

NEWSLETTER

June 2010



Editorial

Here, once again as in previous years, is the pre-summer newsletter for the organisations and networks that support the principles and recommendations of the Care Full initiative.

In general terms we can say that important steps have been taken in the last twelve months. But there were also some backward steps. The progression seems to mirror a European tradition: the Luxembourg procession of two steps forward, one step back. But all in all, we can say that progress has definitely been made.

To start with the positive developments, some major changes were proposed in December 2009 by the European Commission on the Procedure Directives - see [proposal](#). Most relevant is that at national level necessary conditions have to be created for vulnerable applicants in order to safeguard their access to procedures (20). The proposed new directives then state that (21): '*National measures dealing with identification and documentation of symptoms and signs of torture or other serious acts of physical or mental violence, including acts of sexual violence, in procedures covered by this directive should inter alia be based on the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*'. In Article 4 on Training Programmes, references are made to the relevant topics to be raised and to the expertise of trainers, while in Article 17 on Medico-legal reports proposals are made regarding the timing and the necessary arrangements to be made. In short, the use of the Istanbul Protocol, the fact that medico-legal documents can serve as supportive evidence and the need to give applicants who have been tortured or maltreated more time – all of these are elements that the Care Full initiative has lobbied for and are now to be found in the proposed new Procedure Directives.

Aside from this positive change in policy at EU level, in a number of EU Member States activities and projects are running that involve the requirement that medico-legal reports be drawn up or that require strict adherence to the use of such reports. A number of projects are described in this newsletter. In the Netherlands important changes have also taken place this year. Letters written to the Ministry of Justice and the parliamentary commission plus information passed on to lawyers and medical professionals, in combination with frequent negotiations with asylum authorities (the Immigration and Naturalisation Department - IND) about the means and benefits of making medico-legal reports and the results of the MAPP pilot (see [last year's newsletter](#)) – all of that created a sense of urgency as well as the feeling that viable solutions are possible.

More about the activities in the Netherlands and about what the Medical Examination Group (MOG) of Amnesty International has accomplished in the last ten years can be found in what follows.

Unfortunately there are also backward steps. The rather negative tendency in Europe concerning migrants, in combination with the economic crisis, may cause delay in the progress made thus far. A serious threat to such progress is that, according to our sources, the Spanish Presidency plans to 'soften' article 17 of the Procedure Directives, proposing to change the wording "*should be based on the IP*" in that article into "*maybe based on the IP*". One more reason to continue our work.

With the Belgian Presidency to come, we might, however, be able to counter this backward step. Also because a new initiative, known as Constats, has been set up in Belgium. Information about Constats can be found in this newsletter. Furthermore this newsletter draws attention to the meeting the IRCT had with the World Medical Association and Manfred Novak on the institutionalisation of the Istanbul Protocol. The final pages provide short descriptions of a number of new, relevant publications and some interesting hyperlinks.

Hopefully this Newsletter will encourage NGOs working in the field to engage even more strongly in calling for a systematic acknowledgment of medical aspects as part and parcel of the Procedural Directives. If we can help you out, we will.

[Evert Bloemen](#) and [Erick Vloeberghs](#) (Pharos)
[Angelina van Kampen](#) (Amnesty International)
[Myrthe Wijkoop](#) and [Bernadette Hoekstra](#)
(Dutch Refugee Council)

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Relevant developments within CEAS

[Last year's newsletter](#) set out the importance of the Common European Asylum System (CEAS) in achieving The Care Full Initiative's goals: more attention for medical aspects and the Istanbul protocol during the asylum procedure; adequate identification of vulnerable asylum seekers, and an RSD procedure that takes into account these vulnerabilities, on a national and international level. Agreement on a set of minimum rules within EU Member States may lead to harmonised rules and practice on the use of medical information within the asylum procedures in the future.

