rural people, nomadic people.

Mr. BURTON. Where are you getting that information. What rural people have you talked to over there?

Mr. NEIER. Again, if I could, I would, and I am saying that one of the problems here is the lack of access.

Mr. BURTON. Well, that is what I am saying. Deductive reasoning, it would appear to me to be flawed right now because you do not have all the facts. That is why a complete investigation is necessary.

Mr. NEIER. Right.

Mr. BURTON. But I do not think we should go off half-cocked and start blaming the Somali Government, saying that—

Mr. NEIER. We can blame the Somali Government for cutting off access. If the Somali Government would allow journalists to go in and I know journalists who want to get there and they cannot get there, if they would allow the journalists to get in, we would know a lot more about what is going on.

Mr. BURTON. Yes. Well, all I am saying is that the information that you have is fragmentary, and you are using deductive reasoning, and you are condemning people before you know all the facts.

Now, whether or not those facts will be changed when media does get in there remains to be seen.

Mr. NEIER. Will you at least join me in condemning them for denying access to the journalists?

Mr. BURTON. I think the journalists should be allowed access as long as—

Mr. NEIER. Would you at least join me in condemning them for denying access to human rights groups?

Mr. BURTON. I have no problem with that. I have no problem with——

Mr. NEIER. Okay. Well, we are agreed that one should condemn them for denying the ability to gather the information that is needed.

Mr. BURTON. Well, let me just say this, that your organization is not always a hundred percent accurate. You know——

Mr. NEIER. We try very hard.

Mr. BURTON. Just let me finish. In Mozambique, you made some assertions about a massacre that took place in Homine and you had eyewitnesses.

Mr. NEIER. We never issued any statements on Mozambique.

Mr. BURTON. That was not your organization?

Mr. NEIER. No. We never issued any statements. I said the State Department conducted an investigation. I was glad the State Department did. We had not conducted an investigation.

Mr. BURTON. Well, the investigation to which you allude was deeply flawed in the case of Homine because of the people who committed the atrocity down there, according to the reports that I have, were wearing new uniforms and the Renamo forces did not have new uniforms.

In fact, they were wearing anything they could get their hands on, and the only soldiers down there that had new uniforms were the Zimbabwean troops or the Frelimo troops, the Community Frelimo troops down there.

Mr. NEIER. You are talking about the State Department.

Mr. BURTON. The point I am trying to get across is that a condemnation that you are apparently making with voluntary information is not justified till you get the facts.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 26 of 50 PAGEID #: 1125

Now, I do not mind you raising Cain about human rights groups not being allowed access or the media not being allowed access in there. I think there is justification for that. But to make these deductions without having all the facts, I think, is premature to say the least.

Mr. NEIER. Congressman, could I respond to that?

Mr. BURTON. No.

Mr. NEIER. When we know about nineteen years of the record of a government, when we know that it has engaged in torture over that period of time, when we know that it has completely denied freedom of the press, when we know that it has no respect for due process of law, when we know all of those kinds of things, and we also know that the government is denying access on this occasion, and we see the flights of refugees, at the very least, the burden of proof is on the government rather than the other way around, at the very least.

Mr. BURTON. Well, the rebels that you are talking about and Mr. Bradshaw alluded to the fact that the rebels were in the town——

Mr. NEIER. I hold no brief for the rebels.

Mr. BURTON. The rebels were fighting. There was a confrontation going on. People were shooting at each other. He could not even tell which troops were which, and, so, there is a state of confusion there, and there is a lot of killing going on.

Mr. NEIER. Troops have every right to shoot rebels. They do not have a right to shoot civilians.

Mr. BURTON. Does your wife ever get a word in edgewise?

Mr. NEIER. She is very good. She does.

Mr. BURTON. Boy, that house must be something to listen to.

You alluded to a Frenchman, Jean Meteneir——

Mr. NEIER. Meteneir.

Mr. BURTON. Meteneir, John Meteneir. He said that there were people lined up against his house and shot.

Mr. NEIER. Yes.

Mr. BURTON. Who did the executing?

Mr. NEIER. This was a statement that was quoted in the Sunday Times of London.

Mr. BURTON. Well, was it government troops or the other?

Mr. NEIER. His statement was government troops.

Mr. BURTON. I wonder how he could tell that. I am just curious.

Mr. NEIER. You will have to ask him that.

Mr. BURTON. Could you differentiate, Mr. Bradshaw, between government troops and the other troops?

Mr. BRADSHAW. SNM wear yellow sashes.

Mr. BURTON. When you looked outside and you said you saw people shooting each other, could you tell?

Mr. BRADSHAW. No, not all of them were wearing yellow sashes.

Mr. BURTON. So, some are not.

Well, you know, these atrocities, and they may very well be at the hands of the government, and, if so, they should be condemned, but, once again, I think that we need to wait until we get additional in[redacted]n because what happens when we have these hearings is t[redacted]a comes to these hearings and we have the television came[redacted] rolling, and they come to conclusions which we see on the

nightly news and then we find out later on that that may not have been all the facts.

What happens is the people of the country get one set of facts and it distorts in their minds what is actually going on over there, and all I am cautioning against today is that we make sure that we have the accurate information before we come to conclusions, and if the Government of Somalia is lining up people and executing them, that is a violation of the Geneva Convention, and we ought to raise Cain about that, and we ought to do everything we can to get the media in, as you said, and human rights groups in.

I do not have any problem with that. But what I am cautioning this committee today is to let us take a slow approach, get all the facts, and then, if there is some condemnation that should take place, then, by golly, let us do it. But let us not do it before we have all the information.

Mr. NEIER. Congressman, as far as I know, the planes belong to the government. I do not think anybody has suggested that the planes belong to the SNM.

Mr. BURTON. Let me ask you about that.

When the planes were doing the bombing and strafing, were there enemy troops in those areas they were strafing?

Mr. NEIER. Congressman, the Rules of War or the Geneva Convention requires that there has to be care taken to try to avoid or minimize casualties to civilians.

Mr. BURTON. I understand that.

Mr. NEIER. And the reports that are coming out do not indicate any such care.

Mr. BURTON. Indications are one thing. There is deductive reasoning again. What I was asking you just then, is there any evidence that there were enemy troops stationed in the areas that were being strafed. There may have been a calculated——

Mr. NEIER. That is not the question.

Mr. BURTON. Decision made by the Somali military that there was a large concentration of military people, enemy, in that area, and they may have made a calculated decision to attack those people and kill them.

Now, I do not know. I do not know if they were indiscriminately bombing people or not, civilians, but the fact is that we need to get those facts, and I will do everything in my power, and I will join the Chairman in this effort, to try to get media in there and human rights groups, including yours, in there so we can get the facts.

But, once again, I would like to caution everybody on the committee before we start making statements and getting the media all heated up about this, that we do have fragmentary information and we need a lot more.

Mr. NEIER. I would only make one other point, and that is the National Security Service, as far as I know, is a government agency. The National Security Service, which is reported to be torturing detainees.

Mr. BURTON. Well, if that is the case, then something needs to be done about it.

Thank you.

Mr. WOLPE. Thank you, Mr. Burton.

P-000157

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 27 of 50 PAGEID #: 1126

Mr. Clarke.

Mr. CLARKE. Thank you, Mr. Chairman.

I just had a couple of questions.

Mr. Neier, who supports the SNM? What is their backing?

Mr. NEIER. Well, I have been trying to find out as much as I can about the SNM, and I am not able to find out a great deal. I was trying to find out if they had separatist tendencies and so far as I can tell, they are not a separatist group.

I was trying to find out what their ideological orientation is, and as far as I can tell, they seem to be united principally by antagonism to the Siad Barre Government.

I am sure that they are getting some kind of foreign support. I do not know what that foreign support is. So, I am really not well informed enough to be able to answer you.

Mr. CLARKE. How much strength do they appear to have?

Mr. NEIER. Well, they clearly were able to attack the major cities in northern Somalia, and apparently at least for a period to overrun those cities.

That suggests fairly substantial strength.

Mr. CLARKE. Mr. Bradshaw, I want to ask you about the Indian community.

How large was the Indian community there or that was there?

Mr. BRADSHAW. I understand there were about eighty-five families that were evacuated. Perhaps eighty-five adults. I am not quite sure.

The Indian community was evacuated after I was evacuated. While we were preparing for the evacuation, I was asked about the Indian community, and at that point, I knew very little about it, except it was there, they were the shopkeepers, and they were in the center of town, and that was where a lot of fighting took place.

But I did not find any specifics about that community, and I was asked if I could investigate and see if that would be possible. I made a few attempts to get to the city and there was just no way I could get there, and, so, on June 4th, well, between June 3rd and 4th, the international community had evacuated, and after that, the Indian community, it was a later date that the Indian community left.

So, I did not participate in that as thoroughly, except to know that they were there. I understand the term eighty-five comes to mind. Whether that was eighty-five adults, eighty-five of everybody, I am not quite sure.

Mr. CLARKE. So, we are not talking about large numbers of people?

Mr. BRADSHAW. Well, to say it is a large number, yes, it is a large number in relation to the number of foreigners in Hargeisa. There were about 120 people like myself. There were forty people from the Chinese community. So, the evacuation—the Chinese community were doing development work in the north, and, so, there were about 165 of us who were in the initial phase of the evacuation, and then we had the Indian community.

So, that was probably about one-third of the people who evacuated. So [redacted] you know, eighty-five is not such a large number, but, yes, p[redacted]ntage-wise, it is a fairly respectable number.

Mr. [redacted]ARKE. Thank you.

Thank you, Mr. Chairman.

Mr. WOLPE. Thank you very much, Mr. Clarke.

Mr. Bradshaw, one last question.

Within the expatriate community, what was the perception with respect to the question of summary executions occurring or civilian massacres? Had you heard of those reports?

Mr. BRADSHAW. Yes. We had certainly heard of that.

I did not meet anybody who said, yes, I saw it happen.

Mr. WOLPE. Was there a general feeling within the expatriate community as to whether or not that had, in fact, happened or the culpability for those events?

Mr. BRADSHAW. Well, I would say there was a general sense that, yes, it was going on. Part of that might be because you hear the same rumors three times, it must be true.

In a situation like that, people are very tense and they are concerned about their safety and they are concerned about what is going on, and, so, almost anything is believable, and if it starts from one source and it is told to another and to another, and those three sources tell, it is increasing exponentially and then it becomes believable.

Mr. WOLPE. Okay. Well, let me express my appreciation to both of you gentlemen for your testimony this afternoon and for your assistance with this committee.

Thank you very much.

Mr. NEIER. Thank you very much.

Mr. WOLPE. I would like now to call upon the State Department to come to the witness table.

Our witness will be Mr. Kenneth Brown, the Deputy Assistant Secretary of State for African Affairs.

Accompanying him is Mr. Davison and I am delighted to have both of you with us this afternoon.

The full text of any written testimony that you have submitted will be entered into the record in its entirety. I would ask that you might summarize and contain within the maximum of the minutes your oral presentation so we might have an opportunity for questions.

Mr. Brown.

STATEMENT OF KENNETH BROWN, DEPUTY ASSISTANT SECRETARY OF STATE FOR AFRICAN AFFAIRS, ACCOMPANIED BY JOHN DAVISON, DIRECTOR, OFFICE OF EAST AFRICAN AFFAIRS, MARGARET McKELVEY, DIRECTOR, OFFICE OF AFRICAN REFUGEE ASSISTANCE

Mr. BROWN. Thank you, Mr. Chairman.

The written text, which we will submit, actually is brief and, therefore, I can read it within the amount of time allotted.

Thank you for the invitation to be here, and we are pleased to offer the views of the State Department on the situation in northern Somalia.

The recent fighting there began on May 27th, when forces of the Somali National Movement or the SNM launched [redacted]ttack on Burao. With the advantage of surprise and after [redacted]nating the top military and civilian leadership in the town, th[redacted]M took con-

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 28 of 50 PAGEID #: 1127

trol of Burao until Somali forces retook it about May 30th, after air and artillery bombardment. SNM forces evacuated Burao north into the Sheikh Mountains where they remain. SNM forces also attacked the Town of Hargeisa on May 31st. The fighting for Burao and Hargeisa was at times intense.

In the case of Hargeisa, the fighting continues intermittently.

There has been no fighting in the port town of Berbera, which is roughly sixty miles north of the Hargeisa-Burao area. I have heard a report that there have been some SNM claims this morning that they have taken positions outside Berbera, but I have no confirmation of that.

At present, the situation for both sides has settled into what may be a protracted guerrilla conflict. SNM and Somali Government forces are engaged in intermittent action from west of Hargeisa to east of Burao, essentially, the northwest of Somalia, although not as far as the border with Djibouti.

Within this northwest area, it appears that the SNM holds parts of Hargeisa, the village of Adadle, and other villages in the Sheikh Mountains and around Burao. The Somali Army holds other parts of Hargeisa, including the airport, Burao and Berbera.

The SNM's early advances, its persistent occupation with some areas, and its continuing engagement has surprised some observers. The SNM draws its support from the Isaaq clan of the north, a clan, which, in the main, has opposed centralized rule from Mogadishu and alleged neglect of the north.

The SNM's political agenda remains unclear, except for the persistent call for the overthrow of Siad Barre's government. Since 1981, the SNM has waged a low intensity insurgency in the northwest. Its current operation represents its broadest and most persistent push.

Once the fighting intensified, particularly around Hargeisa, our first concern was for the safety of the Americans and other expatriates in danger of being caught in the crossfire. We helped facilitate the United Nations-sponsored evacuation of Hargeisa, which brought out nearly 240 expatriates, including eight Americans.

The situation in northern Somalia is particularly difficult. There has been a history of active resistance to the government in that area by the SNM and its sympathizers and a legacy of bitterness, distrust and hostility on both sides.

The fighting which occurred in recent weeks was frequently intense, as government forces faced a broad challenge to their authority in the north by the determined SNM fighters. Civilians were caught in the middle and we understand that many have left to avoid the fighting.

Some expatriates who came out of the north reported that Somali Army troops had summarily executed an undetermined number of SNM soldiers and presumed SNM sympathizers. These actions reportedly occurred in the early days of the fighting in Hargeisa where fighting was particularly intense. We have not been able to verify through other sources what happened, but we condemn such actions as we condemn similar actions, such as assassinati[illegible] the SNM.

We re[illegible]at there has been bloodshed and we hope that it will stop. As [illegible] have done in other cases in which individuals' rights

are at risk, we have let Somali officials know of our concerns that human rights be respected. We have made clear that the United States favors internal reconciliation in Somalia.

We have urged President Siad to take this course and he has told us that he is trying to do so.

We hope that the SNM will respond positively. Our Ambassador also delivered our message of support for reconciliation and observance of human rights publicly in his Fourth of July speech this month in Somalia. This message was broadcast on Somali National Television, and it was circulated widely in written form.

That is all I have, Mr. Chairman. I would be pleased to take your questions.

[Prepared statement of Mr. Brown follows:]

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 29 of 50 PAGEID #: 1128

P-000159

Opening Statement of
Kenneth L. Brown, Deputy Assistant Secretary
Bureau of African Affairs
Human Rights Situation in Northern Somalia
Hearings of the Africa Subcommittee of the
House Foreign Affairs Committee
July 14, 1988

GOOD AFTERNOON, MR. CHAIRMAN. I AM PLEASED TO OFFER THE VIEWS OF THE STATE DEPARTMENT ON THE SITUATION IN NORTHERN SOMALIA.

THE RECENT FIGHTING THERE BEGAN ON MAY 27 WHEN FORCES OF THE SOMALI NATIONAL MOVEMENT (SNM) LAUNCHED AN ATTACK ON BURAO. WITH THE ADVANTAGE OF SURPRISE, AND AFTER ASSASSINATING THE TOP MILITARY AND CIVILIAN LEADERSHIP IN THE TOWN, THE SNM TOOK CONTROL OF BURAO UNTIL SOMALI FORCES RETOOK IT ABOUT MAY 30 AFTER AIR AND ARTILLERY BOMBARDMENT. SNM FORCES EVACUATED BURAO NORTH INTO THE SHEIKH MOUNTAINS, WHERE THEY REMAIN. SNM FORCES ALSO ATTACKED THE TOWN OF HARGEISA MAY 31. THE FIGHTING FOR BURAO AND HARGEISA WAS AT TIMES INTENSE. IN THE CASE OF HARGEISA, THE FIGHTING CONTINUES INTERMITTENTLY. THERE HAS BEEN NO FIGHTING IN THE PORT TOWN OF BERBERA, WHICH IS ROUGHLY 80 MILES NORTH OF THE HARGEISA-BURAO AREA.

AT PRESENT, THE SITUATION FOR BOTH SIDES HAS SETTLED IN TO WHAT MAY BE A PROTRACTED GUERRILLA CONFLICT. SNM AND SOMALI GOVERNMENT FORCES ARE ENGAGED IN INTERMITTENT ACTION FROM WEST OF HARGEISA TO EAST OF BURAO, ESSENTIALLY THE NORTHWEST OF SOMALIA, ALTHOUGH NOT AS FAR AS THE BORDER WITH DJIBOUTI. WITHIN THIS NORTHWEST AREA, IT APPEARS THAT THE SNM HOLDS PARTS OF HARGEISA, THE VILLAGE OF ADADLE AND OTHER VILLAGES IN THE SHEIKH MOUNTAINS AND AROUND BURAO. THE SOMALI ARMY HOLDS OTHER PARTS OF HARGEISA, INCLUDING THE AIRPORT, BURAO AND BERBERA.

THE SNM'S EARLY ADVANCES, ITS PERSISTENT OCCUPATION OF SOME AREAS, AND ITS CONTINUING ENGAGEMENT HAS SURPRISED SOME OBSERVERS. THE SNM DRAWS ITS SUPPORT FROM THE ISSAK CLAN OF THE NORTH, A CLAN WHICH IN THE MAIN HAS OPPOSED CENTRALIZED RULE FROM MOGADISHU AND ALLEGED NEGLECT OF THE NORTH. THE SNM'S POLITICAL AGENDA REMAINS UNCLEAR EXCEPT FOR THE PERSISTENT CALL FOR THE OVERTHROW OF SIAD BARRE'S GOVERNMENT. SINCE 1981, THE SNM HAS WAGED A LOW-INTENSITY INSURGENCY IN THE NORTHWEST. ITS CURRENT OPERATION REPRESENTS ITS BROADEST AND MOST PERSISTENT PUSH. ONCE THE FIGHTING INTENSIFIED, PARTICULARLY AROUND HARGEISA, OUR FIRST CONCERN WAS FOR THE SAFETY OF AMERICANS AND OTHER EXPATRIATES IN DANGER OF BEING

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 30 of 50 PAGEID #: 1129

CAUGHT IN THE CROSSFIRE. WE HELPED FACILITATE THE UNITED NATIONS-SPONSORED EVACUATION OF HARGEISA WHICH BROUGHT OUT NEARLY 240 EXPATRIATES, INCLUDING 8 AMERICANS.

THE SITUATION IN NORTHERN SOMALIA IS PARTICULARLY DIFFICULT. THERE HAS BEEN A HISTORY OF ACTIVE RESISTANCE TO THE GOVERNMENT IN THAT AREA BY THE SNM AND ITS SYMPATHIZERS, AND A LEGACY OF BITTERNESS, DISTRUST, AND HOSTILITY ON BOTH SIDES. THE FIGHTING WHICH OCCURRED IN RECENT WEEKS WAS FREQUENTLY INTENSE, AS GOVERNMENT FORCES FACED THE BROAD CHALLENGE TO THEIR AUTHORITY IN THE NORTH BY DETERMINED SNM FIGHTERS. CIVILIANS WERE CAUGHT IN THE MIDDLE, AND WE UNDERSTAND THAT MANY LEFT THE TOWNS TO AVOID THE FIGHTING.

SOME EXPATRIATES WHO CAME OUT OF THE NORTH REPORTED THAT SOMALI ARMY TROOPS HAD SUMMARILY EXECUTED AN UNDETERMINED NUMBER OF SNM SOLDIERS AND PRESUMED SNM SYMPATHIZERS. THESE ACTIONS REPORTEDLY OCCURRED IN THE EARLY DAYS OF THE FIGHTING IN HARGEISA, WHERE FIGHTING WAS PARTICULARLY INTENSE. WE HAVE NOT BEEN ABLE TO VERIFY THROUGH OTHER SOURCES WHAT HAPPENED, BUT WE CONDEMM SUCH ACTIONS, AS WE CONDEMM SIMILAR ACTIONS, SUCH AS ASSASSINATIONS, BY THE SNM.

WE REGRET THAT THERE HAS BEEN BLOODSHED AND HOPE THAT IT WILL STOP. AS WE HAVE DONE IN OTHER CASES IN WHICH INDIVIDUALS' RIGHTS ARE AT RISK, WE HAVE LET SOMALI OFFICIALS KNOW OF OUR CONCERNS THAT HUMAN RIGHTS BE RESPECTED. WE HAVE MADE CLEAR THAT THE UNITED STATES FAVORS INTERNAL RECONCILIATION IN SOMALIA. WE HAVE URGED PRESIDENT SIAD TO TAKE THIS COURSE AND HE HAS TOLD US THAT HE IS TRYING TO DO SO. WE HOPE THAT THE SNM WILL RESPOND POSITIVELY. OUR AMBASSADOR ALSO DELIVERED OUR MESSAGE OF SUPPORT FOR RECONCILIATION AND OBSERVANCE OF HUMAN RIGHTS PUBLICLY IN HIS FOURTH OF JULY SPEECH THIS MONTH IN SOMALIA. THIS MESSAGE WAS BROADCAST ON SOMALI NATIONAL TELEVISION AND CIRCULATED IN WRITTEN FORM.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 31 of 50 PAGEID #: 1130

Mr. WOLPE. Thank you very much, Mr. Brown.

First of all, just in terms of the origins of the conflict, could you comment as to the basis of the conflict? Is this a conflict that is, as I think your testimony indicated, a product of indigenous local historic tensions or is it a conflict that is primarily a result of outside intervention, stimulated by Ethiopia?

Mr. BROWN. Well, the rivalry and discord among clans has been historic in Somalia. The SNM was receiving support from Ethiopia. They were operating out of bases in Ethiopia.

With the recent agreement between Ethiopia and Somalia to enter into an accord for peace, it was agreed that both sides would stop support for subversive actions by elements that were opposed to the other side.

So, in regard to this particular fighting, we do not have evidence that the Ethiopians are supporting this particular activity. We do not have firm information one way or the other, but we do not have any conclusionary evidence that they instigated or supported the main part of the fighting in this case, and the indications are that the fighting originated on the Somali side.

Mr. WOLPE. So, the conflict is much more clearly understood as indigenous internal conflict?

Mr. BROWN. That is right.

Mr. WOLPE. If there are Soviet or East European armaments being utilized in the conflict, would that be the product of earlier arms that had come in during the period of time that the Ethiopians were, in fact, supporting the rebel activity within Somalia?

Mr. BROWN. We understand that the SNM, when they crossed into Somalia, after the agreement, after the agreement between Ethiopia and Somalia, brought their arms with them.

Mr. WOLPE. We have reports that there has been systematic saturation bombings of northern towns by the Somali military. Some reports indicate that Hargeisa, a city with a population of more than 300,000, has been severely bombed beyond recognition.

There have been reports that the Somali military has utilized Hawker Hunter planes, piloted or maintained by ex-Rhodesian technicians, for these reported attacks.

Yesterday, according to a BBC report, a Somali pilot defected to Djibouti after Somali generals in Berbera ordered him to bomb civilian targets in Hargeisa. Instead of complying or resisting, the pilot flew to Djibouti where he defected.

What information do you have on the Somali military's bombings of northern towns and can you provide us with any information on these other incidents, including the reported activities of ex-Rhodesian mercenaries?

Mr. BROWN. Well, I would have to start by saying that we do not have very complete information on what has happened in the north. We have not been able to go into the areas where the fighting has taken place. So, we are not current. We certainly do not have definitive information.

Information we do have indicates that SNM forces did occupy tow[illegible]ccupy Hargeisa, did occupy Burao, and that in reaction to [illegible]ccupation, there were bombardments and bombings from the Somali Government side.

In regard to the use of foreign pilots, I believe there are people under contract who have been involved in the aviation side of the operation.

Mr. WOLPE. Former Rhodesians?

Mr. BROWN. Former Rhodesians.

Mr. WOLPE. South African?

Mr. BROWN. Not that I am aware of. I have seen reference to Zimbabwean, but I have not seen references to South Africans.

Mr. WOLPE. Rhodesia, as an entity, was not in existence in 1979, when it became the country of Zimbabwe.

Is it your understanding that the pilots are living in South Africa, were living in South Africa, or in Zimbabwe?

Mr. BROWN. I do not know much about the origins. I have seen them described as Zimbabweans under contract to maintain the Hawker Hunters. I do not know anything about where they lived beforehand.

Mr. WOLPE. What have we said to the Government of Somalia specifically on the bombing activities which impacts severely on the civilian population, and what, if any, has been the Government's response?

Mr. BROWN. The discussions that we have had with the President in Somalia through our Ambassador have centered primarily on the question of now that the fighting has taken place, although, as I noted, there is still fighting going on, what happens now, and the emphasis there on what we have said and on the emphasis and the emphasis of what President Siad has said has been on reconciliation.

The need now to reconcile differences in the north.

Mr. WOLPE. But aside from the political dimension, what have we said, if anything, about the bombing of civilian populations?

Mr. BROWN. I do not know that we have had specific conversations about the fighting itself in regard to the attacks by the SNM and the reaction, the reaction from the Government side.

We certainly have discussed with the President in terms of the question of trying to assure that the rights of civilians in that area are protected and that, of course, would include the right to not be injured.

But we have not heard reports that there was saturation bombings, but that there were bombings of SNM forces in the cities or in the towns, I guess, one would more properly say.

Mr. WOLPE. There are numerous press reports that two to three hundred thousand Ethiopian refugees have themselves fled from Ethiopia and are in fifteen camps in northwest Somalia, in danger of starvation in Somalia after having been cut off from food and water supplies by the civil war.

What is our current information on that situation? Are you aware of the condition in the camps and are there any alternative ways of ensuring that food can reach these refugees, such as routing supplies through Ethiopia?

Mr. BROWN. It is my understanding that food is getting to the camps, and we do have a representative here of [illegible]fugee programs who might be better able to answer that q

Mr. WOLPE. Could you please identify yourself?

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 32 of 50 PAGEID #: 1131

Ms. McKELVEY. Margaret McKelvey, the Director of the Office of African Refugee Assistance, State Department.

Mr. WOLPE. Okay.

STATEMENT OF MARGARET McKELVEY, DIRECTOR OF THE OFFICE OF AFRICAN REFUGEE ASSISTANCE, U.S. DEPARTMENT OF STATE

Ms. McKELVEY. I think the latest information we have which I think probably parallels what you have seen as well is that food is being delivered in some quantity to almost all of the camps in the northwest. Almost all being defined as all but one.

Now, we do not have exact confirmation of what level of rations is going through. A number of the camps have been and continue to be served directly from Berbera.

As Mr. Bradshaw said, the compound associated with logistics in Hargeisa has been badly damaged. We understand that of the trucking fleet, about a third remain operating, some are in the hands of the Somali military, some are in the hands of the SNM, and some are otherwise unaccounted for.

So, if we could engage in some deductive reasoning, all of that would lead you to believe that not as much is going through, but I guess it needs to be seen in the context of how food is delivered, which is every ten days, and, so, they have been able to speed up some of the turn-around times and so on and continue to supply food to those camps.

The numbers question has always been a contentious one as to exactly how many refugees there are there. We can say that there are ration cardholders and there is a question as to how dependent those people are for day-to-day survival, but it is clear that the most recent arrivals from Ethiopia, we are talking about 1984 through 1986, are in the northwest and, therefore, one would presume that those people are more dependent.

But, also, those most recent arrivals are closer to deliveries from Berbera. So, we are watching it as carefully as we can. Most of these reports are secondhand by radio contact from the Somali employees of the National Refugee Commission, Logistics Unit.

Mr. WOLPE. There have been some press reports that the Somali military have armed Ethiopian refugees to fight in the civil conflict. What is the State Department's assessment of that report?

Ms. McKELVEY. Well, we had asked for an assessment of that and, again, we are dealing with secondhand information, but it appears that the refugees may have in some measure armed themselves, may—there were reports of conscription as well and it seems that what we are dealing with is the refugee population that is—would be considered to be not aligned with the insurgents. Their interests would be different from those.

So, we do not have anything, I would say, definitive on that, but there certainly have been reports of both conscription and of arming of refugees to defend themselves.

Mr. [redacted] On this matter of the camps, I assume you are aware that [redacted]HCR representative in speaking with CARE recently indicated that many of these camps are empty

Ms. McKELVEY. I guess I have not seen that specific report. A number of—I think three or four of the camps, the people moved to a location where they could be better served.

It may go back to the issue of how many refugees are there in these camps in any given time, and whether the people that were in those camps and receiving food had, in fact, left and where they have gone.

Mr. WOLPE. Well, let me now yield to my colleague, Mr. Clarke.

Mr. CLARKE. Thank you, Mr. Chairman.

Mr. Brown, we have reports that an American team is helping to maintain and run the military's communications network in the north.

Can you tell us if this is accurate?

Mr. BROWN. We did repairs to the communications facility in Berbera.

Mr. CLARKE. We repaired it?

Mr. BROWN. Yes.

Mr. WOLPE. Would the gentleman yield on that point?

Mr. CLARKE. Yes.

Mr. WOLPE. I just want to understand this.

What was the reason for our repairing that facility? Is this not a direct contribution to the Somali military in their civil conflict?

Mr. BROWN. My colleague, Mr. Davison, tells me that I misspoke. It was not Berbera. It was at Hargeisa.

This is the—just in terms of part of our MAP program, where we have provided communications to the Somali military.

When the facility broke down at Hargeisa, which became a major problem for them in terms of communications, not only with regard to the fighting but in regard to such questions as getting civilians out, getting those who needed to be evacuated, including eight Americans, out, there was a severe communications problem and we helped correct that problem.

Mr. WOLPE. Will we continue to assist the Government of Somalia in its military operations as it relates to its civil conflict? Is that America's role?

Mr. BROWN. Well, I am not certain how one would characterize it in terms of helping Somalia in this civil conflict. We have an ongoing MAP program with Somalia, which continues, but I would not say that we have been engaged in the conflict.

Mr. WOLPE. How did the communications system incur its difficulty?

Mr. BROWN. I guess it was hit during the fighting. The generator was hit apparently. The generator broke down.

Mr. WOLPE. That is a product of the civil conflict.

Mr. BROWN. As part of the civil conflict.

Mr. WOLPE. Does the normal MAP contract involve us in repairing communication facilities that are disrupted in the course of civil conflict in countries in which we have MAP relationships?

Mr. BROWN. The action we took in regard to repairing the generator was within the context of our MAP program.

Mr. WOLPE. That was not my question.

Mr. BROWN. Well, the answer to your questi[redacted] what we did was legitimate.

P-000163

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 33 of 50 PAGEID #: 1132

Mr. WOLPE. And you do not see this as involving us in the Somali civil conflict?

Mr. BROWN. No.

Mr. WOLPE. Mr. Clarke, thank you for yielding.

Mr. CLARKE. Mr. Brown, in your statement, I think you say that the political agenda of the SNM is unclear. Yet apparently they have produced a lot of written material and their representative has met over the years with U.S. officials from various agencies.

Is there any further information that we have in regard to this movement that we should know?

Mr. BROWN. Well, we said unclear. Perhaps there is another way to characterize it, has been—that it has been somewhat variable, depending on who was talking to the SNM representative.

It sort of tended to be that if one from the West is talking with SNM, the SNM policy tends to be characterized in regard to democracy and free enterprise and, yet, declarations on the ground by the SNM in Somalia have tended to be more in the other direction.

Mr. CLARKE. So, it is a confused picture?

Mr. BROWN. Not clear-cut, that is true, sir, and it seems—what I wanted to note in the statement was that the constant seems to be opposition to the government in Mogadishu, a feeling that the north has been neglected, and we must recall that before Siad Barre took over, the Isaaqs had a prominent role in the Government of Somalia.

So, they are now out, and they feel that the north has been neglected. They want to remedy that, and, so, they are opposed to Siad Barre. They would like his government to fall. That seems to be the constant in the program.

Mr. CLARKE. Is there any—has there been any fighting near the U.S. bases?

Mr. BROWN. Well, sir, we do not have bases. We do have—we have access to facilities there in Berbera. There has not been fighting in Berbera. I did note as an aside in my earlier comment that they had been reporting that the SNM was claiming to have taken some positions outside Berbera, that they had captured some hills outside Berbera. I do not know whether that is true, but Berbera is still in government hands.

So, there has not been any danger to any American personnel.

Mr. CLARKE. Thank you.

Thank you, Mr. Chairman.

Mr. WOLPE. Thank you, Mr. Clarke.

Mr. Brown, you mentioned in your statement the central government has allegedly "neglected" the north.

Is it not clear that the Government of Somalia has had an explicit policy of economic discrimination against the predominant Isaaq group and reacted to SNM attacks by a scorched earth policy of razing villages, destroying water wells? Are those really allegations that are not known or substantiated?

Mr. BROWN. Well, when I used the word "allegedly," I meant that in terms of alleged by the SNM. I was not making a value judgment one way or the other.

The [redacted] not know scorched earth tactics. The—I think it is a fair [redacted]on to ask whether the north gets its fair share. I do not have an answer for that, but in the country with the configuration

of Somalia, which, as you know, is long and stretched out, with two parts of the country having different histories, there may be some grounds for questions as to how benefits are divided up.

But, certainly, they do not feel on the political side that they have received their share of representation.

Mr. WOLPE. Is it not true that the government has severely repressed all peaceful opposition in the north or recently has gone so far as to freeze peoples' bank accounts?

I mean, are these not facts that are known to our government?

Mr. BROWN. Mr. Davison will reply to that question.

Mr. DAVISON. I am sorry. I did not get the last part of the question.

Mr. WOLPE. Are these facts with respect to the severe repression by the government of all peaceful opposition in the north, more recently the use of such tactics as the freezing of bank accounts. These are these facts, as I understand them to be now. This is not known to our own government?

Mr. DAVISON. You mean since the beginning of the fighting or before?

Mr. WOLPE. Both. I was asking more of a historical question in terms of the background of the fighting.

Mr. DAVISON. I do not think we believe there has been economic discrimination as such. There certainly, as Mr. Brown has said, has been—the Isaaqs feel they have been left out politically and in countries like Somalia, there does sometimes tend to be a connection between the political power you hold and the economic benefits that you can derive.

There are, however—the Isaaqs are generally considered industrious and, indeed, within the context of Somalia, a prosperous group, known for their skills in trading and commerce. Outside the country, particularly.

I am unaware, frankly, of reports that bank accounts were frozen before the present hostilities began.

Mr. WOLPE. Expatriates that have come back to this country after living in Somalia, have brought these accounts to us the Africa subcommittee. I am surprised the State Department has not heard them.

Has the government not engaged in a pretty thorough and systematic repression of peaceful opposition in the north over the years?

Mr. DAVISON. I would not describe it as that at all. The government, in fact, has had for many years an amnesty held out to the SNM when they were in Ethiopia.

Mr. WOLPE. Mr. Brown, you mentioned that the political agenda of the Somalia National Movement is unclear, yet the SNM has produced a great deal of written material, its representative has met over the years with U.S. officials from various agencies, and he is a member of the Movement's central committee.

What is unclear and what have you done to obtain additional information about the SNM?

Mr. BROWN. Well, as to what is unclear, I would just refer to my reply to the question from Mr. Clarke, but in terms [redacted]at we do to obtain more information, we do have contact wi[redacted]SNM, and we do listen to what they have to say.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 34 of 50 PAGEID #: 1133

So, of course, we are interested in that and we certainly would not be saying that the Isaaqs do not have legitimate grievances.

Mr. WOLPE. You have spoken of unconfirmed reports of summary executions by the Somali Government. Do you have any reason to doubt the expatriate reports that were made by officials of very respected AID agencies? I guess I would also be interested in knowing what you have done to either confirm or to deny the authenticity of those reports, if you doubt that.

Mr. BROWN. Well, I am not saying that we doubt them. I am saying that we do not have confirmation of them. The people that we have talked to or the reports that we have heard normally have not been firsthand witnesses, although I understand there may have been one eyewitness to some executions.

So, I am not denying that the executions may have taken place.

Mr. WOLPE. One last question I would like to ask relates to reports that a ship arrived a few days ago at the Port of Berbera carrying American rifles, grenade launchers and other equipment, and I guess if that report is accurate, how can you explain to this committee the justification for sending military equipment in the midst of a civil war in which large numbers of civilians are being killed?

Mr. BROWN. There was a ship that delivered small arms to the Port of Berbera, I believe, arriving on June 29th. This was equipment that was in the MAP pipeline. We have not suspended our MAP program to Somalia. It continues normally.

Mr. WOLPE. Is further military assistance contemplated then?

Mr. BROWN. The—as I say, the MAP program continues normally.

We have sped up some humanitarian assistance in that context.

Mr. WOLPE. For the civilians or for the military?

Mr. BROWN. We have sent medicines and I believe a transportable hospital is on the way, yes, and that would be for the provision of assistance to whoever needs it.

Mr. WOLPE. I hope there is someone that is looking at this in terms of American national interests in our long-term relationship to Somalia. Might we at least consider the wisdom of continuing in an indiscriminate fashion the military program in the midst of the kinds of reports that we are receiving.

I find it extraordinary that I have not had a hint from you that that kind of assessment is in process right now. Also, I would like to, in writing, have you tell us what you are doing in the way of contingency planning to deal with the emergency that is out there, the human emergency.

I cannot believe that we have not heard a word of comment on that either.

Mr. BROWN. Well, may I just say, sir, that we certainly are looking at the situation in Somalia. We certainly are looking at our policy with regard to Somalia and in regard to our programs.

The fact that the programs are continuing does not mean that we have not been thinking about it or reflecting on it or examining our pro[redacted]s.

M[redacted]E. But at least as of this moment in time, nothing has cha[redacted] I think it is a matter of substantial concern that we are

that slow to react to an increasingly dangerous and urgent situation.

Let me thank you both for being here. I know that we are kind of accelerating the conclusion of this hearing. I would have liked to have gone a little bit further, but with a vote in process, I do not think that would be possible.

But let me thank you both for being here again on, I know, relatively short notice, that you have both had to adjust your schedules.

Thank you very much.

Mr. BROWN. Thank you.

[Whereupon, at 3:05 p.m., the subcommittee was adjourned.]

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 35 of 50 PAGEID #: 1134

P-000165

APPENDIX 1.

A listing of International Press Accounts concerning the deteriating situation in Somalia, submitted by Howard Wolpe, Chairman of the Subcommittee on Africa

INTERNATIONAL PRESS ACCOUNTS OF THE INCREASED MILITARY CONFLICT AND WORSENING REFUGEE SITUATION IN NORTHERN SOMALIA

There are many recent accounts of heavy fighting between government forces and Somali National Movement (SNM) guerrillas:

* On July 2 AP reported charges against the Somali government of "indiscriminate shelling and bombing of northern cities."

* The Guardian reported on June 24: "Systematic bombing of northern towns, massacres of civilians, arrests, and summary executions in northern Somalia by the Government . . . are being reported by human rights organisations gathering evidence from refugees arriving in Djibouti. . . . Amnesty International reports that arbitrary executions by government forces in Hargeisa began on May 31, when the battle for control of the town began. During house-to-house searches for SNM supporters, people were shot dead, or arrested and subsequently executed. . . ."

* The July 2 Washington Post reported that: "Informed observers said that the civil war has caused as many as 10,000 deaths in the past four weeks. The fighting has flattened a number of towns in the region and triggered a flood of refugees out of northern Somalia into bordering Ethiopia."

The Somali refugee situation has also received a great deal of attention:

* The July 3 Observer notes: "Reliable reports speak of 35,000 people, mostly women and children, fleeing into the Ogaden region of Ethiopia, and of another 40,000 fleeing into the Somali countryside."

* According to Ethiopian officials, Reuters reported on June 30, "About 110,000 refugees have fled fighting between government troops and rebels in northern Somalia and crossed into the Odaden region. . . ."

* On July 8 Reuters quoted UN officials on the condition of the refugees: "They are almost bare. They are running for their lives. They need blankets, clothing, tents and food."

Ethiopian refugees in Somalia are also at risk:

* On June 12 the Sunday Times of London reported: "Hundreds of thousands of Ethiopian refugees are in danger of starvation in Somalia after being cut off from food supplies by civil war. . . . The 300,000 refugees, who themselves had fled from persecution and famine in Ethiopia, are in 15 camps in northwest Somalia. . . ."

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 36 of 50 PAGEID #: 1135

* An anonymous relief worker expressed concern for these refugees: "my main concern now is for the people who lived in the refugee camps we worked with. . . . I believe many people have starved or died of thirst by now because the whole infrastructure for dealing with refugees has been destroyed."

The fighting has caused a breakdown in infrastructure, further threatening the civilian population in the region:

* The Kenyan Daily Nation reported on June 13 that accusations had been made against Somali troops of "systematically destroying communications systems, roads, water reservoirs and electricity installations. . . ."

* The Sunday Times of London reported on the dangerous conditions in the northern city of Hargeisa: "The absence of clean water and the unburied bodies threaten a cholera epidemic in the town, while the 200,000 refugees from Ethiopia in camps in the north are equally at risk. They depend on food, water and medical supplies trucked in by aid agencies, which the fighting and the withdrawl of relief workers have halted."

Eyewitnesses have reported summary executions:

* On June 8 UPI ran a story quoting a French technician who had recently been evacuated from Hargeisa: "I lived very near the center of town. I saw alot of bodies -- up to 1,500. . . . Those were the bodies of people killed in the fighting and summarily executed in the streets. . . . I saw 21 people summarily executed by the army behind my house."

* An anonymous confidential report by another recently evacuated expatriate highlights executions of 14-18 year old boys by government troops in a northern city.

* The Kenya Times reported on June 9 that an aid worker, while being evacuated from Hargeisa, "saw about ten bodies laid out in the road 'as an example'."

* The June 25 issue of The Nation reported: "In March 1988 more than twenty people suspected of S.N.M. sympathies were drowned in wells in the town of Gebiley."

To the south, in and around the capital of Mogadishu, extensive detentions are occuring:

* A June 30 letter from Human Rights Watch to Somalian President Mohamed Siad Barre lists over twenty citizens of Mogadishu who have been detained arbitrarily, seemingly because of their northern ancestry.

* A July 2 Washington Post article (cited above) reported that "some detainees are being held in the headquarters of the national security service at Godka prison in Mogadishu, a site known as 'The Hole,' where large numbers of political prisoners reportedly have been tortured in recent years."

APPENDIX 2

Statement Submitted by
THE ORGANIZATION FOR SOMALI AFFAIRS
-U.S.A.-

PRESS RELEASE

Background on the Organization

OSA is an educational non-profit corporation headquartered here in Washington since its creation 4 years ago. The organization draws its membership from Somalia and American friends of Somalia.

OSA is dedicating to educating the American people about Somalia and to promoting in Somalia a democracy founded on representative government, individual liberty, social justice and economic growth through free enterprise.

The Civil War In Somalia

Since late May of this year, a human tragedy has been taking place in Somalia. In his attempt to suppress a popular uprising against his brutal rule, General Mohamed Siad Barre has waged an unholy war on the Somali people.

In this war, the General has used every military weapon available to him including heavy artillery, tanks, rockets and aircrafts against heavily populated centers, thus killing thousands of civilians including women and children. In fact, such principal cities as Hargeisa and Burao have been flattened to the ground. According to reports reaching us from our contacts in Somalia, the ten thousands reported by the international press is only a small fraction of the actual casualties so far. This is not surprising given the fact that the General has refused to allow foreign reporters to enter the country.

The war is not limited to the north. Indeed, the revolt against the regime is spreading to the southern regions. We have information indicating that such urban centers as Garoe, Galcaio, Dusamareem and Baletweyne as well as surrounding villages and settlements are under siege. And the people in these areas face the same fate as that already encountered by their brethren to the north.

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 37 of 50 PAGEID #: 1136

The Root Cause of the Crisis

The current crisis is not a sudden occurrence but has been building up since October of 1969, when General Barre seized power in a military coup d'etat. Upon assumption of power, the General dismantled the democratic institutions. He did so by dissolving the Parliament, banning political opposition, outlawing independent press and suspending the constitution and with it all safeguards of civil liberties including writs of habeas corpus.

In the place of the scuttled institutions, the General created a Marxist police state equipped with its normal apparatus namely, network of vicious secret police, prison camps, indoctrination centers and one political party with "scientific socialism" as its guiding religion.

By centrally controlling the economy, the General destroyed incentive for economic growth and by alloting inordinate portion of the national resources to internal security, he starved the people.

But the more the economic situation deteriorated, the more repressive the General has become. Thus, arbitrary arrest, torture and summary execution by firing squads have been his routine response to any dissenting view, no matter how innocuous.

The Nature of the Somali People

Characteristically, the Somali people are decent, friendly, hospitable and fiercely independent. Above all, they love freedom and abhor dictatorship. Democractic ideals are deeply ingrained in the culture of the Somali people.

It is the manifestation of this political culture that led to the uprising, hence the war.

The United States Position

Where does the U.S. stand in the Somali situation? The Reagan Administration has been silent on both the general lack of freedom and the current massacre in Somalia. What kind of relationship exists between the Barre regime and the Reagan Administration? Apparently, the relationship is so cozy that the American press has no trouble in describing the Barre regime as the "U.S.-backed government".

However, such relationship can no longer be defended on moral or pragmatic grounds. The General or anyone associated with his regime will serve neither the interests of Somalia nor those of the United States.

This is not to suggest that the U.S. should cut its ties and withdraw from the Somali scene. To the contrary, the U.S. can play constructive role in the quest to restore democracy, stability and economic viability in Somalia. The U.S. can begin its part of the process by withholding further aid until the General stops the massacre, respects human rights and begins the process of turning power back to the people.

The U.S. is not without financial and diplomatic clout over the General. According to The Washington Post (July 2, 1988), Barre receives about $75 million annually in economic and military assistance from the United States. Moreover, American allies in Europe and the Middle East provide substantial aid with the General.

Mohamed H. Awale
Acting Vice President
For Communications

P-000168

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-3 Filed: 08/09/12 Page: 38 of 50 PAGEID #: 1137

Exhibit 8: May 1989 U.S. Department of State Cable No. 1989MOGADUI5258
(Bates Nos. P-000728-38)

A021

Current Class: ~~LIMITED OFFICIAL USE~~ UNCLASSIFIED Page: 1
Current Handling: n/a
Document Number: 1989MOGADI05258 Channel: n/a

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PAGE 01 MOGADI 05258 01 OF 04 090553Z
ACTION AF-00

INFO	LOG-00	ADS-00	AID-00	INR-07	EUR-00	SS-00	CIAE-00
	DODE-00	H-01	IO-19	NEA-06	NSCE-00	NSAE-00	HA-09
	L-03	TRSE-00	PM-10	PA-01	OMB-01	INRE-00	USIE-00
	SP-02	SNP-01	FAIM-01	PRS-01	P-02	T-01	/065 W

----------371570 090736Z /22

P 081205Z MAY 89
FM AMEMBASSY MOGADISHU
TO SECSTATE WASHDC PRIORITY 1738
INFO AMEMBASSY ADDIS ABABA
AMEMBASSY CAIRO
AMEMBASSY DJIBOUTI
AMEMBASSY LONDON
AMEMBASSY NAIROBI
AMEMBASSY RIYADH
AMEMBASSY ROME
USMISSION GENEVA
AMCONSUL JEDDAH
USCINCCENT MACDILL AFB FL//POLAD/CCJ4/7-S/CCJ5//

Dept. of State, RPS/IPS, Margaret P. Grafeld, Dir.
(X) Release ( ) Excise ( ) Deny ( ) Declassify
Date 10/21/05 Exemption _____

~~LIMITED OFFICIAL USE~~ SECTION 01 OF 04 MOGADISHU 05258

C O R R E C T E D C O P Y -- FOR LINE ADDED. (AID/W)

DEPT PASS TO AID/W

LONDON FOR KOLKER

E.O. 12356: N/A
TAGS: PHUM, PREL, SO
SUBJECT: POLITICAL PRISONERS: LIST PRESENTED TO GSDR

REF: A.) STATE 125887 (NOTAL), B.) STATE 096637 (NOTAL),
C.) MOGADISHU 01074 (NOTAL), D.) STATE 100956 (NOTAL)

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PAGE 02 MOGADI 05258 01 OF 04 090553Z

1. ~~(LOU)~~ ON MAY 2, AMBASSADOR GAVE MINISTER OF INTERIOR A LIST OF 66 ALLEGED OR SUSPECTED POLITICAL DETAINEES/

PRISONERS, AND ASKED HIM TO PROVIDE INFORMATION ON THEIR STATUS. THE NEXT DAY HE SENT A LETTER TO THE PERMANENT SECRETARY OF THE MINISTRY OF FOREIGN AFFAIRS, ENCLOSING THE SAME LIST AND AGAIN REQUESTING INFORMATION WHICH WE WOULD RELAY TO CONCERNED PERSONS AND ORGANIZATIONS IN THE U.S.

2. ~~(LOU)~~ LIST INCLUDES SEVERAL DOZEN NAMES OF PERSONS WHOM WE BELIEVE HAVE BEEN RELEASED, E.G., THE FIVE MILITARY CADETS FORCIBLY RETURNED FROM EGYPT (MOGADISHU 01655), THE REMAINING "HARGEISA GROUP" PRISONERS IDENTIFIED IN REF A, AND OTHERS WHOM ONE PERSON OR ANOTHER HAS TOLD US ARE OUT. THUS IT SHOULD BE RELATIVELY EASY FOR THE GOVERNMENT OF SOMALIA (GSDR) TO REPLY THAT SOME OR MOST OF THE PERSONS LISTED ARE FREE.

3. ~~(LOU)~~ STATUS OF OTHERS ON THE LIST, HOWEVER, IS MUCH MORE UNCERTAIN. IN ASKING FOR INFORMATION ABOUT THESE 66 WE BUMP UP AGAINST TWO FUNDAMENTAL PROBLEMS OF ACCOUNTING FOR POLITICAL PRISONERS IN SOMALIA:

- A. THE GOVERNMENT DOES NOT KNOW WHO IS IN ITS JAILS. NAMES, NUMBERS, LOCATION, OFFENSE ORIGINALLY SUSPECTED OF, PHYSICAL AND MENTAL CONDITION: SOMETIMES ALL ARE UNKNOWN.

- B. PRISONERS ONCE RELEASED ARE NOT/NOT FULLY FREE. NOT ONLY ARE THEY NOT PERMITTED TO TRAVEL OR TO LEAVE SOMALIA, THEY ARE RELUCTANT TO APPEAR IN PUBLIC. FRIENDS-INCLUDING HIGH RANKING GOVERNMENT OFFICIALS - MAY VISIT THEM PRIVATELY, BUT DO NOT WANT TO RISK APPEARING IN PUBLIC WITH FORMER POLITICAL PRISONERS. THUS WE ARE ABLE TO

GATHER NEWS PASSED ALONG THE GRAPEVINE, OFTEN BY FORMER PRISONERS, THEIR FAMILIES AND FRIENDS, THAT CERTAIN PEOPLE ARE NOW OUT OF JAIL, BUT RARELY DO WE SEE FORMER PRISONERS IN PERSON.

4. ~~(LOU)~~ WE WOULD APPRECIATE DEPARTMENT'S, EMBASSY LONDON'S, AND OTHER ADDRESSEES' ASSISTANCE IN PIECING TOGETHER STATUS OF THESE PERSONS. SOME, FOR EXAMPLE, WERE TRIED SEVERAL YEARS AGO AND SENTENCED TO DEATH. THEY MAY IN FACT HAVE BEEN EXECUTED AT THAT TIME; OUR RECORDS ARE UNCLEAR.

5. ~~(LOU)~~ FOLLOWING EACH NAME ON THE LIST IS OUR GUESS AS TO THEIR STATUS: IT IS CODED AS FOLLOWS:

- A. PERSISTENT REPORTS THAT THEY HAVE/HAVE BEEN RELEASED.
- B. SPOTTY, INCONSISTENT REPORTS OF RELEASE.
- C. CONSENSUS THAT THEY HAVE NOT/NOT BEEN RELEASED.
- D. NO INFORMATION.

6. (U) THE LIST IS AS FOLLOWS:
6. (U) THE LIST OF ALLEGED/ACTUAL POLITICAL DETAINEES/PRISONERS IS AS FOLLOWS:

(NOTES) A. "HG" STANDS FOR THE "HARGEISA GROUP" PRISONERS DETAINED NOV/DEC 1981, AND TRIED MARCH 1982.

- B. "FEB 88" INDICATES THAT A PERSON WAS TRIED IN THE FEBRUARY 1988 NATIONAL SECURITY TRIAL.

(1) ABDI ADEN QEYS POET. DETAINED FEB 88,

NOTE BY OCT: AID TAKE AS ORIGINAL. ALL OTHERS TAKE AS CORRECTED COPY,,

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PAGE 04 MOGADI 05258 01 OF 04 090553Z

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PAGE 01 MOGADI 05258 02 OF 04 090552Z
ACTION AF-00

INFO	LOG-00	ADS-00	AID-00	INR-07	EUR-00	SS-00	CIAE-00
	DODE-00	H-01	IO-19	NEA-06	NSCE-00	NSAE-00	HA-09
	L-03	TRSE-00	PM-10	PA-01	OMB-01	INRE-00	USIE-00
	SP-02	SNP-01	FAIM-01	PRS-01	P-02	T-01	/065 W

----------371537 090731Z /22

P 081205Z MAY 89
FM AMEMBASSY MOGADISHU
TO SECSTATE WASHDC PRIORITY 1739
INFO AMEMBASSY ADDIS ABABA
AMEMBASSY CAIRO

AMEMBASSY DJIBOUTI
AMEMBASSY LONDON
AMEMBASSY NAIROBI
AMEMBASSY RIYADH
AMEMBASSY ROME
USMISSION GENEVA
AMCONSUL JEDDAH
USCINCCENT MACDILL AFB FL//POLAD/CCJ4/7-S/CCJ5//

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C O R R E C T E D C O P Y--FOR LINE ADDED. (AID/W)

DEPT PASS TO AID/W

LONDON FOR KOLKER

E.O. 12356: N/A
TAGS: PHUM, PREL, SO
SUBJECT: POLITICAL PRISONERS: LIST PRESENTED TO GSDR

- NO TRIAL. (B)

(2) ABDI DAHIR ABDULLEH ARMY (ENLISTED).
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PAGE 02 MOGADI 05258 02 OF 04 090552Z

- DET FEB 88, NO TRIAL. (D)

(3) ABDI DAHIR AINASHE STUDENT. JUN 86 DEATH
- SENTENCE, UNCLEAR IF
- CARRIED OUT. (D)

(4) ABDI JAMA SED (SAID) SOMPET. DET JUN 88. (A)

(5) ABDUL AZIZ MOUSSA KOUROUMA SENEGALESE
- JOURNALIST. DET 1977. (C)

(6) ABDULLAHI JAMA SAMATER ARMY OFFICER (LTC).
- FEB 88--15 YEAR SENTENCE. (B)

(7) ABDIRAHMAN ABDULLAHI HAJI ADAN CIVIL SERVANT
- HG (SEE NOTE)--30 YEAR
- SENTENCE. (A)

(8) ABDULLAHI NUR GUHAD ARMY OFFICER. DET 1978,

NO TRIAL. (D)

(9) ABDULLAHI YUSUF AHMED 24 YEAR SENTENCE. (D)

(10) ABDULWAHAB HAJI HASSAN MILITARY CADET.
DET AUG 88, REL JAN 89? (A)

(11) ABUKAR HASSAN YARE LAWYER. DET 81,
REL MAR 87, DET NOV 88. (A)

(12) ADEN HUSSEIN "BERBERAWI" TEACHER. (D)

(13) ADEN MOHAMED SAMAKAAB ARMY OFFICER (LTC).
FEB 88--20 YEAR SENTENCE. (B)

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PAGE 03 MOGADI 05258 02 OF 04 090552Z

(14) AHMED ABDI OMAR MAY 87 DEATH SENTENCE (D).

(15) AHMED ALI ADEN RELIGIOUS LEADER.
DET APR 87. (D)

(16) AHMED FARAH DHOORE JUDGE. (D)

(17) AHMED HASSAN MADAR HG--ACQUITTED. PRESENT
STATUS UNKNOWN. (D)

(18) AHMED HUSSEIN ABBY CIVIL SERVANT.
HG--20 YEAR SENTENCE. (A)

(19) AHMED MOHAMED JAMA MILITARY CADET.
DET AUG 88, REL JAN 89? (A)

(20) AHMED MOHAMED MADAR BIOLOGIST. HG--8 YEAR
SENTENCE, RELEASED? (B)

(21) AHMED MOHAMED YUSUF TEACHER.
HG--LIFE SENTENCE. (A)

(22) ALI EGEH FARAH DIR HARG BLDG GP. HG--
3 YR SENTENCE, RELEASED? (B)

(23) AMINA ALI STUDENT.
24 YR SENTENCE. (D)

(24) BASHE ABDI YUSUF BUSINESSMAN.

- 20 YEAR SENTENCE. (D)

(25) DERIA SUGAL HERSI - MILITARY CADET. ALLEGED KILLED, REL JAN 89? (A)

(26) FAHIMA DAHIR JAMA STUDENT.

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PAGE 04 MOGADI 05258 02 OF 04 090552Z

- LIFE SENTENCE. (D)
-

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PAGE 01 MOGADI 05258 03 OF 04 090537Z
ACTION AF-00

INFO	LOG-00	ADS-00	AID-00	INR-07	SS-00	CIAE-00	DODE-00
	H-01	IO-19	NSCE-00	NSAE-00	HA-09	L-03	AMAD-01
	TRSE-00	PM-10	PA-01	OMB-01	INRE-00	USIE-00	SP-02
	SNP-01	FAIM-01	PRS-01	P-02	T-01	/060 W	

----------370770 090553Z /61/44

P 081205Z MAY 89
FM AMEMBASSY MOGADISHU
TO SECSTATE WASHDC PRIORITY 1740
INFO AMEMBASSY ADDIS ABABA
AMEMBASSY CAIRO
AMEMBASSY DJIBOUTI
AMEMBASSY LONDON
AMEMBASSY NAIROBI
AMEMBASSY RIYADH
AMEMBASSY ROME
USMISSION GENEVA
AMCONSUL JEDDAH
USCINCCENT MACDILL AFB FL//POLAD/CCJ4/7-S/CCJ5//

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C O R R E C T E D C O P Y (CAPTION)
DEPT PASS TO AID/W

LONDON FOR KOLKER

E.O. 12356: N/A
TAGS: PHUM, PREL, SO
SUBJECT: POLITICAL PRISONERS: LIST PRESENTED TO GSDR

(27) FAISA GUR SIAIB — STUDENT. (D)

(28) FARAH HUSSEIN AHMED — ENGINEER.
FEB 88--ACQUITTED. (D)

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PAGE 02 MOGADI 05258 03 OF 04 090537Z

(29) HASSAN ABDILLAHI ALI — HG--CHARGES DROPPED. (D)

(30) HASSAN ABDISALAM SHEIKH ALI — PEPSI COLA EMPL.
HG--ACQUITTED. (D)

(31) HASSAN OLHAYE KHALIL — SHEIKH.
LIFE SENTENCE. (D)

(32) HASSAN OSMAN OMAR — STUDENT.
MAY 87 DEATH SENTENCE. (D)

(33) HUSSEIN I. ABDI "KARAASH" — ARMY OFFICER (MAJ).
FEB 88--20 YEAR SENTENCE. (B)

(34) HUSSEIN MOHAMED DUALEH — TEACHER.
HG--20 YEAR SENTENCE. (A)

(35) IBAADO ALI FARAH — STUDENT.
24 YEAR SENTENCE. (D)

(36) ISMAIL ABDI HURRE — BUSINESSMAN.
HG--ACQUITTED. (D)

(37) ISMAIL HASHI MADAR — ARMY OFFICER (MAJ).
HG--CHARGES DROPPED. (D)

(38) ISMAIL HOREH QALOMBE — BRIGADIER GENERAL.
FEB 88--ACQUITTED. (D)

(39) JAMA OSMAN ISMAIL — FEB 88--ACQUITTED. (D)

(40) KHADRA ABDI DIRIYE — STUDENT.
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PAGE 03 MOGADI 05258 03 OF 04 090537Z

- 24 YEAR SENTENCE. (D)

(41) KHADRA ALI JAMA STUDENT. (D)

(42) MOHAMED ABDI ADEN ARMY OFFICER (COL).
- FEB 88--20 YEAR SENTENCE. (B)
-

(43) MOHAMED ABDI DUALEH BUSINESSMAN.
- HG--ACQUITTED. (D)

(44) MOHAMED ABDI JE'ER TEACHER. HG--8 YEAR
- SENTENCE, RELEASED? (D)

(45) MOHAMED ABDI SAMANTAR ARMY OFFICER. DET 1978,
- NO TRIAL. (D)

(46) MOHAMED ABDI YARE (D)

(47) MOHAMED ALI SULUB MEDICAL DOCTOR. HG--
- 3 YR, REL; DET FEB 87,
- NO TRIAL. RELEASED? (D)

(48) MOHAMED DAGAL HERSI TEACHER.
- HG--ACQUITTED. (D)

(49) MOHAMED HASSAN ISMAIL FEB 88--ACQUITTED. (D)

(50) MOHAMED ISLAN ABDULLE ARMY OFFICER.
- DET 1978, NO TRIAL. (D)

(51) MOHAMED "JABANE" HARGEISA LOCAL GOVT. (D)

(52) MOHAMED MA'ALIN OSMAN TEACHER. HG--8 YEAR
- SENTENCE, RELEASED? (D)

(53) MOHAMED MOHAMOUD IBRAHIM MILITARY CADET.
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PAGE 04 MOGADI 05258 03 OF 04 090537Z

- DET AUG 88, REL JAN 89? (A)

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PAGE 01 MOGADI 05258 04 OF 04 090541Z
ACTION AF-00

INFO	LOG-00	ADS-00	AID-00	INR-07	EUR-00	SS-00	CIAE-00
	DODE-00	H-01	IO-19	NEA-06	NSCE-00	NSAE-00	HA-09
	L-03	TRSE-00	PM-10	PA-01	OMB-01	INRE-00	USIE-00
	SP-02	SNP-01	FAIM-01	PRS-01	P-02	T-01	/065 W

----------371175 091308Z /22

P 081205Z MAY 89
FM AMEMBASSY MOGADISHU
TO SECSTATE WASHDC PRIORITY 1741
INFO AMEMBASSY ADDIS ABABA
AMEMBASSY CAIRO
AMEMBASSY DJIBOUTI
AMEMBASSY LONDON
AMEMBASSY NAIROBI
AMEMBASSY RIYADH
AMEMBASSY ROME
USMISSION GENEVA
AMCONSUL JEDDAH
USCINCCENT MACDILL AFB FL//POLAD/CCJ4/7-S/CCJ5//

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C O R R E C T E D C O P Y -- FOR LINE ADDED. (AID/W)

DEPT PASS TO AID/W

LONDON FOR KOLKER

E.O. 12356: N/A
TAGS: PHUM, PREL, SO
SUBJECT: POLITICAL PRISONERS: LIST PRESENTED TO GSDR

(54) MOHAMED SULEIMAN YUSUF FEB 88--5 YEAR,
4 MONTH SENTENCE. (C)

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PAGE 02 MOGADI 05258 04 OF 04 090541Z

(55) MOHAMOUD HERSI DAROOR MILITARY CADET.
- DET AUG 88, REL JAN 89? (A)

(56) MUSSA FARAH GULAID ARMY OFFICER. DET 1978,
- NO TRIAL. (D)

(57) OMAR ISSA AWALEH ACCOUNTANT. HG--3 YEAR
- SENTENCE, RELEASED? (D)
-

(58) SAEED AHMED ISMAIL DET MAY OR SEP 88.
- NO TRIAL, NO CONTACT. (C)

(59) SAEED DAHIR JAMA STUDENT. MAY 87 DEATH
- SENTENCE (D).

(60) SAID MOHAMED IBRAHIM TEACHER.
- HG--CHARGES DROPPED. (D)

(61) SHEIKH ISSA ADEN NUR FEB 88--ACQUITTED. (D)

(62) SHEIKH MOHAMED NUR QAWI RELIGIOUS LEADER. (B)

(63) SHEIKH NUR BARUD GURHAN KORANIC TEACHER,
- BLIND. LIFE SENTENCE. (D)

(64) YUSUF ABDILLAHI IBRAHIM FARMER.
- HG--20 YEAR SENTENCE. (A)

(65) YUSUF ABDILLAHI KAHIN AGRICULTURAL ENGINEER.
- (SAME AS Y.A. IBRAHIM?) (D)

(66) YUSUF ABDULLAHI BUSINESSMAN. (D)
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PAGE 03 MOGADI 05258 04 OF 04 090541Z

-
7. ~~(LOU)~~ SOME PERSONS ON THIS LIST ARE THE SUBJECT OF CONGRESSIONAL OR OTHER INQUIRIES. SENATOR BOB GRAHAM OF FLORIDA, FOR EXAMPLE, REQUESTED INFORMATION ABOUT ABUKAR HASSAN YARE (11) (REF B). POL/ECON CHIEF WAS TOLD THAT HASSAN YARE HAS BEEN RELEASED (APPARENTLY SOME TIME IN MARCH) BUT WE HAVE BEEN UNABLE TO OBTAIN CONFIRMATION. HASSAN YARE IS APPARENTLY THE SAME PERSON WHOM WE DESCRIBED IN REF C AS HAVING BEEN ARRESTED AS A "SPY" FOR AMNESTY INTERNATIONAL.

8. ~~(LOU)~~ AS POINTED OUT BY THE NATIONAL ACADEMY OF SCIENCES (REF D), MOHAMED ALI SULUB AND MOHAMED ALI IBRAHIM SULUB ARE INDEED TWO DIFFERENT PERSONS. IBRAHIM SULUB WAS ONE OF THE GROUP RELEASED IN MARCH. ALI SULUB (47) WAS RELEASED BUT DETAINED AGAIN; HIS PRESENT STATUS IS UNCERTAIN.
CRIGLER

NOTE BY OCT: AID TAKE AS ORIGINAL. ALL OTHERS TAKE AS CORRECTED COPY,,

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Exhibit 9: January 1, 1990 *Human Rights Watch World Report 1989 – Somalia*
(Bates Nos. P-000768-73)

Refworld
The Leader in Refugee Decision Support

UNHCR
The UN Refugee Agency

Title	Human Rights Watch World Report 1989 - Somalia
Publisher	Human Rights Watch
Country	Somalia
Publication Date	1 January 1990
Cite as	Human Rights Watch, *Human Rights Watch World Report 1989 - Somalia*, 1 January 1990, available at: http://www.unhcr.org/refworld/docid/467bb499c.html [accessed 18 July 2009]

HUMAN RIGHTS WATCH

Human Rights Watch World Report 1989 - Somalia

For the past 20 years, Somali president Mohamed Siad Barre has presided over a one-party military dictatorship. His reign has been characterized by vicious discrimination against certain ethnic groups – currently the Isaaqs in northern Somalia – as well as political imprisonment, torture and summary executions, in an effort to suppress all dissent in Somalia. A long-simmering war in northern Somalia between the Somali National Movement ("SNM") and government forces erupted in May 1988 when the SNM launched military operations from Ethiopia. The army responded with a savage counterinsurgency campaign. Throughout the rest of 1988 and 1989, the Somali armed forces engaged in extensive efforts to deprive the SNM of civilian support – members of the Isaaq clam make up most SNM combatants – by driving Isaaq noncombatants from the country through such means as indiscriminate aerial bombardment, the widespread killings of civilians, the destruction of crops, cattle and food-storage facilities, the poisoning of wells, and the jailing of hundreds of political prisoners. Some 450,000 Somalis fled such attacks for Ethiopia, Djibouti and Kenya, and an additional 600,000 were displaced within Somalia.

Until September 1989, the Bush administration's policy toward Somalia was largely a continuation of that of the Reagan administration. That policy was based on interest in the Berbera port as a strategic location – it is viewed as an important staging area for the Indian Ocean, the Red Sea and the Persian Gulf. That interest provided the rationale to extend economic, military and diplomatic support to the U.S. ally in

Mogadishu. At the same time, paradoxically, the administration went to considerable lengths to investigate the human rights situation in Somalia, and U.S. officials appeared to have no delusions about the ruthlessness of the Barre regime.

By late 1989, the Bush administration appeared to have reevaluated its policy toward Somalia, and took steps to limit U.S. assistance to the government. A factor in this seemingly revised policy was that the confidence of U.S. military analysts in the capabilities of the Somali army appeared to have been seriously shaken in the summer of 1989 when intense fighting broke out between government forces and soldiers from the Ogaden region who had deserted the Somali army. The government forces, despite brutal reprisals against civilians from Ogaden as well as those from the Harwiye clan, have been unable to retake portions of southern Somalia held by the Ogadenis. This erosion of confidence appears to have led to the cancellation of the "Brightstar" military exercises with Somalia this year. These exercises are high-visibility maneuvers, conducted by the United States with a number of countries in the region, and their cancellation was a blow to Barre's stature as a close U.S. ally. Both the Reagan and Bush administrations – prompted by Congressional interest in human rights violations in Somalia – have attempted to persuade the Barre regime to take steps to improve its human rights record. According to U.S. Ambassador to Somalia Frank Crigler, he raised the issue of certain political prisoners in private discussions with the government on several occasions.

Both the Reagan and Bush administrations also took steps to investigate gross abuses of human rights in Somalia. In August 1988, for example, the Reagan administration sent Deputy Assistant Secretary of State for International Refugee Assistance Kenneth Bleakley to investigate human rights abuses by visiting refugee camps in Ethiopia and displaced Somalis within Somalia. Assistant Secretary Bleakley spoke frankly with human rights advocates and Congressional staff about his findings, which confirmed prior reports of indiscriminate aerial bombardment, hundreds of political prisoners and torture. Assistant Secretary Bleakley conveyed his findings in a cable to U.S. Ambassador Crigler, who reportedly gave the cable to President Barre. But when members of Congress asked to see the cable, it was promptly classified, according to Congressional sources. This reluctance to publicize its findings deprived the administration of an excellent opportunity to pressure the Somali government. Moreover, the act of classifying the document suggested that the administration wanted to shelter the Somali government from Congressional criticism. In August 1989, at the request of Congress, the State Department released an investigation by Robert Gersony, a consultant and refugee expert who had investigated the situation of Somali refugees in Ethiopia and those displaced within Somalia. He conducted some

252 interviews with refugees and displaced persons, and concluded that the government had committed extensive abuses, including targeted bombings of civilian structures and fleeing refugees, and extrajudicial executions.

Unfortunately, the potential impact of the Bush administration's decision to investigate and report on Somali abuses was all but nullified by the administration's efforts to persuade Congress to provide military and economic assistance to the very forces responsible for those abuses. At various critical moments over the past two years, when abuses have been at their height, the Reagan and Bush administrations have acted to shore up the faltering Barre regime. Military aid, including arms and ammunition, was shipped to the Somali government in 1988, Included in the military aid provided to the Somali government in 1988 was a $1.4 million shipment of M-16 automatic rifles and ammunition. The shipment arrived on June 28, 1989, and was used to arm Ethiopian refugees living in camps in Somalia operated by the U.N. High Commissioner for Refugees. The timing of the aid could not have been worse: it arrived at precisely the moment when government forces were waging indiscriminate warfare against unarmed civilians throughout northern Somalia. To escape government terror, as noted, hundreds of thousands of Somalis fled into Ethiopia. and the Reagan administration requested an additional $38 million in military and budgetary support for Somalia in its request to Congress for fiscal year 1990.

In similar fashion, in mid-July 1989 the Bush administration went so far as to request an infusion of $21 million in additional assistance in the form of Economic Support Funds – direct budgetary assistance to the government. The timing of the request sent a terrible signal, since it came as the Barre regime was engaging in a massive crackdown in Mogadishu in which hundreds of civilians were executed and many hundreds more were jailed in sweeps through Isaaq and Harwiye neighborhoods.

When members of Congress blocked the additional aid and criticized the Bush administration for the poor timing of its request, State Department officials claimed to Congressional aides that the request had long been pending and that the notification to Congress just days after the July massacres was simply an unfortunate coincidence. The officials did not explain why the request was not reconsidered once the massacres became known.

Moreover, the Assistant Secretary of State for Human Rights and Humanitarian Affairs, Richard Schifter, actively defended the aid request in a letter to *The New York Times* on September 2, 1989. Rejecting the suggestion that the aid infusion was an attempt

by the Bush administration to shore up the faltering Barre regime, Assistant Secretary Schifter defended the aid, stating:

The administration's request to obligate $21 million in economic support funds for Somalia was directly tied to our support for economic reforms in that country. These reforms, worked out with the International Monetary Fund and the World Bank, are designed to transfer economic decision-making power from the Government to the people and the marketplace – to support the very people who are suffering both from poverty and from human rights abuses.

Assistant Secretary Schifter's defense of the balance-of-payments support for the government is highly objectionable. First, despite the claimed economic benefits, the aid violates Section 502B of the Foreign Assistance Act of 1961, which prohibits the granting of Economic Support Funds to governments such as that of Somalia which engage in "a consistent pattern of gross violations of internationally recognized human rights." Second, the notion that Somali citizens can benefit from aid at a time when many are fleeing in the face of summary execution, torture and political imprisonment seems insensitive at best.

We note, however, that Schifter did acknowledge the severe abuses being committed by the Barre regime. He stated:

The United States has strongly protested the latest human rights violations in Somalia, asked for an investigation and insisted that those responsible be brought to justice.... The serious human rights violations in Mogadishu ... compel us to give careful scrutiny to assistance to Somalia.

This was a welcome departure from the State Department's prior refusal to condemn the Barre government publicly – even when the Department's own investigations revealed extensive atrocities. But it is regrettable that this new human rights message was overshadowed by Assistant Secretary Schifter's public support for aid to the abusive regime.

On one occasion, the State Department not only failed to condemn an important human rights abuse, but also rebuked Africa Watch for calling for an investigation of the problem. In 1988 and 1989, the international press carried numerous credible reports that Libyan President Quadaffi had shipped chemical weapons to Somalia. One such report was aired on January 12, 1989 by NBC news, and the British Foreign Office was said to be deeply concerned about the reports. The State Department denied

these reports, and when Africa Watch raised concerns about the possible use of chemical weapons against civilians in northern Somalia, then-Assistant Secretary of State for African Affairs Chester Crocker rebuked Africa Watch. In a January 4, 1989 letter, he stated that he was satisfied with the Somali government's categorical denials, and reminded Africa Watch that "prudence and fairness warrant a heavy burden of proof with respect to charges about willful use of weapons of mass destruction by a government against its own people." In view of the Somali government's campaign of mass destruction in the northern part of the country, which caused the death or flight of hundreds of thousands of noncombatants, the Assistant Secretary's failure to investigate the charges of possible use of chemical weapons and his uncritical acceptance of the government's denial seems unwarranted.

On June 20, 1989, the Bush administration missed an important opportunity to condemn the Somali government's abuses publicly when it refused to send a witness to a hearing sponsored by the House Banking Subcommittee on International Development Institutions and Finance. The hearing was called to examine U.S. human rights policy with regard to multilateral lending to China and Somalia. The administration's failure even to appear at the hearing, after having been invited by the subcommittee chairman, Representative Walter Fauntroy, says volumes about its disinclination to embarrass the Barre regime.

Undoubtedly another factor in the administration's refusal to appear before the subcommittee was the U.S. law barring U.S. support for loans to such abusive regimes as that of Somalia. Section 701 of the International Financial Institutions Act requires that U.S. representatives to the multilateral development banks (such as the World Bank and the African Development Bank) oppose loans to governments engaged in "gross violations of internationally recognized human rights." Far from opposing loans to Barre, the Bush administration reportedly promoted Somalia's cause within the banks. In June 1989, the World Bank approved a $70 million "quick disbursing cash loan" to Somalia, and the African Development Bank supplied an additional $25 million as part of the economic stabilization package. According to World Bank officials and Congressional staff, human rights conditions in Somalia were completely ignored in both the administration's and the World Bank's deliberations on future lending to Somalia. On September 29, Chairman Fauntroy, along with 46 other members of the House of Representatives, wrote a letter to Secretary of State Baker urging him to reexamine U.S. support for loans to Somalia by the World Bank and African Development Bank.

What progress has been made in using U.S. influence to promote human rights in Somalia is largely due to Congressional efforts. In 1989, Congress placed aid to Somalia on a "reprogramming basis," which requires advance notification from the executive branch before aid is disbursed. After Congress requested a hold on the $2.5 million in military aid allocated to Somalia in fiscal year 1989, the Bush administration, apparently so as not to lose the amount completely, reprogrammed the amount to other countries. Beginning in July 1988, the Reagan administration suspended shipment of arms and ammunition, but it and the Bush administration continued to provide non-lethal military assistance left over from previous years, until the Congressional action. In July 1989, as noted, Congress also prevented the administration from providing $21 million in Economic Support Funds which had been authorized but not spent for fiscal year 1988. By September, the administration announced its intention to reprogram the $21 million to other countries in Africa. We hope that this welcome decision, in part in response to Congressional criticism, represents a new willingness by the Bush administration to use aid as a lever for promoting human rights in Somalia.

We urge the Bush administration to continue to limit assistance and to take further steps to distance itself from the Barre government. It is important that the U.S. take the lead and make clear, in forceful terms, that a government which consistently disregards human life and basic rights has no place in the international community and will not benefit from international largesse.

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Exhibit 10: 1990 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000756-62)

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 9 of 52 PAGEID #: 1158

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102d Congress
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COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 1990

REPORT

SUBMITTED TO THE

COMMITTEE ON FOREIGN RELATIONS
U.S. SENATE

AND THE

COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES

BY THE

DEPARTMENT OF STATE

IN ACCORDANCE WITH SECTIONS 116(d) AND 502B(b) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

FEBRUARY 1991

Printed for the use of the Committees on Foreign Relations and Foreign Affairs of the Senate and House of Representatives respectively

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Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 10 of 52 PAGEID #: 1159

SOMALIA

Somalia has been ruled since 1969 by President Mohamed Siad Barre, who controls the Government through the presidentially appointed Council of Ministers, the National People's Assembly which is subordinate to the executive, and a single political party, the Somali Revolutionary Socialist Party (SRSP). Members of the President's clan, the Marehan, held many key positions. However, in late December, an outbreak of fighting between rival clans in the capital, Mogadishu, created a state of anarchy and brought into question the Government's ability to continue in control.

During 1990 the Government was under increasing internal and international pressures to seek political reform and help stop human rights abuses committed by all parties to the 3-year-old civil conflict. Responding to these pressures, the Government introduced a new, provisional Constitution, effective for 1 year from October 12, 1990. The Constitution and its related statutes, if fully respected by the Government, would repeal a series of repressive security laws; permit free, multiparty elections; guarantee a number of individual rights; and transfer considerable power from the President to the Prime Minister, Cabinet, and Parliament. At the end of 1990, the heavy fighting that engulfed Mogadishu cast grave doubt on whether the new Constitution would have any practical impact.

At year's end, only portions of the capital city, Mogadishu, and a few other places where troops were garrisoned, remained in government hands. During the last 3 months of the year, massacres by government forces and other politically related as well as criminal violence escalated dramatically even in the capital, resulting in many deaths, injuries, and the widespread evacuation of most foreigners. The main opposition, the Isaak-based Somali National Movement (SNM), controlled much of the north, and the Hawiye-based United Somali Congress (USC) was active in central Somalia, including Mogadishu. The Government's arming of a number of clan militias exacerbated the conflict and encouraged general lawlessness.

The Somali armed forces number not more than 35,000 troops. Internal security responsibilities, including coping with the civil conflict, are shared by the National Army, the military police, the Defense Intelligence Security Agency ("Hangaash"), the National Police, and the National Security Service (NSS). In all, nine different entities have arrest powers, an organizational situation which has exacerbated human rights abuses.

Most of Somalia's estimated 8 million people manage a bare subsistence as herders or farmers. The modern sector of the economy consists mainly of banana plantations in the south; the chief exports are livestock, bananas, and hides and skins. Mogadishu has a population approaching 2 million, many of whom are unemployed migrants and displaced persons from the countryside. In 1990 further economic decline, made worse by sharply reduced support from foreign donors, contributed to increasing crime.

Widespread severe violations of human rights occurred in Somalia in 1990, most of them attributable to the Government and its security forces. There were repeated, credible reports of army units attacking villages and murdering suspected opponents, and presidential guards (Red Berets)

SOMALIA

were implicated in robberies and killings. In July presidential guards shot and killed 60 to 100 people fleeing a Mogadishu stadium after fans at a soccer match booed the President. There is no evidence of serious attempts by the Government to investigate these abuses or to punish those responsible. Other areas of human rights abuses included torture and other mistreatment of prisoners and detainees, arbitrary detention, denial of fair trial, massive abuses of civilians by both government and rebel forces, restrictions on freedom of speech, press, assembly, and association, and the denial of the right to change the government as well as the denial of worker rights and pervasive discrimination against women.

RESPECT FOR HUMAN RIGHTS

Section 1 Respect for the Integrity of the Person, Including Freedom from:

a. Political and Other Extrajudicial Killing

In addition to the July killing of 60 to 100 persons in the Mogadishu stadium, Red Berets in December, without apparent motive, massacred from 10 to 20 persons (primarily from the Hawiye clan) at the animal market in Mogadishu. There are frequent but unverified claims that certain "criminal" killings in Mogadishu are actually carried out by agents of the Government for political purposes. For instances of excessive use of force and killings of civilians, see Section 1.g.

There were no known instances of the Government punishing those who committed political killings or other abuses. One Marehan general, the chief of airport security, who shot several bystanders at the Mogadishu airport in December, was subsequently transferred to another high-ranking position in the police. An investigation ordered by President Siad into the reprisal killings of Isaak men in Mogadishu by government troops in July 1989 has yet to produce indictments or any other known result.

b. Disappearance

Disappearances were hard to distinguish from arbitrary arrests and detentions (see Section 1.d.) and extrajudicial killings, because these were not acknowledged by the authorities. The number of disappearances during the year was unknown.

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment

The new Constitution prohibits mental and physical torture. There were no confirmed instances of torture in Somalia in 1990. However, there is strong evidence that prisoners held by the security forces were tortured. Screams of pain were frequently clearly audible in the night to those living near an NSS prison in Mogadishu. Since the Government almost never investigates charges of torture and as detainees are often held incommunicado, it is difficult to judge the frequency of torture.

Harsh treatment of prisoners remained commonplace. In one extreme example, in June a visiting Italian professor strayed on foot into a sensitive area of Mogadishu. He was detained by soldiers, beaten, and died in his cell.

P-000757

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 11 of 52 PAGEID #: 1160

Prominent political prisoners were, by comparison, well treated. Forty-five prominent politicians and clan elders who were detained for about 1 month at Lanta Bur maximum security prison for signing a manifesto critical of the Government (see Section 2.a.) were allowed one visit each from family members. Their wives brought food to them daily at the prison, although they were not allowed to give the food directly to the prisoners. For ordinary prisoners, however, conditions are harsh: sanitation is poor, cells are overcrowded, diet is inadequate and must be supplemented by family members or friends, and there is a lack of clean water and medical care.

d. Arbitrary Arrest, Detention, or Exile

Although the former constitution accorded citizens the right to be formally charged and to receive a speedy trial, national security laws enacted in 1970 exempted crimes involving security from time limits and rules of procedure. As the Government struggled to suppress increasingly bold and numerous opponents, reliable sources reported that the jails were filling with detainees arrested under the security laws. In practice, the concept of "national security" has sometimes been stretched to mean almost anything. Persons detained for various periods of time included both the composer and the singer of a popular song critical of the Government, 9 prominent Isaak businessmen or their sons, a Somali employee of the U.S. Embassy who came to the aid of a Marine security guard who had been wounded by robbers, 45 persons who had signed a political manifesto, and a contractor providing heavy equipment for petroleum exploration companies. The contractor was detained apparently because powerful people wanted to take over his business. Other wealthy people were apparently detained for purposes of extortion. In some cases, authorities held people for 1 to 2 weeks with little or no attempt to interrogate them, then released them suddenly, with as little explanation as when they were arrested.

The number of political detainees still in prison at year's end was unknown; the Government does not disclose such information. Among those still in detention were Major General Aden Abdullahi Nur, a former Minister of Defense, and General Mohamed Abdullahi Ba'adleh, a former Minister of Interior. Both were arrested in July 1989.

The Government does not practice exile as a means of political punishment. However, the Government's arbitrary use of legal powers to silence its critics has the effect of forcing many persons into exile, e.g., the editor of the party newspaper in 1990 (see Section 2.a. and 2.d.).

e. Denial of Fair Public Trial

The Somali judicial system includes civil and criminal courts. Members of the public are usually barred from trials. There are no religious courts, but in civil proceedings judges are reportedly under instructions to disregard statute law regarding women's inheritance rights and to follow the more conservative Shari'a law instead. In the civil and criminal courts, legal assistance is provided, and there are established rules of evidence. The right to appeal exists in criminal and civil cases but until October 12 not in cases heard by the National Security Court.

The National Security Court was abolished then, and its pending cases transferred to the ordinary courts. Lawyers were permitted to represent suspects before the National Security Court but usually were granted very little time to prepare their cases. For example, lawyers for the 45 manifesto defendants had about 48 hours from the time of their appointments until the trial began. For persons formerly convicted by the National Security Court, the only avenue for clemency was through the Politburo of the ruling party.

Although the judiciary is nominally independent, the executive reviews and controls judicial decisions. For example, the order to acquit the 45 manifesto defendants "for lack of evidence" came directly from President Siad. All judges are appointed by the President with the advice of the Higher Judicial Council, of which the President is chairman. Judges of the National Security Court were usually military officers posted to the Court.

The only National Security Court trial that received publicity in 1990 was that of the 45 manifesto signers in July, which lasted only 4 hours and resulted in the acquittal and release of all defendants.

Until the new Constitution went into effect on October 12, there were a number of severe security laws. The status of these laws was unclear at the end of 1990. Law No. 54 of 1970 provided the death penalty for political offenses "against national security," defined as behavior "which may be considered prejudicial to the maintenance of peace, order and good government." Among the 20 offenses punishable by death were "organizing a subversive association," "exploiting religion for creating national disunity," and "publishing antistate propaganda." The manifesto signers and other advocates of reform recommended to the Government in 1990 that the National Security Court and the 1970 security laws, including Law No. 54, be abolished.

At the end of 1990, the number of political prisoners, as distinguished from political detainees who had never been brought to trial, was unknown and difficult to estimate because of government secrecy. However, one credible estimate placed the number of such political prisoners at several hundred, with at least 200 being held in Mogadishu's central prison. Most of the latter had been arrested on the pretense of having committed common crimes.

f. Arbitrary Interference with Privacy, Family, Home, or Correspondence

The telephone conversations and mail of suspected persons are sometimes monitored, and informants keep watch on the movements of people at embassies, mosques, and other sensitive locations.

In June and July, security services conducted repeated raids in Mogadishu neighborhoods in search of weapons and material critical of the Government, including cassette tapes of Somali songs and poetry. These searches were carried out without warrants or the consent of the searched. No probable cause was required.

P-000758

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 12 of 52 PAGEID #: 1161

g. Use of Excessive Force and Violations of Humanitarian Law in Internal Conflicts

Sporadic, low-intensity warfare continued and gradually escalated in many regions of Somalia during 1990, with government authority eroding throughout the country. Government forces and, to a lesser extent, their opponents, e.g., the Isaak-based SNM and the Hawiye-based USC, continued a pattern of killing unarmed and unresisting civilians. To counter the growing threat, the Government further armed clan-based civilian militias, particularly Marehan in southwestern and central Somalia and Gadaboursi in the north. They also continued to arm Ethiopian refugees in northern camps, and there were some reports that refugees in the Belet Weyne and Jalalaqsi camps in the south were also armed by the Government. Such groups, once armed, were under no effective control. Extrajudicial killings fell most heavily on Hawiye (especially Habr Gedr Sa'ad) in the central regions, Isaaks in the north, and Issas in the far northwest.

The U.S.-based human rights group, Africa Watch, issued a report in early 1990, "Somalia: A Government at War With Its Own People," charging the Said Barre regime with responsibility for the deaths of 50,000 to 60,000 civilians since the conflict with the SNM began in May 1988.

Among the most serious extrajudicial incidents in 1990 in which civilians were killed were: in March government troops in a major offensive near the Djibouti border rounded up and killed more than 100 civilians of the Issa clan, which had formed an alliance with the SNM; in May in Belet Weyne (central Somalia), following a USC attack on government installations, government troops massacred about 100 civilians, including women and children, and confiscated most of their livestock; in August, following an SNM guerrilla attack near Berbera which killed 5 workers, government troops rounded up 21 young Isaak men in Berbera, killing 18; in November, after USC forces left Johar (having sacked government installations), government troops arrived and summarily executed 10 to 20 civilians for suspected rebel sympathies.

In addition to killing civilians, government soldiers and opposition forces looted and destroyed property. Government troops in particular dynamited artificial reservoirs to deny water to local inhabitants. There were reports of soldiers raping women and girls. Among many examples, in August USC forces attacked the district police station in the town of Jalalaqsi, then looted the compounds of the United Nations High Commissioner for Refugees (UNHCR) and of three private charitable organizations. A few days later, Somali army forces retook Jalalaqsi, destroying much of what remained in the town and killing any local inhabitants in their path. In September government forces looted a German-supported hospital and the compound of a private voluntary organization in Belet Weyne.

