ON BEHALF OF THE
EUROPEAN NETWORK OF CENTRES FOR TREATMENT AND REHABILITATION OF VICTIMS OF TORTURE AND OTHER HUMAN RIGHTS VIOLATIONS

CONDITIONS FOR MAINSTREAMING TREATMENT AND REHABILITATION SERVICES FOR VICTIMS OF TORTURE AND OTHER HUMAN RIGHTS VIOLATIONS IN THE EUROPEAN REGION

A study based on reports from 30 rehabilitation centres in 22 European countries collected and analysed by

Professor Erik Holst, MD, ICAR Foundation, Romania

with a

Proposal for a national strategy for mainstreaming treatment and rehabilitation services for victims of torture and other human rights violations suggested by Nora Sveeass, Norway, member of the UN Committee against Torture. Annex II

CONTENT

SUMMARY AND CONCLUSIONS

- While the number of new and recent cases of torture and other human rights violations is fortunately small in most European countries, victims of past torture and other human rights violations are still prevalent in many European countries and new victims continue to arrive in Europe as asylum seekers from other parts of the world.
- With increasingly tight immigration policies in Europe it becomes critically important to identify such victims among refugees and asylum seekers at arrival, partly to prevent *refoulement* of such victims against international law and partly to ensure that they are offered the assistance such victims are entitled to as part of international obligations.
- Appropriate special services for victims of torture and other human rights violations are therefore still a necessity even the EU
- The necessary comprehensive special services for such victims are not today a normal part of national health care and/or social services in most European countries.
- However, national and local authorities in a number of European countries provide direct or indirect financial assistance and/or contributions in kind to non-governmental centres for victims of torture and other human rights violations
- The combined capacity of public and non-governmental centres providing such services does not cover the estimated actual need
- National health care and/or social services have a potential for providing such services but need an incentive to prioritise the establishment of such services
- If the state decides to offer such services to victims of torture and other human rights violations within their public health system, the question of assuring access to these services for all potential clients is crucial. Existing barriers to access must be removed or overcome.
- There is a need to establish this as a responsibility for members of EU and further for all members of the Council of Europe even where this responsibility already flows from existing international obligations
- This may be seen also as a step towards implementing the EU directive on minimum standards for the reception of asylum seekers
- The idea of mainstreaming services for victims of torture and other human rights violation is in principle positive but before the EU Commission decides to leave this task to its member states it must actively promote this as a policy in all EU member countries - and preferably also in the member countries of the Council of Europe.
- The continued existence and further development of independent specialised centres for victims of torture and other human rights violations is absolutely necessary – even after successful mainstreaming of services in countries where this is possible - but they will be much more effective if given secure conditions within the general health care system.

- A European Strategy as well as National Strategies should be developed to ensure the implementation of state obligations to victims of torture and other human rights violations.
- The national efforts in this respect may even need to become subject to some form of European supervision e.g. under the umbrella of the European Convention for the Prevention of Torture
- In the meantime the EU must maintain and as needed expand its vital financial support for centres in member countries of EU as well as in member countries of the Council of Europe and in the rest of the world where mainstreaming has not yet been – or is unlikely to be - adopted and implemented as a national policy
- The stricter immigration policies in Europe means a *de facto* reduction of access to appropriate treatment and rehabilitation services for an increasing number of victims who cannot get such services in their own countries. An added argument for increasing funding for such services in third countries.

Historical Background or

How specialized services for treatment and rehabilitation of victims of torture and other human rights violations emerged as the health professions response to a previously unrecognised need.