Update on Medical aspects and the Common European Asylum System (CEAS)

In December 2009 the European Commission published the recast of the EU Asylum Procedures Directive. These proposals to revise the Directive entail some rather promising improvements of the asylum procedure vis-à-vis vulnerable asylum seekers, thereby strengthening the importance of medical aspects to be taken into account when the asylum claim is being assessed. The proposed Preamble makes explicit reference to the Istanbul Protocol, this being the basis of any national measure dealing with the identification and documentation of symptoms and signs of torture and/or physical or mental violence (21). Furthermore it is stated that on a national level necessary conditions have to be created for vulnerable applicants in order to safeguard their access to procedures. These basic principles are elaborated in several articles of the Directive. Article 4 refers to the need for training and expertise of the decision-making authority in the field of trauma, identification and documentation of medical aspects. And, as a result of hard work and extensive lobby efforts on the part of several organisations – including The Care Full Initiative – a new article 17 has been introduced which deals exclusively with medico-legal reports and the need for national authorities to make arrangements in relation to these reports. Furthermore, medical examinations need to be taken *'into account when establishing whether the applicant's statements are credible and sufficient'* (par. 6). To conclude, the newly proposed article 20 states that asylum seekers with special needs, such as victims of torture or other violence, are provided with sufficient time *'to enable them to submit evidence'* and *'to prepare for a personal interview'*.

All these promising developments are very much welcomed by The Care Full Initiative, not only because of their merits, but also because they illustrate that long-term and intensive lobbying and advocacy efforts may produce a worthwhile result. And in an area such as asylum, where the margins of (political) success are narrow, this should be celebrated as a victory.

However there is still a lack of political will to proceed on this issue. Many member states are reluctant to adhere to these Commission proposals, because of financial aspects, but also out of political fear of becoming too lenient towards asylum seekers and of 'medicalising' the asylum procedure. Negotiations within the Council on the recast proposals, including those on the Reception Directive, are still pending.

The Belgian Presidency is expected to take the issue some steps further, but our work is not yet done.

The Care Full Initiative therefore calls upon all signatories to the Care Full recommendations to urge their national governments to uphold the amendments to the Asylum Procedures and Reception Directive during the Council negotiations and to work towards a harmonised process of early identification of persons with special needs within the asylum procedure, the use of medico-legal reports and the specific training of decision-making authorities, on the basis of the EU Directives.

In this perspective it would also be highly appreciated if you keep us informed about existing practices of medical examinations within identifying procedures used on a national level. Having overview of (good) practices amongst EU Member States would be a valuable and support the ECRE-network in their efforts and lobby-activities towards the European Parliament and Council.

Please send your contribution by mail to: [Myrthe Wijkoop](#) or [Erick Vloeberghs](#)

Medical Advice: a new medical instrument in Dutch asylum procedure

Introduction

In 2007 the Dutch government announced measures to make the asylum procedure faster and more secure. A component of the improved asylum procedure is a Rest and Preparatory Period (RPP) of at least six days. This period creates space for rest and preparation before the asylum procedure starts effectively. Another measure of improvement is to recognise and to take into account medical and psychological problems that could interfere with the asylum interview and determination of the refugee status. The medical advice forms the main point for the first and closer interview in the general asylum procedure. All aliens who submit an asylum application are entitled to a medical examination. The medical advice takes place on a voluntary basis.

This new medical advice is really the result of years of lobbying and creating awareness by several NGOs linked to the Care Full initiative. The MAPP project (see previous Care Full Newsletters) identified through its (psychological) examinations a vulnerable group of asylum seekers with psychological problems. The MAPP reports focus on the relationship between mental health problems and the applicant's inability to make coherent and consistent statements. This led to jurisprudence, giving the final push to make the government ready to introduce this medical examination.

The Dutch government explicitly did not make the identification of medical, supportive evidence part of this new medical examination. Lobbying by the Care Full Initiative and other NGOs failed to change this decision.



Continuation Medical Advice

The motivation is that the medical advice takes place before the start of the actual asylum procedure. At that moment nothing is yet officially known about the asylum seeker's background. The immigration authorities did not want the nurse or physician involved in the medical advice being the first one to talk about the asylum background. For a medical report about the relationship of the asylum background with scars or other after-effects it is essential that the asylum story can be addressed. We can conclude that the new medical advice will not be in line with the Istanbul Protocol for the part of medical evidence and documenting the effects of torture or ill treatment.

