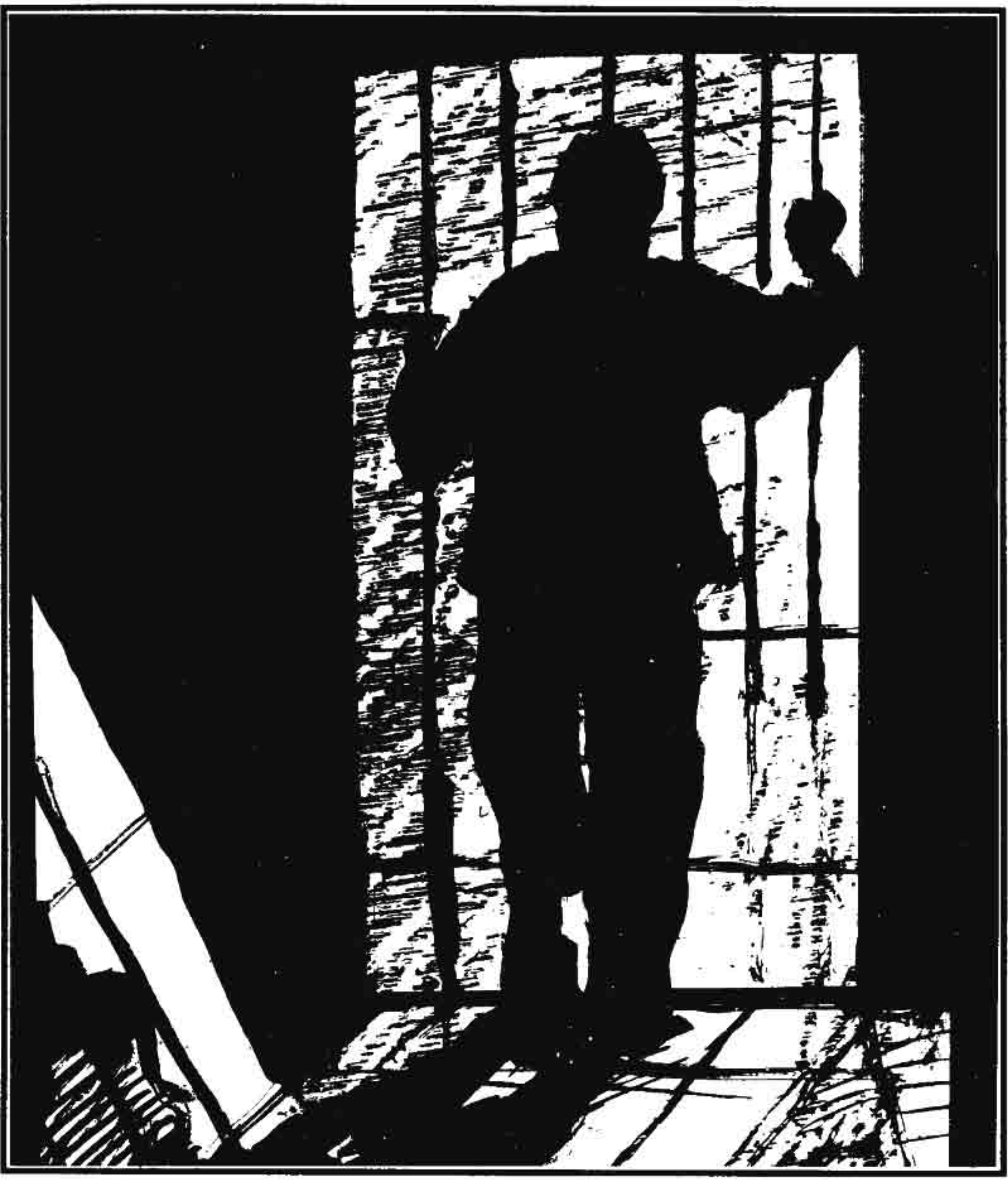
Critical Health

Number 26 May 1989



Detentions and hunger strikes

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Editorial

Increasing dissatisfaction with apartheid's policies has resulted in thousands of people joining forces in protest. The state has responded by declaring a state of emergency, detaining thousands of its opponents and banning and restricting popular organisations, in an attempt to crush resistance.

During the second half of 1985, 329 people were detained but in the nine months following June 1986, this number escalated to over 30 000 people. This accounts for nearly half of the 70 000 people detained since the early 1960s. Most of these detainees have been released under growing local and international protest. Emergency detainees are incarcerated for indefinite periods under harsh conditions. Legal attempts to secure their release have often proved futile. It was out of desperation, therefore, that on 23 January 1989, a number of detainees at Diepkloof Prison in the Transvaal embarked on a hunger strike as a last resort to secure their release. They were soon joined by hundreds of detainees nationwide, forcing the Minister of Law and Order, Mr Adriaan Vlok, to take heed of their plight. The fact that so many of these detainees were subsequently released is testimony to the arbitrary nature of their detentions.

The first article in this edition provides a current review of detention in South Africa. Although at the time of writing the detainee population is numbered as a couple of hundred, it must be remembered that while Mr Vlok released many hunger striking detainees, others were being detained. The serving of severe restriction orders on those released has replaced one type of imprisonment with another. The enforced reporting to police stations, as one aspect of these restrictions, has made ex-detainees' movements predictable and therefore vulnerable to right wing attacks.

The article by John Kalk looks into the medical consequenses of detention in general, and of hunger strikes in particular, and raises debate around the ethical dilemmas facing doctors who treat these detainees. A recent decision by MrVlok, to transfer all detainees on hunger strike to a central hospital, will make access by family and friends difficult.

Many people have found that far from weakening them, periods spent in detention often serve to strengthen their political resolve. An article written by people involved in the counselling of detainees provides valuable insight into the devastating effect that detention can have on the detainee's psyche. The article stresses the way in which these effects extend beyond the individual detainee, to his or her family, friends and to the community at large. Although the release of detainees is a victory in itself, the tremendous restrictions (a more subtle method of repression) placed on ex-detainees, as well as the continuous harassment they are subjected to, have resulted in the identification of a "continuous stress syndrome" experienced by detainees upon release.

There are a number of areas where women are specifically affected by detention. A short article in this edition focuses on some of these problems.

The district surgeon occupies a crucial position in the safeguarding of detainees' health. He/she has a statutory obligation to visit and treat detainees. The tradgedy of Simon Marule, who died while in police custody of a preventable disease, is covered briefly in this edition and raises serious questions as to the kind of treatment detainees receive while in detention. Clearly, the existing laws are not sufficient to safeguard the detainee's health. The article on his story outlines the problems and emphasises the need for urgent attention to be given to this issue.

While Marule's death highlights the inadequacy of medical treatment in detention, another article, by Yosuf Veriava, looks at the areas where doctors, in South Africa and other countries, may collude with the poor treatment received. The role of a district surgeon is not an easy one, and in spite of the guidelines given in the Declaration of Tokyo, to which the Medical Association of South Africa (MASA) subscribes, evidence from a number of cases suggests that some doctors subordinate ethical medical behaviour to political beliefs. Such evidence points to instances of complicity of doctors in interrogation and torture in South African jails. The secrecy that surrounds the examination of some political prisoners is conducive to doctors being able to "cover up" the effects of interrogation techniques. Lack of adequate history taking and the dismal records that are kept on the examination, findings and treatment of detainees allow doctors to protect themselves against accusations of malpractice. A set of protocols for the examination of detainees by district surgeons has been drawn up by the Faculty of Medicine, at the University of the Witwatersrand. A summary of the protocol's principles is included in this edition of *Critical Health*.

Despite Amnesty International's Twelve Point Programme for the Prevention of Torture, also included in this edition, the reality is that an overwhelming number of governments use torture as a means of attempting to control and crush political opposition. It is estimated that one in every three countries in the world supports its use. Melvyn Freeman's article provides insights into the global nature of the problem, as well as highlighting areas where concerned health workers have come together to share their skills with oppressed people.

In South Africa, concerned health workers provide services for ex-detainees to help them cope with the effects of detention. The article by the Detainee Service in the Transvaal outlines the kind of facilities that are provided. Detainees are referred to these services through the various detainee aid centres, established nationally. The Transvaal Detainee Aid Centre has contributed an article on the services it provides.

The system of detention prevailing in South Africa is inhumane and the risk of physical and mental abuse is high. Health workers have an important role to play in demanding safeguards for detainees' health but it must be stressed that no solution will be adequate unless it addresses the root pathology, that of the system of apartheid itself.

This edition is concluded with a tribute to David Webster. David pledged his life to expose the atrocities of the detention system and to assist detainees and their families.

As members of the Editorial Collective of *Critical Health*, we join those individuals and organisations who experienced the political resolve and humane gentleness of this fallen comrade in condemning his senseless assasination.

Critical Health, like so many others, benefitted greatly from David's assistance. He provided rich contributions both in his writing and his advice. We will miss him.

We trust that David's untimely death will increase the resolve of all those struggling for the release of political detainees and for a free and democratic South Africa.

Dr Allan Boesak speaks at a National Detainees Day meeting

Detentions - developments during 1988/9

During 1988 new strategies were employed by both the state and by the detainees themselves, which set the scene for the dramatic events of early 1989, where the initiative to end detention without trial was taken from inside the detention cells. Detentions have been used in South Africa as a tool to suppress all forms of organised resistance. The main thrust of detentions was felt in the Pietermaritzburg area, and also in the school-going, or potentially school-going, youth and civic organisations in the PWV area. However, the year will be remembered mainly for the actions of the detainees themselves and the means they employed for publicising their circumstances.

The youth of South Africa were detained in large numbers over the past few years

What the statistics show

The year saw an overall decrease in the number of detentions but the detainee population experienced an increase in average time served. Many of the new detentions in 1988 were a state response to particular events. The most notable of these was the municipal elections in October, which prompted a surge of detentions in various parts of the country, mainly in the Transvaal and the Western Cape. Nelson Mandela's birthday was a national occasion which also triggered a number of detentions amongst organisers of the celebrations. An anti-apartheid conference organised for September, but banned, also resulted in many detentions.

Table 1 below has been compiled from the records of the Human Rights Commission. The collection of this information is made extremely difficult by the secrecy surrounding detentions and by the way in which the Minister of Law and Order, Minister Vlok, chooses to present lists of detainees to parliament. Only the names of those who have been in detention for over 30 days are given. No additional information, other than names of those detained, is issued. As in the previous year, detentions were heaviest in the Transvaal and Natal. New detentions were markedly lower in the Eastern Cape and Border areas, where organisations in the democratic movement had already suffered badly from repression. This resulted in less resistance from the community. However, amongst the detainee population are many community leaders from these places who were detained in 1986 and who spent yet another long year behind bars. Some United Democratic Front (UDF) activists spent their third Christmas in detention.

	PWV	TVL	Natal	OFS	N. Cape	E. Cape	W. Cape	Un-known	Total
Scholars/students/teachers	445	5	30	5	1	25	14	3	528
Trade unionists/workers	83	4	18	1	-	12	11	3	132
Community/political	287	16	20	4	6	56	47	3	439
Others	21	3	-	-	-	4	9	-	37
Unknown	557	61	935	35	-	264	106	613	2571
Total	1393	89	1003	47	7	361	187	622	3707

Table 1: category of detentions under the state of emergency by area, Jan 1988 - Dec 1988 (These detentions do not include those under the Internal Security Act)

Detentions from the Pietermaritzburg area account for nearly one third of the total number. It is probable that many of the detainees in the category "Unknown" are also from Natal. In contrast with what happened in other regions, these detentions were mainly for short periods.

Concern for her 2 sons in detention — 70 000 people have been detained since the 1960s

In the Transvaal, the two largest categories of detainees were students and community workers, reflecting the controversial issues of the year. The education crisis remains unresolved and many SOSCO (Soweto Students Congress) members are amongst those still in detention. Similarly, the continuing rent boycott has accounted for large numbers of detainees categorised as political and community workers, which includes members of street committees and civic associations.

Releases, hunger strikes and escapes

Overall, the picture of detentions in 1988 is dominated by the releases during that year and during the first months of 1989, bringing the number of detainees to the lowest figure since the declaration of the emergency of 1985. The year 1988 started with the strategic gesture of releasing fourteen detainees, allegedly at the request of the late

In 1988 eighteen popular organisations were restricted as part of a general intensification of state repression

Bavarian Prime Minister, Mr. Strauss, who was visiting the country at the time. The action was much paraded by the state as a demonstration of its moderation, but sceptically regarded by many as a demonstration of the arbitrary nature of detention without trial.

On 24 February 1988, heavy restriction orders were served on 18 organisations. This was accompanied by the severe restriction of ten prominent UDF figures and three journalists and the release from detention of four UDF leaders who were also placed under restriction orders. These restrictions had a severe effect on these organisations with the exception of the Congress of South African Trade Unions (COSATU) which was only allowed to continue with work that was strictly labour-related. It is clear that the state has found this strategy effective.

Detainees started devising new ways of applying pressure on the state for their release. The first was escaping from custody and taking refuge in foreign consulates and embassies amidst international publicity and threatening to damage diplomatic relationships. The first of these escapers were Murphy Morobe, Valli Moosa and Vusi Khanyile (the "Kine 3"), all long-term detainees and prominent leaders. They spent thirty-seven days in the United States consulate in Johannesburg. They left with assurances from the Minister of Law and Order that they would not be re-detained and would not be restricted. This assurance has been honoured - but with the virtual

The "Kine 3" escaped detention and took refuge in the U.S. consulate to highlight their plight

banning of the organisations to which they belong, namely the UDF and the NECC (National Education Crisis Committee), the state is able to give these assurances in relative comfort.

The second initiative taken by detainees was that of hunger strikes. Hunger strikes featured regularly during the year with seventeen different hunger strikes being undertaken by at least five hundred detainees. These occured in twelve different prisons and police stations throughout the country. The first dramatic case was that of Tozamile Taai, a SARHWU member held under Section 29, a man of forty-four and suffering from diabetes. After thirty-three days he was charged by a court convened at his hospital bedside. A few days later the charges were dropped and he was released. This was a forerunner of the concerted hunger strike of 1989 which resulted in the release of many detainees who feared indefinite detention. However, most of the recently released detainees were placed under severe restrictions. Thus, being imprisoned in their own homes has to some extent replaced detention without trial as a major tactic of repression. The strategy of imposing restrictions on both organisations and individuals in place of widespread detentions has also acted to diffuse the emotive issue around detentions whereby sympathy for detainees had been effectively used to mobilise opposition both locally and internationally.

By the Human Rights Commission

Medical and ethical aspects of detention and hunger strikes

The following article, written by Professor J Kalk of the Department of Medicine at the University of the Witwatersrand examines the complex ethical problems created for health workers by the hospital presence of detainees on hunger strike. It argues that the doctor's role in the management of such patients is not a passive one.