Survivors of Nazi concentration camps were recognized in their home countries on their return, but seldom received any specific treatment. They were diagnosed with a new diagnostic entity termed the *KZ-Syndrome* and offered disability pensions, but no specific interventions to deal with their problems – except in the Netherlands.
Survivors of genocide in Cambodia were identified and offered treatment through the Harvard project in Cambodia and Boston.
Survivors of torture in dictatorships in Latin American, Greece and the Philippines arrived as refugees in the US, Canada and Western Europe and were recognised as a special category separate from traditional PTSD cases. And it was realized that they needed special assistance beyond the shelter, clothing, food and basic medical care - the traditional recipe for dealing with refugee needs both by national Red Cross organizations and the international refugee organization UNHCR.
With the fall of these dictatorships it became possible to establish treatment centres in these countries based on the diagnostic and therapeutic experiences gained at the centres in North America and Europe.

The fall of the Soviet empire made visible the large number of survivors of communist repression in Central and Eastern Europe, including survivors of torture, of political prisons and concentration camps and of psychiatric abuse. With support from Western European centres treatment and rehabilitation services were initiated also in this part of the world after 1989.

Finally victims of torture under military dictatorships and other forms of repressive governments in Africa, Asia, and the Middle East became visible either as refugees from these regimes or among the patients seen and increasingly recognised as such by health professionals in these continents. Centres providing appropriate services for these victims and training of health professionals were initiated in the late eighties and especially in the nineties.

To the victims of political repression could be added large numbers of victims of armed international conflicts, and - increasingly – victims of internal conflicts found among international refugees from these conflicts or as internally displaced persons in their own countries. The kind of treatment offered at the centres for victims of torture were found increasingly to be relevant also for this category of victims, which were included in the target group of many such centres..

Providing appropriate care to victims of torture and other human rights violations is a state obligation

In principle victims of torture are entitled to appropriate assistance in all state parties to the UN Convention against Torture according to article 14 of this Convention:

"Each state party shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full a rehabilitation as possible."

Other international instruments contain similar obligations - e.g. the Geneva Conventions – and all these obligations have been emphasized in

"The Basic Principles and Guidelines of Remedy and Reparations for Victims of Human Rights and Humanitarian Law Violations"

which were finally adopted by the 61st session of the UN Human Rights Commission in 2005

Rehabilitation services for victims of torture were in practice initiated by non-State actors

In spite of a clear obligation undertaken by state parties to these international instruments few states have established special services for victims of torture within their general health care system.

From its earliest days the provision of services to torture survivors both among refugees and in their own countries came to be provided outside the

general health care system. For refugees this was partly due to limitations in their access to the general health care system in their host country. For victims treated in their own countries during the transitional period after the end of a repressive political system this was either due to unavailability of appropriate services or the victims' lack of trust in a health system controlled by the same state, that was responsible for their sufferings.

In countries where the practice of torture is still used by the law enforcement agencies such services are by necessity provided by non-governmental and even clandestine groups of health professionals working under the risk of persecution by state or para-state agents.

A variety of approaches were used depending on circumstances in each country:

The non-governmental organisations providing care for victims of torture had many different backgrounds

1. Some were created as extensions of or with the support of Amnesty International as in the U.K., Denmark, France and Pakistan
2. Some were extensions of local and international University community services (U.S., Switzerland)
3. Some represented spontaneous initiatives within the medical and psychological profession in countries having experienced political repression or armed conflict (Latin America, the Philippines, South Africa) as well as in countries receiving victims from these countries (Italy, France) In the Netherlands this development was triggered by the arrival of large numbers of boat refugees from Vietnam.
4. Some were the result of international promotion among groups of motivated health professionals in countries with endemic torture and human rights violations or in the transitional process from political repression or armed conflict (Central and Eastern Europe, East Africa).
5. Some were extension of other Human Rights NGO activities e.g. focusing on detained persons (Turkey)
6. Some were extensions of refugee services operated by semi-official National Refugee Organisations or National Red Cross Societies (e.g. Australia, Canada, Italy, Sweden, Switzerland)
7. Some were an extension of refugee services operated by local UNHCR missions (e.g. in UNHCR camps for Bhutanese refugees in Nepal)
8. Some were an extension of religious community services (Germany)
9. Finally some were initiatives within immigrant communities themselves headed by health professionals within that group (Belgium, Germany)