Despite this shortcoming Care Full welcomes the medical advice. Further on in this newsletter the medical advice will be described as it will start in July 2010.

Aim

The aim of the medical advice is to determine possible functional impairment and disabilities in asylum seekers, originating from medical and psychological problems and leading to difficulties in recounting their asylum background, as also to gaps, incoherences and inconsistencies. The medical advice is an advice about these impairments for the use of officers of the Immigration and Naturalisation Department before the asylum procedure starts. These officers should consider the content of the medical advice in their interview and their decisions on the asylum request.

Health problems

Research shows that asylum seekers have more medical problems than the native Dutch or other immigrant groups. The medical problems of asylum seekers that lead to impairments as previously mentioned can be of a somatic or psychiatric nature. The majority of the impairments are a result of mental health problems.

The medical problems can include the following:

- Physical: disorders with fever and severe pain, brain disorders etc.
- Mental: post-traumatic stress disorder (PTSD), depressive disorder, sometimes with dissociative and psychotic symptoms. Rarely are psychotic and paranoid disorders seen nor is retardation.

It is not possible to produce a complete list of medical problems that lead to functional impairments.

Impairments

The functional impairments originating from these medical problems can include such things as cognitive functioning, memory function, concentration, distrust, social avoidance, strong emotional reactions and confusion. These impairments can lead to disabilities such as incomplete or absent memory with regard to dates and other details, in such a way that it can lead to incoherent and inconsistent recall. These impairments can have a negative influence on the asylum interview and the decision.

Working method

All asylum seekers are given a medical advice before the asylum interview takes place. Their permission is required for this advice and for passing on the results to the immigration authorities. From efficiency considerations a funnel model is necessary, where the medical advisor (a doctor) has the final responsibility for the advice.

At first a nurse sees all asylum seekers, and does a first initial intake. This intake divides asylum seekers into those with and those without serious medical impairments that can affect the IND's interview and decision. In the case of the group without serious medical problems and without impairments, the nurse prepares the medical advice to be signed by the medical advisor. If the nurse finds medical problems and indications for impairments or when she/he has doubts about this, she/he refers the asylum seeker to the medical advisor for a closer and more detailed examination. For the entire process a protocol will be designed and some additional instruments (checklists) will be developed

Product

The final product is a medical advice in a format in which the medical advisor indicates if there are impairments due to medical problems. If so, the Immigration officer has to take these impairments into account in the interview and decision.

Despite the fact that medical evidence is not part of the medical advice the medical advisor will be asked to mention in the medical advice scars and other physical signs indicated by the asylum seeker. This will not be a forensic evaluation, but merely a mention. The medical advisor will also point to the need for further medical attention from the family doctor.

For questions, contact [Evert Bloemen](#), MD

Institutionalisation of the Istanbul Protocol (Asger Kjærum, IRCT Copenhagen)

Following a six-year period of global capacity development of health and legal professionals on documenting torture in accordance with the Istanbul Protocol, the International Rehabilitation Council for Torture Victims (IRCT) has now turned its attention towards facilitating the Protocol's use in domestic and international legal proceedings.

This objective presents two key tasks. First, the use of the Istanbul Protocol needs to be streamlined throughout relevant government institutions as an official torture documentation tool in the same way as rape kits are used to examine rape victims in many western countries. Second, it needs to be promoted to the different actors in legal processes – mainly lawyers, prosecutors and judges - as a scientifically reliable tool for developing medical expert opinions for courts.

Two of the main obstacles to these efforts are the continuing lack of awareness of the Istanbul Protocol among key actors and the potential complications related to engaging with government institutions in the context of anti-torture activities. As torture is by definition committed by or at the instigation of public officials, the political environment is often not



Continuation of Institutionalisation of the I.P.

not conducive to promoting full transparent and independent investigations and monitoring procedures and governments might be less open to collaborate with civil society actors on this issue. Therefore, the IRCT in collaboration with the World Medical Association (WMA) arranged a side event at the March 2010 session of the Human Rights Council to draw attention to the usefulness of the Istanbul Protocol and to facilitate a discussion on how to engage most effectively with government institutions on these complex issues.

