Justice Denied:

The experiences of 100 torture surviving women of seeking justice and rehabilitation

MEDICAL FOUNDATION
for the care of victims of torture

www.torturecare.org.uk

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Cover: Rehemi, 18, who is awaiting an operation for the internal injuries she suffered when she was gang-raped by a group of seven rebels in the Democratic Republic of Congo.
Photographer Robert Hammond, Panos Pictures

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EXECUTIVE SUMMARY

"Whether perpetrated in conflict or in peace, the root causes of violence against women [are] deep-seated inequalities and discrimination"[1]

The case histories of 100 women survivors of torture from 24 countries who sought asylum in the United Kingdom were reviewed in order to assess their experiences of torture and ill treatment and of accessing justice and rehabilitative help and support in their countries of origin. These women first sought the services of the Medical Foundation for the Care of Victims of Torture throughout a six month period in 2008.

The stark reality for these women is that of sexual torture – 80 of the 100 women were raped - some were raped with an implement, including gun barrels, sticks and bottles. Many were raped and sexually assaulted numerous times, frequently involving multiple perpetrators. In addition to the 80 women who were raped, another six reported violent sexual assault. Most of these women also reported a high incidence of beating, including beating with a weapon, cutting, stabbing and burning.

Age was no barrier, as girls as young as six and women in their 60s were tortured. One woman was first raped when she was as young as nine, and 12 women in total were first raped when they were 16 years old or less. Seventeen women were impregnated as a result of rape, while a further seven lost pregnancies due to rape.

Women in the study exhibited high levels of depression, sleeplessness, nightmares and flashbacks requiring ongoing treatment, counselling and support. Thirty-eight had scars, typically on their faces, breasts and genital areas. Twelve had fistula or other forms of damage to their reproductive organs compatible with having been raped with a sharp implement,[I] while seven women who had undergone testing had contracted sexually transmitted diseases, including three who tested HIV+.

No perpetrators were successfully prosecuted in any of these cases. In the overwhelming majority of cases, torture was not reported because the police or other law enforcement personnel were directly responsible for the harm suffered. Women also blamed police ineffectiveness, indifference and bias for either their failure to report violence or the consequent lack of any procedural investigation where a report was made. In a number of cases, torture was not reported because there was no one to report to or no discernible State structure, while in several other cases, women did not report torture where violations were being perpetrated on a mass scale affecting a wide geographical area. Finally, a number of women in the study were unable to report torture in their countries of origin because they fled to seek safety – either to refugee camps or across borders.

Resort to healthcare in the immediate aftermath of torture was surprisingly low given the brutality of the violence inflicted. Treatment was often sought informally or in secret to avoid public or community knowledge of sexual violation. Where women formally sought professional care from medical staff, it was often for the treatment of physical injuries, including for broken bones and to get stitches for wounds. Many women seeking medical assistance failed to report rape, and none reported that they accessed specific care for sexual violence. One client was referred for psychiatric support following her abuse, compared with two others who were forcibly detained in psychiatric facilities as a result of filing a complaint.

A review of information relating to access to justice in the countries of origin of women in the study and more broadly indicates that many State investigative, judicial and rehabilitative services are often inadequately and ineffectively run and poorly resourced. Where services do exist, there are continuing problems of accessibility that are compounded by gender inequalities, which result in a lack of prioritisation of resources and services.

The inability of women to report abuse either to security personnel or clinical staff is exacerbated by difficulties of disclosure stemming from the social stigmatisation of survivors of rape and sexual violence. This, combined with the difficulties generated by an individual's response to trauma, the impact of fragmented recall, emotional numbing and late disclosure, are powerful factors that militate against women accessing justice. It also means there is ongoing impunity for perpetrators of torture.

Pre-existing gender inequalities and systemic violence against women in many communities contributes to women's vulnerability, whilst at the same time restricting practical avenues of redress and rehabilitation. In the case of the women in the study sample, the lack of therapeutic and rehabilitative care may lead to long-term mental health difficulties.

Reparations under international law aim to put the victim back in to the position they were in prior to the abuse. In the case of women survivors of torture, however, this approach is often inadequate and untenable: it fails to address the underlying and pervasive gender inequalities which render women vulnerable to violence and torture in the first place and severely limit, if not wholly negate, their ability to seek out any form of reparations. A more robust and gender-sensitive approach to reparations, which situates the individual within the context of their community and which tackles legislative, cultural and societal inequalities is essential.

Without such an approach, women survivors of torture will fail to achieve justice, and perpetrators will continue to enjoy impunity for torture.

I Fistula can also be caused by rape with extreme violence: UNFPA report the incidence of fistula amongst thousands of women in eastern Congo, caused by "systematic, violent gang rape", Campaign to end Fistula, UNFPA website. Fistula can also be caused by FGM or obstructed labour.

INTRODUCTION

This report considers whether systems of reparation are adequate and appropriate for women torture survivors. The torture experiences of women survivors living in exile are examined and situated in the broader context of societies where violence against women is rife and access to justice limited. The report then looks at barriers that limit women from seeking some form of legal redress in their countries of origin, including the adequacy of the investigative and judicial processes generally and barriers which are specific to women.

The additional barriers imposed by the fact of torture on the ability of women to seek some form of legal redress in their own countries, is considered with particular attention to the mental and physical health impact of torture and its consequent effect on reporting and evidence. A similar approach is then followed in relation to accessing therapeutic care and support. The report concludes with a consideration of how the right to reparation might be made more realisable.

Women suffer disproportionately from gender-specific torture, sexual violence and abuse,[II] including rape, deliberate infection with HIV, enforced impregnation, sexual slavery, disfigurement, mutilation of sexual organs and enforced nakedness or sexual humiliation during questioning or detention. Such harm arises both during conflict and in times of peace.

The trauma experienced by survivors may be compounded where there is a lack of measures aimed at providing full and meaningful reparation,[III][2] and the UN Committee against Torture has described sexual violence as a continuing violation in circumstances where avenues of justice are absent.[3] By contrast, redress has a positive therapeutic benefit in the cases of many survivors of torture.[4]

Accountability is a key component in torture prevention. International law requires States to provide justice, reparation and rehabilitation for acts of torture for which they are responsible. In many countries, however, rape stigmatises the victim rather than the perpetrator. Impunity leads to contempt for the law, recurring cycles of violence and injustice for the victims. Conversely, criminal investigation, prosecution and punishment of such acts underlines those social assumptions which disadvantage victims, and at the same time give a clear indication that past or future acts will not be tolerated, helping in the prevention of subsequent abuse. Prosecutions also send a clear message to society that violence against women, perpetrated predominantly but not exclusively by men, is unacceptable. This in turn can both generate a shift in public opinion and precepts, and restore the reputations and dignity of victims in the eyes of their communities.

The effective pursuit of justice is essential for both the prevention of future acts of torture and the recovery of the individual survivor.

This report is based on an examination of information provided by 100 women clients of the Medical Foundation during a six month period in 2008 for whom the MF provided therapeutic services, a medico-legal report or, in some cases, both.[5]

Countries of origin of women in the study sample	Number of women
Sri Lanka	16
Democratic Republic of Congo	15
Zimbabwe	12
Cameroon	8
Somalia	7
Uganda	7
Africa other	7
Turkey	6
Nigeria	5
Eritrea	4
Pakistan	3
Europe other	3
Iran	2
Ivory Coast	2
Kenya	2
Other	1
Total	100

The impetus for this report was the lack of access to justice experienced by women clients of the Medical Foundation in their countries of origin. Data obtained in the study has been supplemented by corroborative information from all 24 countries of origin of women in the study.[IV] However, the issues and concerns raised in this study are not peculiar to the countries of origin of the women in the study sample. This report reflects the expertise and experience of the Medical Foundation of working with women torture survivors for over 20 years.

It is understood that both clinical and non-clinical rehabilitation form an integral aspect of any "full" legal remedy and that the pursuit of justice and therapeutic rehabilitation are inextricably linked in practice. There is a clear therapeutic benefit of justice.

II For the purpose of this report, "torture" refers to the definition contained in Article 1 of the UN Convention against Torture (1984). The terms "violence" and "abuse" refer to the infliction of physical or mental pain and suffering" and are used interchangeably in this report. The terms "sexual violence" and "sexual abuse" refer to the infliction of physical or mental pain and suffering which has a sexual nature or sexual connotation, and are used interchangeably. "Gender-specific torture", gender-specific violence" and "gender-specific abuse" refer to acts perpetrated because of the survivor's gender, and include, but are not limited to, acts which are sexual in nature, as well as acts intended to disfigure.

III The term "reparations", together with its component elements of "rehabilitation", "compensation", "restitution", "satisfaction" and "guarantees of non-repetition", is described later in the report.

IV Corroborative country information consulted consisted of specific country reports from State or governmental departments, human rights NGOs and international bodies, as well as thematic reports, books, learned articles and media articles.

TORTURE IN THE CONTEXT OF VIOLENCE AGAINST WOMEN

"It has probably become more dangerous to be a woman than a soldier in an armed conflict".[6] In 2009, Oxfam estimated that more than 1,000 women are raped every day in the DRC.[7]

Violence against women has been reported in every international and non-international conflict zone, either during the conflict itself or in its aftermath.[8] Sexual violence during conflict has been inflicted on a widespread and systematic scale, reaching shocking levels of brutality. John Holmes, UN Undersecretary-General for Humanitarian Affairs and Emergency Relief Coordinator, recounted evidence of sexual violence in the Democratic Republic of Congo (DRC) "so brutal it staggers the imagination", [9] while the former UN High Commissioner for Human Rights, Louise Arbour, noted that "violence, including sexual violence, has been committed and continues to be perpetrated in the midst of conflict and in post-conflict societies on a magnitude and level of brutality that defies belief".[10]

The targeting of women and girls is frequently employed as a deliberate tactic of war, where torture and abuse is intended to "humiliate, dominate, instil fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group".[11] Cycles of impunity in the aftermath of a conflict permit the continued perpetration of sexual violence, with the result that an end to hostilities seldom means safety for civilian women. In addition, displaced women and girls living in refugee camps experience rape, beatings and abductions when they leave the camps for necessities[12] or within the confines of the camp itself.[13]

The problem of violence against women and girls reaches far beyond conflict and post-conflict situations, however, and is described as being of "pandemic proportions".[14] According to Amnesty International, "the experience or threat of violence affects the lives of women everywhere, cutting across boundaries of wealth, race and culture. In the home and in the community, in times of war and peace, women are beaten, raped, mutilated, and killed with impunity".

The findings of this study are stark and indicate a very high level of sexual violence overall: 80 of the 100 women in the study sample were raped.

Of the 20 who were not raped, six were sexually assaulted. Over two thirds of the 80 women were raped by multiple perpetrators,[V] and more than half were raped on more than one occasion.[VI] Over a third[VII] were unable to recall the precise number of rape episodes. Thirty-three of the 80 women were also raped anally, and many were anally raped by multiple perpetrators, on more than one occasion. Twenty of the 80 women were also raped orally. All but two of these cases involved multiple perpetrators, numerous episodes, or both.

Six of the women in the study were raped with implements, including truncheons, bottles and rifles. In one case a woman was raped by four men before a fifth raped her with his rifle, while in another, guards forced a bottle into a woman's anus. She was subsequently forced to balance on the bottle, and was threatened with rape if she fell off.

Women experienced numerous forms of sexual assault and humiliation. In many cases, rapes were committed in front of family members, including children, or in public, community settings. In four cases, perpetrators cut or bit a woman's breasts, while in a further four cases women's breasts were burned. In one case, a woman's breasts were bound with wire and electrical shocks administered, while in another, shocks were applied through electrodes attached to her nipples. In a number of cases, perpetrators ejaculated and/or urinated on women.

Women in the study sample experienced high levels of beatings, including with implements. Fifteen of the women were cut or stabbed, with knives, razor blades, machetes, broken glass, a belt buckle and sharpened pieces of wood. Nearly a third of the women (33) were burned with cigarettes, boiling water, caustic liquid, metal rods or heated knives.

Fifty-five women said they were targeted because of their own political activity, religion, ethnicity, sexuality or cultural identity, and a further five were subjected to abuse within the domestic sphere. Thirty-two of the women believed they were tortured because of the activities of their family or partner. This resonates with other findings of the Medical Foundation as it has worked with a number of survivors whose rape was either photographed or filmed, to be shown to husbands held in detention. The targeting of eight other women in the study appears random.

