STOCKHOLM
EVALUATION
UNIT

EVALUATION OF MSF TREATMENT & REHABILITATION OF VICTIMS OF TORTURE PROGRAMS IN FOUR LOCATIONS

FEBRUARY 2020
This publication was produced at the request of MSF-OCB under the management of the Stockholm Evaluation Unit.

It was prepared independently by Pau Pérez-Sales (MD PhD Psychiatrist), and Christina Psarra (MSc).

DISCLAIMER
Due to the sensitivity of managed information, any mention regarding the specific locations of the settings where MSF is operating has been removed. Location A, Location B, Location C, Location D is used in this document to refer to each of them.

The author's views expressed in this publication do not necessarily reflect the views of Médecins Sans Frontières, nor the Stockholm Evaluation Unit.

Management Response

- by Stefano Argenziano on January 2021

Evaluation Recommendations and Management's Comments

Recommendation 1: Adopt a layered response	
Response:	Accepted
Timeframe:	Immediate
Comment:	*None*
Recommendation 2: Endorse flexibility in care practices and approaches	
Response:	Accepted
Timeframe:	Immediate
Comment:	*None*
Recommendation 3: Improve torture documentation and provision of certificates	
Response:	Accepted
Timeframe:	Immediate
Comment:	Re. the "partial" Istanbul Protocol approach that evaluators seem to be recommending and the further training on the IP. It remains unclear how does this partial approach differ from the current recommended documentation approach using the Medico-legal toolbox other than, as the report states, using cameras to document scars?
Recommendation 4: Introduce efficacy indicators urgently and adapt data management to projects' needs	
Response:	Accepted
Timeframe:	Immediate
Comment:	We would suggest to change from "efficacy" to "effectiveness" indicators. Efficacy is the extent to which an intervention does more good than harm under ideal circumstances. "Effectiveness" assesses whether an intervention does more good than harm when provided under usual circumstances of healthcare practice. It would be important to focus on the correct definition in the recommendations.
Recommendation 5: Consider an alternative to current human resource structure and hierarchy	
Response:	Accepted
Timeframe:	After two (2) years
Comment:	The HR set up and structure is a subject of ongoing attention in the VoT programs as in other operations. In the past we had deployed similar alternative structures", but this recommendation is not perceived as useful in the framework of this evaluation.

Continued →

PAGE	COMMENTS TO SPECIFIC STATEMENTS IN THE FINAL REPORT
8	"There is a perception that the legal department has advised against documentation of cases." - This statement appears to be unsubstantiated in the text, therefore the Management will ignore it.
26	"Employ [national] staff in advocacy positions…" "Employ national staff for advocacy related positions…" - Management sees no pertinence in systematic "profiling" of staff for such positions. We had and we have [national staff] in advocacy positions and the recruitment will be done based on qualifications and not nationality.
32	"Projects in the Global North, and in especially Location A, are comparatively much more expensive than projects in Global South (Location C). Location D lays in between due to logistic costs. Cost per patient is up to fifteen times higher…" - Indeed, the costs for similar operations differ greatly as per project locations (global south / global North). While management can agree on the final conclusions in the paragraph, we also reject the figures presented and the way the calculations on budget have been conducted. They are inaccurate and not detailed and therefore the calculations presented should not be used as "hard data" to draw conclusions.
41	" While there is a whole community with basic needs often unattended, physical and mental suffering and social suffering, by working only with VoT as vulnerable population we risk to reinforce a cheap, charity-based approach rather than a rights-based approach that considers torture as a disease break the community by privileging some members." - Management rejects these conclusions. In Location D the VOT care is just a part of a larger programme and in Location C VOT activity accounts for less than half of our operations-evaluators seem to have totally ignored the GBV care in Location C.
41	" Accordingly, to the problems of a narrow definition of torture and working with VoT as a vulnerable population, we recommend that in the formulation of projects, the target population be 'victims of torture and other serious human rights violations', in order, in any case, to avoid being constrained by a narrow definition of the concept of torture." - As we do include ill-treatment and degrading treatment in our definition Management does not see why we should include the human rights violation perspective in order not to be constrained in a "too narrow torture definition".
42	" The manual of procedures of the Technical referent considered MDTi the most essential element in work organization." - It is important to mention that the "Manual" by the Technical Referent was only a draft - never validated for use.

TABLE OF CONTENTS

List of Tables and Figures 5

List of Annexes 5

ACRONYMS 6

EXECUTIVE SUMMARY 7

INTRODUCTION 8

- Evaluation scope 8
- Methodology 8

KEY FINDINGS 10

RECOMMENDATIONS 12

DATA, FINDINGS AND RECOMMENDATIONS 13

COMPARATIVE ANALYSIS 34

- Global Budget 34
- Theoretical Model 34
- Efficacy of Existing Programs 40
- Target Population 42
- Work Organization 43
- Advocacy 46
- Supervision: Clinical or Managerial? 47
- Emotional Support 47

TRANSVERSALIZATION: TRANSFERABILITY TO OTHER PROJECTS 49

- Proposal 50

List of Tables and Figures

Table 1. Human and Financial Resources....13
Table 2. Referrals....13
Table 3. Profile of Patients....14
Table 4. Consultations/Workload - 2019....14
Table 5. Consultations at discharge - 2019....15
Table 6. Outcome indicators (Discharge status)....15
Table 7. Outcome indicators (GAF Score)....15
Table 8. Cost-benefit analysis....15
Table 9. Findings and Recommendations by Site....16
Table 10. Psychosocial work with Victims of Torture....36
Figure 1. Layered intervention with VoT....36
Figure 2. A Model of Vulnerabilities....42
Table 11. Proposal of three packages of care based on complexity....50

List of Annexes

Annex 1: Recommendations Per Site
Annex 2: Best Practices for Group Therapy

ACRONYMS

CM	Cultural Mediators
CBT	Cognitive-Behavioural Therapy
CoPro	*Comité de Projet*/Project Committee
EBE	Experts by Experience
EU	European Union
FGD	Focus Group Discussion
GAF	Global Assessment of Functioning
HQ	Headquarters
HP	Health Promotion
IFRC	International Federation of the Red Cross
IRCT	International Rehabilitation Council for Torture Victims
IP	Istanbul Protocol
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LuxOR	Luxembourg Operational Research
MDT	Multidisciplinary team
MedCo	Medical Coordinator
MHAM	Mental Health Activity Manager
MHPSS	Mental Health and Psychosocial Support
MSF	*Médecins Sans Frontières*/Doctors Without Borders
M&E	Monitoring and Evaluation
NFI	Non-food items
NGO	Non-Governmental Organization
PMR	Project Medical Referent
SEU	Stockholm Evaluation Unit
SoT	Survivors of Torture
SGBV	Sexual Gender-Based Violence
SV	Sexual Violence
SW	Social Worker
OCB	Operational Centre Brussels
UNCAT	United Nations Convention against Torture
VoT	Victims of Torture
VoV	Victims of Violence
WMA	World Medical Association

EXECUTIVE SUMMARY

Médecins Sans Frontières (MSF) had always been treating victims of violence and/or torture all over the world but no vertical Victims of Torture (VoT) projects have existed before 2012. Documented knowledge of the activities remains extremely limited even today. Despite the operational investments and engagement of field teams, MSF struggles to answer questions related to care practices and effective approaches.

This document reports findings from an extensive and multivariable evaluation (2019-2020) of all MSF Operational Centre Brussels (OCB) projects offering treatment and rehabilitation services to victims of torture. Two independent evaluators carried the assessment on behalf of the MSF Stockholm Evaluation Unit (SEU).

The general report provides a comprehensive overview of the technical and operational endeavours. It addresses issues of appropriateness and effectiveness and proposes critical recommendations for the overall MSF engagement to VoT care. Additionally, four detailed reports on the modus operandi of each project have been produced offering insight and recommendations per site (see Annex 1) and a special technical review on options and suggestions for best practice for group therapy (Annex 2).

INTRODUCTION

EVALUATION SCOPE

The emphasis of this evaluation exercise is at the level of activities and outcomes in four projects offering services to Victims of Torture (VoT), which are under the control of MSF. By looking at four projects transversally, the evaluation identified recommendations and proposes changes as well as lessons learned to be transferred.

This exercise aims to contribute to MSF's knowledge in the form of general practices and principles within an appropriate medical and humanitarian, ethical framework. Findings are expected to inform the development of guidelines and internal standard operating procedures for VoT projects, acknowledging thought context and operations diversity.

Geographical coverage was four project locations in two continents.

METHODOLOGY

For answering the evaluation's questions, a mixed-methods approach was used, comprising of different stages: a document analysis, descriptive data analysis and key informant interviews. We have chosen this study design analysis to build on the findings at each stage, following Palinkas et al.'s taxonomy of mixed methods design. This sequential collection and analysis are considered appropriate where stages of research are connected for complementarity and expansion of findings, and it included:

1. Literature and Documentation Review
   a. Review of project documents, including Field Reports, Medical Field Reports, CoPro and ARO documents,
   b. Narratives and Logframes, EOM and Field Visit Reports if available, Assessment Reports, SOPs, minutes from strategic meetings and incidence reports.
   c. Literature review of recent scholarly secondary sources and grey bibliography on torture rehabilitation and relevant topics. Advocacy and policy briefs.
2. **Quantitative data** collection, management and analysis from datasets available at HQ and field level. The collection is dynamic and included consultations and briefings with field members and data collectors for quality assurance.
3. **Qualitative data** collection: in-depth interviews, focus group discussions based on questionnaires with the coordination teams, first-line care providers, medical and operational referents as well as external partners, authorities, and patients if deemed necessary and possible. Special precautions will be taken to avoid reporting bias, and informed consent will be secured. A full list of interviewees is provided in Annex.
4. **Observations and site visit assessments:** Observation of multidisciplinary intakes, triage sessions and daily activities in all sights.

Limitations are mainly associated with the varied approaches on documentation and data management, but we considered them balanced with additional information provided from qualitative sources.

Each field visit started with a briefing with field and mission coordination members and was followed by a debriefing to provide strategic reflection and feedback. The evaluator team was in regular coordination with the evaluation's Focal Point from Cell 2.

The strength of the evaluation is greatly enhanced because of

I. High participation of patients with the organization of five focus group discussions in three different locations.
II. Key informant interviews with partner organisations.
III. Full observations of clinical practices such as intakes and consultations.

CONSIDERATIONS OF DATA PROCESSING

All data from the databases were already pseudonymous, and for the vast majority, the databases are entirely anonymous.

As this is a sensitive topic, written documentation related to patients will be minimum, and no identifying codes were traced back to any other written source.

Documents from the document analysis: the documents were stored in a shared Dropbox protected library accessible only by the two evaluators. The file will be destroyed upon completion of the evaluation.

