Stockholm Evaluation Unit

MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER

EVALUATION OF MSF-OCB TORTURE REHABILITATION PROJECTS

Lessons Learned from three projects

Anonymized version

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

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

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

ACRONYMS

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

EXECUTIVE SUMMARY

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

1.1 KEY FINDINGS FROM PROJECT A

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

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

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

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

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

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

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

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

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

1.2 KEY FINDINGS FROM PROJECT B

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

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

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

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

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

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

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

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

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

1.3 KEY FINDINGS FROM PROJECT C

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

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

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

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

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

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

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

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

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

1.4 SWOT ANALYSIS OF THE VOT INITIATIVE

Strengths

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

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

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

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

Weaknesses

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

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

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

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

Opportunities

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

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

Threats

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

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

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

1.5 RECOMMENDATIONS

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

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

1.6 ROADMAP OF THE REPORT

The next section describes the project context, namely the situation of torture among people crossing the Mediterranean, and presents a timeline of the origins and evolution of the VoT program. Section 3 reviews the purpose and methods of the evaluation. Section 4 summarizes findings and recommendations from the three field visits to project A, B and C, previously shared in oral and written debriefings. Section 5 offers a numeric scorecard of the three clinics and the overall VoT program against OECD-DAC criteria, as well as key takeaways related to the projects' relevance, effectiveness, efficiency, impact, and sustainability. Section 6 extrapolates cross-cutting findings about the VoT thematic initiative, presented in the form of a SWOT analysis. Section 7 closes the report with some conclusions and lessons learned to keep in mind when designing future VoT interventions. Finally, Section 8 offers five strategic recommendations in a one-page brief. Annex I presents a data profile of the three clinics with graphs and key interpretations, including 'as-is' data on patient demographics, the nature of torture suffered, identified needs, clinic workload, and patient outcomes. Annex II is a list of interviewees. Annex III presents the terms of reference for this evaluation.

PROJECT BACKGROUND

2.1. DESCRIPTION OF THE PROJECT

The MSF torture rehabilitation clinics in countries A, B and C operate with a common general design, while also respecting the differences of the operational environments. They feature diverse team composition, comprehensive case management, a patient-centered approach, and networking with other actors. Medical doctors, physiotherapists, psychologists, psychiatrists, social workers, and cultural mediators work together to treat victims of torture and ill-treatment.[1] Cases come to the teams' attention through external referral networks or spontaneous self-referral. The clinics in country B and C run in partnership with local associations – namely, the NGO 1 and 2 in project B, and NGO 3 and 4 in country C. Clinic A operates in coordination with various collaborating actors. Collectively, these projects have treated 1900 refugees, asylum-seekers, and migrants who suffered torture or ill-treatment in their home countries or on their journey toward Europe; in 2015 alone, the clinics took in charge more than 850 new cases. The aim of these clinics is to restore survivors' mental and physical health – as well as their dignity.

In the different operating contexts, there have been specific challenges related to the launch and implementation of torture rehabilitation clinics, and these have been compounded by the lack of MSF's experience in this area. However, MSF solicited the technical assistance of different external actors, including the International Rehabilitation Council for Torture Victims (IRCT), Handicap International, Freedom From Torture, the Human Rights Foundation of Turkey, and the Center for Trauma, Asylum, and Refugees at the University of Essex. Overall, MSF is applying lessons from the opening of the first center to the latter two centers.

Sufficient time has now elapsed to evaluate MSF's trio of clinics in their own right and to make recommendations for their improvement, as well as to identify cross-cutting lessons applicable to future efforts in similar contexts. This is especially important as the clinics in countries A, B and C represent the first experiences for MSF in the specialized rehabilitation of victims of torture. It is assumed that MSF has developed some level of expertise in working with torture victims over the years; however, MSF has yet to collect or compile these experiences in a meaningful way, either for internal capacity-building or external awareness-raising.

2.2. PROJECT TIMELINE: ORIGINS AND EVOLUTION OF THE PROJECT

2011: Encounters with torture in Libya. MSF-OCB's interest in torture crystallizes during the so-called 'Arab Spring' and especially the humanitarian response to the Libyan civil war in 2011. MSF has been treating detainees in two detention centers in Misrata, but withdraws in January 2012, after raising the alarm about more than 100 patients who are suffering torture at the hands of the revolutionaries who overthrew Moammar Qaddafi. It becomes clear that MSF needs a pool of expertise and acquired experience to react and position itself when it encounters systemic torture in the course of its interventions worldwide.

2012: Building institutional buy-in. In December 2011, a point-person is charged within the Advocacy and Analysis Unit to visit the headquarters of international torture rehabilitation organizations in Brussels, Paris, Geneva, and Copenhagen, and to chart the course forward. Then, within weeks of pulling out of Misrata, a small team of internal and external experts (both medical and non-medical) is assembled to conduct fact-finding missions to rehabilitation centres in four countries one being in country A, to gauge if there is added value for MSF to enter this field. Following these visits, MSF organizes an internal workshop on the subject in Istanbul and invites the input of experts from the region. At the workshop, a decision is taken to assess Lybia for a special project; and so an exploratory mission is then made to Libya. A Torture Committee is also constituted as a platform for exchange. All these activities elevate the issue onto MSF's agenda. Ultimately, MSF chooses to develop capabilities in torture rehabilitation through a learning-by-doing approach. Two pilot projects are proposed, one in Libya and one in country A.

2013: A slow start in country A. There is some foot-dragging at HQ with regards to the Libya project, and in the meantime, relationships from MSF's prior work in the country fizzle out. However, MSF already operates a mental health and sexual violence clinic for migrants in country A. Given the evident needs of this cohort, the mission takes up the challenge of adding torture rehabilitation services to its scope. By mid-year, the team in project A begins referring all tortured mental

[1] The internationally agreed definition of torture as per the 1984 UN Convention Against Torture and the International Committee of the Red Cross is the infliction of severe pain or suffering, whether mental or physical, by a person of authority for such purposes as obtaining information or a confession, punishment, intimidation, or discrimination. Ill-treatment is generally any cruel, degrading, or inhuman act that induces severe mental or physical suffering, causes humiliation, or constitutes a serious outrage upon individual dignity.

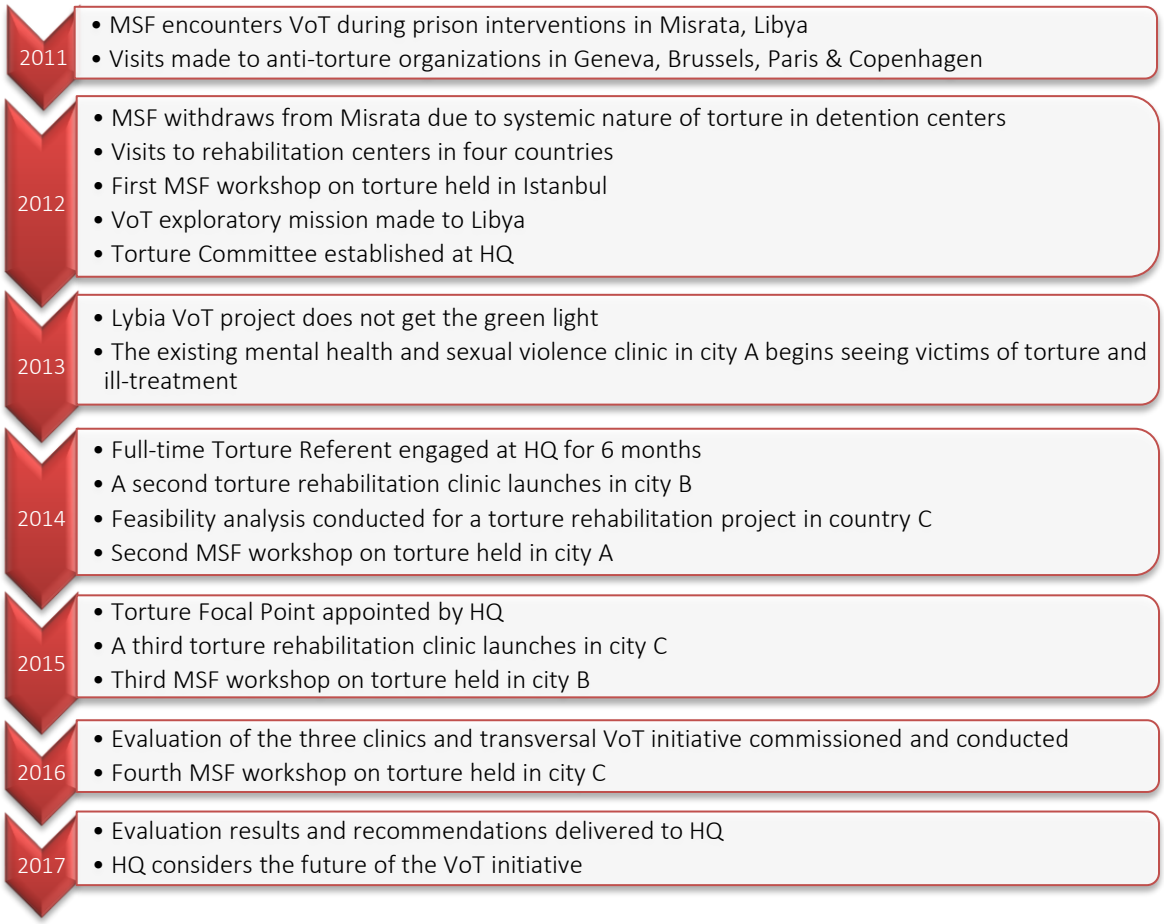
health patients to the clinic that is treating sexual violence survivors. In November, the Torture Committee develops specific terms of reference to support the country A mission, and in January 2014, the medical focal point for torture travels to project A to assist the team in developing a medical package for torture survivors.

2014: Launch of a second clinic in city B; HQ steps on the gas. A non-medical Torture Referent is recruited for a 6-month mission in early 2014, with view to refining the non-medical aspects of the rehabilitation package, including medico-legal documentation of torture. In May, this Referent, together with the Migration Referent in country B, identifies an opportunity to reinforce an existing torture rehabilitation project for migrants, whereby MSF would offer the medical component of care. The project is quickly devised and approved, and the project B clinic opens its doors in October. Around the same time, the mission in country C conducts a feasibility analysis for opening its own torture rehabilitation clinic, based on needs it has identified among the refugee population in reception centers and landing sites. Meanwhile, an MSF workshop on torture treatment and documentation is held in city A in June, which helps to consolidate the service offering there. Over the course of 2014 – the first full year of offering medical services to victims of torture – the project A clinic treats 536 new cases of torture.

2015: Launch of a third clinic in city C. LuxOR visits the clinic A end of 2014, and in the beginning of 2015 devises an EpiData-based platform for tracking patient outcomes and service-level performance. In March, a new Torture Focal Point is created at coordination-level, and subsequently there is a switch from torture to ill-treatment as the intervention target – although both categories of violence were being explored and treated from 2013 onward. Meanwhile, the mission in country C identifies the host city for its clinic. The project commences in June, and after identifying and renovating a site, serves its first patients in October. A workshop is held in November in city B, where representatives from the three clinics exchange their experiences and address common challenges. Over the course of the year, 850 new cases of torture are taken into charge across the three clinics. By year's end, the plan is in action: by implementing vertical projects in torture rehabilitation, MSF will cultivate a body of trained professionals and generate in-house expertise. This, in turn, could be capitalized and shared in future, and guide how MSF missions around the world provide medical care to victims of torture.

2016-2017: MSF takes stock. The three clinics now operate against the backdrop of MSF's multi-pronged humanitarian response to the Mediterranean mixed migration crisis, as well as the unique country context of each field mission. In November, the fourth annual workshop on the thematic of torture is held, this time in city C, including HQ representatives and external actors. MSF looks to consolidate the service and take stock of lessons learned, and commissions the present evaluation of the trio of clinics.

Figure 1: Summary of the VoT Initiative Timeline



2.3. PROJECT CONTEXT: SITUATION OF TORTURE AMONG PEOPLE CROSSING THE MEDITERRANEAN

While North Africa has long stood at the apex of transcontinental migration, the so-called 'Arab Spring' gave rise to a breadth of new drivers of migration affecting migrants, smugglers, and states. Data from the EU agency Frontex show unprecedented numbers of undocumented refugees and migrants entering the EU irregularly. In 2015, more than 1 million people arrived to Europe by boat, a five-fold leap from the year prior. Hundreds of thousands of migrants are stranded in countries bordering the Mediterranean, often in deplorable conditions. Millions more are biding their time in North African countries and country D, working to save money, planning their journey to Europe, evading the police, or languishing in migrant detention centers. The wave of migration is characterized by refugees and asylum-seekers who are fleeing persecution for their political beliefs, religion, race, gender, or sexual identity; displaced persons whose homes and communities were ravaged in war; and migrants who are escaping debilitating poverty to provide for their families. Migrants come from every corner of the globe – and every migrant's path is different – but suffice it to say that the majority of migrants either come from sub-Saharan Africa, including the poorest countries of the Sahel; or from Western Asia, including war-torn places like Syria, Iraq, and Afghanistan. The vast majority of migrants are young men, but families with children, as well as unaccompanied minors, are common, as are trafficked women and girls.

The Mediterranean mixed migration-flow has set up severe situations in 'transit countries' in southern Europe and North Africa, places that migrants may not consider their final destination (which is often northern Europe), but where they settle temporarily (which in many cases, can mean their whole lives). These transit countries themselves suffer from fractured governance and unpredictable political tremors. In this environment, sophisticated criminal networks of human smugglers have arisen to do a remarkably efficient job of moving people across borders – but in the most unsafe and inhumane of ways.

There are widespread reports of detention and torture of migrants in transit countries from North Africa and country D, and more recently, even inside country C and country B. In Lybia – where MSF's institutional interest in torture emerged, and whence most refugees in country C come – migrants from Sudan, Chad, Niger, Eritrea, and Somalia, among other countries, are often rounded up in major cities or at border crossings, and then held in informal detention facilities. These facilities are often makeshift camps or farmhouses – or in the most shocking case, the Tripoli Zoo – and

are mostly run by armed groups outside of state control[2]. There is a curious relationship between these armed groups and human smuggling networks. Detainees are held indefinitely, in conditions that fail international standards, with overcrowded sleeping quarters, dismal hygiene, a high incidence of infectious disease, and insufficient food or water. Some detainees are subjected to forced labor under slavery-like conditions, with the promise of a place on a boat to Europe[3]. Migrant detainees are subjected – either by their smugglers or their captors – to beating with rifles, metal bars, and belts; burning by electric shocks and cigarettes; mock execution; being hung upside-down for lengthy periods; rape and sexual assault; deprivation of sleep, water, and food; and solitary confinement. There have been multiple cases of death in custody, including victims who were tortured to death within the first 72 hours after arrest, including by heavy blows to the head with the butt of a rifle, electric shocks, and gunshot wounds, followed by denial of medical attention[4].

These victims of torture generally suffer physical and psychological injuries. The physical consequences can include severe musculoskeletal pain, neurological impairment, fractures, dermatological damage and scarring, headaches, low vision and blindness, hearing loss, and gynecological and sexual problems, among other symptoms and conditions. The most common psychological problems include symptoms of post-traumatic stress and depression, like flashbacks, insomnia, hyper-arousal, atypical behavior, memory loss, somatic complaints, psychosis, and substance abuse. However, it is critical to recognize that reactions to torture and trauma vary widely from person to person, given their unique cultural, social, and political experiences and interpretations. Accordingly, migrants' and refugees' willingness or ability to access or adhere to care may be compromised, and cultural mediation and alternative vocabularies may be necessary. What is clear is that torture often causes long-lasting physical and psychological damage, and the international standard of care is holistic rehabilitation in which medical, psychological, physical, social, and legal remedies are sought in harmony.

The science of torture rehabilitation and trauma recovery is informed by certain legal and medical protocols, like the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, also known as the Istanbul Protocol. Access to torture rehabilitation services is recognized as a human right by all signatories of the 1984 UN Convention Against Torture. States parties are obliged – though sometimes reluctantly – to provide these services. Accordingly, advocacy efforts are often included as part of torture rehabilitation projects.

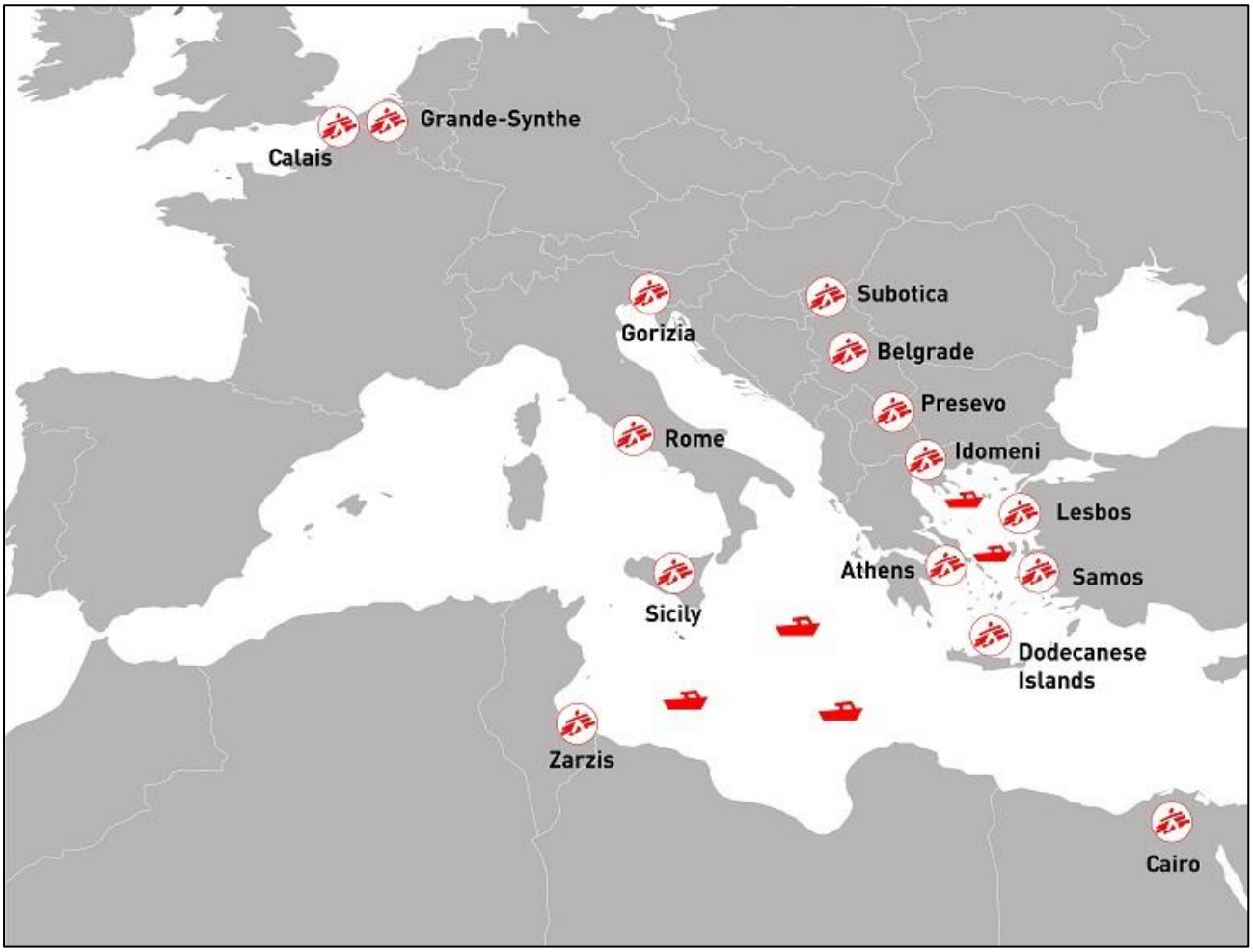
In the face of this vast need, MSF has begun offering specialized torture rehabilitation services, first in city A, then city B, now city C. These services are conceived within MSF's multi-pronged humanitarian response to the Mediterranean mixed migration crisis (see Figure 2). The closure of the Balkan route and the EU-Country E deal have forced changes on the management of the ongoing humanitarian crisis in Europe. MSF provides primary and mental health care, shelter, and NFI assistance to migrants, asylum-seekers, and refugees at reception centers and camps different european countries. MSF also operates search and rescue vessels in the Mediterranean Sea, where they have rescued or accompanied more than 41,000 boat people in distress.