Indefinite detention may have severe effects on a person's physical and mental health

Dawn Eliot (R) is reunited with family after 11 months in detention - the impact of detention extends beyond detainees, to their families and friends

The major health impact of detention without trial is psychological and psychiatric. Thus long-term political detainees are regularly brought to the psychiatric services in Johannesburg. Experience in working with these patients has led to the development of the concept of "chronic traumatic stress disorder or syndrome". "Traumatic Stress" is defined as a stress beyond the range of normal human experience. Here in South Africa, it occurs in detainees who have been in detention for long periods of time and who have been denied easy access to family, friends and the usual social support systems. Traumatic stress results from the interruption of normal, regular life activities which include normal food, work, study, exercise, leisure and sleep environments. Common symptoms are those of depression with insomnia (inability to sleep) and nightmares. Multiple complaints, including vague aches and pains, eye problems, skin complaints (pimples), headaches and abdominal pains are also often reported. Some women have reported changes in their menstrual cycle. The symptoms lessen as soon as the stress factor is removed - for example, when people suffering from such stress are admitted to hospital.

Detention is an injury to all

It must be remembered, however, that the impact of detention is not confined to the detainee him/herself. Each detainee has a family that is directly affected; each detainee is part of a community, often in a leadership role. Thus, the damage caused to society as a whole is felt far beyond the detainees themselves.

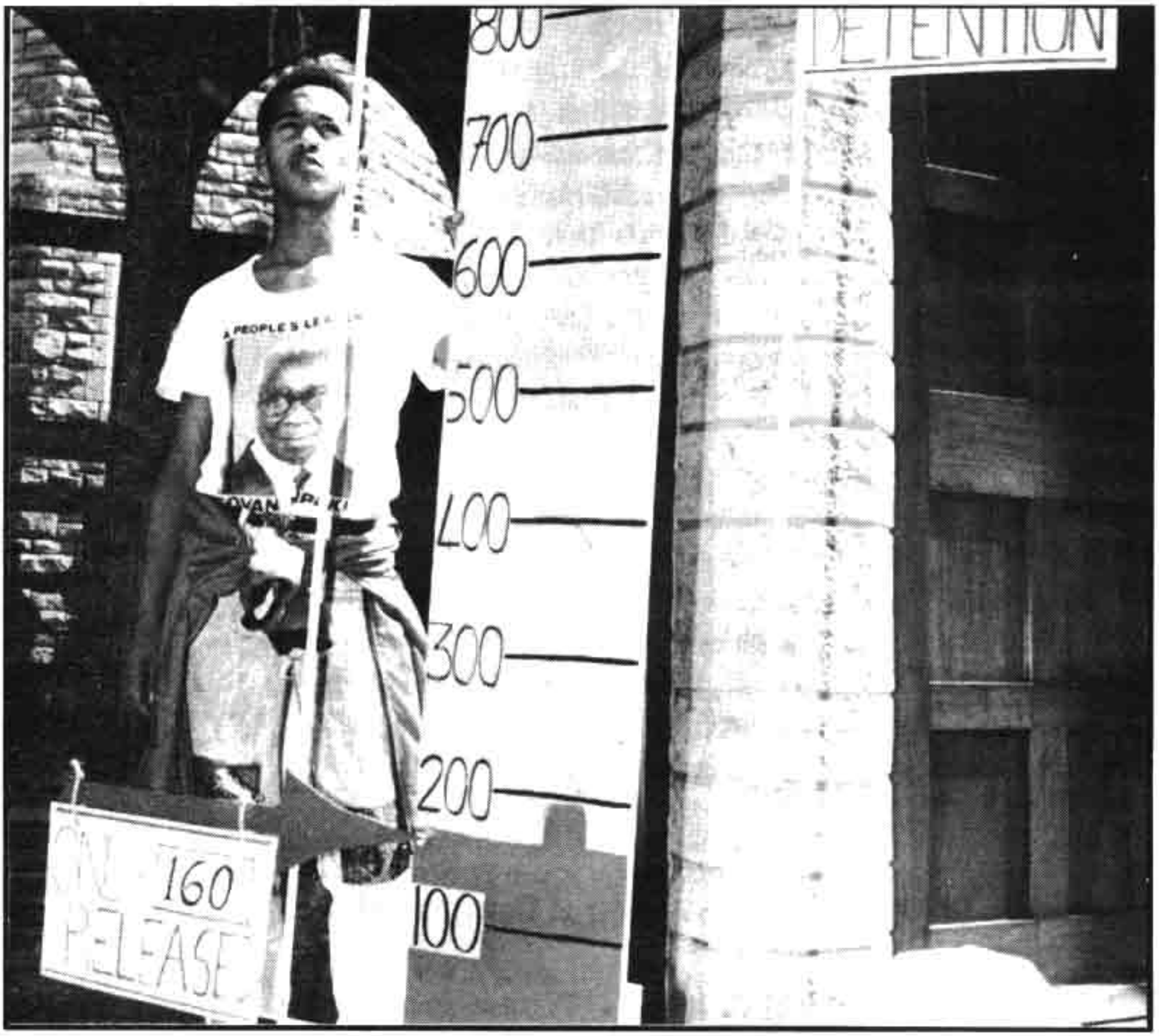
The motivation for fasting

Given all these stresses experienced by detainees, including prolonged detention with no end in sight, and with the possibility of being forgotten altogether by society, it is not surprising that detainees have resorted to fasting to draw attention to their plight. Hunger strikes by political detainees can be viewed as an attempt to reassert some control over their own lives.

What happens to the hunger striker?

The term "Voluntary Total Fasting" (VTF) has been coined as the medical name for hunger strike. The changes in physical condition during VTF have been fairly well described. In the first week there is a rapid loss of weight of about 3-4 kilograms. Thereafter, weight loss is much slower with a steady average loss of about 300 grams per day over the following weeks. Energy during this period is supplied mainly from the breakdown of the body's fat stores. It normally takes about four weeks to use up these stores in the average well-nourished individual. After four weeks, protein breakdown, especially from muscles, increasingly becomes the important source of

Charles Malunga after a 29 day hunger strike - a desperate attempt to secure his release



Detainees' barometer - monitoring the release of detainees during the national hunger strike

energy. This is the stage of potential complications, and at this stage, vitamin deficiencies may develop. Wernecke's encephalopathy - an acute brain disease caused by thiamine (vitamin B) deficiency - has been described in hunger strikers. This problem can be treated by replacing this vitamin.

The symptom of hunger experienced by detainees during a total fast may, paradoxically, disappear in a day or two. But as the fast continues, symptoms of increasing lethargy (loss of energy), weakness, lack of concentration and sleepiness occur. Some patients also complain of headaches, abdominal cramps, dizziness and faintness. Bleeding gums and haematuria (blood in the urine) may also develop. A universal complaint is that of feeling cold. After about 30 days, the hunger striker may no longer feel thirst. He or she may experience episodes of confusion which may lead onto more persistent confusion, followed by coma and death. Blindness also develops in this late stage. Most individuals will die after 40-60 days of the VTF.

The South African experience

Some of the detainees in the recent hunger strikes reached the critical stage of complications rather earlier than expected. Some developed severe medical problems after only 2-3 weeks of fasting. One reason may be that many detainees were physically fit and thin. Thus, they started the fast with relatively small amounts of body fat. Their fat stores would then not last as long as in fatter individuals. They presumably quickly reached the stage of breaking down the body's protein for energy.

Secondly, because of a poor prison diet, the possibility existed that they may have started the hunger strike with reduced vitamin stores.

Thirdly, for whatever reason, many individuals appeared to lose their thirst drive early. As a consequence, they drank less and became dehydrated with hypotension (low blood pressure) and signs of their kidneys starting to fail (pre-renal failure). This was a common reason for admission to hospital.

On average, patients in Johannesburg had lost about 10 kg in weight by the time they were admitted. This amounted to about 10- 15% of their initial body weight over a period of 3 weeks. What little medical literature there is on the topic suggests that better-nourished individuals usually reach this stage after 4-5 weeks of fasting when they have lost 18-20% of their initial body weight.

The role of health workers in a hunger strike

For doctors and other health personnel, VTF creates some complex medical and ethical problems. The doctor specifically is confronted by individuals who are voluntarily harming themselves and who become slowly but progressively weaker and sicker. This must present itself as a contradiction for a doctor, who has been trained to intervene in sickness and to preserve life. The doctor is now constrained to stand back and watch the patients deteriorate instead of providing very simple remedies to reverse the process. Against this contradiction, it must be stressed that the hunger strike is voluntary and that it is motivated by the prevailing conditions of detention. It is an act that requires great courage and determination.

Article 6 of the Declaration of Tokyo provides some useful guidelines to the doctors of such patients. It states: "Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner".

Thus, most doctors reject the option of force feeding mentally competent hunger strikers. But this does not mean that the doctor's role is a passive one and that he or she must stand back and do nothing. The declaration itself places an obligation on the doctor to establish mental competence and explain the medical consequences of the fast. This includes an explanation of the complications which may be anticipated as the fast progresses. When providing these explanations, the doctor must adopt a "neutral attitude" to the patient's responses. Specifically, there should be no pressure to break the fast, and no threat, direct or implied, to withdraw medical attention.

It is also the doctor's medical responsibility to actively monitor the hunger striker's medical and mental condition. Doctors should explain and alleviate symptoms as they develop. They should also ensure that proper nursing and supportive care are available at all times. When complications develop, appropriate therapy must be offered. For example, supplementation of fluids, either taken by mouth or even given intravenously, may be acceptable after appropriate explanations. Antibiotics for infections may also be accepted. It must be understood, however, that acceptance of such treatment does not necessarily indicate an end to the fast. Nor should the patient's refusal to accept intervention prejudice any other aspect of medical care.

The doctor should explain the medical consequences of fasting but no attempt should be made to force the hunger striker to eat

The problem of whether or not to resuscitate an unconscious hunger striker must also be addressed while the patient is still mentally competent. The doctor must obtain, in writing, instructions as to the wishes of the patient regarding emergency assistance in the event of the patient becoming confused or unconscious at some later stage. These instructions must be regarded with the utmost confidentiality. Moreover, this statement from a conscious subject should generally be respected into the period of unconsciousness. If, however, no such declaration has been obtained from a patient who is seen for the first time in a stuporose, confused condition, attempts to revive the patient should be undertaken.

The advocacy role of the doctor

The active advocacy-role of the doctor on behalf of his/her patient extends beyond illness and health issues, into psychological and social areas. It applies especially to those situations where the patients cannot help themselves. Detainees are extreme examples of those powerless to control their own personal circumstances. So it is part of a physician's role to intervene on behalf of the patient if the conditions under which the detainee-patient is held are medically or ethically unacceptable. Although it may be difficult, the medical staff must not allow themselves to become, or to be perceived as an extension of the prison services. They are there to serve the best interests of their individual patient.

The doctor should ensure that the patient in "hospitalised detention" has access to family, friends, media and study material

Thus, all patients should have ready access to family and friends, priests and social workers, reading, writing, study materials, media, and to exercise and to participate in occupational and leisure pursuits. Some or even all of these may be expressly prohibited by the conditions of detention, which, in practice, the police do sometimes try to extend into the hospital. If conditions of "hospitalised detention" preclude any of these patient rights, it is the doctor's duty to try to alleviate them through the district surgeon.

This applies also in cases when the detainee recovers from the fast but has not been released from detention. Ethical doctors may be faced with a dilemma of refusing to discharge a patient from hospital back into detention. They will be aware of the psychological problems caused by prolonged detention and that return to prison will be likely to cause the recurrence or intensification of the problems which precipitated the hunger strike in the first place. Very strong arguments, therefore, can be put forward that doctors should not willingly send their patients back to prison.

Introducing food after a hunger strike

After a prolonged fast, eg after 3 or more weeks, there may be atrophy (wasting away) of the lining of the intestine which may result in malabsorption of food. Thus refeeding should not start with normal food but with easily digestible food.

Day 1

About 1 litre of half strength skim milk should be consumed in divided helpings. An additional litre of water should also be taken.

Day 2

If half strength skim milk is tolerated, one litre of full strength milk should be given for the next 24 hours, also with additional water.

Day 3

If all is well after 48 hours, refeeding with soft, easily digestible foods can be started. If this food is tolerated the individual can gradually eat more and more normal foods over the next few days expecting to get onto a normal full diet within one week. It will take several weeks to regain the lost weight.

Should diarrhoea develop at any stage, it should be taken seriously. Oral food should be stopped although fluids should continue. If diarrhoea persists, a doctor must be consulted - intravenous treatment may be indicated.

Vitamins

Vitamin supplements should be started immediately refeeding starts. For example, simple and cheap "vitamin B Complex" or multivitamin tablets, and vitamin C tablets - one of each twice a day for a few weeks.

Exercise

Exercise should be discouraged until the individual is on a full diet. Thereafter gradually increase the amount of exercise as desired.

By Professor John Kalk
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Voluntary total fasting - guidelines for health workers

The fact that the hunger striking individual may be perceived as deliberately harming him/herself, may lead the doctor to believe that no care is indicated. Believing that this attitude would be an abrogation of medical responsibilities, the Faculty Board of the Department of Medicine at the University of the Witwatersrand adopted a set of principles concerning the medico-ethical considerations involved in the treatment of detainees on hunger strike. These principles are summarised below.

- Health personnel, particularly the doctor (and preferably a senior doctor) must inform the hunger striker of the health consequences of voluntary total fasting (VTF) and of the complications that may develop.
- The paramount principle is fidelity to the will of the patient and no pressure should be put on the person to break the fast.
- No threat to withdraw medical attention should be made and the hunger striker should be assured that normal nursing care will be available at all times.
- Permission (preferably in writing, to protect medical staff) should be sought for non-invasive monitoring, eg regular measurements of weight, pulse, blood pressure and temperature as well as blood and urine tests, X-rays and so on. It must be explained that these measurements will be used to inform the patient of impending serious consequences of the fast, when medical intervention will be offered.
- Symptoms should not be ignored and the causes should be sought.
- While the patient is mentally competent (as assessed by at least two doctors, one of whom should be senior) the doctor must obtain written instructions, in the early stages of the fast, as to the wishes of the patient regarding resuscitation, should s/he become confused or unconscious. This statement must be kept strictly confidential and must be respected. The patient may alter it at any stage. If there are no written instructions to the contrary, the patient should be resuscitated.

If the hunger striker is a minor or has dependants and becomes comatose or stuporose, the doctor should take legal advice (and advice from senior medical

colleagues) before deciding how to proceed, especially if there is a risk of death.
- If medical intervention (eg intravenous fluids and electrolytes, glucose, antibiotics etc) is deemed necessary, it should be offered with full explanations as to the reasons for the intervention as well as the risks of refusing or delaying such treatment.

