



USAID
FROM THE AMERICAN PEOPLE

**USAID'S VICTIMS OF TORTURE PROGRAM MONITORING
VISIT: DEMOCRATIC REPUBLIC OF CONGO**

**USAID'S VICTIMS OF TORTURE PROGRAM
MONITORING VISIT:
DEMOCRATIC REPUBLIC OF CONGO
MAY 13-24, 2013**



Dr. Paul Bolton
Cathy Savino
Victims of Torture Program

The DCOF team wishes to express its sincere thanks to USAID.Kinshasa and Interchurch Medical Assistance-World Health for their excellent hospitality. In particular, we would like to thank the Mission Director, Dr. Diane Puttman for her interest and support in DRC's emerging evidence base on treatment and healing of torture survivors and the Social Protection Team, Marcel Ntumba, Asta Zimbo and Sara Rasmussen-Tall, who provided overall guidance and support for the visit. We are grateful to Steve Brewster, of IMA, the Chief of Party for the USHINDI project and an able team, including Louise Bashige, Paulin Bukundika, Yvette Mulongo and Daniel Mbungu who supported all aspects of the visit as well as many more USHINDI staff who made things run smoothly. Thank you.

This publication was produced for review by the U.S. Agency for International Development's Victims of Torture fund, DCHA/DRG, under contact #AID-OAA-M-10-00010, with New Editions Consulting Group, Inc. The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

Table of Contents

I. Executive Summary.....	1
II. Background	3
III. Mental Health in the DRC	4
A. Government of Congo’s Mental Health Perspective.....	4
B. IMA’s Staff and Their Work at the Community Level	5
1. Counselors.....	5
2. The Process of Helping Survivors.....	5
3. Coordinators	6
4. Child Counselors.....	7
5. Lawyers	7
C. The Community.....	7
6. Ushindi Program Volunteers, Noyou (GBV Committee) and VSLA Members	7
7. Non Ushindi-Related Community Members.....	8
IV. Observations on the USHINDI Program.....	8
V. Conclusions and Recommendations.....	10
ANNEXES	12
ANNEX A: DEBRIEF Victims of Torture Program	13
ANNEX B: Contacts.....	15
ANNEX C: Map.....	16
ANNEX D: USAID/Victims of Torture Guidelines.....	17
ANNEX E: Scope of Work for VOT DRC	Error! Bookmark not defined.

I. Executive Summary

Dr. Paul Bolton of Johns Hopkins University and Ms. Catherine Savino of the Victims of Torture (VOT) Program travelled to Democratic Republic of Congo from May 13- 24, 2013, to meet with VOT grantees in country to conduct a general assessment of the torture treatment programs, focusing in particular on the IMA World Health program, USHINDI. USHINDI, Swahili for “overcome” or “victory” was designed to support survivors of sexual and gender-based violence through integrated psychosocial, medical, legal, and economic activities.

The Victims of Torture Program (VOT) provides financial and technical assistance to programs worldwide that assist in the rehabilitation of individuals who suffer from the physical and psychological effects of torture. The program’s mandate derives from the Torture Victims Relief Act (TVRA), first authorized in 1999, which directs funding to the U.S. Agency for International Development (USAID) to provide (1) direct services to torture survivors; (2) build the capacity of individuals and organizations to treat and help restore the functioning of those affected by torture; and, (3) increase the level of knowledge and understanding about the effectiveness of treatment methods. The fund is managed under USAID’s Center of Excellence on Democracy, Human Rights and Governance, (DRG) by Mr. Rob Horvath.

There were three primary goals of the Victims of Torture Program (VOT) assessment of the sexual and gender-based violence programs in the Democratic Republic of the Congo: 1) to assess the mental health component of the VOT-funded programs, primarily IMA and share evidence-based studies on treatment and healing; 2) to determine if there are other programmatic areas, e.g., economic strengthening, that could benefit from an external evaluation across the three projects (IMA, IMC, IRC); and 3) to understand how the current VOT funded programs fit within the USAID DRC strategy and confer with the mission regarding future programming.

The Bolton/Savino team was invited to DRC by USAID/Kinshasa and program managers, Sara Rasmussen Tall and Marcel Ntumba accompanied the team throughout the trip. The group travelled to Kisangani, Obokote and environs for field visits and in Kinshasa, met with key stakeholders and grantees to discuss VOT programming.

The team conducted meetings with over 30 people not including group meetings of approximately 20-40 people at the regional and local levels in the province of Orientale.

Stakeholders included the Government of the Democratic Republic of Congo (GDRC), current VOT grantees, IMA counselors, staff, leadership and volunteers. Main topics included how torture is treated within the community, how it is viewed and how it was addressed in the past.

Conclusions and Recommendations

Overall, the IMA-World Health program is as good as or superior to most other torture treatment programs that seek to serve all trauma survivors without focusing on those individuals who are more severely affected and in need of more care. However, the state of the art is shifting and even for programs that do not focus on treating individuals who have severe effects, there is

more emphasis needed on counselor supervision, ongoing training, program quality, and impact assessment.

For USAID

- Staff has done an excellent job of providing extensive geographic coverage for SGBV survivors. Agreements were planned with care and technical skill and successfully combined many types of disparate funding. Nonetheless, people who experience torture or trauma outside of the SGBV programs do not appear to have access to the same range of services as SGBV survivors. It is worth considering whether it is time to broaden the definition beyond SGBV to include other forms of torture and trauma.
- With many personnel changes expected at the Mission, it will be important to fully support the remaining team member, Marcel Ntumba, as he moves into a new role within the three VOT-supported projects.