[2] 'Migrants being held in cages at Tripoli zoo by Libyan armed groups', Telegraph (2015). Available at: http://www.telegraph.co.uk/news/worldnews/africaandindianocean/libya/11578241/Migrants-being-held-in-cages-at-Tripoli-zoo-by-Libyan-armed-groups.html

[3] Stakeholder submission to the UN Human Rights Council on the occasion of Libya's Universal Periodic Review (2015), World Organization Against Torture (OMCT). Available at: http://www.refworld.org/pdfid/553a036b4.pdf

[4] Ibid.

Figure 2: Map of MSF EU Migration Activities, June 2016



EVALUATION METHODS & LIMITATIONS

3.1 PURPOSE OF THE EVALUATION

Coming five years after MSF-OCB's first concrete actions on torture and three years since the launch of the torture rehabilitation projects, this evaluation is intended to take stock and plan for the future. There are two discrete but interrelated objectives, as follows:

- To evaluate the torture rehabilitation clinics in project A, B, and C against OECD-DAC Criteria; assess the relevance, effectiveness, efficiency, impact, and sustainability of existing activities, outputs, and processes.
- To capture lessons learned to date: build MSF's knowledge bank about what does and does not work in terms of torture rehabilitation, to improve the management of existing projects at field and HQ levels and to identify transversal lessons for future actions.

3.2 EVALUATION METHODS

The evaluation unfolded in five phases, as follows.

First, the team aligned evaluation expectations and priorities at the HQ level. A series of consultations were held across HQ functions. A complete list is available in Annex B.

Second, the evaluation team conducted a thorough review of project documents, including Field Reports, Medical Field Reports, project Committee (CoPro) documents, Annual Review of Operations (ARO) documents, project Narratives and Logframes, Field Visit Reports, IRCT and Handicap International Assessment Reports, LuxOR's Operational Research Report, clinic forms and materials (anonymized patient files, intake templates, flipcharts), MSF standard operational procedures, and strategic reports and memos produced at HQ, among other documents. The documentation amounted to several thousand pages, and was prioritized and tackled using a step-wise approach. An external bibliography on torture rehabilitation was also consulted to contextualize findings and elaborate recommendations.

Third, the evaluation team collected qualitative and quantitative data during field visits to projects A, B and C. Each field visit started with a briefing with the Head of Mission and Field Coordinator, followed by in-depth interviews and focus group discussions with key informants – including external partners, authorities, and patients, where possible. A full list of interviewees is provided in Annex B. The evaluation team also conducted a 360^0 Site Visit Assessment, which was an 'as-is' analysis of each clinic's physical, financial, and human resources; its modus operandi; and its needs and challenges. Using a modified version of Dr. Joan Othieno's Evidence-Based Practices for Torture Survivor Programs, the team conducted a 'walk-through' of each clinic, assessing its organizational structure, administrative processes, operational preparedness and regularity, adherence to project objectives and protocols, and quality of service delivery. The evaluation team 'shadowed' some clinicians and staff, with their consent and the consent of their patients, so as to directly observe dynamics in intake processes, consultations, and group sessions. Prior to departure, the evaluation team presented preliminary findings and strategic recommendations from each field visit to the Field Coordinator, and the Head of Mission and Medical Coordinator when possible. These debriefings were an opportunity for field leadership to provide strategic reflection and feedback, which was later incorporated into field visit reports, as well as the present evaluation report.

Fourth, upon completing the field visits, the evaluation team entered the analysis and write-up phase, focused on cross-cutting findings and recommendations. With the support of Field Coordinators, field-based data operators, and LuxOR, a wide-ranging quantitative analysis of the EpiData database and other data collection tools was also conducted to clarify and complement field findings. Overall findings were presented at HQ, and comments and feedback were solicited.

The fifth and final stage pursuant to this report is the strategic review and uptake of recommendations by MSF leadership.

3.3 LIMITATIONS

This report seeks to strike a balance between responsiveness to the particular needs and exigent circumstances of each field mission, and triangulation of research findings to draw transversal conclusions and recommendations. It also reaches beyond a technical review of care provision to torture victims, looking to assess the projects as a whole from a programmatic perspective. Even so, project-level planning and monitoring (e.g., via logical frameworks) has been largely ad hoc. Considering then the limited value of an overly-technical approach against the vast scope of the evaluation objectives, the team has chosen to present findings and recommendations in this report as a strategic review, rather than a scientific evaluation. More detailed assessments are available in the field visit reports.

Then, there were strict limitations in the availability and reliability of quantitative data on the projects, namely backlog in data encoding and the absence of quality control mechanisms. These are elaborated further in Annex A. As no quantitative data was available to illustrate improvements in patients' conditions, the interventions' impact was assessed mainly via qualitative interviews with beneficiaries and clinicians.

Finally, the condensed timeline of this evaluation, scheduling constraints, and insufficient internal coordination led to minor but important limitations in data collection in the field, especially in project C, and specifically with regard to patient interviews. Nonetheless, the team managed to formally interview four patients (two patients each in project B and project A), and enjoyed numerous informal interactions and observations at the three clinics.

FIELD FINDINGS

4.1 PROJECT A: 11 SALIENT POINTS

1. A unique service offering with massive reach. The sheer quantity of patients served since the project's inception is impressive: the clinic has taken in charge more than 6000 patients, of whom about 1500 (25 percent) are victims of torture. There is a continuous, enthusiastic demand that presents itself at the clinic from morning to evening, creating a busy atmosphere full of energy and friendly interaction, while dealing with some of the toughest situations and emergencies. To have this reach and presence is a very positive sign for the clinic; it is possible this demand is the result of a high quality of care. However, it could also be a simple reflection of the size of the market for the clinic's services. After all, there is a high percentage of drop-outs and cases lost to follow-up (about 50 percent, with slight variations by specialty).

How to make it better? The service offering is unique in city A, and time has come for the clinic to consolidate its presence and gains, while taking a data-driven approach to assess patient outcomes and narrow its scope as needed. The multi-disciplinary model of care was only consolidated in the past year; accordingly, any decision to narrow the scope should be made based on a detailed analysis of patient profiles, clinic workload, and available alternative services.

2. Rigor of research done to date. LuxOR has collaborated with the team at clinic A to conduct rigorous research into the demographic profile, pathway of care, and patient outcomes at the clinic. The research was able to identify baseline performance and outcomes for psychology, psychiatry, and physiotherapy services. Of particular value, LuxOR helped identify the large number of patients lost to follow-up as an adverse program outcome, and extrapolated possible explanatory factors. In response, the Health Promotion team in the field has been charged to conduct a qualitative survey with a sample of patients lost to follow-up.

How to make it better? The mission requested an Epidemiologist for the coming year, which has been validated. This is welcome news; however, it is recommended to define this person's responsibilities to include, in addition to routine analysis, a concrete research agenda that builds on the LuxOR report, focusing on which populations are best served and how. In any event, project-level data officers must also be maintained and trained, because of quality control issues elaborated below.

3. Overlooking the operating context. The clinic has been continuously responding to emerging needs and adapting to changes in the operational environment. Political sensitivities and bureaucracy have inconvenienced the project and threatened it at times. The project has successfully managed these change processes, retaining and treating a high number of vulnerable patients. At the same time, the civil society groups face an existential threat in the face of unprecedented attacks by authorities. Citizens of country A are themselves being arbitrarily arrested, arbitrarily detained, forcibly disappeared, killed extra judicially, and subjected to torture and ill-treatment – but the MSF clinic does not treat them. Rather, MSF made the strategic choice to discreetly serve migrant victims of torture – also a vulnerable group – in line with the mission's objectives and based on the fact that a local NGO (NGO 8) was already providing care to victims of torture from country A. The authorities are sensitive on the subject of torture, especially when they are themselves implicated; since February 2016, they have ordered the closure of NGO 8 and repeatedly tried to shut it down. The MSF clinic's choice to serve migrants, and to offer torture rehabilitation services discreetly, is urgent and noble; it also overlooks critical realities of the broader operating context, in which torture is fast becoming a rising pattern of abuse against citizens of country A and migrants alike. This is becoming increasingly difficult to sustain, as even among the migrants served at the clinic, many have been victimized in the country itself. Such patients are having difficulty accessing care in the country.

What to do about it? There are no obvious solutions, but this situation poses challenging questions for the mission about if and how and whom to treat, and if and how and when to speak out. It is advisable for MSF to strengthen relationships with high-level authorities in the country (including power-brokers in the Army, whose reach extends into civilian authorities like the Ministry of Health), and align this effort with an international advocacy strategy to elevate the issues identified at country level.

4. Improving data management and M&E mechanisms. The EpiData-based platform for VoT data collection was initially devised with and for project A, and clinic staff are generally satisfied with the system. Indicators were recently reviewed and improved for 2017, and a special effort has been made to integrate social work performance and outcomes into the database. However, the database is riddled with errors and discrepancies, and data operators

say forms are sometimes submitted incompletely or not at all. Our review of a random sample of patient files confirms that some forms were not fully or properly completed.

How to make it better? Quality control mechanisms should be put in place for data collection and encoding. These mechanisms can draw on the project Medical Referent and other supervisors, and must clarify the roles and responsibilities of all people involved, including clinicians and encoders. Then, the monitoring and evaluation framework should look beyond the EpiData platform to systematically capture qualitative evidence of patient outcomes and perspectives.

5. Latent racial tensions at the clinic. While relationships in the clinic are generally collegial, there is a latent tension between country A national staff and patients/staff of refugee backgrounds. The racism, discrimination, and harassment against sub-Saharan Africans and darker-skinned nationals in country A and across North Africa is well-known. Numerous anecdotes reveal this to be a 'sensitive nerve' at the clinic. Supervisors must be made aware of this dynamic; it has been presented by several interviewees as a potential reason patients are dropping out at such high rates. These interviewees (who are project staff, and not patients themselves) report that patients often feel comfortable disclosing case-relevant information to the Social Workers, Interpreters, and Receptionists, who also come from refugee backgrounds, but not to their own clinicians, who are from country A. Aside from patients, this same latent tension is reported among staff of different backgrounds.

What to do about it? First, all staff – and especially clinicians – should have experience and passion for working with migrant and refugee communities, or firsthand experience in sub-Saharan Africa. Second, all staff – and especially clinicians – should be trained in culturally sensitive interviewing and treatment techniques. Third, the human resources policy and recruitment process need to be revisited; it will be important to recruit more clinicians from within the refugee community. While this may go against limitations based on MSF's registration status in the country, the clinic is already being creative with getting around these limitations in hiring other staff members of refugee backgrounds. The fourth and final mitigation measure is to retrain Interpreters – who are currently being under-valued – as Cultural Mediators; as such, they would represent the face and voice of the service, and would be invited into joint case discussions to improve the relevance and effectiveness of treatment plans.

6. Compulsory disclosure upon intake. The evaluation team's observations of the intake process indicate that it can be abrupt and intrusive for patients. Some patients exhibited difficulty in articulating their experiences as well as signs of stress and discomfort during the initial assessment. A few clinicians take a highly pragmatic approach to the process: checking the appropriate boxes without much sensitivity to the nature of trauma suffered. Clinic staff have indeed been trained and reminded to complete the interviews in ten minutes. As the Mental Health Referent and LuxOR have acknowledged in their field reports, while compulsory disclosure at intake may streamline patients' linkage to appropriate care, it may also be contributing to the high percentage of post-intake drop-outs, and has probably dissuaded males and undocumented migrants from presenting at the clinic. This intake practice was agreed at the project- and mission-level based on the experiences and needs of the clinic; it was not 'validated', per se, by the VoT focal point or anyone else at HQ level. While this screening process may be justified because of the overwhelming caseload and consequent need to quickly identify patients who meet the admission criteria, the current intake mechanism is not an ideal foundation for a proper therapeutic relationship with victims of trauma and torture.

What to do about it? Supervisors should conduct an audit of the intake process, especially as the scope changes. Team leads should train their teams in sensitive interviewing techniques and the approach should be harmonized across teams, to mitigate any negative consequences on patients. A larger concern of the evaluation team (which was not pursued due to time constraints) is whether the intake process is representative of regular consultations once the patient enters care, or not, in terms of imposing a rhythm on the patient over the course of care.

7. Refining the scope in the face of overwhelming demand. The scale of medical needs among the migrant community in city A is many, many times more than can be met by MSF, no matter how much the clinic expands. Already, wait times are about one month, and have been as long as three months; this is unacceptable when serving a sometimes-transient population. In addition to the waitlist, the existing caseload can compromise the quality of services and staff well-being.

What to do about it? It is logical to periodically refine the scope of the project to reach either the most vulnerable cases, or those cases where MSF can have the most impact. Removing street violence from the scope of the clinic and referring

such patients to other existing services will free up some capacity and reduce wait times. Next, a detailed assessment of intake and the booking system can help optimize the number of patients seen daily while guaranteeing a high quality of care. Then, firmer discharge criteria could be delineated per specialty; on its field visit, LuxOR observed that 'patients were rarely discharged, and were kept in care for an indeterminate period of time'. However, even these moves may not be sufficient. The project may need to make a big, bold, and difficult decision to slash the scope of work. Such a choice should be based on rigorous study and demonstrated need, and feature a participatory decision-making process. While a hard choice may be unpalatable, it is advisable for the health, safety, and sustainability of the staff and clinic.

8. Relocating the clinic. The clinic is situated in a relatively peaceful, leafy suburb of city A; however, it has outgrown itself quickly. Concerns about the premises include lack of confidentiality in the waiting area; lack of physical access for people with disabilities; and some closed, dark spaces that are not conducive to the rehabilitation of victims of torture. The process of relocating to a new facility will take at least nine months due to the time it takes to first find an appropriate space and then undergo complex administrative licensing procedures as well as renovations.

What to do about it? This process should begin immediately with the concerted efforts of those involved in project A and mission representatives. In the meantime, cosmetic renovations can be made to the existing premises, for example in lighting ergonomics (improving illumination while reducing glare), painting the walls – soft, tranquil colors for treatment rooms and bolder, warmer colors for common areas – and installing ramps and handrails.

9. Offering training and psychological support to staff. For all the benefits of the multi-disciplinary team approach, the model of care has developed experientially. There is a need for more formal training for all staff in torture rehabilitation theory and practice, especially given that MSF is new to the field. One of MSF's partner organizations could not identify any specific service that the clinic offers that is unique to torture survivors, as opposed to mental health patients or victims of sexual violence. Across the board, all interviewees expressed a desire for greater training, in torture rehabilitation specifically, and in cultural sensitivity when working with refugees. Meanwhile, staff have experimented with canceling their Tuesday 'training day' (which is reserved for joint case discussions and mentorship) in favor of having more consultations with patients. This is dangerous and should not be regularized, due to concerns about staff well-being. The caseload and exposure to trauma are overwhelming almost all clinic staff; many are exhibiting signs of job-related stress.

What to do about it? As some staff cannot travel (due to their legal status), international experts can travel to country A to deliver trainings. Select partners could also be discreetly invited to these trainings (as they have requested), thereby strengthening relationships and joint case management and building local capacity. All staff, including support staff, should have access to psychological support. A special effort should be made to assure that support staff who come from the refugee community have access to rehabilitative care if they themselves meet the admission criteria, e.g., by covering their visits to private clinicians of their choice, so as to guarantee a proper therapeutic relationship outside their place of work.

10. Developing a two-pronged exit strategy. The complexity and size of the clinic, the steady decline in funds available to refugee agencies, and the existential crisis faced by civil society in the country are clear threats to the continuity of services provided by MSF. Currently there is no agreed exit or handover strategy, except that the project will continue operating as a standalone clinic for the foreseeable future.

What to do about it? Many interviewees suggested 'decentralizing' the clinic by specialty over the medium-term, wherein patients could receive different services by different actors in different locations in the city. Such talk is premature, and anyway would be antithetical to the holistic model of care. There is an urgent need to design and start preparing for an exit strategy that could take years. In addition to a 5-year handover plan, a second scenario of a sudden forced exit should be part of this exit strategy, defining contingency mechanisms to ensure thorough care of patients. The two-pronged approach would include mapping of actors, identifying service priorities and alternatives to the current structure of care, strengthening joint case management with partners, local capacity-building, and advocacy activities.

11. Reinforcing legal capacity and the medical documentation of torture. The clinic currently issues 'medical reports' and 'mental health assessments' upon request to patients who are integrated into the clinic's rehabilitation program. There is considerable doubt about the quality and utility of these reports. Based on IRCT's prior assessment and some of the evaluation team's interviews, there seems to be a gap in the provision of medico-legal reports as per the Istanbul Protocol that would be useful in obtaining a positive outcome for victims of torture who seek legal protection, are awaiting their refugee status determination, need financial assistance, or are pursuing resettlement.