Moderated by UN Special Rapporteur on Torture, Prof. Manfred Nowak, the event was attended by some fifty representatives from governments, NGOs, the academic community, UN agencies and health professional organisations. The panellists included a member of the IRCT Forensic Expert Group, a member of the UN Subcommittee for the Prevention of Torture, a representative of the Association for the Prevention of Torture (APT), and representatives of the Turkish (TMA) and Danish (DMA) medical associations. Collectively the panel brought extensive experience in the area of implementation of anti-torture activities at international and national level. Some panellists drew attention to the need for a careful evaluation of the interest in good-faith engagement by the relevant government institutions and to ensure that institutional adoption of the Istanbul Protocol is not used as an excuse for judicial bodies to exclude or disregard the medical expert opinions delivered by independent doctors. The role of medical associations was highlighted through the example of a recently concluded major training project in Turkey for physicians, judges and prosecutors facilitated by the TMA and the IRCT. Another important aspect highlighted by the panellists was the need to increase the level of education of health workers in this field and to promote a multidisciplinary approach to monitoring and investigating torture allegations.

Concluding the workshop Prof. Nowak emphasised that "Forensic medical science is a crucial tool in proving cases of torture and helping victims in their uphill struggle" and that "routine medical entry- and exit examinations would create a system of "checkpoints" to minimize unaccounted cases of torture and prevent shifting of blame and accountability".

**The IRCT is currently implementing a project aimed at bringing medical evidence of torture to domestic and international courts and tribunal. We welcome receiving suggestions for potential cases with strategic value to the anti torture movement.
With suggestions and questions please contact [Asger Kiærnum](#)*

Announcement of PROTECT, an ERF-project

The Care Full initiative is happy that the PROTECT application was approved by the EU-commission. PROTECT (Process of Recognition and Orientation of Torture victims in European Countries to facilitate Care and Treatment) is a European project involving organisations from France (Parcours d'Exil), Netherlands (Pharos) Germany (BZFO), Hungary (Cordelia) and Bulgaria (ACET).

The project runs from July 1, 2010 to December 2011.

The associate partners are the IRCT, the international network involved in rehabilitation and care of torture victims (Denmark) and Mrs de Bauche, legal researcher and expert on the evaluation of the European reception directive's implementation in member states (the Odysseus-project).

The PROTECT project aims at exchanging practices, through research, in producing a process of early recognition of torture victims or victims of serious forms of psychological, physical or sexual violence and their orientation towards care and treatment. Such a process can be used throughout European countries, regardless of national particularities, in order for member states to comply with European directives on asylum.

The activities will consist in drafting the compulsory elements of an early identification process:

- Analysis of the member state's situation with regard to the implementation of the reception directive and the recognition of torture victims
- Early recognition tools and the recognition process,
- Training booklet on the symptoms and impediments left by torture and/or severe physical, sexual and/or psychological violence and their impact during the Refugee Status Determination
- Documentation on why and how the previous documents were created and asserting their impartiality and value.

The above documents will be translated into seven European languages (English, French, German, Dutch, Hungarian, Bulgarian & Spanish).

The impact of the PROTECT project in the medium and long term will include:

- The provision of guidelines and a working model on the identification of victims of torture enabling asylum authorities to recognise those applicants at an early stage within the Refugee Status Determination (RSD)
- Better working conditions for asylum officers, encouraging them to treat each case fairly and thus avoiding burn-out of professionals
- And, ultimately, better and more equal treatment of torture victims and unaccompanied minors, as they will benefit from a fairer examination of their asylum request, taking into consideration the particularities of their sequelae and as such, answering their specific needs.

CONSTATS, a Belgian counterpart

In the summer of 2009 the Belgian association CONSTATS was set up. The association consists of French speaking NGOs in and around Brussels, such as CIRE, Ulysse, and Exil. The purpose of the association is to defend and promote the implementation of the Istanbul Protocol in connection with the asylum procedure in Belgium.