For IMA-World Health USHINDI

- The purpose of the IMA-World Health program, *Overcoming Sexual and Gender-Based Violence in Eastern Congo, (USHINDI)*, is to ensure that individuals affected by SGBV gain access to care and treatment, improve community capacity to respond effectively to survivors, and promote community-based integration of survivors and strengthen prevention. The team's main recommendations, in brief, include
 - *Monitor the functioning of survivors as indicators of need and impact,*
 - *Improve supervision of counselors,*
 - *Improve staff care, particularly of counselors,*
 - *Expand training/supervision capacity for coordinators and for counselors,*
 - *Review the impact of Village Saving and Loan Associates (VSLAs) and assess how well they serve survivors, particularly those who are very poor.*

For International Rescue Committee

- The IRC program, *Ending Sexual Violence by Promoting Opportunities and Individual Rights (ESPOIR)*, is the only program primarily funded by the VOT program. Since awarded, it has partnered with Johns Hopkins University to establish a strong evidence base for the program. The purpose of the IRC award is to meet the safety, health and psychosocial, economic and justice needs of women and girls who are survivors of SGBV. Based on the recently IRC/JHU *Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence* in The New England Journal of Medicine (June 6, 2103, Volume 368, No. 23, p2182), IRC needs to devise a distribution plan for the evidence-based SGBV treatment study (French copies have been ordered) including UNICEF and USAID/Kinshasa in planning meetings. Four additional studies are expected from the IRC/JHU partnership.

Key observations with respect to torture treatment programs in DRC:

- Programs are tied to larger well-funded health programs and tend to focus more on the medical aspects of care (for example Pep Kits) than mental health.
- Despite commonalities and regular Kinshasa meetings, there is a lack of productive coordination among grantees.

- The role of the government responsible for coordinating programs, collecting data and leading the fight against gender based violence is itself a weak and poorly staffed office with few resources.
- Security remains an overriding issue.
- Conditions and context vary widely and grantees tailor their programs to the environment but SGBV in practice may be related to early marriage, domestic violence, or rape by illegal armed forces depending on the geographic area. Grantees have done a good job of tailoring interventions but the label, SGBV, is an inadequate descriptor of a complex situation.

II. Background

The Victims of Torture Program supports three separate awards in the Democratic Republic of Congo. In both 2009 and 2010, USAID/Kinshasa issued a Request for Applications (RFA) that included support for Victims of Torture. IMA-World Health was awarded under Cooperative Agreement AID-623-A-10-00012 for Project *USHINDI Overcoming Sexual and Gender Based Violence in Eastern DRC*. The award began in July 2010 and ends July 2015 with a total estimated cost of \$17,423,076, of which \$11,912,525 has been obligated through five (5) modifications. Approximately 25 percent of these funds were provided by the Victims of Torture Program (VOT).

Project *USHINDI* implements holistic approaches to combat Sexual and Gender Based Violence (SGBV) in the Eastern Democratic Republic of Congo by 1) Increasing access to timely and quality services for individuals affected by SGBV; 2) Improving the quality of services and interventions for individuals and communities affected by SGBV; and 3) Reducing the vulnerability of individuals to future acts of abuse and violence.

The project is implemented through three implementing partners; Heal Africa, Panzi Hospital and PPSSP (Promotional Program for Primary Health Care) in Kivus and Maniema.

Two other cooperative agreements were awarded through RFAs whose purpose was to increase coverage for SGBV survivors throughout Eastern Congo (See map in Annex C).. The awards to the International Rescue Committee (IRC) and International Medical Corps (IMC) are described in the box below.

Three Awards funded, in part, by the Victims of Torture fund

IMA World Health (Interchurch Medical Assistance), award # AID-623-A-10-00012-00
Start 7/2/10 to 7/1/2015, TEC \$17,423,076

USHINDI Overcoming Sexual and Gender Based Violence in Eastern DRC
Technical Partners: American Bar Association Rule of Law Initiative, Save the Children, Children's Voice, CARE, IMA World Health
Location: In Orientale, North and South Kivu and Maniema Provinces

International Medical Corps, award # AID-623-A-10-00013-00
Start 7/14/10 to 7/13/2015 Total Estimated Cost \$17,225,000

Care, Access, Safety and Empowerment (CASE) in Eastern Congo
Consortium Partners: COOPI, American Bar Association Rule of Law Initiative
Location: In North Kivu, South Kivu and Maniema Provinces

International Rescue Committee, award # AID-623-A-09-00012, is \$11,800,000;
Start date, 9/11/2009, End date 9/30/2014

Ending Sexual Violence by Promoting Opportunities and Individual Rights (ESPOIR)
Location: In North Kivu (Misisi and Rutchuru) and South Kivu (Kalehe, Kabara, Uvira, Fizi and Walungu)

III. Mental Health in the DRC

A. Government of Congo's Mental Health Perspective

A meeting was held with two members of the DRC Ministry of Health Mental Health staff, Dr. Eric Mukala (chief epidemiologist working on surveillance of mental health) and Dr. Abraham Kanyama (physician responsible for the care and treatment of mental illness). Though they noted that DRC has had a mental health plan in place since 2012, they highlighted problems that included a lack of legislative emphasis on mental health services and a lack of trained mental health providers and supervisors to maintain the quality of services. Many structures are providing psychosocial care to GBV survivors, mostly NGOs who depart after a few years without leaving anything behind. In addition there is a desire by the Government of DRC, to standardize approaches to psychosocial problems of GBV survivors.

The MoH has been working on this with the help of UNICEF, including developing training manuals to train community based organizations (CBOs). They have also begun training of trainers (TOT) workshops in Kinshasa for organizations working in eastern DRC, as well as going to north and south Kivu and providing TOT trainings there for local MoH and NGO staff. Training lasts for eight days including five days on assessment and care and three days on how to train providers. These workers are then to train local providers including nurses in charge of health centers, psychologists and doctors (i.e., those working with GBV survivors). Training is based on WHO guidelines and includes initial assessment and referral of those with severe mental health problems.

(http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/)

B. IMA's Staff and Their Work at the Community Level

1. Counselors

IMA's USHINDI project supports a system of local counselors who are usually the first point of contact with SGBV survivors. The activities of the counselors are well publicized in the communities and SGBV usually seek out the counselors at the counselors' homes or are referred by community members or via the local USHINDI community core group. A counselor uses active listening skills to interview a survivor and to complete an intake form, including her assessment of the survivor and a recording of which services she will refer the SGBV to: **psychosocial counseling (by the counselor), legal, medical, and/or economic support.** The latter mainly consists of referral to VSLA groups set up by USHINDI (but whose members are mainly non-survivors), once the counselor considers the survivor is ready to join. The counselor also maintains a follow-up form that monitors the receipt of services and summarizes the survivor's problems at assessment and on exit from the program. Monitoring of the services received and assessment of the severity of the survivors' problems is used by counselor to decide when to discharge the survivor from services.