The mission took this issue up with the Legal Unit at HQ, and in August 2016, templates for medical certificates for torture survivors were drawn up and validated. The evaluation team could not collect sufficient evidence to judge the value of these new templates, or how they are being used. There is also a lack of legal capacity at the clinic, and the pure-referral model for legal services is insufficient from the viewpoint of holistic rehabilitation. Indeed, one legal referral partner did not even recognize that the MSF clinic treats victims of torture, in addition to victims of sexual violence. Increasingly, patients – especially those victimized in country A – find themselves in dealings with police, prosecutors, and child and family services, in ways that are compromising their recovery.

What to do about it? The clinic staff have devised and shared a draft protocol for providing medical certificates, which demonstrates attention and need to the matter. It is advisable that the project further sensitize clinic staff, project partners, and refugee agencies about the value and purpose of medical documentation of torture; and be proactive to use the clinic and clinic staff (for example, by hiring forensic medical consultants) as a staging-ground to begin providing these certificates to select patients in immediate need in city A. The recruitment of a project-level Legal Advisor could reinforce the referral model and flag cases that require dedicated accompaniment, certification, or follow-through.

4.2 PROJECT B: 8 SALIENT POINTS

1. Good karma. Two years after the launch of the project, the VoT clinic B is operating at full capacity in two bright, friendly spaces. Staff and management are highly satisfied with the structure and function of the project. The clinic is a welcoming, intimate environment treating patients in a sensitive and dignified way. The positivity of the staff and physical space – described by one interviewee as full of 'good karma' – has created an environment conducive to the rehabilitation of victims of torture and ill-treatment.

How to make it better? The environment of the clinic could barely be improved, though sometimes the space is still cramped.

2. High-quality professional service. The clinic staff have devised an inter-disciplinary, patient-centered therapeutic approach drawn from techniques of trauma resilience and holistic rehabilitation. The three partner organizations report general satisfaction with the current model of coordinated care, which features 'morning meetings' for MSF staff and weekly working groups with partner personnel for joint case management. The model of care was drawn from the local partner organizations, who had some experience serving victims of torture, as well as the technical advice of the Center for Trauma, Asylum, and Refugees at the University of Essex. However, MSF staff did not have prior professional experience in rehabilitation of victims of torture, and generally learned on the job through training and mentorship. This learning included two trainings on the Istanbul Protocol from the Human Rights Foundation of Country E; trainings in trauma treatment and the use of interpretation in a clinical setting; and continuous mentorship from Renos Papadopoulos of the University of Essex.

How to make it better? The learning and training held to date is admirable, yet there is a need for more subject-specific training for all staff in torture rehabilitation theory and practice, especially given that MSF (and most clinic staff) are new to the field. This training could include the current literature on torture and ill-treatment and refugee and war trauma; the biomedical, psychological, and cross-cultural interface of torture and the rehabilitation of survivors; physical and psychological symptoms and consequences of torture, and instruments, measures, and scales for assessing these; treatment modalities and intervention techniques for torture survivors; medico-legal investigation and documentation of torture and ill-treatment; and the monitoring and evaluation of torture rehabilitation programs.

3. Superior project management capacity. The Field Coordinator has an unparalleled knowledge of the situation of refugees, asylum-seekers, and migrants in country B and responded rapidly to changes in the operational environment. MSF staff attribute the survival and strength of the project to her management capabilities and interpersonal skills, which were especially advantageous during emergency and post-emergency periods of the mission, when the project received little support from coordination. Meanwhile, among external actors, the Field Coordinator's stature and style have enhanced perceptions of MSF in the broader community of practice. This superior project management capacity is observed as an unusual strength – and a potential vulnerability. Specifically, the Field Coordinator had to take an unusually engaged role in patient case management, during the first year when no Medical Activities Manager was provisioned for, and also later, during intermittent gaps in coverage. This is seen as an outgrowth of the desire to put patients first, but is viewed ultimately as a handicap to the project.

How to make it better? The recent recruitment of a national language speaking Medical Activities Manager will help considerably, and project management must now divest itself of patient case management to focus on strengthening priority areas of improvement. And given that the current Field Coordinator is concluding her mission, there is a significant risk in case of abrupt transfer of leadership; this can be mitigated by ensuring a thorough handover to the new Field Coordinator and arranging a temporary assignment, after the handover, for discrete capitalization exercises like documentation of project protocols and strategies.

4. Catalytic partnership model. The MSF clinic operates in close cooperation with the NGO 1 and the NGO 2. These partner organizations already offered coordinated psychosocial and legal aid to victims of torture from February 2013 through September 2016, in the frame of the EU-funded projects. MSF was able to catalyze this capacity by contributing the medical component of care and launching a dedicated facility for comprehensive case management, amounting to significant added value. Since the conclusion of the mentioned projects, both partners have continued offering their services to victims of torture alongside MSF; MSF is supporting them to identify a donor to continue these activities through 2017 and beyond.

How to make it better? First, it appears the two local partners have diverging views about the project's future. For example, the partners are not equally committed to a specialized center for torture rehabilitation, where they could offer an integrated service – in part because treatment of victims of torture is marginal to their core services. MSF must thus cultivate a common vision and greater ownership of the two local partners for the continuity of the project, as currently neither partner (as expressed in interviews) is able or willing to assume greater responsibility or commit to torture rehabilitation in the long-term. Second, MSF should provide structural support to this partnership, defining clear coordination mechanisms and continuing to identify donors. And third, NGO 1 and NGO 2 should be encouraged to integrate their personnel more closely into the day-to-day treatment offered at the clinic. While current coordination is sufficient, there have been occasional slips and gaps in case management. Greater integration could begin with having NGO 1 lawyers sit in two days a week at the clinic, and co-locating NGO 2 and MSF staff, who already share a building. Doing so would enable a smoother transfer of knowledge to the local partners by truly integrating them into the model of holistic rehabilitation.

5. Medical documentation of torture. The clinic currently issues 'medical reports' upon request to patients who are integrated into the clinic's rehabilitation program. In addition, two trainings on the Istanbul Protocol were held in city B, featuring experts from the Human Rights Foundation of Turkey and were opened to MSF staff and local actors. Nevertheless, based on IRCT's prior assessment and our own conversation with the Asylum Service, there is a 'void' in the provision of medico-legal reports as per the Istanbul Protocol that would be very useful in obtaining a positive outcome for victims of torture who seek asylum.

What to do about it? The Field Coordinator devised and shared a strategy paper regarding this issue in January 2016, but this appears to have gotten lost at coordination level. It is advisable that the project further sensitize clinic staff, project partners, and the Asylum Service about the value and purpose of medical documentation of torture; and resource and renew an initiative to use the clinic and clinic staff (for example, the pending hire of a forensic medical consultant) as a platform to begin providing these certificates and to build a permanent capacity in city B that can offer such a service, perhaps with the Forensic Medical Faculty, or with a separate team at the NGO 2, who have expressed interest.

6. Formalizing a plan for advocacy and local capacity-building. To date, the project has undertaken trainings for country B medical professionals on torture documentation and also trainings for Asylum Service case officers on detecting and referring cases of torture and ill-treatment. Such achievements are indicative of the project's 'firm anchorage in the ecosystem of services' in city B.

How to make it better? There is a clear need to further develop a project-level advocacy strategy that specifies objectives and targets, including additional trainings in torture rehabilitation for country B's professionals. Advocacy activities can also be aligned with the handover strategy and consequently focused on access to care for victims of torture or on public communications to sensitize the general public about this population. In general, there are quick and easy ways to attach the issue of torture to the mission's high-level advocacy efforts on refugee protection and policy, including early detection and management of vulnerable groups.

7. Creating a coherent brand identity. Clinic management has made a conscious decision to treat victims of violence beyond a strict definition of torture and ill-treatment, partly because not all victims of torture conceive of themselves as such. The majority of interviewees refer to the clinic as a place for victims of violence ('VoV'), rather than victims of torture ('VoT'), although both are used interchangeably in interviews and project documents. The evaluation team agrees on the practicality of the matter: the clinic should treat the medical consequences of all forms of extreme violence that come to its doors. At the same time, it must be acknowledged that torture has particularities in terms of medical and legal consequences, especially among the target population of asylum-seekers.

What to do about it? It is recommended to label the project As a clinic for victims of torture and ill-treatment ('VoT') across the public interface, for four reasons: (1) a coherent brand identity will put the clinic top-of-mind among partners as the only specialized torture treatment service in city B, and streamline their referrals; (2) as word of mouth spreads, the clinic is beginning to enjoy recognition among the migrant population in city B as a one-stop-shop for torture treatment; (3) it is advisable to maximize the proportion of torture victims in the cohort, for staff to acquire experience with the particularities of torture and for data tracking purposes (since victims of torture and victims of other kinds of violence will need to be disaggregated); and (4) a 'victims of torture' label will align the project with MSF's institutional interest in the arena as well as position the project to match the priorities of prospective donors.

8. **Technical support for data entry and analysis.** To collect patient data and monitor the intervention, clinic B has imported the EpiData-based platform from the clinic A, with the help of LuxOR. The system is basically in place, but has not been fully taken advantage of. Staff and management recognize the need for improvement. In meantime, some clinicians take narrative notes and use their own templates to track their patients' progress.

What to do about it? Priorities for improvement of M&E mechanisms include: (1) retrospectively entering the data collected to date into EpiData, for which a temporary hire is required; (2) analyzing the data collected, for which special staff trainings will be necessary; and (3) regular qualitative collection of patient outcomes and perspectives via sensitive interviewing techniques or culturally responsive and participatory questionnaires. Alongside this kind of basic analysis, special research projects could be developed with LuxOR or a different agency to fill gaps in the literature about victims of torture and their medical rehabilitation, as MSF continues to find the place for a medical organization within the VoT field and contribute to advocacy objectives.

4.3 PROJECT C: 10 SALIENT POINTS

1. The power of positive thinking. One year after the launch of the project, the clinic is operating at full capacity in a bright, tranquil space. Staff exhibit high levels of satisfaction and generally maintain a collegial attitude and positive spirit, which is conducive to the rehabilitation of victims of torture.

How to make it better? Ensure in recruitment processes that clinicians have compatible approaches, to avoid unnecessary stresses and promote a collegial and productive team interaction.

2. High-quality professional service. The clinic has adopted an inter-disciplinary, trauma-informed therapeutic approach, drawn from techniques of ethno-psychiatry. All team members – including cultural mediators – participate in joint case discussions and consultations, attempting to understand and treat the mental and physical disturbances of migrants in their own cultural context.

How to make it better? There is a noted lack of training in torture rehabilitation theories and practices for all staff. The project's proposed investments for staff training in the coming year ought to be approved and supported.

3. Productive partnership model. The clinic's model of care was based on the model of a NGO (NGO 3), which has treated victims of torture in city C for more than thirty years. NGO 3 shares the clinic space to treat victims two days a week, enabling more beneficiaries to be reached.

How to make it better? A gradual merging of MSF and NGO 3 personnel should be put to the test at the clinic through joint casework, which has heretofore been ad hoc (namely, consultation on difficult cases). Meanwhile, the informal accompaniment already provided to NGO 3 for the professionalization of their organization should be stepped up and resourced. This professionalization could start with an organizational capacity assessment and would help strengthen NGO 3 capacities in strategic planning, including developing vision and mission statements; governance; human resources training and development, including transitioning from (largely retired) volunteers to paid staff; financial management, including fundraising and networking with donors; and the use of technology and communications tools[5].

4. Insufficient integration of legal services. Medical certificates are issued and offered to some patients by a Forensic Doctor, present in the clinic two days per week. NGO 4 has also been contracted to provide part-time legal aid two days a week. Nevertheless, due to high volume, MSF social workers are still spending more than half their time performing legal assistance activities for which they are not uniquely trained.

What to do about it? A request has been made to increase the part-time engagement of NGO 4; this would be a good start, but still insufficient. A torture rehabilitation clinic of this size should be maintaining a full-time presence of at least one legal operator, and it is advisable to more completely integrate legal services into the treatment approach, which may involve retraining staff.

5. Insufficiencies in the data management system. With the help of LuxOR, the clinic has imported the EpiData-based data management system from project B and project A. The system is in place, but has not been fully taken advantage of. Moreover, the data collection is not analyzed; not aligned with the model of care; and does not enjoy the buy-in of staff, who view it as a burden.

What to do about it? Data management improvements should be embedded into the design of a VoT-specific M&E framework, for which HQ, LuxOR, or external advisory services will be required. This comprehensive framework would also enable the qualitative assessment of patient outcomes and perspectives.

6. Slow start to local capacity-building. To date, the project has conducted informal and opportunistic advocacy before the Ministry of Health and through provision of feedback to centers for asylum-seekers. However, it has not taken the initiative to organize any local capacity-building activities, either for medical professionals in the country or otherwise. (These are now being planned).

What to do about it? The project is already planning to host capacity-building trainings for Italian professionals in the detection and treatment of torture; and should develop a formal advocacy strategy with HQ and mission support

[5] There are many models to jumpstart such local capacity-building. See, e.g., the Organizational Capacity Assessment Tool, as developed by McKinsey & Company; available at: http://mckinseyonsociety.com/ocat/.

focused on national-level policy reform (like the criminalization of torture, which is still pending in country C) and access to rehabilitation.

7. Low accessibility of vulnerable populations. The project may be faced with hard choices within the next year. There are a set of accessibility challenges: 3 of 86 patients served to date (3.5 percent) are women; 2 of 86 patients (2.3 percent) are minors; and 2 of 86 (2.3 percent) are irregular migrants. However, even if these populations present themselves, there is a waitlist for clinic services; so the project must decide who its target population is and how to reach them given resource constraints.

What to do about it? A closer mapping of the population and needs of migrants would be useful in this regard. To guide these strategic choices, counterparts at field, coordination, and HQ levels must seek alignment on the ultimate objective for the project – i.e., meeting the population's needs, establishing a model service for country C and comparable contexts, strategic learning for MSF, or other.

8. Autonomy. The project enjoys a high degree of freedom and unusual lines of reporting and responsibility. Generally, the evaluation team sees this as having given the project leadership the necessary latitude to achieve its objectives, especially considering MSF's lack of expertise in the field.

How to make it better? Careful attention must be paid to assure that counterparts across MSF buy in to the project and this kind of intervention – and to make sure the project gets the support it needs from the mission and cell.

9. Low staff salaries. Low salaries (as reported by clinic staff across functions and levels) are threatening staff morale and compelling staff to take second jobs in addition to their full-time duties at the clinic.

What to do about it? If the project seeks to maintain its quality of care, a review of salaries and benefits at project-level will be required to attract and retain competent clinicians. This may take more than a traditional benchmarking process and actually involve rethinking the conventional wisdom about 'national' and 'international' staff salaries and benefits in a place like country C.

10. Making the most of the spin-off project. The VoT project is subsuming a spin-off project on rheumatic heart disease (RHD). The spin-off is observed to be remarkably efficient and impactful in its own right. However, with only two referrals of minors to the VoT clinic, and two more pending, it has so far been unsuccessful in expanding the clinic's access to new populations.

What to do about it? In the coming year, it is advisable to make the most of the spin-off by taking advantage of its open access to centers for minors, especially for girls, whom the clinic has not yet treated. It is also advisable to implement other proactive mechanisms to reach vulnerable populations, and to reconsider the strategic positioning and sustainability of the RHD initiative vis-à-vis the VoT project.

EVALUATION OF OECD-DAC CRITERIA

The terms of reference for this evaluation indicated to compare and contrast the three projects. Given the diversity of origin, development, operation, stage of completion, and socio-political context across the three projects, it is difficult to make a formal evidence-based comparison, in terms of the projects' relative strengths and weaknesses. However, the team has sought to investigate the relative strengths of the projects by asking, *What does each project do particularly well for itself?* Based on the field observations, interviews, and review of documents, as well as the evaluation team's own technical expertise, the three projects have been scored against OECD-DAC criteria of relevance, effectiveness, efficiency, impact, and sustainability. A fourth column provides a simple average of the three scores, giving an indication of the VoT initiative as a whole. That said, there is considerable diversity across the three projects, and any such scorecard is necessarily reductive. These scores are not meant to be deterministic or all-encompassing; rather, the idea here is to capitalize on actual experiences and identify good practices and red flags that could be replicated or avoided in other clinics or future VoT interventions. The scorecard is presented on the following page.

5.1 OECD-DAC SCORECARD

SCALE

4 = Excellent; best practice
3 = Good/great
2 = Basic
1 = Inadequate; red flag

	PRO. A	PRO. B	PRO. C	VOT
RELEVANCE				
Validity of overall goal and strategic objectives	4	4	4	4
Appropriately tailored to local needs and context	1	4	3	2.666667
Adaptability to changes in operating environment	2.5	3.5	2.5	2.833333
Coherence of project design with theory of change	3	3	3	3
Connectedness with related projects of mission	2.5	1	1	1.5
Relevance Average	**2.6**	**3.1**	**2.7**	**2.8**
EFFECTIVENESS				
Satisfactory achievement of objectives	3	3	3	3
Regular assessment of needs and coverage	2.5	2	2.5	2.333333
Activities and outputs leading to intended outcomes	2.5	3.5	3.5	3.166667
Accessibility of women and vulnerable groups	4	4	1	3
Overcoming obstacles and constraints	3	3.5	3.5	3.333333
Mitigation of adverse consequences	2	2	2	2
Effectiveness Average	**2.833333**	**3**	**2.583333**	**2.805556**
EFFICIENCY				
Resource-efficiency	4	2	2	2.666667
Timeliness of delivery	3.5	3.5	3.5	3.5
Consideration of alternative approaches	2.5	2.5	1.5	2.166667
Effective management and optimization of human resources	3	4	2.5	3.166667
Optimization of physical resources	4	4	3.5	3.833333
Efficiency Average	**3.4**	**3.2**	**2.6**	**3.066667**
IMPACT				
Makes a difference to beneficiaries' lives and communities	4	3.5	2.5	3.333333
MSF presence has added value	4	3	3	3.333333
Contribution to institutional learning	4	2	2	2.666667
Impact Average	**4**	**2.833333**	**2.5**	**3.111111**
SUSTAINABILITY				
Development of handover or exit strategy	1	3	2.5	2.166667
Identifies and builds local capacities and resources	1.5	3.5	2	2.333333
Probability of long-term benefits	1	3	2	2
Contributes to systemic change	1	2	2.5	1.833333
Sustainability Average	**1.125**	**2.875**	**2.25**	**2.083333**
OVERALL SCORE	2.825	3.101667	2.71	2.878889

5.2 KEY TAKEAWAYS

Relevance

Validity of overall goal and strategic objectives: The goal of all the clinics is to offer a holistic torture rehabilitation service to migrants, to improve their physical and psychosocial well-being, and to help restore their dignity. Given the scale of torture and ill-treatment suffered by migrants in their home countries or en route to Europe, this is a valid and timely goal.