SURVIVOR PROFILE

Sixteen percent of women were first tortured when they were 16 years old or under. One girl was tortured at age six and a woman at age 62. Thirteen percent of the women were first raped when they were 16 years or younger, with the youngest first rape occurring at just nine years old, and the oldest at 50. Exactly half of the women were raped for the first time between the ages of 19 and 30, with first experiences of both rape and of torture more generally peaking in women in their mid-twenties.

Eight percent of women in the study sample had received no formal education, while a further 13% had been educated only to primary level. Forty-five percent had received secondary level education and 34% beyond secondary level.

Twenty-eight percent of the women were unemployed, worked within the domestic environment or in domestic agriculture, while a further 10% helped relatives (usually their parents) in family businesses. As a result, for these women exposure to, and participation in public life through their occupations was limited or non-existent. Seven percent of the women were formally employed

V 67.5%

VI 53.75%

VII 36.25%

in menial or low-skilled work – as cleaners, in factories or in hotel catering. Thirty-two percent were formally employed in trades or in skilled labour, while a further 16% were professionals, including one client who was a civil servant, one a teacher, and another who was the manager of a bank.

Other occupations identified by women in the study sample included working as a waitress, as a beautician, seamstress, or hairdresser, or in childcare, secretarial or administrative work. Where women were involved in trade, this was typically of fabrics or domestically-grown produce. Full engagement at the formal, public level, on an equitable footing with men was largely absent.

Thirty-nine percent of women were married. Seven percent were divorced and a further 9% were widowed. Two percent of the women indicated they had partners, while 43% identified themselves as single. Fifty-nine percent of the women had children and some of these children had died due to shooting and beating, as well as starvation, dehydration and disease.

All of these women fled to the United Kingdom to seek protection having been tortured in locations including their homes, in detention, in police custody, in the bush and in one case, in a graveyard. In most instances those who perpetrated the torture and ill treatment were known and included the police, military personnel, prison guards, and members of other political and ethnic groups. Women reported other violence at the hands of private actors, including husbands and other family members, traffickers and even members of the public/fellow students.

BARRIERS TO SEEKING REDRESS[15]

Many women in the study sample did not seek redress because those perpetrators of torture were the very ones who they would have had to rely on in accessing justice - the police. Women also did not seek redress because of their lack of faith in the quality and impartiality of the investigative and judicial systems, a simple absence of anyone to report to, fear for the safety of family members or because they fled to seek safety.

Where women in the study sample reported torture to the authorities, there was a lack of action in the vast majority of cases. There was no single successful prosecution of a perpetrator.

Of the 80 cases of women we had information about, 16 reported incidences of violence to the police or to other law-enforcement bodies. All but one experienced sexual violence as part of their abuse and eleven had been raped. The remaining 4 experienced violent sexual assault, including an attempted rape during which the perpetrator, a chief of police, only stopped when he realised the woman concerned was menstruating.[16]

Two of the eleven rape survivors failed to initially disclose the sexual violence they experienced, reporting only the non-sexual aspects of their abuse, while another reported a third act of rape, but not two previous offences. In 12 cases, no action was taken by police and women in the study describe law enforcement personnel refusing or otherwise failing to take their complaints seriously. In two of those cases, women ascribe ethnic bias of the police as the principal reason for the lack of activity, while a further two women, who had experienced violence as a result of their sexuality, attributed police inaction to homophobic discrimination.

In four of the 12 cases, women experienced further violence and/or detention at the hands of the police when they reported the abuse.

D is from Eastern Europe. In 2006 she was detained and questioned by national security personnel about the political activities of her father, and held in a small cell measuring approximately 2 metres square with a concrete floor and with just a bucket for a toilet. During her detention she was raped on four separate occasions, beaten and burned with cigarettes. On her release she reported the abuse to security officials. They told her she had imagined it, and had her transferred to a psychiatric hospital, where she was forcibly medicated and was sent to work in a local factory. Whilst there, she was raped by the factory manager.

In the remaining two cases, arrests were made, and in one of those cases, an action proceeded to court. In that case, police initially refused to act on the allegation, and only pursued it when the survivor's family challenged their inactivity and filed a formal complaint with the local chief of police. The case collapsed, however, when violent threats to the survivor and her family forced her to change her account of events. The perpetrator walked free, and within a month of his acquittal threw acid in the survivor's face while she was out on the street.

Of the 64 women in the study sample who did not report their abuse to the authorities, 37 provided some indication as to why this was. In the overwhelming majority of cases (34), women indicated that police or other law enforcement agents had been the perpetrators, rendering reporting both futile and potentially dangerous. Additional reasons given for not reporting abuse included a lack of faith in the adequacy and impartiality of the investigative and judicial system, and an inability to trust uniformed officials where perpetrators had been uniformed personnel. In a number of instances, women did not report abuse due to a perceived ethnic bias within the police, or where they feared that going to the police would jeopardise the security of family members.

M is from Uganda. She had been lobbying police to investigate the politically-motivated disappearance and subsequent murder of her father, and seeking to highlight the lack of police activity in the case. During 2006 and early 2007 she was detained and tortured as a result of her activities on a number of occasions. Her aunt also disappeared and her daughter was violently beaten. M was released from detention and advised that the violence against her and her family would stop if she ceased to speak out about her father's disappearance and murder.

Some women did not report abuse because of a simple absence of anyone to report the offence(s) to or, in the case of Somalia, of any discernible State structure. A number of clients, including those from Zimbabwe, Somalia and the Democratic Republic of Congo, indicated that they did not report individual acts of violence in circumstances where abuses and atrocities were being perpetrated on a large scale and over a wide geographical area. Torture is so endemic that it was pointless to report it.

Finally, several women in the study sample fled violence to seek relative safety in refugee camps or across borders, or were trafficked out of the country against their will, and so did not have an opportunity to make a complaint.

ACCESS TO JUSTICE ILLUSORY

As evidenced by the experiences of women in this study, there is no real prospect of access to justice because of the conflict, post-conflict or dysfunctional societies that they live in. In societies seeking to build even the most basic of systems for the administration of justice, there is insufficient attention paid to the particular needs of women.

Clients came from countries experiencing a range of conflict or post-conflict difficulties or repressive State actions, all of which impact upon the quality of justice meted out and accountability for human rights violations. In post-conflict societies, police forces are typically going through a period of transition and reinvention, while in the case of failed States, there is simply an absence of any properly functioning security institutions.

Police forces may be inadequately serviced in terms of appropriate, trained recruits and material resources. Low and/or inconsistent pay renders other forces highly susceptible to widespread corruption and bribery, while external influence and political or ethnic bias similarly affects the standard and objectivity of investigations and policing.

H, a woman from Somalia, hasn't seen her family since the war broke out, when she was nine years old. Her family home was taken over by militia forces, and she was held there as a slave. She was raped and beaten repeatedly over a period of three years, between the ages of 12 and 15. She was unable to report the crimes committed against her because there was no individual or authority for her to report them to.

Similar problems affect judicial mechanisms in many of the countries of origin of women in the study sample. Institutions may be newly-forming or alternatively lacking in adequately trained personnel or legal resources, while fragmented countries, or those experiencing ongoing conflict, operate separate courts in their various regions which typically consisted of judges with little or no legal training and without codified or defined authority, essentially serving as agents for occupying or rebel forces.

Corruption is manifest in many instances, while political bias affects judicial impartiality. Interference from the Executive arm of government, security services or State prosecutors is rife in many cases, with threats of violence or even death severely hampering judicial independence.

In other cases, formal justice mechanisms co-exist with local, traditional courts, which apply customary laws and hence offer an alternative justice forum, or which, in some instances, represented the sole judicial route, in circumstances where individuals were otherwise unaware of their legal rights.

Even where judicial procedures result in a judgement against an accused, the execution of the judgement may be problematic. Court orders may be ignored by State officials, while scarce police resources severely hampered the enforcement of other orders.

The use of amnesties, pardons and light or subsequently commuted prison sentences similarly detracts from the perception of justice.

ACCESS TO JUSTICE FOR WOMEN

In many of the societies that these women come from, there is a general lack of access to justice. Women encounter additional barriers simply because they are women.

They may be unaware of their legal rights or of how they might practically realise these. The problem is exacerbated by the discriminatorily poor and curtailed education women often receive, while a lack of awareness of legal rights is not peculiar to women, their educational disadvantage, coupled with their often limited engagement in the public sphere, means that it is likely to affect them disproportionately. Women may be both less aware of and less capable of articulating their legal rights than their male counterparts.

In many countries of origin of women in this study sample, access to education for girls is low and illiteracy. particularly for those in rural areas, is high.The burden of cultural prejudice, early marriage, sexual harassment, caring for family members and domestic work threatened to curtail the education of many girls.

Many women do not enjoy the same degree of autonomy as their male counterparts, and as a result are less able to report crimes or to participate in any judicial process. In some cases, women's mobility is limited, with many unable to travel unless accompanied by a male relative. In other cases women are targeted for undertaking normal activities such as driving a car, in an attempt to force them to remain in the home.

This lack of autonomy is reflected in the limits posed on many women's ability to work outside of the domestic sphere, as well as in the nature and conditions of available employment, and in many countries of origin of those in the study sample, women received less remuneration than their male counterparts for similar work, were unemployed or were in poorly paid, menial jobs. Employment choices may additionally be subject to the control of male relatives or otherwise restricted by law.

In societies where women are economically disenfranchised, the cost of court and legal fees are prohibitive and limit or deny them the opportunity to seek justice.

Women's economic activity may be further restricted by requirements that a married woman obtain her husband's consent before entering into any legal transaction, prior to opening a bank account, or before selling or renting property.

A lack of autonomy is also evident in the inability of many women to engage substantively in political life, either as politicians or as part of the electorate, significantly impacting upon the ability of women to act to change disadvantageous laws or practices. Confinement to the domestic sphere, and in some cases, to the family home, means that many women are disengaged from public life, and as such have either no access or concept of access to the reparative services it offers. This disengagement is compounded in many cases by socio-cultural precepts, which regard women as the property of their families or husbands.

J is from Kenya. She was persecuted and abused over a number of years by her partner's family and tribe members because she belonged to a minority tribe. During that time she was beaten, cut, branded with a hot blade and forcibly subjected to genital mutilation. She was gang raped on three separate occasions, leading in one case to a miscarriage. In 2007 she was dragged from her home and raped by two men. Her husband, and not J, reported this final episode of rape to the police.

Prevailing customary and legal rules are, in many cases, less favourable and discriminatory towards women. In many countries of origin of women in the study, girls were forced into marriages at a young age, while divorce laws remained prejudicial to women. Laws relating to the distribution of property on the breakdown of a marriage also favoured men, and in some cases gave fathers automatic custody of any children of the marriage. Inheritance laws may enable men to limit women's inheritance rights, while customs gave greater authority and benefit to male heirs. The age of criminal responsibility is sometimes lower for girls than boys, while in other instances rules of evidence provide that a woman's legal testimony is given a lesser weight than that of a man.

Such discriminatory legislative and customary provisions will do little to encourage women to view the law as a mechanism of protection or advancement, while it is unlikely that a woman in such a disadvantaged and disempowered position might simultaneously view herself as a potential subject and user of legal rights and judicial avenues.

PRACTICAL BARRIERS TO SEEKING REDRESS IN CASES OF TORTURE

In many cases, police or other security personnel are the perpetrators of abuse, and as a result women will not report torture for fear of repetition or because the complaint is unlikely to be investigated. Abuse by State actors is committed with impunity where police fail to properly and conscientiously investigate allegations of torture, and/or Courts fail to adequately process or punish abusers.

Impunity goes hand-in-hand in many cases with legislative and societal tolerance of abuse, and of violence against women in particular.

In a number of countries of origin of women in the study sample, States were not party to the UN Convention against Torture, [17] and while in most instances torture is an offence under the State's domestic criminal law,[18] the practice remained rife. Rape is an offence in the legal systems of all countries of origin of the women in the study, although many States failed to recognise spousal rape,[19] and domestic violence was not universally criminalised.[20] Where laws existed, they were ignored with impunity.