2. The Process of Helping Survivors

Counselors in Obokote described how they greet new survivors and use active listening skills to assess them, as well as assessing their physical presentation: appearance, dress, stress, emotion. Psychosocial care begins with the first meeting with the survivor. The counselor offers water to the survivor to wash herself and comforts her, or may be quiet if that is what the survivor wants. In response to what skills they use, counselors emphasized active listening and comforting the person but did not mention other specific skills. Four to five psychosocial counseling visits are typical but it can be up to 20. Psychosocial sessions continue until the counselor finds that the survivor is joining in community activities and her symptoms are reduced, and she reports that she has returned to her normal state. If the survivor does not improve the counselor refers the survivor to the psychosocial coordinator. Counselors reported that few survivors require such referrals. Counselors reported that they have the time (they typically work three hours a day three days a week) and the skills they need to assist almost all survivors. However, in response to a direct question, they did report that the work could be upsetting and that they need skills to help themselves cope with their work. Counselors are not paid but do receive reimbursements for transport costs.

3. Coordinators

Coordinators act as the counselor's supervisors. For each health zone there is one coordinator for each of the main USHINDI activities: psychosocial, medical, legal, and economic. The counselors meet each other and the supervisors monthly at the safe house for two days. There is not a specific process but usually the coordinators ask about the problems of each of the counselors' survivors and what they did for them. Typically each counselor has four to five cases to review with the coordinator. The coordinator considers whether the case is being dealt with appropriately by reviewing the intake and follow up forms and by verbal report of the counselor. The coordinators also try to meet each counselor in their village for half a day once a quarter to observe their practice, although this appears to have been difficult to do to date.

Coordinators also receive referrals from the counselors. For psychosocial services the psychosocial coordinator (referred to as the chief counselor) received the same training as the counselor as well as additional training by a Heal Africa specialist. The content of this training was described as additional active listening methods and how to de-traumatize persons by conducting various non-specific activities such as chatting and eating with them. This staff also visits the coordinators to provide supervision and ongoing training in the form of data review and role playing respectively. Coordinators also have a higher level of education than the counselors, which they feel better equips them to deal with difficult cases. The coordinator reported that it is uncommon or rare to get cases that do not get better with the psychosocial care provided by the counselors and herself. She did request additional psychosocial training for both counselors and herself, but did not refer to any specific needs.

Review of Counselor and Coordinator Basic Training Materials

The training materials provide good coverage on the situation and needs of survivors and their rights. These sections take up much of the manual, covering topics that are important for individuals working with survivors of trauma and clearly laying out different concepts, such as SGBV, and describing them well with a case study. The manual describes the consequences of trauma and violence, both for children and adults and addresses some legal aspects such as the violations and punishments for violence, and the rights of individuals.

On psychosocial issues the manual defines and describes the symptoms of trauma, and lists out in bullet form questions that are good to ask and those that should be avoided. Throughout, there are overarching techniques that are highlighted, such as good, active listening, use of open-ended questions, and reflecting what the survivor is saying. The manual is not designed for dealing with severely affected survivors. As such, it does not equip the counselors or coordinators for dealing with severely affected survivors. Critical elements for such treatment are not included, such as how to assess for major psychological problems or develop a treatment plan. The manual does not refer to specific techniques for treatment of such cases, except for 2 specific activities - psychoeducation and problem solving and here it is not specific on how to do these. Instead, instructions for psycho-education consist of general guidance on how to talk and what not to say and problem solving guidance consists of one page describing steps.

Overall, this manual appears useful in achieving what appears to be its main purpose: providing counselors with an educational background to working with non-severely affected trauma survivors. It is mostly psycho-educational, providing a basis for general or non-specific counseling which would likely be helpful and sufficient for most SGBV survivors who are not severely psychologically affected. It does not reflect evidence-based treatment processes (e.g., cognitive work, gradual desensitization) that would be required

4. Child Counselors

In addition to a psychosocial coordinator, there is also a child counselor based at the safe house. This person deals with children facing problems — both survivors and children of survivors. The child counselor reported that the most common child issue she deals with in Obokote is ‘rapt’ a longstanding practice where a young girl is raped by a boy as a means of forcing her to marry him. The child counselor works with the chief counselor to provide supervision during the monthly visits by the counselors. There is also a psychologist who supervises both the chief counselor and the 12 local counselors

5. Lawyers

The lawyer responsible for legal services to survivors, the social mobilization coordinator, and the women’s empowerment coordinator also described their work. The lawyer explained that both physical and mental/emotional abuse are recognized by the law and are illegal. The empowerment coordinator described the problems of women in general which make the situation of the survivors more difficult. These include illiteracy, women feeling inferior, and taboos against women standing up to men. Women also complain of forced sex within marriage and of rejection by husbands of women who have been raped outside marriage. The coordinator has been asked to counsel some of these men to encourage them not to reject their wives.

C. The Community

6. Ushindi Program Volunteers, Noyou (GBV Committee) and VSLA Members

The team met with community members at the Kabakaba center. The focus of this meeting was on the problems of the community, rather than on the activities of USHINDI. Attendees described the many deaths during the war resulting in the virtual loss of a generation of people. Cases of SGBV/rape used to be frequent during the conflict, but are now rare. Members attribute this to the end of the conflict and to USHINDI activities. Some commented that if a girl is raped now USHINDI will do a lot for her in terms of justice and other assistance. Additional comments were that there is a lot of money going into USHINDI, but the family gets nothing. The lack of assistance or compensation to the family was a concern, particularly since traditional practices of compensation might be more likely to result in financial assistance to the family. There is one Noyou in each of the 108 health districts. These committees are responsible for developing community action plans with respect to SGBV. They also assist in identifying and referring relevant cases to the counselors. Currently 20 percent of SGBV join VSLAs. Even when VSLAs are full, survivors are still able to join as “cases of special need” while maintaining their confidentiality as survivors. How this is achieved was not clear from the meeting. Members of VSLAs described the need for members to be able to make regular contributions and stay active in the program. Therefore, those with little or no capital or ability to stay active in the program tend not be accepted into the VSLAs and/or drop out.