Handwritten notes were typed up and anonymized after the interviews and saved in the same format as the transcripts. Original hard copies of notes were shredded.

KEY FINDINGS

Rehabilitation. The distinction in MSF between *rehabilitation* and *functional recovery* is an ad-hoc distinction, not supported conceptually. MSF grey-literature uses rehabilitation as synonymous with "*attaining the maximum level of holistic healing*". Functional recovery, on the other hand, is used as "*a practical here-and-now stabilization that includes (1) ability to control symptoms /…/, (2) fulfilling life roles /…/, and (3) expanding resources"*, which in fact is what rehabilitation is about. This is a false debate. MSF uses rehabilitation when the outcome is points 1 to 3 and functional recovery when it just points 1. Alternatively, simply use rehabilitation "at the best attainable level" (see full discussion and proposal on p.25 below).

Definition of VoT Used by MSF. The definition in the United Nations Convention of Torture (UNCAT) is the instrument for international consensus, and therefore as such, it must be the main working reference, especially when gathering forensic documentation. However, in the context in which MSF operates, the definition of both the World Medical Association (WMA) and the International Federation of the Red Cross (IFRC) includes non-state actors and is less strict in intention and purpose criteria gives more flexibility to interventions. Using this definition is also a possibility (see full discussion on p.29)

Identification of VoT. Working with torture survivors, it is essential to be proactive in detection and acknowledge that the most affected people are not those who actively seek help. Community work is thus key to proactive detection. No active identification of VoTs is developed in any of the projects. In all sites, teams work on referrals from partner organizations. Self-referrals were accepted in all cases at the beginning, and were later restricted due to a heavy workload. Now there is only one clinic allowing self-referrals. None of the projects have active detection of cases in community, shelters, or points of access to the system (see p.29).

Multi- and Interdisciplinary Teams. Interdisciplinarity seems a fair and efficient way to work, although, in some exceptional circumstances, multi-disciplinarity can be a useful adjunctive tool. Multidisciplinary intakes should not be the rule but an exception to be reserved for severe patients that will likely need long and complex interventions (see full discussion on p.30).

Documentation of Torture. Medico-psychological documentation of torture is a crucial component according to Istanbul Protocol (IP) principles and a area of interest for MSF. However, MSF field teams are not documenting torture. This situation can be partly attributed to a lack of guidance – or guidance for avoidance, miscommunication, incapacity to manage data and confusion with personal files (although medical files are kept). In addition, other reasons may be lack of understanding of the added value and purpose of this type of documentation, lack of material (such as cameras and guidance on how to photograph adhering to the rules) and/or protocols in general. This is not to be confused with doing full IP (only required for strategic litigation and complex legal cases) or with the provision of medical certificates for asylum claims.

Additionally, MSF teams have been advised to limit the number of medical certificates. Proper documentation is essential for the follow-up of patients, case reports and advocacy, including justice and reparation measures. Certificates can be determinant for patients' legal status, access to care services and remain a legitimate patients' request. Moreover, it is a patient's right to receive a medical certificate when requesting it. There is a perception that the legal department has advised against documentation of cases. We must stress that what we are discussing here is about proper *medical* documentation, using international accepted protocols. If MSF

wants to prove that in a country there is torture, it needs to support it with proper medical documentation. This is not a legal question, but a question of good medical practice.

Lack of Care Measurement Indicators. There is an urgent need to decide and implement care quality and efficacy indicators. Two projects had zero effectiveness indicators, and in the other two, there were minimal indicators in few disciplines as data were only kept for activities. There are some laudable small initiatives, albeit not enough due to lack of coverage of essential elements and low involvement by teams.

The scarce available data on efficacy suggests that the percentage of patients discharged for feeling better is low (15% to 30%). This can be contrasted by an even lower improvement in Global Assessment of Functioning (GAF score) among patients, which is around 10%, (only on Location D),. This can be partially justifiable according to the mobility of the population and extreme psychosocial conditions. However, this also demands an immediate compulsory collection of indicators and closer monitoring of programs, including six to 24 months of follow-up. Based on the available data, we cannot conclude which are the best options for clinical care not to scale up existing programs (see full discussion in p.27).

Inadequate Data Management and Ownership. The lack of effectiveness indicators, in combination with the use of the EpiData software requiring specialized HR resources, creates an almost impossible situation for the monitoring of VoT projects as it allows minimum ownership of data from field teams. No comparative data are possible. Teams use multiple databases, different data forms per discipline, there are frequent errors and discrepancies, and despite the quantity of data recorded there is minimal beneficial analysis.

High Engagement. All teams have demonstrated a profound engagement to the cause and the care of VoTs, and this engagement must be highlighted and acknowledged. For many practitioners, their own and MSF’s involvement with VoT signifies a political stance and an engagement to restore trust to humanity.

RECOMMENDATIONS

The key findings led to five key recommendations that were put forward to the program team for consideration.

⇒ **Recommendation 1: Adopt a layered response**

Adopting a layered response would make MHPSS interventions real MH and PSS interventions. Include Level 1 (Psychosocial and Community Work), Level 2 (Focal interventions) and Level 3 (Specialized interventions) in all vertical VoT project. While keeping the significant effort on the clinical, reorganise the teams also to have a powerful highly qualified Psychosocial and Community Team at the same level of expertise (not size) than the clinical team.

⇒ **Recommendation 2: Endorse flexibility in care practices and approaches.**

Interdisciplinarity is an advisable approach, with MDTi in exceptional circumstances. Consider not only the individual approach to care but also group therapy.

⇒ **Recommendation 3: Improve torture documentation and provision of certificates**

a. Facilitate provision of certificates, and
b. Initiate proper documentation of torture, nowadays inexistent in any project.

Consider increasing MSF's role in VoT specific advocacy. Approach advocacy as an integral part of VoT projects and enforce MSF's targeted messages to raise awareness at all levels on VoTs protection needs and vulnerabilities.

Patient-led Advocacy is a promising development, and VoTs shall be given access to opportunities; overprotection and patronization must be reduced.

⇒ **Recommendation 4: Introduce efficacy indicators urgently and adapt data management to projects' needs.**

Specific Indicators on efficacy are needed per discipline, and they must be mandatory and not based on teams' preferences. Discharge and drop out data collection should be considered compulsory.

⇒ **Recommendation 5: Consider an alternative to current human resource structure and hierarchy.**

Consider coordination and/or managerial positions to experienced national staff and promote combinations of expatriates and national staff working at the same level.

DATA, FINDINGS AND RECOMMENDATIONS - BY PROJECT

The following two tables summarize:
(a) basic -raw data to compare the size and profile of the four projects (table 1-8) and
(b) main findings and recommendations by the site (table 10).

A detailed explanation of the tables can be found in the four detailed site reports (Annex 1).

Table 1. Human and Financial Resources

2019	Location ALocation A	Location BLocation B	Location CLocation C	Location DLocation D
A. Budget (approx.)[1]	1.050.000 €	1.390.000 € 1.39 m	2.240.000 €	2.000.000 € 2
B. Project team[2]				
MD	1,6	3	6	2
Psychologists	2	3	13	4
Psychiatrists	1/0	0	3	1
Physiotherapists	1,5	2	4	0
Social Workers	2	3	9	2
Intercultural Mediators	5	13	15	25
Health Promoters	-	-	7	5
Expatriates	0	0	7	1
Local	7,6	11	104	11

[1]Financial and HR figures are indicative and subject to constant changes.
[2] Most approximate figure - team has changed along 2019.

Table 2. Referrals

Referrals 2019	Location A	Location B	Location C	Location D
Referrals	Local Council reception system (43%)	MSF-Location D (52%)	UNHCR (30%) INGOs (35%)	Partners in Camp D (48%)
Main Sources	Self-referrals	Self-referrals, later not accepted	Self-referrals	No self-referrals
Other referrals	Other NGOs	Partners (Babel/GCR)	Local NGOs	Other NGOs

Table 3. Profile of Patients

	Location A	Location B	Location C	Location D
Male	97%	89.9%	31.4%	64.1%
Mean age	26.5	31.2	28.7	28.7
<18 years	n.s.	n.s.	25%	n.s.
Three main nationalities	Senegal Gambia Ivory Coast	DRC Cameroun Guinea	Sudan South Sudan Ethiopia	Afghanistan DRC Cameroun
Legal Status	Asylum seeker 58% Rejected in appeal 23%	Asylum seeker 6.3% Rejected in appeal 22%	Yellow Card 44% Blue Card 38%	Before full registration or first interview 73%
Length of stay in country[1] (%): <6 months 6-12 months 1-3 years >3 years	 27 25 43 5	 13 30 54 4	 11 11 18 60	 74 26 - -
VoT SGVB Severe MH	100%	100%	35% 65% -	35% 25% 45%
Patients 2019[1] New intakes/week	69 1.3	312 5.8	1 982 37.4	230 4.3
Waiting list 31.12.2019	108 cases 6 months	150 cases 9 months	443 cases 4 months	12 cases 4 weeks

[1]Data are collected differently in each location. Values shown are the best approximates.

Table 4. Consultations/Workload - 2019

Average patients per workday	Location A[1]	Location B	Location C	Location D
MD	720	1.305 6	4 033	1 473 3[2]
Psychologists	1 100	1.406 5	5 976	1 962 2.3
Psychiatrists	-	N/A	1 206	457
Physiotherapists	680	709 2	2 264	-

[1] Estimated figures.
[2] 5 excluding empty slots due to no-show patients.

Table 5. Consultations at discharge - 2019

	Location A[1]	Location B	Location C[1]	Location D
MD	Not available	8	4.5	7
Psychologists	Not available	18	8.3	8
Psychiatrists	-	?	7.9	6
Physiotherapists	Not available	6	8.1	-

[1] For those finishing treatments including dropouts 3 (MD), 4 (MH), 6 (Physio).

Table 6. Outcome indicators (Discharge status)

	Location A	Location B[1]	Location C	Location D[2]
Mean-time in treatment (active)	2 years	2 years	6 months	4 months
Drop-Out - Lost	Not collected	N/A	60%	28%
Discharge with improvement - Mental Health	Not collected	N/A	16%	13%
Discharge w/out Improvement Mental Health	Not collected	N/A	24%	
Other	Not collected	N/A		48.7% (Transferred)

[1] For 2019 we could only estimate 44% discharge for MD and 51% for MH. They could not provide better data.
[2]See specific section on GAF score in Report.