In addition to legal tolerance of abuse, many States exhibit a societal acceptance of widespread and systematic violence perpetrated against women where abuse forms a part of women's daily lives. As a result, women may fail to recognise gender-specific torture and other forms of sexual violence as a breach of their human rights, and consequently do not report it.

T is a Kurd from Turkey. She was raped by police on several occasions between 2005 and 2007 when she sought to highlight the murder of her husband and disappearance of her nephew. She did not report the rapes committed by the police because she and the rest of her community regarded them simply as "the way things are", unavoidable and inevitable.

Where reporting does take place, survivors typically encounter discrimination within the investigative and judicial stages of the complaint. In many cases, there is an absence of adequately trained personnel to deal sensitively and appropriately with allegations of rape and other forms of sexual violence, including in the collection of both clinical and non-clinical evidence.

Manfred Nowak, UN Special Rapporteur on Torture, stated that "women victims of sexual violence may be interviewed and examined by personnel that have not been trained in gender-sensitive methods of recording evidence and interviewing",[21] and in some instances there is a scarcity or absence of female police officers.[22]

He concluded that "collecting evidence of gender-based violence is a neglected area in many law enforcement contexts".[23] This resonates with the Medical Foundation findings where in the cases of the 16 women who reported torture to the police, no medical evidence was taken. In many cases, the investigation of allegations of violence

against women is not a priority where law enforcement resources are limited. While a number of countries operate independent medical facilities for such purposes, many other police forces are not required to send alleged survivors of rape for an immediate medical examination. It is exceptional to find scars in the genital area following a rape, and even where a woman is examined within 24 hours of being raped there is often little physical evidence other than bruises or abrasions, which heal quickly without leaving a scar.[24] A lack of prompt action is therefore detrimental to the successful prosecution of a complaint of rape, and the problem is compounded by negative judicial attitudes to "soft" evidence, such as reports by psychological therapists attesting to the impact on an individual's mental and emotional health of sexual violence.

Domestic rules of procedure and evidence may often lack gender sensitivity, requiring, for example, evidence of physical resistance on the part of the survivor before lack of consent can be established, or requiring eye-witnesses to the rape before the crime can be proven. Such rules can lead to the survivor's conviction for adultery, or, where the survivor was not married, they are considered to have committed a "moral" offence subject to formal sanction.

The use of evidence about sexual history increases the trauma of the survivor, who is often humiliated and forced to recount aspects of her private life that have no bearing on the case. While a woman will need to establish that the sexual violence experienced was traumatic, she must also be able to show that the trauma, including any ongoing trauma, does not impact on the credibility of her testimony, while the provision of clinical and/or therapeutic support to a survivor testifying in court may similarly be employed as a basis for attacking credibility. As noted previously, the prescribed weight given to the evidence of a woman may be less than that of a man. The cumulative impact of these factors renders a conviction almost impossible.

Finally, the suffering of the survivor may be compounded where customary or formal rules exempt a perpetrator from punishment where he marries the survivor.[25]

GENERAL BARRIERS TO ACCESSING JUSTICE: THE IMPACT OF REPORTING

"In many societies, the legal system and community attitudes add to the trauma that rape survivors' experience. Women are often held responsible for the violence against them, and in many places laws contain loopholes which allow the perpetrators to act with impunity."[26]

The reasons women in the study did not pursue redress is linked to the general situation in their countries of origin. This includes practical and legal difficulties of pursuing an allegation of rape or other form of sexual abuse and women choosing not to disclose their experiences due to the social, cultural and familial consequences such disclosure might engender.

A victim of rape may be viewed as being in some way culpable or complicit in her abuse because of her failure to fight off her attacker(s) or might otherwise be deemed to have encouraged or "consented" to intercourse. Disclosure of rape may therefore have devastating consequences for a survivor's marriage, where an attack is interpreted as an act of adultery, and divorce and ostracism from the family may signify an effective end to the survivor's relationship with her children, impoverishment and destitution. In cases of unmarried rape survivors, sexual violence may drastically reduce the individual's prospects of marriage, while beyond the family, women who are survivors of sexual violence and/or are divorced frequently experienced social exclusion and ostracism within the community, leading to poor prospects for reintegration.[27]

In many societies sex remains a taboo subject, and as a result, survivors may not report an attack even to their own family. Where survivors are able to disclose their abuse, family members may discourage them from reporting the attack to the police in an attempt to protect and safeguard the reputation of the family, and instead seek to settle the matter privately between the families concerned. In some cases survivors are forced by their families into marriage with the perpetrator, or are otherwise urged to forego prosecution in exchange for money or goods from the perpetrator or his family. Families might alternatively resort to traditional or inter-clan mechanisms in actions aimed at restoring family honour, effectively communalising the issue and seeking resolution and compensation for the affected family, tribe or clan, hence ignoring the survivor's personal situation. Reporting rape or other forms of sexual violence even within the family may lead to further violence or even death in the form of honour crimes.

EMOTIONAL AND PSYCHOLOGICAL CONSEQUENCES OF TORTURE

C is from Zimbabwe. Zanu-PF representatives murdered her husband, a member of the MDC. In late 2007 four men who she believes to be ruling party supporters abducted her from the street. She was taken to a nearby garage, where she was tied-up, beaten, raped by all four of the men and forced to drink their urine. She was left naked. C reported that she had been beaten and left naked, but was too ashamed and humiliated to report to the police that she had been raped. She has similarly been unable to tell her lawyers in the UK who are dealing with her claim for asylum, and as a result, the rapes are not included in her application.

In considering the impact of torture and sexual violence on reporting and giving evidence, it is important to understand the context in which it occurred. For many of the women that the Medical Foundation offers therapeutic services to, rape and other forms of sexual violence inflicted duringconflict or in detention settings[VIII] constitutes part of a continuum of violence in their societies, the impact of which is cumulative.

VIII Including situations of de facto detention, as defined in Rape as a Method of Torture, Medical Foundation for the Care of Victims of Torture, 2004.

For women who have been sexually abused in childhood, have experienced female genital mutilation (FGM) or witnessed as children the rape and violation of female relatives or community members within war or camp settings, the memories of previous abuse are re-triggered by adult experiences of violence. For many in our study, sexual violence began in childhood, and continued in to adult relationships, and women in the study evidence domestic violence, forced marriage, FGM and rape at a young age. For women who have experienced rape and sexual assault as an aspect of their torture and who are in violent relationships, traumatic and distressing memories are re-triggered constantly by the abuse within that relationship.

In exploring the impact of sexual violence, it is important to understand survivor responses not only in a pathological sense but as the common and understandable reactions of anyone who has faced a profound threat to their bodily integrity and is traumatised as a result. In many cases, responses are affected or dictated by a woman's struggle to resist and survive in what are often dangerous and life-threatening circumstances. While the diagnoses of Post Traumatic Stress Disorder (PTSD) and Rape Trauma Syndrome are often used within clinical settings to describe women's responses to torture and sexual violation, such descriptions can ignore the context of the world a woman finds herself in, medicalise her responses and limit the focus to a range of psychological symptoms. The sense of shame, lack of justice and ongoing environment of oppression and gendered violence make such diagnoses limited and problematic. Reference is therefore made in this report to symptoms and responses to abuse, rather than to clinical diagnoses.[IX] Such an approach is appropriate, since it considers abuse in its context, reflecting the complexity of the way in which violence is experienced.

Women frequently describe a profound sense of shame, humiliation and guilt following their experiences of sexual violence and abuse, believing themselves somehow "responsible" for the crime(s) committed against them. Many women describe a loss of "sexual honour", and this loss causes a deep sense of shock. Many talk about having lost themselves, feeling stripped of their identity and different from others. They feel that everyone knows what has happened to them.

D is from Kosovo. She was repeatedly raped by Serbian soldiers during the war and had managed to keep this information from her husband and his family. She described how whenever she was out in the community, she felt that people knew what had happened to her: she believed that they could somehow see the rapes in her face and she became terrified of leaving the house.

Many describe a sense of being forever "damaged" or "dirty" and feeling that they will never be clean.

R is a nurse from Zimbabwe. She is married with three children, the first of whom was conceived as a result of rape. In 2007, when she refused to join Zanu-PF, she was taken from her house, slashed with a broken bottle, burned with sticks from a fire and beaten. In a separate incident, shortly after the birth of her third child, she was taken from her house and raped by four men. She was lactating at the time of the rapes. One of the men refused to rape her and was beaten by the others. R is HIV+ as a result of the attack, and experiences fear, anxiety, eating problems, nightmares and flashbacks. She washes obsessively in an attempt to clean herself.

Women feel fearful, exposed and vulnerable long after the attack is over and the threat of danger has passed, and may live day-to-day in a hyper-aroused state. Where rape constitutes the first "sexual" experience for a survivor, many experience a profound and lasting sense of shock, and years later these women may still feel the rape happened very recently. This same sense of deep shock is also seen in the cases of some married women.

Women frequently describe experiencing intrusive memories, in which the sexual violence is re-played over and over in their mind and out of their control. Many hear the voices of the perpetrator, particularly where rape was accompanied by verbal abuse. Memories can be triggered by external, environmental factors. Women may seek to avoid potential triggers by limiting their lives to such an extent that they rarely go out, or otherwise attempt to control their immediate environment to limit distress. Commonly the sight of men in groups, uniformed men or violent images on the news caused psychological and physiological distress. Sexual contact or even the company of men was described by some as triggering distress. For many, their lack of control over their environment means there is little they can do to prevent being overwhelmed by memories.

Women commonly experience flashbacks, where a traumatic event is re-experienced. This can involve both sensory perceptions and motor re-enactment, and episodes may be brief or long. Some women do not recognise they are having a flashback, or are unable to recall what has happened afterwards. Women may also experience profound physical responses to particular triggers, yet are unable to remember much of their experience of sexual violence.

IX Although the symptoms rather than the diagnosis of PTSD are used here, information relating to PTSD diagnosis was gathered at the data collection stage. This is because the 100 women were seen by clinicians and therapists at the Medical Foundation from a diverse range of clinical disciplines. In some cases, PTSD diagnoses were made, while in other cases, therapists refer instead to specific symptoms.

W had experienced repeated rape whilst detained in the Democratic Republic of Congo, and was unable to remember a significant proportion of her time there: she could only recall the face of one of the guards, and the "rape cell" where she was taken at night, alongside other women. She could remember the smell of the cell and feel of cold concrete on her back. She began seeing a counsellor in the UK following an incident in the city she lived in: she walked past a butcher's shop and the sight and smell of the blood made her collapse in the street. She felt a profound sense of terror and was violently sick. She was often overwhelmed by strong physical responses to triggers in the environment, which she was unable to connect to her history of sexual violence in detention.

Survivors commonly report dissociative experiences, making it extremely difficult to focus or concentrate on the present. Many speak of having no access or emotional connection to their experiences and describe feeling "dead inside" (emotional numbing). This "deadness" can come as a relief, since it enables them to cope with their multiple domestic responsibilities and ensures survival in precarious environments, but equally means they feel no range of affect, and often experience no emotional contact with others.

The constant remembering and re-experiencing of distressing memories make living in the present exhausting, and women describe a lack of control over their minds and emotions, often resulting in many survivors finding public and social environments both overwhelming and anxiety-provoking.

IMPACT OF SEXUAL VIOLENCE ON RECALL AND TESTIMONY

Traumatic memories can continue for decades, and their affect-laden quality can make them hard to translate into words, making disclosure difficult. Women's shame and sense of violation is so profound that they do not feel able to disclose to others what is deeply humiliating and painful. Many women have difficulty in recalling aspects of their abuse history. Such fragmented memories can both lead women to doubt themselves, deterring them from reporting the abuse experienced, and affect the apparent credibility of their account. Dissociative responses can be experienced at the time of the trauma as well as in the aftermath of violence, affecting women's ability to fully remember what has happened. The emotional numbing associated with dissociation affects a survivor's demeanour when giving testimony, leading to perceptions of "coldness", which in turn can be interpreted negatively to impinge her credibility.