Appropriately tailored to local needs and context: The Field Coordinator of the project B had extensive prior experience in the field of migration and detention in country B, and knew the landscape well. This enabled the project to have 'a firm anchorage in the ecosystem of services' in city B, wherein MSF contributed added value. Project C sought out and received valuable inputs from local actors as well. Project A, while expansive and responsive, seems to be overlooking the political and security situation in country A, where torture is fast becoming a blatant pattern of abuse against nationals from and migrants to country A.

Adaptability to changes in operating environment: Projects A and B have persevered in the face of contextual challenges. Soon after the EU-Turkey deal came into effect in March 2016 and left an estimated 60,000 migrants 'stranded' in country B, the demand for clinic B's services doubled. The project's rapid response was to recruit additional clinic staff and set up a second treatment facility across the street. As for project A, the clinic has been continuously adapting to the complex operating environment of country A, where political sensitivities and bureaucracy have inconvenienced the project, and threatened it at times. The project has successfully managed these change processes, retaining and treating a high number of vulnerable cases. However, according to a partner organization, when project A narrowed the scope previously (to detract general mental health cases), cases were 'dropped' and other agencies had to 'pick up the pieces', including dealing with resultant psychiatric emergencies and receiving insufficient cooperation from MSF. (It is important to note that these comments come from a long-time, but sometimes-antagonistic, referral partner) Project C has not faced any drastic changes in the operating environment, but interviewees report a timely adaptation to context.

Coherence of project design with theory of change: The theories of change as elaborated in project documents are extremely limited; however, interviews reveal that leadership of the three clinics are aware of the pathways to change, in terms of desired impact for beneficiaries and local refugee communities, and are primed to take these steps.

Connectedness with related projects of the mission: The mission C has deputized supervision of the project C VoT project to a Deputy Head of Mission, and the VoT project B has been outside of the mission's ambit during emergency and post-emergency periods for about six months in total, since inception. In both countries, the ongoing projects in migrant reception centers and landing sites are not sensitized about VoT. As one interview put it, 'If it is difficult to transfer knowledge about VoT within a mission, what hope is there to transfer this knowledge outside a mission?' In project A, the mission and the project have long been one and the same, effectively; managerial attention is therefore less dispersed and more focused on the project, resulting in the higher score. At the same time, there have been some misunderstandings about roles and responsibilities in this setup, and the projects in country A are not particularly well connected.

Effectiveness

Satisfactory achievement of objectives: Patients in projects A and B have reported improvements in their physical, psychological, and social conditions, and attributed these improvements to the comprehensive, individualized care they received at the clinic. It is important to note that the visit to project C could not produce any evidence of positive outcomes for patients; though it is early, and clinic staff already report some positive patient outcomes. All the projects are clearly responsive to the nature – if not the scale – of the needs of the target population.

Regular assessment of needs and coverage: Project A is highly aware of gaps in needs and coverage, and while these concerns have been debated, very little action has been taken to formally study the target population – until recently, as evidenced by the ongoing qualitative study of patients lost to follow-up. Project C conducted a thorough feasibility analysis prior to start-up but has struggled to get a grasp on their target population since then. Project B has informal ways of assessing needs, but needs to formalize their approach.

Activities and outputs leading to intended outcomes: Based on an analysis of the projects' (fairly rudimentary) logical frameworks, as well as in-depth interviews and a thorough review of monthly, quarterly, and annual reports, it appears that activities and outputs are having a satisfactory effect on beneficiaries and the community of practice. However, in project A, there are some dynamics – namely the high rate of patient drop-outs and the relatively limited partnership model – that call into question whether activities and achievements are leading to intended outcomes.

Accessibility of women and vulnerable groups: All three of the projects are consistent with the needs of women and vulnerable groups, and are well-equipped to deal with members of these populations who have suffered torture or ill-treatment. In project B, a total of 315 patients have been served by the clinic to date, including women, minors, and LGBT people. Project A also has wide-ranging diversity in the cohort, including women, children, and people of many nationalities. Project C, however, is experiencing a set of accessibility challenges. Only 3 of 86 patients served to date (3.5 percent) are women, and though there are some demographic and practical explanations for this, they do not entirely account for the disparity. Then, 2 of 86 patients (2.3 percent) are minors, referred via the spin-off project, and a similar proportion of patients are undocumented migrants.

Overcoming obstacles and constraints: All the projects have done a good job surmounting challenges thrown in their path. Admittedly, project A has had a lot thrown in its path due to sensitivities in the operational environment, and has done a satisfactory job of clearing these hurdles.

Mitigation of adverse consequences: In project A, LuxOR helped identify the large number of patients lost to follow-up as an adverse program outcome, and extrapolated possible explanatory factors; project A has been slow on the uptake, but is beginning to investigate the matter and is prepared to take action to improve. Project B is aware of potential unintended negative consequences, like potentially reinforcing a kind of favoritism at the Asylum Service by providing medical certificates to victims of torture who seek asylum (as this may put these asylum-seekers at an advantage over other victims of torture who have been unable to procure such certificates). Consequently, project B has undertaken trainings with the Asylum Service to raise awareness and mitigate this. It is early still for project C to have identified any adverse consequences.

Efficiency

Resource-efficiency: Resource-efficiency here does not refer to financial efficiency or the efficiency of medical treatments with regard to patient recovery; no data were available on these matters. Rather, the phrase is used to acknowledge that there are more expensive (resource-intensive) and less expensive (resource-efficient) models of torture rehabilitation, the primary variables being service offering and period of care. The scores presented here reflect that in project B and C, the modalities of care offered are more resource-intensive, whereas in project A – largely due to pace and demand, but also the chosen therapeutic approach – the modality of care is more resource-efficient. Acknowledging a trade-off between the breadth and depth of patient care (in terms of which services to prioritize; capacity overload and existing accessibility challenges; and whether or not to treat long-term residuals of torture), questions of resource-efficiency can complicate future efforts to expand coverage or replicate the service.

Timeliness of delivery: Projects A, B and C are all meeting their stated objectives according to schedule.

Consideration of alternative approaches: Project A has recently modified its model of care by introducing multi-disciplinary teams. Project B has done a lot of international outreach by itself with regard to learning about trauma, torture, and resilience. Project C has an excellent model based on the local partner's well-informed therapeutic approach, as well as the exceptional training of their own staff. However, all clinics need more precise training in torture rehabilitation theories and practices.

Effective management and optimization of human resources: All the clinics feature a highly collegial and collaborative environment for staff. Project A juggles some 80 staff providing some 2000 consultations per month, which is no small feat; however, they struggle with latent racial tensions at the clinic. In project C, while there have been episodic problems (like diverging approaches among team members) that have caused a degree of stress, these have generally been worked through. Project B interviewees report best-in-class management skills from the part of the Field Coordinator, who has also provided close accompaniment and mentorship to staff. Across the clinics, an effort has been made to offer preventive psychological support to staff, who are themselves exposed to trauma; while laudable, this support has been intermittent in project A.

Optimization of physical resources: Projects B and C feature beautiful, bright, and peaceful spaces that are cramped – given the level of activity – but are certainly conducive to the task at hand. Clinic A is located in a large, standalone building in a leafy suburb of the city. There is continuous, enthusiastic demand that presents itself at the clinic from morning to evening, creating a busy atmosphere full of energy and friendly interaction, while dealing with some of the toughest situations and emergencies. Staff are making more than full use of the premises and doing what they can where they can, but need to make cosmetic improvements and minimize the frenzy.

Impact

Makes a difference to beneficiaries' lives and communities: The force of the demand in project A and the culture of the clinic in the neighborhood in which it resides are signs of tremendous presence and impact, reinforced by a robust Health Promotion team – unique to project A – that does extensive community outreach and training. Project B also enjoys a forceful presence in the neighborhood in which it resides and patients report feeling part of a family.

MSF presence has added value: There is significant value added across the three clinics, as identified by both MSF staff and external actors. Project B partners identified a clear value for MSF to supplement the medical component of care within a pre-existing torture rehabilitation service, effectively guaranteeing its continuity and moving it into a dedicated space. Project C's chief partner organization celebrated MSF's help in increasing the reach and growth of their model of care, saying that it was 'like looking at our own reflection in a mirror, but better-looking'. Partners in project A emphasized the value of MSF's financial independence, in a context where refugee agencies are facing tight resource constraints.

Contribution to institutional learning: Project A's close collaboration with LuxOR's research initiative demonstrated the capabilities and interest of the project A team in contributing to institutional learning and filling gaps in the literature on victims of torture. Project B has also engaged in a significant amount of learning, even internationally, but it is doubtful this learning is being transferred to other levels or projects.

Sustainability

Development of handover or exit strategy: Project A has implemented no relevant activity related to an exit or handover strategy. The clinic B is based in the building of a local partner, so they have a promising route for a smooth handover of the medical component of care to the local partners, or identifying an alternative. Project C also has a unique and valuable partnership model that puts them on track for handover, but this needs to start formalizing.

Identifies and builds local capacities and resources: Project B has done an excellent job to host capacity-building trainings for the country professionals, including trainings for the Asylum Service in the early detection and referral of torture cases. Project C has a good setup going in which – rather than working with the broader community of practice – they have concentrated their resources to help their main local partner professionalize their organizational management. This could benefit, however, from some diversification. Project A has some 28 local referral partners, but for better or for worse, is a silo unto itself; relationships with these referral partners – while ultimately favorable – are spotty.

Probability of long-term benefits: Because the project B piggybacked on a pre-existing torture rehabilitation service, and because of the Field Coordinator's broad and deep knowledge and relationships in the migration sector in country B, there is a relatively high probability that the local capacity built will amount to some permanent platform for torture rehabilitation in city B. In project C, it remains to be seen. Project A at the moment is unpromising in terms of any long-term benefits, because of the lack of good handover options and limited local capacity-building.

Contributes to systemic change: Project B has already begun to target the Asylum Service and Forensic Medical Faculty with specific advocacy objectives, like pursuing some kind of permanent platform for the medical documentation of torture in city B. Project C has already begun some advocacy activities before the Ministry of Health and centers for asylum-seekers. In both of these cities, however, advocacy plans must be formalized, where it is recognized that there are 'quick and easy' advocacy wins that can link the issue of torture to mission-level and HQ-level advocacy around the refugee crisis in Europe.

TRANVERSAL FINDINGS: SWOT ANALYSIS OF THE VOT INITIATIVE

What follows is a transversal assessment of the strengths, weaknesses, opportunities, and threats within MSF-OCB's thematic initiative for victims of torture.

Table 1. SWOT Analysis of Transversal Findings

Strengths	Weaknesses
• HQ buy-in and field-level autonomy • Holistic model of care • Partnership with local actors • LuxOR's engagement on data management	• Inadequate monitoring and evaluation • Limited knowledge of medical documentation • Poor integration of clinic experiences • Gaps in VoT management structure
Opportunities	**Threats**
• Cross-cutting advocacy • Publishable research	• Nature of torture in the operational environment • Lack of diversification of learning contexts • Existential crisis with regards to coverage, sustainability, and resource-efficiency

6.1 STRENGTHS

High-level buy-in meets field-level autonomy. The call to get engaged on torture was led by the General Director of MSF-OCB in November 2011 and was strongly supported by the associative members of the MSF Assembly; the VoT program has benefited from high-level buy-in at HQ ever since. There has long been institutional will to learn about global torture rehabilitation needs and practices and to gauge if MSF has value to add in this space, despite it being an unconventional thematic for MSF. However, this has not always translated into continuous or sufficient resourcing and support. At the same time, the field projects have enjoyed sufficient autonomy – in part due to the strength and experience of Field Coordinators – and in some cases unusual lines of reporting and responsibility, as compared to MSF's normal modus operandi. This has given the projects' leadership teams the necessary latitude to define and achieve their objectives as they see fit, especially given MSF's lack of expertise in this field. This combination of field-level autonomy and high-level buy-in has been ideal for putting different models to the test in different environments as MSF grows its experience base on the subject.

Holistic model of care, with especially strong physio and cultural mediation. Though new to the modalities of torture rehabilitation, staff of the three clinics have taken up a trauma-informed, holistic model of care, featuring especially strong physiotherapy services and – in project B and project C – strong cultural mediation capacity. Each clinic has developed its treatment model experientially, and while all of them are holistic, they have (appropriate) variations in their therapeutic approaches and case management systems. Comparing with general MSF practices in the field, it is especially outstanding that all disciplines are equally empowered to weigh in on case management decisions and the design of therapeutic plans. Across the clinics, physiotherapists have taken it upon themselves to begin developing shared protocols and systems; and in project A, physiotherapy has significantly better retention and lower attrition than other services. This speaks to the centrality of physiotherapy to torture rehabilitation, and also presents a potential added value for MSF to build on the early work of physiotherapists to define common treatment protocols, develop collective data collection tools, and share best practices with one another. Then, project B and project C have deep respect for the value of cultural mediation in tailoring treatment plans to individuals of refugee backgrounds; both teams have closely integrated cultural mediators into case management, to impressive effect.

Advantages of the partnership model. Working so closely in partnership with local NGOs – whereby these partners are mentoring MSF based on their experience in torture rehabilitation – is a point of strength for the VoT program. The clinics B and C, in particular, have designed strong partnership models, whereby MSF and its partners share a physical space and have put in place a foundation for joint case management. In project B, MSF was able to strengthen a pre-existing project that offered psychosocial and legal services to torture victims, by taking charge of the medical component of care and launching a dedicated facility for comprehensive case management. In project C, the clinic's model of care was based on the model of a local medical NGO that has treated victims of torture in country C for more than thirty years, and MSF has started to professionalize their organizational capacities for strategic planning, financial

management, and fundraising. Moreover, such partnerships make possible a range of opportunities for local capacity-building, advocacy, and handover. And while clinic space is shared to some degree in both projects B and C, the partnerships can be reinforced with greater co-location, whereby MSF and partners would have a progressive integration or 'merging' of personnel in the day-to-day operation of the clinic. Beyond the daily interactions with partners at project level, external partners have offered additional support and technical expertise, and this has been mentioned by many interviewees as one of the keys to success.

LuxOR's engagement in data management and research, especially with project A. LuxOR has done a commendable job to develop an EpiData-based data management platform for the three clinics and to facilitate a multi-pronged research initiative in project A based on this platform. LuxOR initially developed the platform for the clinic A in 2014, using participatory methods to select service-level inputs and indicators. And while project B and project C have adopted and adapted the platform with LuxOR's support, it has not earned the buy-in of clinic staff in those cities. However imperfect, it is currently the only available mechanism to systematically track patient outcomes, identify the value and performance of different specialties, and better understand the needs of the cohort. For example, a LuxOR team worked closely with project A staff to conduct six retrospective studies of project data, which, among other findings, identified high rates of patients lost to follow-up and offered several hypotheses as to why. Together, LuxOR and clinic supervisors then devised a qualitative study to pursue this line of inquiry, which could help the clinic target those populations most in need or those most likely to benefit from the service. All the while, LuxOR has sought to train project staff and strengthen field-level capacity in data analysis. OCB should ensure that field representatives are equipped with the tools and skills to collect and analyze their own data, and then also ensure that either LuxOR, or some other internal unit or external agency, is able to accompany the projects in the roll-out of improved data management systems.

6.2 WEAKNESSES

Insufficient data quality control, and lack of a comprehensive M&E framework. While the EpiData system is in place, the data collection process is haphazard across the clinics. Forms are frequently late, incomplete, or inaccurate – when they are encoded at all. Errors and discrepancies are thus common in the database, and can be attributed to poor quality control on the part of clinicians, data operators, and supervisors. Moreover, the platform does not enjoy the buy-in of staff in project C, especially, and also some clinicians in project B, who report that indicators are not aligned with their treatment approach. As a result, some clinicians in these cities perceive the EpiData system as a 'useless' and 'heavy' burden, and use their own templates and notes to track their patients' progress. Indeed, many complaints have been fielded about EpiData at all levels, and a decision should be taken to either adapt it or start over with a new platform. Then, there is insufficient data management capacity at the three clinics. In project A, a mission-level epidemiologist is required to lead a multi-pronged research agenda. In project B and project C, there is simply insufficient time for the data operators, who are also receptionists and schedulers, to enter or analyze data; and even if they had the time, they have not been sufficiently trained. Data management improvements should be embedded into the design of a VoT-specific monitoring and evaluation framework, for which HQ or external advisory services will be required. This comprehensive M&E framework should look beyond the EpiData system to systematically capture qualitative evidence of patient outcomes and perspectives, either through sensitive interviewing techniques or culturally responsive and participatory questionnaires.

Limited knowledge transfer on medical documentation of torture. While medical documentation of torture has been identified for years as a central interest and component of care by HQ, the field projects have pushed back and have not managed to implement a uniform protocol for medico-legal documentation. Acknowledging some contextual specificities for the projects, this can be attributed partly, but not only, to a lack of clear communication and transfer of knowledge about the value and purpose of medical documentation of torture. The clinics currently issue 'medical reports' upon request to patients who are integrated into their rehabilitation program; however, there is considerable doubt about the quality and utility of these reports. (In this regard, project C is better off, with a well-trained, part-time forensic medical consultant in charge of this process.) What more, there are practical challenges to medical documentation in the different operating contexts, with regard to the services that have performed this function in the past, what is known or acceptable in the political environment, and the particularities of the different asylum services. Managers and staff acknowledge that documentation and asylum are part of the rehabilitative process; however, they prefer that treatment and documentation be done by separate teams, out of concerns for the therapeutic relationship and to prioritize treatment over documentation. There are also fears of reputational risk and questions about the value of medico-legal reports in the given local contexts. Based on IRCT's prior assessment and the evaluation team's own interviews, there seems to be a gap in the provision of medico-legal reports as per the Istanbul Protocol that would be useful in obtaining a positive outcome for victims of torture who seek asylum, refugee status, legal protection, financial

assistance, or resettlement. Medical documentation is acknowledged globally as a central component of torture rehabilitation when patients wish to pursue legal proceedings or asylum. While IRCT's reports acknowledge that 'the systematic issuance [of medico-legal reports] should be avoided in the framework of this project', they also identify the medical documentation as a 'critical need'. According to IRCT, 'This should be considered in particular cases, in which there is a clear intention to undertake legal proceedings or for asylum procedures in countries where the [Istanbul Protocol] is recognized'. It is advisable that HQ take a direct role in sensitizing clinic staff about the value and purpose of medical documentation of torture; and support the clinics in creating a platform to begin providing these certificates and to build (alongside local partners or forensic medical faculties) a permanent capacity that can offer such a service.