By the end of the year, clan-related violence between security forces and armed opponents escalated considerably in Mogadishu, resulting in hundreds of civilian deaths.

Both government and opposition forces have hindered delivery of food to refugees, resulting in periodic suspension of feeding programs and subsequent malnutrition. With the completion of the U.N.'s Extraordinary Interim Emergency

Program for refugees in late August, the International Committee of the Red Cross (ICRC) became increasingly involved in relief operations for victims of the northern conflict, both refugee and nonrefugee. However, in October an ICRC worker was killed in an SNM ambush, casting doubt on the practicability of future relief operations in the area. Of the three others abducted in the ambush, one expatriate and one Somali national were later released, while another Somali national escaped confinement and returned to safety on his own.

There is little information on the fate of prisoners taken in Somalia's civil conflict. In general, it seems that few prisoners are taken. All sides welcomed deserters from opposing forces and civilian returnees from enemy-controlled territory.

Section 2 Respect for Civil Liberties

a. Freedom of Speech and Press

Freedom of speech is provided for in the constitution of 1979 and theoretically by the revised Constitution enacted on October 12, 1990. However, under the new Constitution, freedom of speech "must not contravene the discipline and stability of the nation."

In practice, freedom of speech was not tolerated in 1990. Events, however, suggested that Somalis were increasingly determined to exercise freedom of speech, even at considerable personal risk.

In January, for example, the editor of the ruling party's newspaper published a series of articles critical of the Government, and a leading entertainment troupe performed a satirical program in the presence of President Siad. One of their songs, "The Landcruiser Song" (named for the vehicle favored by wealthy Somalis and the security services), ridiculed the corruption and extravagance of the ruling elite, including by implication the President's family. The song gained instant popularity and was widely circulated in the black market for audio tapes. President Siad reacted angrily: the composer and the singer of the "Landcruiser Song" were detained for about 2 months, and the acting Minister of Information was fired. Police prohibited the printing of the party newspaper, and the editor fled to Kenya.

In May a group of former politicians, businessmen, intellectuals, and clan elders published an open letter to President Siad, which came to be called the "Somali Manifesto." It combined bitter criticism of Siad Barre with a call for a transitional government to lead Somalia into a post-Siad era. The manifesto became a test of whether the Government, which had announced its intention to permit new political parties and open political discussion, was willing to permit free speech in practice. At first, the Government appeared to tolerate the manifesto signers but eventually charged 45 of them with antigovernment propaganda (an offense requiring the death penalty). On July 15, when the defendants were brought to trial, demonstrations broke out in Mogadishu. Within 4 hours, the National Security Court announced that the 45 defendants had been released "for lack of evidence."

Government ownership of radio and television, and its monopoly of the country's newspapers, had little practical effect on Somalis' access to information. City dwellers and nomads

P-000759

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 13 of 52 PAGEID #: 1162

listened to the British Broadcasting Corporation's Somali Service, by far the most influential news service in the country. The security services were unable to stem a lively traffic in audio tapes and photocopies of antigovernment writings. It remains to be seen whether the Government will tolerate independent media, which are to be allowed under the new Constitution.

The question of academic freedom hardly arose, because there was only one university, staffed primarily by Italian professors who were careful not to stray into controversy. Some law school professors, however, made serious, uncoerced contributions to the technical committee appointed to revise the Constitution.

In early 1990, the Government allowed several foreign journalists to visit Somalia. Two of them interviewed President Siad, after which visas for journalists once again became difficult to obtain. Eight Western journalists were invited to Mogadishu in September but were given access to only one top government official. In November and December, visas were issued more freely, and journalists' access improved somewhat.

b. Freedom of Peaceful Assembly and Association

Despite constitutional safeguards, throughout most of 1990 the authorities attempted to prevent peaceful assembly and to keep independent associations from forming. Nevertheless, several times in 1990 politically active Somalis asserted these rights, and in some cases the Government acquiesced, e.g., a public procession and funeral was held in July for the lawyer and human rights activist Ismail Jumale Ossoble, whose body was flown in from Rome.

Also, the signers of the Somali Manifesto continued political activities after their trial and release. This group is considered by many to be a political party in all but name.

c. Freedom of Religion

Islam is the state religion and nearly 100 percent of the population is Muslim, predominantly of the Sunni sect. The old and new Constitutions state that every person shall be entitled to profess any religion or creed. Members of religions other than Islam, however, may not proselytize.

Mogadishu has a Roman Catholic community numbering 2,000, which was established during the period of Italian colonial rule. Both Protestant and Catholic houses of worship operate openly. No other religious group has significant representation in Somalia. Christian charitable organizations operate in Somalia but confine their activities to humanitarian and technical assistance.

The Government is sensitive to the threat of disparate opposition groups uniting under the banner of Islam. Since 1985, the Government has licensed all mosques and Koranic schools, and since 1986 it has approved all imams and paid them a salary.

Ethiopian Christian refugees sometimes claim to face persecution in Somalia, but that persecution seems to be based more on nationality than on religion.

d. Freedom of Movement Within the Country, Foreign Travel, Emigration, and Repatriation

The new Constitution provides the right to move freely within Somalia and to leave and return to the country at will. Most Somalis are nomads, and the nomadic tradition remains strong. Travel within Somalia is a freely practiced right.

While most citizens who can afford it are able to travel internationally, the Government has sometimes restricted the travel of former detainees and political prisoners by denying them passports or stopping them at the airport. For example, the singer of the "Landcruiser Song," Sado Ali, was twice turned back at the airport. After the new Constitution came into effect, guaranteeing the right to travel, the Foreign Minister personally refused Ms. Ali the return of her passport. After the manifesto incident, most of the manifesto signers' names were added to the list of those not allowed to leave the country. A few, however, received special permission from the head of the NSS to travel out of Somalia.

Somalis who have emigrated are generally permitted to return. Nevertheless, some Somalis remained abroad in 1990 because they feared possible imprisonment for opposition activity if they returned.

There have been massive displacements of persons as a result of the civil conflict. At the end of 1990, the best estimates indicated that there were 370,000 displaced persons and refugees from Somalia (mainly Isaaks) in Ethiopia and 30,000 in Djibouti.

The Government reports there are 837,000 Ethiopian refugees in Somalia, but outside observers, including those from the United Nations, indicated that fewer than half that number remained in refugee camps at the end of 1990. Conscription of refugees into the Somali army continued in 1990, in violation of international covenants.

In late August, the United Nations suspended assistance to refugees in northern Somalia due to continued lack of security and the inability to monitor food distributions. Both organized and spontaneous repatriation of refugees to Ethiopia continued from the north and the south. The UNHCR completed registration of ration card holders in southern Somalia for voluntary integration or repatriation and also registered approximately 54,000 refugees for repatriation in the Borama area in the north. More than 4,000 refugees were repatriated from Borama to eastern Ethiopia under the auspices of the ICRC and UNHCR. The repatriation was temporarily halted in October when the governor of Borama closed the road to the border. However, the ICRC repatriation convoys resumed in late December.

Section 3 Respect for Political Rights: The Right of Citizens to Change Their Government

In 1990 citizens had neither the legal right nor the ability peacefully to change their government or the form of their government. For most of the year there was only one legal party, the SRSP. Opposition groups and criticism of the Government were illegal. However, in December a new law was passed permitting the formation of multiple political parties. Under the new Constitution, the SRSP is to be removed from its leading role in the State and society, and

P-000760

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 14 of 52 PAGEID #: 1163

the President did resign as chairman of the SRSP when the new Constitution was provisionally implemented on October 12. The first multiparty elections were tentatively scheduled for late 1991. As 1990 drew to a close, however, fighting in Mogadishu escalated, and serious doubts emerged as to whether the new Constitution would have any effect.

For many Somalis, the traditional clan system is the accepted vehicle of political expression. President Siad Barre and other officials consult frequently with clan elders. Since 1982, however, President Siad has been widely perceived as relying on and furthering the interests of his family and his Marehan subclan by playing off other clans against one another. Although members of the Marehan clan did not dominate the Cabinet--the Prime Minister, for example, was an Isaak--many key decisionmaking roles were filled by Marehan.

Section 4 Governmental Attitude Regarding International and Nongovernmental Investigation of Alleged Violations of Human Rights

There are no human rights organizations as such in Somalia, but the Association of Somali Lawyers concerns itself with human rights issues. A governmental human rights commission chaired by the Foreign Minister (and including senior officials responsible for security) advised the President on tactics for dealing with the issue of international concern over human rights practices. Although proclaiming the Government's desire for better relations with human rights groups and improved international understanding of human rights conditions in Somalia, the commission produced few practical results. During 1990 there were no visits by human rights organizations. The Government postponed the visit by Amnesty International indefinitely following the arrests of the manifesto signers.

In September, the European Community condemned human rights violations in Somalia, specifically mentioning the killing of Isaaks in Berbera by Somali military forces. Several governments successfully pressed the Somali Government to release those arrested for having signed the May manifesto.

The Government cooperated with the ICRC's operations in government-controlled territory in the north. The Government and the SNM were not as cooperative in allowing the ICRC to assist conflict victims in nongovernment-controlled areas. The ICRC was able to gain access to these areas for the first time in early December. In addition to food relief operations, the ICRC's emergency hospital in Berbera and medical evacuation flights provided practically the only medical care in the northern portion of the country.

Section 5 Discrimination Based on Race, Sex, Religion, Language, or Social Status

Because Somalia is racially homogeneous, there is little racial discrimination as such. Animosities and rivalries based on bloodline and clan affiliation, however, are a fundamental cause of the country's continuing civil conflict. Many persons continued to capitalize on their clan and family affiliations to gain economic advantage or privilege. The President's Marehan clan, for example, enjoys disproportionate access to bank loans, often unsecured, as well as preferential admission to the Somali National University.

The new Constitution specifically guarantees equal rights for all citizens, including the right of women to participate in the political system. However, in practice, Somali women suffer discrimination in education, work, and family matters. Female enrollment in schools remains far below that for males at all levels of education for traditional and cultural reasons. Almost 96 percent of female Somalis cannot read. The payment of dowry and bride wealth are common marriage customs. Divorce laws and practices still strongly favor the male partner. Despite conservative opposition, the Siad Barre Government long supported women's rights, ensuring constitutional equality, rewriting some laws to permit women to inherit and own property, and taking a strong stand against such practices as female circumcision. During 1990, however, judges were instructed to apply Shari'a law in cases involving inheritance (see Section 1.e.).

Violence in the form of female circumcision is still commonplace. It is performed in state-run hospitals. Pharaonic circumcision (the most extreme and dangerous form of female genital mutilation) is widely practiced, particularly in the north. The less extreme "Sunna" form of circumcision is, however, growing more popular among members of the educated elite.

Excepting female circumcision, domestic violence against women is not a significant social problem in Somalia. Wife beating is uncommon because the wife's family is prepared to enforce the marriage contract that she should not be abused and because wife beating carries a stigma which makes it difficult for the husband to remarry. Furthermore, the present generation of young men treat their wives with greater respect since economic realities render them unable to practice polygamy.

Women's rights groups, including those associated with opposition groups, were forming in 1990. In part, these groups aimed at countering fundamentalist pressures to set back previous gains in women's rights and ensuring that opposition groups included women's rights in their political programs. In July Somalia hosted a conference that examined women's issues such as family health and planning.

Section 6 Worker Rights

a. The Right of Association

The new Constitution promises workers the right to form independent unions, a right not available in practice before October 12. So far, no unions have been organized under the new Constitution. There is a single labor confederation, the government-controlled General Federation of Somali Trade Unions (GFSTU), which is run by government-appointed officials. The GFSTU's main function is to monitor the work force and provide a conduit for worker grievances. The GFSTU is a member of the Organization of African Trade Union Unity and the International Confederation of Arab Trade Unions. Somalia has been a member of the International Labor Organization since 1960.

Until October 1990, strikes were outlawed, and organizing a strike was legally punishable by death. Nevertheless, there were wildcat strikes by transportation workers in 1987 and by quarry workers in 1989. The Government took no action against the striking workers.

P-000761

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 15 of 52 PAGEID #: 1164

SOMALIA

b. The Right to Organize and Bargain Collectively

The right to organize does not appear to be infringed by employers. Because the GFSTU speaks for the Government, its dealings with employers on wages, hours, and working conditions tend to resemble binding arbitration rather than collective bargaining. Some negotiation between employers and employees goes on outside the union framework. Given the official status of the GFSTU, antiunion discrimination appears to be a moot question. Labor courts adjudicate employer-employee disputes with relative impartiality. There are no export processing zones in Somalia.

c. Forced or Compulsory Labor

Forced or compulsory labor is prohibited by law, as well as by the new Constitution, but the Government and party occasionally organize campaigns of "voluntary labor" to clean streets or boost production of state-owned factories.

d. Minimum Age for Employment of Children

The minimum age for the employment of children is 15, and persons under 18 are not permitted to work at night or in certain hazardous occupations. However, the law imposing these requirements is not effectively implemented, and there is considerable child labor on the margins of the wage economy, e.g., selling cigarettes on the street and carrying bags in the market to support themselves and to supplement family incomes.

e. Acceptable Conditions of Work

There is no legal minimum wage, and salaries are extremely low, especially in the public sector. The average salary of a civil servant is equivalent to about $5 per month and is not adequate to maintain a decent standard of living. Productivity in the public sector is correspondingly low, and many civil servants make only minimal appearances in their offices. Workers resort to second jobs, corruption, assistance from other family members, and remittances from abroad to support themselves and their families.

In theory, the workday is 8 hours per day, 6 days per week, with limits on overtime hours. Workers are entitled to paid holidays, annual leave, holiday bonuses, and a variety of fringe benefits.

Somalia has comprehensive labor legislation setting minimum safety and health standards for the workplace. In theory inspectors from the Ministry of Labor carry out enforcement. However, these are only applicable to the small, modern wage sector of an economy that is predominantly pastoral and agricultural and are not normally enforced.

SOUTH AFRICA

Under the leadership of State President F. W. de Klerk, 1990 was an important year of transition in South Africa. While the country's black majority remained disenfranchised and continued to suffer from pervasive discrimination under the apartheid system, the Government committed itself to genuine constitutional negotiations aimed at dismantling this system. President de Klerk suspended the ban on political activities of the African National Congress (ANC) and other organizations and released a number of political prisoners from long-term confinement, including Nelson Mandela, the country's most renowned prisoner. Formal meetings between the ANC and the Government resulted in agreement that the ANC would suspend its armed struggle in the context of the release of political prisoners and the return of opposition exiles. Thereafter, the Government and ANC announced that the way had been cleared for multiparty negotiation of a new constitution, with exploratory talks to begin in the near future. The ruling National Party publicly endorsed majority rule, one man one vote on a common voters' roll, and equal economic, political, and social rights for all South Africans. It also opened its membership to all races. The 4-year-old State of Emergency (SOE) was lifted. While the Government repealed the Separate Amenities Act, some of the key legislative pillars of apartheid remained in place.

Forming a bloody backdrop to this reform process was escalating violence, in particular the spread of black factional violence from Natal Province to Transvaal townships near Johannesburg. The violence appeared to stem from a variety of factors, including political and ethnic rivalries. There also appeared to be an element of randomness which suggested to many the involvement of a "third force" (i.e., rightwing extremist elements of the security forces). It prompted the imposition of special security measures, including curfews and confiscation of dangerous weapons, which contributed to some lessening of the violence. Violent incidents attributable to other causes also increased, such as the police shooting of demonstrators at Sebokeng and unprecedented rioting in mixed race areas of Port Elizabeth, both of which produced large death tolls. Rightwing terrorism also increased significantly.

The doctrine of apartheid prescribes the basic rights and obligations of people according to their racial or ethnic origin. The country's black majority (numbering 27 million, or 74.7 percent of the population) suffers from legally sanctioned discrimination based on race in political, economic, and social aspects of life. Individuals classified by the Government as "colored" (mixed-race) or Asian (8.7 percent and 2.6 percent of the population, respectively) also suffer from extensive racial discrimination, although to a somewhat lesser degree than South Africa's black population. While the Government claims that South Africa is a parliamentary democracy, whites (14 percent of the population) still retain a monopoly of political power. Blacks continue to be denied the right to vote in national elections and to be represented in Parliament. A new Constitution in 1984 replaced the previously all-white parliament with a tricameral one with separate chambers for whites, "coloreds", and Asians. However, whites retain parliamentary control over key affairs, and the executive branch (headed by the State President with extraordinarily strong powers) remains under white control.

P-000762

Exhibit 11: 1991 U.S. Department of State Country Report on Human Rights Practices relating to Somalia (Bates Nos. P-000763-67)

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102d Congress
2d Session

COUNTRY REPORTS ON HUMAN RIGHTS PRACTICES FOR 1991

REPORT

SUBMITTED TO THE

COMMITTEE ON FOREIGN AFFAIRS
HOUSE OF REPRESENTATIVES

AND THE

COMMITTEE ON FOREIGN RELATIONS
U.S. SENATE

BY THE

DEPARTMENT OF STATE

IN ACCORDANCE WITH SECTIONS 116(d) AND 502B(b) OF THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED

FEBRUARY 1992

Printed for the use of the Committee on Foreign Affairs and Foreign Relations of the House of Representatives and the Senate respectively

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Case 2:10-cv-00342-GGS-MRA Doc # 97-4 Filed: 08/09/12 Page: 17 of 52 PAGEID # 1166

P-000763

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 18 of 52 PAGEID #: 1167

SOMALIA

The 21-year rule of Mohamed Siad Barre ended in January 1991, when Siad fled an uprising in the capital, Mogadishu. Efforts to establish a new government have stalled repeatedly, with central and southern clan factions involved in repeated bitter fighting. Foreign embassies were evacuated in January and most, including that of the United States, remain vacant. The successors to Siad, 10 or more clan-based factions, exercise varying degrees of control in their home regions. The two most powerful groups are the United Somali Congress (USC), predominantly of the Hawiye clan, located in central Somalia, including in Mogadishu, and the Somali National Movement (SNM), predominantly of the Isaak clan, located in northwestern Somalia. Siad Barre and his supporters regrouped to form yet another faction in southwestern Somalia, home of Siad's Marehan clan. Elements of the large Darod clan family, of which the Marehan are a small segment, fought the USC while trying to distance themselves from Siad.

In January the USC proclaimed a provisional government which none of the other factions recognized. In May the SNM declared an independent "Somaliland Republic" which neither the other factions nor any foreign countries recognized. In July, at a meeting in Djibouti, six factions--including the USC and two Darod movements but not the SNM--agreed to form an interim government, under the old 1961 constitution, with a 2-year term of office until elections could be held. The six factions announced a 72-member cabinet, headed by Ali Mahdi Mohamed as President. However, their efforts to establish a government were aborted by fighting between factions of the USC, i.e. Ali Mahdi's Abgal subclan and General Mohamed Farah Aideed's Habr Gedr subclan. In November and December, thousands of people were killed in Mogadishu, and at year's end Somalia had almost ceased to exist as a state, and Somali society had increasingly disintegrated into chaos and general disregard for human rights.

Somalia's security forces consist of clan militias and the uniformed police. Remnants of the former Somali National Army (SNA), which disintegrated when Siad fell, are scattered among the militias according to clan loyalties. Armed bands associated with the USC engaged in indiscriminate killing of members of other clans in Galkayo and Brava, as well as in extensive pillage and rape. Uniformed police units, reconstituted in Mogadishu and in the SNM-controlled north, continued a tradition of professionalism, despite a lack of resources. In Mogadishu the police struggled unsuccessfully to confiscate weapons and suppress criminal gangs. Secret police organizations probably existed but were minuscule compared to Siad Barre's former extensive internal security apparatus.

Continued internal warfare in 1991 drastically slowed the rudimentary pastoral and agricultural economy; disrupted infrastructure, including water supplies; and international telecommunications links. Malnutrition and disease were widespread, especially in the southern and central regions, particularly among vulnerable groups such as mothers and small children. At year's end, the fighting in Mogadishu disrupted international food relief efforts.

Serious human rights abuses occurred often in a country racked by war, anarchy, and poverty. Neither President Ali nor General Aideed, the most prominent clan leaders, showed any determination to require respect for human rights by their various armed forces. Undisciplined militias killed, looted, and raped. Several prominent political figures were killed

SOMALIA

either for revenge or simply because of their clan affiliation. Combat often produced disproportionate numbers of women and children killed or wounded, suggesting a pattern of clan-motivated revenge. Security forces sometimes summarily executed persons suspected of banditry.

RESPECT FOR HUMAN RIGHTS

Section 1 Respect for the Integrity of the Person, Including Freedom from:

a. Political and Other Extrajudicial Killing

Among the approximately 20,000 people killed in the chaos of early 1991 were several well-known political figures. Hashi Weheliye Malin (Abgal Hawiye clan) and Haji Musse Bokor (Majertain clan), two senior opposition leaders attempting to arrange a cease-fire during the January fighting, were killed, apparently on orders from Siad Barre. During the same period Hawiye gangs killed Abdalla Mohamed Fadil, a Somali of Yemeni ancestry who had served as assistant prime minister and commissioner for northern reconstruction in the Siad government, and Professor Ibrahim Mohamoud Abyan, a Dolbahante, former president of the Somali National University, who led a coalition of veteran politicians known as the Manifesto Group. In September two adult sons of the elderly chairman of the chamber of commerce, Haji Osman Ahmed Robleh (Abgal Hawiye), were killed along with their wives and children. It is unclear whether they were deliberately targeted or were random victims of fighting in Mogadishu that took several hundred lives.

Somali activists in the United States and Canada published lists of dozens of "elders" in various regions who were allegedly victims of political killings.

According to credible reports, the USC chairman, General Aideed, ordered his militia to execute summarily suspected robbers and looters, sometimes within minutes of capture. A militia commander in the northern city of Hargeisa is reported to have carried out similar executions, and authorities in other areas probably conducted much the same kind of campaign against crime. Dozens, probably hundreds, of suspected bandits suffered summary execution.

b. Disappearance

Some disappearances occurred when groups resembling death squads attacked people because of their clan background and for the opportunity to loot their property. Some of the perpetrators were undoubtedly members of clan militias. Local authorities did not condone these killings, but were unable to prevent them. Such disappearances would have been hard to distinguish from the thousands of people who disappeared as the result of mass migrations to avoid conflict, deaths from disease among refugee and displaced populations, and killings in battle. The International Committee of the Red Cross (ICRC) has established a tracing network, covering a large part of the country, which handles thousands of messages per month as family members try to relocate one another. There is no known compilation of disappearances. Most will likely remain unsolved.

P-000764

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 19 of 52 PAGEID #: 1168

SOMALIA

c. Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment

In the uprising against Siad Barre, Somalia's internal security apparatus was shattered and the doors of the country's prisons were opened, allowing some 20,000 prisoners, including violent criminals, to go free. Because of these events, there were probably far fewer instances of torture by secret police than in previous years. Temporarily at least, harsh treatment of prisoners and deplorable prison conditions also ceased to be relevant problems. Mogadishu Central Prison, a medieval castle with seriously inadequate sanitation, resumed operations June 30. Its fate in the subsequent fighting is not known.

With increasing disorder, other forms of degrading treatment increased; militia forces and bandits allegedly committed rape on a massive scale (see Section 1.g.).

d. Arbitrary Arrest, Detention, or Exile

Information on these subjects is lacking, although at the Djibouti conference the factions reportedly agreed to use the 1960 penal code based on the Napoleonic Code. It appears that arbitrary arrests and detentions decreased substantially, in part because local security forces were weak and disorganized, in part because the new authorities were less zealous than their predecessors in detaining suspected opponents. At year's end, the SNM and possibly other factions held an unknown number of former members of Siad's army as prisoners of war. The feuding factions in Mogadishu held an unknown number of persons in detention. Some local authorities as well as the interim Government granted the ICRC access to detainees, but chaotic conditions throughout Somalia made it difficult for the ICRC to maintain access and systematically pursue detainee visitations.

There were credible reports of clan factions abducting members of unfriendly clans and holding them hostage as insurance against attacks on their own people. The USC militia, for example, allegedly abducted 200 Majertain from the town of Galkayo; SNM militia allegedly abducted 116 Warsangeli from Erigavo and kept them in an open-air holding pen. There were no known instances of exile.

e. Denial of Fair Public Trial

The regular judicial system collapsed with the end of the Siad government. There is little available information about the successor authorities' efforts to revive and operate court systems. In April, Radio Mogadishu announced the establishment of an Islamic court. No details were given. Later, Radio Mogadishu announced that regular courts and prisons hoped to resume their functions by June 15. In the north, the SNM announced that it was adopting Shari'a law, but how this worked in practice is not known. It appears that none of the factions created a version of the Siad government's National Security Court, which tried political cases in secret with no regular rules of procedure.

f. Arbitrary Interference with Privacy, Family, Home, or Correspondence

Because all telephones were out of service, and the post office stopped functioning for more than 6 months, phone tapping and interception of mail ceased, for the time being, to be significant problems.

SOMALIA

g. Use of Excessive Force and Violations of Humanitarian Law in Internal Conflicts

The January uprising produced thousands of casualties and violations of human rights. Siad Barre shelled Mogadishu with field artillery, inflicting heavy casualties on clans he considered enemies. One Siad loyalist distributed flyers urging a war of extermination against non-Darod clans. The insurrectionists in Mogadishu gave no quarter to Siad's forces; members of the hated "Red Hat" presidential guard were left unburied where they died.

At about the same time, armed Hawiye gangs began attacking Darod neighborhoods in Mogadishu. There are credible reports that hundreds of unresisting people--mostly Darod but Hawiye as well--were killed in ethnically motivated violence. Other reports, which cannot be confirmed, indicated people were hacked to death with axes or killed by other brutal methods. Mogadishu's population dropped by half or more as hundreds of thousands of Darod residents and between 7,000 and 15,000 Isaaks fled the killing.

Atrocities were not limited to Mogadishu. On February 10, USC militias entered the ancient coastal town of Brava in pursuit of Darod forces. Although welcomed by the Bravanese (a people of mixed Persian, Portuguese, Arab, and African ancestry) the USC thoroughly looted the town. During their 36-day occupation, repeated waves of USC combatants, many 14 to 16 years old, came through town looting, killing, and raping. USC forces reportedly shot dead about 120 Bravanese, raped young girls in front of their parents, and repeatedly robbed houses and businesses. Girls carried away when the USC left Brava are still missing.

Darod organizations in the United States estimate that 500 civilians were killed, 1,000 wounded, and 200 taken hostage in the February attack by USC forces on Galkayo in north-central Somalia. Although the numbers may be inflated, the allegation appears to be based on fact.

In the northwest, the SNM forces attacked and looted Borama; about 80,000 people fled into Ethiopia. SNM units also raided villages in Sanaag Region; Darod organizations in the United States claim that civilian casualties in these raids ranged into the hundreds, including children and some politically active elders. Corroboration of numbers is lacking, but it appears that the incidents did happen.

In addition to the SNM offensive, the USC attacked refugee camps at Jalalaqsi and other locations in south central Somalia. Opponents of the USC claim that thousands of refugees were killed in these raids.

In December a Belgian ICRC worker died after being shot in downtown Mogadishu, as well as a Somali Red Crescent worker who tried to protect him. In early January 1992, a Bulgarian UNICEF doctor was machine-gunned by assassins in the northeastern town of Bosaso. By year's end, the resumption of fighting in Mogadishu had almost brought international humanitarian relief efforts to a halt. An ICRC official reported, according to the international press, that 60 percent of the children in some areas suffered from severe malnutrition.

Although some commanders controlled their troops better than others, there are no reports of members of clan militias or

P-000765

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 20 of 52 PAGEID #: 1169

other security personnel being disciplined or otherwise called to account for human rights abuses.

Section 2 Respect for Civil Liberties

a. Freedom of Speech and Press

When Siad Barre fell, restraints on speech disappeared. Prominent politicians expressed controversial views; in March, Mohamed Omar Jama, a member of the 1990 Manifesto Group, accused the USC of persecuting Darods. Members of the Mogadishu Government denounced Jama, accusing him of being in league with Siad Barre, but took no action against him. In the north, the SNM's political control may have discouraged expression of unsanctioned views.

Radio Mogadishu continued to broadcast as the voice of the USC. A rehabilitated Radio Hargeisa was similarly controlled by the SNM. The Mogadishu television station was destroyed during the January fighting and had not been rebuilt by year's end. There was no private broadcasting in Somalia.

By March there were at least six newspapers publishing in Mogadishu. Largely independent of factional control, these papers carried on a lively commentary as the clan struggles unfolded. By October over 22 "newspapers" operated in Mogadishu, mainly printed on photocopy machines. It is not known how many survived the fighting of November and December.

Academic freedom was a moot question, as the Somali National University remained closed after Italian professors fled.

b. Freedom of Peaceful Assembly and Association

The demise of Siad's security apparatus opened new possibilities for peaceful assembly and association. People began to demonstrate, seemingly undeterred by the climate of violence and insecurity. By June peaceful demonstrations in favor of peace, demanding more food, or calling for an end to crime were occurring almost daily in Mogadishu. People in Mogadishu not only supported General Aideed's campaigns for the USC chairmanship and against the Darod, they also demonstrated against Aideed and in favor of USC participation in the conference held in Djibouti with other clans. Demonstrations also occurred in the SNM's capital, Hargeisa. Information is lacking on freedom of assembly in other parts of the country.

c. Freedom of Religion

Nearly 100 percent of the population is Muslim, predominantly of the Sunni sect. The fall of Siad Barre's regime, which was both secular and fearful of religious opposition, eliminated constraints on the practice of Islam. Political figures declared their solidarity with Islam, and the SNM's Somaliland Republic adopted Shari'a law and described itself as an Islamic state, though what that meant was unclear. The practice of religions other than Islam ceased in 1991 because practically all non-Muslims were evacuated from Somalia. In Mogadishu vandals looted, defaced, and burned the Catholic cathedral.

d. Freedom of Movement Within the Country, Foreign Travel, Emigration, and Repatriation

With the breakdown of government, movement within Somalia was unconstrained except by the risks of encountering bandits or

the militias of hostile clans. Hundreds of thousands of people moved into the countryside or traveled great distances to their home regions to avoid the fighting and clan-motivated killings in Mogadishu and other cities.

Government controls on foreign travel also ceased, but for most Somalis the practical difficulties of international travel became acute. Air transport services were suspended, and foreign embassies and their visa sections closed. Somalis living overseas were free to return home if they were not deterred by the dangers and the difficulty of travel.

Practically all 350,000 refugees believed to be in the country fled back into Ethiopia. These included ethnic Somali (Ogadeni) refugees from Ethiopia and Ethiopian Oromos, camped in Somalia since the 1977-78 Ogaden War. As a result of the SNM campaigns early in the year and the continuing reluctance of most Isaaks to return to their homes despite the SNM victory, the number of Somali refugees in Ethiopia reached 500,000, up from 370,000 at the end of 1990. About 100,000 Isaak refugees in eastern Ethiopia did return to northwestern Somalia by the end of 1991.

Section 3 Respect for Political Rights: The Right of Citizens to Change Their Government

Despite the end of the Barre regime, people still did not have the right to change their government through democratic means. However, as the year unfolded the people exerted considerable influence, mainly through large demonstrations, on political developments. General Aideed won an indirect election as chairman of the USC with genuine popular support, yet when he vetoed USC participation in the Djibouti Conference he was overruled by public opinion favoring national reconciliation. When politicians in northern Somalia tried to stop short of declaring independence, they were overruled by grass roots demands for secession.

At the end of 1991, for all practical purposes Somalia did not exist as a unified state. No general elections could be held, and the clan based movements functioned much like local one-party states; there was debate within the organizations--sometimes erupting into battles in which hundreds were killed--but no competing political parties. The role of women in the political events of 1991 was minimal, except as victims.

Section 4 Government Attitude Regarding International and Nongovernmental Investigation of Alleged Violations of Human Rights

Although the Association of Somali Lawyers formerly was involved with human rights issues, their activities in 1991 were unknown. The various authorities' attitudes toward human rights organizations were unclear. No international human rights groups attempted to send delegations to Somalia for investigative purposes.

Section 5 Discrimination Based on Race, Sex, Religion, Language, or Social Status

Eighty percent or more of the population are ethnic Somalis. The Somali majority looks down upon the minorities of Bantu and Asian extraction. Somalis also view as inferior members of several small client or "outcast" clans, who are relegated to

P-000766

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-4 Filed: 08/09/12 Page: 21 of 52 PAGEID #: 1170

certain low-prestige occupations and who rarely intermarry with members of majority Somali clans.

Racial tensions are a minor problem, however, compared to animosities and rivalries between ethnic Somalis based on clan affiliation. These are the fundamental cause of the country's continuing civil conflict. Siad Barre's favoritism towards his family and members of the Marehan clan, and corrupt accumulation of wealth by Siad's cronies, were common grievances among the clans which rebelled against Siad's rule.

Somali women suffer discrimination in education, work, and family matters. About 96 percent of female Somalis cannot read, and females receive about one-third the schooling of males. A year of turmoil in Somalia seriously weakened women's rights as recognized in the 1990 Constitution. The intentions announced by some officials to promote greater adherence to Islam and the adoption of Shari'a law in northern Somalia indicated that religious practices will probably become more conservative. Nevertheless, at least one women's group (associated with the USC) continued in existence, working to counter fundamentalist pressures to reduce women's rights.

Female circumcision remained a common practice, including Pharaonic circumcision, the most extreme and dangerous form. However, the risks of undergoing circumcision in the midst of war and famine may have led some families to delay subjecting their daughters to the procedure. The chances of getting medical attention in case of infection or other complications of circumcision were even less in 1991 than in past years. The Siad Barre government opposed female circumcision and organized campaigns against it; attitudes of Somalia's new governing authorities toward female circumcision are unknown.

The absence of alcohol in Somali culture and the tradition that the family protects a daughter after her marriage help shield women against domestic violence, such as wife beating. There are suggestions, however, of these constraints breaking down under the strains of civil war, anarchy, and urban life.

Section 6 Worker Rights

a. The Right of Association

The Constitution adopted in October 1990 granted workers the right to form independent unions and to strike, but this reform was not implemented in practice before Somalia descended into anarchy. It is unknown if any unions are functioning in the current situation or if there were any strikes during 1991.

b. The Right to Organize and Bargain Collectively

No instances in 1991 of collective bargaining are known, nor were there any known cases of antiunion discrimination. There are no export processing zones in Somalia.

c. Forced or Compulsory Labor

There were no known instances of forced or compulsory labor.

d. Minimum Age for Employment of Children

During the Siad years the minimum age for employment was 15, but the law was widely ignored, with considerable child labor on the margins of the wage economy. Civil war and anarchy have

probably made these conditions worse, with street children engaged in begging and thievery more often than work or education, which are increasingly unavailable.

e. Acceptable Conditions of Work

During the Siad years there was no legal minimum wage. Inflation reduced salaries in the public sector to the equivalent of a few dollars a month. To survive, government workers resorted to corruption and outside business activities.

In theory the small modern sector of Somalia's economy had an 8-hour workday, 6 days per week, with limits on overtime. Workers were entitled to paid holidays, annual leave, and other benefits. Laws set minimum safety and health standards in the workplace, and in theory inspectors from the Ministry of Labor enforced these standards. Because of inflation and low productivity, these benefits were mostly fictional. In 1991 political instability and economic contraction further undermined working conditions for those persons lucky enough to be employed.

P-000767

Exhibit 12: November 17, 2010 Defendant's Responses to Plaintiff's First Set of Interrogatories.

IN THE UNITED STATES DISTRICT COURT FOR
THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

ABUKAR HASSAN AHMED,	)	
	)	
Plaintiff,	)	
	)	**Case No. 2:10-cv-342**
v.	)	
	)	
ABDI ADEN MAGAN,	)	
	)	
Defendant.	)	

DEFENDANT ABDI MAGAN'S RESPONSES TO PLAINTIFF ABUKAR AHMED'S FIRST SET OF INTERROGATORIES

Pursuant to Fed. Civ. R. 26 and 33, Defendant Abdi Aden Magan ("Defendant" or "Mr. Magan") hereby responds in writing to the interrogatories propounded upon him by Plaintiff Abukar Hassan Ahmed ("Plaintiff"), subject to the General Objections and specific objections noted below.

These answers and objections rely upon information that is currently available or known to Defendant after diligent investigation. Defendant reserves the right to amend or revise these answers, objections, and/or responses as necessary in the event additional information becomes available to him or comes to his attention.

GENERAL OBJECTIONS

Defendant objects to Plaintiff's instructions and definitions in the paragraphs preceding the discovery requests to the extent that they seek to impose upon Defendant obligations in addition to, inconsistent with, or which are not authorized by the Federal Rules of Civil Procedure. Defendant will respond to Plaintiff's interrogatories in accordance with the obligations imposed by the applicable rules and law.

Defendant further objects to Plaintiff's interrogatories to the extent they seek admission

or disclosure of information, documents, or things that are protected from disclosure by the attorney-client privilege, the attorney work-product doctrine, and all other applicable privileges, protections, or immunities from discovery. If and to the extent the Defendant inadvertently discloses in this litigation, information that is, or may be, protected from discovery, such inadvertent disclosure is not intended to, and shall not be construed to, waive any such privilege, protection or immunity.

Defendant further objects to the interrogatories to the extent they seek information that is overly broad and unduly burdensome and/or is without appropriate temporal limitation or qualification.

Defendant further objects to the interrogatories to the extent they refer to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

The absence of an objection to a particular interrogatory, or any part thereof, shall not be deemed to be an acknowledgment that information responsive to such interrogatory, or an admission or agreement that the subject of any such interrogatory, or any part thereof, is relevant to the subject matter of this case. Defendant hereby reserves the right to object to relevancy and/or admissibility of any information provided in these answers, objections, and responses.

INTERROGATORIES

INTERROGATORY NO. 1:

For each person included in Defendant Magan's Initial Disclosures (filed pursuant to Federal Rule of Civil Procedure 26 (a)), state the full name, any aliases or nicknames, last known address, telephone number, occupation, and identify the person's knowledge of the facts relating to any claims and defenses stated in the "pleadings" (as that term is defined pursuant to Rule 7(a) of the Federal Rules of Civil Procedure), the entire factual basis of that person's knowledge, and indicate whether such person will be called to testify at trial. For each expert witness identified, describe his or her qualifications, opinions, conclusions and basis for conclusions.

ANSWER:

See initial disclosures. New information that is responsive to this request that is not listed on the initial disclosures is listed below. Defendant does not yet know who he plans to call as a witness at trial. Defendant's full name is Abdi Aden Magan. He resides at 3183 Pendleton Ct., Columbus, Ohio, 43219. The phone number for Abdeqadir Aden is 614-281-7823. The phone number of Abdi Ali is 614-424-2468. The phone number for Ibrahim Moalin is 937-450-6656. The phone number of Jama Egal is 614-475-7265. The phone number of Mohamed Samatar is 614-556-0223.

INTERROGATORY NO. 2:

Provide a timeline of your work history for the last 35 years. For each position you held, identify:

(a) your position and title or rank at the time;

(b) the dates of service in that position;

(c) all aspects of your role and responsibilities in that position;

(d) for National Security Service ("NSS") positions, each unit of the NSS under your authority;

(e) your immediate superiors; and

(f) your immediate subordinates

ANSWER:

Objection, Mr. Magan is unable to provide a complete response to this request because this information is not available to him. Without waiving said objection, Mr. Magan's work history:

1. Army officer: 1976-1980, Specialized in Antiaircraft artillery

2. Antiterrorism Officer, 1980-1986, specialized in bomb squad

3. Student from approximately 1986-1987

4. Department of Criminal Investigation at the National Security Service, from approximately 1988-1990. There was very little stability in Somalia at this time. Mr. Magan did not apply for this position or ask for this position. Mr. Magan was ordered to take this job. He had no choice. This was a dangerous position. Both of Mr. Magan's children were murdered as a result of him holding this position. Defendant's immediate superior was General Mohammed Jibril Muse Commander of the National Security Service. Towards the end of 1990 General Adan Cirday became commander of the National Security Service.

5. 2000 Limited Brands.

6. 2001 BP Gas Station.

7. 2001-2007 Kroger bakery.

INTERROGATORY NO. 3:

State the procedure in effect from 1986 to 1990 for disciplining or removing an NSS officer that has violated military rules of conduct or committed a crime.

ANSWER:

Objection this request is vague and overbroad. Without waiving said objection Mr. Magan does not know other than this would be handled by the court system.

INTERROGATORY NO. 4:

Describe your authority to discipline subordinate NSS officers for violating military rules of conduct or committing a crime during your tenure as Chief of the NSS Department of Investigations.

ANSWER:

None.

INTERROGATORY NO. 5:

Describe in detail:

1) your responsibilities relating to operation of the NSS prison from 1986 to November 1990;
2) the types of charges against detainees in the NSS prison during the period 1986 to November 1990; and
3) the types of reports made documenting the names of persons detained in the NSS prison and the charges against them, the location of the reports, who was responsible for creating them, and the persons who received copies of the reports and the frequency with which the reports were circulated.

ANSWER:

Objection, this question is vague and ambiguous. Defendant further objects to this interrogatory to the extent it refers to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

The National Security Service had numerous divisions. Mr. Magan worked in the criminal investigation department. Without waiving said objection, the criminal investigation department of the National Security Service did not maintain a prison. If "NSS prison" refers to the central jail Mr. Magan did not work there or have any authority there. Anyone questioned by the Department of Criminal Investigation was there temporarily similar to a law enforcement station. Captain Sheikh Mohamed Hussein was responsible for the prisoner, their food, and their safety. The Department of Criminal Investigation investigated cases related to national security. The case would be with the National Security Court. To the best of Mr. Magan's knowledge any reports generated would go to the National Security Court and/or the headquarters of the National Security Service.

INTERROGATORY NO. 6:

Identify NSS officers and members of the Somali Armed forces that operated and worked within the NSS prison under your authority. Your answer should include but not be limited to their full name, nickname or alias, title, rank, last known address, and telephone number.

ANSWER:

Objection, this question is vague and ambiguous. Mr. Magan does not know what "NSS prison" is referring to. Defendant further objects to this interrogatory to the extent it refers to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

Without waiving said objection, the National Security Service had numerous divisions. Mr. Magan worked in the criminal investigation department. The criminal investigation department of the National Security Service did not maintain a prison. Abdullahi Ismail Ciro, Col. Abdullahi Agojiid, and Col. Abdirashid Yasin worked at the Department of Criminal Investigation. Mr. Magan does not know the location of Col. Abdullahi Agojiid. Abdullahi Ismail Ciro. is in Somaliland. Col. Abdirashid Yasin lives in Denmark.

INTERROGATORY NO. 7:

State all facts known to you regarding Hussein Sufi Derow, including but not limited to, his rank, title and position in the NSS in 1988 and 1989, his supervising and superior officers within the NSS in 1988 and 1989, his relationship to you as Chief of the NSS Department of Investigations, any disciplinary proceedings against him for criminal activity or violation of military rules of conduct, his travel since 1989 and his last known address and phone number.

ANSWER:

To the best of Mr. Magan's knowledge Hussein Sufi Derow was a Lieutenant and a

member of the National Security Service. He was in training to be an investigator in approximately 1988 and was transferred to the National Security Service headquarters after that. His superior was Abdi Duale. Mr. Magan does not know his location. Mr. Magan has no knowledge regarding any disciplinary action against him.

INTERROGATORY NO. 8:

State all facts known to you regarding Mohamoud Hagi Farah Igal, including but not limited to his rank, title and position in the NSS in 1988 and 1989, his supervising and superior officers within the NSS in 1988 and 1989, his relationship to you as Chief of the NSS Department of Investigations, any disciplinary proceedings against him for criminal activity or violation of military rules of conduct, his travel since 1989 and his last known address and phone number.

ANSWER:

To the best of Mr. Magan's knowledge Mohamed Haji Farh Igal was a Lieutenant and a member of the National Security Service. He was a case investigator. His superior was Col. Abdirashid Yasin. Mr. Magan does not know his location. Mr. Magan has no knowledge regarding any disciplinary action against him.

INTERROGATORY NO. 9:

State all facts known to you concerning the treatment of persons detained in the NSS prison during your tenure as Chief of the NSS Department of Investigations, including:

1) the conditions of confinement of persons detained at the NSS prison, including a description of the prison cells, whether persons detained at the NSS prison were kept

in solitary confinement, whether they were kept in handcuffs, the type and amount of food provided daily to them, and how often they were permitted to go to the toilet and bathe;

2) the questioning of persons detained at the NSS prison, including who questioned them, how often they were questioned, what types of interrogation techniques were used on them, how information obtained from questioning was stored, and how information obtained from questioning was reported to you in your capacity as Chief of the Department of Investigations.

ANSWER:

Objection, this question is vague and ambiguous. Defendant further objects to this interrogatory to the extent it refers to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

The National Security Service had numerous divisions. Mr. Magan worked in the criminal investigation department. Without waiving said objection, the criminal investigation department of the National Security Service did not maintain a prison. Anyone held at the Department of Criminal Investigation was there at the order of the court. Anyone held there would be there temporarily until the case was investigated or the court ordered otherwise. There were two rooms that faced outside and four rooms inside. Each room was 4 x 6 meters. There were two bathrooms and two toilets. The toilets could be used at any time. Meals were served three times per day. Handcuffs were not used inside the building. There was no solitary room in

the facility at all. Suspects were asked questions by the officer who was investigating the case. The officer responsible for investigating the case would transfer the information to prosecutors at the court. Information that the Department of Criminal Investigations used came from the National Security Service headquarters.

INTERROGATORY NO. 10:

State all facts known to you, and the date in which you first learned this information, regarding Plaintiff Abukar Hassan Ahmed, especially with regard to any NSS investigation, surveillance, arrest, imprisonment and treatment during imprisonment, and any evidence collected by the NSS and presented to the National Security Court in support of criminal charges against Plaintiff Abukar Hassan Ahmed.

ANSWER:

Mr. Magan does not know the Plaintiff and has no recollection of ever meeting him.

INTERROGATORY NO. 11:

Identify all communications that you have had with Plaintiff Abukar Hassan Ahmed and concerning Plaintiff Abukar Hassan Ahmed, including communications with the National Security Court and the Office of the Attorney General.

ANSWER:

None.

INTERROGATORY NO. 12:

Identify each person with knowledge of facts relating to the arrest, detention and interrogation of Plaintiff Abukar Hassan Ahmed between and including 1988 and 1989, and your relationship to that person.

ANSWER:

None.

INTERROGATORY NO. 13:

State all facts known to you concerning the NSS procedure in effect from 1980 to 1990 for investigating an individual for suspicion of security related offenses. Include any procedures for documenting and reporting information obtained through investigations, identify the NSS officers with authority to order an investigation or the continuation of an investigation and the NSS officers that supervised and carried out orders for an investigation.

ANSWER:

Objection, Mr. Magan is not qualified to answer questions concerning National Security Service procedures from 1980 to 1990. Without waiving said objection, Mr. Magan served as Chief of the Department of Criminal Investigations from approximately 1988 to 1990. Commander of the National Security Service, General Mohamed Jibril, was the officer with authority to order any investigation. This was done in conjunction with the National Security Court. The only exception to this during Mr. Magan's tenure with the Department of Criminal Investigation, while General Mohamed Jibril was in charge, was the detention of Osman Hassan Ali Atto. Mr. Magan refused to allow Osman Hassan Ali Atto to be detained at the Department of Criminal Investigation. Towards the end of 1990 General Adan Cirday became Commander of the National Security Service. General Cirday did order people detained without involvement of the National Security Court. This escalated a conflict between Mr. Magan and General

Cirday. General Cirday arrested Mr. Magan.

INTERROGATORY NO. 14:

State all facts known to you concerning the NSS procedure for arresting persons during your tenure as Chief of the NSS Department of Investigations. Include any procedures for documenting and reporting the arrest, and identify the NSS officers with authority to order an arrest, the NSS officers authorized to carry out an arrest and the persons and NSS officers that were notified when an arrest was made.

ANSWER:

During my tenure documentation and reports came from the National Security Service headquarters under the order of General Mohmed Jibril Muse. After the Department of Criminal Investigation received the report the procedure was to consult with the prosecutors at the National Security Court. During my tenure Col. Nur Hasan Hussien was in charge of the prosecutors at the National Security Court. The court had to issue a warrant for the arrest of a person. After the warrant was issued an officer assigned to the investigation would usually arrest the person. Within days the officer assigned to the investigation would report to the prosecutor's office at the National Security Court. If an investigation could not be completed within days the officer assigned to the case would have to ask the court for an extension. After the investigation was completed the court would either order the person released or to the central jail. Mr. Magan had no authority over how the central jail was run.

INTERROGATORY NO. 15:

State all facts known to you regarding the NSS procedure for detaining a civilian for security related offenses in the NSS prison. Identify any and all procedures for pre-trial detention in the NSS prison and documenting and reporting the detention. Identify NSS officers with authority to order the continued detention of a civilian for security related offenses.

ANSWER:

Objection the question is vague and ambiguous. Mr. Magan worked at the Department of Criminal Investigations. His is only familiar with the procedures at the Department of Criminal Investigations. Defendant further objects to this interrogatory to the extent it refers to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

Without waiving said objection, the court had the authority to order the continued detention of a civilian for security related offenses. Also, see response to Interrogatory 14.

INTERROGATORY NO. 16:

State all facts known to you concerning the National Security Court during the time you were a member of the NSS, including:

1) the types of cases tried before the Court;

2) the key members of the Court; and

3) the collaboration between the NSS prison and the National Security Court in the prosecution of an accused before the Court.

ANSWER:

Objection, Mr. Magan is only familiar with the National Security Court to the extent that they worked with the Department of Criminal Investigations. Defendant further objects to this interrogatory to the extent it refers to the "NSS prison". Mr. Magan does not know what is being referred to. When the term NSS prison is used in popular media sources they are usually referring to an interrogation center in Mogadishu, referred to as *Godka*, or other centers including the Mogadishu Central Prison, and stations at Lanta Bur, Labtanjirow and Burwein. Mr. Magan did not work or have any authority at any of these places.

Without waiving said objections:

1) Cases related to the safety and/or stability of Somalia.

2) Majesty, Mohamud Gelle, Attorney General Col. Nur Hasan Hussien

3) The court ordered warrants for arrest, and the Court then prosecuted the cases.

INTERROGATORY NO. 17:

Identify any incidents known to you, and the time at which you first learned of them, relating to the arbitrary arrest, detention, mistreatment, torture, or killing of any civilian in Somalia alleged to have been committed by the NSS during the period 1970 through 1989.

ANSWER:

Objection, the request is overbroad. Without waiving said objection, Mr. Magan worked in one of numerous National Security Service divisions. During Mr. Magan's tenure at the Department of Criminal Investigation he is unaware of any instance of torture or killing of a

civilian. Mr. Magan served as Chief of the Department of Criminal Investigations from approximately 1988 to 1990. Commander of the National Security Service, General Mohamed Jibril, was the officer with authority to order any investigation. This was done in conjunction with the National Security Court. The only exception to this during Mr. Magan's tenure with the Department of Criminal Investigation, while General Mohamed Jibril was in charge, was the detention of Osman Hassan Ali Atto. Mr. Magan refused to allow Osman Hassan Ali Atto to be detained at the Department of Criminal Investigation. Towards the end of 1990 General Adan Cirday became Commander of the National Security Service. General Cirday did order people detained without involvement of the National Security Court. This escalated a conflict between Mr. Magan and General Cirday. General Cirday arrested Mr. Magan.

INTERROGATORY NO. 18:

Identify any litigation that you have initiated or been involved with, either as a party or witness, since the date of your first entry into the United States, including the outcome of the litigation, any award of damages and any money obtained through settlement.

ANSWER:

See http://fcdcfcjs.co.franklin.oh.us/CaseInformationOnline/ case numbers 08 CV 007049, 08 DD 002001 (divorce), and 10 CV 008228 (Mr. Magan was shot. The case is pending). In addition, Mr. Magan had a workers compensation case from when he worked with the Limited.

INTERROGATORY NO. 19:

Identify all instances in which you have been arrested and/or convicted of a crime. Include the nature of the offense, the arresting agency, the outcome, and the case number and court identification.

ANSWER:

In 1990, General Cirday arrested Mr. Magan. See response to Interrogatory 17.

INTERROGATORY NO. 20:

Identify your immigration status in the United States, from the date of your first entry into the United States of America.

ANSWER:

Mr. Magan is a Permanent Resident of the United States.

Respectfully submitted and
as to objections,

Jeffrey Donnellon (0079472)
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Attorney for Mr. Magan

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Defendant Abdi Aden Magan's Responses To Plaintiff Abukar Hassan Ahmed's First Set of Interrogatories was served on the 17th day of November, 2010, by first class U.S. mail, postage prepaid, upon:

Tiffany Smith
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Exhibit 13: December 1989 U.S. Department of State Cable No. 1989MOGADI14054
(P-000905-16)

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Current Handling: n/a
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PAGE 01 MOGADI 14054 01 OF 05 211347Z
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~~C O N F I D E N T I A L~~ SECTION 01 OF 05 MOGADISHU 14054

E.O. 12356: DECL: OADR
TAGS: PHUM, SO
SUBJECT: SOMALIA HUMAN RIGHTS REPORT: SUGGESTED EDITING OF SECOND DRAFT

REF: A) STATE 386200, B) MOGADISHU 11894

1. (U) THE FOLLOWING ARE OUR RESPONSES TO QUESTIONS AND COMMENTS CONCERNING THE DEPARTMENT'S REVISED DRAFT OF THE SOMALIA HUMAN RIGHTS REPORT (REF A), TAKEN FROM THE TOP.

Dept. of State, RPS/IPS, Margaret P. Grafeld, Dir.
(X) Release ( ) Excise ( ) Deny ( ) Declassify
Date 10/21/05 Exemption

2. DEPARTMENT'S QUESTIONS

-- ~~(LOU)~~ SECTION 1 C. THE "MIG" METHOD OF TORTURE WAS APPARENTLY USED IN INTERROGATING DETAINEES FOLLOWING THE JULY DISTURBANCES. WE HAVE LOCATED SOME ALLEGED VICTIMS AND HOPE TO INTERVIEW THEM.

-- ~~(C)~~ SECTION 1 D, FIRST PARA. WE HEARD FROM AT LEAST THREE SOURCES THAT THE SECURITY SERVICES WERE DETAINING FEWER PERSONS IN EARLY 1989, AND USUALLY RELEASING THEM QUICKLY IF EVIDENCE WAS LACKING. THESE SOURCES INCLUDED THE BRITISH EMBASSY, WHO GOT IT FROM PEOPLE WITH TIES TO THE SNM; AMCIT FORMER POLITICAL PRISONER NUR ABBY HUSSEIN, WHO HAS CONTACTS WITH THE NSS; AND NSS DIRECTOR OF INVESTIGATIONS COL. ABDI ADAN MAGAN (POSSIBLY A SELF-~~CONFIDENTIAL~~

~~CONFIDENTIAL~~

PAGE 02 MOGADI 14054 01 OF 05 211347Z

SERVING SOURCE; HE WAS LOOKING FOR A VISA FOR HIS BROTHER).

Current Class: ~~CONFIDENTIAL~~ Page: 1

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CONFIDENTIAL INFORMATION

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-- [redacted] SECTION 1 D, FOURTH PARA. NINE OR MORE AGENCIES HAVE THE POWER TO DETAIN. IN ADDITION TO THE SIX LISTED, OTHERS WITH POWER TO DETAIN INCLUDE THE CUSTODIAL CORPS (IN ADDITION TO THEIR MAIN FUNCTION OF OPERATING THE PRISONS), AND REGIONAL GOVERNORS AND DISTRICT COMMISSIONERS. BECAUSE PARTY AND GOVERNMENT OFFICES AT VARIOUS LEVELS ALL HAVE THE POWER TO DETAIN, AND A PERSON SEARCHING FOR A DETAINEE WOULD HAVE TO CHECK WITH ALL OF THEM, THE EFFECTIVE NUMBER OF AGENCIES WITH POWER TO DETAIN IS GREATER THAN NINE.

-

-- [redacted] SECTION 1 D. ADEN NUR AND BA'ADLEH ARE STILL IN DETENTION. YUSUF OSMAN SAMANTAR WAS RELEASED IN FEBRUARY (MOGADISHU 01587). SHEIKH MOALLIM WAS RELEASED ABOUT THE SAME TIME (MOGADISHU 03446).

-- (U) SECTION 2 A. SOMALI EMBASSIES HAVE NOW BEEN INSTRUCTED TO ISSUE VISAS TO U.S. AND OTHER FOREIGN JOURNALISTS. SEVERAL EUROPEAN JOURNALISTS HAVE VISITED SOMALIA SINCE THE JULY INCIDENTS. THE FIRST NAIROBI-BASED AMERICAN JOURNALIST IN TWO YEARS ARRIVED IN MOGADISHU DECEMBER 13 AND DEPARTED DECEMBER 20 (MOGADISHU 13271).

-

-- [redacted] SECTION 2 D, LAST PARA. SULEIMAN NUH ALI'S WIFE INQUIRED WITH THE SECOND IN COMMAND OF THE NSS'S IMMIGRATION DEPARTMENT ABOUT SECURING RETURN OF ALI'S AND YUNIS'S PASSPORTS, BUT SHE WAS TOLD THAT THE MATTER WAS OUT OF IMMIGRATION'S HANDS. (MOGADISHU 13960).

-- [redacted] SECTION 4, FIRST PARA LAST SENTENCE. SOMALI OFFICIALS INCLUDING PRESIDENT SIAD (MOGADISHU 09580) HAVE EXCORIATED AMNESTY INTERNATIONAL IN PRIVATE CONVERSATIONS [redacted]

[redacted]

PAGE 03 MOGADI 14054 01 OF 05 211347Z

WITH U.S. OFFICIALS. SINCE THESE WERE GOVERNMENT-TO-GOVERNMENT CONVERSATIONS, IT IS PERHAPS BETTER TO DROP THE REFERENCE TO OFFICIALS EXPRESSING ANGER. SEE SUGGESTED REVISION OF TEXT BELOW.

-

-- [redacted] SECTION 5, FIRST PARA. YES, THERE IS A NORTH VERSUS SOUTH ASPECT TO CLAN DIFFERENCES, AND AN ARAB VERSUS AFRICAN ONE AS WELL. THE MAREHAN PROBABLY DO HAVE PREFERRED ACCESS TO HEALTH FACILITIES, BECAUSE MORE CLINICS HAVE BEEN BUILT IN THEIR AREAS THAN ELSEWHERE. AS TO EDUCATION, THE HAWIYA PROBABLY HAVE SOME ADVANTAGES BECAUSE

THEY LIVE IN THE MOGADISHU AREA, WHICH HAS A CONCENTRATION OF SCHOOLS AS WELL AS THE SOMALI NATIONAL UNIVERSITY, THE COUNTRY'S ONLY UNIVERSITY.

-- (LOU) SECTION 5, VIOLENCE AGAINST WOMEN. DOMESTIC VIOLENCE AGAINST WOMEN, THE MAIN CONCERN OF THE REWRITE, IS NOT/NOT A SIGNIFICANT SOCIAL PROBLEM OR PUBLIC ISSUE IN SOMALIA. SEE SUGGESTED REVISION OF TEXT BELOW.

3. LINE BY LINE COMMENTS AND REVISION OF DEPARTMENT'S DRAFT (REMAINDER OF TEXT LOU)

INTRODUCTION

-- PARA ONE. ONE-PARTY RULE. IT IS TRUE THAT SOMALIA IS A ONE-PARTY STATE. IT IS WRONG, HOWEVER, TO MAKE ONE-

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PAGE 01 MOGADI 14054 02 OF 05 211349Z
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TO SECSTATE WASHDC IMMEDIATE 6015

C O N F I D E N T I A L SECTION 02 OF 05 MOGADISHU 14054

E.O. 12356: DECL: OADR
TAGS: PHUM, SO
SUBJECT: SOMALIA HUMAN RIGHTS REPORT: SUGGESTED EDITING

PARTY RULE THE VILLAIN OF THE PIECE. AS WE POINTED OUT DURING THE EDITING OF THE 1988 REPORT, SOMALIA IS NOT NORTH KOREA; IT IS MUCH MORE LOOSELY ORGANIZED, AND THE PARTY IS ABOUT AS RAMSHACKLE AS ANY INSTITUTION IN THE COUNTRY. WE SUGGEST OMITTING THE CLAUSE, "EXACERBATED BY RIGID ONEPPARTY RULE".

-- PARA ONE, "POPULAR DISCONTENT WITH THE GOVERNMENT

INCREASED AS IT FAILED TO DEAL SUCCESSFULLY WITH SOMALIA'S DEEPENING CRISIS AND THE NEED FOR REFORMS." THIS STATEMENT, THOUGH ARGUABLY TRUE GIVEN THE REPEATED MUTINIES OF GOVERNMENT TROOPS, GIVES A DIFFERENT SLANT TO THE REPORT FROM WHAT WE HAD INTENDED. WE WANTED TO SUGGEST THAT DESPITE -- OR BECAUSE OF -- THE GOVERNMENT'S NEAR COLLAPSE THERE IS POLITICAL FERMENT IN THE AIR. THE TREND FOR HUMAN RIGHTS IS NOT UNRELIEVEDLY DOWNWARD; THERE IS STILL HOPE. WE RECOMMEND THE FOLLOWING COMPROMISE WORDING: "CIVIL CONFLICT CONTINUED DURING 1989, WITH AN OUTBREAK OF RIOTING IN THE CAPITAL, MOGADISHU, FOLLOWED BY OFFICIALS REPRISALS. TROOPS MUTINIED IN THE SOUTHERN, CENTRAL, AND NORTHERN REGIONS, AND POLITICAL FERMENT INTENSIFIED."

[redacted]

[redacted]

PAGE 02 MOGADI 14054 02 OF 05 211349Z

-- PARA THREE: ECONOMY. WE STARTED THIS PARA WITH TWO TRANSITIONAL SENTENCES: "POVERTY ACCOUNTS IN SOME MEASURE FOR THE VIOLENCE WHICH PLAGUED SOMALIA IN 1989. CLANS CONTINUED THEIR AGE-OLD COMPETITION FOR WATERHOLES AND GRAZING LANDS, AND AT THE NATIONAL LEVEL THE GOVERNING ELITE, BASED ON THE MAREHAN SUBCLAN, STRUGGLED WITH OTHER CLANS FOR CONTROL OF THE COUNTRY'S FEW RESOURCES." THESE SENTENCES HELPED PUT THE SITUATION IN SOMALIA IN CONTEXT AND FORESHADOWED DISCUSSION IN SECTION 5 ON DISCRIMINATION. WE RECOMMEND RESTORING THESE SENTENCES. (FYI: IN THE FUNCTIONAL QUESTIONNAIRE PREPARATORY TO THE PENDING INSPECTION OF EMBASSY MOGADISHU, WE COMMENTED: "OUR ONLY SUGGESTION FOR IMPROVING THE QUALITY OF THE ANNUAL HUMAN RIGHTS REPORTS WOULD BE MODIFY THE LOCK-STEP FORMAT REQUIRED FOR THE INTRODUCTION TO ALL REPORTS. EXAMINING OUR OWN DRAFT, WHICH CONFORMED FAITHFULLY TO THE REQUIREMENTS, WE FOUND THAT IT WAS DISJOINTED AND POINTLESS, NOT A PROPER INTRODUCTION TO A SERIOUS DISCUSSION. THEREFORE, INTERPRETING THE INSTRUCTIONS AS LIBERALLY AS POSSIBLE, WE REWROTE THE INTRODUCTION TO SUIT OUR NEEDS." WE HAD PARA THREE IN PARTICULAR IN MIND WHEN WE WROTE THIS. END FYI.)
-- PARA FOUR: SUMMARY OF THE YEAR'S HUMAN RIGHTS DEVELOPMENTS.

-- "AT LEAST 100 PEOPLE WERE KILLED, AND THOUSANDS INJURED ." OUR INFORMATION ON THE NUMBER INJURED IS VERY

SKETCHY. "THOUSANDS INJURED" SEEMS HIGH. RECOMMEND "AND HUNDREDS MORE INJURED. . ."

-- "ISSAKS". THE DEPARTMENT'S DRAFT SPELLS THE NAME OF THIS TRIBE "ISAAKS" AND "ISSAKS" (APPARENTLY A BORROWING [redacted]

[redacted]

PAGE 03 MOGADI 14054 02 OF 05 211349Z

FROM THE GERSONY REPORT). WE PREFER "ISAAKS".

-- ". . . BUT AT THE END OF 1989 HE HAD TAKEN NO PRACTICAL STEPS TO IMPLEMENT THIS PROMISE OR TO SEEK RECONCILIATION WITH THE ISSAKS" ("ISSAKS" AGAIN.) PRACTICAL STEPS HAVE BEEN ATTEMPTED. WE RECOMMEND THE FOLLOWING REVISION: "IN NOVEMBER HE APPOINTED A TECHNICAL COMMITTEE TO PROPOSE REVISIONS TO THE CONSTITUTION TO ACCOMMODATE MULTIPLE PARTIES AND FREE ELECTIONS. HE REPEATEDLY OFFERED TO NEGOTIATE WITH DISSIDENT ORGANIZATIONS, 'ANYWHERE, ANY TIME,' AND SENT EMISSARIES TO INITIATE SUCH CONTACTS, BUT WAS REBUFFED BY THE SNM AND OTHER GROUPS." IT IS HARD TO SEE WHAT FURTHER "PRACTICAL STEP" SIAD COULD OFFER THE ISAAKS, EXCEPT TO RESIGN.

-- SECTION 1 C, FIRST PARA. IN LIGHT OF NEWLY DEVELOPED INFORMATION (PARA 2, ABOVE) WE SUGGEST CHANGING THIS PARA, BEGINNING WITH THE SECOND SENTENCE, TO READ AS FOLLOWS: "SOME RECENTLY RELEASED SHORT-TERM DETAINEES COMPLAINED, HOWEVER, THAT THEY WERE SUBJECTED TO TORTURES SUCH AS THE "MIG", IN WHICH THEIR HANDS AND FEET WERE TIED TOGETHER BEHIND THEIR BACKS WITH A ROPE, WHICH WAS PULLED TIGHT SO THAT THE BODY WAS ARCHED BACKWARDS, TO RESEMBLE THE SWEPT-BACK WINGS OF A MIG AIRCRAFT. THE CANADIAN CENTER FOR VICTIMS OF TORTURE CONTINUED TO REPORT SEEING TORTURE VICTIMS FROM SOMALIA."

-- SECTION 1 C, SECOND PARA, ON PRISON CONDITIONS. OUR DESCRIPTION OF THE SHIPPING CONTAINER SUFFOCATION INCIDENT CALLS THIS AN ACT OF NEGLIGENCE, TO DISTINGUISH

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PAGE 01 MOGADI 14054 03 OF 05 211350Z

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E.O. 12356: DECL: OADR
TAGS: PHUM, SO
SUBJECT: SOMALIA HUMAN RIGHTS REPORT: SUGGESTED EDITING

IT FROM GOVERNMENT POLICY. WE BELIEVE THAT THAT DISTINCTION SHOULD BE MAINTAINED, AND PREFER OUR ORIGINAL VERSION TO THE REWRITE. THE AUTHORITIES HAVE NOT ANNOUNCED ANY DISCIPLINARY ACTION, BUT THE AUTHORITIES DID IN FACT PUBLISH AN EXPLANATION OF THE INCIDENT. SEE THE TEXT IN MOGADISHU 11657.

-- SECTION 1 D, FIRST PARA. THERE APPEARS TO BE A GARBLE IN THE LINES: ". . . MANNER TO DETAIN, OFTEN INCOMMUNICADO, SUSPECTED POLITICAL OPPOSTION OF CRITICS. IN THE FIRST HALF. . ."

-- SECTION 1 D, FIRST PARA, AT THE BOTTOM. THE RELEASE OF 200 POLITICAL PRISONERS DURING THE FIRST THREE MONTHS OF 1989, THOUGH RELATED TO THE SAME EFFORTS AT REFORM THAT PRODUCED CHANGES IN DETENTION PRACTICES, IS A SEPARATE ISSUE, AND MIXES UP POLITICAL PRISONERS, TREATED MORE APPROPRIATELY UNDER SECTION 1 E, WITH DETAINEES.

-- SECTION 1 E. RATHER THAN DISCUSS ONCE AGAIN EVENTS THAT TOOK PLACE IN EARLY 1988, IT WOULD SEEM MORE APPROPRIATE TO FOCUS ON ACTIVITY IN THE NATIONAL SECURITY COURT IN 1989. IN LIGHT OF RECENT EVENTS (MOGADISHU 13335) WE CONFIDENTIAL

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PAGE 02 MOGADI 14054 03 OF 05 211350Z

SUGGEST THE FOLLOWING SUBSTITUTE LANGUAGE: "ONLY ONE TRIAL BEFORE THE NATIONAL SECURITY COURT RECEIVED ANY PUBLICITY. THIS WAS THE NOVEMBER 1989 CONVICTION AND SENTENCING TO DEATH OF FIVE PERSONS ACCUSED OF EMBEZZLING FUNDS FROM THE COMMERCIAL AND SAVINGS BANK. THESE WERE THE FIRST DEATH SENTENCES ANNOUNCED IN SOMALIA

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IN OVER A YEAR. IT APPEARED THAT SOME OF THOSE CONVICTED WERE STILL AT LARGE. AT YEAR'S END NONE OF THE DEATH SENTENCES HAD BEEN CARRIED OUT. BY MID-YEAR MOST OR ALL POLITICAL PRISONERS HAD BEEN RELEASED. MOST OF THE THOUSANDS OF PERSONS DETAINED IN JULY WERE RELEASED, FEW IF ANY DETAINEES WERE TRIED AND CONVICTED OF POLITICAL OFFENSES."

-- NOTE REGARDING THE 1988 NATIONAL SECURITY TRIAL: THE PROCEEDINGS WERE NOT/NOT SECRET; SOMALIS, E.G. FAMILY MEMBERS AND SOME EMBASSY FSN'S, ATTENDED. FOREIGN OBSERVERS, HOWEVER, WERE EXCLUDED.

-- SECTION 1 G. A SYNOPSIS OF THE GERSONY REPORT IS UNQUESTIONABLY RELEVANT TO THIS YEAR'S REPORT. WE SEE NO POINT, HOWEVER, IN RECAPITULATING LAST YEAR'S REPORT ABOUT THE OUTBREAK OF CIVIL WAR IN 1988. WE SUGGEST THE FOLLOWING (SHORTER) ALTERNATIVE: "ABOUT A HALF MILLION PEOPLE FLED THE OUTBREAK OF FIGHTING IN NORTHERN SOMALIA IN 1988. A U.S. GOVERNMENT SPONSORED 1989 STUDY (THE GERSONY REPORT) . . . ETC."

-- NOTE THAT "SAF" SHOULD BE IDENTIFIED AS MEANING "SOMALI ARMED FORCES".

-- SECTION 1 G, END OF THIRD PARA. IN LIGHT OF RECENT EVENTS IN CENTRAL SOMALIA, IT IS APPROPRIATE TO SAY,
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PAGE 03 MOGADI 14054 03 OF 05 211350Z

"WHEN COMBATING REBELS, MUTINEERS, AND BANDITS IN THE CENTRAL REGIONS . . . ETC."

-- SECTION 1 G, DOCUMENTED INCIDENTS. THE ESTIMATE OF 94 DEAD IN THE BURAO-BERBERA ROAD LANDMINE REPRISAL KILLINGS MAY BE TOO HIGH. WE BELIEVE THAT GERSONY, WHO VISITED BURAO AT ABOUT THE TIME OF THE INCIDENT, MENTIONED A FIGURE OF ABOUT 30 KILLED.

-- SECTION 1 G, DOCUMENTED INCIDENTS. THE GEZIRA BEACH SHOOTINGS, LAST SENTENCE, "MEMBERS OF THE GOVERNMENT AS WELL AS ORDINARY CITIZENS EXPRESSED OUTRAGE OVER THE INCIDENT." IN OUR ORIGINAL DRAFT THIS SENTENCE WAS PART OF A TRANSITION TO A DISCUSSION OF THE GSDR'S INVESTIGATION OF THE BEACH SHOOTINGS, WHICH HAS NOW BEEN MOVED ELSEWHERE IN THE DEPARTMENT'S REDRAFT. THOUGH THE

STATEMENT IS TRUE, IN THE NEW DRAFT IT IS DANGLING. WE SUGGEST DELETING IT.

-- SECTION 1 A, END OF THIRD PARA, SHOULD READ, ". . WAS DETAINED FOR SEVERAL MONTHS IN 1988 AND 89."

-- SECTION 2 A, FOURTH PARA, ON FOREIGN JOURNALISTS, SHOULD BE REWRITTEN AS REFLECTED IN ANSWERS TO QUESTIONS, ABOVE. OUR SUGGESTION: "INFORMATION ON THE SITUATION IN SOMALIA WAS DIFFICULT TO OBTAIN BECAUSE THROUGHOUT THE FIRST HALF OF 1989, THE GOVERNMENT REFUSED TO ISSUE VISAS TO FOREIGN JOURNALISTS. SEVERAL EUROPEAN JOURNALISTS WERE PERMITTED TO ENTER THE COUNTRY IN THE LATTER PART OF 1989. THE FIRST AMERICAN JOURNALIST IN OVER TWO YEARS

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PAGE 01 MOGADI 14054 04 OF 05 211352Z
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[redacted] SECTION 04 OF 05 MOGADISHU 14054

E.O. 12356: DECL: OADR
TAGS: PHUM, SO
SUBJECT: SOMALIA HUMAN RIGHTS REPORT: SUGGESTED EDITING

ARRIVED IN MOGADISHU IN DECEMBER FOR A ONE-WEEK VISIT.

-- SECTION 2 B, FIRST PARA. PLEASE DELETE THE SENTENCES, "AN EXCEPTION TO THIS RULE WAS THE TRADITIONAL CLAN GATHERING. THESE WERE NOT CURTAILED AS LONG AS THE GATHERING WAS LIMITED TO ONE CLAN." THAT INFORMATION IS WRONG; SUCH A MEETING WOULD ALMOST CERTAINLY BE PROHIBITED.

-- SECTION 2 B, SECOND PARA, SHOULD READ, ". . . IS IMPLICITLY PROVIDED FOR BY ARTICLE 20 OF THE CONSTITUTION, WHICH ENTITLES . . ."

-- SECTION 2 D, FIRST PARA, SHOULD READ, ". . . THERE ARE, HOWEVER, NO REQUIREMENTS TO REPORT RESIDENCE TO THE POLICE . . .", RPT "NO REQUIREMENTS".

-- SECTION 2 D, SECOND PARA. ADD THE CONCLUDING SENTENCE, "AT THE END OF 1989 THEIR PASSPORTS HAD NOT BEEN RETURNED."

-- SECTION 2 D, FIFTH PARA. WE WOULD PREFER NOT TO BURDEN THE HUMAN RIGHTS REPORT WITH THE UN VS GSDR CONTROVERSY.

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PAGE 02 MOGADI 14054 04 OF 05 211352Z

ALSO, BECAUSE THE UN HAS NOW REVERSED ITSELF ON SUSPENDING FOOD AID, IT MIGHT BE BEST NOT TO MENTION THE ISSUE. OUR PROPOSED ALTERNATIVE WOULD BE: "THE GOVERNMENT REPORTS THAT THERE ARE 837,000 ETHIOPIAN REFUGEES IN SOMALIA, BUT OUTSIDE OBSERVERS, INCLUDING THE UNITED NATIONS, INDICATED THAT ABOUT HALF THAT NUMBER REMAINED IN REFUGEE CAMPS AT THE END OF 1989. CONSCRIPTION OF REFUGEES INTO THE SOMALI ARMY CONTINUED IN 1989, IN VIOLATION OF INTERNATIONAL COVENANTS. REPATRIATION OF REFUGEES TO ETHIOPIA CONTINUED THROUGHOUT THE YEAR, AND TRIPARTITE NEGOTIATIONS INVOLVING SOMALIA, ETHIOPIA AND THE UNHCR MADE PROGRESS ON ARRANGEMENTS FOR OFFICIALLY SPONSORED VOLUNTARY REPATRIATION. IN ADDITION TO UNHCR, ICRC AGREED TO PARTICIPATE."

-- SECTION 3, FIRST PARA. DELETE THE SENTENCE, "THE GOVERNMENT HAS NOT AS YET INDICATED HOW IT INTENDS TO IMPLEMENT THIS DECISION." INSERT IN ITS PLACE: "IN NOVEMBER A COMMITTEE OF LAWYERS BEGAN DRAFTING PROPOSED CHANGES IN THE CONSTITUTION THAT WOULD REMOVE THE SRSP FROM ITS LEADING ROLE IN STATE AND SOCIETY, PERMIT THE OPERATION OF MULTIPLE PARTIES, AND ALLOW OPERATION OF A FREE PRESS AND OTHER INSTITUTIONS OF AN OPEN SOCIETY. AT THE END OF 1989 NO PRACTICAL STEPS HAD BEEN TAKEN TO IMPLEMENT THESE PROPOSALS."

-- SECTION 3, THIRD PARA. THERE ARE TWO FEMALE VICE MINISTERS AND TWO RPT TWO FEMALE AMBASSADORS.

-- SECTION 4. THE GSDR DID NOT KNOW THAT GERSONY WAS INVESTIGATING ALLEGED VIOLATIONS OF HUMAN RIGHTS; HE WAS ADVERTISED TO THEM AS A REFUGEE EXPERT COME TO STUDY WAYS TO SOLVE THE REGION'S REFUGEE PROBLEMS. THE GOVERNMENT'S

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Document Number: 1989MOGADI14054

Page: 10
Channel: n/a

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PAGE 03 MOGADI 14054 04 OF 05 211352Z

COOPERATION WITH GERSONY SHOULD THEREFORE NOT BE CITED AS EVIDENCE OF ITS WILLINGNESS TO COOPERATE WITH HUMAN RIGHTS ORGANIZATIONS AND ADVOCATES. WE RECOMMEND THAT THE REFERENCE TO GERSONY BE DELETED AND THAT THE PARAGRAPH READ; "DURING THE FIRST HALF OF 1989, THE GOVERNMENT SHOWED A WILLINGNESS TO COOPERATE WITH INTERNATIONAL AND OTHER HUMAN RIGHTS ORGANIZATIONS. A VISIT BY AMNESTY INTERNATIONAL..."

-- THE CONCLUDING PART OF THIS PARA SHOULD OMIT THE PART ABOUT GOVERNMENT OFFICIALS EXPRESSING ANGER AGAINST AI. A POSSIBLE ALTERNATIVE WOULD BE: ". . . INTERNATIONAL MEDIA CARRIED UNFAVORABLE COMMENTARY ON SOMALIA, AND IT BECAME UNLIKELY THAT AI OFFICIALS WOULD BE WELCOME TO RETURN THERE."

-- SECTION 4, THIRD PARA. ". . . AND IT IS UNLIKELY ANY WOULD BE PERMITTED TO OPERATE." THIS IS SPECULATIVE AND SHOULD BE DELETED. IN FACT, THE ASSOCIATION OF SOMALI LAWYERS, AN ORGANIZATION HEADED BY ISMAIL JUMALE OSSOBLE (DETAILED IN JULY AND NOW A MEMBER OF THE TECHNICAL COMMITTEE FOR REVISING THE CONSTITUTION), DOES CONCERN ITSELF WITH HUMAN RIGHTS ISSUES.

-- SECTION 5, FIRST PARA. THE INSTRUCTIONS FOR PREPARING THIS SECTION (STATE 261720, PARA 28) STATE THAT INS WILL USE THIS INFORMATION "TO BETTER ADJUDICATE REFUGEE AND ASYLUM APPLICATIONS." IF THIS IS SO, THEN THE DISCLAIMER WHICH WAS IN OUR ORIGINAL DRAFT NEEDS TO BE KEPT IN THE FINAL VERSION: "NEVERTHELESS, IT DOES NOT

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PAGE 01 MOGADI 14054 05 OF 05 211353Z
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[redacted] SECTION 05 OF 05 MOGADISHU 14054

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SUBJECT: SOMALIA HUMAN RIGHTS REPORT: SUGGESTED EDITING

FOLLOW THAT PERSONS ARE SUBJECT TO PERSECUTION SIMPLY BECAUSE THEY ARE ISAAKS. CLAIMS OF PERSECUTION HAVE TO BE EXAMINED ON A CASE BY CASE BASIS." (SEE ALSO MOGADISHU 01073.)

-- SECTION 5, THIRD PARA. THOUGH IT WILL TAKE MORE THAN A GENERATION BEFORE FEMALE CIRCUMSICISION IS A CUSTOM OF THE PAST, THE TREND IS DOWNWARD, A FACT THAT WE SHOULD ACKNOWLEDGE. WE SUGGEST THE FOLLOWING REVISION: "THE GOVERNMENT'S CAMPAIGN AGAINST FEMALE CIRCUMCISION, LED BY THE SOMALI WOMEN'S DEMOCRATIC ORGANIZATION OF THE SRSP, CONTINUED TO MAKE PROGRESS IN 1989. ALTHOUGH THE PRACTICE MEMAINED COMMON, ESPECIALLY IN RURAL AREAS, "PHARONIC" CIRCUMCISIONS (THE MOST EXTREME AND DANGEROUS FORM OF FEMALE GENITAL MUTILATION) BECAME LESS COMMON."

-- (NOTE: USAID MOGADISHU MAY BE ABLE TO PROVIDE STATISTICS ON THIS TREND BEFORE THE 1989 HUMAN RIGHTS REPORT IS SENT TO PRESS.)

-- SECTION 5, FOURTH PARA. FILLING IN THE BLANKS IS NOT CONSISTENT WITH HONEST REPORTING. WE WOULD DESCRIBE THE SITUATION IN QUITE DIFFERENT TERMS, AS FOLLOWS:
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PAGE 02 MOGADI 14054 05 OF 05 211353Z

"DOMESTIC VIOLENCE AGAINST WOMEN IS NOT A SIGNIFICANT SOCIAL PROBLEM IN SOMALIA. THERE ARE SEVERAL INTERLOCKING CULTURAL AND ECONOMIC REASONS WHY SUCH PRACTICES AS WIFE BEATING ARE RELATIVELY UNCOMMON. ONE IS THAT SOMALIS, BEING MUSLIMS, DO NOT GENERALLY DRINK ALCOHOL. (ABUSE OF WOMEN AND ABUSE OF ALCOHOL ARE CLOSELY CORRELATED.) A SECOND REASON IS THAT SOMALI MARRIAGES ARE CONTRACTUAL, WITH THE WIFE'S RELATIVES PREPARED TO ENFORCE THE AGREEMENT THAT SHE WILL BE TREATED WITH DIGNITY. WIFE BEATING CARRIES A STIGMA WHICH MAKES IT DIFFICULT FOR DIVORCED WIFE-BEATING MALES TO REMARRY.

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FINALLY ECONOMIC CONDITIONS, WHICH HAVE MADE IT INCREASINGLY DIFFICULT FOR MEN TO HAVE MORE THAN ONE OR AT MOST TWO WIVES, ALSO TEND TO CURTAIL VIOLENCE AGAINST WOMEN. (A VETERAN POLICE OFFICER, ASKED WHETHER WIFE BEATING WAS A PROBLEM, SAID THAT IN THE DAYS BEFORE INDEPENDENCE IT WAS: IT WAS COMMON THEN FOR MEN TO HAVE THREE OR FOUR WIVES, AND TO TREAT THE LESS FAVORED OF THEM AS BEASTS OF BURDEN, BEATING THE ONES WHO FALTERED OR WERE LAZY. YOUNG MEN OF THE PRESENT GENERATION CANNOT AFFORD MORE THAN ONE WIFE, AND THEREFORE THEY ARE CONSTRAINED TO TREAT HER WITH RESPECT.)" BORICH

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Exhibit 14: May 24, 2012 Plaintiff's Second Set of Interrogatories to Defendant.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

Abukar H. Ahmed,	)	**Case No. 2:10-cv-342**
Plaintiff	)	
v.	)	**PLAINTIFF'S SECOND SET OF INTERROGATORIES AND SECOND REQUEST FOR PRODUCTION OF DOCUMENTS TO DEFENDANT ABDI ADEN MAGAN**
Abdi A. Magan,	)	
Defendant	)	
	)	

PLAINTIFF'S SECOND SET OF INTERROGATORIES

TO DEFENDANT ABDI ADEN MAGAN

Pursuant to Federal Rule of Civil Procedure 33, Plaintiff Abukar Hassan Ahmed ("Plaintiff") hereby requests that Defendant Abdi Aden Magan ("Defendant") answer, separately and truthfully, in writing under oath within 30 days of service hereof, each of the Interrogatories set forth below in accordance with the Definitions and Instructions as they appear below.

DEFINITIONS

A. "You" and "your" shall mean defendant Abdi Aden Magan, his representatives, subordinates, agents, employees, attorneys, companies or any other person or entity acting or purporting to act on his behalf.

B. "Somali" or "Somalia" shall refer to the Somali Democratic Republic, as it existed during the period 1969 through 1991.

C. The National Security Service ("NSS") shall refer to any unit or member of the government institution in Somalia known as the National Security Service between 1970 and 1990, including any persons working in conjunction with, or with the acquiescence of the NSS.

D. "NSS Officer" shall refer to a person holding a post of employment under the National Security Service or anyone acting or purporting to act under the authority of the National Security Service.

E. "Security related offenses" shall mean any alleged or perceived allegiance to, sympathy for, interest in, or involvement in activities perceived to oppose the Somali Government, or in support of the Somali National Movement ("SNM") or the United Somali Congress ("USC"), including authoring or possession of materials perceived as opposing the Somali Government.

F. "Arrest" (and its forms) shall mean any arrest (with or without warrant or legal charges), detention, confinement, apprehension, or questioning of any civilian by the Somali Armed Forces, paramilitary, or other persons associated therewith.

G. "Detain" (and its forms) shall mean any imprisonment or confinement, with or without warrant or legal charges, of any civilian by the Somali Armed Forces, NSS, paramilitary, or other persons associated therewith.

H. "Person" shall mean a natural person and any other cognizable entity, including without limitation, firms, partnerships, corporations, divisions, proprietorships, joint ventures, consortiums, clubs, associations, foundations, governmental agencies or instrumentalities, societies, orders, or any other organization or entity.

I. "Communicate" and "Communication" shall mean any transmission or exchange of information by any manner including telephonic "statements," voicemail, inquiries, negotiations, discussions, agreements, understandings, meetings, notes, mail, facsimile, letters, electronic mail (e-mail), telegrams, teletypes, telexes, telecopies, computer linkups, written memoranda, face-to-face conversations and any verbal or non-verbal assertion (or "statement") by one or more persons or among two or more persons.

J. "Document" and/or "thing" shall be synonymous in meaning and equal in scope to the usage of the term in Rule 34(a) of the Federal Rules of Civil Procedure and the term "writing" as defined in the Rule 1001 of the Federal Rules of Evidence. Electronic correspondence is also included within the meaning of this term. A draft or non-identical copy is a separate document within the meaning of this term.

K. "Refer," "Relate" and "Concern" (and their forms), shall mean refer to, relate

to, pertaining to, having a relationship to, evidencing or constituting evidence of in whole or in part, concern, involve, be connected with, reflect, indicate, disclose, summarize, explain, support, refute, exhibit, entail, illustrate, record, memorialize, discuss, include, implicate, name, reveal, expose, denote, imply, suggest, show, mention, demonstrate, embody, comprise, constitute, contain, identify, state, pertain directly or indirectly to, show signs of, or be in any way relevant to the particular subject matter identified.

L. "Position" shall refer to a post of employment under the Somali Government or Somali Armed Forces, including a post of employment in any of the following units within the Somali Armed Forces: (a) the Somali military forces: army, navy, air force, or special forces; (b) the National Security Service ("NSS"); (c) the Red Berets; (d) any police organization including the Defense Intelligence Security Agency (also known as "Hangash"); (e) anyone acting or purporting to act under the authority (whether actual or apparent) of the Somali Armed Forces; and (f) any other military force, unit, organization, department or agency of Somalia and any of the aforementioned predecessor or successor organizations or groups (whether or not formally instituted) and shall be construed so as to mean any of these organizations individually, severally, or collectively.

M. To the extent necessary to bring within the scope of the Interrogatories contained herein any information that might otherwise be construed to be outside their scope, (a) the words "and" and "or" shall be read in the conjunctive and in the disjunctive wherever they appear; (b) the word "all" means "any and all"; (c) the word "including" means "including but not limited to"; (d) the word "any" means and includes both "any" and "every"; (e) "each" shall mean both "each" and "every," and the word "every" shall mean "each" and "every," as appropriate; (e) the singular form of a noun or pronoun shall be considered to include within its meaning the plural form of the noun or pronoun, and vice versa; (f) the neuter form of a pronoun shall be considered to include within its meaning the masculine and feminine forms of the pronoun, and vice versa; and (f) the use of any tense of any verb shall be considered to include also within its meaning all other tenses of the verb.

