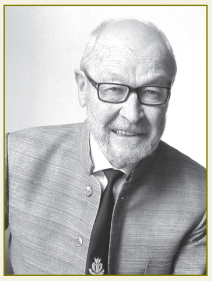
Don't let torture victims fall through the cracks

Survivors of torture and other violent abuses often miss out on crucial treatment. Erik Holst spoke with Fiona Fleck about the role of doctors and health systems in their rehabilitation.



Courtesy of Erik Holst

Erik Holst

Erik Holst is emeritus professor of social medicine at the University of Copenhagen, Denmark, and now an international consultant with the ICAR Foundation, Romania, which gives free medical, psychological, social and legal assistance to victims of torture and other abuses. Since 1990, he has focussed on rehabilitation of torture victims, and has served as president of the Rehabilitation and Research Centre for Torture Victims in Copenhagen, and as executive vice president of the International Rehabilitation Council for Torture Victims, Denmark.

Q: How did working with the victims of torture become the main focus of your professional life?

A: I was invited to chair the board of the Rehabilitation and Research Centre for Torture Victims in Copenhagen from February 1990. At the time I didn't think that I would be doing anything other than chairing the meetings, but then I attended a meeting at the University of Tromsö in northern Norway and became aware of the psychiatric abuses that had been going on in eastern Europe. It was really then that it came home to me that the medical profession – my profession – had debts to pay. I also realized that my particular background, both in academia and in professional organizations, serving for example as president of the Standing Committee of Doctors in the European Economic Community (now European Union), could be put to good use. And so I said to myself: "This is a challenge that I cannot refuse."

Q: You started out by tackling the issue from a medical ethics perspective, but later on focused more on assistance for victims. How did that transition occur?

A: I realized that there was a limit to what could be achieved by making declarations about doctors and torture. The experiences of eastern Europe with psychiatric abuses, and then in Algeria, Northern Ireland and Latin America where military doctors were involved, showed me that it was not enough to tell doctors that they should stay away from torture. The truth is that if they are part of a hierarchy, as is the case with military doctors or prison doctors, they risk getting involved. It is very difficult for individual doctors to stand up against a system that is using torture because it means exposing the system itself, which can then turn against the doctor. While it's a good thing to have doctors exposing torture, in reality it almost never happens. On the other hand there is a great deal that can be done for the victims of torture. This was already understood back in 1980 at the Rehabilitation and Research Centre in Copenhagen, and also at the Harvard Refugee Trauma Program in Boston. Clearly, helping the victims of torture is an obvious approach for the medical profession to take, whereas the writing of resolutions against torture is not.

Q: Are you saying that the various declarations made against torture had little or no effect?

A: Well, I think they had some effect. I am sure that the Amnesty International campaign in 1972 and 1973 put the issue on the global agenda and prompted the United Nations to talk about it. But just going after the health professionals to encourage them not to take part in it…as I said before, it's easy to say but it's not easy to do. Sometimes doctors face a genuine dilemma.

Q: What do you mean?

A: Well, our profession obliges us to do whatever we can to relieve pain or to save the lives of people but if you do that, knowing full well that you are just helping to keep that person alive for the next day's torture, then you are in a double bind. The World Medical Association's declaration in Tokyo in 1975 states that doctors should never be present where torture takes place or is threatened and they should never lend their knowledge to this practice – before, during or after. So, in fact, in this situation our basic obligation to preserve life doesn't apply.

Q: How did ICAR get started?

A: In 1991 the International Rehabilitation Council for Torture Victims organized a symposium on torture in Budapest, Hungary, and we invited representatives from all eastern European countries, including Dr Camelia Doru from Romania. That symposium inspired Dr Doru to set up the ICAR Foundation in Bucharest to treat Romanian nationals who had suffered during the communist repression. Now ICAR also offers assistance to victims of torture and other human rights violations who come to Romania from other repressive regimes, mainly from the Middle East and other parts of eastern Europe.

Q: To what extent do health professionals agree on the treatment of victims of torture?

A: The tendency now is towards a multidisciplinary approach to treatment. Most centres provide medical and psychological assistance, along with social and legal assistance that includes helping victims obtain asylum. That is also why addressing the needs of these people is not something you can easily slot into a hospital system but it is possible in smaller, independent centres.

Q: Does that mean that you favour smaller centres over hospitals for this kind of treatment?