Women are often exhausted by sleeplessness and anxiety. This is exacerbated where internal resources are invested in hiding from others the impact of their experiences, particularly where women are deliberately hiding the rapes from husbands, families and communities. Women will often repeat to practitioners at the Medical Foundation, "I just want to forget, how can I learn to forget?" This exhaustion, compounded by feelings of profound hopelessness resulting from depression, leave women with little energy or motivation to act in any way, deterring reporting.[28]

Sexual violence impacts upon a woman's ability to trust, producing feelings of overwhelming fear, anxiety and a loss of belief in others. These feelings can both leave women isolated from any networks they do have, and prevent them from reporting violence.

Women who have been subjected to sexual violence may also fail to disclose this fact for a long period, if at all. Clients of the Medical Foundation can take many years to disclose their experience of sexual violence, and even then, finding the words can be very difficult: the violence is often hinted at initially rather than named. The process is distressing and overwhelming emotionally. In a safe and supportive therapeutic setting, late disclosure is common, yet in any legal action late disclosure may well be construed negatively, and used against a survivor to challenge her credibility.

Physical violence, including repeated beatings to the head and loss of consciousness, can often occur during rape and other forms of sexual abuse and torture. The experience of physical pain adds to women's impaired functioning and can exacerbate depression. Blows to the head can also directly affect memory recall.

CLINICAL CONSEQUENCES OF TORTURE

Women in the study sample experienced high levels of depression, sleeplessness, nightmares, fear and anxiety and flashbacks. They reported distress at external cues which reminded them of their trauma. Twenty-nine women were suicidal, with a smaller number self-harming. Thirty described having intrusive thoughts, and 40 reported poor concentration.

All the above responses are commonly associated with trauma, and clearly indicate high levels of distress and ongoing difficulty requiring both support and counselling.[X]

While the high level of depression evident in the study sample is unsurprising given the women's experiences, it must also be seen in its context: women in the study are living in exile, in many cases without the grant of any form of legal protection. Depression can also be a response to grief, loss and separation from children, families, culture and communities, and in the case of the women in the study sample, this is further compounded by the inherent difficulties of living in exile and the vagaries of the asylum process.

Seventeen women conceived following rape, and seven miscarriages were reported, including one woman who delivered a stillborn baby in a cell following repeated rape. Twelve women reported fistula/damage to reproductive organs. Seven women reported STDs and three contracted HIV following rape.[XI] Thirty-eight of the women have scars following physical assaults, often on the face, breasts and genital area.

The symptoms and responses shown in the table generate therapeutic and/or clinical needs. It is therefore appropriate to consider the extent to which these needs were met in the countries of origin of the women in the study sample.

X Other responses such as avoidance, detachment, emotional numbing and eating problems are not reported as commonly as one might expect, and our experience suggests there is also a probable under-reporting of sexual abuse in childhood. This phenomenon is also well documented: see for example A Sourceboook on child sexual abuse, David Finkelhor and Associates, 1986. Women in the study sample include both those who are receiving treatment from the Medical Foundation and those for whom a medico-legal report was produced. A medico-legal report is produced following two or three sessions with an examining doctor, and so is less likely to produce the depth of information relating to impact and survival than can be found in clinical files. Often in therapeutic work, we learn several months into our work with a woman that, for example, she sleeps under the bed because she is so frightened, or is too anxious to leave the house. Admitting such difficulties to a doctor in a report writing setting can be difficult. However, the sample still indicates high levels of trauma, particularly in relation to women re-living past experiences in the form of nightmares, flashbacks, intrusive thoughts and memories.

XI Not all women in the study sample have received screening for STDs including HIV/AIDS. These figures will therefore most likely under-represent infection figures within the 100 women in the study sample.

The table below illustrates the range of physical and psychological responses identified by women in the study sample.

Clinical consequences of torture – physical and psychological	Incidence
Physical scars	38
Ongoing pain	42
HIV/AIDS (where tested)	3
STDs (where tested)	7
Pregnancy	19
Fistula/damage to reproductive organs	12
Miscarriage	7
Sexual problems	10
Headaches	42
Fear and anxiety	37
Depression	53
Other mood related symptoms	12
Suicidal ideation	29
Panic attacks	12
Poor appetite	31
Eating problems	5
Self harm	7
Nightmares	62
Flashbacks	33
Intrusive thoughts	30
Intense psychological/physiological distress at cues that relate to the trauma	26
Memory loss – inability to recall aspects of the trauma	13
Detachment and separation	13
Restricted range of effect	1
Sense of foreshortened future	15
Avoidance of thoughts/feelings, activities, places or people that relate to the trauma	9
Dissociation	8
Sleeplessness	74
Hyper vigilance	9
Extreme startle response	11
Poor concentration	40
Irritability and anger	15
Other	11

Common manifestations and comments
Cigarette burns on chest and other areas/caustic liquid on face, shoulder and thigh/scars on breasts/scars under breast and pubic area/cut with knife on genital area/burnt face and cut abdomen/cut on breast/burns with hot water
Lower back pain/Pelvic Inflammatory Disease/abdominal and pelvic pain common/period pains
Three tested HIV positive, three awaiting test results
17 conceived as a result of rape, one woman conceived twice by rape
Pain in cervix area/pain on intercourse/wounding to bowels/ irregular periods and vaginal discharge common/loss of periods/ PID/ stress incontinence/hysterectomy – following rapes/bled very badly after rapes/left eye damaged and vision blurred
Delivered a still born baby in cell
Unable to sleep with husband/shame/loss of sexual interest
Low mood/self reproach, worthlessness, guilt and shame/grief and loss/loss and worthlessness/hopeless and guilty/ashamed of the rapes/loss of energy
Attempted suicides/overdoses and attempts to strangle self in prison
Men in groups/army or other uniforms/TV and news/ thought of sex
Only leaves house to attend church
Washing excessively or scrubbing body/poor memory and difficulty trusting others/loss of meaning in life and hopelessness/guilt/grief/avoidance of being near men/checking daughters' underpants – fear daughter will be raped/ auditory hallucinations/fits when severely distressed – following head injury

DOUBLY DISADVANTAGED

Despite the international legal obligations of offending States to provide retributive and reparative forms of justice to victims of torture, justice for women is often inaccessible and elusive.

Of the 80 women in the study, there was not a single successful prosecution of a perpetrator. Reporting of violence was low, due in large part to the direct involvement of law enforcement personnel in the abuse. In many cases, the State's investigative and judicial mechanisms were (and remain) poorly equipped, under-resourced, corrupt or otherwise ineffective. Poor evidence-gathering, discriminatory procedural rules and a simple lack of prioritisation further hamper the effective pursuit of any legal action.

Women who seek justice are further disadvantaged by poor education and a consequent lack of awareness of rights, whilst discriminatorily poor employment leads to an inability to pay legal fees. Women's lack of autonomy, coupled with their exclusion from the public sphere, conspire to prevent many from seeking justice through formal procedures, while cultural notions of women as property, together with life-long gendered abuse, mean that many survivors of sexual violence will fail either to identify themselves as potential subjects of human rights provisions, or to view the abuse suffered as a human rights violation.

The problem is exacerbated where women have experienced torture of a sexual nature, where disclosure may have dire social, familial and economic consequences, or where a deep sense of shame, guilt and debasement inhibits disclosure. Further, precepts of family honour encourage cases to be resolved between families or tribes, effectively communalising the issue and so failing to address the issue of justice to the individual.

Survivors may find their experiences of abuse too difficult or horrific to verbalise, while fragmented or disturbed recall, severe exhaustion, emotional numbing and late disclosure all impact upon survivor testimony and perceptions of credibility. The fact of abuse therefore affects not only the ability of a survivor of sexual violence to report trauma but also the way in which testimony is delivered and perceived. As a result, justice for many women who have been subjected to gender-specific torture, including sexual violence, may never be achieved.

BARRIERS TO WOMEN SEEKING CARE

ACCESS TO CLINICAL AND THERAPEUTIC CARE AND SUPPORT

N lived in Zimbabwe with her husband and two children. In 2002, Zanu PF supporters forced their way into the house, accusing her and her husband of supporting the MDC. She was beaten, cut and raped. A friend took her to hospital to have her hands, arm and leg stitched and her wounds dressed. There is no indication that she sought or received help in respect of the rape.

Women in the study sample sought medical care or support from both the formal and informal sector, including from hospitals, prison medical staff, private doctors, chemists, traditional healers, family members and neighbours.

Information relating to whether women sought medical treatment following their abuse was available in 79 of the 100 files in the study sample. In 57 of those cases, women sought treatment of some kind. This figure is low given the brutality of the physical assaults experienced and the seriousness of injuries sustained.

Where women accessed formal healthcare, it was often for the treatment for burns, knife wounds and broken body parts, and the medical treatment offered related to dressing wounds, sutures or setting of broken body parts.

Despite a perceived need in many survivors of rape to get pregnant in order to satisfy themselves that they are still able to conceive and to somehow compensate for loss of their marriage and the opportunity to have a family, women rarely disclosed rape when they sought medical attention. In none of the cases did a woman refer to specific medical treatment or health screening following sexual violence. Only one woman received therapeutic care from a psychiatrist following her torture. Given the severity of the abuse experienced by women in the study sample and the high levels of distress and the mental health impact recorded, the lack of therapeutic care illustrates how poorly women were supported, and is of particular concern.

In a number of cases, care was accessed "in secret", to avoid communities or extended families from discovering the abuse. One woman was taken to the hospital at night and treated by an uncle who worked in the hospital. In other cases, neighbours cared for women, or families paid for private doctors to discreetly visit the house.

B is from Cameroon. In July 2001 she was arrested and detained for three months. During her detention she was suspended and beaten by police. She spent ten days in hospital following her release. Two years later, she was abducted and forced to marry a tribal chief. She was raped several times by the chief and became pregnant as a result. She was ritually scarred and genitally mutilated. B did not seek formal medical care in respect of the rapes. Her friend organised an illegal termination of the pregnancy.

Information as to why women did not seek treatment is available in 13 of the remaining 22 cases. In one case the woman reported that she had no injuries requiring immediate treatment. In another four cases women either left the country or made arrangements to leave the country straight away, and so did not have an opportunity to seek help. Others still described feeling too ashamed to seek help, or were unable to afford treatment. In one case, there was simply no medical clinic on the island, and in a further case, a torture survivor did not seek medical care because she feared a prejudicial response from clinical staff because of her sexual orientation.

ACCESS TO HEALTHCARE FOR WOMEN IN THEIR COUNTRIES OF ORIGIN

The countries of origin of women in the study sample have a range of healthcare systems delivering differing forms and standards of healthcare provision. In some cases, there is no state medical service, or services are in a transitional period of post-conflict reconstruction. In many instances, States are unable to provide anything other than rudimentary care, and/or are consumed with responding to health needs generated by disease or natural disasters. Where they are present, facilities are typically poorly resourced in terms of infrastructure, personnel, equipment and drugs, sometimes dispensing treatment inequitably. Where medication is available, it is frequently beyond the financial means of many, while a concentration of facilities within urban areas, together with general insecurity, poor road networks, roadblocks, curfews and a lack of private resources mean that many are practically inaccessible. Many States suffer a severe shortage of adequately trained healthcare professionals. Where facilities exist, they are typically concentrated in major cities, rendering healthcare practically inaccessible to many in rural areas.

In the case of failed States still experiencing conflict, an absence of State structures means that there are simply no State medical services at a time when continuous fighting has had a catastrophic impact on the health of the people. In States newly emerging from conflict, health infrastructure has been damaged, destroyed, or has otherwise collapsed due to under-funding, a lack of foreign exchange for importing drugs, and attrition of qualified clinical staff.

Corruption poses an additional barrier to accessing healthcare for many, including pressure on staff from armed groups to prioritise treatment for its members or a refusal of treatment to patients who were not carrying ruling party membership cards.

Although the obstacles identified above affect the population of a State as a whole, many will impact disproportionately on women. The burden of poverty shows a clear gender bias and as a result women will be less able to meet the costs of medication and treatment. Long or difficult journeys to treatment facilities will particularly hamper women's physical access to healthcare services, where regional insecurity or systemic

gender violence render women vulnerable to attack, while poor education and confinement to the domestic sphere will hinder access for many more.

