EVALUATION REPORT
TORTURE REHABILITATION CENTRES

Final Report

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ABBREVIATIONS

25 HSCL	25 Hopkins Symptom Checklist
AI	Amnesty International
CAPS	Centre for Psychosocial Attention (Peru)
CAT	Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CBO	Community Based Organisation
CEAS	Episcopal Commission for Social Action (Peru)
CNDDHH	National Coordinator for Human Rights (Peru)
COMISEDH	Commission for Human Rights (Peru)
CVICT	Centre for the Victims of Torture (Nepal)
DAS	Disability Assessment Schedule
DfID	Directorate for International Development (of the British Government)
EC	European Commission
EIDHR	European Initiative for Democracy and Human Rights
EMDR	Eye Movement Desensitization and Reprocessing
EU	European Union
FPPHR	Former Political Prisoners for Human Rights
GCRT	Georgian Centre for Psychosocial and Medical Rehabilitation of Torture Victims
GTIS	Global Torture Victims Information System
HTQ	Harvard Trauma Questionnaire
HR	Human Rights
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
INSEC	Informal Sector Service Centre (Nepal)
IPEDEHP	Peruvian Institute for Human Rights Education and Peace (Peru)
IRCT	International Rehabilitation Council for Torture Victims
NGO	Non-governmental organisation
NIS	New Independent States
OHCHR	Office of High Commissioner for Human Rights
RCT	Rehabilitation and Research Centre for Torture Victims
TCA	Torture Compensation Act (TCA) (Nepal)
TPO	Transcultural Psychosocial Organisation
UK	United Kingdom

EXECUTIVE SUMMARY

Introduction

In the past few years the European Commission has gradually shifted the focus of its financial support for rehabilitation centres for victims of torture, through the European Initiative for Democracy and Human Rights (EIDHR), to prevention of torture initiatives. The rehabilitation centres for victims of torture, however, have argued that the distinction between rehabilitation and prevention is artificial and that a reduction of funding for rehabilitation activities will have an adverse effect on the prevention of torture. For that reason, EIDHR wished to evaluate torture rehabilitation programmes in order to assess the effectiveness and impact of those programmes in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture.

The impact and effectiveness of the rehabilitation centres in Nepal, the Centre for Victims of Torture (CVICT), and in Peru, Centro de Atencion Psicosocial (CAPS), were evaluated as case studies. Besides, key persons in Denmark and England were interviewed, and documents provided by European Initiative for Democracy and Human Rights (EIDHR) as well as various other relevant documents were studied.

Findings

Contextual situation

The social political situation in which the various rehabilitation centres for victims of torture and/or victims of organised violence function, differs. Globally a distinction can be made in four categories of contextual situations: a) a conflict situation (e.g. Nepal); b) a post conflict situation with a transition towards democracy (e.g. Peru); c) a (post) conflict situation with a transition towards democracy, in which victims of torture from other countries are also hosted (e.g. Georgia); d) third, hosting countries (e.g. EU countries).

CVICT is an example of a centre working in a conflict situation, while CAPS is conducting its work in a post-conflict situation, in which a transition towards democracy is taking place.

Target groups for rehabilitation

The target groups of the rehabilitation centres differ considerably. Some focus mainly on victims of torture, while others assist victims of organised violence in general. Other differences are for example the age and gender of the target group. The clinic in Kathmandu of the EIDHR funded CVICT project assists victims of torture without distinctions. CAPS, in Peru, mainly provides psychotherapeutic care to ex-prisoners who have not been convicted of any crime. Some EIDHR funded projects, i.e. in East European countries, only conduct preventive activities.

Approaches in rehabilitation

The approaches in the medical and psychosocial rehabilitation programmes of the various rehabilitation centres differ as well. The rehabilitation programme of CVICT can be characterised as primary health care, in combination with legal assistance and individual psychotherapy. By their mobile clinics their work is outreaching, with a community approach, which advances timely identification and treatment. In fact they have developed a model of an integral approach, in which only the social-economic assistance to victims of torture is missing. CAPS is formed by a highly specialised psychotherapeutic and psychiatric team, whose methodologies are mainly based on psychoanalytic theories, providing care that does not seem to be

geared to the needs of the majority of victims of torture in Peru at this moment. The difference in approach of these two centres can be seen as a characterisation of the broad spectrum of approaches of the rehabilitation centres in the various regions in the world.

Prevention activities

The same can be said about the prevention activities of the various rehabilitation centres. CVICT seems to have developed a vision about the challenges and risks of prevention activities in Nepal, while CAPS misses that vision until now.

Nevertheless, CAPS was and is contributing to the prevention of torture, e.g. by its input in the work of the Truth Commission in Peru, and, although indirectly, through its (future) membership of the network of human rights organisations of the National Coordinator for Human Rights (CNDDHR).

Both centres are collaborating with (a network of) human rights organisations on a national and international level, and exchange their experiences with peers on regional and international levels. Besides, CAPS also participates in various national and local networks of mental health workers.

There are also EIDHR funded centres that only conduct a variety of prevention activities, with at least one of them working in close, synergetic collaboration with a rehabilitation centre for victims of torture.

Centres in the European Union (EU) contribute mainly to the prevention of torture by individual medical assessments for asylum procedures (non-refoulement), training in medical assessments for health professionals, documentation and raising the awareness of the public.

1. Influence of prevention activities on medical-psychological work

Do prevention activities detract from the rehabilitation work?

There is no sign that prevention activities detract from rehabilitation work. The number of CVICT's activities in the area of prevention shows that a centre can do more than financially covered with a network of volunteering lawyers, health professionals and journalists. However, it is justified to ask whether medical-psychosocial centres dispose of the rights skills for awareness-raising activities. For reasons of cost effectiveness it could be recommendable that centres adapt the composition of their staff to the activities carried out, or that they collaborate with organisations that do posses the necessary expertise and skills.

Do prevention activities have any beneficial or detrimental effects on the victims?

The case study in Nepal shows that in a conflict situation, prevention activities may reduce the number of clients consulting a rehabilitation centre. On the other hand, the participation of victims of torture in prevention activities, e.g. in the radio messages of CVICT, has an empowering effect on the victim and at the same time strengthens the message. The input of CAPS to the Truth Commission – the preparation and training of the members of the Commission and its volunteers, the preparation of and assistance to the witnesses before, during and after their testimonies – clearly had a beneficial effect on the victims, as well as on the functioning of the commission. The decision of CAPS, however, to establish a working relation with the police was not quite appreciated by their clients. To avoid such reactions it is recommendable to involve clients in the policies of a centre.

In general, rehabilitation centres – whether in conflict, post conflict and/or in third, hosting countries - have a symbolic function for the victims: it is a symbol of recognition of their suffering. Preventive activities express the solidarity of the centres with the victims. In EU-countries (immigration) authorities may consider this solidarity as an over-involvement and put medical assessments for asylum procedures aside as being subjective. This is enhanced if the standard of the medical assessment is not at an appropriate academic, professional level. Tentatively, a division was made of possible actions in the prevention of torture of rehabilitation centres, with their methods and indicators, as well as their risks, based on Amnesty International's 12-point program of action (see Annex 4, pg - 58 -).

2. Opinion of Local Human Rights Organisations about the Rehabilitation Centres

On the local level, CVICT and CAPS are highly respected by local human rights organisations for their work in the medical and psychosocial area. Although the ways in which they are contributing to the activities of the local human rights organisations differ, in general they are contributing to the activities of the main human rights organisations in their respective countries. Other human rights organisations in Nepal and Peru tend to compare the activities of the rehabilitation centres with those of their own and/or with their own interests and are more critical. CVICT is criticised because its community work in rural areas in Nepal is limited, they do not provide social-economic support and their prevention activities are hardly visible. CAPS is criticised because it has not developed interventions geared to the needs of the majority of the victims of torture in Peru, especially in the psychosocial area, nor contributes to a larger extent to legal actions in favour of victims of torture.

It was not possible to assess the opinion of local human rights organisations regarding other rehabilitation centres in the world on the basis of the available documents.

3. Indicators

Indicators used by the centres to measure impact of rehabilitation and prevention, if any?

In general, rehabilitation centres seem to struggle with defining the criteria for measuring the impact of their prevention activities. Many seem to use numbers of people reached, without mentioning percentages of the number of people reached in relation to the total number of people to be reached. Moreover, the number and percentage of people reached does not particularly assess the impact of the activities on the views and norms of the target group.

Many centres also confuse indicators and methods. For example, training is a method of transfer of information and skills, but giving a training cannot be seen as an indicator of the impact of the training on the participants. The assessment of the satisfaction of participants with the contents and the presentation is a good example of indicating the impact of training. Even better would be an assessment of the impact of a training on daily functioning. The indicator of legal support can be the number of legal cases filed, or supported with medical documentation, and won. The number and results depend on the contextual situation.

Both CVICT and CAPS are aware of the importance of indicators to assess the impact of their work. They assess the impact of their rehabilitation work by the reduction of symptoms and the improvement of social functioning. CVICT uses internationally acknowledged instruments for their assessments, although discussions are going on, as within CVICT, as to whether these instruments are culture sensitive. However, CVICT has not published the results of these assessments in their reports.

Both centres mention ‘drop-outs’, i.e. clients who decide not to continue a treatment or therapy. CVICT does not report the percentage. Both centres have not studied the causes of those drop-outs.

CVICT has also identified the indicators for their prevention activities, but some of them are not assessed or were too ambitious. CAPS has not identified criteria for their preventive activities in the logical framework of their project description, but in practice they do evaluate their trainings and meetings e.g. by surveys of the satisfaction of the participants regarding the contents and presentation.
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Possible criteria/indicators that could be used to judge the impact of rehabilitation on prevention activities?

The question of possible criteria or indicators to measure the impact of rehabilitation on prevention activities was not easily answered. The data collection and documentation for national and international pressure on governments generally has an effect on long term. The adoption of the Torture Compensation Act in Nepal, which CVICT in Nepal contributed to and lobbied for, is an example of the way a rehabilitation centre contributes to the prevention of torture. The same can be said of the input of CAPS to the Truth Commission in Peru. The interviewed victims of torture confirmed the impact of that input. Other indicators can be the number of cases of torture brought to court, directly by the legal support of a

rehabilitation centre, or, indirectly, with medical documentation of the centre. The support to self-organisations and survivor groups by means of assistance and support or (group)therapy, strengthens their coping and therewith can advance their seeking for justice. The training of police by CAPS in which not only the physical and psychosocial effects torture has on victims are pointed out, but also what is does to them, can only be given by mental health professionals familiar with these subjects. The same can be said about the training of (mental) health personnel in the identification of consequences of torture for documentation reasons. The specific input of (mental) health professionals in e.g. training of the judiciary system or awareness-raising activities on various levels, is complimentary to that of other (HR) organisations.

4. Effectiveness and Impact of the Rehabilitation and Prevention Work

Activities and plans of IRCT-members and other EU-funded centres with respect to rehabilitation and prevention

In so far as the documentation of other IRCT members and EU funded centres could be studied, they all differ in target groups, methodology and focus on rehabilitation vis-à-vis prevention. This wide range has already been described globally above. IRCT is presently conducting long-term research on the indicators for assessment of the impact of rehabilitation and prevention.

Assessment of the strength of the rehabilitation and prevention work in the countries of origin

The case studies of CVICT in Nepal and CAPS show that rehabilitation centres can contribute to the prevention of torture. They also show that in particular situations, especially in conflict situations, and to a certain degree, the prevention activities might scare off potential clients. Other skills are required for community approaches and support to income generating activities of clients, than for specialized psychotherapeutic and psychiatric care. The same can be said regarding prevention activities in the legal and the awareness-raising area. In particular contextual situations, a separation or delineation between legal aid, prevention activities and medical, psychosocial rehabilitation might be more effective. In others an integral approach with rehabilitation and prevention combined, will prove to be beneficial for both victims of torture and the centre's own personnel. In general the more medicalised, i.e. specialised a centre or programme is, the less likely it is to contribute directly to the prevention of torture.

A strategic plan is required in which the aims of the centre, the methodology and its indicators are defined, based on an analysis of the contextual situation, the target groups, the other stakeholders, the challenges and risks, and the strength and weaknesses of the centre in question.

Assessment of the strength of the rehabilitation and prevention work in the countries where they are treated (as regards refugees and minorities)

On the basis of the few available documents of the rehabilitation centres in Europe only, or more in general, the same as in 4.2 can be repeated. However, it can be concluded that the contribution to the prevention of torture in EU countries is relatively limited, especially in comparison with that of centres in post-conflict situations.

Assessment of the strength of the rehabilitation and prevention work at international level

The activities of IRCT and its members are generally highly respected in the world. Nevertheless, criticism can also be heard regarding their (specialised) centre approach, and question marks are placed regarding the cost effectiveness of some of their awareness-raising activities.

5. Alternative Sources of Funding available locally for Rehabilitation or Prevention

The case studies of CVICT and CAPS show that all parties concerned opine that on short or longer term the respective governments should provide reparation to victims of torture. The case study of CAPS, however also shows that in post-conflict situations, governments are mostly struggling with the political dynamics of a transition towards democracy. In conflict situations, in which for example CVICT is functioning, a neutral position with regard to finances and target groups will guarantee the best accessibility of the services for all victims of torture.

In third countries, the possibilities for alternative financing depend on the health care policies in the country, and the centre's position in health care and society. In countries in transition towards democracy also hosting refugees, the poor social economic situation will mostly dominate.

Within the EU, the EC Directive concerning the minimum standards for reception of asylum seekers gives direction to the provision of assistance and care to victims of torture. There are examples within the EU of governments or health insurances financing or having financed rehabilitation centres for victims of torture, and/or refugees and asylum seekers, where integration of the rehabilitation methodologies in mainstream health care is promoted. Mainstream health care can benefit from a transfer of the developed methodologies, since mostly they can also be applied to other victims of violence and psycho-traumas, and at the same time more victims can be reached in this way. Nevertheless, rehabilitation centres also have a symbolic value for the victims and form a body of knowledge, which in policies and decisions should also be taken into consideration.

6. Conclusive remarks

The answer to the main question of the evaluation as to whether rehabilitation centres (can) contribute to the prevention of torture is affirmative. However, the possibilities, extent, effectiveness and impact of prevention activities depend mainly on:

- The contextual situation
- The chosen strategy with regard to the rehabilitation and prevention approach
- The composition of the staff
- The existence of (other) human rights organisation and the collaboration with those centres.

Since the possibilities, extent, effectiveness and impact of prevention activities of rehabilitation programmes depend on the various factors mentioned above, the selection criteria for programmes coming into consideration for EU funds will not be easily determined, considering the shifting of the focus of the EC from rehabilitation towards prevention activities.

- By a strict requirement of rehabilitation centres to dedicate a fixed share of their time and budget to the prevention of torture, centres in conflict areas as well as EU based rehabilitation centres might be excluded from funding.

- A distinction could be made regarding the percentage of time /budget dedicated to prevention in relation to the contextual situation. The proportion of time and budget for prevention activities of rehabilitation centres in EU based countries, however, does not seem easy to determine. And what about centres working synergistically in collaboration with other (human rights) organisations?
- The composition of the technical staff gives an indication of the centre's rehabilitation and prevention approaches, but should also be seen against the background of the contextual situation, as well as in relation with the collaboration with other (HR) organisations.
- A rating by points, based on the strategic plan of centres, could be developed in collaboration with NGOs involved in rehabilitation and prevention, but such rating requires sound strategic plans. This might, however, lead to the exclusion of those centres not (yet) able to develop such plans.
- Selection on basis of certain areas in the world would exclude centres pioneering in rehabilitation and prevention.