Continuation of CONSTATS

The CONSTATS association is open to candidate refugees or asylum seekers who seek protection in Belgium and who have been victims of torture or other inhuman and degrading treatment in their country of origin. It aims to achieve, at the request of legal, social, medical and psychological stakeholders or the victim her/himself, a medical and/or psychological in-depth examination and provide the victim, if necessary, with a detailed report.

Currently, a small group of health professionals perform these examinations. Examinations are performed in compliance with the recommendations of the Istanbul Protocol on how to assess and record the medical evidence of torture.

CONSTATS also provides information and plans to take public initiatives. Contact is possible through the [website](#).

The role of medical evidence in the Dutch asylum procedure (Mark Stolwijk, Amnesty International, section Netherlands)

A recent study shows that in 75% of cases in which a medico-legal report by the Medical Examination Group (MEG) of Amnesty International is submitted, the asylum application is eventually granted. Thus medical evidence appears to be relevant for individual officers of the Dutch Immigration Service (IND).

For years in Dutch asylum policy, medical evidence has not been taken into account when assessing asylum claims. According to the current legal text: 'In principal, medical aspects do not have any role in the assessment of an asylum application, since, from a medical point of view, (most often) no certain statements can be made about the cause of the medical problems and/or scarring.' The law is ambiguous though, as it also says 'the decision-making authorities solely assess whether medical aspects are in line with the asylum claim'. Medical evidence is not conducted on the instruction of the authorities, nor on the instruction of the court. Voluntary groups including the MEG have filled this gap.

The MEG was founded in 1977 and currently consists of approximately 30 physicians and psychiatrists who voluntarily perform medical examinations of asylum seekers. MEG reports address the issue of whether the medical findings are consistent with the alleged torture or traumatic events. MEG reports are usually submitted after an initial rejection of the asylum request by the IND, or during the appeal phase. Almost half of the MEG reports are submitted with a repeated (second or more) asylum application, after all legal remedies in the first asylum procedure have been exhausted.

The Dutch section of Amnesty International has recently conducted a study on how MEG reports are assessed by the Dutch immigration authorities and courts and, in particular, the extent to which the MEG report has contributed to the credibility of the asylum application.

The study addressed 164 MEG reports issued in the period 2004-2008. In 129 cases, it was possible to assess the outcome of the asylum procedure. In 5 cases the outcome of the procedure was unknown and 31 cases were still pending at the time of conducting the study. In approximately 75% of the cases in which a MEG report was submitted, the asylum application was eventually approved.

Surprisingly enough, the stage of the procedure during which the MEG report is submitted does not appear to have a significant influence on the outcome of the procedure. Almost half the MEG reports are submitted with a repeated asylum application and their impact on the outcome of the asylum procedure appears to be the same as MEG reports submitted at an earlier stage.

We tried to assess to what extent the MEG report has effectively contributed to the granting of the application. For this purpose, we analysed 'minutes' (internal motivation of the decisions by the IND), court verdicts, and other documents produced during the course of the asylum procedures. This allowed us to obtain some insight into the arguments used by the IND and into the way MEG reports are considered in relation to other arguments to assess the credibility of the asylum application.

It is fair to conclude that in most of the cases the medical evidence provided by the MEG report contributed to the credibility of the case. Thus it appears that for individual IND officers the role of medical evidence in assessing asylum applications is more relevant than actually prescribed by the text of Dutch asylum law.

Although individual IND officers often take medical evidence into consideration, MEG reports are often dealt with in an arbitrary fashion. For example, in most cases where a MEG report is submitted with a repeated asylum application the MEG report is considered as a 'novum' (a new fact that could not be submitted during the first asylum procedure). However, in some cases the MEG report is not considered as a novum. Amnesty thinks that a MEG report should always be considered as a novum, certainly as long as the Dutch authorities do not authorise medical examinations themselves.

The study also shows that IND officers regularly have difficulties in properly interpreting the MEG report. This may mean that particular elements of the MEG report are quoted, but the overall general conclusions of the report are neglected. When the MEG is able to react to such misreadings of the report, the asylum application is mostly eventually granted.

A full version of the study (in Dutch) can be obtained through [Marc Stolwijk](#).