Even where States aim to meet basic health needs, the low status of women correlates to low prioritisation of services dedicated to women, and maternal mortality rates in many States provide a clear and stark example of this. The problem is exacerbated by cultural values and norms such as poor treatment of women, meaning that many are in a poor state of health and/or are malnourished before pregnancy. Obstetric difficulties, together with mother and child mortality rates, threaten to rise further as a result of high levels of stress generated by insecurity, leading to increased miscarriages and complicated deliveries, while pregnant and lactating women are more vulnerable to the country's endemic diseases.

A lack of female clinical staff in many facilities also acts as a barrier to women accessing services. In some instances, sexes are separated in the provision of medical care. Male gynaecologists are targeted by religious extremist groups, accusing them of invading the privacy of women, and in a number of cases, gender segregation is so deeply rooted that a husband would reportedly rather let his wife die in childbirth than allow a male clinician to treat her.

In many countries of origin of women in the study sample, State healthcare facilities are unable to respond to the various physical and emotional consequences of torture.

In the case of mental healthcare provision, services typically suffer from a lack of prioritisation within already-poor healthcare infrastructures, or are otherwise inadequately resourced. In some cases, there is an absence of any mental health policy or strategy within the State's healthcare plan, while in other instances particular clinical disciplines or treatment models are not recognised within the healthcare practice.

State services for the treatment of AIDS/HIV and other sexually transmitted diseases are similarly lacking or poorly resourced in many countries of origin of women in the study sample, and a lack of appropriately trained personnel and/or knowledge and education relating to diseases such as HIV/AIDS mean many more fail to seek medical help.

Drugs are either unavailable or prohibitively expensive for many. Where the cost of anti-retroviral treatments (ARVs) has been heavily subsidised, transport costs, together with the price of drugs needed to treat opportunistic infections and the cost of laboratory tests have made treatment cripplingly expensive, and a lack of security, together with an absence of governmental capacity, meant that in some cases there was little opportunity to develop future medical and resource-distribution strategies.

THE EFFECT OF TORTURE AND ITS IMPACT ON DISCLOSURE IN CLINICAL SETTINGS

Many of the problems which emanate from the sequelae of torture and which prevent or otherwise militate against a woman's ability to report acts of abuse to the police similarly prevent women from seeking medical help and/or therapeutic support. In addition to those problems, however, a number of factors peculiar to clinical disclosure arise as a result of torture and sexual violence.

N is from Uganda and was targeted for abuse because of her sexual orientation. She was subjected to rape on four separate occasions between 2004 – 2007, including two cases of gang rape. In one episode, a perpetrator urinated over her after he had raped her. She was also burned when a caustic liquid was thrown at her and slashed with razor blades. She has scars on her genital area and burn scars on her arms where she held them in front of her face to protect herself from the caustic liquid. N sought medical care but the clinicians were very unsympathetic, implying that her sexuality was the reason for the rapes.

Women may lack confidence in the confidentiality of any clinical relationship, fearing that doctors or therapists might tell others, including family members, about their rape or abuse. Similar issues of confidentiality arise in relation to traditional healers, where women might also fear the adoption of negative community attitudes which stigmatise women victims of sexual violence, and where women identify a State hospital with the State itself, they fear that information about them will be relayed directly back to the authorities.

Women may fail to seek help due to fear of an internal medical examination. Such examinations, particularly when conducted with a lack of sensitivity or regard for the emotional consequences of violation, risk retraumatising a woman, particularly where the examining doctor is male, or where there are several clinical staff present.

Others may avoid seeking clinical help or support because they feel unable psychologically and emotionally to cope with additional problems in the form of bad news concerning their health. Information relating to damage to reproductive organs, for example, could potentially have a devastating effect on women, particularly in cultures where there is an expectation that all women will have children. Many clients of the Medical Foundation delay having HIV tests until after they have received a positive determination of their claim for asylum because they simply feel unable to deal with the additional burden of a positive result, or fear such a result will expose the fact of their rape to husbands or other family members.

Naming abuse and its associated health consequences can feel to many as if the experience has been unwelcomely brought out into the open, such that the woman no longer feels the abuse is something she can try to bury or ignore.

CHALLENGES AND GAPS AT EVERY LEVEL

The experiences of the women in the study sample illustrate the profound impact on women's mental health, as well as the physical consequences of torture and sexual violence. Physical consequences include injury, pregnancy, STD and HIV infection, gynaecological problems and persistent, on-going physical pain. In relation to women's long-term mental health, the absence of appropriate and accessible support and care in the countries of origin of women in the study has led to a high number of women becoming depressed and experiencing traumatic responses, such as flashbacks, nightmares and sleeplessness, many years after the attacks.

In just one case, a woman was referred for psychiatric care in her country of origin. In stark contrast, two of the women in the study sample were forcibly detained and abused in psychiatric facilities as "punishment" for making a formal complaint in respect of the abuse they experienced.

In the vast majority of cases, systems of healthcare in countries of origin were ill-equipped, poorly serviced or absent. Prohibitive distances, together with a lack of prioritisation of specialist services for women meant that for many, healthcare was practically inaccessible, while difficulties of disclosure and communal attitudes towards survivors of sexual violence deterred them from seeking help.

The consequences of this inability to seek clinical and/or therapeutic help and support can be devastating, potentially resulting in failure to access post-exposure prophylactics which can help prevent AIDS/HIV infection, as well as anti-retroviral treatment designed to improve AIDS-related symptoms, unwanted pregnancy, non-treatment of sexually transmitted infections, ongoing problems associated with fistula and other damage to reproductive organs, miscarriage, and a lack of any therapeutic care which might enable the individual to rehabilitate to the fullest possible extent.

MAKING THE RIGHT TO REPARATION AND REHABILITATION REAL FOR WOMEN TORTURE SURVIVORS

"...reparation must drive post-conflict transformation of socio-cultural injustices, and political and structural inequalities that shape the lives of women and girls... reintegration and restitution by themselves are not sufficient goals of reparation, since the origins of violations of women's and girls' human rights predate the conflict situation".[29]

It is clear from the experiences of the women in the study sample, together with country of origin information, that many women have no real access to the right to reparation. The challenge is to ensure that access to reparations encompasses approaches that are sensitive to gender-specific torture and sexual violence.

THE LEGAL FRAMEWORK

International law provides that victims of human rights violations or breaches of humanitarian law are entitled to a remedy in respect of abuse suffered.[30] The UN Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (the "Basic Principles")[31] were adopted by the General Assembly in December 2005, and codify pre-existing obligations on States under international law arising from gross human rights abuses, including torture.[32]

The Basic Principles require States to conscientiously investigate allegations of torture, and where possible, to prosecute and punish perpetrators. A victim's right to a remedy includes the right to restorative justice in the form of reparation, [33] which in turn should be "full and effective".[34]

Reparation will necessarily mean different things to victims, while the forms of reparation adopted will depend upon the survivor's specific needs and circumstances. The concept is variously understood as being:

(i) psychological in nature encompassing measures which acknowledge harm done and responsibility for that harm, or which seek to restore the dignity of the individual;
(ii) social including rehabilitative elements, as well as reconciliation and restitution;
(iii) economic including compensation and indemnification;
(iv) religious or moral including notions of forgiveness and atonement;
(v) political relating to democracy and the enjoyment of freedoms; and
(vi) legal entailing the pursuit of judicial mechanisms to establish responsibility, accountability and justice.[35]

The Basic Principles describe five forms of reparation, which collectively seek to adopt an integrated approach to

"repairing" survivors of abuse:[36]

1. Restitution[37] involves the application of measures aimed at the restoration of the survivor to the situation they were in prior to the abuse suffered, and will include:

- the restoration of liberty and the enjoyment of other human rights, including family life and citizenship as appropriate;
- the restoration of employment;
- return to one's place of residence; and
- the return of property.

2. Compensation[38] involves the payment of money for financially quantifiable damages resulting from the abuse, including:
- physical or mental harm suffered;
- any consequent loss of opportunity, including employment, education and social benefits;
- material damages such as loss of or damage to property and loss of earnings, including earning potential;
- moral damage;
- the costs of legal or other expert assistance, including recourse to medical, psychological and social services.

3. Rehabilitation[XII] involves the application of provisions and/or services aimed at the recovery and reintegration of the individual, and encompasses the direct or indirect provision of medical and psychological care, as well as legal and social services.

4. Satisfaction[39] is of broader application, unlike restitution, compensation and rehabilitation which are specific to the individual. While of benefit to the individual, the aim of satisfaction is to benefit an abused group, the community or the State as a whole. Measures may aim to affect the context and environment of abuse, make both public and demonstrative findings of accountability and justice or, where relevant, seek to contribute to a lasting peace. Measures may include:

- the taking of effective steps aimed at the cessation of continuing violations;
- the verification of the facts, together with a full and public disclosure of the truth;
- the search for the whereabouts of the disappeared, for the identities of the children abducted, and for the bodies of those killed, including assistance in the recovery, identification and reburial of bodies in accordance with the expressed or presumed wish of the victims or cultural practices of families and communities;
- an official declaration or judicial determination restoring the dignity, reputation and rights of the victim and of those closely associated with them;
- a public apology, including an acknowledgement of the facts and acceptance of responsibility; and
- commemorations, memorials and/or tributes to the victims.

5. Guarantees of non-repetition[40] are broad and reach beyond the needs of the individual victims. They are preventative measures, and may include:
- a review and reform of those discriminatory laws which facilitated, supported or otherwise lead to a culture of abuse;
- the reform of the State's military and police forces to ensure they operate in compliance with international standards, including training in international ethical codes and human rights standards and the monitoring of reform progress and success;
- strengthening and providing greater support for judicial independence;
- protecting members of the legal and medical professions, as well as those involved in the media, from State interference; and
- promoting conflict resolution mechanisms.

In most cases the State will be responsible for providing reparation, either as a result of its involvement in the abuse or because of its failure to protect individuals from abuse at the hands of private actors.[41] International law also recognises that individual perpetrators, rebel or armed groups or third party States active in the Host State's territory can also be responsible for providing certain forms of reparation in respect of abuses committed.[XIII]

XII Article 21. "Rehabilitation" is not defined in the Basic Principles or in any other legal instrument. For a detailed examination of the meaning of rehabilitation see the forthcoming Medical Foundation publication on Article 14 UNCAT.

XIII Reparative forms with broader, societal implications and/or which effect changes within State mechanisms, practices or conduct can only be made by the State itself (to the extent it is in control of a territory), reflecting State responsibility for the discriminatory context of gender-specific violence against women.

A GENDER-SENSITIVE APPROACH TO REPARATIONS

International law provides that reparations should, as far as possible:

"...wipe out all the consequences of the illegal act and re-establish the situation which would, in all probability, have existed if that act had not been committed".[42]

As already noted, the social and cultural context within which many women live render them vulnerable to violence and abuse, heightening the risk of harm whilst at the same time hindering their ability to obtain justice and reparation in respect of the abuse suffered. In the case of women survivors of torture, therefore, a simple return to the situation existing prior to the abuse is inadequate as a remedy, and reparations will not achieve their stated aims unless the underlying discriminations which both contribute to and compound violence against women are also addressed.

Rape and other forms of sexual violence are frequently a form of torture. The impact both on the individual and the societies they live in can be profound where the responses of others to the survivor are themselves informed by social and cultural traditions and understandings, which typically lead to the rejection and isolation of the survivor rather than the perpetrator. In considering the provision and form of full and effective reparations the context within which the abuse took place cannot be ignored. Reparations should seek not only to provide for the survivor at an individual level, but also to prevent future acts of violence, address pre-existing discriminatory attitudes and practices, raise the status of women within society and promote gender equality.

Women have identified the need for reparations that ensure economic independence and enhance their ability to live their lives without constant fear, stigmatisation or discrimination.[43] To achieve this, reparations must be approached with the specific needs of women in mind, in order that reparative measures avoid reinforcing, replicating or tacitly endorsing pre-existing gender inequalities. Reparations should be viewed as an opportunity to move society towards a more egalitarian position in terms of gender parity.

This can be achieved through a more considered application of existing principles and forms of redress. A greater emphasis is needed on reparative measures constituting satisfaction and guarantees of non-repetition in addition to mechanisms aimed at achieving justice, compensation and rehabilitation.

Women approach the reparative process in various and multiple capacities: as survivors, as widows, as carers, as providers and as vulnerable individuals post-conflict or on return to their countries or towns of origin. It is essential that a reparations model is able to recognise and differentiate between the status and corresponding needs of women. An effective reparations model must go beyond addressing the needs of individual survivors, and seek also to prevent future violations and promote the status of women. Reparative elements should be employed flexibly in order that a model is able to respond effectively and adequately to post-conflict or repressive-state scenarios alike.