Table 7. Outcome indicators (GAF Score)

IMPROVEMENT IN GAF SCORE[1]				
	Location A	Location B	Location C	Location D
Drop-Out Lost	Not collected	Not collected	Not collected	>20% 42% <20% 58%
Discharge with improve-MH	Not collected	Not collected	Not collected	>20% 69% <20% 31%
Discharge w/out Improve-MH	Not collected	Not collected	Not collected	
Transferred to Mainland	Not collected	Not collected		>20% 15% <20% 41% No data 44%

1 Positive Outcome: >20% improvement in GAF Score. Negative Outcome: Less than 20% improvement, no or negative improvement.

Table 8. Cost-benefit analysis

	Location A	Location B	Location C	Location D
Budget/Cohort	15.217 €	4.455 €	1.130€	8.695€

Table 9. Findings and Recommendations by Site

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
POPULATION	Refugees and immigrants VoT Province of Location A.	Refugees and Immigrants, residing at Prefecture B. Medical or mental health needs of VoT.	Refugees and immigrants. Also sexual violence including emergency care Greater Location C area Focus on horizontalisation	Refugees and immigrants with severe MH problems as a consequence of torture, sexual violence and other forms of violence.
DETECTION	Local Council reception points NGOs Self-referrals The project was phased out and closed at the end of 2019.	From MSF-Location D (max 5 cases/month) Babel partner organization (max. 3 cases/month). No self-referrals now	UNHCR Referrals from other international organizations Self-referrals	Referrals from organizations Extreme cases referred by Health Promoters team or other partners in Camp D No self-referrals now
OVERALL OBJECTIVE	Rehabilitation Defined as "Pilot experience" – learning process	Full Rehabilitation (in as much as possible due to psychosocial conditions)	Functional recovery	Functional recovery

THEORETICAL FRAMEWORK (as expressed in grey documentation, agreed in meetings FGD with Coordination and team)				
	Psychoanalytic and psychosocial background Multidisciplinary and Interdisciplinary: (a) Professionals attend simultaneously at most points + (b) Act always in direct collaboration No protocols. Therapy as "art". Open-ended counselling, according to therapist training and supervision (psychoanalytic). Ethno-psychiatry Radical respect for the patient. Everything agreed. Extensive inclusion criteria (95% acceptance at intake). No discharge criteria No protocols No family or group interventions No emergency care	Systemic, psychoanalytic and psychosocial background "High quality" of care upon high number attended. No protocols. Therapy as an "art." Radical respect for patient Holistic – multidisciplinary (a) Professionals attend simultaneously at different point + (b) Act always in direct collaboration Long-term therapeutic approach – no discharge criteria Tailor-made treatment No emergency care – all by appointment	Systemic and psychosocial Allegedly best possible care according to context. Trying a balance. Rigorous admission and discharge criteria Medical/emergency model with essential psychosocial or social support Multidisciplinary and interdisciplinary. (a) MDTi (b) Coordination of cases if needed Strict protocols fully manualized. Therapeutic groups (forthcoming) No family interventions Emergency care provided 24/7 Phone hotline	Systemic and psychosocial "High quality" of care upon high number attended Rigorous admission and discharge criteria Medical/emergency model with minimum psychosocial or social support Multidisciplinary and interdisciplinary (a) MDTi (b) Weekly coordination of all cases Strict protocols fully manualized. No therapeutic groups No family interventions Emergency care although far from the spot

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
LEVELS OF INTERVENTION	ALL is level 3	Level 3 / Level 2	ALL is level 2	All are level 3 / short version (or 2 adapted)
DATA	Different ad-hoc Excel databases by professional groups. “Socio-legal” database as the most comprehensive EPIDATA with basic information and many missing data Registers only by data. Not a cohort. No indicators of results – active resistance to use any	EPIDATA Registers by month /year Only available by the time, not by cohort – Essential No Indicators of results– only activity indicators	EPIDATA. Difficulties in M&E with the current data system. No activity and outcome indicators Most patients drop out 60% of those finishing treatments discharged with improvement. In overall between 9% and 24%	EPIDATA locally adapted Registers by data and cohort Activity and outcome indicators (GAF score) Ad-hoc registers of discharge and drop-out data

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
WORK ORGANIZATION	3 hours multidisciplinary intake in all cases + full individual interview by each professional area Intervention targets extremely low Long discharge period (2 years) 9 months waiting list Admission of new cases closed 1 year before the expected date of closure.	Intervention targets are low (see below by profession) Unacceptable waiting list (150 persons / 9 months). No emergencies accepted No discharge criteria Meantime in cohort: 2 yr 3 ½ days of actual clinical work	High activity Long waiting list Emergencies accepted and phone line available 24/7	Low to medium activity Short waiting list Unacceptable barriers to accessibility (see Report) Intake sessions are screening but therapeutic Emergencies accepted 40% transferred to the mainland without notice: challenge continuity of care

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
HUMAN RESOURCES	Only national staff Stable team of professionals with low turnover. Coordination (ex-pats) high turn-over. Poor visibility and control of work.	Higher turnover of field coordinators and medical referents (generates confusion with team and partners) The team is unbalanced due to too strict MDTi – too many MD, lack Psychologists - No psychiatrist Essential daily management of the clinic's staff and medical leadership Excessive number of weekly meetings	Big clinical team essential daily management and medical leadership	High turnover of coordinators and medical referents (confusion) No physiotherapist

MEDICAL	1-time and 1 part-time doctor. 4 new cases/month MD had no leading role, Medicalization was seen as a potentially risky practice in the rehabilitation Initial intake interviews MD takes the initial victim's account. No consultation for minor pathologies, nor treatment of pain unless this is associated with psychological therapy, Medical reports for legal cases are done strictly and by request	3 MDs, 1 nurse (+PMR, +MAM, +expatriates). Exceeds the usual. 7 consultations/working day. 6 new cases/month Initial intake interviews MD takes the initial victim's account. Primary health care for minor pathologies Consultations are equivalent to pain unit, coordinated with the physiotherapy unit. Accompaniment to the hospital of some people with a physical sequel Medical reports for legal cases only on demand by legal organizations	4 MD + Medical Case Manager + 1 Gynaecologist + MD Supervisor + MAM. 5 nurses. High number of patients with significant sequels and medical needs. Nurse conducts 3' triage After 2 wks waiting list, MD and psychologist brief intake (5-7') without providing care Primary health care for minor pathologies Consultations equivalent to a pain unit, coordinated with the physiotherapy unit. Max. # consultations/day: 6. (+ emergency + Intakes). No documentation of torture is presently done. Medical reports for legal cases are done only by request of third-party organizations.	2 MDs and 1 expat psychiatrist. Low number of patients have a significant physical sequel of torture. Initial/Intake interviews, jointly with a psychologist. Do not assume PHC or pain consultations. Medico-legal reports only by third party request - No proper medical documentation of torture is presently done. MD assumes Psychiatric Care under supervision. Assumes around 50% cases Psychiatrist. Expat and part of the medical team. Supervised drug administration in acute/severe cases

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
PSYCHOLOGY	4 clinical Psychologists reporting directly to the PMR Focus on life trajectory, including present and past traumas and all the forms of violence experienced. Long-term treatment	3 clinical Psychologists 1 MHAM Each therapist decides the type of therapeutic intervention. Therapist, team and patient, decide the duration of the intervention.	12 Psychologists + supervisor + MHAM 2 Psychiatrists + occasional expat Psychiatrist coach – only by referral from psychology (a) Very strict supervised protocols/intervention manual – Cognitive-behavioural focused on symptom alleviation. Working with trauma is generally avoided. (b) Very strict admission and discharge criteria. Maximum 6 months. Short-term therapies lasting a maximum of 6 months	- 4 Psychologists and the MHAM (a) Each therapist acts according to a brief intervention manual. (b) Very strict admission and discharge criteria.

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
PHYSIOTHERAPY	1 full and 1 part-time Physiotherapist working on rehabilitation Lack of formal training No intervention protocols for VoT. general pain management and functional recovery. No indicators.	2 professionals who work primarily in functional and clinical pain rehabilitation. Common framework of MSF Physiotherapy teams. Well-trained professionals working long time with MSF. Lacked formal training in working with SoT and specific intervention protocols. No restrictions of cases provided they are in the MDT program.	4 Physiotherapists + Supervisor. Functional and clinical rehabilitation and management of pain. M&E through pain scales. 60% of discharged patients showed improvement after an average of 10 sessions. Well trained professionals working long time with MSF. Important workload	No Physiotherapy

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
SOCIAL WORK CULTURAL MEDIATORS	2 social workers Often leading the team from initial intake ("holistic" approach) SW would get involved in most social needs of the patient even to the level of housing and job finding. Legal support was permanently provided by the partner organization ASGII	3 social workers + 1 supervisor (psychologist) Case managers – often person of reference in the team – leader role under a "psychosocial perspective". Not provide direct assistance. Practical support of cases through referral Bridge to external organizations	7 social workers + Supervisor (both for VoT and SV) Auxiliary role - Do not intervene either in triage or intake. Patients referred after admitted to the cohort of the MD or MH department Bridge to external organizations	2 Case Workers Legal information Referral to organizations for assistance in the basic needs of MSF patients Visual Analog Scale considered as an indicator

OTHER KEY ELEMENTS				
	Network: No networking nor coordination with public institutions in general and the Public Health System in particular. They were seen as "enemies" or "part of the problem", and thus the team rejected coordination. Partnership: - Reluctance to coordinate with other NGO's also assuming they did not have the standards of quality and would not understand MSF work. - Key actors distanced from MSF - Partnership with an NGO from 2016 to 2018. Advocacy: Any advocacy activity is seen as potentially re-traumatizing or dangerous. Active resistance.	Network: - See specific elements in Report. - Increase strategic litigation - Redefine referrals Partnership: Consider increasing communication at senior managerial levels and offer standardized direct channels of communication Consider a roundtable discussion with the partners to review past experience. Advocacy: - Understaffed - VoT Conference big success which created national momentum - Advocacy activities in North Country of Location B and D (in another city by UNHCR) - The team only does legal Report on demand. Cases in need of an IP are referred to another town. Legal documentation / Strategic litigation: - Not involved in cases of strategic litigation.	Network: - See specific elements in Report - Support capacity building of local and other NGOs - Low level of joint actions with other NGOs Advocacy: -Low profile due to fear of reprisals by authorities – case management advocacy - LGBTI community and unaccompanied minors identified as key populations for Advocacy Community work: Health promotion activities Outreach and awareness-raising activities Capacity building: Internal and external training activities.	Network: - Coordination iNGO – Local NGOs - Agreement with local hospital - Economic supports to stakeholders Advocacy: - MSF main advocacy actor and very high profile - Emergency logic following advocacy - Reports and Media - Lack work with local community. - No Humanitarian Affairs Officer – disruptions and gaps in advocacy - Very good initiative to offer legal support through a partner organization Legal documentation – Strategic litigation: - Few cases – need to reformulate and to be monitored via the partnership with RSA

	Location A	Location B	Location C	Location D
	Since 2015	Since 2014	Since 2012	Since 2015
	- No efforts to cooperate with ASGII, for legal support - Active resistance to collect data, seen as a distraction from clinical care - VoT not consulted on these topics. <u>Legal documentation / Strategic litigation:</u> - No activities - Medical certification for asylum only by request of Legal NGOs <u>Capacity building:</u> - No capacity building activities documented or observed	- Materials from Symposium June 2019 not yet published <u>Capacity building:</u> - Not carrying out substantial training activities as the model of care of MSF is impossible to apply in other contexts.		Experts-based in experience - It did not work <u>Community work</u> - Health promotion activities. - No engagement in community work with refugees due to security and lack of clear leadership

.