N. The term "Identity" (and its forms), when used with respect to documents or things, means to provide, to the extent known, a description of each document or thing sufficient to obtain production thereof by subpoena, discovery request, or court order, including:

(a) the type of document or thing (letter, photograph, etc.);

(b) the name and current business or residential address of the author(s) or originator(s), including each person or persons who (a) prepared or participated in the preparation or creation of the document or thing, (b) signed it, initialed it or over whose signature or initials it was issued, and (c) to whom it was addressed or distributed;

(c) the title and nature of the document's or thing's contents;

(d) the date appearing on the document or thing and the date or dates when it was prepared;

(e) a brief summary of the substance of each document or thing;

(f) the current physical location of the document or thing; and

(g) if the document or thing is no longer in existence or in defendant's control, the disposition that was made of it and the location of any copies of the document or thing known to the defendant. Alternatively, you may identify any document or thing by instead attaching a full, clear, legible copy thereof to your response hereto, provided that each such copy contains a reference to each Interrogatory to which it is responsive.

O. The term "Identify" (and its forms), when used with respect to persons, means to provide, to the extent known, such person's full name (or if not known, provide sufficient description so that such person will be identifiable to the plaintiffs), present or last known business or residential address, and previous or last known telephone number(s). If the person is a natural person, also provide that person's present or last known job title, place of employment or business affiliation and business telephone number. If the person was a former officer in the Somali Armed Forces, provide their position and rank and their relationship to you, the Defendant Abdi Aden Magan, as Chief of the NSS Department of Investigations. If the person is a governmental or business entity, also provide the address of its principle place of business, the address of the particular office and the identity of the person or persons having knowledge of the matter with respect to which the business or governmental entity is named.

P. The term "Identify" (and its forms), when used with respect to communications, means, to the extent known:

(1) state the date and place of each communication;

(2) state the medium through which such communication was made *(e.g.,* in

person, by telephone, etc.);

(3) identify each person who participated in the Communication;

(4) identify each person (other than a participant) who heard or had access to the communication;

(5) state the substance of the communication, including any discussion constituting or relating to the communication, the order in which such discussion was had, and any decisions or conclusions reached in the course of or as a result of the communication; and

(6) identify each document or thing relating to the substance of the communication.

Q. The term "Identify" (and its forms), when used with respect to actions, means, to the extent known:

(1) state the date and place of each action;

(2) identify each person who participated in the action;

(3) identify each person (other than a participant) who heard or bore witness to the action;

(4) state the substance of the action, including any discussion constituting or relating to the action, the order in which such discussion was had, and any decisions or conclusions reached in the course of or as a result of the action; and

(5) identify each document or thing relating to the substance of the action.

R. "Jurisdiction" shall refer to the Southern District of Ohio.

INSTRUCTIONS

1. Plaintiffs incorporate herein by reference Rules 26 and 33 of the Federal Rules of Civil Procedure and the Local Rules of the United States District Court for the Southern District of Ohio. These Interrogatories seek responses to the full extent of the Federal and Local Rules.

2. In answering these Interrogatories, you are required to furnish truthfully, fully and in good faith, all information that is presently available to you, regardless of whether such information was obtained directly by you, your former or present attorneys, agents, consultants, employees, investigators, accountants, experts or anyone acting or purporting to act on their behalf or your behalf. If, after having consulted all the aforementioned persons, you are unable

to provide the information being sought by any Interrogatory or any portion thereof, describe in detail your efforts to obtain such information.

3. If any of the following Interrogatories cannot be answered in full, answer to the extent possible, specifying the reasons for your inability to answer the remainder of the Interrogatory and stating whatever information, k knowledge or belief you do have relating to the unanswered portion thereof.

4. A request to "state the entire factual basis" for an allegation or contention means to:

(a) State all facts in your knowledge, possession or control regarding any allegation or contention, including all facts that you may use to support the allegation or contention, as well as all facts that tend to contradict or undermine the allegation or contention;

(b) Identify each person having knowledge relating to the subject matter of the allegation or contention, regardless of whether such person's knowledge tends to support or contradict or undermine the allegation or contention; and

(c) Identify each document or thing relating to the subject matter of the claim or defense, regardless of whether such document or thing tends to support or contradict or undermine the allegation or contention.

5. If and to the extent to which you claim a privilege as a ground for refusing to answer an Interrogatory in whole or in part, describe the bases for such claim of privilege and provide such other information as is required by Federal Rule of Civil Procedure 26(b)(5) and other applicable rules of court or law.

6. If you object to or refuse to answer any part of an Interrogatory on grounds other than privilege, describe the ground(s) separately, fully and with particularity.

7. These interrogatories shall be deemed continuing, and you shall be obligated to change, supplement, and correct your answers to conform to all available information, including such information as first becomes available to you after your answers hereto are served.

INTERROGATORIES

Interrogatory No. 21.

State all facts known to you concerning NSS personnel Lieutenant Mohamed Abdi, who worked at the NSS during 1988-1989, including without limitation:

a) his rank, position and responsibility;
b) the supervision you exercised on him;
c) the frequency that he reported to you;
d) his duties, authority and tactics in conducting investigations; and
e) if he has ever disobeyed your order and in what circumstances.

Answer:

a)

b)

c)

d)

e)

Interrogatory No. 23.

State all facts known to you concerning an NSS personnel, who worked at the NSS during 1988-19989, referred to by the name of "Antar," including without limitation:

a) his rank, position and responsibility;
b) the supervision you exercised on him;
c) the frequency that he reported to you;
d) his duties, authority and tactics in conducting investigations; and
e) if he has ever disobeyed your order and in what circumstances.

Answer:

a)

b)

c)

d)

e)

Interrogatory No. 24.

State all facts known to you concerning an NSS personnel who worked at the NSS during 1988-1989, referred to by the name of "Deeq," including without limitation:

a) his rank, position and responsibility;
b) the supervision you exercised on him;
c) the frequency that he reported to you;
d) his duties, authority and tactics in conducting investigations; and
e) if he has ever disobeyed your order and in what circumstances.

Answer:

a)

b)

c)

d)

e)

Interrogatory No. 25.

State all facts known to you concerning NSS personnel who worked at the NSS during 1988-1989, Hassan Ga'al, including without limitation:

a) his position, rank and responsibilities;
b) whether he was working in NSS the Department of Investigations;
c) whether he was assisting the investigators in interrogations or had any contact with detainees.

Answer:

a)

b)

c)

This is a continuing request and Plaintiff reserves the right to renew or make additional requests.

Dated: May 24, 2012

ABUKAR HASSAN AHMED

By Counsel

s/ Kenneth Cookson

Kenneth Cookson (0020216)
Trial Attorney
KEGLER BROWN HILL & RITTER, LPA
Capitol Square, Suite 1800
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Natasha E. Fain
Center for Justice & Accountability
870 Market Street, Suite 682
San Francisco, CA 94102
Ph: (415) 544-0444

Attorneys for Plaintiff
Abukar Hassan Ahmed

PROOF OF SERVICE

These interrogatories were sent via ordinary U.S. mail and e-mail, this 24th day of May, 2012 to the Defendant via **Email and Express Mail**:

Abdi Aden Magan
3183 Pendleton Court Columbus,
Ohio 43249
aamagan@hotmail.com

Dated: May 24, 2012

s/ Kenneth Cookson

Kenneth Cookson (0020216)
Trial Attorney
KEGLER BROWN HILL & RITTER, LPA
Capitol Square, Suite 1800
65 East State Street
Columbus, OH 43215
Ph: (614) 462-5445
Fax: (614) 464-2634
kcookson@keglerbrown.com

Attorney for Plaintiff
Abukar Hassan Ahmed

Exhibit 15: April 20, 2000 Amnesty International letter from Dr. M. Hill
(Bates No. P-000917-20)

AMNESTY INTERNATIONAL
AMNISTÍA INTERNACIONAL
AMNISTIE INTERNATIONALE
МЕЖДУНАРОДНАЯ АМНИСТИЯ
منظمة العفو الدولية
國際特赦組織

20 April 2000

TO WHOM IT MAY CONCERN

Abukar Hassan Ahmed (also known as "Yare"), asylum-seeker from Somalia

I write to confirm that Abukar Hassan Ahmed ("Yare"), who arrived in the United Kingdom on 30 March 2000 and has applied for asylum, has been known to me for several years. He was a professor of law at the Somali National University in Mogadishu in the 1970s until he was detained without charge or trial from January 1981 to March 1986 on account of his criticisms of the Siad Barre government (see attached article from the 1987 Amnesty International Report). He was later detained again from November 1988 to February 1989, on account of possessing an Amnesty International report on Somalia - "Somalia: a long-term human rights crisis", which was published that year following an Amnesty International visit where we decided it was not safe for us to meet him.

During his detentions he was adopted by Amnesty International as a prisoner of conscience. He later fled the country when civil war broke out after the overthrow of the Siad Barre dictatorship.

In our estimation, he would face considerable risk to his safety if he was returned to Somalia on account of his opinions which are critical of the political factions in Mogadishu, and on account of the general situation of insecurity there, which the UN still designates as a "crisis" zone.

Martin Hill (Dr), Researcher on the Horn of Africa

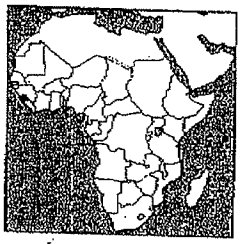
AMNESTY INTERNATIONAL
INTERNATIONAL SECRETARIAT
1 Easton Street, London WC1X 0DW, United Kingdom
Tel: Int. Code: 44 (20) 7413 5500. UK Code: 020 7413 5500. Fax: Int. Code: 44 (20) 7956 1157. UK Code: 020 7956 1157
E-Mail: amnestyis@amnesty.org Web: http://www.amnesty.org

29-DEC-05 13:32 abukar h.ahmed 02089022683 PAGE : 5

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-5 Filed: 08/09/12 Page: 17 of 36 PAGEID #: 1218

court of law. A Review Tribunal exists to consider each detainee's case within a month of detention and thereafter every six months. However, this tribunal sits *in camera* and its recommendations are not binding upon the President.

There were new politically motivated arrests in early June. Several known critics of the government of President France-Albert René, including Richard Ponwaye and Philip d'Offay, both businessmen, and Philip Boule, a lawyer, were alleged to have endangered state security. They were reportedly held incommunicado at Victoria Central Police Station but no formal charges were brought against them. Amnesty International wrote to the Attorney General in July seeking clarification of their status but received no reply. However, all those arrested were released uncharged in October.



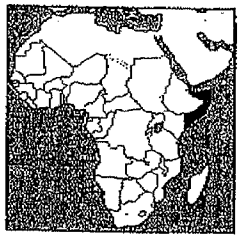
Sierra Leone

Amnesty International was concerned about the imprisonment of ordinary criminal prisoners in conditions reported to be so harsh that they amounted to cruel, inhuman or degrading treatment and caused many deaths. Amnesty International was also concerned about the use of the death penalty; at least two people were sentenced to death but it was not known if there were any executions.

Throughout 1986 Amnesty International received reports from diverse sources that criminal prisoners and suspects held on remand in Pademba Road Prison in Freetown were subject to grossly inadequate conditions. In particular, prisoners were reported to be denied adequate food and medical attention. As a result, the mortality rate among such prisoners was reported to be high and Amnesty International considered that their conditions constituted cruel, inhuman or degrading treatment. Amnesty International wrote to President Joseph Saidu Momoh in December calling for urgent government action to improve prison conditions. In doing so, Amnesty International stated that it had received no suggestion that prisoners had been starved as a matter of deliberate policy, but rather had suffered because of an apparent lack of resources at the prison. Amnesty International maintained, however, that the government had a responsibility to ensure that sufficient resources were made

available to ensure that all prisoners were treated in accordance with standards laid down by the UN Standard Minimum Rules for the Treatment of Prisoners. Amnesty International cited the cases of a number of prisoners reported to have died in prison in 1985 and 1986, including four prisoners who died on one particular day, 30 June 1986. Amnesty International asked for confirmation from the government of this information and for details of what measures were being taken to correct the situation.

Amnesty International learned of two death sentences passed in 1986, one passed in June for murder and one passed on a police officer convicted of murder in November. Amnesty International appealed for clemency in both cases. The organization did not learn of any executions. There were believed to be a number of prisoners on "death row" in Pademba Road Prison and other prisons outside the capital.



Somalia

Amnesty International was concerned about the imprisonment of prisoners of conscience, one of whom had been held without trial for over 11 years. Many other political prisoners arrested in 1986 or in previous years were detained without trial or imprisoned after unfair trials. The organization was also concerned about reports of torture and ill-treatment of political prisoners and about the use of the death penalty.

Armed conflict continued in 1986 between government forces and two opposition organizations, the Somali National Movement (SNM) and the Democratic Front for the Salvation of Somalia (DFSS). In the north, civilians suspected of contact with the SNM were arrested, ill-treated and in some cases summarily executed. There were also reports of killings of government officials or sympathizers by opposition forces.

In late January about 50 school students and up to 100 other people were arrested in Hargeisa in northern Somalia on suspicion of links with the SNM shortly after an attack in the vicinity by SNM guerrillas. Amnesty International asked the authorities about their legal status and treatment in custody and appealed for them to be released if they were not to be charged and brought to trial. Several

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Case: 2:10-cv-00342-GCS-MRA Doc #: 97-5 Filed: 08/09/12 Page: 18 of 36 PAGEID #: 1219

P-000919

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of the prisoners were released in the following months but some were brought to trial before the National Security Court on 30 June. Abdi Dahir Ainanshe, a student, was sentenced to death for possessing weapons. Amnesty International appealed for the commutation of his death sentence and expressed concern that those convicted by the National Security Court have no right of appeal. He was still under sentence of death at the end of 1986.

In February there were unofficial reports that the presidential review of the death sentences imposed for treason on seven secondary school students by the National Security Court in Hargeisa in October 1984 (see *Amnesty International Report 1986*) had been completed. The death sentence imposed on Abdi Dama Abbi was upheld and he was secretly executed in Mandera in March, although the government would not confirm this. The other six students had their sentences commuted to life imprisonment. Amnesty International had been investigating whether the seven might be prisoners of conscience and believed that they had not received fair trials and that they had been tortured. The organization had appealed for clemency for all seven students.

Large-scale arrests of Islamic religious leaders and members of their organizations took place in Burao on 16 April. Over 300 men, women and children were reportedly detained without charge or trial for their religious activities. They were believed to have been critical of the government's policies of "scientific socialism". Many other members of Islamic organizations were arrested in Mogadishu and Merca the following month after the announcement in Mogadishu on 9 May of the formation of the Somali Islamic Movement (SIM). The SIM said that it would seek to educate society to follow "moderate Islamic beliefs and laws". It criticized the repression of religious activities by the authorities, particularly the regulations affecting mosques and religious teaching which were issued in August 1985. Among those arrested in Mogadishu were Sheikh Mohamed Moallim Hassan, a former Director General in the Ministry of Justice and Religious Affairs and a prisoner of conscience from 1976 to 1982, and Sheikh Mohamed Nur Qawi, who was alleged to have been tortured. Amnesty International appealed for their release as prisoners of conscience. Several of the prisoners were released over the following months but by the end of 1986 Sheikh Mohamed Moallim Hassan and several other religious leaders, including Sheikh Ahmed Ali Aden, the Imam of the central mosque in Burao, were still detained without charge or trial.

On 31 May, 23 people, some of them school students, who were arrested in Hargeisa in July 1985, were brought to trial before the National Security Court in Hargeisa, charged with treason. They

were reportedly accused of involvement with the United Somali Students Organization, an unofficial opposition organization. Three of the students — Saeed Dahir Jama, Ahmed Abdi Omar and Hassan Osman Omar — were sentenced to death for distributing subversive literature. Other defendants were sentenced to prison terms ranging from five years to life imprisonment for lesser offences. Amnesty International appealed for the commutation of the death sentences and expressed concern that the prisoners did not receive fair trials — they were reportedly denied legal representation as well as having no right of appeal. Several were alleged to have been tortured and to be held in harsh conditions. Amnesty International was investigating whether they were prisoners of conscience. At the end of 1986 the death sentences had neither been carried out nor commuted.

Amnesty International continued to press for the release of several long-term prisoners of conscience. Abukar Hassan Yare, a law lecturer detained without trial since 1981, was released in March. Others still held at the end of 1986 included Yusuf Osman Samantar ("*Berda'ad*"), a politician and lawyer detained without trial since 1975 and Abdi Ismail Yunis, an educationalist, and Suleiman Nuh Ali, an architect, both imprisoned without trial since 1982. Amnesty International also continued to appeal for the release of 17 doctors, teachers and civil servants imprisoned in 1982 on charges of participating in a subversive organization. Three of these prisoners were released in October 1985 by presidential amnesty, but the others, including Aden Yusuf Abokor, director of Hargeisa hospital, were still in prison. Appeals continued to be made for the release of Ismail Ali Abokor, a former Vice-President of Somalia, Omar Arteh Ghalib, a former Foreign Minister, Mohamed Aden Sheikh, a doctor and former President of the Somali Academy of Sciences, and three former members of parliament detained since 1982. They were publicly accused of treason shortly after their arrest but had been continually refused access to their lawyers and families. Despite rumours in early 1986 of an imminent trial, all were still held at the end of 1986 without formal charge or trial.

Other prisoners whose cases were under investigation by Amnesty International included those of four former army officers detained without charge or trial since a coup attempt in 1978; two students detained without trial since 1984 for refusing to be conscripted into the army; and 11 prisoners sentenced to life imprisonment by the National Security Court in Burao in December 1984 for alleged links with the SNM. Amnesty International believed that these were a small proportion of the total number of political prisoners in the country, which the organization was unable to estimate. The

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-5 Filed: 08/09/12 Page: 19 of 36 PAGEID #: 1220

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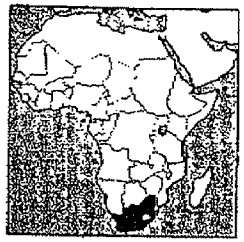
government published no figures on political prisoners and in most cases did not reply to Amnesty International's inquiries.

On 21 October, Revolution Day, 2,506 prisoners were released and 30 sentences of death or life imprisonment were commuted by presidential order. Amnesty International welcomed the commutation of the death sentences and requested details of any political prisoners released in the amnesty. A few political prisoners were believed to have been released, among them some of the prisoners arrested in April and May 1986 for their religious activities.

Amnesty International continued to be concerned about the detention without trial of several hundred Ethiopian civilians, abducted from Ethiopia by Somali forces in 1977. They were held in a rural settlement in Hawai under the control of the National Security Service. Their detention has not been acknowledged by the government. A number of refugees who had fled from Ethiopia to avoid political persecution were also believed to be detained, some of them for alleged security offences and others apparently because they had criticized the treatment of refugees by the Somali authorities.

Political prisoners were subject to harsh prison conditions. Those detained in Lanta Bur and Labatan Firow prisons were denied contact with their families and several were held in prolonged solitary confinement. There were reports of prisoners held in National Security Service custody, particularly in Mogadishu, being tortured and ill-treated. Conditions in government prisons, such as Mogadishu Central Prison and Hargeisa Prison, were also harsh, with prisoners being given only occasional access to their families.

Amnesty International appealed to President Mohamed Siad Barre to commute 15 death sentences imposed by the National Security Court in 1986 for treason, armed robbery and homicide. It was believed that many more death sentences were imposed during the year. In February, Amnesty International's concern at the considerable number of executions that had taken place in the previous year — probably over 100 — led the organization to appeal to the government for an inquiry into the use of the death penalty. Amnesty International noted, in particular, the wide range of offences for which the death penalty was imposed; the absence of any right of appeal for defendants before the National Security Court, which tried all capital cases; and reports that several executions had taken place in public within 24 hours of confirmation by the President. No reply was received.



South Africa

Amnesty International was concerned about the detention without trial of several thousand critics and opponents of the government, including many prisoners of conscience, under state of emergency regulations and other security laws. Other prisoners of conscience were among hundreds of people brought to trial for alleged political offences. There were new reports of torture and ill-treatment of uncharged detainees, and there were further deaths in detention in suspicious circumstances. Administrative banning orders were effectively invalidated by an Appeal Court ruling but the government used its emergency powers to restrict critics. The death penalty remained a major concern: there were 121 executions in Pretoria Central Prison and others were carried out in nominally independent "homelands".

South African security forces abducted political opponents from neighbouring countries, killing others in the process, and appeared closely connected with attacks on opponents of the government carried out by armed vigilante groups in areas such as Cape Town and KwaNdebele. The police and military were also accused of unprovoked killings of civilians and there was suspicion that people acting on behalf of the government may have been responsible for the murder of a leading black doctor and his wife in December. No arrests were made in connection with killings of several political opponents which had occurred in 1985.

In January, Amnesty International published *South Africa: Imprisonment under the Pass Laws* to document its concern about the imprisonment of up to a quarter of a million black people each year, effectively on grounds of race. The report criticized the so-called pass laws as flagrantly discriminatory in their nature and application and said that they provided a context for systematic and extensive violations of fundamental human rights. The report also criticized the conditions under which pass law prisoners were held and a parole system which appeared to be close to a system of forced labour. Amnesty International called for the total abolition of the pass laws as a necessary step to ending the imprisonment of black people on account of their race.

A few days after publication of the report, State President P.W. Botha announced the government's intention to withdraw the pass laws, and this was accomplished on 1 July. However, the law continued to provide for registration of the population by race and

Exhibit 16: Photographs of Abukar Hassan Ahmed Scars (Bates Nos. P-000812-14)



P-000812



P-000813



Exhibit 17: March 5, 2012 email and letter from Plaintiff to Defendant attaching the Notice of Deposition.

From: Cookson, Kenneth
To: aamagan@hotmail.com
Cc: Hioureas, Christina (NY); Georgieva, Katya (DC)
Subject: Notice of Deposition; Ahmed v. Magan
Date: Monday, March 05, 2012 4:28:37 PM
Attachments: Magan.PDF

Good Afternoon.

Enclosed please find a Notice of Deposition served in the above-captioned case.

This Notice of Deposition calls for Mr. Magan to be at 65 East State Street, Columbus, Ohio at the offices of Kegler Brown Hill & Ritter at 9:00 a.m. on April 10, 2012. Please conduct yourself accordingly.

Ken Cookson
Kenneth R. Cookson
Kegler, Brown, Hill & Ritter Co., LPA
Capitol Square, Suite 1800
65 East State Street
Columbus, Ohio 43215
(614) 462-5445
(614) 464-2634 facsimile
kcookson@keglerbrown.com

STEPHEN C. BARSOTTI
DANIEL J. BENNETT
MARY F. BRENNING
JOHN P. BRODY
ERIN C. CLEARY
ROBERT G. COHEN
KENNETH R. COOKSON
KACIE N. DAVIS
ERIC D. DUFFEE
CATHRYN R. ENSIGN**
BRENDAN P. FEHELEY
LAWRENCE F. FEHELEY
KATHERINE C. FERGUSON
LORIANN E. FUHRER
DONALD W. GREGORY
ALLEN L. HANDLAN
PAUL R. HESS
THOMAS W. HILL
TIM JOCHIM
CHARLES J. KEGLER
TODD M. KEGLER
TIMOTHY A. KELLEY
RASHEEDA Z. KHAN
MARGEAUX KIMBROUGH
MICHAEL J. MADIGAN
DAVID M. McCARTY
LARRY J. McCLATCHEY
TRACI A. McGUIRE
VINITA B. MEHRA
JAMES J. PINGOR**
BRIAN C. POLIS**
JEFFREY D. PORTER
REBECCA R. PRICE
CHRISTY A. PRINCE
MARK R. REITZ
PAUL D. RITTER, JR.
JEFFREY D. ROBERTS
RICHARD W. SCHUERMANN, JR.

KEGLER BROWN HILL & RITTER
A LEGAL PROFESSIONAL ASSOCIATION

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S. MARTIJN STEGER
GEOFFREY STERN
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ROGER P. SUGARMAN
KEVIN L. SYKES
JEREMIAH E. THOMAS
ERIC B. TRAVERS
STEVE TUGEND
TIMOTHY T. TULLIS
STEPHANIE P. UNION
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MICHELLE H. WONG HALABI
MICHAEL E. ZATEZALO

OF COUNSEL

LUIS M. ALCALDE
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ANTHONIO C. FIORE
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TED M. McKINNISS*
RANDALL W. MIKES
S. MICHAEL MILLER
ANEEZAL H. MOHAMED
DAVID M. WILSON

*Resident in Marion Office
**Resident in Cleveland Office

March 5, 2012

Via U.S. Mail and Certified Mail

Abdi Aden Magan
3183 Pendleton Court
Columbus, Ohio 43249
aamagan@hotmail.com

Re: *Ahmed v. Magan*, Case No. 2:10-cv-342

Dear Mr. Magan:

Enclosed please find a copy of the Notice of Deposition with regard to the above-captioned case which we have filed with the Court.

Very truly yours,

Kenneth R. Cookson

KRC/ee
cc: Christina Hioureas, Esq. (Christina.Hioureas@lw.com)
Natasha Fain, Esq. (nfain@cja.org)

THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

ABUKAR H. AHMED,		:	**Case No. 2:10-cv-342**
	Plaintiff	:	**District Judge: George C. Smith**
		:	**Magistrate Judge: Mark R. Abel**
vs.		:	
		:	
		:	
ABDI ADEN MAGAN,		:	
	Defendant	:	

NOTICE OF DEPOSITION OF ABDI ADEN MAGAN

PLEASE TAKE NOTICE that, pursuant to Rule 30(b)(6) of the Federal Rules of Civil Procedure, Plaintiff Abukar Hassan Ahmed, by his attorneys, will take the deposition upon oral examination of Abdi Aden Magan, residing at 3183 Pendleton Court, Columbus, Ohio 43249.

The deposition will begin on April 10, 2012, at 9:00 a.m. EST, at the law offices of Kegler, Brown, Hill & Ritter Co., LPA, Capitol Square, Suite 1800, 65 East State Street, Columbus, Ohio 43215, and will continue until completed, with such adjournments as to time and place as may be necessary. The deposition will be taken before a Notary Public (or another officer duly authorized to administer oaths) and will be recorded by stenographic and/or videographic means. Plaintiff Abukar Ahmed reserves the right to use any information produced through the deposition process for the purpose of discovery, for use at trial, or for other such purposes as may be permitted under the Federal Rules of Civil Procedure or the Federal Rules of Evidence.

Dated: March 5, 2012

Respectfully submitted,

Kenneth R. Cookson

Kegler, Brown, Hill & Ritter Co., LPA
Capitol Square, Suite 1800
65 East State Street
Columbus, Ohio 43215
(614) 462-5445
(614) 464-2634 facsimile

Andrea Evans (*admitted pro hac vice*)
Center for Justice & Accountability
870 Market Street, Suite 684
San Francisco, CA 94102
(415) 544-0444, ext. 302

Mark D. Beckett (*admitted pro hac vice*)
Christina G. Hioureas (*admitted pro hac vice*)
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+1.202.637.3328 Phone
+1.202.637.2201 Fax

ATTORNEYS FOR PLAINTIFF ABUKAR HASSAN AHMED

SCHEDULE A

I. Deposition Topics

1. Defendant Abdi Aden Magan.

2. Plaintiff Abukar Hassan Ahmed and all the circumstances leading up to and surrounding his arrest and detention in 1981 to 1986. Plaintiff Ahmed's detention from Nov. 20, 1988 to March 8, 1989 and trial in March 1989.

3. Somalia and the Barre Regime.

4. The National Security Service ("NSS") and the National Security Court ("NSC").

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 5th day of March, 2012, a copy of the foregoing NOTICE OF DEPOSITION OF ABDI ADEN MAGAN was served by electronic mail and certified U.S. mail on:

Abdi Aden Magan
3183 Pendleton Court
Columbus, Ohio 43249
aamagan@hotmail.com

Dated: March 5, 2012

Kenneth R. Cookson
Kegler, Brown, Hill & Ritter Co., LPA
Capitol Square, Suite 1800
65 East State Street
Columbus, Ohio 43215
(614) 462-5445
(614) 464-2634 facsimile

Exhibit 18: March 22, 2012 email and letter from Plaintiff to Defendant attaching the subpoena.

From:	Elman, Elise
To:	aamagan@hotmail.com
Cc:	Cookson, Kenneth; Hioureas, Christina (NY); nfain@cja.org; Georgieva, Katya (DC)
Subject:	Adbi Aden Magan Letter
Date:	Thursday, March 22, 2012 1:44:04 PM
Attachments:	Magan Ltr - 3-22-12.PDF

I am sending this on behalf of Kenneth R. Cookson, Esq. Thank you.

Elise Elman
Legal Secretary
Kegler Brown Hill & Ritter
A Legal Professional Association
65 E. State Street, Suite 1800
Columbus, OH 43215
614-462-5400 extension 290
614-464-2634 fax

Think GREEN! Please do not print this email unless it is necessary.

STEPHEN C. BARSOTTI
DANIEL J. BENNETT
MARY F. BRENNING
JOHN P. BRODY
ERIN C. CLEARY
ROBERT G. COHEN
KENNETH R. COOKSON
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MICHAEL J. MADIGAN
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LARRY J. McCLATCHEY
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JEFFREY D. ROBERTS
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KEGLER BROWN HILL & RITTER
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MICHAEL E. ZATEZALO

OF COUNSEL
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ANTHONIO C. FIORE
ROBERT D. MAROTTA
TED M. McKINNISS*
RANDALL W. MIKES
S. MICHAEL MILLER
ANEEZAL H. MOHAMED
DAVID M. WILSON

*Resident in Marion Office
**Resident in Cleveland Office

March 22, 2012

Via Email and U.S. Mail
Abdi Aden Magan
3183 Pendleton Court
Columbus, Ohio 43249
aamagan@hotmail.com

Re: *Ahmed v. Magan*, Case No. 2:10-cv-342

Dear Mr. Magan:

I am writing to you regarding your deposition which we have scheduled for April 10, 2012. A deposition is the part of a lawsuit where, before any trial, the lawyers can ask witnesses and parties a series of questions under oath. The questions and answers are recorded by a stenographer.

We provided a formal Notice of Deposition to you on March 5, 2012. To be sure that there is no misunderstanding, here is a subpoena. This subpoena requires you to attend your deposition scheduled for April 10, 2012 at 65 East State Street, Suite 1800, Columbus, Ohio at the offices of Kegler Brown Hill & Ritter at 9:00 a.m. As a party to the lawsuit you are required to attend your noticed deposition. We have also served you with a subpoena to ensure that you understand that you are required, by the Federal Rules of Civil Procedure, which govern the lawsuit, to attend your deposition and give testimony.

We understand that presently you may be out of the United States. We urgently request that you confirm, without delay, your attendance at the deposition as required by the Rules.

If you fail to respond to these requests timely, we reserve our right ask the Court to charge you with costs, and, if necessary, sanctions. Additionally, if you fail to attend your deposition, we may seek a monetary judgment by default against you if the Court concludes that you do not plan to defend yourself in this lawsuit.

Very truly yours,

Kenneth R. Cookson

KRC/ee
cc: Christina Hioureas, Esq. (Christina.Hioureas@lw.com)
Katya Georgieva, Esq. (katya.Georgieva@lw.com)
Natasha Fain, Esq. (nfain@cja.org)

AO 88A (Rev. 06/09) Subpoena to Testify at a Deposition in a Civil Action

UNITED STATES DISTRICT COURT

for the

Southern District of Ohio

ABUKAR HASSAN AHMED
Plaintiff
v.
ABDI ADEN MAGAN
Defendant

Civil Action No. 2:10cv000342

(If the action is pending in another district, state where:

SUBPOENA TO TESTIFY AT A DEPOSITION IN A CIVIL ACTION

To: Abdi Aden Magan, 3183 Pendleton Court, Columbus, Ohio 43249

☑ *Testimony:* **YOU ARE COMMANDED** to appear at the time, date, and place set forth below to testify at a deposition to be taken in this civil action. If you are an organization that is *not* a party in this case, you must designate one or more officers, directors, or managing agents, or designate other persons who consent to testify on your behalf about the following matters, or those set forth in an attachment:

Place:	Date and Time:
Kegler, Brown, Hill & Ritter Co., LPA, Capitol Square, Suite 1800, 65 East State Street, Columbus, Ohio 43215	04/10/2012 9:00 am

The deposition will be recorded by this method: stenographic and/or videographic

☐ *Production:* You, or your representatives, must also bring with you to the deposition the following documents, electronically stored information, or objects, and permit their inspection, copying, testing, or sampling of the material:

The provisions of Fed. R. Civ. P. 45(c), relating to your protection as a person subject to a subpoena, and Rule 45 (d) and (e), relating to your duty to respond to this subpoena and the potential consequences of not doing so, are attached.

Date:

CLERK OF COURT

OR

Signature of Clerk or Deputy Clerk *Attorney's signature*

The name, address, e-mail, and telephone number of the attorney representing *(name of party)* Plaintiff Abukar Hassan Ahmed, who issues or requests this subpoena, are:
Kenneth R. Cookson, Kegler, Brown, Hill & Ritter Co., LPA, Capitol Square, Suite 1800, 65 East State Street, Columbus, Ohio 43215
Phone #: (614) 462-5445, E-mail: KCookson@keglerbrown.com

Civil Action No. 2:10cv000342

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)

This subpoena for *(name of individual and title, if any)* Abdi Aden Magan

was received by me on *(date)* _____ .

❒ I served the subpoena by delivering a copy to the named individual as follows: _____

_____ on *(date)* _____ ; or

❒ I returned the subpoena unexecuted because: _____

_____ .

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also tendered to the witness fees for one day's attendance, and the mileage allowed by law, in the amount of $ _____ .

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

Server's signature

_____

Printed name and title

_____

Server's address

Additional information regarding attempted service, etc:

Federal Rule of Civil Procedure 45 (c), (d), and (e) (Effective 12/1/07)

(c) Protecting a Person Subject to a Subpoena.

(1) ***Avoiding Undue Burden or Expense; Sanctions.*** A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The issuing court must enforce this duty and impose an appropriate sanction — which may include lost earnings and reasonable attorney's fees — on a party or attorney who fails to comply.

(2) ***Command to Produce Materials or Permit Inspection.***

(A) *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

(B) *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing or sampling any or all of the materials or to inspecting the premises — or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

(i) At any time, on notice to the commanded person, the serving party may move the issuing court for an order compelling production or inspection.

(ii) These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

(3) ***Quashing or Modifying a Subpoena.***

(A) *When Required.* On timely motion, the issuing court must quash or modify a subpoena that:

(i) fails to allow a reasonable time to comply;

(ii) requires a person who is neither a party nor a party's officer to travel more than 100 miles from where that person resides, is employed, or regularly transacts business in person — except that, subject to Rule 45(c)(3)(B)(iii), the person may be commanded to attend a trial by traveling from any such place within the state where the trial is held;

(iii) requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

(iv) subjects a person to undue burden.

(B) *When Permitted.* To protect a person subject to or affected by a subpoena, the issuing court may, on motion, quash or modify the subpoena if it requires:

(i) disclosing a trade secret or other confidential research, development, or commercial information;

(ii) disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party; or

(iii) a person who is neither a party nor a party's officer to incur substantial expense to travel more than 100 miles to attend trial.

(C) *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(c)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

(i) shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

(ii) ensures that the subpoenaed person will be reasonably compensated.

(d) Duties in Responding to a Subpoena.

(1) ***Producing Documents or Electronically Stored Information.*** These procedures apply to producing documents or electronically stored information:

(A) *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(B) *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(C) *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

(D) *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

(2) ***Claiming Privilege or Protection.***

(A) *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

(i) expressly make the claim; and

(ii) describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(B) *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information to the court under seal for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

(e) Contempt. The issuing court may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena. A nonparty's failure to obey must be excused if the subpoena purports to require the nonparty to attend or produce at a place outside the limits of Rule 45(c)(3)(A)(ii).

Exhibit 19: April 3, 2012 email and letter from Plaintiff to Defendant reminding him about the Court's Discovery Order.

From:	Hioureas, Christina (NY)
To:	"aamagan@hotmail.com"
Cc:	Cookson, Kenneth (KCookson@keglerbrown.com); Beckett, Mark (NY); Natasha Fain (nfain@cja.org); Georgieva, Katya (DC)
Subject:	April 3, 2012 Deadline
Date:	Tuesday, April 03, 2012 7:24:56 PM
Attachments:	Apr 3 2012 letter to mr magan.pdf

Dear Mr. Magan:

Please see attached. This has also been sent to you by US mail.

Kind regards,

Christina

Christina G. Hioureas

LATHAM & WATKINS LLP
885 Third Avenue
New York, NY 10022-4834
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Fax: +1.212.751.4864
Email: christina.hioureas@lw.com
http://www.lw.com

* admitted to practice in California

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Houston	Silicon Valley
London	Singapore
Los Angeles	Tokyo
Madrid	Washington, D.C.
Milan	

BY EMAIL AND U.S. MAIL

Abdi Aden Magan

3183 Pendleton Court
Columbus, Ohio 43249
aamagan@hotmail.com

April 3, 2012

Re: Ahmed v. Magan, Case No. 2:10-cv-342

Dear Mr. Magan:

As you know, on March 29, 2012, the Court in *Ahmed v. Magan*, Case No. 2:10-cv-342 ordered that you communicate with Plaintiff's counsel no later than the close of business in Eastern Daylight Time on April 3, 2012 to advise us whether you intend to attend your deposition scheduled on April 10, 2012. The Court also ordered you to inform us of whether you intend to represent yourself in these proceedings or to engage a new counsel.

As you know, in this discovery order, the Court also warned you that "**a party failing to obey a discovery order and failure of a party to attend his deposition may be subject to sanctions up to and including the rendition of default judgment against the disobedient party**." It is now past the close of business day in Easter Daylight Time on April 3, 2012 and you have failed to inform us of whether you will attend your deposition and engage a new counsel. Please do so immediately.

Very truly yours,

/s/

Christina Hioureas
of LATHAM & WATKINS LLP

Exhibit 20: Medical Records of Abukar Hassan Ahmed submitted *in camera*
(Bates Nos. P-000821-29, P-000833-80)

EXHIBIT SUBMITTED *IN CAMERA*

Exhibit 21: May 31, 2012 Expert Report of Dr. Coleen Kivlahan, M.D., MSPH submitted *in camera*.

EXPERT REPORT SUBMITTED

IN CAMERA, APPENDICES ARE ANNEXED HERETO

APPENDIX A

COLEEN KIVLAHAN, MD, MSPH
SUMMARY OF PROFESSIONAL EXPERIENCE AND ACCOMPLISHMENTS

3/2012-present
Senior Director, Health Care Affairs, Association of American Medical Colleges, Washington, DC
Lead health care policy recommendations for Best Practices for Better Care and Readiness for Reform programs for academic health centers(AMCs) nationally. Provide clinical leadership and support to improve care, access, cost and quality in AMCs.

1/08-2/2012
Chief Medical Officer, Senior Vice President of Medical Affairs, SchallerAnderson/Aetna, Inc
Lead the Corporate office of the National Medicaid program for Aetna. Lead the development of comprehensive electronic tools designed to integrate medical management activities for the Medicaid population at the health plan level. Core activities include prior authorization, concurrent review, quality management, utilization management, pharmacy, long term care and HEDIS. Development of integrated toolsets that promote rapidly improved health for vulnerable Medicaid populations consistent with the best available evidence. Led development of an integrated physical and behavioral health predictive model focused on the most complex co-morbid patients. Supervise all medical management staff (50+ staff, including senior physicians) and lead health policy for 13 states Medicaid managed care health plans. Matrix supervision of chief medical officers in all Aetna Medicaid health plans.
Volunteer weekly delivering primary care for complex comorbid patients at the Herndon Free Clinic and for human rights clinics performing forensic torture evaluations for political asylum seekers. Serve on AHRQ, HRSA and CHCS national committees as Medicaid expert.

9/05-1/08
Senior Vice President and Corporate Medical Director, Schaller Anderson, Inc. Phoenix, Arizona
Led the development of comprehensive health policy for our insurance products for 1 million Medicaid members. Direct utilization, care and quality management, pharmacy management, behavioral health integration and enhanced care coordination. Implement interventions designed to reduce the overuse and underuse of medical services, implement prevention and wellness activities, create profiles for providers and members using predictive modeling, direct interventions to minimize unwanted variation in practice by monitoring appropriateness, quality, effectiveness and accessibility of care, review clinical quality indicators, including HEDIS. Directly supervised multiple professionals including 5 senior physicians.

Additional current roles:
- Staff physician St Vincent de Paul Homeless Clinic, Phoenix, Arizona. Primary care physician for Pediatric Obesity/Insulin Resistance Clinic for undocumented Hispanic children
- Volunteer and Trainer, Healthright International and Physicians for Human Rights Virtual Human Rights Clinic, political asylum evaluations for victims of torture

COMMUNICATION: Demonstrated ability to build partnerships across multiple sectors using non-hierarchical leadership approach. I led the growth of the medical management department and recruited mature, senior physician leaders, and enjoy the one of the highest staff retention and engagement rates in the company.

INNOVATION- Lead the organization's electronic tools committee across 5 organizational units, I co-chair the predictive modeling innovation unit with health plans and analytics units. We have created new complex care, member centric management programs; new standardized training and audit tools for health plans, and new electronic, managed care support tools such as inpatient census tools linked to our internally developed

predictive model. I led a national conference on complex patient management with national publication of the proceedings.

POPULATION MANAGEMENT- Used my extensive knowledge of public health principles including disease-specific knowledge, population management and policy issues, and trends in health care innovation within the nonprofit and public sectors to enhance our business model.

FLEXIBILITY, OPENNESS AND TRANSPARENCY- Recognized for my staff's high level of trust in my leadership and satisfaction with their roles. I am highly adaptable with health system environmental changes and frequently represent the company in national settings, including NCQA and Center for HealthCare Strategies.

STRONG OUTCOME ORIENTATION, FOCUS ON MEASURABLE IMPACT AND RESULTS- Use population management analytic skills daily; built our predictive modeling system to support analyses of behavioral and physical health integration and gaps in care analysis; developed ROI value analyses and expanded reporting capabilities throughout our company.

LEADERSHIP-I am a member of the Senior Leadership team; have extensive experience working with senior executives in business, foundations and other nonprofit enterprises, and national and state government leaders. I initiated an internal leadership development program called No More Heroes which is now a leading contributor to company strategy and execution.

2/05-8/05
Medical Director of Special Projects, Consultant, Schaller Anderson, Inc, Phoenix. Arizona and Family Medicine clinician at Fantus Health Center and Prieto Health Center, Chicago, Ill.

8/2003-1/1/05
Chief Medical Officer of Fantus Health Center, Chicago, Illinois
The largest primary care ambulatory center in Chicago's Cook County hospital and clinic system. Supervised internal medicine, family practice, OB-Gyn and pediatrics practices as well as specialty services such as psychiatry, diabetes, asthma, and hypertension programs and an urgent care center providing over 80,000 visits annually. Created a model chronic disease site for minorities with diabetes and hypertension who had no identified primary care physician, redesigned the General Medicine Clinic, created a fast track for urgent care reducing wait time from 6-8 hours to 45 minutes, and completed a study of national experts in primary care redesign for our health center.

LEADERSHIP IN DIVERSE ENVIRONMENT: I worked in an intensely diverse environment, exercising independent decision-making in a politically and racially charged atmosphere, worked with limited resources in a center full of tradition and history and developed innovative primary care redesign projects.

INNOVATION IN CHALLENGING ENVIRONMENT: I set up a unique clinical setting for patients with severe hypertension and diabetes with advanced access, group visits, model kitchen, self-management and exercise area, EHR access for patients and providers, reducing ED and urgent care visits dramatically. This project was executed within existing budget and inspiring current personnel.

University of Missouri Health Sciences Center 1996-2003:
MU health center is a major academic health center in the Midwest serving the state, between the metropolitan areas of St Louis and Kansas City with 4466 employees and annual total revenue of $436M.

Vice President for Medical Affairs and Chief Medical Officer, October 2002-August 2003. Requested by the Chancellor and President of MU Health Center to serve as leader during the Hunter consulting engagement to accomplish an organizational turnaround of finances and quality.

Associate Dean/Director of Health Improvement, 1997 to October, 2002 Developed Office of Clinical Effectiveness and led multiple effective improvement projects to reduce wait time, reduce LOS, and reduce medical errors.

CHANGE AGENT-In recognition of my efforts to create an Office of Clinical Effectiveness and having achieved statewide recognition for high quality programs while in its second year; for my efforts to create an electronic patient safety reporting system and implement it throughout the health system; and for my leadership and bridge-spanning skills across the enterprise, I was appointed to the role of Associate Dean and Director of Health Improvement responsible for promoting excellence in clinical quality throughout the enterprise.

HUMANISM/INTEGRITY-Awarded the 2001 AAMC Humanism in Medicine award by the medical students of my medical school, and in 2005, the national recipient of the Pride in the Profession award by the AMA. I maintained a busy complex practice in a community health center I created in 1993. I tried to model my core values: integrity, trust, comprehensive care, knowledge-based practice and compassion.

PASSION/ENDURANCE/MOTIVATION: Built the first office for tracking, reporting and improving clinical outcomes at MU, saving the system over $1.5M in two years from clinical practice changes in improvement projects. I created a leadership program for mid-career, multidisciplinary professionals, funded by the Academic Medicine and Managed Care Forum that dramatically improved retention of high quality clinical faculty, improved morale and enhanced innovation.

STABILIZING FORCE: At a time of change in the Dean, CEO, CIO and CFO positions, I was selected to offer stability, focus on cost reduction simultaneously with quality improvement, and worked as a bridge-spanner between faculty and administration.

State of Missouri, Director, Department of Health, 1993-1997
The Department of Health is one of 14 cabinet level departments with 1700+ employees and an annual budget of $350M+. I served under now deceased Governor Mel Carnahan.

MATURITY/GROWTH: Within months of my appointment, my father died and the Great Flood of 1993 had occurred. The Department received statewide recognition for our high quality approach to public health impact of the flood. I developed a leadership program for the 100 top managers, developed new employee incentives for exemplary teamwork, increased diversity dramatically and received the Governor's recognition award for doing so. I was successful in increasing the department's budget for all 4 budget years despite cuts in other departments' budgets.

INNOVATION: Increased childhood immunization status from among the lowest rates in the nation to one of the highest in 4 years; I increased the number of doctors willing to perform sexual assault exams on young children statewide and developed a nationally known program to identify and prevent childhood fatalities (Child Fatality Review Project and the SAFE Network).

LEADERSHIP: The challenges of continuous public visibility, multiple constituencies, the short duration of most state health officers' terms in office, an AIDS funding crisis, a neonatal syphilis epidemic in St Louis, abortion and family planning debates all taught me a great deal of restraint, wisdom, patience, timing and enhanced my sense of humor!

PERSONAL SKILLS:
ADVENTURER: I have worked in countries in Africa, Central and South America, Pakistan and traveled throughout the world. I have a passion for international health and the uninsured. My willingness to take measured risks has led me to become engaged in some fascinating and exciting projects that have made me who I am.
NURTURER: I love being a mother and I will always treasure that role. I deeply love children and enjoy caring for their health. I support and care for those who work for and with me.
COLLABORATOR: I know how to be a good team member. I am a good follower, and unlike most physician leaders, I know how to implement programs and believe in servant leadership. In other words, I regularly set tables and make coffee, print copies and stuff folders, listen to problems and comfort the frustrated! I am a scholar of leadership and a believer in high-performance teams.

COLEEN KIVLAHAN, MD, MSPH

PERSONAL INFORMATION

Business Address	AAMC 2450 N Street, NW Washington DC 20037-1127 ckivlahan@aamc.org
Home Address	1319 South 23rd Street Arlington, Va 22202
Phone	(571) 594-2223
Email	ckivlahan@hotmail.com

Birthplace	Alliance, Ohio
Date of Birth	6/26/53
Citizenship	United States
Medical Licenses:	Arizona AZ34633 current Virginia 0101242931 current DC license pending application Illinois 036-107731 expired 2005 due to move Missouri R8626 expired 2004 due to move

Board certification:
American Board of Family Practice, 1980. Continuously recertified. Due in 2014

EMPLOYMENT

3/08-present	Senior Director, Policy and Regulatory Group, Health Care Affairs, Association of American Medical Colleges, Washington, DC
1/08-2/12	Chief Medical Officer, Senior Vice President of Medical Affairs, Schaller Anderson/Aetna Medicaid, Inc
9/05-1/08	Senior Vice President and Corporate Medical Director, Schaller Anderson, Inc
8/03-8/05	Chief Medical Director, Fantus Health Center, Cook County Bureau of Health Services, Chicago, Illinois
1996 – 2003	Clinical Professor of Family & Community Medicine Senior Associate Dean/Director of Health Improvement, School of Medicine, MUHC Associate Chief of Staff for University Hospital and Clinics Director, Office of Clinical Effectiveness Chief Medical Officer, MUHC University of Missouri-Columbia, Columbia, MO
1994- 2003	Associate Medical Director, Family Health Center, Columbia, MO and Staff Physician, Family Health Center, Columbia, MO
1993- 1997	Director, Department of Health (Cabinet level agency), State of Missouri, Jefferson City, MO serving Gov. Mel Carnahan Clinical Associate Professor, Department of Family and Community Medicine, University of Missouri-Columbia
1991-1993	Director, Missouri Child Fatality Review Project; Department of Social Services, State of Missouri
1990- 1991	Chief Medical Officer, Health Resources and Services Administration, Department of Health and Human Services, Washington, D.C.
1989- 1993	Medical Director, Department of Social Services, Division of Medical Services, Medicaid Agency, State of Missouri
1989- 1991	Medical Director, SAFE Network (Sexual Assault Forensic Examinations in Children), State of Missouri
1987- 1989	Medical Director, Division of Maternal, Child and Family Health, Department of Health, State of Missouri. Acted as a joint consultant on maternal child health affairs with Missouri Medicaid Agency(DSS).
1984 - 1992	Clinical Assistant Professor, Department of Family and Community Medicine, University of Missouri Health Sciences Center, Columbia, Missouri.
1984 - 1987	Medical Director, Columbia/Boone County Health Department, Columbia, Missouri.
1980- 1981	Six months as faculty at University of Missouri Health Sciences Center,

Department of Family and Community Medicine; five months at the University of Washington-Seattle, Obstetrics Department for high risk gyn training

EDUCATION

09/71 - 06/74	St. Louis University, St. Louis, Missouri; BA degree, biology major, Magna cum laude.
09/74 - 06/77	Medical College of Ohio at Toledo; MD degree
07/81 - 05/83	University of Missouri-Columbia; MSPH degree. RWJF Family Medicine Fellowship

INTERNSHIP/RESIDENCY

07/77 - 07/80	University of Missouri Medical Center, Department of Family and Community Medicine.

FELLOWSHIP

07/81 - 06/83	Robert Wood Johnson Academic Fellowship Program, University of Missouri, Columbia, Missouri.

ADVANCED LEADERSHIP TRAINING

07/92	John F. Kennedy School of Government, Harvard University, Cambridge, MA. State and Local Government Leadership Program.
03/95	Center for Creative Leadership, San Diego, CA. Leadership Development Program.
03/96	John F. Kennedy School of Government, Harvard University, Cambridge, MA. Leadership for the 21st Century: Chaos, Conflict and Courage.

HONORS

1977	AMWA (American Medical Women's Association) National Outstanding Woman Physician.
1977	Mead Johnson Award - Outstanding Medical Student.
1981 - 1983	Robert Wood Johnson Academic Fellowship Program.
1990	Faculty Service Award - University of Missouri Medical Center for outstanding service to students, community and profession.
1991	AMWA National Woman Mentor of the Year.
1991	Commissioner's Award - Department of Health and Human Services, Administration for Children and Families for outstanding leadership and service in the prevention of child abuse and neglect.
1992	National Child Labor Committee, Lewis Hine Award for exceptional service to children and youth
1992	Outstanding Unit Citation, U. S. Public Health Service Primary Care Policy

	Fellowship Planning Group
1992	U. S. Public Health Service Special Recognition Award.
1992	Youthful Mid-Missouri Mover and Shaker, Mid-Missouri Magazine
1995	Missouri "Health Care Communicator of the Year" Award by the Missouri Hospital Association
1996	Outstanding Advocate for Children Award - Cardinal Glennon Children's Hospital, St. Louis, MO.
1996	Celebration of Service Award for Distinguished Contributions to Health Service in Columbia, Mo by Altrusa International, Inc.
1996	American Academy of Family Physicians National Public Health Award AAFP Scientific Assembly, New Orleans, LA.
1997	Distinguished Friend Award of the Sinclair School of Nursing, University of Missouri
1999	Quality Research Fund Award, The Academic Medicine and Managed Care Forum: Health Care Quality Leadership Development
1999	Missouri Team Quality Award, Excellence in Missouri Foundation for CQI project on acute pancreatitis
2000	Presented invited eulogy at the memorial service for Governor Mel Carnahan with President Bill Clinton
2001	Humanism in Medicine national award, AAMC (nominated by MUHC medical school)
2001	Dr Coleen Kivlahan Day, Proclamation by Clarence Harmon, Mayor St Louis
2005	AMA National Pride in the Profession Award
2006	Doctors of the World Volunteer of the Year, Florence Immigration Project
2007	Finalist for the Healthcare Heroes Award in the "Health Care Provider-Physician" category of *The Business Journal of Phoenix's* 2007
2008	Appointed to Aetna's Leaders Group (100 top leaders in company)
2009	Unsung Hero Award, Jeanie Schmidt Free Clinic, Northern Virginia Free Clinics
	Helen Muldrum, Characteristics of Compassion: Portraits of Exemplary Physicians, Jones and Bartlett Publishers, Sudbury, MA 2007 (Chapter on my life)
2010	Silver Award, Aetna Leadership award

2010	Jeanie Schmidt Free Clinic Founder's Award: The award is given each year to an individual who makes an exceptional contribution to the clinic and its ability to serve people in need
2010	Healthright International annual volunteer highlight presentation http://www.healthright.org/item-files/AR07_for%20web.pdf
2011	Torture and Abolition Survivors Support Coalition International recognition as individual contributor of the year in advocating against torture

PROFESSIONAL SOCIETY MEMBERSHIPS

2009-present	American College of Physician executives
1997 - Present	AAFP, American Academy of Family Physicians
1997 - Present	AOA, Alpha Omega Alpha, Medical Honor Society
1998-2001	Chair, Missouri Academy of Family Physicians Public Relations Committee
1995 - 2000	American College of Physician Executives
1995 - 1999	Missouri Public Health Association
1992 - 1996	Missouri Perinatal Association
1987 - 1999	APHA, American Public Health Association
1981 - 1992	STFM, Society of Teachers of Family Medicine
1981 - 1992	NAPCRG, North American Primary Care Research Group

PROFESSIONAL POSITIONS/ACTIVITIES

1983	Leader of Medical Project with Operation Crossroads Africa to Sierra Leone, West Africa.
1989 - 1991	Director and Founder, SAFE Network (Sexual Assault Forensic Examinations): an innovative, statewide cooperative of physicians committed to high quality examinations for child victims of violence.
1985 - 1990	Chairman, ICAN (Interagency Council on Child Abuse and Neglect) of Boone County; 17 agency organization to improve investigation and treatment of child victims of violence in Boone County.
1988 - 1989	First Vice-President of the Missouri Chapter of the National Commission for the Prevention of Child Abuse.
1989 - 1993	Co-Chairperson, Physician Services Task Force for Missouri Medicaid.policy
1989 - 1990	Member, Perinatal Advisory Committee to the Department of Health, State of Missouri.
1989	Senior Executives in State and Local Government program, Harvard Kennedy School of Government
5/93 – 1/97	Board Member, State Employees Health Insurance Purchasing Cooperative (Missouri Consolidated Health Care Plan).

1993 - 1/97	Board Member, Family Investment Trust: 5 state cabinet departments focused on improved services to families.
1993-2000	Adjunct Associate Professor, St Louis University School of Public Health
8/1996	Medical team leader for medical mission to Guatemala.
1996-1998	Chair, Medicaid Managed Care Statewide Quality Improvement Committee.
1996	Leadership for the 21st Century: Chaos, Conflict and Courage Harvard University, Kennedy School of Government
1996	Chair, Missouri Health Systems Partnership, funded by RWJF, providing state health reform recommendations in Missouri
1996 - 1999	Member, National Advisory Committee, "Turning Point" grant for the future of public health, Robert Wood Johnson and Kellogg Foundations.
1997	Developed and implemented the Missouri Physician Leadership Program
1997- 1999	Heartland Health System Board Associate, Heartland Health System, St Joseph, MO.
1997 - 1998	Chairperson: Family and Community Medicine and Radiology Chair Search Committees, University of Missouri, Columbia, Mo
1998	Milbank Memorial Fund/RWJF invited participant, public health redesign
1999	Chairperson: Missouri Child Fatality Task Force resulting in model statewide legislation on child deaths
	Served in Guatemala, Quiche district and established primary health and women's health clinics (1999, 2001, 2003 for 3 weeks each)
2000-2002	Developed and led physician and nursing leadership program grant: Millennium Leadership program, MUHC; funded by Aetna Foundation grant
10/99-10/2002	Affiliated Faculty Member, Graduate School of Public Affairs (GSPA), University of Missouri
2000-3	Board of Directors, Missouri Foundation for Health, $1B conversion foundation
2001	Missouri Academy of Family Physicians, Public Relations Committee
2000-04	Member National Advisory Committee, Robert Wood Johnson Clinical Scholars Program Vice Chair Dean's Advisory Committee on Clinical Practice, MUHC Member Missouri Immunization Advisory Committee, State of Missouri Patient Safety Network development (electronic medical error system), MUHC

2002-04	Institute of Medicine, Member National Committee on Bioterrorism and Smallpox
2002	Center for Family Policy and Research fellow, University of Missouri, Columbia
2003-5	Volunteer Physician, Marjorie Kovler Center for the Treatment of Survivors of Torture, Chicago, Illinois
2005-present	Volunteer Physician, Doctors of the World and Physicians for Human Rights Human Rights Clinics
2005-present	Volunteer Physician, Childhood obesity program, St Vincent de Paul Clinic, Phoenix, Az
2007	Primary physician, Project Hope mission to Haiti, Colombia and Ecuador
2008-present	Volunteer Physician, Diabetes/Hypertension clinic, Jeanie Schmidt Free Clinic , Herndon, Va

2009 Primary physician consultant to health care professionals for the Heartland Alliance in Democratic Republic of Congo on gender-based violence

2011 Medical consultant on sexual violence to Physicians for Human Rights for needs assessment to Kenya and Congo

CONSULTATION SERVICES/COMMITTEE MEMBERSHIPS

Member, Public Health Working Group on Cervical Cancer Screening at the National Cancer Institute, 1987.

Governor's Blue Ribbon Commission on the Future of Services to Children and Families; 1987.

Board Member, Therapy for Kids - Non-profit organization for children with special health care needs; 1986 - 1989.

Board of Directors, National Committee for Prevention of Child Abuse, Missouri Chapter

Board Member, Missouri Community Health Corporation - Non-profit organization for women's health; 1984 - 1987.

Member, Research Committee, Society of Teachers of Family Medicine; 1985 - 1987.

Member, Interagency Committee on Infant Mortality; Interagency Committee on Immunizations, U.S. Public Health Service; 1991.

Member, Healthy Start Initiative (national infant mortality reduction initiative): succeeded in reaching a cooperative agreement with the Ad Council to target a public relations campaign on infant mortality; 1991.

Reviewer, Family Practice Research Journal, 1992 - Present.

Reviewer, Journal of Family Practice, 1990 - Present.

Chairman, National Child Fatality Advisory Work Group, 1992 - 1993.

Gubernatorial Appointee, Advisory Board of the Southern Regional Project on Infant Mortality; 1992.

Quality Care Research Fund Selection Committee of the Aetna & Academic Medical Center Forum June 1998 to June 2000.

Trainer, Physicians for Human Rights and Healthright International political asylum physician training-2005-present

National Advisory Committee to Center for Health Care Strategies on Medicaid Leadership Institute 2009-present

GRANT ASSISTANCE

Robert Wood Johnson State Health Initiatives Grant: Co-Principal Investigator, 1995 - 1996.

Centers for Disease Control: Surveillance system for child fatalities; 1989 - 1992 (in cooperation with Missouri Department of Health).

Robert Wood Johnson Foundation: Development of a classification system for childhood fatalities; 1989 - 1991.

Children's Miracle Network Grant: A pilot project studying an intervention directed toward toddlers at risk for child abuse; 1989 - 1990.

University of Missouri Research Council Awards: Child Fatality Project, 1989, Firefighters' Noise Intervention, 1986, Papanicolaou Smear Intervention Trial, 1985.

Academic Medicine and Managed Care Forum, Quality Research Award, "Health Care Quality Leadership Development", 1999-2002

Aetna Foundation, Millennium Health Care Leadership grant 2000-2002

COMMUNITY INVOLVEMENT/HOBBIES

Treasurer, Central MO Orchid Society, 1995-2000.

PADI Scuba Certification, advanced open water skills.

Marathon running, Ballroom dancing, Sewing, Meditation

Bull Run Unitarian Church Social Justice committee, member

HEALTH AND HUMAN RIGHTS POSITIONS/ACTIVITIES

1983	Leader of Medical Project with Operation Crossroads Africa to Sierra Leone, West Africa.
1989 - 1991	Director and Founder, SAFE Network (Sexual Assault Forensic Examinations): an innovative, statewide cooperative of physicians committed to high quality examinations for child victims of violence.
1985 - 1990	Chairman, ICAN (Interagency Council on Child Abuse and Neglect) of Boone

	County; 17 agency organization to improve investigation and treatment of child victims of violence in Boone County.
1991-1993	Director, Missouri Child Fatality Review Project; Department of Social Services, State of Missouri
1996, 1999, 2001, 2003	Led Guatemala health and human rights missions
2002-05	Institute of Medicine, Member National Committee on Bioterrorism and Smallpox
2000-2002	Aetna Foundation, Millennium Health Care Leadership grant
2003-5	Volunteer Physician, Marjorie Kovler Center for the Treatment of Survivors of Torture, Chicago, Illinois
2005-present	Physician Board member Florence Immigration Project, Florence, Az and volunteer and trainer for Physicians for Human Rights and Healthright International virtual human rights clinics
2007	Project Hope staff physician, medical missions Ecuador, Colombia, Haiti
2009	Democratic Republic of Congo with Heartland Alliance/Kovler Center Chicago. Led three week training course with physicians, nurses, social workers and psychologists in forensic evaluation of rape victims and behavioral/medical integration
2011	Physician consultant in sexual violence needs assessment with Physicians for Human Rights to Kenya/DRC

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Bladder Outlet Obstruction: Etiology and Evaluation

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- Other Sections ▼
  - Abstract
  - Bladder Outlet Obstruction In Women
  - Bladder Outlet Obstruction in Men
  - Conclusions
  - References

Abstract
Numerous gender-specific etiologies are responsible for bladder outlet obstruction (BOO). BOO may be induced by specific functional and anatomic causes. The resulting obstruction frequently produces lower urinary tract symptoms (LUTS). Categorizing and understanding these entities is crucial when proceeding with a LUTS evaluation as specific diagnostic modalities may then be used to fully delineate the degree of BOO and any secondary issues. Although urodynamic evaluation and pressure flow evaluation is the gold standard diagnostic tool, other modalities may also be used, including post void residual analysis, urinary flow rates, cystoscopy, and selected radiologic ones. Patient self-appraisal of symptoms using various inventories such as the American Urologic Association Symptom Index or the International Prostate Symptom Score is relevant to the initial assessment and subsequent longitudinal follow up. Analysis of secondary symptoms of obstruction in women is often performed using a subjective symptom appraisal and is determined urodynamically, assessing the pressure-flow relation during voiding. The complete assessment of LUTS arising from BOO often includes several of these modalities to fully define the obstructive impact on the individual's urinary function and quality of life.
Key words: Bladder outlet obstruction, Lower urinary obstruction, Lower urinary tract symptoms, Benign prostatic obstruction, Gender differences, Urodynamic studies, Cystoscopy, Quality of life issues, Noninvasive measures

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PubMed articles by these authors

- Dmochowski, R.

PubMed related articles

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  Vesely S, Knutson

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When considering the causes of bladder outlet obstruction (BOO), it is important to appreciate that BOO results from a variety of etiologies, which may be functional or anatomic. BOO often produces lower urinary tract symptoms (LUTS), although the degree of bother by LUTS is highly variable and not predictable on the basis of the specific inciting etiology. Induced LUTS symptoms may be predominantly obstructive, irritative, or often a combination of both. Typically, obstructive symptoms include hesitancy, sensation of incomplete bladder emptying, diminished urinary stream, and post voiding urinary dribbling. Irritative complaints include urinary urgency, frequency of urination, occasional dysuria, and nocturia. Rarely are symptoms related to BOO isolated; often the individual experiencing LUTS presents with a variety of mixed symptoms of obstruction and irritation. BOO may also occur in the complete absence of symptoms and be first identified in the scenario of urinary retention or decompensation of the upper urinary tracts.

Functional obstruction may be caused by detrusor-sphincter dyssynergia (DSD), either at the level of the smooth muscle or rhabdosphincter; primary bladder neck obstruction, which may be functional and anatomic in character; or due to dysfunctional voiding, associated with learned voiding disorders or pelvic floor dysfunction associated with pain syndromes. Anatomic obstruction in men results most commonly from benign prostatic enlargement (BPH) or urethral stricture. In women, anatomic obstruction most commonly arises from incontinence procedures.

Whatever the etiology, BOO produces compression or resistance upon the bladder outflow channel at any location from the bladder neck to urethral meatus. This induced resistance initiates a bladder response that is highly variable and quite unpredictable. The characteristic symptomatic response—with some combination of obstructive and irritative complaints—is nonspecific for causation and intensity. Therefore, disabling irritative symptoms can exist with minimal objective findings, whereas complete decompensation of the lower urinary tract may be identified in an otherwise asymptomatic individual.

Given the substantive symptomatic impact of BOO regardless of gender, symptomatic appraisal is a crucial aspect of evaluation. When used in association with screening history, physical examination, and postvoid residual urine volume (PVR) determination, symptomatic response may be used as a monitor for LUTS progression and response to therapy. This proposed evaluation paradigm presupposes that confounding factors are not present or identified on initial screening (eg, significant PVR, neurologic disease, prior lower urinary tract surgical intervention, etc). Under the circumstance of identified comorbidity, lack of response to initial empiric therapy, progression of symptoms despite therapy, or in the case of doubt regarding etiology, more advanced urodynamic evaluation is indicated.

The evaluation goal is not only to establish a likely diagnosis, but to define bladder storage and emptying characteristics. Bladder storage abnormality is often an underappreciated sequela of BOO, and is associated with substantive symptomatic and physiologic effect. Urodynamic evaluation is the gold standard for quantitating the degree of obstruction, related detrusor contractile dysfunction, and simultaneous pressure/flow analysis. The evaluation of detrusor contraction magnitude with contemporaneous analysis of flow, often with fluoroscopic observation, provides the most definitive assessment of the voiding event.

Urodynamic assessment of voiding, however, is not without confounding variables (eg, urethral catheter size, ability of the individual to void in the circumstances of the study, academic disagreement surrounding absolute and cutoff criteria for obstruction). Nonetheless, urodynamic studies (UDS) supply critical data for

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management and treatment planning, and represent an integral component of assessing complicated BOO.

- Other Sections ▼
  - Abstract
  - Bladder Outlet Obstruction In Women
  - Bladder Outlet Obstruction in Men
  - Conclusions
  - References

Bladder Outlet Obstruction In Women

Causation

The etiologies for BOO in women are diverse and represent a combination of functional and anatomic issues. The most common causative factor is considered to be obstruction from stress urinary incontinence (SUI) surgery (Table 1). The overall adjusted incidence of BOO arising from incontinence interventions is estimated to be approximately 2%.[1] However, this approximation is assumed for urinary retention after surgery. Given that BOO may present with less dramatic but bothersome symptoms (eg, positional voiding dysfunction, hesitancy, interrupted urinary flow, and de novo or exacerbated urinary urgency and frequency), the overall incidence of postoperative obstruction is probably much higher and more properly reflected by the ranges reported by the American Urologic Association (AUA) Guidelines on SUI.[2]

Table 1

Etiologies of Bladder Outlet Obstruction in Women

Furthermore, obstructive symptoms may be obfuscated by either persistent SUI or urinary tract infection. More recent meta-analysis has similarly reported that varying rates of voiding dysfunction, mainly obstruction, after incontinence surgery are somewhat dependent on the type of procedure performed. These procedures are retropubic (Burch), 4% to 22%; retro-pubic (Marshall-Marchetti-Krantz), 5% to 20%; pubovaginal sling, 4% to 10%; transvaginal needle suspension, 5% to 7%; and tension-free vaginal tape, 2% to 4%. Autologous slings, as the gold standard intervention, have associated rates of obstruction as defined by the author of 1% to 33%, although the definition of "obstruction" is extremely varied across series.[2]

A consequence of postoperative obstructive phenomenon is secondary intervention to relieve sling tension or to explant the sling due to associated obstructive phenomena. The rates of lysis for autologous slings range from 1% to 30% with additional patients who require long-term catheterization (2 to 42%) and urethral dilation (3 to 8%).[1] New onset storage symptoms range from 0 to 43%. Similar cumulative rates of obstruction, retention, and storage abnormality have been reported with allograft slings. Although ostensibly less morbid, even newer midurethral technologies for sling application appear to have persistent rates of retention and new urinary symptoms that reflect the altered dynamic of urethral support associated with these techniques. No standardized method for reporting voiding difficulties after surgical intervention for SUI yet exists; however, a proposed system might include some combination of symptomatic and objective assessment.

Noniatrogenic anatomic causes of obstruction include pelvic organ prolapse (cystocele, rectocele, enterocele, uterine procidentia), genital malignancy (such as uterine or cervical carcinoma), extra-urinary vaginal masses (vaginal cysts, Gartner's duct remnants), and urethral pathology (diverticulum, urethral carcinoma) (Figure 1). Gynecologic lesions also may produce BOO inclusive of large ovarian cysts or tumors,[3,4] and cervical or uterine tumors. BOO may also occur during pregnancy due to uterine displacement.[5–7] Usually, retention in

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pregnancy resolves within the first trimester due to uterine enlargement and anteversion.[5–7]

Figure 1
Complex urethral diverticulum causing urethral obstruction. Arrow denotes relative area of urethral stenosis.

Pelvic prolapse is increasingly being identified as contributing to voiding dysfunction in many women. Gardy and colleagues[8] reported a rough correlation between grade of cystocele and residual urine volume in a group of women with prolapse, with higher grades (3 and 4) having a 30% higher association with elevated PVR. High grade prolapse may also lead to renal deterioration due to obstruction of the bladder outlet, ureteral orifices, or both.[9] Even prolapse lesions arising in other compartments such as large rectoceles can produce anatomic obstruction at the bladder outlet.[10]

Functional obstruction can arise from sphincteric dyssynergia, smooth or skeletal, arising from neurogenic causes; smooth muscle dyssynergia without neurogenic cause (primary bladder neck obstruction); and sphincteric pseudo-dyssynergia secondary to dysfunctional voiding (Hinman's syndrome).

Dysfunctional voiding can produce profound effects on the urinary tract with both symptomatic and anatomic sequelae.[11–14] Although previously considered a pediatric diagnosis, it is increasingly being recognized in adults who present with mixed irritative and obstructive complaints.[15–17] Dyssynergy manifested by these patients has been explained as a compensatory response of the urethral sphincteric mechanism to sudden detrusor overactivity. With chronicity, this response becomes ingrained into the voiding habit resulting in incomplete emptying and staccato or poor urinary flow.[15–17] External sphincter spasticity has been reported to arise from inflammatory conditions of the pelvic floor such as urethritis, cystitis, or periurethral glandular infection.[18,19]

Neurogenic dyssynergia is commonly seen with multiple sclerosis (MS) and other suprasacral neurologic lesions in women. Although several forms of dyssynergia may exist,[20] what commonly arises is an obstructive pattern most often seen with MS. Sirls and colleagues[21] reported that 28 of 113 women with MS demonstrated DSD, with 70% also manifesting detrusor overactivity. These urodynamic findings have been correlated with plaque progression and atrophy in patients with progressive MS.[22]

The distinct entity of primary bladder neck obstruction in women is assumed to be rare. Groutz and colleagues noted that it accounted for 8% of 38 women in their series.[23] Kuo diagnosed this entity in 30 of 76 women with BOO on the basis of pressure/flow criteria.[24] Others have reported incidences ranging from 0 to 4% in large well-characterized groups of women with voiding dysfunction.[25,26] Although unknown, putative etiologies for this clinical entity include smooth muscle hyper-trophy due to collagen deposition,[27] increased smooth tonus imparting loss of elasticity to the proximal bladder neck,[28] or increased or aberrant adrenergic receptor density in the smooth muscle of the proximal urethra.[29–31]

Primary urethral stricture disease is rare in women, usually being identified in those with prior urethral instrumentation or surgery, such as diverticular resection. In one series, however, primary urethral stricture disease accounted for 13% of women with BOO.[23]

Evaluation

Evaluation of the female patient with BOO requires a relatively high level of suspicion by the examining physician. Often significant symptoms lead to an initial consultation; as in men, the time course of symptom evolution may be

variable. Inciting events, such as recent SUI surgery or development of an acute or subchronic anatomic lesion (eg, an infected diverticulum or vaginal prolapse), may assist in recognizing the etiology.

A variety of modalities may assist in the BOO diagnosis. Nonurodynamic testing modalities are usually used in combination with some urodynamic evaluation to give a complete delineation of the inciting etiology and the overall impact of lower urinary tract function (Figure 2).

Figure 2

Urodynamic tracing, including pressure-flow analysis, of woman with BOO after pubovaginal sling surgery. Note voiding pressures greater than 100 cm H_2O. BOO, bladder outlet obstruction.

Medical history and physical examination provide the basic foundation for subsequent evaluation. Certain factors such as medication use, changes in mobility, and alterations in bowel function must be considered. The time course of symptom development and the possible relationship with inciting events (eg, SUI surgery or an acute neurogenic event, such as exacerbation or development of overt MS) also must be factored into the decision and diagnostic paradigm. Similarly, certain physical examination factors must also be evaluated. These include the presence and degree of concomitant vaginal prolapse, inclusive of anterior, posterior, and apical compartments of the vagina; the presence and degree of urethral hypermobility; the degree of anterior vaginal wall fibrosis if BOO is present after surgery; and any associated neurologic abnormalities, such as loss or change of perineal sensation, anal sphincteric tone, bulbocavernosus reflex, or other lower extremity neurologic findings.

Nonurodynamic assessment modalities include PVR assessment, cystoscopy, radiographic techniques such as the voiding cystourethrogram (VCUG), and occasionally advanced assessments, such as MRI of the bladder outlet and urethra.

Urinary residual assessment is considered a vital factor in the over-all estimation of the degree of BOO. Previously, this assessment was performed by urethral catheterization. The recent development of accurate and reproducible ultrasonographic techniques that use portable devices and are comparable to stationary ultrasound results has allowed for the general use of these methods in the outpatient setting. Huang and colleagues found that although the percentage differences varied between techniques (eg, mean percentage error 13.1% with stationary and 36% with portable, mean volume differences 21.9 mL vs 34.4 mL respectively), the accessibility and ease of the portable method made it a very convenient approach for PVR assessment.[32]

Furthermore, ultrasound use in determining PVR has been an excel-lent predictor of catheterization in at-risk populations, such as post-partum women. Yip and colleagues noted significant correlation values between PVR estimated by ultrasound and by catheterized volumes in a group of postpartum women.[33] Therefore, evidence supporting the reproducibility of ultrasound as an assessment of PVR suggests that this technique is not only an accurate but a facile and less invasive method than urethral instrumentation.

Cystoscopy provides visual assessment of the urethra and bladder, especially any alteration in the relationship between these structures, such as acute proximal urethral angulation or changes in urethral distensibility associated with fixation and peri-urethral fibrosis. Foreign bodies within the urinary tract also are best identified by this technique. Urethral abnormalities such as diverticuli or peri-urethral masses impinging on the urethral lumen may also be identified.

I find cystoscopy particularly important in the postoperative state, not only as a discriminating tool for locating obstruction foci, but as an outcome indicator of interventions for surgically induced BOO. Urethrolysis should correct any urethral deformation suspected of inducing the obstructive phenomenon and this resolution is confirmed intraoperatively with repeat cystoscopy before surgery is

viewed as anatomically successful.

Advanced techniques such as VCUG may be used in conjunction with multichannel urodynamics when videourodynamic studies are not available. The VCUG may identify specific anatomic areas of obstruction, any radiographic evidence of prolapse, abnormal relationships between bladder lumen and urethral axis (consistent with hyperangulation), and urethral pathology, such as diverticulum resulting in obstruction or deformation of the urethra.

MRI evaluation of the female urethra has now become the gold standard for identification and assessment of both extrinsic and intrinsic urethral pathology. Endoluminal[34] and external coil techniques have been used to assess urethral diverticular location and complexity with a high degree of specificity.[35,36] MRI also has been found to provide delineation of extrinsic lesions such as mullerian duct remnants[37] and leiomyoma.[38] The unparalleled anatomic depiction that MRI provides established this technique as the radiologic test of choice when diagnostic possibilities include peri- or paraurethral lesions as possible etiologies for BOO in women.

Given the unique male and female differences in voiding, many of the prior micturition analyses standardized for men do not apply to women. The nomograms for obstruction in men applicable in the circumstance of prostatic obstruction pre- and post-treatment, for instance, do not apply to women. Due to the varying etiologies for BOO and the lack of standardized "normal" voiding parameters in women, no urodynamic definition of obstruction in women has been generally accepted.

Initial attempts to assess urodynamic obstruction in women used only noninvasive flow parameters with 15cc/s maximal flow chosen as the separation point.[39] Others added the configuration of the flow pattern and the absence of significant PVR as an additional variable to this arbitrary flow magnitude.[25] More complicated definitions have used multiple factors including detrusor pressure (> 50 cm H_2O), maximum flow rate (< 12 mL/s), urethral resistance, and elevated in combination as indicating BOO.[26] Further attempts at refining the urodynamic diagnosis have used simultaneous pressure/flow analysis to determine the optimum segregation values for peak flow (Q_{max}) and peak detrusor pressure at peak flow (P_{det} @ Q_{max}).[40]

In a prospective evaluation of symptomatic women, the differentiating values for these variables were Q_{max} of 15 mL/s or less and a P_{det} @ Q_{max} of greater than 20 cm H_2O. Subsequent evaluation of a larger group noted that a $Q_{max} \leq 11$ mL/s and a P_{det} @ $Q_{max} \geq 21$ cm H_2O provided greater sensitivity and specificity.[41] Further refinement and more patients have used $Q_{max} \geq 12$ and P_{det} @ $Q_{max} \geq 25$ as the most discriminating values, with each variable, if not normal, indicative of BOO.[42]

In addition, the simultaneous use of fluoroscopy can add to the diagnosis of obstruction, allowing localization of the obstruction site.[43] Nitti and colleagues also reported maximum flow (Q_{max}), detrusor pressure at maximum flow (P_{det} @ Q_{max}), and magnitude of PVR as significant independent differentiating factors between obstruction and nonobstruction.

Other groups have reported similar segregating values. Blaivas and Groutz[44] developed a nomogram for obstruction in women using some-what more strict segregating values.[44] These were ($Q_{max} \leq 12$ mL/s combined with a P_{det} @ Q_{max} of > 20 cm H_2O) and/or the presence of urinary retention, or inability to void despite sustained voiding pressures of > 20 cm H_2O, or the presence of radiographically localized obstruction in the presence of sustained voiding

pressures of > 20 cm H_2O.

Given methodologic difficulties in obtaining the values defined above, the authors constructed their nomogram using noninstrumented flow and maximum voiding pressure as the variables. The resultant nomogram was then stratified by severity of obstruction, with moderate and severe obstruction being differentiated from no or mild obstruction at the relatively high peak voiding pressure of approximately 58 cm H_2O.[44] Although there has been reported agreement between these varied methods for determining obstruction,[45] no absolute criteria as yet exist to fully differentiate obstruction in women, especially in cases when obstruction is superimposed on either low-pressure, premorbid voiding habits or in borderline cases.

Even in the case of suspected post-operative obstruction, absolute diagnosis is often evasive, and must be based on a composite assessment of subjective and objective criteria.

- Other Sections ▼
  - Abstract
  - Bladder Outlet Obstruction In Women
  - Bladder Outlet Obstruction in Men
  - Conclusions
  - References

Bladder Outlet Obstruction in Men

Causation

BOO in men has traditionally been linked to the prostate. Recent terminological changes have led to the use of benign prostatic obstruction/enlargement (BPO/BPE) as nomenclature to replace previously used eponyms such as benign prostatic hyperplasia (BPH). Also synonymous with BOO in men is LUTS.[46] It is clear that LUTS, in both sexes, is at least partially due to a component of age-related detrusor dysfunction with the subsequent superimposition of other pathologies, most common of which in men is BPO (Figure 3). The appreciation that prostatic glandular and stromal hyper-plasia is not synonymous with BOO or LUTS has allowed a more advanced understanding of the dynamic factors involved in BOO in men.

Figure 3

Detrusor storage abnormality associated with high pressure obstruction in male with BOO due to prostatic enlargement. BOO, bladder outlet obstruction.

By far, BPO is the most common cause of BOO in men and stems from a variety of etiologies. Glandular and stromal hyperplasia of the prostate has long been supposed to be a primary contributor to BPO. However, complex aging-related factors probably also play a role in maturation and subsequent senescence of hyperplastic tissue within the prostate. Recently the documentation of senescent prostatic epithelial cells in men with enlarged prostates suggests that these cells may play a role in BPO development.[47]

Although androgens do not fundamentally produce BPH, the presence of androgens is required for subsequent development of BPH and this is a permissive effect. With age, despite the diminishing levels of circulating testosterone, levels of dihydrotestosterone (DHT) and androgen receptor remain high, therefore implicating the potential role of these 2 components of the androgen cascade in the perpetuation of prostatic enlargement.[48] The enzyme 5α-reductase is critical for conversion of testosterone into DHT, which remains the principal androgen within the prostate throughout life.[49]

Withdrawal of the high local concentration of androgens results in cellular apoptosis and is considered one of the crucial components of involution of

hyperplastic cells.[50] At least two 5α-reductase enzymes are known to exist (Type 1 and Type 2). The Type 2 enzyme is considered to be the critical component for hyper-plastic growth in middle and later age.[51] The type 2 subtype of 5α-reductase has a predominant effect in the prostatic stroma.

Increasing evidence also suggests that stromal and epithelial interactions in the prostate produce both the normal prostatic environment as well as the aberrant one necessary for the development of hyperplastic prostatic tissue. Some data suggest that BPH arises due to a defect in the stromal control component within the unique stromal-epithelial interaction.[52]

Another important factor in the development of hyperplastic tissue within the prostate may be inter-action between local growth factors and steroid hormones. These growth factors include a diverse stimulatory group such as insulin-like growth factor (IGF), transforming growth factor-beta (TGF-β) and other epithelial type growth factors.[53]

Finally, familial and genetic contributions also must be factored into the development of the hyper-plastic prostate. Analysis of inheritance patterns of men undergoing treatment for BOO due to prostatic disease suggests an autosomal dominant inheritance pattern with a higher concordance rate in monozygotic twins as compared to identical embryos.[54] Also, prostatic hyperplasia associated with familial inheritance patterns usually is characterized by larger glandular size compared to men with sporadic BPH.

Other prevailing causes of BOO in men include urethral stricture disease. This is a much more common entity in men than in women and often is not perceived as an anatomic finding until a patient presents with urinary retention or other symptoms initially thought to be due to non-specific LUTS. Previously considered to be primarily due to inflammatory disorders such as urethritis, urethral stricture disease is now considered to be most commonly due to trauma.

The interrelationship between detrusor and sphincteric function is also as important for BOO in men as in women. Dysfunctional voiding is being increasingly recognized as a component of chronic pain in LUTS syndromes, such as chronic prostatitis. Also, neurogenic-based DSD is commonly seen in various spinal cord and suprasacral neurologic processes. True dyssynergia is limited to spinal lesions that are suprasacral but infra-pontine in location. Pseudo-dyssynergia has been attributed to bradykinesia of the sphincter in Parkinson's disease and may also be present in other movement disorders, such as multiple systems atrophy.

Primary bladder neck obstruction in men is a much more common entity than in women, with incidence more substantially weighted towards younger men. (See Figure 4.) The contribution of smooth muscle tone as a basic etiology for primary bladder neck obstruction in men has been well documented.

Figure 4
Fluoroscopic image of non-relaxing bladder neck in young male with presumptive primary bladder neck obstruction.

Evaluation

The evaluation of BOO in men is dependent on similar fundamental principles as that of women. Examination of historical and physical evidence of both onset and magnitude and severity of symptoms is critical in the primary evaluation of these patients.

Basic evaluation of LUTS and BOO in men includes ultrasonographic PVR; symptomatic assessment using validated tools, such as the AUA Urinary Symptom Index (AUA-7) or the International Prostate System Score (IPSS); and urinary flow rate determination. Neither uroflowmetry nor PVR is specific to BOO causation.[55–59] Urinary flow rate is standardized and well accepted as a criterion for assessment of flow patterns. Flow rate parameters are well established (less than 10 mm/s consistent with obstruction).[58–59]

However, approximately one third of men with decreased flow rates are not obstructed and their diminished flow rates are representative of poor detrusor contractility. A normal flow rate also does not preclude the possibility of obstruction. Similarly, only about 50% of men with LUTS and increased PVR will be obstructed and one fourth of men with severe obstruction will not demonstrate any significant PVR elevation.[60–61] There-fore, concomitant analysis of flow rates and residual volumes is important to avoid misinterpretation of isolated data. The combination of both tools, when viewed in light of bothering symptoms, is considered to be the best initial paradigm for establishing the BOO diagnosis.[62–64]

Noninvasive measures of the relationship between bladder pressure and flow rate have been described using 2 techniques. Both techniques use pressure transmission through a standing column of fluid, associated with an isovolumetric detrusor pressure, with occlusion of the urethral meatus during free urinary flow.[65] One technique uses a condom catheter and occlusion technique with pressure transduction occurring distal to the urethral meatus.[66] The other method uses a cuff that is inflated to compress the urethra. The pressure associated with interruption of urinary flow is equated to the isovolumetric detrusor pressure.[67]

Both techniques have some pitfalls and require further validation. The possible addition of this technique to other less invasive measures may provide an ideal minimally invasive paradigm for the assessment of BOO in the future.

In the case of failed presumptive therapy, complex presentation scenarios, ambiguous screening evaluation criteria, or when diagnosis is in doubt, more directed evaluation may be indicated. This would include urodynamics, alternative radiologic procedures, or cystoscopy. Cystoscopy is generally considered to be the most specific method with which to evaluate degree and magnitude of stricture presence within the urethra. Perineal ultrasonography has been used for this indication as well, although with less degree of familiarity in the hands of most urologists.

The one advantage of perineal ultrasonography may be its ability to determine the extent of mural fibrosis associated with the actual luminal stricture disease. Ultrasonography may also serve a role in patients suspected of having upper tract changes related to BOO, and may provide evidence for the effect of BOO on upper tract strictures. Urodynamic techniques include complete uroflowmetry, multi-channel urodynamics for complex cases, and video urodynamics in specialized situations.

Formal urodynamic evaluation is usually reserved for complicated cases or in situations where there has been no response to therapy that is seemingly appropriate on the basis of prior initial uroflow and PVR assessment. In men, urodynamics is often performed in conjunction with a simultaneous pressure flow evaluation. Although the *sine qua non* of obstruction in pressure/flow evaluation is high detrusor pressure associated with low urinary flow rate, other combinations may indicate the possibility of detrusor failure, such as low detrusor pressure with low urinary flow. Also, relatively increased urinary flow rates may be associated with high pressures, indicating an obstruction variant.

The pressure flow evaluation of complex BOO in men has been reasonably well standardized beginning with the International Continence Society nomogram for BPO first described in 1997.[68] Other nomograms, such as the Abrams-Griffiths nomogram and the Schafer nomogram are relatively concordant.[69] Using these nomograms, various subsidiary calculations have been proposed for obstruction. The Bladder Outlet Obstruction Index (BOOI) [where BOOI = P_{det} @Q_{max} – 2(Q_{max})] and Bladder Contractility Index (BCI) [where BCI = P_{det} Q_{max} + 5(Q_{max})] have both been proposed as bladder function assessments associated

with BOO.[64,68] Both calculations simplify computations and allow the categorization of men with BOO and LUTS into subsidiary groups depending upon bladder contractility and outlet obstruction.[68]

- Other Sections ▼
  - Abstract
  - Bladder Outlet Obstruction In Women
  - Bladder Outlet Obstruction in Men
  - Conclusions
  - References

Conclusions

The etiology of BOO is diverse and definitely gender specific. Often anatomic causes induce functional abnormality that remains somewhat unique for each individual, regardless of sex. A full appreciation of the possible etiologies of obstruction is necessary in order to identify overt and more subtle scenarios. In women, iatrogenic causes of obstruction are the most common. Other entities account for far fewer of the cases. The obstruction evaluation in women is somewhat more diverse in terms of modalities used, with no single grouping of techniques that are generally apropos. Individualized evaluation remains a tenet of analysis, and urodynamic criteria used to diagnose BOO in women continue to evolve.

In men, by far the most common entity producing BOO is BPO/BPE. Again, symptomatic appraisal is a crucial component of evaluation in order to assess the magnitude of symptom impact. The combination of PVR, urinary flow measures, and symptom appraisal has been generally accepted as the initial screening and evaluation paradigm for BOO and LUTS in men and are now considered standard. More complex techniques such as voiding pressure flow studies remain the gold standard and are more thoroughly standardized in men than in women. Future trends will continue to focus on enhancing diagnostic accuracy and specificity of BOO evaluation. Noninvasive measures may become more commonly used as their validation against older techniques occurs.