These considerations regarding the selection criteria and its limitations are certainly not all inclusive. A fair distribution of funds, with consideration for the contextual situation of a rehabilitation centre and therewith for its possibilities and limitations, as well as for its alternative funding sources, seems the best option.

I. INTRODUCTION AND METHODOLOGY

1.1 Background

For many years, the European Commission (EC) has funded centres for the rehabilitation of victims of torture in many countries, through the European Initiative for Democracy and Human Rights (EIDHR). The number of such centres has grown considerably in recent years, and the Commission has found it timely to review its funding policy, especially concerning the emphasis to be assigned to the support of torture prevention activities. Considerations about a shift in funding policy already started some years ago.

A report to the Commission by the European Human Rights Foundation[1] in 2000 discusses and recommends a more focussed strategy for EU funding initiatives in the field of rehabilitation of victims of torture. It argues that the Commission should decide if funding through the EIDHR should focus on torture prevention initiatives. The report also recommends that if EIDHR continues direct support of rehabilitation centres, the types of rehabilitation work eligible for EU-funding should be clearly defined.

In an EC Communication from 2001 on the EU's role in promoting human rights and democracy in third countries, four priorities are set out for the use of EIDHR, one of which is support for the fight against torture. The Communication also reflects a clear decision regarding the focus in its future support to the combat of torture. The Communication states that "in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through a human rights education of the police and other possible agents of torture". In response to this, the Commission has begun a gradual shift in the focus of its financing, away from rehabilitation of victims towards torture prevention.

A Commission Programming Update from January 2003[2] clarifies that the emphasis on prevention should include a strengthened prevention component at local and regional levels:

- Within the activities carried out by the rehabilitation centres;
- Through bolstering the work of ombudsmen;
- Through training of key personnel (e.g. prison staff, police officers, doctors and lawyers);
- Through monitoring and reporting of incidences of torture in third countries.

According to Gurr & Quiroga[3], the prevention activities of rehabilitation centres are not well known, but most prevention work seems to be in the area of education and public awareness raising. Out of 26 centres, 23 answered affirmatively when asked if prevention was a matter of specific concern, and 17 said that it was formally incorporated in their work.

During a meeting between the Commission and Human Rights NGOs[4] in January 2003, the torture rehabilitation centres argued that the distinction between rehabilitation and prevention is "artificial" and that a reduction of funding for rehabilitation work will have adverse effects on prevention.

[1] European Initiative for Democracy and Human Rights (June 2000). EHRF monitoring report on EU-supported organisations providing rehabilitation for survivors of torture.
[2] European Initiative for Democracy and Human Rights Programming Update 2003. Brussels: Commission Staff Working Document, 20 January 2003.
[3] Gurr, R. & Quiroga, J. (December 1998). Desk study on approaches to torture rehabilitation. Copenhagen: Ministry of Foreign Affairs.
[4] European Commission, Human Rights and Democratisation (2003). Note on NGO meeting on torture, 17th January 2003.

Whether or not the distinction between prevention and rehabilitation is artificial, as rehabilitation centres have argued, will to a large degree be connected to the definition of the concept "prevention", and of the concept "rehabilitation". How are torture prevention and rehabilitation activities defined and related to each other?

1.2 Definitions of prevention and rehabilitation and their relation

1.2.1 Definition of prevention

The argument that prevention and rehabilitation are interconnected, builds on a public health discourse that emphasises levels of intervention (in preventive work), seeing rehabilitation as one level of preventive interventions. At a seminar in 2001, organised by RCT on prevention of torture[5], these levels were discussed. It was argued that rehabilitation and prevention are complementary, inter-dependent and mutually reinforcing:

- At the primary level, preventive work is aimed at the international and national bodies, especially through legal interventions such as the strengthening of the application of legal instruments and systems in the fight against impunity;
- At the secondary level, preventive work is aimed at groups that have been or may be involved in torture, e.g. the police, the prison authorities, judges, civil servants, in alliance with civil society organisations that can influence these groups;
- At the tertiary level, preventive work is aimed at rehabilitating victims of torture in order to lessen the effects of torture, thereby also documenting the effects of torture, and empowering communities of victims, thus enabling them to fight for a culture of human rights.

According to this viewpoint, rehabilitation is thus preventive at the tertiary level.

However, there are at least two main schools of thought concerned with the importance of the various levels of intervention: the first school of thought emphasises preventive work at the societal-legal level (mainly human rights organisations), while the other gives more importance to work at the individual level through medical and psychological rehabilitation activities (mainly rehabilitation centres).

In public mental health other distinctions are made in the relation between (mental) health care and prevention; translated to the consequences and prevention of torture:

- Primary prevention is the identification and signalling of (the consequences of) torture (and other causes that lead to distress and (mental) health disorders among victims of torture), and the promotion of adequate measures to reduce or eradicate torture (and other causes) [6]; health care can contribute to the reduction and eradication directly (information, education, training) and/or indirectly (providing documentation and data to relevant bodies).
- Secondary prevention is the assistance (empowerment) in coping with the consequences of torture, and the provision of adequate medical, psychosocial and/or psychotherapeutic care in order to treat or cure the consequences. [7]

[5] Rehabilitation and Research centre for Torture Victims (RCT) (January 2001). Prevention of torture and organised violence in the 21st century – reassessing the strategy. Copenhagen: Report.
[6] Other causes can be other human rights violations, and/or the (bad) social conditions in which victims of torture are living.
[7] On this level the distinction between (health) prevention and promotion vis-à-vis curation, treatment, is vague.

- Tertiary prevention is the provision of adequate medical, psychotherapeutic and/or psychiatric care to victims of torture so the consequences of torture (and other causes) do not return or deteriorate.

From this public mental health perspective, rehabilitation of torture victims can contribute to the prevention of torture by identification, documentation and signalling, as well as by stimulating and motivating the relevant authorities to take reducing and eradicating measures and by (contributing to) information, education and training. The secondary level, the empowerment of victims of torture, coincides with the tertiary level of the RCT division, as described above.
In both the RCT and public health categorisations on levels of prevention, a distinction can be made in activities aimed at prevention on macro (international and national), meso (institutions and organisations) and micro (community, family and individual) level.

Legal interventions and aid do not normally belong to the mental health care sector, but with regard to victims of torture it could be seen as part of an integral approach in medical and psychosocial rehabilitation, i.e. reparation (as described in the Convention against Torture, see below).

Whether a rehabilitation centre contributes to the primary, secondary or tertiary level of prevention of torture depends on its own definition of its position within (mental) health care.

1.2.2 Definitions of rehabilitation and the relation with prevention

According to the Convention against Torture (CAT), art. 14.1, a victim of torture is entitled to (the means for) "as complete a rehabilitation as is possible".[8] The Council Directive 2003/9/EC, in which the minimum standards for the reception of asylum seekers are laid down, states that necessary medical or other assistance should be provided to those with special needs (art 15), and that victims of torture and violence should receive the necessary treatment of damages caused by such acts (art 20).[9] A similar article can be found in the Council Directive 2001/55/EC regarding the minimum standards for giving temporary protection in the event of a mass influx of displaced persons (art. 13.4).[10] In other words, the EC recognizes the need for "rehabilitation" of victims of torture within third, hosting countries belonging to the EU territory, and its member states' obligations regarding the provision.

When looking at definitions of "rehabilitation", there are also at least two schools of thought among the rehabilitation centres for torture victims: one school of thought conceives rehabilitation as community-based psychosocial interventions that include support for the development of healing group processes at the local level (in public health terms the secondary level of prevention), while the other defines rehabilitation as individual psychotherapy interventions (the tertiary level). Some rehabilitation centres, especially in post-conflict situations, seem to adhere mostly to the community-based approach, while others, e.g. in third, hosting countries, are more oriented towards the individual, psychotherapeutic approach.

[8] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. www.hrweb.org/legal/cat.html (28-10-2003)
[9] Council Directive 2003/9/EC. Official Journal of the European Union. L 31/ 18 - 25
[10] Council Directive 2001/55/EC. Official Journal of the European Communities. L 212/12

Given the nature of the consequences of torture and other human rights abuses, both schools have their value, and in fact the two approaches are complimentary. [11] [12] Nevertheless, with the community approach the majority of the victims can be reached; an individual, psychotherapeutic approach is appropriate for those victims who suffer serious mental distress or disorders, which is only a relatively small percentage of the victims. [13]

Whether or not rehabilitation contributes to prevention would seem to be influenced by the rehabilitation approach chosen by the centres. If the approach is community-based, the chance of contributing to prevention would be greater, e.g. through the empowerment of communities of survivors, thus enabling them to fight for a culture of human rights. Also, more representative data can be gathered with this approach. In other words, following the public health distinctions, does a centre position itself as a public (mental), or primary health care centre, thus contributing to the primary or secondary prevention of torture, or is it positioned as a specialized mental health care organisation, providing treatment and care on the secondary and tertiary level? The more a centre tends, in public health perspective, to the tertiary level of prevention, the less likely it is that it contributes to the prevention of torture, e.g. since it only sees a, mostly small, selection of the whole target group.

1.2.3 The impact of rehabilitation on prevention

The problem of establishing criteria or indicators for assessing the impact of rehabilitation on prevention is complicated. These indicators are not easily defined because they represent processes of social change that may have multiple causes, with interventions mostly carried out under conditions that are unpredictable and unstable. However, indicators can be viewed as statements (either quantitative or qualitative) that serve as metaphors for phenomena that are not directly measurable, yet still revealing.[14] Although indicators for impact of prevention are not easily defined, they are important because they can give direction to the rehabilitation interventions.

An example of indicators revealing the impact of rehabilitation on prevention could, for example, be defined as the number of rehabilitated clients who have brought their cases to court, or the number of rehabilitated clients who have become member of survivor's associations fighting for the promotion of human rights as agents of social change.

Besides, the surplus value of a rehabilitation centre performing prevention activities should not be under estimated, and can be sought in the profession of its workers: in most societies in the world health care professionals are still highly respected. They contribute to the prevention of torture on basis of their own expertise, which is complimentary to those of other (human rights) organisations.

However, the possibilities for these kinds of activities and their impact depend to a great extent to the contextual situation of a rehabilitation centre, e.g. whether it is situated in a conflict or post conflict situation, in a third, democratic country, or in a combination of the last two situations. In a conflict situation, the prevention activities of a centre might be limited to providing data and documentation to international human rights organisations, while for example in third, democratic

[11] See for example G. Perren-Klinger in: European Initiative for Democracy and Human Rights (June 2000) see note 1, and Gurr and Quiroga, see note 3.
[12] Weiss M.G. e.a. (2003) Mental Health in the Aftermath of Disasters. Consensus and Controversy. The Journal of Nervous and Mental Disease, 191 (9): 611 - 615
[13] Ibid 11 and 12
[14] See Sano, H.O. in RCT, January 2001. p. 26.

countries, centres providing rehabilitation to asylum seekers and refugees might contribute to the prevention of torture on the individual level by their medical documentation to prevent 'refoulement', and on a society level by awareness-raising activities.

The discussion about the relation between rehabilitation and prevention is important as a means for the rehabilitation centres to reflect on and develop their working methods. As Quiroga and Gurr comment, "... *prevention should be an important part of any torture rehabilitation program, but the situations in each country are so particular that they defy any type of generalization. Therefore the appropriate prevention activities have to be tailored to the reality of each country*."[15] This requires the development of a sound strategy or policy plan of each centre, in which the social political environment, the target groups, the stakeholders and the position of the centre within this context have been described, and the challenges and risks as well as the strengths and the weaknesses of the organisation have been analysed.

1.3 Aim and questions of the evaluation

The Commission wished to evaluate the strength of the argument that rehabilitation of torture victims contributes to the prevention of torture, by conducting two case studies of torture rehabilitation centres that the Commission has funded for some time. The first is the Centre for the Victims of Torture (CVICT) in Kathmandu, Nepal, and the second is the Centre for Psychosocial Attention (CAPS) of the National Co-ordinator of Human Rights of Lima, Peru. (See Terms of Reference, Annex 1, pg - 49 -).
The central questions in the evaluations were:
How effectively does the work of centres for the rehabilitation of torture victims contribute to the prevention of torture (a) in the countries from which these victims originate (b) in the countries in which they are treated and (c) at the international level?
Inter alia, attention had to be paid to the following aspects:

- whether or not prevention activities detract from the medico-psychological work of the centres;
- whether or not prevention work has any beneficial/detrimental effects on the victims themselves;
- the opinions of other local human rights NGOs which work exclusively on prevention, if these exist;
- the extent of any verifiable indicators used by the Centres to measure the impact of their work, both as regards the rehabilitation of victims as well as the prevention of torture;
- the extent to which alternative sources of funding are available in the country for either rehabilitation or prevention activities.
- definition of the criteria to be used in judging whether rehabilitation activities play roles in prevention of torture
- brief overview of other EU-funded centres working with torture and their activity plans, and a similar overview of the IRCT-members' activities with respect to rehabilitation and prevention work, including an assessment of the strength of rehabilitation and prevention work respectively.

1.4 Methodology of the study

The evaluation has been carried out through the study of documents regarding the torture rehabilitation programmes (see References, pg - 47 -), case studies in

[15] Ibid 3

Nepal and Peru, and interviews with key persons in England and Copenhagen. In Nepal, the team visited the Centre for the Victims of Torture (CVICT) in Kathmandu, and in Peru the Centre for Psychosocial Attention (CAPS) of the National Co-ordinator of Human Rights of Lima. Both in Nepal and in Peru a national consultant joined the international team.

During the fieldwork in Nepal and Peru, the team interviewed the persons responsible for the projects, staff members, and beneficiaries of the projects. The team also interviewed representatives from local and international organisations and experts in the human rights movement, including civil society stakeholders and advocacy groups. At the end of each mission the preliminary findings were shared with the directors of the respective centres. Before the draft report was submitted to the EC, the centres were given the opportunity to comment on the factual data of the report regarding their own centre. In England and Copenhagen, the team interviewed key persons involved in torture prevention campaign and research including the former Special Rapporteur on the Prevention of Torture, in order to cover the international dimensions of the evaluation.

Besides, during the missions the authors of this report tentatively 'translated' the Amnesty International 12-point program for the prevention of torture[16] to prevention activities of rehabilitation centres, its indicators and its risks in certain contextual situations: see Annex 4, pg. - 58 -.

1.4.1 Team composition

The team was composed of two international experts, Dr. Mrs. Loes van Willigen (Team Leader), specialised in (refugee) health and human rights, and Dr. Mrs. Inger Agger, specialised in psychosocial interventions in conflict and post-conflict contexts.

The mission to Nepal took place from 19–26 September 2003, and was carried out by Dr.van Willigen and the Nepalese consultant, Mr. Prakash Khanal, journalist. The mission to Peru took place from 8–14 October 2003 and was carried out by Dr.van Willigen, Dr.Agger and the Peruvian consultant, Mrs.Tutty Barandiarán, expert in human rights work.

Dr.van Willigen interviewed key persons in the United Kingdom (UK), 11-12 September 2003, while Dr.Agger interviewed key persons in Copenhagen, 1-2 October 2003.