After the MAPP pilot now the ZAPP Project

The subject “Medical aspects in the asylum process” currently has more attention in the Netherlands and Europe than before. The result of the concluded MAPP pilot (see [last year's newsletter](#)) shows that this attention is justified. Over the past three years, more than 800 asylum seekers suffering from psychiatric problems were registered by MAPP. Psychologists and psychiatrists working for MAPP examined over 300 of these applicants. Among 72% of the investigated asylum seekers such serious symptoms and distress were found that further medical research and short-term treatment was indicated.

Lawyers and staff of the Dutch Refugee Council indicate that a large proportion of the asylum seekers under investigation do not receive care or that treatment has not yet started. There are several reasons why support for this vulnerable group is insufficient. Sometimes applicants with mental health problems do not ask for help because of feelings of shame. Often they are not familiar with the possibilities of assistance and treatment in the Netherlands. Applicants also irregularly move from one asylum seeker centre to another causing delays in care giving. Also mentally ill asylum seekers often disappear from sight. In addition, some (mental health) institutions in the Netherlands question the care given to (traumatised) people who do not as yet have residence status.

All these signals led to the formation of the ZAPP project. An innovative aspect of this project is the attempt to give voice to all actors involved in the care process. Asylum seekers with mental health problems and other stakeholders are actively involved in research and in the project. Asylum seekers who were examined by a psychologist or psychiatrist at MAPP are interviewed about their experiences with health care in the Netherlands.

Purpose and design

The aim of the ZAPP project is to improve the accessibility and continuity of professional care for asylum seekers with psychological problems. Therefore the ZAPP project will:

1. Identify bottlenecks in the flow and accessibility of health care for asylum seekers with psychological problems.
2. Together with stakeholders, improve the access to health care for asylum seekers with mental health difficulties.
3. Subsequently launch a pilot

The ZAPP project entails a number of activities. During the first phase a mixed method study is performed, examining the existing barriers as well as identifying the conditions needed to improve access to health care for this group. Another researcher will look into and provide a state-of-the-art review on the situation in the EU.

The final report of the research project is intended to contribute to the direct dialogue between asylum seekers, policy-makers and practitioners. During a conference in which the results are presented, this dialogue will continue with other actors involved: health care professionals, GPs, mental health institutions, policy-makers, researchers, etc. Based on the research results and recommendations a pilot will be implemented to increase and promote the access of asylum seekers with mental health problems.

Care Full related interesting publications

1. ***La prise en considération de la santé mentale dans la procédure d'asile*** (Considering mental health in the asylum procedure)– (2009: **Alain Vanoeteren and Lys Gehrels**). Ulysse. In: Revue du droit des étrangers N°155, ADDE, Brussels)

Recent European history has seen ‘right of asylum’ become intertwined with ‘migration control’, one consequence being the heightened psychological distress that this frequently causes for vulnerable people. In line with the notion – or the myth – that the majority of asylum seekers are ‘bogus’, and that they unduly invoke the Geneva Convention in order to be granted the right to remain, European States have put into place asylum evaluation procedures whose efficiency and effects can be called into question.

Centred primarily on the credibility of autobiographical accounts, these assessment methods discriminate against people with fragile mental health, whilst also causing stress and the potential re-emergence of psychopathological symptoms. The mental health service Ulysse has just published a study on this subject in the light of the particular case of Belgium. This study highlights the fact that autobiographical accounts are one of the most unreliable means of assessing the veracity of asylum claims, as demonstrated by social and experimental psychology research. Even under normal circumstances, human memory is a process of subjective reconstruction rather than a gateway to objective truth. Its usefulness in this regard is further diminished in times of stress, in unknown contexts and with people of different cultural backgrounds. Psychopathological disorders, especially those directly resulting from war, organised violence or torture, have a considerable impact on recall ability. They affect the capacity to concentrate and to produce an organised and coherent account; they generate confusion and forgetfulness. Yet this ability to produce an organised and coherent account is precisely what is expected of asylum seekers in order to assess their credibility. Fear, shame, distrust and misunderstandings in communication are further contextual, non-pathological, obstacles to the recounting of intimate details in an unsettling relational environment, with a State representative whose expectations and underlying intentions are unknown.