RECOMMENDATIONS				
	Location A	Location B	Location C	Location D
GENERAL - CLINICAL CARE	- VoT considered as "fragile" – confusion between control and empowerment. - "Do no harm" pushed to a limit that blocked (a) good and efficient clinical care (b) advocacy (c) operational research and learning from experience - Deep isolation, including failure to communicate lessons learned and expose project's strengths or limitations - Allegedly "high quality" treatment for a small group of patients, not supported by evidence. - Longer interventions do not necessarily mean better interventions	- Accept self-referrals - Any potential patient reaching MSF should always be briefly screened by a professional. Classify according to urgency and severity (see Report) - Stop MDTi as a regular procedure. Limit MDTi for severe and complex cases detected in initial screening - Optimize protocols – more realistic treatment goals – define discharge criteria. Use Location C and Location D models - Increase number of days/hours of consultation. Avoid excessive coordination and meetings. - Strong policy to prevent no-show and empty slots. - Guarantee daily presence of PMR or FCo in the clinic	- Lifesaving activities and very well-functioning emergency care - Consider merging triage and intake in a single interview - Make intake an initial PHC – MH basic diagnostic - therapeutic session. - Invest in the physical scape of intake session - Address complaints with reception area. Appoint a devoted person in charge of it and helping people on arrival. - Proper management of appointments cancelled by therapist. Avoid unnecessary displacement or attend if not avoided. - **70% are not considered in scope either in triage or intake.** Offer practical guide and first-aid support to those not admitted.	- Solve accessibility problems (see Report) – Ensure selection is done according to proactive screening and criteria of urgency and need (see Report). - Pro-active detection of unaccompanied minors - Maintain in-depth intake (MD& Psychologist) as a good practice - Increase number of patients seen by day and prevent no-show (see Report) – Decrease frequency and number of meetings - Cases in detention included in agenda as normal routines.

	- All cases were treated in the same way: as extremely severe cases. Interventions were not modulated. - Operations department seemed not to have had enough support from other interlocutors to enforce necessary changes - Non-replicable model	- Reduce doctors VS increase psychologists. - Increase social workers (see Report and below). - Incorporate Community Promoters to allow level 1 and level 2 interventions (see Report). - Discuss with partners (referral of cases, mutual support for strategic litigation and Advocacy). *Open self- and general referrals as soon as possible; this is an extreme measure and a last resort.	- Strongly consider the use of accommodation facilities for extremely vulnerable case and emergencies (therapeutic apartments) (see Report) - Guarantee daily presence of PMR in the clinic - Increase networking and context analysis -Cconsider childcare station inside the clinic (max. 10 children)	- Negotiate with authorities' previous notice of cases to be transferred to mainland. - Deepen coordination for continuity of care - Increase engagement with local and refugees' communities *Open self and general referrals as soon as possible, this is an extreme measure and a last resort.
GENERAL - OTHER ELEMENTS	- Do not allow such disconnection between coordination and team and coordination and HQ. - Plan multi-layered interventions that address all the different levels of complexity and better adjust needs and efforts. - Network and Advocacy must be integrated from day one.	<u>Advocacy:</u> - Fill human resources already planned dedicated for Advocacy (min. 2 persons). - Employ [national] staff in advocacy positions. - Increase bilateral meetings. - Include operational research, clinical data and testimony. - Expose psychosocial and living conditions Consider a more direct involvement as a part of teamwork in doing strategic litigation. Reinforce EBE team.	- Urgent implementation of a new system of data collection linking all activities and including M&E indicators. Develop new data collection tools. - Strongly recommend follow-up study of patient outcomes in a random sample of the 2019 cohort (see Report) - Develop indicators before implementing group activities. - Consider Advocacy through increasing discussions of the medical	- Increase Advocacy with local authorities and public healthcare facilities and stabilize - Employ national staff for advocacy related positions - Continue supporting local organizations and increase their capacity - Maintain and strengthen litigation efforts - Reconsider the provision of IP certificates according to IP Principles (see Report)

	- Systems of indicators must be in place from the beginning and not subject to internal discussion or development once the program has already started. - Consider sharing experience from the management of Location A project internally and share lessons learned	- Trainings about detection, Functional recovery and for referral of serious cases. - Appoint stable referent for the partnerships. - Nationalize MAM or PMR and assign responsibility of networking - Change data as related to cohorts instead of time	consequences of SGBV at private forum and among partners - Advocacy related to LGTBi, Unaccompanied minors and other vulnerated groups. - Implement systematic data collection for advocacy purposes - Discuss with the team ideas regarding new strategies for community work - Take stock of capacity building activities	- Provide certificates in [local language] and signed by [a national] MD. DO operational research: - Good data. - Unique position - Skilled data manager - Easy comparison with other spots - Consider setting up a system of short-term home hospitalization in Mytilene for extremely severe cases - Partner with organizations to further consider the creation of peer-support groups / EBE groups - According to evolution in terms of security and EU policies towards dismantling the camp and transferring people, consider level of involvement in strengthening refugees' community processes under a human rights perspectives.

MEDICAL	Not applicable – project has closed Note: the theoretical approach of "no medicalizations" and "no leadership to medicine" is a very interesting and legitimate debate but should not impact project activities and operational decisions	- Activity for MD is unacceptably low. Either increase the number of patients or decrease the number of doctors. The MAM or PMR can help too and must be national staff - Proper medico-legal documentation for advocacy purposes. - Medico-legal Report compliant with IP principles. - A training on the new version of the IP - Narration of events as part of MH intervention and not as core task in MD work. Share account of events. - Accompaniment to hospitals could be developed by other professionals (nurse, cultural mediator) - Reinforce the network with public hospitals and private specialists through [national] stable staff. - Incorporate indicators of the efficacy of interventions – GAF, as used in other VoT MSF projects, is a mandatory beginning	- Proper documentation of severe cases of torture – advocacy/support asylum. - Provide training for torture documentation including secondary test / pictures etc. -Train MD in emotional support in crisis, active listening. - Reconsider role of MD in intake process (see Report) - Consider recognising physiotherapists salary scale and level to ensure highly skilled professionals remain in the project	- Review the policy of medico-legal reports and certificates. Proper documentation of severe cases of torture – advocacy / support asylum. - Provide training for torture documentation - Carefully monitor the role of MDs as providers of psychiatric care both in terms of quality and burn-out. - Move psychiatrist data to MH - Reinforce network with public hospitals - Nationalise position of MAM or PMR - Provide supervised drug administration by MH nurse on spot in Camp D
PSYCHOL OGY/MH	Not applicable – project has closed	- Filtering to classify cases by their severity. Adjusting interventions to demand and needs.	-The CBT model lacks evidence . No indicators . No follow-up	- Increase workload (25%) - Increase the team by 2-3 psychologists. Consider doing

		- Protocol interventions for mild cases. - Allow unstructured interventions only in highly experienced therapists (minimum 5 years of full-time practice in psychotherapy)	. Patients (FGD) moderately supportive of the model (seen as "teaching" not as "therapy") - Before escalating needs further empirical support. - Consider implementation of therapeutic groups *in parallel* but not as the only treatment provided. - Consider groups based on the best available evidence (see specific annex on Group Therapy)	morning and afternoon work shifts sharing spaces. - Consider 2nd Psychiatrist / preferable local - Consider therapeutic groups as a priority -Ex-pats psychologists and MHAM national can also be an alternative set up to balance team dynamics
PHYSIOTHERAPY		The package of care is aimed to restore functionality in as much as possible. It does not include psychological or psychosocial components. The project should try to assess whether this is enough for people to have the quality of life needed. The program needs to evolve toward models that integrate the physiotherapy and psychological processes in joint work according to what is suggested in literature.	There are experiences of group work in pain management in the literature that seem to offer promising results. The Staff in Location C was open to explore it and this should be encouraged. There are different models that go from more psycho-education based to more experiential and somato-sensory therapy based.	
SOCIAL WORK	Not applicable – project has closed	- Reconsider psychologist as coordinator of SW - Consider providing basic assistance. Negotiate temporary food vouchers.	- Consider providing accommodation assistance.	- Maintain connection with the legal support and continue investing in the rights-based approach.

		- 25% patients (at least) are homeless and a big number is at immediate risk of eviction. Consider direct provision of shelter at least during stabilization phase of treatment (see Report). - Introduce quality indicators and right based approach as in Location D.		- Introduce quality indicators. VAS as a useful proposal that can be adopted in all locations. - Maintain right based approach. - Avoid turnover.

OVERALL CONSIDERATIONS (GENERAL)

1. Adopt a <u>layered response</u> that makes MHPSS interventions genuine MH and PSS interventions. Include Level 1 (Psychosocial and Community Work), Level 2 (Crisis Interventions + Focal interventions) and Level 3 (Specialized interventions) in all vertical VoT project. While keeping the significant effort on the clinical, reformulate the teams also to have a powerful highly qualified Psychosocial and Community Team. The PSS-Community team must have the same level of expertise (not size) than the MH-clinical team. Collaborate with other organizations, especially on Level 1.

2. Initiate proper documentation of torture, nowadays inexistent in any project. Medical and psychological documentation of torture should follow international standards as described in the Istanbul Protocol. Teams need to be trained (or re-trained) as an on-going process. Include photography and secondary tests if needed. Doing proper documentation is *independent* of elaborating, when necessary, medico-legal reports. There is a need to clarify better with the legal department when to issue medico-legal reports. It is crucial to keep in mind that they are a right of a torture survivor, especially when having to face asylum processes, and any documentation during the journey to a safe country can make a difference.

3. Introduce URGENTLY outcome indicators/indicators of efficacy.

(a) GAF is useful and already in place in Location D and soon in Location C. Drawbacks: 1. Based only on therapist impression. 2. Overall functioning.
→ Consider adding clinical, well-being and short psychosocial measures. → Use should be MANDATORY and not an election of the team

(b) Physiotherapy needs specific indicators related to VAS measures of pain and mobility

(c) The medical and social work areas need specific indicators. Fix objectives in the initial intake and assess the level of achievement at discharge through specific discharge/drop-out formularies

(d) Include a COMPULSORY collection of this drop-out and discharge data through particular formularies to be filled by each professional.