1.4.2 Constraints

The field to be covered by the team was extensive within a rather limited time frame, especially for the fieldwork in Nepal and Peru. Thus, there was no time to visit project activities of the rehabilitation centres in the provinces outside Kathmandu and Lima, which would have added to the understanding of the preventive aspects of their rehabilitation work. Besides, during the first days of the visit to Kathmandu the mobility of the mission was limited by a national strike called by the Maoists.
A thorough assessment of the rehabilitation and prevention activities of other rehabilitation centres was constrained by time and available documents.

All interviewed persons and organisations received the team with great openness and readiness to share their viewpoints and working methods. The team would

[16] Amnesty International (2003) Combating Torture – a manual for action. Appendix 16. www.amnesty.org

especially like to thank the Delegations of the European Commission in Nepal and Peru for the support received during the field missions, as well as for the feedback received during the whole process from Dr. Hans Otto Sano from the Danish Institute for Human Rights.

1.5 Structure of the report

The evaluation of the EC funded and IRCT related centres and the results of the interviews with key persons in Denmark and England will be described first. The evaluations of respectively the case studies in Nepal and Peru follow. Then the conclusions are given, based on the results of the evaluations. At the request of EIDHR, some considerations regarding the consequences of the EC's increased focus on prevention initiatives are added as an epilogue. In the annexes the literature references, the terms of reference of the evaluation, the itineraries and the people and organisations interviewed, as well as the Amnesty International's 12-points of action 'translated' to the rehabilitation centres can be found.

2. REHABILITATION AND PREVENTION OF EU FUNDED AND IRCT RELATED CENTRES

This chapter discusses the rehabilitation and prevention activities of EU funded and IRCT related centres in general, based on a global study of the available documents provided by EIDHR, and of randomly searched descriptions of centres belonging to the network of IRCT and found on its website, and interviews with key persons in England and Denmark.

2.1 EU funded centres

According to the overview provided by EIDHR, the EC is at present financially supporting 48 rehabilitation centres / programmes: 18 in EU countries, 14 in Central and Eastern Europe and the Baltic States, 9 in Latin America, 4 in the Middle East, 2 in Africa and 1 in Asia. One of these centres is IRCT in Copenhagen. The majority of the centres/programmes are situated either in post conflict situation in which a transition to democracy is taking place, and/or in third hosting, mostly EU countries. Some centres and programmes in Eastern European countries, e.g. Georgia, provide rehabilitation services to Internally Displaced Persons (IDP's), refugees from a neighbouring country, and victims of torture living in their own country. The contextual situation in those East European countries can be characterised as states in which a laborious transition towards democracy is taking place, which at the same time are hosting refugees from neighbouring countries.

Only a few centres funded by EIDHR are situated in the middle of a conflict situation. In the EIDHR overview, at least two programmes for the prevention of torture, funded by EIDHR, were not included: the project "Campaigning against torture and cruel treatment in Ukraine" of the Kharkiv Human Rights Protection Group, and the "Prevention of Torture – Support for the Rehabilitation of Victims of Torture" of Former Political Prisoners For Human Rights in Georgia.

2.2 IRCT related centres

By September 2003 the IRCT network consisted of 96 *accredited* centres, 64 *registered* centres, and 40 *listed* centres, in total 200. The 96 accredited centres form the immediate target group of the IRCT. The centres are divided into five regional coordination networks (Latin America, Asia, Central and Eastern Europe, Sub Saharan Africa, Middle East and North Africa). IRCT is supporting its accredited members by providing technical assistance, capacity building training seminars and programmes, the development of working standards, and organisational development and prevention projects.

It is a criterion for membership of the IRCT network that the centres work with rehabilitation, but it is not a criterion that they should also work with prevention. IRCT has only recently developed its overall strategy for prevention. [17]
Various surveys have been made of the centres, but there is no overall survey of the preventive work of the centres in the IRCT network. However, an estimated 75% work with advocacy and 50% with documentation. Some centres are involved in conflict resolution (e.g. Indonesia). For some centres (e.g. Zimbabwe and Sudan) it has been too dangerous to be involved in prevention of torture; their directors are in exile (Zimbabwe) or detained (Sudan).

[17] See "Centre Support & Development Programme Strategy 2003-2007". (IRCT, Draft, 19 March 2002).

There exists a certain degree of overlap between the EC funded centres / programmes and the IRCT network of accredited centres. The extent of the overlap could not be assessed.

2.3 Approaches in rehabilitation

The target groups of the rehabilitation centres differ. Some centres focus only on victims of torture, with or without making distinctions in social political background; others focus on victims of organised violence in general (e.g. GCRT, in Georgia; Geneva Initiative On Psychiatry in the New Independent States (NIS region), also focusing on the victims of the Gulags, etc.). Other differences concern age (e.g. OMEGA, Austria, focusing on children; the Centre de Rehabilitacion de Abuelas de Plaza de Mayo in Argentine, mainly elderly persons) and gender (e.g. Vive Zene, Bosnia, a Centre for Women and Children).

Also the approaches differ and reflect the differences in schools, and all that lies between those. Some centres use a variety of psychotherapeutic techniques, and/or creative therapy, and/or physiotherapy, and/or group- versus individual therapy. Some combine the medical, psychosocial and psychotherapeutic aid with legal assistance (e.g. Geneva Initiative on Psychiatry in the NIS region).

2.4 Approaches in prevention

The approaches vary as well. Some EIDHR funded centres only conduct a wide range of prevention activities (e.g. FPPHHR, Georgia). Centres in the European Union contribute mainly to the prevention of torture by individual medical assessments for asylum procedures (non-refoulement), training in medical assessments for health professionals and awareness-raising in the public (e.g. the Behandlungsszentrum für Folteropfer e.V. in Berlin). Raising the awareness of the public promotes recognition for the victims of torture, which may contribute to their rehabilitation and to their integration in the host societies, although, as far as known, this has never been assessed.

2.5 Influence of prevention activities on the medical-psychological work

There is no indication that prevention activities detract from the medical-psychological work. Of course, this depends on a clear, transparent budgeting, the definition of the centre's core business, the composition of the team and good management. With regard to cost-effectiveness one can question whether a medical-psychological team disposes of the right skills for certain prevention activities. For example, a good doctor can be very professional as such, but does not necessarily possess good training or awareness-raising skills. It might be more cost effective to have a communication officer in a team for certain prevention activities, e.g. awareness raising.

Interestingly, the FPPHHR in Georgia works in close collaboration with the Georgian Centre for Psychosocial and Medical Rehabilitation of Torture Victims, in Georgia. As they state in their project descriptions, their activities are mutually enhancing.

In certain, mostly conflict situations, some prevention activities can have a detrimental effect. Victims of torture might be scared to consult the centre because of intimidations by authorities and/or fighting parties. This will depend on the perceived neutrality of the centre and the protection of the centre by relevant authorities and (inter-) national organisations.

In general, rehabilitation centres - in conflict, post conflict and/or third countries - have a symbolic function for the victims: it is a symbol of the recognition of their suffering. Preventive activities express the solidarity of the centres with the victims. In EU countries (immigration) authorities may consider this solidarity as over-involvement, and put medical assessments for asylum procedures aside as being subjective. This is enhanced if the standard of the medical assessment is not on an appropriate academic, professional level.

2.6 The opinion of key persons about the rehabilitation centres

The interviewed representatives of AI and the former Rapporteur of the UN of the Prevention against Torture are of the opinion that rehabilitation does contribute to the prevention of torture, but that the possibilities of carrying out certain prevention activities highly depends on the contextual situation. Besides, it was pointed out that reports on the physical sequelae of torture might lead to a sophistication of the torture methods by the perpetrators. Also, not all medical documentation of rehabilitation centres shows the required professional standard. The frequent travelling around the world for advocacy reasons of IRCT leaders was questioned in relation to its cost effectiveness.

2.7 Indicators

In general, quite a few rehabilitation centres seem to struggle with defining the criteria for measuring the impact of their prevention activities. Many seem to use numbers of people reached, without mentioning percentages of the number of people reached in relation to the total number of people to be reached. The numbers of interviews, publications, radio messages, etc. are measures of the methods used, but do not particularly form an assessment of their impact on the conduct, views and /or norms of the target groups.

Many centres also confuse indicators and methods. For example, training is a method of transfer of information and skills, but giving a training cannot be seen as an indicator of the impact of the training on the participants. The assessment of the satisfaction of participants with the contents and the presentation can indicate the impact of training. An even better measure would be the assessment of the impact of transferred information and skills on daily functioning. Nevertheless, such an assessment has its limitations and biases as well. The indicator of legal support might be the number of legal cases filed, or supported with medical documentation, and won. However, if the judicial system is biased for any reason, it cannot be held against the rehabilitation centre that only a few or no cases were won.

Another indicator might be the number of clients forming self-organisations fighting for the truth and justice, and/or the contribution of a rehabilitation centre to such processes.

As described earlier, the target group(s) and methodologies in rehabilitation and the possibilities for rehabilitation centres to develop preventive activities, highly depend on the contextual situation. Besides, the impact of those activities also depends on the strength and weaknesses of a particular centre seen against the background of the contextual situation: national and international support, managerial experience, professional skills, and a good vision of the risks and challenges of the rehabilitation and the prevention activities. Furthermore, as said in the Introduction, the target goals of rehabilitation and prevention activities of rehabilitation centre are never reached by those activities alone. For example, in rehabilitation the social networks of - and support to victims are also of influence. In rural areas in developing countries, victims of torture often also consult traditional

healers: what is the result of the rehabilitation centre and what can be considered the result of a traditional healer. Or was the combination of the two approaches healing? The participation of victims of torture in the development and implementation of policies of the centres might form an indication as to whether centres gear their activities to the needs and demands of their target group.

The same can be said, and more strongly, about the impact of prevention activities. Most will need multiple and continuous actions on macro, meso and micro level. In most cases the results can never be claimed by one organisation alone.

As said in the Introduction, the authors have tentatively made a division of prevention activities, based on the 12-point program of AI, with methods and indicators, and risks in certain circumstances. A global division of these activities in conflict and post conflict situations and/or third, hosting countries has been drafted in a second scheme (see Annex 4, pg.- 58 -).

2.8 Effectiveness and impact of the rehabilitation and prevention activities

For the assessments of the effectiveness and the impact of rehabilitation and prevention activities of the centres only some general remarks can be made, since this requires a good analysis of the surroundings, including the potential numbers of target groups and potential collaborators, the risks and challenges, and the strengths and weaknesses of a centre. In other words, it requires an analysis of the policy or strategic plan of a centre and its implementation in practice.

2.9 The role of IRCT within its network

Until a few years ago IRCT focused mainly on the rehabilitation of victims of torture. IRCT has only recently developed its overall strategy for prevention. The preventive work of IRCT is mostly related to:

- Global Torture Victims Information System (GTIS): this project is in the planning phase, funded by the Dutch government, and aims to collect detailed information from victims and centres on the basis of an 80 item questionnaire, in order to get a global picture of torture that can be used for advocacy;
- Istanbul Implementation Project: training in medical reporting that can be used in courts.
- Regional Strengthening Programme (RSPII): building institutional capacity of the accredited centres and regional networks.

IRCT will work with prevention on all levels: the political (pressure on the government through UN), the rehabilitation centres (providing evidence in courts); other civil society organisations (e.g. awareness-raising and pressure on government, through national professional associations such as doctors associations).

IRCT is currently performing an IRCT Impact Assessment Study consisting of five phases in which, amongst others, the outcome indicators of rehabilitation centres will be identified. The study will be conducted during five to six years. The first phase was finished in 2002.[18]

In general IRCT is highly respected for its awareness-raising activities in the world. Recently, IRCT received the Hilton award for its activities. Nevertheless, criticism can also be heard out- and inside of the IRCT. For example, quite a few rehabilitation centres, having originally started with an IRCT approach, have

[18] The IRCT Rehabilitation Impact Study. www.irct.org (19-10-03)

distanced themselves from that approach and developed their own, more appropriate for the context they are working in. At this moment IRCT is confronted with internal organisation problems. DANIDA asked a team of international consultants to promote a change in the organisational dynamics within the international secretariat of IRCT.

2.10 Alternative sources of funding

According to the CAT, art. 14.1, a victim of torture is entitled to (means for) as full a rehabilitation as is possible. The former Special Rapporteur on the Prevention of Torture does not see this as a human right, but as a moral obligation of a government to repair (what they have damaged). In post-conflict situations, however, governments are mostly struggling with the political dynamics of a transition towards democracy. The economic situation in such States is generally poor. In conflict situations centres, the State is mostly, directly or indirectly, responsible for human rights abuses. A centre financed by the same State will not be seen as neutral. A neutral (financial) position guarantees the best accessibility of the services for all victims of torture.

In third countries, the possibilities for alternative financing depend on the health care policies in the country. According to the Council Directive 2003/9/EC, in which the minimum standards for the reception of asylum seekers are laid down, necessary medical or other assistance should be provided to those with special needs (art 15), and victims of torture and violence should receive the necessary treatment of damages caused by such acts (art 20).[19] However, recent country descriptions show that in many EU countries health care provisions for asylum seekers are limited to emergency care. [20] Within these countries, mostly exceptions are made for victims of torture, but their referral to specialized services in general requires a lot of bureaucracy.

There are however examples within the EU of governments, and health insurances, financing or having financed rehabilitation centres for victims of torture, and / or refugees and asylum seekers (e.g. Denmark, the Netherlands, Norway), and where integration of the rehabilitation methodologies in mainstream health care is promoted (e.g. the Netherlands, Norway). Some centres in the EU, however, are marginalized in society together with their target groups; others consider themselves too specialized to integrate their methods in mainstream health care. Mainstream health care can however benefit from a transfer of the developed methodologies, since they can mostly also be applied to other victims of violence and psycho traumas. At the same time, more victims can be reached by integrating rehabilitation methodologies in mainstream health care. Nevertheless, as said, rehabilitation centres also have a symbolic value for the victims, and form a body of knowledge, which in policies and decisions should also be taken into consideration.

2.11 Conclusion regarding the rehabilitation and prevention of EU funded and IRCT related centres

The documents provided and searched, as well as the interviews with key persons in Denmark and the UK, show that there exists a direct relation between rehabilitation of victims of torture and the prevention of torture. However, the context in which the centres are functioning differs, and influences the activities

[19] Ibid 9
[20] Background documents of the Conference on the EU Directive on Minimum Standards for the Reception of Asylum Seekers, organised by the EU office of the Red Cross, in Jesolo, Italy, October 24 and 25, 2003; to be found on www.redcross-eu.net/sw540.asp (29-10-2003)

and possibilities of the centres/programmes. The activities in the area of rehabilitation and of prevention of the EU funded and IRCT related centres vary, and reflect the differences in 'schools'. All centres seem to contribute to the prevention of torture, but especially in EU countries, the activities and their impact seem relatively small compared to those conducted in post-conflict situations. For safety reasons, the prevention activities of rehabilitation centres in conflict situations may be limited to the gathering of data and documentation for national and international action. The indicators of the impact of the prevention activities vary, according to the methods and contextual situation. There is a need for improvement of the indicators to assess the impact of the rehabilitation and prevention activities. Especially in the EU countries, governments should be made responsible for the provision of adequate assistance and care for victims of torture and other cruel, inhuman or degrading treatment, in accordance with the EC Directives. More victims can be reached if the expertise of the specialized centres is integrated in mainstream health care.

