Looking for stability: Experiences of rehabilitation for Congolese survivors of torture in Athens and the role of the Congolese community in their support

Maria-Angeliki Psyrraki[1], Emilie Venables[2], Christos Eleftherakos[3], Nathalie Severy[4], Declan Barry[5], Nikos Gionakis[6], Maria Episkopou[7], Aikaterini Komita[8] and Gianfranco De Maio[9]

Key points of interest

- Survivors of torture from Democratic Republic of Congo (DRC) felt their rehabilitation was incomplete without stable accommodation, refugee status and employment.
- Whilst many survivors did not trust other Congolese people, the local community could still support their rehabilitation by assisting with their integration in Athens.
- A synergic, participatory approach is recommended in collaboration between organisations and policy-makers and the local Congolese community.

Abstract

Introduction: This study explored the experiences of rehabilitation for male Congolese survivors of torture living in Athens, as well as the potential role of the wider Congolese community in Athens in supporting rehabilitation.

Methods: In-depth interviews with survivors of torture attending a rehabilitation clinic and key informant interviews with representatives of the wider Congolese community in Athens. Data was thematically analysed to construct and develop codes and themes.

Results: 19 survivors and 10 key informants were interviewed. For many survivors, rehabilitation was an unclear concept. Despite the appreciation for services received at the clinic and the amelioration of physical and psychological symptoms, survivors felt rehabilitation was incomplete as it did not meet their accommodation needs nor provide stability through granting refugee status. Survivors were wary of trusting other Congolese people after expe-

1) Médecins Sans Frontières, Operational Centre Brussels, Athens, Greece. Correspondence to: psyrraki@gmail.com
2) Médecins Sans Frontières, Operational Research Unit (LuxOR), Operational Centre Brussels, Luxembourg, Luxembourg. Division of Social and Behavioural Sciences, School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa. Correspondence to: emiliecvenables@gmail.com
3) Médecins Sans Frontières, Operational Centre Brussels, Athens, Greece. Correspondence to: celeftherakos@gmail.com
4) Medical Department, Médecins Sans Frontières, Operational Centre Brussels, Brussels, Belgium. Correspondence to: severy@clubinternet.fr
5) Médecins Sans Frontières, Operational Centre Brussels, Athens, Greece. Correspondence to: declan.barry@yahoo.co.uk
6) Babel Day Centre for the Mental Health of Migrants and Refugees, Athens, Greece Correspondence to: nikosgionakis@gmail.com
7) Médecins Sans Frontières, Operational Centre Brussels, Athens, Greece. Correspondence to: episkopoumaria@msn.com
8) Greek Council for Refugees, Athens, Greece. Correspondence to: komita@gcr.gr
9) Médecins Sans Frontières, Operational Centre Brussels, Rome, Italy.

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riencing torture and did not always associate themselves with the local Congolese community. The role of local Congolese leaders and organisations was not seen as replacing the clinical element of rehabilitation but aiding in practical issues such as information sharing and integration, especially in partnership with other organisations.

Discussion: Systemic shortcomings in Greece, including poor access to accommodation and insecure asylum status, impeded processes of rehabilitation. Many participants found themselves navigating an unstable and unpredictable landscape in their journey towards "feeling whole again". The role of the wider Congolese community in Athens in supporting rehabilitation remains complex and a lack of trust threatens social cohesion. Nonetheless, the willingness of the community to be more proactive should not be ignored by organisations and policy-makers.

*Keywords***:** torture survivors, rehabilitation, Greece, Congolese, asylum seekers, refugees.

Introduction

UNHCR has estimated that between 5 and 35 percent of refugees are torture victims (OHCHR, 2017). Increased migratory flows to Europe have highlighted the need for a rehabilitation response to meet the needs of survivors of torture (SoT). This is especially relevant in the current Greek context, where migration is increasing (UNHCR, 2020a), and survivors of torture and ill-treatment are often not recognised, lacking access to the rehabilitation services they desperately need (Bourmpoulas, 2019; MSF, 2017)

Following the implementation of the EU-Turkey statement in 2016, Greece has become a country of slow transit and containment (Episkopou et al., 2019). Those who have gone through border procedures and had their geographical restrictions lifted gain the right to freedom of movement within the borders of Greece, but asylum procedures can take years.