Acceptance of the treatment does not necessarily indicate the fast has ended. Refusal of part or all of the intervention must not prejudice any other aspect of health care or monitoring.
- Once the fast has ended (for whatever reason) refeeding and other medical treatment must be instituted. This includes the management of psychological problems, especially those associated with detention.
- If conditions of "hospitalised detention" preclude access to family and other people, to media and study material, it is the doctor's duty to try to alleviate the conditions through the appropriate channels.
- A return to prison is likely to cause the recurrence or intensification of the problems which caused the hunger strike in the first place. Such patients, once ready for discharge, should not be sent back to prison without their written consent.

Released detainees display their restriction orders after a 24 day hunger strike

The psychological effects of detention and hunger strikes on mental health

The everyday problems that people have to cope with can change the way they think and behave. Apartheid creates many stresses and frustrations and with the state of emergency, all these stresses become intensified. Over the last few years, thousands of people have been detained. Although many people emerge from detention strengthened in their resolve, there is much evidence that detention can cause severe stress, often requiring psychological intervention.

After detention, people may have problems communicating and may withdraw from their families or from the community at large

An ex-detainee has outlined some of the emotions experienced while in detention. The detainee's prison experience begins with the process of dehumanisation; the detainee becomes a number. He or she may be inclined to identify with the oppressor during solitary confinement when the jailer is the only human contact allowed. The detainee may go through a period of fantasising often about release. Depression, understandably, is a common experience. A summary of the common stress responses to detention that many ex-detainees have reported is outlined below:

- Thinking all the time about the bad experience.
- Flashbacks; an ex-detainee may relive experiences such as interrogation.
- Feeling sick and pains in the body.
- Problems with sleeping; these include problems of getting to sleep, waking often and nightmares.
- Problems with eating.
- No interest in life and a withdrawal from family, friends and the community.
- No energy and feeling tired all the time.
- Problems with sex.
- Bad concentration, bad memory and difficulty reading.
- Feeling guilty about leaving other detainees in prison, or about things one might have said during the pain of interrogation; feeling bad to be alive.
- Changing quickly from one mood to another.

Flashbacks: many ex-detainees relive their bad experiences in detention, such as interrogation

Mood swings - detention can cause extreme stress, making people change suddenly from joy to saddness

- Getting angry about small things. Often an ex-detaince may realise that the anger is more than the other person or situation deserves. It is natural to feel angry about all that has happened but it is impossible to direct that anger at the people who caused the ex-detainee's suffering. The anger sometimes comes out at other people over small problems.
- Irritability; some detainees report that they cannot do the things they easily coped with before detention, for example, chairing a meeting and responding to many different people at the same time.
- Not caring for oneself or other people.
- Feeling afraid, for example if a car stops outside the house at night.
- Feeling nervous and worried.
- Feeling grief and loss.
- Feeling depressed.

Levin reports that three significant psychological varieties of stress inevitably accompany detention conditions. These have been identified as debility, dependency and dread. (1)

Debility (or weakness)

This results from the manipulation by the jailer of the detainee's environments. Stimulation is lacking and is aggravated by lack of sleep, abnormal amounts and types of exercise, physical torture, beatings, electric shocks and inadequate food. All these stresses promote specific psychological reactions.

Dependency

A dependency may be created and maintained by the inability of the detainees to control significant aspects of their social environment. This dependency begins, according to Levin, from the "instant of capture and tends to grow as captivity continues". Detainees may feel helpless as their needs are not met. This results in experiences of fear. The detainee may also identify with the oppressor. This identification occurs when the detainee is helpless and dependent on others.

After release from detention people may experience problems with sleeping

Dread

This may be a consequence of a number of fears which result directly from the inability of the detainee to control or predict events. Dread is a type of continuing fear that is made up of all the small fears a detainee may have. One fear is that the detention will continue indefinitely. There may also be a fear of what the jailers might do while the person is in detention and fear of what may happen to oneself and one's loved ones, when detainees are released. Detainees are vulnerable to torture and beatings but often the smallest amount of abuse can produce this response and clearly demonstrates the vulnerability of the detainee.

Prison experiences are usually beyond the detainee's control. They are not predictable in any meaningful way. Detainee are often unable to effectively confront these conditions because of the apparent unaccountability of those with whom they are in contact. All power is ultimately in the hands of the detaining authority. Thisuncontrollability, unpredictability and unaccountability add to the promotion of the dependency, debility and dread responses.

Responses to stress

Responses to these stresses may include depression, anxiety and occasionally a severe disorientation in which the detainees may be unable to understand the reality of their situation. These responses can result in suicide. The anxiety response precipitated in a detained person is known as Post Traumatic Stress Syndrome (PTSD). This is probably the most frequent syndrome to occur after the detainee is released. Post traumatic stress develops into an ongoing stress syndrome.

Continuous fears may be experienced and are related to harassment and the possibility of rearrest. Many ex-detainees, on their release, report that they live in fear of going back to prison, and of visits by the security police.

Many released detainees have been subjected to severe restrictions. In some cases, these prevent them from continuing their studies or resuming employment. Under the restrictions, they must report to police stations at least once, and in many cases, twice a day. The cost of transport to and from police stations is an added burden to families already under financial strain. People are usually restricted to their homes for the most part of 24 hours and are subjected to constant surveillance by the security police to ensure they are not breaking their restriction orders. They have been released from one type of imprisonment into another.

Other effects of detention may include difficulties with studying. This is because students are often unable to concentrate for extended periods. The psychological effects of detention may interfere with reading, concentration and memory. Their

problems are also made worse by the interruption of their studies as a result of detention. Because ex-detainees may be having difficulty coping with their own feelings and problems, the problems of others may seem like a burden. Also, family and friends, who see the suffering of the ex-detainee, often want to help but do not know how. It is often difficult for the ex-detainee to communicate with others and to talk about their feelings. They should be encouraged to talk to people who have had the same experience. It is often easier to talk to such people and can help the ex-detainee to recover.

Hunger strikes

The present protest action of detainees is a desperate attempt to end arbitrary and indefinite detention. The hunger strike is the last weapon of detainees and prisoners and is undertaken after all efforts to highlight their plight have been exhausted. Hunger strikers will probably be experiencing intense emotions and sensitivity and understanding is required from health workers and other people who come into contact them. Some of the emotions that hunger strikers may experience are outlined below.

Making the decision

Deciding to join a hunger strike is a desperate attempt to compensate for the helplessness experienced in prison. This helplessness includes having no power or control over one's life and no voice to describe or negotiate one's situation. A final expression of one's power is the power over one's body. The decision to join a hunger strike may lead to a new feeling of inner strength and personal power. This may offset the helplessness experienced before. Hunger strikes also represent an appeal to humanity to take heed of the situation. However, the asumption is that there is a common respect for human life which is put above any political, social or racial differences.

The effects of fasting and of hospitalisation

Although hunger strikers may have a feeling of strength on being able to overcome the needs of the body, it becomes difficult to deal with increasing levels of physical pain. After a certain period of fasting, thinking may become confused and detainees may no longer realise that their lives are in danger. Emotions may include a sense of power and triumph (at having acted effectively and caused reaction) and an anticipation of improved treatment. There may, however, be a strong fear of the damage that one may be inflicting on one's body. This may be followed by a feeling of passivity.

One may even begin to resign oneself to one's fate. Being put on a drip may cause a sense of relief together with some disappointment; one may feel invaded, with the initial feeling of power being taken away.

After coming off the strike

After coming off the strike and having been released there may be feelings of guilt at leaving comrades behind and anger about those not released. At the same time one may feel a sense of power as a result of effective action. If redetained, the person may feel anger together with the resolve to fight to the death the next time. Alternatively, there may be feelings of extreme helplessness and passivity.

What can be done about all these feelings

This article has mentioned many of the emotions and problems experienced by detainees on hunger strike, in prison and after their release. Detainee services, established in various parts of the country, have counsellors who are trained to understand the specific problems experienced by detainees. A description of these services, and how to contact them, is provided elsewhere in this edition of *Critical Health.*

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By Betty Livingstone, Dee Pinto, Louise Frankel
of the Organisation for Appropriate Social Services in South Africa (OASSSA).

Interview with a hunger striker

In January 1989, after two and a half years in detention, United Democratic Front (UDF) Northern Transvaal organiser Blessing Mphela and 19 other Diepkloof detainees decided to go on an indefinite hunger strike.

Their hunger strike was the forerunner to a nationwide hunger strike involving some 350 detainees which forced Law and Order Minister Adriaan Vlok to release large numbers of detainees.

Mphela was on hunger strike for 24 days. On behalf of Critical Health, Kerry Cullinan, of the New Nation, spoke to him about his experiences. Much of the interview concerning his treatment and conditions in detention, cannot be printed in terms of the Emergency regulations.

CH: How do you feel now?
BM: It all seems like a dream now - that hunger strike. We did not know whether we would survive those days but we knew we had to go on.

What made you decide to go on hunger strike?
Some of us had been in detention under terrible conditions for over two years without any promise of release. We had tried many times through memorandums to the authorities and court cases to secure our release, but had no success.

We believed that we would be kept in detention until the end of the emergency, and we believe that the government can't rule without the emergency which meant that we would be held for a long time. We were especially worried when they started justifying the emergency by saying that there had been one in Zimbabwe for over 12 years.

How did your relatives react to your decision to refuse food until you were released?
They were worried because they realised that it could mean we would die. But they also supported our decision because we had been inside for so long with no hope of release. We got a lot of support from them, which made us strong.

Trevor Manuel with his family - the first of a nmber of political detainees released following the national hunger strike

How did you feel while on hunger strike?

The first few days were very bad. We felt very hungry and very dizzy as our bodies tried to adjust to the terrible stress.

The worst time though was the second week. That was when we started feeling really dizzy and getting bad stomach cramps. Most of us thought we wouldn't make it through that week, especially as we had been warned of the terrible effects of going on hunger strike.

Mentally, our resolve was strong and we were determined to carry out our action even if it meant death. But when some people collapsed that week, it affected us badly. We did not know whether they had been permanently damaged, and we also did not know what would happen to us. We could not be sure that we would be released.

Were you hospitalised?

Yes, but only on the 22nd day. I had to threaten the prison doctor with legal action before he would agree to send me to the hospital.

What was the attitude of hospitals, generally, to the hunger strikers?
We were worried about their attitude at first, as they tried to force us to start eating. Initially, some hunger strikers were sent back to prison by the hospitals because they refused to eat.

Their attitude only changed when attention was focussed on the hunger strike, and they realised that they would look really bad if they were seen refusing to admit us for no reason at all.

How were you treated by the hospital staff?
I was in the Jo'burg Gen. Treatment there was generally very good. Generally, the doctors were very fine. There were a few exceptions that co-operated with the prison authorities, but the rest of the doctors and the nurses treated us well.

Some of the matrons were very hostile to us though. One kept on asking the security police when we were going to be taken away. We were also not allowed visitors, and one of the matrons phoned the police when some of our family members managed to get in to see us. We asked her why she was doing police work.

But our health was monitored well, and we were also given psychological help. The doctors also put me on a glucose and vitamin C drip at first because I was very weak.

NAMDA also played a very important role in monitoring the hunger strike, and giving second opinions in medical matters.

Do you feel the demands of the hunger strikers have been met?
No. Most of us have been released into another prison through heavy restrictions. We demanded that we be unconditionally released, but we are now expected to monitor ourselves.

No offence has been proven against us, but we are still being punished and we don't understand why.

We demand that our restrictions are lifted. We are not entering into any contract with the government to monitor ourselves.

Our demands that detention without trial be abolished and the state of emergency lifted also remain unchanged, as does our commitment to see a free, democratic South Africa in our lifetime.

What do you think organisations should be doing to help detainees and those recently released?
Vlok has threatened organisations involved in helping detainees, but I think it is very important that they help us to adapt to society again. These detentions have been at huge cost to many of us in terms of our personal programmes. Many of us have lost our jobs, or cannot study anymore. Organisations should find ways of accommodating people and make them feel accepted back into society and the new conditions that face

A member of the Black Sash stages a placard demonstration on a busy Johannesburg street

us. For example, I worked for the UDF before my detention but on my release, I cannot work for the Front any longer because it was banned while I was in detention.

Organisations must find a way of engaging restricted people in meaningful work, instead of leaving us to find our way on our own. It is very hard to adapt to these new conditions.

What are your plans now?

Well, I would really like to further my studies. I was studying at Turfloop before my detention. But I am restricted to Johannesburg and to my Soweto home at night, so I cannot return to the campus.

I also have a responsibility to support my family. I have a five year old daughter, Fundo. So I must find employment and earn some money.

If you were re-detained, would you go on hunger strike again?

Definitely!

Medical care in detention - the death of Simon Marule

Simon Marule was a twenty year old political activist. He died in detention of an easily diagnosed and a treatable disease. An inquest, held recently into the circumstances surrounding his death, found no-one responsible. This case raises serious questions about the quality of medical treatment received by detainees.

Marule's detention and medical history

On June 20, 1986, Marule was detained under the Emergency Regulations at the Dunnottar Police Station and on July 1, was transferred to Modderbee Prison. He was unwell on arrival, having been assaulted by police. (During the inquest, the police admitted to the assault.)

A fellow detainee at Dunnottar testified that Marule could barely move; he thought Marule might even die. He also testified that he saw injuries on Marule's back that were consistent with Marule's story that the police had assaulted him with a plank. As stated in the detainee's affidavit, it was only after detainees threatened to go on hunger strike that Marule was examined by a doctor. A witness testified during the inquest that the examination by the district surgeon was extremely superficial, and only involved looking into Marule's eye. The district surgeon insisted, at the inquest, that Marule did not complain of assault to his back. As a result, he did not think it necessary to do a urine test, which is performed to detect blood in the urine as a result of trauma to the kidneys. Doctors' evidence during the inquest suggested that the kidney disease which caused Marule's death, was probably present at the time of his detention and could have been detected from a urine test at this point. Despite the fact that many doctors may not perform a urine and blood pressure test, if the patient only seems to have trauma to the eye, detainees, in terms of prison regulations are required to undergo a proper medical examination whilst in detention. The examining doctor is obliged to "report fully on the physical and mental condition" of the prisoner. It is widely accepted that urine and

blood pressure tests are fundamental in a proper medical examination. The inquest held into Marule's death revealed that these were never performed.

The following day Marule was taken to hospital for about 40 minutes. When he returned he told detainees there had been no doctors at the hospital and that, despite protests from the nurses, the police had insisted on bringing him back to the police station.

Following his transfer to Modderbee, detainees there also tried to draw attention to Marule's medical condition. The examination took place on 3 July 1986. During the inquest, the doctor responsible for this examination admitted that it was a superficial one. He testified that it is the prison authorities' job to do the urine and blood pressure tests. Despite the fact that the authorities were not doing such tests, he never complained about this nor did he take steps to ensure they were carried out.