Main Points

- Bladder outlet obstruction (BOO) results from functional or anatomic etiologies. BOO produces compression or resistance upon the bladder outflow channel at any location from the bladder neck to the urethral meatus. This produces lower urinary tract symptoms (LUTS), which may be predominantly obstructive, irritative, or often a combination of both.
- The most common cause of BOO in women is obstruction from stress urinary incontinence (SUI) surgery. Recent meta-analysis has reported that varying rates of voiding dysfunction, mainly obstruction, after incontinence surgery are somewhat dependent on the type of procedure performed.
- Nonurodynamic testing modalities are usually used in combination with urodynamic evaluation to diagnose BOO in women. Nonurodynamic assessment modalities include postvoid residual urine volume (PVR) assessment, cystoscopy, voiding cystourethrogram, and magnetic resonance imaging.
- Due to the varying etiologies for BOO and the lack of standardized "normal" voiding parameters in women, no urodynamic definition of obstruction in women has been generally accepted.
- In men, benign prostatic obstruction (BPO) is the most common cause of BOO and stems from a variety of etiologies. Other causes of BOO include urethral stricture disease, dysfunctional voiding, neurogenic-based detrusor-sphincter dyssynergia (DSD), and primary bladder neck obstruction.
- A normal flow rate in men does not preclude the possibility of obstruction.

Concomitant analysis of flow rates and residual volumes is important to avoid misinterpretation of isolated data.
- Urodynamics, alternative radiologic procedures, or cystoscopy is recommended in the case of failed presumptive therapy, a complex presentation scenario, or when a diagnosis is in doubt.
- Formal urodynamic evaluation is usually reserved for complicated cases and is often performed in conjunction with a pressure flow evaluation.

- Other Sections ▼
  - Abstract
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  - References

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EXHIBIT 2: Norredam M, Crosby S., *et al.*, *Urologic Complications of Sexual Trauma Among Male Survivors,* Reviews In Urology (2005)

ADULT UROLOGY

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UROLOGIC COMPLICATIONS OF SEXUAL TRAUMA AMONG MALE SURVIVORS OF TORTURE

MARIE NORREDAM, SONDRA CROSBY, RICARDO MUNARRIZ, LIN PIWOWARCZYK, and MICHAEL GRODIN

ABSTRACT

Objectives. To describe the urologic and sexual complications of male survivors of sexual torture, including prevalence, sequelae, diagnosis, and treatment.

Methods. Through chart reviews, we identified all male survivors of torture who had been treated for physical and/or psychological symptoms due to sexual trauma at the Boston Center for Refugee Health and Human Rights at Boston Medical Center between January 1, 2001 and January 1, 2002. Of the 72 men seen, 20 (28%) were survivors of sexual trauma. Our study focused on genital trauma leading to urologic and/or sexual dysfunction. Therefore, all cases of male genital trauma that had been referred to the urology department (3 of 20) were selected for this review.

Results. The patients presented with chronic genital and erectile pain, lower urinary tract symptoms, and sexual dysfunction. The diagnostic workup included history, physical examination, and ultrasonography. Treatment included steroid injections for chronic pain and oral erectogenic agents for sexual dysfunction.

Conclusions. The apparent prevalence and severity of the physical and mental sequelae to sexual trauma make it an important area for screening when treating survivors of torture. Our study is the first of its kind to document urologic complications of sexual torture in a foreign-born U.S. cohort of tortured men, including prevalence, diagnosis, and treatment. The proposed use of steroid injections in the clinical treatment of these patients has not been previously reported. UROLOGY **65:** 28–32, 2005. © 2005 Elsevier Inc.

Thousands of asylum seekers and refugees enter Western countries every year. Between 1991 and 2000, about 1 million people applied for asylum in the United States.[1] Among those seeking asylum are torture survivors. In 1999, 400,000 survivors of torture were estimated to reside in the United States.[2] Although not necessarily self-proclaimed, survivors of torture and refugee trauma are consequently bound to appear in the offices of health professionals. A U.S. study of the prevalence of torture survivors among a random sample of foreign-born patients in primary care in a metropolitan area showed that 25% had suffered from torture.[3] It is of concern that health professionals often fail to ask about torture or are not trained to recognize the physical and psychological symptoms.[2] Additionally, survivors rarely volunteer their history of persecution because of shame or out of fear because the clinical setting is reminiscent of prior experiences of torture.[4] Men are especially ashamed to discuss sexual trauma because of fear of stigmatization and the shame of a perceived loss of masculinity.[5]

The United Nations Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment defines torture as "an act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or confession. . . ."[6] Male sexual trauma, which is a form of torture, can be characterized according to the methods used[7,8]:

1. Direct genital trauma: hitting, kicking, or applying electric shocks to genitals and/or anus, object inserted into urethral meatus and/or anus, cigarette burns to penis

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TABLE I. ***Most common methods of sexual torture and physical sequelae among 20 survivors of torture treated at Boston Center for Refugee Health and Human Rights at Boston Medical Center between January 1, 2001 and January 1, 2002***

Physical Trauma	Acute Physical Sequelae	Chronic Physical Sequelae
Forced nakedness	Groin/genital pain	Groin/genital pain
Anal rape	Fecal incontinence	Erectile dysfunction
Genital beatings with fists, sticks, or other instruments	Rectal bleeding	Urethral stricture
Electric shocks to genitals	Rectal pain	Fecal incontinence
Forced fellatio		
Insertion of toothpicks into the penis		

2. Nonconsensual sexual acts: pawing, anal rape, forced masturbation, and forced fellatio
3. Mental assaults: forced nakedness, sexual humiliation, and threats

On the basis of our work with survivors of torture and refugee trauma, we report 3 cases of genital trauma and their physical sequelae, focusing on the urologic complications. Our aim was to sensitize medical professionals to the male genital trauma that occurs in the context of sexual torture by discussing the methods of torture and the physical sequelae, diagnosis, and treatment strategies.

MATERIAL AND METHODS

Through chart reviews, we identified all male torture survivors who had been treated for physical or psychological symptoms due to sexual trauma at the Boston Center for Refugee Health and Human Rights at the Boston Medical Center. Between January 1, 2001 and January 1, 2002, 20 (28%) of the 72 men seen were identified as survivors of sexual trauma. The patients were all between 31 and 50 years of age and refugees from African countries in conflict. They had all been imprisoned or captured and had suffered torture, including severe genital beatings. Table I lists the most common methods of sexual torture, as well as the acute and chronic physical sequelae, among the 20 survivors of torture. Most patients had experienced multiple sexual assaults of the same or different kinds. We focus on the genital trauma leading to urologic and/or sexual dysfunction. Therefore, all cases of male genital trauma that had been referred to the urology department (3 of 20) were selected for this review. The cases are presented and serve to illustrate the different aspects of the symptoms, diagnosis, and treatment of male genital trauma. All patients have been kept anonymous. The Institutional Review Board at Boston Medical Center approved the study.

RESULTS

Case 1

Patient 1 was a 50-year-old man who had fled from a country in Central Africa after being persecuted by the military for rebel activity and imprisoned on 7 occasions between 1996 and 2000. During imprisonment, he was repeatedly beaten with fists and sticks all over his body, including the genital area. On one occasion, he was suspended naked from the ceiling by his arms with his legs bent, his feet secured to the floor wide apart, and his genitalia tied to the floor for 12 hours. He was unable to stand upright without painfully stretching his genitalia. He presented with complaints of erectile dysfunction and chronic incapacitating genital pain. On physical examination, he had diminished tunica elasticity and compliance, consistent with Peyronie's disease. Penile stretching elicited exquisite proximal dorsal penile pain radiating to the pubic bone and suspensory ligament. After he provided informed consent, two subcutaneous steroid injections (triamcinolone 50 mg) on the dorsal aspect of the penis, fundiform ligament, and pubic tubercles were performed within a 4-month period. After the first steroid injection, the patient experienced immediate and significant improvement of his incapacitating genital pain. After the second injection, the pain resolved completely. At last follow-up, his erectile dysfunction was being managed with oral erectogenic agents (sildenafil) with excellent results.

Case 2

Patient 2 was a 31-year-old man who had also been repetitively beaten in the genitals by fists and sticks while imprisoned in an East African country for political activities. He also presented with complaints of erectile dysfunction and severe and chronic genital pain. He had no orgasmic or ejaculatory problems, but his erections were reduced in rigidity compared with previously. The physical examination revealed exquisite pubic tubercle, cord, and suspensory ligament tenderness. Penile duplex Doppler ultrasonography after intracavernosal injection of vasoactive agents revealed decreased cavernosal systolic velocities and normal end-diastolic velocities. These findings were consistent with pure (no corporeal occlusive dysfunction) cavernosal artery insufficiency, most likely secondary to blunt perineal trauma. No penile plaques or tunica thickening were observed. After he provided informed consent, two steroid injections (triamcinolone 50 mg) were given into the cord, fundiform, and pubic tubercle, with complete resolution of his genital pain. At last follow-up, he was taking oral erectogenic agents (silde-

nafil) for the management of his erectile dysfunction, with excellent results.

CASE 3

Patient 3 was a 39-year-old man who had fled from a West African country after being captured by rebels and forced to do hard labor. During captivity, he was severely beaten in the genital area with fists and sticks on multiple occasions. He presented with complaints of erectile dysfunction and lower urinary tract symptoms (International Prostate Symptom Score of 23) characterized by decreased force of stream, incomplete emptying, and urinary frequency. He achieved an approximately 50% erection, which had poor spontaneity and sustaining capabilities. His past medical history was only remarkable for a urethral stricture managed endoscopically several years previously. His physical examination was unremarkable, but urethroscopy revealed a tight bulbar urethral stricture. Penile duplex Doppler ultrasonography after intracavernosal injection of vasoactive agents revealed a peak systolic velocity of 31 and 15 cm/s for the right and left cavernosal artery, respectively, with normal end-diastolic velocities. These findings were consistent with pure (no corporeal occlusive dysfunction) cavernosal artery insufficiency, most likely secondary to blunt perineal trauma because of torture. He underwent internal (endoscopic) urethrotomy of a long bulbar stricture. However, the stricture recurred within 6 months, requiring a second internal urethrotomy with excellent results. The patient also began taking sildenafil, with excellent results. A detailed vascular evaluation was obtained to assess the feasibility of penile revascularization from the dorsal to the cavernosal artery in an attempt to reestablish normal erectile function.

COMMENT

Little has been written about the sexual trauma of men within the published medical reports on torture. Attention has so far mainly been devoted to female survivors of sexual trauma. The myth that men are only aggressors and not victims seems prevalent.[9] The legal definition of rape in many countries and in some states in the United States dismisses that men may be victims.[10] The prevalence of male sexual trauma is uncertain. Estimates, however, have shown that 5000 to 8000 men were raped in the former Yugoslavia and that thousands of men and boys were raped during the Iraqi invasion of Kuwait.[11] Male sexual trauma mostly takes place during detention and is perpetrated by guards, interrogators, or other prisoners. Agger[12] found that 52% of male political prisoners who sought help after torture had been sexually abused. Peel *et al.*[13] specifically studied male sexual trauma among Tamil refugees, who had been imprisoned, and found a prevalence of 21%. In a different study, Peel[8] studied 607 men from 45 countries, of whom 25% had been sexually assaulted. Of these, 21% had been raped, 47% had had assaults to the genitals, 27% had had electric shocks to the genitals, and/or 21% had had an object inserted in the anus or urethral meatus. These prevalence figures may be underestimates because of the taboo and stigmatization to discussing male sexual trauma inherent in most cultural norms. A study of British male victims of sexual assaults in general showed that 79% of raped men sought no help for a mean time of 16 years after the assault.[14]

The sequelae of sexual torture include both psychological[15–17] and physical manifestations.[15,18,19] In this report, we focused on the physical sequelae. When reviewing published reports, we found few studies describing the physical sequelae of sexual trauma.[15,18,19] Blunt genital trauma from other causes has, however, been documented. Erectile dysfunction has resulted from innocent falls or blows to the crotch.[20,21] Avid bikers can develop erectile dysfunction and groin pain owing to prolonged pressure on the pudendal nerves[22] and arteries.[23,24] Earlier studies and our work have suggested that blunt genital trauma may roughly result in four clinical problems that are not mutually exclusive:

1. Chronic genital pain, including erectile pain
2. Peyronie's disease characterized by penile pain, penile curvature, and erectile dysfunction
3. Lower urinary tract symptoms
4. Erectile dysfunction

These clinical problems arise from different pathologic mechanisms. Chronic genital pain may result from injury to the inguinal cord, suspensory and/or fundiform ligaments, or tunica albuginea, leading to Peyronie's disease.[25] Peyronie's disease is characterized by decreased tunica elasticity and compliance secondary to fibrosis and plaque formation. Lower urinary tract symptoms may be due to urethral trauma leading to stricture formation. Apart from Peyronie's disease, erectile dysfunction may result from compression injuries of the pudendal arteries as they enter the perineum through Alcock's canal and/or corporal damage leading to corporeal veno-occlusive dysfunction (venous leak). Depending on the symptoms, the diagnosis of male genital trauma is based on the physical examination and penile duplex Doppler ultrasound findings. Not yet described in published reports, we propose that chronic genital pain due to Peyronie's disease, pubitis, or suspensory ligament injury can be successfully treated with steroid injections. Penile curvature can be managed medi-

cally (verapamil, interferon, colchicine, vitamin E)[25] or surgically (Nesbit plication versus tunica incision/excision and grafting).[25] Urethral strictures can be generally treated. The treatments for erectile dysfunction include oral erectogenic agents (sildenafil, vardenafil, tadalafil),[26] penile revascularization procedures, intracavernosal therapy, and penile implants.[27–29] Erectile dysfunction is most common in survivors who have been exposed to sexual trauma, but it may also arise after nonsexual torture.[30]

Sexual trauma may also lead to psychological disturbances, including post-traumatic stress disorder and major depressive disorder. These disorders include symptoms such as insomnia, nightmares, irritability, avoidance behavior, and depression,[15–17] according to the DSM-IV. Post-traumatic stress disorder and/or major depressive disorder occur in most patients who have been tortured,[15,17] and the recognition and treatment of the underlying psychological disorder is essential to therapeutic success.

Torture survivors may be exposed to human immunodeficiency virus through contaminated blood, anal rape, or unsterile instruments of torture, or when seeking medical care for wounds that occurred during torture. Thus, all male rape victims and torture survivors with male genital trauma should be screened for human immunodeficiency virus.

CONCLUSIONS

The results of this study and others have indicated that male sexual trauma is an important issue in refugee and asylum seeker populations. Still, the subject of male sexual trauma has rarely been addressed in published reports and is little understood. This is partly a result of the silence of the victims, as well as lack of awareness by, or discomfort among, medical professionals. The apparent prevalence and the severity of the physical and mental sequelae to sexual trauma, however, make it an important area for screening when treating survivors of torture and refugee trauma. It is, therefore, crucial that health professionals working with asylum seeker and refugee populations are aware of the problem and trained to recognize the physical and psychological symptoms and make appropriate referrals to knowledgeable providers or treatment centers (National Consortium of Torture Treatment Programs). This includes referral to a urologist in the case of urologic complications. Also, urologists need to be aware of the diagnostic tools and possible treatment strategies. In this context, our study is the first of its kind to document the urologic complications occurring after sexual torture in a U.S. cohort of tortured men, including the prevalence, diagnosis, and treatment. The proposed use of steroid injections in the clinical treatment of these patients has not been previously reported.

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EXHIBIT 3: Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Henry L. Lew, John D. Otis, Carlos Tun, Robert D. Kerns, Michael E Clark, David X. Cifu *Polytrauma Clinical Triad*, Journal of Rehabilitation Research & Development Analyses, Vol. 46, No. 6 (2009)

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Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Polytrauma clinical triad

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Abstract — This study examines the prevalence and coprevalence with which returning Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans were reporting symptoms consistent with chronic pain, posttraumatic stress disorder (PTSD), and persistent postconcussive symptoms (PPCS). The medical records of 340 OIF/OEF veterans seen at a Department of Veterans Affairs Polytrauma Network Site were comprehensively reviewed. Analyses indicated a high prevalence of all three conditions in this population, with chronic pain, PTSD, and PPCS present in 81.5%, 68.2%, and 66.8%, respectively. Only 12 of the veterans (3.5%) had no chronic pain, PTSD, or PPCS. The frequency at which these three conditions were present in isolation (10.3%, 2.9%, and 5.3%, respectively) was significantly lower than the frequency at which they were present in combination with one another, with 42.1% of the sample being diagnosed with all three conditions simultaneously. The most common chronic pain locations were the back (58%) and head (55%). These results underscore the complexity of the presenting complaints in OIF/OEF veterans and support the importance of a multidisciplinary team approach to assessment and treatment.

Key words: brain injuries, explosions, Iraq, military personnel, pain, posttraumatic stress disorder, rehabilitation, veterans, war, wounds and injuries.

Abbreviations: OEF = Operation Enduring Freedom, OIF = Operation Iraqi Freedom, PNS = Polytrauma Network Site, PPCS = persistent postconcussive symptoms, PRC = Polytrauma Rehabilitation Center, PTSD = posttraumatic stress disorder, TBI = traumatic brain injury, VA = Department of Veterans Affairs, VHA = Veterans Health Administration.

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INTRODUCTION

Advances in battlefield medicine and protective armor for the torso have led to a higher percentage of soldiers surviving physical injuries that would have been fatal in prior conflicts [1-3]. Many of these injuries sustained from the current conflict in the Middle East have been described as "polytrauma," defined by the Veterans Health Administration (VHA) as "two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability " While the concomitant injuries accompanying traumatic brain injury (TBI) may be manifold, including fractures, amputations, burns, spinal cord injury, eye injury, and auditory trauma, the two most prevalent and functionally disabling conditions may be posttraumatic stress disorder (PTSD) and chronic pain. This "polytrauma clinical triad" of chronic pain, PTSD, and persistent postconcussive symptoms (PPCS) presents a significant diagnostic and therapeutic challenge to healthcare providers.

With the extreme forces used in combat and the resultant physical injuries, pain from trauma or injury is, not surprisingly, a significant problem in combat returnees. Commonly reported locations of pain include the head, back, legs, and shoulders [4-6]. Pain that persists for an extended period of time (i.e., >3-6 months) and initially accompanies a disease process or bodily injury that has subsequently resolved or healed may be referred to as chronic pain [7]. Chronic pain is often associated with other problems, including functional disability, psychological distress, as well as family discord and vocational issues.

Many combat returnees also report symptoms of acute combat stress disorder or PTSD. While symptoms of acute combat stress may occur after prolonged exposure to military theater conditions, these symptoms often gradually remit by themselves within 30 days. However, servicemembers who continue to exhibit these symptoms for more than 30 days may meet criteria for PTSD. A recent study demonstrated that of 103,788 Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans seen at Department of Veterans Affairs (VA) facilities, approximately 25 percent received one or more distinct mental health diagnoses, with the single most common diagnosis being PTSD [8]. PTSD can occur following exposure to an event that is, or is perceived to be, threatening to the well-being of oneself or another person. Symptoms of PTSD may include reexperiencing the event in the form of intrusive thoughts; nightmares; avoidance of thoughts, people, and places that resemble the traumatic event; and symptoms of hyperarousal, including heightened startle, poor sleep, attentional difficulties, or anger [9].

TBI is a "signature injury" in this modern warfare [10]. Considerable attention has been paid to the dramatic nature of severe TBI. However, the vast majority of military servicemembers are actually at a

much higher risk of sustaining a mild TBI [11]. While postconcussive symptoms often resolve within a month of the injury [12], for some individuals the symptoms can last for months or years. Given that the exact cluster of symptoms varies substantially across postconcussion patients, use of the term "syndrome" or "disorder" may not be accurate or clinically useful. Instead, it has been suggested that the unique individual pattern of symptoms should be documented and be the focus of treatment. Throughout this article, persistent and ongoing physical, cognitive, or behavioral difficulties lasting longer than 3 months following a mild TBI are referred to as PPCS [4].[1]

To meet the healthcare needs of returning veterans, the VHA established the Polytrauma System of Care, consisting of 5 Polytrauma Rehabilitation Centers (PRCs), 22 Polytrauma Network Sites (PNSs), 80 Polytrauma Support Clinical Teams, and about 50 Polytrauma Points of Contact. Level 1 PRCs provide acute, comprehensive, inpatient rehabilitation, while Level 2 PNSs provide interdisciplinary, specialized, postacute rehabilitation services in consultation with the PRCs as needed. Several studies have reported on the prevalence of TBI, chronic pain, and PTSD among OIF/OEF veterans receiving care at Level 1 and 2 facilities. A study by Sayer et al. found that in a sample of 188 combat injured servicemembers treated at a Level 1 PRC, 93.0 percent incurred a combat-related TBI, 81.0 percent report a pain problem, and 52.6 percent received some type of mental health services [13]. In another study of 50 OIF/OEF veterans treated at a Level 1 PRC, 80 percent incurred a combat-related TBI, 96 percent reported at least one pain problem, and 44 percent reported experiencing PTSD [5]. Clark and colleagues discussed the complex array of pain issues and the challenges related to the reliable assessment and care management of servicemembers being seen in the PRC [14]. Lew et al. found that in a sample of the first 62 patients evaluated at a Level 2 PNS, 97 percent reported three or more PPCS (i.e., headache, dizziness, fatigue), 97 percent complained of chronic pain, and 71 percent met criteria for PTSD [4]. Taken together, these studies underscore the high prevalence rates of these conditions among the most severely injured servicemembers from the wars in Iraq and Afghanistan.

However, no study to date has reported the extent to which these three conditions occur in combination with one another. This study examines the coprevalence rates of chronic pain, PTSD, and PPCS in returning OIF/OEF veterans referred to a Level 2 PNS. When chronic pain was present, additional analyses were performed to identify the specific pain sites.

METHODS

After obtaining approval from the local institutional review board, we systematically reviewed the VA Computerized Medical Record System for 340 OIF/OEF veterans seen at a PNS between January 1, 2007, and October 27, 2008 (22 months). All 340 OIF/OEF veterans enrolled for care in this setting during the period were included in the analyses.

Every OIF/OEF returnee's first point of contact with any VA clinic would automatically trigger an electronic clinical reminder for TBI screening. The screening includes (1) history of injury events that may increase risk for TBI, (2) symptoms related to alteration of consciousness appearing immediately after the traumatic event, (3) new or worsening TBI symptoms after the traumatic event, and (4) persistence of these symptoms into the present. The presence of all four screening criteria constitutes a "positive TBI screen" and an automatic referral to the local PNS for further evaluation. The PNS typically comprises a

physiatrist, a neuropsychologist, a nurse, a case manager/clinical coordinator, a physical therapist, a speech-language pathologist, and an occupational therapist. Following clinical evaluation by the physiatrist and case manager/clinical coordinator, other members of the team were consulted as needed. For this project, each medical record was individually reviewed by an independent PhD-level clinical psychologist with training and expertise in the assessment and diagnosis of chronic pain, PTSD, and PPCS. The data obtained for this study were based on the second-level TBI comprehensive evaluation conducted by the designated physiatrist of the PNS. Only formal diagnoses reached by the physiatrist of the PNS and placed in the structured progress note were included in the study analyses. Chronic pain was defined as persisting reports of pain in one or more parts of the body for more than 3 months after onset [15]. The diagnosis of PTSD was reached based on criteria established by the American Psychiatric Association [9]. For this study, PPCS was defined by the presence of an initial TBI (evidence of exposure to a trauma that resulted in an initial alteration or loss of consciousness with partial or total amnesia for the events immediately preceding and/or following the event), followed by three or more PPCS lasting for more than 3 months postinjury [16]. The categories of pain locations used for this study were obtained from a previous study defining the characteristics of returning veterans [4].

RESULTS

We conducted frequency analyses to determine the extent to which chronic pain, PTSD, or PPCS was diagnosed in our sample of OIF/OEF veterans. The results indicated that of the 340 veterans in our sample, 12 (3.5%) did not meet criteria for chronic pain, PTSD, or PPCS. Our results indicated a high prevalence of all three conditions in the sample, with chronic pain, PTSD, and PPCS being present in 81.5, 68.2, and 66.8 percent, respectively. As shown in **Figure 1**, the frequency at which these three conditions were present in isolation was significantly lower than the frequency at which they were present in combination with one another ($c^2 = (2, N = 340) = 33.88, p > 0.001$). In fact, analyses demonstrate that 42.1 percent of the sample was diagnosed with all three conditions simultaneously.

Given the high prevalence of chronic pain in this sample, we conducted additional analyses to determine the most common locations of chronic pain symptoms reported. As summarized in **Figure 2**, the most common chronic pain locations were the back (58%) and head (55%). These were followed by chronic pain involving the shoulder (21%), neck (19%), and knee (18%).



DISCUSSION

The results of this study are consistent with previous research describing the high rates of chronic pain, PTSD, and PPCS in OIF/OEF veterans at a Level 2 PNS [4]. Our observation of a different rate of PPCS in our sample compared with the results of other studies may reflect variations in the OIF/OEF population sampled or individual differences in the criteria employed in the various settings. Despite the differences, data from the present study clearly demonstrate the extent to which chronic pain, PTSD, and PPCS overlap with one another. Consistent with Lew et al., the results of this study also support that back pain and headache are the most common pain symptoms reported by OIF/OEF veterans [4]. These results are clinically significant because they underscore the complexity of presenting complaints in returning servicemembers and veterans, which would support the importance of a multidisciplinary team approach to these patients' assessment and treatment [17-18].

Closer inspection reveals that many symptoms and problems associated with chronic pain, PTSD, andPPCS overlap. For example, poor concentration is often associated with both PTSD and PPCS, while depressed mood is common in both chronic pain and PTSD. This overlap can challenge a clinician's

ability to accurately attribute symptoms and arrive at an accurate diagnosis. It may also make choosing the most appropriate treatment plan difficult, which can subsequently result in decreased treatment efficacy and patient satisfaction. Therefore, it is critical that clinicians and researchers work as a team to integrate their understanding of the relationships among these problems so that treatment can be appropriate and well-coordinated.

The ways in which chronic pain, PTSD, and PPCS may interact with one another warrant further investigation. For example, sleep issues, cognitive problems, or emotional issues associated with PTSD may negatively impact one's ability to cope with PPCS. Similarly, PPCS are likely detrimental to factors that increase one's resilience in overcoming PTSD or adaptively coping with a chronic pain condition. In a similar manner, the experience of a chronic pain flare-up may trigger PTSD-related thoughts, while PTSD symptoms such as hyperarousal may increase pain intensity [19-20]. Research funded by VA Rehabilitation Research and Development is currently investigating the efficacy of an integrated approach to the psychological management of chronic pain, PTSD, and PPCS. More translational research is needed to better understand the interrelationships among chronic pain, PTSD, and PPCS and the ways in which existing evidence-based treatments can be modified to meet the needs of these veterans.

The results of this study have clinical applications because the data revealed not only the individual occurrence rates but also the level of coprevalence of chronic pain, PTSD, and PPCS among OIF/OEF returnees at a VA facility. While the sample size of this study ($n = 340$) is larger than that of a recent report on the PNS patient population ($n = 62$) [4], several limitations bear mentioning. During the chart review for this study, we did not differentiate "upper" from "lower" back pain. However, in the updated TBI PNS clinical evaluation template, back pain is differentiated into upper and lower back pain. It is likely that once back pain is subcategorized into lower and upper areas, headache will be the number one complaint for pain. Another limitation of this study is that it did not assess for the presence of substance abuse or dependence, which are likely important issues for OIF/OEF veterans. Finally, while the International Classification of Diseases-Revision 9 criteria related to the diagnosis of chronic pain are quite clear, PPCS and PTSD may be challenging to diagnose and differentiate. Follow-up studies should consider using validated measures of PTSD (e.g., Clinician Administered PTSD Scale [21]) and neuropsychological assessments of PPCS when attempting to replicate or validate the results of this study.

It is important to consider that some OIF/OEF returnees have other health insurance plans and thus do not seek healthcare through the VA. Of those veterans who have sought healthcare with the VA and completed the TBI screening questionnaire, approximately 20 percent have answered positive to all four screening questions.[2] Our data represent only those veterans who answered positive to all four screening questions, agreed to undergo further evaluation, and then completed a comprehensive evaluation at the PNS. The data did not include those veterans who declined the recommended evaluation after a "positive TBI screen" or those who agreed to further evaluation but did not show up to the clinic. The healthcare needs of these veterans remain to be explored. Thus, we must (1) provide follow-up care to those veterans who presented to the PNS clinic with physical, cognitive, or emotional issues, and (2) reach out to those not represented in this study to determine effective ways of delivering assistance to veterans who may potentially be in need of help.

CONCLUSIONS

The results of this study suggest that the polytrauma clinical triad of chronic pain, PTSD, and PPCS is highly prevalent among OIF/OEF veterans seeking healthcare through the VA. The data also indicate that each of these problems rarely occurs by itself; in fact, the three conditions most often occur in combination with one another. Overall, healthcare providers and researchers who specialize in helping OIF/OEF veterans will need to work together to gain a broader understanding of how the experience of war-related injury has affected our returning soldiers, to recognize the importance of treating the entire person rather than a particular disorder, and to prioritize the development of innovative and effective treatment approaches for this population.

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Go to TOP

Go to the Table of Contents of Vol. 46 No. 6

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EXHIBIT 4: Alexandra Liedl & Christine Knaevelsrud, *Chronic pain and PTSD: the Perpetual Avoidance Model and its treatment implications*, Torture, No. 2, Vol. 18, (2008)

SCIENTIFIC ARTICLE

Chronic pain and PTSD: the Perpetual Avoidance Model and its treatment implications

Alexandra Liedl, DiplPsych*, ** & Christine Knaevelsrud, DrPhil DiplPsych*,***

Abstract

Posttraumatic Stress Disorder (PTSD) and chronic pain are frequently seen in the aftermath of a traumatic experience. Torture survivors have an increased risk to suffer from these two disorders. Although many studies report high comorbidity, there is still insufficient knowledge on the mechanisms of the development and maintenance of PTSD and chronic pain.

After providing an overview of the current literature concerning the comorbidity of these two disorders, we will present the "Perpetual Avoidance Model" (PAM). This model provides an explanation of the reciprocal maintenance of both disorders and offers treatment implications.

Keywords: torture survivors, chronic pain, PTSD, comorbidity, Perpetual Avoidance Model

Introduction

Chronic pain as a posttraumatic disorder in torture survivors

The experience of torture is related to a wide array of psychological and somatic consequences. A frequently diagnosed disorder in the aftermath of these man-made traumatic experiences is Posttraumatic Stress Disorder (PTSD). PTSD is characterized by symptoms of reexperiencing the traumatic event, avoiding reminders of the trauma and hyperarousal. According to a review of PTSD in civilian adult survivors of war trauma and torture from Johnson and Thompson,[1] the prevalence of PTSD in refugee torture victims ranges from 14 to 92%.

Besides PTSD, the experience of pain is one of the most frequent complaint of torture survivors. In a study with Buthanese refugees Van Ommeren et al.[2] found that 84% of the tortured group reported one or more somatic complaints. The most common pain is headache, from 39%[3] to 93%[4] and back/neck pain from 60%[5] to 87%.[3] Frequently, patients suffer from multiple pain sensations[6] lasting over decades. In a follow-up study with torture survivors in Denmark, Olsen et al.[7] even showed an increase of prevalence over 10 years: 58% still reported pain in the head (compared to 48% at baseline) and 76% in the back (compared to 48% at baseline).

For an understanding of the high prevalence of chronic pain in torture survivors, several factors have to be taken into account. Rasmussen et al.[8] examined in their study the chronic pain and associated symptoms

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and the possible torture techniques causing them. One typical consequence from suspension by the arms, for example, is pain in the shoulder, upper arms and neck. Not surprisingly, pain is a direct result of the pain-inflicting torture experiences. Besides pain as a direct sequel of torture, many survivors suffer from another type of chronic pain. Due to their traumatic experiences they live with a persistent state of high arousal, because of flashbacks (also nightmares) and memories of the traumatic event. In addition, the health status of tortured refugees is influenced by multiple stressors such as leaving family members behind, an insecure asylum status and the exile situation. Clinical experience has shown that these persons respond with a heightened psychophysiological response (e.g. heart rate, muscle tension) to trauma-related as well as more general environmental stimuli. This contributes to increased pain mainly in the neck, shoulders or in the back.

As many traumatized suffer from both disorders, we will now give an overview of the comorbidity-rates of PTSD and chronic pain.

Comorbidity of chronic pain and PTSD

The comorbidity of chronic pain and PTSD was repeatedly shown across different populations. In studies with war veterans up to 80% of those suffering from PTSD also reported symptoms of chronic pain.[9,10] In a study with psychiatric outpatients Villano et al.[11] found that 46% met the criteria for PTSD (according to DSM IV), 40% reported chronic severe pain and 24% had both disorders.

In a large community sample with N = 36,984 Sareen et al.[12] showed a considerable discrepancy with regard to chronic pain between patients with and without a PTSD diagnosis. In patients suffering from PTSD 46% also reported chronic back pain (compared to 21% without PTSD) and 33% reported migraine (compared to 10%).

The prevalence of pain in PTSD samples is, according to Otis, Keane and Kerns,[13] 34-80% substantially higher than the PTSD prevalence in pain patients ranging between 10% and 50%. This difference may be explained by the fact that many traumatic events are associated with physical injury. Norman et al.[14] examined 115 patients at the Trauma Center of the University of California San Diego. It emerged that peritraumatic pain is a risk factor for PTSD. According to the authors, the relationship can be explained by a mediation effect: peritraumatic pain may lead to more negative evaluations of the trauma memory and more distress associated with the traumatic event.

Dirkzwager et al.[15] investigated the way in which PTSD may influence the development and the chronification of pain symptoms. With a longitudinal study on survivors of a firework disaster in the Netherlands, the authors conclude that PTSD may be a potential risk-factor in the development of physical health problems: 18 months in the aftermath of the disaster PTSD survivors reported more pain symptoms and more restrictions in their daily life because of physical problems compared to those who show no PTSD symptoms.

For a better understanding of the relationship and the reciprocal maintenance of PTSD and chronic pain it is necessary to take a closer look at the risk factors for the development of the two disorders.

Risk factors for PTSD and chronic pain

Brewin et al.[16] identified in a meta-analysis with 85 studies the following variables as predictors for PTSD: the intensity of the traumatic event and posttraumatic factors like missing social support and additional

life stress. In addition being female, prior trauma and history of psychopathology emerged as risk factors. Empirical evidence shows that the substantial discrepancy between the lifetime-prevalence of a traumatic experience (over 50%) and the lifetime-prevalence of PTSD (about 7%) can be largely explained by the nature of the traumatic event: individuals who experience a man-made traumatic event (e.g. rape) are more likely to develop PTSD than victims of natural disasters (e.g. earthquake or hurricane).[17]

Furthermore, individuals who experience a trauma that included bodily injury like torture survivors show an eight times higher risk for development of PTSD than individuals who experienced traumatic events without physical injury.[18] Similar results were found in a study with Iraq war veterans.[19] Of those veterans who were wounded or injured 32% met PTSD criteria, compared to only 14% of those who were not injured. Besides the aforementioned trauma related aspects, cognitive factors have become a key focus in the development of PTSD: the perceived uncontrollability, negative appraisals of the trauma and its consequences and inadaptive control strategies such as avoidance are of crucial importance.[20,21]

As in PTSD, cognitive processes prove to play an important role in the development and maintenance of chronic pain. Empirical evidence suggests that pain related fear is a significant predictor for chronification in pain symptoms. Picavet, Vlaeyen and Schouten[22] investigated the influence of catastrophizing and kinesiophobia (fear of movement/fear avoidance beliefs) on chronic back pain. It emerged that high levels of catastrophizing and fear-avoidance beliefs predicted lower back pain with significant disability at a six months follow up. Woby et al.[23] examined the influence of cognitive factors on perceived pain intensity in chronic pain patients. It turned out that self-efficacy and catastrophizing explained 30% of the variance in pain intensity. In addition, research revealed that it was not the severity of injury which was associated with back pain but rather psychological and social factors such as stress that predicted chronic pain. These aspects increase the likelihood for the development of pain up to 13 times.[24, 25] As refugees have a higher risk for psychosocial problems, these results may be especially relevant to this group.

The fact that all studies mentioned above are cross-sectional implicates that the direction of causality stays ambiguous. Although the chronification of pain is a very complex and multifactorial problem with interrelationships of somatic, psychological and social factors, cognitive factors and the avoidance aspect emerged as crucial aspects in the development of chronic pain and PTSD.

To specify the mechanisms of PTSD and chronic pain development after a traumatic event, below we will discuss the most important models concerning PTSD and pain development. Furthermore empirical data examining the development of pain after traumatic events will be presented.

Development and maintenance of PTSD and chronic pain

One of the most cited PTSD models is the well-established and validated model of Ehlers and Clark[21] which attributes cognitive processes a crucial role. According to this model, negative appraisals of the trauma and its consequences and certain characteristics of the trauma memory (such as poor elaboration and integration, strong priming and associative learning) predict the development of PTSD in the aftermath of a traumatic event. For the maintenance of PTSD, the authors suggest cognitive and behavioural

aspects such as avoidance of trauma reminders or safety behaviours that individuals use to control the threat and symptoms.

For chronic pain, the fear avoidance model[26] is one of the most important models. It offers a mechanism of how the development from acute pain to chronic pain can be explained and how the avoidance aspect plays a crucial role. The model stresses the role of catastrophic interpretations following a pain experience and subsequent fear and hypervigilance. The fear that physical activity will cause harm and therefore worsen the pain problem leads to avoidance of activity. Research supports that fear avoidance beliefs are strongly related to chronic pain and disability.[27]

Concerning the development of pain in the aftermath of a traumatic event, it is important to note that the crucial factor, and a better predictor for the development of pain, is not the trauma alone but PTSD.[24,28] Tagay et al.[29] found in a study (N=483), that patients suffering from PTSD showed significantly more somatoform symptoms than traumatized patients without a PTSD diagnosis. Hoge et al.[19] examined the association of PTSD with somatic symptoms among Iraq war veterans and found that all health measures (e.g. poor self related health, two or more sick call visits, somatic symptoms) were strongly associated with PTSD, even after controlling injury sustained in combat. One third of the soldiers who screened positive for PTSD had high somatic symptom severity. Campbell and colleagues[30] revealed in their study with female veterans (N=268) that PTSD fully mediated the relationship between violence and physical health symptomatology.

On the basis of the well-established models and the aforementioned findings, we developed the Perpetual Avoidance Model (PAM)[31] which provides an explanation for the development and mutual maintenance of PTSD and chronic pain. The single components and their interaction will be presented in the following section.

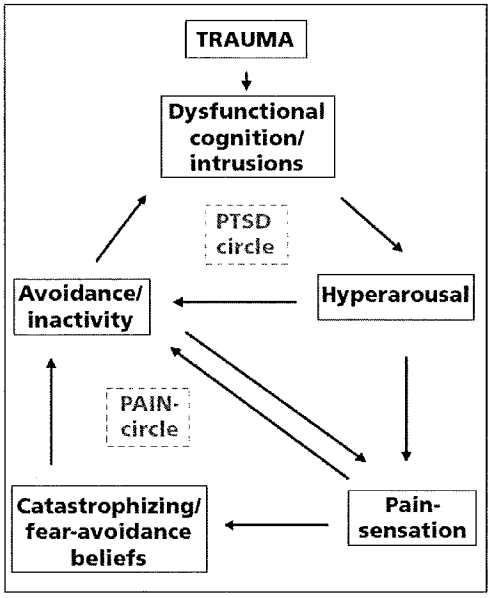


Figure 1. *The Perpetual Avoidance Model (Liedl & Knaevelsrud).*

The Perpetual Avoidance Model

As can be seen in Figure 1, the PAM consists of two circles: the PTSD and the PAIN circle.

According to the PTSD model of Ehlers and Clark[21] cognitive, affective and behavioural aspects are taken into consideration in the PTSD circle. Dysfunctional cognitive processing during and in the aftermath of the traumatic event leads to an increase of psychological and physical arousal. Flashbacks or intrusive memories with a "here and now" quality increase the (bodily) arousal in form of increased heart rate, blood pressure, muscle tension and gastrointestinal activity. These physiological

symptoms result in avoidance. Moreover, hyperarousal may directly increase pain sensation and reinforce negative beliefs and fears that activities will be painful. The consequence of these misinterpretations (fear avoidance beliefs) is the avoidance of movements or activities. The inactivity responds on the perceived pain sensation and vice versa. The PAIN circle results in increased avoidance and eventually leads to inactivity and depression.

To empirically validate the PAM, we will subsequently present a number of studies which examine the interactions of the different components of the PAM.

The link between PTSD and psychophysiological variables such as hyperarousal indicated by muscle tension, heart rate, skin conductance or blood pressure is well proven (for a review see Pole[32]). According to Blechert et al.[33] PTSD related hyperarousal is significantly related to high sympathetic activity (e.g. increased heart rate) with parallel low parasympathetic cardiac control. The important role of the sympathetic nervous system in pain patients is also well known. A study with chronic back pain patients (N=39) conducted by Gockel et al.[34] revealed a significant association between heart rate variability and perceived physical impairment. As McFarlane[35] pointed out in his article about stress related musculoskeletal pain, protective muscular activity can emerge after a traumatic event and escalate into a cycle of neck pain and headaches. Wall & Melzack[36] argued that the association between emotional stress and increased pain severity can be explained by increasing activity in the central nervous system, autonomic nervous system and musculoskeletal system.

The key aspect of avoidance in the development and maintenance of PTSD is discussed in the review by Nemeroff et al.[37] on the basis of a study conducted by North et al.: North and colleagues examined psychiatric disorders among survivors of the Oklahoma City bombing (N=182). They showed that despite the fact that only 36% met the criteria for avoidance symptoms (over the first six months after the disaster), 94% of those had a diagnosis of PTSD.

Taking into consideration the dysfunctional cognitions, there is much evidence for their influence on pain-sensation (for review see Tunks, Weir & Cook[38]). In a study with chronic pain patients (N=156) Turner et al.[39] found that cognitive variables such as changes in pain beliefs, catastrophizing, pain self-efficacy and perceived controllability turned out as mediators for the improvement in pain and activity one year after a cognitive behavioural therapy. Furthermore a substantial body of empirical evidence emphasizes the crucial role of fear avoidance beliefs in chronic pain patients (e.g. Leeuw et al., 2007). Grotle, Vollestad & Brox[40] showed in a prospective cohort study (N=173) of acute and low back pain that patients with chronic low back pain had more fear avoidance beliefs than patients with acute low back pain.

The Perpetual Avoidance Model offers different treatment implications. Based on these components of the PAM that are assumed to be responsible for the maintenance of both disorders the authors propose specific interventions that might be useful to integrate into the treatment of PTSD and chronic pain.

Treatment implications

An important and one of the first components in treating traumatized patients with chronic pain should be a theoretical model educating them about the relationship between chronic pain and PTSD. The understanding of the function of cognitive and behavioural avoidance and the interaction of

hyperarousal, catastrophizing, avoidance and pain perception is of crucial importance.

Cognitive and behavioural avoidance/ inactivity as part of the PTSD circle and as part of the PAIN circle play a significant role in the PAM. Therefore an important aim in treating PTSD and chronic pain should be to break the vicious circle of mutual maintenance by reducing the avoidance. Well-tested and standard treatment methods for PTSD are exposure strategies. In confronting patients with their traumatic and feared experiences patients learn to reinterpret the situation and see it as part of their past. The "here and now" quality of the reminders will be changed and integrated in the autobiographical memory.

Exposure strategies are also helpful in treating chronic pain: pain patients are invited to engage in physical activities that were previously avoided because of fear of causing more pain. The exercises should be designed to help patients focus and cope with uncomfortable physiological sensations and reduce fear avoidance beliefs (e.g. "Physical activity might harm my back"). These experiences help patients to restructure misinterpretations and catastrophizing and get out of the inactivity. Maquet and colleagues[41] highlighted in their review the vicious cycle of pain and avoidance/ inactivity behaviours. Based on several studies they affirmed the benefits of physical exercises for pain patients on parameters like pain-threshold, well-being, self-confidence and feelings of helplessness. Consequently physical activity can help to break the vicious circle of chronic pain and inactivity.

For reducing the general high somatic arousal, relaxation techniques such as Progressive Muscle Relaxation or diaphragmatic breathing are helpful treatment approaches. In combination with biofeedback, a well established treatment method with pain patients, patients learn to influence internal physiological responses. Thereby they gain control over their body and increase the sense of self-efficacy. One of the most common types of biofeedback is Electromyography (EMG): the muscle tension in the pain area is measured and recorded back (visual or auditory) to the patients. In a first step they become aware of internal biological activity such as muscle tension and body reactions in different situations (stressful/ trauma situations versus relaxed situations). In a second step, patients learn to reduce their high tension and thus to control their pain experience. Moreover the positive effects should be supported by physical activation: fitness exercises can help patients to improve body awareness and general well being.

With these treatment methods all crucial elements of the PAM PAIN circle will be addressed: hyperarousal and pain sensation (relaxation techniques), catastrophizing and avoidance (biofeedback, physical activation). Because of the overlapping elements in the PTSD and PAIN circle (hyperarousal and avoidance) the aforementioned treatment methods are also helpful for the improvement of the PTSD symptomatic.

An effective therapy for traumatized patients suffering from PTSD and chronic pain should therefore combine psychoeducation of the development and maintenance of PTSD and chronic pain and biofeedback with exposure-strategies, relaxation techniques and physical activation.

The advantage of a physiologically oriented intervention such as biofeedback can be very helpful in treating refugees from non-Western cultures. These patients tend to have a rather somatic understanding of illness. It is essential to take this into account by applying a physiologically oriented intervention. The presented treatment methods

– a combination of biofeedback, exposure strategies and relaxation techniques – is therefore a very promising therapy for tortured refugees, suffering from PTSD and chronic pain. The Treatment Center for Torture Victims in Berlin – in cooperation with the University of Zurich, the University of Dresden and the University of Southhampton – is examining a biofeedback-based cognitive behavioral therapy for traumatised refugees with chronic pain that combines the mentioned components.[42] Preliminary data of a pilot study show promising results.[43]

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SCIENTIFIC ARTICLE

Asylum seekers in Denmark

A study of health status and grade of traumatization of newly arrived asylum seekers

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This article is translated from the report "Asylansøgere i Danmark – en undersøgelse af nyankomne asylansøgeres helbredstilstand og traumatiseringsgrad" published by Amnesty International Danish Medical Group, Amnesty International, www.amnesty.dk.

Abstract

Background: An unknown number of asylum seekers arriving in Denmark have been exposed to torture or have experienced other traumatising events in their country of origin. The health of traumatised asylum seekers, both physically and mentally, is affected upon arrival to Denmark, and time in asylum centres leads to further deterioration in health.

Methods: One hundred forty-two (N=142) newly arrived asylum seekers were examined at Center Sandholm by Amnesty International Danish Medical Group from the 1st of September until the 31st of December 2007.

Findings: The asylum seekers came from 33 different countries, primarily representing Afghanistan, Iraq, Iran, Syria, and Chechnya. Of the asylum seekers, 45% had been exposed to torture – approximately one-third within the year of arrival to Denmark. Unsystematic blows, personal threats or threats to family, degrading treatment, isolation, and witnessing torture of others were the main torture methods reported. The majority of the asylum seekers had witnessed armed conflict, persecution, and imprisonment. The study showed that physical symptoms were approximately twice as frequent and psychological symptoms were approximately two to three times as frequent among torture survivors as among non-tortured asylum seekers. However, even the health of non-tortured asylum seekers was affected. Among the torture survivors, 63% fulfilled the criteria for post-traumatic stress disorder, and 30-40% of the torture survivors were depressed, in anguish, anxious, and tearful in comparison to 5-10% of the non-tortured asylum seekers. Further, 42% of torture survivors had torture-related scars.

Interpretation: Torture survivors amid newly arrived asylum seekers are an extremely vulnerable group, hence examination and inquiry about the torture history is extremely important in order to identify this population to initiate the necessary medical treatment and social assistance. Amnesty International Danish Medical group is currently planning a follow-up study of the present population which will focus on changes in health status during their time in Denmark.

Keywords: torture; health status; post-traumatic stress disorder; physical examinations; interview; Denmark; survivors

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Introduction

In recent years, the number of asylum seekers arriving in Denmark has decreased. Currently, around 2,000 asylum seekers come to Denmark each year.[1] An unknown number of these asylum seekers has been tortured or experienced other traumatising events in their country of origin. Several studies show that the health of traumatised asylum seekers, both physically and mentally, is affected upon arrival in Denmark, and that the waiting time in asylum centres leads to further deterioration of their health.[2-8]

As a result of this knowledge, Amnesty International Danish Medical Group conducted a study, where all newly arrived asylum seekers, who arrived at Center Sandholm, were offered a health examination within the first few days after arrival. The study had two objectives, one was to identify the number of asylum seekers having been exposed to torture, severe war trauma, or other traumatising events prior to their arrival. The second objective was to assess the asylum seekers general health status upon arrival and the health related consequences of exposure to torture. Amnesty International Danish Medical Group consists of doctors, who document torture, both nationally and internationally. The Medical Group has more than 30 years of experience and its members have received specific training enabling them to examine potential torture survivors. The project was conducted in collaboration with the Danish Red Cross. All medical examinations were performed at Center Sandholm.

Materials and methods

From the 1st of September until the 31st of December 2007, Amnesty International Danish Medical Group offered a health examination to all newly arrived asylum seekers at Center Sandholm. Center Sandholm is responsible for the registration of all newly arrived asylum seekers in Denmark, except for unaccompanied children under the age of 18 years. Two project coordinators were employed by Amnesty International and worked at Center Sandholm. The project coordinators were responsible for making contact with the newly arrived asylum seekers and for providing general information about the project including information about voluntary participation, anonymity of identity, and confidentiality of data collected by Amnesty International Danish Medical Group. Written information about the project had been prepared in seven different languages (available on request), with the intention that most asylum seekers should be able to read the information in their mother tongue. During the medical examination the asylum seeker received additional information about the project and if they wished to participate they gave their written informed consent.

If written material or consent form was not available in the mother tongue of the asylum seekers, a translator was used and an English or Danish consent form was used. The routinely used Red Cross' telephone translators in the Center Sandholm were used during the vast majority of the medical examinations. Translators were not used if the asylum seeker and the examiner were able to communicate in the same language. The study intended to include all newly arrived asylum seekers regardless of age, however all children under the age of 18 were required to have a parent or a guardian present during information and examination. Unaccompanied children were not examined.

The medical examination lasted on average one hour and took place in Center Sandholm's medical examination rooms. The medical examination consisted of a structured interview (questionnaire available

on request), which sought to disclose the following information:

- Background (age, country of origin etc.)
- Imprisonment, torture and other traumatising events
- Health status prior to traumatizing event
- Current physical and psychological symptoms
- Self rated psychological health status
- Current use of medicine and abuse
- Objective physical and psychological health status

The definition of torture and the medical examination were based on the principles described in the United Nation's "Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment".[9] The World Health Organization's (WHO) International Classification of Disease Codes (ICD-10)[10] was used for diagnosing Posttraumatic Stress Disorder (PTSD).

The WHO's General Health Questionnaire was used for the self-judged psychological health status.[11,12] Scores vary by study population. Scores about 11-12 are typical. A score >15 is evidence of distress. A score >20 suggests severe problems and psychological distress.

In both the physical and psychological examination of the asylum seekers, emphasis was placed on finding a connection to torture sequel.

No advanced investigations, such as for example gynaecological examinations or radiological examinations, were carried out.

Ethics

The project was reported to the local ethical committee in June 2007. The committee had no objection to the execution of the project. The project was also reported to the Danish Data Protection Agency. The considerations of Amnesty International Danish Medical Group in relation to the present project are based on the following ethical codes and protocols: The International Code of Medical Ethics,[13] the Helsinki Declaration,[14] and the ethical protocol described in the United Nation's "Istanbul Protocol".[9]

The medical interview conducted by the doctors within Amnesty International Danish Medical Group had no curative purpose, however, if during an examination the doctor found that an asylum seeker needed medical treatment, the doctor contacted the health personnel at the Red Cross after having received verbal consent from the asylum seeker in order to let the Red Cross initiate the appropriate diagnostic and treatment.

All asylum seekers exposed to torture can free of charge have a more detailed medical examination done by the Amnesty International Danish Medical Group. The medical report can be used as documentation in their asylum case.

The Amnesty International Danish Medical Group is financially independent and all asylum seekers and doctors have participated voluntarily in this study.

The asylum seekers were informed that Amnesty International and Danish Red Cross are politically independent organizations and that participation in the project would have no consequences for the asylum seekers' asylum case in Denmark.

Results

According to The Ministry of Refugee, Immigration and Integration Affairs in Denmark, 720 asylum seekers arrived in Denmark during the project period.[1] Amnesty International's project coordinators were in contact with 164 asylum seekers at Center Sandholm during the project period. Four

EXHIBIT 5: Dorte Reff Olsen, Edith Montgomery, Jessica Carlsson, Anders Foldspang, *Prevalent Pain and Pain Level Among Torture Survivors Danish*, Medical Bulletin - No. 2, Vol. 53 (May 2006)

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original article

Prevalent pain and pain level among torture survivors:

A follow-up study

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Abstract

Aim: To estimate change over nine months and over two years, as concerns the prevalence and level of pain in the head, back and feet, among previously tortured refugees settled in Denmark, and to compare associations between torture methods and the prevalence of pain at baseline and at follow-up.

Methods: Sixty-nine refugees previously exposed to torture in their home country were interviewed at a Danish rehabilitation clinic. Fifty-four accepted to be re-interviewed after nine months, and 47 were interviewed again 14 months later. Interviews focussed on the history of exposure to physical and mental torture and on pain in the head, back and feet at baseline and at follow-up.

Results: The mean cumulative duration of imprisonment was 1.7 years, and on the average more than 10 years elapsed between torture and examination. The most frequent physical torture method reported was beating (97%), whereas the main mental torture method was threats of death (97%). The prevalence of pain reported at the follow-up interviews did not differ significantly from that reported at baseline (pain in the head, 81% at baseline and 77% at 23-month follow-up; back, 78% and 81%; feet, 59% and 70%). The same pattern was found when examining the level of pain as indicated by Visual Analogue Scales. Pain in the feet at follow-up was associated with previous exposure to beating against the feet. Pain in the back at baseline and pain in the head at follow-up were associated with suffocation.

Conclusion : More than ten years after the torture took place, survivors of torture continue to suffer from pain associated with the type of torture they had been subjected to. This presents a considerable challenge to future evidence-based development of effective treatment programmes.

Introduction

Pain of the musculo-skeletal system (prevalence up to 48%), headache (38-50%), pain in the back (up to 43%), pain in the feet (19-28%), and joint pain (19-43%) are examples of frequently reported somatic symptoms among previously tortured refugees (1-3). Published studies on the association between refugees' health and exposure to violence and torture are mainly cross-sectional and the time from exposure to violence till examination thus varies among included refugees. Such studies have documented a high prevalence of mental (4, 5) as well as somatic (1-3, 6) complaints associated with the exposure, even if it happened many years before study.

The published literature based on follow-up designs is, however, extremely scant. We were only able to identify four studies involving cohorts of persons previously exposed to conditions of war, organised violence and torture, with the aim to describe the course of the symptoms. Three of these studies (7-9) dealt with mental symptoms, which were followed-up after three years. In the fourth study, Hermansson et al (10= followed a group of 44 war-wounded refugees for eight years and found that about 3/4 had chronic pain at follow-up as compared to less than 2/3 six years before. The increasing prevalence found may indicate either a less outspoken contact with the health care system or a lack of curative success, or it may be an effect of selection for study participation. Moreover, as we have not been able to identify any randomised controlled studies focussing on the treatment of torture victims' somatic symptoms, a possible effect of curative or rehabilitative interventions still seems undocumented.

In accordance with the overwhelming need for basic scientific documentation on the course of somatic symptoms, the aim of the present study was to estimate the change over approximately two years as concerns the prevalence and level of pain in the head, back and feet among previously tortured refugees, and to identify and compare associations between torture and the pain reported at the initial contact with a rehabilitation clinic, and pain prevalent nine months and two years later.

Material and methods

Participants

The study includes 97 refugees who were consecutively accepted for examination at the Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen, Denmark from 1 January 2001 to 15 May 2002. The refugees were referred to RCT by their general practitioner. Nineteen (20%) turned out not to have been exposed to torture previously, six refugees (6%) refused to participate and three were excluded because of incomplete data, which left 69 (71%) participants for the baseline interview. Of the 69 refugees one (2%) died during the follow-up period, 11 (16%) refused further participation and another three (4%) refugees were excluded because of incomplete data, which left 54 (78%) participants for the first follow-up interview. Of these 54 refugees 47 (87%) participated in the second follow-up interview (five (9%) refused to participate and two (4%) were excluded because of incomplete data).

Participants of the baseline interview differed significantly from non-participants as concerns the distribution of gender (82% male vs. 35% female participated, OR male gender 8.80, $p < 0.001$), whereas no significant difference was found as concerns age. Relatively frequent participation (at baseline interview, 81%, OR 5.27, $p < 0.001$; at first follow-up interview, 85%, OR 6.53, $p < 0.01$) was found among refugees who, after the initial examination, were offered treatment at the RCT. Refugees who reported headache at the first follow-up interview participated frequently in the second follow-up interview (participation 93%, OR 6.50, $p < 0.05$).

Data

Demographic data (age, gender and present citizenship) and data on previously experienced traumatic conditions and events (arrest and detention, exposure to torture, living under conditions of war, serving as a soldier at war, being a refugee in the home country, residing in a refugee camp, being subjected to house search) were collected at the RCT examination by a specialist in psychiatry with special expertise in examining torture victims. Information on the refugee's physical health was collected by three interviews: (a) a baseline interview and (b) on the average 9.2 months

(range 7-15) and (c) 22.9 months (range 20-25) thereafter. The repeated pain questionnaire included pain in the head, back and feet during the preceding 24 hours and the pain level "most of this time span" in the three loci, measured by a Visual Analogue Scale (VAS) ranging from 0 (no pain) to 100 (worst conceivable pain). Authors DRO and JC collected the baseline and 9-month data, and a bilingual (Danish and Arabic) research assistant collected the 23-month data, in both instances supported by an interpreter when necessary. All data were collected by use of assisted self-administered questionnaires developed for the study. Questionnaires were translated and back translated into Arabic and Persian by bilingual interpreters; oral translation was used for other languages.

Analysis

To examine changes in proportions of prevalent pain, McNemar's ? 2 -test for two dependent groups was used, and Wilcoxon Signed Ranks Test was applied to test changes in VAS-scores between the three interviews. Furthermore, the statistical analysis applied ? 2 tests for the 2 × 2 table and Odds Ratio (OR) estimation and bivariate and multiple logistic regression to identify associations between exposure to torture and pain.

Information on pain in the head, back and feet, prevalent at the three interviews, functioned as dependent variables. Two different types of relationships were analysed: (a) the association between independent dichotomous torture variables and pain (presented in tabular form), and (b) the association between independent continuous torture variables and pain (significant results presented in text). To avoid overloading of the models, the number of candidate predictors for multiple regression was reduced by use of the bivariate analyses, so that only variables significant at $p < 0.10$ level were included in the multiple regression. Furthermore, indicators of torture previously documented to be associated with pain were included (11). To adjust for confounding, age, gender and - in order to correct for cultural variation - present citizenship were included in all multiple regression analyses. The ? 2 distributed Wald statistic was used as significance test in the analyses, and $p < 0.05$ was applied as final level of significance. Model fit was estimated by use of the Hosmer and Lemeshow statistic (12).

The project complies with the Helsinki II declaration. Participants signed an informed consent form. The Regional Committee for Ethics in Medicine and the Danish Data Protection Agency approved the study and its database.

Results

Demographic information

Of the 69 tortured refugees, 61 (88%) were male and eight (12%) were female. The mean age at initial contact was 38.4 years (range, 19-66 years). Thirty-three refugees (48%) had present citizenship in Iraq (Denmark, 15 refugees (22%); Afghanistan, six (9%); other citizenship, 15, (22%)).

History of imprisonment and torture

The mean number of years imprisoned was 1.7 (range, 0-14 years), and the mean duration from the final release to the examination at RCT was 10.6 years (range, 1-27 years).

Before emigration more than nine out of ten had their home searched by armed forces, and nearly half of the refugees had been soldiers at war or armed conflict (Table 1). Almost all had been exposed to beating and more than half to forced positions (e.g. cramped confinement in a cage) and electrical torture. About one third reported burning and suffocation. Also more specific loci like beating of the soles of the feet (falanga) were experienced by most of the refugees. As concerns mental torture methods, nine out of ten reported threats of death, and nearly two thirds had witnessed the torture of fellow prisoners.

Prevalent pain and pain level

No significant difference was found as concerns reporting of pain at the three interview times, neither in the head, back nor feet (Table 2). Thus, 77% reported pain in the head at the 23-month follow-up vs. 81% at baseline interview (p=1.000); 81% reported pain in the back at 23-month follow-up vs. 78% at baseline (p=1.000), and 70% reported pain in the feet at 23-month follow-up vs. 59% at baseline (p=0.092).

As indicated by use of VAS, no significant pain level difference was found between baseline and follow-up in any of the three loci of the body (Table 3). Thus, the mean VAS-score for pain in the head was 52 at 23-month follow-up vs. 58 at baseline (p=0.317); for pain in the back the mean was 54 at 23-month follow-up as contrasted to 61 at baseline (p=0.107); and the mean VAS-score was 46 for pain in the feet at 23-month follow-up vs. 44 at baseline (p=0.403).

Treatment

Of the 69 refugees interviewed at baseline, 58 (84%) were offered and received a multidisciplinary treatment at RCT consisting of individually adjustable medical assistance, physiotherapy, psychotherapy and social counselling.

Prevalent pain and imprisonment and torture

Based on multiple regression, pain in the head at 9-month follow-up was found to be positively correlated with previous exposure to suffocation during torture (Table 4). Pain in the head was un-associated with other indicators of torture, such as, the number of torture methods, duration of imprisonment, and duration from final release to examination.

Also pain in the back reported at baseline was found to be associated with suffocation (Table 4) and - in separate analyses with continuous independent variables - with the number of torture methods exposed to (OR 1.3 per method, $p < 0.025$). Pain in the back at 9-month follow-up was negatively correlated with the duration of imprisonment (OR 0.7 per year, $p < 0.05$).

At baseline, pain in the feet was un-associated with indicators of specific torture methods. As reported at 9-month follow-up, pain in the feet was strongly associated with suffocation and beating against the head and less strongly with mock execution (Table 4). At 23-month follow-up, pain in the feet was significantly associated with previous beating against the feet. Moreover, in the separate analyses with continuous independent variables, pain in the feet reported at baseline and at 23-month follow-up was significantly associated with duration from final release to examination (OR 1.1 per year, $p < 0.025$ and OR 1.1 per year, $p < 0.05$, respectively). At 9-month follow-up, pain in the feet was positively associated with the number of torture methods (OR 1.3 per method, $p < 0.05$).

Discussion

Considering the continuing high incidence of torture in many countries of the world (13), and the prevalence of previous exposure to torture among refugees arriving in Western countries (14-16), the almost total lack of published scientific research focussing on the natural history of health problems following exposure to torture - not to mention the shortage of scientific effect studies - may appear paradoxical. The focus of the present non-experimental study is therefore a mapping of the long-term course of somatic symptoms in torture victims.

The study involved 69 refugees previously exposed to torture mainly in the Middle East. Consequently, results from the study cannot be generalised to other refugee populations without hesitation. Moreover, the participants represent a selected part of the total torture victim population from the countries in question: they survived torture; they escaped or were released from prison; they managed to emigrate from their home country; they were granted asylum in Denmark; and finally they were referred to and accepted for an examination at the RCT, Copenhagen. Accordingly, results cannot be generalised to, e.g., populations of torture survivors continuing to reside in the home country. Such a potential of

complicated selection biases is, however, necessarily inherent in the major part of empirical research concerning refugee populations in Western countries, when it focuses on long-term consequences of torture.

The size of the study population was rather small, and the dropout considerable. Moreover, pain having been observed by use of an identical technique at baseline and at follow-up denotes strength of the study. Furthermore, the intensity of pain was translated to VAS-scores by the client, indicating that most of the reported pain was not negligible. The present observation of continuation of prevalent pain is parallel to the findings among victims of war in the study by Hermansson (10).

Torture survivors may suffer from impaired memory (17, 18), so that concrete details of exposure to torture may be obscure. Moreover, in everyday practice, being ashamed and feeling guilty have presented themselves as - paradoxical - mental sequelae, and in general a not negligible degree of trust will thus be needed for the victim to share the torture experience with other persons (19). This may have influenced the precision of the present information, especially as concerns the type and number of torture incidents reported, enhancing under-reporting rather than over-reporting and possibly leading to bias towards the null-hypothesis. This hesitation especially regards reports of mental, not least sexual torture. The precise impact on associations cannot be estimated readily.

According to the International Association for the Study of Pain, pain is defined as: "An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"(20). Persisting pain may well be explained by modern pain theory; possible pain-generating mechanisms are constituted by persisting peripheral injury in the tortured region and persisting peripheral or central sensitisation ("pain memory") as well as somatisation phenomena (21, 22) Permanent structural changes in pain-generating structures may be the result of beating a locus of the body, as this makes permanent impulse-generation likely, which in turn may lead to a neuropathic pain condition. Central sensitisation ("pain memory") would not need an ongoing process in the periphery to generate a pain experience, and it is possible that both regional and generalised pain conditions can be precipitated through such mechanisms. The term "somatisation" refers to a condition characterised by physical symptoms without an adequate organic or patophysiological explanation. The term is descriptive and does not in itself imply any causal inference (23). Pain may originate from experience of severe stress (24) and lack of control (25).

In the present study, pain in the head, back and feet was found to be associated with exposure to suffocation. In a descriptive study of 18 torture survivors (26), 1/3 of the examined persons had been exposed to asphyxia/submersion, and they reported pain in the head, the low back and the lower limbs. Regardless of whether suffocation is carried out by preventing the victim from breathing by covering his or her face with a plastic bag or by submerging the victim's face in fluid, perpetrators can easily exceed the physical limits that a person can tolerate without air and produce cerebral anoxia, which subsequently may lead to cerebral damages (27-29), and, potentially, to injury of the pain-perceiving parts of the central nervous system. Moreover, emotional distress may elicit sympathetic nervous system discharge resulting in increased muscle tension (21). Following this, pain may become a stressor in itself.

Association of pain in the feet with previous exposure to falanga has been found in only one previous study (1). In our study, exposure to mock execution also predicted pain in the feet, which may indicate a somatising effect, or it may be the result of unveiled exposures. However, overemphasising the mental aspects may result in an imprecise pain diagnosis and thereby less specific and less effective treatment.

The mere amount of exposure to torture was found to be of importance, i.e. the number of torture methods was a positive predictor of pain in the back and pain in the feet. The duration in years from the final release from confinement - and thus from exposure to torture - to examination predicted increased pain in the feet, and this may indicate not only a possible age effect but also a need for early intervention to prevent further pain development. No randomised controlled studies focussing on the treatment of torture victims' somatic symptoms could however be identified to support this.

In multiple regressions, the probability of reporting pain presented itself as a function of rather complicated determinant patterns. When interpreting these patterns one should bear in mind the rather small sample size and the considerable, unavoidably selective dropout. The fact that most significant associations were present at follow-up but not at baseline could be due to dropout over time, which may have introduced a selection bias away from the null hypothesis.

The present results underscore the necessity of the application of strict scientific approaches in the development of curative and rehabilitative interventions targeting torture victims: the symptom prevalence was unchanged in spite of the fact that more than 80% of the refugees underwent comprehensive treatment at the RCT, and the remaining 20% may have been offered treatment at other Danish centres. In the absence of scientific experimental evidence of effect it is, however, not possible to estimate whether the found unchanged prevalence would have been higher without treatment. Considering the high symptom prevalence, it suffices to state that evidently treatment has not substantially reduced the victims' long-term risk of continuing symptoms of pain. Disappointing as this may be, it still remains an open question whether pain following exposure to a varied pattern of torture is actually amenable to any known curative procedure.

In conclusion, in spite of many factors being potentially co-responsible for prevalent pain more than ten years after the torture took place the torture presents itself as associated with specific localisations of pain, with general processes and with potentially somatising processes. This constitutes a considerable challenge to the evidence-based development of effective treatment programmes in the future.

Acknowledgements

The mere amount of exposure to torture was found to be of importance, i.e. the number of torture methods was a positive predictor of pain in the back and pain in the feet. The duration in years from the final release from confinement - and thus from exposure to torture - to examination predicted increased pain in the feet, and this may indicate not only a possible age effect but also a need for early intervention to prevent further pain development. No randomised controlled studies focussing on the treatment of torture victims' somatic symptoms could however be identified to support this.

References

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3. Hondius A, van Willigen L, Kleijn W, van der Ploeg H. Health Problems Among Latin-American and Middle-Eastern Refugees in the Netherlands: Relations With Violence Exposure and Ongoing Sociopsychological Strain. Journal of Traumatic Stress 2000; 13(5):619-634.
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26. Thomsen A, Eriksen J, Smidt-Nielsen K. Chronic pain in torture survivors. Forensic Science International 2000; 108:155-163.
27. Moreno A, Grodin M. Torture and its neurological sequelae. Spinal Cord 2002; 40:213-223.
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Prevalent pain nd pain level among torture survivors:

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Exhibit 22: May 29, 2012 Expert Report of Dr. Stuart Lorin Lustig, M.D., M.P.H. submitted *in camera*.

EXPERT REPORT SUBMITTED

IN CAMERA, APPENDICES ARE ANNEXED HERETO

EXHIBIT A: Curriculum Vitae

CURRICULUM VITAE
Prepared 5/21/12

NAME: **Stuart Lorin Lustig, M.D., M.P.H.**

Position: Regional Medical Director, Cigna Behavioral Health

Address: 445 Scott St. #2
San Francisco, CA 94117

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EDUCATION:

1986-1990	University of Chicago, Chicago, IL	B.A.	History, Philosophy, and Social Studies of Science and Medicine
1990-1992	University of Illinois School of Public Health, Chicago, IL	M.P.H.	Epidemiology/Biostatistics
1992-1996	Rush University College of Medicine, Chicago, IL	M.D.	Medicine
1996-1997	Stanford Health Services, Stanford, CA.	Intern	Psychiatry
1997-1999	Harvard Longwood Psychiatry Residency Training Program, Boston, MA Boston, MA	Resident Psychiatry	
1999-2001	Children's Hospital, Boston, MA Boston, MA	Fellow	Child Psychiatry

LICENSURE AND CERTIFICATION:

1998	Full medical license, state of Massachusetts
2001	Diplomate of the American Board of Psychiatry and Neurology
2002	Diplomate of the American Board of Psychiatry and Neurology with Certification in Child and Adolescent Psychiatry
2005	Full medical license, state of California

PRINCIPAL POSITIONS HELD:

2001-2004	Boston University School of Medicine	Assistant Professor	Psychiatry
2001-2005	Harvard Medical School	Instructor	Psychiatry
2005-2011	University of California San Francisco School of Medicine	Director, Child Psychiatry Training Assistant Clinical Professor	Psychiatry
2011	University of California		

	San Francisco School of Medicine	Director, Child Psychiatry Training Associate Clinical Professor Psychiatry
2011	Cigna Health Care	Rgional Medical Director

AWARDS

1987 & 1988	University of Chicago Richter Research Grant
1988	University of Chicago Richter Internship Grant
1989	University of Chicago Maroon Key Society
1992	Management Sciences for Health Paul Alexander Memorial Fellowship for International Health
1993	United States Department of Health and Human Services Secretary's Award for Innovations in Health Promotion/Disease Prevention, Third Place.
1993	Rush Medical College Research Fellowship
1995	American Medical Association Education and Research Foundation Award
1995	American Medical Student Association Foundation International Health Fellowship
1995	American Medical Association Glaxo Achievement Award Recipient
1995	Rush University Program in Healthcare and the Humanities Third Annual Arts Competition, First Place Poetry
1997	American Medical Association Glaxo Wellcome Leadership Award Recipient
1998	Harvard Longwood Psychiatry Residency Training Program Award for Excellence in Academic Writing
2001	American Academy of Child and Adolescent Psychiatry Eli Lilly Pilot Research Award
2001	American Psychiatric Association Research Colloquium for Junior Investigators
2000	American Academy of Child and Adolescent Psychiatry Bristol-Myer Squibb Presidential Scholar Award
2000	Harvard Medical School Consolidated Department of Psychiatry Ethyl Dupont-Warren Award
2000	Harvard Medical School Consolidated Department of Psychiatry Livingston Award
2003	Rotary International Group Study Exchange
2006	Haile T. Debas Academy of Medical Educators Excellence in Teaching Award

KEYWORDS/AREAS OF INTEREST:

Medical student education, graduate medical education, refugee mental health, political asylum, global health, school consultation

PROFESSIONAL ACTIVITIES:

PROFESSIONAL ORGANIZATIONS

1988-1992	Society of Medical History of Chicago

1993	International Society for AIDS Education
1992-1995	American Medical Student Association
1995-1996	Illinois State Medical Society
1995-1996	Chicago Medical Society
1995-1996	American Orthopsychiatric Association
1995-1998	American Medical Association
1997-2005	Massachusetts Psychiatric Society
1996-1997, 2005-2008	Northern California Psychiatric Society
2002-2003	American Academy of Child and Adolescent Psychiatry Early Investigators Group
2002-2003	International Society for Traumatic Stress
1994-now	American Psychiatric Association
1998-now	Physicians for Human Rights
1999-now	American Academy of Child and Adolescent Psychiatry
2005-now	Northern California Regional Organization of Child and Adolescent Psychiatry

CLINICAL ACTIVITIES

1998-1999	On Call Psychiatrist, Faulkner Hospital, Jamaica Plain, Massachusetts
1998-2000	On Call Psychiatrist, Erich Lindemann Mental Health Center, Boston, Massachusetts
1999-2001	On Call Psychiatrist, Quincy Mental Health Center, Quincy, Massachusetts
2001-2003	Staff Psychiatrist, Boston Medical Center, Boston, Massachusetts Conducted research on the impact of trauma in young people, particularly child and adolescent refugees, and on relevant psychotherapies. Provided care to patients in outpatient clinic. Directed Boston University School of Medicine's outpatient child psychiatry rotation for 3rd-year psychiatry residents, and provided psychiatric consultations to medical students, 2002-2003.
2001-2004	Psychiatric Consultant, Lowell Public Schools Consult to Special Education Department regarding students' psychiatric diagnoses, clinical care, and academic placements.
2003-2004	Founder and Director, School Psychiatrists (www.schoolpsychiatrists.com) Provide school-based consultations to five Boston-area and three Bay area school systems and educational programs regarding students' psychiatric diagnoses, clinical care, and academic placements.
2003-2004	Staff Psychiatrist, Cambridge Hospital, Cambridge, Massachusetts Conduct and supervise assessments of patients in the psychiatric emergency room. Conduct morning teaching rounds. Review charts for quality control.
2006-2008	Staff Psychiatrist, Consultation Clinic, Langley Porter Psychiatric Institute, UCSF Supervise child psychiatry fellows for afternoon-long evaluations of physician-referred cases.

2007-2008 Associate Director, Child and Adolescent Psychiatry Outpatient Clinic, Langley Porter Psychiatric Institute, UCSF
Assisted Clinic Director in the oversight of clinic functions and clinical service.

2008-2011 Staff Psychiatrist, Third-year adult resident (PGY3) Child Assessment Clinic,
Langley Porter Psychiatric Institute, UCSF
Supervise residents for three-session evaluations of community-referred cases.

2010-2011 Staff Psychiatrist, University of California Center on Deafness
Langley Porter Psychiatric Institute, UCSF
Evaluate and treat hearing impaired children and adolescents.

RESEARCH AWARDS AND GRANTS

2001 **American Academy of Child and Adolescent Psychiatry Eli Lilly Pilot Research Award**
Awarded for the topic, "Clonidine for Intrusive Symptoms of Post-Traumatic Stress Disorder: a double-blind, randomized, placebo-controlled trial among pediatric, psychiatric inpatients. Funds research expenses ($9,000).

2001 **American Psychiatric Association Research Colloquium for Junior Investigators**
Funded participation in an interactive forum at the APA annual meeting. Awarded for the topic, "Clonidine for Intrusive Symptoms of Post-Traumatic Stress Disorder: a double-blind, randomized, placebo-controlled trial among pediatric, psychiatric inpatients.

2000 **American Academy of Child and Adolescent Psychiatry Bristol-Myer Squibb Presidential Scholar Award**
Funded a one-week tutorial at the World Bank Headquarters and includes participation in the Academy's International Affairs Committee.

2001 **Harvard Medical School Consolidated Department of Psychiatry Ethyl Dupont-Warren Award**
Salary supported to adapt testimonial psychotherapy to an adolescent refugee population ($40,000).

2001 **Harvard Medical School Consolidated Department of Psychiatry Livingston Award**
Research stipend to support project costs for testimonial psychotherapy project (see above, $1,000).

2007 **University of California San Francisco Research Evaluation and Allocation Committee Grant, Principal Investigator.**
Research grant for projects costs: Prevalence of secondary traumatic stress and burnout among immigration judges ($9,534).

2007 **University of California San Francisco Academic Senate Grant, Principal Investigator.**
Research grant for projects costs: Prevalence of secondary traumatic stress and burnout among immigration judges ($9,539).

2009 **University of California San Francisco Community Partnership Grant, Co-Principal Investigator.**
Research grant for salary and project costs in a collaboration with Survivors International: Assessment and Treatment of Young Survivors of Torture, War Trauma and Gang Violence ($44,626).

2010 **University of California San Francisco Clinical and Translational Science Institute, Principal Investigator**
Research grant for salary and project costs: Judicial Perceptions of Credibility among Legally Represented, Medically Evaluated Asylum Seekers: Prevalence and Types of Concerns, and Associations with Judicial Stress and Burnout ($30,000).

OTHER RESEARCH ACTIVITIES:

2006-2007 **Sub-investigator**
Cephalon, Inc, C1538d/312/AD/US to Keith McBurnett, University of California San Francisco.
A 1-Year, Open-Label, Flexible Dosage Study to Evaluate the Safety and Continued Efficacy of Modafinil in Children and Adolescents with Attention-Deficit/Hyperactivity Disorder Followed by an Open-Label Extension Period.

2007-2008 **Sub-investigator**
Shire 310, SPD 489-310 awarded to Keith McBurnett, University of California San Francisco.
Title: A Prospective, Open-Label, Multi-Center, Dose-Optimization Study Evaluating the Efficacy, Safety and Tolerability of Vyvanse 20-70 mg in Children aged 6-12 Diagnosed with ADHD.
Physically examined study subjects. Dispensed study medication to subjects.

2007–2011 **Sub-investigator**
Eli Lilly & Company, B4Z-US-LYEB awarded to Keith McBurnett, University of California San Francisco.
A Double-Blind, Placebo-Controlled Study of Atomoxetine Hydrochloride for the Treatment of Attention-Deficit/Hyperactivity Disorder (ADHD) in Children and Adolescents with ADHD and Comorbid Dyslexia
HALP and Child Psychiatry Clinic
Physically examined study subjects. Dispensed study medication to subjects.

2008-2010 **Sub-investigator**
Shire Pharmaceutical Development, SPD 503-313 awarded to Keith McBurnett, University of California San Francisco. A Phase III, Double-Blind, Randomized, Placebo-Controlled, Multi-Center Dose Optimization Study Evaluating the Safety and Efficacy of SPD503 in Combination with Psychostimulants in Children and Adolescents Aged 6-17 with a Diagnosis of (ADHD)
HALP and Child Psychiatry Clinic. Physically examined study subjects. Dispensed study medication to subjects.

SERVICE TO PROFESSIONAL PUBLICATIONS:

1999-2005 Assistant Editor, *Harvard Review of Psychiatry*

2004-now Reviewer for *The Lancet; Journal of Applied Developmental Psychology; Journal of Nervous and Mental Disease; Social Science and Medicine; Transcultural Psychiatry; Journal of Consulting and Clinical Psychology, Journal of Immigrant and Minority Health, Child and Adolescent Psychiatry and Mental Health, Pediatrics, International Migration*

PRESENTATIONS:
INTERNATIONAL:

C Vaquero, L Fügedi, **S Lusting** *(sic)*, MA Villanueva, González, JC Martín. "Esudio sobre la absorción de glucosa de los efectos de la isquemia intestinal provocada por shock hipovolémico." Reunión de la Asociación Castellana de Aparato Digestivo: Enfermedad Inflamatoria Intestinal. Albacete, Spain: October 15-16, 1993.

Lustig S. "Childhood and adolescent diagnoses on initial presentation to a Nigerian outpatient psychiatry clinic." First International Pan African Congress of Psychiatry. Cairo, Egypt: December 16-18, 1998.

Grant Knight W, Geltman P, Goodman J, **Lustig S.** Psychological functioning in resettled unaccompanied refugee minors. International Society for Traumatic Stress Studies 18th Annual Meeting, Baltimore, MD: November 8, 2002.

Lustig SL. Current Advances and Controversies in Psychopharmacology in Children and Adolescents. Lecture given at the International Center for Psychosocial Trauma's 11th Annual Summer Institute: Hope for the Children." Columbia, MO: June 17, 2005.

Lustig SL. "Behavioral Disorders." Lecture given as part of the International Center for Psychosocial Trauma's (Columbia, MO) "Training the Trainers" workshop in Karachi, Pakistan: December 30, 2003.

Lustig SL. "Testimonial Psychotherapy: A Theoretical Basis and Introduction to Methodology." Lecture given as part of the International Center for Psychosocial Trauma's (Columbia, MO) "Training the Trainers" workshop in Islamabad, Pakistan: January 2, 2004.

NATIONAL:

Lustig SL, Baier CA, Daugherty SR, Eckenfels EJ. "The AIDS Prevention Magic Show: avoiding the tragic with magic." Presented at:
World AIDS Day Celebration. Chicago, IL. January 20, 1993.

Fifth Annual Adolescent AIDS Conference: Taking it to the Streets. Chicago, IL: November 12, 1993.
Seventh International Conference on AIDS Education: Diversity on Common Ground: Bridging Research and Practice. Chicago, IL: November 13-17, 1993.
Reducing the Risk: Educator Training Design. Chicago, IL: December 13-14, 1993.
AIDS in West Virginia 1994: Challenges in Education, Prevention, and Treatment in a Rural State. Charleston, WV: March 18-19, 1994.
Prevention 94. Atlanta, GA: March 19-22, 1994.

Lustig S, Vaughan B, Mezzacappa E. "Clonidine for Intrusive Symptoms of Post-Traumatic Stress Disorder: a double-blind, randomized, placebo-controlled trial among pediatric, psychiatric inpatients." American Psychiatric Association Annual Convention, New Orleans, LA: May 5-10, 2001.

Lustig SL, Botelho C, Lynch L, Nelson SV, Eichelberger WJ, Vaughan BL. Implementing a randomized clinical trial on a pediatric psychiatric inpatient unit at a children's hospital: the case of clonidine for post-traumatic stress. American Academy of Child and Adolescent Psychiatry 49th Annual Meeting, San Francisco, CA: October 22-27, 2002.

Lustig SL. Testimonial psychotherapy for adolescent refugees. International Society for Traumatic Stress Studies 18th Annual Meeting, Baltimore, MD: November 7-10, 2002.

Lustig SL, Kureshi S, Delucchi KL, Morse S. Political Asylum Rates among Recipients of Medical and Psychological Evaluations of Torture and Ill Treatment among Political Asylum Applicants in the United States. American Public Health Association 134th Annual Meeting, Boston, MA, November 6, 2006.

Lustig, SL, Delucchi KL, Tennakoon L, Kaul B, Marks D, Slavin D. Stress and Burnout among Immigration Judges. Executive Office of Immigration Review Annual Legal Training Conference, Washington, DC, August 6, 2007.

Lustig, SL. Panel on Credibility Determinations and Special (Traumatized) Populations; Working with Traumatized Asylum Seekers: Maximizing their Comfort to Get Better Information. Executive Office of Immigration Review Annual Training, Washington, DC, July 22, 2010.

Lustig, SL. Judicial Wellness and Stress Management. Executive Office of Immigration Review Annual Legal Training Conference, Washington, DC, July 23, 2010.

Dingle A, McGinty K, **Lustig S**, Peterson E, Quigley J, Schlesinger A. Advocacy in Psychiatry: Teaching and Engaging Residents. American Association of Directors of Psychiatry Residency Training, Austin, TX, March 5, 2011.

Lustig, SL, Grisez KT, Gangesi D. Frequently Asked Questions from Adjudicators Concerning Mental Health Evaluations: Panel Discussion. At: Torture Survivors Seeking Asylum: The Intersection of Forensic Mental Health Evaluation and Legal Representation. Center for Victims of Torture Annual Training, Los Angeles, CA, July 27th, 2011.

REGIONAL AND OTHER INVITED PRESENTATIONS:

Lustig, SL. "Epilepsy in the Developing World: Shaking off the Shackles", World Bank, Health, Nutrition and Population Sector, Public Health Thematic Group, Washington D.C. June 7, 2001.

Geltman PL, Grant-Knight W, Lloyd-Travaglini C, **Lustig S**, Landgraf J, Wise P. The Lost Boys of Sudan: Functional and Behavioral Health of a Nationwide Cohort of Unaccompanied Refugee Minors. Platform (oral) presentation at the annual meeting of the Pediatric Academic Societies (APA), Seattle, WA, May 5, 2003.

Lustig SL. Testimonial psychotherapy for Sudanese refugee adolescents.
Pre-Conference Institute titled: Multicultural Interventions with Refugee Populations, May 29, 2003, part of: Psychological Trauma: Maturational Processes and Therapeutic Interventions, Boston University School of Medicine, Boston, MA: May 30-31, 2003.
Grand Rounds, Department of Pediatrics, University of California San Francisco, San Francisco, CA: January 26, 2006.
Grand Rounds, Department of Psychiatry, Alta Bates Medical Center, Berkeley, CA: March 20, 2006.
Grand Rounds, San Mateo County Psychiatry Residency Training Program, San Mateo, CA: January 9, 2007.
Grand Rounds, Napa State Hospital, Napa, CA: March 1, 2007.

AJ Flisher, **S Lustig**, M Funk and M Belfer. The World Health Organization Mental Heath Policy Project: Child and Adolescent Mental Health. 14th Bienniel South African Association of Child and Adolescent Psychiatry and Allied Professions (SAACAPAP) Conference. Port Elizabeth, South Africa, October 1-3, 2003.

Lustig, SL. Behavior Disorders of Childhood and Adolescence: Implications for School and Home. Day-long workshop for the Massachusetts Society for the Prevention of Cruelty to Children, Hyannis, MA, October 24, 2003.

Lustig SL. Refugee Children's Mental Health: The Need for Services and the Quest for Meaning. Presented at: War, Terrorism and Children: Supporting Family Strengths and Resilience. Sponsored by the Psychoanalytic Couple and Family Institute of New England; Boston, MA: November 15, 2003.

Lustig S. Child and Adolescent Refugee Mental Health: Issues in Treatment, Research and Policy. Harvard Medical School, Children's Hospital International Child Mental Health Seminar Series, March 17, 2004.

Lustig SL. Common Casualties of Human Rights Abuses: Child Refugees. Guest Lecturer, Harvard Medical School, elective course: Ethics, Human Rights, and the Physician. November 2, 2004.

Lustig SL, Kureshi S, Delucchi KL, Morse S. Political Asylum Rates among Recipients of Medical and Psychological Evaluations of Torture and Ill Treatment among Political Asylum Applicants in the United States. University of California Department of Psychiatry Research Retreat, San Francisco, CA, September 14, 2005.

American Public Health Association 134th Annual Meeting, Boston, MA, November 6, 2006.

Lustig SL. The Lost Boys of Sudan: Functional and Behavioral Health of a Nationwide Cohort of Unaccompanied Refugee minors. University of California Department of Psychiatry Post-Traumatic Stress Disorder Retreat (presented in absentia), San Francisco, CA, March 9, 2005.

Meffert S (moderator), Annan J, **Lustig S.** (panelists). "War, Children and Recovery: A Perspective from International Mental Health. 8th Annual Northern California International Health Conference, University of California Davis, Davis,CA, April 8, 2006.

Lustig SL. Vicarious Traumatization and Burnout among Legal Professionals Working with Asylum Survivors: Protecting Oneself. University of California Hastings College of the Law Refugee Clinic Seminar, San Francisco, CA, February 8, 2007, September 18, 2007, February 7, 2008, February 25, 2009, March 3, 2010, September 23, 2010, February 9, 2011, September 19, 2011; University of California Berkeley School of Law International Human Rights Clinic, October 25, 2011

Lustig SL. Psychiatric Assessment of Torture Survivors. Survivors. HealthRight International (formerly Doctors of the World) Human Rights Clinic Volunteer Training Seminar; San Diego, CA, March 31, 2007; San Jose, CA, September 12, 2009; Seattle, WA, June 11, 2010; San Francisco, CA, September 24, 2011.

Lustig SL. University of California San Francisco Department of Psychiatry Child and Adolescent Training Analysis of Learning Yielding a Systemwide Transformation (CATALYST): Process for Graduate Medical Education Program Reform. Presented at the Harvard Macy Institute Program for Educators in the Healthcare Professions, Boston , MA, May 22, 2007.

Baron R, Reilly L, Eisely D, **Lustig S.** How to prepare for an ACGME site visit. University of California San Francisco, San Francisco, CA, June 12, 2007.