The regional asylum offices and asylum units in the wider Attica region received the second highest number of applications across Greece during 2019 (Asylum Service, 2020), and Athens hosts the highest number of asylum seekers and refugees in UNHCR-supported accommodation (UNHCR, 2020b).

In 2019, 233 asylum seekers were registered as victims of torture, rape or other serious forms of violence or exploitation (AIDA, 2020). This number concerns only the applicants who disclosed their torture history at registration; there is no data available on applicants identified at a later stage of their asylum claim. This number, however, appears significantly low considering the 77.285 asylum applications in 2019 (Asylum Service, 2020), or even the lowest estimated prevalence of torture in the general refugee population of 5 percent according to UNHCR (OHCHR, 2017). While survivors of torture are included in the list of vulnerabilities recognised by Greek law, identification and subsequent provision of support is not always guaranteed (AIDA, 2020). In addition, according to Greek asylum law (L. 4636/2019), certification of survivors of torture should be done by a public hospital or by an adequately trained doctor within a public-sector health care service provider. As of October 2020, no such provisions exist within the national health system.

In 2019, the DRC was the third most common country of origin for people arriving through Greece's islands (UNHCR, 2020a). The political situation in DRC has been characterised by instability and conflict since independence, which has in turn led to people fleeing the country. An increase in human rights abuses, sexual violence and torture has

been documented (Freedom from Torture, 2018; UKFCO, 2018).

Men make up the majority of the adult migratory flows to Greece (UNHCR, 2020a). Single males are frequently classified as "not vulnerable" by default, which leads to difficulties in accessing support services, particularly for mental health and issues relating to torture (Arsenijević, 2018; MSF, 2016, 2017).

The study aimed to understand more about the perceptions of the rehabilitation of male Congolese survivors of torture in Greece, and whether the Congolese community in Athens has a role to play in supporting their rehabilitation through informing and improving services and strengthening community links.

Methods

Study Design
A qualitative exploratory approach was used in this study, with data collection taking place between June and September 2019. This study involved in-depth interviews (IDIs) with selected survivors receiving rehabilitation services and Congolese key informants living in Athens.

Study Setting
Many rehabilitation programs adopt a multidisciplinary approach when working with survivors of torture (Jaranson & Quiroga, 2011; Persson & Gard, 2013, ODIHR/CTI, 2018).

In 2013, the Greek Council for Refugees (GCR) and the Babel Day Centre for the Mental Health of Migrants and Refugees (Babel) began implementing the Program for the Rehabilitation of Survivors of Torture "Prometheus" in Athens. Babel specialises in psychological support for refugees and migrants; GCR in legal and social support. The program provides holistic services including legal, social, psychological and medical support. Babel and GCR have cooperated with several actors experienced in the field of the rehabilitation: DIGNITY - Danish Institute against Torture, the Centre for Trauma, Asylum and Refugees (University of Essex), REDRESS and the Human Rights Foundation of Turkey.

In October 2014, Médecins Sans Frontières (MSF) began collaborating with the consortium, providing medical, mental health, social and physiotherapy services to SoT (the MSF clinic). Interdisciplinary collaboration is the core of this partnership. There is no public specialised support program for SoT.

Concerning the definition of SoT, MSF follows the ICRC definition of torture and ill-treatment (ICRC, 2016), while GCR applies the definition of UNCAT (UN General Assembly, 1984). As a result, the beneficiary cohort across the three services does not always overlap. This study focuses on the MSF clinic cohort.

Approximately 1030 individuals from 47 different nationalities have been seen in the MSF clinic since October 2014, with those from DRC comprising 26.2% of the overall beneficiaries.

Study Population
Two groups were included in the study. The first consisted of key informants from the Congolese community in Athens, recruited using snowball sampling, who held formal or informal positions of leadership and/or influence and were involved with community organisations. The second consisted of male, Congolese SoT actively enrolled at the MSF clinic, including SoT also receiving services from Babel and GCR. Purposive sampling was used to sample survivors. Taking into consideration the availability of potential participants who had seasonal work and recommendations from the MSF clinic therapeutic

team, 33 survivors were informed about the study. Six refused to participate, and eight were not in Athens.

Data Collection
The principal investigator (PI) and two co-investigators conducted the interviews. The PI did not interview survivors to whom she had directly provided social work services, to avoid therapeutic misconception. No other investigator was providing services to participants. In-depth interviews were conducted in French, Lingala or Greek with three translators assisting the investigators who did not speak French. All interviews were conducted in person, apart from one key informant interview which was conducted over Skype.