7. Non Ushindi-Related Community Members

After the initial meeting with community members, a second sub-meeting was held with persons who are not program beneficiaries. The purpose was to hear about psychosocial problems and persons likely affected by psychosocial issues who are not currently being reached by USHINDI. Approximately 10 persons participated, all elderly, although this was not a criterion. This group was treated as a focus group and asked a grand-tour-type question to get the attendees talking about problems in general. The intent was to see if (and which) psychosocial problems were mentioned and then explore those problems in detail. Attendees initially responded to the grand-tour question by referring to personal problems, such as deafness and disability, then moved to wider issues such as poverty, lack of income, and access to food and assistance with processing rice and cassava. Some discussed lack of schools and health care. In response to probes about "head and heart" problems, attendees described bad dreams as very common and caused by having too many problems to deal with. Another problem of the head was confusion and shouting due to witches and/or Satan. The head problems of rape survivors were said to be unknown because such acts were kept secret. However, rape survivors were known and they tended to suffer from fear and guilt. Survivors expressed fear of their families being upset about what happened, making it difficult for them to return home. Before, USHINDI rape cases were dealt with by aunts and grandparents, but now this role is increasingly being taken on by USHINDI counselors. Attendees were asked whether there are people who stay at home, withdrawn, but stated that only persons who are sick or who have lost a family member do this.

IV. Observations on the USHINDI Program

Strengths and Opportunities

USHINDI has many fundamental areas of strength. Some key ones are noted in the following paragraphs.

- Committed and experienced project staff
- Activity implementation on track
- Good relationships with provincial government
- Valuable community partners
- Continuity of some activities from previous projects and
- Well respected, accomplished reputation in country

A. Service Reach (Penetration): USHINDI appears to be effective in reaching large numbers of SGBV survivors. During the six-month period from September 2012 to March 2013 alone, the project reports identifying and offering services to 2,881 people including 1,368 reporting SGBV. Counselors and coordinators in Obokote Health Zone believe that they are identifying and offering services to most SGBV survivors who are willing to come forward.

B. Structure: The program is based on the community based counselors. These are volunteers who have received a course of training in SGBV identification and services based on a training manual (see below for review). They received a travel cost reimbursement for monthly travel two days/month to the local safe house facility for collective reporting and supervision with coordinators. A review of the notes collected during one of these visits suggests that these sessions are semi-structured. Each case is discussed, focusing on numbers of SGBV, the type of violence they have experienced, and the nature of the referrals. According to the notes and the counselor meeting, performance is not otherwise assessed although any problems are discussed and plans for dealing with them developed. Coordinators visit the counselors monthly at their homes, also to provide supervision. Here they report use of a more structured supervision approach including review of performance and potentially observing counselor working with cases. However, these quarterly home visits have not yet become routine. Counselors report working approximately nine hours/week and having four to five cases at any one time. The program reports that all SGBV survivors have access to psychosocial services from the counselors, which suggests that the large numbers of SGBV survivors served is a function of a large number of active counselors. So far, 421 have been trained to work in 108 health districts. Since this is more than three times the original estimate, it is not clear whether this also represents excessive turnover of staff, which is a common problem with volunteer positions. It is also not clear how coordinators would deal with the additional training and supervision that large numbers and high turnover would require.

C. Data collection: The program is designed to track all identified SGBV survivors and the services they receive. Data collection procedures focus on numbers of survivors, their demographics, details about the violent events they experienced, which services they receive, and the number of contacts/sessions for each service. At enrollment and on the follow-up form there is a space for recording the existence of resulting physical, social, and psychological problems. The latter includes the presence of symptoms related to typical reactions to SGBV: fear, anxiety shame, sadness, crying, shyness, loss of hope, aggression, self-blame, withdrawal, desire for vengeance, refusal to talk, anguish, denial of the violence, painful memories, suicide, and psychosomatic symptoms.

Other symptoms of the common mental disorder symptoms and their severity are not tracked and therefore the need for specific treatments cannot be determined from the forms. The USHINDI staff, including counselors, reported that severely affected persons who do not respond to existing non-specific psychosocial support are rare. This seems unlikely given the numbers of reported SGBV events. It might be that cultural acceptance of the most common sexual traumas—such as rapt and forced sex within marriage—would reduce the psychological impacts of these events in Obokote, particularly compared with the violent rapes and torture reported in the Kivus. However, this would not be enough to make severe psychological problems as rare as they appear to be based in staff reports.

V. Conclusions and Recommendations

(Summarized at a formal debriefing meeting on May 21, 2013 with IMA and Heal Africa staff in Kinsangani):

1. *Strengthen monitoring of problems and functioning of survivors as indicators of need and impact.* The project currently provides excellent monitoring of the numbers of survivors identified and the types of services they receive. It is much less capable of demonstrating their impact on survivors. From the point of view of psychosocial services, the expectation (based on SGBV survivors in other populations) that some cases of SGBV will present with severe symptoms is at odds with the reports of the USHINDI staff. In the absence of clear data supporting this, more rigorous assessment of symptoms at intake would help to confirm staff reports of very few such cases. In summary, the project staff should consider expanding on the existing monitoring process and materials to improve assessment of symptoms and function. This will provide needed evidence that services are meeting SGBV needs.

2. *Improve supervision.* The current system does not appear to monitor the quality of counselor and referral services. Such monitoring should be added in the form of review of the problems of each client, the decision making by the counselor for how to address each problem, a description of what was actually done, comments by the coordinator on the appropriateness of what was done, and (if indicated) actions taken by the coordinator to correct any errors. Coordinators should review this information at least monthly with the counselors (more frequently with new counselors).

At this time it is not clear that the coordinators have the skills to provide expanded supervision as described above and correct any deficits. Further training may be required and subsequent ongoing supervision of their own supervision activities by the senior Goma-based technical staff is likely necessary (see #4 below).

3. *Improve staff care, particularly of counselors.* Dealing with violence survivors and their problems is mentally challenging and normally requires ongoing monitoring, counseling and access to additional care (including breaks) for providers to maintain their mental health and enable them to continue to work. The most likely persons to assess need and provide such care are the coordinators, who therefore need additional training in this regard.

