



# EVALUATION OF MSF-OCB TORTURE REHABILITATION PROJECTS

Lessons Learned from three projects

Anonymized version

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**SHORT VERSION**

This publication was prepared at the request of Médecins sans Frontières. It was prepared independently by *Currin Singh* (Team Lead) and *Eva P. Rocillo Aréchaga* (Medical Evaluation Referent).

## DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of **Médecins sans Frontières** or the Stockholm Evaluation Unit.

NOTE: Because of the sensitivity of the issue, this public report is the anonymized version of the final evaluation document so that the countries, the clinics and the partners and NGOs involved cannot be identified.

Front Cover Picture “The suffering of refugees” by MSF National Staff in one of the VOT clinics

# ACRONYMS

|       |  |
|-------|--|
| MSF   | Médecins Sans Frontières                                 |
| SEU   | Stockholm Evaluation Unit                                |
| LGBT  | Lesbian, Gay, Bisexual, and Transgender                  |
| NGO   | Non-governmental organization                            |
| VoT   | Victims of torture                                       |
| VoV   | Victims of violence                                      |
| HQ    | Headquarters   |
| LuxOR | Luxembourg Operational Research                          |
| OECD  | Organization for Economic Cooperation & Development      |
| DAC   | Development Assistance Committee                         |
| OCB   | Operational Center Brussels                              |
| SWOT  | Strengths, Weaknesses, Opportunities, and Threats        |
| EU    | European Union   |
| UN    | United Nations   |
| NFI   | Non-food items   |
| IRCT  | International Rehabilitation Council for Torture Victims |
| M&E   | Monitoring and evaluation                                |
| RHD   | Rheumatic heart disease                                  |

# EXECUTIVE SUMMARY

This report summarizes key findings from an evaluation of MSF's torture rehabilitation projects in project A, B and C. MSF set up these projects beginning in 2013, in the aftermath of the so-called 'Arab Spring', and situated them in the context of the mixed-migration flow occurring around the Mediterranean. The present report, written by a team of independent evaluators on behalf of the MSF Stockholm Evaluation Unit, is the result of a comprehensive document review, field visits to the three sites, data analysis of patient pathways and outcomes, and more than 70 interviews with internal and external stakeholders, including some patients.

## 1.1 KEY FINDINGS FROM PROJECT A

**Massive presence and reach.** Clinic A has served more than 1500 victims of torture since it opened its doors to this population in 2013. It is a fast-paced environment that offers a unique service in the face of overwhelming demand.

**Multi-disciplinary teams.** The clinic recently reorganized its model of care into a multi-disciplinary team structure, and is now operating at full capacity.

**Benefits to patients.** Interviewed patients reported improvements in their physical, psychological, and social conditions, and attributed these improvements to the care they received at the clinic.

**Lots of drop-outs.** About 50 percent of patients are lost to follow-up across the different specialties. A survey is underway, and hypotheses are presented herein, but no definitive explanation has yet been found.

**Threats in the operational environment.** The clinic's decision to target migrants as a vulnerable group, and to offer torture rehabilitation services discreetly, is urgent and noble; it also overlooks the broader operating context, in which torture is fast becoming a rising pattern of abuse against both nationals from and migrants to country A.

**Racial tensions.** While relationships at the clinic A are generally collegial, there are latent tensions at the clinic between clinicians from country A and patients/staff of refugee backgrounds.

**Harsh intake process.** The intake process can be hurtful for some patients because it requires disclosure of torture or sexual violence upon initial assessment. This screening mechanism may be justified due to high demand, but it is not a good foundation for a proper therapeutic relationship with victims of trauma and torture.

**No handover strategy.** The complexity and size of the clinic, the steady decline in funds available to refugee agencies, and the existential crisis faced by civil society in the country are clear threats to the continuity of services provided by MSF. Currently there is no agreed exit or handover strategy.

**Gaps in legal aid and medical documentation.** There appears to be a gap in the medical documentation of torture as per international standards. There is also a lack of legal assistance at the clinic, and the pure-referral model for legal services is insufficient from the viewpoint of holistic rehabilitation.