Data Analysis
Thematic analysis was conducted, and data was analysed inductively, with coding generation through examination, and in turn, the development of main themes from the information contained within. The process of analysis followed the six steps presented by Braun and Clarke (2006, p. 87).

Ethical Considerations
This study was approved by the Médecins Sans Frontières Ethics Review Board, Geneva, Switzerland. Verbal informed consent was taken from all survivors. Verbal consent was deemed appropriate in this context as those who have experienced torture or who are in the process of applying for asylum are often cautious of signing their names on official documents. Key informants gave written consent but were not required to write their full name on the consent form, as an additional step to preserve anonymity. Information sheets and informed consent forms were provided in French.

Official job profiles of the key informants have been omitted, to prevent individuals from being identified. Survivors were not asked to talk about their individual experiences of torture to avoid re-traumatisation. Participants were offered and/or provided with additional psychosocial support if they requested.

Results

Study Population
Interviews were conducted with 19 survivors and 10 key informants.[1] All interviewees were Congolese, and all were male apart from one key informant. The average age of key informants and survivors was 36 and 35 years respectively. Of the 19 survivors, 16 were homeless or residing in insecure accommodation when they arrived in Athens, and at the time of the interviews, 10 were still homeless or in insecure accommodation. Sixteen survivors and two key informants were unemployed. Of the 19 survivors, 13 were waiting for a decision on their asylum claim or their claim had been rejected. Six out of ten key informants had residence permits or were naturalised Greek citizens.

Experiences of Rehabilitation
"What is rehabilitation?" understandings of the rehabilitation process: Multiple participants expressed confusion when asked to discuss the term "rehabilitation," even if they were currently receiving rehabilitation services. The word was often misunderstood or confused with the restoration of furniture or buildings and not linked to the rehabilitation of a person.

Several survivors described rehabilitation as the support they received after their

experiences of torture and listed multi-disciplinary team members including medical doctors, physiotherapists, psychologists, social workers, psychiatrists and lawyers. Key informants focused more on the need for mental health support when the concept of rehabilitation was mentioned: "*I mostly see [rehabilitation] as a psychological support, someone to talk to about their problems and then gradually someone to follow them, with advice, with medication, depending on their condition*" (Key Informant 2). Many survivors described rehabilitation as the desire for a change in their mental and physical symptoms, improved health and overall life circumstances. One survivor saw rehabilitation as having three parts: "*Health is first part of it [rehabilitation]. Then the second part is good living conditions. Then the third part is being protected [legally]"* (Survivor 3). Ultimately, rehabilitation for survivors of torture was about being healthy, whole and being able to function again in their everyday life.

Rehabilitation and improved health: Survivors described how their physical and mental health had improved as a result of the rehabilitation services they received in Athens: "*At one time I couldn't be with other people, I was isolated. I was crying and I was also thinking of my family… but that has been reduced*" (Survivor 9).

> *"Before I had difficulty sleeping, I was constantly angry. But today there is no anger in me anymore. I can sleep. I had a problem with my back. When my physiotherapist asked me to evaluate the pain, he gave me a scale from zero to four, I think. When I came here, my pain level was even above three; but today it's less than two. That's what I call rehabilitation"* (Survivor 13).

A relationship based on trust with those providing care was described by survivors as a key part of seeing an improvement in their health status, their ability to interact again with others and to receive support:

> *"Without the psychologists, the social workers; maybe I would be already dead. […] They can't give you money, they don't give you food, but they show you respect. This helps. When you go there, you expose all your problems. I had problems; I had many problems in my head… Every time I had an interview with a psychologist or a social worker, I felt relieved"* (Survivor 14).

Rehabilitation as stability: An overarching theme of participants' expectations and experiences of rehabilitation was the need for stability, relating to asylum, housing and integration in Greek society. Survivors were at different stages in their asylum process, whereas most key informants had been in Greece for many years and had residency or Greek citizenship. Survivors saw their legal status as essential for moving forward in life and believed being granted asylum would enhance their rehabilitation. Many had waited years for the outcome of their asylum interviews.

> *"The biggest rehabilitation is to take someone to safety, grant him international protection so that he can say: 'I am safe, and I cannot be deported to my country.' And after that, for me, it's to integrate someone in the society and treat him as a human being, so that he can find a job"* (Survivor 9).