3. REHABILITATION AND PREVENTION IN NEPAL: A CASE STUDY

3.1 A global outline of the present conflict situation

In the Constitution of Nepal, of 1990, torture is outlawed. Nepal became party of the Convention against Torture (CAT) as well as to other major human rights treaties and protocols. However, there is general climate of impunity in relation to human rights violations, and torture has persisted in Nepal. It is a general belief that 70% of people arrested, in many cases arbitrarily, is tortured while in custody. According to the Human Rights Book of Informal Sector Service Centre (INSEC), 3430 persons were arrested and tortured by the State in 2002[21]. Other groups committing torture are the military, the Maoists and forest officials.

In 1996, the government of Nepal passed the Torture Compensation Act, which provided that victims of torture or their relatives can apply for (financial) compensation to the local district courts. The court grants or rejects the claim based on a medical examination and other sorts of proof. The case has to be presented to the court within 35 days after the infliction of torture.

The Act is not in accordance with the CAT in many aspects. One of the major flaws of the Torture Compensation Act is that it does not accept a third party testimony. Another lacuna of the Act is that it only accepts the medical reports of the doctors working in the government hospitals. Besides, torture is not defined as a crime in Nepal, which means that the perpetrators are not punished. Judges may recommend punishment of the perpetrators, but it is not mandatory.

Since the Maoist insurgency, which began in 1996, many rural districts of Nepal have become dangerous for inhabitants and visitors. The number of people leaving their villages out of fear for Maoists and military is increasing. In 2002 almost 5000 people were killed, 1000 injured, 233 disappeared, more than 500 were threatened, and around 17.500 people were displaced.[22]

In 2002, the political situation deteriorated drastically. In May 2002 the parliament was dissolved, and the scheduled elections postponed. In October 2002 the King of Nepal dissolved the existing cabinet and appointed an interim Prime Minister and 5 Ministers all in their private capacity. The parliamentary elections were postponed for an indefinite period of time.

In February 2003 a truce was concluded between the Maoists and government, and peace talks started. During the truce however, killing and torture by both parties have continued, although to a lesser degree. At the end of August 2003 the truce was disrupted violently because of the hijacking and killing of a group of Maoists by the army. Since then the number of killings by Maoists and state has increased as never before.

Nepal has a very active civil society in the cities as well as in rural areas. The society is based on a cast system, with the ‘untouchables’ as the most vulnerable and marginalized, and women still playing a submissive role. For that reason, as it seems, quite some young Dalits (the ‘untouchables’) and women are attracted by the Maoist movement.

[21] Khatwida P. e.a.(Eds) (2003) Human Rights Yearbook 2003. Kathmandu: Informal Sector Service Centre (INSEC)
[22] Ibid 21

3.2 CVICT

Established in 1990, the Centre for Victims of Torture, CVICT, is seen as one of the three major human rights organisations in Nepal, and is the only organisation that provides medical and psychosocial care to victims of torture. It played a major role in the adoption of the TCA of 1996 by the government of Nepal.

It carries out a variety of activities in different locations. It has three clinics, in Kathmandu, Biratnagar and Nepalgunj. The clinic in Biratnagar is financed by US Aid, the clinic in Nepalgunj out of CVICT's own income.

It has counsellors for psychosocial assistance in ten districts. In many other districts they collaborate with locally based NGOs and Community Based Organisations (CBO's). They have trained and supervised counsellors of other NGOs, e.g. nurses of INSEC. They are in contact with a network of medical doctors in the country for referrals. CVICT can also rely on a network of 23 lawyers, covering 35 of the 75 districts of Nepal. Some of these lawyers are on the payroll of CVICT. Most are paid per client.

In three districts CVICT provides mediation and human rights training to NGOs and CBO's, financed by DfID of the British Government. The aim of the training is to promote the prevention and resolution of conflicts within civil society.

Because of the aim of the mission, attention during discussions and interviews was mainly given to the project “Reducing Torture-induced Suffering in Nepal” (co)financed by EIDHR. The Centre has a contract with EIDHR for 24 months, ending on 31 December 2003, with an EC contribution of €501.855, representing 74% of the project costs. The project finances a technical staff of 11 people – project coordinator, medical doctor, counsellors (2), social workers (4), legal coordinator, planning/monitoring coordinator, physiotherapist – working full time, 2 professionals – psychiatrist, professional advisor – working part-time, and 4 staff members working full time.

In percentages, the majority of the staff members working in the clinic in Kathmandu are involved in the medical and psychosocial assistance to the victims of torture. The legal coordinator and volunteers mainly deal with the advocacy activities. There is no special PR or communication officer within the team of CVICT. CVICT relies on the support of journalists sympathetic to their work. CVICT prefers to stay low-key as a measure of defence for themselves and their clients. CVICT carries out the following rehabilitation and prevention activities.

3.2.1 Centre based rehabilitation

CVICT reports that the number of people visiting the clinics is declining. Fewer people are able to reach CVICT since they need letters from respective authorities to leave their villages, their documents are checked at many checkpoints by the security forces and above all they cannot say that they are heading for CVICT. Besides, the impression is that many victims are intimidated either by governmental authorities, the police and/or army, or by the Maoists, to prevent them telling their story.

Nevertheless the counselling and therapies continue to be given to new clients and as follow-up. In 2002, 230 new and 401 follow-up cases received rehabilitation services and in 2003 (till September) the numbers were 247 and 467 respectively. New clients from the countryside mostly stay in Kathmandu for one or two weeks for the first intakes and medical examination. After that, they return to the clinic

each week or month, according to necessity and possibilities. If a client does not show up any more, (s)he is visited at home.

Systematically, the HTQ, the 25 HSC list and part of the DAS are used for the assessment of the psychosocial problems and ability of the CVICT clients. The data of the clients are entered in SPSS.

CVICT is guiding one group therapy for women. Men do not seem to be willing to share their feelings with others. Psycho-education is given individually, and there is no written material for psycho-education. Many of CVICT's clients are illiterate.

3.2.2 Professional development of staff

Before 2002, the organisation was facing quite some internal conflicts. To strengthen the management and organisation of CVICT, it organised seminars in conflict management, given by an external trainer. Since these seminars the number of internal conflicts is reduced.

To improve the quality and variety of CVICT assistance to victims of torture, some counsellors have been sent to Pakistan for training in psychosocial therapy. CVICT also invited trainers from abroad. They received training in creative therapy, stress and pain management and family counselling in 2002. Local expats provided training in family therapy in 2003. However, according to CVICT staff these trainings were insufficient, with regard to duration and quality, for implementing the newly learned methodologies. The trainings should be repeated, including the earlier training in EMDR technique. The effect of the trainings on the quality of their work has not been assessed.

The daily clinical meetings do not always take place and the reporting should be improved. There are meetings of the team once or twice a week.

3.2.3 Mobile clinic based rehabilitation

CVICT organises mobile clinic rehabilitation, or health camps, as they are also called, in various districts. They organise those in collaboration with local NGOs and CBO's. After arrival in a village, people in the (far) neighbourhood are informed about the clinic, mostly by the local authorities. Community-wise information is given about human rights, torture and the Torture Compensation Act. Medical, psychosocial and legal support is offered to individuals and their families. Around 25 % of the people CVICT sees at the mobile clinic are referred to one of the clinics of CVICT. The data gathered by these sessions are documented.

According to CVICT's annual report, service was provided to almost 600 victims of torture by means of their mobile clinics. In 2003 they have reached 1038 victims. In this figure, however, victims seen in prison are also included. Almost half of the number of victims has been reached by six health camps in the countryside. Because of the deterioration of the political situation, organising the mobile clinics is difficult at the moment.

3.2.4 Public awareness building

Each Monday morning 8 FM radio stations, covering mostly the rural and semi-urban population, emit messages of CVICT that torture is wrong. A journalist developed these radio messages, and staff members of the radio station received training about (the prevention of) torture. Clients of CVICT are encouraged to speak about their torture history in the radio programs in their own voice, so that

listeners become aware of their cases and can identify with the victims. At the same time this can contribute to their healing process.

Presently a survey is undertaken to assess the impact of the radio messages. According to a report of CVICT, 120 questionnaires were distributed among the listeners of the stations and 100 listeners responded. Most listeners, male and female, showed their interest in messages concerning human rights and torture and think that they are very useful. They recommended various issues to increase the messages' effectiveness. It has not become clear how many listeners the 8 FM radio stations have, meaning what percentage of the Nepal population the stations reach.

3.2.5 Strengthening regional co-operation in the prevention of torture

In the autumn of this year, a regional consultation was going to take place in Kathmandu, organised by CVICT. To prepare this consultation a national meeting with various stakeholders – journalists, human rights activists, lawyers, police, and army - took place in July of this year to discuss the prevention of torture. Among other things, the weaknesses of the Torture Compensation Act were discussed.

The participants also identified actions promoting the prevention of torture, as well as the aimed outcome thereof, the difficulties they (might) encounter, and the areas to improve. The outcome of that meeting was supposed to be used for a discussion during the regional consultation with representatives of colleague organisations in Asia. The consultation was postponed due to the present situation in Nepal. CVICT is studying the possibility of organising the consultation outside Nepal.

3.2.6 Legal services

It is not easy for CVICT to convince victims of torture to file a court case, because they are scared of being persecuted by the security forces or the Maoists. Also they often withdraw the court case because of threats to them and their family members. Nevertheless, an increasing number of CVICT clients decide to make a claim on the Torture Compensation Act with the support of the legal advisors of CVICT or the lawyers connected with CVICT. In 2002 – 2003, CVICT has filed 58 court cases, of which 15 were won. The financial compensation is relatively low, on average 5000 Nepali rupees (approx. €65, -), and is mostly not paid yet. However, these court cases were covered by the press and therewith have a signalling effect to the population, the authorities and the perpetrators. CVICT has trained some government doctors in identifying the consequences of torture.

3.2.7 Fact finding missions

Like the rehabilitation activities, the fact-finding missions are hampered by the present political conflict situation in the country. In 2002 four cases were documented, and in 2003 five, of which one case seen in prison.

The visits to prison are performed at the request of the prison authorities, and entail medical examination and assistance. During the visit information is also given about human rights and the Torture Compensation Act, and legal support is offered. The documentation of the fact-finding missions has been sent to Amnesty International and/or SOS Torture. It serves for action against torture on international level.

3.2.8 Other prevention activities

CVICT maintains good relations with the police and military, and provides training to the army, police, medical doctors and lawyers about the CAT, the Torture Compensation Act and the consequences of torture. The medical doctors are trained in the documentation of consequences of torture and the Istanbul Protocol. It has established a 'Physicians for Human Rights' network of, mainly, young Nepali medical doctors. As described earlier they also maintain contact with a network of lawyers. Besides, on a national level, it works in close collaboration with the major human rights organisations, e.g. the National Human Rights Organisations and INSEC, and on an international level with IRCT, of which the General Director, Dr. Boghendra Sharma, has recently been elected President, and with the Dutch Transcultural Psychosocial Organisation (TPO). It is a member of the International Society for Health and Human Rights.

3.3 Influence of prevention activities on the medico-psychological work

3.3.1 Do prevention activities detract from the rehabilitation work?

There is no indication that the legal and advocacy work detract CVICT from its medical and psychosocial work. CVICT relies on a network of lawyers, health professionals and journalists not falling under the management of the CVICT.

3.3.2 Do prevention activities have any beneficial or detrimental effects on the victims?

CVICT maintains its neutrality by not taking the side of any one party, and by avoiding reporting directly to the press. Because of its position, victims feel relatively safe and supported. Those clients of CVICT who are submitting a claim based on the Torture Compensation Act receive support from the psychosocial counselling to cope with the legal process. By this legal support, perpetrators are directly exposed to the court, the authorities and the public. Although hard to assess under the present circumstances, this (in combination with other prevention activities by various actors on different levels) will in the long term contribute to the prevention of torture in Nepal. Nevertheless the side effect of the compensation claims might be, theoretically speaking, that perpetrators will sophisticate their torture methods in such a way that consequences of torture are hard to prove. The perpetrators' intimidation and threats to the victims not to communicate about their suffering to medical doctors and/or lawyers might also increase. This seems to be the case at the moment in Nepal. The fact-finding missions and mobile health clinics, in which awareness about (the fight against) torture is raised, can put workers and clients of CVICT at risk.

3.4 The opinion of Local Human Rights Organisations about CVICT

CVICT is highly respected for its activities by the great majority of the interviewed representatives of local human rights organisations. All had heard or read in the newspapers of the election of Dr. Bhogendra Sharma as the President of IRCT, and thought highly of that. CVICT works closely with the two other major human rights organisations, the National Human Rights Commission and the Informal Sector Service Centre (INSEC). For example, CVICT has cooperated in a study on 'Insurgency Related Torture and Disability' of the National Human Rights Commission, by doing the medical examinations of people in five Maoist-dominated regions. It has trained, is paying for, and is supervising nurses working for INSEC in 8 districts.

Nevertheless, all interviewed representatives of local human rights organisation think that CVICT should become more 'visible', meaning that CVICT should improve its communication to the public and to organisations and professionals about its objectives and services. They would like to see a (more visible) expansion of the advocacy activities of CVICT and more activities at root level in the rural areas. Some think that CVICT needs to broaden and widen its partnership with other organizations with similar interests. They opine that the psychosocial and legal assistance should be combined with economic aid to the victims. A few of the respondents have heard the radio messages of CVICT, and think highly of them. Some of the respondents respect CVICT for contributing to the prevention of torture, amongst others, by training law enforcement officials, by collecting evidences and by conducting investigations.

Most respondents opine that the government should take responsibility for the rehabilitation of the victims of torture, suggesting also that the EU and other international, governmental organisations should put pressure on the Nepal government to abide by the CAT and other human rights conventions.

On the question whether rehabilitation contributes to the prevention of torture, most of the interviewed persons, with exclusion of the two major national human rights organisations, did not see the relation (directly). More in general it is thought that the reduction of torture never can be seen as the result of the activities of one organisation.

3.5 The opinion of other stakeholders

Clients

During the visit to the clinic in Kathmandu, three clients of CVICT were interviewed. Two of the three had been severely tortured by the police; the third was 'only' beaten on his back. Two of the three were policemen. The cases characterized the arbitrary arrests in Nepal, as well as the threats against the victims of torture to seek juridical support. One heard of CVICT by their visit to the prison; one heard of CVICT by the radio; and the third through his brother. The latter arrived too late at CVICT (later than 35 days after release) to make a claim for compensation in court. One policeman was imprisoned again after making contact with CVICT. With a 'habeus corpus' he was released. Although he is intimidated and very frightened, he is determined to continue with the legal process, feeling very supported and relatively safe because of the assistance of CVICT. All three showed themselves satisfied with the assistance and/or treatment they received from CVICT.

Representatives of international organisations

The representatives of DfID, of the local office in Kathmandu, are highly impressed by the job done by CVICT and are planning to expand their support for community mediation and human rights program from 3 districts to 20 districts. They are however afraid that CVICT may not have the sufficient manpower to expand the program to that many districts. They think that the way CVICT has used local NGOs to implement the project is very effective. According to the respondents, all the involved NGOs working with CVICT are very pleased with their efficiency and dealings. CVICT has been recognized as a credible organization that has very good rapport with all the important institutions and even with the political parties from the top to the grass roots. This facilitates the project implementation.

According to the DfID respondents, CVICT is perfect on financial management and competent in fulfilling donor requirement in terms of work and timely reporting of

completed activities through progress reports. The conditions of DfID for financial support include three-monthly reporting. Finances for the next term are given after receiving the required reports.