(e) Track follow up data after six months and one year after discharge. Consider two-year follow-up in a 25% subsample. Appoint staff to ensure this is done

(f) If groups are added to the portfolio, do a case-control study individual versus group therapy and include pre/post clinical, functional and psychosocial measures, and six months and one-year follow-up

(g) All indicators must be included in Quarterly reports. Ensure feedback is provided to the team after each Q Report

4. The scarce available data on efficacy suggests that the percentage of patients discharged by feeling better is low (15 to 30%). Where this can be additionally contrasted by an improvement in GAF score (only Location D), the percentage is even lower (around 10%). These shocking data are justifiable according to the high mobility of the population and extreme psychosocial conditions. However, it also demands closer monitoring of programs, including follow-up to detect other potential sources of results being not optimal, including clinical elements. We cannot conclude with available data on best options for clinical care (see Report)

5. Strengthen VoT Advocacy and approach it as an integral part of operational activities.
(a) Ensure proper recollection of data (see recommendation 3).
(b) Ensure proper documentation of torture (see recommendation 2).
(c) provide access to victims either through *Experts based on Experience* teams or through offering SoT the possibility.

6. Do not patronise survivors in any of the activities in which they are involved. Specifically, do not block access without consulting them.

7. Consider offering coordination and/or managerial positions to experienced national staff and promote combinations of expatriates and national staff working at the same level. Among others the high turnover of expatriates, especially in coordination positions, creates difficulties with often well-trained national staff with many years in the project and makes it difficult a consistent direction and stable coordination with partners.

8. Consider Group Therapy as an acceptable and efficient option in all spots, complementary to individual therapy.

OVERALL CONSIDERATIONS (SPECIFIC)				
	- Non-replicable model - Many challenges because of the initial project autonomy - Consider exposing the hard lessons from Location A and avoid repetition in other places	- Maintain program activity in the long term but revise focus of rehabilitation. - Consider the relevance of activities with VoTs needs in Location B and allow context influenced changes.	- Maintain project activities and possible increase capacity. - Invest in accommodation facilities. - Carry a short study to assess patients' status after discharge.	- Invest in Advocacy. - Work with the communities. - Revise operational priorities as it seems that even the highest quality of treatment cannot balance living conditions inCampD.

COMPARATIVE ANALYSIS:
Overall Recommendations for MSF's VoT Projects

GLOBAL BUDGET

Projects in the Global North, and in especially Location A, are comparatively much more expensive than projects in Global South (Location C). Location D lays in between due to logistic costs. Cost per patient is up to fifteen times higher in Location A compared to Location C;

- Location A: 15.217€
- Location D 8.695€
- Location B 4.455€
- Location C 1.130€

It is difficult to justify on any grounds the cost of a patient in Location A. It is unacceptable that the cost by patient is more than 15.000€/year. Even more so when no networking, advocacy or operational research activities and no proper documentation of torture is done. But even if the difference in cost by patient was not so high, there is no outcome data to prove that results in Location A are better than in Location C.

Location A and Location B are oriented to "Full Rehabilitation" (in as much as possible due to psychosocial conditions). Location D and Location C are oriented towards "Functional recovery". "Full rehabilitation" is not necessarily a synonym of more expensive. For instance, a patient in Location B costs half than in Location D.

THEORETICAL MODEL

The theoretical model[2] designed by the VoT Technical Referent considered four levels of intervention according to the needs of the patient, the context, the demands of the person and the time available for the intervention:

- **Level 1** - Assistance,
- **Level 2** - Treatment of some health consequences,
- **Level 3** - Functional recovery,
- **Level 4** - Rehabilitation.

Even though the idea of a tailored layered intervention is clear, it stays on paper. In each of the four locations, **the coordination has chosen one level of intervention** or another. In other words, although all the centres claim to provide personalized treatment according to the patient's needs, this is not what is actually done. Basically, what Coordination teams have done was to choose between two models, the so-called "functional recovery" model and the so-called "rehabilitation model".

It is difficult to understand why this is so and why the initial idea of having scaled-up interventions has not been put into practice. The result is that **a policy of "one-size-fits-all approach" is practiced everywhere** while on paper this is not the guidance for MSF programs.

[2] Gianfranco De Maio, (2019) Care for Victims of Torture and Ill-treatment guidance for implementation of activities. Brussels Operational Centre.

This means that in Location A, and to a large extent in Location B, both the less and the more severe cases are approached from a maximum level of intervention point of view. The system is blocked because it is impossible to build a structure of care in which everyone is treated at "Level 3" (highly specialized care) irrespective of the situation, demands and needs. This is justified by the term “holistic”. But keeping a “holistic” perspective cannot mean that everybody goes through all steps and elements of therapy, which is in practice what happens.

Similarly, this same policy means that in Location D or Location C, minimum intervention short-time schemes are applied to all cases. In some VoT these prêt-à-porter treatments may be enough, but in many others the intervention will remain on the surface of what the person actually needs. Again, **a policy of "one-size-fits-all approach"**, this time "Level 2" (primary care /counselling /focal intervention) is applied in all cases.

In the Terms of Reference of the consultancy we are asked which model is better. The question itself is however misleading because it forces to choose between a model of minimums and a model of maximums and decide, somehow, a tricky apparent choice between quantity and quality. The answer to this dilemma is simply *to really give everyone what the person needs*. No renounce to quality nor quantity but finding a balance.

In short, it is necessary to move towards systems that diagnose and profile cases much better and that offer a range of modular interventions that allow truly personalized treatments.

LEVEL 0 AND LEVEL 1 INTERVENTIONS

The distinction between “functional recovery” and “rehabilitation” only takes into account the clinical axis. The reference is “the clinic”, the building where patients come and the mindset are “symptoms”, as if torture were a disease to be treated.

A genuine phased intervention should also include (a) a level 0 provision of basic services (exceptionally) and (b) a level 1 of Community Intervention. This is lacking in all four projects.
Although MSF wants to do Mental Health and Psychosocial Support (MHPSS) work, the focus is almost exclusively on MH within Level 3 (“Rehabilitation”) or clinical care within Level 2 (“Functional recovery”).

Violence, among other impacts, produces fear, inhibits participation, breaks community support and breaks solidarity. These are all essential elements in any mental health and well-being program in the context of political violence. Those elements must be also priority targets of a true MHPSS intervention. **Although treating symptoms and working with trauma might alleviate a few, and is as necessary as community work, which will help many,** what to emphasise depends on:

- Volume and type of demand from population in addition to level of physical and mental sequels,
- Security and political context, including eventual mixture of victims and perpetrators
- Pre-conditions of the community (cohesion, solidarity, leadership, internal conflict, attitude of authorities etc).

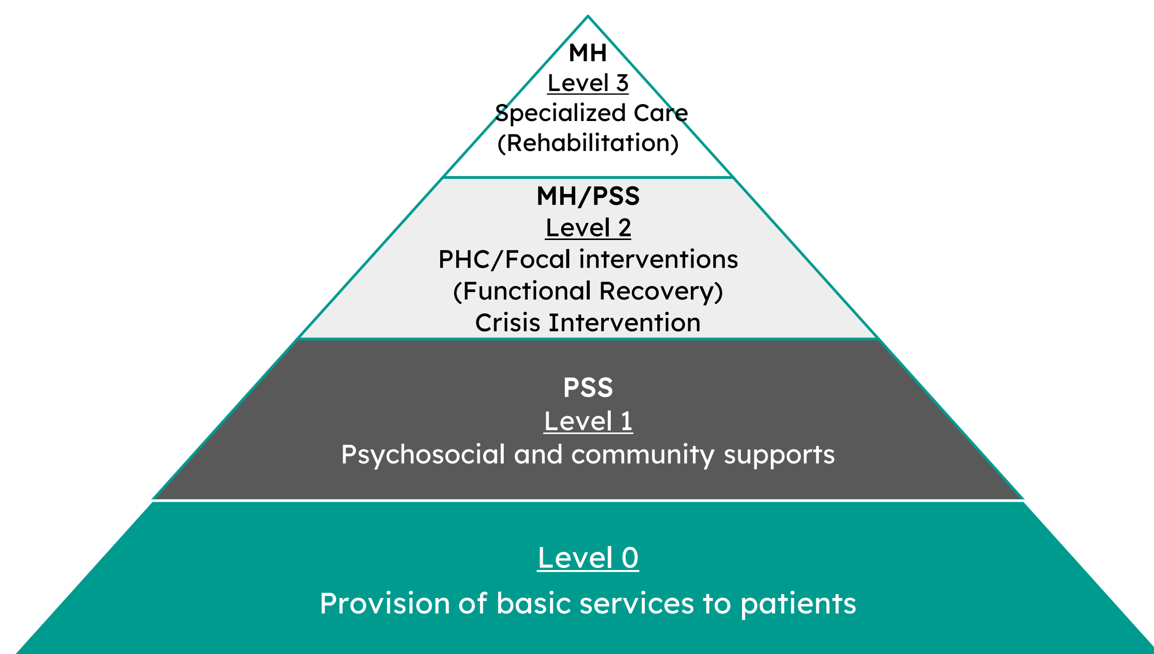

Figure 1. Layered intervention with VoT

While two of the four programs (Location D and Location C) have "community work", this is in fact related to "health promotion" activities, but not to true psychosocial and community work (table 9) .

Table 10. Psychosocial work with Victims of Torture. From "psychoeducation" and health promotion to true community work and community-supports.

"Psychoeducation"	Psychosocial and Community work	Healing Actions
Raising awareness Case detection/Filtering Positive messaging Lecture activities	Facilitating organization Facilitating exchanges Community cohesion Conflict resolution Supporting leadership, participation. Providing information necessary to take informed action. Dignity – Humanizing Aid NGO Coordination	Community activities with leaders or communities related to : Fear/Security Rumours Taking decisions Legal information Stress/Burn-out Sharing resilient coping mechanisms

Level 0 - Provision of basic services (food, shelter etc) is not usually within MSF actions. This is considered to be the responsibility of the State or the duty of NGOs with specific expertise with whom to coordinate or refer victims. But, exceptionally, in contexts where there is a huge need that directly affects MSF clients and there is no other option feasible and available, **very-well targeted Level 0 interventions are essential**.

Providing shelter or food assistance to patients with Severe MH problems within the initial stabilization phase in Location B, Location C or Location D as an equivalent to a day-care hospital, are good examples.