All survivors expressed fears around their living conditions, asylum papers, employment, family or their health. They described feeling insecure and being unable to make long-term plans. These concerns threatened the rehabilitation process.

"We can't say that we are rehabilitated 100 percent because the lack of jobs makes us very ill, mentally and physically. The way we are living you just can't say that we have been rehabilitated 100 percent" (Survivor 5).

"I was hopeful at the beginning, but I'm still not OK. How can I be OK in a country where I don't have any papers? You don't know what will happen, and then what if I get rejected and they put me in prison? That's why I'm scared. I'm scared of going to prison again. I've never been in prison here, but I think of what happened in my country" (Survivor 8).

The waiting process was, for many survivors, preventing them from feeling stable, secure and well: "*As long as I remain like this, doing nothing… all the time I spend waiting for the decision I have a lot of thoughts and that hurts me a lot*" (Survivor 17).

This key informant explained how rehabilitation went beyond papers:

"Rehabilitation doesn't only have to do with papers. Rehabilitation has to do with overcoming what happened to [them] before, or if [they] cannot overcome it, to at least gain something… the person might say that 'I am very strong,' 'I am still alive' and 'I can go on with my life'" (Key Informant 8).

Another challenge to rehabilitation from the perspective of the survivors was living in poor-quality, shared accommodation or being homeless: "*So, the rehabilitation that we are looking for, how will it happen when I can't even pay for my rent? Eating? Don't even talk about it*" (Survivor 4).

Integration into Greek society was a challenge for all the survivors, and key informants also reflected upon obstacles relating to the language and culture. Not speaking English or Greek meant that many survivors were unable to be involved in activities or benefit from services. "*I can be referred to a hospital, but I cannot go because there is no translator, there is a problem with the language*" (Survivor 5). Others were unable to access services such as language classes that would help them overcome this obstacle. "*I registered for [Greek] lessons. But they give the lessons in English, Greek or Arabic. Not in French. So, I started, first day, second day: I didn't understand anything. I left*" (Survivor 6).

Being unable to access work was also a challenge for many who felt unable to fulfil their role as "breadwinners": "*I have a social worker, I have a doctor, I have a psychologist and a psychiatrist. But the problem is that despite everything they've given me, without a job, how can I live?*" (Survivor 10)

Participants described how men should be strong and self-reliant; past torture experiences along with their present inability to cover even their basic needs or support family members back in Congo, threatened that identity even more. *"I was thinking to myself , 'What's the point in staying alive? I am not productive; I am not producing anything yet… What's the point in staying alive?'"* (Survivor 14)

The importance of employment and subsequent integration was unanimously recognised by key informants as an essential step for rehabilitation:

"[Employment] changes the person. He will step away from his community and the five or ten people he knows in Babel, MSF, or GCR. He will go to work, he will socialise, and he will see other things. He will get into a rhythm. He will start waking up in the morning, he will have an occupation, he will feel better in his body… These are the practices we need to look for if we want to work with

this vulnerable population" (Key Informant 8).

The Role of the Formal and Informal Congolese Community in Rehabilitation: "What can the association do for me?"

Community knowledge of rehabilitation: Participants were asked whether they thought the Congolese community could be involved in supporting SoT in Athens, and how this support could be given.

Many key informants were unaware or reluctant to discuss issues surrounding torture. There was also a limited knowledge of programmes supporting SoT, although most were aware of individual services such as language classes or mental health support.

Key informants also stressed the reluctance to share psychological difficulties due to torture out of fear and embarrassment:

> *"No, we do not discuss [torture]. If it has reached the physical, bodily level then there might be a discussion, but the other level, the psychology, it is not discussed and is underestimated"* (Key Informant 9).

Lack of participation in the formal community association was attributed to lack of time, lack of interest or a lack of immediate gain. Poor attendance also meant that there were few occasions to "reach out" to others.

Trusting other Congolese people: Being able to trust others was a huge challenge for many survivors and prevented them from seeking support from and interacting with other Congolese people in Athens.

> *"Since I left my country… to trust someone? [My social worker] asked me if I wanted a Congolese interpreter and I said no. I refused. I spoke in French. I prefer having someone Moroccan, not someone Congolese"* (Survivor 8).