The representatives of ICRC and of the UN Office of the High Commissioner for Human Rights in Nepal also speak about the good reputation of CVICT as one of the leading human rights organization. The communication of ICRC with CVICT is in a one-way direction only, because of the specific policy of ICRC. They meet during activities in rural areas. ICRC is impressed by the Mobile Health Clinic activities of CVICT.

According to the respondents, the major problem regarding the prevention of torture is the impunity of the perpetrators. Again it was suggested during the conversations with the representatives of international organizations that donor countries and the international community should put more pressure on the Nepali government to abide human rights.

3.6 Indicators used by CVICT

3.6.1 Indicators used by the centre to measure impact of rehabilitation and prevention, if any?

As a general indicator CVICT uses the reduction of occurrence of torture. For the “centre based rehabilitation” the indicators are: reduced disability and suffering. Besides, CVICT is convinced that rehabilitation creates awareness in their clients, his/her family and his/her community that torture is wrong. This is, however, not assessed by CVICT.

The results of the medical and psychosocial rehabilitation are measured by CVICT individually: by a comparison of past and present problems of a client, by the observations of the various involved care-providers, by the reduction of medication and by the satisfaction of the client. No reports with data in which the results of the medical and psychosocial rehabilitation on the mental health condition and ability are reflected were presented before or during the mission. No data were provided about the % of drop-outs, e.g. because of dissatisfaction with the services provided.

A recently started research into the cost-effectiveness of the medical and psychosocial assistance to victims of violence, by a TPO researcher, is hampered at the moment, since not many new clients are inscribed. According to this researcher, the pilot of the study took place successfully in 2002.

The data of the clinic(s) are used for signalling the occurrence of torture and its consequences to national and international human rights organisations, and are presented in international journals and other publications and during regional and international meetings. The acting researcher of South Asia of Amnesty International in London is familiar with CVICT’s activities and receives their data.

The indicators for the mobile health clinics are “more victims attend clinic in Kathmandu; more legal cases filed”. No data were given nor found of clients visiting CVICT in Kathmandu because of information through health clinics or relatives. Of the 57 filed compensation claims 10 were filed in Kathmandu. It is unclear however if the other cases were filed because of the information by the mobile health clinics.

As indicator of the public awareness-raising CVICT uses “the responses of interviewees”. These have been described earlier. For regional cooperation the indicator is: “South Asian leaders report that they are implementing developed guidelines.” Until now the guidelines have not been developed.

The indicators for CVICT’s legal support are: “court orders to police departments to take action against perpetrators; government takes action.” During interviews a few court orders were mentioned, but not found in documentation. Newspaper clippings were promised, but not given. CVICT uses numbers as indicators for the fact-finding missions.

3.6.2 Possible criteria/indicators that could be used to judge the impact of CVICT’s activities on prevention of torture in Nepal?

The most significant indicator of the impact of CVICT’s rehabilitation activities on prevention of torture at this moment is the number of clients of the three clinics and the mobile clinics filing a case at the Court with a claim on the TCA, and the results of those claims. The indicator that CVICT has defined for the legal support is even more ambitious. But as long as the judiciary system is biased for whatever reason, it cannot be held against CVICT that it is not reaching its own aim. Under the present situation ‘the government taking action’ should be seen as a long-term aim, depending on combined national and international pressure.

The impact of the medical assistance to prisoners on the prevention of torture can be measured by (data of) the additional legal assistance to those prisoners, as well as by (a survey of) a change in conduct of the prison officers.

The development of guidelines for the prevention of torture, together with regional sister organisations, can also be seen as an indicator of the impact of CVICT’s activities on the prevention of torture.

The lobbying and actions, in collaboration with others, for a modification of the TCA in order for it to become in accordance with the CAT is highly laudable, and hopefully the aim will be met. The impact of the rehabilitation on prevention could be measured by the satisfaction of the other collaborating parties.

The impact of rehabilitation on the awareness-raising activities by the mobile health clinics could be measured by the number of clients organising themselves and fighting for justice. The measurement of the surplus value of the radio messages emitted by CVICT vis-à-vis the radio messages of, for example, INSEC requires a comparative study. Do awareness-raising activities of a medical rehabilitation centre have more or less impact on the norms and values of the target group than awareness-raising activities of ‘pure’ human rights organisations, or a complimentary impact?

3.7 Effectiveness and Impact of the Rehabilitation and Prevention Work of CVICT

3.7.1 Activities and plans of the centre with respect to rehabilitation and prevention

CVICT and other Human Rights organisations, lawyers, and others, are undertaking actions to see the Torture Compensation Act and the rule of law changed, so that torture will be considered a crime, and perpetrators prosecuted. CVICT is expanding their, income generating, trainings with support of TPO.

3.7.2 Assessment of the strength of the centre's rehabilitation and prevention work

Contrary to the statements of DfID, CVICT gave the impression of being an informal organisation of which the internal organisation could be strengthened by a more professional management. This refers, for example, to the lack of (directly) available data and reports, and its informal way of organising team meetings. It would probably gain in visibility among the HR organisations by expanding the team with an expert in communication. Regarding the rehabilitation, CVICT has developed a training program for their counsellors, presently also used for training of other care providers in Nepal. Also CVICT has rightly identified which possibilities there are in the present situation in Nepal for contributing to the prevention of torture. However, the legal support to victims and other activities in the area of prevention might limit the number of people seeking medical and psychosocial care. On the other hand, as CVICT stated, by combining legal aid with rehabilitation it remains unclear to the outside world for what sort of support a victim comes to the clinic. In that sense their medical psychosocial work forms a protective shield for those seeking legal advice.

In their project description CVICT was clearly too ambitious, also mentioning indicators of the impact of their work that are hardly verifiable, especially not in the present political situation of Nepal. Their reports should be accorded to their own described aims, indicators and methods of verification. The organisation would gain in transparency if all activities of CVICT and the relation between them, as well as the various financial sources for those activities, would be described.

3.8 Alternative Sources of Funding Available locally for Rehabilitation or Prevention

In the present situation it is highly improbable that the government of Nepal would provide funds for rehabilitation activities for victims of torture. Besides, that would endanger the neutral position of CVICT. At the moment CVICT is financed by various funds and it has developed income-generating activities. It has not become clear if those activities detract personnel from their core tasks. According to CVICT, the total annual budget of CVICT would be reduced with 30 % were the financial support of the EC be stopped.

3.9 Conclusion regarding the case study in Nepal

The activities of CVICT in the areas of rehabilitation and prevention show that these are interconnected. By providing medical and psychosocial assistance and care, victims for torture are also reached for legal aid. By reaching out with their mobile health clinics, their potential clients not only receive timely assistance and care, but also communities are sensitised regarding human rights. In the present conflict situation the legal assistance and awareness-raising activities might scare potential clients for rehabilitation off. The indicators for the impact of rehabilitation and prevention activities can be improved. For that matter, on the one hand CVICT has identified some good indicators, for example the results of the rehabilitation, but did not provide data about those; on the other hand some indicators, for example regarding the legal support, were too ambitious. The surplus value of the rehabilitation activities of CVICT on the prevention of torture has been indicated by other national and international human rights organisations. Health professionals are highly respected in Nepal's society, and since CVICT treats both conflicting parties it is seen as 'neutral'. Therewith their clients as well as their staff members are relatively protected.

4. REHABILITATION AND PREVENTION IN PERU: A CASE STUDY

4.1 Introduction

Presently Peru is in a process of political transition towards democracy, after having gone through a period of unprecedented internal, armed conflict from 1980 to 2000, during which "innumerable systematic and generalised human rights violations were committed"[23]. The main parties of the conflict were supporters of the Maoist movement, the Shining Path ("Sendero Luminoso"), the Tupac Amaro Revolutionary Movement, government troops, and police, however involving millions of ordinary, innocent peasants whose lives were seriously disrupted[24].

According to the "Census for Peace", the political violence only in the rural areas affected more than 2 million people. [25] Of these, 24,490 were killed, 9,996 disappeared, 43,000 children lost their father or mother, 23, 000 lost their husband or wife, 56,454 were submitted to torture, and 4,204 became handicapped.

The Commission for Truth and Reconciliation estimates that a total of 69,280 people died or disappeared in the period of political violence; it has also registered 4,644 graves all over Peru of which only 3 have been exhumed. According to data from the Unified Register of Detentions, 21,795 people were detained in the period from 1992-2000, of whom 6,075 were released by the police or the army after having in many cases been humiliated and tortured. [26] The Institute for Legal Defence estimates that in total 18,246 innocent people were imprisoned.

The Commission for Human Rights (Comisedh) declares that during the conflict, torture, maltreatment or cruel punishment was widely practised. [27] It has documented 6,443 cases of torture (of which 4,625 were committed by agents of the state).

The annual report from 2002 of the National Coordinator for Human Rights (CNDDHH) notes a positive development in the field of human rights, with a reduction of the number of people who have died from torture. There have also been positive steps in the fight against impunity and in the support to the Committee Against Torture. The data collected by the Defence for the People also indicate a decrease of the violence in Peru. Nevertheless, there are still cases of torture committed by the police (in 2000: 102; in 2003: 19) reported and by members of the military forces (in 2000: 35; in 2003: 11).[28]

In August 2003 the Commission for Truth and Reconciliation has sent its report with findings and recommendations to the Government of Peru. A reaction of the government is still awaited.

The main Human Rights organisation in Peru is the National Coordinator for Human Rights (CNDDHH) - an umbrella organisation of 61 human rights NGOs, founded in 1985. This organisation not only conducts various human rights

[23] Truth and Reconciliation Commission (2003). Lima: Final Report.
[24] Nyberg Soerensen, N. (2002). Representing the Local: Mobile Livelihood Practices in the Peruvian Central Sierra. In N. Nyberg Soerensen & K. Fog Olwig (eds), Work and Migration – Life and Livelyhoods in a Globalizing World. London: Routledge.
[25] Program of Support to Repopulation (PAR) of the Ministry for Women and Human Development (2003). First Phase of the Census for Peace collected in 2192 communities in Ayacucho, Apurí mac, Huancavelica, Huánuco, Junin and Puno.
[26] De Jara, E (2001) Memories and Fights in the Name of the Innocent of Peru 1992-2001). Lima: Institute of Legal Defense.
[27] Comisedh (2003). The torture in Peru. Lima: Report.
[28] Unpublished data provided by the Ombudsman of Peru

activities on the national level, but also on the regional level with sister organisations.

4.2 Centre for Psychosocial Attention (CAPS)

This is the context in which the Centre for Psychosocial Attention (CAPS) started its work in 1994, in the beginning as a volunteer group of psychotherapists under the National Coordinator for Human Rights (CNDDHH). The group of psychotherapists worked in CNDDHH on a voluntary basis until 1998.

In 1997 the group had received their first EC grant of €180.000 for a 12 months project of "Psychotherapeutic Assistance to Victims of Torture and Political Violence". This funding allowed the group to extend their work to the provinces, and provide capacity development and supervision to staff of other human rights organisations that were members of CNDDHH. In 2001, the CNDDHH decided to decentralise their psychosocial assistance, and the group of psychotherapists adopted the name "Centre for Psychosocial Assistance". In the same year CAPS received their second EC grant for a 26 months project of "Psychosocial Assistance to Victims of Political Violence, Torture, and Family Violence". The EC contribution to this project was €586.258 or 82% of project costs.

In September 2002 CAPS received a third EC grant of €663.026 for a further two years for the project "Therapeutic and Psychosocial Recuperation of Victims of Torture and Political Violence".

In January 2003, CAPS registered as an independent NGO, and is in the process becoming an "ordinary" member of the CNDDHH network, which should be approved by the General Assembly in November 2003.

CAPS, which has a staff of 23 people (13 psychotherapists, 2 social psychologists, 2 social workers, 1 psychiatrist, 1 administrator, 2 secretaries and 2 students) has four main areas of work: psychosocial assistance; training and supervision of human rights NGOs; communication and advocacy; and professional development of the staff.

4.2.1 Psycho-social assistance to people who are affected by torture and political violence

The psychosocial assistance is carried out in Lima and 6 provinces. Clients are referred to CAPS by other human rights NGOs. The main modalities of treatment are: psychotherapy and social assistance. Psychotherapy is provided in the form of short-term or longer-term individual therapy, crisis intervention, play therapy (for children), group therapy, or psychotherapeutic workshops (art or drama therapy).

The psychotherapy is psychoanalytically oriented, and in individual psychotherapy patients who have been submitted to torture are offered 80 sessions as a minimum. Since 2000 CAPS has treated 766 torture victims, or family members of torture victims. In 2003, they treated 48 torture victims and 63 family members of victims.

It should be mentioned, though, that during the period 2001-2003, almost half of the clients (43%) dropped out from the psychotherapy sessions, or showed irregular attendance. According to CAPS, the reasons for the 'drop outs' are for example: some victims referred to them expect social-economic support; some lack the basic social means for a therapy; some do not have money for public transport.

Social assistance is provided as counselling, information, material emergency aid, or referrals to other private or governmental institutions. Also self-help groups are promoted, among these a nationwide "*Reflection Group*" of "innocent ex-prisoners" with 190 members who keep contact through e-mail, telephone or visits. The Group has taken the Ministry of Justice to court with 5 claims for compensation on behalf of 110 innocent ex-prisoners. CAPS also supports other organisations of survivors, and an income-generating project promoting the development of small businesses through loans.

4.2.2 Training and supervision

The objective of the training and supervision is to improve the services offered to victims by human rights organisations and other NGOs. The training and supervision is offered in 5 regions of Peru. This included training and supervision of investigators, interviewers, and volunteers of the Commission for Truth and Reconciliation both in Lima and the provinces; identification of local teams working with mental health and formation of a Network of Mental Health and Human Rights organisations. A total of 793 people were trained from 2001-2003.

Recently it signed an agreement with the Ministry of Interior to train the police, and to provide individual and family therapy for individual police officers (mostly in case of family conflicts, which often has an effect on the conduct of the policeman as well) (until Sept. 2003: 10 families treated).

4.2.3 Communication and advocacy

The objective of this activity is raising awareness in public about the consequences of political and social violence and the need to stop human rights violations. This has been carried out through participation in campaigns (4) against torture; publications (2 books and 2 leaflets); media presentations (8 TV programs, 2 radio programs, 6 newspaper articles, 2 articles in scientific journals).

4.2.4 Professional development of the staff

The staff training includes monthly conferences, a reading group, presentation and discussion of clinical cases, clinical supervision, and monthly group supervision, presentation of scientific papers, research, and workshops.

4.3 Influence of prevention activities on the medico-psychological work

4.3.1 Detraction of prevention activities from the rehabilitation work

In general, preventive activities of the CAPS do not detract from rehabilitation work. However, one psychotherapist belonging to the CAPS team mentioned that from a psychoanalytic point of view, the involvement in too many concrete activities might have a negative influence on the symbolic work during psychotherapy. On the other hand a social psychologist of the team opined that prevention activities can have a 'healing' effect on the health professionals, since in that way they can convert their own emotions into direct actions.

4.3.2 Beneficial or detrimental effects of prevention activities on the victims

In the general objective of the present EC funded project, "Therapeutic and Psychosocial Recuperation of Victims of Torture and Political Violence", CAPS states that the project attempts to contribute to the healing of the sequelae caused by the political violence through the elaboration of the traumatic events *in order to*

"prevent that these acts are repeated". CAPS also states that it works with a holistic or "integrated" method that sees individual healing as part of the national and social healing, which presently is taking place in Peruvian society. At this post-conflict stage of democratisation and peace-building, there do therefore not seem to be any detrimental effects for victims of prevention activities; on the contrary: the preventive aspect is beneficial, because the healing of the individual is seen as part of the collective healing. However, as the Director of CAPS told, not all clients understand their agreement made with the police. Those clients see the agreement as a betrayal to their cause.