Towards the end of 1986, Marule developed symptoms of tiredness, breathing difficulty, loss of appetite, headaches, stomach pains and body swelling. He complained to Lieutenant van der Westhuizen, the medical orderly at Modderbee Prison, that his body was swelling and that his shoes no longer fitted him. Many fellow detainees observed this too.

Affidavits by fellow detainees presented to the inquest court stated Marule was told by the orderly that he was getting fat from eating too much. The only treatment received at this stage was Panado (a painkiller) for his headaches.

Simon Marule's death has created concern over the quality of health care received by detainees

Despite numerous requests by Marule and his fellow detainees, he was not examined again until 22 December 1986 after detainees had threatened not to go back into their cells until he was taken to hospital. A prison officer called to defuse the situation informed the detainees that there were no doctors available on the weekend and that Marule would be examined on Monday. On the Monday, he was seen by Dr Dyson who suspected Marule was very ill, possibly in heart failure. Despite giving evidence at the inquest that he had advised hospital treatment that day, he had failed to write "urgent" on Marule's medical card and had not taken any steps to ensure that he was transported urgently to hospital. In fact, Marule was only to leave for hospital the next day. Counsel for Marule's family argued that failure to ensure that Marule be taken to hospital on the same day amounted to a culpable omission which hastened his death.

Marule collapsed in his cell after weeks of requests for medical attention

Marule collapsed that evening in his cell. Detainees tried for a long time to alert the wardens but were told "julle lieg, julle kaffirs, slaap" (you are lying, kaffirs, sleep) or words to that effect. The detainees made a constant noise until the wardens came to investigate. Marule was found collapsed and with blood stained froth around his mouth. He was transferred that night to the Boksburg/Benoni Hospital where he died the next day.

The casualty officer who treated Marule on admission to the hospital told the inquest that no medical report had accompanied the patient from prison. At the hospital, Marule was treated for fits. He was then transferred from the casualty department to a ward where nothing further was done to establish the cause of the fits.

A post mortem was held but the cause of death could not be determined. However, a histopathologist, consulted by Marule's family, determined the cause of death as membranoproliferative glomerulonephritis (MPGN). It is important to emphasise that all the symptoms that Marule complained of fit the picture of this kidney disease and therefore should have alerted doctors to this condition.

Areas of alleged negligence

Medical experts interviewed by *Critical Health* have highlighted eight areas of apparent negligence in Marule's death:

1. He was not examined fully prior to his transfer from Dunnottar to Modderbee, contrary to prison regulations. A complete examination would in all likelihood have detected protein in the urine and a high blood pressure at this stage.
2. At Modderbee he was only seen (after threats from fellow detainees) a few days after his detention despite having been severely assaulted.

Commemorating the death of Neil Aggett who also died while in detention

A woman's anguish for loved ones in detention

3. The examination at Modderbee was only superficial and an adequate medical history was not taken. Legal representatives for his family argued that if a complete history of an alleged assault had been taken, the doctor would have realised the need for a urine test to look for kidney damage. The urine findings would have prompted further tests and the kidney disease could have been detected. Treatment could have then been initiated.
4. He was not examined again despite numerous complaints to the police.
5. The district surgeon did not ensure that Marule was taken to hospital on the same day that he was examined.
6. No medical report accompanied Marule to hospital.
7. Full attempts were not made at the hospital to establish the cause of his fits.
8. Detailed medical reports were not kept at the prison.

During the inquest it appeared that Dr Fletcher, another district surgeon at Modderbee, may have signed Marule's medical card despite the fact that Marule was seen by a Dr Dyson. The suggestion that a doctor may have signed a report of a patient he did not even examine, was not resolved during the inquest.

Marule's medical treatment in detention illustrates that not only are the existing laws insufficient to safeguard detainees' health, but that these very laws themselves

Detainees have a right to receive comprehensive health care while in custody

are not adequately adhered to. Health workers and prison authorities who do not adhere to the regulations should be held responsible for their actions. The University of the Witwatersrand's Medical Faculty has set out guidelines for district surgeons examining detainees. This protocol is included in this edition of *Critical Health*. Health workers responsible for the treatment of detainees have a responsibility to familiarise themselves with such guidelines.

The district surgeons and the medical orderly responsible for the detainees at Modderbee Prison, told the Inquest Court there were too many detainees to examine thoroughly. It is an unacceptable excuse to explain the poor treatment received by detainees. If the patient load is compromising treatment, the health worker is obliged to take the issue to the authorities to demand more personnel. This problem will only be solved by addressing the issue of detention itself.

Marule's case reveals that referral to a district surgeon often depends on the whim

of individual prison authorities. The medical orderly seemed to assume that Marule was "shamming" and did not, therefore, warrant a doctor's attention. Detainees stated in affidavits that the orderly appeared to be avoiding Cell 8 where Marule was held but this was denied during the inquest.

One of the district surgeons stated during the inquest that detainees cannot expect to be given the equivalent of an executive medical check up from the Mayo Clinic (a very sophisticated hospital in America). However, Professor Strauss, professor of Law at the University of South Africa, has stated: "The mere fact that a man becomes a prisoner .... is not regarded as divesting him of the right to receive adequate health care ..... On the contrary, the modern view is that a special duty is cast upon police and prison authorities and upon medical officers, because in consequence of the deprivation of his liberty, the prisoner no longer has any access to medical practitioners and health care facilities."(1)

References

1. Prof Strauss: *The Clinical Independence of the Doctor in Treatment of Prisoners: A Critical Survey of our Law*
2. Court records of the inquest proceedings

Please note: copies of the court records can be obtained, upon request, from *Critical Health.*

Torture and the medical profession in South Africa - complicity or concern?

Detention in South Africa - a brief profile

Since 1963, approximately 65 persons have died in detention. The death in detention of a leading black political activist, Steve Biko, focussed widespread concern on the practice of torture in South Africa. There is now considerable evidence, given under oath in court proceedings and in studies, that incidents of torture, both physical and psychological, have taken place as part of the coercive treatment of security law detainees. The supreme court application by Dr Wendy Orr to prevent the security police in the Eastern Cape from assaulting detainees is a notable example.

Foster and Sandler, in a study of detention and torture in South Africa, reported that 83% of former detainees claimed to have been subjected to physical torture. Over half were also subjected to psychological forms of torture. NAMDA, at its 1987 conference, reported that 72% of 303 detainees who consulted health workers after their release, alleged that they had been physically assaulted. Blacks appeared to be more commonly abused than whites.

Solitary confinement

Solitary confinement had been experienced by 79% and 34% of the detainees in the two above-mentioned studies respectively. It is used as an important tool during interrogation. The effects of this form of inhumane and degrading treatment on the detainee have been described by Professor C Vorster as follows: "If confinement is kept up, the person loses contact with reality, he (she) becomes totally disorientated and he (she) exhibits symptoms you find in a person with psychosis - imbalance of the

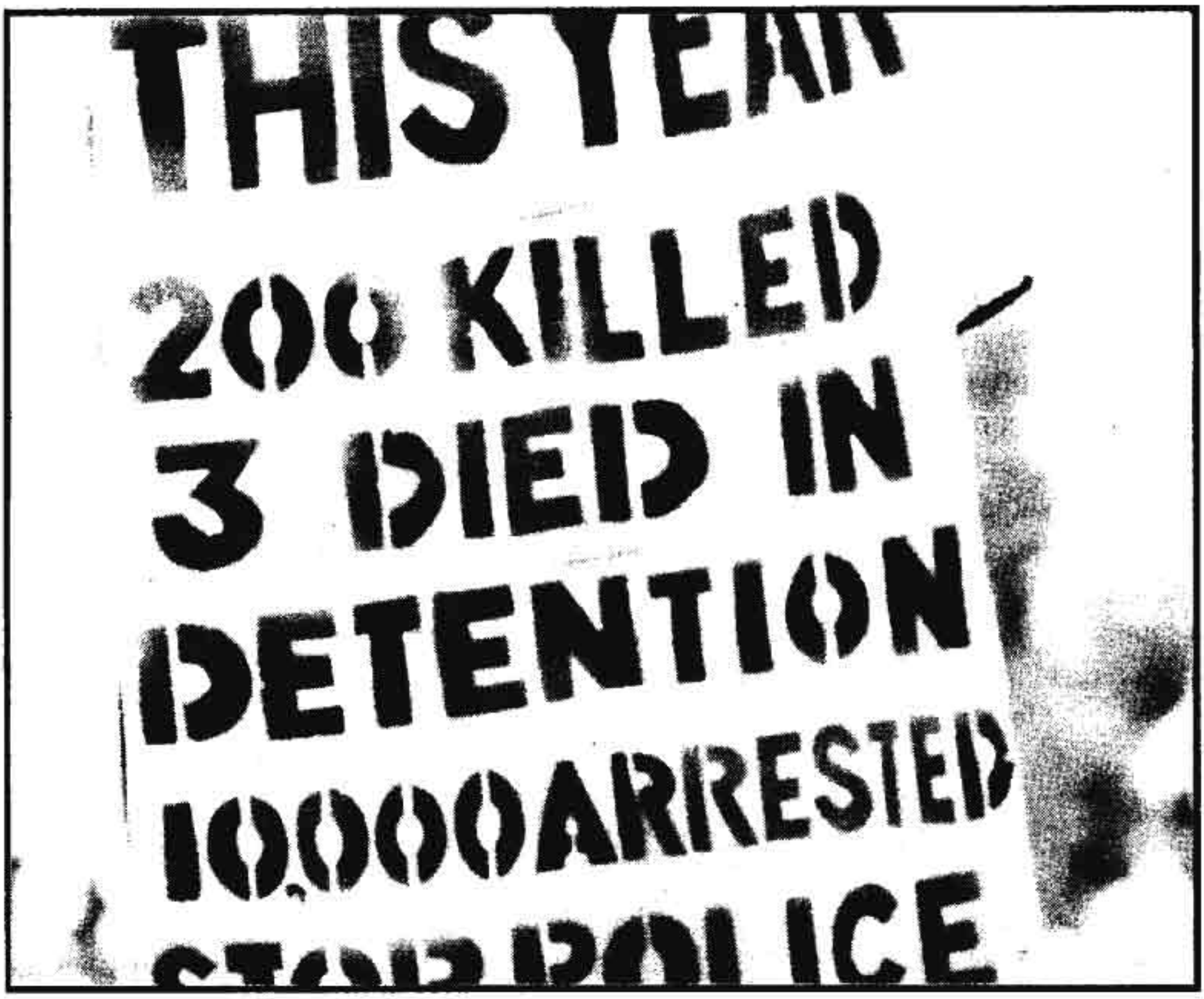
Solitary confinement is inhumane and psychologically harmful

mind - such as high levels of anxiety, panic and delusions. He (she) hallucinates, hears voices. Everything is distorted in terms of distance and height ...".

Solitary confinement and mental torture

A vivid account of the torment experienced by a detainee is given in a note submitted as evidence in the Supreme Court matter of Ebrahim vs Minister of Law and Order. In the note, Ebrahim describes his detention at John Vorster Square, after his abduction at gunpoint from Swaziland, by the South African Police: ".. my interrogators promised to put me under heavy mental strain. W/O Deetlef said if I survived it I would not be a human being".

According to Ebrahim, he was put in a cell which had no visible ceiling and through which little air entered. For four days he was subjected to sharp and piercing noises that were at times continuous throughout the night, at other times intermittent. A visiting



Protesting deaths in detention - 67 people have died in detention over the last 25 years

inspector of detainees intervened and he was removed to another cell. After nine days, the treatment was repeated for seven more nights.

"It was like living in a 'hell'. It completely wrecked my nervous system. I couldn't sit or sleep. Had to walk the cell day and night."

Twenty days after his detention the doctor at the prison told Ebrahim that a hospital appointment would be booked for him. He was to be taken to hospital five days later.

"Presently my mental and nervous health is getting worse ... I need an independent check up or I shall not mentally survive this torture and what is due to come. There are many times I feel my mind is cracking."

Medical intervention under these circumstances may be seen to be beneficial to the detainee, but may also be seen as rendering the detainee mentally fit for continued solitary confinement and interrogation. The administration of tranquillizers or other forms of therapy to counter the medical consequences of solitary confinement without firm recommendations to remove the victim from the harmful situation, constitutes medical complicity in torture.

The Tokyo Declaration and medical ethics

The atrocities committed by Japanese and German doctors during the Second World War prompted international bodies to outlaw medical participation in torture. The World Medical Association's (WMA) Declaration of Tokyo, Article I, states: "The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such a procedure is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife".

Medical complicity or participation in torture is a violation of three fundamental tenets of medical ethics:

- no harm should be done without the expectation of benefit to the patient;
- an intervention should be made only with the consent of the patient in order to obtain some benefit for the patient;
- treatment should be rendered to people in medical need, regardless of their social status, economic resources or political beliefs.