The formal community association was described with ambivalence by survivors. It is an association with paid registration, although support is offered freely to registered members and non-members alike. For some, it was a place of unification, but others described a division between Congolese migrants who had settled many years ago and those who had fled seeking asylum. A fear of people gossiping and talking about them also led survivors to be reluctant to share and seek support from other Congolese people in Athens. A few survivors preferred associating with other French-speaking Africans and purposely avoided other Congolese people as there are "*no secrets"* amongst Congolese. Participants were also concerned about being identified and potentially tortured again, and key informants and survivors shared anecdotes of information travelling back to Africa:

> *"I don't want [another Congolese person] to know what happened to me. My fear is that he will tell somebody else, somebody else, somebody else, until maybe my country will be informed and look for me"* (Key Informant 3).

Whilst there was some support for the idea that the community could support Congolese SoT, the issue of trust and the fear of talking about torture remained a challenge, particularly from the perspective of the survivors.

Potential role of Congolese community members in supporting rehabilitation: Word of mouth was an important way for information about rehabilitation services to spread. Many survivors were directed to supporting services (including rehabilitation) by other Congolese people,

and key informants explained how they are already employing strategies of disseminating information, in person and online, as individuals or through the association. They additionally described how their influential role within the community could aid the spread of information about rehabilitation services

Key informants saw a potential role in providing support and working with other community organisations including associations and churches to raise the issue of survivors of torture amongst Congolese people living in Athens and inform them about available services. They described the need for the organisations offering rehabilitation services to open up to the wider community, so that they could benefit from transfer of knowledge and be able to successfully orient people who needed help.

> *"Meeting with the community, meeting with the churches, seminars inviting people who have been beneficiaries of those projects, who have been through this process and they have been, quote unquote, healed, and rehabilitated"* (Key Informant 8).

Despite the overall reluctance to share their experiences with Congolese people, some survivors expressed a willingness to discuss their positive experiences of rehabilitation with others.

Key informants pointed out that the community in general did not have the same skills as specialist organisations, thus would not be able to substitute a rehabilitation program in its entirety.

> *"The community does not have the capacity to play this role, do you understand? They don't have the capacity to play the role of the psychologist or the psychiatrist, because they haven't studied psychology. They cannot play this role"* (Key Informant 10).

However, the need for the community to address the newly emerging needs of Congolese in Athens was recognized.

> *"That's what we want in the community, a change of mentality. Because it's not only the person who might want to tell you something, what are you going to do with this information? If the mentality changes, then tomorrow, regardless of gender, people could find someone to confide in"* (Key Informant 5).

Discussion

This study explored the perceptions and experiences of rehabilitation from the perspective of male Congolese survivors of torture attending a rehabilitation clinic in Athens, and from members of the formal and informal Congolese community. We also wanted to understand if -and how- local Congolese community members could support the rehabilitation of SoT.

Rehabilitation was an unclear concept to many survivors, despite their direct experience of services. This could be an issue of health literacy, as described in Riggs et al. (2016), as an unknown concept that has the potential to include expectations that will remain unmet. This lack of clarity highlights the importance of the intake process in rehabilitation programs such as the one in this study, to ensure that beneficiaries understand the services themselves and the objectives of care. It also demonstrates the potential for a joint, participatory definition of rehabilitation and well-being that could inform future service provision (Bragin et al., 2014).

Survivors' main expectations of rehabilitation were improved physical and mental health (Persson & Gard, 2013). This is no surprise. However, the study further highlights the importance of a secure and stable context –po-

litically, legally, socially, economically– for the rehabilitation process. Rehabilitation thus extends beyond physical and mental health, to include aspects of the social and material environment such as safety, security, independence, refugee status and social integration.

Survivors in this study clearly stated the need for a calm and stable environment. The consequences of insecurity, unpredictability and the lengthy wait for asylum on the mental health of migrants and refugees in Greece have been previously documented (Bjertrup et al., 2018, Womersley et al., 2018) and our findings support the conclusion that rehabilitation should include these factors. A lack of proper reception conditions and the absence of integration planning at a national level in Greece are creating enormous uncertainty and instability for asylum seekers and refugees (AIDA, 2020). This is especially poignant for SoT, as torture is characterised by a loss of control and safety (Fabri, 2001), which is mirrored in the conditions of their everyday life, inciting feelings of powerlessness and loss of personal agency (Merkord, 2001). Rehabilitation goes beyond focusing on the torture experience and becomes a response to the uncertainty and unpredictability of the state and asylum system.