## 1.2 KEY FINDINGS FROM PROJECT B

**Good karma.** Clinic B is operating at full capacity in two bright, welcoming spaces. The clinic is full of 'good karma' – in the words of one interviewee – because of the positivity of staff and the intimacy of the physical space.

**High-quality professional service.** The clinic features highly competent professionals offering a holistic rehabilitation service in a sensitive and dignified manner. A total of 315 patients have been served to date, including women, minors, and LGBT people.

**Benefits to patients.** Interviewed patients reported improvements in their physical, psychological, and social conditions, and attributed these improvements to the comprehensive, individualized care they received at the clinic.

**Superior project management capacity.** The Field Coordinator has an unparalleled knowledge of the situation of refugees in the country and responded rapidly to changes in the operational environment. Internal and external stakeholders attribute the strength of the project to her management style and interpersonal skills.

**Strong partnership model.** MSF undertook this project in partnership with two local NGOs specializing in legal aid and psychosocial support, respectively. However, it appears the partners have diverging views about the project's future and weaknesses in coordination and fundraising.

**Local capacity-building.** The project has hosted trainings for country B medical professionals on torture documentation and trainings for Asylum Service case officers on early detection and referral of vulnerable groups.

**Limited data analysis.** To collect patient data and monitor the intervention, clinic B has imported an EpiData-based platform. The system is basically in place, but has not been fully taken advantage of. Staff and management recognize the need for improvement.

**Inadequate medical documentation.** There is a 'void' in the provision of medico-legal reports that would be useful in obtaining a positive outcome for victims of torture who seek asylum.

**Incoherent brand identity.** The clinic has a dual identity across the public interface as either a clinic for 'victims of violence' or 'victims of torture', potentially confusing referral partners and the target population.

### 1.3 KEY FINDINGS FROM PROJECT C

**Power of positive thinking.** Clinic C is operating at full capacity in a bright, tranquil space. Staff exhibit high levels of satisfaction and generally maintain a collegial attitude and positive spirit, which is conducive to the rehabilitation of victims of torture.

**High-quality professional service.** The clinic has adopted an inter-disciplinary, trauma-informed therapeutic approach, drawn from techniques of ethno-psychiatry and featuring especially strong cultural mediation capacity.

**Benefits to patients.** The evaluation team's visit could not produce any evidence of positive outcomes for patients. No contact was facilitated between the evaluation team and patients.

**Productive partnership model.** The clinic's model of care is based on the model of an NGO, which has treated victims of torture in the country for more than thirty years; however, the two partners generally do not coordinate on casework.

**Insufficient integration of legal services.** A local NGO has been contracted to provide part-time legal aid two days a week. Nevertheless, due to high volume, MSF social workers still spend more than half their time performing legal assistance activities.

**Poor data management.** The clinic's data collection mechanism is not aligned with the model of care and does not enjoy the buy-in of staff.

**Slow start to local capacity-building.** The project has conducted informal and opportunistic advocacy before the Ministry of Health and centers for asylum-seekers. However, it has not taken the initiative to organize any local capacity-building activities for Italian medical professionals. (These are now being planned.)

**Low accessibility of vulnerable populations.** There are a set of accessibility challenges: 3 of 86 patients served to date (3.5 percent) are women; 2 of 86 patients (2.3 percent) are minors; and 2 of 86 (2.3 percent) are undocumented migrants.

**Low staff salaries.** Low salaries are threatening staff morale and compelling staff to take second jobs in addition to their full-time duties at the clinic.

### 1.4 SWOT ANALYSIS OF THE VOT INITIATIVE

#### Strengths

**High-level buy-in meets field-level autonomy.** The combination of strong will at HQ to engage on torture and the field projects' latitude to define and achieve their objectives has been ideal for putting different models to the test in different environments.

**Holistic treatment approach.** Though new to torture rehabilitation, staff of the three clinics have taken up a trauma-informed, holistic model of care, featuring especially strong physiotherapy services and – in project B and project C – strong cultural mediation capacity.