Areas of conflict over medical ethics

Doctors working in prisons and the military are the ones who are most likely to find themselves in a conflict over the principles of medical ethics. These doctors may, in the course of their official duties be called on to:

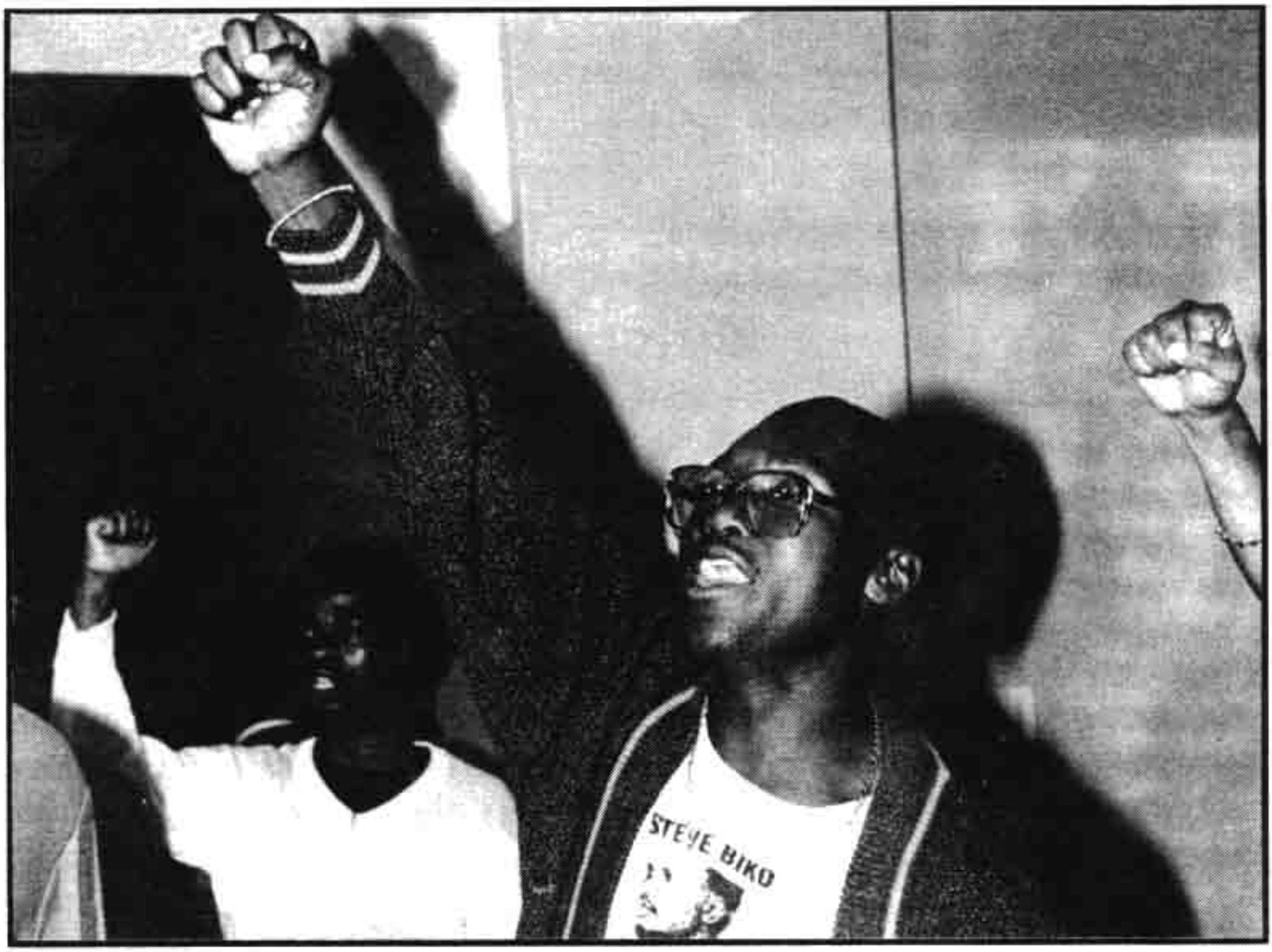
- perform medical examinations of suspects before they are subjected to interrogation which may include torture;
- attend torture sessions in order to intervene when the victim's life is in danger;
- treat the physical effects of torture and attend superficially to a seriously injured torture victim, so that the interrogation can be continued;
- develop medical and psychological methods which assist or protect those responsible for interrogation and torture. As an example, doctors may be asked to issue a false medical or autopsy report so that allegations of torture cannot be substantiated.

Medical care of detainees in South Africa

The key person in the medical care of South African detainees is the district surgeon or the prison medical officer. These doctors have a statutory obligation to visit and treat detainees. Criticism has been levelled against them for negligence, incompetence and for turning a blind eye to brutality. There are, however, district surgeons who claim to

be able to perform their duties according to the guidelines embodied in the Hippocratic Oath and the Declaration of Tokyo. This may be so, but if a doctor in the state's employ encounters evidence of physical and psychological abuse in patients and remains silent or fails to act effectively and continues service under these circumstances, it amounts to condoning torture.

Dr Orr is an example of a South African district surgeon who refused to condone the abuse of detainees. In an affidavit before the Supreme Court, she alleged that the police were responsible for systematically assaulting and torturing detainees. Out of 286 detainees who complained of having been assaulted, she found 153 had sustained injuries that could not have been inflicted lawfully. Of these, 60 had facial injuries, 8 had perforated ear drums and 26 had weals and blisters consistent with quirt blows. Physical abuse was particularly apparent after detainees had returned from interrogation sessions. After prison officials and Dr Ivor Lang, a doctor involved in the Biko case and one of her superiors, had failed to investigate her complaints, she was compelled to take the matter to court. As a result, the police were ordered to stop assaulting present and future detainees, but Dr Orr was relieved of her duties with respect to detainees.



South Africa

Guidelines against medical complicity in torture

Although in South Africa there is no evidence that any doctor assumes the role of torturer, there are indications of medical complicity in the process. This may occur when a detainee is examined and cared for in the immediate detention environment, usually by a district surgeon, or in a private or public hospital, usually by a specialist. In both these situations, medical collaboration can occur with the full knowledge and co-operation of the doctor. They may also be unwitting or reluctant accomplices duped and coerced by their belief that the circumstances are totally out of their control. Detainees are examined by a district surgeon soon after their arrest. This is necessary to evaluate the health needs of the detainee and could also ensure subsequent identification of injuries resulting from the prisoner's custody. However, the findings of the examination could also be used to establish the level of fitness and consequently the degree of torture a detainee is able to withstand. It may also identify weaknesses which might be exploited by the torturer. Medical information on individual detainees that is made available to the security police, is a major breach of confidentiality. The doctor has a responsibility to ensure that this does not occur. Under circumstances where the police have legal access to medical records, collective medical opposition is imperative in order to protect individual doctors from complicity.

Interrogation during detention can cause severe mental anguish

Biko's doctors admitted they would have behaved differently with another type of patient

Doctors in various states' employ are also called upon to attend to detainees who develop problems during detention. These may be unrelated to the circumstances of detention. They may, however, be the outcome of physical or mental abuse in which case medical intervention may amount to a "patch up" process rendering the detainee fit for further violation. It may, however, also be argued that medical intervention can prevent further suffering. Under these circumstances a doctor cannot withhold treatment in order to avoid being an accomplice to further interrogation and torture. The British Medical Association code of ethics provides a guideline to doctors confronted with this situation: "Whether or not a doctor should treat the effects of torture depends on whether the patient wants the doctor's help. The doctor must be prepared to use his or her skills to help the patient, whatever the cause of his or her injuries. But if the victim of torture prefers to die the doctor must respect the patient's wishes".

The doctor is also obliged to report the matter to his/her superiors, protest through official channels as well as solicit the support of colleagues. If these measures fail, the precedent set by Dr Orr, should be followed.

The Biko case

The difficulty in proving that individual doctors are accomplices to acts of torture is inherent in the provisions of the security laws. Strict secrecy often surrounds the circumstances and whereabouts of a detainee. There is, however, evidence from court or inquest proceedings reflecting behaviour verging on complicity or collusion.

The case of Steve Biko, a leading black political activist, who died in detention in 1977, is the best known example in this regard. According to security police evidence, Biko was involved in a scuffle with police the morning after he was detained. The inquest magistrate concluded that this was responsible for the head injury which ultimately led to his death. Dr Lang, a Port Elizabeth district surgeon, examined him that morning for a suspected "stroke" in the security police office and in the presence of Colonel Goosen, the officer in charge of the investigation. Biko lay on a mat tied to a metal grille. Although Dr Lang detected lacerations and bruising as well as neurological signs indicative of brain damage, he issued a false medical certificate stating: "I have found no evidence of any abnormality or pathology in the patient".

Drs Lang and Tucker, the chief district surgeons, examined him the next day. Still lying manacled to a grille, on a mat which was now soaked in urine, additional clinical signs indicative of brain damage were detected and Biko complained of a headache. The doctors never once suggested he be taken off the mat, put to bed and observed and did not inquire of their patient or those in charge of him whether he had suffered any head injury or assault. A private physician examined Biko at Sydenham prison and found neurological abnormalities and blood in the cerebro-spinal fluid. A neurosurgeon was consulted telephonically and advised close supervision of Biko's clinical situation. In spite of all this, Dr Lang wrote in the bedletter: "Dr Hersch and myself can find no pathology".

Protesting against toture

Dr Lang arranged for Biko to be transferred to prison cells claiming that his condition had improved although this was not the case. He also admitted that there were no trained medical staff at the prison and he did not visit the patient until the next afternoon. At the police station Biko lay on a mat on the cement floor with a police warden occasionally looking in on him. Tucker was again called to attend to Biko who had collapsed and was glassy eyed, hyperventilating and frothing at the mouth. Tucker suggested that he be transferred to a provincial hospital in Port Elizabeth, but Colonel Goosen refused permission. Dr Tucker conceded and gave permission for Biko to be transported 1 200 kilometers to Pretoria. He was transported naked, semicomatose and handcuffed in the back of a landrover to Pretoria Central Prison. Dr Tucker, knowing the journey would be made without the presence of a medical attendant, made no attempt to insist on such attention nor to withold his consent for the journey. No medical report was sent with Biko.

At Pretoria prison, Biko was not taken to hospital but received an intravenous drip and a vitamin injection and left on a mat on the floor. He died on the 12 September 1977, almost a month after his original detention. Dr Lang visited the patient on five occasions but made no notes or reports on his findings until the day after the death of his patient. Dr Tucker actually admitted during the inquest that he would have acted differently with any other patient. Clearly, the interest of the patient was subordinated to the interest of the security police.

The case of Simon Mndawe

A similar situation was again encountered during the inquest into the death of detainee, Simon Mndawe. The district surgeon failed to detect and record serious injuries apparently sustained at the time of his arrest. Seven days before his death, Mndawe had made a statement to a government official about his injuries and general state of health. The doctor failed to inquire of Mndawe about assault and relied upon the version of events given to him by the security police who were present during the examination.

The case of Mcube

The case of an African National Congress member, Mncube, who was examined by a doctor to ascertain if he was fit for further interrogation, provides insight into another area of medical complicity. He had been captured in the Messina district having had no food or water for nine days. In court it was alleged that he had been severely assaulted by the security police on two occasions in January 1987. Mncube was examined by a military doctor at the security police offices at Messina on both days. He was examined in a seated position with his arms and legs in chains. He was dehydrated and had scratch marks and abrasions all over his body. The doctor did not

inquire about the origin of these injuries. In court, he explained that the injuries were the result of travelling through bush country and abrasions over his back were due to friction from a ruck sack. He admitted that he was not told by any person whether or not Mncube possessed a ruck sack which in fact he did not. He did not conduct an adequate neurological examination and, concluding that Mncube was relatively well, advised the police to provide him with food and water. The doctor acknowledged in court that he did not understand his role towards his patient to be one in which he could decide upon and provide treatment. Rather, he felt his purpose was primarily to establish whether Mncube could survive questioning. He also believed that he was specifically called upon because Mncube's detention was being kept a secret.

A sum of omissions, deficiencies and failures

These three examples reveal a number of common features:
- shortcomings in the medical examination, with a failure to detect important clinical signs of physical abuse;
- attempts to account for clinical signs of physical abuse detected in a manner which will not implicate the police;
- failure to obtain adequate histories relating to injuries sustained;
- conducting examinations under suboptimal conditions in the secrecy of the security police offices and in the presence of the police;
- a lack of clinical independance in deciding on the care of the detainee;
- subordinating the interests of the patient to those of "security";
- absent, inadequate or inaccurate clinical records;
- apparent disregard for the welfare and dignity of the patient;
- issuing false medical or autopsy reports.

Detainees' specialist care needs: the example of Soni

Detainees requiring specialist care are often referred to either a state or a private hospital. Attending doctors, although appearing to have clinical independence in deciding upon appropriate care, are limited by various provisions of the security act pertaining to the detainee in that they may not be able to make a recommendation in the best interest of the patient. This is illustrated in the matter of Marajee vs Minister of Law and Order and others (1985).

Shirish Soni's mental and physical condition at the time of his detention was normal. After about one month in detention the chief district surgeon, concerned about

Doctors should not examine detainees in the secrecy of police offices and the presence of police guards may make it hard for the detainee to be open

the mental health of Soni, consulted Dr A Valjee, a psychiatrist. Another psychiatrist had already recommended hospitalisation. Dr Valjee treated Soni and later discharged him as he had responded to treatment. Soni was redetained soon after and was brought back to Dr Valjee who reported to the district surgeon that he had found his patient "extremely regressed, depressed and a totally broken man in less than two weeks". He stated that Soni had been in solitary confinement, interrogated and starved. He found Soni to be suicidal and arranged for readmission to hospital. Dr Valjee concluded by stating: "In relation to what I understand to be the purpose of the patient's detention, I must stress that he is in no condition to answer any questions which may form part of an interrogation. No answer that he might give in his condition can be relied upon. I am able to state that for medical reasons, interrogating the patient would be a pointless exercise. It's only consequence would be to worsen his condition .... further interrogation will most likely result in permanent mental damage of the patient .... the further detention of the patient, even without interrogation, is likely to have the same consequence. The patient is no longer in a condition to cope with deprivation of personal liberty which is a necessary consequence of his detention. This is why his surroundings, even in hospital, must be normalised as much as possible immediately".

Access to a radio, reading material and to family members and a priest was advised. It was also stressed that he not be visited by the police who had interrogated him in the past. Dr Valjee added that since these measures were vital in the treatment of his patient holistically, he would have no option but to withdraw psychiatric services if these recommendations were not met. He did state, however, that he was concerned that such action would be another stress upon his patient.

Dr Lasich, a senior lecturer in the Department of Psychiatry, University of Natal, agreed in essence with Dr Valjee, concluding: "The patient cannot under any circumstances be returned to detention which has been the direct cause of his illness. The environment of the police cells that incorporates and represents isolation, interrogation, manipulation of daily existence and pathological relationships with captors can never be considered as acceptable in the effective treatment of detention related psychiatric illnesses".

An affidavit submitted by Dr Porten, a private psychiatrist, on behalf of the Minister of Law and Order disagreed on psychiatric grounds, with the way in which the patient was managed. Porten stated that he would have approached the problem as follows: "Without any fuss, calmly, objectively, I will elicit the patient's complaints. I will point out to him his symptoms, although stressful, are inevitable normal consequences of the situation he put himself in. I would show him alternatives and urge him to make his choice as soon as possible. I might put him even on some mild tranquillisation, if I would feel his anxiety exceeding bearable levels. I would not hospitalise him. I would encourage his interrogators to complete their work as soon as possible and either to charge him or let him go".

He therefore saw his role as assisting the patient to cope with detention and to facilitate the interrogation process. This approach is, in essence, a breach of the obligations demanded by the Declaration of Tokyo. Because of conflicting medical evidence, the matter was referred for oral evidence. Soni was not released initially but concessions were made for "normalising" his immediate surroundings. Soni was released before the oral evidence could be heard.

Guidelines on mental health care

A number of important features emerge from this case. First, it is clear that detention can cause psychiatric disturbances. It also shows that in a recovered patient who returns to detention, psychiatric problems may return. This introduces a serious ethical dilemma for the attending physician. Should the doctor discharge the patient back to detention to the harmful circumstances which originally caused the patient's illness? An action that could be taken by a district surgeon or by a doctor working in a private or state hospital, would be, with the patient's permission, to inform the family, and

through them the detainee's legal representative, of the situation. The family could then take the matter further. The doctor should support any application that is made in the medical interests of the patient. A doctor may also decide to make a supreme court application on behalf of the patient (although such action has not as yet been taken).

