

HAITI 1991–1994: The International Civilian Mission's Medical Unit

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*"Tout Moun Se Moun"
"Every human being is a human being"
Creole Haitian proverb*

The experience of providing assistance to a population subjected to repression led the health care professionals who were members of the Medical Unit of the International Civilian Mission and the International Human Rights Observer in Haiti Mission to the following observations:

- health care workers operating in a context of human rights violations must re-examine their usual approach to medical care; and
- a broadened concept of human rights can lead to a new outlook and approaches to public health.

Repression in Haiti from 1991–1994

Since becoming independent in 1804, Haitian society has endured various forms of repression. Although more or less violent in nature, this repression has always been associated with the state government. The Duvaliers' thirty-year long dictatorship (1957–1986) targeted intellectuals, bourgeois and

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mulatto groups, as well as the black petty bourgeoisie. These people were forced into exile, killed, or simply disappeared.

In contrast, the repression and human rights violations which occurred between 1991 and 1994 were of a different nature and against a different population. The *de facto* government, which came to power following the military coup that overthrew President Jean-Bertrand Aristide on September 30, 1991, involved ferocious repression and organized violence, carried out by the Haitian armed forces and by paramilitary groups connected to them. They systematically targeted poor Haitians, a population that had always lived on the threshold of poverty, if not below it.

The consequences in human rights terms were tragic. Almost 4,000 people were killed and over 300,000 people were internally displaced.¹ For political reasons, many were disappeared, others received gunshot or knife wounds, others, mostly women, were raped and sexually assaulted, and many others were victims of arbitrary arrest and cruel, inhuman, or degrading treatment. This stimulated a large number of people who chose to seek refuge elsewhere, either across the land border with the Dominican Republic or across the sea, in most cases, sailing to the United States, resulting in a "boat people" phenomenon that raised a whole new series of issues while influencing many of the subsequent U.S. policy decisions. This repression included damage or obliteration of the public health infrastructure and health care resources.

The Medical Unit of the Civilian Mission: Creation and Evolution

The human rights situation during this time was recognized internationally as disastrous. Immediately following the 1991 military coup, the Organization of American States (OAS) and the United Nations (UN) voted an embargo of Haiti, which resulted in civil unrest and economic devastation. One year later, acting upon a request from President Aristide, then in exile in the United States, these organizations decided to create an international human rights observer mission for Haiti. In February 1993, a civilian international human rights observer mission was organized (Mission Civile Internationale en Haïti in French, or Civilian Mission), involving approximately 200 people. It was directed by OAS career diplomat

Ambassador Colin Granderson from Trinidad and Ian Martin, a former Secretary General of Amnesty International, as head of its human rights division.

The Civilian Mission was active from February 1993 to February 1996, with two short interruptions due to an evacuation for safety reasons and an expulsion ordered by the *de facto* government.

From the start, the Civilian Mission was faced with victims of severe human rights violations some of whom required immediate medical assistance, and for whom observation and documentation alone was inadequate. For the first time a medical unit for human rights (Medical Unit) was created within an OAS or UN mission and eventually an “active observation” response was implemented. The Medical Unit’s principal objective was to facilitate access to health care for victims of severe human rights violations and to ensure their safety during medical treatment.

The Medical Unit’s initial members were all physicians. From the start, the unit was faced with four urgent needs:

- to facilitate victims’ access to medical care in Haiti’s public hospitals and private clinics;
- to ensure victims’ safety in the context of continued human rights violations;
- to intervene in prison settings—an innovation for Haiti—although accessing the prisons was difficult; and
- to perform medical documentation of human rights violations.

During 1993 and 1994, the Medical Unit experienced many obstacles and was faced with daily difficulties, therefore, three facts concerning its operation are of profound importance. First and most importantly: the majority of the health care was provided by Haitian health care workers, most of whom worked in inadequate health care structures under extremely difficult conditions and at great personal risk. While the Medical Unit team and human rights observers witnessed some instances of refusal to observe medical ethics and to provide care for victims, the courage and dignity of Haitian

health care workers (physicians as well as nurses) who assisted victims of human rights violations must be emphasized.

Second, an essential role was played by nonmedically trained personnel in facilitating access to health care for victims. Most of these workers were members of Haitian human rights organizations or other Civilian Mission observers, especially those working outside of the capital.

And third, the establishment of an emergency fund for victims by the Canadian Fund (a Canadian government project) helped day-to-day field functioning, medical and surgical care, drugs, and medical supplies. This provided decisive help in many difficult situations, such as the purchase of orthopedic equipment prior to performing surgery or obtaining therapeutic drugs for individual victims.