In addition, this study examines the criteria used in the decision-making process, the conclusion being that immigration officials are all too often guided by subjective value judgments, resting on stereotypes and preconceptions that are far from objective. The entire assessment procedure is in itself potentially pathological, requiring the person subjected to it to relive traumatic events under circumstances that may, to a certain degree, bring to mind what was endured under interrogation or torture in the country of origin.



Continuation of *La prise en considération*

This study ends with a number of case studies, extracts from asylum claim decisions, psychological reports and direct testimonies, highlighting situations in which the Belgian asylum procedure either fails to take mental health issues sufficiently into account or adversely affects the claimant's psychological well-being.

More info can be obtained through [Alain Vanoeteren](#)

2. Justice Denied: The experiences of 100 torture surviving women of seeking justice and rehabilitation (2009: Smith, E. & Boyles, J.).

Medical Foundation. [Download](#)

In 2008 the Medical Foundation conducted a review, looking into the case studies of 100 women from twenty-four countries seeking asylum in the UK. According to the medical dossiers 80 women were raped in their Country of Origin (CO). Frequently the women were beaten up, gang raped or severely burned, sometimes implements were used such as gun barrels or bottles. Even girls as young as 9 years were raped. Albeit the women had physical scars and got affected with aids or other STD, the torture was often not reported since: 'in the overwhelming majority of cases... the police or other law enforcement personnel (in CO E.V.) were directly responsible for the harm suffered' (p. 3). Four women got additional beatings when they reported the abuse to the police. Stigmatization of survivors of rape often added to their reluctance to report the origin of the injuries when seeking medical assistance in their country.

The report is interesting since it looks not only into the mental and physical impact of their sufferings but also at its consequent effects on reporting and providing evidential support. Many cases are presented showing the barriers to seeking redress and facing justice. The taboo among many cultures on talking about sex often result in not disclosing the abuse. Family members may discourage the raped women from reporting, thus safeguarding the reputation and honour of the family. Even reporting the rape within the family may lead to violent repercussions or honour crimes. Also many women may feel somehow responsible and guilty for what happened. At the end most of them feel too ashamed or humiliated to even report about these atrocities to their lawyers in the UK when applying for a refugee status. Consequently 'the rapes are not included in her application' (p.9).

The authors further focus on the impact rape and other sexual violence has on the memory of what happened. Clients of the Medical Foundation sometimes need years before they 'find words'. Next to these women having difficulties verbalizing the horrific events, the blurred memory, exhaustion and the emotional numbing all influence the testimony in relation to the refugee status determination as well as the perception of credibility of their story. All in all these women are 'doubly disadvantaged' (p.13).

The authors urge for major changes in the legal framework in order to bring the perpetrators to court and give restitution and compensation to the victims.

They conclude by presenting a 'reparative model' that gives way to the above restorative actions, the improvement of the access to health facilities and vocational trainings to the battered women to enhance their independence.

The women themselves should, according to the 'reparative model', be engaged as decision-maker during the whole process

3. Come provarlo? La scienza indaga sui diritti umani (How to prove it? Science investigates human rights [abuses]) -(2010: **Giovanni Sabato**), Laterza, Roma-Bari. With a foreword by Marcello Flores

In this book Sabato examines how scientists of different specialties (such as genetics, statistics, forensic anthropology, medicine, psychology, geography) help in proving the truth on abuses "in such a way that it cannot be denied", as Patrick Ball said, or at least in the most convincing possible way. The author provides a series of stories and for each case the history of the abuses and the investigations, the strengths and limits of scientific investigations are considered, and their impact in court, in the public arena and on the lives of victims, their relatives and communities. The style is journalistic without too many technicalities, and the book is aimed at readers without specific scientific education.