What are the reasons for breaches in medical ethics

The resolution of these dilemmas is at present a matter of the doctor's own conscience. What then are the reasons that could be given to explain deviant ethical behaviour by a doctor? The British Medical group of Amnesty International suggest the following:

Ideological support for the regime

Doctors who see the political programme of the government as essential for the overall good of society may easily be persuaded that torture is necessary in order to maintain the security of the state. In South African society where the medical profession is dominated by members of the privileged white minority, the political loyalties of the medical profession generally reflect the interests of and the prejudices prevailing in this group. Political opponents are seen as "terrorists" or "communists" and a threat to the security or status of white supremacy.

In South Africa, the political loyalties of the medical profession often reflect the interests of the privileged white minority

Sense of duty

Where ultimate responsibility lies with others, some doctors absolve themselves of personal responsibility for their own actions.

Overt fear of repercussions

Future security may be at risk if a doctor fails to comply. This may apply to job security or even one's own personal security. In South Africa, for example, Dr Wendy Orr was relieved of her duties in respect of detainees for taking the matter of detainee abuse to court.

Humanitarian reasons

Torture must be a highly traumatic experience which some doctors may see as requiring their intervention to minimise the consequences of the practice.

Conclusion

In South Africa, however, there is an ignorance relating to ethical issues and responsibilities that arise under these circumstances. Many doctors do not have adequate training in or have failed to keep up with developments in medical ethics. The Tokyo Declaration was accepted relatively recently, long after the completion of training of many doctors. Clearly there is an urgent need for the medical profession to discuss the dilemmas raised by the issue of detention in South Africa.

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By Dr Yosuf Veriava

Women and detention

Women have played an integral part in the mass struggles against racial and economic oppression. They have mobilised against mass eviction and forced removals, against poor working conditions and inferior education, pass laws and influx control. They have supported consumer and rent boycotts and have campaigned alongside men for an end to military conscription.

Information is difficult to obtain from the police and the prison service as to how many women have been detained in South Africa. A conservative estimate of 25 000 people detained between June 1986 and June 1987 has been made and is thought to include at least 3 050 (12%) women. It is important to note that this low percentage is most probably explained by the fact that few women rise to leadership positions in popular organisations and are therefore less likely to be detained. (This incomplete representation has been challenged and acknowlegded by these organisations.)

Black women of South Africa are often single mothers or have spouses who are unemployed and, therefore, are often the wage earners of the family. Others have been forced into this position by the detention of a husband, boyfriend or father.

While most of the problems experienced by detainees are common to both men and women, there are certain aspects of detention that are specifically related to women. A brief outline of these areas is discussed below.

Approximately 3050 women were detained between 1986 - 1987

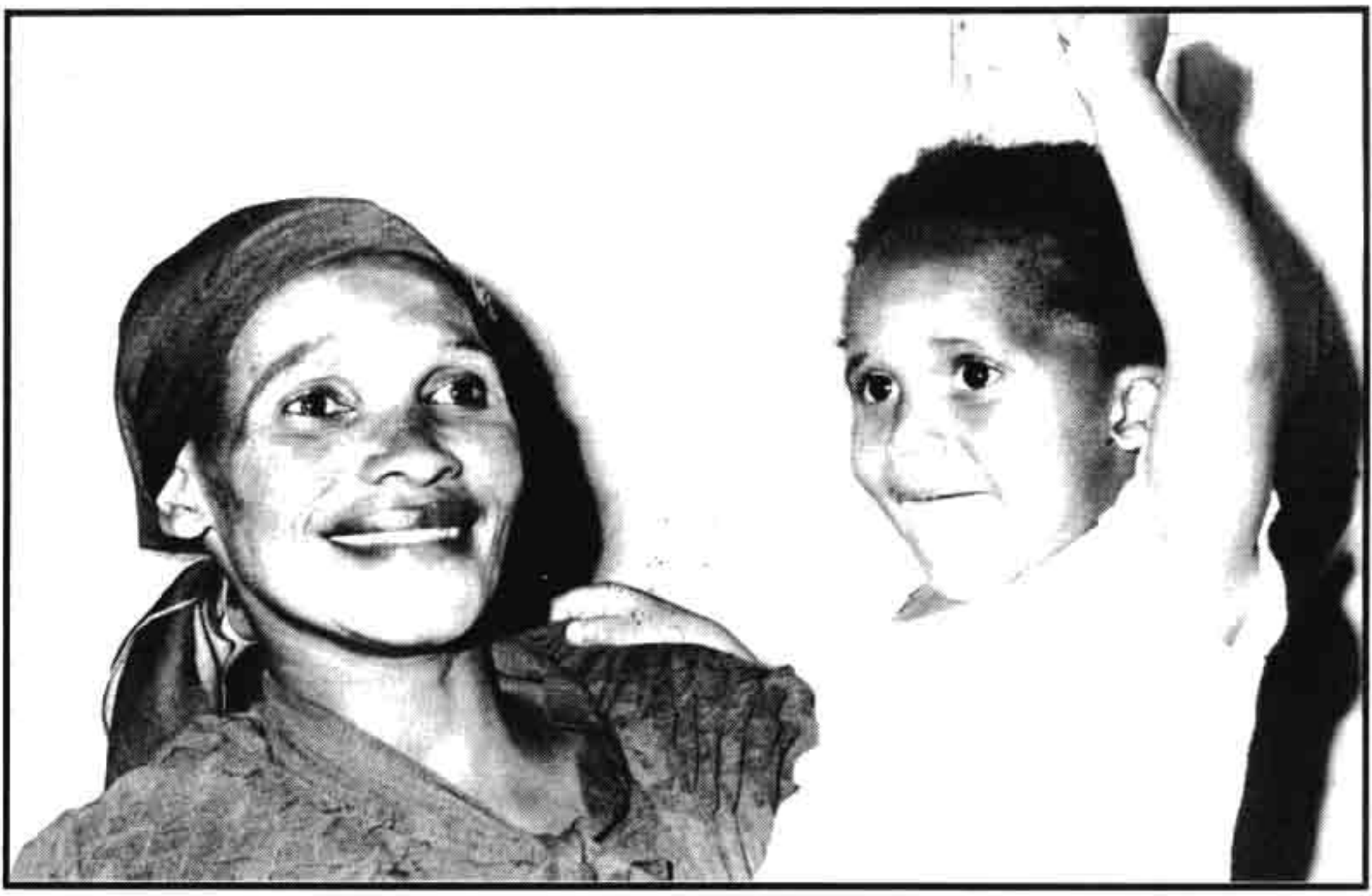
Menstruation

Women detainees have complained that no sanitary towels are provided during their menstrual periods. Sometimes only three towels are provided, per woman, for each period. This situation appears to vary according to the different prisons. Sanitary towels may be purchased from some of the prison shops but money is often scarce and is usually used to supplement a poor prison diet.

Pregnancy

The prison diet may not provide pregnant mothers with sufficient nutrition and antenatal care, if received at all, may be inadequate. Allegations have been made of pregnant women being beaten and tortured. This may account for those women who have allegedly miscarried while in detention, especially when this is added to the possible lack of medical care or the stress of detention. Women who do not miscarry

Released after 7 months in detention - prison diet does not always provide pregnant mothers with sufficient nutrition



Richard Geelbooi, 2, spent 8 months in detention with his mother, Selina

must continue their pregnancy to term, often under unhygienic, intolerable conditions. Women have had to give birth while in police custody. Their new born babies may have been kept with them; subjected to the same poor conditions. For many women, this was their first experience of childbirth. They had to cope with this experience alone, without the support of the child's father, their family or friends.

For those women with children already, being detained means a separation from their children, often without knowing who is caring for them. Children, in turn, are especially traumatised by the detention of the person who is usually their primary carer. A special trauma is often experienced by breastfeeding mothers when they are removed from their children.

Sexual assault

Most women are afraid to talk about these experiences. Body searches and vaginal examinations are allegedly performed on women who have perceived them as being done for no apparent reason other than harassment and humiliation. Many women express a fear of sexual assault arising from the knowledge that male wardens may have access to their prisons. Families who have female relatives in detention worry about the possibility of such assaults.

Protocol for the examination of detainees by district surgeons

A protocol for the examination of detainees has been approved by the Faculty of Medicine, University of the Witwatersrand, to assist district surgeons in dealing with the health care of detainees. It is based on the guidelines contained in the Declaration of Tokyo which have been accepted by the Medical Association of South Africa (MASA).

The protocol aims to assist doctors by standardising procedures for conducting the history, examination, treatment, referral and re-assessment of detainees. It should be completed in full. In the event of future judicial proceedings it may serve to protect both doctor and patient.

The same protocol may also be of use to outside doctors whose medical opinions are requested by district surgeons. In such instances, the outside doctor should, as is customary between colleagues, provide the referring district surgeon with a copy of the full report including recommendations for future management.

In accordance with normal practice, the protocol requires that certain conditions be fulfilled:

- All examinations should be conducted in a consulting room with adequate facilities for a comprehensive examination. If the facilities are not adequate, do not hesitate to request the authorities to provide adequate and appropriate conditions.
(Editors' note: this examination should be conducted in private, with no security guard in attendence.)
- The doctor should always introduce himself or herself to the detainee and a suitable female chaperone should be present whenever a female detainee is examined by a male doctor.
- The doctor should inform the detainee that s/he has the right to be visited on a routine

Indifference from prison authorities forced Dr Wendy Orr to take her complaints of maltreatment of detainees to court

fortnightly basis by a district surgeon. In addition, s/he has the right to request the services of a district surgeon should s/he feel the need for medical attention.

- The detainee should be informed that while every effort will be made to maintain confidentiality, a district surgeon must, under the Act, submit a report to the Office of the Director of Security Legislation and to the Divisional Commissioner.
- Immediate action should be taken if there is any evidence that the conditions of detention have adversely affected the mental or physical wellbeing of the detainee. The persons to be notified include:

1. The Commander of the Police Station or Prison or, if not available, his/her deputy..
2. The Inspector of Detainees or his/her deputy.
3. The Director of the Regional Office of the Department of Health and Welfare or his/her deputy.

(In the case of outside doctors, the persons to be notified should also include the District Surgeon who referred the patient, or his/her deputy.)

In an emergency this should be done verbally and confirmed by letter.

(Editors' note: if none of the above channels achieve positive results, the precedent, set by Dr Wendy Orr, of obtaining independent legal action, should be followed.)

Copies of this protocol are obtainable from the Faculty of Medicine, University of the Witwatersrand, Medical School, 7 York Rd, Parktown, 2193

The Detainees Aid Centre

In 1985 the Detainees Parents Support Committee (DPSC) established an advice office to help the affected families of those detained. In February 1988, the DPSC was restricted. In September 1988, the Detainees Aid Centre (D.A.C.) was established in order to address the needs of detainees and their families.

Families of those detained are assisted to obtain visits to their loved ones as visits are viewed by the authorities as a privilege and not as a right. A lawyer is instructed to represent the detainee if the family does not have its own lawyer.

D.A.C. provides track suits for each detainee and money is given for the detainee to buy from the prison shop.

On release, the detainee is interviewed and a statement is taken of his/her treatment and other aspects of his/her detention.

Every detainee is referred to the National Medical and Dental Association (NAMDA) medical panel for a medical check up and to the Detainee Counselling Service for counselling.

Contacts

Detainees Aid Centre
209 Darragh House
13 Wanderers St.
Johannesburg
Telephone: 232741/2

Kate Turner
P.O. Box 2767
North End
Port Elizabeth
6056

Nehawu
Box 1818
Kimberley
0531

Bizzah Makhate
41 Seeisoville
Kroonstaad
9500

Relief Centre on Top
Community House
41 Salt River Rd
Salt River
7925

Phatheka Mthintsicana
24 N.U. 13
Mdantsane
5219

Y Vawda
P.O. Box 2875
Nelspruit
1200

Dacom Detainees
Advice Centre
P.O. Box 2338 (170 Berg St)
Pietermaritzburg
3200

Legal Resources Centre
Attention: Sandy Steward
116 High St
Grahamstown
6140

D.C.C.
Attention: Barbara
P.O. Box 3932
Durban
4000

Poor Fund Committee
Shop No. 10
Ikageng Shopping Centre
Cnr Curlewis & Ross Sts
Potchefstroom
2520

Thusong Advice Centre
3a Kismet St, First floor
Indian Shopping Complex
Heidelberg
2400

The detainees service

In South Africa there are health services for detainees in Cape Town, Port Elizabeth, Grahamstown, East London, Durban, Pietermaritzburg and Johannesburg. Services were first established in 1985 and have continued to grow as a result of mass detentions under the State of Emergency. Besides these services doctors and a few counsellors, who have an understanding of the health problems of ex-detainees, are also seeing ex-detainees in other places.

The detainee health services are run by members of progressive health organisations, mostly on a voluntary basis. This often makes it difficult to provide an ongoing service as health workers are not always able to take off time from their other work. Because of this we have trained many health workers in the problems of ex-detainees, to cope with the need.

Appointments to be seen in these services are made through the detainee aid centres. (See contact addresses on previous page)

Many detainees choose to go for counselling to work through their feelings after the stress of detention

Why are there special health services for detainees?

It is often difficult for a private or a clinic doctor to spend enough time with ex-detainees to attend to all their health problems. In the detainee health service a doctor may spend up to an hour with each person.

It is clear that counselling is important for ex-detainees but most doctors have not been trained in counselling. This could be harmful as problems may be missed or not taken seriously enough. For this reason, the detainee service offers counselling by counsellors who are trained to help with the special problems of ex-detainees. This is very important as it is difficult to get to these counsellors through the ordinary health services.

What happens in the health service?

The health services differ according to the number of health workers and the way they are run. However, in most health services, one sees both a doctor and a counsellor.

Upon release from detention, ex-detainees can attend special health services, run by progressive health workers

What the doctor will do

The doctor spends time hearing about the health problems and experiences in detention and performs a careful examination to see if there are any serious problems.

If the doctor finds the ex-detainee to be healthy, reassurance should be given that the ex-detainee has not been permanently affected by detention.

The doctor often finds problems to be related to stress. Physical and psychological problems usually come together and can show up as psychological strain through pains in the body. Headaches and stomach pains are examples of this. This is normal and is treated by combining counselling with medicines for the pains. Problems found are explained carefully to the person.

Detainees' problems do not always end after they are released

If needed, follow-up consultations are arranged. For example, a hearing test or an appointment for a specialist for assessment of high blood pressure. In some cases more information is required and X-rays or blood tests may be undertaken.