Aspects of domestic practice need to change in order to render investigative and judicial mechanisms accessible to women who have survived torture. The accessibility of a reparative process for survivors of torture additionally requires the provision of therapeutic care and support services that facilitate access to, involvement in and direction of the rehabilitation and justice process.

DOMESTIC LEGISLATIVE REVIEW AND REFORM[XIV]

As this study shows, violence against women, together with legal and cultural inequalities, produces an atmosphere of violence, tolerance and societal acceptance in which women are tortured with impunity. In order that torture of women be abolished, legislative review and reform must therefore target underlying contextual violence and disparities in addition to torture per se.

In order to ensure that perpetrators of sexual violence and other forms of gender specific abuse are held accountable for their actions, domestic legislation should be reviewed and, where necessary, new legislation enacted providing for the criminalisation of violence against women in all its forms, whether committed by public or private actors, including violence within the community and the family. The review should also encompass traditional and cultural practices which are harmful or otherwise disadvantageous to women. In so far as sexual violence is committed during conflict, national laws should recognise offences such as rape and other forms of sexual assault, sexual slavery and enforced impregnation as war crimes or crimes against humanity, or as a means of committing acts of genocide.

A thorough legislative review and repeal of all discriminatory legislation should be conducted as a means of addressing gender disparity. Such a review should ensure that domestic legislation complies with economic, social and cultural, as well as civil and political international human rights standards. Where appropriate, the state should also sign and/or ratify international and regional human rights treaties, including the Convention on the

XIV While the areas identified are dealt with separately and distinctly for the purpose of this report, they remain inter-linked and interdependent, and there is a marked degree of fluidity between them. As such, it is important that categories should not be considered in isolation.

Elimination of All Forms of Discrimination against Women and its Optional Protocol.

In order that rights can be upheld, it is vital that women and girls are educated about their rights. It is essential that protective legislative measures are enforced in practice. A competent and responsive police force and judiciary are therefore essential.

REPORTING AND INVESTIGATING: THE POLICE

Police officers and security personnel should receive training in human rights and gender issues in order to enable them to respond adequately, sensitively and professionally to complaints of sexual violence and abuse. Forces should actively recruit, train and make available female police officers to deal with sexual and gender-based violence. Complaints relating to the conduct of the police following an allegation of sexual violence should be promptly and adequately investigated in order that survivors gain faith in the system and feel more able to come forward. Allegations against police themselves as perpetrators should be investigated and, where appropriate, perpetrators held accountable in order that the police service is not seen to be above the law.

The adequate investigation of an allegation of sexual violence involves the collection of evidence and interviewing of witnesses, and to this end, the State must ensure that police forces are adequately resourced. Testimony should be taken in an environment which ensures confidentiality of the survivor and any witnesses, such as a secure interview room, and interviewing should be conducted by individuals trained in working with survivors of serious abuse. Medical evidence must be obtained promptly and in a sensitive manner. It is also vital that survivors of sexual violence are kept informed as to the progress of the investigation.

PROSECUTING PERPETRATORS: THE COURTS

In order that an individual's right to justice is rendered practicably realisable, court procedures and rules of evidence should ensure that women are not at a disadvantage, while the legal process must conform to international fair trial standards. In particular, a survivor must be enabled to recount her experience in an environment which ensures not only her security but also her dignity. In light of the context of many acts of sexual violence, rules of evidence should not impose impossible evidentiary burdens on the survivor, including the need for a witness to an attack,[44] pre-suppose her sexual availability, permit the use of evidence relating to the prior sexual conduct of the survivor[45] or otherwise call into question her credibility simply on the basis of gender. Investigative procedures and questioning should not seek to further humiliate, victimise or traumatise a survivor of sexual violence. Rules should also allow the defence of consent to be questioned, including issues of consent where perpetrators are in a position of power or control over the survivor.[46] Courts must also consider evidence from men and women on an equal footing and protect the identity of the survivor and any witnesses where necessary for the fair and proper conduct of the trial.

The court environment is also crucial to the effective prosecution of perpetrators of sexual violence, and to that end, the judiciary and other court staff should be trained in issues of gender and human rights. Training on the content, nature and acceptability of so-called "soft" medical evidence attesting to the psychological impact of sexual violence is also required, together with a greater understanding of expected clinical findings following a physical examination of the survivor.

Training should also encompass the impact of sexual violence and trauma on testimony and recall, such that the evidence which a woman is able to give in court can be considered within its appropriate context, and without gaps in recall deemed automatically to indicate implausibility. Measures designed for the protection and security of survivors and witnesses to crimes of sexual violence, along the lines of services offered by the Victims and Witnesses Unit, based within the Registry of the International Criminal Court also serve to facilitate the giving of testimony without risking further stigmatisation or violence. Protection functions would also encompass counselling services, which in turn should support and enable a survivor throughout the judicial process without negatively impacting on the survivor's credibility. To that end, education of judicial staff relating to the impact of trauma on credibility is essential, and, where appropriate, rules of procedure and evidence should be incorporated to reflect the position, along the lines of those enunciated by the International Criminal Tribunal for the Former Yugoslavia.[47]

FINANCIAL COMPENSATION, REIMBURSEMENT AND RETURN OF PROPERTY

Compensation and reimbursement should be prompt and adequate. Quantification of loss of life or limb, or economic assessment of pain and suffering are inevitably difficult and controversial. Any gender-sensitive compensation assessment model should consider and incorporate material loss, together with the pain, suffering and mental anguish occasioned to the survivor. In the case of sexual violence, this will include not only physical consequences of harm such as damage to reproductive organs, pregnancy and infection, but also emotional consequences of abuse such as shame and feelings of guilt.[XV] Broader consequences of sexual violence, such as stigmatisation, damage to reputation and rejection should also be considered. Loss of opportunities and earning potential over a lifetime, together with any enhanced earning responsibilities due to, for example, rejection, death or incapacitation of husband or other family member, or additional support needs for any child born as a result of rape should also be included in any compensatory

XV The physical and emotional consequences of sexual violence are identified in detail in section 3.1.

payment. Such support might include enabling and empowerment measures such as training designed to increase future earning potential.

In practical terms, compensation should be provided in a sensitive manner and in such a way that payment does not in any way appear, in the eyes of the recipient or community, to devalue the gravity or nature of the harm suffered. Measures may also be required to ensure that compensation should reach the survivor herself, and be used for the purpose intended. By the same token, financial compensation to children born as a result of rape can be placed in a trust fund, for release when they reach 18.

REAFFILIATION: RESTORATION OF DIGNITY AND SATISFACTION

Retributive justice is capable of achieving a reparative effect. As already noted,[XVI] justice can have a positive therapeutic benefit and as such can be rehabilitative in both the legal and clinical senses of the word. Significantly, the effective investigation and prosecution of perpetrators sends out a clear message to the community and society more broadly that sexual violence against women is unacceptable, hence acknowledging the damage that sexual violence has done, whilst contributing to the social and legal rehabilitation of the individual survivor and many other survivors who are unable to take their complaints to court.

For women survivors to reintegrate into society, the restoration of their dignity in the eyes of the community is essential. Measures aimed at the restoration of dignity additionally help to create a social and moral context in which sexual abuse is seen as unacceptable, and hence serve as a means of guaranteeing non-repetition of violations. Reparative forms of justice are important in their impact on the ability of the survivor to reintegrate into society and their ability to live their lives. Measures might include public apologies to the survivors of abuse by individual perpetrators or, in cases where sexual violence has been committed on a massive scale, a State acknowledgement of the abuse inflicted and suffering endured goes some way to restoring the reputations and dignity of survivors of sexual violence, as well as redeeming the memories of the dead.

The success of measures aimed at restoration of dignity and guarantees of non-repetition would hinge, in part, on the reform and education of a State's police force, armed forces, judiciary and other State organs, through education and training in human rights, the rights of women and sexual violence. Changing attitudes to women and to violence committed against them would also necessitate public education, which can be channelled through work with community and tribal leaders and schools, where curricula should include human rights education in general, and women's rights in particular. Such an approach should work to abolish traditional customs or practices harmful or otherwise detrimental to women and girls. Stress must be placed on the education of girls and on the value of women in the workplace and in public life. A similar approach will be required in relation to children born as a result of rape, who are typically stigmatised.

Community and symbolic reparations are also helpful, as they acknowledge the impact of sexual violence on the community more broadly, whilst at the same time serve to restore the dignity of survivors in the eyes of their community.

Naming acts as torture is a powerful weapon in eroding the cultural acceptability of sexual or gender-based violence. Nowak refers in his recent report, for example, to the effect on individual survivors from Guatemala of describing acts of sexual violence as torture: individuals felt relatively insulated from social stigmatisation than when acts were described instead as rape, sexual slavery or enforced impregnation.[48] By contrast, employing euphemisms for rape or sexual slavery denigrates and diminishes the experiences of survivors, and in some cases goes so far as to imply or connote a degree of complicity of the survivor in their abuse.[49] While such an approach might be employed to enable more women to come forward to seek justice, the use of such language is itself borne out of the stigmatisation of rape, and a preferable approach would be to provide an enabling environment which allows women to describe their torture and abuse without fear of further discrimination or stigmatisation, and by demystifying the language of sexual violence such that it becomes owned by the survivors.

XVI See Introduction

REINTEGRATION: SUSTAINABLE AND INDEPENDENT LIVING

The right to own property is curtailed or denied in the cases of women in many cultures. In addition to the reform of discriminatory laws preventing women from owning or otherwise dealing with real estate, a reparations package must ensure that women are able to return to their land in safety and, once there, live in a secure environment. Where individuals have lost their homes as a result of conflict or rejection by their family, adequate housing should be provided for survivors and their dependants, together with household essentials. Damaged homes should be repaired as a priority in order that vulnerable women are able to live in relative security. Reintegration can also be facilitated through the provision of various social services to assist with issues such as family support and economic advice.

Specific training, including adult education to make up for educational opportunities lost in situations where women were girls at the time a conflict started, or to compensate for discriminatory exclusion or withdrawal from the education system, or vocational, business training, will enable women to take a more prominent place in the labour market, raising the status of women, ensuring a greater involvement in public life, a better understanding of their rights and how to articulate them, and lead to enhanced financial independence. Education should be offered to the survivor free of charge, with bursaries or scholarships also available to survivors and a number of school and graduate places being reserved for survivors. The provision of micro-credit and preferential loans, together with ongoing business advice and childcare assistance will also help women who have suffered sexual violence to provide for themselves and their children.[50]

Finally, enhanced efforts to include women and girls in disarmament, demobilisation and reintegration (DDR) processes serve to emphasise the participation and role of women and girls in conflict, whilst at the same time providing resources and training to enable survivors to pursue economically independent lives.

PROVISION OF HEALTH SERVICES, THERAPEUTIC SUPPORT AND ASSISTANCE

Physical and psychological healthcare and support is a vital component in the provision of a remedy to survivors of sexual violence. It is essential that it is offered as a means to rehabilitation itself, and also in the form of support through the legislative process. Free medical care, with an emphasis on specific services for women, should be provided to women survivors of sexual violence. Healthcare provision should respond specifically to women's reproductive and sexual health needs. It should encompass free examination to assess the physical and emotional consequences of rape and other forms of sexual violence, together with free counselling and support, HIV, STD and pregnancy testing together with consequent treatment, including the provisions of anti-retrovirals and necessary surgical interventions such as fistula surgery, when required. It should also include related emergency treatment, as well as prescription drugs and treatment to address infections, physiotherapy and other forms of pain management in respect of ongoing physical pain or discomfort, mobility aids and prosthetics where required. Healthcare should also cover antenatal and maternity care in respect of children born as a result of rape.

Healthcare provision should be accessible, available and appropriate, and provided by staff who in turn should be sufficiently trained and sensitive to issues raised by sexual violence, human rights in general and the rights of women in particular. Services and treatments established and offered by women for women, which are typically under-funded or otherwise poorly resourced, should be supported, and treatment should be provided in concert with, rather than in opposition to, traditional treatment and healing practices provided by indigenous women.