State actors

In a few places such services were initiated as extensions of public social services for immigrants (Norway)

International funding has been crucial in the development and maintenance of services for victims of torture and other human rights violations

Since 1984 the United Nations has provided financial support for services for victims of torture operated by non-governmental organisations, channelling voluntary contributions mainly from member states through to such organisations. The funds are appropriated on the advice of an independent Board of Trustees and in 2005 supported almost 167 centres and programmes with a total of 8.5 Million US$.

Since 1994 the EU has provided additional support to such activities originally through a specific budget line but now as part of a general budget for the European Initiative for Democracy and Human Rights. This programme in 2004 provided 10 million EUR for services for victims of torture within and outside the EU. At one point (1999) continued financial support from the EU to centres in EU member countries had to be channelled through a special budget line for interior activities, as it was considered illegal to use for activities within the EU, since the human rights budget was intended only for third – i.e. mainly developing –countries. However, for administrative reasons the funds were later reincorporated in the funds for rehabilitation of torture victims in the EIDHR programme.

Since 1999 the US has provided substantial international funding of services for victims of torture through the Torture Victims' Relief Act, partly through the above mentioned contribution to the UN voluntary fund (7 million US$ in 2005) and partly as direct support through the USAID to such activities outside the US (12 million US$ in 2005). At the same time this law provides financial support for centres for victims of torture inside the US amounting to 25 million USD in 2005

This international funding has been essential for the development and sustainability of the now more than 200 centres for victims of torture around the world but has been supplemented to varying degrees locally by national public or private funding as well as internationally by national development agencies and private foundations.

Towards mainstreaming services or victims of torture

With time however, services for victims of torture are - in more affluent countries - increasingly funded directly as part of national health or social services for refugees or as public subvention of services provided by semi-official or independent non-governmental organisations.

In Europe this process is most advanced in the Netherlands and in the Scandinavian countries but there have been advocates for the adoption of this manner of financing such services as a general policy within the EU Commission. This would mean transferring the burden of funding

rehabilitation services for victims of torture within the EU to the member states themselves.

And the issue of transferring the burden of funding rehabilitation services for victims of torture to the member states was raised again in a recent evaluation report on four European rehabilitation centres for victims of torture (Athens, Brussels, London and Paris)[1] which included the following among its recommendation:

"The evaluation team recommends the European rehabilitation centres: ***To increase the institutional impact of their work by developing and implementing strategies to channel their expertise into the mainstream national health system.***

Treatment and rehabilitation should clearly be tasks of the mainstream public health services of the (European Union Member) States in which the centres are located. Where these services have failed to meet their obligation, NGOs have started rehabilitation and treatment programmes for torture victims. All over Europe, centres for the rehabilitation (or treatment) of victims of torture have been established and do function to some extent. Indeed, some of them have been operating since the very beginning of the awareness in Europe at the beginning of the 1970s about the physical and mental impact on a victim of torture practices. However, at the beginning no centre thought of the need to finally integrate their expertise into the national public health sector. This attitude persists today in the centres visited, which tend to think that only they are capable of rehabilitating victims of torture. This is a sort of 'ivory tower' thinking, but it is also a serious flaw as regards sustainability.*