Level 1 means a team of trained professionals, usually local or mixed local and survivors with strong ex-pat technical support that assumes psychosocial and community-based interventions that impact on the physical health, mental health and emotional well-being of survivors. Examples are (see also Table 10):

- Case detection on the spot using snowball methodologies that create networks.
- Support in small organizational processes, creation, or maintenance of interfamily and within family support systems, helping to build community solidarity networks,
- Support to leaders that promote information and participation, especially in reference to, vulnerable groups (women, MENA, LGTBi).
- Reinforcement of traditional strategies and ways of coping and healing from culture
- Workshops on self-care, legal information, shelter, and other relevant topics in natural spaces (not in the office!).
- Community activities targeting rumours, fear, restoring sense of agency and control.
- Support for small or middle size lobby experiences based on participatory action research processes. Hosting and facilitating spaces.
- Coffee/meeting spaces where exchange between people is facilitated while providing basic emotional support, case detection and referral to MD, MH teams.

Among them could be, eventually and exceptionally, actions in Level 1 that target Level 0: Support for family or collective forms of accommodation or shelter, food, health care, education that encourage a sense of belonging and group cohesion.

For instance, when, as it happens in Location B, that 25% of the users are homeless and 25% in unstable and precarious hosting, MSF must consider taking action. Doing specialized trauma-therapy with homeless patients that will go back to the streets after a warm psychotherapy session seems irrational. Working with the homelessness of MSF patients can entail one or more of:

a) advocacy with the State and relevant NGOs
b) coordination with organizations providing assistance and referral
c) focusing mutual support and community activities to shared hosting spaces and better access to shelter (Level 1) or even
d) Providing direct economic or logistic support to the most severe cases, at least temporally (Level 0).

When, as is the case in Location C, 90% of MSF users lack any kind of legal information or legal support, including SGBV victims, fear of kidnapping, abuse to children etc, it might be more efficient to facilitate the creation of local women organizations with the presence of migrants to empower, provide agency and sense of control, ensure sustainability and provide long-term assistance.

FUNCTIONAL RECOVERY VERSUS REHABILITATION

The technical referents of the projects have developed two ad-hoc concepts that try to organize the expected outcomes of the program. The distinction deserves some comment.

According to WHO Rehabilitation is a set of interventions needed when a person is experiencing or is likely to experience **limitations in everyday functioning** due to a health condition, chronic diseases, or trauma. Rehabilitation is an essential component of health coverage along with **promotion, prevention, treatment, and palliation**.

Rehabilitation is not defined but in grey documentation from MSF provided for the evaluation, it is presented as synonymous with **attaining the maximum level of holistic recovery**.

Functional recovery is defined as practical here and now stabilization, provided time constraint and psychosocial conditions and includes, at the best attainable level:

1. Ability to
    a. control the symptoms,
    b. stop the Flashback and other symptoms linked to severe suffering,
    c. move out of dissociation and able to distinguish triggers from the actual event.
2. Fulfilling life role (e.g. parent, student), including sustaining Improvement in Quality of Life (engage in learning, concentrate, make friends etc).
3. Expanding Resources (developing more functional coping skills and resilience and improving stress management).

According to the WHO definition, the distinction in MSF documents between “rehabilitation” and “functional recovery” is an ad-hoc distinction, not supported conceptually. If we consider Rehabilitation to mean that the person regains the status quo prior to torture, this will never happen. If we consider rehabilitation that the person is fully integrated into society with a resolved legal situation, economic and work stability and a life project, this is a very difficult horizon to achieve. Unrealistic goals create frustration and can ultimately collapse the team.

The concept of rehabilitation depends on the circumstances and is not the same in a population on the move as in a stabilized population, in people with special vulnerabilities or severe mental disorders, in contexts where there are many resources available and in contexts where objectives and demand have to be adjusted.

The goal of rehabilitation is for the person to be autonomous, to have symptoms that are manageable and do not seriously interfere with his or her daily life, and to have a level of well-being that is acceptable for his or her living conditions. To give an example: sleep disorders appear in 80% of torture victims. In about 40% of survivors they will last 10 or more years and in some cases be permanent. Non-specific chronic pain presents with similar figures and evolution. It cannot be a therapeutic objective to *eliminate* one thing or the other. It must be to achieve that they are within tolerable values, that the person understands their origin and has options to manage them in an autonomous way.

So, Rehabilitation is in practice quite close to what the project defines as Functional Recovery.

Functional recovery, as it is done now, is in fact, quite far from what the program states. It is basically about point 1 of the three stated above. Point 2 and 3 are wishful thinking. Outcomes that will never be reached when the program has a time limit of treatment for six months.

Functional recovery could be the target of MSF programs if it truly tried to achieve the three outcomes stated in the documentation. So, there is a false dichotomy.

Do functional recovery, but true functional recovery or consider functional recovery just Outcome 1 (Ability to control symptoms) but then include Rehabilitation (Fulfilling live roles and expanding resources). In any cases, include evolve towards including all the range of possible outcomes in the 4 spots.

DOES MSF NEED PROTOCOLS FOR MH AND PSS INTERVENTIONS?

Among the advantages of programs based on strict Protocols (Location D, Location C) are that (a) they require much less experience from the therapist to be applied, (b) in case of change of therapist the impact on the patient is much lower, (c) the number of sessions is optimized to the needs and (d) it is possible to have more rigorous evaluation criteria of the efficacy of the intervention.
But there are also many disadvantages, the main one that all-fits-one interventions will necessarily lead to errors[3].

In a well-established centre for the care of victims of torture with experienced staff, it is rarely appropriate to resort to overly protocolized models. But in contexts – like most MSF programs – were professionals are often young and unexperienced and there is a high turnover of professionals, protocols ensure a basic standard of quality, sustainability, and adequate assessment of outcomes. It also decreases burn-out.

As always, a balance must be sought. Protocols are necessary although more experienced professionals should have the freedom to modify it as needed.

GROUP WORK

There was an experience of groupwork in Location D that was discontinued. The team in Location C is setting up the conditions for including groupwork with the support of the Center for Victims of Torture (CVT) from Minnesota (US) – Amman (Jordan) team. At present, the team develops psycho-educational groups that, under the opinion of both the coordination and the professionals involved, have a positive outcome (no indicators).

Group therapy is an excellent possibility to be added to individual therapy and the initiative provides an excellent opportunity for MSF to learn new approaches in contexts of high demand. However, it is important to keep in mind that:

- There is no assessment, up to now, of the efficacy of the psycho-education groups.
- The CVT's cognitive-behavioural group model lacks case-control studies to support its use in front of other models. It does not mean it is not effective. But it has not been tested against any other type of therapy and it is therefore an empirical treatment.

[3] For instance, there are patients who need to narrate what happened to them, while there are patients who do not require it, and forcing can be a useless pain. There are survivors who need to look for the origin of their symptoms in childhood experiences or in family attachment relationships, while there are survivors who present with very specific problems linked to the here and now and who do not need or want to work with elements from personality or from the past. There are VoT who require interventions that frame their political and social militancy as the source of torture, and there are VoT who need to understand why they were tortured when politics were irrelevant to them.

- Group models require careful selection of candidates one by one. They are aimed at people with a low to mild severity of symptoms, especially when the suffering is added to situations of social isolation and lack of community support (as most displaced populations in fact are).
- The introduction of group work should be done progressively. In initial stages it must be a complementary strategy to individual-centered models, and with a powerful research design that includes clinical and functional base indicators, and six and 12 months follow-up to establish their effectiveness. It would be an asset to develop a case-control study comparing group versus individual therapy. This would imply either randomizing patients to one treatment or the other or doing a crossover study in which patients go alternatively to one treatment and the other.

We have reviewed best available practices in group work with specific recommendations (see Annex 2).

EFFICACY OF EXISTING PROGRAMS

The 4 projects lack proper indicators. This is an important source of concern. And the scarce data available are almost impossible to analyse.

When analysing the few indicators available (Table 6, 7 and 1f) the results are worrying and suggest that the actual impact of the programs may be significantly less than expected.

- **Drop-out/Lost-to-follow-up rate is very high**, where data is available, ranging from 60% (Location C) to Location D (75% if included VoT transferred to mainland without prior notice).
- **Discharge with improvement**, where data is available is seemingly low, ranging from 13% in Location D to 16% in Location C
- According to GAF Scores in the only place available (Location D) even not all those discharged with improvement show actual improvement as measured by GAF.

There is an urgent need and should be a priority to put in place a shared system of M&E that includes:

- Qualitative assessment – surveys with VoT on expectancies and outcomes
- General monitoring tool
  - GAF score as administered by the clinician, knowing its important shortcomings (see Location D and Location C detailed Report)
  - Visual scales to be filled by the survivor
- Specific assessment for patients that are screened and part of the "cohort", including
  - A general clinical measure such as the Refugee Health Screener (RS-15).
  - A short measure of PTSD, like the PC-PTSD-5
  - A measure of functionality that includes areas of autonomy in daily life, around family and community if any, and evolution of the survivor's legal status. Consider an adaptation of the WHODA, as suggested by WHO.
  - Specific outcome measures for Physiotherapy and medical consultations.

We strongly recommend carrying out a follow-up study of patients of the 2019-cohort to better understand the results suggested by these data. We suggest to undertake telephone interviews with a random sample (n=120 to 200) of people discharged 6 months (n=60-100) and one year ago (N=60-100), carrying out both a clinical and functional analysis of their condition. Although there are no baseline measures, the information

will provide a rough estimate of how patients are coping after being discharged (see details in Report by sites). Such a study can offer extremely helpful insight with minimum investment compared to other type of study investments or surveys such as the satisfaction survey to be carried out in Location C.

This study should be considered a first step towards a second more in-depth study that includes a baseline measure with clinical and functional indicators and its application every three to five sessions, at discharge and in follow-ups at six and 12 months. In view of the preliminary data shown in this Report, any escalation of the protocols and methods used at this moment without
supporting data, assumes important risks.

DATA MANAGEMENT

The EpiData software is used across all four projects for data entry and documentation; in combination with other databases primarily managed in Excel forms and maintained by teams or supervisors who deem the in-place data mechanisms either inappropriate or insufficient to their needs. The EpiData system was set in the beginning of the VoT era corresponding to the ambitions of the time and has been. **MSF has no technical referent for epidemiologists** and the support to the VoT data managers has been offered by LuxOR VoT Focal Point (FP) on an ad-hoc basis. Despite the mutual willingness and the engagement to improve data quality, several decisions regarding indicators and data entry forms was taken without thoughtful consideration from both sides and without a strong ownership from the medical coordination.

Patients forms are completely different across projects, often submitted incompletely or not at all.

Criteria for admission are different in each project and none of them collect data on rejections rate and reasons for reject. In Location B, for instance, there was a high rejection rate done by people at the reception desk who did an “immediate” assessment and referral to other organizations (see Location B report). According to on-site observations, people were rejected on a weak basis and without proper filtering criteria. In Location D, the filter is done by partner organizations in Camp D. The person seeking attention had sometimes unsurmountable access barriers to get referred, related to clinical, privacy and confidentiality, documentation, economic and physical limitations (see Location D report). No register and analysis of these cases was kept.