In early 1995, several elements helped strengthen the effect of the Medical Unit. Two physicians working with Médecins du Monde (MDM, Doctors of the World), joined the team. A human rights clinic in Port-au-Prince opened which aimed to consolidate access to medical help for victims. A psychologist with ethnopsychiatric training—a practice which takes into account the psychological benefits that a population can achieve from traditional cultural therapeutic sources—was brought in. Up to this time psychological and psychiatric care for victims of human rights violations had not been considered.

Therapeutic Intervention and the Boundaries of Documentation

Within the mandate of the Civilian Mission, therapeutic intervention initially consisted mainly of documenting—case by case—victims of repression who came of their own accord to register a complaint. This documentation was the primary objective of the Medical Unit during the program's early phase. In early 1993, medical evaluation was limited to short case summaries, primarily because the tense situation and fierce repression in the field made emergency assistance and the effort to ensure safety for victims and health care workers the Medical Unit's highest priority.

The Medical Unit sought to document the physical findings of severe human rights violations, including executions,

bullet and knife wounds, torture, and evidence of cruel, inhuman, and degrading treatment. For example, some victims, mainly women, had been threatened with or subjected to politically motivated sexual violence, including many cases of rape. This medical evaluation process was intended to back up the reports of the Civilian Mission's with additional information before they were transmitted to the Secretary-General of the OAS and the UN Secretary-General.

Beginning in 1994, the first time the Civilian Mission returned to Haiti (following reinstatement of constitutional order), three factors contributed to the expansion of a more extensive and thorough documentation process. The Civilian Mission hoped to make up for lost time by adding a medical dimension to the evidence of human rights abuses. In addition, the victims were anxious to go beyond short-term medical care and to seek justice and to add meaning to their experience. Also, Haiti's National Truth and Justice Commission, which operated from March through October of 1996, asked for the Medical Unit's assistance in medical documentation.

In spite of the UN mandate which initially limited their action, the Civilian Mission observers shifted towards "active observation"—in other words, intervention. It was recognized that the reality of medical problems resulting from human rights violations required health professionals to intervene and to establish links with existing public health and health care structures. In addition, health care workers tried to establish the extent to which reliance on traditional and cultural resources had been successful and what coping strategies victims had adopted in situations of destitution at every level—material, therapeutic, institutional and symbolic. As time went on it became increasingly evident that many complaints could no longer be relieved by classical biomedical care, but required a revised therapeutic approach.

All together, approximately 5,000 cases of severe human rights violations were documented by the Civilian Mission: 5,000 stories of horror and irreversible physical and psychological damage.²

Of these 5,000 cases, only 900 victims received assistance from the Medical Unit between 1993 and early 1996. Furthermore, even though most victims presented symptoms

consistent with post-traumatic stress disorder, the belated introduction of psychological and psychiatric support meant that only 80 cases actually benefited from such care.

Limitations

In part a result of the urgency of the situation, there was a lack of preparation, conceptualization and definition of the Medical Unit's role within the scope of the Civilian Mission.

The Medical Unit was further hampered by the narrow interpretation given by the Civilian Mission's mandate. The Mission's headquarters wished to restrict the Medical Unit's role to documenting human rights abuses. Health workers involved with the Medical Unit felt that medical ethics demanded that this process be complemented by providing care whenever the situation called for medical assistance.

The Medical Unit was also confronted daily with difficulties in terms of confidentiality and liability. For example, many victims contacted the Medical Unit after being released from detention centers where they had been tortured. The Civilian Mission leadership sought to lessen the involvement of staff members from the Medical Unit in the follow-up for these cases. They said this was necessary both for security reasons and to maintain the strict neutrality of the health care providers. However, this approach conflicted with the Medical Unit's perspective which called for immediate assistance. Even though the health care workers involved in the Medical Unit were experienced in humanitarian missions, they were often unaccustomed to the specific challenges associated with these forms of human rights violations. Human rights work requires expertise, gained through appropriate training and experience.

Some Medical Unit team members reacted in very different ways when faced with human rights victims, from acute emotional reactions to denial and systematic refusal to acknowledge the reality of long-term health consequences of repression. Cultural prejudice, fear of interaction, deadlocks, exacerbated power struggles, cultural differences, and culture shock: all these reactions were found in the people working on the team.

Medical Unit members were also faced with a major dilemma, which remains unresolved and is applicable to com-

parable situations in many parts of the world. This had to do with the possibility, once immediate safety is assured, of offering victims access to health care beyond the reach of most of the population. For example, should financial support be provided for a surgical procedure or for certain private consultations that are unavailable in the public health care sector? Humanitarian projects seeking to strengthen existing health care structures by introducing state-of-the-art techniques—CT-scans, for example—may turn out to be useless in a society which lacks the necessary technological support. Such projects do not benefit the majority of the population since most Haitians do not have access to even basic health structures.