4. *Expand training/supervision capacity for coordinators and for counselors.* A review of the basic training materials, as described above, suggests that they are appropriate for psychosocial care of non-severe cases. However, there may be need for further training of the coordinators to better fulfill their supervision role, as described above (#1, 2, 3 above). Also, further training of the counselors may be needed if expanded supervision is implemented and shows deficits. Based on experience in other sites, this is likely to be required by at least some counselors. Recent USAID/VOT-supported programming research has found that CPT is effective for addressing mental symptoms and improving function among moderately to severely affected survivors of SGBV in the Kivus. However, given the lateness in the USHINDI project and the lack of evidence for large numbers of SGBV violence survivors with severe mental issues affecting function, this is not at this time recommended for implementation as part of USHINDI.

If it were to be implemented, training of the psychosocial coordinators and referral of cases to them would likely be most appropriate.

5. *Set up a database to track changes in the survivor population.* These changes include demographics, mean severity and function score changes, dropouts and refusal of services. This database would be key to demonstrating impact and identifying the types of SGBV survivors who are resistant to services and need additional help.

6. *Review Village Savings and Loan Associations (VSLAs) to determine how well they serve survivors, particularly those who are very poor.* VSLAs appear to require ongoing resources and energy, which SGBV and very poor persons may not have. A review of the VSLA practices, membership, and dropouts (which are reported as high) is warranted to determine how well VSLAs are suited to helping these groups and how they could be improved. (DCOF has considerable experience in this area.)

ANNEXES

ANNEX A: DEBRIEF Victims of Torture Program

FRIDAY, May 24, 2013

Scope - look at VOT funded programs (IMA World Health, IMC and IRC) with emphasis on Interchurch Medical Assistance World Health (IMA)

STRENGTHS

- JHU/IRC study – plans include wide dissemination of the study; translation of article into French (will take several weeks apparently for the Journal to finish) and presentation of the results at technical meetings (worldwide). There is likely to be an LPA-led DC launch. (n.b. there had to be 4 press contacts named at JHU for the many calls that usually come from the press following publication.)
- The three programs that VOT supports, IMA World Health, IMC and IRC were designed to cover the broadest possible area reaching as many people as possible - its impressive that they were organized this way; each bring their own expertise to the issue and it really seems to be a collegial and cohesive working group.
- In the field, (we went to Kissangani, Obacote, Lubutu), the staff we met were very open and eager to discuss the issues they face. We had the sense that they were willing to answer any questions we asked and the visit was remarkable in that sense. Marcel was a gifted interlocutor. He connects incredibly well with everyone.

COMMENTS/RECOMMENDATIONS

- In the urge to provide immediate and timely services, medical care (PEP kits) understandably receives much attention. IMA is doing good work here.
- Psychosocial support though could be better defined especially between IMA World Health and IMC; there is little emphasis on measuring improvements, more on service alone; Team suggests sharing newly validated IRC assessment forms as a standard, Paul to review IMA materials and provide training recommendation. (Paul's report will cover this issue in depth. We think that the results of the *NEJM* study will be compelling enough so that IMA World Health and IMC may want to follow suit.
- VOT to provide updated *Victims of Torture Guidelines* to share with Mission and grantees. VOT funds are a Congressional earmark, that require include links between an individual's treatment and healing and the intervention offered. Though funds are often comingled in projects, important to know what can and can't be covered by VOT.

GRANTEE ACTIONS

1) International Rescue Committee

- strengthen distribution plan for Johns Hopkins study locally, and in coordination with USAID, and UNICEF's coordinating committees nationally

2) International Medical Corps

- Need to redefine their psychosocial support which seems to have suffered recent setbacks. (of 61 health centers, 4 offer specialized services for those needing more psychosocial help),

b) Use of checklist may best be substituted by revised forms that will be distributed from the JHU study. Purpose of revised form is to provide some assessment of functional change and is likely a better indicator than checklists in use simply because it has been tested.

3) IMA World Health

- a) Appreciate their breadth, and dedication,
- b) Area visited (Kissangani et al) is not typical or areas IMA covers (not conflict affected) so hard to generalize about its relevance to the other areas,
- c) Front line volunteer workers need more support: more supervision, staff care, clearer training on screening,
- d) Need to strengthen existing community support networks,
- e) Supervisors need to follow up where the field counselors work; not just counselors travelling for meetings,
- f) Participation of survivors in VSLA's should be assessed to determine how they are doing, compared to others,
- g) The work of lawyers (ABA) needs to be clarified so that choices/consequences discussed with survivors reflect a realistic and survivor-centered perspective.

ANNEX B: Contacts

US Embassy- USAID/Kinshasa

Immeuble Mobi
Avenue Isuro 198
Kinshasa-Gombe, DRC
243 – 81-555-4434
Diana Putman PhD, Director, dputman@usaid.gov
Nancy Shalala, dputman@usaid.gov)
Sara Rasmussen Tall, srasmussontall@usaid.gov
Marcel Ntumbo, mntumbo@usaid.gov
Asta Zimbo, asinfo@usaid.gov

IMA World Health

73 Avenue de Ron Point
Quartier de Volcan
Goma DRC
0820 476 065
Dr. Larry Sthreshley – Country Director
larrysthreshley@imaworldhealth.org
Nancy Bolan – Deputy Country Director
nancybolan@imaworldhealth.org
Steve Brewster - CoP
stevenbrewster@imaworldhealth.org
Yvette Mulongo – program manager, women’s leadership
Paulin Bukundika, USHINDO Deputy Chief of Party
Daniel Mbungu - USHINDO Program Director

UNICEF

372 Avenue Colonel Mondjiba
Concession Immotex
Kinshasha Gombe, DRC
243-0-991-006-302
Alesandra Dentice
adentice@unicef.org
Marie Mukaya Bingila

Heal Africa

BP 319 Goma
111 Avenue des Ronds Points,
Goma, DRC
Dr. William Bonake – Program
Manager
willbonane@yahoo.fr

International Rescue Committee

243-995-200-058
Monika Topolski
Monika.topolska@rescue.org;
Tamah Murfet
tamah.murfet@rescue.org;
Marie France Guimond
MarieFrance.Guimond@rescue.org;