Poor integration of the clinics' experiences; no uniform model or shared knowledge products. Assumedly, MSF has developed some level of expertise in working with torture victims over the years; however, MSF has yet to collect or compile these experiences in a meaningful way, for either internal capacity-building or external awareness-raising. The development of the three projects has been largely ad hoc until now; time has come to consolidate the model of care and develop common case management systems and treatment protocols per specialty. This will involve (1) building out the EpiData system, or investing in a new cross-cutting data management platform; (2) devising a comprehensive M&E framework for the VoT program, either by drawing on current HQ capacity or by engaging external advisors; (3) identifying shared advocacy opportunities; and (4) collating the common determinants of a holistic therapeutic approach, while maintaining sufficient autonomy at field level. These outputs should be conceived as a set of knowledge management exercises, and as such will need HQ's investment of medical and non-medical expertise to synthesize and shape the model of care for MSF purposes. Any resulting knowledge products could fill gaps in the existing literature on VoT and be of added value. A clear starting point for this effort is to take advantage of the shared foundation built by the physiotherapists of the three clinics, and create an MSF-specific protocol and data tracking system for physical rehabilitation of VoT. This can be published as a knowledge product or guide from which others could benefit as well.

Gaps in the management structure of the VoT program. While the projects have enjoyed a high degree of freedom, and this has been a distinct advantage, they have survived and thrived largely on the strength of their respective Field Coordinators. Fatigue and job-related stress are real for these project managers, and additional support at mission and HQ levels is required – specially to harness institutional learning. Across the projects, consistent frustrations were voiced about not being heard or experiencing delays at HQ level, not only from managers, but also down the line, e.g. when technical training or counsel was requested. Moreover, the mission C has deputized supervision of the VoT project C to a Deputy Head of Mission, and the VoT project B was outside of the mission's ambit during emergency and post-emergency periods for about six months in total since inception. In project A, the mission and the project have long been one and the same, effectively, but there have been some misunderstandings about roles and responsibilities in this setup. As a special initiative of MSF, the VoT projects should continue to enjoy their semi-autonomous status vis-à-vis the missions; limiting this could put in jeopardy the creativity of the learning-by-doing approach. However, additional support from HQ could come as an acknowledgment and backing of the projects' self-defined needs, while streamlining knowledge transfer from HQ to the field. This could take the form of a full-time Torture Referent, as done in 2014. Currently, the roles of Torture Focal Point and Medical Deputy Operations Coordinator are assumed by one person at the cell in charge of migration interventions. This role should be split, and MSF should engage a Torture Referent for the duration of the VoT initiative. The Torture Referent role would include the following objectives: (1) facilitate coordination on VoT among various HQ departments, cells, missions, and projects; (2) oversee uptake of recommendations from this evaluation; (3) liaise with external advisors, both individuals and organizations, to complement MSF rehabilitation activities; and (4) serve as the point of first contact for Field Coordinators in technical matters related to torture, ill-treatment, and rehabilitation of victims. Such a capacity will be required should MSF wish to take this initiative to the next level and to better define the way forward.

6.3 OPPORTUNITIES

A unique vantage point for cross-cutting advocacy. MSF finds itself in a unique position at the nexus of the refugee crisis in Europe and the systematic torture experienced by people crossing the Mediterranean or biding their time in transit countries. Although new to the field of torture rehabilitation, MSF's three clinics now provide the most widespread offering of specialized torture treatment services for this population. And yet, no medical-related advocacy messages have been defined or agreed; this should be the first step. In country C and B, there are quick and easy ways to capitalize on this experience by attaching the issue of torture to the mission's high-level advocacy efforts on refugee protection and policy, including early detection and management of vulnerable groups. Another prime opportunity is to promote the criminalization of torture in country C, which is pending, and which would also guarantee access to rehabilitation for torture survivors. The 1984 UN Convention Against Torture, to which country C is party, requires countries to

criminalize torture within their jurisdiction. The treaty also requires States Party to ensure that torture victims have access to rehabilitation services. Country C has done neither, and this is where advocacy can be useful, to ensure that national legislation is compliant with international law so that people have access to this care. These easy advocacy wins would be different from local capacity-building, which project B has undertaken for example and which should continue. Rather, this is about high-level policy advocacy at national, EU, and UN levels at the nexus of the refugee crisis and torture, to improve public and elite awareness of the situation of torture among Mediterranean migrants and to secure these populations' access to care and access to justice.

Potential for research to fill gaps in the literature on torture rehabilitation. Based on LuxOR's success with the project A team, a concrete research agenda could be designed and implemented that figures out which populations are best served and how, and that identifies and fills gaps in the literature about the medical rehabilitation of victims of torture, as MSF continues to find the place for a medical organization within the VoT field and define advocacy objectives. This is especially important given MSF's singular access to victims of torture among the latest wave of recent arrivals and those still in transit, which is an unstudied population. The research can also help design proactive mechanisms to improve coverage and facilitate access to the clinic of the most vulnerable groups, especially people outside formal systems of care. LuxOR is already preparing another six retrospective studies or mini-research projects with the project A team. OCB should either enter discussions with LuxOR to expand their work with project B and project C, or else engage comparable technical assistance from different mechanisms, units, or services within or outside MSF. Research can culminate in knowledge products that could be widely published as medical protocols, online toolkits, or research papers in professional journals. MSF must first take care of its people and assets, and pursuant to proper risk analysis, should not uncritically fear publishing research conducted in country A. Any publication thereof could be considered part of MSFs ethic to speak out, as it would be related to better understanding the needs and improving the medical care of a highly vulnerable population.

6.4 THREATS

Threats in the operational environment. Torture rehabilitation can be life-threatening work. The public discourse about the refugee crisis in country C and country B is highly politicized and in flux, certainly. But in country A, the situation is far more precarious. Civil society groups in country A face an existential threat in the face of unprecedented attacks by authorities. Most acutely, since February 2016, the authorities in country A have repeatedly tried to shut down NGO 8 after the government ordered its closure. Country A nationals are themselves being arbitrarily arrested, arbitrarily detained, forcibly disappeared, killed extra judicially, and subjected to torture and ill-treatment. International actors also face expulsion, detention, surveillance, and harassment. Whether MSF pursues vertical interventions in future or a globalized 'mainstreaming' approach to treat victims of torture, it is important to remember that torture is a tool of political repression. It could thus be more sensitive and dangerous to offer specialized care to victims of torture in fragile or conflict-affected environments, than to offer medical care to the war-wounded in a spirit of neutrality, for example. In the Mediterranean region, this kind of dilemma could arise easily during interventions in several countries. MSF must stay apprised of the situation in such places, studying how torture, migration, and detention are linked around the Mediterranean. Beyond the shores of the Mediterranean, MSF needs to stay aware of the political and security conditions in any potential operating environment, and understand who is committing torture against whom and why, because these dynamics could threaten the safety of staff and physical assets providing any torture rehabilitation service. The political economic study of armed violence and human rights with a special focus on torture would sharpen MSF's ability to treat victims of torture and ill-treatment while preserving its ability to speak out and mitigating threats to staff and assets.

Lack of diversification. The fact that MSF has developed this trio of torture treatment centers for people crossing the Mediterranean and in littoral transit countries means that they have developed special access and know-how to treat this population, which is a distinct added value. The target countries in southern Europe and North Africa exhibit some diversity of population and context. However, for OCB, if the goal is to learn about torture rehabilitation and how to do this in interventions across the world, then there is a threat of insufficient experimentation in sufficiently diverse contexts. For starters, the fact that two of three clinics are in Europe – where there are fragilities, but relatively democratic and stable infrastructure and institutions – is at odds with the bulk of developing countries and conflict-affected environments in which MSF normally works. If MSF's learning is drawn disproportionately from contexts in Europe – while highly relevant to emergency humanitarian efforts featuring mass displacement and migration – it could later lead to difficulties in translating or applying this learning to resource-poor contexts or places of low-level civil conflict. One option is to double down on this focus and squeeze out all the learning and impact one can from these clinics, and even extend the geographic coverage around the Mediterranean, as the situation of torture among the

target population is worsening; then, when thinking about next steps, it would be wise to diversify the learning environments – perhaps looking to sub-Saharan Africa, or especially to Asia, where the scourge of torture is metastasizing.

The coming existential crisis. There is a threat to the clinics' operation related to a set of issues involving coverage, sustainability, and resource-efficiency. The evaluation team foresees that the three VoT projects will soon be faced with a fork in the road, and that hard choices will have to be made in the coming months and years. This is because the capacity of the clinics is full; so the projects must decide who their primary target populations are and how to reach them given resource constraints. A closer mapping of the population and needs of migrants would be useful in this regard. Related to this question of capacity is the clinics' resource-efficiency. As compared to project A, the projects B and C require heavier investment of human and financial resources, mainly due to their chosen therapeutic approach. Of course, torture rehabilitation in general – and especially the holistic modality adopted by the clinics – is resource-intensive. And this could be a smart strategic choice; it is a hallmark of the Inverse Law of Care, which states that the people who have the least should get the most care. But it begins to pose questions in terms of getting maximum impact for vulnerable people in response to urgent needs. Specifically, resource-efficiency issues will complicate future efforts to expand coverage or replicate the service. The projects will have to make some strategic choices in the near future, namely whether they wish to construct a prototypical clinic that offers a model service ('quality over quantity') – which, for example, is the stated desire of project leadership and staff in project B and C – or whether they wish to expand coverage by identifying economies of scale or changing the modality of operation, or simply operate in cheaper contexts where needs are equally great or greater. To guide these strategic choices, counterparts at field, coordination, and HQ levels must seek alignment on the ultimate objective for the VoT program – i.e., meeting the population's needs, establishing a model service for industrialized contexts that might face humanitarian crises, strategic learning for MSF, or other.

CONCLUSIONS & LESSONS LEARNED

The projects are clearly responsive to the nature – if not the scale – of the needs of the target population. There is a noted lack of quantitative data, but based on interviews with patients and staff, the clinics in projects A, B, C are making a difference in beneficiaries' lives. Interviewed patients reported improvements in their physical, psychological, and social conditions, and attributed these improvements to the care they received from MSF. All told, the clinics have treated 1900 victims of torture with medical care, physiotherapy, mental health services, and socio-legal support. That said, the situation of torture among people crossing the Mediterranean is vast and appalling, with hundreds of thousands more refugees and migrants needing rehabilitative care after escaping abuse in their home countries or brutal conditions of labor and detention en route.

The projects have mixed results with respect to OECD-DAC criteria. By and large, the projects perform satisfactorily against OECD-DAC criteria of relevance, impact, effectiveness, efficiency, and sustainability. The projects have valid goals and strategic objectives, are optimizing their use of physical and human resources, and – with the exception of project C – are accessible to women and vulnerable groups. On the flip side, the projects are not well-connected within their respective missions, and are particularly weak on sustainability, with a lack of handover planning across the board, little to no capacity-building of local actors in project A and project C, and few prospects for contributing to systemic change.

MSF is on track to meeting it original objective – but hasn't achieved it yet. The VoT initiative launched with the objective to learn how to detect and manage VoT cases in any context where MSF might operate. In this respect, the three projects have found some agreement on the common elements of care provision, in the form of holistic torture rehabilitation, a treatment modality that combines medical care, physiotherapy, mental health services, and socio-legal support. Rounding out these services, the experiences of the projects demonstrate other lessons learned: the need for preventive psychological support to staff, the importance of networking with international subject-matter experts, and working in partnership with local associations. That said, these lessons are drawn from specific contexts that differ greatly from the resource-poor, conflict-affected environments in which MSF usually operates. What more, no quantitative analysis has been able to confirm or validate the impact of the interventions generally. Consequently, it is too early for MSF to conclude its learning effort or initiate any formal integration of VoT care across its global projects.

MSF ought to move fast to consolidate its learning. MSF adopted a learning-by-doing approach to acquire experience and a pool of expertise on torture rehabilitation. It has been five years since the start of this exploratory initiative, and three years since the launch of the clinics; and yet, MSF has limited evidence to show for it. There is no way to gauge how much MSF has learned or how much expertise it has acquired, because these experiences have not been capitalized so far. The two exceptions are LuxOR's research program in project A and the physiotherapists of the three clinics, who took it upon themselves to develop common case management systems. More can and should be done, in terms of building out the data management platform, designing a comprehensive M&E framework specific to VoT, analyzing existing data, and publishing knowledge products like research briefs and medical protocols.

MSF must know what it doesn't know. Unlike MSF's other cross-cutting services – like mental health, sexual violence, and HIV/AIDS – torture rehabilitation as a professional practice was conceived in the world of international human rights law, rather than in public health, even though it implicates specialized medical care. MSF, as a medical organization, thus has an awkward positioning vis-à-vis torture rehabilitation across the three projects. Direct legal assistance and the medico-legal documentation of torture – even though acknowledged to be part of the rehabilitative process – are deprioritized and insufficiently integrated into the model of care across the clinics. People at MSF have tried, both at HQ and field levels, to negotiate the difference, but there has been resistance, and it has not amounted to much. The challenge seems to be the organizational culture, which privileges medical care, sometimes to the exclusion of related needs.

Let it be. Whether intentional or not, the VoT initiative has developed a life of its own and found a niche for itself. The individual projects have cropped up through a mix of conscious intention and exploration on the one hand, and seizing advantage of opportunities as they present themselves on the other. As the VoT initiative assumes a critical mass, MSF

must cultivate a network effect among the projects so that, effectively, they direct themselves and their own future. A networked VoT initiative would play to its strengths – by consolidating its impact and influence vis-à-vis the Mediterranean mixed migration crisis – and would also find resilience in the further diversification of operating contexts.

RECOMMENDATIONS

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

⇒ Recommendation 1: Invest resources into an **integrated data management solution**, and embed this into a **comprehensive, VoT-specific M&E framework** that accounts for patient perspectives.

⇒ Recommendation 2: Find alignment on the **ultimate objective** for the VoT initiative, and consider the **diversification of learning environments**, before selecting another project site

⇒ Recommendation 3: Engage in **experience capitalization exercises** to create **publishable knowledge products**, like operational research briefs, scientific papers, technical toolkits, and medical protocols.

⇒ Recommendation 4: Take advantage of **quick and easy advocacy wins** by hitching the issue of torture to **high-level advocacy efforts** on refugee protection and access to care.

⇒ Recommendation 5: Engage a **full-time torture referent** who can help chart the course forward to take the VoT initiative to the next level.

ANNEXES

ANNEX I: DATA PROFILE OF THE THREE CLINICS

What follows is a data profile of the three clinics with graphs and key interpretations. Because of severe limitations with regard to the completeness, representativeness, and reliability of collected data, this data profile should be interpreted with great caution. Information is presented in four main areas – (1) patients' profile; (2) torture typology; (3) patients' identified needs; and (4) clinic workload – and disaggregated where possible by clinic. All data were verified and validated by project managers.

It is important to note that the graphs across the three projects are not direct comparisons; the timelines and data sources vary. In project A, data were extracted from EpiData project files. In project B, different data sources were used, mainly monthly reports, but also clinic registers and social work databases. In project C, all data were extracted from available monthly reports. Data sources and time ranges are specified on each graph. Only data with an acceptable level of reliability (subjectively assessed) were included in this profile. Other data, relating to patient outcomes and average number of consultations, for example, were scrutinized and eventually excluded.

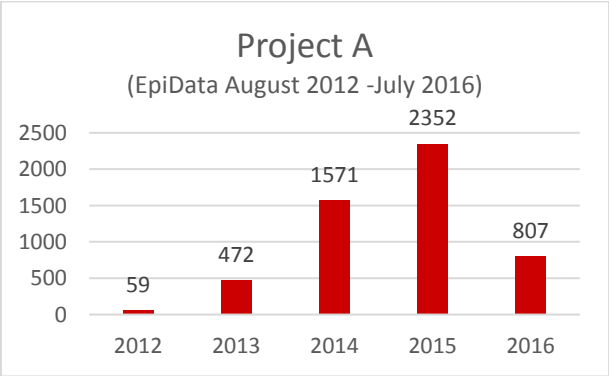
The limitations with data reinforce the evaluation team's conclusion that data collection and analysis are major challenges for these projects.

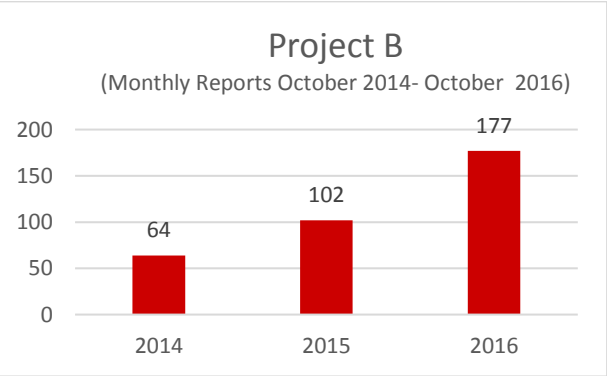
PATIENTS PROFILE

Figure 1. Patients served per clinic, by year (all types of patients included)

These graphs show the number of patients served by the three clinics by year. All patients who attended the clinic at least once in the year are included. This is especially important to consider in project A, where the numbers include non-VoT patients, like mental health and sexual violence cases, which have been part of the clinic's scope. Note that the first column of each graph for project B and project C covers only a three-month period.

The large number of patients in project A (up to 2352 in one year) is in line with the size of the needs identified and mentioned earlier. In project B and project C, many fewer patients are treated (63 in project C in the first ten months of 2016). This was a deliberate choice of the projects, and may also reflect the fact that the target population is smaller and that there are more actors on the ground to treat them.