Exclusion, Dignity and Human Rights

In the context of conventional therapeutic intervention, the Medical Unit was faced every day with the dramatic state of helplessness of most of the victims. These patients were without jobs or financial resources in most cases, and were often homeless. Some arrived at their medical consultations without having eaten for several days. Simple medical care was clearly not enough. Medical intervention commenced along standard medical and psychotherapeutic lines which expected to achieve classical, measurable results was bound to fail. The fact that human rights violations cause specific and severe disorders that sometimes irreversibly alter a victim's health had to be taken into account.

Indeed, this suffering, after being partially relieved by medical care, opened the door to another endemic source of suffering, not treatable with conventional medical and psychological approaches. The victims of torture and other human rights abuses were already societal victims—in other words, victims of stigmatization, discrimination, and violations of their personal dignity. The daily trauma to an individual caused by lack of respect for human rights has been referred to as “survival trauma” and should be distinguished from an exacerbated violation of such rights (e.g. torture). The victims' vulnerability is thus increased and must be examined in its context: these victims' usual, social living conditions entail daily violations of their rights. Therefore, the

Medical Unit was seeking to assist a population already suffering from denial of its civil, economic, political and social rights.

The root of a victim's vulnerability lies in the fact that he or she can never enjoy these rights while existing social and state structures remain unchanged. Care providers cannot provide medical and psychological care to victims of organized violence—who are already victims of human rights abuse—without an expanded understanding of what is a victim and the inherent and concurrent vulnerability which accompanies this status.

Towards a Multidisciplinary and Global Approach

This experience in Haiti prompted recognition of several key aspects regarding medical assistance for the victims of human rights abuses.

Human rights violations carried out against the Haitian population between 1991 and 1994 had a great impact on the health of the population—on an individual as well as a community level. Only 900 victims were evaluated and followed-up during the Medical Unit's 26-month-long mission. Many Haitians were killed, disappeared, or became political refugees. Mental and physical consequences on countless other members of the population are documented, although a quantitative evaluation of the medical consequences of this repression is currently underway. There is a demonstrated need for long-term medical, psychological, and psychiatric follow-up.

Along with other health professionals, the authors are striving to create a Haitian Rehabilitation Center for Victims to continue the work initiated by the Haitian health professionals, Medical Unit members and MDM.

Beyond this conventional approach to health care, the painful realization of the shortcomings of our efforts led us to try to introduce a wider perspective to our work through contacts and conversations with several ministries, including those of Health, Justice, Social Affairs and Women Affairs, with Haitian human rights associations and with international organizations with interests in health and development such as WHO, UNICEF, and the European Union.

Our role as medical evaluators in collaboration with Haiti's National Truth and Justice Commission also involves a new dimension. As health care professionals, we must work jointly with human rights and legal professionals so that victims may be recognized as such, and assist them in their difficult search for justice and compensation.

We would also like to underline two particular roles which health care professionals can and must play. At a national level, health care workers help to protect and enhance human rights by familiarizing themselves with the International Bill of Human Rights and the Alma-Ata Declaration. By doing so, they can provide unique expertise in terms of human rights and their privileged position in civilian society should enable them to exert a favorable influence, becoming important actors working toward change in society. Medical care specifically required in the context of human rights missions should be taught in universities, medical and nursing schools, and international research centers.

A second task and responsibility of health workers is to distribute information and to share experience and knowledge. The same is true for UN agencies and other international organizations, specialized centers which care for victims, human rights organizations, nongovernmental humanitarian organizations, international medical associations, and research centers. This information could widen the international network of health care professionals interested in reflection and action upon health and human rights issues. It could also favorably affect certain political decisions made both at the national and international level in such institutions as the UN or the OAS, so that medical units could be included as a matter of course in other human rights missions.

Conclusion

The experience of health care professionals working for human rights in Haiti was unprecedented. It was unique because of the prevailing international context: this was the first time that two international organizations, the UN and the OAS, created a Medical Unit as part of a human rights mission. But more importantly, our experience in Haiti has shown that we have to go beyond traditional approaches in

both human rights work and health work and that this particular setting called for a re-examination of the role of health care professionals in relation to human rights.

This dimension of the profound linkage between health and human rights is relevant not only to peacetime and traditional public health, but is vital to understanding and responding to conflicts and to situations which have thus far been characterized as humanitarian crises.

References

1. Report of the National Truth and Justice Commission, September 1996.
2. Figures are confirmed by the reports and press releases of the International Civilian Mission and by the reports of the Secretary-General of the UN on Haiti.