Survivors also described how torture and then their subsequent living and employment situation in Athens made them feel that their identity as men was challenged as they were not fulfilling their roles and obligations as fathers, sons and husbands. Men being overlooked within the refugee population (Arsenijević, 2018, Neikirk, 2017) illustrates not so much a problematic of gender but the systemic quantification and categorization of vulnerability as a pre-requisite to receive supporting services within the refugee context (Papadopoulos & Gionakis, 2018). This study did not explore issues of masculinity and fatherhood in-depth, but there is a definite need for awareness on the perspectives of refugee men and fathers, especially in survivors of torture.

Destruction of social links is a direct aim and consequence of torture, and the restoration of trust in others is an integral part of the rehabilitation process (ODIHR/CTI, 2018). Most of the survivors described how the care they received gradually restored their capacity to trust others. Lack of trust was also presented as a deterrent to sharing their experiences with other Congolese; which brings us to the issue of community involvement. Studies have indicated that "*a lack of ties with ethnic and host communities can be a serious source of stress*" for migrants (Dow, 2011, p. 181); however, as we have seen, originating from the same country is not enough to constitute a functional community, especially for those who have been tortured by compatriots. Refugees may belong to several different communities, not necessarily restricted by language or nationality, with an importance placed on the definition coming from the community itself (Mitchell & Correa-Velez, 2009). Papadopoulos (2019a) underlines the same idea, while talking about the assumptions and heterodetermination that humanitarian organisations, as representatives of a "dominant" narrative, may fall into. We do not intend to force the notion of a shared group upon beneficiaries of the clinic (Episkopou et al., 2018), nor insist that they disclose the horrific details of torture with others, but instead wish to reflect on ideas of belonging and possible ways of finding sanctuary and stability in shared experience (Papadopoulos, 1999).

Involving Congolese community organisations, churches or associations in a country such as Greece where current services are limited and overstretched could improve service provision, enable more people to be reached and mitigate the potential isolation that survivors can face. The potential for

community members to aid in the provision of mental health support services has been studied (Williams & Thompson, 2010), as has their role in specific services for SoT (Kotsze et al., 2017). Our results show, however, that divisions and lack of trust between Congolese people living in Athens in terms of social status, employment and migration experience would make this extremely challenging. Key informants acknowledged that there was a need for specialised support and that they did not feel able to provide this, beyond linking people to services or the support provided by religious leaders. The suggestion from several key informants to introduce SoT services to community members at meetings was also reassuring. There was strong motivation and willingness from the formal Congolese association to learn more and maintain its function as an information hub that could direct and advise its members about service provision in Athens. Our findings support the recommendation that organizations should share knowledge, experiences and know-how, and allow communities the space to self-identify without assumptions of homogeneity on the organisations' part.

Likewise, homogeneity should not be assumed about SoT (Cullinan, 2001). Rehabilitation is a dynamic process that requires a holistic, personalised approach (UNCAT, 2012), taking into consideration the "*complexity, uniqueness and totality*" of the person (Papadopoulos & Gionakis, 2018, p. 6; Papadopoulos, 2015). There is no question of whether the destabilising conditions presented by the participants of this study are potentially re-traumatising; the issue is what is required from a rehabilitation program to empower people in a disempowering environment such as Athens.

Focus should not be on "trauma" and "recovery" in a polarised "from-to" discourse, but on a holistic view of the individual, including both adversity and resilience, informed by the wider socio-political context that SoT and professionals operate in (Papadopoulos, 2019a, 2019b). Rehabilitation from the physical and psychological trauma of the past cannot be detached from the current living conditions and the limited prospect of integration for Congolese males in Greece. Accommodation or vocational training should be considered as part of local advocacy and strategy planning to develop meaningful partnerships for the direct or indirect coverage of survivors' needs. Medical and non-medical organisations should also consider the risk of isolation that many survivors are facing and encourage the creation of safe spaces, collective activities and opportunities to participate in society as an equal member as part of the holistic rehabilitation process.

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Note on author's passing

Dr. Gianfranco De Maio was a valued member of MSF since 2001. He was project coordi-nator for the rehabilitation centre for torture survivors in Rome, as well as technical refer-ent of the Brussels operational centre for the rehabilitation of survivors of torture, abuse and intentional violence in support of the projects in Athens, Mexico City, Rome and other places along the migration routes. He untimely passed away in June 2020, leaving behind a legacy of dedication and solidarity. His presence, knowledge and insight will be missed by all.