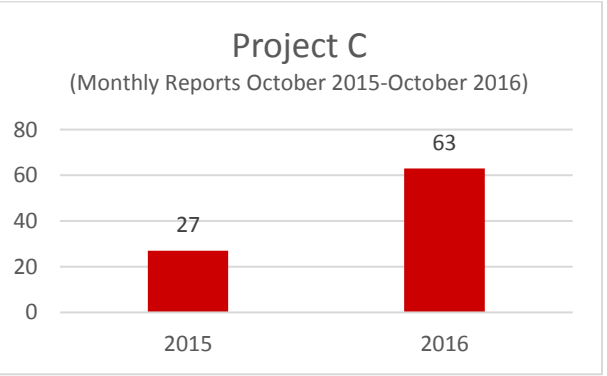


Figure 2. Patients served per clinic, by type of patients

VoT patients in project A represent a minority (20%) of all patients. This is, at least in part, because the VoT component of the project was introduced at a later stage.

The opposite situation prevails in project B, where the clinic always focused on victims of torture and ill-treatment. Although they did not fit the strict definition of VoT, 10% of all patients were accepted as an exception.

No data was available from project C on this topic.

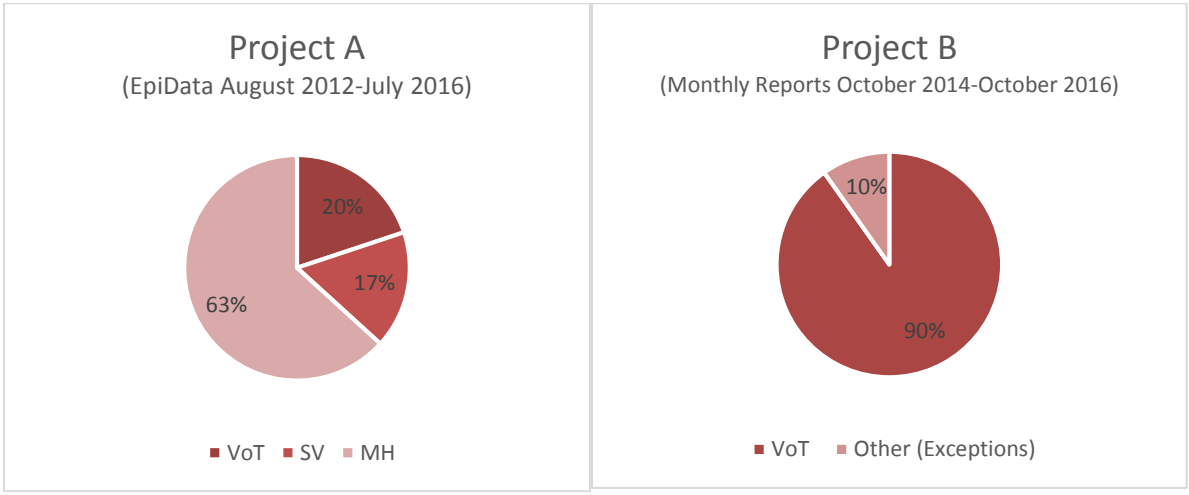


Figure 3. Patients served per clinic, by gender (VoT patients)

All graphs presented below (and through the remainder of this annex) correspond to data exclusively related to VoT patients.

At all three clinics, more men were served than women. Women represented 40% of patients in project A and 23% of patients in project B. Although data were not available to determine how these percentages correspond to the gender distribution of the local migrant population, generally speaking, men vastly outnumber women among the population of refugees, asylum-seekers, and migrants around the Mediterranean.

The very low percentage of female patients in project C (3%) reflects an accessibility challenge. No formal analysis of the reasons for this phenomenon has been conducted at project level.

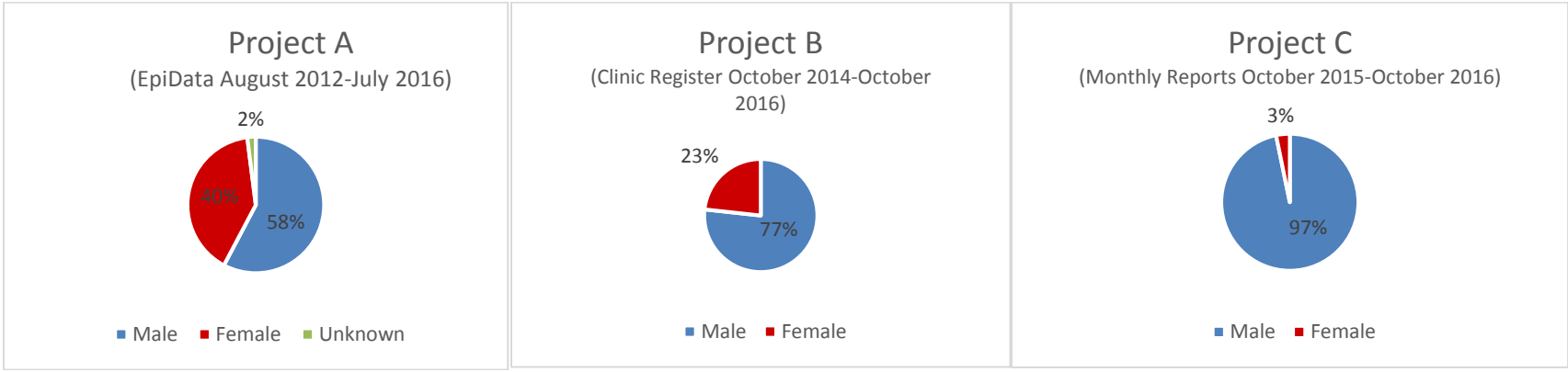


Figure 4. Patients served per clinic, by age (VoT patients)

Because each project uses a different classification system for age groups, comparisons are difficult.

Overall, the majority of VoT patients are young. 64% of patients in project A report being between 18 and 44 years old. 54% of patients in project B and 72% of patients in project C are between 20 and 40 years old.

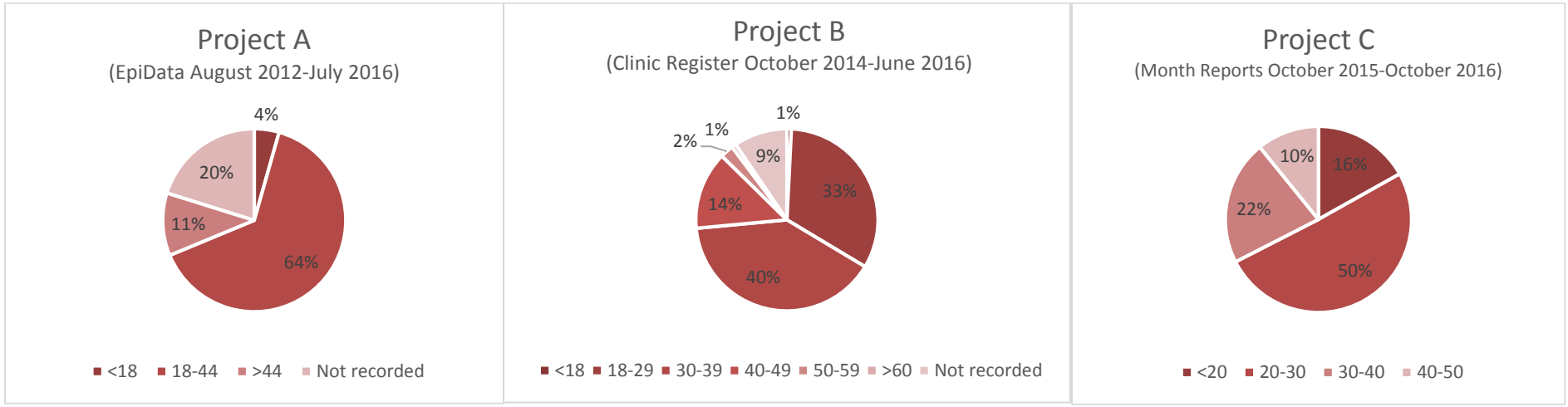


Figure 5. Patients served per clinic, by country of origin (VoT patients)

In this set of graphs, only countries representing at least 1% of the patient population are included.

Countries represented in project A correspond to the specific migration routes through country A. Project C is the clinic with the most ethnic diversity, having served nationals of more than 22 countries with at least 1% of the population.

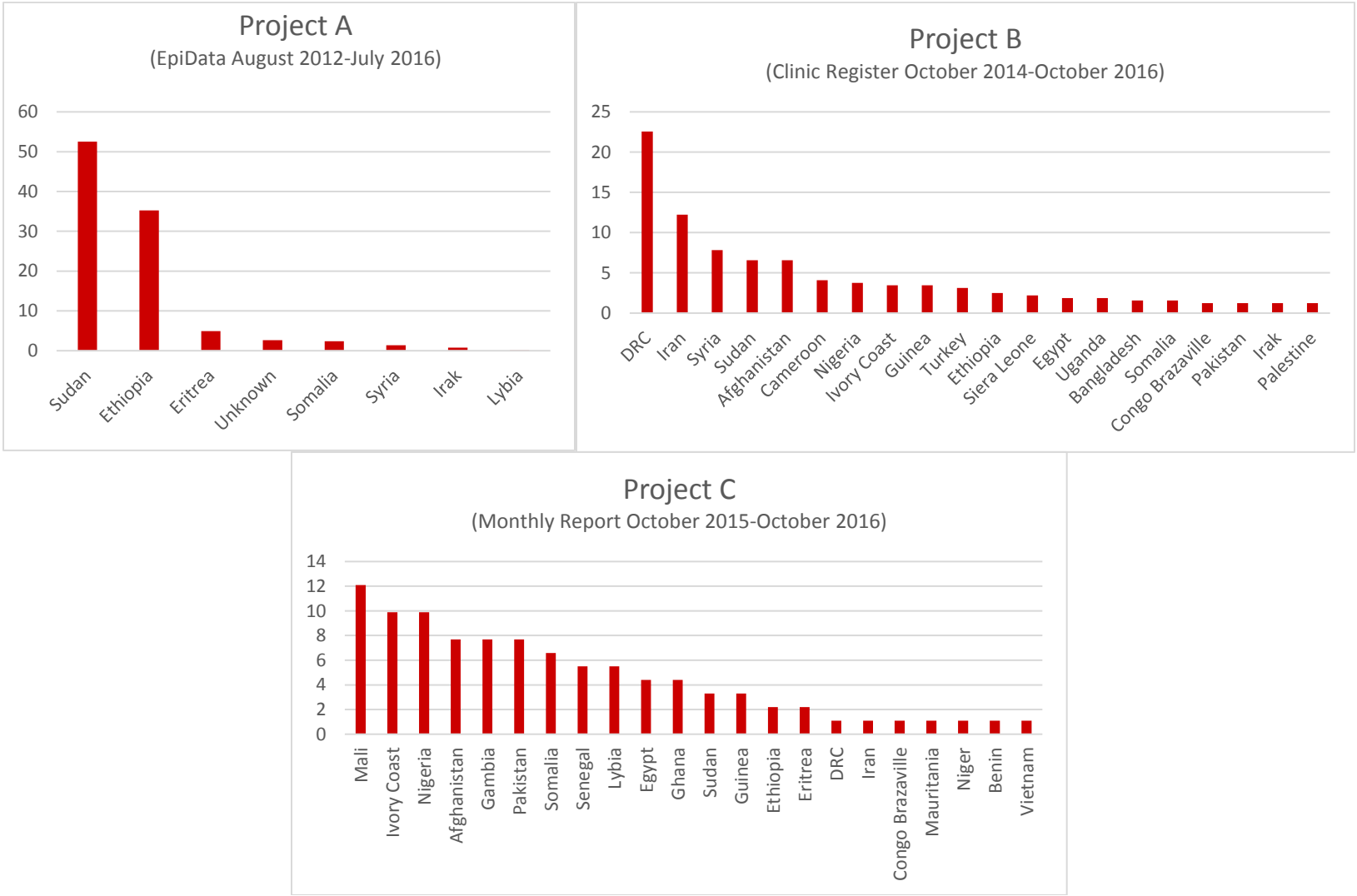
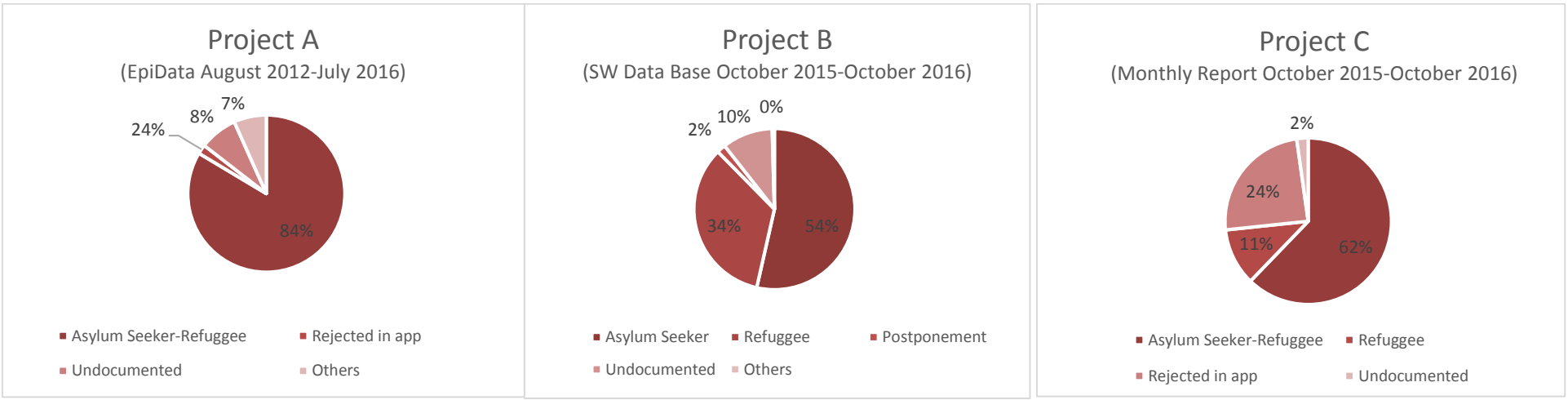


Figure 6. Patients served per clinic, by legal status (VoT patients)

Classification of legal status differs between projects and the data cannot be directly compared. In project A, asylum-seekers and refugees were recorded as a single group until March 2016. These two groups were also combined after this date to avoid misinterpretations of trends. In project B and project C, the majority of patients served were asylum-seekers (54% and 62%, respectively), followed by refugees.

Although a relatively low percentage of undocumented migrants is expected, there were very few in project C (2%). The possible role of a specific barrier to access for this population should be further investigated, although other reasons may be considered as well.



TORTURE TYPOLOGY

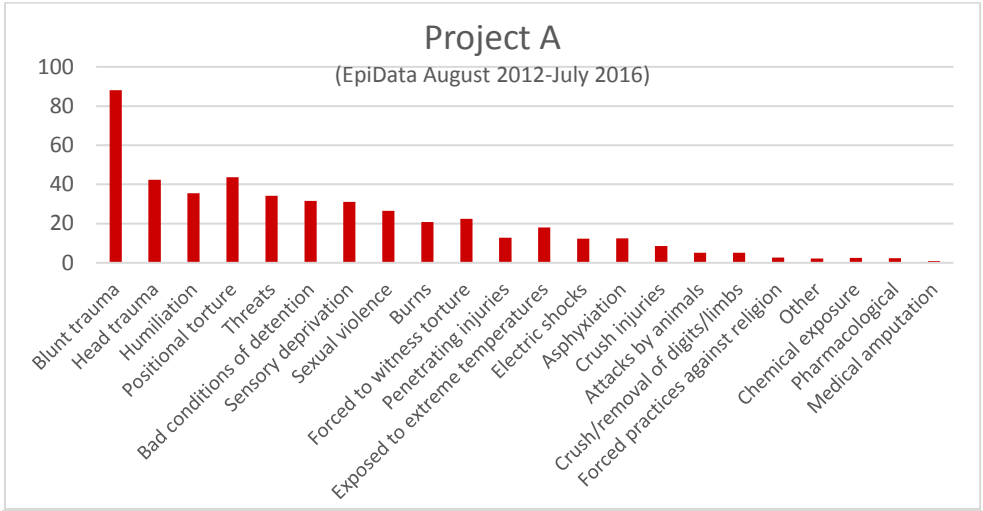
Figure 7. Type of torture reported by patients (%)

These graphs show the prevalence of difference types of torture and ill-treatment experienced by patients. Percentages add up to more than 100%, as one patient may report more than one type of torture or ill-treatment.

Blunt trauma appears to be the most prevalent type of torture in the project A and project B (88% and 76%, respectively), followed by positional torture in project A (43%) and humiliation in project B (68%). 25% of VoT patients of the two clinics suffered sexual violence.

Differences between the projects may reflect differences in countries of origin and migration routes, as specific torture techniques are more common in certain countries or along specific routes.

No data was available from project C on this topic.


Project A
(EpiData August 2012-July 2016)
100
80
60
40
20
0
Blunt trauma
Head trauma
Humiliation
Positional torture
Threats
Bad conditions of detention
Sensory deprivation
Sexual violence
Burns
Forced to witness torture
Penetrating injuries
Exposed to extreme temperatures
Electric shocks
Asphyxiation
Crush injuries
Attacks by animals
Crush/removal of digits/limbs
Forced practices against religion
Other
Chemical exposure
Pharmacological
Medical amputation

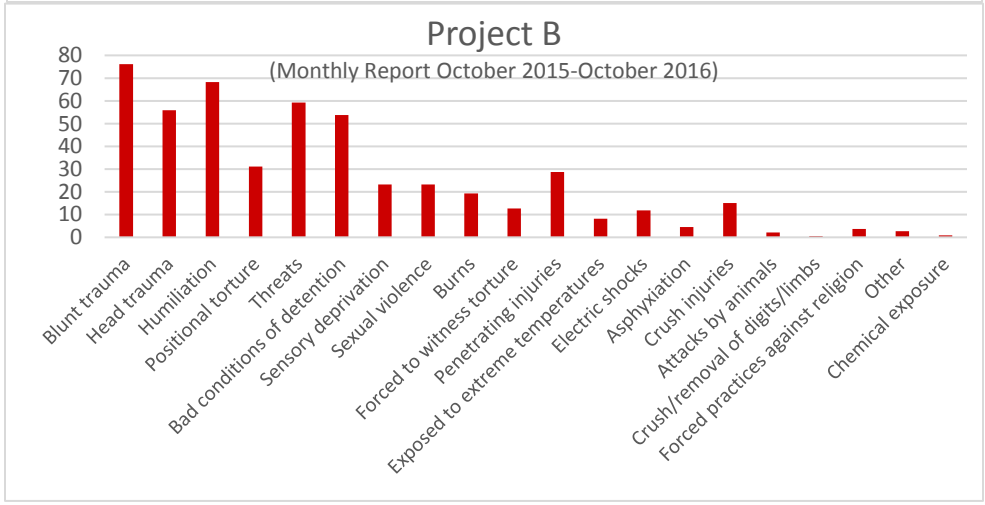

Project B
(Monthly Report October 2015-October 2016)
80
70
60
50
40
30
20
10
0
Blunt trauma
Head trauma
Humiliation
Positional torture
Threats
Bad conditions of detention
Sensory deprivation
Sexual violence
Burns
Forced to witness torture
Penetrating injuries
Exposed to extreme temperatures
Electric shocks
Asphyxiation
Crush injuries
Attacks by animals
Crush/removal of digits/limbs
Forced practices against religion
Other
Chemical exposure

Figure 8. Incident location, reported by patients (%)

Most VoT patients suffered torture in their country of origin (66% in project A and 86% in project B). There was no data available from project C on this topic.