Content of chapters

- 1) The stolen children. How genetics helped (and helps) the Grandmothers of Plaza de Mayo in Argentina to find their grandchildren.
- 2) The Tripoli six. The case of the Bulgarian nurses in Libya, where advocacy for scientists' rights and scientific truth-finding join each other
- 3) History written by bones. Mass grave exhumations and their (sometimes conflicting) roles for families, for trials and for historical memory.
- 4) Extracting the truth hidden in numbers. How statistics helps to build historical memory and support criminal trials on periods of massive abuses. The studies on the civil war in Guatemala and those on the International Tribunal for the former Yugoslavia.
- 5) The unexpected faces of torture. How physicians and psychologists contributed to the movement against torture. The psychology of torturers and the purposes of torture: not so much to (ineffectively) extract information, as to destroy psychologically the victims and their communities. The implications in finding the truth about the alleged victims: from emphasis on physical signs to the discovery and documentation of its complex and very personal psychological consequences. The Istanbul Protocol; the strength and limits of the truth ascertained. The legal and medical purposes of documentation, with a special reference to the examination of asylum seekers and refugees.

CARE FULL

Medico-legal reports and the Istanbul Protocol
in asylum procedures

Continuation of *Como Provarlo?*

Finally, the urge to review the concept of responsibility of abuses in light of social psychology findings that show how easily social pressures can transform a «normal» person in a «monster».

6) Sentries from the sky. The uses of satellite imagery to document prison camps, massacres and mass demolitions in remote areas such as Darfur, Burma, North Korea or Zimbabwe.

7) Perspectives. Some brief considerations on future areas of work, and on the possibility of science not only to prove abuses but also to modify the concepts in HR debate.

Order via the author ([Giovanni Sabato](#)) or through: <http://www.ibs.it/code/9788842092674/sabato-giovanni/come-provarlo-scienza.html> (In Italian only)

Whom to address

If you have questions or want to share information about the situation in your country, contact:

Pharos: [Erick Vloeberghs](#) or [Evert Bloemen](#)
Amnesty International / Dutch section: [Angelina van Kampen](#)
Dutch Refugee Council: [Myrthe Wijnkoop](#) or [Bernadette Hoekstra](#)

Kind regards from the CareFull team

Where to download

Those organizations and individuals that want to know more about the targets and activities of the Care Full Initiative, please go to [The Care Full webpages](#) and surf to the next pages 2,3 and 4. The Istanbul Protocol (IP) can be downloaded on page 1. If you want to read (and preferably!) subscribe to the Carefull Principles & Recommendations ([see P&R](#)) please contact [Erick Vloeberghs](#)

4. Hyperlink. ECHR about medical evidence

In a recent judgement of the European Court on Human Rights (ECHR), *R.C. versus Sweden* (9-3-2010), medical evidence plays an important role. The applicant declared that he joined demonstrations in Iran, and was arrested and tortured. The ECHR judges this statement as coherent, despite some inconsistencies in his story. The medical certificate that the applicant has submitted certifies a strong indication of the existence of severe fear in the applicant.

The ECHR describes it as follows in paragraph 53: *“Firstly, the Court notes that the applicant initially produced a medical certificate before the Migration Board as evidence of his having been tortured (see paragraph 11). Although the certificate was not written by an expert specialising in the assessment of torture injuries, the Court considers that it, nevertheless, gave a rather strong indication to the authorities that the applicant’s scars and injuries may have been caused by ill-treatment or torture. In such circumstances, it was for the Migration Board to dispel any doubts that might have persisted as to the cause of such scarring (see the last sentence of paragraph 50). In the Court’s view, the Migration Board ought to have directed that an expert opinion be obtained as to the probable cause of the applicant’s scars in circumstances where he had made out a prima facie case as to their origin. It did not do so and neither did the appellate courts. While the burden of proof, in principle, rests on the applicant, the Court disagrees with the Government’s view that it was incumbent upon him to produce such expert opinion. In cases such as the present one, the State has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant’s injuries may have been caused by torture. The Court notes that the forensic medical report submitted at its request has documented numerous scars on the applicant’s body. Although some of them may have been caused by means other than by torture, the Court accepts the report’s general conclusion that the injuries, to a large extent, are consistent with having been inflicted on the applicant by other persons and in the manner in which he described, thereby strongly indicating that he has been a victim of torture. The medical evidence thus corroborates the applicant’s story.”*

The ECHR holds that the applicant deportation to Iran would be in violation with article 3 of the convention.

See the [complete text](#)