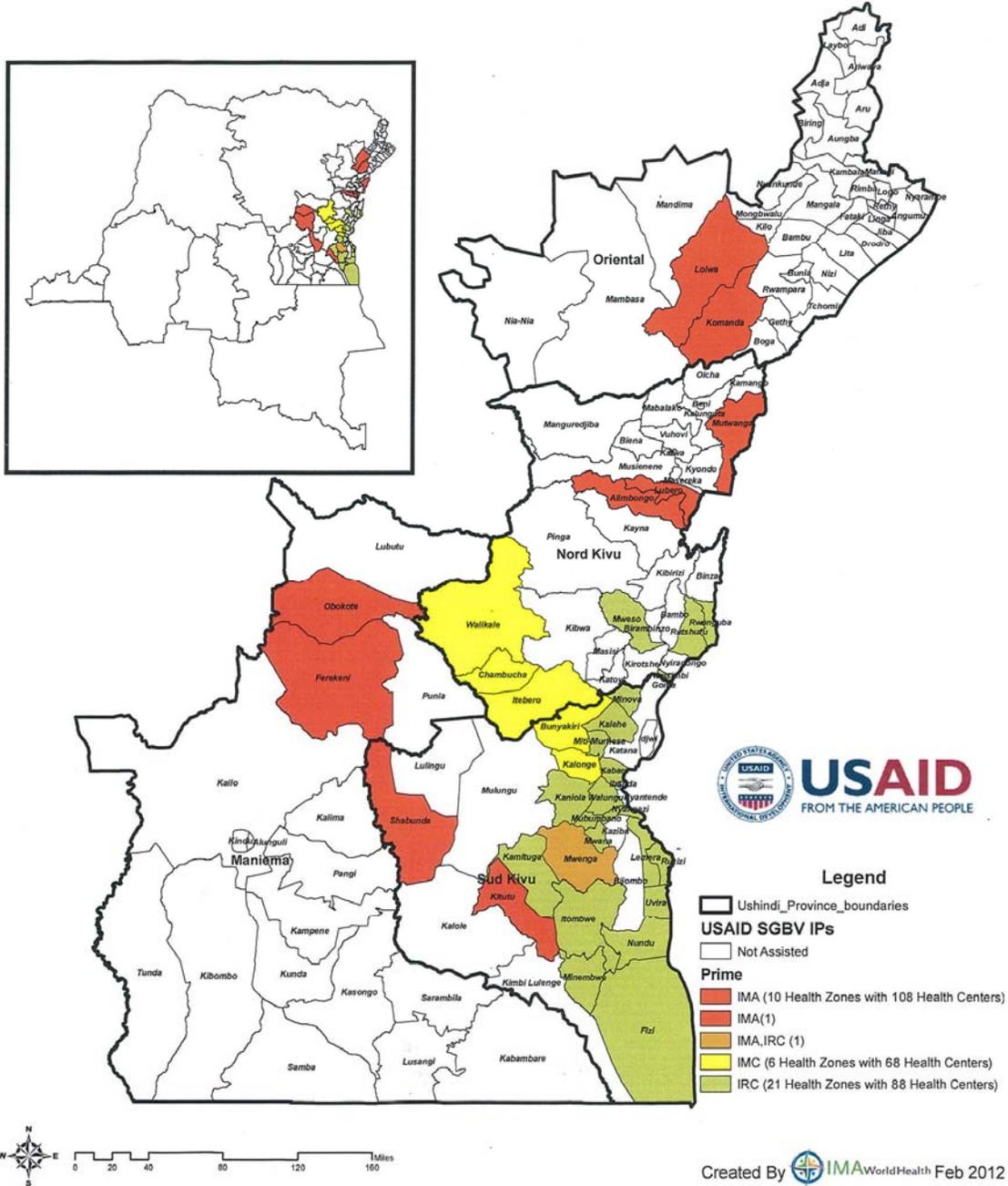
Ministry of Health

Bureau of Surveillance
Erick Mukala, Chief of Surveillance
Abraham Kanyama ,
Abrahamkanyama@yahoo.fr

ANNEX C: Map

Map of GBV programs in Eastern Congo

Health Zones supported by USAID GDO/Social Protection SGBV work 2010 -2015



ANNEX D: Victims of Torture Programming Guidelines

Victims of Torture Programming Guidelines

The following technical guidance is intended to inform the field on victims of torture programming. Within USAID, the Victims of Torture programs are managed under the Center of Excellence for Democracy Rights and Governance, Division of Human Rights.

USAID currently supports the delivery of services in countries with individuals affected by torture through international and local NGOs. Since 2000, USAID has administered treatment programs based in 35 countries that span five regions—Latin America and the Caribbean, Africa, Asia, the Middle East, and Europe and Eurasia—and supported more than 130 local nongovernmental organizations (NGOs) based in the communities where survivors live.

Introduction

In keeping with its legislative mandate under the Torture Victims Relief Act (TVRA) of 1998 and other applicable legislation for assistance to torture victims, USAID works to assist the treatment and rehabilitation of individuals, families and community members who suffer from the physical and psychological effects of torture. In the FY 2012 Committee on Appropriations report dated September 22, 2011, (page 38) the Committee stated their support to “address the needs of victims of torture and victims of trauma resulting from violent conflict.”

Under the TVRA, the definition states:

1. Torture means an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering, (other than pain of suffering incidental to lawful sanctions) upon another person within his custody or physical control.
2. Severe mental pain or suffering means the prolonged mental harm caused by or resulting from:
 - the intentional infliction or threatened infliction of severe physical pain or suffering,
 - the administration or application or threatened administration or application of mind-altering substances or other procedures calculated to disrupt profoundly the sense or the personality, or
 - the threat of imminent death, or
 - the threat that another person will immediately be subjected to death, severe physical pain or suffering or the administration or application of mind altering substances or other procedures calculated to disrupt profoundly the sense or the personality.
 -

As used in this Act, the term torture includes the use of rape and other forms of sexual violence by a person acting under the color of law upon another person under his custody or physical control.

Torture survivors may suffer the prolonged effects of trauma which can affect their ability to perform tasks that are important to caring for themselves, their families and their communities. Recovery from the effects of torture requires thoughtful psychological and medical attention. Treatment aims to restore the survivor's position as a contributing and functioning member of the family and community.