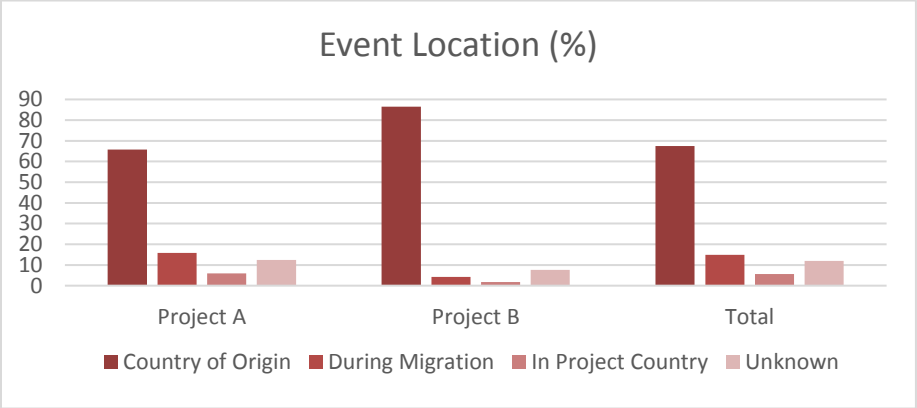


Figure 9. Incident site, reported by patients (%)

Here again, classification differed between projects and data cannot be directly compared. Only information from project A and project B is presented, as no data from project C was available on this topic.

These graphs show the distribution of sites where torture occurred. The percentages add up to more than 100% as patients could report more than one site.

Patients in project A reported being abused most frequently at a public institution (84%). Prison was the most common site of torture among patients in project B, with 33% of patients reporting abuse in detention.

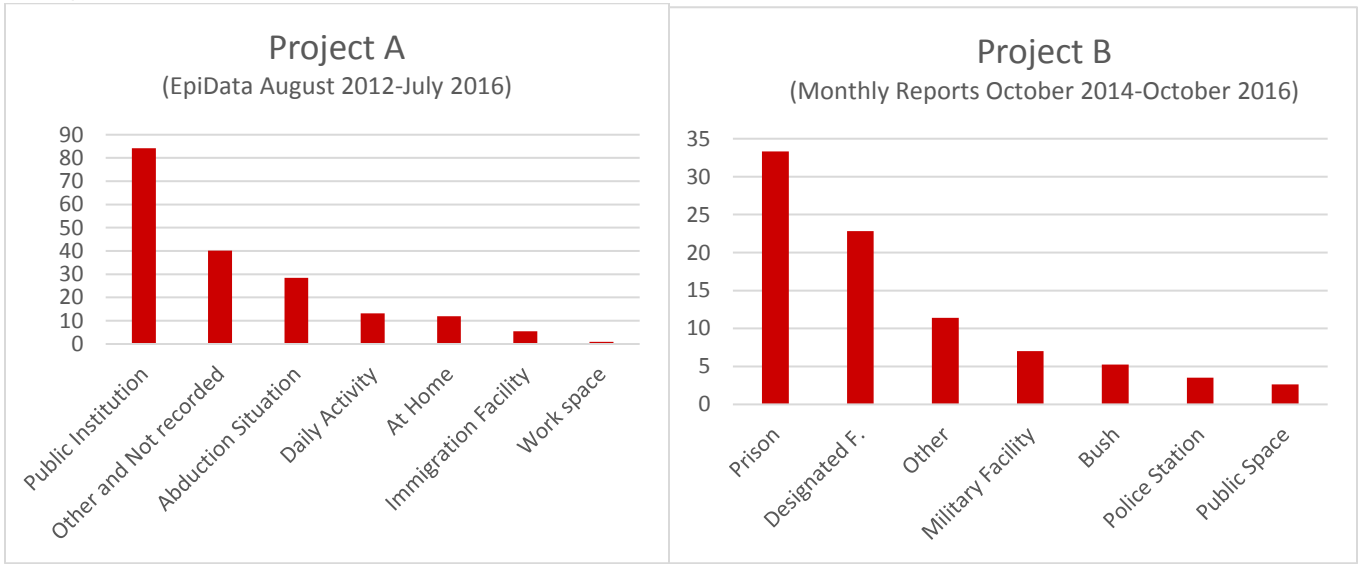
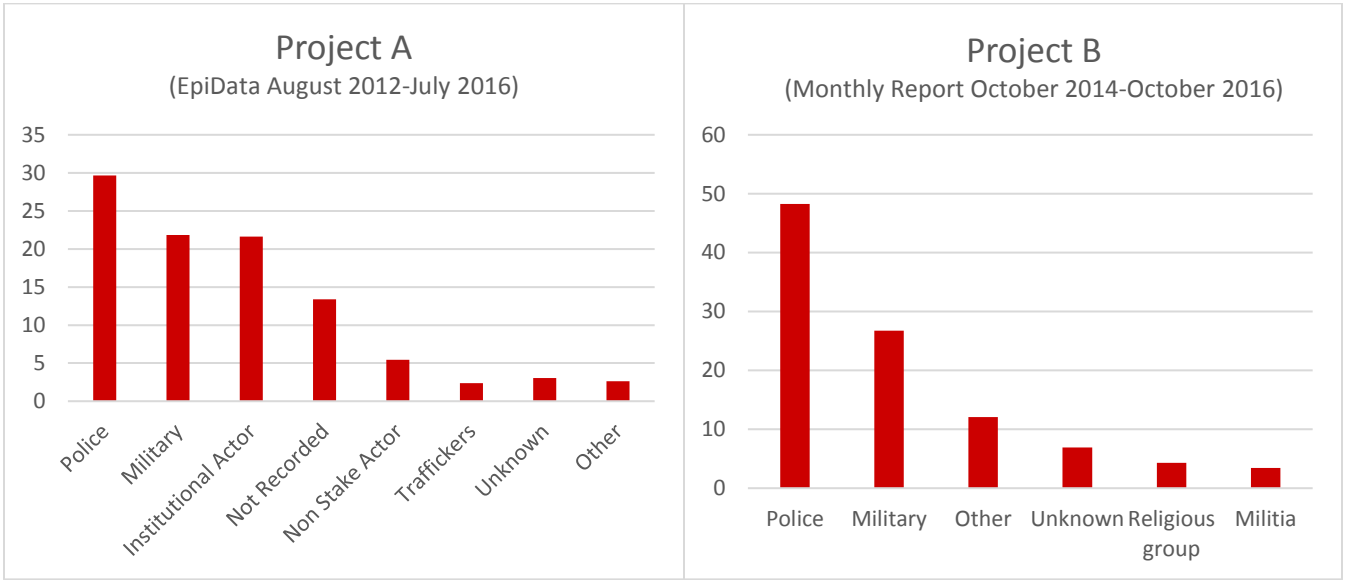


Figure 10. Perpetrators reported by patients (%)

Here also, classification differed between projects and data could not be compared or compiled. No data was available from project C on this topic.
In both project B and project A, police and military forces are the most frequent perpetrators as reported by VoT patients. In project B, police account for almost half of all cases (48%).



IDENTIFIED NEEDS

Figure 11. Prevalence of identified medical needs per clinic (%)

These graphs show the prevalence of medical diagnoses related to torture. Percentages have been calculated using the number of VoT patients presenting certain symptoms or complaints sequent to torture as numerator and the total of VoT attended in each clinic as denominator. The same patient can present more than one medical diagnosis and therefore cumulative percentages may be more than 100%.

As with most other analyses, classification differed between projects and data cannot be directly compared. No data was available from project C on this topic.

The most prevalent medical diagnoses were musculoskeletal (62%) and mental conditions (53%) in project B, and pain in project A (67%).

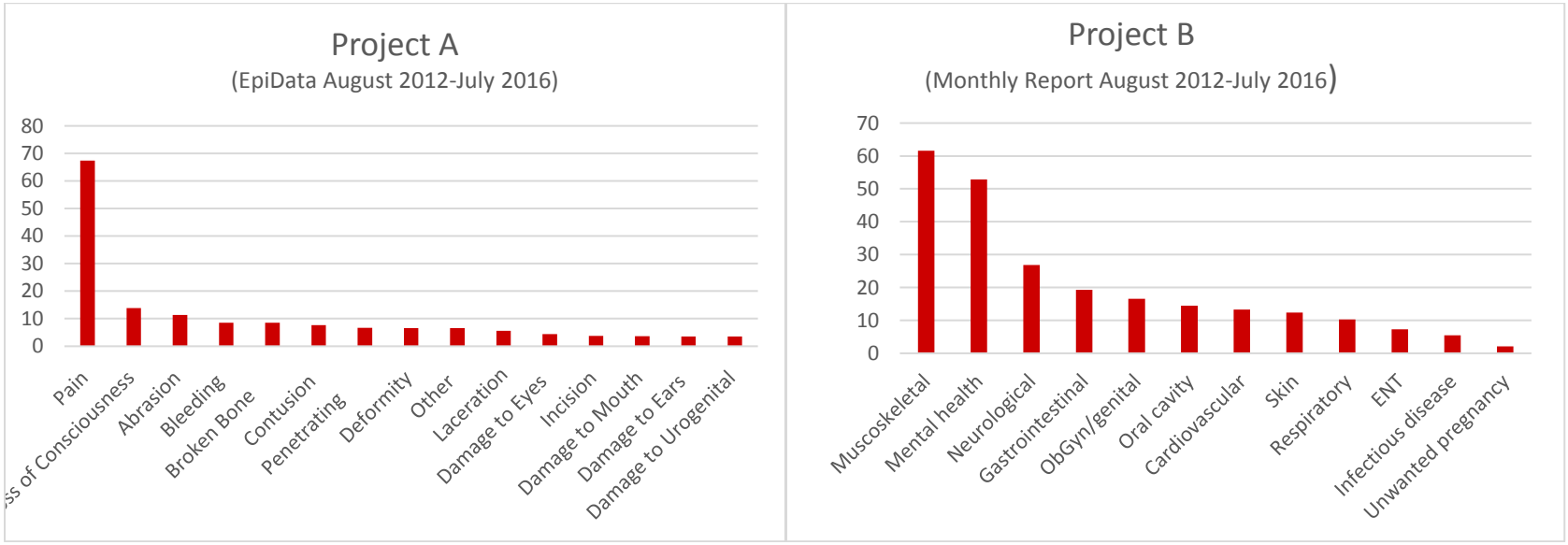


Figure 12. Psychiatric conditions (%)

Prevalence of psychiatric disorders among VoT patients is shown in this graph from project A. Percentages were calculated using the total number of VoT patients tended as denominator. No information was available from project B and project C on this topic. Conditions were defined and determined by mental health specialists of the clinic.

Depression and PTSD were the most common psychiatric diagnoses, representing 12% and 7% of all VoT patients, respectively.

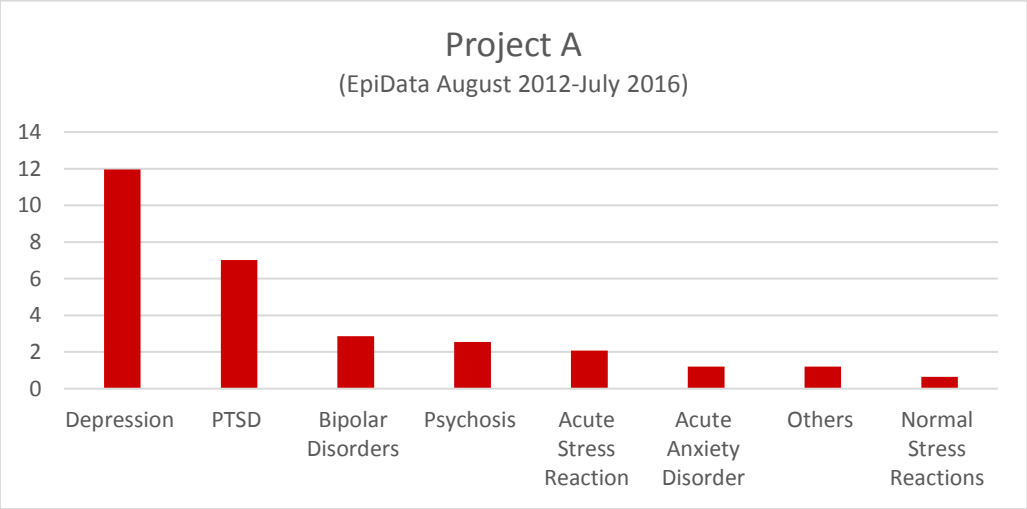


Figure 13. Psychological symptoms (%)

This graph shows the prevalence of mental health symptoms identified and documented among VoT patients by psychologists in project A. No information was available from project C on this topic. In project B, there was data available from only about half of the patients seen by psychologists, as the remaining mental health consultations were carried out by a partner organization.

40% of VoT patients in project A presented symptoms of PTSD. Other symptoms were much less prevalent.

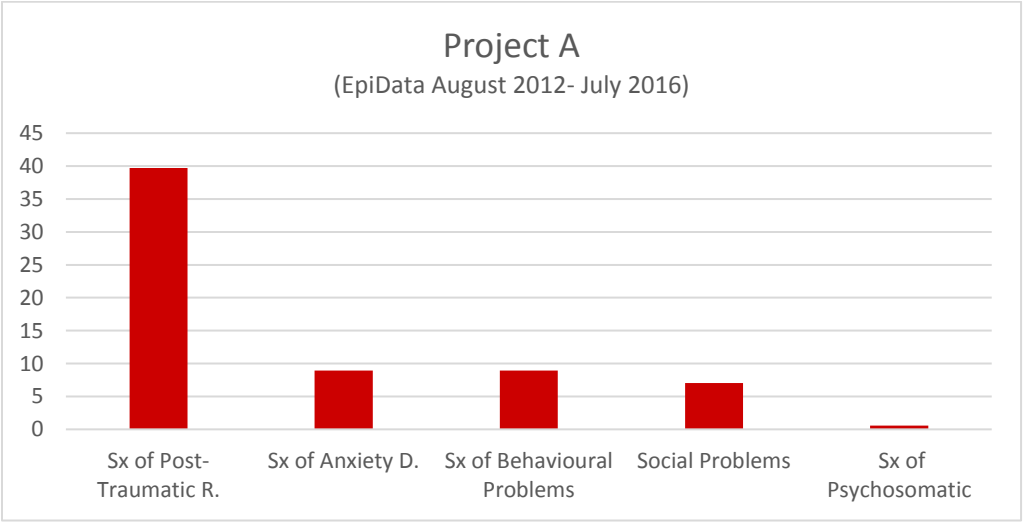


Figure 14. Identified physiotherapy needs (%)

In project B only was data on precise physiotherapy diagnoses available. Pain was the most prevalent symptom (31% of patients), an observation consistent with reported medical needs in project A (see Figure 11).

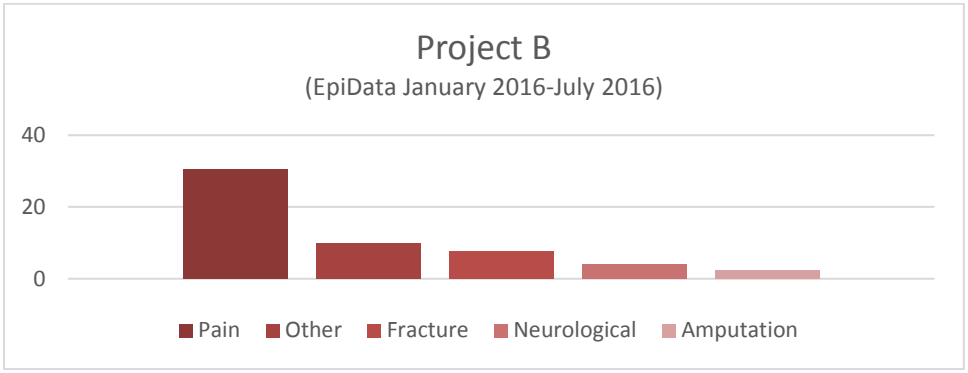


Figure 15. Social work referrals (%)

The number and the type of referrals made by MSF social workers in project B is presented in this figure. It can be considered as a proxy of the prevalence of social needs of VoT patients in the clinic. Percentages have been calculated using the total number of VoT attended in project B clinic. No information was available from project A and project C on this topic.

More than half of patients (52%) presented some material needs. Legal needs were the second most common reason for referral (32% of patients), followed by shelter/housing.