Lustig SL, Smiga S, Randall S, Wu R. CATALYST: a vision for the future, a process for right now. University of San Francisco Department of Psychiatry, Child Psychiatry Grand Rounds, San Francisco, CA, September 14, 2007.

Lustig SL. Johnny is not in school again: causes and management of absenteeism. San Francisco United School District Hear from the Expert Series. September 21, 2007.

Lustig SL. When the Tweens Come Marching In. Presented to the Bay Area Library Information System at San Francisco Public Library, March 7, 2008.

Baron R, Murr AH, Thomas J, **Lustig S**, Piunti C, Day A. Preparing for an ACGME site visit. University of California San Francisco, San Francisco, CA, June 10, 2008.

Lustig SL. Behavioral Problems of Childhood and Adolescence: Implications for School and Home. Marchus School, Concord, CA, September 4, 2008.

Lustig SL. The stories they tell. From refugee children to immigration judges, and the political asylum process in between.

California Pacific Medical Center Grand Rounds, San Francisco, CA, October 14, 2008.

University of California San Francisco, Fresno Campus,Department of Psychiatry Grand Rounds, Fresno, CA, March 31, 2011.

Lustig SL. Interviewing kids: how to maximize their comfort

Vera Institute of Justice, Unaccompanied Children Pro Bono Project Annual Conference. Phoenix, AZ, December 9, 2008.

San Francisco Political Asylum Office Quality Assurance Training, San Francisco, CA, February 4, 2010.

Lustig SL. From refugee children to immigration judges, and the political asylum process: a case study of clinician advocacy.

Sutter Medical Center of Santa Rosa, Department of Family Medicine Grand Rounds, Santa Rosa, CA, June 23, 2010.

Grand Rounds, Department of Psychiatry, Alta Bates Medical Center, Berkeley, CA: December 13, 2010.
Visiting Professor Special Lecture Series, University of California San Francisco Fresno Campus, Fresno, CA, March 31, 2011.

Ally Bolour, J. Craig Fong, **Stuart L. Lustig**, Lourdes Martinez. Representing Gay, Lesbian, Bisexual and Transgender (LBGT) Immigrants: Navigating the Challenges Faced by LGBT Clients Seeking Lawful Immigration Status. Immigrant Legal Resource Center Webinar, San Francisco, CA, November 15, 2011.

Anders T, Feinstein C, Knapp P, Joshi S, **Lustig S,** Forgey M. Training Forum. Presented at the Northern California Regional Organization of Child and Adolescent Psychiatry Annual Meeting, Monterey, CA January 20-22, 2012.

CME AND OTHER EDUCATIONAL COURSES ATTENDED:

Northern California Regional Organization of Child and Adolescent Psychiatry Annual Meeting, Monterey, CA January 20-22, 2012
American Association of Directors of Psychiatry Residency Training, Austin, TX, March 2-5, 2011
Northern California Regional Organization of Child and Adolescent Psychiatry Annual Meeting, Sonoma, CA January 28-30, 2012
American Academy of Child and Adolescent Psychiatry 57th Annual Meeting, New York, NY, October 27-October 31, 2010
American Association of Directors of Psychiatry Residency Training, Orlando, FL, March 13-16, 2010
American Academy of Child and Adolescent Psychiatry 57th Annual Meeting, Honolulu, HI, October 28-November 31, 2009
American Association of Directors of Psychiatry Residency Training, Tucson, AZ, March 12-15, 2009
Medical Education for the 21st Century: Teaching for Health Equality, Havana, Cuba, November 30-December 3, 2008.
American Academy of Child and Adolescent Psychiatry 56th Annual Meeting, Chicago, IL, October 29-November 1, 2008
American Association of Directors of Psychiatry Residency Training, New Orleans, LA, March 12-16, 2008
American Academy of Child and Adolescent Psychiatry 55th Annual Meeting, Boston, MA, October 23-24, 2008
Harvard Macy Institute Program for Educators in the Healthcare Professions, Boston, MA, January 14-24, May 20-25, 2007.
American Association of Directors of Psychiatry Residency Training, San Juan, PR, March 8-11, 2007
American Public Health Association 134th Annual Meeting, Boston, MA, November 4-8, 2006.
American Academy of Child and Adolescent Psychiatry 53rd Annual Meeting, San Diego, CA, October 24-28, 2006
American Association of Directors of Psychiatry Residency Training, San Diego, CA, March 19-12, 2006
Association of Directors of Medical Student Education in Psychiatry, Monterey, CA, June 23-25, 2005
American Association of Directors of Psychiatry Residency Training, Tucson , Arizona, March 10-13, 2005
American Academy of Child and Adolescent Psychiatry, 51st Annual Meeting, Washington, DC, October 19-24, 2004
REACH: Recommendations on Employing Antipsychotics in Children and Adolescents, Boston MA, September 21, 2004
Fill Your Plate- Fortify Your Knowledge on Movement Disorders, Boston, MA, May 22, 2004
Risk Avoidance and Risk Management: Update 2004, Worcester, MA, March 20, 2004
Schizophrenia, Bipolar Disorders, and Diabetes: Interrelationships and Interventions, Boston MA, March 2, 2004
Preventive Psychiatry: Are We There Yet? Boston, MA, September 6, 2003
Psychological Trauma: Maturational Processes and Therapeutic Interventions, Boston, MA, May 29-31, 2003
Disclosure: Truth Telling in Medicine, Boston, MA, May 1, 2003
American Academy of Child and Adolescent Psychiatry 27th Annual Review Course in Child and Adolescent Psychiatry, Greenwich, CT, June 5-8, 2002
American Academy of Child and Adolescent Psychiatry Early Investigators Group Conference, July 25-28, 2002
American Academy of Child and Adolescent Psychiatry 49th Annual Meeting, San Francisco, CA, October 22-27, 2002

OTHER PROFESSIONAL SERVICE

2000-2003 **International Affairs Committee, American Academy of Child and Adolescent Psychiatry**
Served a three-year term.

2003-2008 **Langeloth Foundation, New York, NY**
Grant reviewer.

2007 **Institute for Mental Health Research, Phoenix, AZ**
Grant reviewer.

DEPARTMENT SERVICE

1997-1999 **Training Committee, Harvard Longwood Psychiatry Residency Training Program**
Proposed and helped implement a night float call system.
Helped formulate administrative and clinical policies of the residency.

2002-2003	**Boston University School of Medicine Residency Training Program in Psychiatry Training Committee** As director of the Outpatient Child Psychiatry Rotation, participated in discussions related to all aspects of adult psychiatry residency training.
2005-2006	**University of California School of Medicine Department of Psychiatry Training Integrated Residency Committee** As Director of the Child and Adolescent Psychiatry Training Program, participated in discussions related to all aspects of adult psychiatry residency training.
2005-now	**University of California School of Medicine Department of Psychiatry Child Psychiatry Training Program Selection Committee** Screen all applicants who apply to the program. Interview applicants. Lead recruitment efforts and facilitate Committee's discussions about applicants to help generate a rank order.
2005-now	**University of California School of Medicine Child Psychiatry Training Program Training Committee** As Director of the Child and Adolescent Psychiatry Training Program, I chair this committee of heads of clinical services that deliberate over all aspects of child psychiatry residency training.
2006-2008	**University of California School of Medicine Child Psychiatry Training Program CATALYST (Child and Adolescent Training Analysis of Learning to Yield a Systemwide Transformation) Committee** As Director of the Child and Adolescent Psychiatry Training Program, chaired the steering committee that is implementing a process to overhaul the entire residency training program.
2006-now	**University of California School of Medicine Department of Psychiatry Residency Training Program Selection Committee** Screen all applicants with an interest in child psychiatry. Interview applicants. Participate in discussions of applicants to help generate a rank order.
2006-2007	**University of California School of Medicine Department of Psychiatry, Chairman, Steering Committee for Child and Adolescent Training Analysis of Learning Yielding a Systemwide Transformation** Led the training program's first, thorough analysis of all components of training, culminating in a 49-page report with recommendations for didactics, rotations, evaluations, and leadership. This process and the resulting report will guide the evolution of the training program over the next several years.
2008-now	**Peer Review Committee** Review clinician charts to ensure complete documentation.

UNIVERSITY SERVICE

2007-now	**Graduate Medical Education Resident and Fellows Affairs Committee** Member. This Committee considers all aspects of resident and fellow wellbeing and makes recommendations to the Dean of the UCSF School of Medicine.
2007-now	**Graduate Medical Education Curriculum Committee** Member. This committee evaluates aspects of GME curricula relevant to all training programs.

PUBLIC SERVICE

1992-1996	**AIDS Prevention Magic Show** Created, performed, and evaluated a thirty-minute intervention to provide health skills to adolescents. Television- and radio-featured on Chicago's *Someone You Should Know* and the *Osgood File* respectively, and in the book, *Doctors Serving People: Restoring Humanism to Medicine through Student Community Service* (Eckenfels E. Piscataway, NJ: Rutgers University Press, 2008).

1992-1996	**Rush (Medical School) Community Services Initiatives Program** Helped provide medical care in free, inner-city, Chicago clinics.
1995-1996	**American Medical Student Association (AMSA) AmeriCorps Technical Assistance Program** Selected by AMSA to serve as a consultant to AmeriCorps health education projects nationwide. Wrote bill condemning female genital mutilation adopted by AMSA's Assembly, 1995.
1998-now	**Physicians for Human Rights Asylum Network Evaluator** Evaluate political asylum seekers for the psychological effects of political violence.
2005-now	**HealthRight Internatinonal (formerly Doctors of the World) Human Rights Clinic Trainer and Evaluator** Evaluate political asylum seekers for the psychological effects of political violence. Train other clinicians to perform these evaluations.

TEACHING and MENTORING

INFORMAL TEACHING

2003-2005	Attending Psychiatrist, Psychiatric Emergency Service, Cambridge Hospital, Cambridge, MA.
2005-2008	Faculty Advisor to University of California School of Medicine Medical Student Psychiatry Interest Group *(12hrs/yr).*
2005-2006	Outpatient attending for child psychiatry residents' longterm cases, Langley Porter Psychiatric Institute, San Francisco, CA *(250hrs/yr).*
2007-now	Child caseload supervisor for third- and fourth-year adult psychiatry residents and for second-year child psychiatry fellows *(60 hrs/yr, 20 hrs/yr administration time, total=80hrs/yr).*
2006-2008	Outpatient attending for child psychiatry residents' consultation cases, Langley Porter Psychiatric Institute, San Francisco, CA, *(200hrs/yr).*
2010-now	Faculty Advisor, University of California San Francisco School of Medicine Human Rights Interest Group

FORMAL SCHEDULED CLASSES:

2001	**Section Leader, Boston University School of Medicine; Introduction to Psychiatry** Led group first-year student discussions about normal development, and stress and illness.
2002-2003	**Preceptor, Boston University School of Medicine; Introduction to Clinical Medicine** Taught first-year students individually in the context of clinical outpatient psychiatry visits.
2002-2003	**Director of Outpatient Child Psychiatry Rotation, Boston University School of Medicine Residency Program in Psychiatry** Oversaw residents' caseloads. Coordinated and provided weekly lectures. Attended residents' cases. Ensured smooth communication between residents and other clinic staff. Ran weekly team meetings. Participated in Residency Training Committee meetings.
2005-2006	**Associate Director of Medical Education, Department of Psychiatry, University of California San Francisco School of Medicine** Clerkship Site Director, Langley Porter Psychiatric Hospital and Clinics. Co-Director, Foundations for Patient Care pre-clerkship doctoring course. Faculty Advisor, Psychiatry Interest Group. See below for details.

2005-2006 ***Foundations of Patient Care*** **pre-clerkship doctoring course, University of California San Francisco School of Medicine;**
Section Leader (66 hrs/yr)
Co-led a group of student practice and discussions of student interviews and problem-based learning cases.
Lecturer (4 hrs/lecture, 8 hrs preparation = 12 hrs/yr)
"Challenging Communications": Panel Discussion.
Co-Director, November, 2005 to November, 2006, (250 administration hrs/yr).
Oversaw Brain, Mind and Behavior and Life Cycle blocks of the course; edited syllabi, recruited faculty talent, moderated panel discussions, liaised with concurrently-running Brain, Mind and Behavior course.

2005 ***Brain, Mind and Behavior*** **pre-clerkship neuropsychiatry course, University of California San Francisco School of Medicine**
Discussion Section Leader (8 hrs/yr)
Co-Led problem-based learning groups for this first-year medial school course in neuropsychiatry.
Apprenticeship Group Leader (6hrs/yr)
Led a group of students practicing psychiatric interviews.

2005-2008 ***Brain, Mind and Behavior*** **pre-clerkship neuropsychiatry course, University of California San Francisco School of Medicine**
Lecturer, (1 hr/yr lecture, 6 hrs/yr preparation= 7 hrs/yr for 2005, 2006, and 2007)
"What is Psychotherapy Anyway?"
Lecturer, (1 hr/yr lecture, 25 hrs/yr preparation= 26 hrs/yr for 2007; 1 hr/yr lecture, 3 hrs/yr preparation = 4 hrs for 2008)
"Child Psychiatry, Frontiers Lecture."

2005-2006 **Psychiatry Clerkship Site Director University of California San Francisco School of Medicine**
Provide case-based didactic instruction to third-year medical students rotating through neuropsychiatry rotation at Langley Porter Psychiatric Institute, San Francisco, CA *(100 hrs/y, 150 hrs/yr admin/preparation= 250 hrs/yr).*

2005-2010 **Child Psychiatry Rotation (140.01U) Director University of California San Francisco School of Medicine**
Oversee all aspects of this rotation for fourth-year medical students. *(approximately 50 hrs/yr).*

2005-2010 **Advanced Nurse Practitioner Child Psychiatry LPPI Site Director, University of California San Francisco School of Nursing**
Oversee all aspects of this rotation for nurse practitioner residents. *(approximately 75 hrs/yr).*

2005-2010 **Co-Director, Seminar on Child Development**
Twice completely re-designed and co-directed this nine-month-long seminar for third-year psychiatry residents (2005-2006) and for third-year psychiatry residents and first-year child psychiatry fellows (2006-2008). Taught sessions on "Drive Theory," "School Consultation," and "Attachment." *(30 hrs/yr, 90 hrs/yr preparation=120 hrs/yr)*

2005-2007 **Adult Psychiatry Resident Case Conference**
Co-Facilitate this 12-month-long seminar for third-year psychiatry residents in which residents present cases *(70 hrs/yr)*

2005-2008 **Child Psychiatry Journal Club**
Co-Facilitate, with expert discussants, a discussion of current child psychiatry articles chosen and presented by fellows once a month. *(10 hrs/yr discussion, 20 hrs/yr preparation = 30 hrs/yr)*

2005-2007 **Child Psychiatry Narrative Case Conference**
Co-Facilitate this 12-month-long seminar for first- and second-year child psychiatry fellows in which residents present cases, often by means of creative writing pieces about their patients *(70 hrs/yr).*

2006-2008 **Guest Lecturer, Child Psychopathology Course**
Lectured on "Introduction to Child Psychopathology" for third-year psychiatry residents and first-year child psychiatry fellows. *(1 hr/yr, 9 hrs/yr preparation=10 hrs/yr for2006 and 2007; 4 hr/yr, 1 hr preparation=5 hr/yr for 2008m 1 hr/yr + 1 hr preparation= 2 hrs/yr in 2009)*

2006-2008 **Guest Lecturer, UCSF Medicine-Law Collaborative, Interdisciplinary Approaches to Advocacy Seminar**
Co-taught seminar with Karen Musalo, Legal and Medical Issues in Political Asylum. *(1 hr/yr, 2 hrs/yr preparation=3 hrs/yr for three years)*

2007-now **Guest Lecturer, Hastings College of the Law, Refugee Clinic Seminar**
Lectured on post-traumatic stress and vicarious trauma.
(4 hr/yr, 5 hrs/yr preparation=9 hrs/yr in 2007; 2x2 hrs/yr,1hr/yr preparation = 5hsr/yr in 2008, 2x2 hrs/yr, 1 hr/yr preparation = 5 hrs/yr in 2009; 1 hr/yr preparation = 5 hrs/yr in 2010)

2008-now **Working with Kids: The Basics**
Co-Facilitate this 12-month-long seminar for third-year psychiatry residents. This seminar, newly designed in 2008, covers several practical topics important to the clinical assessment of children and families. *(70 hrs/yr)*

PREDOCTORAL AND POST-DOCTORAL STUDENTS MENTORED

Date	Name	Program	Role	Position	Hrs/ yr
2005-2011	Cynthia Chen, Julie Chilton, Karl Jeffries, Yunnie Lee, Christin Drake, Melanie Thomas, Elizabeth Johnstone-Miller, Karen Finch, Kelli Barbour, Mercedes Paredes, Pamela Lyss-Lerman, Sonal Rana, Toral Surti, Adrienne Ritter, Danielle Carlin, Marcella Smid, Neil Sachs, Carolina Court, Aaron Moore, Karen Tamerius, Eric Yan, Elizabeth Gebis, Sarah Gertler, Kimberly Lo, Stacie Solt, Jessica Myers, Courtney Gonzales, Jessica Plauche, Will Berry, Jessica Woan, David Vargas, Khoa Lam, Anthony Sassong, Jennifer Giampaolo, Carol Peebles, Emily King, Megan Baker, David Young, Meredith Harewood, Mikah Owens	UCSF Medical School	Child Psychiatry Elective Clerkship Director	Medical student	*50*
2005-2006	Cynthia Chen	UCSF Medical School	Scholarship advisor	Medical student	*25*
2004-2006	Sarah Kureshi	Harvard School of Public Health, Mayo Medical Center	Research mentor	Medical student, public health student	*60*
2006-2008	Stephanie Kekulawela	Pennsylvania State College of Medicine	Research mentor	Medical student	*10*

2006-2008	Uma Lerner	UCSF Psychiatry Residency	Informal advisor and caseload supervisor	Psychiatry resident	*20*
2007-2008	Selene Luk	UCSF Child Psychiatry Fellowship	Scholarship advisor	Child psychiatry fellow	*5*
SUM:					*160*

CHILD PSYCHIATRY FELLOWS TRAINED IN MY TRAINING PROGRAM

Date	**Name**	**Program**	**Role**	**Position**	**Hrs/ yr**
3/2005-6/2005	(CAP2s) Marcie Hall-Mennes, Susie Hobbins, Veronica Saleh; (CAP1s) Ken Braslow; Arthur Chou; Stephen Brockway; Eva Ihle; Seema Khan; Karla Petersen;	UCSF Child & Adolescent Psychiatry Training Program	Training Director	Child psychiatry fellows	*30*
7/05-6/06	(CAP2s) Ken Braslow; Arthur Chou; Stephen Brockway; Eva Ihle; Seema Khan; Karla Petersen; (CAP1s): Jon Boone, Dannah Hirsch, Lisa Inman, Omid Naim, Nick Weiss	UCSF Child & Adolescent Psychiatry Training Program	Training Director	Child psychiatry fellows	*30*
7/06-6/07	(CAP2s): Jon Boone, Dannah Hirsch, Lisa Inman, Omid Naim, Nick Weiss (CAP1s): Alexis Anderson, Winston Chung, Brent Fletcher, Selene Luk, Charmi Patel	UCSF Child & Adolescent Psychiatry Training Program	Training Director and supervisor for CAP1 child psychiatry fellows	Child psychiatry fellows	*60*
7/07-6/08	(CAP2s): Alexis Anderson, Winston Chung, Brent Fletcher, Selene Luk (CAP1s): Therese Garrett, Manuj Nanjia, Deborah Raphael; Kristina Shwerin, Saul Zelan;	UCSF Child & Adolescent Psychiatry Training Program	Training Director and Caseload Supervisor for CAP2s and also PGY3 and PGY4 adult psychiatry residents	Child psychiatry fellows, PGY3 and PGY4 residents (not listed by name)	*60*
7/08-6/09	(CAP2s): Therese Garrett, Deborah Raphael; Kristina Shwerin, Saul Zelan; (CAP1s): Helena Chan, Uri Cohen, KJ Cottrell, Jennifer Le, Genevieve Yu	UCSF Child & Adolescent Psychiatry Training Program	Training Director for CAP1s and CAP2s, Caseload Supervisor for PGY3 and PGY4 adult psychiatry residents	Child psychiatry fellows, PGY3 and PGY4 residents (not listed by name)	*60*
7/09-	(CAP2s): Helena Chan,	UCSF Child &	Training	Child	*60*

6/10	Uri Cohen, KJ Cottrell, Jennifer Le, Genevieve Wu (CAP1s): Karl Jeffries, Yunnie Lee, Laurie Mun, Anna Ordonez, Kimberly Tseng	Adolescent Psychiatry Training Program	Director for CAP1s and CAP2s, Caseload Supervisor for PGY3 and PGY4 adult psychiatry residents	psychiatry fellows, PGY3 and PGY4 residents (not listed by name)	
7/10-6/11	(CAP2s): Karl Jeffries, Yunnie Lee, Laurie Mun, Anna Ordonez, Kimberly Tseng (CAP1s): Alysia Han, R. Jefferson Joseph; Erik Sandegard; Shivani Verma	UCSF Child & Adolescent Psychiatry Training Program	Training Director for CAP1s and CAP2s, Caseload Supervisor for PGY3 and PGY4 adult psychiatry residents	Child psychiatry fellows, PGY3 and PGY4 residents (not listed by name)	*60*
7/11-12/11	(CAP2s): R. Jefferson Joseph; Erik Sandegard; Shivani Verma (CAP1s): Rajan Bahl, Farshid Farrahi, Melissa Lorang, Michael Swetye	UCSF Child & Adolescent Psychiatry Training Program	Training Director for CAP1s and CAP2s, Caseload Supervisor for PGY3 and PGY4 adult psychiatry residents	Child psychiatry fellows, PGY3 and PGY4 residents (not listed by name)	
SUM:					*330*

SUMMARY OF UCSF TEACHING HOURS

2004-2005 70 total hours of teaching (including preparation):
Formal class or course teaching hours: *55 hrs/yr*
Informal teaching hours: *0 hrs/yr*
Mentoring hours: *15 hrs/year*

2005-2006 1,051 total hours of teaching (including preparation):
Formal class or course teaching hours: *634 hrs/yr*
Informal teaching hours: *262 hrs/yr*
Mentoring hours: *155 hrs/yr*

2006-2007 725 total hours of teaching (including preparation):
Formal class or course teaching hours: *323 hrs/yr*
Informal teaching hours: *212 hrs/yr*
Mentoring hours:*190 hrs/yr*

2007-2008 626 total hours of teaching (including preparation):
Formal class or course teaching hours: *199 hrs/yr*
Informal teaching hours: *292 hrs/yr*
Mentoring hours: *135 hrs/yr*

TEACHING NARRATIVE

My teaching efforts have spanned all levels of undergraduate and graduate medical education. Medical student educational contributions have included multiple roles within the University of California San Francisco's pre-clerkship courses (*Brain, Mind and Behavior* and *Foundations of Patient Care*), as well as teaching and administrative roles in the clerkship years (Site Director at

Langley Porter Psychiatric Institute for the psychiatry clerkship, and Founding Director of a child psychiatry elective rotation). I train residents in child psychiatry at the PGY3 through PGY6 level.
I focus the bulk of my training efforts on the child and adolescent psychiatry training program which I direct. I have spear-headed and directed an initiative to comprehensively assess our entire program, a process called the Child and Adolescent Training Analysis of Learning to Yield a Systemwide Transformation (CATALYST). I have also initiated a successful series of retreats for child psychiatry faculty members on topics such as formulation, feedback, teaching and learning, and evidenced based psychiatric education. I have developed a collaborative relationship between the child and adolescent psychiatry fellowship program and the San Francisco County Department of Public Health, where our fellows now rotate. I also oversaw our program's very successful site visit from the Accreditation Council of Graduate Medical Education. Other training program initiatives include annual program updates, an online video brochure about the program, and surveys of incoming fellows about their training experiences. Meanwhile, I have helped shepherd our fellows through a three-year transitional period involving multiple changes in leadership at the programmatic, departmental, and university levels.
Starting in 2010, I have begun to focus my attentions on the child and adolescent psychiatry fellowship didactic curriculum. I have initiated and directed a committee comprised of both faculty and fellows, the Educational Policy Committee, charged with overseeing all seminars. Additionally, I have led the design of an innovative curriculum on advocacy, offered to first-year child psychiatry fellows beginning in 2010.

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Geneva



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PARTICIPATING ORGANIZATIONS

Action for Torture Survivors (HRFT), Geneva
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Association for the Prevention of Torture, Geneva
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CONTENTS

		Paragraphs	*Page*
Contributing authors and other participants			viii
Introduction			1
Chapter			
I.	RELEVANT INTERNATIONAL LEGAL STANDARDS	1-47	3
A.	International humanitarian law	2-6	3
B.	The United Nations	7-24	3
1.	Legal obligations to prevent torture	10	4
2.	United Nations bodies and mechanisms	11-24	5
C.	Regional organizations	25-46	7
1.	The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights	26-32	7
2.	The European Court of Human Rights	33-38	8
3.	The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment	39-43	9
4.	The African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights	44-46	9
D.	The International Criminal Court	47	10
II.	RELEVANT ETHICAL CODES	48-73	11
A.	Ethics of the legal profession	49-50	11
B.	Health-care ethics	51-56	11
1.	United Nations statements relevant to health professionals	52-53	11
2.	Statements from international professional bodies	54-55	12
3.	National codes of medical ethics	56	12
C.	Principles common to all codes of health-care ethics	57-65	13
1.	The duty to provide compassionate care	58-62	13
2.	Informed consent	63-64	13
3.	Confidentiality	65	14
D.	Health professionals with dual obligations	66-73	14
1.	Principles guiding all doctors with dual obligations	67	14
2.	Dilemmas arising from dual obligations	68-73	15
III.	LEGAL INVESTIGATION OF TORTURE	74-119	17
A.	Purposes of an investigation into torture	77	17
B.	Principes on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	78-84	17
C.	Procedures of a torture investigation	85-106	18
1.	Determination of the appropriate investigative body	85-87	18
2.	Interviewing the alleged victim and other witnesses	88-101	19
3.	Securing and obtaining physical evidence	102-103	21
4.	Medical evidence	104-105	22
5.	Photography	106	22
D.	Commission of inquiry	107-119	22
1.	Defining the scope of the inquiry	107	22
2.	The power of the commission	108	23
3.	Membership criteria	109-110	23
4.	The commission's staff	111	23

Chapter		*Paragraphs*	*Page*
	5. Protection of witnesses	112	23
	6. Proceedings	113	23
	7. Notice of inquiry	114	23
	8. Receipt of evidence	115	23
	9. Rights of parties	116	24
	10. Evaluation of evidence	117	24
	11. Report of the commission	118-119	24
IV.	GENERAL CONSIDERATIONS FOR INTERVIEWS	120-160	25
	A. Purpose of inquiry, examination and documentation	121-122	25
	B. Procedural safeguards with respect to detainees	123-126	25
	C. Official visits to detention centres	127-134	26
	D. Techniques of questioning	135	27
	E. Documenting the background	136-141	27
	1. Psychosocial history and pre-arrest	136	27
	2. Summary of detention and abuse	137	27
	3. Circumstances of detention	138	28
	4. Place and conditions of detention	139	28
	5. Methods of torture and ill-treatment	140-141	28
	F. Assessment of the background	142-143	28
	G. Review of torture methods	144-145	29
	H. Risk of re-traumatization of the interviewee	146-149	29
	I. Use of interpreters	150-153	30
	J. Gender issues	154-155	30
	K. Indications for referral	156	31
	L. Interpretation of findings and conclusions	157-160	31
V.	PHYSICAL EVIDENCE OF TORTURE	161-233	33
	A Interview structure	163-167	33
	B. Medical history	168-172	34
	1. Acute symptoms	170	34
	2. Chronic symptoms	171	34
	3. Summary of an interview	172	34
	C. The physical examination	173-186	34
	1. Skin	176	35
	2. Face	177-182	35
	3. Chest and abdomen	183	36
	4. Musculoskeletal system	184	36
	5. Genito-urinary system	185	36
	6. Central and peripheral nervous systems	186	36
	D. Examination and evaluation following specific forms of torture	187-232	36
	1. Beatings and other forms of blunt trauma	189-202	37
	2. Beatings to the feet	203-205	38
	3. Suspension	206-209	39
	4. Other positional torture	210-211	40
	5. Electric shock torture	212	40
	6. Dental torture	213	41
	7. Asphyxiation	214	41
	8. Sexual torture including rape	215-232	41
	E. Specialized diagnostic tests	233	44
VI.	PSYCHOLOGICAL EVIDENCE OF TORTURE	234-315	45
	A. General considerations	234-239	45
	1. The central role of the psychological evaluation	234-237	45
	2. The context of the psychological evaluation	238-239	46

		Paragraphs	*Page*
B.	Psychological consequences of torture	240-259	46
	1. Cautionary remarks	240	46
	2. Common psychological responses	241-249	46
	3. Diagnostic classifications	250-259	47
C.	The psychological/psychiatric evaluation	260-315	49
	1. Ethical and clinical considerations	260-262	49
	2. The interview process	263-274	50
	3. Components of the psychological/psychiatric evaluation	275-291	52
	4. Neuropsychological assessment	292-309	54
	5. Children and torture	310-315	57

ANNEXES

I.	Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	59
II.	Diagnostic tests	61
III.	Anatomical drawings for the documentation of torture and ill-treatment	65
IV.	Guidelines for the medical evaluation of torture and ill-treatment	73

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INTRODUCTION

Torture is defined in this manual in the words of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984:

[T]orture means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person, has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[1]

Torture is a profound concern of the world community. Its purpose is to destroy deliberately not only the physical and emotional well-being of individuals but also, in some instances, the dignity and will of entire communities. It concerns all members of the human family because it impugns the very meaning of our existence and our hopes for a brighter future.[2]

Although international human rights and humanitarian law consistently prohibit torture under any circumstance (see chapter I), torture and ill-treatment are practised in more than half of the world's countries.[3, 4] The striking disparity between the absolute prohibition of torture and its prevalence in the world today demonstrates the need for States to identify and implement effective measures to protect individuals from torture and ill-treatment. This manual was developed to enable States to address one of the most fundamental concerns in protecting individuals from torture—effective documentation. Such documentation brings evidence of torture and ill-treatment to light so that perpetrators may be held accountable for their actions and the interests of justice may be served. The documentation methods contained in this manual are also applicable to other contexts, including human rights investigations and monitoring, political asylum evaluations, the defence of individuals who "confess" to crimes during torture and needs assessments for the care of torture victims, among others. In the case of health professionals who are coerced into neglect, misrepresentation or falsification of evidence of torture, this manual also provides an international point of reference for health professionals and adjudicators alike.

During the past two decades, much has been learned about torture and its consequences, but no international guidelines for documentation were available prior to the development of this manual. The *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* is intended to serve as international guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture and for reporting findings to the judiciary or any other investigative body. This manual includes principles for the effective investigation and documentation of torture,

[1] Since 1982, the recommendations concerning United Nations assistance to victims of torture made by the Board of Trustees of the United Nations Voluntary Fund for Victims of Torture to the Secretary-General of the United Nations, are based on article 1 of the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, which provides that "Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment or punishment" and that "It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners", as well as on all other relevant international instruments.

[2] V. Iacopino, "Treatment of survivors of political torture: commentary", *The Journal of Ambulatory Care Management*, vol. 21 (2) (1998), pp. 5-13.

[3] Amnesty International, *Amnesty International Report 1999* (London, AIP, 1999).

[4] M. Başoglu, "Prevention of torture and care of survivors: an integrated approach", *The Journal of the American Medical Association (JAMA)*, vol. 270 (1993), pp. 606-611.

and other cruel, inhuman or degrading treatment or punishment (see annex I). These principles outline minimum standards for States in order to ensure the effective documentation of torture.[5] The guidelines contained in this manual are not presented as a fixed protocol. Rather, they represent minimum standards based on the principles and should be used taking into account available resources. The manual and principles are the result of three years of analysis, research and drafting, undertaken by more than 75 experts in law, health and human rights, representing 40 organizations or institutions from 15 countries. The conceptualization and preparation of this manual was a collaborative effort between forensic scientists, physicians, psychologists, human-rights monitors and lawyers working in Chile, Costa Rica, Denmark, France, Germany, India, Israel, the Netherlands, South Africa, Sri Lanka, Switzerland, Turkey, the United Kingdom, the United States of America, and the occupied Palestinian territories.

[5] The Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment are annexed to General Assembly resolution 55/89 of 4 December 2000 and to Commission on Human Rights resolution 2000/43 of 20 April 2000, both adopted without a vote.

CHAPTER I

RELEVANT INTERNATIONAL LEGAL STANDARDS

1. The right to be free from torture is firmly established under international law. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment all expressly prohibit torture. Similarly, several regional instruments establish the right to be free from torture. The American Convention on Human Rights, the African Charter on Human and Peoples' Rights and the European Convention for the Protection of Human Rights and Fundamental Freedoms all contain express prohibitions of torture.

A. International humanitarian law

2. The international treaties governing armed conflicts establish international humanitarian law or the law of war. The prohibition of torture under international humanitarian law is only a small, but important, part of the wider protection these treaties provide for all victims of war. The four Geneva Conventions of 1949 have been ratified by 188 States. They establish rules for the conduct of international armed conflict and, especially, for the treatment of persons who do not, or who no longer, take part in hostilities, including the wounded, the captured and civilians. All four conventions prohibit the infliction of torture and other forms of ill-treatment. Two Protocols of 1977, additional to the Geneva Conventions, expand the protection and scope of these conventions. Protocol I (ratified to date by 153 States) covers international conflicts. Protocol II (ratified to date by 145 States) covers non-international conflicts.

3. More important to the purpose here, however, is what is known as "Common Article 3", found in all four conventions. Common Article 3 applies to armed conflicts "not of an international character", no further definition being given. It is taken to define core obligations that must be respected in all armed conflicts and not just in international wars between countries. This is generally taken to mean that no matter what the nature of a war or conflict, certain basic rules cannot be abrogated. The prohibition of torture is one of these and represents an element common to international humanitarian law and human rights law.

4. Common Article 3 states:

> ... the following acts are and shall remain prohibited at any time and in any place whatsoever... violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; ... outrages upon personal dignity, in particular humiliating and degrading treatment...

5. As the Special Rapporteur on the question of torture, Nigel Rodley, has stated:

> The prohibition of torture or other ill-treatment could hardly be formulated in more absolute terms. In the words of the official commentary on the text by the International Committee of the Red Cross (ICRC), no possible loophole is left; there can be no excuse, no attenuating circumstances.[6]

6. A further link between international humanitarian law and human rights law is found in the preamble to Protocol II, which itself regulates non-international armed conflicts (such as fully-fledged civil wars), and which states that: "... international instruments relating to human rights offer a basic protection to the human person."[7]

B. The United Nations

7. The United Nations has sought for many years to develop universally applicable standards to ensure adequate protection for all persons against torture or cruel, inhuman or degrading treatment. The conventions, declarations and resolutions adopted by the Member States of the United Nations clearly state that there may be no exception to the prohibition of torture and establish other obligations to ensure protection against such abuses. Among the most important of these instruments are the Universal Declaration of Human Rights,[8] the International Covenant on Civil and Political Rights,[9] the Standard Minimum Rules for the Treatment of Prisoners,[10] the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Declaration on the Protection against Torture),[11] the Code of Conduct on

[6] N. Rodley, *The Treatment of Prisoners under International Law*, 2nd ed. (Oxford, Clarendon Press, 1999), p. 58.

[7] Second preambular paragraph of Protocol II (1977), additional to the Geneva Conventions of 1949.

[8] General Assembly resolution 217 A (III) of 10 December 1948, art. 5; see *Official Records of the General Assembly, Third Session* (A/810), p. 71.

[9] Entered into force on 23 March 1976; see General Assembly resolution 2200 A (XXI), of 16 December 1966, annex, art. 7; *Official Records of the General Assembly, Twenty-first Session, Supplement No. 16* (A/6316), p. 52, and United Nations, *Treaty Series*, vol. 999, p.171.

[10] Adopted on 30 August 1955 by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders.

[11] General Assembly resolution 3452 (XXX) of 9 December 1975, annex, arts. 2 and 4; see *Official Records of the General Assembly, Thirtieth Session, Supplement No. 34* (A/10034), p. 91.

Law Enforcement,[12] the Principles of Medical Ethics Relevant to the Role of Health Personnel Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Principles of Medical Ethics),[13] the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture),[14] the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment (Body of Principles on Detention)[15] and the Basic Principles for the Treatment of Prisoners.[16]

8. The United Nations Convention against Torture does not cover pain or suffering arising only from, inherent in or incidental to lawful sanctions.[17]

9. Other United Nations human rights bodies and mechanisms have taken action to develop standards for the prevention of torture and standards involving the obligation of States to investigate allegations of torture. These bodies and mechanisms include the Committee against Torture, the Human Rights Committee, the Commission on Human Rights, the Special Rapporteur on the question of torture, the Special Rapporteur on violence against women and country-specific special rapporteurs appointed by the Commission on Human Rights.

1. *Legal obligations to prevent torture*

10. The international instruments cited above establish certain obligations that States must respect to ensure protection against torture. These include:

(*a*) Taking effective legislative, administrative, judicial or other measures to prevent acts of torture. No exceptions, including war, may be invoked as justification for torture (art. 2 of the Convention against Torture and art. 3 of the Declaration on the Protection against Torture);

(*b*) Not expelling, returning (*refouler*) or extraditing a person to a country when there are substantial grounds for believing he or she would be tortured (art. 3 of the Convention against Torture);

(*c*) Criminalization of acts of torture, including complicity or participation therein (art. 4 of the Convention against Torture, principle 7 of the Body of Principles on Detention, art. 7 of the Declaration on the Protection against Torture and paras. 31-33 of the Standard Minimum Rules for the Treatment of Prisoners);

(*d*) Undertaking to make torture an extraditable offence and assisting other States parties in connection with criminal proceedings brought in respect of torture (arts. 8 and 9 of the Convention against Torture);

(*e*) Limiting the use of incommunicado detention; ensuring that detainees are held in places officially recognized as places of detention; ensuring the names of persons responsible for their detention are kept in registers readily available and accessible to those concerned, including relatives and friends; recording the time and place of all interrogations, together with the names of those present; and granting physicians, lawyers and family members access to detainees (art. 11 of the Convention against Torture; principles 11-13, 15-19 and 23 of the Body of Principles on Detention; paras. 7, 22 and 37 of the Standard Minimum Rules for the Treatment of Prisoners);

(*f*) Ensuring that education and information regarding the prohibition of torture is included in the training of law enforcement personnel (civil and military), medical personnel, public officials and other appropriate persons (art. 10 of the Convention against Torture, art. 5 of the Declaration on the Protection against Torture, para. 54 of the Standard Minimum Rules for the Treatment of Prisoners);

(*g*) Ensuring that any statement that is established to have been made as a result of torture shall not be invoked as evidence in any proceedings, except against a person accused of torture as evidence that the statement was made (art. 15 of the Convention against Torture, art. 12 of the Declaration on the Protection against Torture);

(*h*) Ensuring that the competent authorities undertake a prompt and impartial investigation, whenever there are reasonable grounds to believe that torture has been committed (art. 12 of the Convention against Torture, principles 33 and 34 of the Body of Principles on Detention, art. 9 of the Declaration on the Protection against Torture);

(*i*) Ensuring that victims of torture have the right to redress and adequate compensation (arts. 13 and 14 of the Convention against Torture, art. 11 of the Declaration on the Protection against Torture, paras. 35 and 36 of the Standard Minimum Rules for the Treatment of Prisoners);

(*j*) Ensuring that the alleged offender or offenders is subject to criminal proceedings if an investigation establishes that an act of torture appears to have been commit-

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[12] General Assembly resolution 34/169 of 17 December 1979, annex, art. 5; see *Official Records of the General Assembly, Thirty-fourth Session, Supplement No. 46* (A/34/46), p. 186.

[13] General Assembly resolution 37/194 of 18 December 1982, annex, principles 2–5; see *Official Records of the General Assembly, Thirty-seventh Session, Supplement No. 51* (A/37/51), p. 211.

[14] Entered into force on 26 June 1987; see General Assembly resolution 39/46 of 10 December 1984, annex, art. 2, *Official Records of the General Assembly, Thirty-ninth Session, Supplement No. 51* (A/39/51), p. 197.

[15] General Assembly resolution 43/173 of 9 December 1988, annex, principle 6; see *Official Records of the General Assembly, Forty-third Session, Supplement No. 49* (A/43/49), p. 298.

[16] General Assembly resolution 45/111 of 14 December 1990, annex, principle 1; see *Official Records of the General Assembly, Forty-fifth Session, Supplement No. 49* (A/45/49), p. 200.

[17] For an interpretation of what constitutes "lawful sanctions", see the report of the Special Rapporteur on torture to the fifty-third session of the Commission on Human Rights (E/CN.4/1997/7, paras. 3-11), in which the Special Rapporteur expressed the view that the administration of punishments such as stoning to death, flogging and amputation cannot be deemed lawful simply because the punishment has been authorized in a procedurally legitimate manner. The interpretation put forward by the Special Rapporteur, which is consistent with the positions of the Human Rights Committee and other United Nations mechanisms, was endorsed by resolution 1998/38 of the Commission on Human Rights, which "[r]eminds Governments that corporal punishment can amount to cruel, inhuman or degrading treatment or even to torture".

ted. If an allegation of other forms of cruel, inhuman or degrading treatment or punishment is considered to be well founded, the alleged offender or offenders shall be subject to criminal, disciplinary or other appropriate proceedings (art. 7 of the Convention against Torture, art. 10 of the Declaration on the Protection against Torture).

2. *United Nations bodies and mechanisms*

(a) *Committee against Torture*

11. The Committee against Torture monitors implementation of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Committee consists of 10 experts appointed because of their "high moral standing and recognized competence in the field of human rights". Under article 19 of the Convention against Torture, the States parties submit to the Committee, through the Secretary-General, reports on the measures they have taken to give effect to their undertakings under the Convention. The Committee examines how the provisions of the Convention have been incorporated into domestic law and monitors how this functions in practice. Each report is considered by the Committee, which may make general comments and recommendations and include this information in its annual report to the States parties and to the General Assembly. These procedures take place in public meetings.

12. Under article 20 of the Convention against Torture, if the Committee receives reliable information that appears to contain well-founded indications that torture is being systematically practised in the territory of a State party, the Committee must invite that State party to cooperate in the examination of the information and, to this end, to submit observations with regard to the information concerned. The Committee may, if it decides that this is warranted, designate one or more of its members to make a confidential inquiry and to report to the Committee urgently. In agreement with that State party, that inquiry may include a visit to its territory. After examining the findings of its member or members, the Committee transmits these findings to the State party concerned together with any comments or suggestions that seem appropriate in view of the situation. All the proceedings of the Committee under article 20 are confidential, and, at all stages of the proceedings, the cooperation of the State party is sought. After completion of these proceedings, the Committee may, after consultations with the State party concerned, decide to include a summary account of the results of the proceedings in its annual report to the other States parties and to the General Assembly.[18]

13. Under article 22 of the Convention against Torture, a State party may at any time recognize the competence of the Committee to receive and consider individual complaints from or on behalf of individuals subject to its jurisdiction who claim to be victims of a violation by a State party of the provisions of the Convention against Torture. The Committee then considers these communications confidentially and shall forward its view to the State party concerned and to the individual. Only 39 of the 112 States parties that have ratified the Convention have also recognized the applicability of article 22.

14. Among the concerns addressed by the Committee in its annual reports to the General Assembly is the necessity of States parties to comply with articles 12 and 13 on the Convention against Torture to ensure that prompt and impartial investigations of all complaints of torture are undertaken. For example, the Committee has stated that it considers a delay of 15 months in investigating allegations of torture to be unreasonably long and not in compliance with article 12.[19] The Committee has also noted that article 13 does not require a formal submission of a complaint of torture, but that "[i]t is sufficient for torture only to have been alleged by the victim for [a State Party] to be under an obligation promptly and impartially to examine the allegation".[20]

(b) *Human Rights Committee*

15. The Human Rights Committee was established pursuant to article 28 of the International Covenant on Civil and Political Rights and the requirement to monitor implementation of the Covenant in the States parties. The Committee is composed of 18 independent experts who are expected to be persons of high moral character and of recognized competence in the field of human rights.

16. States parties to the Covenant must submit reports every five years on the measures they have adopted to give effect to the rights recognized in the Covenant and on progress made in the enjoyment of those rights. The Human Rights Committee examines the reports through a dialogue with representatives of the State party whose report is under consideration. The Committee then adopts concluding observations summarizing its main concerns and making appropriate suggestions and recommendations to the State party. The Committee also prepares general comments interpreting specific articles of the Covenant to guide States parties in their reporting, as well as their implementation of the Covenant's provisions. In one such general comment, the Committee undertook to clarify article 7 of the International Covenant on Civil and Political Rights, which states that no one shall be subject to torture or to cruel, inhuman or degrading treatment or punishment. In the general comments on article 7 of the Covenant in the report of the Committee, it specifically noted that prohibiting torture or making it a crime was not sufficient implementation of article 7.[21] The Committee stated: "... States must ensure an effective protection through some machinery of control. Complaints about ill-treatment must be investigated effectively by competent authorities."

17. On 10 April 1992, the Committee adopted new general comments on article 7, further developing the previous comments. The Committee reinforced its reading of article 7 by stating that "[c]omplaints must be investi-

[18] It should be pointed out, however, that application of article 20 can be limited because of a reservation by a State party, in which case article 20 is not applicable.

[19] See Communication 8/1991, para. 185, Report of the Committee against Torture to the General Assembly (A/49/44) of 12 June 1994.

[20] See Communication 6/1990, para. 10.4, Report of the Committee against Torture to the General Assembly (A/50/44) of 26 July 1995.

[21] United Nations, document A/37/40 (1982).

gated promptly and impartially by competent authorities so as to make the remedy effective". Where a State has ratified the first Optional Protocol to the International Covenant on Civil and Political Rights, an individual may submit a communication to the Committee complaining that his rights under the Covenant have been violated. If found admissible, the Committee issues a decision on the merits, which is made public in its annual report.

(c) *Commission on Human Rights*

18. The Commission on Human Rights is the primary human rights body of the United Nations. It is composed of 53 Member States elected by the Economic and Social Council for three-year terms. The Commission meets annually for six weeks in Geneva to act on human rights issues. The Commission may initiate studies and fact-finding missions, draft conventions and declarations for approval by higher United Nations bodies and discuss specific human rights violations in public or private sessions. On 6 June 1967, the Economic and Social Council, in resolution 1235, authorized the Commission to examine allegations of gross violations of human rights and to "make a thorough study of situations which reveal a consistent pattern of violations of human rights".[22] Under this mandate, the Commission has, among other procedures, adopted resolutions expressing concern about human rights violations and has appointed special rapporteurs to address human rights violations falling under a particular theme. The Commission has also adopted resolutions regarding torture and other cruel, inhuman or degrading treatment or punishment. In its resolution 1998/38, the Commission stressed that "all allegations of torture or cruel, inhuman or degrading treatment or punishment should be promptly and impartially examined by the competent national authority".

(d) *Special Rapporteur on the question of torture*

19. In 1985, the Commission decided, in resolution 1985/33, to appoint a Special Rapporteur on the question of torture. The Special Rapporteur is charged with seeking and receiving credible and reliable information on questions relevant to torture and to respond to that information without delay. The Commission has continued to renew the Special Rapporteur's mandate in subsequent resolutions.

20. The Special Rapporteur's authority to monitor extends to all Member States of the United Nations and to all States with observer status, regardless of the State's ratification of the Convention against Torture. The Special Rapporteur establishes contact with Governments, asks them for information on legislative and administrative measures taken to prevent torture, requests them to remedy any consequences and asks them to respond to information alleging the actual occurrence of torture. The Special Rapporteur also receives requests for urgent action, which he or she brings to the attention of the Governments concerned in order to ensure protection of an individual's right to physical and mental integrity. In addition, the Special Rapporteur holds consultations with government representatives who wish to meet with him or her and, in accordance with the position's mandate, makes *in situ* visits to some parts of the world. The Special Rapporteur submits reports to the Commission on Human Rights and to the General Assembly. These reports describe actions that the Special Rapporteur has taken under his or her mandate and persistently draw attention to the importance of prompt investigation of torture allegations. In the Report of the Special Rapporteur on the question of torture of 12 January 1995, the Special Rapporteur, Nigel Rodley, made a series of recommendations. In paragraph 926 (*g*) of the report, he stated:

> When a detainee or relative or lawyer lodges a torture complaint, an inquiry should always take place... Independent national authorities, such as a national commission or ombudsman with investigatory and/or prosecutorial powers, should be established to receive and to investigate complaints. Complaints about torture should be dealt with immediately and should be investigated by an independent authority with no relation to that which is investigating or prosecuting the case against the alleged victim.[23]

21. The Special Rapporteur emphasized this recommendation in his report of 9 January 1996.[24] Discussing his concern about torture practices, the Special Rapporteur pointed out in paragraph 136 that "both under general international law and under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, States are obliged to investigate allegations of torture".

(e) *Special Rapporteur on violence against women*

22. The Special Rapporteur on violence against women was established in 1994 by resolution 1994/45 of the Commission on Human Rights and that mandate was renewed by resolution 1997/44. The Special Rapporteur has established procedures to seek clarification and information from Governments, in a humanitarian spirit, on specific cases of alleged violence in order to identify and investigate specific situations and allegations of violence against women in any country. These communications may concern one or more individuals identified by name or information of a more general nature relating to a prevailing situation condoning or perpetrating violence against women. The definition of gender-based violence against women used by the Special Rapporteur is taken from the Declaration on the Elimination of Violence against Women, adopted by the General Assembly in resolution 48/104 of 20 December 1993. Urgent appeals may be sent by the Special Rapporteur in cases of gender-based violence against women that involve or may involve an imminent threat or fear of threat to the right to life or physical integrity of a person. The Special Rapporteur urges the competent national authorities not only to provide comprehensive information on the case but also to carry out an independent and impartial investigation concerning the case transmitted and to take immediate action to ensure that no further violation of the human rights of women occur.

[22] Ibid., E/4393.

[23] Ibid., E/CN.4/1995/34.

[24] Ibid., E/CN.4/1996/35.

23. The Special Rapporteur reports annually to the Commission on Human Rights on communications sent to Governments and on replies received by him or her. On the basis of information received from Governments and other reliable sources, the Special Rapporteur makes recommendations to the Governments concerned with a view to finding durable solutions to the elimination of violence against women in any country. The Special Rapporteur may send follow-up communications to Governments when no replies have been received or when insufficient information has been provided. Should a particular situation of violence against women in any given country persist and information received by the Special Rapporteur indicate that no measures are or have been taken by a Government to ensure the protection of the human rights of women, the Special Rapporteur may consider the possibility of seeking permission from the Government concerned to visit that country in order to carry out an on-site fact-finding mission.

(f) *United Nations Voluntary Fund for Victims of Torture*

24. The physical and psychological after-effects of torture can be devastating and last for years, affecting not only the victims but also members of their families. Assistance in recovering from the trauma suffered can be obtained from organizations that specialize in assisting victims of torture. In December 1981, the General Assembly established the United Nations Voluntary Fund for Victims of Torture to receive voluntary contributions for distribution to non-governmental organizations (NGOs) that provide psychological, medical, social, economic, legal and other forms of humanitarian assistance to victims of torture and members of their families. Depending on the voluntary contributions available, the Fund may finance about 200 NGO projects assisting about 80,000 victims of torture and members of their families in about 80 countries worldwide. The Fund financed the drafting and translation of the present manual and recommended its publication in the Professional Training Series of the Office of the United Nations High Commissioner for Human Rights, following a recommendation of its Board of Trustees, which subsidizes a limited number of projects to train health professionals and others on how to provide specialized assistance to victims of torture.

C. Regional organizations

25. Regional bodies have also contributed to the development of standards for the prevention of torture. These bodies include the Inter-American Commission on Human Rights, the Inter-American Court of Human Rights, the European Court of Human Rights, the European Committee for the Prevention of Torture and the African Commission on Human Rights.

1. *The Inter-American Commission on Human Rights and the Inter-American Court of Human Rights*

26. On 22 November 1969, the Organization of American States adopted the American Convention on Human Rights, which entered into force on 18 July 1978.[25] Article 5 of the Convention states:

> 1. Every person has the right to have his physical, mental, and moral integrity respected.
>
> 2. No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment. All persons deprived of their liberty shall be treated with respect for the inherent dignity of the human person.

27. Article 33 of the Convention provides for the establishment of the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. As stated in its regulations, the Commission's principal function is to promote the observance and defence of human rights and to serve as an advisory body to the Organization of American States in this area.[26] In fulfilling this function, the Commission has looked to the Inter-American Convention to Prevent and Punish Torture to guide its interpretation of what is meant by torture under article 5.[27] The Inter-American Convention to Prevent and Punish Torture was adopted by the Organization of American States on 9 December 1985 and entered into force on 28 February 1987.[28] Article 2 of the Convention defines torture as:

> ...stany act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.

28. Under article 1, the States parties to the Convention undertake to prevent and punish torture in accordance with the terms of the Convention. States parties to the Convention are required to conduct an immediate and proper investigation into any allegation that torture has occurred within their jurisdiction.

29. Article 8 provides that "States Parties shall guarantee that any person making an accusation of having been subjected to torture within their jurisdiction shall have the right to an impartial examination of his case". Likewise, if there is an accusation or well-grounded reason to believe that an act of torture has been committed within their jurisdiction, the States parties must guarantee that their respective authorities will proceed properly and immediately to conduct an investigation into the case and initiate, whenever appropriate, the corresponding criminal process.

30. In one of its 1998 country reports, the Commission noted that an obstacle to the effective prosecution of torturers is the lack of independence in an investigation of claims of torture, as the investigation is required to be undertaken by federal bodies likely to be acquainted with

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[25] Organization of American States, *Treaty Series*, No. 36, and United Nations, *Treaty Series,* vol. 1144, p. 123, reprinted in "Basic documents pertaining to human rights in the inter-American system" (OEA/Ser. L.V/II.82, document 6, rev. 1), p. 25 (1992).

[26] "Regulations of the Inter-American Commission on Human Rights" (OEA/Ser.L.V/II.92), document 31, rev. 3 of 3 May 1996, art. (1).

[27] See case 10.832, report No. 35/96, Inter-American Commission on Human Rights Annual Report 1997, para. 75.

[28] Organization of American States, *Treaty Series,* No. 67.

parties accused of committing torture.[29] The Commission cited article 8 to underscore the importance of an "impartial examination" of each case.[30]

31. The Inter-American Court of Human Rights has addressed the necessity of investigating claims of violations of the American Convention on Human Rights. In its decision in the Velásquez Rodríguez case, judgement of 29 July 1988, the Court stated that:

> The State is obligated to investigate every situation involving a violation of the rights protected by the Convention. If the State apparatus acts in such a way that the violation goes unpunished and the victim's full enjoyment of such rights is not restored as soon as possible, the State has failed to comply with its duty to ensure the free and full exercise of those rights to the persons within its jurisdiction.

32. Article 5 of the Convention provides for the right to be free from torture. Although the case dealt specifically with the issue of disappearance, one of the rights referred to by the Court as guaranteed by the American Convention on Human Rights is the right not to be subjected to torture or other forms of ill-treatment.

2. *The European Court of Human Rights*

33. On 4 November 1950, the Council of Europe adopted the European Convention for the Protection of Human Rights and Fundamental Freedoms, which entered into force on 3 September 1953.[31] Article 3 of the European Convention states that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment". The European Convention established control mechanisms consisting of the European Court and the European Commission of Human Rights. Since the reform that entered into force on 1 November 1998, a new permanent Court has replaced the former Court and Commission. The right of individual applications is now mandatory, and all victims have direct access to the Court. The Court has had the occasion to consider the necessity of investigating allegations of torture as a way of ensuring the rights guaranteed by article 3.

34. The first judgement on this issue was the decision in the *Aksoy* v. *Turkey* case (100/1995/606/694), delivered on 18 December 1996.[32] In that case, the Court considered that:

> [w]here an individual is taken into police custody in good health but is found to be injured at the time of release, it is incumbent on the State to provide a plausible explanation as to the causing of the injury, failing which a clear issue arises under Article 3 of the Convention.[33]

35. The Court went on to hold that the injuries inflicted on the applicant resulted from torture and that article 3 had been violated.[34] Furthermore, the Court interpreted article 13 of the Convention, which provides for the right to an effective remedy before a national authority, as imposing an obligation to investigate claims of torture thoroughly. Considering the "fundamental importance of the prohibition of torture" and the vulnerability of torture victims, the Court held that "Article 13 imposes, without prejudice to any other remedy available under the domestic system, an obligation on States to carry out a thorough and effective investigation of incidents of torture".[35]

36. According to the Court's interpretation, the notion of an "effective remedy" in article 13 entails a thorough investigation of every "arguable claim" of torture. The Court noted that although the Convention has no express provision, such as article 12 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, "such a requirement is implicit in the notion of an 'effective remedy' under Article 13".[36] The Court then found that the State had violated article 13 by failing to investigate the applicant's allegation of torture.[37]

37. In a judgement of 28 October 1998 in the case of *Assenov and Others* v. *Bulgaria* (90/1997/874/1086), the Court went even further in recognizing an obligation for the State to investigate allegations of torture not only under article 13 but also under article 3. In this case, a young Romany arrested by the police showed medical evidence of beatings, but it was impossible to assess, on the basis of available evidence, whether these injuries were caused by his father or by the police. The Court recognized that "the degree of bruising found by the doctor who examined Mr. Assenov …indicates that the latter's injuries, whether caused by his father or by the police, were sufficiently serious to amount to ill-treatment within the scope of Article 3".[38] Contrary to the Commission that held that there was no violation of article 3, the Court did not stop there. It went on and considered that the facts raised "a reasonable suspicion that these injuries may have been caused by the police".[39] Hence the Court held that:

> [I]n these circumstances, where an individual raises an arguable claim that he has been seriously ill-treated by the police or other such agents of the State unlawfully and in breach of Article 3, that provision, read in conjunction with the State's general duty under Article 1 of the Convention "to secure to everyone within their jurisdiction the rights and freedoms defined in [the] Convention", requires by implication that there should be an effective official investigation. This investi-gation… should be capable of leading to the identification and punishment of those responsible. If this were not the case, the general legal prohibition of torture and inhuman and degrading treatment and punishment, despite its fundamental importance…, would be ineffective in practice and it would be possible in some cases for agents of the State to abuse the rights of those within their control with virtual impunity.[40]

38. For the first time, the Court concluded that a violation of article 3 had occurred, not from ill-treatment per se but from a failure to carry out effective official investigation on the allegation of ill-treatment. In addi-

[29] Inter-American Commission on Human Rights, *Report on the Situation of Human Rights in Mexico*, 1998, para. 323.

[30] Ibid., para. 324.

[31] United Nations, *Treaty Series,* vol. 213, p. 222.

[32] See Additional Protocols Nos. 3, 5 and 8, which entered into force on 21 September 1970, 20 December 1971 and 1 January 1990, *European Treaty Series* Nos. 45, 46 and 118, respectively.

[33] See European Court of Human Rights, *Reports of Judgments and Decisions* 1996–VI, para. 61.

[34] Ibid., para. 64.

[35] Ibid., para. 98.

[36] Ibid.

[37] Ibid., para. 100.

[38] Ibid., *Reports of Judgments and Decisions* 1998–VIII, para. 95.

[39] Ibid., para. 101.

[40] Ibid., para. 102.

tion, the Court reiterated its position in the Aksoy case and concluded that there had also been a violation of article 13. The Court considered that:

> Where an individual has an arguable claim that he has been ill-treated in breach of Article 3, the notion of an effective remedy entails, in addition to a thorough and effective investigation of the kind as also required by Article 3 . . . , effective access for the complainant to the investigatory procedure and payment of compensation where appropriate.[41]

3. *The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment*

39. In 1987, the Council of Europe adopted the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, which entered into force on 1 February 1989.[42] By 1 March 1999, all 40 member States of the Council of Europe had ratified the Convention. This Convention complements the judicial mechanism of the European Convention on Human Rights with a preventive mechanism. The Convention intentionally does not create substantive norms. The Convention established the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, consisting of one member per member State. The members elected to the Committee should be of high moral standard, impartial, independent and also available to carry out field missions.

40. The Committee carries out visits to member States of the Council of Europe, partially on a regular periodic basis and partially on an ad hoc basis. A visiting delegation of the Committee consists of members of the Committee, accompanying experts in the medical, legal or other fields, interpreters and members of the secretariat. These delegations visit persons deprived of their liberty by the authorities of the country visited.[43] The powers of each visiting delegation are quite vast: it may visit any place where persons are held deprived of their liberty; make unannounced visits to any such place; repeat visits to these places; talk to persons deprived of their liberty in private; visit any or all persons it chooses to in these places; and see all premises (not only cell areas) without restrictions. The delegation can have access to all papers and files concerning the persons visited. The entire work of the Committee is based on confidentiality and cooperation.

41. After a visit, the Committee writes a report. Based on the facts observed during the visit, the report comments on the conditions found, makes concrete recommendations and asks any questions that need further clarification. The State party answers the report in writing and thereby establishes a dialogue between the Committee and the State party, which continues until the following visit. The Committee's reports and the State party's answers are confidential documents, but the State party (not the Committee) may decide to publish both the reports and the answers. So far, nearly all the States parties have made public both reports and answers.

42. In the course of its activities over the past 10 years, the Committee has gradually developed a set of criteria for the treatment of persons held in custody that constitutes general standards. These standards deal not only with the material conditions but also with procedural safeguards. For example, three safeguards advocated by the Committee for persons held in police custody are:

(*a*) The right of a person deprived of liberty, if he or she so desires, to inform immediately a third party (family member) of the arrest;

(*b*) The right of a person deprived of liberty to have immediate access to a lawyer;

(*c*) The right of a person deprived of liberty to have access to a physician, including, if he or she so wishes, a physician of his or her own choice.

43. Furthermore, the Committee has stressed repeatedly that one of the most effective means of preventing ill-treatment by law enforcement officials lies in the diligent examination by competent authorities of all complaints of such treatment brought before them and, where appropriate, the imposition of a suitable penalty. This has a strong dissuasive effect.

4. *The African Commission on Human and Peoples' Rights and the African Court on Human and Peoples' Rights*

44. In comparison with the European and inter-American systems, Africa does not have a convention on torture and its prevention. The question of torture is examined on the same level as are other human rights violations. The question of torture is dealt with primarily in the African Charter of Human and Peoples' Rights, which was adopted by the Organization of African Unity on 27 June 1981 and which entered into force on 21 October 1986.[44] Article 5 of the African Charter states:

> Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.

45. In accordance with article 30 of the African Charter, the African Commission on Human and Peoples' Rights was established in June 1987 and was charged "to promote human and peoples' rights and ensure their protection in Africa". In its periodic sessions, the Commission has passed several country resolutions on matters concerning human rights in Africa, some of which have dealt with torture, among other violations. In some of its country resolutions, the Commission raised concerns about the degradation of human rights situations, including the practice of torture.

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[41] Ibid., para. 117.

[42] *European Treaty Series,* No. 126.

[43] A person deprived of liberty is any person deprived of liberty by a public authority, such as, but not exclusively, persons arrested or in any form of detention, prisoners awaiting trial, sentenced prisoners and persons involuntarily confined to psychiatric hospitals.

[44] Organization of African Unity, document CAB/LEG/67/3, Rev. 5, 21, *International Legal Materials*, 58 (1982).

46. The Commission has established new mechanisms, such as the Special Rapporteur on Prisons, the Special Rapporteur on Arbitrary and Summary Executions and the Special Rapporteur on Women, whose mandate is to report during the open sessions of the Commission. These mechanisms have created opportunities for victims and NGOs to send information directly to special rapporteurs. At the same time, a victim or an NGO can make a complaint to the Commission regarding acts of torture as defined in article 5 of the African Charter. While an individual complaint is pending before the Commission, the victim or the NGO can send the same information to special rapporteurs for their public reports to the Commission's sessions. To provide a forum for adjudicating claims of violations of the rights guaranteed in the African Charter, the Organization of African Unity Assembly adopted a protocol for the establishment of the African Court of Human and Peoples' Rights in June 1998.

D. The International Criminal Court

47. The Rome Statute of the International Criminal Court, adopted on 17 July 1998, established a permanent international criminal court to try individuals responsible for genocide, crimes against humanity and war crimes (A/CONF.183/9). The Court has jurisdiction over cases alleging torture either as part of the crime of genocide or as a crime against humanity, if the torture is committed as part of a widespread or systematic attack, or as a war crime under the Geneva Conventions of 1949. Torture is defined in the Rome Statute as the intentional infliction of severe pain or suffering, whether physical or mental, upon a person in the custody or under the control of the accused. As of 25 September 2000, the Rome Statute of the International Criminal Court had been signed by 113 countries and ratified by 21 States. The Court will have its headquarters in The Hague. This Court has jurisdiction only in cases in which States are unable or unwilling to prosecute individuals responsible for the crimes described in the Rome Statute.

CHAPTER II

RELEVANT ETHICAL CODES

48. All professions work within ethical codes, which provide a statement of the shared values and acknowledged duties of professionals and set moral standards with which they are expected to comply. Ethical standards are established primarily in two ways: by international instruments drawn up by bodies like the United Nations and by codes of principles drafted by the professions themselves, through their representative associations, nationally or internationally. The fundamental tenets are invariably the same and focus on obligations owed by the professional to individual clients or patients, to society at large and to colleagues in order to maintain the honour of the profession. These obligations reflect and complement the rights to which all people are entitled under international instruments.

A. Ethics of the legal profession

49. As the ultimate arbiters of justice, judges play a special role in the protection of the rights of citizens. International standards create an ethical duty on the part of judges to ensure that the rights of individuals are protected. Principle 6 of the United Nations Basic Principles on the Independence of the Judiciary states that "The principle of the independence of the judiciary entitles and requires the judiciary to ensure that judicial proceedings are conducted fairly and that the rights of the parties are respected".[45] Similarly, prosecutors have an ethical duty to investigate and prosecute a crime of torture committed by public officials. Article 15 of the United Nations Guidelines on the Role of Prosecutors states: "Prosecutors shall give due attention to the prosecution of crimes committed by public officials, particularly corruption, abuse of power, grave violations of human rights and other crimes recognized by international law and, where authorized by law or consistent with local practice, the investigation of such offences."[46]

50. International standards also establish a duty for lawyers, in carrying out their professional functions, to promote and protect human rights and fundamental freedoms. Principle 14 of the United Nations Basic Principles on the Role of Lawyers provides: "Lawyers, in protecting the rights of their clients and in promoting the cause of justice, shall seek to uphold human rights and fundamental freedoms recognized by national and international law and shall at all times act freely and diligently in accordance with the law and recognized standards and ethics of the legal profession."[47]

B. Health-care ethics

51. There are very clear links between concepts of human rights and the well-established principle of health-care ethics. The ethical obligations of health professionals are articulated at three levels and are reflected in United Nations documents in the same way as they are for the legal profession. They are also embodied in statements issued by international organizations representing health professionals, such as the World Medical Association, the World Psychiatric Association and the International Council of Nurses.[48] National medical associations and nursing organizations also issue codes of ethics, which their members are expected to follow. The central tenet of all health-care ethics, however articulated, is the fundamental duty always to act in the best interests of the patient, regardless of other constraints, pressures or contractual obligations. In some countries, medical ethical principles, such as that of doctor-patient confidentiality, are incorporated into national law. Even where ethical principles are not established in law in this way, all health professionals are morally bound by the standards set by their professional bodies. They are judged to be guilty of misconduct if they deviate from professional standards without reasonable justification.

1. *United Nations statements relevant to health professionals*

52. Health professionals, like all other persons working in prison systems, must observe the Standard Minimum Rules for the Treatment of Prisoners, which require that medical, including psychiatric, services must be

[45] Adopted by the Seventh United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Milan, Italy, from 26 August to 6 September 1985 and endorsed by General Assembly resolutions 40/32 of 29 November 1985 and 40/146 of 13 December 1985.

[46] Adopted by the Eighth United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held in Havana from 27 August to 7 September 1990.

[47] See footnote 46 above.

[48] There are also a number of regional groupings, such as the Commonwealth Medical Association and the International Conference of Islamic Medical Associations that issue important statements on medical ethics and human rights for their members.

available to all prisoners without discrimination and that all sick prisoners or those requesting treatment be seen daily.[49] These requirements reinforce the ethical obligations of physicians, discussed below, to treat and act in the best interests of patients for whom they have a duty to care. In addition, the United Nations has specifically addressed the ethical obligations of doctors and other health professionals in the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.[50] These make clear that health professionals have a moral duty to protect the physical and mental health of detainees. They are specifically prohibited from using medical knowledge and skills in any manner that contravenes international statements of individual rights.[51] In particular, it is a gross contravention of health-care ethics to participate, actively or passively, in torture or condone it in any way.

53. "Participation in torture" includes evaluating an individual's capacity to withstand ill-treatment; being present at, supervising or inflicting maltreatment; resuscitating individuals for the purposes of further maltreatment or providing medical treatment immediately before, during or after torture on the instructions of those likely to be responsible for it; providing professional knowledge or individuals' personal health information to torturers; and intentionally neglecting evidence and falsifying reports, such as autopsy reports and death certificates.[52] The United Nations Principles also incorporate one of the fundamental rules of health-care ethics by emphasizing that the only ethical relationship between prisoners and health professionals is one designed to evaluate, protect and improve prisoners' health. Thus, assessment of detainees' health in order to facilitate punishment or torture is clearly unethical.

2. *Statements from international professional bodies*

54. Many statements from international professional bodies focus on principles relevant to the protection of human rights and represent a clear international medical consensus on these issues. Declarations of the World Medical Association define internationally agreed aspects of the ethical duties to which all doctors are held. The World Medical Association's Declaration of Tokyo[53] reiterates the prohibition of any form of medical participation or medical presence in torture or ill-treatment. This is reinforced by the United Nations Principles that specifically refer to the Declaration of Tokyo. Doctors are clearly prohibited from providing information or any medical instrument or substance that would facilitate ill-treatment. The same rule is specifically applied to psychiatry in the World Psychiatric Association's Declaration of Hawaii,[54] which prohibits the misuse of psychiatric skills to violate the human rights of any individual or group. The International Conference on Islamic Medicine made a similar point in its Declaration of Kuwait,[55] which bans doctors from allowing their special knowledge to be used "to harm, destroy or inflict damage on the body, mind or spirit, whatever the military or political reason". Similar provisions are made for nurses in the directive on the Nurse's Role in the Care of Detainees and Prisoners.[56]

55. Health professionals also have a duty to support colleagues who speak out against human rights violations. Failure to do so risks not only an infringement of patient rights and a contravention of the declarations listed above but also brings the health professions into disrepute. Tarnishing the honour of the profession is considered to be serious professional misconduct. The World Medical Association's resolution on human rights[57] calls on all national medical associations to review the human rights situation in their own countries and ensure that doctors do not conceal evidence of abuse even where they fear reprisal. It requires national bodies to provide clear guidance, especially for doctors working in the prison system, to protest alleged violations of human rights and provide effective machinery for investigating doctors' unethical activities in the human rights sphere. It also requires that they support individual doctors who call attention to human rights abuses. The World Medical Association's subsequent Declaration of Hamburg[58] reaffirms the responsibility of individuals and organized medical groups worldwide to encourage doctors to resist torture or any pressure to act contrary to ethical principles. It calls upon individual doctors to speak out against maltreatment and urges national and international medical organizations to support doctors who resist such pressure.

3. *National codes of medical ethics*

56. The third level at which ethical principles are articulated is through national codes. These reflect the same core values as mentioned above, since medical ethics are the expression of values common to all doctors. In virtually all cultures and codes, the same basic presumptions occur about duties to avoid harm, help the sick, protect the vulnerable and not discriminate between patients on any basis other than the urgency of their medical needs. Identical values are present in the codes for the nursing profession. A problematic aspect of ethical principles is that they do not, however, provide definitive rules for every dilemma but require some interpretation. When weighing ethical dilemmas, it is vital that health professionals bear in mind the fundamental moral

[49] Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Standard Minimum Rules, adopted by the United Nations in 1955.

[50] Adopted by the General Assembly in 1982.

[51] Particularly the Universal Declaration of Human Rights, the International Covenants on Human Rights and the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

[52] Health professionals must, however, bear in mind the duty of confidentiality owed to patients and the obligation to obtain informed consent for disclosure of information, particularly when individuals may be put at risk by such disclosure (see chapter II, sect. C.3).

[53] Adopted by the World Medical Association in 1975.

[54] Adopted in 1977.

[55] Adopted in 1981 (1401 in the Islamic calendar).

[56] Adopted by the International Council of Nurses in 1975.

[57] Adopted in 1990.

[58] Adopted in 1997.

obligations expressed in their shared professional values but also that they implement them in a manner that reflects the basic duty to avoid harm to their patients.

C. Principles common to all codes of health-care ethics

57. The principle of professional independence requires health professionals always to concentrate on the core purpose of medicine, which is to alleviate suffering and distress and avoid harm, despite other pressures. Several other ethical principles are so fundamental that they are invariably found in all codes and ethical statements. The most basic are the injunctions to provide compassionate care, do no harm and to respect patients' rights. These are central requirements for all health professionals.

1. *The duty to provide compassionate care*

58. The duty to provide care is expressed in a variety of ways in national and international codes and declarations. One aspect of this duty is the medical duty to respond to those in medical need. This is reflected in the World Medical Association's International Code of Medical Ethics,[59] which recognizes the moral obligation of doctors to provide emergency care as a humanitarian duty. The duty to respond to need and suffering is echoed in traditional statements in virtually all cultures.

59. Underpinning much of modern medical ethics are the principles established in the earliest statements of professional values that require doctors to provide care even at some risk to themselves. For example, the Caraka Samhita, a Hindu code dating from the first century AD, instructs doctors to "endeavour for the relief of patients with all thy heart and soul. Thou shall not desert or injure thy patient for the sake of thy life or thy living". Similar instructions were given in early Islamic codes and the modern Declaration of Kuwait requires doctors to focus on the needy, be they "near or far, virtuous or sinner, friend or enemy".

60. Western medical values have been dominated by the influence of the Hippocratic oath and similar pledges, such as the Prayer of Maimonides. The Hippocratic oath represents a solemn promise of solidarity with other doctors and a commitment to benefit and care for patients while avoiding harming them. It also contains a promise to maintain confidentiality. These four concepts are reflected in various forms in all modern professional codes of health-care ethics. The World Medical Association's Declaration of Geneva[60] is a modern restatement of the Hippocratic values. It is a promise by which doctors undertake to make the health of their patients their primary consideration and vow to devote themselves to the service of humanity with conscience and dignity.

61. Aspects of the duty to care are reflected in many of the World Medical Association's declarations, which make clear that doctors must always do what is best for the patient, including detainees and alleged criminals. This duty is often expressed through the notion of professional independence, requiring doctors to adhere to best medical practices despite any pressure that might be applied. The World Medical Association's International Code of Medical Ethics emphasizes doctors' duty to provide care "in full technical and moral independence, with compassion and respect for human dignity". It also stresses the duty to act only in the patient's interest and says that doctors owe their patients complete loyalty. The World Medical Association's Tokyo Declaration and Declaration on Physician Independence and Professional Freedom[61] make unambiguously clear that doctors must insist on being free to act in patients' interests, regardless of other considerations, including the instructions of employers, prison authorities or security forces. The latter declaration requires doctors to ensure that they "have the professional independence to represent and defend the health needs of patients against all who would deny or restrict needed care for those who are sick or injured". Similar principles are prescribed for nurses in the International Council of Nurses Code of Ethics.

62. Another way in which duty to provide care is expressed by the World Medical Association is through its recognition of patient rights. Its Declaration of Lisbon on the Rights of the Patient[62] recognizes that every person is entitled, without discrimination, to appropriate health care and reiterates that doctors must always act in a patient's best interest. Patients must be guaranteed autonomy and justice, according to the Declaration, and both doctors and providers of medical care must uphold patient's rights. "Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them." Individuals are entitled to appropriate health care, regardless of factors such as their ethnic origin, political beliefs, nationality, gender, religion or individual merit. People accused or convicted of crimes have an equal moral entitlement to appropriate medical and nursing care. The World Medical Association's Declaration of Lisbon emphasizes that the only acceptable criterion for discriminating between patients is the relative urgency of their medical need.

2. *Informed consent*

63. While the declarations reflecting a duty of care all emphasize an obligation to act in the best interests of the individual being examined or treated, this presupposes that health professionals know what is in the patient's best interest. An absolutely fundamental precept of modern medical ethics is that patients themselves are the best judge of their own interests. This requires health professionals to give normal precedence to a competent adult patient's wishes rather than to the views of any person in authority about what would be best for that individual. Where the patient is unconscious or otherwise incapable of giving valid consent, health professionals must make a judgement about how that person's best interests can be

[59] Adopted in 1949.

[60] Adopted in 1948.

[61] Adopted by the World Medical Association in 1986.

[62] Adopted by the World Medical Association in 1981; amended by its General Assembly at its forty-seventh session in September 1995.

protected and promoted. Nurses and doctors are expected to act as an advocate for their patients, and this is made clear in statements such as the World Medical Association's Declaration of Lisbon and the International Council of Nurses' statement on the Nurse's Role in Safeguarding Human Rights.[63]

64. The World Medical Association's Declaration of Lisbon specifies the duty for doctors to obtain voluntary and informed consent from mentally competent patients to any examination or procedure. This means that individuals need to know the implications of agreeing and the consequences of refusing. Before examining patients, health professionals must, therefore, explain frankly the purpose of the examination and treatment. Consent obtained under duress or as a result of false information being given to the patient is invalid, and doctors acting on it are likely to be in breach of medical ethics. The graver the implications of the procedure for the patient, the greater the moral imperative to obtain properly informed consent. That is to say, where examination and treatment are clearly of therapeutic benefit to individuals, their implied consent by cooperating in the procedures may be sufficient. In cases where examination is not primarily for the purposes of providing therapeutic care, great caution is required in ensuring that the patient knows and agrees to this and that it is in no way contrary to the individual's best interests. As previously stated, examination to ascertain whether an individual can withstand punishment, torture or physical pressure during interrogation is unethical and contrary to the purpose of medicine. The only ethical assessment of a prisoner's health is one designed to evaluate the patient's health in order to maintain and improve optimum health, not to facilitate punishment. Physical examination for evidential purposes in an inquiry requires consent that is informed in the sense that the patient understands factors such as how the health data gained from the examination will be used, how they will be stored and who will have access to them. If these and other points relevant to the patient's decision are not made clear in advance, consent to examination and recording of information is invalid.

3. *Confidentiality*

65. All ethical codes, from the Hippocratic oath to modern times, include the duty of confidentiality as a fundamental principle, which also features prominently in the World Medical Association's declarations, such as the Declaration of Lisbon. In some jurisdictions, the obligation of professional secrecy is seen as so important that it is incorporated into national law. The duty of confidentiality is not absolute and may be ethically breached in exceptional circumstances where failure to do so will foreseeably give rise to serious harm to people or a serious perversion of justice. Generally, however, the duty of confidentiality covering identifiable personal health information can be overridden only with the informed permission of the patient.[64] Non-identifiable patient information can be freely used for other purposes and should be used preferably in all situations where disclosure of the patient's identity is non-essential. This may be the case, for example, in the collection of data about patterns of torture or maltreatment. Dilemmas arise where health professionals are pressured or required by law to disclose identifiable information which would be likely to put patients at risk of harm. In such cases, the fundamental ethical obligations are to respect the autonomy and best interests of the patient, to do good and avoid harm. This supersedes other considerations. Doctors should make clear to the court or the authority requesting information that they are bound by professional duties of confidentiality. Health professionals responding in this way are entitled to the support of their professional association and colleagues. In addition, during periods of armed conflict, international humanitarian law gives specific protection to doctor-patient confidentiality, requiring that doctors do not denounce people who are sick or wounded.[65] Health professionals are protected in that they cannot be compelled to disclose information about their patients in such situations.

D. Health professionals with dual obligations

66. Health professionals have dual obligations, in that they owe a primary duty to the patient to promote that person's best interests and a general duty to society to ensure that justice is done and violations of human rights prevented. Dilemmas arising from these dual obligations are particularly acute for health professionals working with the police, military, other security services or in the prison system. The interests of their employer and their non-medical colleagues may be in conflict with the best interests of the detainee patients. Whatever the circumstances of their employment, all health professionals owe a fundamental duty to care for the people they are asked to examine or treat. They cannot be obliged by contractual or other considerations to compromise their professional independence. They must make an unbiased assessment of the patient's health interests and act accordingly.

1. *Principles guiding all doctors with dual obligations*

67. In all cases where doctors are acting for another party, they have an obligation to ensure that this is understood by the patient.[66] Doctors must identify themselves to patients and explain the purpose of any examination or treatment. Even when doctors are appointed and paid by a third party, they retain a clear duty of care to any patient whom they examine or treat. They must refuse to comply with any procedures that may harm patients or leave them physically or psychologically vulnerable to harm. They must ensure that their contractual terms allow them professional independence to make clinical judgements. Doctors must ensure that any person in custody has access to any medical examination and treatment needed. Where the detainee is a minor or a vulnerable adult, doctors have additional duties to act as an advocate. Doctors retain a

[63] Adopted in 1983.

[64] Except for common public health requirements, such as the reporting by name of individuals with infectious diseases, drug addiction, mental disorders, etc.

[65] Article 16 of Protocol I (1977) and article 10 of Protocol II (1977), additional to the Geneva Conventions of 1949.

[66] These principles are extracted from *Doctors with Dual Obligations* (London, British Medical Association, 1995).

general duty of confidentiality so that information should not be disclosed without the patient's knowledge. They must ensure that their medical records are kept confidential. Doctors have a duty to monitor and speak out when services in which they are involved are unethical, abusive, inadequate or pose a potential threat to patients' health. In such cases, they have an ethical duty to take prompt action as failure to take an immediate stand makes protest at a later stage more difficult. They should report the matter to appropriate authorities or international agencies who can investigate, but without exposing patients, their families or themselves to foreseeable serious risk of harm. Doctors and professional associations should support colleagues who take such action on the basis of reasonable evidence.

2. *Dilemmas arising from dual obligations*

68. Dilemmas may occur when ethics and law are in contradiction. Circumstances can arise where their ethical duties oblige health professionals not to obey a particular law, such as a legal obligation to reveal confidential medical information about a patient. There is consensus in international and national declarations of ethical precepts that other imperatives, including the law, cannot oblige health professionals to act contrary to medical ethics and to their conscience. In such cases, health professionals must decline to comply with the law or a regulation rather than compromise basic ethical precepts or expose patients to serious danger.

69. In some cases, two ethical obligations are in conflict. International codes and ethical principles require the reporting of information concerning torture or maltreatment to a responsible body. In some jurisdictions, this is also a legal requirement. In some cases, however, patients may refuse to give consent to being examined for such purposes or to having the information gained from examination disclosed to others. They may be fearful of the risks of reprisals for themselves or their families. In such situations, health professionals have dual responsibilities: to the patient and to society at large, which has an interest in ensuring that justice is done and perpetrators of abuse are brought to justice. The fundamental principle of avoiding harm must feature prominently in consideration of such dilemmas. Health professionals should seek solutions that promote justice without breaching the individual's right to confidentiality. Advice should be sought from reliable agencies; in some cases this may be the national medical association or non-governmental agencies. Alternatively, with supportive encouragement, some reluctant patients may agree to disclosure within agreed parameters.

70. The ethical obligations of a doctor may vary according to the context of the doctor-patient encounter and the possibility of the patient being able to exercise free choice about the disclosure decision. For example, where the doctor and patient are in a clearly therapeutic situation, such as the provision of care in hospital, there is a strong moral imperative for doctors to preserve the usual rules of confidentiality that normally prevail in therapeutic relationships. Reporting evidence of torture obtained in such encounters is entirely appropriate as long as the patient does not forbid it. Doctors should report such evidence if patients request it or give properly informed consent to it. They should support patients in such decisions.

71. Forensic doctors have a different relationship with the individuals they examine and usually have an obligation to report their observations factually. The patient has less power and choice in such situations and may not be able to speak openly about what has occurred. Before beginning any examination, forensic doctors must explain their role to the patient and make clear that medical confidentiality is not a usual part of their role, as it would be in a therapeutic context. Regulations may not permit the patient to refuse examination, but the patient has an option of choosing whether to disclose the cause of any injury. Forensic doctors should not falsify their reports but should provide impartial evidence, including making clear in their reports any evidence of maltreatment.[67]

72. Prison doctors are primarily providers of therapeutic treatment but they also have the task of examining detainees arriving in prison from police custody. In this role or in treatment of people within a prison, they may discover evidence of unacceptable violence, which prisoners themselves are not in a realistic position to denounce. In such situations, doctors must bear in mind the best interests of the patient and their duties of confidentiality to that person, but the moral arguments for the doctor to denounce evident maltreatment are strong, since prisoners themselves are often unable to do so effectively. Where prisoners agree to disclosure, no conflict arises and the moral obligation is clear. If a prisoner refuses to allow disclosure, doctors must weigh the risk and potential danger to that individual patient against the benefits to the general prison population and the interests of society in preventing the perpetuation of abuse.

73. Health professionals must also bear in mind that reporting abuse to the authorities in whose jurisdiction it is alleged to have occurred may well entail risks of harm for the patient or for others, including the whistle-blower. Doctors must not knowingly place individuals in danger of reprisal. They are not exempt from taking action but should use discretion and must consider reporting the information to a responsible body outside the immediate jurisdiction or, where this would not entail foreseeable risks to health professionals and patients, report it in a non-identifiable manner. Clearly, if the latter solution is taken, health professionals must take into account the likelihood of pressure being brought on them to disclose identifying data or the possibility of having their medical records forcibly seized. While there are no easy solutions, health professionals should be guided by the basic injunction to avoid harm above all other considerations and seek advice, where possible, from national or international medical bodies.

[67] See V. Iacopino and others, "Physician complicity in misrepresentation and omission of evidence of torture in postdetention medical examinations in Turkey", *Journal of the American Medical Association (JAMA)*, vol. 276 (1996), pp. 396-402.

CHAPTER III

LEGAL INVESTIGATION OF TORTURE

74. States are required under international law to investigate reported incidents of torture promptly and impartially. Where evidence warrants it, a State in whose territory a person alleged to have committed or participated in torture is present, must either extradite the alleged perpetrator to another State that has competent jurisdiction or submit the case to its own competent authorities for the purpose of prosecution under national or local criminal laws. The fundamental principles of any viable investigation into incidents of torture are competence, impartiality, independence, promptness and thoroughness. These elements can be adapted to any legal system and should guide all investigations of alleged torture.

75. Where investigative procedures are inadequate because of a lack of resources or expertise, the appearance of bias, the apparent existence of a pattern of abuse or other substantial reasons, States shall pursue investigations through an independent commission of inquiry or similar procedure. Members of that commission must be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any institution, agency or person that may be the subject of the inquiry.

76. Section A describes the broad purpose of an investigation into torture. Section B sets forth basic principles on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. Section C sets forth suggested procedures for conducting an investigation into alleged torture, first considering the decision regarding the appropriate investigative authority, then offering guidelines regarding collection of oral testimony from the reported victim and other witnesses and collection of physical evidence. Section D provides guidelines for establishing a special independent commission of inquiry. These guidelines are based on the experiences of several countries that have established independent commissions to investigate alleged human rights abuses, including extrajudicial killings, torture and disappearances.

A. Purposes of an investigation into torture

77. The broad purpose of the investigation is to establish the facts relating to alleged incidents of torture, with a view to identifying those responsible for the incidents and facilitating their prosecution, or for use in the context of other procedures designed to obtain redress for victims. The issues addressed here may also be relevant for other types of investigations of torture. To fulfil this purpose, those carrying out the investigation must, at a minimum, seek to obtain statements from the victims of alleged torture; to recover and preserve evidence, including medical evidence, related to the alleged torture to aid in any potential prosecution of those responsible; to identify possible witnesses and obtain statements from them concerning the alleged torture; and to determine how, when and where the alleged incidents of torture occurred as well as any pattern or practice that may have brought about the torture.

B. Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

78. The following principles represent a consensus among individuals and organizations having expertise in the investigation of torture. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter referred to as torture or other ill-treatment) include the following:

(*a*) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(*b*) Identification of measures needed to prevent recurrence;

(*c*) Facilitation of prosecution or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

79. States must ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation should be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, must be competent and impartial. They must have access to or be empowered to commission investigations by impartial medical or other experts. The methods used to carry out these investigations must meet the highest professional standards, and the findings must be made public.

80. The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.[68] The persons conducting the investigation must have at their disposal all the necessary budgetary and technical resources for effective investigation. They must also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same applies to any witness. To this end, the investigative authority is entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence. Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families must be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment should be removed from any position of control or power, whether direct or indirect, over complainants, witnesses or their families, as well as those conducting the investigation.

81. Alleged victims of torture or ill-treatment and their legal representatives must be informed of, and have access to, any hearing as well as to all information relevant to the investigation and must be entitled to present other evidence.