4.4 Opinion of Local Human Rights Organisations about CAPS

In general, other human rights organisations have very positive comments to the work of CAPS. The *Commission for Truth and Reconciliation* valued highly the research work of CAPS that has demonstrated that torture was a systematic tool used by all the conflicting parties. Also the training carried out by CAPS of the Commission members and support of testifiers was valuable, as well as its work with the police, which presently is still obtaining information by means of torture and inhuman or degrading treatment.

The *National Coordinator for Human Rights* emphasised the public awareness activities of CAPS, which explained to the public the significance of torture and its terrible consequences. Also the lobbying work of CAPS with members of Congress is important.

The *Commission for Human Rights (COMISEDH)* thought that the information and educational activities of CAPS were important as indirectly preventive activities by raising public awareness, and enabling victims to become conscious of their human rights. By providing documentation of the effects of torture, CAPS has assisted victims in condemning perpetrators and gain justice at courts, thus reinforcing the legal work for human rights. However, this organisation did not find that CAPS contributed directly to prevention, but only indirectly – mainly by strengthening the victims. COMISEDH had referred 20 cases to CAPS for therapeutic support during legal proceedings, however some of these cases had not continued in treatment with CAPS, maybe due to "resistance" against therapy, or practical problems of transport. COMISEDH recommended that CAPS make greater efforts at presenting their research in a more "simple" and less academic manner; that CAPS intensify its support to legal human rights work by writing more expert statements for court proceedings; and that CAPS develop a closer collaboration with the other NGOs in the human rights network.

Paz and Esperanza thought that the clinical work of CAPS was unique and important, but that victims sometimes did not receive the assistance they needed from CAPS, because their primary needs were not for psychotherapy but for social assistance, especially assistance in obtaining a job, or a place to live.

The Peruvian Institute for Human Rights Education and Peace (IPEDEHP) found that the work of CAPS was important because it contributes to the rehabilitation of victims, but that it only indirectly contributes to prevention. Important aspects of the preventive work of CAPS were its contribution to governmental mental health policy, and to the training of police.

The representative of the local office of *Amnesty International* found that the work of CAPS contributes indirectly to the prevention of torture, especially through its work with training of police, and its public awareness-raising activities.

The Episcopal Commission for Social Action (CEAS) thought that the work of CAPS with the Commission for Truth and Reconciliation and with the training of police formed important preventive activities, although CEAS had another approach to rehabilitation than CAPS.

4.5 Opinion of other stakeholders

Clients

During a visit to CAPS a group of victims of torture and family members was interviewed. This group represented the 'Grupo de Reflexion'. In their opinion, CAPS helped them to overcome the consequences of torture and of having been innocently imprisoned. CAPS has given them moral support and a space to meet with each other. They highly respect CAPS for their role in the Truth Commission. However, they think that CAPS should also provide social economic support, since quite a few of them do not have means to study or find work. Without fulfilling the basic needs all other things, in their opinion, are irrelevant. They also miss legal and medical assistance in the provisions of CAPS. Nevertheless, they believe that CAPS is contributing to the prevention of torture by supporting them in their fight for seeking justice.

Representatives of governmental bodies

The representatives of the Ministry of Home Affairs, charged with the organisation of the police, think highly of CAPS. They have seen that many policemen have been affected by the violence, during 1980 – 2000, resulting in aggressive behaviour and conflicts on professional and personal level. Since the medical service of the police does not have the necessary experience to deal with these problems they have asked CAPS to provide psychotherapeutic care. Also training has been requested, as an addition and complimentary to the trainings given by other organisations, e.g. ICRC and IPEDEHP, to the police. They think that CAPS contributes to the prevention of torture indirectly, by treating the policemen and by their trainings.

The representative of the Research Institute of the Ministry of Health described the mental health structure in Peru: no national budget for mental health, 70% of the mental health professionals are situated in Lima, and in the regions most affected by the violence there is no psychiatrist. He thinks that CAPS is doing good work, but he would prefer them to develop primary health care, with more focus on the psychosocial need of the majority of the affected populations in the remote areas of Peru. He showed his reservations regarding the role CAPS is playing in the prevention of torture.

4.6 Indicators used by CAPS

4.6.1 Indicators used by the centre to measure impact of rehabilitation and prevention

CAPS has established indicators for assessing the impact of psychotherapy by measuring psychological symptoms at intake and at the end of rehabilitation. No attempts have been made to assess the impact of preventive activities in the logical framework, but in their reports they mention the numbers of trainings, publications etc. Furthermore, CAPS evaluates the satisfaction of the target groups having attended courses, training and meetings.

4.6.2 Possible criteria/indicators for assessing the impact of rehabilitation on prevention

With the staff of CAPS, the evaluation team discussed the possibility of assessing the impact of rehabilitation on prevention by estimating the number of rehabilitated clients who had brought their cases to court. CAPS informed the team that it had treated 72 clients, who belong to the network of "innocent ex-prisoners" which is fighting for justice at the courts.

Another possible quantitative criteria or indicator would be the number of rehabilitated clients who join associations of survivors fighting for human rights. Besides the number of policemen/women reached by training or therapy, the results of those activities, with regard to satisfaction, conduct and well-being would be qualitative criteria of the impact of their activities.

4.7 Effectiveness and Impact of the Rehabilitation and Prevention Work

4.7.1 Activities and plans of the centre with respect to rehabilitation and prevention

Rehabilitation

CAPS is an ambitious organisation that in its vision for 2007 states that it hopes to achieve a leadership position in Latin America in the field of study and treatment of the effects of political-social violence. CAPS also aims at developing a systematic and validated method of psychological and social assistance, which can become part of public health policies; by 2007 it hopes to be able to offer services to 10% of the affected population in Lima and in the 7 locations where it plans to have sub-offices.

It has established contact with its sister organisation in Guatemala to learn from their community approach. It is considering a revision of its mission and vision for 2007 during the annual institutional evaluation.

Prevention

Among the most important preventive activities mentioned by CAPS and other actors is the assistance of CAPS to the Commission for Truth and Reconciliation, and to the Police Defence Unit of the Ministry of Interior. Besides, input is given to the 61 human rights NGOs in the CNDDHH network.

CAPS plans to focus more on preventive activities relating to the recommendations of the Commission for Truth and Reconciliation: by contributing to the National Council for Rehabilitation, which will implement the recommendations of the Commission; and by organising a campaign with Amnesty International and producing a TV program to disseminate the results of the Commission's work. CAPS also plans to create a social program for the Reflection Group, and to strengthen regional collaboration through the Mental Health Network.

4.7.2 Assessment of the strength of the centre's rehabilitation and prevention work

The strength of the rehabilitation work of CAPS would seem to be its highly professional and locally respected approach to rehabilitation. However, this approach, which builds on psychoanalytic theory, and is focused on (costly) individual psychotherapy, is questionable in a context with thousands of affected

people in need of support. The emphasis on symptoms and pathology could also contribute to identification with the victim role among the survivors. A more community-based, psychosocial approach building on the strength and resilience of survivors might have more impact and be more cost-effective, and might also meet the needs of more survivors.

The strength of the preventive work of CAPS is mainly indirect through its participation in the network of human rights organisations, and its support to and supervision of other human rights organisations and NGOs, as well as the Commission for Truth and Reconciliation.

4.8 Alternative Sources of Funding Available locally for Rehabilitation or Prevention

The recommendations of the Truth Commission in Peru include the responsibility of the government for reparation. Until now the Peruvian government has not responded to the Commission's report. However, it is generally assumed that because of the poor economic situation of Peru, the government will not take financial responsibility for victims of torture's reparation. This is characteristic for most post-conflicts situations.

However, a number of international donors have offices in Lima, and are interested in funding CAPS. Most prominent is USAID which is co-funding CAPS with $350.000, amongst others for its income-generating projects, community assistance in regions of exhumations, and medical aid.

4.9 Conclusion regarding the case study in Peru

In this case it is shown that a highly specialized mental health care centre focussing on the secondary and tertiary level of prevention, in public health terms, is not giving much direct attention to the prevention of torture. However, it should be added that CAPS has only recently become an independent organisation, and it is planning to become a more active member of the large Human Rights network in Peru. Before, during and after the work of the Truth Commission CAPS has played an important role in the functioning and results of the Commission. Presently, CAPS is mainly contributing to the prevention of torture by empowering their clients to fight for their rights and justice. The prevention activities do not detract from rehabilitation, and are in general beneficial for the clients (and workers). CAPS has developed the indicators for their rehabilitation activities, but none for the prevention (in the logical framework), although they do measure the satisfaction of their target groups. CAPS is highly respected in Peru for their work, mostly for their contribution to the Truth Commission, and for their training of the police. CAPS envisages broadening their rehabilitation activities with a community approach. With that their contribution to the prevention of torture would be strengthened.

5. CONCLUSION

The following conclusions reflect the general conclusions drawn from the global study of the descriptions of other EIDHR funded projects and the results of the interviews with the key persons in Denmark and the UK, as well as the two case studies, in Nepal and Peru.

5.1 Influence of prevention activities on the medical-psychological work

5.1.1 Do prevention activities detract from the rehabilitation work?

- **There is no indication that prevention activities detract from rehabilitation**.

With good management and administration, and a clear definition of the core business of a centre, prevention activities do not need to detract from the rehabilitation work.

5.1.2 Do prevention activities have any beneficial or detrimental effects on the victims?

- **In general prevention activities have a beneficial effect.**
- **In conflict situations, however, (public) prevention activities may put both clients and care providers at risk.**

In general the prevention activities have a beneficial effect on the victims, and vice versa, in the sense that rehabilitation, for example, strengthens a victim to cope with legal actions and/or testifying. Prevention activities can have detrimental effects on the victims as well. Because of these activities victims might be reluctant to consult a centre and/or might suffer repercussions from authorities. In some contextual situations, e.g. in conflict situations, prevention activities of a rehabilitation centre might have to be limited to documentation and provision of data for national, and/or international pressure on government(s). Other prevention activities might have to be left to other national and/or international human rights organisations for effectiveness and/or safety reasons. This depends on the context in which a centre is functioning.

5.2 The opinion of local Human Rights Organisations about the Rehabilitation Centres

- **The main local human rights organisations respect the visited centres for their contribution to the prevention of torture.**

The main local human rights organisations in Nepal and Peru respect the rehabilitation centres for their rehabilitation work and their contribution to prevention. Others, more distanced from the rehabilitation centres, do not directly see the relation between rehabilitation and prevention and/or think that they could do more. However the impression is that to a certain extent their own interests and visions influenced their opinions about the rehabilitation centres. The opinion of local human rights organisations in other countries could not be assessed, with the exclusion of the HR and rehabilitation centre in Georgia, which state that their collaboration in the area of prevention is mutually enhancing.

5.3 Indicators

5.3.1 Indicators used by the centre to measure impact of rehabilitation on prevention, if any?

- **Most centres use quantitative indicators for measuring the impact of their rehabilitation and prevention activities (number of patients, number of trainings); some also qualitative (satisfaction of target group).**
- **The impact of rehabilitation on prevention activities of the centres varies from being direct, e.g. legal claims of (groups of) clients, to indirect, e.g. the provision of data and documentation to national and/or international human rights organisations.**

All centres use the number of patients consulting the centre as an indicator of their rehabilitation work. Many, e.g. CVICT and CAPS, also assess the results of the counselling and therapies, although CVICT has not published those (yet). CVICT also started a study on the cost effectiveness of its rehabilitation work in collaboration with TPO.

CIVCT has defined various indicators for assessing the direct or indirect impact of rehabilitation on prevention activities, among which the number of clients submitting a claim on the Torture Compensation Act in court. CAPS has not determined those indicators, at least not in the logical frame work; it does assess numbers and satisfaction rates of trainings and meetings with others. In general, rehabilitation centres often confuse indicators for the impact of activities of prevention with methods, for example (the number of) trainings, publications, etc. In many cases for awareness-raising the number of people reached is used as an indicator and not the impact of the activity on the target group.

5.3.2 Possible criteria/indicators that could be used to judge the impact of rehabilitation on prevention?

Without discrimination with regard to the contextual situation, the methods and indicators could be, amongst others:

- **Data collection and documentation: goals reached, satisfaction stakeholders, (verifiable) influence on (inter)national policies;**
- **Collaboration and networking: goals of this method attained (data collection, distribution, collective action); verifiable results;**
- **Legal rehabilitation – cases filed, cases won; government takes responsibility for reparation; prevention of refoulement (%);**
- **(Contribution to) awareness raising: numbers of target groups, percentage reached, satisfaction, press clippings, perceived position of centre by stakeholders, public, norms and values changed in target groups;**
- **Education and training of law enforcement personnel, military and judicial system: level in hierarchy, % of total, satisfaction, change in norms and values, reduction in number of incidences of torture and other human rights violations (if possible);**
- **Awareness-raising and training of health care professionals, taking into account culture within (governmental and non-governmental) health care: levels in hierarchy, % of number, satisfaction, change in norms and values, collaboration, integration in own practice.**

With the definition of indicators of the impact of rehabilitation on prevention activities, the context in which a rehabilitation centre functions has to be taken into account. The impact of some activities, e.g. data collection and documentation for national and international pressure, is hard to assess because of its, often, long

term goal. Besides, the goal often is not reached by the centre's activities alone. Collaboration with other human rights organisation might lead to a synergy. Nevertheless, the impact of rehabilitation work on prevention activities can be assessed by numbers of torture cases brought to court, directly or indirectly supported by the centre, by surveys, evaluation of satisfaction of target groups and evaluation by outsiders, like the press and collaborating organisations.

5.4 Effectiveness and Impact of the Rehabilitation and Prevention Work

5.4.1 Activities and plans of the centre with respect to rehabilitation and prevention

- **There seems to be a general tendency to focus more on prevention of torture**

IRCT and its accredited centres recently started to focus on prevention and are studying the indicators for assessments of rehabilitation and prevention activities. CVICT is developing guidelines for the prevention of torture in collaboration with regional partners, and undertakes action together with local HR organisation to get the TCA changed and torture included in national laws as a crime. CAPS is studying the possibilities to broaden its activities towards community and more culture sensitive approaches, and as a (future) member of the National Coordinator on Human Rights will contribute to its prevention activities.

5.4.2 Assessment of the strength of the centres' rehabilitation and prevention work

- **The strength of a rehabilitation centre regarding the prevention of torture depends on the contextual situation. In general, the possibilities and impact of prevention activities will be the greatest in a post-conflict situation, by a centre focusing on the primary and secondary prevention of torture, as defined in public health terms.**
- **The more medicalised / specialised a rehabilitation centre is, the less likely it is to contribute to the prevention of torture**.

Under the present circumstances in Nepal and in the absence of a description of the total organisation of CVICT, the strength of the centre's rehabilitation and prevention work was hard to assess. The impression was that the professionalism of its organisation could be improved: e.g. their reporting and communication with other organisations. Directly and indirectly, however, CVICT contributes to the primary and secondary prevention of torture, according to public health definitions. CAPS is formed by a highly specialized, professionally run psychotherapeutic and psychiatric team, focusing mainly on the secondary and tertiary level of prevention, in public health terms. A clear vision on their contribution to the primary prevention of torture still has to be developed.