Reasons for drop-out and discharge are an important source of knowledge. Only in Location D are there specific forms to collect this essential data and the therapist does follow-up phone calls to fill it. There are discharge forms in Location B, but not lost-to-follow-up data gathering.

Only **cohort analysis** allows for follow-up in terms of effectiveness and should be the way in which information is systematically collected and delivered in all projects

Data Management – Human Resources: only one among the four projects had a dedicated epidemiologist, the absence of an epidemiologist from the rest was justified based on the low number of patients and clinical activities. It is worth saying that only Location D and partially Location C were able to provide all data requested for the evaluation exercise. Investment in capacity building and thoughtful recruitment of data analysts is extremely relevant if operational research and M&E are a priority.

Ownership: medical coordination teams both at mission and project level shall have ownership and understanding of the data gathering and analysis needs.

TARGET POPULATION

DEFINITION OF TORTURE USED BY MSF

The definition in the UNCAT constitutes the instrument of international consensus and therefore as such, it must be the main working reference. However, in the contexts in which MSF works, there are (a) many victims of acts that fall within the definition of torture that are perpetrated by non-State actors or by actors whose link to the State is unclear, and (b) victims of very serious human rights violations that may not fall under the terms of the Convention. For example, prisoners in poor conditions, victims of sexual violence by private actors (i.e "honour killings"), kidnappings, or any form of collective punishment of human groups, etc.

The definition of the Convention has criteria that require a legal opinion (especially regarding intent and purpose criteria) and a forensic opinion (regarding severity of suffering) that make its use impractical as a criterion for deciding whether or not a victim should be in-scope by MSF.

Consequently, although the definition in the convention is the benchmark for any program, its strict application is unpractical. The World Medical Association's definition or the IFRC definition that includes non-state actors and is less strict in intention and purpose criteria gives more flexibility to interventions.

SURVIVORS OF TORTURE AS VULNERABLE POPULATION

Working with "victims of torture" means feeding and strengthening a "model of vulnerabilities" that addresses the scarce help available by international humanitarian aid by choosing to help just "the vulnerable". In some, "the vulnerable of the vulnerable from the vulnerable".

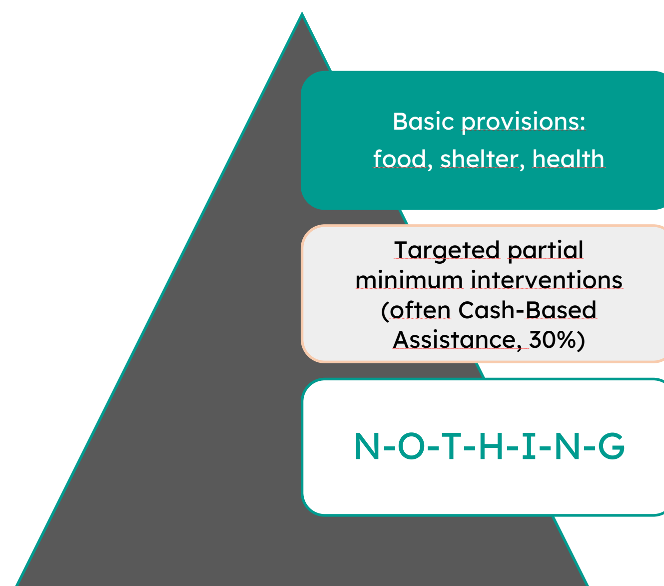

Figure 2. A Model of Vulnerabilities

While there is a whole community with basic needs often unattended, physical and mental suffering and social suffering, by working *only* with VoT as vulnerable population we risk to reinforce a cheap, charity-based approach rather than a rights-based approach that considers torture as a disease break the community by privileging some members.

It is essential not to lose the focus on the community and the structural causes of torture.

Accordingly to the problems of a narrow definition of torture and working with VoT as a vulnerable population, we recommend that in the formulation of projects, **the target population be "victims of torture and other serious human rights violations",** in order, in any case, to avoid being constrained by a narrow definition of the concept of torture.

PROACTIVE DETECTION

Patients are referred by partner organizations (Location A, Location B, Location D) or iNGOs (Location C). Self-referrals were accepted in all cases at the beginning, and later restricted due to high workload.

None of the projects does active detection of cases. Being proactive is essential in the work with torture survivors. The most affected persons are not those who seek for help.

Community work is essential.

WORK ORGANIZATION

MULTI-DISCIPLINARY VERSUS INTERDISCIPLINARY

Multi-disciplinarity is defined within MSF VoT projects as tasks done jointly by two or more professionals. It includes MDT intakes and multi-professional follow-ups (see project reports, especially Location A). It follows the models of the French ethno-psychiatric school.

Interdisciplinarity is defined within MSF VoT projects as independent work with close coordination of cases among professionals, at least on a weekly basis.

The manual of procedures of the Technical referent considered MDTi the most essential element in work organization, associated to an attitude of respect and do-no-harm policy towards patients. Although acknowledging this, the teams in Location A and Location B developed the concept to its most extreme version. All the work is organized around multi-professional teams that must work simultaneously and perfectly coordinated. As a consequence, the capacity of the team is seriously hindered due to coordination of multiple agendas and the number of patients actually seen by each professional is extremely low. The result is simply unsustainable. Furthermore, direct observation of MDTi in Location B did not really show any advantage over other methods. The survivor did not seem more engaged, nor was there a better result, and in all projects it takes a substantial part of the team's time.

Interdisciplinarity seems a good and efficient way to work, although in some very special circumstances, MDT can be a useful adjunctive tool.

All projects need a filtering system that can classify cases by severity and design interventions adjusted in number and professionals and characteristics proportionate to the demand and needs. Multidisciplinary intakes should be an exception and not the rule, and be reserved for severe patients, that will likely need long and complex interventions.

HUMAN RESOURCES

Composition of teams

The multi-disciplinary approach has significantly hampered the composition of the teams (Location A, Location B, Location D). These were not configured according to the needs of the patients, but rather based on achieving a similar number of professionals from the different disciplines. The demands of MH, both in terms of frequency and complexity, require a ratio of 4-5 professionals from the MH area (psychology, psychiatry) by 1 person from the medical area (MD, nurse). The suitability of incorporating physiotherapy must be assessed on a case-by-case basis. A psychosocial approach requires a strong social work area, even comparable to MH in very deprived contexts.

In addition to this, a **multidisciplinary team focused in psychosocial and community work** with high-level training (social or community psychologists, social educators, community managers). Work is thus organized into a clinical team and a community team, both at a full professional level.

Dynamics

In all four projects we observed negative team dynamics impacting quality and level of activities and in the two projects developed in Europe (Location A and Location B), we observed a worrying level of tension between the clinic's and the project and/or mission coordination team. At the same time, clinicians were deeply engaged and committed to the cause and many expressed feelings of pride for MSF being engaged with VoT care (see site-reports specially Location A and Location B regarding findings and recommendations for each project).

Advocacy is part of clinical work. In all four projects there was a lack of understanding of advocacy tasks and the need for collecting and analyzing indicators. Consider a training or workshop related to MSF communication and advocacy principles adapted to all team members. Collecting indicators is not a choice. It is simply a task.

Melding vs Dividing Change the imbalance; allow expatriates to be managed by nationals and simultaneously nationalize some managerial and/or coordination positions. Expatriates psychologists could respond to the project requirements contrary to social workers or medical doctors and positions in project medical coordination can be attributed to nationals increasing sustainability of strategies and advancing networking. Consider revising MSF HR policies in settings with qualified and highly educated national staff.

Workload

There are concerns that the number of patients seen by day is too low in some of the projects (table 4). All the teams have one day without patients, to be added to weekends. Additionally, of the remaining days, at least

half a day is devoted to meetings and in some projects the "all-together" approach forces participation of everyone to all meetings with no specific reason. In most projects, there is a maximum number of patients to be cited by day which is extremely conservative. As long as no-show appointments remain around a 30%, the resulting case load is low.

In some places there is a shared feeling to be constantly "on the edge" that does not coincide neither with what an external observer can see nor what the figures suggest.

In a context of enormous need and long waiting lists the average number of patients per working day must be reconsidered.

Physiotherapy

See the Report in each location and table 10 for a detailed analysis and recommendations for each discipline.

Physiotherapy requires a special analysis as **physiotherapy interventions have been questioned in work with torture survivors**. Although isolated studies with low sample size suggest positive outcomes, meta-analyses and reviews are not able to show that physiotherapy significantly contributes to the overall intervention. While some authors stress that physiotherapy should be part of a more global Body Awareness Therapy[4] or Narrative Sensorimotor Therapies[5], others suggest that this is also pending to show. Excessive psychologization of pain[6] might hinder the fact that there is actual physical pain in many patients secondary to physical torture that needs proper medical and traumatological assessment and treatment[7]. Nevertheless, no alternative intervention has probed efficacy[8]. The scarce available suggest that the best results are obtained through[9] medical and traumatological in-depth assessment of pain.

Therapies in which physical exercises and psychological therapy are integrated. Therapy and exercises are structured to work on mobility or pain while working with the reminds, emotions and physical consequences of the situations that caused them, including but not limited to the way they were experienced in the body, the relationship between pain and torture and the ways this can be expressed in moments of greater tension.

Under the MSF and Handicap International (HI) partnership agreement, the Project has well defined intake, discharge and referral criteria[10]. The scarce available data suggest that patients benefit from the intervention. The team in all locations are in contact with each other and are highly motivated to do research and innovate.

[4] Madsen, T. S., Carlsson, J., Nordbrandt, M., & Jensen, J. A. (2016). Refugee experiences of individual basic body awareness therapy and the level of transference into daily life. An interview study. Journal of Bodywork and Movement Therapies, 20(2), 243–251. https://doi.org/10.1016/j.jbmt.2015.10.007
[5] Gene-cos, N., Fisher, J., Ogden, P., Cantrel, A., Service, T. S., & Hospital, M. (2016). Sensorimotor Psychotherapy Group Therapy in the Treatment of Complex PTSD. Annals of Psychiatry and Mental Health, 4(6), 1–7.
[6] Amris, K., Jones, L. E., & Williams, A. C. de C. (2019). Pain from torture. PAIN Reports, 4(6), e794. https://doi.org/10.1097/PR9.0000000000000794
[7] Williams, A. C. de C., Peña, C. R., & Rice, A. S. C. (2010). Persistent pain in survivors of torture: a cohort study. Journal of Pain and Symptom Management, 40, 715–722. https://doi.org/10.1016/j.jpainsymman.2010.02.018.
[8] Baird, E., Williams, A. C. de C., Hearn, L., & Amris, K. (2017). Interventions for treating persistent pain in survivors of torture. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.CD012051.pub
[9] DIGNITY. (2013). Field Manual on Rehabilitation. Version 2.2. Copenhague. Available in www.dignity.dk
[10] Roriz, M. (2016). Physical Therapy Rehabilitaton Criteria - MSF - Location C. Internal Project document.