**Strong partnership models.** Working so closely in partnership with local NGOs – whereby MSF is actually learning from them – is a point of strength for the VoT program. Clinics B and C, in particular, feature strong models in which MSF and its partners share a physical space and have put in place a foundation for joint case management.

**LuxOR's engagement.** Luxembourg Operational Research has done a commendable job developing an EpiData-based data management platform for the three clinics and facilitating a multi-pronged research initiative in project A based on this platform.

## Weaknesses

**Insufficient data management.** While the EpiData system is in place, the data collection process is haphazard across the clinics. Projects B and C perceive that the platform was not adapted to their needs as it was rolled out. There are frequent errors and discrepancies due to poor quality control, and there is inadequate data management capacity at the three clinics.

**Limited knowledge transfer on medical documentation.** While medical documentation of torture has been identified for years as a central interest and component of care by HQ, the field projects have pushed back and have not managed to implement a uniform protocol for medico-legal documentation. Acknowledging some contextual specificities for the projects, this can be attributed partly, but not only, to a lack of clear communication and transfer of knowledge about the value and purpose of medical documentation of torture.

**Poor integration of the clinics' experiences.** Assumedly, MSF has developed some level of expertise in working with torture victims over the years; however, these experiences have not been collected or compiled in a meaningful way, for either internal capacity-building or external awareness-raising.

**Gaps in the management structure of the VoT program.** While the projects have enjoyed a high degree of freedom, and this has been a distinct advantage, they have survived and thrived largely on the strength of their respective Field Coordinators. Fatigue and job-related stress are real for these project managers, and additional support at mission and HQ levels is required – specially to harness institutional learning.

## Opportunities

**Unique vantage point for cross-cutting advocacy.** MSF finds itself in a unique position at the nexus of the refugee crisis in Europe and the systematic torture experienced by people crossing the Mediterranean or biding their time in transit countries. In country C and country B, there are quick and easy ways to capitalize on this experience by attaching the issue of torture rehabilitation to the missions' high-level advocacy efforts on refugee protection and policy.

**Potential for research.** Based on LuxOR's success with the clinic A team, a concrete research agenda could be designed and implemented that figures out which populations are best served and how, and that identifies and fills gaps in the literature about the medical rehabilitation of victims of torture.

## Threats

**Threats in the operational environment.** Because torture is a common tool of political repression, it can be more dangerous to offer specialized care to victims of torture in conflict-affected environments, than to offer medical care to the war-wounded in a spirit of neutrality. These sensitivities are playing out in country A, where anti-torture groups face an existential threat in the face of unprecedented attacks by authorities.

**Lack of diversification.** Given MSF's goal to learn how to offer torture rehabilitation services in its interventions worldwide, there is a threat of insufficient experimentation in sufficiently diverse contexts. If MSF's learning is drawn disproportionately from contexts in Europe, it could later lead to difficulties in translating or applying this learning to resource-poor contexts or conflict-affected environments.

**Resource-efficiency.** Resource-efficiency concerns and capacity constraints will complicate future efforts to expand coverage or replicate the service.

## 1.5 RECOMMENDATIONS

The evaluation team presents the following 5 key recommendations to improve the projects and consolidate learning to date:

1. Invest resources into an **integrated data management solution**, and embed this into a **comprehensive, VoT-specific M&E framework** that accounts for patient perspectives.
2. Find alignment on the **ultimate objective** of the VoT initiative and consider the **diversification of learning environments**, before selecting another project site.
3. Engage in **experience capitalization exercises** to create **publishable knowledge products**, like operational research briefs, scientific papers, technical toolkits, and medical protocols.
4. Take advantage of **quick and easy advocacy wins** by hitching the issue of torture to **high-level advocacy efforts** on refugee protection and access to care.
5. Engage a **full-time torture referent** who can help chart the course forward to take the VoT initiative to the next level.

**Stockholm Evaluation Unit**

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