82. In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse, or for other substantial reasons, States must ensure that investigations are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission should be chosen for their recognized impartiality, competence and independence as individuals. In particular, they must be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission must have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these principles.[69] A written report, made within a reasonable time, must include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. On completion, this report must be made public. It must also describe in detail specific events that were found to have occurred, the evidence upon which such findings were based and list the names of witnesses who testified with the exception of those whose identities have been withheld for their own protection. The State must, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

83. Medical experts involved in the investigation of torture or ill-treatment should behave at all times in conformity with the highest ethical standards and, in particular, must obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations must be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials. The medical expert should promptly prepare an accurate written report. This report should include at least the following:

(*a*) The circumstances of the interview. The name of the subject and name and affiliation of those present at the examination; the exact time and date, location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g. detention centre, clinic, house, etc.); any appropriate circumstances at the time of the examination (e.g. nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner, threatening statements to the examiner, etc.); and any other relevant factor;

(*b*) The background. A detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, the time when torture or ill-treatment was alleged to have occurred and all complaints of physical and psychological symptoms;

(*c*) A physical and psychological examination. A record of all physical and psychological findings upon clinical examination including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(*d*) An opinion. An interpretation as to the probable relationship of physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment or further examination should also be given;

(*e*) A record of authorship. The report should clearly identify those carrying out the examination and should be signed.

84. The report should be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process should be solicited and recorded in the report. The report should be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that the report is delivered securely to these persons. The report should not be made available to any other person, except with the consent of the subject or when authorized by a court empowered to enforce the transfer. For general considerations for written reports following allegations of torture, see chapter IV. Chapters V and VI describe in detail the physical and psychological assessments, respectively.

C. Procedures of a torture investigation

1. *Determination of the appropriate investigative body*

85. In cases where involvement in torture by public officials is suspected, including possible orders for the use of torture by ministers, ministerial aides, officers acting with the knowledge of ministers, senior officers in State ministries, senior military leaders or tolerance of torture by such individuals, an objective and impartial investigation may not be possible unless a special commission of inquiry is established. A commission of inquiry may also

[68] Under certain circumstances professional ethics may require information to be kept confidential. These requirements should be respected.

[69] See footnote 68.

be necessary where the expertise or the impartiality of the investigators is called into question.

86. Factors that support a belief that the State was involved in the torture or that special circumstances exist that should trigger the creation of a special impartial investigation mechanism include:

(*a*) Where the victim was last seen unharmed in police custody or detention;

(*b*) Where the modus operandi is recognizably attributable to State-sponsored torture;

(*c*) Where persons in the State or associated with the State have attempted to obstruct or delay the investigation of the torture;

(*d*) Where public interest would be served by an independent inquiry;

(*e*) Where investigation by regular investigative agencies is in question because of lack of expertise or lack of impartiality or for other reasons, including the importance of the matter, the apparent existence of a pattern of abuse, complaints from the person or the above inadequacies or other substantial reasons.

87. Several considerations should be taken into account when a State decides to establish an independent commission of inquiry. First, persons subject to an inquiry should be guaranteed the minimum procedural safeguards protected by international law at all stages of the investigation. Second, investigators should have the support of adequate technical and administrative personnel, as well as access to objective, impartial legal advice to ensure that the investigation will produce admissible evidence for criminal proceedings. Third, investigators should receive the full scope of the State's resources and powers. Finally, investigators should have the power to seek help from the international community of experts in law and medicine.

2. *Interviewing the alleged victim and other witnesses*

88. Because of the nature of torture cases and the trauma individuals suffer as a result, often including a devastating sense of powerlessness, it is particularly important to show sensitivity to the alleged torture victim and other witnesses. The State must protect alleged victims of torture, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Investigators must inform witnesses about the consequences of their involvement in the investigation and about any subsequent developments in the case that may affect them.

(a) *Informed consent and other protection for the alleged victim*

89. From the outset, the alleged victim should be informed, wherever possible, of the nature of the proceedings, why his or her evidence is being sought, if and how evidence offered by the alleged victim may be used. Investigators should explain to the person which portions of the investigation will be public information and which portions will be confidential. The person has the right to refuse to cooperate with all or part of the investigation. Every effort should be made to accommodate his or her schedule and wishes. The alleged torture victim should be regularly informed of the progress of the investigation. The alleged victim should also be notified of all key hearings in the investigation and prosecution of the case. The investigators should inform the alleged victim of the arrest of the suspected perpetrator. Alleged victims of torture should be given contact information for advocacy and treatment groups that might be of assistance to them. Investigators should work with advocacy groups within their jurisdiction to ensure that there is a mutual exchange of information and training concerning torture.

(b) *Selection of the investigator*

90. The authorities investigating the case must identify a person primarily responsible for questioning the alleged victim. While the alleged victim may need to discuss his or her case with both legal and medical professionals, the investigating team should make every effort to minimize unnecessary repetitions of the person's story. In selecting a person as the primary investigator with responsibility for the alleged torture victim, special consideration should be given to the victim's preference for a person of the same gender, the same cultural background or the ability to communicate in his or her native language. The primary investigator should have prior training or experience in documenting torture and in working with victims of trauma, including torture. In situations where an investigator with prior training or experience is not available, the primary investigator should make every effort to become informed about torture and its physical and psychological consequences before interviewing the individual. Information about torture is available from sources including this manual, several professional and training publications, training courses and professional conferences. The investigator should also have access to international expert advice and assistance throughout the investigation.

(c) *Context of the investigation*

91. Investigators should carefully consider the context in which they are working, take necessary precautions and provide safeguards accordingly. If interviewing people who are still imprisoned or in similar situations in which reprisals are possible, the interviewer should use care not to put them in danger. In situations where talking to an investigator may endanger someone, a "group interview" may be preferable to an individual interview. In other cases, the interviewer must choose a place for the private interview where the witness feels comfortable to talk freely.

92. Evaluations occur in a variety of political contexts. This results in important differences in the manner in which evaluations should be conducted. The legal standards under which the investigation is conducted are also affected by the context. For example, an investigation culminating in the trial of an alleged perpetrator will require the highest level of proof, whereas a report supporting an application for political asylum in a third country need provide only a relatively low level of proof of torture. The investigator must adapt the following guidelines according to the particular situation and purpose of the

evaluation. Examples of various contexts include, but are not limited to, the following:

(i) In prison or detention in the individual's home country;

(ii) In prison or detention in another country;

(iii) Not in detention in the home country but in a hostile oppressive climate;

(iv) Not in detention in the home country during a time of peace and security;

(v) In another country that may be friendly or hostile;

(vi) In a refugee camp setting;

(vii) In a war crimes tribunal or truth commission.

93. The political context may be hostile towards the victim and the examiner, for example, when detainees are interviewed while they are held in prison by their governments or while they are detained by foreign governments in order to be deported. In countries where asylum-seekers are examined in order to establish evidence of torture, the reluctance to acknowledge claims of trauma and torture may be politically motivated. The possibility of further endangering the safety of the detainee is very real and must be taken into account during every evaluation. Even in cases where persons alleging torture are not in imminent danger, investigators should use great care in their contact with them. The investigator's choice of language and attitude will greatly affect the alleged victim's ability and willingness to be interviewed. The location of the interview should be as safe and comfortable as possible, including access to toilet facilities and refreshments. Sufficient time should be allotted to interview the alleged torture victim. Investigators should not expect to get the full story during the first interview. Questions of a private nature will be traumatic for the alleged victim. The investigator must be sensitive in tone, phrasing and sequencing of questions, given the traumatic nature of the alleged victim's testimony. The witness must be told of the right to stop the questioning at any time, to take a break if needed or to choose not to respond to any question.

94. Psychological counsellors or those trained in working with torture victims should be accessible, if possible, to the alleged torture victim, witnesses and members of the investigating team. Retelling the facts of the torture may cause the person to relive the experience or suffer other trauma-related symptoms (see chapter IV, sect. H). Hearing details of torture may result in secondary trauma symptoms to interviewers, and they must be encouraged to discuss their reactions with one another, respecting their professional ethical requirements of confidentiality. Wherever possible, this should be with the help of an experienced facilitator. There are two particular risks to be aware of: first, there is a danger that the interviewer may identify with those alleging torture and not be sufficiently challenging of the story; second, the interviewer may become so used to hearing histories of torture that he or she diminishes in his or her own mind the experiences of the person being interviewed.

(d) *Safety of witnesses*

95. The State is responsible for protecting alleged victims, witnesses and their families from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture should be removed from any position of control or power, whether direct or indirect over complainants, witnesses and their families as well as those conducting investigations. Investigators must give constant consideration to the effect of the investigation on the safety of the person alleging torture and other witnesses.

96. One suggested technique for providing a measure of safety to interviewees, including prisoners in countries in conflict situations, is to write down and keep safe the identities of people visited so that investigators can follow up on the safety of those individuals at a future return visit. Investigators must be allowed to talk to anyone and everyone, freely and in private, and be allowed to repeat the visit to these same persons (thus the need for traceable identities of those interviewed) as the need arises. Not all countries accept these conditions, and investigators may find it difficult to obtain similar guarantees. In cases in which witnesses are likely to be put in danger because of their testimony, the investigator should seek other forms of evidence.

97. Prisoners are in greater potential danger than persons who are not in custody. Prisoners might have different reactions to different situations. In one situation, prisoners may unwittingly put themselves in danger by speaking out too rashly, thinking they are protected by the very presence of the "outside" investigator. This may not be the case. In other situations, investigators may come up against a "wall of silence", as prisoners are far too intimidated to trust anyone, even when offered talks in private. In the latter case, it may be necessary to start with "group interviews", so as to be able to explain clearly the scope and purpose of the investigation and subsequently offer to have interviews in private with those persons who desire to speak. If the fear of reprisals, justified or not, is too great, it may be necessary to interview all prisoners in a given place of custody, so as not to pinpoint any specific person. Where an investigation leads to prosecution or another public truth-telling forum, the investigator should recommend measures to prevent harm to the alleged torture victim by such means as expunging names and other information that identifies the person from the public records or offering the person an opportunity to testify through image or voice-altering devices or closed circuit television. These measures must be consistent with the rights of the accused.

(e) *Use of interpreters*

98. Working through an interpreter when investigating torture is not easy, even with professionals. It will not always be possible to have interpreters on hand for all different dialects and languages, and sometimes it may be necessary to use interpreters from the person's family or cultural group. This is not ideal, as the person may not always feel comfortable talking about the torture experience through people he or she knows. Ideally, the interpreter should be part of the investigating team and knowl-

edgeable about torture issues (see chapters IV, sect. I, and VI, sect. C.2).

(f) *Information to be obtained from the person alleged to have been tortured*

99. The investigator should attempt to obtain as much of the following information as possible through the testimony of the alleged victim (see chapter IV, sect. E):

(i) The circumstances leading up to the torture, including arrest or abduction and detention;

(ii) Approximate dates and times of the torture, including when the last instance of torture occurred. Establishing this information may not be easy, as there may be several places and perpetrators (or groups of perpetrators) involved. Separate stories may have to be recorded about the different places. Expect chronologies to be inaccurate and sometimes even confusing; notions of time are often hard to focus on for someone who has been tortured. Separate stories about different places may be useful when trying to get a global picture of the situation. Survivors will often not know exactly to where they were taken, having been blindfolded or semi-conscious. By putting together converging testimonies, it may be possible to "map out" specific places, methods and even perpetrators;

(iii) A detailed description of the persons involved in the arrest, detention and torture, including whether he or she knew any of them prior to the events relating to the alleged torture, clothing, scars, birthmarks, tattoos, height, weight (the person may be able to describe the torturer in relation to his or her own size), anything unusual about the perpetrator's anatomy, language and accent and whether the perpetrators were intoxicated at any time;

(iv) Contents of what the person was told or asked. This may provide relevant information when trying to identify secret or unacknowledged places of detention;

(v) A description of the usual routine in the place of detention and the pattern of ill-treatment;

(vi) A description of the facts of the torture, including the methods of torture used. This is understandably often difficult, and investigators should not expect to obtain the full story during one interview. It is important to obtain precise information, but questions related to intimate humiliation and assault will be traumatic, often extremely so;

(vii) Whether the individual was sexually assaulted. Most people will tend to answer a question on sexual assault as meaning actual rape or sodomy. Investigators should be sensitive to the fact that verbal assaults, disrobing, groping, lewd or humiliating acts or blows or electric shocks to the genitals are often not taken by the victim as constituting sexual assault. These acts all violate the individual's intimacy and should be considered as being part and parcel of sexual assault. Very often, victims of sexual assault will say nothing or even deny any sexual assault. It is often only on the second or even third visit, if the contact made has been empathic and sensitive to the person's culture and personality, that more of the story will come out;

(viii) Physical injuries sustained in the course of the torture;

(ix) A description of weapons or other physical objects used;

(x) The identity of witnesses to the events involving torture. The investigator must use care in protecting the safety of witnesses and should consider encrypting the identities of witnesses or keeping these names separate from the substantive interview notes.

(g) *Statement from the person who is alleging torture*

100. The investigator should tape-record a detailed statement from the person and have it transcribed. The statement should be based on answers given in response to non-leading questions. Non-leading questions do not make assumptions or conclusions and allow the person to offer the most complete and unbiased testimony. Examples of non-leading questions are "What happened to you and where?" rather than "Were you tortured in prison?". The latter question assumes that what happened to the witness was torture and limits the location of the actions to a prison. Avoid asking questions with lists, as this can force the individual into giving inaccurate answers if what actually happened does not exactly match one of the options. Allow the person to tell his or her own story, but assist by asking questions that increase in specificity. Encourage the person to use all his/her senses in describing what has happened to him or her. Ask what he or she saw, smelled, heard and felt. This is important, for instance, in situations where the person may have been blindfolded or experienced the assault in the dark.

(h) *Alleged perpetrator's statement*

101. If possible, the investigators should interview the alleged perpetrators. The investigators must provide them with legal protections guaranteed under international and national law.

3. *Securing and obtaining physical evidence*

102. The investigator should gather as much physical evidence as possible to document an incident or pattern of torture. One of the most important aspects of a thorough and impartial investigation of torture is the collection and analysis of physical evidence. Investigators should document the chain of custody involved in recovering and preserving physical evidence in order to use such evidence in future legal proceedings, including potential criminal prosecution. Most torture occurs in places where people are held in some form of custody, where preservation of physical evidence or unrestricted access may be initially difficult or even impossible. Investigators must be given authority by the State to obtain unrestricted access to any place or premises and be able to secure the setting where torture allegedly took place. Investigative personnel and other investigators should coordinate their efforts in

carrying out a thorough investigation of the place where torture allegedly occurred. Investigators must have unrestricted access to the alleged scene of torture. Their access must include, but not be limited to, open or closed areas, including buildings, vehicles, offices, prison cells or other premises where torture is alleged to have taken place.

103. Any building or area under investigation must be closed off so as not to lose any possible evidence. Only investigators and their staff should be allowed entry into the area once it has been designated as under investigation. Examination of the scene for any material evidence should take place. All evidence must be properly collected, handled, packaged, labelled and placed in safekeeping to prevent contamination, tampering or loss of evidence. If the torture has allegedly taken place recently enough for such evidence to be relevant, any samples found of body fluids (such as blood or semen), hair, fibres and threads should be collected, labelled and properly preserved. Any implements that could be used to inflict torture, whether they be destined for that purpose or used circumstantially, should be taken and preserved. If recent enough to be relevant, any fingerprints located must be lifted and preserved. A labelled sketch of the premises or place where torture has allegedly taken place must be made to scale, showing all relevant details, such as the location of the floors in a building, rooms, entrances, windows, furniture and surrounding terrain. Colour photographs must also be taken to record the same. A record of the identity of all persons at the alleged torture scene must be made, including complete names, addresses and telephone numbers or other contact information. If torture is recent enough for it to be relevant, an inventory of the clothing of the person alleging torture should be taken and tested at a laboratory, if available, for bodily fluids and other physical evidence. Information must be obtained from anyone present on the premises or in the area under investigation to determine whether they were witness to the incidents of alleged torture. Any relevant papers, records or documents should be saved for evidential use and handwriting analysis.

4. *Medical evidence*

104. The investigator should arrange for a medical examination of the alleged victim. The timeliness of such medical examination is particularly important. A medical examination should be undertaken regardless of the length of time since the torture, but if it is alleged to have happened within the past six weeks, such an examination should be arranged urgently before acute signs fade. The examination should include an assessment of the need for treatment of injuries and illnesses, psychological help, advice and follow-up (see chapter V for a description of the physical examination and forensic evaluation). A psychological appraisal of the alleged torture victim is always necessary and may be part of the physical examination, or where there are no physical signs, may be performed by itself (see chapter VI for a description of the psychological evaluation).

105. In formulating a clinical impression for the purpose of reporting physical and psychological evidence of torture, there are six important questions to ask:

(*a*) Are the physical and psychological findings consistent with the alleged report of torture?

(*b*) What physical conditions contribute to the clinical picture?

(*c*) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(*d*) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where in the course of recovery is the individual?

(*e*) What other stressful factors are affecting the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.)? What impact do these issues have on the victim?

(*f*) Does the clinical picture suggest a false allegation of torture?

5. *Photography*

106. Colour photographs should be taken of the injuries of persons alleging that they have been tortured, of the premises where torture has allegedly occurred (interior and exterior) and of any other physical evidence found there. A measuring tape or some other means of showing scale on the photograph is essential. Photographs must be taken as soon as possible, even with a basic camera, because some physical signs fade rapidly and locations can be interfered with. Instantly developed photos may decay over time. More professional photos are preferred and should be taken as soon as the equipment becomes available. If possible, photographs should be taken using a 35-millimetre camera with an automatic date feature. The chain of custody of the film, negatives and prints must be fully documented.

D. Commission of inquiry

1. *Defining the scope of the inquiry*

107. States and organizations establishing commissions of inquiry need to define the scope of the inquiry by including terms of reference in their authorization. Defining the commission's terms of reference can greatly increase its success by giving legitimacy to the proceedings, assisting commission members in reaching a consensus on the scope of the inquiry and providing a measure by which the commission's final report can be judged. Recommendations for defining terms of reference are as follows:

(*a*) They should be neutrally framed so that they do not suggest a predetermined outcome. To be neutral, terms of reference must not limit investigations in areas that might uncover State responsibility for torture;

(*b*) They should state precisely which events and issues are to be investigated and addressed in the commission's final report;

(*c*) They should provide flexibility in the scope of inquiry to ensure that thorough investigation by the com-

mission is not hampered by overly restrictive or overly broad terms of reference. The necessary flexibility may be accomplished, for example, by permitting the commission to amend its terms of reference as necessary. It is important, however, for the commission to keep the public informed of any amendments to its mandate.

2. *The power of the commission*

108. Principles should set out the powers of the commission in a general manner. The commission specifically needs the following:

(*a*) Authority to obtain all information necessary to the inquiry including the authority to compel testimony under legal sanction, to order the production of documents including State and medical records, and to protect witnesses, families of the victim and other sources;

(*b*) Authority to issue a public report;

(*c*) Authority to conduct on-site visits, including at the location where the torture is suspected to have occurred;

(*d*) Authority to receive evidence from witnesses and organizations located outside the country.

3. *Membership criteria*

109. Commission members should be chosen for their recognized impartiality, competence and independence as individuals as defined as follows:

(*a*) Impartiality. Commission members should not be closely associated with any individual, State entity, political party or other organization potentially implicated in the torture. They should not be too closely connected to an organization or group of which the victim is a member, as this may damage the commission's credibility. This should not, however, be an excuse for blanket exclusions from the commission, for instance, of members of large organizations of which the victim is also a member or of persons associated with organizations dedicated to the treatment and rehabilitation of torture victims;

(*b*) Competence. Commission members must be capable of evaluating and weighing evidence and exercising sound judgement. If possible, commissions of inquiry should include individuals with expertise in law, medicine and other appropriate specialized fields;

(*c*) Independence. Members of the commission should have a reputation in their community for honesty and fairness.

110. The objectivity of the investigation and the commission's findings may, among other things, depend on whether it has three or more members rather than one or two. A single commissioner should in general not conduct investigations into torture. A single, isolated commissioner will generally be limited in the depth of the investigation that he or she can conduct alone. In addition, a single commissioner will have to make controversial and important decisions without debate and will be particularly vulnerable to State and other outside pressure.

4. *The commission's staff*

111. Commissions of inquiry should have impartial, expert counsel. Where the commission is investigating allegations of State misconduct, it would be advisable to appoint counsel outside the Ministry of Justice. The chief counsel to the commission should be insulated from political influence, through civil service tenure or as a wholly independent member of the bar. The investigation will often require expert advisers. Technical expertise should be available to the commission in areas such as pathology, forensic science, psychiatry, psychology, gynaecology and paediatrics. To conduct a completely impartial and thorough investigation, the commission would almost always need its own investigators to pursue leads and develop evidence. The credibility of an inquiry would thus be significantly enhanced to the extent that the commission would be able to rely on its own investigators.

5. *Protection of witnesses*

112. The State shall protect complainants, witnesses, those conducting the investigation and their families from violence, threats of violence or any other form of intimidation (see section C.2 (*d*) above). If the commission concludes that there is a reasonable fear of persecution, harassment or harm to any witness or prospective witness, the commission may find it advisable to hear the evidence in camera, keep the identity of an informant or witness confidential, use only evidence that will not risk identifying the witness and take other appropriate measures.

6. *Proceedings*

113. It follows from general principles of criminal procedure that hearings should be conducted in public, unless in-camera proceedings are necessary to protect the safety of a witness. In-camera proceedings should be recorded and the sealed, unpublished record kept in a known location. Occasionally, complete secrecy may be required to encourage testimony, and the commission may want to hear witnesses privately, informally or without recording testimony.

7. *Notice of inquiry*

114. Wide notice of the establishment of a commission and the subject of the inquiry should be given. The notice should include an invitation to submit relevant information and written statements to the commission and instructions to persons willing to testify. Notice can be disseminated through newspapers, magazines, radio, television, leaflets and posters.

8. *Receipt of evidence*

115. Commissions of inquiry should have the power to compel testimony and produce documents, plus the authority to compel testimony from officials allegedly involved in torture. Practically, this authority may involve the power to impose fines or sentences if government officials or other individuals refuse to comply. Commissions

of inquiry should invite persons to testify or submit written statements as a first step in gathering evidence. Written statements may become an important source of evidence if their authors are afraid to testify, cannot travel to proceedings or are otherwise unavailable. Commissions of inquiry should review other proceedings that could provide relevant information.

9. *Rights of parties*

116. Those alleging that they have been tortured and their legal representatives should be informed of and have access to any hearing and all information relevant to the investigation and must be entitled to present evidence. This particular emphasis on the role of the survivor as a party to the proceedings reflects the especially important role his/her interests play in the conduct of the investigation. However, all other interested parties should also have an opportunity to be heard. The investigative body must be entitled to issue summonses to witnesses, including the officials allegedly involved, and to demand the production of evidence. All these witnesses should be permitted legal counsel if they are likely to be harmed by the inquiry, for example, when their testimony could expose them to criminal charges or civil liability. Witnesses may not be compelled to testify against themselves. There should be an opportunity for the effective questioning of witnesses by the commission. Parties to the inquiry should be allowed to submit written questions to the commission.

10. *Evaluation of evidence*

117. The commission must assess all information and evidence it receives to determine reliability and probity. The commission should evaluate oral testimony, taking into account the demeanour and overall credibility of the witness. The commission must be sensitive to social, cultural and gender issues that affect demeanour. Corroboration of evidence from several sources will increase the probative value of such evidence and the reliability of hearsay evidence. The reliability of hearsay evidence must be considered carefully before the commission accepts it as fact. Testimony not tested by cross-examination must also be viewed with caution. In-camera testimony preserved in a closed record or not recorded at all is often not subject to cross-examination and, therefore, may be given less weight.

11. *Report of the commission*

118. The commission should issue a public report within a reasonable period of time. Furthermore, when the commission is not unanimous in its findings, the minority commissioners should file a dissenting opinion. Commission of inquiry reports should contain, at a minimum, the following information:

(*a*) The scope of inquiry and terms of reference;

(*b*) The procedures and methods of evaluating evidence;

(*c*) A list of all witnesses, including age and gender, who have testified, except for those whose identities are withheld for protection or who have testified in camera, and exhibits received as evidence;

(*d*) The time and place of each sitting (this might be annexed to the report);

(*e*) The background of the inquiry, such as relevant social, political and economic conditions;

(*f*) The specific events that occurred and the evidence upon which such findings are based;

(*g*) The law upon which the commission relied;

(*h*) The commission's conclusions based on applicable law and findings of fact;

(*i*) Recommendations based on the findings of the commission.

119. The State should reply publicly to the commission's report and, where appropriate, indicate which steps it intends to take in response to the report.

CHAPTER IV

GENERAL CONSIDERATIONS FOR INTERVIEWS

120. When a person who has allegedly been tortured is interviewed, there are a number of issues and practical factors that have to be taken into consideration. These considerations apply to all persons carrying out interviews, whether they are lawyers, medical doctors, psychologists, psychiatrists, human rights monitors or members of any other profession. The following section takes up this "common ground" and attempts to put it into contexts that may be encountered when investigating torture and interviewing victims of torture.

A. Purpose of inquiry, examination and documentation

121. The broad purpose of the investigation is to establish the facts related to alleged incidents of torture (see chapter III, sect. D). Medical evaluations of torture may be useful evidence in legal contexts such as:

(*a*) Identifying the perpetrators responsible for torture and bringing them to justice;

(*b*) Support of political asylum applications;

(*c*) Establishing conditions under which false confessions may have been obtained by State officials;

(*d*) Establishing regional practices of torture. Medical evaluations may also be used to identify the therapeutic needs of survivors and as testimony in human rights investigations.

122. The purpose of the written or oral testimony of the physician is to provide expert opinion on the degree to which medical findings correlate with the patient's allegation of abuse and to communicate effectively the physician's medical findings and interpretations to the judiciary or other appropriate authorities. In addition, medical testimony often serves to educate the judiciary, other government officials and the local and international communities on the physical and psychological sequelae of torture. The examiner should be prepared to do the following:

(*a*) Assess possible injury and abuse, even in the absence of specific allegations by individuals, law enforcement or judicial officials;

(*b*) Document physical and psychological evidence of injury and abuse;

(*c*) Correlate the degree of consistency between examination findings and specific allegations of abuse by the patient;

(*d*) Correlate the degree of consistency between individual examination findings with the knowledge of torture methods used in a particular region and their common after-effects;

(*e*) Render expert interpretation of the findings of medical-legal evaluations and provide expert opinion regarding possible causes of abuse in asylum hearings, criminal trials and civil proceedings;

(*f*) Use information obtained in an appropriate manner to enhance fact-finding and further documentation of torture.

B. Procedural safeguards with respect to detainees

123. Forensic medical evaluation of detainees should be conducted in response to official written requests by public prosecutors or other appropriate officials. Requests for medical evaluations by law enforcement officials are to be considered invalid unless they are requested by written orders of a public prosecutor. Detainees themselves, their lawyers or relatives, however, have the right to request a medical evaluation to seek evidence of torture and ill-treatment. The detainee should be taken to the forensic medical examination by officials other than soldiers and police since torture and ill-treatment may have occurred in the custody of these officials and, therefore, that would place unacceptable coercive pressures on the detainee or the physician not to document torture or ill-treatment effectively. The officials who supervise the transportation of the detainee should be responsible to the public prosecutors and not to other law enforcement officials. The detainee's lawyer should be present during the request for examination and post-examination transport of the detainee. Detainees have the right to obtain a second or alternative medical evaluation by a qualified physician during and after the period of detention.

124. Each detainee must be examined in private. Police or other law enforcement officials should never be present in the examination room. This procedural safeguard may be precluded only when, in the opinion of the examining doctor, there is compelling evidence that the detainee poses a serious safety risk to health personnel. Under such circumstances, security personnel of the health facility, not the police or other law enforcement officials, should be available upon the medical examiner's request. In such cases, security personnel should still remain out of earshot (i.e. be only within visual contact) of the patient. Medical evaluation of detainees should be conducted at a location that the physician deems most

suitable. In some cases, it may be best to insist on evaluation at official medical facilities and not at the prison or jail. In other cases, prisoners may prefer to be examined in the relative safety of their cell, if they feel the medical premises may be under surveillance, for example. The best place will be dictated by many factors, but in all cases, investigators should ensure that prisoners are not forced into accepting a place with which they are not comfortable.

125. The presence of police officers, soldiers, prison officers or other law enforcement officials in the examination room, for whatever reason, should be noted in the physician's official medical report. Their presence during the examination may be grounds for disregarding a negative medical report. The identity and titles of others who are present in the examination room during the medical evaluations should be indicated in the report. Medical-legal evaluations of detainees should include the use of a standardized medical report form (see annex IV for guidelines that may be used to develop standard medical report forms).

126. The original, completed evaluation should be transmitted directly to the person requesting the report, generally the public prosecutor. When a detainee or a lawyer acting on his or her behalf requests a medical report, the report must be provided. Copies of all medical reports should be retained by the examining physician. A national medical association or a commission of inquiry may choose to audit medical reports to ensure that adequate procedural safeguards and documentation standards are adhered to, particularly by doctors employed by the State. Reports should be sent to such an organization, provided the issues of independence and confidentiality have been addressed. Under no circumstances should a copy of the medical report be transferred to law enforcement officials. It is mandatory that a detainee undergo a medical examination at the time of detention and an examination and evaluation upon release.[70] Access to a lawyer should be provided at the time of the medical examination. An outside presence during examination may be impossible in most prison situations. In such cases, it should be stipulated that prison doctors working with prisoners should respect medical ethics, and should be capable of carrying out their professional duties independently of any third-party influence. If the forensic medical examination supports allegations of torture, the detainee should not be returned to the place of detention, but rather should appear before the prosecutor or judge to determine the detainee's legal disposition.[71]

C. Official visits to detention centres

127. Visits to prisoners are not to be considered lightly. They can in some cases be notoriously difficult to carry out in an objective and professional way, particularly in countries where torture is still being practised. One-off visits, without follow-up to ensure the safety of the interviewees after the visit, may be dangerous. In some cases, one visit without a repeat visit may be worse than no visit at all. Well-meaning investigators may fall into the trap of visiting a prison or police station, without knowing exactly what they are doing. They may obtain an incomplete or false picture of reality. They may inadvertently place prisoners that they may never visit again in danger. They may give an alibi to the perpetrators of torture, who may use the fact that outsiders visited their prison and saw nothing.

128. Visits should best be left to investigators who can carry them out and follow them up in a professional way and who have certain weathered procedural safeguards for their work. The notion that some evidence is better than no evidence is not valid when working with prisoners who might be put in danger by giving testimony. Visits to detention facilities by well-meaning people representing official and non-governmental institutions can be difficult and, worse, can be counter-productive. In the case in point here, a distinction should be made between a bona fide visit necessary for the inquiry, which is not in question, and a non-essential visit that goes beyond that, which when made by non-specialists could cause more harm than good in a country that practises torture. Independent commissions constituted by jurists and physicians should be given ensured periodic access to visit places of detention and prisons.

129. Interviews with people who are still in custody, and possibly even in the hands of the perpetrators of torture will obviously be very different from interviews in the privacy and security of an outside, safe medical facility. The importance of obtaining the person's trust in such situations cannot be stressed enough. However, it is even more important not, even unwittingly, to betray that trust. All precautions should be taken to ensure that detainees do not place themselves in danger. Detainees who have been tortured should be asked whether the information can be used and in what way. They may be too afraid to allow use of their names, fearing reprisals for example. Investigators, clinicians and interpreters are bound to respect that which has been promised to the detainee.

130. A clear dilemma may arise if, for example, it is evident that a large number of prisoners have been tortured in a given place, but they all refuse to allow investigators to use their stories because of fear. The options are either betraying the prisoners' trust in the effort to stop torture or respecting trust and going away without saying anything; a useful way has to be found out of this dilemma. When confronted with a number of prisoners with clear signs on their bodies of whippings, beatings, lacerations caused by canings, etc., but who all refuse mention of their cases out of fear of reprisal, it is useful to organize a "health inspection" of the whole ward in full view in the courtyard. In that way, the visiting medical investigator walking through the ranks and directly observing the very visible signs of torture on the backs of the prisoners is able to make a report on what he has seen and will not have to say that prisoners complained about torture. This first step ensures the prisoners' trust for future follow-up visits.

[70] See the United Nations Standard Minimum Rules for the Treatment of Prisoners (chap. I, sect. B).

[71] "Health care for prisoners: implications of Kalk's refusal", *The Lancet*, vol. 337 (1991), pp. 647-648.

131. Other more subtle forms of torture, psychological or sexual, for example, clearly cannot be dealt with in the same way. In these cases, it may be necessary for investigators to refrain from comment for one or several visits until the circumstances allow or encourage detainees to be less afraid and to authorize the use of their stories. The physician and interpreter should provide their names and explain their role in conducting the evaluation. Documentation of medical evidence of torture requires specific knowledge by licensed health practitioners. Knowledge of torture and its physical and psychological consequences can be gained through publications, training courses, professional conferences and experience. In addition, knowledge about regional practices of torture and ill-treatment is important because such information may corroborate an individual's accounts of these. Experience in interviewing and examining individuals for physical and psychological evidence of torture and in documenting findings should be acquired under the supervision of experienced clinicians.

132. Those still in custody may sometimes be too trusting in situations where the interviewer simply cannot guarantee that there will be no reprisals, if a repeat visit has not been negotiated and fully accepted by the authorities or if the person's identity has not been recorded so as to ensure follow-up, for example. Every precaution should be taken to be sure that prisoners do not place themselves at risk unnecessarily, naively trusting an outsider to protect them.

133. Ideally, when visits are made to people still in custody the interpreters should be outsiders and not recruited locally. This is mainly to avoid them or their families being put under pressure from inquisitive authorities wanting to know what information was given to the investigators. The issue may be more complex when the detainees are from a different ethnic group than their jailers. Should the local interpreter be from the same ethnic group as the prisoner, so as to gain his/her trust, but at the same time arousing the mistrust of the authorities who would possibly attempt to intimidate the interpreter? Furthermore, the interpreter may be reluctant to work in a hostile environment, which would potentially place him or her at risk. Or should the interpreter come from the same ethnic group as the captors, thereby gaining trust, but losing that of the prisoner, while still leaving the interpreter vulnerable to intimidation by the authorities? The answer is obviously and ideally neither of the above. Interpreters should be from outside the region and seen by all to be as independent as the investigators.

134. A person interviewed at 8 p.m. deserves as much attention as one seen at 8 a.m. Investigators should arrange to have enough time and not overwork themselves. It is unfair to the 8 p.m. person (who in addition has been waiting all day to tell his or her story) to be cut short because of the time. Similarly, the nineteenth story about *falanga* deserves as much attention as the first. Prisoners who do not often see outsiders may never have had a chance to talk about their torture. It is an erroneous assumption to think that prisoners talk constantly among themselves about torture. Prisoners who have nothing new to offer the investigation deserve as much time as the other prisoners.

D. Techniques of questioning

135. Several basic rules must be respected (see chapter III, sect. C.2 (*g*)). Information is certainly important, but the person being interviewed is even more so, and listening is more important than asking questions. If only questions are asked, all that are obtained are answers. To the detainee, it may be more important to talk about family than to talk about torture. This should be duly considered, and time should be allowed for some discussion of personal matters. Torture, particularly sexual torture, is a very intimate subject and may not come up before a follow-up visit or even later. Individuals should not be forced to talk about any form of torture if they feel uncomfortable about it.

E. Documenting the background

1. *Psychosocial history and pre-arrest*

136. If an alleged torture victim is no longer in custody, the examiner should inquire into the person's daily life, relations with friends and family, work or school, occupation, interests, future plans and use of alcohol and drugs. Information should also be elicited regarding the person's post-detention psychosocial history. When an individual is still in custody, a more limited psychosocial history regarding occupation and literacy is sufficient. Inquire about prescription medication being taken by the patient; this is particularly important because such medications may be denied to a person in custody, with significant adverse health consequences. Inquiries into political activities, beliefs and opinions are relevant insofar as they help to explain why a person was detained or tortured, but such inquiries are best made indirectly by asking the person which accusations were made or why they think they were detained and tortured.

2. *Summary of detention and abuse*

137. Before obtaining a detailed account of events, elicit summary information, including dates, places, duration of detention, frequency and duration of torture sessions. A summary will help to make effective use of time. In some cases in which survivors have been tortured on multiple occasions, they may be able to recall what happened to them, but often they cannot recall exactly where and when each event occurred. In such circumstances, it may be advisable to elicit the historical account according to methods of abuse rather than relating a series of events during specific arrests. Similarly, in writing up the story it may often be useful to have "what happened where" documented as much as possible. Holding places are operated by different security, police or armed forces, and what happened in different places may be useful for a full picture of the torture system. Obtaining a map of where the torture occurred may be useful in piecing together the stories of different people. This will often prove very useful for the overall investigation.

3. *Circumstances of detention*

138. Consider the following questions: what time was it? Where were you? What were you doing? Who was there? Describe the appearance of those who detained you. Were they military or civilian, in uniform or in street clothes? What type of weapons were they carrying? What was said? Any witnesses? Was this a formal arrest, administrative detention or disappearance? Was violence used, threats spoken? Was there any interaction with family members? Note the use of restraints or blindfold, means of transportation, destination and names of officials, if known.

4. *Place and conditions of detention*

139. Include access to and descriptions of food and drink, toilet facilities, lighting, temperature and ventilation. Also, document any contact with family, lawyers or health professionals, conditions of overcrowding or solitary confinement, dimensions of the detention place and whether there are other people who can corroborate the detention. Consider the following questions: what happened first? Where were you taken? Was there an identification process (personal information recorded, fingerprints, photographs)? Were you asked to sign anything? Describe the conditions of the cell or room (note size, others present, light, ventilation, temperature, presence of insects, rodents, bedding and access to food, water and toilet). What did you hear, see and smell? Did you have any contact with people outside or access to medical care? What was the physical layout of the place where you were detained?

5. *Methods of torture and ill-treatment*

140. In obtaining background information on torture and ill-treatment, caution should be used about suggesting forms of abuse to which a person may have been subjected. This may help separate potential embellishment from valid experiences. However, eliciting negative responses to questions about various forms of torture may also help establish the credibility of the person. Questions should be designed to elicit a coherent narrative account. Consider the following questions. Where did the abuse take place, when and for how long? Were you blindfolded? Before discussing forms of abuse, note who was present (give names, positions). Describe the room or place. Which objects did you observe? If possible, describe each instrument of torture in detail; for electrical torture, the current, device, number and shape of electrodes. Ask about clothing, disrobing and change of clothing. Record quotations of what was said during interrogation, insults hurled at the victim, etc. What was said among the perpetrators?

141. For each form of abuse, note: body position, restraint, nature of contact, including duration, frequency, anatomical location and the area of the body affected. Was there any bleeding, head trauma or loss of consciousness? Was the loss of consciousness due to head trauma, asphyxiation or pain? The investigator should also ask about how the person was at the end of the "session". Could he or she walk? Did he or she have to be helped or carried back to the cell? Could he or she get up the next day? How long did the feet stay swollen? All this gives a certain completeness to the description, which a checklist of methods does not. The history should include the date of positional torture, how many times and for how many days the torture lasted, the period of each episode, the style of the suspension (reverse-linear, being covered by thick cloth-blanket or being tied directly with a rope, putting weight on the legs or pulling down) or position. In cases of suspension torture, ask which sort of material was used (rope, wire and cloth leave different marks, if any, on the skin after suspension). The examiner must remember that statements on the length of the torture session by the torture survivor are subjective and may not be correct, since disorientation of time and place during torture is a generally observed finding. Was the person sexually assaulted in any manner? Elicit what was said during the torture. For example, during electric shock torture to the genitals, perpetrators often tell their torture victims that they will no longer have normal sexual relations or something similar. For a detailed discussion of the assessment of an allegation of sexual torture, including rape, see chapter V, sect. D.8.

F. Assessment of the background

142. Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

(*a*) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.;

(*b*) Fear of placing themselves or others at risk;

(*c*) A lack of trust in the examining clinician or interpreter;

(*d*) The psychological impact of torture and trauma, such as high emotional arousal and impaired memory, secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder (PTSD);

(*e*) Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning or starvation;

(*f*) Protective coping mechanisms, such as denial and avoidance;

(*g*) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.[72]

143. Inconsistencies in a person's story may arise from any or all of these factors. If possible, the investigator should ask for further clarification. When this is not possible, the investigator should look for other evidence that supports or refutes the story. A network of consistent supporting details can corroborate and clarify the person's story. Although the individual may not be able to provide the details desired by the investigator, such as dates, times, frequencies and exact identities of perpetrators, a broad outline of the traumatic events and torture will emerge and stand up over time.

[72] R. F. Mollica and Y. Caspi-Yavin, "Overview: the assessment and diagnosis of torture events and symptoms", in *Torture and Its Consequences: Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 38-55.

G. Review of torture methods

144. After eliciting a detailed narrative account of events, it is advisable to review other possible torture methods. It is essential to learn about regional practices of torture and modify local guidelines accordingly. Questioning about specific forms of torture is helpful when:

(*a*) Psychological symptoms cloud recollections;

(*b*) The trauma was associated with impaired sensory capabilities;

(*c*) There is a case of possible organic brain damage;

(*d*) There are mitigating educational and cultural factors.

145. The distinction between physical and psychological methods is artificial. For example, sexual torture generally causes both physical and psychological symptoms, even when there has been no physical assault. The following list of torture methods is given to show some of the categories of possible abuse. It is not meant to be used by investigators as a checklist or as a model for listing torture methods in a report. A method-listing approach may be counter-productive, as the entire clinical picture produced by torture is much more than the simple sum of lesions produced by methods on a list. Indeed, experience has shown that when confronted with such a "package-deal" approach to torture, perpetrators often focus on one of the methods and argue about whether that particular method is a form of torture. Torture methods to consider include, but are not limited to:

(*a*) Blunt trauma, such as a punch, kick, slap, whipping, a beating with wires or truncheons or falling down;

(*b*) Positional torture, using suspension, stretching limbs apart, prolonged constraint of movement, forced positioning;

(*c*) Burns with cigarettes, heated instruments, scalding liquid or a caustic substance;

(*d*) Electric shocks;

(*e*) Asphyxiation, such as wet and dry methods, drowning, smothering, choking or use of chemicals;

(*f*) Crush injuries, such as smashing fingers or using a heavy roller to injure the thighs or back;

(*g*) Penetrating injuries, such as stab and gunshot wounds, wires under nails;

(*h*) Chemical exposure to salt, chilli pepper, gasoline, etc. (in wounds or body cavities);

(*i*) Sexual violence to genitals, molestation, instrumentation, rape;

(*j*) Crush injury or traumatic removal of digits and limbs;

(*k*) Medical amputation of digits or limbs, surgical removal of organs;

(*l*) Pharmacological torture using toxic doses of sedatives, neuroleptics, paralytics, etc.;

(*m*) Conditions of detention, such as a small or overcrowded cell, solitary confinement, unhygienic conditions, no access to toilet facilities, irregular or contaminated food and water, exposure to extremes of temperature, denial of privacy and forced nakedness;

(*n*) Deprivation of normal sensory stimulation, such as sound, light, sense of time, isolation, manipulation of brightness of the cell, abuse of physiological needs, restriction of sleep, food, water, toilet facilities, bathing, motor activities, medical care, social contacts, isolation within prison, loss of contact with the outside world (victims are often kept in isolation in order to prevent bonding and mutual identification and to encourage traumatic bonding with the torturer);

(*o*) Humiliation, such as verbal abuse, performance of humiliating acts;

(*p*) Threats of death, harm to family, further torture, imprisonment, mock executions;

(*q*) Threats of attack by animals, such as dogs, cats, rats or scorpions;

(*r*) Psychological techniques to break down the individual, including forced betrayals, accentuating feelings of helplessness, exposure to ambiguous situations or contradictory messages;

(*s*) Violation of taboos;

(*t*) Behavioural coercion, such as forced engagement in practices against the religion of the victim (e.g. forcing Muslims to eat pork), forced harm to others through torture or other abuses, forced destruction of property, forced betrayal of someone placing them at risk of harm;

(*u*) Forcing the victim to witness torture or atrocities being inflicted on others.

H. Risk of re-traumatization of the interviewee

146. Taking into consideration that lesions of different types and levels may occur according to the methods of torture practised, the data acquired subsequent to a comprehensive medical history and physical examination should be assessed together with appropriate laboratory and radiological examinations. Providing information and making explanations for each process to be applied during the medical examination and ensuring detailed awareness about the laboratory methods play a significant role (see chapter VI, sect. B.2 (*a*)).

147. The presence of psychological sequelae in torture survivors, particularly the various manifestations of PTSD, may cause the torture survivor to fear experiencing a re-enactment of his or her torture experience during the interview, physical examination or laboratory test. Explaining to the torture survivor what he or she should expect prior to the medical examination is an important component of the process. Those who survive torture and remain in their country may experience intense fear and suspicion about being re-arrested, and they are often forced to go underground to avoid being arrested again. Those who are exiled or refugees may leave behind their native language, culture, family, friends, work and everything that is familiar to them.

148. The torture survivor's personal reactions to the interviewer (and the interpreter, in cases where one is used) can have an effect on the interview process and, in

turn, the outcome of the investigation. Likewise, the personal reactions of the investigator towards the person can also affect the process of the interview and the outcome of the investigation. It is important to examine the barriers to effective communication and the understanding that these personal reactions might impose on an investigation. The investigator should maintain an ongoing examination of the interview and investigation process through consultation and discussion with colleagues familiar with the field of psychological assessment and treatment of torture survivors. This type of peer supervision can be an effective means of monitoring the interview and investigation process for biases and barriers to effective communication and for obtaining accurate information (see chapter VI, sect. C.2).

149. Despite all precautions, physical and psychological examinations by their very nature may re-traumatize the patient by provoking or exacerbating symptoms of post-traumatic stress by reviving painful effects and memories (see chapter VI, sect. B.2). Questions about psychological distress and, especially, about sexual matters are considered taboo in most traditional societies, and the asking of such questions is regarded as irreverent or insulting. If sexual torture was part of the violations incurred, the claimant may feel irredeemably stigmatized and tainted in his or her moral, religious, social or psychological integrity. The expression of a respectful awareness of these conditions, as well as the clarification of confidentiality and its limits, are, therefore, of paramount importance for a well-conducted interview. A subjective assessment has to be made by the evaluator about the extent to which pressing for details is necessary for the effectiveness of the report in court, especially if the claimant demonstrates obvious signs of distress in the interview.

I. Use of interpreters

150. For many purposes, it is necessary to use an interpreter to allow the interviewer to understand what is being said. Although the interviewer and the interviewee may share a little of a common language, the information being sought is often too important to risk the errors that arise from an incomplete understanding of one another. Interpreters must be advised that what they hear and interpret in interviews is strictly confidential. It is the interpreters who get all the information, first-hand and uncensored. Individuals must be given assurances that neither the investigator nor the interpreter will misuse information in any way (see chapter VI, sect. C.2).

151. When the interpreter is not a professional, there is always the risk of the investigator losing control of the interview. Individuals may be carried away talking to the person who speaks their language, and the interview may divert from the issues at hand. There is also a risk that an interpreter with a bias might lead the interviewee on or distort the replies. Loss of information, sometimes relevant, sometimes not, is inevitable when working through interpretation. In extreme cases, it may even be necessary for investigators to refrain from taking notes during interviews and carry out interviews in several short sessions, so as to have time to write down the main points of what has been said between sessions.

152. Investigators should remember to talk to the person and to maintain eye contact, even if he or she has a natural tendency to speak to the interpreter. It helps to use the second person when speaking through the interpreter, for example "what did you do next", rather than the third person "ask him what happened next". All too often, investigators write their notes during the time when the interpreter is either translating the question or the interviewee answering it. Some investigators do not appear to be listening, as the interview is going on in a language they do not understand. This should not be the case, as it is essential for investigators to observe not just the words but also the body language, facial expressions, tone of voice and gestures of the interviewee if they are to obtain a full picture. Investigators should familiarize themselves with torture-related words in the person's language so as to show that they know about the issue. Reacting, rather than showing a blank face, when hearing a torture-related word such as *submarino* or *darmashakra* will add to the investigator's credibility.

153. When visiting prisoners, it is best never to use local interpreters if there is a possibility of their being considered untrustworthy by those interviewed. It may also be unfair for the local interpreters, who may be "debriefed" by the local authorities after a visit, or otherwise put under pressure, to be involved with political prisoners. It is best to use independent interpreters, clearly seen as coming from elsewhere. The next best thing to speaking the local language fluently is to work with a trained interpreter with experience, who is sensitive to the issue of torture and to the local culture. As a rule, co-detainees should not be used for interpretation, unless it is obvious that the interviewee has chosen someone he or she trusts. In the case of people who are not in detention, many of these same rules also apply, but it may be easier to bring in someone (a local person) from the outside, which is rarely possible in prison situations.

J. Gender issues

154. Ideally, an investigation team should contain specialists of both genders, permitting the person who says that they have been tortured to choose the gender of the investigator and, where necessary, the interpreter. This is particularly important when a woman has been detained in a situation where rape is known to happen, even if she has not, so far, complained of it. Even if no sexual assault takes place, most torture has sexual aspects (see chapter V, sect. D.8). The re-traumatization can often be worse if she feels she has to describe what happened to a person who is physically similar to her torturers, who will inevitably have been mostly or entirely men. In some cultures, it would be impossible for a male investigator to question a female victim, and this must be respected. However, in most cultures, if there is only a male physician available, many women would prefer to talk to him rather than a female of another profession in order to gain the medical information and advice that she wants. In such a case, it is essential that the interpreter, if used, be female. Some interviewees may also prefer that the interpreter be from

outside their immediate locality, both because of the danger of being reminded of their torture and because of the perceived threat to their confidentiality (see chapter IV, sect. I). If no interpreter is necessary, then a female member of the investigating team should be present as a chaperone throughout at least the physical examination and, if the patient wishes, throughout the entire interview.

155. When the victim is male and has been sexually abused, the situation is more complex because he too will have been sexually abused mostly or entirely by men. Some men would, therefore, prefer to describe their experiences to women because their fear of other men is so great, while others would not want to discuss such personal matters in front of a woman.

K. Indications for referral

156. Wherever possible, examinations to document torture for medical-legal reasons should be combined with an assessment for other needs, whether referral to specialist physicians, psychologists, physiotherapists or those who can offer social advice and support. Investigators should be aware of local rehabilitation and support services. The clinician should not hesitate to insist on any consultation and examination that he or she considers necessary in a medical evaluation. In the course of documenting medical evidence of torture and ill-treatment, physicians are not absolved of their ethical obligations. Those who appear to be in need of further medical or psychological care should be referred to the appropriate services.

L. Interpretation of findings and conclusions

157. Physical manifestations of torture may vary according to the intensity, frequency and duration of abuse, the torture survivor's ability to protect him or herself and the physical condition of the detainee prior to the torture. Other forms of torture may not produce physical findings, but may be associated with other conditions. For example, beatings to the head that result in loss of consciousness can cause post-traumatic epilepsy or organic brain dysfunction. Also, poor diet and hygiene in detention can cause vitamin deficiency syndromes.

158. Certain forms of torture are strongly associated with particular sequelae. For example, beatings to the head that result in loss of consciousness are particularly important to the clinical diagnosis of organic brain dysfunction. Trauma to the genitals is often associated with subsequent sexual dysfunction.

159. It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and torture victims are sometimes covered with a rug, or shoes in the case of *falanga*, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also forms of torture with the intention of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels are used with electric shocks.

160. The report must list the qualifications and experience of the investigator. Where possible, the name of the witness or patient should be given. If this puts the person at significant risk, an identifier can be used that allows the investigating team to relate the person to the record, but that will not allow anyone else to identify the individual. The report must indicate who else was in the room at the time of the interview or any part of it. It should detail the relevant history, avoiding hearsay and, where appropriate, report the findings. It must be signed, dated and include any necessary declaration required by the jurisdiction for which it is written (see annex IV).

CHAPTER V

PHYSICAL EVIDENCE OF TORTURE

161. Witness and survivor testimony are necessary components in the documentation of torture. To the extent that physical evidence of torture exists, it provides important confirmatory evidence that a person has been tortured. However, the absence of such physical evidence should not be construed to suggest that torture did not occur, since such acts of violence against persons frequently leave no marks or permanent scars.

162. A medical evaluation for legal purposes should be conducted with objectivity and impartiality. The evaluation should be based on the physician's clinical expertise and professional experience. The ethical obligation of beneficence demands uncompromising accuracy and impartiality in order to establish and maintain professional credibility. When possible, clinicians who conduct evaluations of detainees should have specific essential training in forensic documentation of torture and other forms of physical and psychological abuse. They should have knowledge of prison conditions and torture methods used in the particular region where the patient was imprisoned and the common after-effects of torture. The medical report should be factual and carefully worded. Jargon should be avoided. All medical terminology should be defined so that it is understandable to lay persons. The physician should not assume that the official requesting a medical-legal evaluation has related all the material facts. It is the physician's responsibility to discover and report upon any material findings that he or she considers relevant, even if they may be considered irrelevant or adverse to the case of the party requesting the medical examination. Findings that are consistent with torture or other forms of ill-treatment must not be excluded from a medical-legal report under any circumstance.

A. Interview structure

163. These comments apply especially to interviews conducted with persons no longer in custody. The location of the interview and examination should be as safe and comfortable as possible. Sufficient time should be allotted to conduct a detailed interview and examination. A two-to-four-hour interview may be insufficient to conduct an evaluation for physical or psychological evidence of torture. Furthermore, at any given time of an evaluation, situation-specific variables, such as the dynamics of the interview, a patient's feelings of powerlessness in the face of having his/her intimacy intruded upon, fear of future persecution, shame about events and survivor guilt may simulate the circumstances of a torture experience. This may increase the patient's anxiety and resistance to disclose relevant information. A second, and possibly a third, interview may have to be scheduled to complete the evaluation.

164. Trust is an essential component of eliciting an accurate account of abuse. Earning the trust of someone who has experienced torture or other forms of abuse requires active listening, meticulous communication, courtesy and genuine empathy and honesty. Physicians must have the capacity to create a climate of trust in which disclosure of crucial, though perhaps very painful or shameful, facts can occur. It is important to be aware that those facts are sometimes intimate secrets that the person may reveal at that moment for the first time. In addition to providing a comfortable setting, adequate time for the interviews, refreshments and access to toilet facilities, the clinician should explain what the patient can expect in the evaluation. The clinician should be mindful of the tone, phrasing and sequencing of questions (sensitive questions should be asked only after some degree of rapport has been developed) and should acknowledge the patient's ability to take a break if needed or to choose not to respond to any question.

165. Physicians and interpreters have a duty to maintain confidentiality of information and to disclose information only with the patient's consent (see chapter III, sect. C). Each person should be examined individually with privacy. He or she should be informed of any limits on the confidentiality of the evaluation that may be imposed by State or judicial authorities. The purpose of the interview needs to be made clear to the person. Physicians must ensure that informed consent is based on adequate disclosure and understanding of the potential benefits and adverse consequences of a medical evaluation and that consent is given voluntarily without coercion by others, particularly law enforcement or judicial authorities. The person has the right to refuse the evaluation. In such circumstances, the clinician should document the reason for refusal of an evaluation. Furthermore, if the person is a detainee, the report should be signed by his or her lawyer and another health official.

166. Patients may fear that information revealed in the context of an evaluation may not be safely kept from being accessed by persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers were participants in the torture. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the patient, in the situation and location of the interview, is likely to belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential

sense of fear, mistrust and forced submission in the patient.

167. Empathy and human contact may be the most important thing that people still in custody receive from the investigator. The investigation itself may contribute nothing of specific benefit to the person being interviewed, as in most cases their torture will be over. The meagre consolation of knowing that the information may serve a future purpose will however be greatly enhanced if the investigator shows appropriate empathy. While this may seem self-evident, all too often investigators in prison visits are so concerned about obtaining information that they fail to empathize with the prisoner being interviewed.

B. Medical history

168. Obtain a complete medical history, including information about prior medical, surgical or psychiatric problems. Be sure to document any history of injuries before the period of detention and any possible after-effects. Avoid leading questions. Structure inquiries to elicit an open-ended, chronological account of the events experienced during detention.

169. Specific historical information may be useful in correlating regional practices of torture with individual allegations of abuse. Examples of useful information include descriptions of torture devices, body positions, methods of restraint, descriptions of acute or chronic wounds and disabilities and identifying information about perpetrators and places of detention. While it is essential to obtain accurate information regarding a torture survivor's experiences, open-ended interviewing methods require that patients should disclose these experiences in their own words using free recall. An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use these trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use these, there are numerous questionnaires available; however, none are specific to torture victims. All complaints made by a torture survivor are significant. Although there may be no correlation with the physical findings, they should be reported. Acute and chronic symptoms and disabilities associated with specific forms of abuse and the subsequent healing processes should be documented.

1. *Acute symptoms*

170. The individual should be asked to describe any injuries that may have resulted from the specific methods of alleged abuse. These can be, for example, bleeding, bruising, swelling, open wounds, lacerations, fractures, dislocations, joint stress, haemoptysis, pneumothorax, tympanic membrane perforation, genito-urinary system injuries, burns (colour, bulla or necrosis according to the degree of burn), electrical injuries (size and number of lesions, their colour and surface characteristics), chemical injuries (colour, signs of necrosis), pain, numbness, constipation and vomiting. The intensity, frequency and duration of each symptom should be noted. The development of any subsequent skin lesions should be described indicating whether or not they left scars. Ask about health on release; was he or she able to walk or confined to bed? If confined, for how long? How long did wounds take to heal? Were they infected? What treatment was received? Was it a physician or a traditional healer? Be aware that the detainee's ability to make such observations may have been compromised by the torture itself or its after-effects and should be documented.

2. *Chronic symptoms*

171. Elicit information on physical ailments that the individual believes were associated with torture or ill-treatment. Note the severity, frequency and duration of each symptom and any associated disability or need for medical or psychological care. Even if the after-effects of acute lesions cannot be seen months or years later, some physical findings may still remain, such as electrical current or thermal burn scars, skeletal deformities, incorrect healing of fractures, dental injuries, loss of hair and myofibrosis. Common somatic complaints include headache, back pain, gastrointestinal symptoms, sexual dysfunction and muscle pain. Common psychological symptoms include depressive affect, anxiety, insomnia, nightmares, flashbacks and memory difficulties (see chapter VI, sect. B.2).

3. *Summary of an interview*

172. Torture victims may have injuries that are substantially different from other forms of trauma. Although acute lesions may be characteristic of the alleged injuries, most lesions heal within about six weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Under such circumstances, the physical examination may be within normal limits, but this in no way negates allegations of torture. A detailed account of the patient's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill-treatment.

C. The physical examination

173. Subsequent to the acquisition of background information and after the patient's informed consent has been obtained, a complete physical examination by a qualified physician should be performed. Whenever possible, the patient should be able to choose the gender of the physician and, where used, of the interpreter. If the doctor is not of the same gender as the patient, a chaperone who is should be used unless the patient objects. The patient must understand that he or she is in control and has the right to limit the examination or to stop it at any time (see chapter IV, sect. J).

174. In this section, there are many references to specialist referral and further investigations. Unless the patient is in detention, it is important for physicians to have access to physical and psychological treatment facilities, so that any identified need can be followed up. In many situations, certain diagnostic test techniques will

not be available, and their absence must not invalidate the report (see annex II for further details of possible diagnostic tests).

175. In cases of alleged recent torture and when the clothes worn during torture are still being worn by the torture survivor, they should be taken for examination without having been washed, and a fresh set of clothes should be provided. Wherever possible, the examination room should be equipped with sufficient light and medical equipment for the examination. Any deficiencies should be noted in the report. The examiner should note all pertinent positive and negative findings, using body diagrams to record the location and nature of all injuries (see annex III). Some forms of torture such as electrical shock or blunt trauma may be initially undetectable, but may be detected during a follow-up examination. Although it will rarely be possible to record photographically lesions of prisoners in custody of their torturers, photography should be a routine part of examinations. If a camera is available, it is always better to take poor quality photographs than to have none. They should be followed up with professional photographs as soon as possible (see chapter III, sect. C.5).

1. *Skin*

176. The examination should include the entire body surface in order to detect signs of generalized skin disease including signs of vitamin A, B and C deficiency, pre-torture lesions or lesions inflicted by torture, such as abrasions, contusions, lacerations, puncture wounds, burns from cigarettes or heated instruments, electrical injuries, alopecia and nail removal. Torture lesions should be described by their localization, symmetry, shape, size, colour and surface (e.g. scaly, crusty, ulcerating) as well as their demarcation and level in relation to the surrounding skin. Photography is essential whenever possible. Ultimately, the examiner must offer an opinion as to the origin of the lesions: inflicted or self-inflicted, accidental or the result of a disease process.[73, 74]

2. *Face*

177. Facial tissues should be palpated for evidence of fracture, crepitation, swelling or pain. The motor and sensory components, including smell and taste of all cranial nerves, should be examined. Computerized tomography (CT), rather than routine radiography, is the best modality to diagnose and characterize facial fractures, determine alignment and diagnose associated soft tissue injuries and complications. Intracranial and cervical spinal injuries are often associated with facial trauma.

[73] O. V. Rasmussen, "Medical aspects of torture", *Danish Medical Bulletin*, vol. 37, supplement No. 1 (1990), pp. 1-88.

[74] R. Bunting, "Clinical examinations in the police context", *Clinical Forensic Medicine*, W. D. S. McLay, ed. (London, Greenwich Medical Media, 1996), pp. 59-73.

(a) *Eyes*

178. There are many forms of trauma to the eyes, including conjunctival haemorrhage, lens dislocation, subhyeloid haemorrhage, retrobulbar haemorrhage, retinal haemorrhage and visual field loss. Given the serious consequences of lack of treatment or improper treatment, ophthalmologic consultation should be obtained whenever there is a suspicion of ocular trauma or disease. CT is the best modality to diagnose orbital fractures and soft tissue injuries to the bulbar and retrobulbar contents. Nuclear magnetic resonance imaging (MRI) may be an adjunct for identifying soft tissue injury. High resolution ultrasound is an alternative method for evaluation of trauma to the eye globe.

(b) *Ears*

179. Trauma to the ears, especially rupture of the tympanic membrane, is a frequent consequence of harsh beatings. The ear canals and tympanic membranes should be examined with an otoscope and injuries described. A common form of torture, known in Latin America as *telefono*, is a hard slap of the palm to one or both ears, rapidly increasing pressure in the ear canal, thus rupturing the drum. Prompt examination is necessary to detect tympanic membrane ruptures less than 2 millimetres in diameter, which may heal within 10 days. Fluid may be observed in the middle or external ear. If otorrhea is confirmed by laboratory analysis, MRI or CT should be performed to determine the fracture site. The presence of hearing loss should be investigated, using simple screening methods. If necessary, audiometric tests should be conducted by a qualified audiometric technician. The radiographic examination of fractures of the temporal bone or disruption of the ossicular chain is best determined by CT, then hypocycloidal tomography and, lastly, linear tomography.

(c) *Nose*

180. The nose should be evaluated for alignment, crepitation and deviation of the nasal septum. For simple nasal fractures, standard nasal radiographs should be sufficient. For complex nasal fractures and when the cartilaginous septum is displaced, CT should be performed. If rhinorrhea is present, CT or MRI is recommended.

(d) *Jaw, oropharynx and neck*

181. Mandibular fractures or dislocations may result from beatings. Temporomandibular joint syndrome is a frequent consequence of beatings about the lower face and jaw. The patient should be examined for evidence of crepitation of the hyoid bone or laryngeal cartilage resulting from blows to the neck. Findings concerning the oropharynx should be noted in detail, including lesions consistent with burns from electrical shock or other trauma. Gingival haemorrhage and the condition of the gums should also be noted.

(e) *Oral cavity and teeth*

182. Examination by a dentist should be considered a component of periodic health examination in detention. This examination is often neglected, but it is an important

component of the physical examination. Dental care may be purposefully withheld to allow caries, gingivitis or tooth abscesses to worsen. A careful dental history should be taken, and, if dental records exist, they should be requested. Tooth avulsions, fractures of the teeth, dislocated fillings and broken prostheses may result from direct trauma or electric shock torture. Dental caries and gingivitis should be noted. Poor quality dentition may be due to conditions in detention or may have preceded the detention. The oral cavity must be carefully examined. During application of an electric current, the tongue, gums or lips may be bitten. Lesions might be produced by forcing objects or materials into the mouth, as well as by applying electric current. X-rays and MRI are able to determine the extent of soft tissue, mandibular and dental trauma.

3. *Chest and abdomen*

183. Examination of the trunk, in addition to noting lesions of the skin, should be directed towards detecting regions of pain, tenderness or discomfort that would reflect underlying injuries of the musculature, ribs or abdominal organs. The examiner must consider the possibility of intramuscular, retroperitoneal and intra-abdominal haematomas, as well as laceration or rupture of an internal organ. Ultrasonography, CT and bone scintigraphy should be used, when realistically available, to confirm such injuries. Routine examination of the cardiovascular system, lungs and abdomen should be performed in the usual manner. Pre-existing respiratory disorders are likely to be aggravated in custody, and new respiratory disorders frequently develop.

4. *Musculoskeletal system*

184. Complaints of musculoskeletal aches and pains are very common in survivors of torture.[75] They may be the result of repeated beatings, suspension, other positional torture or the general physical environment of detention.[76] They may also be somatic (see chapter VI, sect. B.2). While they are non-specific, they should be documented. They often respond well to sympathetic physiotherapy.[77] Physical examination of the skeleton should include testing for mobility of joints, the spine and the extremities. Pain with motion, contracture, strength, evidence of compartment syndrome, fractures with or without deformity and dislocations should all be noted. Suspected dislocations, fractures and osteomyelitis should be evaluated with radiographs. For suspected osteomyelitis, routine radiographs should be taken, followed by three-phase bone scintigraphy. Injuries to tendons, ligaments and muscles are best evaluated with MRI, but arthrography can also be performed. In the acute stage, this can detect haemorrhage and possible muscle tears. Muscles usually heal completely without scarring; thus, later imaging studies will be negative. Under MRI and CT, denervated muscles and chronic compartment syndrome will be imaged as muscle fibrosis. Bone bruises can be detected by MRI or scintigraphy. Bone bruises usually heal without leaving traces.

5. *Genito-urinary system*

185. Genital examination should be performed only with the consent of the patient and, if necessary, should be postponed to a later examination. A chaperone must be present if the examining physician's gender is different from that of the patient. For more information, see chapter IV, sect. J. See section D.8 below for further information regarding examination of victims of sexual assault. Ultrasonography and dynamic scintigraphy can be used for detecting genito-urinary trauma.

6. *Central and peripheral nervous systems*

186. The neurological examination should evaluate the cranial nerves, sensory organs and peripheral nervous system, checking for both motor and sensory neuropathies related to possible trauma, vitamin deficiencies or disease. Cognitive ability and mental status must also be evaluated (see chapter VI, sect. C). In patients who report being suspended, special emphasis on examination for brachial plexopathy (asymmetrical hand strength, wrist drop, arm weakness with variable sensory and tendon reflexes) is necessary. Radiculopathies, other neuropathies, cranial nerve deficits, hyperalgesia, parasthesias, hyperaesthesia, change in position, temperature sensation, motor function, gait and coordination may all result from trauma associated with torture. In patients with a history of dizziness and vomiting, a vestibular examination should be conducted, and evidence of nystagmus noted. Radiological evaluation should include MRI or CT. MRI is preferred over CT for radiological evaluation of the brain and posterior fossae.

D. Examination and evaluation following specific forms of torture

187. The following discussion is not meant to be an exhaustive discussion of all forms of torture, but it is intended to describe in more detail the medical aspects of many of the more common forms of torture. For each lesion and for the overall pattern of lesions, the physician should indicate the degree of consistency between it and the attribution given by the patient. The following terms are generally used:

(*a*) Not consistent: the lesion could not have been caused by the trauma described;

(*b*) Consistent with: the lesion could have been caused by the trauma described, but it is non-specific and there are many other possible causes;

(*c*) Highly consistent: the lesion could have been caused by the trauma described, and there are few other possible causes;

(*d*) Typical of: this is an appearance that is usually found with this type of trauma, but there are other possible causes;

[75] See footnote 73 above.

[76] D. Forrest, "Examination for the late physical after-effects of torture", *Journal of Clinical Forensic Medicine*, vol. 6 (1999), pp. 4-13.

[77] See footnote 73 above.

(*e*) Diagnostic of: this appearance could not have been caused in any way other than that described.

188. Ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is important in assessing the torture story (see chapter IV, sect. G, for a list of torture methods).

1. *Beatings and other forms of blunt trauma*

(a) *Skin damage*

189. Acute lesions are often characteristic of torture, because they show a pattern of inflicted injury that differs from non-inflicted injuries, for example, their shape, repetition, distribution on the body. Since most lesions heal within about six weeks of torture, leaving no scars or non-specific scars, a characteristic history of the acute lesions and their development until healing might be the only support for an allegation of torture. Permanent changes in the skin due to blunt trauma are infrequent, non-specific and usually without diagnostic significance. A sequel of blunt violence, which is diagnostic of prolonged application of tight ligatures, is a linear zone extending circularly around the arm or leg, usually at the wrist or ankle. This zone contains few hairs or hair follicles, and this is probably a form of cicatricial alopecia. No differential diagnosis in the form of a spontaneous skin disease exists, and it is difficult to imagine any trauma of this nature occurring in everyday life.

190. Among acute lesions, abrasions resulting from superficial scraping lesions of the skin may appear as scratches, brush-burn type lesions or larger scraped lesions. At times, abrasions may show a pattern that reflects the contours of the instrument or surface that inflicted the injury. Repeated or deep abrasions may create areas of hypo or hyperpigmentation, depending on skin type. This occurs on the inside of the wrists if the hands have been tied together tightly.

191. Contusions and bruises are areas of haemorrhage into soft tissue due to the rupture of blood vessels from blunt trauma. The extent and severity of a contusion depend not only on the amount of force applied but also on the structure and vascularity of the contused tissue. Contusions occur more readily in areas of thin skin overlying bone or in fatty areas. Many medical conditions, including vitamin and other nutritional deficiencies, may be associated with easy bruising or purpura. Contusions and abrasions indicate that blunt force has been applied to a particular area. The absence of a bruise or abrasion, however, does not indicate that there was no blunt force to that area. Contusions may be patterned, reflecting the contours of the inflicting instrument. For instance, rail-shaped bruising may occur when an instrument, such as a truncheon or cane, has been used. The shape of the object may be inferred from the shape of the bruise. As contusions resolve, they undergo a series of colour changes. Most bruises initially appear dark blue, purple or crimson. As the haemoglobin in the bruise breaks down, the colour gradually changes to violet, green, dark yellow or pale yellow and then disappears. It is very difficult, however, to date accurately the occurrence of contusions. In some skin types, this can lead to hyperpigmentation, which can last several years. Contusions that develop in deeper subcutaneous tissues may not appear until several days after injury, when the extravasated blood has reached the surface. In cases of an allegation but an absence of a contusion, the victim should be re-examined after several days. It should be taken into consideration that the final position and shape of bruises bear no relationship to the original trauma and that some lesions may have faded by the time of re-examination.[78]

192. Lacerations, a tearing or crushing of the skin and underlying soft tissues by the pressure of blunt force, develop easily on the protruding parts of the body, since the skin is compressed between the blunt object and the bone surface under the subdermal tissues. However, with sufficient force the skin can be torn on any part of the body. Asymmetrical scars, scars in unusual locations and a diffuse spread of scarring all suggest deliberate injury.[79]

193. Scars resulting from whipping represent healed lacerations. These scars are depigmented and often hypertrophic, surrounded by narrow, hyperpigmented stripes. The only differential diagnosis is plant dermatitis, but this is dominated by hyperpigmentation and shorter scars. By contrast, symmetrical, atrophic, depigmented linear changes of the abdomen, axillae and legs, which are sometimes claimed to be torture sequelae, represent striae distensae and are not normally related to torture.[80]

194. Burning is the form of torture that most frequently leaves permanent changes in the skin. Sometimes, these changes may be of diagnostic value. Cigarette burns often leave 5-10-millimetre-long, circular or ovoid, macular scars with a hyper or a hypopigmented centre and a hyperpigmented, relatively indistinct periphery. The burning away of tattoos with cigarettes has also been reported in relation to torture. The characteristic shape of the resulting scar and any tattoo remnants will help in the diagnosis.[81] Burning with hot objects produces markedly atrophic scars which reflect the shape of the instrument and which are sharply demarcated with narrow hypertrophic or hyperpigmented marginal zones corresponding to an initial zone of inflammation. This may, for instance, be seen after burning with an electrically heated metal rod or a gas lighter. It is difficult to make a differential diagnosis if many scars are present. Spontaneously occurring inflammatory processes lack the characteristic marginal zone and only rarely show a pronounced loss of tissue. Burning may result in hypertrophic or keloid scars as is the case following a burn produced by burning rubber.

195. When the nail matrix is burnt, subsequent growth produces striped, thin, deformed nails, sometimes broken up in longitudinal segments. If a nail has been pulled off, an overgrowth of tissue may be produced from

[78] S. Gürpinar and S. Korur Fincanci, "Insan Haklari Ihlalleri *ve* Hekim Sorumluluğu" (Human rights violations and responsibility of the physician), *Birinci Basamak Için Adli Tip El Kitabi* (Handbook of Forensic Medicine for General Practitioners) (Ankara, Turkish Medical Association, 1999).

[79] See footnote 73 above.

[80] L. Danielsen, "Skin changes after torture", *Torture*, vol. 2, supplement 1 (1992), pp. 27-28.

[81] Ibid.

the proximal nail fold, resulting in the formation of pterygium. Changes in the nail caused by *Lichen planus* constitute the only relevant differential diagnosis, but they will usually be accompanied by widespread skin injury. On the other hand, fungus infections are characterized by thickened, yellowish, crumbling nails, different from the above changes.

196. Sharp trauma wounds are produced when the skin is cut with a sharp object, such as a knife, bayonet or broken glass and include stab wounds, incised or cut wounds and puncture wounds. The acute appearance is usually easy to distinguish from the irregular and torn appearance of lacerations and scars found upon later examination that may be distinctive. Regular patterns of small incisional scars could be due to traditional healers.[82] If pepper or other noxious substances are applied to open wounds, the scars may become hypertrophic. An asymmetrical pattern and different sizes of scars are probably significant in the diagnosis of torture.

(b) *Fractures*

197. Fractures produce a loss of bone integrity due to the effect of a blunt mechanical force on various vector planes. A direct fracture occurs at the site of impact or at the site where the force was applied. The location, contour and other characteristics of a fracture reflect the nature and direction of the applied force. It is sometimes possible to distinguish fracture inflicted from accidental injury by the radiological appearance of the fracture. Radiographic dating of relatively recent fractures should be done by an experienced trauma radiologist. Speculative judgements should be avoided in the evaluations of the nature and age of blunt traumatic lesions, since a lesion may vary according to the age, sex, tissue characteristics, the condition and health of the patient and the severity of the trauma. For example, well-conditioned, muscularly fit, younger individuals are more resistant to bruising than frail, older individuals.

(c) *Head trauma*

198. Head trauma is one of the most common forms of torture. In cases of recurring head trauma, even if not always of serious dimensions, cortical atrophy and diffuse axonal damage can be expected. In cases of trauma caused by falls, countercoup (location in opposition to the trauma) lesions of the brain may be observed. Whereas in cases of direct trauma, contusions of the brain may be observed directly under the region in which the trauma is inflicted. Scalp bruises are frequently invisible externally unless there is swelling. Bruises may be difficult to see in dark-skinned individuals, but will be tender upon palpation.

199. Having been exposed to blows to the head, a torture survivor may complain of continuous headaches. These are often somatic or may be referred from the neck (see section C above). The victim may claim to suffer pain when touched in that region, and diffuse or local fullness or increased firmness may be observed by means of palpation of the scalp. Scars can be observed in cases where there have been lacerations of the scalp. Headaches may be the initial symptom of an expanding subdural haematoma. They may be associated with the acute onset of mental status changes, and a CT scan must be performed urgently. Soft tissue swelling or haemorrhage will usually be detected with CT or MRI. It may also be appropriate to arrange psychological or neuropsychological assessment (see chapter VI, sect. C.4).

200. Violent shaking as a form of torture may produce cerebral injury without leaving any external marks, although bruises may be present on the upper chest or shoulders where the victim or his clothing has been grabbed. At its most extreme, shaking can produce injuries identical to those seen in the shaken baby syndrome: cerebral oedema, subdural haematoma and retinal haemorrhages. More commonly, victims complain of recurrent headaches, disorientation or mental status changes. Shaking episodes are usually brief, only a few minutes or less, but may be repeated many times over a period of days or weeks.

(d) *Chest and abdominal trauma*

201. Rib fractures are a frequent consequence of beatings to the chest. If displaced, they can be associated with lacerations of the lung and possible pneumothorax. Fractures of the vertebral pedicles may result from direct use of blunt force.

202. In cases of acute abdominal trauma, the physical examination should seek evidence of abdominal organ and urinary tract injury. However, the examination is often negative. Gross haematuria is the most significant indication of kidney contusion. Peritoneal lavage may detect occult abdominal haemorrhage. Free abdominal fluid detected by CT after peritoneal lavage may be from the lavage or haemorrhage; thus invalidating the finding. On a CT, acute abdominal haemorrhage is usually isointense or reveals water density unlike acute central nervous system (CNS) haemorrhage, which is hyperintense. Organ injury may be present as free air, extraluminal fluid or areas of low attenuation, which may represent oedema, contusion, haemorrhage or a laceration. Peripancreatic oedema is one of the signs of acute traumatic and non-traumatic pancreatitis. Ultrasound is particularly useful in detecting subcapsular haematomas of the spleen. Renal failure due to crush syndrome may be acute after severe beatings. Renal hypertension can be a late complication of renal injury.

2. *Beatings to the feet*

203. *Falanga* is the most common term for repeated application of blunt trauma to the feet (or more rarely to the hands or hips), usually applied with a truncheon, a length of pipe or similar weapon. The most severe complication of *falanga* is closed compartment syndrome, which can cause muscle necrosis, vascular obstruction or gangrene of the distal portion of the foot or toes. Permanent deformities of the feet are uncommon but do occur, as do fractures of the carpal, metacarpal and phalanges. Because the injuries are usually confined to soft tissue, CT or MRI are the preferred methods for radiological documentation of the injury, but it must be emphasized that physical examination in the acute phase should be

[82] See footnote 76 above.

diagnostic. *Falanga* may produce chronic disability. Walking may be painful and difficult. The tarsal bones may be fixed (spastic) or have increased motion. Squeezing the plantar (sole) of the foot and dorsiflexion of the great toe may produce pain. On palpation, the entire length of the plantar aponeurosis may be tender and the distal attachments of the aponeurosis may be torn, partly at the base of the proximal phalanges, partly at the skin. The aponeurosis will not tighten normally, making walking difficult and muscle fatigue may follow. Passive extension of the big toe may reveal whether the aponeurosis has been torn. If it is intact, the beginning of tension in the aponeurosis should be felt on palpation when the toe is dorsiflexed to 20 degrees; maximum normal extension is about 70 degrees. Higher values suggest injury to the attachments of the aponeurosis.[83, 84, 85, 86] On the other hand, limited dorsiflexion and pain on hyperextension of the large toe are findings of *Hallux rigidus*, which results from dorsal osteophyte at the first metatarsal head and/or base of the proximal phalanx.

204. Numerous complications and syndromes can occur:

(*a*) Closed compartment syndrome. This is the most severe complication. An oedema in a closed compartment results in vascular obstruction and muscle necrosis, which may result in fibrosis, contracture or gangrene in the distal foot or toes. It is usually diagnosed by measuring pressures in the compartment;

(*b*) Crushed heel and anterior footpads. The elastic pads under the calcaneus and proximal phalanxes are crushed during *falanga*, either directly or as a result of oedema associated with the trauma. Also, the connective tissue bands that extend through adipose tissue and connect bone to the skin are torn. Adipose tissue is deprived of its blood supply and atrophies. The cushioning effect is lost and the feet no longer absorb the stresses produced by walking;

(*c*) Rigid and irregular scars involving the skin and subcutaneous tissues of the foot after the application of *falanga*. In a normal foot, the dermal and sub-dermal tissues are connected to the planter aponeurosis through tight connective tissue bands. However, these bands can be partially or completely destroyed due to the oedema that ruptures the bands after exposure to *falanga*;

(*d*) Rupture of the plantar aponeurosis and tendons of the foot. An oedema in the post-*falanga* period may rupture these structures. When the supportive function necessary for the arch of the foot disappears, the act of walking becomes more difficult and foot muscles, especially the *quadratus plantaris longus*, are excessively forced;

(*e*) Planter fasciitis. May occur as a further complication of this injury. In cases of *falanga*, irritation is often present throughout the whole aponeurosis, causing chronic aponeurositis. Studies on the subject have shown that in prisoners released after 15 years of detention and who claimed to have been subjected to *falanga* application when first arrested, positive bone scans of hyperactive points in the calcaneus or metatarsal bones were observed.[87]

205. Radiological methods such as MRI, CT scan and ultrasound can often confirm cases of trauma occurring as a result of the application of *falanga*. Positive radiological findings may also be secondary to other diseases or trauma. Routine radiographs are recommended as the initial examination. MRI is the preferred radiological examination for detecting soft tissue injury. MRI or scintigraphy can detect bone injury in the form of a bruise, which may not be detected by routine radiographs or CT.[88]

3. *Suspension*

206. Suspension is a common form of torture that can produce extreme pain, but which leaves little, if any, visible evidence of injury. A person still in custody may be reluctant to admit to being tortured, but the finding of peripheral neurological deficits, diagnostic of brachial plexopathy, virtually proves the diagnosis of suspension torture. Suspension can be applied in various forms:

(*a*) Cross suspension. Applied by spreading the arms and tying them to a horizontal bar;

(*b*) Butchery suspension. Applied by fixation of hands upwards, either together or one by one;

(*c*) Reverse butchery suspension. Applied by fixation of feet upward and the head downward;

(*d*) "Palestinian" suspension. Applied by suspending the victim with the forearms bound together behind the back, the elbows flexed 90 degrees and the forearms tied to a horizontal bar. Alternatively, the prisoner is suspended from a ligature tied around the elbows or wrists with the arms behind the back;

(*e*) "Parrot perch" suspension. Applied by suspending a victim by the flexed knees from a bar passed below the popliteal region, usually while the wrists are tied to the ankles.

207. Suspension may last from 15 to 20 minutes to several hours. "Palestinian" suspension may produce permanent brachial plexus injury in a short period. The "parrot perch" may produce tears in the cruciate ligaments of the knees. Victims will often be beaten while suspended or otherwise abused. In the chronic phase, it is usual for pain and tenderness around the shoulder joints to persist,

[83] G. Sklyv, "Physical sequelae of torture", in *Torture and Its Consequences: Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 38-55.

[84] See footnote 76.

[85] K. Prip, L. Tived, N. Holten, *Physiotherapy for Torture Survivors: A Basic Introduction* (Copenhagen, International Rehabilitation Council for Torture Victims, 1995).

[86] F. Bojsen-Moller and K. E. Flagstad, "Plantar aponeurosis and internal architecture of the ball of the foot", *Journal of Anatomy*, vol. 121 (1976), pp. 599-611.

[87] V. Lök and others, "Bone scintigraphy as clue to previous torture", *The Lancet*, vol. 337, No. 8745 (1991), pp. 846-847. See also M. Tunca and V. Lök, "Bone scintigraphy in screening of torture survivors", *The Lancet*, vol. 352, No. 9143 (1998), p. 1859.

[88] See footnotes 76 and 83 and V. Lök and others, "Bone scintigraphy as an evidence of previous torture", *Treatment and Rehabilitation Center Report of the Human Rights Foundation of Turkey* (Ankara, 1994), pp. 91-96.

as the lifting of weight and rotation, especially internal, will cause severe pain many years later. Complications in the acute period following suspension include weakness of the arms or hands, pain and parasthesias, numbness, insensitivity to touch, superficial pain and tendon reflex loss. Intense deep pain may mask muscle weakness. In the chronic phase, weakness may continue and progress to muscle wasting. Numbness and, more frequently, parasthesia are present. Raising the arms or lifting weight may cause pain, numbness or weakness. In addition to neurologic injury, there may be tears of the ligaments of the shoulder joints, dislocation of the scapula and muscle injury in the shoulder region. On visual inspection of the back, a "winged scapula" (prominent vertebral border of the scapula) may be observed with injury to the long thoracic nerve or dislocation of the scapula.

208. Neurologic injury is usually asymmetrical in the arms. Brachial plexus injury manifests itself in motor, sensory and reflex dysfunction.

(*a*) Motor examination. Asymmetrical muscle weakness, more prominent distally, is the most expected finding. Acute pain may make the examination for muscle strength difficult to interpret. If the injury is severe, muscle atrophy may be seen in the chronic phase;

(*b*) Sensory examination. Complete loss of sensation or parasthesias along the sensory nerve pathways is common. Positional perception, two-point discrimination, pinprick evaluation and perception of heat and cold should all be tested. If at least three weeks later, deficiency or reflex loss or decrease is present, appropriate electrophysiological studies should be performed by a neurologist experienced in the use and interpretation of these methodologies;

(*c*) Reflex examination. Reflex loss, a decrease in reflexes or a difference between the two extremities may be present. In "Palestinian" suspension, even though both brachial plexi are subjected to trauma, asymmetric plexopathy may develop due to the manner in which the torture victim has been suspended, depending on which arm is placed in a superior position or the method of binding. Although research suggests that brachial plexopathies are usually unilateral, that is at variance with experience in the context of torture, where bilateral injury is common.

209. Among the shoulder region tissues, the brachial plexus is the structure most sensitive to traction injury. "Palestinian" suspension creates brachial plexus damage due to forced posterior extension of the arms. As observed in the classical type of "Palestinian" suspension, when the body is suspended with the arms in posterior hyperextension, typically the lower plexus and then the middle and upper plexus fibres, if the force on the plexus is severe enough, are damaged, respectively. If the suspension is of a "crucifixion" type, but does not include hyperextension, the middle plexus fibres are likely to be the first ones damaged due to hyperabduction. Brachial plexus injuries may be categorized as follows:

(*a*) Damage to the lower plexus. Deficiencies are localized in the forearm and hand muscles. Sensory deficiencies may be observed on the forearm and at the fourth and fifth fingers of the hand's medial side in an ulnar nerve distribution;

(*b*) Damage to the middle plexus. Forearm, elbow and finger extensor muscles are affected. Pronation of the forearm and radial flexion of the hand may be weak. Sensory deficiency is found on the forearm and on the dorsal aspects of the first, second and third fingers of the hand in a radial nerve distribution. Triceps reflexes may be lost;

(*c*) Damage to the upper plexus. Shoulder muscles are especially affected. Abduction of the shoulder, axial rotation and forearm pronation-supination may be deficient. Sensory deficiency is noted in the deltoid region and may extend to the arm and outer parts of the forearm.

4. *Other positional torture*

210. There are many forms of positional torture, all of which tie or restrain the victim in contorted, hyperextended or other unnatural positions, which cause severe pain and may produce injuries to ligaments, tendons, nerves and blood vessels. Characteristically, these forms of torture leave few, if any, external marks or radiological findings, despite subsequent frequently severe chronic disability.

211. All positional torture is directed towards tendons, joints and muscles. There are various methods: "parrot suspension", "banana stand" or the classic "banana tie" over a chair just on the ground, or on a motorcycle, forced standing, forced standing on a single foot, prolonged standing with arms and hands stretched high on a wall, prolonged forced squatting and forced immobilization in a small cage. In accordance with the characteristics of these positions, complaints are characterized as pain in a region of the body, limitation of joint movement, back pain, pain in the hands or cervical parts of the body and swelling of the lower legs. The same principles of neurologic and musculoskeletal examination apply to these forms of positional torture as apply to suspension. MRI is the preferred radiologic modality for evaluation of injuries associated with all forms of positional torture.

5. *Electric shock torture*

212. Electric current is transmitted through electrodes placed on any part of the body. The most common areas are the hands, feet, fingers, toes, ears, nipples, mouth, lips and genital area. The power source may be a hand-cranked or combustion generator, wall source, stun gun, cattle prod or other electric device. Electric current follows the shortest route between the two electrodes. The symptoms that occur when electric current is applied have this characteristic. For example, if electrodes are placed on a toe of the right foot and on the genital region, there will be pain, muscle contraction and cramps in the right thigh and calf muscles. Excruciating pain will be felt in the genital region. Since all muscles along the route of the electric current are tetanically contracted, dislocation of the shoulder, lumbar and cervical radiculopathies may be observed when the current is moderately high. However, the type, time of application, current and voltage of the energy used cannot be determined with certainty upon physical examination of the victim. Torturers often use water or gels in order to increase the efficiency of the tor-

ture, expand the entrance point of the electric current on the body and prevent detectable electric burns. Trace electrical burns are usually a reddish brown circular lesion from 1 to 3 millimetres in diameter, usually without inflammation, which may result in a hyperpigmented scar. Skin surfaces must be carefully examined because the lesions are not often easily discernible. The decision to biopsy recent lesions to prove their origin is controversial. Electrical burns may produce specific histologic changes, but these are not always present, and the absence of change in no way mitigates against the lesion being an electrical burn. The decision must be made on a case-by-case basis as to whether or not the pain and discomfort associated with a skin biopsy can be justified by the potential results of the procedure (see annex II, sect. 2).

6. *Dental torture*

213. Dental torture may be in the form of breaking or extracting teeth or through application of electrical current to the teeth. It may result in a loss or breaking of the teeth, swelling of the gums, bleeding, pain, gingivitis, stomatitis, mandibular fractures or loss of fillings from teeth. Temporomandibular joint syndrome will produce pain in the temporomandibular joint, limitation of jaw movement and, in some cases, subluxation of this joint due to muscle spasms occurring as a result of the electrical current or blows to the face.