ADVOCACY

MSF is not an "anti-torture" organization but can play a role against normalization of torture and expose medical consequences and survivors needs.

In Country of Location B and D, the context is ever time more complex with new laws by the national government violating basic rights and gross human right violations in all locations. MSF has many success stories related to case management and overall advocacy, but two main challenges have been identified in all projects a. The reluctance of clinicians to support advocacy activities and b. the reactive character and the emergency approach to Advocacy.

MSF raised awareness about prevalence of torture and victims needs in Country of Location B and D with the survivors-centric conference *Pathways to Recovery for Torture Victims in Flight* organized in Location B in June 2019. Proceedings are pending to be published. An especially relevant example of good practice in the same period, is that MSF submitted a shadow report to the UNCAT session on Country of Location B and D. Following these events, UNHCR initiated a protection working group for people with specific needs including VoT.

There is a detailed analysis of advocacy challenges and recommendations in Table 10 (see detailed description in each project report). Important to stress in overall:

- The **advocacy areas are understaffed in all locations**. Furthermore, it is strongly recommended to employ national staff in advocacy positions to sustainably strengthen both analysis and representation especially towards public institutions. Consider national staff with legal background.
- All projects share an overall weakness of adequate and appropriate data oriented for advocacy.
- Strongly recommended to **liaise operational research with advocacy** for the identification of research topics. Especially relevant is to conduct an assessment of reception centers in islands as torturing environments as compared to shelters in mainland.

THE SURVIVORS SQUARE GROUP: AN ADVOCACY-TRAINING GROUP

Survivor's participation is key "not only in shaping the rehabilitation and other services they receive but also in advocating for positive change in the wider world"[11].The Survivors Square group (also called EBE as of Experts by Experience) has been initiated in Location B to promote a survivor-centered approach in the VoT project and since its early days has raised great interest and gained recognition within the organization and partly outside. Attempts to replicate the experience in Location D and Location C have been unsuccessful.

A specific analysis would help on better shaping the conditions for a successful implementation of EBE experiences.

EBE is a relevant experience in terms not only of Advocacy but also and foremost to provide input and an active role in shaping decisions in MSF organization and work. This does not need a formal EBE group, but to have participant-action methodologies in mind.

11 Shameem Sadiq-Tang, "Building Survivor Activism: An Organisational View," Torture Journal 28, no. 2 (2018): 140–49, https://doi.org/10.7146/torture.v28i2.106853.

SUPERVISION: CLINICAL OR MANAGERIAL?

In all levels, MSF started the VoT care project without prior institutional experience. Most field teams and the VoT technical referent established their practice on the go, through trainings and technical advices from partner organizations and consultants.

The supervision offered or not to clinicians seems to have played a crucial in the formation of the practice as well as the general management of the clinics. In most cases, clinical supervision was mixed with emotional support to the teams and the selection of the external professionals to supervise teams has been quite problematic.

Medical coordinators in the frame of their responsibilities, they are called to also select and validate the technical experts providing clinical guidance to the team. Very often, supervisors are private clinicians residing in the projects area offering their services to MSF as external consultants on a regular basis. In none of the projects visited, **the externally identified supervisors had any technical experience in VoT care**; in one case the clinical supervisor has been the therapist of a team member. For Location B project, supervision was offered together with the partner organization Babel and by a well- known practitioner, Renos Papadopoulos but team recently decided to stop collaboration and identify an external. Internal clinical supervision is offered by the Mental Health Activity Manager, this is the case in Location D.

We strongly recommend:

1. That external experts offering clinical supervision to the teams on a regular basis (once per month) to be selected and validated at HQ level by the Mental Health Referent and VoT Referent. Selection of such experts is an impossible task for medical coordinators and it is highly unlikely that in every location you can identify quality practitioners; distance supervision seems the most appropriate solution and can have added value in the quality of care offered.
2. That Mental Health Referent and VoT Referent develops objectives for technical supervision
3. To avoid mixing emotional support with clinical supervision.
4. Clinical supervision for psychologists shall not be offered to the whole team in the name of the multidisciplinary approach.

EMOTIONAL SUPPORT

The MSF Staff Health Unit (SHU) has identified missions in the Europe migration context as high risk for staff distress due to:

(a) High exposure to extreme violence & trauma – therefore high risk of **vicarious traumatization,**

(b) Working in migration context in Europe; feelings of guilt & powerlessness within the staff,

(c) Reasons related to management, decision-making, operational impact and sense of meaning.

SHU offers services only to expatriates.

All projects visited had in place a mental health support policy for the national staff which is worth highlighting as the number of expatriates is limited.

VoT projects exposed a variety of distress during the evaluation exercise and especially as the projects developed "as something special and unique", there was a lack of clear guidance in some teams, people experienced compassion fatigue, an emergency approach for long-term projects and due to the team dynamics between ex-pats and locals (see Human Resources).

Identification with the VoT and the political notion of torture rehabilitation was evident in Location A and Location B; where resistance to criteria and strict protocols can be interpreted as a resistance from clinicians to place limits and become complicit with EU system. For some, it was **an act of solidarity and political stance to always be there for their patients and care for them with no limits**.

Operations have taken lots of side steps to improve working and living conditions for their staff; offer trainings, allow breaks, medical leaves and have also established one day without consultations in all VoT projects.

None of the teams indicated burnout because of excessive work. We suggest challenging the "day off" idea as counterproductive for projects with low activity and revise the need periodically (see Workload). Except for Location C, VoT projects seems to have considerable amount of time dedicated to discussions and this creates a vicious circle of more meetings, more debate and a constant need for everyone to be aware of everyone's else activities and cases. The weekly agenda of projects and the amount of supervisions and other meetings is indicative of the situation.

Besides, in some of the teams there is a lack of technical supervision and training.

Failure to produce guidelines: Despite the overwhelming amount of standard operational procedures (SOPs), protocols and guidelines developed by field teams, no document has been officially validated by the technical referents in the medical department; leaving teams with no reference materials. Teams in many cases have produced high quality documents which remain in their personal computers, and it is remarkable the absence of an MSF manual or protocol at produced and validated by HQ. Transferability to horizontal projects.

TRANSVERSALIZATION
Transferability to Other Projects

MSF Projects in Bangladesh, Nigeria and the Democratic Republic of Congo (DRC) have been examined as paradigms.

The main problems for the transferability of vertical projects with torture victims such as those examined in this consultancy to other multi-sectorial projects are related to the following considerations:

1. **The definition of torture victims used**. In Bangladesh, many cases of torture happen in Non-Custodial Settings or in situations of collective punishment with an ethnic background that fit into various criminal types of International Humanitarian Law. In the case of Nigeria, there are reports of torture by state and non-state actors and in many situations human rights violations in the framework of an open conflict in which the criteria of the Geneva Convention would operate. In the DRC there are quite often cases where the classification of the crime will depend on age (actions in the framework of forced recruitment) or on the attribution of responsibility (in cases of SGBV whether considered a common crime among private actors or sexual torture). It would not be appropriate to build programs with a scope focused only on a strict definition of torture, even if this was the WMA or the IFRC definitions. The scope should be *victims of serious human rights violations, including torture*, and the selection made by *criteria of urgency and severity* of a clinical nature.
2. **Security**. In contexts of open conflict, it is necessary to assess the extent to which the security of people participating in the program is at risk. For example, being seen entering and exiting a torture victim care facility may signal some people as potential political targets. This assessment should be made on a country-by-country basis. Security concerns may also raise for the MSF staff per se and the overall presence of the organization in the country. In any case a risk assessment should proceed.
3. **Type of population**. In the case of urban refugees, the work of detection and community articulation is much more complicated. It would require doubling the staff of the psychosocial and community team. In refugee camps or where the population is clustered, the team may be smaller and more reinforced on the clinical side.
4. **Expected prevalence**. It would be advisable to carry out a prior survey among the refugee population or among those who attend primary care facilities. It is recommended to articulate a program on those contexts where *more than 10% of the total persons interviewed (or 15% of women / 15% of men)* describe personal situations of human rights violations, including torture.
5. **Length of stay**, which should be at least six months, and desirable longer (see proposal below).
6. Although MSF has accumulated extraordinary experience and has a level of knowledge that is currently far superior to that of other organizations, it has a model that never been tested with powerful indicators that allow the model to be scaled up with some evidence of its usefulness.

MSF lacks a properly validated intervention model. It is necessary to build a manual with intervention guidelines that includes a proper layered intervention. The four models assessed in this Report have advantages and disadvantages. Probably Location C and Location D are the experiences closer to what would be a desirable model. In both cases, there is a need to fully develop Level 1 and Level 3, according to what it has been suggested in this Report.

PROPOSAL

With the knowledge accumulated, we suggest that a starting point could be having 3 packages of care of increasing complexity. The staff is calculated as a ratio per 200 expected cases/year. Readjust accordingly to the dimensions of the intervention and expected cases/year.

Table 11. Proposal of three packages of care based on complexity

Package 1 Minimum Intervention	Package 2 Basic Intervention	Package 3 Comprehensive Intervention
200 expected cases/year per Team Unit	300 expected cases/year per Team Unit	400 expected cases/year per Team Unit
Expected less than 1 year or Complementary to other programs	Expected 1–3 years or designed as a program in itself	Expected >3 years or designed as one of the leading programs in place
Community Work including detection + Testimonial Therapy (4 to 6 sessions) +/- Psychiatric care	Package 1 + Short Term Therapy – Level 2 interventions + Group Therapy	Package 2 + Advocacy and Legal Documentation + Long-Term Therapy for selected cases + Physiotherapy
TEAM UNITS		
2 Psychologist + 2 PSS community workers 1 Psychiatrist, part-time	1 MD + 1 trained Community Psychologist with ≥3yrs experience + 2 Community workers + 2 Psychologists with ≥3yrs clinical experience + 1 Psychiatrist, part-time	2 MD + 1 trained Community 1 Psychologist with ≥3yrs experience + 2 Community MH workers + 4 Psychologists with ≥3yrs clinical experience + 1 psychiatrist 1 physiotherapist * To be considered: 1 Gynaecologist or experienced midwife, part-time

Stockholm Evaluation Unit

http://evaluation.msf.org/

Médecins Sans Frontières

Independently written by

Pau Pérez-Sales MD. PhD. Psychiatrist, and Christina Psarra MSc (February 2020)