The clinic cannot see ex-detainees for all their problems and is also unable to continue providing services to individuals seen. After the first one or two visits individuals are referred to a private doctor or clinic for follow up.

The service does provide some medication. A common need is for medicines to help people sleep. Careful attention is given so that medicines will not cause addiction or make one very sleepy during the day.

Some clinics offer some other services like physiotherapy which is used to help body pains and tension through treatments like massage and exercises.

What the counsellor will do

Many people find it difficult to understand how counselling works. Strong feelings can be unpleasant and difficult to understand and often make people feel upset and unhappy. The counsellor helps the person understand what these feelings are all about.

It can be difficult for a person to explain how they are feeling. Counsellors help the person to explain their feelings to others. This helps the ex-detainee make better contact with other people. Counsellors encourage ex-detainees to talk to family members, friends or comrades whom they can trust and whom they feel can understand them.

Counselling is not just talking. Counselling deals with feelings through talking. If you only talk about feelings and do not feel them, the counselling is not working. It is not easy to work on feelings. It can be painful and tiring. Some people are not used to it and find it too difficult. More and more ex-detainees are finding counselling useful. Some enter the clinic saying "I don't mind seeing the doctor but I came to see the psychologist. I have a psychological problem".

We think there is a growing awareness of the psychological effects of detention. Some ex-detainees have reported that counselling has helped them recover faster.

Some people do not choose counselling and prefer, rather, to talk to family or friends. Some people try to bury their problems and others land up feeling helpless.

Where a counsellor can help

The counsellor is trained to understand the problems of the ex-detainee and how to work with their problems. With counselling a person can work through the feelings to the point where they can cope with them. From there, a person can develop normally. For many detainees release from detention brings new problems such as harassment, unemployment, accommodation problems, family crises and court cases. Under these conditions recovery is more difficult and takes longer. A person may need more help.

How the counsellor works with the ex-detainee

Firstly the ex-detainee needs to trust the counsellor. The counsellor will try to build this trust and discuss it with the ex-detainee. The counsellor aims to respond to the problems of the ex-detainee at this time.

The counsellor is not there to judge the detainee personally or politically, eg the

Counsellors at the Detainees Service are trained to understand the specific problems of ex-detainees. They can help them to cope with their problems

way the detainee responded to interrogation. Bad experiences in detention are often caused by people. This makes it more difficult for the ex-detainee to trust the counsellor. Building trust helps the detainee to recover.

From there the counsellor encourages the ex-detainee to talk about his/her feelings. This can be difficult and take time but the counsellor helps the person understand the feelings.

Mostly counsellors don't give advice. They help the person come to their own decisions. For example, if the person is feeling very helpless, the counsellor works on the helplessness until the person can take his/her own decision.

Counsellors usually want to see people more than once. With serious problems the counsellor can work with the ex-detainee for some months or for however long is needed.

By the Transvaal Detainees Service

Aims for the doctor in seeing the ex-detainee

- Give the ex-detainee as much control as possible over the interview.
- Attend to health problems raised by the ex-detainee, explain all findings.
- Check general health and exclude serious illness. Reassure the patient if well.
- Refer problems for follow-up or further assessment as needed.
- Give medicines as needed.
- Document injuries.
- Understand and identify psychological problems. Deal with basic counselling if there is no counsellor available, and refer serious problems.
- Work closely with counsellors and other health workers in a team approach.

Aims for the counsellor

- To build trust with the ex-detainee.
- To assess if there is Post Traumatic Stress Syndrome, and its severity.
- To reach some of the worst feelings that result from the trauma of detention. This can be difficult where the detainee has withdrawn or has strong defences.
- Provide follow-up where possible.

By the Transvaal Detainees Service

International responses by medical and psychological personnel to organised violence

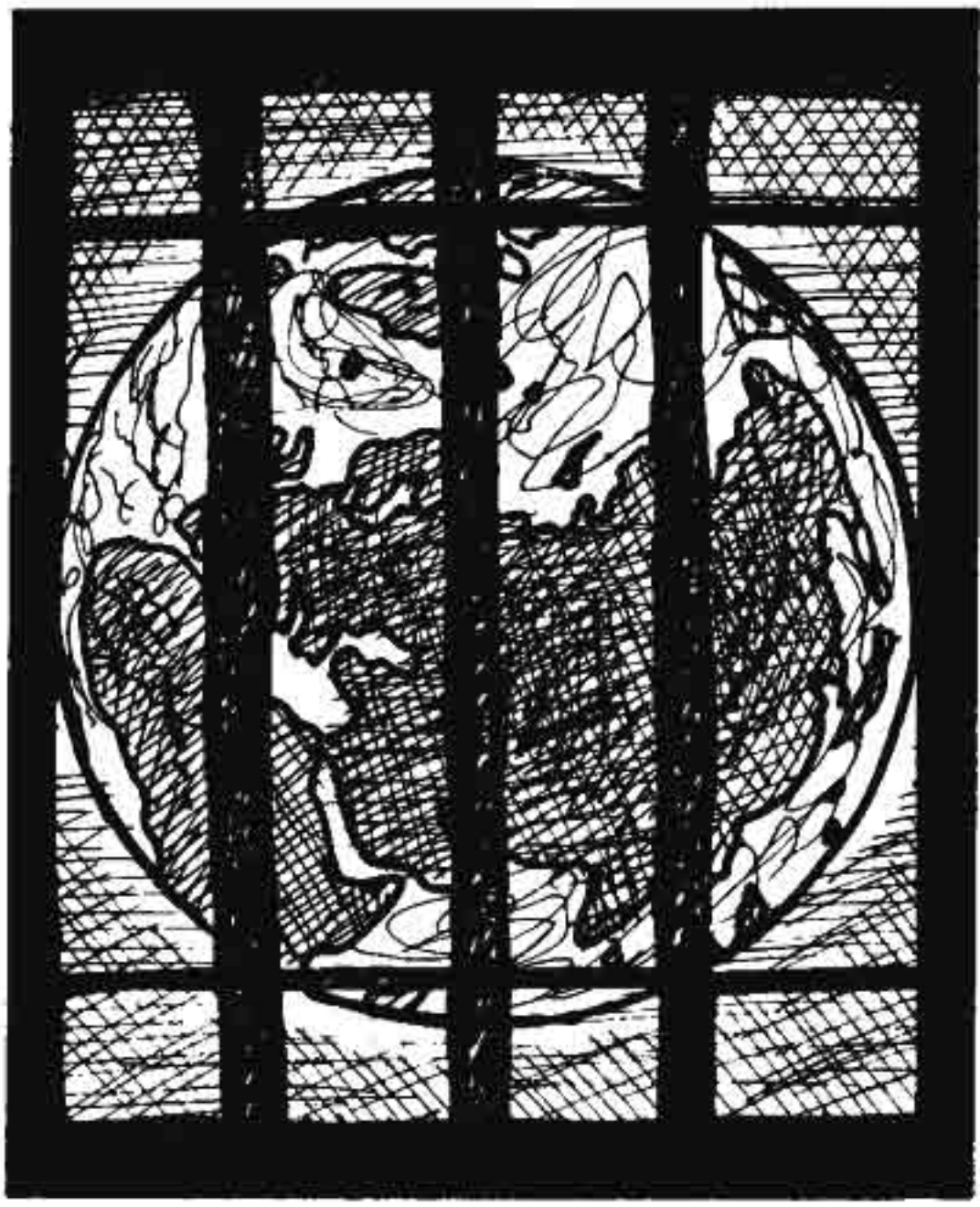
Organised violence by the state to control political opposition is not confined to South Africa. In fact various methods have been used in many parts of the world to maintain unpopular and oppressive governments. Detention with or without torture has been, and continues to be, a favoured response in many countries, however it is not the only approach. Other cynical methods have, for example, been to make people "disappear", to kill people in the streets and to force activists into exile.

The response to state violence by medical and psychological groups seems to have been as varied as there are political positions. There have been those who have formed part of the alliance of oppression and participated in torture teams and been part of state strategies. Others have turned a blind eye, while yet other practitioners have (sometimes at risk to themselves) treated people who have been tortured or affected by other means of state violence, and have actively opposed organised violence and political oppression in general.

Co-operation with the state

In many areas of the world there has been documented evidence that doctors, psychiatrists and other health practitioners have been actively involved with and assisted the state in acts which contravene medical ethics and have acted to help maintain repressive political orders.(1) The allegations levelled at various Chilian medical personnel by human rights organisations, (and validated by evidence presented to the Committee on Scientific Freedom and Responsibility of the American Association for

the Advancement of Science, Washington 1987), reflect some of the ways in which medical people can and have co-operated with the state. The following examples relate to active involvement or complicity with torture. Medical personnel were accused in Chile of: performing medical examinations on suspects before and after torture; attending torture sessions in order to intervene when a victim's life was in danger (or to advise whether the victim could withstand further torture); assisting interrogators through the administration of non-therapeutic drugs and the practice of hypnosis; and issuing false certificates of good health before the torture victim left the detention centre and was brought before a judge.



Many countries use detention to maintain repressive governments

Involvement of practitioners opposing repressive action

Over the years there have been many individuals and organisations in the medical and psychological fields who, rather than working with the state, have acted in support of struggles against oppression. Two countries which have faced state violence have been chosen as examples to show some of the responses from the medical and psychological professions. As will be seen, these responses reflect specific needs at particular historical points.

The Philippines

In the Philippines, popular government has been denied the people since (at least) the early '70s when President Marcos declared military rule. In this time, tens of thousands of people have been detained and many tortured. Amongst those detained were doctors arrested for providing medical care to "politically suspicious patients". In response to the oppression in the country and the established medical community's failure to take up health and human rights issues in the Philippines, a number of medical personnel

formed themselves into a group called the Medical Action Group. From small beginnings the group has expanded its membership, has offices in several centres and is involved with many projects. These include a network of primary health care projects, a prison medical care project, educational seminars and clinics for the treatment of torture victims. They also monitor the health conditions at detainee centres throughout the country and have managed to gain the victory of being able to provide medical care by civilians in the detention camps.

Under the auspices of the Medical Action Group is the Philippines Action Concerning Torture grouping (PACT). This group provides a clinic for the physical and psychological examination and treatment of former detainees, many of whom have been tortured. Workers at the centre report that many of the people coming in to the centre say that what they need most is not so much physical and psychological help and "rehabilitation" but to be surrounded by supportive and caring political people. As one person using the centre put it, "I don't need a therapist, I need a collective". This shows that although many people released from detention may be suffering physical and psychological effects they should not be seen as "patients", but rather need a particular kind of caring within an environment which is supportive to them and to their cause. This is not to say that they do not want or need medical and psychological help,

In some countries health workers have been accused of active participation in torture

but rather that the distanced "neutral" approach which many of the medical people convey is counter to the needs of the person. The doctor or therapist then must act as part of that person's "collective". As can be seen, PACT serves as more than just a professional service. They provide a personal and political support to the people who come through the centre.

Besides seeing ex-detainees themselves, the staff of PACT conduct seminars at hospitals and clinics throughout the country to educate health professionals about the physical and psychological effects of detention and torture.

Argentina

Until the mid '80s, Argentina was also under military rule and during this time, violence against the people was intense. Many thousands of people "disappeared" with no legal guarantees whatsoever and no contact with family or friends. There were said to be nearly 50 secret camps set up around the country where people were kept and tortured. Some of these people were later transferred to official prisons and their detention was acknowledged, while others were released. Many people, however, were taken away and have never been seen again. According to Amnesty International, over 5 000 people have never been accounted for.(2) Moreover, in order to avoid the junta, thousands of Argentinians fled the country to exile.

Though the military regime no longer rules in Argentina, the state violence has left scars which still need attention from health practitioners. In the first place, the many families of the "disappeared" still seek assistance. Though most disappearances have stopped, the psychological stress which families were put under in this process were severe and are long lasting, and intervention is still needed. With "disappearances" families are left with some hope that the disappeared person will someday reappear, and are thus often not able to go through the mourning process that is possible when there is a death. Even many years after a disappearance, many families are reluctant to give in to the fact that their loved ones are dead. As a result, they face ongoing psychological stress, hoping, and in many cases still hunting for the missing person. A group of psychologists, Equip de Asistencia Psicologica de Madres de Plazo De Mayo, offer ongoing support and therapeutic help for people in this position.

A second area where intervention has been seen to be necessary in Argentina has been with the flood of "returnees" who have come back from exile since military rule was ousted. People who leave a country because of the threat of persecution, manage to establish a life elsewhere. When they return to their country of origin they often face extreme stress. Before their exile, people fitted in and understood their "slot" in society but when they return they feel displaced and out of touch. The physical environment has often changed in their absence, but more importantly, social processes are likely

Burying a victim of apartheid - in cases where people have disappeared, families and friends are unable to go through the normal process of mourning that occurs when a person has died

to be different. It is often difficult for people to accept that life has continued and progressed without them. There are also problems of a more material nature such as the lack of accommodation and employment. While people expect to be reintroduced into the society with such essentials available to them, they are often disappointed.

The "Centro Medico Psicosocial" in Mendoza is one group which has addressed itself to this problem. Besides helping people with their medical and psychological problems by conventional means, the staff of the centre (mostly returnees themselves) have developed creative programmes to help people to reintegrate into the community. For example, they arrange hikes into the surrounding mountains where people are able to loosen up and talk about their problems with people in a similar position to themselves, as well as with others from the community who accompany them on the walk. This group has also started co-operatives of returnees and former detainees through which people can begin earning a living again, and again feel part of a supportive social grouping. This form of intervention has proved invaluable to the psychological and economic well being of those involved.

These two examples from the Philippines and Argentina bear testament to the hundreds of medical and psychological practitioners all over the world who have dedicated themselves to the support of individuals engaged in struggles against oppression.