7. *Asphyxiation*

214. Near asphyxiation by suffocation is an increasingly common method of torture. It usually leaves no mark, and recuperation is rapid. This method of torture was so widely used in Latin America, that its name in Spanish, *submarino*, has become part of human rights vocabulary. Normal respiration might be prevented through such methods as covering the head with a plastic bag, closure of the mouth and nose, pressure or ligature around the neck or forced aspiration of dust, cement, hot peppers, etc. This is also known as "dry *submarino*". Various complications might develop, such as petechiae of the skin, nosebleeds, bleeding from the ears, congestion of the face, infections in the mouth and acute or chronic respiratory problems. Forcible immersion of the head in water, often contaminated with urine, faeces, vomit or other impurities, may result in near drowning or drowning. Aspiration of the water into the lungs may lead to pneumonia. This form of torture is called "wet *submarino*". In hanging or in other ligature asphyxiation, patterned abrasions or contusions can often be found on the neck. The hyoid bone and laryngeal cartilage may be fractured by partial strangulation or from blows to the neck.

8. *Sexual torture including rape*

215. Sexual torture begins with forced nudity, which in many countries is a constant factor in torture situations. An individual is never as vulnerable as when naked and helpless. Nudity enhances the psychological terror of every aspect of torture, as there is always the background of potential abuse, rape or sodomy. Furthermore, verbal sexual threats, abuse and mocking are also part of sexual torture, as they enhance the humiliation and its degrading aspects, all part and parcel of the procedure. The groping of women is traumatic in all cases and is considered to be torture.

216. There are some differences between sexual torture of men and sexual torture of women, but several issues apply to both. Rape is always associated with the risk of developing sexually transmitted diseases, particularly human immunodeficiency virus (HIV).[89] Currently, the only effective prophylaxis against HIV must be taken within hours of the incident, and it is not generally available in countries where torture occurs routinely. In most cases, there will be a lewd sexual component, and in other cases torture is targeted at the genitals. Electricity and blows are generally targeted on the genitals in men, with or without additional anal torture. The resulting physical trauma is enhanced by verbal abuse. There are often threats of loss of masculinity to men and consequent loss of respect in society. Prisoners may be placed naked in cells with family members, friends or total strangers, breaking cultural taboos. This can be made worse by the absence of privacy when using toilet facilities. Additionally, prisoners may be forced to abuse each other sexually, which can be particularly difficult to cope with emotionally. The fear of potential rape among women, given profound cultural stigma associated with rape, can add to the trauma. Not to be neglected are the trauma of potential pregnancy, which males, obviously, do not experience, the fear of losing virginity and the fear of not being able to have children (even if the rape can be hidden from a potential husband and the rest of society).

217. If in cases of sexual abuse the victim does not wish the event to be known due to sociocultural pressures or personal reasons, the physician who carries out the medical examination, investigative agencies and the courts have an obligation to cooperate in maintaining the victim's privacy. Establishing a rapport with torture survivors who have recently been sexually assaulted requires special psychological education and appropriate psychological support. Any treatment that would increase the psychological trauma of a torture survivor should be avoided. Before starting the examination, permission must be obtained from the individual for any kind of examination, and this should be confirmed by the victim before the more intimate parts of the examination. The individual should be informed about the importance of the examination and its possible findings in a clear and comprehensible manner.

(a) *Review of symptoms*

218. A thorough history of the alleged assault should be recorded as described earlier in this manual (see section B above). There are, however, some specific questions that are relevant only to an allegation of sexual abuse. These seek to elicit current symptoms resulting from a recent assault, for example bleeding, vaginal or anal discharge and location of pain, bruises or sores. In cases of sexual assault in the past, questions should be directed to ongoing symptoms that resulted from the

[89] I. Lunde and J. Ortmann, "Sexual torture and the treatment of its consequences", *Torture and Its Consequences, Current Treatment Approaches*, M. Başoğlu, ed. (Cambridge, Cambridge University Press, 1992), pp. 310-331.

assault, such as urinary frequency, incontinence or dysuria, irregularity of menstruation, subsequent history of pregnancy, abortion or vaginal haemorrhage, problems with sexual activity, including intercourse and anal pain, bleeding, constipation or incontinence.

219. Ideally, there should be adequate physical and technical facilities for appropriate examination of survivors of sexual violation by a team of experienced psychiatrists, psychologists, gynaecologists and nurses, who are trained in the treatment of survivors of sexual torture. An additional purpose of the consultation after sexual assault is to offer support, advice and, if appropriate, reassurance. This should cover issues such as sexually transmitted diseases, HIV, pregnancy, if the victim is a woman, and permanent physical damage, because torturers often tell victims that they will never normally function sexually again, which can become a self-fulfilling prophecy.

(b) *Examination following a recent assault*

220. It is rare that a victim of rape during torture is released while it is still possible to identify acute signs of the assault. In these cases, there are many issues to be aware of that may impede the medical evaluation. Recently assaulted victims may be troubled and confused about seeking medical or legal help due to their fears, sociocultural concerns or the destructive nature of the abuse. In such cases, a doctor should explain to the victim all possible medical and judicial options and should act in accordance with the victim's wishes. The duties of the physician include obtention of voluntary informed consent for the examination, recording of all medical findings of abuse and obtention of samples for forensic examination. Whenever possible, the examination should be performed by an expert in documenting sexual assault. Otherwise, the examining physician should speak to an expert or consult a standard text on clinical forensic medicine.[90] When the physician is of a different gender from the victim, he or she should be offered the opportunity of having a chaperone of the same gender in the room. If an interpreter is used, then the interpreter may also fulfil the role of the chaperone. Given the sensitive nature of investigation into sexual assaults, a relative of the victim is not normally an ideal person to use in this role (see chapter IV, sect. I). The patient should be comfortable and relaxed before the examination. A thorough physical examination should be performed, including meticulous documentation of all physical findings, including size, location and colour, and, whenever possible, these findings should be photographed and evidence collected of specimens from the examination.

221. The physical examination should not initially be directed to the genital area. Any deformities should be noted. Particular attention must be given to ensure a thorough examination of the skin, looking for cutaneous lesions that could have resulted from an assault. These include bruises, lacerations, ecchymoses and petechiae from sucking or biting. This may help the patient to be more relaxed for a complete examination. When genital lesions are minimal, lesions located on other parts of the body may be the most significant evidence of an assault. Even during examination of the female genitalia immediately after rape, there is identifiable damage in less than 50 per cent of the cases. Anal examination of men and women after anal rape shows lesions in less than 30 per cent of cases. Clearly, where relatively large objects have been used to penetrate the vagina or anus, the probability of identifiable damage is much greater.

222. Where a forensic laboratory is available, the facility should be contacted before the examination to discuss which types of specimen can be tested, and, therefore, which samples should be taken and how. Many laboratories provide kits to permit physicians to take all the necessary samples from individuals alleging sexual assault. If there is no laboratory available, it may still be worthwhile to obtain wet swabs and dry them later in the air. These samples can be used later for DNA testing. Sperm can be identified for up to five days from samples taken with a deep vaginal swab and after up to three days using a rectal sample. Strict precautions must be taken to prevent allegations of cross-contamination when samples have been taken from several different victims, particularly if they are taken from alleged perpetrators. There must be complete protection and documentation of the chain of custody for all forensic samples.

(c) *Examination after the immediate phase*

223. Where the alleged assault occurred more than a week earlier and there are no signs of bruises or lacerations, there is less immediacy in conducting a pelvic examination. Time can be taken to try to find the most qualified person to document findings and the best environment in which to interview the individual. However, it may still be beneficial to photograph residual lesions properly, if this is possible.

224. The background should be recorded as described above, then examination and documentation of the general physical findings. In women who have delivered babies before the rape, and particularly in those who have delivered them afterwards, pathognomonic findings are not likely, although an experienced female physician can tell a considerable amount from the demeanour of a woman when she is describing her history.[91] It may take some time before the individual is willing to discuss those aspects of the torture that he or she finds most embarrassing. Similarly, patients may wish to postpone the more intimate parts of the examination to a subsequent consultation, if time and circumstances permit.

(d) *Follow-up*

225. Many infectious diseases can be transmitted by sexual assault, including sexually transmitted diseases such as gonorrhoea, chlamydia, syphilis, HIV, hepatitis B and C, herpes simplex and *Condyloma acuminatum* (venereal warts), vulvovaginitis associated with sexual abuse, such as trichomoniasis, *Moniliasis vaginitis*, *Gardnerella vaginitis* and *Enterobius vermicularis* (pinworms), as well as urinary tract infections.

[90] See J. Howitt and D. Rogers, "Adult sexual offences and related matters", *Journal of Clinical Forensic Medicine*, W. D. S. McLay, ed. (London, Greenwich Medical Media, 1996), pp. 193-218.

[91] G. Hinshelwood, *Gender-based persecution* (Toronto, United Nations Expert Group Meeting on Gender-based Persecution, 1997).

226. Appropriate laboratory tests and treatment should be prescribed in all cases of sexual abuse. In the case of gonorrhoea and chlamydia, concomitant infection of the anus or oropharynx should be considered at least for examination purposes. Initial cultures and serologic tests should be obtained in cases of sexual assault, and appropriate therapy initiated. Sexual dysfunction is common among survivors of torture, particularly among victims who have suffered sexual torture or rape, but not exclusively. Symptoms may be physical or psychological in origin or a combination of both and include:

(i) Aversion to members of the opposite sex or decreased interest in sexual activity;

(ii) Fear of sexual activity because a sexual partner will know that the victim has been sexually abused or fear of having been damaged sexually. Torturers may have threatened this and instilled fear of homosexuality in men who have been anally abused. Some heterosexual men have had an erection and, on occasion, have ejaculated during non-consensual anal intercourse. They should be reassured that this is a physiological response;

(iii) Inability to trust a sexual partner;

(iv) Disturbance in sexual arousal and erectile dysfunction;

(v) Dyspareunia (painful sexual intercourse in women) or infertility due to acquired sexually transmitted disease, direct trauma to reproductive organs or poorly performed abortions of pregnancies following rape.

(e) *Genital examination of women*

227. In many cultures, it is completely unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. If the woman demonstrates clear evidence of rape on external inspection, it may be unnecessary to conduct an internal pelvic examination. Genital examination findings may include:

(i) Small lacerations or tears of the vulva. These may be acute and are caused by excessive stretching. They normally heal completely, but, if repeatedly traumatized, there may be scarring;

(ii) Abrasions of the female genitalia. Abrasions can be caused by contact with rough objects such as fingernails or rings;

(iii) Vaginal lacerations. These are rare, but, if present, may be associated with atrophy of the tissues or previous surgery. They cannot be differentiated from incisions caused by inserted sharp objects.

228. It is rare to find any physical evidence when examining female genitalia more than one week after an assault. Later on, when the woman may have had subsequent sexual activity, whether consensual or not, or given birth, it may be almost impossible to attribute any findings to a specific incident of alleged abuse. Therefore, the most significant component of a medical evaluation may be the examiner's assessment of background information (for example, correlation between allegations of abuse and acute injuries observed by the individual) and demeanour of the individual, bearing in mind the cultural context of the woman's experience.

(f) *Genital examination of men*

229. Men who have been subjected to torture of the genital region, including the crushing, wringing or pulling of the scrotum or direct trauma to that region, usually complain of pain and sensitivity in the acute period. Hyperaemia, marked swelling and ecchymosis can be observed. The urine may contain a large number of erythrocytes and leucocytes. If a mass is detected, it should be determined whether it is a hydrocele, haematocele or inguinal hernia. In the case of an inguinal hernia, the examiner cannot palpate the spermatic cord above the mass. With a hydrocele or a haematocele, normal spermatic cord structures are usually palpable above the mass. A hydrocele results from excessive accumulation of fluid within the tunica vaginalis due to inflammation of the testis and its appendages or to diminished drainage secondary to lymphatic or venous obstruction in the cord or retroperitoneal space. A haematocele is an accumulation of blood within the tunica vaginalis, secondary to trauma. Unlike the hydrocele, it does not transilluminate.

230. Testicular torsion may also result from trauma to the scrotum. With this injury, the testis becomes twisted at its base, obstructing blood flow to the testis. This causes severe pain and swelling and constitutes a surgical emergency. Failure to reduce the torsion immediately will lead to infarction of the testis. Under conditions of detention, where medical care may be denied, late sequelae of this lesion may be observed.

231. Individuals who were subject to scrotal torture may suffer from chronic urinary tract infection, erectile dysfunction or atrophy of the testes. Symptoms of PTSD are not uncommon. In the chronic phase, it may be impossible to distinguish between scrotal pathology caused by torture and that caused by other disease processes. Failure to discover any physical abnormalities on full urological examination suggests that urinary symptoms, impotence or other sexual problems may be explained on psychological grounds. Scars on the skin of the scrotum and penis may be very difficult to visualize. For this reason, the absence of scarring at these specific locations does not demonstrate the absence of torture. On the other hand, the presence of scarring usually indicates that substantial trauma was sustained.

(g) *Examination of the anal region*

232. After anal rape or insertion of objects into the anus of either gender, pain and bleeding can occur for days or weeks. This often leads to constipation, which can be exacerbated by the poor diet in many places of detention. Gastrointestinal and urinary symptoms may also occur. In the acute phase, any examination beyond visual inspection may require local or general anaesthesia and should be performed by a specialist. In the chronic phase, several symptoms may persist, and they should be investigated. There may be anal scars of unusual size or position, and these should be documented. Anal fissures may persist for many years, but it is normally impossible to

differentiate between those caused by torture and those caused by other mechanisms. On examination of the anus, the following findings should be looked for and documented:

(i) Fissures tend to be non-specific findings as they can occur in a number of "normal" situations (constipation, poor hygiene). However, when seen in an acute situation (i.e. within 72 hours) fissures are a more specific finding and can be considered evidence of penetration;

(ii) Rectal tears with or without bleeding may be noted;

(iii) Disruption of the rugal pattern may manifest as smooth fan-shaped scarring. When these scars are seen out of midline (i.e. not at 12 or 6 o'clock), they can be an indication of penetrating trauma;

(iv) Skin tags, which can be the result of healing trauma;

(iv) Purulent discharge from the anus. Cultures should be taken for gonorrhoea and chlamydia in all cases of alleged rectal penetration, regardless of whether a discharge is noted.

E. Specialized diagnostic tests

233. Diagnostic tests are not an essential part of the clinical assessment of a person alleging having been tortured. In many cases, a medical history and physical examination are sufficient. However, there are circumstances in which such tests are valuable supporting evidence. For example, where there is a legal case against members of the authorities or a claim for compensation. In these cases, a positive test might make the difference between a case succeeding or failing. Additionally, if diagnostic tests are performed for therapeutic reasons, the results should be added to the clinical report. It must be recognized that the absence of a positive diagnostic test result, as with physical findings, must not be used to suggest that torture has not occurred. There are many situations in which diagnostic tests are not available for technical reasons, but their absence should never invalidate an otherwise properly written report. It is inappropriate to use limited diagnostic facilities to document injuries for legal reasons alone, when there are greater clinical needs for those facilities (for further details, see annex II).

CHAPTER VI

PSYCHOLOGICAL EVIDENCE OF TORTURE

A. General considerations

1. *The central role of the psychological evaluation*

234. It is a widely held view that torture is an extraordinary life experience capable of causing a wide range of physical and psychological suffering. Most clinicians and researchers agree that the extreme nature of the torture event is powerful enough on its own to produce mental and emotional consequences, regardless of the individual's pre-torture psychological status. The psychological consequences of torture, however, occur in the context of personal attribution of meaning, personality development and social, political and cultural factors. For this reason, it cannot be assumed that all forms of torture have the same outcome. For example, the psychological consequences of a mock execution are not the same as those due to a sexual assault, and solitary confinement and isolation are not likely to produce the same effects as physical acts of torture. Likewise, one cannot assume that the effects of detention and torture on an adult will be the same as those on a child. Nevertheless, there are clusters of symptoms and psychological reactions that have been observed and documented in torture survivors with some regularity.

235. Perpetrators often attempt to justify their acts of torture and ill-treatment by the need to gather information. Such conceptualizations obscure the purpose of torture and its intended consequences. One of the central aims of torture is to reduce an individual to a position of extreme helplessness and distress that can lead to a deterioration of cognitive, emotional and behavioural functions.[92] Thus, torture is a means of attacking an individual's fundamental modes of psychological and social functioning. Under such circumstances, the torturer strives not only to incapacitate a victim physically but also to disintegrate the individual's personality. The torturer attempts to destroy a victim's sense of being grounded in a family and society as a human being with dreams, hopes and aspirations for the future. By dehumanizing and breaking the will of their victims, torturers set horrific examples for those who later come in contact with the victim. In this way, torture can break or damage the will and coherence of entire communities. In addition, torture can profoundly damage intimate relationships between spouses, parents, children, other family members and relationships between the victims and their communities.

236. It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, many victims experience profound emotional reactions and psychological symptoms. The main psychiatric disorders associated with torture are PTSD and major depression. While these disorders are present in the general population, their prevalence is much higher among traumatized populations. The unique cultural, social and political implications that torture has for each individual influence his or her ability to describe and speak about it. These are important factors that contribute to the impact that torture inflicts psychologically and socially and that must be considered when performing an evaluation of an individual from another culture. Cross-cultural research reveals that phenomenological or descriptive methods are the most rational approaches to use when attempting to evaluate psychological or psychiatric disorders. What is considered disordered behaviour or a disease in one culture may not be viewed as pathological in another.[93, 94, 95] Since the Second World War, progress has been made towards understanding the psychological consequences of violence. Certain psychological symptoms and clusters of symptoms have been observed and documented among survivors of torture and other types of violence.

237. In recent years, the diagnosis of PTSD has been applied to an increasingly broad array of individuals suffering from the impact of widely varying types of violence. However, the utility of this diagnosis in non-Western cultures has not been established. Nevertheless, evidence suggests that there are high rates of PTSD and depression symptoms among traumatized refugee populations from many different ethnic and cultural backgrounds.[96, 97, 98] The World Health Organization's cross-

[92] G. Fischer and N. F. Gurris, "Grenzverletzungen: Folter und sexuelle Traumatisierung", *Praxis der Psychotherapie–Ein integratives Lehrbuch für Psychoanalyse und Verhaltenstherapie*, W. Senf and M. Broda, eds. (Stuttgart, Thieme, 1996).

[93] A. Kleinman, "Anthropology and psychiatry: the role of culture in cross-cultural research on illness and care", paper delivered at the World Psychiatric Association regional symposium on psychiatry and its related disciplines, 1986.

[94] H. T. Engelhardt, "The concepts of health and disease", *Evaluation and Explanation in the Biomedical Sciences*, H. T. Engelhardt and S. F. Spicker, eds. (Dordrecht, D. Reidel Publishing Co., 1975), pp. 125-141.

[95] J. Westermeyer, "Psychiatric diagnosis across cultural boundaries", *American Journal of Psychiatry,* vol. 142 (7) (1985), pp. 798-805.

[96] R. F. Mollica and others, "The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thailand-Cambodia border camps", *Journal of the American Medical Association* (*JAMA*), vol. 270 (1993), pp. 581-586.

[97] J. D. Kinzie and others. "The prevalence of posttraumatic stress disorder and its clinical significance among Southeast Asian refugees", *American Journal of Psychiatry,* vol. 147 (7) (1990), pp. 913-917.

[98] K. Allden and others, "Burmese political dissidents in Thailand: trauma and survival among young adults in exile", *American Journal of Public Health,* vol. 86 (1996), pp. 1561-1569.

cultural study of depression provides helpful information.[99] While some symptoms may be present across different cultures, they may not be the symptoms that concern the individual the most.

2. *The context of the psychological evaluation*

238. Evaluations take place in a variety of political contexts. This results in important differences in the manner in which an evaluation should be conducted. The physician or psychologist must adapt the following guidelines to the particular situation and purpose of the evaluation (see chapter III, sect. C.2).

239. Whether or not certain questions can be asked safely will vary considerably and depends on the degree to which confidentiality and security can be ensured. For example, an examination in a prison by a visiting physician, that is limited to 15 minutes, cannot follow the same course as a forensic examination in a private office that may last for several hours. Additional problems arise when trying to assess whether psychological symptoms or behaviours are pathological or adaptive. When a person is examined while in detention or living under considerable threat or oppression, some symptoms may be adaptive. For example, diminished interest in activities and feelings of detachment or estrangement would be understandable in a person in solitary confinement. Likewise, hypervigilance and avoidance behaviours may be necessary for persons living in repressive societies.[100] The limitations of certain conditions for interviews, however, do not preclude aspiring to application of the guidelines set forth in this manual. It is especially important in difficult circumstances that governments and authorities involved be held to these standards as much as possible.

B. Psychological consequences of torture

1. *Cautionary remarks*

240. Before entering into a technical description of symptoms and psychiatric classifications, it should be noted that psychiatric classifications are generally considered to be Western medical concepts and that their application to non-Western populations presents, either implicitly or explicitly, certain difficulties. It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies. Nonetheless, there is considerable evidence of biological changes that occur in PTSD and, from that perspective, PTSD is a diagnosable syndrome amenable to treatment biologically and psychologically.[101] As much as possible, the evaluating physician or psychologist should attempt to relate to mental suffering in the context of the individual's beliefs and cultural norms. This includes respect for the political context as well as cultural and religious beliefs. Given the severity of torture and its consequences, when performing a psychological evaluation, an attitude of informed learning should be adopted rather than one of rushing to diagnose and classify. Ideally, this attitude will communicate to the victim that his or her complaints and suffering are being recognized as real and expectable under the circumstances. In this sense, a sensitive empathic attitude may offer the victim some relief from the experience of alienation.

2. *Common psychological responses*

(a) *Re-experiencing the trauma*

241. A victim may have flashbacks or intrusive memories, in which the traumatic event is happening all over again, even while the person is awake and conscious, or recurrent nightmares, which include elements of the traumatic event in their original or symbolic form. Distress at exposure to cues that symbolize or resemble the trauma is frequently manifested by a lack of trust and fear of persons in authority, including physicians and psychologists. In countries or situations where authorities participate in human rights violations, lack of trust and fear of authority figures should not be assumed to be pathological.

(b) *Avoidance and emotional numbing*

(i) Avoidance of any thought, conversation, activity, place or person that arouses a recollection of the trauma;

(ii) Profound emotional constriction;

(iii) Profound personal detachment and social withdrawal;

(iv) Inability to recall an important aspect of the trauma.

(c) *Hyperarousal*

(i) Difficulty either falling or staying asleep;

(ii) Irritability or outbursts of anger;

(iii) Difficulty concentrating;

(iv) Hypervigilance, exaggerated startled response;

(v) Generalized anxiety;

(vi) Shortness of breath, sweating, dry mouth or dizziness and gastrointestinal distress.

[99] N. Sartorius, "Cross-cultural research on depression", *Psychopathology*, vol. 19 (2) (1987), pp. 6-11.

[100] M. A. Simpson, "What went wrong?: diagnostic and ethical problems in dealing with the effects of torture and repression in South Africa", *Beyond Trauma: Cultural and Societal Dynamics*, R. J. Kleber, C. R. Figley, B. P. R. Gersons, eds. (New York, Plenum Press, 1995), pp.188-210.

[101] M. Friedman and J. Jaranson, "The applicability of the post-traumatic stress disorder concept to refugees", *Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees*, A. Marsella and others, eds. (Washington, D. C., American Psychological Association, 1994), pp. 207-227.

(d) *Symptoms of depression*

242. The following symptoms of depression may be present: depressed mood, anhedonia (markedly diminished interest or pleasure in activities), appetite disturbance or weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue and loss of energy, feelings of worthlessness and excessive guilt, difficulty paying attention, concentrating or recalling from memory, thoughts of death and dying, suicidal ideation or attempted suicide.

(e) *Damaged self-concept and foreshortened future*

243. The victim has a subjective feeling of having been irreparably damaged and having undergone an irreversible personality change.[102] He or she has a sense of foreshortened future without expectation of a career, marriage, children or normal lifespan.

(f) *Dissociation, depersonalization and atypical behaviour*

244. Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. A person may be cut off or unaware of certain actions or may feel split in two as if observing him or herself from a distance. Depersonalization is feeling detached from oneself or one's body. Impulse control problems result in behaviours that the survivor considers highly atypical with respect to his or her pre-trauma personality. A previously cautious individual may engage in high-risk behaviour.

(g) *Somatic complaints*

245. Somatic symptoms such as pain, headache or other physical complaints, with or without objective findings, are common problems among torture victims. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches, often from head injuries. Headaches are very common among torture survivors and often lead to chronic post-traumatic headaches. They may also be caused or exacerbated by tension and stress.

(h) *Sexual dysfunction*

246. Sexual dysfunction is common among survivors of torture, particularly among those who have suffered sexual torture or rape, but not exclusively (see chapter V, sect. D.8).

(i) *Psychosis*

247. Cultural and linguistic differences may be confused with psychotic symptoms. Before labelling someone as psychotic, the symptoms must be evaluated within the individual's unique cultural context. Psychotic reactions may be brief or prolonged, and the symptoms may occur while the person is detained and tortured or afterwards. The following findings are possible:

(i) Delusions;

(ii) Auditory, visual, tactile and olfactory hallucinations;

(iii) Bizarre ideation and behaviour;

(iv) Illusions or perceptual distortions that may take the form of pseudo-hallucinations and border on true psychotic states. False perceptions and hallucinations that occur on falling asleep or on waking are common among the general population and do not denote psychosis. It is not uncommon for torture victims to report occasionally hearing screams, their name being called or seeing shadows, but not to have florid signs or symptoms of psychosis;

(v) Paranoia and delusions of persecution;

(vi) Recurrence of psychotic disorders or mood disorders with psychotic features may develop among those who have a past history of mental illness. Individuals with a past history of bipolar disorder, recurrent major depression with psychotic features, schizophrenia and schizoaffective disorder may experience an episode of that disorder.

(j) *Substance abuse*

248. Alcohol and drug abuse often develop secondarily in torture survivors as a way of obliterating traumatic memories, regulating affects and managing anxiety.

(k) *Neuropsychological impairment*

249. Torture can cause physical trauma that leads to various levels of brain impairment. Blows to the head, suffocation and prolonged malnutrition may have long-term neurological and neuropsychological consequences that may not be readily assessed during the course of a medical examination. As in all cases of brain impairment that cannot be documented through head imaging or other medical procedures, neuropsychological assessment and testing may be the only reliable way of documenting the effects. Frequently, the target symptoms for such assessments have significant overlap with the symptomatology arising from PTSD and major depressive disorder. Fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning may result from functional disturbances as well as have organic causes. Therefore, specialized skill in neuropsychological assessment and awareness of problems in cross-cultural validation of neuropsychological instruments are necessary when such distinctions are to be made (see section C.4 below).

3. *Diagnostic classifications*

250. While the chief complaints and most prominent findings among torture survivors are widely diverse and relate to the individual's unique life experiences and his or

[102] N. R. Holtan, "How medical assessment of victims of torture relates to psychiatric care", *Caring for Victims of Torture*, J. M. Jaranson and M. K. Popkin, eds. (Washington, D. C., American Psychiatric Press, 1998), pp. 107-113.

her cultural, social and political context, it is wise for evaluators to become familiar with the most commonly diagnosed disorders among trauma and torture survivors. Also, it is not uncommon for more than one mental disorder to be present, as there is considerable co-morbidity among trauma-related mental disorders. Various manifestations of anxiety and depression are the most common symptoms resulting from torture. Not infrequently, the symptomatology described above will be classified within the categories of anxiety and mood disorders. The two prominent classification systems are the International Classification of Disease (ICD-10)[103] classification of mental and behavioural disorders and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).[104] For complete descriptions of diagnostic categories, the reader should refer to ICD-10 and DSM-IV. This review will focus on the most common trauma-related diagnoses: PTSD, major depression and enduring personality changes.

(a) *Depressive disorders*

251. Depressive states are almost ubiquitous among survivors of torture. In the context of evaluating the consequences of torture, it is problematic to assume that PTSD and major depressive disorder are two separate disease entities with clearly distinguishable aetiologies. Depressive disorders include major depressive disorder, single episode or major depressive disorder and recurrent (more than one episode). Depressive disorders can be present with or without psychotic, catatonic, melancholic or atypical features. According to DSM-IV, in order to make a diagnosis of major depressive episode, five or more of the following symptoms must be present during the same two-week period and represent a change from previous functioning (at least one of the symptoms must be depressed mood or loss of interest or pleasure): (1) depressed mood; (2) markedly diminished interest or pleasure in all or almost all activities; (3) weight loss or change of appetite; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue or loss of energy; (7) feelings of worthlessness or excessive or inappropriate guilt; (8) diminished ability to think or concentrate; and (9) recurrent thoughts of death or suicide. To make this diagnosis the symptoms must cause significant distress or impaired social or occupational functioning, not be due to a physiological disorder and unaccounted for by another DSM-IV diagnosis.

(b) *Post-traumatic stress disorder*

252. The diagnosis most commonly associated with the psychological consequences of torture is PTSD. The association between torture and this diagnosis has become very strong in the minds of health providers, immigration courts and the informed lay public. This has created the mistaken and simplistic impression that PTSD is the main psychological consequence of torture.

253. The DSM-IV definition of PTSD relies heavily on the presence of memory disturbances in relation to the trauma, such as intrusive memories, nightmares and the inability to recall important aspects of the trauma. The individual may be unable to recall with precision specific details of the torture events but will be able to recall the major themes of the torture experiences. For example, the victim may be able to recall being raped on several occasions but not be able to give the exact dates, locations and details of the setting or the perpetrators. Under such circumstances, the inability to recall precise details supports, rather than discounts, the credibility of a survivor's story. Major themes in the story will be consistent upon re-interviewing. The ICD-10 diagnosis of PTSD is very similar to that of DSM-IV. According to DSM-IV, PTSD can be acute, chronic or delayed. The symptoms must be present for more than one month and the disturbance must cause significant distress or impairment in functioning. In order to diagnose PTSD, the individual must have been exposed to a traumatic event that involved life-threatening experiences for the victim or others and produced intense fear, helplessness or horror. The event must be re-experienced persistently in one or more of the following ways: intrusive distressing recollections of the event, recurrent distressing dreams of the event, acting or feeling as if the event were happening again including hallucinations, flashbacks and illusions, intense psychological distress at exposure to reminders of the event and physiological reactivity when exposed to cues that resemble or symbolize aspects of the event.

254. The individual must persistently demonstrate avoidance of stimuli associated with the traumatic event or show general numbing of responsiveness as indicated by at least three of the following: (1) efforts to avoid thoughts, feelings or conversations associated with the trauma; (2) efforts to avoid activities, places or people that remind the victim of the trauma; (3) inability to recall an important aspect of the event; (4) diminished interest in significant activities; (5) detachment or estrangement from others; (6) restricted affect; and (7) foreshortened sense of future. Another reason to make a DSM-IV diagnosis of PTSD is the persistence of symptoms of increased arousal that were not present before the trauma, as indicated by at least two of the following: difficulty falling or staying asleep, irritability or angry outbursts, difficulty concentrating, hypervigilance and exaggerated startle response.

255. Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability dominate the clinical picture. At these times, the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times, the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. It must be kept in mind that not meeting diagnostic criteria of PTSD does not mean that torture was not inflicted. According to ICD-10, in a certain proportion of cases PTSD may follow a chronic course over many years with eventual transition to an enduring personality change.

[103] World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders* (Geneva, 1994).

[104] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*: DSM-IV-TR, 4th ed. (Washington, D.C., 1994).

(c) *Enduring personality change*

256. After catastrophic or prolonged extreme stress, disorders of adult personality may develop in persons with no previous personality disorder. The types of extreme stress that can change the personality include concentration camp experiences, disasters, prolonged captivity with an imminent possibility of being killed, exposure to life-threatening situations, such as being a victim of terrorism, and torture. According to ICD-10, the diagnosis of an enduring change in personality should be made only when there is evidence of a definite, significant and persistent change in the individual's pattern of perceiving, relating or thinking about the environment and him or herself, associated with inflexible and maladaptive behaviours not present before the traumatic experience. The diagnosis excludes changes that are a manifestation of another mental disorder or a residual symptom of any antecedent mental disorder, as well as personality and behavioural changes due to brain disease, dysfunction or damage.

257. To make the ICD-10 diagnosis of enduring personality change after catastrophic experience, the changes in personality must be present for at least two years following exposure to catastrophic stress. ICD-10 specifies that the stress must be so extreme that "it is not necessary to consider personal vulnerability in order to explain its profound effect on the personality". This personality change is characterized by a hostile or distrustful attitude towards the world, social withdrawal, feelings of emptiness or hopelessness, a chronic feeling of "being on edge", as if constantly threatened, and estrangement.

(d) *Substance abuse*

258. Clinicians have observed that alcohol and drug abuse often develop secondarily in torture survivors as a way of suppressing traumatic memories, regulating unpleasant affects and managing anxiety. Although co-morbidity of PTSD with other disorders is common, systematic research has seldom studied the abuse of substances by torture survivors. The literature on populations that suffer from PTSD may include torture survivors, such as refugees, prisoners of war and veterans of armed conflicts, and may provide some insight. Studies of these groups reveal that prevalence of substance abuse varies by ethnic or cultural group. Former prisoners of war with PTSD were at increased risk of substance abuse, and combat veterans have high rates of co-morbidity of PTSD and substance abuse.[105, 106, 107, 108, 109, 110, 111, 112] In summary, there is considerable evidence from other populations at risk of PTSD that substance abuse is a potential co-morbid diagnosis for torture survivors.

(e) *Other diagnoses*

259. As is evident from the catalogue of symptoms described in this section, there are other diagnoses to be considered in addition to PTSD, such as major depressive disorder and enduring personality change. The other possible diagnoses include but are not limited to:

(i) Generalized anxiety disorder features excessive anxiety and worry about a variety of different events or activities, motor tension and increased autonomic activity;

(ii) Panic disorder is manifested by recurrent and unexpected attacks of intense fear or discomfort, including symptoms such as sweating, choking, trembling, rapid heart rate, dizziness, nausea, chills or hot flushes;

(iii) Acute stress disorder has essentially the same symptoms as PTSD but is diagnosed within one month of exposure to the traumatic event;

(iv) Somatoform disorders featuring physical symptoms that cannot be accounted for by a medical condition;

(v) Bipolar disorder featuring manic or hypomanic episodes with elevated, expansive or irritable mood, grandiosity, decreased need for sleep, flight of ideas, psychomotor agitation and associated psychotic phenomena;

(vi) Disorders due to a general medical condition often in the form of brain impairment with resultant fluctuations or deficits in level of consciousness, orientation, attention, concentration, memory and executive functioning;

(vii) Phobias such as social phobia and agoraphobia.

C. The psychological/psychiatric evaluation

1. *Ethical and clinical considerations*

260. Psychological evaluations can provide critical evidence of abuse among torture victims for several reasons: torture often causes devastating psychological symptoms, torture methods are often designed to leave no physical lesions and physical methods of torture may result in physical findings that either resolve or lack specificity.

[105] P. J. Farias, "Emotional distress and its socio-political correlates in Salvadoran refugees: analysis of a clinical sample", *Culture, Medicine and Psychiatry*, vol. 15 (1991), pp. 167-192.

[106] A. Dadfar, "The Afghans: bearing the scars of a forgotten war", *Amidst Peril and Pain: The Mental Health and Well-being of the World's Refugees*, A. Marsella and others (Washington, D. C., American Psychological Association, 1994).

[107] G. W. Beebe, "Follow-up studies of World War II and Korean war prisoners: II. Morbidity, disability, and malajustments", *American Journal of Epidemiology*, vol. 101 (1975), pp. 400-422.

[108] B. E. Engdahl and others, "Comorbidity and course of psychiatric disorders in a community sample of former prisoners of war", *American Journal of Psychiatry*, vol. 155 (1998), pp. 1740-1745.

[109] T. M. Keane and J. Wolfe, "Comorbidity in post-traumatic stress disorder: an analysis of community and clinical studies", *Journal of Applied Social Psychology*, vol. 20 (21) (1990), pp. 1776-1788.

[110] R. A. Kulka and others, *Trauma and the Vietnam War Generation: Report of Findings from the National Vietnam Veterans Readjustment Study* (New York, Brunner/Mazel, 1990).

[111] B. K. Jordan and others, "Lifetime and current prevalence of specific psychiatric disorders among Vietnam veterans and controls", *Archives of General Psychiatry*, vol. 48, No. 3 (1991), pp. 207-215.

[112] A. Y. Shalev, A. Bleich and R. J. Ursano, "Posttraumatic stress disorder: somatic comorbidity and effort tolerance", *Psychosomatics*, vol. 31 (1990), pp.197-203.

261. Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations. The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history, a mental status examination, an assessment of social functioning and the formulation of clinical impressions (see chapters III, sect. C, and IV, sect. E). A psychiatric diagnosis should be made, if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable for any evaluation of torture to include a psychological assessment.

262. The assessment of psychological status and the formulation of a clinical diagnosis should always be made with an awareness of the cultural context. Awareness of culture-specific syndromes and native language-bound idioms of distress through which symptoms are communicated is of paramount importance for conducting the interview and formulating the clinical impression and conclusion. When the interviewer has little or no knowledge of the victim's culture, the assistance of an interpreter is essential. Ideally, an interpreter from the victim's country knows the language, customs, religious traditions and other beliefs that must be taken into account during the investigation. The interview may induce fear and mistrust on the part of the victim and possibly remind him or her of previous interrogations. To reduce the effects of retraumatization, the clinician should communicate a sense of understanding of the individual's experiences and cultural background. It is inappropriate to observe the strict "clinical neutrality" that is used in some forms of psychotherapy, during which the clinician is inactive and says little. The clinician should communicate that he or she is an ally of the individual and adopt a supportive, non-judgemental approach.

2. *The interview process*

263. The clinician should introduce the interview process in a manner that explains in detail the procedures to be followed (questions asked about psychosocial history, including history of torture and current psychological functioning) and that prepares the individual for the difficult emotional reactions that the questions may provoke. The individual needs to be given an opportunity to request breaks, interrupt the interview at any time and be able to leave if the stress becomes intolerable, with the option of a later appointment. Clinicians need to be sensitive and empathic in their questioning, while remaining objective in their clinical assessment. At the same time, the interviewer should be aware of potential personal reactions to the survivor and the descriptions of torture that might influence the interviewer's perceptions and judgements.

264. The interview process may remind the survivor of interrogation during torture. Therefore, strong negative feelings towards the clinician may develop, such as fear, rage, revulsion, helplessness, confusion, panic or hatred. The clinician should allow for the expression and explanation of such feelings and express understanding for the individual's difficult predicament. In addition, the possibility that the person may still be persecuted or oppressed has to be kept in mind. When necessary, questions about forbidden activities should be avoided. It is important to consider the reasons for the psychological evaluation, as they will determine the level of confidentiality to which the expert is bound. If an evaluation of the credibility of an individual's report of torture is requested within the framework of a judicial procedure by a State authority, the person to be evaluated must be told that this implies lifting medical confidentiality for all the information presented in the report. However, if the request for the psychological evaluation comes from the tortured person, the expert must respect medical confidentiality.

265. Clinicians who conduct physical or psychological evaluations should be aware of the potential emotional reactions that evaluations of severe trauma may elicit in the interviewee and interviewer. These emotional reactions are known as transference and countertransference. Mistrust, fear, shame, rage and guilt are among the typical reactions that torture survivors experience, particularly when being asked to recount or remember details of their trauma. Transference refers to the feelings a survivor has towards the clinician that relate to past experiences but which are misunderstood as directed towards the clinician personally. In addition, the clinician's emotional response to the torture survivor, known as countertransference, may affect the psychological evaluation. Transference and countertransference are mutually interdependent and interactive.

266. The potential impact of transference reactions on the evaluation process becomes evident when it is considered that an interview or examination that involves recounting and remembering the details of a traumatic history will result in exposure to distressing and unwanted memories, thoughts and feelings. Thus, even though a torture victim may consent to an evaluation with the hope of benefiting from it, the resulting exposure may renew the trauma experience itself. This may include the following phenomena.

267. The evaluator's questions may be experienced as forced exposure akin to an interrogation. The evaluator may be suspected of having voyeuristic or sadistic motivations, and the interviewee may ask him or herself questions such as: "Why does he or she make me reveal every last terrible detail of what happened to me? Why would a normal person choose to listen to stories like mine in order to make a living? The evaluator must have some strange kind of motivation." There may be prejudices towards the evaluator because he or she has not been arrested and tortured. This may lead the subject to perceive the evaluator as being on the side of the enemy.

268. The evaluator is perceived as a person in a position of authority, which is often the case, and for that reason may not be trusted with certain aspects of the trauma history. Alternatively, as is often the case with subjects still in custody, the subject may be too trusting in situations where the interviewer cannot guarantee that there

will be no reprisals. Every precaution should be taken to ensure that prisoners do not put themselves at risk unnecessarily, naively trusting the outsider to protect them. Torture victims may fear that information that is revealed in the context of an evaluation cannot be safely kept from persecuting governments. Fear and mistrust may be particularly strong in cases where physicians or other health workers have been participants in the torture.

269. In many circumstances, the evaluator will be a member of the majority culture and ethnicity, whereas the subject, in the situation of the interview, will belong to a minority group or culture. This dynamic of inequality may reinforce the perceived and real imbalance of power and may increase the potential sense of fear, mistrust and forced submission in the subject. In some cases, particularly with subjects still in custody, this dynamic may relate more to the interpreter than to the evaluator. Ideally, therefore, the interpreter should also be an outsider and not be recruited locally, so that he or she can be seen by all to be as independent as the investigator. Of course, a family member on whom the authorities can later apply pressure to find out what was discussed in the evaluation should not be used as an interpreter.

270. If the evaluator and the victim are of the same gender, the interview may be more readily perceived as directly resembling the torture situation than if the genders were different. For example, a woman who was raped or tortured in prison by a male guard is likely to experience more distress, mistrust and fear when facing a male evaluator than she might with a female interviewer. The opposite is true for men who have been assaulted sexually. They may be ashamed to tell the details of their torture to a female evaluator. Experience has shown, particularly in cases of victims still in custody, that in all but the most traditionally fundamentalist societies (where it is out of the question for a male to even interview, let alone examine, a woman), it may be much more important that the interviewer be a physician to whom the victim can ask precise questions, rather than not being a male as in a case of rape. Victims of rape have been known to say nothing to non-medical female investigators, but to request to talk to a physician, even if male, so as to be able to ask specific medical questions. Typical questions are about possible sequelae, such as being pregnant, being able to conceive later on or about the future of sexual relations between spouses. In the context of evaluations conducted for legal purposes, the necessary attention to detail and precise questioning about history are easily perceived as a sign of mistrust or doubt on the part of the examiner.

271. Because of the psychological pressures mentioned earlier, survivors may be re-traumatized and overwhelmed by memories and, as a result, affect or mobilize strong defences that result in profound withdrawal and affective flattening during examination or interview. For the purposes of documentation, the withdrawal and flattening present special difficulties because torture victims may be unable to communicate their history and current suffering effectively, although it would be most beneficial for them to do so.

272. Countertransference reactions are often unconscious, and when a person is unaware of countertransference, it becomes a problem. Having feelings when listening to individuals speak of their torture is to be expected, although these feelings can interfere with the clinician's effectiveness, but when understood they can guide the clinician. Physicians and psychologists involved in the evaluation and treatment of torture victims agree that awareness and understanding of typical countertransference reactions are crucial because countertransference can have significantly limiting effects on the ability to evaluate and document the physical and psychological consequences of torture. Effective documentation of torture and other forms of ill-treatment requires an understanding of personal motivations for working in this area. There is a consensus that professionals who continuously conduct this kind of examination should obtain supervision and professional support from peers who are experienced in this field. Common countertransference reactions include:

(*a*) Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material. This may lead to forgetting some details and underestimating the severity of physical or psychological consequences;

(*b*) Disillusionment, helplessness, hopelessness and overidentification that may lead to symptoms of depression or vicarious traumatization, such as nightmares, anxiety and fear;

(*c*) Omnipotence and grandiosity in the form of feeling like a saviour, the great expert on trauma or the last hope for the survivor's recovery and well-being;

(*d*) Feelings of insecurity about professional skills when faced with the gravity of the reported history or suffering. This may manifest as lack of confidence in the ability to do justice to the survivor and unrealistic preoccupation with idealized medical norms;

(*e*) Feelings of guilt over not sharing the torture survivor's experience and pain or over the awareness of what has not been done on a political level may result in overly sentimental or idealized approaches to the survivor;

(*f*) Anger and rage towards torturers and persecutors are expectable, but may undermine the ability to maintain objectivity when they are driven by unrecognized personal experiences and thus become chronic or excessive;

(*g*) Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety. This may also arise as a result of feeling used by the victim when the clinician experiences doubt about the truth of the alleged torture history and the victim stands to benefit from an evaluation that documents the consequences of the alleged incident;

(*h*) Significant differences between the cultural value systems of the clinician and the individual alleging torture may include belief in myths about ethnic groups, condescending attitudes and underestimation of the individual's sophistication or capacity for insight. Conversely, clinicians who are members of the same ethnic group as a victim might form a non-verbalized alliance that can also affect the objectivity of the evaluation.

273. Most clinicians agree that many countertransference reactions are not merely examples of distortion but are important sources of information about the psychological state of the torture victim. The clinician's effectiveness can be compromised when countertransference is acted upon rather than reflected upon. Clinicians engaged in the evaluation and treatment of torture victims are advised to examine countertransference and obtain supervision and consultation from a colleague, if possible.

274. Circumstances may require that interviews be conducted by a clinician from a cultural or linguistic group different from that of the survivor. In such cases, there are two possible approaches; each with advantages and disadvantages. The interviewer can use literal, word-for-word translations provided by an interpreter (see chapter IV, sect. I). Alternatively, the interviewer can use a bicultural approach to interviewing. This approach consists of using an interviewing team composed of the investigating clinician and an interpreter, who provides linguistic interpretation and facilitates an understanding of cultural meanings attached to events, experiences, symptoms and idioms. Because the clinician often does not recognize relevant cultural, religious and social factors, a skilled interpreter will be able to point out and explain these issues to the clinician. If the interviewer is relying strictly on literal, word-for-word interpretation, this type of in-depth interpretation of information will not be available. On the other hand, if interpreters are expected to point out relevant cultural, religious and social factors to the clinician, it is crucial that they do not attempt to influence in any way the tortured person's responses to the clinician's questions. When literal translation is not used, the clinician needs to be sure that the interviewee's responses, as communicated by the interpreter, represent exclusively what the person said without additions or deletions by the interpreter. Regardless of the approach, the interpreter's identity and ethnic, cultural and political affiliation are important considerations in the choice of an interpreter. The torture victim will have to trust the interpreter to understand what he or she is saying and to communicate it accurately to the investigating clinician. Under no circumstances should the interpreter be a law enforcement official or government employee. A family member should never be used as an interpreter, in order to respect privacy. The investigating team must choose an independent interpreter.

3. *Components of the psychological/ psychiatric evaluation*

275. The introduction should contain mention of the referral source, a summary of collateral sources (such as medical, legal and psychiatric records) and a description of the methods of assessment used (interviews, symptom inventories, checklists and neuropsychological testing).

(a) *History of torture and ill-treatment*

276. Every effort should be made to document the full history of torture, persecution and other relevant traumatic experiences (see chapter IV, sect. E). This part of the evaluation is often exhausting for the person being evaluated. Therefore, it may be necessary to proceed in several sessions. The interview should start with a general summary of events before eliciting the details of the torture experiences. The interviewer needs to know the legal issues at hand because that will determine the nature and amount of information necessary to achieve documentation of the facts.

(b) *Current psychological complaints*

277. An assessment of current psychological functioning constitutes the core of the evaluation. As severely brutalized prisoners of war and rape victims show a lifetime prevalence of PTSD of between 80 and 90 per cent, specific questions about the three DSM-IV categories of PTSD (re-experiencing of the traumatic event, avoidance or numbing of responsiveness, including amnesia, and increased arousal) need to be asked.[113, 114] Affective, cognitive and behavioural symptoms should be described in detail, and the frequency, as well as examples, of nightmares, hallucinations and startle response should be stated. An absence of symptoms can be due to the episodic or often delayed nature of PTSD or to denial of symptoms because of shame.

(c) *Post-torture history*

278. This component of the psychological evaluation seeks information about current life circumstances. It is important to inquire about current sources of stress, such as separation or loss of loved ones, flight from the home country and life in exile. The interviewer should also inquire about the individual's ability to be productive, earn a living, care for his or her family and the availability of social supports.

(d) *Pre-torture history*

279. If relevant, describe the victim's childhood, adolescence, early adulthood, his or her family background, family illnesses and family composition. There should also be a description of the victim's educational and occupational history. Describe any history of past trauma, such as childhood abuse, war trauma or domestic violence, as well as the victim's cultural and religious background.

280. The description of pre-trauma history is important to assess mental health status and level of psychosocial functioning of the torture victim prior to the traumatic events. In this way, the interviewer can compare the current mental health status with that of the individual before torture. In evaluating background information, the interviewer should keep in mind that the duration and severity of responses to trauma are affected by multiple factors. These factors include, but are not limited to, the circumstances of the torture, the perception and interpretation of torture by the victim, the social context before, during and after torture, community and peer resources and values and attitudes about traumatic experiences, political and

[113] B. O. Rothbaum and others, "A prospective examination of post-traumatic stress disorder in rape victims", *Journal of Traumatic Stress*, vol. 5 (1992), pp. 455-475.

[114] P. B. Sutker and others, "Cognitive deficits and psychopathology among former prisoners of war and combat veterans of the Korean conflict", *American Journal of Psychiatry,* vol. 148 (1991), pp. 62-72.

cultural factors, severity and duration of the traumatic events, genetic and biological vulnerabilities, developmental phase and age of the victim, prior history of trauma and pre-existing personality. In many interview situations, because of time limitations and other problems, it may be difficult to obtain this information. It is important, nonetheless, to obtain enough data about the individual's previous mental health and psychosocial functioning to form an impression of the degree to which torture has contributed to psychological problems.

(e) *Medical history*

281. The medical history summarizes pre-trauma health conditions, current health conditions, body pain, somatic complaints, use of medication and its side effects, relevant sexual history, past surgical procedures and other medical data (see chapter V, sect. B).

(f) *Psychiatric history*

282. Inquiries should be made about a history of mental or psychological disturbances, the nature of problems and whether they received treatment or required psychiatric hospitalization. The inquiry should also cover prior therapeutic use of psychotropic medication.

(g) *Substance use and abuse history*

283. The clinician should inquire about substance use before and after the torture, changes in the pattern of use and whether substances are being used to cope with insomnia or psychological/psychiatric problems. These substances are not only alcohol, cannabis and opium but also regional substances of abuse such as betel nut and many others.

(h) *Mental status examination*

284. The mental status examination begins the moment the clinician meets the subject. The interviewer should make note of the person's appearance, such as signs of malnutrition, lack of cleanliness, changes in motor activity during the interview, use of language, presence of eye contact, ability to relate to the interviewer and the means the individual uses to establish communication. The following components should be covered, and all aspects of the mental status examination should be included in the report of the psychological evaluation; aspects such as general appearance, motor activity, speech, mood and affect, thought content, thought process, suicidal and homicidal ideation and a cognitive examination (orientation, long-term memory, intermediate recall and immediate recall).

(i) *Assessment of social function*

285. Trauma and torture can directly and indirectly affect a person's ability to function. Torture can also indirectly cause loss of functioning and disability, if the psychological consequences of the experience impair the individual's ability to care for himself or herself, earn a living, support a family and pursue an education. The clinician should assess the individual's current level of functioning by inquiring about daily activities, social role (as housewife, student, worker), social and recreational activities and perception of health status. The interviewer should ask the individual to assess his or her own health condition, to state the presence or absence of feelings of chronic fatigue and to report potential changes in overall functioning.

(j) *Psychological testing and the use of checklists and questionnaires*

286. Little published data exist on the use of psychological testing (projective and objective personality tests) in the assessment of torture survivors. Also, psychological tests of personality lack cross-cultural validity. These factors combine to limit severely the utility of psychological testing in the evaluation of torture victims. Neuropsychological testing may, however, be helpful in assessing cases of brain injury resulting from torture (see section C.4 below). An individual who has survived torture may have trouble expressing in words his or her experiences and symptoms. In some cases, it may be helpful to use trauma event and symptom checklists or questionnaires. If the interviewer believes it may be helpful to use these, there are numerous questionnaires available, although none are specific to torture victims.

(k) *Clinical impression*

287. In formulating a clinical impression for the purposes of reporting psychological evidence of torture, the following important questions should be asked:

(i) Are the psychological findings consistent with the alleged report of torture?

(ii) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(iii) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?

(iv) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

(v) Which physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture or detention;

(vi) Does the clinical picture suggest a false allegation of torture?

288. Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged abuse. The emotional state and expression of the person during the interview, his or her symptoms, the history of detention and torture and the personal history prior to torture should be described. Factors such as the onset of specific symptoms related to the trauma, the specificity of any particular psychological findings and patterns of psychological functioning should be noted. Additional factors should be considered, such as forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, family and social status. The relation-

ship and consistency between events and symptoms should be evaluated and described. Physical conditions, such as head trauma or brain injury, may require further evaluation. Neurological or neuropsychological assessment may be recommended.

289. If the survivor has symptom levels consistent with a DSM-IV or ICD-10 psychiatric diagnosis, the diagnosis should be stated. More than one diagnosis may be applicable. Again, it must be stressed that even though a diagnosis of a trauma-related mental disorder supports the claim of torture, not meeting criteria for a psychiatric diagnosis does not mean the person was not tortured. A survivor of torture may not have the level of symptoms required to meet diagnostic criteria for a DSM-IV or ICD-10 diagnosis fully. In these cases, as with all others, the symptoms that the survivor has and the torture story that he or she claims to have experienced should be considered as a whole. The degree of consistency between the torture story and the symptoms that the individual reports should be evaluated and described in the report.

290. It is important to recognize that some people falsely allege torture for a range of reasons and that others may exaggerate a relatively minor experience for personal or political reasons. The investigator must always be aware of these possibilities and try to identify potential reasons for exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess. Inconsistencies in testimony can occur for a number of valid reasons, such as memory impairment due to brain injury, confusion, dissociation, cultural differences in perception of time or fragmentation and repression of traumatic memories. Effective documentation of psychological evidence of torture requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report. If the interviewer suspects fabrication, additional interviews should be scheduled to clarify inconsistencies in the report. Family or friends may be able to corroborate details of the story. If the clinician conducts additional examinations and still suspects fabrication, the clinician should refer the individual to another clinician and ask for the colleague's opinion. The suspicion of fabrication should be documented with the opinion of two clinicians.

(l) *Recommendations*

291. The recommendations resulting from the psychological evaluation depend on the question posed at the time the evaluation was requested. The issues under consideration may concern legal and judicial matters, asylum, resettlement or a need for treatment. Recommendations can be for further assessment, such as neuropsychological testing, medical or psychiatric treatment, or a need for security or asylum.

4. *Neuropsychological assessment*

292. Clinical neuropsychology is an applied science concerned with the behavioural expression of brain dysfunction. Neuropsychological assessment, in particular, is concerned with the measurement and classification of behavioural disturbances associated with organic brain impairment. The discipline has long been recognized as useful in discriminating between neurological and psychological conditions and in guiding treatment and rehabilitation of patients suffering from the consequences of various levels of brain damage. Neuropsychological evaluations of torture survivors are performed infrequently and to date there are no neuropsychological studies of torture survivors available in the literature. The following remarks are, therefore, limited to a discussion of general principles to guide health providers in understanding the utility of, and indications for, neuropsychological assessment of subjects suspected of being tortured. Before discussing the issues of utility and indications, it is essential to recognize the limitations of neuropsychological assessment in this population.

(a) *Limitations of neuropsychological assessment*

293. There are a number of common factors complicating the assessment of torture survivors in general that are outlined elsewhere in this manual. These factors apply to neuropsychological assessment in the same way as to a medical or psychological examination. Neuropsychological assessments may be limited by a number of additional factors, including lack of research on torture survivors, reliance on population-based norms, cultural and linguistic differences and re-traumatization of those who have experienced torture.

294. As mentioned above, very few references exist in the literature concerning the neuropsychological assessment of torture victims. The pertinent body of literature concerns various types of head trauma and the neuropsychological assessment of PTSD in general. Therefore, the following discussion and subsequent interpretations of neuropsychological assessments are necessarily based on the application of general principles used with other subject populations.

295. Neuropsychological assessment as it has been developed and practised in Western countries relies heavily on an actuarial approach. This approach typically involves comparing the results of a battery of standardized tests to population-based norms. Although norm-referenced interpretations of neuropsychological assessments may be supplemented by a Lurian approach of qualitative analysis, particularly when the clinical situation demands it, a reliance on the actuarial approach predominates.[115, 116] Moreover, a reliance on test scores is greatest when brain impairment is mild to moderate in severity, rather than severe, or when neuropsychological deficits are thought to be secondary to a psychiatric disorder.

296. Cultural and linguistic differences may significantly limit the utility and applicability of neuropsychological assessment among suspected torture victims. Neuropsychological assessments are of questionable validity when standard translations of tests are unavailable and the clinical examiner is not fluent in the subject's

[115] A. R. Luria and L. V. Majovski, "Basic approaches used in American and Soviet clinical neuropsychology", *American Psychologist*, vol. 32 (11) (1977), pp. 959-968.

[116] R. J. Ivnik, "Overstatement of differences", *American Psychologist*, vol. 33 (8) (1978), pp. 766-767.

language. Unless standardized translations of tests are available and examiners are fluent in the subject's language, verbal tasks cannot be administered at all and cannot be interpreted in a meaningful way. This means that only non-verbal tests can be used, and this precludes comparison between verbal and non-verbal faculties. In addition, an analysis of the lateralization (or localization) of deficits is more difficult. This analysis is often useful, however, because of the brain's asymmetrical organization, with the left hemisphere typically being dominant for speech. If population-based norms are unavailable for the subject's cultural and linguistic group, neuropsychological assessment is also of questionable validity. An estimate of IQ is one of the central benchmarks that allow examiners to place neuropsychological test scores into proper perspective. Within the population of the United States, for example, these estimates are often derived from verbal subsets using the Wechsler scales, particularly the information subscale, because in the presence of organic brain impairment, acquired factual knowledge is less likely to suffer deterioration than other tasks and be more representative of past learning ability than other measures. Measurement may also be based on educational and work history and demographic data. Obviously, neither one of these two considerations applies to subjects for whom population-based norms have not been established. Therefore, only very coarse estimates concerning pre-trauma intellectual functioning can be made. As a result, neuropsychological impairment that is anything less than severe or moderate may be difficult to interpret.

297. Neuropsychological assessments may re-traumatize those who have experienced torture. Great care must be taken in order to minimize any potential re-traumatization of the subject in any form of diagnostic procedure (see chapter IV, sect. H). To cite only one obvious example specific to neuropsychological testing, it would be potentially very damaging to proceed with a standard administration of the Halstead-Reitan Battery, in particular the Tactual Performance Test (TPT), and routinely blindfold the subject. For most torture victims who have experienced blindfolding during detention and torture, and even for those who were not blindfolded, it would be very traumatic to introduce the experience of helplessness inherent in this procedure. In fact, any form of neuropsychological testing in itself may be problematic, regardless of the instrument used. Being observed, timed with a stopwatch and asked to give maximum effort on an unfamiliar task, in addition to being asked to perform, rather than having a dialogue, may prove to be too stressful or reminiscent of the torture experience.

(b) *Indications for neuropsychological assessment*

298. In evaluating behavioural deficits in suspected torture victims, there are two primary indications for neuropsychological assessment: brain injury and PTSD plus related diagnoses. While both sets of conditions overlap in some aspects, and will often coincide, it is only the former that is a typical and traditional application of clinical neuropsychology, whereas the latter is relatively new, not well researched and rather problematic.

299. Brain injury and resulting brain damage may result from various types of head trauma and metabolic disturbances inflicted during periods of persecution, detention and torture. This may include gunshot wounds, the effects of poisoning, malnutrition as a result of starvation or forced ingestion of harmful substances, the effects of hypoxia or anoxia resulting from asphyxiation or near drowning and, most commonly, from blows to the head suffered during beatings. Blows to the head are frequently inflicted during periods of detention and torture. For example, in one sample of torture survivors, blows to the head were the second most frequently cited form of bodily abuse (45 per cent) behind blows to the body (58 per cent).[117] The potential for brain damage is high among torture victims.

300. Closed head injuries resulting in mild to moderate levels of long-term impairment are perhaps the most commonly assessed cause of neuropsychological abnormality. While signs of injury may include scars on the head, brain lesions cannot usually be detected by diagnostic imaging of the brain. Mild to moderate levels of brain damage might be overlooked or underestimated by mental health professionals because symptoms of depression and PTSD are likely to figure prominently in the clinical picture, resulting in less attention being paid to the potential effect of head trauma. Commonly, the subjective complaints of survivors include difficulties with attention, concentration and short-term memory, which can be the result of either brain impairment or PTSD. Since these complaints are common in survivors suffering from PTSD, the question whether they are actually due to head injury may not even be asked.

301. The diagnostician must rely, in an initial phase of the examination, on reported history of head trauma and the course of symptomatology. As is usually the case with brain-injured subjects, information from third parties, particularly relatives, may prove helpful. It must be remembered that brain-injured subjects often have great difficulty articulating or even appreciating their limitations because they are, so to speak, "inside" the problem. In gathering first impressions regarding the difference between organic brain impairment and PTSD, an assessment concerning the chronicity of symptoms is a helpful starting point. If symptoms of poor attention, concentration and memory are observed to fluctuate over time and to co-vary with levels of anxiety and depression, this is more likely due to the phasic nature of PTSD. On the other hand, if impairment seems to appear chronic, lacks fluctuation and is confirmed by family members, the possibility of brain impairment should be entertained, even in the initial absence of a clear history of head trauma.

302. Once there is a suspicion of organic brain impairment, the first step for a mental health professional is to consider a referral to a physician for further neurological examination. Depending on initial findings, the physician may then consult a neurologist or order diagnostic tests. An extensive medical work-up, specific neurological consultation and neuropsychological evaluation

[117] H. C. Traue, G. Schwarz-Langer and N. F. Gurris, "Extremtraumatisierung durch Folter: Die psychotherapeutische Arbeit der Behandlungszentren für Folteropfer", *Verhaltenstherapie und Verhaltensmedizin,* vol. 18 (1) (1997), pp. 41-62.

are among the possibilities to be considered. The use of neuropsychological evaluation procedures is usually indicated if there is a lack of gross neurological disturbance, reported symptoms are predominantly cognitive in nature or a differential diagnosis between brain impairment and PTSD has to be made.

303. The selection of neuropsychological tests and procedures is subject to the limitations specified above and, therefore, cannot follow a standard battery format, but rather must be case-specific and sensitive to individual characteristics. The flexibility required in the selection of tests and procedures demands considerable experience, knowledge and caution on the part of the examiner. As has been pointed out above, the range of instruments to be used will often be limited to non-verbal tasks, and the psychometric characteristics of any standardized tests will most likely suffer when population-based norms do not apply to an individual subject. An absence of verbal measures represents a very serious limitation. Many areas of cognitive functioning are mediated through language, and systematic comparisons between various verbal and non-verbal measures are typically used in order to arrive at conclusions regarding the nature of deficits.

304. What complicates matters further is evidence that significant inter-group differences in performances of non-verbal tasks have been found between relatively closely related cultures. For example, research compared the performance of randomly selected, community-based samples of 118 English-speaking and 118 Spanish-speaking elders on a brief neuropsychological test battery.[118] The samples were randomly selected and demographically matched. Yet, while scores on verbal measures were similar, the Spanish-speaking subjects scored significantly lower on almost all non-verbal measures. These results suggest that caution is warranted when using non-verbal and verbal measures to assess non-English-speaking individuals, when tests are prepared for English-speaking subjects.

305. The choice of instruments and procedures in neuropsychological assessment of suspected torture victims must be left to the individual clinician, who will have to select them in accordance with the demands and possibilities of the situation. Neuropsychological tests cannot be used properly without extensive training and knowledge in brain-behaviour relations. Comprehensive lists of neuropsychological procedures and tests and their proper application can be found in standard references.[119]

(c) *Post-traumatic stress disorder*

306. The considerations offered above should make it clear that great caution is needed when attempting neuropsychological assessment of brain impairment in suspected torture victims. This must be even more strongly the case in attempting to document PTSD in suspected survivors through neuropsychological assessment. Even in the case of assessing PTSD subjects for whom population-based norms are available, there are considerable difficulties to consider. PTSD is a psychiatric disorder and traditionally has not been the focus of neuropsychological assessment. Furthermore, PTSD does not conform to the classical paradigm of an analysis of identifiable brain lesions that can be confirmed by medical techniques. With an increased emphasis on and understanding of the biological mechanisms involved in psychiatric disorders generally, neuropsychological paradigms have been invoked more frequently than in the past. However, as has been pointed out, "... comparatively little has been written to date on PTSD from a neuropsychological perspective".[120]

307. There is great variability among the samples used for the study of neuropsychological measures in post-traumatic stress. This may account for the variability of the cognitive problems reported from these studies. It was pointed out that "clinical observations suggest that PTSD symptoms show the most overlap with the neurocognitive domains of attention, memory and executive functioning". This is consistent with complaints heard frequently from survivors of torture. Subjects complain of difficulties in concentrating and feeling unable to retain information and engage in planned, goal-directed activity.

308. Neuropsychological assessment methods appear able to identify the presence of neurocognitive deficits in PTSD, even though the specificity of these deficits is more difficult to establish. Some studies have documented the presence of deficits in PTSD subjects when compared to normal controls but they have failed to discriminate these subjects from matched psychiatric controls.[121, 122] In other words, it is likely that neurocognitive deficits on test performances will be evident in cases of PTSD, but insufficient for diagnosing it. As in many other types of assessment, interpretation of test results must be integrated into a larger context of interview information and possibly personality testing. In that sense, specific neuropsychological assessment methods can make a contribution to the documentation of PTSD in the same manner that they do for other psychiatric disorders associated with known neurocognitive deficits.

309. Despite significant limitations, neuropsychological assessment may be useful in evaluating individ-uals suspected of having brain injury and in distinguishing brain injury from PTSD. Neuropsychological assessment may also be used to evaluate specific symptoms, such as problems with memory that occur in PTSD and related disorders.

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[118] D. M. Jacobs and others, "Cross-cultural neuropsychological assessment: a comparison of randomly selected, demographically matched cohorts of English and Spanish-speaking older adults", *Journal of Clinical and Experimental Neuropsychology*, vol. 19 (No. 3) (1997), pp. 331-339.

[119] O. Spreen and E. Strauss, *A Compendium of Neuropsychological Tests,* 2nd ed. (New York, Oxford University Press, 1998).

[120] J. A. Knight, "Neuropsychological assessment in posttraumatic stress disorder", *Assessing Psychological Trauma and PTSD*, J. P. Wilson and T. M. Keane, eds. (New York, Guilford Press, 1997).

[121] J. E. Dalton, S. L. Pederson and J. J. Ryan, "Effects of post-traumatic stress disorder on neuropsychological test performance", *International Journal of Clinical Neuropsychology*, vol. 11 (3) (1989), pp. 121-124.

[122] T. Gil and others, "Cognitive functioning in post-traumatic stress disorder", *Journal of Traumatic Stress,* vol. 3, No. 1 (1990), pp. 29-45.

5. *Children and torture*

310. Torture can impact a child directly or indirectly. The impact can be due to the child's having been tortured or detained, the torture of parents or close family members or witnessing torture and violence. When individuals in a child's environment are tortured, the torture will inevitably have an impact on the child, albeit indirect, because torture affects the entire family and community of torture victims. A complete discussion of the psychological impact of torture on children and complete guidelines for conducting an evaluation of a child who has been tortured is beyond the scope of this manual. Nevertheless, several important points can be summarized.

311. First, when evaluating a child who is suspected of having undergone or witnessed torture, the clinician must make sure that the child receives support from caring individuals and that he or she feels secure during the evaluation. This may require a parent or trusted care provider to be present during the evaluation. Second, the clinician must keep in mind that children do not often express their thoughts and emotions regarding trauma verbally, but rather behaviourally.[123] The degree to which children are able to verbalize thought and affect depends on the child's age, developmental level and other factors, such as family dynamics, personality characteristics and cultural norms.

312. If a child has been physically or sexually assaulted, it is important, if at all possible, for the child to be seen by an expert in child abuse. Genital examination of children, likely to be experienced as traumatic, should be performed by clinicians experienced in interpreting the findings. Sometimes it is appropriate to videotape the examination so that other experts can give opinions on the physical findings without the child having to be examined again. It may be inappropriate to perform a full genital or anal examination without a general anaesthetic. Furthermore, the examiner should be aware that the examination itself may be reminiscent of the assault and it is possible that the child may make a spontaneous outcry or psychologically decompensate during the examination.

(a) *Developmental considerations*

313. A child's reactions to torture depend on age, developmental stage and cognitive skills. The younger the child, the more his or her experience and understanding of the traumatic event will be influenced by the immediate reactions and attitudes of caregivers following the event.[124] For children under the age of three who have experienced or witnessed torture, the protective and reassuring role of their caregivers is crucial.[125] The reactions of very young children to traumatic experiences typically involve hyperarousal, such as restlessness, sleep disturbance, irritability, heightened startle reactions and avoidance. Children over three often tend to withdraw and refuse to speak directly about traumatic experiences. The ability for verbal expression increases during development. A marked increase occurs around the concrete operational stage (8-9 years old), when children develop the ability to provide a reliable chronology of events. During this stage, concrete operations and temporal and spatial capacities develop.[126] These new skills are still fragile, and it is not usually until the beginning of the formal operational stage (12 years old) that children are consistently able to construct a coherent narrative. Adolescence is a turbulent developmental period. The effects of torture can vary widely. Torture experiences may cause profound personality changes in adolescents resulting in antisocial behaviour.[127] Alternatively, the effects of torture on adolescents may be similar to those seen in younger children.

(b) *Clinical considerations*

314. Symptoms of PTSD may appear in children. The symptoms can be similar to those observed in adults, but the clinician must rely more heavily on observations of the child's behaviour than on verbal expression.[128, 129, 130, 131] For example, the child may demonstrate symptoms of re-experiencing as manifested by monotonous, repetitive play representing aspects of the traumatic event, visual memories of the events in and out of play, repeated questions or declarations about the traumatic event and nightmares. The child may develop bedwetting, loss of control of bowel movements, social withdrawal, restricted affect, attitude changes towards self and others and feelings that there is no future. He or she may experience hyperarousal and have night terrors, problems going to bed, sleep disturbance, heightened startle response, irritability and significant disturbances in attention and concentration. Fears and aggressive behaviour that were non-existent before the traumatic event may appear as aggressiveness towards peers, adults or animals, fear of the dark, fear of going to the toilet alone and phobias. The child may demonstrate sexual behaviour that is inappropriate for his or her age and somatic reactions. Anxiety symptoms, such as exaggerated fear of strangers, separation anxiety, panic, agitation, temper tantrums and uncontrolled crying may appear. The child may also develop eating problems.

(c) *Role of the family*

315. The family plays an important dynamic role in persisting symptomatology among children. In order to preserve cohesion in the family, dysfunctional behaviours

[123] C. Schlar, "Evaluation and documentation of psychological evidence of torture", unpublished paper, 1999.

[124] S. von Overbeck Ottino, "Familles victimes de violences collectives et en exil : quelle urgence, quel modèle de soins ? Le point de vue d'une pédopsychiatre", *Revue française de psychiatrie et de psychologie médicale,* vol. 14 (1998), pp. 35-39.

[125] V. Grappe, "La guerre en ex-Yougoslavie: un regard sur les enfants réfugiés", *Psychiatrie humanitaire en ex-Yougoslavie et en Arménie. Face au traumatisme*, M. R. Moro and S. Lebovici, eds. (Paris, Presses universitaires de France, 1995).

[126] J. Piaget, *La naissance de l'intelligence chez l'enfant* (Neuchâtel, Delachaux et Niestlé, 1977).

[127] See footnote 125.

[128] L. C. Terr, "Childhood traumas: an outline and overview", *American Journal of Psychiatry,* vol. 148 (1991), pp. 10-20.

[129] National Center for Infants, Toddlers and Families, *Zero to Three* (1994).

[130] F. Sironi, "On torture un enfant, ou les avatars de l'ethnocentrisme psychologique", *Enfances*, No. 4 (1995), pp. 205-215.

[131] L. Bailly, *Les catastrophes et leurs conséquences psychotraumatiques chez l'enfant* (Paris, ESF, 1996).

and delegation of roles may occur. Family members, often children, can be assigned the role of patient and develop severe disorders. A child may be overly protected or important facts about the trauma may be hidden. Alternatively, the child can be parentified and expected to care for the parents. When the child is not the direct victim of torture but only indirectly affected, adults often tend to underestimate the impact on the child's psyche and development. When loved ones around a child have been persecuted, raped and tortured or the child has witnessed severe trauma or torture, he or she may develop dysfunctional beliefs such as that he or she is responsible for the bad events or that he or she has to bear the parent's burdens. This type of belief can lead to long-term problems with guilt, loyalty conflicts, personal development and maturing into an independent adult.

ANNEX I

Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*

1. The purposes of effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment (hereinafter "torture or other ill-treatment") include the following:

(*a*) Clarification of the facts and establishment and acknowledgement of individual and State responsibility for victims and their families;

(*b*) Identification of measures needed to prevent recurrence;

(*c*) Facilitation of prosecution and/or, as appropriate, disciplinary sanctions for those indicated by the investigation as being responsible and demonstration of the need for full reparation and redress from the State, including fair and adequate financial compensation and provision of the means for medical care and rehabilitation.

2. States shall ensure that complaints and reports of torture or ill-treatment are promptly and effectively investigated. Even in the absence of an express complaint, an investigation shall be undertaken if there are other indications that torture or ill-treatment might have occurred. The investigators, who shall be independent of the suspected perpetrators and the agency they serve, shall be competent and impartial. They shall have access to, or be empowered to commission investigations by, impartial medical or other experts. The methods used to carry out such investigations shall meet the highest professional standards and the findings shall be made public.

3. (*a*) The investigative authority shall have the power and obligation to obtain all the information necessary to the inquiry.[a] The persons conducting the investigation shall have at their disposal all the necessary budgetary and technical resources for effective investigation. They shall also have the authority to oblige all those acting in an official capacity allegedly involved in torture or ill-treatment to appear and testify. The same shall apply to any witness. To this end, the investigative authority shall be entitled to issue summonses to witnesses, including any officials allegedly involved, and to demand the production of evidence.

(*b*) Alleged victims of torture or ill-treatment, witnesses, those conducting the investigation and their families shall be protected from violence, threats of violence or any other form of intimidation that may arise pursuant to the investigation. Those potentially implicated in torture or ill-treatment shall be removed from any position of control or power, whether direct or indirect, over complainants, witnesses and their families, as well as those conducting the investigation.

4. Alleged victims of torture or ill-treatment and their legal representatives shall be informed of, and have access to, any hearing, as well as to all information relevant to the investigation, and shall be entitled to present other evidence.

5. (*a*) In cases in which the established investigative procedures are inadequate because of insufficient expertise or suspected bias, or because of the apparent existence of a pattern of abuse or for other substantial reasons, States shall ensure that investiga-

* The Commission on Human Rights, in its resolution 2000/43, and the General Assembly, in its resolution 55/89, drew the attention of Governments to the Principles and strongly encouraged Governments to reflect upon the Principles as a useful tool in efforts to combat torture.

[a] Under certain circumstances, professional ethics may require information to be kept confidential. These requirements should be respected.

tions are undertaken through an independent commission of inquiry or similar procedure. Members of such a commission shall be chosen for their recognized impartiality, competence and independence as individuals. In particular, they shall be independent of any suspected perpetrators and the institutions or agencies they may serve. The commission shall have the authority to obtain all information necessary to the inquiry and shall conduct the inquiry as provided for under these Principles.[b]

(*b*) A written report, made within a reasonable time, shall include the scope of the inquiry, procedures and methods used to evaluate evidence as well as conclusions and recommendations based on findings of fact and on applicable law. Upon completion, the report shall be made public. It shall also describe in detail specific events that were found to have occurred and the evidence upon which such findings were based and list the names of witnesses who testified, with the exception of those whose identities have been withheld for their own protection. The State shall, within a reasonable period of time, reply to the report of the investigation and, as appropriate, indicate steps to be taken in response.

6. (*a*) Medical experts involved in the investigation of torture or ill-treatment shall behave at all times in conformity with the highest ethical standards and, in particular, shall obtain informed consent before any examination is undertaken. The examination must conform to established standards of medical practice. In particular, examinations shall be conducted in private under the control of the medical expert and outside the presence of security agents and other government officials.

(*b*) The medical expert shall promptly prepare an accurate written report, which shall include at least the following:

(i) Circumstances of the interview: name of the subject and name and affiliation of those present at the examination; exact time and date; location, nature and address of the institution (including, where appropriate, the room) where the examination is being conducted (e.g., detention centre, clinic or house); circumstances of the subject at the time of the examination (e.g., nature of any restraints on arrival or during the examination, presence of security forces during the examination, demeanour of those accompanying the prisoner or threatening statements to the examiner); and any other relevant factors;

(ii) History: detailed record of the subject's story as given during the interview, including alleged methods of torture or ill-treatment, times when torture or ill-treatment is alleged to have occurred and all complaints of physical and psychological symptoms;

(iii) Physical and psychological examination: record of all physical and psychological findings on clinical examination, including appropriate diagnostic tests and, where possible, colour photographs of all injuries;

(iv) Opinion: interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. A recommendation for any necessary medical and psychological treatment and/or further examination shall be given;

(v) Authorship: the report shall clearly identify those carrying out the examination and shall be signed.

(*c*) The report shall be confidential and communicated to the subject or his or her nominated representative. The views of the subject and his or her representative about the examination process shall be solicited and recorded in the report. It shall also be provided in writing, where appropriate, to the authority responsible for investigating the allegation of torture or ill-treatment. It is the responsibility of the State to ensure that it is delivered securely to these persons. The report shall not be made available to any other person, except with the consent of the subject or on the authorization of a court empowered to enforce such a transfer.

[b] See footnote (*a*) above.

ANNEX II

Diagnostic tests

Diagnostic tests are being developed and evaluated all the time. The following tests were considered to be of value at the time of writing of this manual. However, when additional supporting evidence is required, investigators should attempt to find up-to-date sources of information, for example by approaching one of the specialized centres for the documentation of torture (see chapter V, sect. E).

1. *Radiological imaging*

In the acute phase of injury, various imaging modalities may be quite useful in providing additional documentation of skeletal and soft tissue injury. Once the physical injuries of torture have healed, however, the residual sequelae are generally no longer detectable by the same imaging methods. This is often true even when the survivor continues to suffer significant pain or disability from his or her injuries. Reference has already been made to various radiological studies in the discussion of the examination of the patient or in the context of various forms of torture. The following is a summary of the application of these methods. However, the more sophisticated and expensive technology is not universally available or at least not to a person in custody.

Radiological and imaging diagnostic examinations include routine radiographs (X-rays), radioisotopic scintigraphy, computerized tomography (CT), nuclear magnetic resonance imaging (MRI) and ultrasonography (USG). Each has advantages and disadvantages. X-rays, scintigraphy and CT use ionizing radiation, which may be a concern in cases of pregnant women and children. MRI uses a magnetic field. Potential biologic effects on foetuses and children are theoretical, but thought to be minimal. Ultrasound uses sound waves, and no biologic risk is known.

X-rays are readily available. Excluding the skull, all injured areas should have routine radiographs as the initial examination. While routine radiographs will demonstrate facial fractures, CT is a superior examination as it demonstrates more fractures, fragment displacement and associated soft tissue injury and complications. When periosteal damage or minimal fractures are suspected, bone scintigraphy should be used in addition to X-rays. A percentage of X-rays will be negative even when there is an acute fracture or early osteomyelitis. It is possible for a fracture to heal, leaving no radiographic evidence of previous injury. This is especially true in children. Routine radiographs are not the ideal examination for evaluation of soft tissue.

Scintigraphy is an examination of high sensitivity, but low specificity. It is an inexpensive and effective examination used to screen the entire skeleton for disease processes such as osteomyelitis or trauma. Testicular torsion can also be evaluated, but ultrasound is better suited to this task. Scintigraphy is not a method to identify soft tissue trauma. Scintigraphy can detect an acute fracture within 24 hours, but it generally takes two to three days and may occasionally take a week or more, particularly in the case of the elderly. The scan generally returns to normal after two years. However, it may remain positive for years in cases of fractures and cured osteomyelitis. The use of bone scintigraphy to detect fractures at the epiphysis or metadiaphysis (ends of long bones) in children is very difficult because of the normal uptake of the radiopharmaceutical at the epiphysis. Scintigraphy is often able to detect rib fractures that are not apparent on routine X-ray films.

(a) *Application of bone scintigraphy to the diagnosis of* falanga

Bone scans can be performed either with delayed images at about three hours or as a three-phase examination. The three phases are the radionucleide angiogram (arterial phase), blood pool images (venous phase, which is soft tissue) and delayed phase (bone phase). Patients examined soon after *falanga* should have two bone scans performed at one-week intervals. A negative first delayed scan and positive second scan indicate exposure to *falanga* within days before the first scan. In acute cases, two negative bone scans at an interval of one week do not necessarily mean that *falanga* did not occur, but that the severity of the *falanga* applied was below the sensitivity level of the scintigraphy. Initially, if three-phase scanning is done, increased uptake in the radionucleide angiogram phase and the blood pool images and no increase uptake in the bone phase would indicate hyperaemia compatible with soft tissue injury. Trauma in the foot bones and soft tissue can also be detected with MRI.[a]

(b) *Ultrasound*

Ultrasound is inexpensive and without biological hazard. The quality of an examination depends on the skill of the operator. Where CT is not available, ultrasound is used to evaluate acute abdominal trauma. Tendonopathy can also be evaluated by ultrasound, and it is a method of choice for testicular abnormalities. Shoulder ultrasound is carried out in the acute and chronic periods following

[a] See chapter V, footnotes 76 and 83; also refer to standard radiology and nuclear medicine texts for further information.

suspension torture. In the acute period, oedema, fluid collection on and around the shoulder joint, lacerations and haematomas of the rotator cuffs can be observed by ultrasound. Re-examination with ultrasound and finding that the evidence in the acute period disappears over time strengthen the diagnosis. In such cases, MRI, scintigraphy and other radiological examinations should be carried out together, and their correlation should be examined. Even without positive results from other examinations, ultrasound findings alone are adequate to prove suspension torture.

(c) *Computerized tomography*

CT is excellent for imaging soft tissue and bone. However, MRI is better for soft tissue than bone. MRI may detect an occult fracture before it can be imaged by either routine radiographs or scintigraphy. Use of open scanners and sedation may alleviate anxiety and claustrophobia, which are prevalent among torture survivors. CT is also excellent for diagnosing and evaluating fractures, especially temporal and facial bones. Other advantages include alignment and displacement of fragments, especially spinal, pelvic, shoulder and acetabular fractures. It cannot identify bone bruising. CT with and without intravenous infusion of a contrast agent should be the initial examination for acute, sub-acute and chronic central nervous system (CNS) lesions. If the examination is negative, equivocal or does not explain the survivor's CNS complaints or symptoms, proceed to MRI. CT with bone windows and a pre- and post-contrast examination should be the initial examination for temporal bone fractures. Bone windows may demonstrate fractures and ossicular disruption. The pre-contrast examination may demonstrate fluid and cholesteatoma. Contrast is recommended because of the common vascular anomalies that occur in this area. For rhinorrhea, injection of a contrast agent into the spinal canal should follow a temporal bone. MRI may also demonstrate the tear responsible for leakage of the fluid. When rhinorrhea is suspected, a CT of the face with soft tissue and bone windows should be performed. Then a CT should be obtained after a contrast agent is injected into the spinal canal.

(d) *Magnetic resonance imaging*

MRI is more sensitive than CT in detecting CNS abnormalities. The time course of CNS haemorrhage is divided into immediate, hyperacute, acute, sub-acute and chronic phases and CNS haemorrhage has ranges that correlate with imaging characteristics of the haemorrhage. Thus, the imaging findings may allow estimation of the timing of head injuries and correlation to alleged incidents. CNS haemorrhage may completely resolve or produce sufficient haemosiderin deposits for the CT to be positive even years later. Haemorrhage in soft tissue, especially in muscle, usually resolves completely, leaving no trace, but, in rare cases, it can ossify. This is called heterotrophic bone formation or *Myositis ossificans* and is detectable with CT.

2. *Biopsy of electric shock injury*

Electric shock injuries may, but do not necessarily, exhibit microscopic changes that are highly diagnostic and specific for electric current trauma. Absence of these specific changes in a biopsy specimen does not mitigate against a diagnosis of electric shock torture, and judicial authorities must not be permitted to make such an assumption. Unfortunately, if a court requests a petitioner alleging electric shock torture to submit to a biopsy for confirmation of the allegations, refusal to consent to the procedure or a negative result is bound to have a prejudicial impact on the court. Furthermore, clinical experience with biopsy diagnosis of torture-related electrical injury is limited, and the diagnosis can usually be made with confidence from the history and physical examination alone.

This procedure is, therefore, one that should be done in a clinical research setting and not promoted as a diagnostic standard. In giving informed consent for biopsy, the person must be informed of the uncertainty of the results and permitted to weigh the potential benefit against the impact upon an already traumatized psyche.

(a) *Rationale for biopsy*

There has been extensive laboratory research measuring the effects of electric shocks on the skin of anaesthetized pigs.[b,c,d,e,f,g] This work has shown that there are histologic findings specific to electrical injury that can be established by microscopic examination of punch biopsies of the lesions. However, further discussion of this research, which may have significant clinical application, is beyond the scope of this publication. The reader is referred to the footnote references for additional information.

Few cases of electric shock torture of humans have been studied histologically.[h,i,j,k] Only in one case, where

[b] H. K. Thomsen and others, "Early epidermal changes in heat and electrically injured pigskin: a light microscopic study", *Forensic Science International*, vol. 17 (1981), pp. 133-143.

[c] Ibid., "The effect of direct current, sodium hydroxide and hydrochloric acid on pig epidermis: a light microscopic and electron microscopic study", *Acta Pathol. Microbiol. Immunol. Scand*, vol. 91 (1983), pp. 307-316.

[d] H. K. Thomsen, "Electrically induced epidermal changes: a morphological study of porcine skin after transfer of low-moderate amounts of electrical energy", dissertation (University of Copenhagen, F.A.D.L., 1984), pp. 1-78.

[e] T. Karlsmark and others, "Tracing the use of torture: electrically induced calcification of collagen in pigskin", *Nature,* vol. 301 (1983), pp. 75-78.

[f] Ibid., "Electrically induced collagen calcification in pigskin: a histopathologic and histochemical study", *Forensic Science International,* vol. 39 (1988), pp. 163-174.

[g] T. Karlsmark, "Electrically induced dermal changes: a morphological study of porcine skin after transfer of low to moderate amounts of electrical energy", dissertation, University of Copenhagen, *Danish Medical Bulletin*, vol. 37 (1990), pp. 507-520.

[h] L. Danielsen and others, "Diagnosis of electrical skin injuries: a review and a description of a case", *American Journal of Forensic Medical Pathology,* vol.12 (1991), pp. 222-226.

[i] F. Öztop and others, "Signs of electrical torture on the skin", *Treatment and Rehabilitation Center Report 1994* (Human Rights Foundation of Turkey), vol. 11 (1994), pp. 97-104.

[j] L. Danielsen, T. Karlsmark, H. K. Thomsen, "Diagnosis of skin lesions following electrical torture", *Rom. J. Leg. Med.*, vol. 5 (1997), pp. 15-20.

[k] H. Jacobsen, "Electrically induced deposition of metal on the human skin", *Forensic Science International,* vol. 90 (1997), pp. 85-92.

lesions were probably excised seven days after the injury, were alterations in the skin believed to be diagnostic of the electrical injuries observed (deposition of calcium salts on dermal fibres in viable tissue located around necrotic tissue). Lesions excised a few days after alleged electrical torture in other cases have shown segmental changes and deposits of calcium salts on cellular structures highly consistent with the influence of an electrical current, but they are not diagnostic since deposits of calcium salts on dermal fibres were not observed. A biopsy taken one month after alleged electrical torture showed a conical scar, 1-2 millimetres wide, with an increased number of fibroblasts and tightly packed, thin collagen fibres, arranged parallel to the surface, consistent with but not diagnostic of electrical injury.

(b) *Method*

After receiving informed consent from the patient, and before biopsy, the lesion must be photographed using accepted forensic methods. Under local anaesthesia, a 3-4 millimetre punch biopsy is obtained, and placed in buffered formalin or a similar fixative. Skin biopsy should be performed as soon as possible after injury. Since electrical trauma is usually confined to the epidermis and superficial dermis, the lesions may quickly disappear. Biopsies can be taken from more than one lesion, but the potential distress to the patient must be taken into account.[l] Biopsy material should be examined by a pathologist experienced in dermatopathology.