A: Both have a role to play. I have made a study of conditions for mainstreaming appropriate treatments for victims of torture in national health-care systems in Europe. The underlying problem is that, in most countries, asylum seekers don't have access to the domestic health system even for general health problems, and even if they're allowed

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access, the system is not necessarily geared to helping victims of torture. One of the challenges we face is providing any services at all. It is not so much that we do not know how to help these people, but rather how to organize things in such a way that a torture victim arriving in a country can be rapidly identified and referred to the appropriate expert services.

Q: Do any countries do this already?

A: As far as I know, Norway is the only country where this kind of service is integrated into the health system. The danger, of course, is that smaller centres can get sidelined or disappear altogether. Small, specialized centres play an important role in developing treatment, but also in keeping the issue on the agenda. In Denmark and the Netherlands, the government has taken over the cost of these centres so they are part of the national health services. In the United States of America, specialized centres also have considerable, but not full, government financial support. In many other countries however, the centres are entirely dependent on external funding from the United Nations, the European Union and from private funds such as the Oak Foundation.

Q: What is being done at the international level to strengthen specialized care for torture victims?

A: In March last year, the United Nations Human Rights Council adopted the Danish Resolution 16/23 that expressly mentions the need for specialized centres for helping torture victims. It urges States to ensure that victims of torture receive specialized social, psychological and medical rehabilitation and calls on governments to "establish, maintain, facilitate or support rehabilitation centres or facilities where victims of torture can receive such treatment and where effective measures for ensuring the safety of their staff and patients are taken". You may have wondered why the Danes put forward this resolution: Well, it has been a tradition from the time of the Commission on Human Rights that the Danish permanent mission to the United Nations Office at Geneva coordinated the annual resolution on torture. I was involved in the Danish government delegation to the Commission from 1996–99. The chapter on torture in the Vienna Declaration was also a Danish contribution, to which I had the privilege of supplying the language. Denmark has somehow become a specialist on torture and I just follow the tradition.

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Q: Is there a consensus on what WHO's role should be in addressing torture?

A: I am not close enough to know, but I have expressed a certain disappointment. Back in the 1980s there were several meetings held that attempted to address the various psychosocial consequences of violence. They started off dealing with treatment methods and approaches but then, at one point, they turned towards dealing with mental problems in conflict and post-conflict situations, treating it as a problem affecting populations rather than individuals. That meant that the manual, produced in collaboration with the Office of the United Nations High Commissioner for Refugees, was all about what to do with a large number of people in conflict and post-conflict situations. I think there should be more work on individual treatment, even if that approach requires more manpower and health professionals. I am hoping that WHO goes back to the earlier track and that it will hold an international consultation on how to secure rehabilitation services for torture survivors.

Q: What international conventions have had the most impact for victims of torture?

A: To me the most relevant is probably paragraph 59 in the Declaration and Action Plan for Human Rights adopted at the World Conference on Human Rights on 25 June 1993 in Vienna, Austria. It asks for further concrete action within the framework of the United Nations with the view to providing assistance to victims of torture and ensure more effective remedies for their physical, psychological and social rehabilitation. The WHO meetings that I refer to earlier may be considered a response to this request. They dealt first with identifying the health consequences (called hazards) of "organized violence" and then with ways to deal with these consequences – but did not discuss the creation of the framework necessary for providing individualized long-term rehabilitation such as in the host countries for asylum seekers. WHO's new *Psychological first aid: guide for fieldworkers* continues this line, since this is only about improving the mental health of disaster affected populations and does not deal with long-term care for individual victims of torture outside a disaster situation.

Q: What are your hopes for the future for victims of torture?

A: Clearly the efforts to enforce an absolute prohibition of torture have not stopped its practice in a large number of countries. In real life, torture continues to be practiced and most torturers as well as their taskmasters enjoy de facto impunity. According to Amnesty International's most recent annual report, torture, cruel, inhuman or degrading treatment is practiced in 111 countries – in some countries sporadically and in others it is an endemic phenomenon. Ultimately our aim is that victims of torture are recognized, just as we recognize cancer patients. Even if WHO is mainly working on prevention, it is also there to support the development of appropriate health services for everybody. It is important that this "everybody" includes the victims of torture.

Erik Holst was interviewed as a guest speaker of the World Health Organization's global health history seminar series. Access the seminars online at: http://www.who.int/global_health_histories ■