A general conclusion of other centres' strengths cannot be made without a thorough assessment of the context in which they are functioning. In some situations a separation between purely prevention activities and rehabilitation work might prove to be more beneficial for clients and workers, while in others the combination of both is to their benefit. This depends on the context – conflict, post conflict and/or third countries – the health care system, the existence of other HR organisations, etc., as well as on the (internal) strength of the organisation itself. Generally speaking however, the impact of rehabilitation centres on the prevention of torture will be the greatest in post-conflict countries in which a transition towards democracy is taking place. Nevertheless, as the case study in Peru has shown, a rehabilitation centre created during a conflict situation can play an important role in the prevention of torture after the conflict. The contribution of centres based in the

EU to the prevention of torture is relatively small, and indirect by their contribution to the prevention of refoulement of victims of torture through medical declarations.

5.5 Alternative Sources of Funding available locally for Rehabilitation or Prevention

- **In conflict and post conflict situations governments in general, for various, mostly obvious reasons, do not provide means for reparation, and alternative sources of funding locally available are mostly scarce.**
- **According to EC Directives, member states should take responsibility for necessary medical treatment and other assistance to victims of torture.**

According to the Convention against Torture, victims of torture are entitled to as full a rehabilitation as is possible, but there are not many countries in which the government has taken the direct responsibility to provide the (financial) means for rehabilitation.

CVICT is funded by various major and smaller donors and develops income-generating activities to finance part of their work. In the present situation, which will be characterising for other conflict situations as well, finances from their own government, even if that would be considered, would limit their rehabilitation possibilities. CAPS is also funded by various major and smaller donors, and according to them, is not totally dependent on the EIDHR funds. In general in a post-conflict situation, even if a government recognizes the need for rehabilitation of victims of torture, whether it concerns its own nationals or refugees from neighbouring countries, the national budget will be too small to accept that responsibility. EC Directives refer to the EU member states' responsibility to provide assistance and care to victims of torture. There are examples of EU States that have taken this responsibility, but many of them still do not, or only partly.

6. IN SUMMARY

- **Rehabilitation of victims of torture and the prevention of torture are interrelated.**
- **The impact of rehabilitation on prevention depends on:**
  - **The context: in conflict situations prevention activities may put clients and care providers at risk; in democratic hosting countries, i.e. the EU countries, the extent of the prevention activities of rehabilitation centres, compared with the extent of those in post conflict situations, is quite small.**
  - **The rehabilitation approach: a community approach is more likely to contribute to the prevention of torture than individual psychotherapeutic and psychiatric care.**
  - **The composition of the technical staff of the rehabilitation centre regarding expertise and skills, and/or collaboration with other (Human Rights) organisations with complimentary expertise and skills.**
- **The indicators for the assessment of the impact of prevention activities needs to be further developed.**
- **In conflict and post conflict situations, alternative sources of funding for rehabilitation centres are hardly available.**

7. CONSIDERATIONS REGARDING THE EC'S INCREASED FOCUS ON PREVENTION OF TORTURE

With the increased focus of the EC on initiatives of prevention activities, EIDHR will be faced with the dilemma how to make a just selection of rehabilitation programmes coming into consideration for its financial support. If, for example, the contextual situation of rehabilitation centres is not taken into consideration, with this shift of policy in favour of prevention initiatives, rehabilitation centres in conflict situations, as well as rehabilitation centres based in EU countries, might be excluded from EIDHR funding. The case study in Peru has shown that rehabilitation centres created during a conflict situation might play an important role in the area of prevention after the conflict.

Since the possibility for, and the effectiveness of, certain methods and their impact on prevention activities of rehabilitation centres depend on many factors, the criteria for a just selection are not easy to determine. Without the pretension of being all-inclusive, the following considerations regarding the criteria for selection and its limitations are given.

Percentage in time and budget

To prevent rehabilitation centres in conflict areas of being excluded, a distinction in percentages in time and budget could be made with regard to the contribution to the prevention of torture in relation to the contextual situation, e.g. 0 – 10 % for rehabilitation centres situated in conflict situations; e.g. 20 – 30 % for centres based in post-conflict situations and/or third hosting countries. Such a policy would however exclude rehabilitation centres that collaborate with human rights organisations in such a synergetic way that hardly a distinction can be made as to the effectiveness and impact of the individual centre's activities. And how to assess the percentage of the contribution to the prevention of torture of a centre situated in a country in which a conflict situation deteriorates (e.g.Nepal)? In case of the EU based rehabilitation centres, which are contributing mainly to the prevention of torture by their medical documentation for asylum procedure purposes, a percentage is even harder to determine, since the number of those documentations depend on the admission policies for asylum seekers of the respective countries.

Composition of the technical staff

The composition of the technical staff of a centre can give an indication of the centre's rehabilitation and prevention approach. But again the contextual situation of a centre should be taken into account, not only because of the possible limitations in prevention activities, but also because of the unavailability of certain skills in the country concerned. Besides, when a rehabilitation centre works in close collaboration with a human rights organisation that is developing prevention of torture initiatives, the technical staff does not need to be so multi-disciplinary as the staff of a rehabilitation centre developing prevention activities itself.

Rating with points

Another way of determining whether a centre in a particular contextual situation contributes sufficiently to the prevention of torture could be with a rating with points, in which the contextual situation is taking into account. The strategic plan of a centre regarding the rehabilitation and prevention activities could form the basis for such a rating. The rating could be developed and determined in collaboration with NGOs involved in rehabilitation and prevention activities. However, such a rating

will require sound strategic plans, which not all rehabilitation centres are (yet) able to develop, and would most likely favour EU- or Western influenced rehabilitation centres.

Selection by area

Last but not least, the EIDHR funding for rehabilitation centres could be limited to certain areas in the world where combined actions in the prevention of torture and other human rights violations are taking place. This might increase the impact of the prevention activities in those areas, and at the same time facilitate the selection of rehabilitation centres coming into consideration for financial support.

However, such a policy would exclude, for example, pioneering centres, such as CVICT, which started rehabilitation and prevention activities regarding torture in Nepal, without the existence of other major, national human rights organisations.

In conclusion

Whatever policy concerning the selection criteria will be chosen, with the increased focus on prevention of torture initiatives of the EC, some rehabilitation centres for the victims of torture that were (co)financed by EIDHR before, will be excluded. A fair distribution of funds, with consideration for the contextual situation of a rehabilitation centre and therewith for its possibilities and limitations, as well as for its alternative funding sources, seems the best option.

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ANNEXES

Annex 1: Terms of reference

Title: **Torture rehabilitation centres**

Reference: EuropeAid/B7-701/2000/C99/0328
EuropeAid/B7-701/2001/2077

1. Outline of the evaluation

The evaluation will consider the different Torture rehabilitation programmes currently financed by the EC, focussing in particular on two on-going programmes in Nepal and Peru. It will assess the effectiveness and impact of the programmes in relation to the argument that the work of torture rehabilitation centres contributes towards the prevention of torture

2. Background

The EC Communication on the EU's role in promoting human rights and democracy in third countries has four priorities for the use of EIDHR, one of which is support for the fight against torture.

For several years, the European Commission has funded centres for the rehabilitation of victims of torture in many countries. The number of such centres has grown considerably in recent years. Those outside the EU are funded from budget line B7-701 and those inside the EU from budget line B5-813. This latter budget line is likely to return to JHA in 2005, to be managed with the European Refugee Fund.

The Communication states that "in seeking to be an agent of change, the EU should ensure that it focuses as much as possible on prevention, including through human rights education of the police and other possible agents of torture".

In response to this, the Commission has begun a gradual shift in the focus of its financing, away from rehabilitation of victims and towards torture prevention. However, the torture rehabilitation centres have argued that their work contributes towards the prevention of torture. The Commission wishes to evaluate the strength of this argument by examining the work of two torture rehabilitation centres that the Commission has funded for some time.

The first is the Centre for the Victims of Torture in Kathmandu, Nepal. This Centre currently has a contract for 24 months, ending on 31 December 2003, with an EC contribution of €501.855, representing 74% of project costs.

The second is the National Co-ordinator of Human Rights of Lima, Peru. This had a contract for 26 months from January 2001, with an EC contribution of €586.258 or 82% of project costs, and has recently received another grant for a further two years.

Both Centres have produced interim reports from their earlier projects and final reports are awaited.

3. Issues to be studied

The consultant is requested to address the following question:

How effectively does the work of centres for the rehabilitation of torture victims contribute to the prevention of torture (a) in the countries from which these victims originate (b) in the countries in which they are treated and (c) at the international level? This will be particularly relevant as regards the treatment of refugees and minorities.

Inter alia, attention should be paid to the following aspects:
- whether or not prevention activities detract from the medico-psychological work of the centres;
- whether or not prevention work has any beneficial/detrimental effects on the victims themselves;
- the opinions of other local human rights NGOs which work exclusively on prevention, if these exist;
- the extent of any verifiable indicators used by the Centres to measure the impact of their work, both as regards the rehabilitation of victims and the prevention of torture;
- the extent to which alternative sources of funding are available in the country for either rehabilitation or prevention activities.
- definition of criteria to be used in judging whether rehabilitation activities play roles in prevention of torture
- brief overview of other EU-funded centres working with torture and their activity plans, and a similar overview of the IRCT-members' activities with respect to rehabilitation and prevention work, including an assessment of the strength of rehabilitation and prevention work respectively.

4. Methodology

The main reference documents will be the project proposals, the activity reports and the EHRF monitoring report (in annex). The EC Task Manager responsible for each programme will be available to discuss and provide further documentation on the projects.

The evaluation techniques and research methods will be:
- study of documents/materials regarding the Torture rehabilitation programmes;
- interviews with the persons responsible for the projects;
- interviews with representatives from local and international organisations and experts in this area, including civil society stakeholders and advocacy groups in respectively Peru and Nepal;
- interviews in London and Copenhagen with key persons involved in torture prevention campaign and research. Contacts will also be established with the Special Rapporteur of OHCHR on Prevention of Torture in order to cover international dimensions of the evaluation.

5. Expertise

The evaluation will require two international experts and two local experts with the following profile:
- one international expert with experience in the evaluation of torture centres and with a background in social science;
- one international expert with experience in the cooperation with torture centres with a medical background; one of the international experts should be Spanish

speaking, ideally both of them. The team leader is the expert with the most extensive experience in the field of rehabilitation and torture prevention;
- one local expert from Peru familiar with the Co-ordinator of Human Rights of Lima, Peru;
- one local expert from Nepal familiar with the Centre for the Victims of Torture in Kathmandu.

6. Workplan and timeschedule

a) Workplan

Activity	**Number of days**
- Inception Reading of documentary material - Collation of available documentation from EU-funded centres - Visit to Copenhagen and London - Preparation of country visits	- two international experts, one for 3 days, the other for 2 days: 5 days - two local experts 2 days each: 4 days
- Mission Visit to the respective centres in Nepal and Peru - Interviews with centre staff and with local stakeholders	- two international experts, 7 days each: 14 days - two local experts 6 days each: 12 days
- Draft final report Report writing	- two international experts 3 days each: 6 days - two local experts 1 day each: 2 days
- Feedback presentation - De-briefing in Brussels	- two international experts, 1 day each: 2 days
- Final report Final Draft of report	- two international experts 2 days each: 4 days
Total:	- **International experts: 31 days** - **Two local experts: 18 days**

b) Time schedule

Deadline for draft: 20 October
Deadline for final report: 1 November

c) Communication

Reports (draft and final) to be submitted by MEDE European Consultancy to:
- Tim Clarke, Head of Unit EuropeAid F3, Timothy.Clarke@cec.eu.int
- Peter Ashman, EuropeAid F3, Peter.Ashman@cec.eu.int
- Mario Rui Queiro, EuropeAid F3, Mario-Rui.Queiro@cec.eu.int

Annex 2: Itineraries

Mission to Nepal:

September 19, Friday

09:00 AM	-	Evaluation Planning Meeting and Agenda Finalization, Division of Work and Responsibility
11:30 AM	-	Meeting with Dr. Bhogendra and his team at CVICT
12:00 Noon	-	Discussion with Dr. Bhogendra about Study References
01:00 PM	-	Break for Lunch
02:30 PM	-	Meeting at CVICT Continue
06:30 PM	-	Return to hotel

September 20, Saturday

09:00 AM	-	Report Study and discussion Tour of the city. Take photos and talk to some people in the street
04:30 PM	-	Sindhu Nath Pyakurel President of Nepal Bar Association and former MP From United People's Front later converted to CPN (Maoists)
06:00 PM	-	Return to hotel

September 21, Sunday

08:00 AM	-	Breakfast meeting with Agni Kharel Senior Advocate with specialization in torture
09:30 AM	-	CVICT: meeting with victims/clients of CVICT
01.00 PM	-	lunch with Dr. Bhogendra Sharma and other CVICT team members
03:00 PM	-	Subodh Raj Pyakurel Chairman, INSEC Office Naikap, Kathmandu
06:00 PM	-	Return to base

September 22, Monday

10:00 AM	-	Dr. Ram Krishna Timsina Joint Registrar, Supreme Court
11:30 AM	-	Sushil Pyakurel, Dr. Gaurishankar Lal Das Human Rights Commissioners and Kedar Paudyal – Secretary Nepal Human Rights Commission Harihar Bhawan, Lalitpur
01:00 PM	-	Quick Lunch
02:00 PM	-	Dr. Sailendra Sigdel/Ms. Bandana Risal DfID/Enabling State Program
04:00 PM	-	Krishna Pahari Chairman, Human Rights and Peace Society
05:30 PM	-	Return to hotel

September 23, Tuesday

09:30 AM	-	Dr. Durga Pokhrel Chairperson, National Women's Commission
11:30 Noon	-	Brigadier General B. A. Sharma Chief of Human Rights Cell, Royal Nepal Army

01:30 PM	-	Quick lunch
03:30 PM	-	Udo Wagner-Meige/Nicolas Bachman ICRC, Minbhawan
05:30 PM	-	Return to hotel

September 24, Wednesday

10:00 AM	-	Durga Sob Member Secretary, National Dalit Commission Thapathali
11:30 AM	-	John R. Bevan Senior Human Rights Adviser Office of High Commissioner for Human Rights (UN)
01:00 PM	-	Lunch
02:30 PM	-	Dr. Bidur Osti, Medical Director of CVICT, and other teammembers Last interview and debriefing
07:00 PM	-	Dinner at Bhojan Griha

September 25, Thursday

10:00 AM	-	Shopping
03:00 PM	-	Discussion at hotel about the report
09:00 PM	-	Departure for Airport

Mission to Peru:

JUEVES 9 DE OCTUBRE

8:00 AM	-	Desayuno de Trabajo - Reunión del Equipo para revisión de la Agenda y criterios de trabajo
9:00 AM	-	1ra. Reunión con Manuel de Rivera, Joven Experto de Cooperación de la Unión Europea
11:00 AM	-	Reunión con Salomón Lerner, Ex Presidente de la Comisión de la Verdad y Reconcialiación (CVR)
1:00 PM	-	Cambio de Hotel y Almuerzo
3:30 PM	-	Reunión con Francisco Salomón, Secretario Ejecutivo de la Coordinadora Nacional de Derechos Humanos (CNDDHH)
5.00 PM	-	Instalación en nuevo hotel
6:00 PM	-	1ra. Reunión con Carmen Wurst , Directora Ejecutiva del Centro de Atención Psicosocial (CAPS)
8:00 PM	-	Descanso