All four centres included in this evaluation have only loose links with the national health systems.
It is interesting to note that their pioneering work with victims of violence in the 1970s has not been used in the implementation of strategies in the emerging European preoccupation with family violence, violence against women and children, child abuse etc. Their pioneering experiences have, unfortunately, not been integrated into the national health systems. It is as if the experience of torture and political violence is something so different from 'normal national' violence that no link between the two forms of violence would be possible. This attitude might be valid when seen from the perspective of the reasons for the violence, however, it is only partly valid from the perspective of the medical and psychological effects of the violence on individuals and communities.
The only centre which has started to investigate this potential is EXIL, in a study on family violence and its prevention in refugee families, undertaken jointly with the WHO collaborating centre of the Catholic University of Louvain. The partial funding of EXIL as a centre for mental health by the local authorities is a step in the direction of integrating it into the local mainstream health facilities.
The lack of strategy of the four centres to integrate their work centres into the national health systems threatens the long-term sustainability of their work. There is a risk that their accumulated knowledge and experience will disappear when the centres cease functioning due to organisational malfunctioning or lack of funding.
Today, in Europe, the national health systems are increasingly aware of the difficulties of treating migrants from many parts of the world and have to find ways of dealing with this issue. It is evident that the European health systems have a legal obligation to provide the migrant populations with care that is adequate and equal to that provided to the indigenous population. The existing centres for treating psycho-social consequences of family violence can profit from the know-how of the centres for the rehabilitation of torture victims and vice versa. This might be a chance for the centres to obtain a better connection to university units

[1] Torture rehabilitation centres Europe
By Sara Guillet, Gisela Perren-Klingler and Inger Agger
Human European consultancy in partnership with the Netherlands Humanist Committee on Human Rights and the Danish Institute for Human Rights
January 2005

specialised in psycho-traumatology and to become more effective in their treatment approaches. It would also be a way of integrating the specific (transcultural) experiences of the centres into the national health system. Mainstreaming this expertise into one single channel would, of course, also help to enhance the integration of the specific group of persecuted and often forced migrants into a 'normal' group of clients of national health systems.

However, this integration needs a long-term strategy, with mutual co-operation from both sides. The national health systems must be sensitised about their obligations and their capacity to care for this specific group of migrants. They will have to learn from or be informed by the centres about how to approach this specific group and what sort of training to give to the basic health care providers in each national system. It is not clear whether the national health systems or the centres themselves have resisted this view, nor to what extent and within what timescale this integration will have an impact on the centres.

BUT DO CONDITIONS FOR MAINSTREAMING CURRENTLY EXIST IN EUROPE?

The European Network of Centres for Treatment of Victims of Torture and Human Rights Violations decided to take up this challenge by identifying the basic conditions for mainstreaming services for victims of torture and other human rights violations and provide insight into the current ability of European countries to fulfil these conditions.
Summary of conditions for mainstreaming:

The following conditions for mainstreaming services for victims of torture and other human rights violations would be necessary in countries receiving victims of torture as refugees

In immigration services

1. Effective identification and recognition as such of all victims of torture and other human rights violations on arrival. This requires appropriate training of immigration personnel including training of health professionals in these services in Istanbul Protocol procedures.
2. Effective guarantee against *refoulement* for all victims of torture and other human rights violations.
3. Capacity in the public health and social system or in specialised publicly funded services to provide all the basic and specialised care needed by victims
4. Willingness to ensure that victims of torture and other human rights violations – nationals as well as refugees - have appropriate social and living conditions making rehabilitation possible

In health service policy

5. Willingness to prioritise provision of appropriate services to this group ahead of other demands on the system.
6. Willingness to develop the services in the relevant specialties with special focus on the needs of this category of clients.

In access to health services

7. Willingness to give access to all categories of victims to these services irrespective of their refugee status

In recognition by the system of the special needs of the victims

8. Need to secure complete confidentiality
9. Need for recognition of past suffering and for moral support
10. Need to secure personalised services with committed and specially trained professionals

In Psychiatry – regarding types and duration of interventions

In Clinical Psychology - regarding types and duration of intervention

In Social integration or re-integration in host society or own society

In family oriented approach as needed

In legal advice and support before administrative or judicial authorities even beyond the national systems (e.g. the European Court on Human Rights or the UN Office of the High Commissioner on Human Rights)