Reparations should include the repair or restoration of healthcare facilities and infrastructure damaged by conflict or repressive State actions in order to render services and treatments accessible and available in the long-term.

DETERMINING THE REPARATIVE MODEL

The process of change is as important as the changes themselves, since it represents a further opportunity for the promotion and advancement of women within their respective societies. Women typically encounter difficulties in taking advantage of development opportunities,[51] yet serve a vital role in rebuilding post-conflict societies.[52] It is therefore essential that women survivors are directly involved in and consulted on any reparations package, and their views on the nature of remedies required incorporated and reflected in the resulting model. In the case of individual survivors, direct consultation must be a part of the reparative and retributive process. Consultation more broadly with women's groups and other survivors is especially important in cases of mass violations, where many women will be unable to bring individual claims before the courts. Participation in the consultative process has its own empowering and rehabilitative benefits, and raises the status of participants, particularly where community or symbolic reparations are required.

The implementation of agreed reparations should similarly be gender sensitive, and any implementing body should include representatives with gender expertise, including expertise in gender-based violence. Both the formulation and implementation of reparations must be transparent, and bodies responsible for both should be accountable and subject to monitoring. Realistic, timed targets for implementation should be set to ensure prompt and adequate delivery. National and, where appropriate, international monitoring, accountability and support should also be made available, and survivors directly involved in the monitoring and evaluation of reparative programmes. International donors should enhance implementation through

reporting requirements as well as technical support and assistance. International reporting mechanisms such as the Committee against Torture and the Committee on the Elimination of Discrimination against Women can also assist implementation, where a lack of remedy would otherwise constitute an abuse of governing human rights instruments. The international community can also ensure the implementation of reparations packages through fact-finding and monitoring missions, to include scrutiny of a range of laws of particular relevance to women.[53]

Monitoring and recording mechanisms should also be established to track the incidence of sexual violence and in order to gauge and assess progress in its eradication.

Having identified key areas for change, together with essential key features of any process to facilitate change, it is essential that steps are taken to ensure accessibility to the process. To this end, measures are required which enable the identification of survivors and which allow for their safe involvement. Identification and outreach systems should be constructed transparently, with both establishment and implementation involving civil society organisations, women's groups and survivors, where possible. Steps should also be taken to ensure that women and girls are included in any processes, through the promotion of measures aimed at countering shame and stigmatisation and through gender-specific programmes.

Access can also be facilitated practically by a revision of obstacles to reparations in the form of administrative eligibility requirements. Such obstacles might include the prior presentation of a birth certificate, publication of victims' names, and the non-recognition of traditional, customary marriages. Legal assistance and advice, together with therapeutic support, should be provided on a free and confidential basis.

ACCESS TO A REMEDY IN PRACTICE

Reparation and rehabilitation is inaccessible in practice for many women survivors tortured by the State. Torture, and sexual violence in particular, often stigmatise the victim rather than the perpetrator, and disclosure may have dire social, economic and familial consequences. Notions of family honour lead to pressure not to report sexual violation or to seek therapeutic care in respect of harm suffered, while the emotional impact of abuse severely inhibits help-seeking and reporting, where survivors are often left feeling depressed, isolated, ashamed and exhausted.

Where violence is reported, difficulties in recall, fragmented accounts, late disclosure and emotional numbing are seen as factors which impugn the survivor's credibility rather than as natural responses to trauma. These difficulties are compounded by pre-existing gender inequalities, including discriminatorily poor or curtailed education and limited employment prospects, which impact upon the degree of exposure to the public domain, which in turn affect women's awareness of rights, together with their ability and confidence to articulate them.

Ingrained cultural notions of women as property, together with a societal toleration of life-long gendered abuse mean that many women may simply fail to identify themselves as potential subjects of protective provisions or human rights standards. Others may view their experiences as an inevitable continuum of the abuse they have already suffered as girls, domestically, and in the work place, or simply lack the necessary degree of autonomy to act independently to report the abuse experienced.

Gender inequalities also produce bias within the systems designed to provide redress, reparation and rehabilitation, manifesting as police failings to conscientiously investigate allegations of torture and sexual abuse, discriminatory procedural and evidential rules of court and a lack of prioritisation of gender-appropriate therapeutic services. In many cases, cultural perceptions of women are reflected in the State's legislative provisions.

The consequent lack of justice leads to cycles of impunity, compounding the abuse suffered. Failure to provide appropriate rehabilitative care engenders long-term mental health difficulties, while physical conditions, when left untreated, typically deteriorate, profoundly affecting the individual's quality of life, and in some cases proving fatal.

A reparations model which seeks to put the survivor back in to the position they were in prior to the occurrence of the abuse is therefore inadequate in the case of many women survivors of torture. Inequalities which produced a susceptibility to violence are the very same factors which affect access to justice and healthcare in the aftermath of abuse suffered, and so their revision itself must form a vital component of a reparative process. Such a process must consider not only justice at the individual level, but also seek to address underlying causation, and hence also provide a form of justice at the societal level. Such a process does not require the enactment of new rights, but simply the better recognition and enforcement of existing rights, bringing into stark focus the strong and direct link between the protection of civil and political rights, and respect for economic, social and cultural standards.

RECOMMENDATIONS

UNDERSTANDING AND ACTING ON BASIS OF WOMEN'S CONTEXTS

States should demonstrate commitment to eradicating torture by implementing standards and taking actions to ensure accountability, by:

- ratifying and implementing UN and regional standards for the prohibition of torture and ill-treatment and for the prevention of torture.
- ratifying and implementing UN and regional standards on the elimination of violence against women.
- declaring commitment to and implementing the Nairobi Declaration on the Rights of Women and Girls to a Remedy and Reparation and the UN Basic Principles on Reparation to punish perpetrators and ensure survivors have meaningful access to reparations.
- implementing a gender-appropriate reparations plan in situations of large scale abuse, and ensure consultation, gender expertise and survivor representation in the design and implementation of the plan.
- ensuring that courts pay particular attention to gender issues in awarding reparations, including consultation with the survivor where abuses have been perpetrated on an individual level.

States where women flee to seek protection should:

- take positive steps to ensure decision makers understand the context of women victims of torture in terms of disclosure and create the context for them to disclose in order to gain meaningful protection and access to rehabilitation.
- hold States accountable to respond effectively to torture by raising awareness of concerns in international fora and bringing pressure to bear so that they comply with international standards.

VICTIM PARTICIPATION IN DECISION MAKING AT ALL LEVELS

States should:

- actively ensure women survivors of torture are able to access reparative procedures, through steps such as outreach work, contact with women's groups or local women's NGOs and healthcare workers.
- ensure that reparations models recognise the specific needs of women torture survivors.
- design and implement a national strategy for the payment of reparations, with particular reference to women survivors of torture and sexual violence, and ensure that survivors, experts in gender issues and local NGO groups are involved in the development and implementation of the strategy.
- identify and promote key individuals as representatives on reparation design and implementation bodies and actively include civil society and survivor's groups at all stages.

INTERNATIONAL DONOR COMMUNITY ENGAGEMENT

International donors should:

- ensure that funded projects are gender-sensitive and recognise difficulties in accessing justice, reparation and healthcare of women who have been tortured.
- monitor and evaluate projects to ensure continued compliance with approaches aimed at ensuring women survivors of torture access justice, rehabilitation and perpetrators are brought to account.

ANNEX A

HOW TORTURE IS EXPERIENCED BY WOMEN

The table below represents the various forms of torture and abuse experienced by the 100 women in the study sample.

Form of torture or abuse experienced	Incidence
Beating, kicking, punching	82
Whipping, beating with implement	44
Cutting/stabbing/slashing	15
Shooting	2
Falaka (beating on soles of feet)	11
Suspension, other hanging	3
Enforced standing	4
Electrical torture	5
Heat, burning, acids	33
Immersion, submarino	5
Rape (including rape with implement)	80
Other forms of sexual assault	31
Binding, tying, handcuffs, leg irons	23
Cold water, hosing	13
Medical (drugs, dental)	4
Loss of consciousness	33
Suffocation	5
Isolation, solitary confinement	19
Sensory deprivation (blindfolding, hooding etc)	16
Deprivation of fluid (incl foul water)	23
Deprivation of food (incl foul food)	33
Deprivation of sleep	7
Denial of toilet	18
Loud noises/music	2
Threats of violence/death to self	46
Threats of violence/death to others	12
Sight/sound of others being tortured	28
Enforced nakedness	22

Reports of vaginal rape	Incidence
One rape, one man	13
One man, more than one occasion, number known	5
One man, more than one occasion, number of episodes unknown	8
One episode, more than one man - 2 perpetrators (10); 3 perpetrators (5); 4 perpetrators (6); 5 perpetrators (2); unknown no. of perpetrators (1)*	24
More than one episode, more than one man, number of episodes known	9
More than one man, more than one episode, number of episodes not known	21
Total	80

*Numbers in brackets indicate number of episodes

Reports of anal rape	Incidence
One man, one rape	22
One man, more than one occasion, number known (3)	1
One man, more than one occasion, number unknown	2
One episode, more than one man (number of perpetrators unknown)	1
More than one episode, more than one man, number of episodes known	2
More than one man, more than one episode, number of episodes not known	5
Total	33

Reports of oral rape	Incidence
One man, one rape	2
One man, more than one occasion, number known (3)	1
One man, more than one occasion, number unknown	1
One episode, more than one man (3, unknown, unknown)	3
More than one episode, more than one man, number of episodes known	7
More than one man, more than one episode, number of episodes not known	6
Total	20

Age when first raped	Incidence
16 and under	12
17 – 18	2
19 – 30	40
31 – 40	18
41 – 50	2
Not raped	20

Mean average: 25.6
Median average: 25
Age spread in years: 9 – 50

ANNEX B

SURVIVOR'S PROFILE: EDUCATION, OCCUPATION AND MARITAL STATUS - STATISTICS

AGE WHEN FIRST TORTURED

Information relating to age when first raped or otherwise tortured was available in 94 of the 100 cases in the study sample.

Age when first tortured	Incidence
16 and under	15
17 – 18	3
19 – 30	47
31 – 40	25
41 – 50	3
Over 50	1

Mean average: 26.03
Median average: 25
Age spread in years: 6 – 62

LEVEL OF EDUCATION

Data relating to level of education was available in the cases of 69 of the 100 women in the study sample.

Level of education	Incidence
No education	5
To primary level	9
To secondary level	31
To tertiary/college/university level	23
Home educated	1

OCCUPATION

Information concerning the occupations of women in the study sample was available in 81 cases.

Occupation	Incidence
Unemployed, domestic work including domestic agriculture, work from home, domestic work for others	23
Working in family businesses or other family enterprises	8
Low-skilled and/or menial work, formal sector	6
Formal sector skilled and/or trade	26
Formal sector professional	13
Student	5

MARITAL STATUS

Information relating to the marital status of women in the study sample was available in 92 cases.

Marital status	Incidence
Married	36
Divorced	6
Widowed	8
Partner	1
Single	41

WOMEN WITH CHILDREN

Information relating to whether women in the study sample had children was available in 87 instances.