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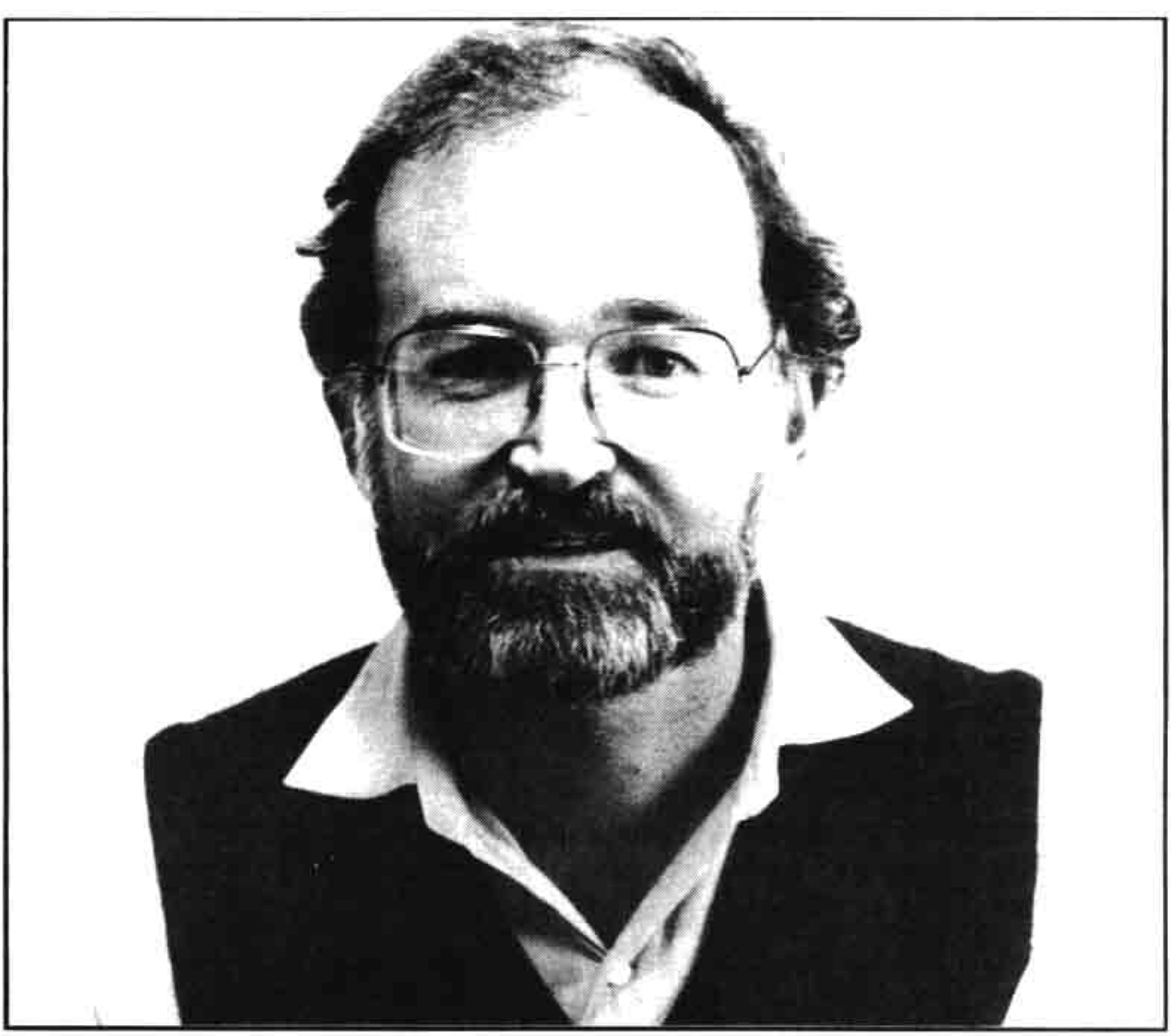
By Melvyn Freeman
Centre for the Study of Health Policy

A tribute to David Webster

The death of David Webster on 1 May 1989 marks the latest in a long line of as yet unsolved assasinations of anti-apartheid activists. It is clear from the overwhelming response to his murder, that David played an important role in the struggle for a non-racial democratic South Africa, touching the lives and work of many individuals and organisations.



David Webster - tireless in his attempts to highlight the injustices of detention

His work in the DPSC and DEW

David was tireless in his work for detainees and their families. He was an active member of the Detainees' Parents Support Committee (DPSC) where he fought to improve the conditions under which those detained were imprisoned.

David's energy, skills and commitment helped to broaden the DPSC's original focus from a human rights group to an organisation which aligned itself with the mass democratic movement. He contributed to many anti-apartheid publications and spoke at many grass-roots meetings. His humility and common touch endeared him to all South Africans.

In 1984 and 1985 he presented written and oral evidence on human rights violations in South Africa to the United Nations Commission on Human Rights. Ironically, he became an expert in extra-legal repression perpetrated by vigilantes, hit squads and assassins.

In the mid-1980s, when the number of detentions rocketed from hundreds to tens of thousands a year, David helped the DPSC's Johannesburg advice office to respond to the overwhelming demands for assistance. After the DPSC was effectively banned on February 24 1988, David was among those who helped to found Detainees' Education and Welfare (DEW) which sought to provide material and moral support for those detained.

David worked hard to provide direct material aid to detainees. For example, he helped collect and distribute running shoes, tracksuits, games, shorts and T-shirts for detainees. Sports clubs were asked to request members to donate their shoes. Runners were asked to remember that while they had the freedom to move, others were confined to cells. Through such actions, David's work helped to make the white community aware of the system of detention.

He was instrumental in organising tea parties for released detainees and the relatives of those still incarcerated. At the last three parties, members of the Security Police, the South African Police and the South African Defence Force interrupted the events in large numbers. More than once David was told that he would be held responsible for anything that occurred at these parties.

An academic for society

At the time of his death, David was a senior lecturer in social anthropology at the University of the Witwatersrand. David was an example of how academics could use their skills for society at large. He was unanimously elected honorary vice-president of the National Union of South African Students (NUSAS) at every congress since 1982 and was a well known political figure on many campuses. David told students:

"We must recognise that the university is an integral part of South African society ... we must fight for the university to serve the needs of the poor, the illiterate and the powerless" (NUSAS July Conference 1981).

David saw the importance of organising academics in support of the democratic movement. He was the key figure behind the formation of the Conference Academics for a Democratic Society (CADS) which aimed to build unity with students in fighting apartheid and raising debate about the role of the university in a transitional society .

His role as a white democrat

Although he was a widely respected academic, David devoted much of his time to anti-apartheid work. He believed that the Freedom Charter provides the framework for a just and democratic future in South Africa and saw the democratic movement of mass-based community, youth, student and worker organisations as the key force for making such a future a reality.

In his work in the white community he was committed to building people's understanding of the mass struggles taking place in the townships and showed that a future without apartheid was not to be feared, but to be fought for. To this end David was involved in numerous support campaigns for workers on strike and was a founder member of the United Democratic Front - affiliate, the Johannesburg Democratic Action Committee (JODAC). He was also active in the UDF's Call to Whites Campaign. In 1985 he was involved in the formation of the Concerned Citizens Group which sought to bring together a broad range of white organisations to protest the violation of human rights under the state of emergency. Two years later he was elected to the first executive of the Five Freedoms Forum, a coalition of white liberal and left organisations.

Press statement

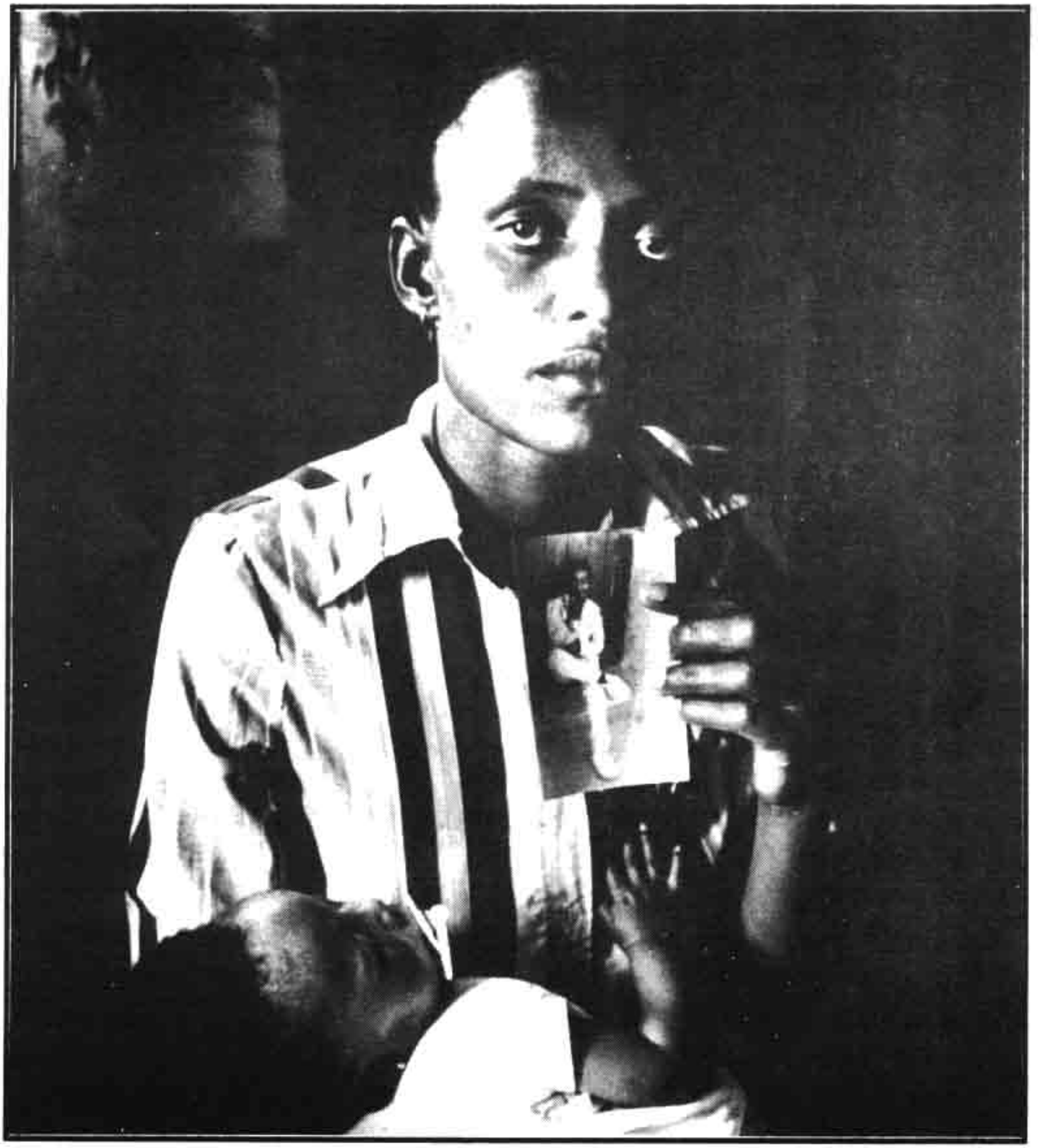
The Editorial Collective of *Critical Health* joins those individuals and organisations who experienced the political resolve and humanity of this fallen comrade in condemning his senseless assasination.

The following statement was released to the press: "As members of the Editorial Collective of *Critical Health* journal, we condemn the murder of David Webster. We see this murder as part and parcel of the repression and violence perpetrated against the oppressed on a large scale.

We would like to pay tribute to David as a democrat who taught us a great deal about

the causes of ill health, and about the diseases of inequality and oppression in South Africa. His work in campaigning for detainees' rights and health, and for the abolition of the apartheid system as a whole, has focussed health workers' attention and action on these issues.

In David we are losing a respected adviser, contributor, supporter and friend. We will honour his contribution by attempting to take it further. Hamba Kahle David!



A mother holds a photo of her detained child - David spent much of his time helping detainees and their families

Declaration of Tokyo

In 1975 the World Medical Association adopted the following guidelines for medical doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment (Declaration of Tokyo).

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.

2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture, or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive, whether personal, collective or political, shall prevail against this higher purpose.

5. Where a prisoner refuses nourishment and is considered by the doctor as capable of performing an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors, to support the doctor and his or her family in the face of such threats or reprisals resulting from refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

Twelve-point Program for the Prevention of Torture - Amnesty International

Torture is a fundamental violation of human rights, condemned by the General Assembly of the United Nations as an offence to human dignity and prohibited under national and international law.

Yet torture persists, daily and across the globe. In Amnesty International's experience, legislative prohibition is not enough. Immediate steps are needed to confront torture and other cruel, inhuman or degrading treatment or punishment wherever they occur and to eradicate them totally.

Amnesty International calls on all governments to implement the following Twelve-Point Program for the Prevention of Torture. It invites concerned individuals and organisations to join in promoting the program. Amnesty International believes that the implementation of these measures is a positive indication of a government's commitment to abolish torture and to work for its abolition worldwide.

1. Official condemnation of torture

The highest authorities of every country should demonstrate their total opposition to torture. They should make clear to all law enforcement personnel that torture will not be tolerated under any circumstances.

2. Limits on incommunicado detention

Torture often takes place while the victims are held incommunicado - unable to contact people outside who could help them or find out what is happening to them. Governments should adopt safeguards to ensure that incommunicado detention does not become an opportunity for torture. It is vital that all prisoners be brought before a judicial authority promptly after being taken into custody and that relatives, lawyers and doctors have prompt and regular access to them.

3. No secret detention

In some countries torture takes place in secret centres, often after the victims are made to "disappear". Governments should ensure that prisoners are held in publicly recognised places, and that accurate information about their whereabouts is made available to relatives and lawyers.

4. Safeguards during interrogation and custody

Governments should keep procedures for detention and interrogation under regular review. All prisoners should be promptly told of their rights, including the right to lodge complaints about their treatment. There should be regular independent visits of inspection to places of detention. An important safeguard against torture is the separation of authorities responsible for detention from those in charge of interrogation.

5. Independent investigation of reports of torture

Governments should ensure that all complaints and reports of torture are impartially

and effectively investigated. The methods and findings of such investigations should be made public. Complainants and witnesses should be protected from intimidation.

6. No use of statements extracted under torture

Governments should ensure that confessions or other evidence obtained through torture may never be invoked in legal proceedings.

7. Prohibition of torture in law

Governments should ensure that acts of torture are punishable offences under the criminal law. In accordance with international law, the prohibition of torture must not be suspended under any circumstances, including states of war or other public emergency.

8. Prosecution of alleged torturers

Those responsible for torture should be brought to justice. This principle should apply wherever they happen to be, wherever the crime was committed and whatever the nationality of the perpetrators or victims. There should be no "safe haven" for torturers.

9. Training procedures

It should be made clear during the training of all officials involved in the custody, interrogation or treatment of prisoners that torture is a criminal act. They should be instructed that they are obliged to refuse to obey any order to torture.

10. Compensation and rehabilitation

Victims of torture and their dependants should be entitled to obtain financial compensation. Victims should be provided with appropriate medical care and rehabilitation.

11. International response

Governments should use all available channels to intercede with governments accused of torture. Intergovernmental mechanisms should be established and used to investigate reports of torture urgently and to take effective action against it. Governments should ensure that military, security or police transfers or training do not facilitate the practice of torture.

12. Ratification of international instruments

All governments should ratify international instruments containing safeguards and remedies against torture, including the International Covenant on Civil and Political Rights and its Optional Protocol which provides for individual complaints.

The Twelve-Point Program was adopted by Amnesty International in October 1983 as part of the organisation's Campaign for the Abolition of Torture.

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- **show that good health is a basic right**
- **provide a forum for the discussion of health-related issues**
- **provide insight into the political nature of health**

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