Background

USAID envisions a world free of torture where survivors, their families and communities receive the support they need. With this aim, USAID primarily supports programs that help treat and heal the psychological and physical trauma caused by torture. Additionally, USAID recognizes that communities are an integral component to facilitating the recovery of the survivors. To this end, USAID supports programs that affirm the dignity of the survivor by restoring his or her position as a functioning and contributing member of the family and community.

USAID promotes the treatment of individuals, families and community members who suffer from the physical and psychological effects of torture. USAID supports nongovernmental organizations that (1) provide direct services to torture survivors; (2) build the capacity of individuals and organizations to treat and help restore the functioning of those affected by torture; and, (3) increase the level of knowledge and understanding about the effectiveness of treatment methods.

USAID projects work with various community stakeholders to treat and rehabilitate individuals and communities affected by torture. In particular, effort is made to increase access to and improve the quality of services that improve the status and function of survivors; bolster the capacity of organizations and individuals delivering services to torture-affected individuals, families, and communities; and, improve the quality of interventions through evaluation and the dissemination of findings related to long-term improvement in function.¹

Improving access through local partnerships

Enlisting local organizations and strengthening their ability to deliver services and effectively assist target populations has long been a central component of USAID's approach. In countries where torture has been widespread or systematic—with effects reaching into all or most communities and regions—it is unrealistic to expect a single group or organization to effectively tackle all areas of social reintegration and healing.

¹ Within the context of this program description, “function” refers to the tasks that persons in the affected communities do on a regular (daily or weekly) basis in order to care for themselves, their families and their communities.

For this reason, USAID projects include a deliberate “multiplier effect” that incorporates local NGOs, and community-based organizations and supports them in identifying and meeting the needs of the populations they serve. Building the critical threshold of local services for survivors through foreign torture treatment centers and local NGOs is an important goal of USAID as it strives to bring services to where survivors live. Past projects have featured capacity building of local staff and organizations as a means to improve and sustain services for torture survivors through local providers. In addition to expanding organizations’ capacity, USAID works to build networks and coalitions and to strengthen connections among diverse providers of supports and services to meet the wide range of practical, psychological, and social needs of people and communities affected by conflict and torture.

Improving quality of services through training and evaluation

Improving quality of services through comprehensive and consistent evaluations across programs and regions is an ongoing challenge. Because contexts and countries vary as do priorities of implementing organizations and their choice of mental health interventions, USAID emphasizes the use of rigorous measurement standards to improve practice. An understanding of programs’ impacts is essential to identifying best practices and lessons learned, building capacity of service providers, replicating and scaling programs, and ensuring the ongoing sustainability of efforts.

Program Activities and Goals

The goal of the Victims of Torture Program is to enable torture affected persons and communities² to resume their roles within family and community.

The objectives under this goal are:

1. Improved access to services that improve functioning in torture affected individuals and communities.
2. Improved quality of interventions for torture affected individuals and communities through the study of the impact of interventions.

Objective 1: Improved access to services that improve functioning in torture affected individuals and communities.

To achieve this objective, consideration should be given to an integrated service delivery program that meets the expressed needs of torture-affected persons and communities, and includes interventions designed to improve the functioning of torture-affected survivors and torture-affected communities in selected areas. The program should include linkages to existing local NGOs and CBOs which are providing medical, psychological, social, protection (human rights, legal) or economic assistance to communities that have been affected by torture.

Discussion: Individuals who have experienced torture directly or indirectly often need specialized medical and/or psychological assistance to meet their unique needs. A broader range

² Defined as persons currently suffering reduced function due to direct or indirect exposure to torture, and communities with many such persons.

of interventions also may be needed to help improve function, particularly in the context of rehabilitation following treatment where individuals returning to communities need to meet the challenges of everyday life.

Linkages among the key local organizations are essential to building a successful community-based program that addresses treatment through a tiered approach and provides opportunities for social and economic reintegration or rehabilitation once treatment is concluded. An active psychological education and outreach program might be considered to inform others about the medical and psychological effects and symptoms associated with torture (such as, insomnia, psychosomatic complaints, anxiety, depression) and how to access assistance.

Illustrative Partners:

- National and local NGOs and CBOs and governmental partners who are connected to target communities and have the capacity to provide services needed by individuals and communities with reduced function. Where clinical services are provided, the implementing partners should provide clinical supervision to ensure delivery of quality care.

Illustrative Results:

- Number of individuals with reduced function due to torture accessing services in selected torture-affected communities.
- Number of available interventions focused on supporting improved functioning.
- Number of affected individuals (percentage of program participants) who achieve significant recovery of their ability to perform their roles within family and community as a result of the intervention.

Illustrative Deliverables:

- In collaboration with local communities, undertake a needs assessment that identifies local priorities and service delivery modalities (as tied to a tiered program).
- Based on identified needs, an integrated service delivery program to meet needs of torture survivors and torture-affected communities in selected areas.
- Assessment of improvements in functioning.
- Mapping of local resources.
- Training programs for local NGOs/CBOs to incorporate basic forms of psychosocial care and referral into their regular programs.

Objective 2: Improved quality of interventions for torture-affected individuals and communities through training, monitoring and evaluation.

To achieve this objective, the program should measure the effectiveness of interventions in terms of improving function as part of an overall Monitoring and Evaluation strategy.

Discussion: Torture treatment centers and programs can strengthen services by (1) building evidence-based treatment protocols, (2) elevating capacity of counselors and therapists through training, (3) strengthening linkages with other service providers to complement mental health services in the treatment of survivors, and (4) evaluating the effectiveness of interventions.

Successful programs are able to present clear criteria for selecting mental health interventions for training, describe interventions and their suitability to the culture and needs of populations being served, develop training programs (which include follow up and clinical supervision), and utilize a strategy for measuring the effectiveness of interventions selected for training. Training for service providers can include linkages with local or regional universities, certification programs, mentoring, and in-country training institutes.

There is a widely held belief that psychosocial interventions should be an essential component of a treatment program for torture-affected individuals and communities. However, the field is challenged by the appearance of numerous approaches and methods without clear evidence of what works in low resource environments. This situation has resulted in a wide range of interventions, titles, and training models, but little agreement on the efficacy of various psychosocial interventions and, therefore, the appropriate training needs for such interventions.