(c) *Diagnostic findings for electrical injury*

Diagnostic findings for electrical injury include vesicular nuclei in epidermis, sweat glands and vessel walls (only one differential diagnosis: injuries via basic solutions) and deposits of calcium salts distinctly located on collagen and elastic fibres (the differential diagnosis, *Calcinosis cutis*, is a rare disorder only found in 75 of 220,000 consecutive human skin biopsies, and the calcium deposits are usually massive without distinct location on collagen and elastic fibres).[m]

Typical, but not diagnostic, findings for electrical injury are lesions appearing in conical segments, often 1-2 millimetres wide, deposits of iron or copper on epidermis (from the electrode) and homogenous cytoplasm in epidermis, sweat glands and vessel walls. There may also be deposits of calcium salts on cellular structures in segmental lesions or no abnormal histologic observations.

[l] S. Gürpinar and S. Korur Fincanci, "Insan Haklari Ihlalleri *ve* Hekim Sorumlulugu" (Human rights violations and responsibility of the physician), *Birinci Basamak Için Adli Tip El Kitabi* (Handbook of Forensic Medicine for General Practitioners) (Ankara, Turkish Medical Association, 1999).

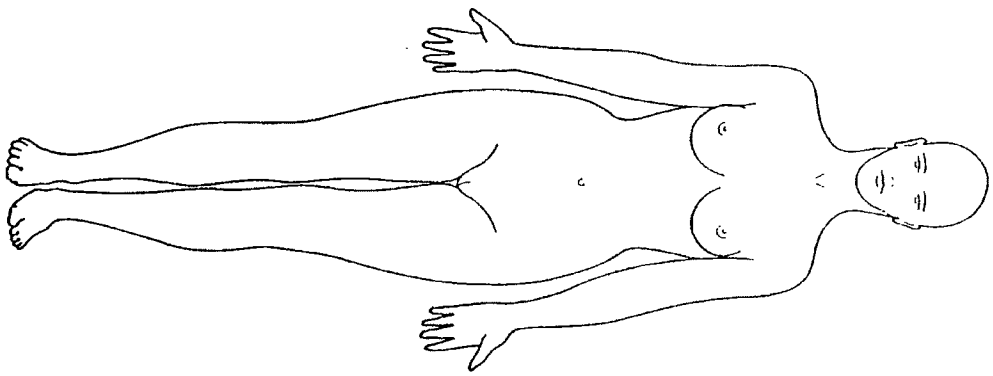
[m] See footnote (h) above.

ANNEX III

Anatomical drawings for documentation of torture and ill-treatment

Name _____ Case No. _____

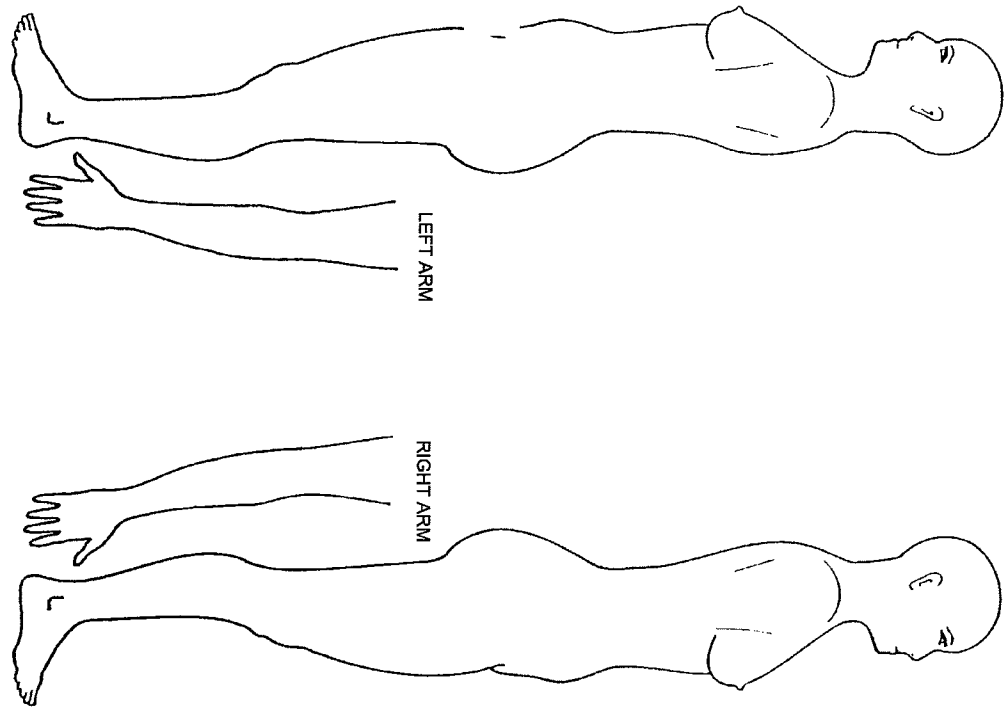
Date _____



FULL BODY, FEMALE—ANTERIOR AND POSTERIOR VIEWS

Name _____ Case No. _____

Date _____

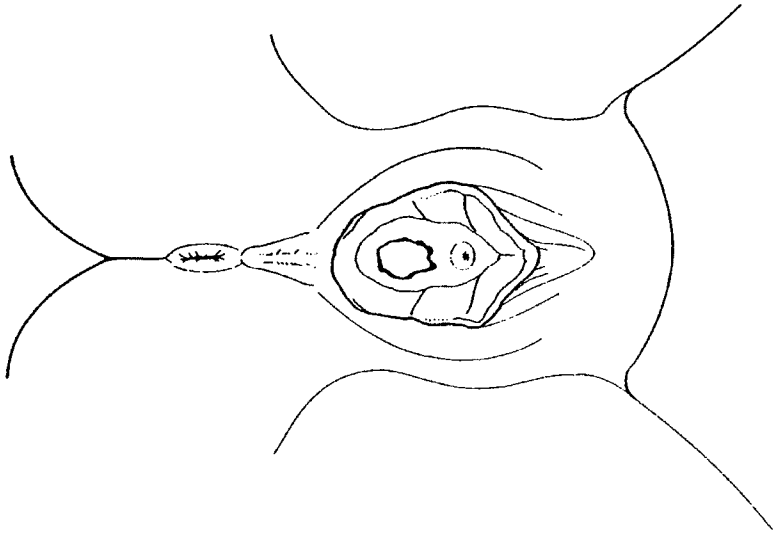


FULL BODY, FEMALE—LATERAL VIEW

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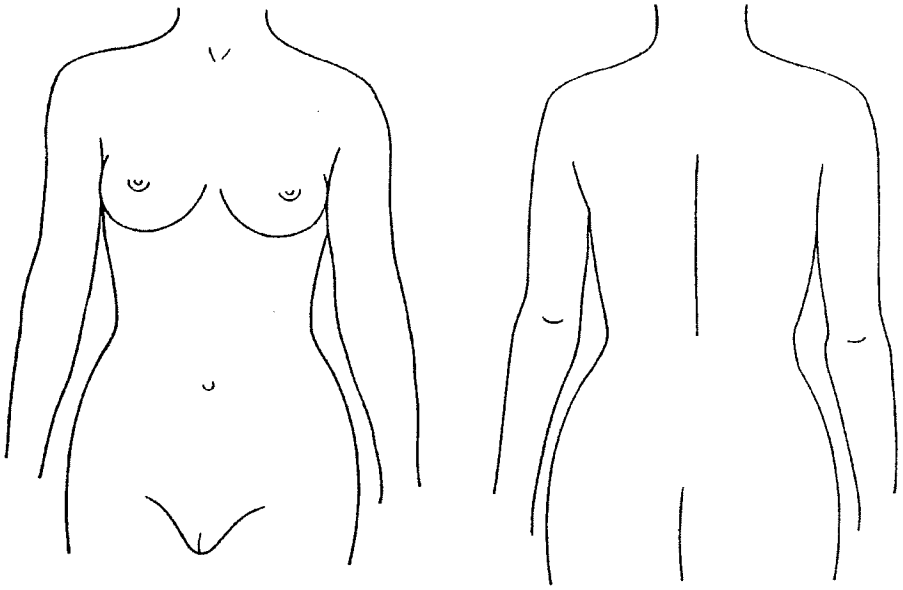
PERINEUM—FEMALE



Name _____ Case No. _____

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THORACIC ABDOMINAL, FEMALE—ANTERIOR AND POSTERIOR VIEWS



FULL BODY, MALE—ANTERIOR AND POSTERIOR VIEWS (VENTRAL AND DORSAL)

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FULL BODY, MALE—LATERAL VIEW

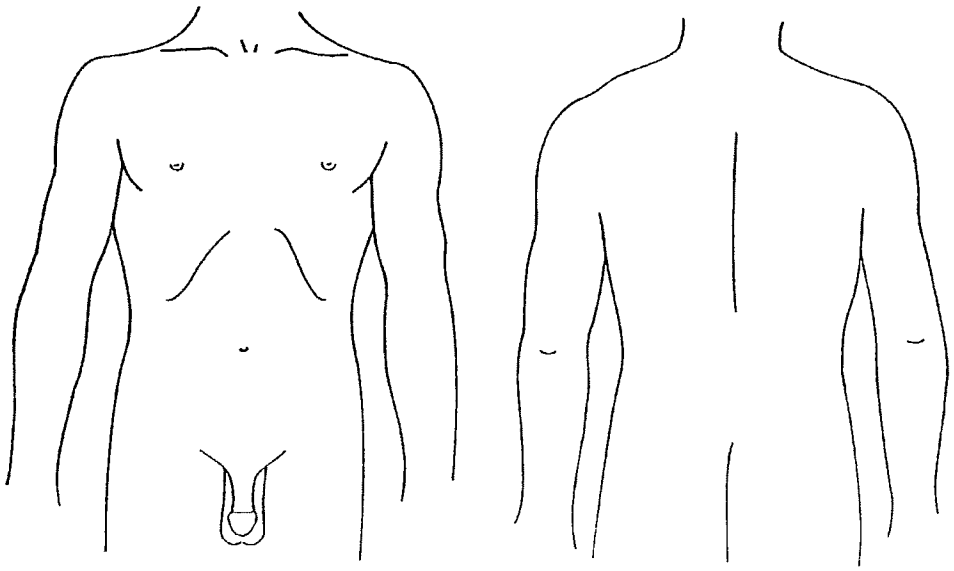
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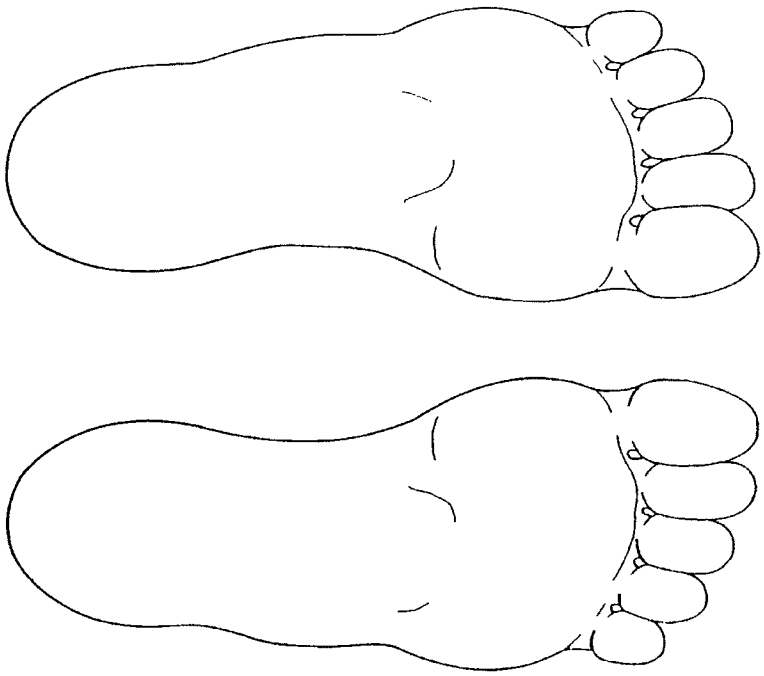
THORACIC ABDOMINAL, MALE—ANTERIOR AND POSTERIOR VIEWS



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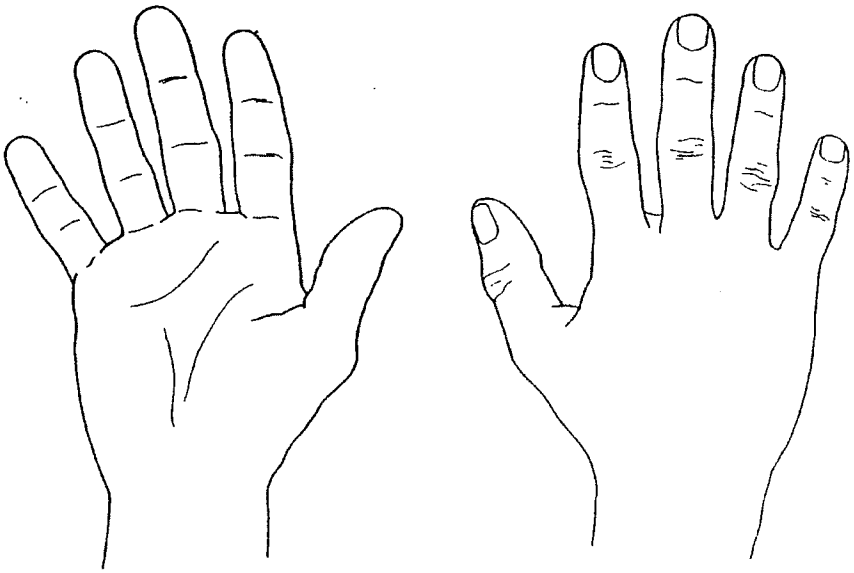
FEET—LEFT AND RIGHT PLANTAR SURFACES



Name _____ Case No. _____

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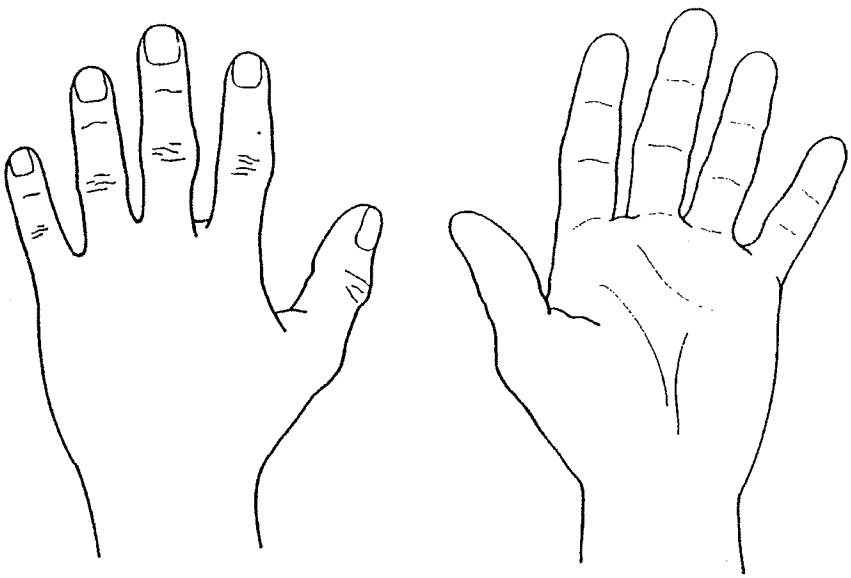
RIGHT HAND—PALMAR AND DORSAL



Name _____ Case No. _____

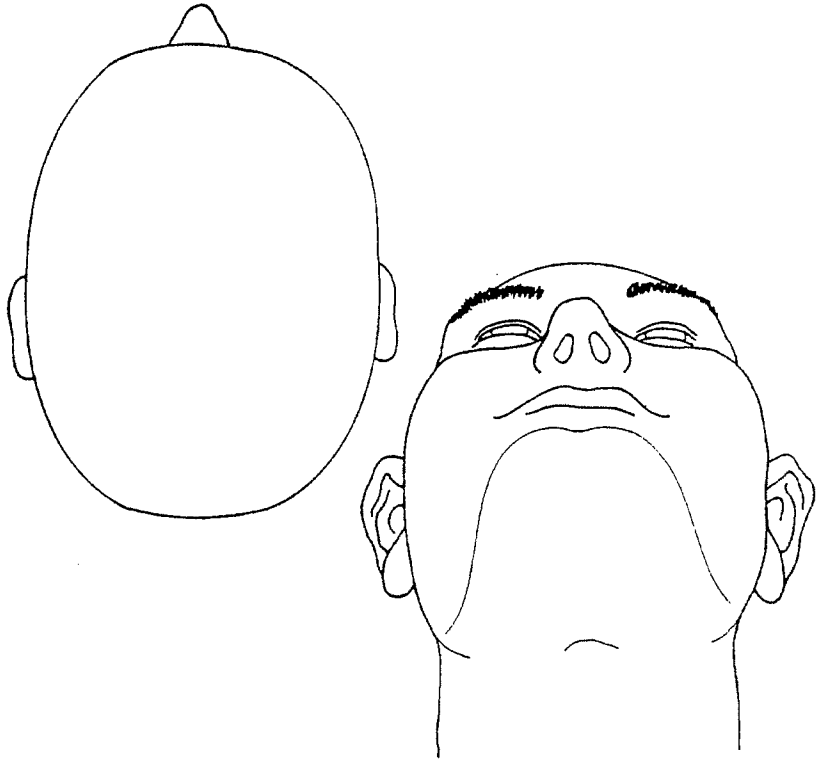
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LEFT HAND—PALMAR AND DORSAL



Case: 2:10-cv-00342-GCS-MRA Doc #: 97-8 Filed: 08/09/12 Page: 26 of 66 PAGEID #: 1419

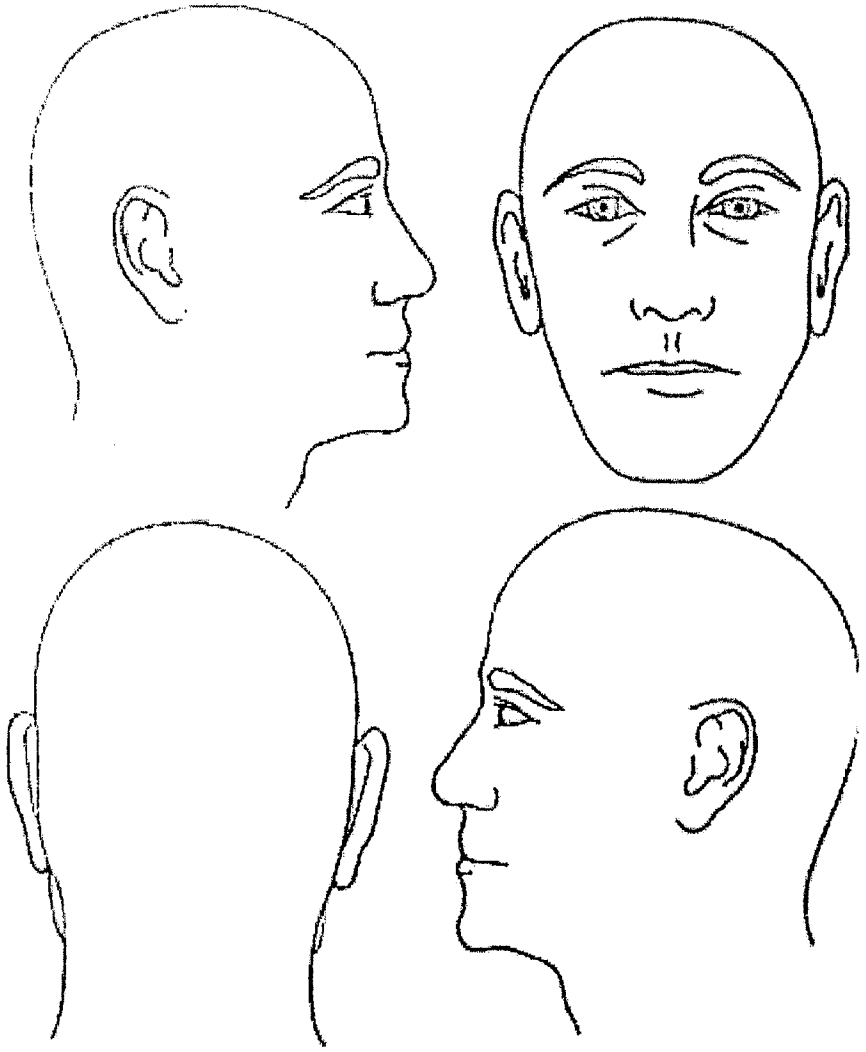
HEAD—SURFACE AND SKELETAL ANATOMY, SUPERIOR VIEW—INFERIOR VIEW OF NECK



Name _____ Case No. _____

Date _____

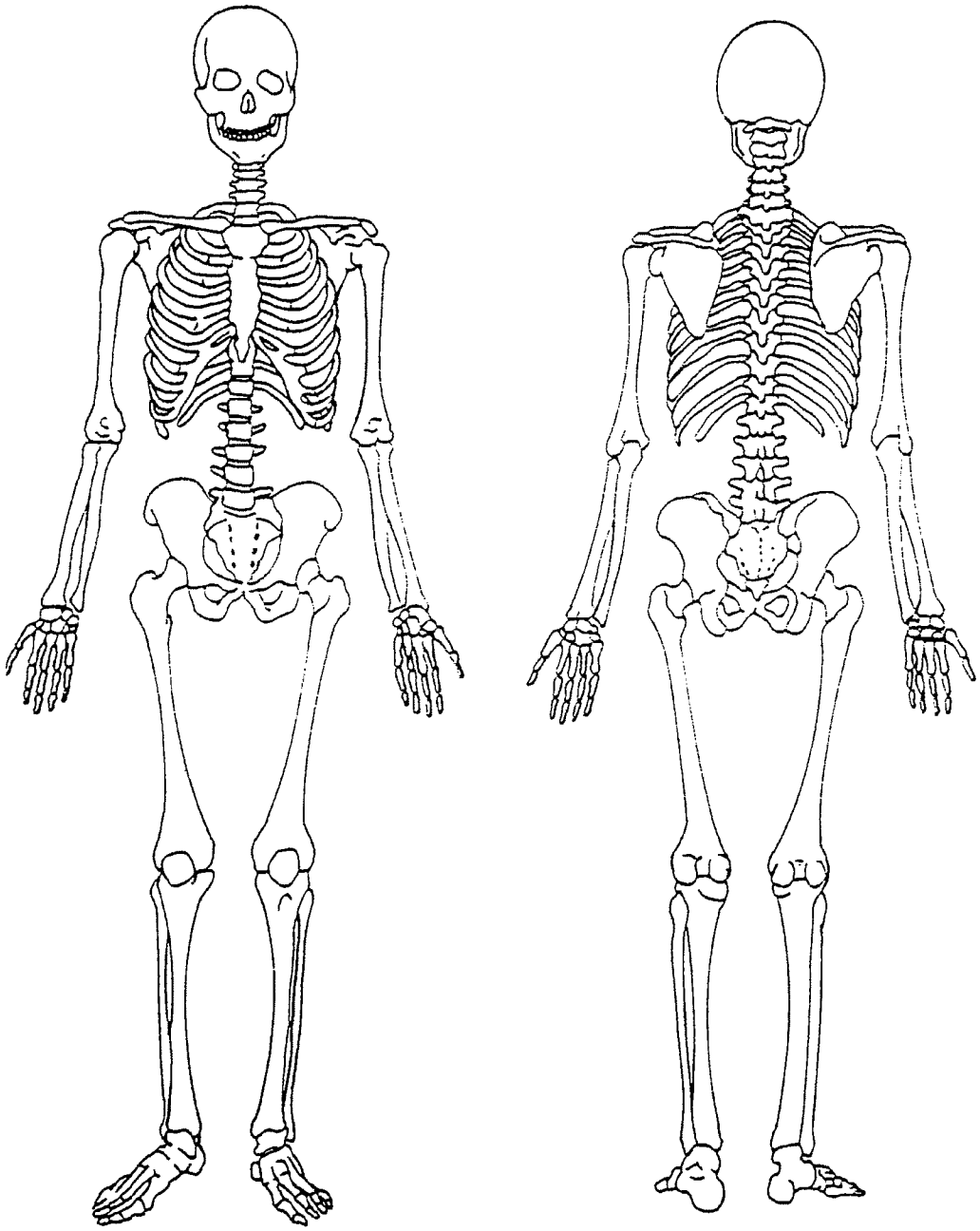
HEAD—SURFACE AND SKELETAL ANATOMY, LATERAL VIEW



Name _____ Case No. _____

Date _____

SKELETON—ANTERIOR AND POSTERIOR VIEWS



Name _____ Case No. _____

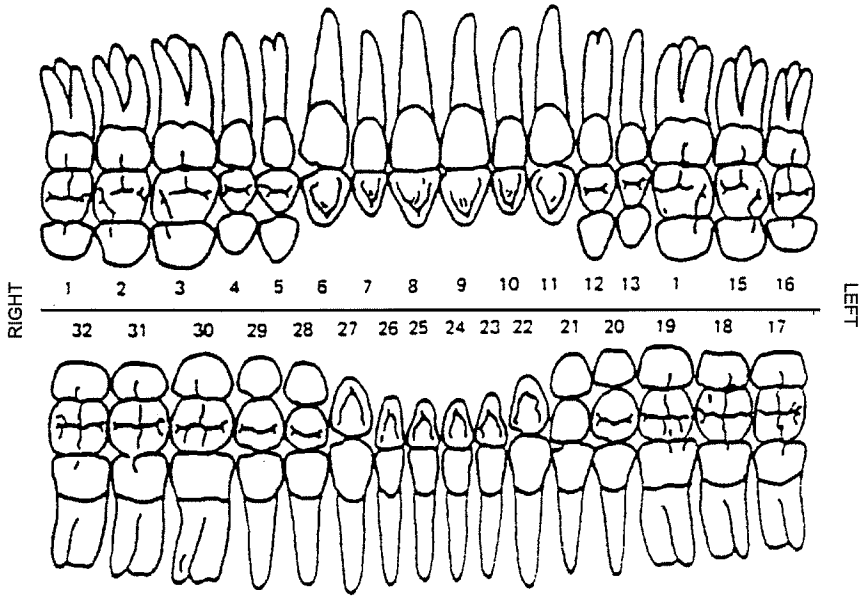
Date _____

MARK ALL EXISTING RESTORATIONS AND MISSING TEETH ON THIS CHART

Estimated Age _____

Sex _____

Race _____



Circle descriptive term

Prosthetic appliances present

Maxilla

Full denture

Partial denture

Fixed bridge

Mandible

Full denture

Partial denture

Fixed bridge

Describe completely all prosthetic appliances or fixed bridges _____

_____

_____

_____

_____

Stains on teeth

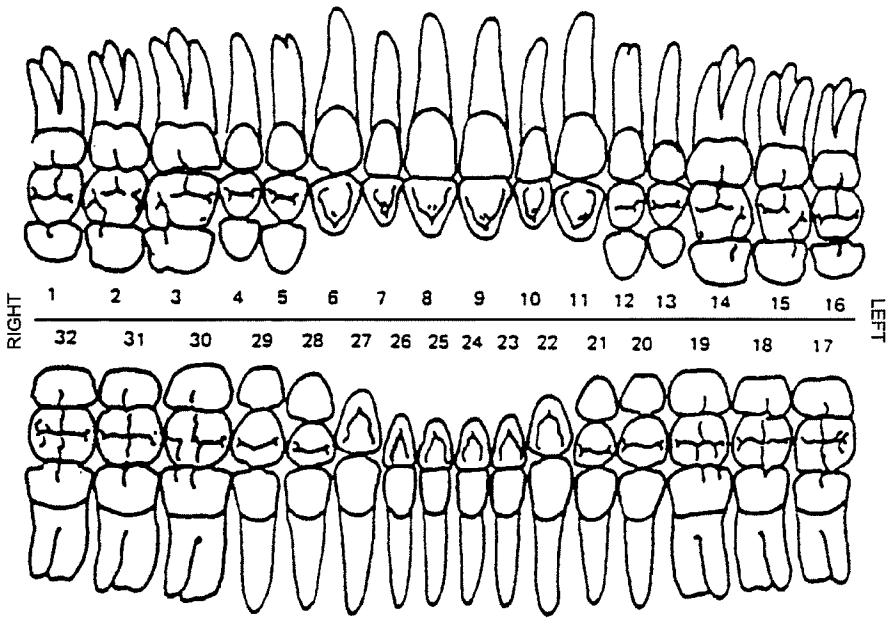
Slight

Moderate

Severe

MARK ALL CARIES ON THIS CHART

Outline all caries and "X" out all missing teeth



Circle descriptive term

Relationship

Normal

Undershot

Overbite

Periodontal Condition

Excellent

Average

Poor

Calculus

Slight

Moderate

Severe

ANNEX IV

Guidelines for the medical evaluation of torture and ill-treatment

The following guidelines are based on the *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. These guidelines are not intended to be a fixed prescription, but should be applied taking into account the purpose of the evaluation and after an assessment of available resources. Evaluation of physical and psychological evidence of torture and ill-treatment may be conducted by one or more clinicians, depending on their qualifications.

I. Case information

Date of exam: ..... Exam requested by (name/position): .....

Case or report No.: ..... Duration of evaluation: ..... hours, ... minutes

Subject's given name: ..... Birth date: ..... Birth place: .....

Subject's family name: ..... Gender: male/female: .....

Reason for exam: ..... Subject's ID No.: .....

Clinician's name: ..... Interpreter (yes/no), name: .....

Informed consent: yes/no If no informed consent, why?: .....

Subject accompanied by (name/position): .....

Persons present during exam (name/position): .....

Subject restrained during exam: yes/no; If "yes", how/why? .....

Medical report transferred to (name/position/ID No.): .....

Transfer date: ..... Transfer time: .....

Medical evaluation/investigation conducted without restriction (for subjects in custody): yes/no

Provide details of any restrictions: .....

II. Clinician's qualifications (for judicial testimony)

Medical education and clinical training

Psychological/psychiatric training

Experience in documenting evidence of torture and ill-treatment

Regional human rights expertise relevant to the investigation

Relevant publications, presentations and training courses

Curriculum vitae.

III. Statement regarding veracity of testimony (for judicial testimony)

For example: "I personally know the facts stated below, except those stated on information and belief, which I believe to be true. I would be prepared to testify to the above statements based on my personal knowledge and belief."

IV. Background information

General information (age, occupation, education, family composition, etc.)

Past medical history

Review of prior medical evaluations of torture and ill-treatment

Psychosocial history pre-arrest.

V. Allegations of torture and ill-treatment

1. Summary of detention and abuse
2. Circumstances of arrest and detention
3. Initial and subsequent places of detention (chronology, transportation and detention conditions)
4. Narrative account of ill-treatment or torture (in each place of detention)
5. Review of torture methods.

VI. Physical symptoms and disabilities

Describe the development of acute and chronic symptoms and disabilities and the subsequent healing processes.

1. Acute symptoms and disabilities
2. Chronic symptoms and disabilities.

VII. Physical examination

1. General appearance
2. Skin
3. Face and head
4. Eyes, ears, nose and throat
5. Oral cavity and teeth
6. Chest and abdomen (including vital signs)
7. Genito-urinary system
8. Musculoskeletal system
9. Central and peripheral nervous system.

VIII. Psychological history/examination

1. Methods of assessment
2. Current psychological complaints
3. Post-torture history
4. Pre-torture history
5. Past psychological/psychiatric history
6. Substance use and abuse history
7. Mental status examination
8. Assessment of social functioning
9. Psychological testing: (see chapter VI, sect. C.1, for indications and limitations)
10. Neuropsychological testing (see chapter VI, sect. C.4, for indications and limitations).

IX. Photographs

X. Diagnostic test results (see annex II for indications and limitations)

XI. Consultations

XII. Interpretation of findings

1. Physical evidence
   A. Correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities with allegations of abuse.
   B. Correlate the degree of consistency between physical examination findings and allegations of abuse. (Note: The absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)
   C. Correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region.
2. Psychological evidence
   A. Correlate the degree of consistency between the psychological findings and the report of alleged torture.
   B. Provide an assessment of whether the psychological findings are expected or typical reactions to extreme stress within the cultural and social context of the individual.
   C. Indicate the status of the individual in the fluctuating course of trauma-related mental disorders over time, i.e. what is the time frame in relation to the torture events and where in the course of recovery is the individual?
   D. Identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role, etc.) and the impact these may have on the individual.
   E. Mention physical conditions that may contribute to the clinical picture, especially with regard to possible evidence of head injury sustained during torture or detention.

XIII. Conclusions and recommendations

1. Statement of opinion on the consistency between all sources of evidence cited above (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill-treatment.
2. Reiterate the symptoms and disabilities from which the individual continues to suffer as a result of the alleged abuse.
3. Provide any recommendations for further evaluation and care for the individual.

XIV. Statement of truthfulness (for judicial testimony)

For example: "I declare under penalty of perjury, pursuant to the laws of ..... (country), that the foregoing is true and correct and that this affidavit was executed on ..... (date) at ..... (city), ... (State or province)."

XV. Statement of restrictions on the medical evaluation/investigation (for subjects in custody)

For example: "The undersigned clinicians personally certify that they were allowed to work freely and independently and permitted to speak with and examine (the subject) in private, without any restriction or reservation, and without any form of coercion being used by the detaining authorities"; or "The undersigned clinician(s) had to carry out his/her/their evaluation with the following restrictions: ....."

XVI. Clinician's signature, date, place

XVII. Relevant annexes

A copy of the clinician's curriculum vitae, anatomical drawings for identification of torture and ill-treatment, photographs, consultations and diagnostic test results, among others.

Further information can be obtained from: The Office of the United Nations High Commissioner for Human Rights, Palais des Nations, 1211 Geneva 10, Switzerland

Tel: (+41-22) 917 91 59

E-mail: infodesk@ohchr.org *Internet*: www.ohchr.org

EXHIBIT C: Nat'l Ctr. for PTSD, U.S. Dep't of Veteran Affairs, *DSM Criteria for PTSD*, (July 5, 2007), http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp

UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS

NATIONAL CENTER FOR PTSD

DSM Criteria for PTSD

In 2000, the American Psychiatric Association revised the PTSD diagnostic criteria in the fourth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)(1). The diagnostic criteria (A-F) are specified below.

Diagnostic criteria for PTSD include a history of exposure to a traumatic event meeting two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms. A fifth criterion concerns duration of symptoms and a sixth assesses functioning.

Criterion A: stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear,helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

Criterion B: intrusive recollection

The traumatic event is persistently re-experienced in at least **one** of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: in young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes,including those that occur upon awakening or when intoxicated). Note: in children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C: avoidant/numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least **three** of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma
4. Markedly diminished interest or participation in significant activities
5. Feeling of detachment or estrangement from others
6. Restricted range of affect (e.g., unable to have loving feelings)
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Criterion D: hyper-arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least **two** of the following:

1. Difficulty falling or staying asleep
2. Irritability or outbursts of anger
3. Difficulty concentrating
4. Hyper-vigilance
5. Exaggerated startle response

Criterion E: duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

Criterion F: functional significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With or Without delay onset: Onset of symptoms at least six months after the stressor

References

1. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.

Date Created: 07/05/2007 See last Reviewed/Updated Date below.

The National Center for PTSD does not provide direct clinical care or individual referrals.
Please see: Where to Get Help for PTSD

PTSD Information Voice Mail: (802) 296-6300
Contact Us: ncptsd@va.gov
Also see: VA Mental Health

**Links take you outside the VA website to a non government site.*
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Reviewed/Updated Date: December 20, 2011

EXHIBIT D: Lustig SL, "Symptoms of Trauma Among Political Asylum Applicants: Don't Be Fooled," *Hastings International and Comparative Law Journal* 2008, 31(2):725-734

Symptoms of Trauma Among Political Asylum Applicants: Don't Be Fooled[†]

By STUART L. LUSTIG, MD, MPH [*]

I. What is Post-Traumatic Stress Disorder?

Since 1981, mental health clinicians have recognized Post-Traumatic Stress Disorder (PTSD) as a psychiatric disorder that comprises a constellation of symptoms directly resulting from trauma.[1] PTSD is diagnosed by psychiatrists, psychologists, psychiatric social workers, marriage and family therapists, and other mental health clinicians who have spent sufficient time with the trauma survivor to elicit the symptoms. There are also many standardized interviews and survey instruments, used commonly in research settings, that can also generate this diagnosis.[2]

PTSD occurs only in trauma survivors, and, by definition, the trauma must be *perceived* as life threatening, and in many cases actually *is* life threatening. Typical examples include torture, physical and sexual assaults, natural disasters, and motor vehicle accidents. As a result of the trauma(s), the survivor suffers from symptoms such as unwanted memories, intrusive thoughts, nightmares, or flashbacks of the event.

Because these reminders of the original trauma are often quite disturbing, PTSD sufferers go to great lengths to avoid triggering any sort of reminder, and will therefore, by definition, shun places,

[†] This article is a companion piece with Karen Musalo and Marcelle Rice's article.

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1. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL (3d ed. 1981).

2. There are many examples: the Clinician Administered PTSD Scale (CAPS), the PTSD Reaction Index (PTSD-RI), the PTSD sections of the Structured Clinical Interview for DSM Disorders (SCID), and the Composite International Diagnostic Interview (CIDI).

activities, or people who remind them of what happened. For example, a victim of an armed robbery may never again walk along the same street (i.e., avoidance of the place). A survivor of a highway car accident may completely avoid freeway driving (i.e., avoidance of the activity). A survivor of sexual abuse at the hands of the police may avoid police, or anyone dressed similarly (i.e., avoidance of people). They also often avoid even talking about the traumatic experience because of the unpleasant memories and feelings evoked. In addition to memories, flashbacks, nightmares, and anything that can trigger reminders of the trauma, PTSD sufferers may become emotionally numb. Rather than bursting into uncontrollable tears at the thought of the trauma, the PTSD sufferer can appear "out of touch" with feelings, feeling neither pleasure nor pain. This inability to feel pain may initially be adaptive in the face of overwhelming trauma, but this restricted emotional range ultimately limits the person's ability to form normal relationships, which depend upon the experience and expression of emotion. This numbness can often take the form of a foreshortened sense of the future. Those with PTSD often have difficulty anticipating being alive for long, or planning very far ahead beyond their immediate survival needs.

Another symptom of PTSD is hypervigilance. Sufferers of PTSD may compulsively check doors, windows, locks, and scan the room or sidewalk frequently to see who is around them. One PTSD patient's auditory vigilance rendered him capable of hearing doors opening and closing down the hall, sounds of which I was only dimly aware and to which I had attributed no significance. For him, however, the sound of a door opening had at one point in his life reportedly signified the possible arrival of armed militiaman at his home. Always on a heightened state of alert, PTSD sufferers can be easy to startle. Noises in the average range (a hand suddenly clapping, or a door slamming) can be quite alarming and frightening.

II. Psychiatric Studies of Asylum Seekers: Emerging Trends

An emerging literature of stress among asylum seekers is beginning to elucidate the extent of their psychiatric symptoms, particularly PTSD. While several studies have enumerated the types of traumas (e.g., rape, torture, etc) reported by asylum seekers, these research efforts are not reviewed here because the information is derived by self-reports from the asylum seekers themselves and generally cannot be verified independently. However, psychiatric

diagnoses are determined by expert clinician interviewers and specific survey instruments, so these findings are reviewed.

For example, in one Australian study,[3] forty consecutive asylum-seekers attending a community resource center in Sydney were interviewed using structured instruments and questionnaires. Of thirty subjects reporting a traumatic event such as witnessing killings, being assaulted, or suffering torture and captivity, fourteen subjects (47 perent) were diagnosed with PTSD. In a British study of twenty-seven asylum seekers, the average score on a seventeen item scale PTSD severity scale (with items scored from zero, which represents no symptoms, to three, which represents symptoms five or more times a week) was thirty-three (out of fifty-one), which indicates fairly severe symptoms.[4] In a study of 134 consecutive asylum seekers who sought mental health services at a program caring for survivors of torture and refugee trauma, PTSD and depressive disorders, as identified in a chart review, were the most common diagnoses, with frequencies of 82 percent and 96 percent respectively.[5] A Dutch study found that 76 percent of male asylum seekers from Asian and African countries suffered from PTSD, and that the diagnosis was associated with more frequent medical consultations. Meanwhile, asylum seekers who had received therapy for their PTSD symptoms used fewer medical consultations compared to those who had not received treatment.[6]

Among 70 detained asylum seekers who were given self-report measures, at baseline, fifty-four (77 percent) participants had clinically significant symptoms of anxiety, sixty (86 percent) of depression, and thirty-five (50 percent) of post-traumatic stress disorder; all symptoms were significantly correlated with length of detention (p=0.004, 0.017, and 0.019, respectively). At follow-up, participants who had been released had marked reductions in all psychological symptoms, but those still detained were more distressed

3. D. Slove, et al., *Depression and PTSD in Asylum-Seekers: Associations with Pre-Migration Trauma and Post-Migration Stressors*, 170 BRIT. J. PSYCHIATRY 351-357 (April 1997).

4. D. Bogner, et al., *Impact of Sexual Violence on Disclosure During Home Office Interviews*, 191 BRIT. J. PSYCHIATRY 75-81 (Jul. 2007).

5. Linda Piwowarczyk, *Asylum Seekers Seeking Mental Health Services in the United States: Clinical and Legal Implications*, 195 J. NERVOUS & MENTAL DISEASE 715-22 (Sept. 2007).

6. Boris Drozdek, et al., *Chronic PTSD and Medical Services Utilization by Asylum Seekers*, 16 J. REFUGEE STUD. 202-11, (2003).

than at baseline, which suggests that detention of asylum seekers exacerbates psychological symptoms.[7]

Less is known about psychiatric symptoms in asylum seekers who are children, but another Dutch study found that, based on data derived from initial intakes, PTSD and anxiety disorders were presumed present among 84 percent of the 129 child and adolescent asylum seekers evaluated by a multidisciplinary team in a specialized psychiatric clinic.[8] Depressive disorders were prevalent among 36 percent of the sample. For both diagnoses, unaccompanied minors seeking asylum were at significantly greater risk than were youngsters with families.

There are several obstacles to studying the unique effects of torture and maltreatment among political asylum seekers, not the least of which include distinguishing these effects from the emotional impact of migration itself, or the impact of detention, when applicable, as illustrated above. Although the exact origin of stress symptoms may be difficult to pinpoint, in an Australian study of post-traumatic stress among 196 Tamil refugees, asylum seekers and immigrants,[9] pre- and post-migration stress each accounted for 20 percent and 14 percent respectively of the variance in post-traumatic stress symptoms among the sample. In other words, migration and post-settlement stress are traumatic, but most of the symptoms are attributable to traumas reported in conjunction with alleged political persecution. Furthermore, symptoms of PTSD and other diagnoses, though by no means universal, are common among applicants for political asylum.

III. Credibility in the Courtroom: How *Not* to Be Led Astray by Symptoms of Trauma

Unfortunately for survivors of trauma who are also seeking political asylum, telling and retelling the events of the past can be

7. Allen Keller, et al., *Mental Health of Detained Asylum Seekers*, 362 LANCET 1721-23, (Nov. 22, 2003).

8. Ingrid Burhorst & Elizabeth Batista Pinto Wiese, *The Mental Health of Asylum-seeking and Refugee Children and Adolescents Attending a Clinic in the Netherlands*, 44 TRANSCULTURAL PSYCHIATRY 596-613 (2007).

9. Kevin Bird, Patrick McGorry, P. Mohan, Derrick Silove, & Zachary Steel, *Pathways from War Trauma to Posttraumatic Stress Symptoms Among Tamil Asylum Seekers, Refugees, and Immigrants*, 12 J. TRAUMATIC STRESS 421-435 (1999).

extremely painful. Just recounting the story is enough to trigger uncontrollable tears, panic attacks, or flashbacks of the event. Thus, many asylum seekers may never actually recount all the details, particularly those that are shameful in their society, such as details of sexual violations. Or they may tell incomplete versions, or versions that vary over time such that an affidavit prepared with the help of an attorney may differ from the story recounted to a mental health professional, or an adjudicator. These inconsistencies can be indicative of a trauma story that is too painful to share in its entirety, but may be misinterpreted erroneously by adjudicators during an asylum hearing as a lack of credibility on the part of its victim.

In addition to the intentional filtering of information in affidavits to protect themselves from painful memories and shame, asylum seekers who have been traumatized may unintentionally omit key aspects of the story due to memory problems. Memory problems which can affect credibility in the courtroom occur with PTSD, specifically with "dissociation," a psychiatric term used to describe a kind of numbing that occurs at the time of the trauma itself. Someone who is dissociating may feel as though she is not in her body, but looking down on it while it is being raped or beaten, or he may feel that the assault is happening to someone else instead. From the standpoint of adaptation, dissociation permits a person to endure a trauma that would otherwise be too horrific. Dissociation is like emotional and physical anesthesia. However, despite its initially adaptive quality, a significant longterm problem with dissociation is that it makes it extremely difficult for people to make sense of what happened to them, in part because they simply do not remember the details. The who/what/where/when/how of the details of the trauma are often lost to them. Ironically, the dissociation caused by the trauma can adversely affect asylum applicants' credibility as they attempt, with difficulty, to describe the trauma. Immigration Judges and Asylum Officers are understandably suspicious of factual accounts with conflicting, inaccurate, or missing data, but need to take into account the possibility that the very experience itself of severe trauma could be interfering with its description in an affidavit, an interview, or a courtroom.

Numbness associated with PTSD on an ongoing basis, rather than at the time of the trauma, may adversely affect the credibility of asylum seekers in the courtroom in a different way. Many adjudicators understandably expect that survivors of trauma, particularly in its more horrific forms such as torture, will have such

overwhelmingly strong feelings about what they have endured that they will weep when recounting traumatic memories. In fact, their deadpan narratives are typical of the emotional numbing that often follows severe trauma. Many PTSD patients cannot access these feelings when describing the trauma. They may or may not cry when talking about other emotional topics.

Asylum seekers, by definition, come from other countries, and therefore other cultures. Cultural factors may strongly influence the types of information asylum seekers are comfortable sharing, as well as the pace of disclosure. In many cultures, victims of sexual abuse, rape, or sexual torture experience an overwhelming amount of shame. Because in many cultures it is important to not lose face, these painful experiences would be difficult to share with loved ones, let alone with strangers in a public setting, especially government officials who might evoke memories of the perpetrators in cases where applicants have been terrorized by the agents of the state. Many asylum applicants offer only the sketchiest of details about these horrors, even though a more complete rendition could be helpful to their cases. For example, one study of British asylum seekers from multiple countries found that those who experienced sexual violence reported more difficulty disclosing personal information during asylum interviews than those who had not experienced sexual violence.[10] Survivors of sexual violence also reported greater dissociation as well, although they experienced more difficulty in reporting sexual violations independently of this increased dissociation. Thus, whereas adjudicators may attribute the timing of traumatic disclosures to an applicants' attempts to favorably (i.e., fraudulently) alter the outcome of their cases, the timing often reflects their great difficulty reporting these types of symptoms any earlier.

Eye contact is another culturally variable pattern of behavior. To quote from a primer on career advice for those seeking to adapt to British culture, "In many countries looking directly at a person's eyes while speaking is disrespectful. However in British culture having shifty eyes or not looking at the person you are speaking to is taken to show that you have something to hide or are not speaking the truth."[11]

10. Bogner et al., *supra* note 4.

11. Raj Mehta R and Kathane, R. *Adapting to British Culture*, BMJ CAREERS, June 19, 2004, <http://careers.bmj.com/careers/advice/view-article.html?id=268> (visited Apr. 7, 2008).

Lewdness or aggression is associated with prolonged eye contact in many cultures, though not in the U.S. However, newly arrived asylum seekers may not have sufficiently assimilated to western culture to look directly at the person to whom they are speaking, particularly if that person is an Asylum Officer or Immigration judge by whom they may feel very intimidated. Thus, in U.S. culture, ironically, some asylum seekers may arouse suspicion by the aversion of gaze that to them is innately ingrained as a sign of respect or deference.

In the companion paper by Musalo et al.,[12] the case of the Guatemalan domestic violence victim whose PTSD was not recognized as a valid diagnosis because she was able to pay her bills on time, nor was the case of the Kenyan woman whose PTSD supposedly could not have contributed to her delay in filing for asylum because she was still able to attend church. Both cases demonstrate a fundamental misunderstanding of what PTSD is and is not. Traumatized people often avoid people, places, and activities that are unwelcome reminders of the original traumatic event or events. In other words there is specificity to the avoidance, and also to the associated disability. By and large, such people may function quite well so long as they are not reminded of the original event. A common example of this phenomenon is the Vietnam veteran who appears to function indistinguishably well from his civilian colleagues, until he is within hearing distance of a car backfiring, at which point, based upon an increased startle response, he may leap under a piece of furniture for cover, as if he were being fired upon anew in the battle field. At that moment, it is as if he is suffering from the flashbacks and memories that are the hallmark of PTSD. Veterans such as he know to avoid fireworks celebrations or any other situation where sudden, loud noises are likely to hurl them back into the horrors of their pasts. However PTSD would not prevent them from paying their bills on time, or attending church because there is nothing about those activities that reminds them of the traumas they endured.

A quick anatomy lesson may further clarify the specificity of the symptom. At a neuroanatomical level, the part of this veteran's brain (the amygdala) which instantly responds to perceptions of danger by

12. Karen Musalo & Marcelle Rice, Ctr. for Gender and Refugee Studies, *The Implementation of the One-Year Bar to Asylum*, 31:2 Hastings Int'l & Comp. L. Rev. 693-724 (2008).

triggering the body's fight or flight response (i.e., hyperarousal) has hijacked his behavior and induced a series of physiologic reactions (rapid heart rate, palpitations, sweating, increased blood flow to large muscle groups) which are entirely appropriate for dealing with actual threats to one's survival. For a person suffering from PTSD, it takes much longer than normal for the part of his brain (the hippocampus) that rationally assesses the situation and synthesizes data about the environment to override the amygdala and restore a feeling of personal safety. For example, if we hear a car backfire nearby, our amygdale instantly raises our level of alertness, but if similar loud noises have not, in the past, been associated with dire consequences, the hippocampus almost immediately takes over and reminds us that we are on a street where cars may backfire fairly commonly, with no real danger. This process happens very quickly for most of us, but the hippocampus of someone who has been shot while hearing similar sounds would take much longer to restore equanimity. Again, however, these neurological structures which regulate our response to the environment are not functioning abnormally except when the environment contains a perceived threat. Paying bills, which has no relation to this Guatemalan domestic violence victim's trauma, would not induce traumatic symptoms; however, completing an asylum application based on the domestic violence she suffered would induce these traumatic symptoms. The veteran in our example, similarly, would have no difficulty paying pills or going to church, despite suffering from PTSD.

Asylum Officers and Immigration Judges are faced with the daunting task of weeding out fraudulent claims from the truthful ones. In fact, among data collected during a recent study of stress and burnout among Immigration Judges,[13] concern about fraud was a recurrent theme,[14] and the incentive is clearly high for asylum seekers to not only invent aspects of their story, but potentially to create medical or psychiatric symptom profiles consistent with their claims.Mental health professionals have no truth serum that can definitively determine which asylum seekers are truthful in their claims. However, there is a well-described clinical syndrome known

13. Kevin Delucchi, Brent Kaul, Dana Leigh Marks, Stuart L. Lustig, Denise Slavin, & Lakshika Tennakoon, *Burnout and Stress Among United States Immigration Judges*, 13 BENDER'S IMMIGR. BULL., 1, 22-30 & 43-47 (2008).

14. Lustig S. L. University of California, San Francisco (data on file with author).

as Malingering that is relatively easy for clinicians to detect.[15] The malingering patient is one who derives an obvious benefit from being perceived as ill by others, even though he or she is not. These benefits may include access to pain medications, paid sick days at work, disability payments, or, in the case of an asylum seeker, a potential grant of asylum, or eligibility to apply for relief despite the passage of more than one year since entry into the U.S. Certain characteristics render malingerers easily identifiable. They are often well-versed in the details of the physical or mental condition which they are feigning, which for PTSD are readily available on the internet. They have often read the diagnostic criteria, and list as many symptoms as they can remember, even without prompting. They are also quick to deny the absence of symptoms, all in an effort to be a more convincing patient. By contrast, during the past decade of assessing asylum seekers, while I have encountered some asylum seekers who did not exhibit outward signs of trauma that I could document (either because they may have not been traumatized by their experiences, or were traumatized and recovered, or they may have been lying about what actually happened), I have never encountered a malingering asylum seeker. Some asylum seekers had very little idea what a psychiatrist does, or why their attorneys had referred them to me for evaluation. Others who understood my role nevertheless only revealed their symptoms when probed. Had I not asked about them, I would never have known about them. Furthermore, many were only too glad to deny symptoms, or to let me know the many things in their lives that they perceived as going well. By contrast, malingerers tend to list all the symptoms of the disorder from which they are claiming to suffer, in order to appear to be more convincingly ill. In short, while I cannot vouchsafe the veracity of their asylum claims, nor opine about the political conditions in their countries of origin, the psychiatric symptoms I elicited, in those cases when present, seemed genuine.

IV. Summary

In summary, trauma is a common response to events perceived

15. James Knoll & Phillip J. Resnick, *The Detection of Malingered Post-traumatic Stress Disorder*, 29 Psychiatric Clinics of N. Am. 629-647 (2006).

as life threatening, with associated neurobiological abnormalities. PTSD often is prevalent among asylum seekers. Symptoms include nightmares, flashbacks, intrusive memories, avoidance of triggers, numbing, hyperarousal, hypervigilance, and dissociation. Unfortunately for asylum applicants, their credibility in the courtroom may be undermined unless Immigration Judges and Asylum Officers are aware that trauma compromises consistent memories of the event, that avoidance of trigger-related stress or cultural factors such as shame may decrease their willingness or ability to disclose what has happened to them, and that PTSD symptoms do not affect daily activities in which memories of the trauma are not evoked. Eye contact is variable among cultures and may be diminished or absent in asylum applicants. Malingering (faking of illness) is usually easy to detect by psychiatric clinicians, but seldom occurs in this population. Adjudicators who keep in mind these signs of trauma will be less likely to wrongly conclude that an applicant lacks credibility when in fact he or she is suffering from a psychiatric disorder directly attributable to the trauma(s) in question.

EXHIBIT E: Knoll J and Resnick PJ, "The Detection of Malingered Post-traumatic Stress Disorder," *Psychiatr Clin N Am* 2006, 29:629-647

Psychiatr Clin N Am 29 (2006) 629–647
PSYCHIATRIC CLINICS
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The Detection of Malingered Post-traumatic Stress Disorder

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> The old timer shows the new guy how to work the system. Before you go in for treatment or evaluation, don't shave for three or four days. Wear old fatigues, some unit patches, an old beret. Study the symptoms of PTSD [1].

Post-traumatic stress disorder (PTSD) is easy to fake. Researchers and forensic evaluators have had to contend with this problem since the diagnosis was first included in the DSM-III in 1980. Since its initial inclusion, the diagnosis has been associated with substantial political and scientific controversy [2]. Significant debate remains over the sociopolitical origins of the diagnosis and whether it was a valid scientific discovery or a consequence of advocacy efforts on behalf of Vietnam combat veterans [3]. In 1994, the controversy surrounding PTSD was further stimulated when the DSM-IV broadened the definition of the traumatic stressor criterion. As a result, criterion A for the traumatic event was changed from an objective standard (the event would be markedly distressing to almost anyone), to a subjective standard (the individual personally found the event distressing).

The diagnostic criteria of PTSD stand alone as the only ones to specify a causal link to an external event and have been criticized for producing "illusory objectivity" in the legal arena [4]. Plaintiffs' attorneys have found the diagnosis to be a boon because DSM criteria specifically attribute their client's symptoms to the litigated traumatic event. The symptoms are based almost entirely on the client's report of subjective symptoms. Furthermore, once the PTSD diagnosis is raised, it tends to preclude consideration of other potential causal factors [5].

The DSM-IV-TR criteria for PTSD are widely accessible in print and on the internet, which allows resourceful malingerers to familiarize themselves with what symptoms to report. Even untrained individuals, however, are able to endorse the correct symptoms for PTSD. In a study of untrained college students,

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86% were able to successfully meet criteria for PTSD on a symptom checklist [6]. In another study of untrained, PTSD-naïve subjects, 94% of participants were able to fulfill diagnostic criteria using a standard checklist [7]. These studies strongly suggest that symptom guessing may occur when checklists are used, and underscore the leading nature of most inquiries into PTSD symptomatology.

Because of the subjective nature of PTSD symptoms, the diagnosis of malingered PTSD requires a meticulous review of records, a detailed history, and careful corroboration of the information collected. Psychiatrists who base their assessment merely on asking the evaluee if they suffer from the symptoms of PTSD listed in the DSM-IV-TR are easily fooled. A reliable evaluation for PTSD is a complex endeavor, requiring the psychiatrist to take a special approach as opposed to relying on self-report and intuitive judgments.

Malingering should be considered in the assessment of all claimants in a forensic context. In a clinical context, many psychiatrists are reluctant to diagnose malingering even when it is suspected [8]. Reasons for this reluctance include a fear of misdiagnosis, because the possible consequences of an incorrect diagnosis of malingering may include refusal of needed care and stigma that may be difficult to shed [9]. An additional reason for the reluctance to diagnose malingering is the fear of litigation, particularly defamation of character that may not be covered by a malpractice insurance policy. Psychiatrists also may fear being physically assaulted, because essentially they are labeling the evaluee a liar.

Unless the examiner has substantial evidence to support a diagnosis of malingering, it is best not to make the formal diagnosis. It has been suggested that there are only two situations in which malingering can be confirmed with certainty: (1) when the malingerer believes he is unobserved and is caught in the act and (2) when the malingerer confesses he is faking [10]. Neither of these situations occurs frequently, yet a reliable assessment of malingered mental illness remains a necessity in many forensic and clinical contexts. It is thus particularly important for psychiatrists to use a systematized, thorough approach for detecting malingering, rather than merely forming a global impression [11].

DEFINITIONS

Malingering is described in DSM-IV-TR as a condition the clinician may encounter that is not attributable to a mental disorder. It is defined as the intentional production of false or grossly exaggerated physical or psychologic symptoms motivated by external incentives [12]. In practice, malingering commonly requires differentiation from a factitious disorder, which also involves the intentional production of symptoms. In factitious disorders, however, the motivation is to assume the sick role, which can be thought of as an internal or psychologic incentive.

Malingering can be categorized further into (1) pure malingering, (2) partial malingering, and (3) false imputation [13]. When an individual feigns a disorder that does not exist at all, this is referred to as pure malingering. Partial malingering occurs when an individual does have actual symptoms but consciously

exaggerates them or falsely alleges that previous genuine symptoms are still present. Cases of pure malingering of PTSD are uncommon, whereas exaggeration of symptoms is seen frequently [14]. False imputation refers to the ascribing of actual symptoms to a cause that the individual consciously recognizes as having no relationship to the symptoms. In malingered PTSD, this may be seen in the claimant who has authentic psychiatric symptoms caused by a prior traumatic event, but falsely attributes the symptoms to a litigated traumatic event in an effort to obtain compensation.

Malingered PTSD must be distinguished clearly from factitious PTSD. In factitious PTSD, the individual intentionally produces symptoms because of a psychologic need to assume the patient role. The sick role is the ultimate goal for the person who has factitious PTSD, as opposed to a temporary means of achieving some external benefit [15]. Suspected malingerers who obtain hospital admission alleging PTSD should be evaluated carefully for factitious PTSD.

MOTIVATIONS TO MALINGER

The motives of an individual to malinger generally fall into two categories: (1) avoiding difficult situations or punishment (avoiding pain) and (2) obtaining compensation or medications (seeking pleasure). In the criminal justice system, a diagnosis of PTSD may result in reduction of charges or mitigation of penalty [16]. PTSD as a basis for an insanity defense is rare and seldom successful [17].

The primary motivation to malinger PTSD for most accident victims is financial gain. Indeed, it is a rare individual who is not influenced to some degree by the possibility that an injury may lead to financial gain [18]. After PTSD was included in the DSM in 1980, the filing of personal injury lawsuits in federal court increased by more than 50% over the next decade [19]. Mental stress related disorders became the most rapidly increasing type of worker's compensation claim, and insurance costs for stress claims began to outstrip costs for physical injury claims [20,21].

Financial gain may be the sole motive to malinger PTSD, or it may be in addition to personal psychologic reasons. For example, an "official" determination of disability may provide a face-saving solution for personal life crises or other accumulated factors (ie, substance use, interpersonal problems, and personality disorders) that are separate from the alleged trauma [22]. Adverse or shameful consequences arising from personal decisions thus may be transformed into sympathy and support for a disability. Furthermore, financial compensation can take on different meanings for different people. For one claimant, money may represent security, to another, revenge against a hated employer or perceived aggressor. In some cases, malingered PTSD may represent a last ditch effort for a claimant whose physical injury claims have been unsuccessful.

Once an individual takes on the role of a personal injury or worker's compensation claimant, the nature of the litigation may alter the claimant's attitudes and course of illness. The attorney for the plaintiff may overdramatize the client's impairment, whereas the defense attorney may imply that the plaintiff is

a pure malingerer. As a result, litigants may become angry easily or worry that they will be cheated out of justified compensation [23]. It is not uncommon that such scenarios have a negative impact on the claimant's overall mental health. Furthermore, the claimant may feel it is necessary to exaggerate her claim to obtain what she believes she is fairly due.

COLLATERAL DATA

A review of collateral data is a critical step toward offsetting the subjectivity of self-reported PTSD symptoms. The psychiatrist should consider any information that assists in supporting or refuting the alleged symptoms. Collateral data are most helpful when gathered before the evaluation, particularly so that evaluees can be asked about any contradictions between their self-reported history and the records. Data should include police reports on the traumatic event and any witness statements. Such data are extremely helpful because of the phenomenon of biased retrospective recall observed in trauma victims [3]. Biased retrospective recall tends to cause individuals who allege greater PTSD symptom severity to amplify their memory for the traumatic event over time [24].

If past mental health records are available, complete progress notes should be reviewed as opposed to summary letters. Treating clinicians may consciously or unconsciously send biased summary letters because they want what is "best" for their patients. Although medical records also may be reviewed, evaluators should be aware that primary care health records have been found to underestimate the presence of anxiety disorders [3]. Employment files and tax returns also may lend perspective on the evaluee's daily functioning. The psychiatrist should interview close friends or family members of the evaluee when possible, for the purpose of corroborating or contradicting the evaluee's self-reported history and symptoms.

Key data can be addressed in a collateral interview, such as the evaluee's body movements during dreams, sleep patterns, and other relevant symptoms. The reliability of family or friends' reporting must be taken into account, because it is possible that they may stand to benefit in some way from the evaluee's claims [22]. Access to relatives varies depending on the jurisdiction and whether one is employed by the claimant's attorney or the defense attorney. If denied direct access, the psychiatrist can request that close relatives be deposed.

INTERVIEW STYLE

Careful interview technique is critical to detecting malingering accurately. When malingering is suspected, the psychiatrist should refrain from showing suspicion and proceed in conducting an objective evaluation. A careful history should be taken without verbal or nonverbal communications of skepticism. An annoyed or incredulous response risks having the evaluee become more defensive, thus decreasing the ability of the psychiatrist to detect evidence of malingering [25]. The psychiatrist also should refrain from adopting a challenging manner that may cause the evaluee to perceive that he must exaggerate

symptoms to be believed. To begin the evaluation, the psychiatrist should ask open-ended questions, which allows the evaluee to report symptoms in her own words. In the initial stage, inquiries about symptoms should be phrased carefully to avoid leading questions that give clues to genuine symptoms. Later in the interview, the psychiatrist can proceed to more detailed questions of specific symptoms as discussed.

In a forensic context, evaluations for PTSD sometimes are performed under highly contentious conditions. Although the psychiatrist's opinion may be protected by witness immunity, the performance of the actual evaluation may be subject to liability if the evaluee alleges "suffering" that resulted from the evaluation. Although suits against psychiatrists arising from forensic evaluations are rare, prudent examiners should be sensitive to the effects of stress during an evaluation [26].

Because of the subjective nature of PTSD symptoms, the psychiatrist must be firm in insisting on detailed illustrations of symptoms. A malingerer may be able to recite easily DSM PTSD symptoms, but may have difficulty elaborating on them with convincing personal life details. In contrast, fabricated symptoms are more likely to have a vague or artificial quality [27]. All symptoms alleged by the evaluee must be explored in detail. For example, conclusory statements such as "I can't concentrate" should not be accepted at face value [22]. Details, such as circumstances, degree, frequency, and context, should be elaborated on. School grades, work evaluations, and psychologic tests should be compared with the self report for confirmation.

During assessments of mental status, the psychiatrist should look carefully for actual evidence of concentration deficits, irritability, and hypervigilance. It is also helpful to obtain details about daily activities before and after the stressor to ascertain whether or not symptoms were present before the trauma. The psychiatrist should assess whether the evaluee minimizes other causes of his symptoms or describes his pre-trauma functioning in an exclusively complimentary manner [28]. Careful analysis and consideration should be given to the reasonableness of the relationship between the alleged symptoms and the stressor and a temporal course of symptom development. Distinguishing an evaluee's capacity to work versus his ability to enjoy recreation is sometimes a revealing line of inquiry.

During the interview, special attention should be given to instances in which an evaluee endorses rare or improbable symptoms. Rare symptoms occur infrequently, and improbable symptoms are almost never reported, even in severely disturbed patients [29]. At appropriate points during the interview, evaluees may be asked about improbable symptoms or rare symptom combinations to see if they endorse them. The evaluee may be asked about symptoms that are not typically seen in PTSD. For example, the psychiatrist may inquire about symptoms such as inflated self-esteem, decreased need for sleep, increased talkativeness, or impulsive traveling.

It is advisable to exclude third parties from the personal evaluation of the subject. The presence of relatives may preclude using them as an independent

source of verification of the evaluee's history and symptoms. In addition, the presence of third parties reduces the possibility that an evaluee will acknowledge malingering, should the psychiatrist choose to confront the issue.

DIAGNOSTIC CONSIDERATIONS

In the clinical assessment of malingered PTSD, the psychiatrist must attend to several important diagnostic issues. These considerations include differential diagnoses, pre-trauma vulnerability factors for PTSD, and comorbid conditions. A psychiatric differential diagnosis after a trauma may include: PTSD, malingering, depressive disorders, other anxiety disorders, conversion disorders, postconcussive syndromes, and psychoses. PTSD may be seen after motor vehicle accidents that cause head injury and concussion. When PTSD symptoms follow an accident, the assessment may be complicated by physical symptoms, such as pain and the sequelae of a concussion. Even without loss of consciousness, head injuries may produce symptoms that can be confused with PTSD. Postconcussion syndrome (PCS) thus must be distinguished from PTSD. PCS is manifested by headaches, anxiety, emotional lability, impaired concentration, and memory problems [30]. It is possible for a trauma victim to develop PTSD and PCS in response to the same injury [31]. For a detailed discussion of assessing malingered PCS, post-traumatic depression, and conversion disorder, the reader should consult Resnick [32].

When an evaluee alleges that a minor stressor has produced symptoms of PTSD, the psychiatrist may be inclined to suspect malingering. Some individuals are more prone to develop PTSD, however, because of a high degree of premorbid vulnerability. Several risk factors have been associated with an increased likelihood of developing PTSD after a trauma. Such pre-trauma vulnerabilities include low intelligence [33,34], pre-existing mood or anxiety disorder [35], childhood abuse [36], and personality characteristics such as negative emotionality (neuroticism) [3]. In a meta-analysis of studies focusing on pre-trauma risk factors for PTSD, three main factors were consistently identified: (1) psychiatric history, (2) family history of mental disorders, and (3) childhood abuse [37]. Personality traits also were identified as predictors of PTSD, particularly hostility and low self-efficacy. Self-efficacy is a psychologic measure and predictor of a subject's perception of his own competence and his capacity to act efficiently and autonomously. The combination of low self-efficacy and high hostility levels were found to be strongly predictive of PTSD in a prospective study of professional firefighters [38]. Box 1 gives a list of pre-trauma vulnerability factors for PTSD.

In attempting to detect malingered PTSD, the psychiatrist is likely to encounter complexities produced by the high degree of comorbid psychopathology seen in PTSD. PTSD is associated with high rates of depression, personality disorders, and other anxiety disorders. In a large sample of treatment-seeking outpatients who had a principal diagnosis of PTSD, 92% had another active psychiatric diagnosis [39]. The challenge for the psychiatrist is to determine what, if any, comorbid pathology predated the alleged trauma. This becomes

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-8 Filed: 08/09/12 Page: 54 of 66 PAGEID #: 1447

Box 1: Pre-trauma vulnerability factors for post-traumatic stress disorder [3,33–37]

Developmental
Childhood abuse
Parental poverty
Unstable family during childhood
Behavior disorder in childhood or adolescence
Poor self-confidence before age 15 years

Psychiatric
Prior psychiatric disorder
Introversion
Low intelligence
Neurologic soft signs
Neuroticism

Historical
Female gender
Family history of mental illness in first-degree relatives
Life stress before and after the trauma
Previous trauma
Previous development of PTSD
Previous episodes of general emotional problems

especially difficult given that increased comorbid pathology has the effect of increasing the severity of PTSD symptoms [40]. Evaluators thus must thoroughly investigate comorbid psychopathology for (1) its presence or absence before the alleged trauma, (2) its course after the alleged trauma, and (3) its relative contribution to the evaluee's alleged disability and current symptoms.

CLINICAL INDICATORS OF MALINGERED POST-TRAUMATIC STRESS DISORDER

Malingerers are like actors who portray a role as best they understand it [41]. They thus may be detected when they have incomplete knowledge of the illness they are faking. In the case of PTSD, it is exceedingly easy to obtain copies of the diagnostic criteria, yet subtle nuances of the disorder are more likely to be misunderstood and incorrectly reported by the malingerer. Additionally, a malingerer may overact his part by giving an excessively dramatic report of symptoms. Conversely, "successful" malingerers are more likely to endorse fewer symptoms and avoid endorsing dramatic or unusual symptoms [42].

Malingerers may take an unusual approach to the interview, such as eagerly "thrusting forward" their illness to a much greater extent than an individual with genuine PTSD. Alternatively, the malingerer may adopt a globally evasive posture or show unwillingness to make definitive statements on clear-cut matters, such as the presence of previous disability claims. Finally, a malingerer may attempt to take control of the interview and behave in an intimidating or hostile manner. Such behavior raises the possibility that the evaluee is attempting to avoid careful scrutiny.

According to the DSM-IV-TR, the presence of antisocial personality disorder and a medicolegal context should arouse strong suspicions of malingering. Furthermore, the presence of psychopathic traits has been associated with malingering [43]. In contrast, an individual who has always been a responsible, honest member of society is less likely to malinger PTSD [44]. Malingerers are more likely to have poor social and occupational adjustment before the alleged trauma [45], yet may be reticent to acknowledge such circumstances. A malinger may claim an inability to work because of PTSD symptoms, yet acknowledge retaining the capacity for recreational activities. The evaluee who has genuine PTSD symptoms is more likely to withdraw from both recreation and work.

Malingerers are more likely to give vague or hedging answers to straightforward questions. For example, when asked for specific details of alleged traumatic nightmares, the malingerer is more likely to reply "I don't know." Although a person who has genuine PTSD can answer such questions easily, the malingerer may never have experienced the symptoms and "doesn't know" what the correct answer is.

Malingerers may be detected by inquiring in detail about the nature and pattern of alleged traumatic nightmares. In genuine civilian (not combat-related) PTSD, nightmares after a trauma usually progress over time to involve variations on a theme of the traumatic event [46]. In contrast, a malingerer may claim experiencing repetitive, unchanging dreams that re-enact the alleged trauma in exactly the same way. Genuine post-traumatic nightmares of civilians typically diminish after several weeks or months, and psychotherapy is likely to hasten their resolution.

Considerable body movement almost always accompanies genuine post-traumatic nightmares [47]. The spouse of a suspected malinger thus may be questioned about this phenomenon. When appropriate, an inpatient assessment may allow for more objective monitoring. Under inpatient observation, the evaluee may be monitored by staff for thrashing body movements during sleep, sleep disturbances, social withdrawal, and exaggerated startle responses (see Box 2).

The psychiatrist should pay close attention to evidence of inconsistency in the presentation of a suspected malingerer. Inconsistencies may be thought of as either internal or external to the individual's presentation. Internal inconsistencies exist when a malingerer reports severe symptoms, such as an inability to concentrate or severe anterograde amnesia, yet is able to articulate clearly

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-8 Filed: 08/09/12 Page: 56 of 66 PAGEID #: 1449

Box 2: Clinical indicators of malingered (civilian) post-traumatic stress-disorder

Capacity for recreation but not work
Poor occupational or social adjustment before trauma
Unvarying, repetitive nightmares
Nightmares unaccompanied by thrashing movement
Antisocial traits or psychopathy
Overidealized functioning before trauma
Evasiveness, frequent response of "I don't know"
Inconsistency of symptom presentation
Overly dramatic symptoms
Endorsement of unusual or improbable symptoms

multiple examples of poor concentration and memory loss. Another type of internal inconsistency occurs when a malingerer gives grossly conflicting versions of his own history to the same evaluator.

There may be external inconsistency between what the evaluee reports and the symptoms that are observed. For example, a malingerer may allege severe distraction caused by ongoing "flashbacks," yet appear consistently calm and show no evidence of being distracted. There may be an external inconsistency between the evaluee's reported level of functioning and the observation of their level of functioning by others. For example, a malingerer may allege a feeling of social detachment from others, yet eagerly engage in various social and recreational activities. Finally, there may be inconsistencies between the evaluee's subjective report and hospital or police records of the traumatic event.

MALINGERED COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

The Veterans Administration (VA) began to accept claims of PTSD as potentially compensable in 1980. Efforts to malinger PTSD were facilitated significantly after lists of PTSD symptoms were distributed widely by national service organizations [48]. Malingerers were aided further by exposure to combat veterans who had genuine PTSD at veterans' centers and VA hospitals [49]. More recently, numerous internet sites have been developed that detail PTSD symptoms and how to present oneself successfully so as to maximize the chances of receiving service connected benefits [50,51]. Some sites provide step-by-step instructions for writing "stress letters" to be submitted to the VA ratings board [52].

Research estimates of genuine PTSD among combat veterans have been the subject of controversy for two main reasons: (1) many have relied only on self-report test instruments and (2) few have verified research subjects' combat experience by checking military records. Estimates also have varied according to

the methods used and have ranged from 20% to 70% [53,54]. According to studies of Gulf War veterans, the rates of PTSD were actually well below national estimates (1.9% in Gulf War veterans versus 7.8% in the general population) [55]. Few studies have investigated the prevalence of malingered combat PTSD, perhaps because of the politically sensitive nature of the subject. One study of VA outpatients using the Minnesota Multiphasic Personality Inventory, Revised (MMPI-2) estimated a 20% base rate of malingered PTSD [56].

MOTIVATIONS TO MALINGER COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

The motives for veterans to malinger PTSD generally fall into three categories: (1) to obtain financial compensation, (2) to reduce criminal culpability, and (3) to obtain admission to a VA hospital. The veteran who successfully malingers PTSD may be well rewarded. An individual who qualifies for a 100% "service connected" disability because of PTSD may be eligible for life-long, tax-free compensation in the range of $36,000 to $40,000 per year, in addition to other military-related benefits [1]. Once individuals have qualified for PTSD-related disability, there is thus an ongoing financial incentive to appear disabled regardless of their true status [57].

Although the differential diagnosis of those seeking admission to a VA hospital should include factitious PTSD, some individuals simply may be malingering. One possible goal of the malingerer who seeks a VA psychiatric hospital admission is to increase the percentage of his service connected disability by building an official VA "record" of mental instability. Finally, some individuals who have never served in the military have fraudulently convinced the VA that they are combat veterans and have applied successfully for PTSD disability benefits [1].

COLLATERAL DATA FOR COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

In addition to the guidelines mentioned for civilian PTSD, some unique steps are involved in collateral data gathering for detecting malingered combat PTSD. Military records and eyewitness accounts provide some of the only independent substantiation of the validity of the stressor. Both of these sources have their limitations, however; third party documentation of exposure to combat stress is difficult to acquire, and military records are forged easily. The documentation used most commonly for verifying military service is the veteran's discharge papers, or the DD 214 form. Evaluators should be aware, however, that this form is easily forged, altered, or bought on the open market [1]. Consultation with an actual combat veteran or other military personnel may be invaluable for spotting phony or altered military records.

Vietnam veteran and author B.G. Burkett uncovered numerous cases of fraudulent claims of combat-related PTSD by use of the Freedom of Information Act [1]. He recommends obtaining military records by contacting the National Personnel Records Center in St. Louis, Missouri, to reduce the chances of accepting a fraudulent record. Some malingerers may claim that their

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-8 Filed: 08/09/12 Page: 58 of 66 PAGEID #: 1451

records were destroyed in a fire that occurred in the National Personnel Records Center in 1973. The records damaged were pre-Vietnam era, however, and 94% were salvaged from microfilm and other archives [2].

Graphic, detailed stories of combat are not conclusive proof that an individual was exposed to combat stress. Persons malingering combat PTSD are able to fabricate stories of combat that are equally as vivid and horrifying as those presented by genuine combat veterans [1,58]. Indeed, some veterans who malingered PTSD have been able to pass multiple screening interviews by Vietnam veterans and staff [36]. It may be possible, however, to pinpoint a malingerer's lack of knowledge regarding Vietnam geography, culture, military terminology, and conflict dates [1,32]. Consultation or evaluation assistance by an actual Vietnam or Gulf War combat veteran greatly enhances the psychiatrist's ability to detect such discrepancies.

INTERVIEW STYLE FOR COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

Evaluating genuine versus malingered combat PTSD requires special attention to maintaining objectivity and equanimity. Because war typically invokes strong feelings, the evaluator must recognize the potential for powerful and potentially biasing emotions during the evaluation. In particular, evaluees who recount horrific combat experiences may produce a highly charged, affect-laden interview that can be stressful for both parties [31]. In the face of powerful emotions or outbursts of anger, the psychiatrist may feel moved to diagnose PTSD in the absence of objective data out of a sense of moral responsibility for the Vietnam veteran as "victim" [49,59].

Psychiatrists should be aware that some Vietnam and Gulf War veterans regard the federal government with animosity and suspicion, which may affect the evaluation adversely [31]. In this sense, a strong authoritarian approach by the psychiatrist is unlikely to be productive. An interview style that is composed, impartial, and respectful is recommended.

The presence of antisocial personality disorder does not rule out PTSD; however, it should increase the psychiatrist's index of suspicion for malingering. Unfortunately there is significant overlap between the two, particularly in areas such as inconsistent work pattern, poor parenting, repeated legal difficulties, interpersonal difficulties, irritability, failure to honor financial obligations, and impulsive behavior. In addition, veterans who have genuine combat-related PTSD frequently engage in substance abuse and reckless behaviors. It is thus important to search for early developmental evidence of antisocial personality from sources such as school records, family interviews, and juvenile offender records.

CLINICAL INDICATORS OF MALINGERED COMBAT-RELATED POST-TRAUMATIC STRESS DISORDER

The clinical indicators for malingered combat-related PTSD are based primarily on individual case reports and anecdotal descriptions. They thus should be

considered tentative and must be weighed together with all available data. Box 3 provides a summary of clinical indicators of malingered combat-related PTSD.

The psychiatrist should pay attention to how the evaluee attributes blame for his stressor and symptoms. Veterans who have genuine PTSD are more likely to feel intense guilt, and perceive themselves as the cause of their problems. They are more likely to express survivor's shame for having lived, while others who fought alongside them died [1]. They are generally hesitant to blame their problems directly on their combat experience [60] and often seek help at the insistence of family members. In contrast, the malingerer is more likely to present himself as a victim and emphasize how his problems are a direct result of alleged war experiences. The malingerer is more likely to dwell on themes of condemnation of war and authority.

Malingerers of combat-related PTSD are more likely to give a chief complaint of fear of losing control and harming others [60]. This complaint is used commonly by malingerers to gain admission to a psychiatric inpatient unit. Malingerers also have a tendency to overplay their war experience or claim improbable combat heroics. For example, the psychiatrist should be

Box 3: Clinical indicators of malingered combat-related post-traumatic stress disorder

Genuine

Minimize relationship of problems to combat
Blame self
Dreams: themes of helplessness, guilt
Deny emotional impact of combat
Reluctant to discuss combat memories
Survivor guilt relates to specific incidents
Avoidance of environmental stimuli
Anger over helplessness

Malingered

Emphasize relationship of problems to combat
Blame others
Dreams: themes of grandiosity, power
Act out alleged feelings
Relish discussing combat tales
Generalized guilt over surviving war
No avoidance of environmental stimuli
Anger toward authority

particularly suspicious of the evaluee who alleges overly dramatic exploits, such as escaping from a POW camp by fighting off enemy forces in hand-to-hand combat or other highly improbable events.

Malingerers may allege experiencing trauma while engaged in dramatic and horrifying top-secret covert missions or so-called "black ops." Furthermore, they may claim that such exploits are not listed on their records because the government had to disavow its knowledge of such activities. The special training required for such elite missions, however, is always listed on a veteran's record. In addition, although the details of a covert mission may be redacted, the phrase "Classified Assignment" will appear together with dates of the mission [1]. Claims of unusually high decorations, such as the Medal of Honor or Distinguished Service Cross, should be verified carefully by knowledgeable military consultants. In reality, such awards are given infrequently. Burkett's book *Stolen Valor* contains a list of all officially recorded recipients of such high decorations [1].

Individuals who recite DSM criteria or who introduce psychiatric jargon, such as, "I have intrusive recollections," should be viewed with suspicion because of the likelihood that they have received coaching. Malingerers are more likely to make gratuitous, conclusory statements, such as, "I've got PTSD. I've got flashbacks and nightmares." [61]. Veterans who have genuine PTSD are more likely to downplay their combat experiences or make statements such as "Lots of men had it worse than me."

Veterans' post-traumatic nightmares take on a pattern that is distinct from those in civilian PTSD, although the reasons for this are unclear. The nightmares of veterans who have PTSD take the form of an encapsulated traumatic combat scene that may become isolated. When activated, the dream proceeds in an almost identical fashion for many years. A veteran who has genuine post-traumatic nightmares may wake up terrified and report having a dream of the combat stressor exactly or almost exactly as it occurred in reality [48]. It is possible that this phenomenon may represent nighttime flashbacks as opposed to actual dream states.

The dreams of veterans who have genuine PTSD generally contain themes of helplessness regarding the combat stressor, as opposed to themes of grandiosity and power seen in malingerers [61]. Veterans who have genuine PTSD often report experiencing themes of helplessness, guilt, or rage. Conversely, the themes of intrusive recollections in malingered combat PTSD often consist of anger toward authority.

The psychiatrist should make note of how emotions are handled and expressed by the evaluee. The veteran who has genuine PTSD often denies or else has numbed the emotional impact of combat. In contrast, the malingerer often makes special efforts to impress evaluators with how emotionally traumatizing the war was for him. Such efforts may include acting out of alleged feelings. Veterans who have genuine PTSD are more likely to downplay symptoms, such as trying not to call attention to hyperalertness or suspicious eye movements. On the other hand, malingerers are more likely to overplay alleged symptoms, and may present them

with a dramatic, attention seeking quality. Similarly, the malingerer is likely to acknowledge dwelling on his alleged war experiences and seems to relish relating combat tales and memories [61].

Veterans who have genuine PTSD acknowledge appropriate instances in which they avoided the associated environmental conditions (criterion C of PTSD). For example, a PTSD combat veteran may stay at home on hot, rainy days because of the resemblance to weather in Vietnam. Camping or boat rides may be avoided because of the resemblance of military terrain or circumstances. Individuals who attempt to malinger combat PTSD are less likely to report having such post-combat reactions to environmental stimuli [61].

PSYCHOLOGIC TESTING

At the present time, there is no method or single instrument that is universally recognized as being the best tool to detect malingering of PTSD [62]. Although there are scores of tests available to assist in the detection of malingering in general, only a few have been validated. The tests that have been shown to be among the most reliable for the general detection of malingering are the Structured Interview of Reported Symptoms (SIRS), the MMPI-2, and the Miller Forensic Assessment of Symptoms Test (M-FAST). The MMPI-2, M-FAST, and Trauma Symptom Inventory (TSI) are the tests that have received the most study for detecting malingered PTSD.

The SIRS was designed to detect malingered psychiatric illness; it takes 30 to 60 minutes to administer [63]. It has been tested in inpatient, forensic, and correctional populations with consistently high accuracy in detecting malingering [64]. The SIRS tests for malingering by using questions about rare symptoms, uncommon symptom pairing, atypical symptoms, and other indices involving excessive symptom reporting.

The MMPI-2 is the test used most frequently for evaluating suspected malingering. To detect malingering, the two traditional MMPI-2 scales that are analyzed are the F-scale and F-K Index. Psychiatrists using the MMPI-2 in this manner should consult the literature to determine the appropriate cut-off scores to be used [65]. Two scales on the MMPI-2, the PK and PS scales, have been investigated for assessing combat-related PTSD [66,67]. Because they tend to measure general maladjustment and emotional distress, however, their ability to distinguish genuine from malingered PTSD is unclear at present. Although the MMPI-2 is the most validated psychometric method for detecting malingering, it is possible that high intelligence and previous knowledge of the test can facilitate evading detection [68].

The M-FAST was developed to provide a brief and reliable screen for malingered mental illness. It takes only 10 to 15 minutes to administer and measures rare symptom combinations, excessive reporting, and atypical symptoms. It has shown good validity and a high correlation with the SIRS and MMPI-2 [69,70].

The TSI is a 100-item test designed to evaluate post-traumatic stress and other psychologic sequelae of traumatic events; it takes approximately 20

Case: 2:10-cv-00342-GCS-MRA Doc #: 97-8 Filed: 08/09/12 Page: 62 of 66 PAGEID #: 1455

minutes to administer. The TSI was normed on a nationally representative sample of more than 800 adults from the general population and more than 3500 Navy recruits. The TSI contains three validity scales (Response Level, Atypical Response, and Inconsistent Response), which assess the subject's tendency to over-report unusual or bizarre symptoms or to respond to items in an inconsistent or random manner. Guriel et al have combined the M-FAST and TSI to assess malingered PTSD [71]. Despite receiving coaching on PTSD symptoms, 90% of malingerers were identified when the M-FAST and TSI were used together. Elhai et al, however, recommend caution when using the TSI, and point out that the Atypical Response scale was not developed as a malingering screen per se, but as a general validity screen [72].

Psychophysiologic Testing

The measurement of physiologic reactivity has been used primarily for research purposes. Investigators in the area, however, foresee a transition from experimental to forensic use that might help "redeem the PTSD diagnosis from its subjectivity" [73]. To date, the two most well studied psychophysiologic methods are script-driven traumatic imagery and sudden loud tones.

The script-driven method involves reading a narrative of the individual's traumatic experience in their own words. The subject is instructed to imagine script events as their physiologic measures are taken (heart rate, skin conductance, muscle tension). The sudden loud tone method measures a subject's physiologic and startle responses to loud, unexpected tones. The psychophysiologic data can demonstrate physiologic reactivity to a stimulus exposure, yet cannot be used alone to prove that an individual's claim of PTSD is genuine. At the present time, current applications of psychophysiologic methods are limited by issues of practicality and variable admissibility in courts. They may be helpful, however, as an ancillary measure of PTSD symptoms in conjunction with a full forensic psychiatric evaluation [74].

CONFRONTING THE SUSPECTED MALINGERER

After a thorough investigation has concluded that malingering is probably present, the psychiatrist may decide to confront the evaluee. The psychiatrist should avoid direct accusations of lying [13]. A more fruitful method is to ask the evaluee for clarification of inconsistencies. One approach is to convey a sympathetic understanding of the temptation to exaggerate symptoms of PTSD; this may present the evaluee with an easier forum to acknowledge malingering. Inducing shame is likely to increase feelings of anger and opposition in the evaluee. Once an evaluee feels accused of malingering and has denied it, subsequent acknowledgment of malingering is unlikely.

Shame and indignation thus should be eschewed, and the suspected malingerer should be given every opportunity to save face. For example, it is preferable to say, "You haven't told me the whole truth" rather than, "You have been lying" [75]. This approach is more likely to be productive and safe for the psychiatrist. Individuals who have a history of violence should be

confronted in the presence of adequate security measures. In at least one federal appellate case, the court determined that malingering was equivalent to obstruction of justice and could result in an enhancement of a defendant's penalty [76]. In certain cases in which a criminal defendant is malingering, the psychiatrist thus may wish to consider the strategic decision about whether to notify the defendant that his malingering may result in an enhancement of his penalty. Of course, such a notification may result in the defendant clinging more fiercely to his malingered symptoms.

SUMMARY

The detection of malingered PTSD is made particularly challenging by the subjective nature of PTSD criteria and requires a thorough, systematic approach. The psychiatrist must gather and analyze evidence from the evaluation, clinical records, psychologic testing, third parties, and other sources. Although some individuals may malinger PTSD to avoid criminal sanctions, the most common motivation for malingering PTSD is financial gain. Clinical nuances may help distinguish genuine from malingered PTSD. The psychiatrist should be aware of the differences observed between civilian and combat-related PTSD. Although special effort is required, the psychiatrist bears considerable responsibility to assist society in differentiating true PTSD from malingering.

Undetected malingering is not limited simply to fraudulent monetary awards, but can involve misuse of limited mental health resources, leading to negative consequences for the mental health system. As Burkett aptly notes, malingered combat PTSD cases "take time, energy, and financial resources away from treating true combat veterans with PTSD. And real combat vets who truly need help end up in group therapy with phonies, get disgusted, and quit treatment" [1].

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