VIERNES 10 DE OCTUBRE

9:00 AM	-	Reunión con Pablo Rojas y Equipo del Comisedh
11:00 AM	-	Reunión con Alfonso Wielland – Director de Paz y Esperanza y con Ruth Céspedes Responsable de Lima.
1:00 PM	-	Almuerzo
2.00 PM	-	Reunión con Pablo Zavala, Director de Ipedehp
4:30 PM	-	Reunión en el Ministerio del Interior con Carlos Romero y su Equipo, de la Secretaría de la Comisión de Derechos Humanos
6:00 PM	-	Regreso al Hotel

SABADO 11 DE OCTUBRE

10:00 AM	-	Reunión con el Grupo de Reflexión del CAPS (Pacientes)

12:30 PM	-	Shopping y Almuerzo
3:30 PM	-	Reunión con el Equipo del CAPS (Psicoterapeutas, Trabajadora Social, Fisioterapeuta y Psiquiatra)
7:00 PM	-	Cena
8:00 PM	-	Regreso al Hotel

DOMINGO 12 DE OCTUBRE

11:00AM	-	Concierto con la Orquesta Sinfónica Nacional
1:30 PM	-	Almuerzo
3:00 PM	-	Visita a la Exposición Fotográfica de la Comisión de la Verdad y Reconciliación
5:00 PM	-	Shopping y Regreso al Hotel

LUNES 13 DE OCTUBRE

9:00 AM	-	Reunión de Trabajo del Equipo para intercambiar opiniones y avanzar con el llenado de respuestas de los Términos de Referencia – División de Tareas
11:00 AM	-	Reunión con Teresa Carpio, Directora de la Sección Peruana de Amnistía Internacional
1:00 PM	-	Almuerzo
2:30 PM	-	Reunión con Oscar Ayzanoa, Responsable del Departamento de Dignidad Humana del Ceas.
4:00 PM	-	Reunión con Paul Schellekens, Embajador y Ellen Roof , Oficial de Programa – Cooperación Técnica de la Embajada Real de los Países Bajos
5:30 PM	-	Regreso al Hotel
8:00 PM	-	Reunión con Manuel Escalante, Médico Psiquiatra del Instituto Especializado de Salud Mental “Honorio Delgado y Hideyo Noguchi”

MARTES 14 DE OCTUBRE

9:00 AM	-	Reunión con Miguel Huerta, Defensor del Policía del Ministerio del Interior y su Equipo
10:30 AM	-	2da. Reunión con Manuel de Rivera de la Unión Europea para informarle las conclusiones de la Misión y escuchar sus opiniones.
12:15 PM	-	Pequeña visita turística por el Centro de Lima
1:00 PM	-	Almuerzo de Trabajo con Carmen Wurst, Directora Ejecutiva del CAPS para hacerle conocer las conclusiones del trabajo de la Misión
2:30 PM	-	Reunión con Eduardo Vega, Jefe del Area de Secuelas de la Violencia de la Defensoría del Pueblo
4:00 PM	-	Regreso al Hotel
4:30 PM	-	Salida al Aeropuerto

Annex 3: People and Organisations interviewed

In UK

Amnesty International
James Welsh, Coordinator of the Medical Program
Liz Rowsell, acting researcher South Asia Team
Guadelupe Marengo, researcher of the Americas Program

University of Essex:
Prof. Sir Nigel Rodley, former Special Rapporteur of OHCHR on Prevention of Torture

In Nepal

CVICT
Dr. Bhogendra Sharma, President
Dr. Bidur Osti, Medical Director
Mark Jordans, Psychologist, TPO, Amsterdam, training coordinator of CVICT
Wietse Tol, TPO, Amsterdam, research coordinator of CVICT
Dr. Laxmi Dhakal, Medical Officer
Hemang Sharma, Legal Officer
Ms. Sushila Sharma, Counselor
Ms. Shanta Ale, Counselor
Ms. Jamuna Maharjan, Counselor
Mr. Agni Kharel, Legal Coordinator of CVICT, Senior Advocate with Specialization in Torture Cases

3 Torture Victims, clients of CVICT

ICRC
Udo Wagner-Meige, Deputy Head of Delegation
Nicolas Bachman, Communication Delegation
Laurent Gisel, Deputy Head of Delegation (replacing Udo Wagner-Meige)

National Women's Commission
Dr. Durga Pokhrel, Chairperson

Office of High Commissioner for Human Rights (UN)
John R. Bevan, Senior Human Rights Adviser

National Dalit Commission
Durga Sob, Member Secretary

Nepal Bar Association
Sindhunath Pyakurel, President
Satis Kharel, Secretary

DFID, ESP
Dr. Sailendra Sigdel/ Ms. Bandana Risal, Advisors

Human Rights and Peace Society
Krishna Pahari, Chairman

Royal Nepal Army Headquarters, Judge Advocate General Office
Brig. General B. A. Sharma, Chief of Human Rights Cell,

Captain Ms. Yvetta Rana, Legal Officer Human Rights Cell
Supreme Court
Dr. Ram Krishna Timsina, Joint Registrar

Nepal Human Rights Commission
Sushil Pyakurel, Member
Dr. Gaurishankar Lal Das, Member
Kedar Paudyal , Secretary

Informal Service Center (INSEC)
Subodh Raj Pyakurel, Chairman

Delegation of the European Union in Nepal
Mr. Rudiger Wenk, Charge d'affair
Dr. Giap Dang, Adviser

In Copenhagen

Danida consulting team
Donald Foster, Research & Documentation, Euro Health Group
Soeren Buus Jensen, Team Leader, Euro Health Group

Danish Centre for Human Rights
Hans Otto Sano, Research Director

Danish Institute for International Studies
Ninna Nyberg Soerensen, Head of Department

International Rehabilitation Council for Torture Victims (IRCT)
Anders Buhelt, Programme Coordinator, Latin America
Jens Modvig, Secretary-General
Anton Petrenko, Head of Support and Development Unit

Rehabilitation and Research Centre for Torture Victims
Peter Vedel Kessing, Project Coordinator Prevention

In Peru

Ministerio del Interior
Carlos Romero, Secretario permanente de la Comision de Derechos Humanos

Ministerio del Interior – Defensoria del Policia
Miguel Huera, Defensor del Policia
Defensoria del Pueblo
Eduardo Vega, Jefe del Area de Secuelas de la Violencia

Comision de la Verdad y Reconciliacion
Salomón Lerner, Ex-Presidente de la Comision de la Verdad y Reconciliacion

Ministerio de Salud – Instituto especializado de Salud Mental "Honorio Delgado y Hideyo Noguchi"
Manuel Escalante, Medico Psiquiatra

Seccion Peruana de Amnestia Internacional
Teresa Carpo, Directora

Coordinadora Nacional de Derechos Humanos (CNDDHH)
Francisco Soberon, Secretario Ejecutivo
Comision Episcopal de Accion Social (CEAS)
Oscar Ayzanoa, Responsible Departemento de Dignidad Humana

Asociación Paz y Esperanza Ministerio Diaconal (Paz y Esperanza)
Alfonso Wieland, Director Ejecutivo

Comision de Derechos Humanos (COMISEDH)
Pablo Rojas, Director

Instituto Peruano de Educación en Derechos Humanos y La Paz (IPEDEHP)
Pablo Zavala

Centro de Atención Psicosocial (CAPS)
Carmen Wurst, Directora
"Grupo de Reflexion" – Pacientes del CAPS
Personal – Grupo de Terapeutas del CAPS, Asistenta Social y Fisioterapeuta

Embajada Real de los Paises Bajos
Paul Schellekens, Embajador
Ellen Roof, staffmember

Union Europea
Manuel de Rivera, Joven Experto de Cooperación

Annex 4: Rehabilitation and prevention activities put in schemes

12 Points of action to combat torture, according to AI, translated to the prevention and rehabilitation activities of rehabilitation centres for victims of torture – methods, indicators, and possible limitations and risks

Action	Aim	Method for rehabilitation centres	Methods and verifiable criteria and indicators for assessment, globally indicated	Limitations and risks in conflict situation
1. Condemn torture	Torture should be condemned by government	Contribution to national and/or international pressure to adopt and/or implement CAT	- (collection of) clinical data - data of fact-finding missions - testimonies - lobbying - verifiable results - awareness-raising in clients, public, state authorities and other key actors, by lobbying, media, publications, leaflets, presentations, information and educational activities in communities, etc.: impact, satisfaction, numbers and % reached - co-ordination and networking with other HR organizations: satisfaction, results, impact	- fact-finding missions might be too dangerous - awareness-raising might scare clients off, especially when taking sides in the conflict

Action	**Aim**	**Method for rehabilitation centres**	**Methods and verifiable criteria and indicators for assessment, globally indicated**	**Limitations and risks in conflict situation**
2. Ensure access to prisoners	The practice of incommunicado detention should be ended	Contribution to national and/or international pressure. If possible, access to prisons.	- see point 1 - data about visits to prisons / fact findings - collaboration with ICRC: satisfaction	- see above - visit to prisons might been seen as taking sides - might contribute to sophistication of torture methods
3. No secret detention	Governments should ensure that all prisoners are brought before an independent judicial authority without delay after being taken into custody	Contribute to international action, e.g. 'prisoners of conscience' Legal action – 'habeus corpus'	(contribution to) legal actions and assistance: numbers, %, results	- might be detrimental for medical / psychosocial care
4. Provide safeguards during detention and interrogation	Governments should ensure that conditions of detention conform to international standards for the treatment of prisoners, and take into account the needs of members of particularly vulnerable groups	If visits to prisons possible, inform prisoners of their rights. Support legal claims, if those are possible. Promote awareness among judicial system and medical personnel in/around detention centre.	(contribution to) legal action. Training for judicial system: satisfaction, level of hierarchy, numbers, %. Training for health care workers in and around detention centres – implementation of Istanbul protocol; satisfaction; impact on work	see above

Action	**Aim**	**Method for rehabilitation centres**	**Methods and verifiable criteria and indicators for assessment, globally indicated**	**Limitations and risks in conflict situation**
5. Prohibit torture in law	Governments should adopt the CAT and other relevant international standards	- national and/or international lobbying - co-ordination and networking with national and international HR organisations	- national and international networking: satisfaction, results on work - progress and/or developments (if any possible)	
6. Investigate	Complaints and reports of torture should be promptly, impartially and effectively investigated by a body independent of the alleged perpetrators.	Fact-finding missions. Medical documentation. Reports based on data.	numbers sent to national and/or international HR organizations and/or judicial system and/or governmental bodies: impact if verifiable	depends on contextual possibilities
7. Prosecute	Those responsible for torture must be brought to justice. Impunity should not exist.	National and / or international lobbying. Contribute to prosecution by medical documentation and/or support to victim, directly and/or indirectly.	- networking and lobbying: results - number of medical documentations (depending on context), results - legal and/or psychosocial (indirect) support to victim: satisfaction	- legal assistance: see earlier

Action	**Aim**	**Method for rehabilitation centres**	**Methods and verifiable criteria and indicators for assessment, globally indicated**	**Limitations and risks in conflict situation**
8. No use of statements extracted under torture	Governments should ensure that statements and other evidence obtained through torture may not be invoked in any proceedings.	- See number 5. - Training of judicial system. - Training of medical personnel in charge of medical assessments of torture victims (depending of national law). - (contribution to) medical declarations. (Public) rehabilitation of innocent prisoners.	Number of trainings provided (if any possible): level of hierarchy, satisfaction, change in norms (if verifiable). Number of medical declarations (if any possible and relevant). Individual or group wise support to prisoners found innocent for public rehabilitation: meets their needs, satisfaction.	Re legal support see earlier.
9. Provide effective training	a. All officials involved in the custody, interrogation or medical care of prisoners should become aware that torture is a criminal act. Aim should be a culture change.	Depends on context if possible and effective.	Number of trainings (% of all, multiplier effect – train the trainers). Results – satisfaction; assessment of changed norms, rules, values. Training not only on work floor level, but also of those in charge, administration, opinion leaders within organizations. One mono-disciplinary, training is never sufficient.	Training could be seen as taking side.
	b. In case of victims in exile: all officials involved in admission and reception procedures should be aware of the consequence of torture, (non) refoulement, risk of re-traumatisation. Aim should be an impartial vision with abidance to international laws.	(Contribution to) training of officials concerned with admission procedures and reception of asylum seekers and refugees. (Contribution to) training of judicial system. Training of health care professionals.		

Action	**Aim**	**Method for rehabilitation centres**	**Methods and verifiable criteria and indicators for assessment, globally indicated**	**Limitations and risks in conflict situation**
10. Provide reparation	Victims of torture and their dependants are entitled to obtain prompt reparation from the State including restitution, fair and adequate financial compensation and appropriate medical care and rehabilitation.	- Lobbying - Networking - Provision of integral rehabilitation (legal, medical, psychosocial and economic), if relevant with other NGOs and / or governmental institutions. - promotion of public and professional recognition.	- see point 1 - needs assessment of victims: assistance meets their needs? - type of integral rehabilitation, methodologies, number of victims, % reached, in collaboration with other organisations? Results: reduction of symptoms, improved coping, psychosocial functioning - participation of clients in policies: satisfaction - peer review: result	re legal support see earlier re awareness (and recognition) see earlier % might be limited by contextual situation
11. Ratify international treaties	Governments should ratify international treaties and comply with the recommendations of international bodies and experts on the prevention of torture.	Direct or indirect national and/or international lobbying. National and/or international networking. See also point 1.	See point 1.	See point 1.
12. Exercise international responsibility	Inter alia: governments must not forcibly return a person to a country where he or she risks being tortured.	Training – see point 9 b. Individual medical declarations. Networking and lobbying.	See point 9.	Being seen as taking sides. More medical declarations for clients, more actions, less governmental support.

Rehabilitation and prevention of torture in conflict, post conflict and third countries in scheme – global division of possible methods and aims

In the fourth category of contextual situations, a (post) conflict situation in which refugees from neighbouring countries are also hosted, the methods and aims in respectively the conflict or post conflict situation will dominate.

Type of activities	Conflict situation	Post-conflict / transition to democracy	Third country hosting victims of torture
1. Fact-finding and data collection re incidence and consequences of torture for national and/or international pressure on government	can put medical and psychosocial rehabilitation at risk	contributes to and advances fight against impunity and adoption or implementation of CAT (including State's responsibility for reparation)	contributes to data collection and documentation internationally and to point 3
2. Human rights organizations cooperation / networking	national and/or international networking will strengthen prevention activities	strengthens prevention and rehabilitation activities – accent on national cooperation	strengthens prevention and rehabilitation activities; focus more on networking among care providers and legal assistance
3. Awareness-raising activities for public, state authorities and other key actors by: ***- lobbying*** ***- media*** ***- publications*** ***- presentations***	see point 1	recognition for victims (rehabilitation) by public, politicians and government and promotion of point 1	recognition for victims as part of rehabilitation
4. Legal, medical and psychosocial support to victims / rehabilitation	legal support can undermine the medical, psychosocial support	integral rehabilitation (should include social-economic support, if necessary); contribution to legal actions	individual legal support (medical documentation) might be necessary in case of imminent refoulement
5. Education and training of law enforcement personnel, military and judicial system	might not be possible	essential, but could also be indirect, by contributing to education and training activities of other HR organizations	education and training of immigration officers, lawyers and others involved in admission and reception of refugees and asylum seekers
6. Awareness-raising and training of health care professionals in documentation, assistance and treatment	advances early identification and documentation, e.g. prevention and rehabilitation	essential	advances timely identification and treatment; could/should be aimed at integration in mainstream health care