Women/number of children	Incidence
Women with no children	36
Women with one child	17
Women with two children	14
Women with three children	9
Women with more than three children	11

ENDNOTES

1 Statement by Louise Arbour, UN High Commissioner for Human Rights, Human Rights Council discussion of Violence Against Women, Maternal Mortality and Human Rights of Women, 5th June 2008.
2 For more information, see Medical Foundation Statement in Support of the Torture Damages Bill, published in Torture (Damages) Bill 2007-08 – A Private Member's Bill to Provide a Remedy for Torture Survivors in the United Kingdom: Compilation of Evidence Received following the Call for Evidence launched by Lord Archer of Sandwell QC, compiled by the Redress Trust, July 2008. See also Justice heals: The impact of impunity and the fight against it on the recovery of severe human rights violations' survivors, Knut Rauchfussm and Bianca Schmolze, in Torture, Vol. 18, No. 1, 2008, where the authors note "Ongoing impunity... represents an important obstacle for the recovery of survivors of serious human rights violations".
3 The Committee against Torture noted in relation to the sexual slavery of Japanese women during the Second World War: "The survivors of the wartime abuses... experience continuing abuse and re-traumatization as a result of the State party's official denial of the facts, failure to prosecute those criminally responsible for acts of torture, and failure to provide adequate rehabilitation to the victims and survivors." CAT/C/JPN/CO/1, 3rd August, 2007, para.24.
4 For further information on this see Medical Foundation Statement in Support of the Torture Damages Bill, published in Torture (Damages) Bill 2007-08 – A Private Member's Bill to Provide a Remedy for Torture Survivors in the United Kingdom: Compilation of Evidence Received following the Call for Evidence launched by Lord Archer of Sandwell QC, compiled by the Redress Trust, July 2008. See also Justice heals: The impact of impunity and the fight against it on the recovery of severe human rights violations' survivors, Knut Rauchfussm and Bianca Schmolze, in Torture, Vol. 18, No. 1, 2008.
5 In addition to details relating to clients' physical and emotional responses to torture, client files contain full and detailed testimonies of the experiences of clients, including biographical information relating to the survivor's life in their countries of origin. The women are clients of the organisation's centres in London (74), Manchester (10), Newcastle (5) and Glasgow (11). Information was gathered from their case files using a data collection form, a copy of which is attached at Annex A.
6 Retired Major General Patrick Cammart, Former Division Commander of the United Nations Organisation Mission in the Democratic Republic of the Congo, speaking in the Security Council debate on Resolution 1820 (2008), which calls for the immediate and complete cessation of sexual violence against civilians in conflict zones, adopted on 19th June 2008.
7 Congo – Sexually Abused Women Subject to Fact-Finding Mission, Voice of America, 13th March, 2009.
8 Unifem.
9 John Holmes described the situation of rape victims in a hospital in the South Kivu province of the DRC in Congo's Rape War, Los Angeles Times, October 11th, 2007.
10 Statement by Ms. Louise Arbour, UN High Commissioner for Human Rights, 8th Session of the Human Rights Council Meeting on Human Rights of Women, Geneva, 5th June 2008.
11 Security Council Resolution 1820 (2008).
12 Unifem website: http://www.unifem.org/campaigns/vaw/facts_figures.php?page=7.
13 See for example Rape common in north Uganda refugee camp, Reuters, June 15, 2005; Seeking Protection: Addressing Sexual and Domestic Violence in Tanzania's Refugee Camps, Human Rights Watch, October 2000; UNHCR found sexual abuse to be "endemic" in IDP camps in Sri Lanka, and there were widespread reports that security forces occasionally ordered the men within IDP camps to report to security bases for the night, leaving the camp's female population vulnerable to abuse and exploitation: Country Reports on Human Rights Practices 2007: Sri Lanka, U.S Department of State, 11th March, 2008. See also Country Reports on Human Rights Practices 2007: Somalia, U.S Department of State, 11th March, 2008.
14 In-Depth Study on All Forms of Violence against Women: Report of the Secretary General, 2006. A/61/122/Add.1, 6 July 2006.
15 /16 Information about whether individuals sought any form of legal and/or judicial redress in respect of the abuse they suffered is available in 80 of the 100 cases of women in the study sample.
17 For example, Eritrea and Zimbabwe.
18 Torture is not recognised under domestic law in the DRC.
19 Of the countries of origin of women in the study sample, these included Somalia, DRC, Uganda, Pakistan, Cote d'Ivoire, Guinea, Kenya, Sierra Leone and Jamaica.
20 Domestic violence was criminalised in Zimbabwe by the Domestic Violence Act, 2006. The practice is also illegal in Sri Lanka, Turkey, Eritrea, Guinea, Sierra-Leone, Turkmenistan and Jamaica. Despite specific criminalisation, however, domestic violence remained a serious problem in those States. In other instances, the issue is deemed to be encompassed by domestic provisions relating to assault and bodily harm. The offence, however, is often regarded as a private matter or otherwise ignored, and the act is expressly permitted

under Nigerian law, which allows husbands to physically chastise their wives so long as it does not result in "grievous harm" – defined in turn as harm entailing loss of sight, hearing or speech, facial disfigurement or life-threatening injuries: Penal Code, Northern Nigerian Law, 1963 cap 89.
In the case of Cameroon, there were no gender-specific assault laws, and no legal definition of "discrimination" Afrol Gender Profiles: Cameroon, Afrol News.

21 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January, 2008, at para 61.

22 Report of the Special Rapporteur on violence against women, its causes and consequences, Yakin Erturk, 15th February, 2006.

23 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January, 2008, at para 61.

24 Women Who Are Raped, Dr Petra Clarke, in Rape as a Method of Torture, Medical Foundation, 2004.

25 See for example the Concluding Observations of the UN Committee Against Torture on Cameroon, CAT/C/CR/31/6, 5th February 2004, para 7(c); on Burundi, CAT/C/BDI/CO/1, 15th February 2007, para 11; and on Guatemala, CAT/C/GTM/CO/4, 26th July, 2006, para 19.

26 The UN Special Rapporteur on Violence against Women.

27 See for example, Situation in Iran, Netherlands Ministry of Foreign Affairs, December 1988. In Sierra Leone, Amnesty International report that shame prevents many women affected by rape and other forms of sexual violence from returning to live in their communities; See Sierra Leone: Getting reparations right for survivors of sexual violence, 1st November, 2007. Further, in Darfur, some women choose to stay in IDP camps within Darfur rather than travel to camps in Chad to join family members because of their fear of stigmatisation; Sudan: Darfur: Rape as a weapon of war: sexual violence and its consequences, Amnesty International, 19th July, 2004.

28 Safe in our hands? A study of suicide and self-harm in asylum seekers, Dr. Juliet Cohen, Medical Foundation for the Care of Victims of Torture, Journal of Forensic and Legal Medicine, Volume 15, Issue 4, May 2008, pp235 – 244.

29 The Nairobi Declaration of Women's and Girls' Right to a Remedy and Reparation, March 2007, Article 3. The Declaration was produced and adopted at a meeting of civil society and women's rights organisations.

30 See for example Article 2(3)(a) of the International Covenant on Civil and Political Rights (1966), which requires State Parties "To ensure that any persons whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity". In addition, the right to a remedy in respect of both general and specific breaches of Human Rights conventions can be found in Article 13 of the European Convention on Human Rights and Fundamental Freedoms (1950), which provides "Everyone whose rights and freedoms as set forth in this Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation had been committed by persons acting in an official capacity". Article 5(5) of the Convention also contains a specific and express right to a remedy in respect of incidences of deprivation of liberty in breach of the provisions of Article 5. Similarly, Article 25(1) of the Inter-American Convention on Human Rights, (1969) provides "Everyone has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal for protection against acts that violate his fundamental rights recognized by...this Convention". See also the International Covenant on Civil and Political Rights (art 9(5) and 14(6)), the International Convention on the Elimination of All Forms of Racial Discrimination (art 6), the Convention of the Rights of the Child (art. 39), the Convention against Torture and other Cruel Inhuman and Degrading Treatment, (art. 14); the Inter-American Convention on Human Rights (arts 68 and 63(1)), the African Charter on Human and Peoples' Rights (art. 21(2)); The Geneva Conventions (1949) require signatory States to effectively investigate and prosecute allegations of grave breaches. See Articles 49 & 50 of the Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field; Articles 50 & 51 of the Convention for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea; Articles 129 & 130 of the Convention Relative to the Treatment of Prisoners of War; and Articles 146 & 147 of the Convention Relative to the Protection of Civilian Persons in Times of War. The 1977 Additional Protocol I expressly provides for the payment of compensation to victims of abuses.

31 Resolution 60/147.

32 The Basic Principles reflect binding treaty provisions, which, in relation to the right to a remedy and the right to reparation, have also attained the status of customary international law. For further information on the legal and binding nature of the right to a remedy, see Promoting the right to reparation for survivors of torture: What role for a permanent international criminal court?, Redress, June 1997; Torture Survivors' Perceptions of Reparations: Preliminary Survey, Redress, 2001.

33 The right to reparation is widely recognised in international law: see for example, Article 13 UN Torture

ENDNOTES

Convention; Article 8, Universal Declaration of Human Rights; Article 2(3) ICCPR; Article 13 CERD; Article 47 American Convention on Human Rights; Article 7(1)(a) African Charter on Human and Peoples' Rights; Article 9 Arab Charter on Human Rights; Article 8 Inter-American Convention to Prevent and Punish Torture; Articles 9 and 13 Declaration on the Protection of All Persons from Enforced Disappearance; Article 3(1) Inter-American Convention on Forced Disappearances of Persons.

34 Article 18.

35 See Torture Survivors' Perceptions of Reparations: Preliminary Survey, Redress, 2001.

36 See also Sierra Leone: Getting reparations right for survivors of sexual violence, Amnesty International, November 2007; Reparation – A Sourcebook for Victims of Torture and other Violations of Human Rights and International Humanitarian Law, Redress, March 2003.

37 Article 19.

38 Article 20.

39 Article 22.

40 Article 23.

41 See, for example, the report of the Truth and Reconciliation Commission of Sierra Leone, which notes "the State has a legal obligation to provide reparations for violations committed by both state actors and private actors…States do not only have an obligation to respect human rights themselves; they are also obliged "to ensure compliance with international obligations by private persons and an obligation to prevent violations. If governments fail to apply due diligence in responding adequately to, or in structurally preventing human rights violations, they are legally and morally responsible""; The Final Report of the Truth & Reconciliation Commission of Sierra Leone, Volume 2, Chapter 4, para 21.

42 Chorzow Factory Case, Merits (1928), PCIJ, Series A, No. 17, p.47.

43 Sierra-Leone: Getting reparations right for survivors of sexual violence, Amnesty International.

44 The Rules of Procedure and Evidence for both the International Criminal Tribunal for the Former Yugoslavia and the International Criminal Tribunal for Rwanda provide that "no corroboration of the victim's testimony shall be required", Rule 96(i).

45 See for example rules 70(d) and 71 of the Rules of Procedures and Evidence of the International Criminal Court; Article 69(4) of the Rome Statute; Rule 96(iv), Rules of Procedure and Evidence, International Tribunal for the Former Yugoslavia, IT/32/Rev.41, 28th February, 2008 and for Rwanda, adopted 29th June 1995, consolidated text, March 2008.

46 The Rules of Procedures and Evidence of the International Criminal Court, for example, provide specifically that silence or a lack of resistance cannot be taken to imply consent. Similarly, the rules indicate that the words or conduct of a victim cannot be taken as consent in situations where the perpetrator was subjected to force, threats or was otherwise in a coercive environment; rule 70, paras (a), (b) and (c). The Rules of Procedure and Evidence for both the International Criminal Tribunal for the Former Yugoslavia and the International Criminal Tribunal for Rwanda similarly exclude consent as a defence in cases of sexual assault where the victim had been threatened with or subjected to "violence, duress, detention or psychological oppression" or had reason to believe that if she did not submit, another would be subjected or threatened, Rule 96 (ii)(a) and (b). In addition, Manfred Nowak, the UN's Special Rapporteur on Torture, notes that "in situations where the perpetrator has complete control over the victim the issue of consent becomes irrelevant"; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January 2008.

47 The Tribunal has stated that post-traumatic stress disorder does not affect the credibility of the victim: see the judgment of the Trial Chamber in the case of Furundzija, 10th December, 1998.

48 Report of the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January 2008.

49 In the case of Sierra Leone, for example, the many women and girls who were kidnapped, subjected to multiple rape and abuse and held as sex slaves by rebel forces were described by the Truth and Reconciliation Commission as victims of "forced marriage". See also Report of the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January 2008, para 66.

50 See, for example, the recommendation of the Truth and Reconciliation Commission for Sierra Leone, Volume 2, Chapter 4.

51 See Nairobi Declaration on Women's and Girls' Right to a Remedy and Reparation, 2007, para 3B.

52 This role is acknowledged, for example, in Security Council resolution 1325, 31st October 2000; and see also the preamble to the Nairobi Declaration on Women's and Girls' Right to a Remedy and Reparation, 2007.

53 See also in this regard, Report of the UN Special Rapporteur on Torture and other cruel, inhuman or degrading treatment or punishment, A/HRC/7/3, 15th January 2008, at para 76. See also, for example, the role of the Gender Equality Fund, which evolved out of the 52nd Session of the UN Commission on the Status of Women on Financing Gender Equality.

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