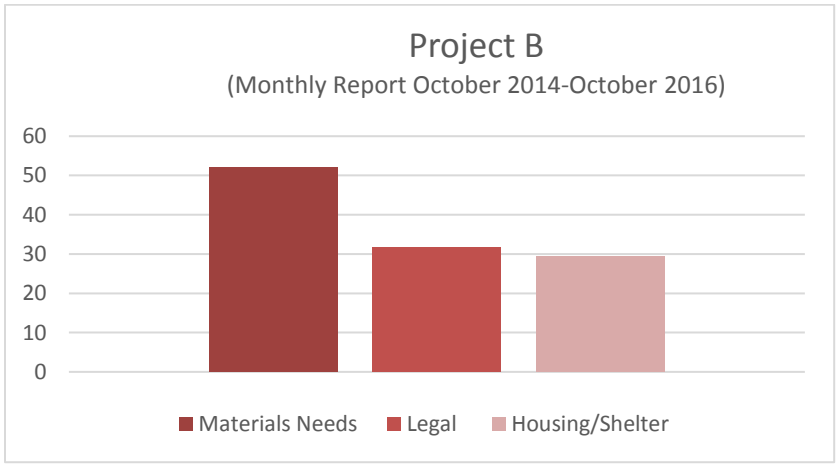
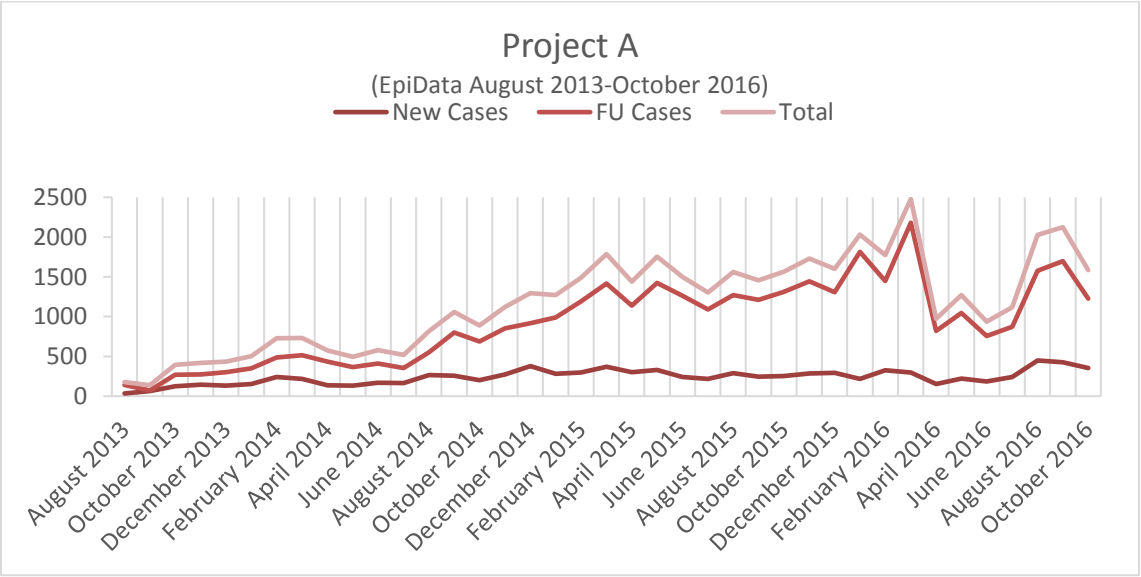


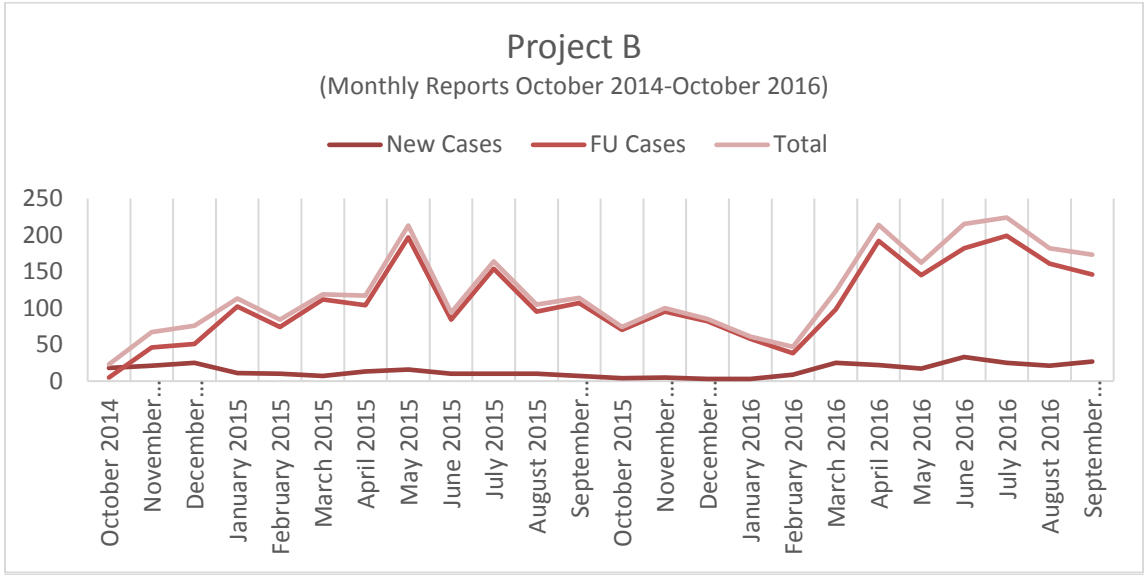
Figure 16. Number of consultations per month, by new and follow-up cases

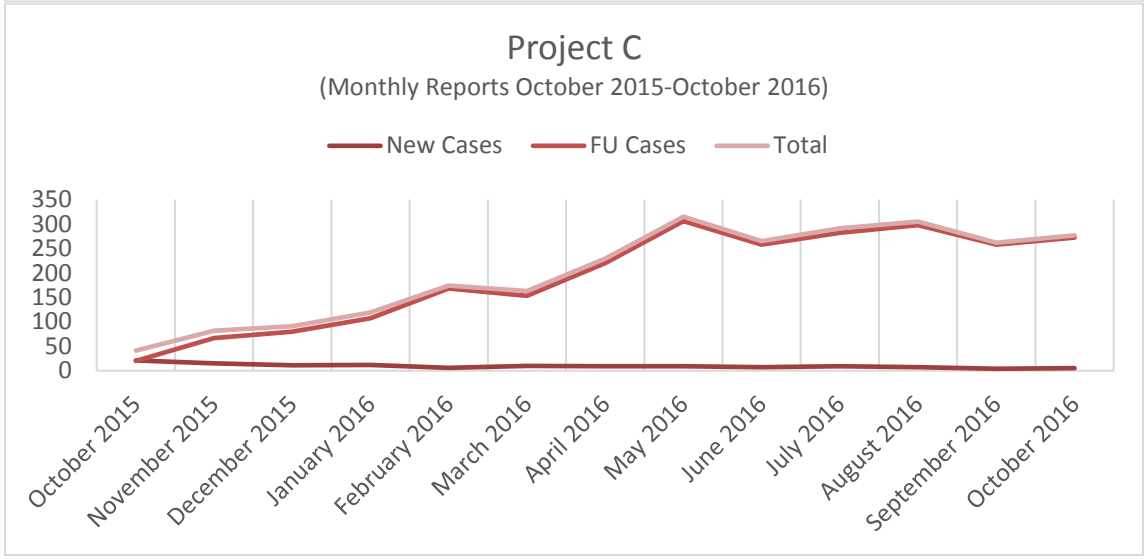
This set of figures shows the number of new and follow-up consultations per month. The total number of consultations differs markedly between clinics, especially in project A where demand and provision of care was almost ten times higher than in the other two MSF projects.

Overall, an increasing trend in the number of consultations was observed over time at all clinics. Monthly variations in some clinics (notably project A and project B) were related to project and context specificities (e.g., closure of the clinic in project A during the second and third trimester of 2016).

Although the number of consultations for new cases is fairly stable after a few months, the number of follow-up consultations continues to increase before stabilizing. This is part of the treatment approach to torture rehabilitation as implemented by the clinics, which acknowledges the need for consistent follow-up care over some time.




Project B
(Monthly Reports October 2014-October 2016)
New Cases
FU Cases
Total
250
200
150
100
50
0
October 2014
November…
December…
January 2015
February 2015
March 2015
April 2015
May 2015
June 2015
July 2015
August 2015
September…
October 2015
November…
December…
January 2016
February 2016
March 2016
April 2016
May 2016
June 2016
July 2016
August 2016
September…


Project C
(Monthly Reports October 2015-October 2016)
New Cases
FU Cases
Total
350
300
250
200
150
100
50
0
October 2015
November 2015
December 2015
January 2016
February 2016
March 2016
April 2016
May 2016
June 2016
July 2016
August 2016
September 2016
October 2016

ANNEX II: LIST OF INTERVIEEWS

HQ INTERVIEWS	
Date	Role/Position
22/09/2016	OCB-Torture Focal Point (former)
22/09/2016	OCB-Operational Researcher
27/09/2016	OCB-Torture Focal Point (current)/ Deputy Operations Coordinator Cell 2
29/09/2016	OCB-Field Legal Advisor
29/09/2016	OCB-Mental Health Referent
02/11/2016	OCB-Operational Coordinator Cell 2
07/11/2016	OCB-Migration Advocacy Referent
08/11/2016	OCB-General Director
08/11/2016	OCB-Director of Operations
PROJECT C INTERVIEWS	
Date	Role/Position
28/09/2016	OCB-Social Worker Project C
28/09/2016	OCB-Psychologist, Physiotherapist, Psychiatrist, MD, SW Project C
28/09/2016	OCB-Project Coordinator Project C
28/09/2016	NGO 3, President
28/09/2016	OCB-HoM Country C
29/09/2016	OCB-Project Staff Project C
29/09/2016	OCB-CM Supervisor Country C
29/09/2016	OCB-Psychologist Project C
29/09/2016	OCB-Social Worker Project C
29/09/2016	OCB-Advocacy Referent Country C
29/09/2016	OCB-Deputy Head of Mission Country C
12/10/2016	NGO 4, Lawyer
13/10/2016	OCB-Medical Coordinator Country C
PROJECT B INTERVIEWS	
Date	Role/Position
03/10/2015	OCB-Medical Coordinator Country B
03/10/2016	NGO 5, Coordinator
03/10/2016	NGO 1, Director
03/10/2016	NGO 1, Project Manager
03/10/2016	NGO 1, Candidate for next director
04/10/2016	OCB-Physiotherapist Project B
04/10/2016	OCB-Medical Doctor Project B
04/10/2016	NGO 1, Social Worker
04/10/2016	NGO 6, Lawyer
04/10/2016	Patient (Male, Syria)
05/10/2016	OCB-Project Coordinator project B
05/10/2016	OCB-Psychologist Project B
05/10/2016	OCB-Psychologist Project B
05/10/2016	Asylum Service, Public Relations and Communications Officer
05/10/2016	NGO 2, Scientific Coordinator and Psychologist
05/10/2016	NGO 2, Psychologist
05/10/2016	Patient (Male, Cameroon)
06/10/2016	NGO 7, Coordination Accommodation Program
06/10/2016	NGO 2, Psychiatrist
06/10/2016	OCB-Social Worker Project B
06/10/2016	OCB-Social Worker Project B

06/10/2016	OCB-Advocacy Officer Country B
06/10/2016	OCB-Cultural Mediator Project B
06/10/2016	OCB-Cultural Mediator Project B
07/10/2016	OCB-Head of Mission Country B
07/10/2016	OCB-Cultural Mediator Project B
PROJECT A INTERVIEWS	
Date	Role/Position
17/10/2016	OCB-Project A Team
17/10/2016	OCB-Medical Coordinator Country A
17/10/2016	OCB-Project Coordinator Project A
18/10/2016	OCB-Clinic Supervisor Project A
18/10/2016	OCB-Data Operator Project A
18/10/2016	OCB-Health Promoter Project A
18/10/2016	OCB-Head of Mission Country A
19/10/2016	OCB-Physiotherapy Supervisor Project A
19/10/2016	OCB-Physiotherapist Project A
19/10/2016	OCB-Physiotherapist Project A
19/10/2016	OCB-Medical Doctor Project A
19/10/2016	OCB-Medical Doctor Project A
20/10/2016	OCB-Psychologist Project A
20/10/2016	OCB-Social Work Supervisor Project A
20/10/2016	OCB-Mental Health Supervisor Project A
20/10/2016	OCB-Psychologist Project A
20/10/2016	OCB-Interpreters Project A
23/10/2016	OCB-Social Worker Project A
23/10/2016	NGO 9, Director
23/10/2016	Patient (Woman, Sudan)
23/10/2016	Patient (Woman, Sudan)
23/10/2016	OCB-Health Promoter Project A
23/10/2016	OCB-Medical Doctors Supervisor Project A (former)
24/10/2016	NGO 10, Psychosocial Services Director
25/10/2016	OCB-Medical Case Manager Project A
24/10/2016	OCB-Nurse Supervisor Project A
29/10/2016	OCB-Project Coordinator Project A (former)
30/10/2016	OCB-Head of Mission Country A (former)
02/11/2016	OCB-Project Medical Referent Project A (former)

ANNEX III: TERMS OF REFERENCE

Terms of Reference

EVALUATION OF OCB SURVIVORS OF TORTURE AND OTHERS FORMS OF ILL TREATMENT REHABILITATION PROJECTS – A, B, C*

CONTEXT AND BACKGROUND

Since 2013 MSF-OCB is running clinics for the rehabilitation of survivors of torture and other forms of ill treatment (SoV-survivors of violence). The first one was opened in A in 2013, to complement the already existing mental health clinic. In October 2014 the second one was opened in B in collaboration with two local organisations. In October 2015 the third clinic was opened in C (in collaboration with a voluntary based association working with VoT for the past 30 years), building on the experiences of the other two previously mentioned clinics. A total of 850 new cases were treated in the three MSF clinics in 2015.

The challenges related to launch and implementation of any VoT program were compounded by the lack of MSF organizational experience in this field. Efforts and obtained experience by MSF-OCB in supporting the opening of the first centre (A) facilitated the later management of new other two centres but haven´t been formally capitalized.

With a common general design (interdisciplinary team composition, comprehensive case management, patient centred approach, networking with other actors, advocacy activities…) the three projects have also some differences, mainly due to the different contexts in which they operate.

In 2015 the A and B centres were visited by the IRCT (international rehabilitation council for torture victims) with the purpose to identify possible areas of support of our staff. Conclusions, capacity development proposals and recommendations for each clinic were collected in an assessment report.

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

REASON FOR EVALUATION / RATIONALE

These three centres represent the first experience within OCB focus specifically in the rehabilitation of victims of torture. No experience based knowledge has been collected so far at MSF level in this field.

The time since the projects started is the adequate to ensure enough collected experience at the same time than to offer a room for potential modifications.

The comparison between the different projects will contribute to extract the context specificities but also the transversal identified lessons easily applicable to any context.

OVERALL OBJECTIVE and PURPOSE

To capitalise on MSF's VoT experience over the last 3 years in A B & C, with the aim of enabling improvements to the management of the existing VoT projects (at project, coordination and HQ level), whilst also contributing to future management of VoT projects through the drawing of key transversal lessons.

SPECIFIC OBJECTIVES / Evaluation questions

Appropriateness

- Are the strategies appropriate in order to achieve the objectives?
- Are/were appropriate and timely adaptations made in response to changes in the environment?
- Comparing the three projects, what are the relative strengths and weaknesses of the strategies for achieving the objectives and what lessons can be identified relating to strategic approaches for future VoT projects?

Effectiveness (including coverage, timeliness, coherence)

- To what extent are the agreed objectives being achieved?
- What are/were reasons for achievement or non-achievement of objectives?
- What are the limitations/opportunities inherent in the approach?
- What could have been/can be done to make the intervention more effective?
- Are there any factors that hinder us in reaching the population most in need?
- To which extent do beneficiaries have access to project services?
- Comparing the three projects, what are the relative strengths and weaknesses in terms of achieving the objectives and what lessons can be identified for future VoT projects?

Efficiency

- Are inputs and resources used appropriately and to their maximum potential?
- How are human resources managed?
- Comparing the three projects, what are the relative strengths and weakness related to proper use of resources and what lessons can be identified for future VoT projects?

Impact

- Does the programme make a difference?
    - What do beneficiaries and other stakeholders affected by the intervention perceive to be the effects of the intervention?
    - Does our presence have any unforeseen positive or negative impact?
- Comparing the three projects, what are the relative strengths and weakness in terms of impact and what lessons can be identified for future VoT projects?

Continuity

- Is a phasing-out strategy designed and achieved? What does it consist of?
- What long-term problems can be identified, and how have they been taken into consideration?
- What local capacities and resources have been identified? How does the project Connect with these?
- Comparing the three projects, what are the relative strengths and weakness from the continuity perspective and what lessons can be identified for future VoT projects?

EXPECTED RESULTS

- Initial debriefing of key findings at coordination level (partners included) after visiting each project
- Initial field visit report after visiting each project
- Presentation of evaluation initial results in HQ (to main stakeholders)
- Written Report answering to above mentioned questions, including transversal lessons identified and a maximum of 5 key recommendations
- External Version of Evaluation Report (without A mentions)

TOOLS AND METHODOLOGY PROPOSED

- Review and analysis of project documents, reports, relevant guidelines and tools, routine project data
- Semi-structured interviews (and focus groups where relevant) with key-team members at HQ and field levels, and counterparts/partners.
- Semi-structured interviews (and focus groups where relevant) with patients/former patients in case it will be possible (due to sensitive of the issue)
- Observation at different intervention sites

RECOMMENDED DOCUMENTATION:

- Field Reports (Monthly, Quarterly, Yearly)
- Medical Field Reports (Monthly, Quarterly, Yearly)
- COPRO Documents

- ARO Documents
- project Documents (Narrative, Logframe)
- Field Visits Reports by HQ
- Assessment Reports carried out by IRCT
- Final Report/Conclusions of Operational Research carried out in A
- Clinic Forms and Materials (Patients Files, Data Collection Forms, Flipcharts)
- MSF/project Guidelines and Tools
- Relevant information exchange documentation (project, coordination, HQ)

PRACTICAL IMPLEMENTATION OF THE EVALUATION

Number of evaluators	2
Timing of the evaluation	September-November 2016
Required amount of time (Days);	Max 40
• For preparation (Days)	5
• For field visits (Days)	17 (suggested order B-A-C)
• For interviews (Days), HQ	8
• For presenting the results (Days)	1
• For writing up report (Days)	10
Total time required (Days)	40

Notes:

*External Evaluator contracted by SEU will act as Lead Evaluator; Medical Evaluation Referent from SEU will act as second evaluator and evaluation manager.
*Discretion should be ensured during all evaluation process, especially regarding MSF Intervention in A.
*To assess time for VISA Procedures and Nationality limitations of Evaluators
*Exact dates for field visits will be defined based on feasibility at field level
*Need of Translator during interviews/group discussion with national staff, counterparts and patients
*Need of Written Consent Form (in local languages) for focus groups/interviews with beneficiaries
*Initial proposed field visit days as following: 5 C, 5-B; 7 A

PROFILE /REQUIREMENTS: EVALUATOR(S)

- Experience in management positions and/or experience in VoT programs
- Strong evaluation competencies
- Language requirements: English
- MSF experiences is an asset

Stockholm Evaluation Unit

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