Based on these concerns, and because of a dearth of scientific evidence of the effectiveness of psychosocial interventions for torture victims, as well as a lack of standardization of these same interventions, Objective 2 is an analytical component to accompany service delivery in order to investigate the true effectiveness of interventions. This component will require the applicant to select and test those interventions they believe are most likely to be effective in helping restore function. In the context of these guidelines, ‘function’ refers to the tasks that persons in the affected communities do on a regular (daily or weekly) basis in order to care for themselves, their families and their communities. USAID is interested in the extent to which the ability to do these tasks is affected by torture, and the extent to which psychosocial/counseling and other interventions can help to restore functioning.

Illustrative Partners:

- Private and public researchers and research organizations including universities, institutes (national, international).
- Training organizations (national, international).

Illustrative Results:

- Evidence of the effectiveness (or lack of effectiveness) of tested interventions in improving function.
- For those interventions (if any) found to be effective, evidence that at least one of the implementing organizations will continue to provide this intervention/s as part of their programming. This evidence would include training programs for participating organizations in the effective intervention(s).
- Refined roles for professionals and community workers engaged in service delivery, treatment or rehabilitation based on the interventions found to be effective.

Illustrative deliverables:

- Record of research/impact analysis into the effectiveness of the project interventions, conducted using sound qualitative and quantitative methodology.
- Research findings shared through meetings, publications, media and the Internet.

- Only if possible, scientific (using controlled comparisons) assessment of the impact of program elements designed to improve function.

IV. USAID PRINCIPLES OF PRACTICE IN ASSISTING TORTURE SURVIVORS

USAID believes that a number of fundamental principles must be incorporated in the implementation of all programs for torture-affected populations. These principles derive from an underlying commitment to (1) increase access to services that treat and thus improve the status and function of victims of torture and promote healing; and, (2) improve the quality of interventions for torture-affected individuals through the study of the impact of interventions.

Recipients shall adhere to the following USAID principles in programming for victims of torture:

Community-based. To be accessible, interventions need to be based in communities where survivors live. Referral networks incorporating professionals at all levels of technical expertise in rural and urban settings improve coverage and opportunities for survivors to receive the services they most need. The design of community-based mental health interventions specific to torture affected populations should be appropriate for low resource environments.

Culturally grounded. USAID recognizes the importance of understanding local definitions of function and well-being. Ethnographic assessment methods can help identify local meanings, evolve appropriate strategies and interventions to improve the status of torture survivors, and contribute to a baseline of information that can serve as a marker of progress.

Evidence-based. The organizations that USAID supports must demonstrate the effectiveness and impact of interventions to improve the functioning and well-being of victims of torture and build an evidence base for practice. USAID asks that grantees incorporate monitoring and evaluation systems to measure improvements. Interventions should be matched to population needs. Culturally adapted measurement or screening mechanisms should be employed to determine need and most appropriate services for affected populations.

Holistic. Affected populations have multiple needs and not all survivors may suffer the long-term effects of trauma. Trauma specific interventions should be applied only if indicated through appropriate screening. Counseling can effectively link individuals with appropriate services, based on assessment of need. Services for torture affected individuals should incorporate several avenues to healing, such as medical attention, physical rehabilitation, documentation of experiences, and mental health support and socio-economic activities which can help individuals reintegrate into families and communities.

Collaborative. Collaboration with and among other organizations is critical to ensuring a holistic and integrated approach. USAID supports interventions that build and strengthen existing community networks and resources. Working through local organizations, USAID hopes to improve access to services and strengthen responses to torture.

In-country capacity. The human factor is the key to sustainable, quality care and services. Appropriately trained, supervised and supported service providers are essential to success.

Sustainable practice. Follow-up is vital to the success of any program, during implementation and after a project cycle has ended. Programs should demonstrate a clear and feasible exit strategy or plan for continuance after the initial grant.

For additional information, please contact SPANS program manager, Rob Horvath, rhovath@usaid.gov.

Victims of Torture revised Guidelines – 2013.doc

ANNEX E: Scope of Work for Victims of Torture DRC Site Visit

There are three primary goals of the Victims of Torture program (VOT) assessment of the sexual and gender based violence programs in the Democratic Republic of the Congo: 1) to monitor project progress, achievements and challenges vis-à-vis the original program descriptions and current country context, 2) determine if there are programmatic areas, e.g. counseling, economic strengthening, etc., that could benefit from an external evaluation across the three projects (IMA, IMC, IRC), and 3) gather information regarding possible future programming. The assessment is primarily a technical visit and thus activities should be geared towards providing the VOT team with the technical information necessary to understand the evolution of the projects, and what, if anything, can be done to improve the projects or overcome any current obstacles. Site visits and meetings should be prioritized towards activities that are representative of the program components and challenges generally experienced by all three of the implementing partners.

Since 2002, the Victims of Torture program has funded programs that provide for the treatment and healing of survivors of Sexual and Gender Based Violence (SGBV) in the Democratic Republic of the Congo (DRC). These programs were highlighted during and after Secretary of State Hillary Clinton's August 2009 DRC visit. The VOT program contributes to two areas of the 2010 U.S. SGBV strategy in the DRC: increasing the prevention of and protection from SGBV, and increasing access to high-quality services for SGBV survivors.

Eastern DRC is an extremely volatile region and USAID implementing partners (IPs) face many challenges in achieving program objectives. After 10 years of focused SGBV programs, tangible progress has been made in several areas, e.g. building local capacity to provide medical and counseling services as well as in the education of large numbers of Congolese regarding how to prevent and respond to SGBV. However, without a vast improvement in the security sector, there are limits as to how much external actors can contribute to sustainable change in the DRC.

In determining next steps therefore, it is important for the VOT team to have a realistic understanding of the country context, USAID/Kinshasa's future plans regarding SGBV programming, and the organizational strengths and weaknesses of the partners.

Additional considerations for the USAID assessment team (time permitting)

- Expanded geographic coverage vs. program quality
- CBOs vs. NGOs as community partners
- Given the weaknesses of the DRC's judicial system, what level of programmatic effort (LOE) do the IPs currently provide for survivor legal assistance?
- What is the general quality of the data collected by the IPs?

U.S. Agency for International Development
1300 Pennsylvania Avenue, NW
Washington, DC 20523
www.usaid.gov