In implementation of victims' rights

11. Recognition by the system of the special rights of the victims in accordance with *"The Basic Principles and Guidelines of Remedy and Reparations for Victims of Human Rights and Humanitarian Law Violations"* adopted by the 61st session of the UN Human Rights Commission in 2005

Additional conditions for mainstreaming will be necessary in countries where the practice of torture or other forms of cruel, inhuman or degrading treatment by law enforcement or penitentiary personnel is endemic or at least not fully eradicated

12. Willingness of the authorities to recognise the existence of torture, where this practice is endemic or not fully eradicated
13. Willingness to tolerate exposure of the continued practice of torture – to which the medical profession is obliged through international ethical codes - through medical reports from the services providing assistance to its victims
14. Willingness to abstain from any kind of pressure on such services, their clients or their staff

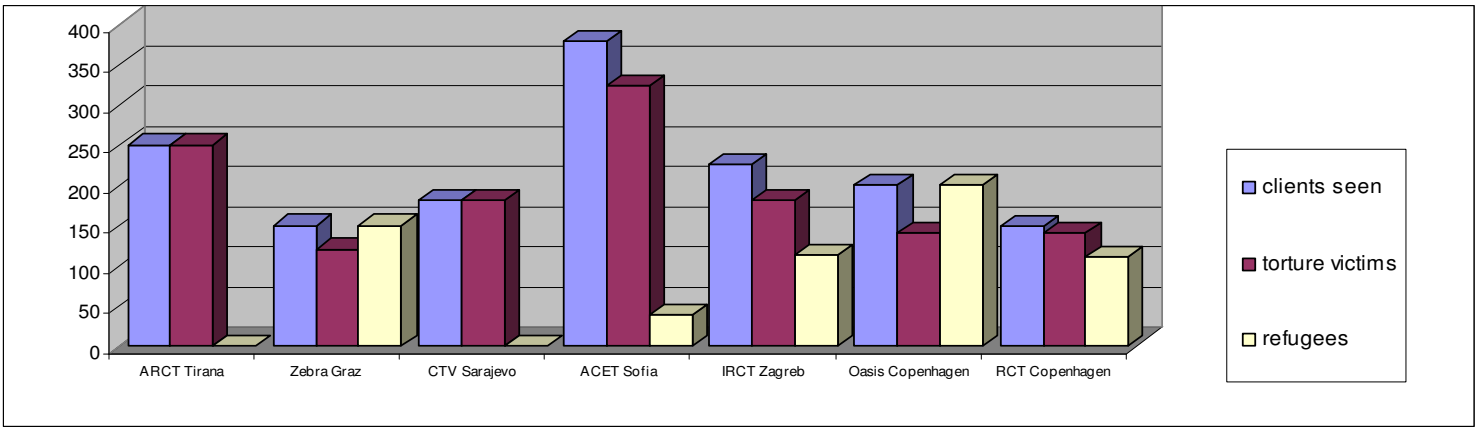
A questionnaire or checklist was circulated in December 2005 by e-mail to all centres in the European Network. Reminders were sent in two waves aiming at obtaining response from at least one centre in each country. Finally responses were received from 30 centres in 22 of the 27 European countries represented in the Network

The following pages will represent the finding of this survey:

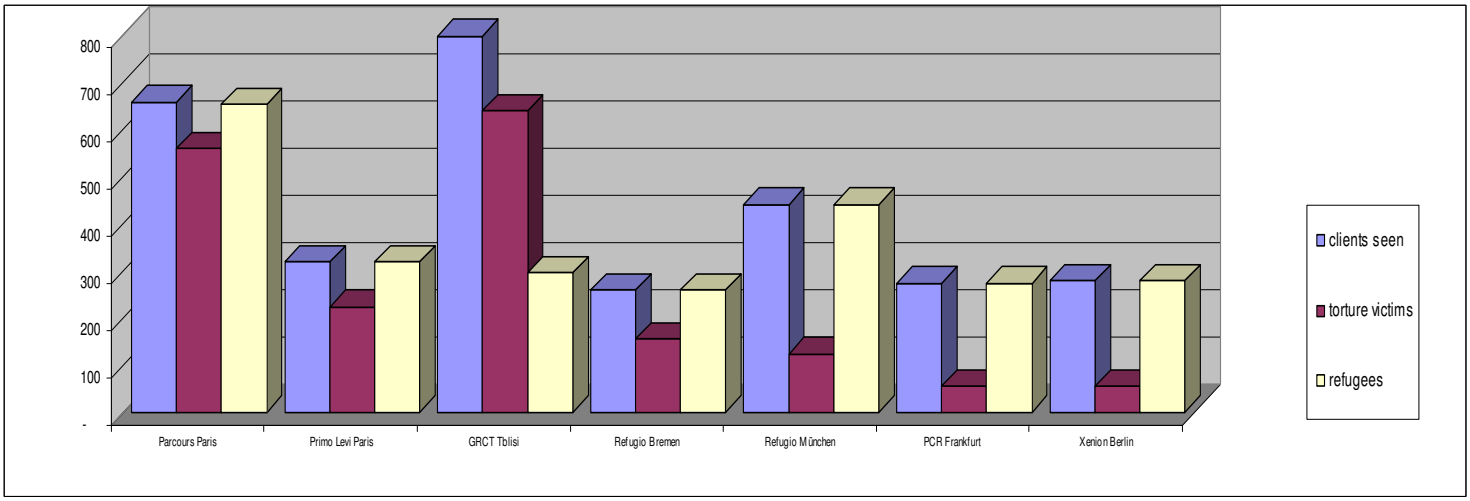
Who are the clients of current European Centres?

Before we start assessing the possibility of mainstreaming our activities we need to determine what these activities are and - more importantly - who the people we are currently serving are Responses to this survey allow us to present a profile of clients served by 29 treatment and rehabilitation centres in 21 European countries (Graph 1-5)

Graph 1

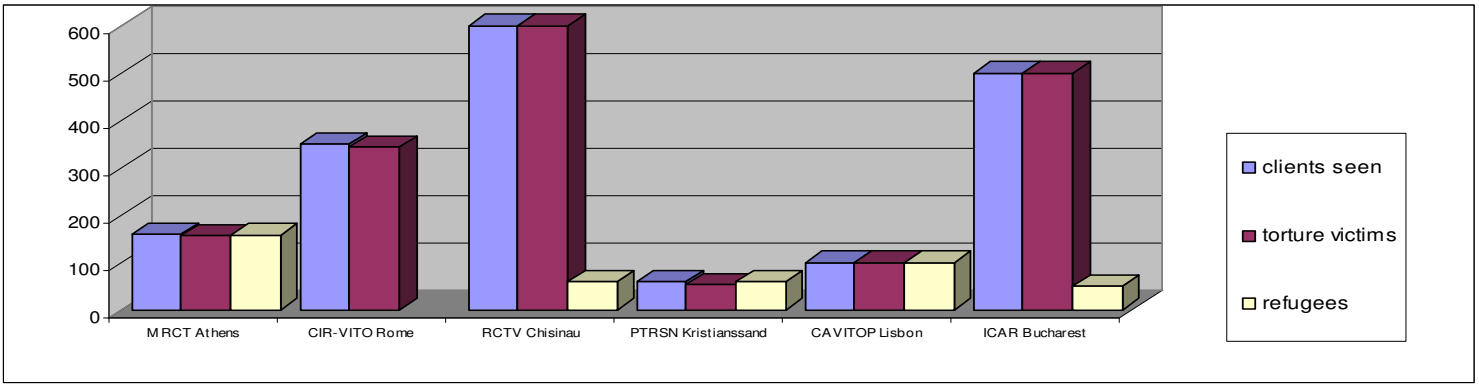


Graph 2

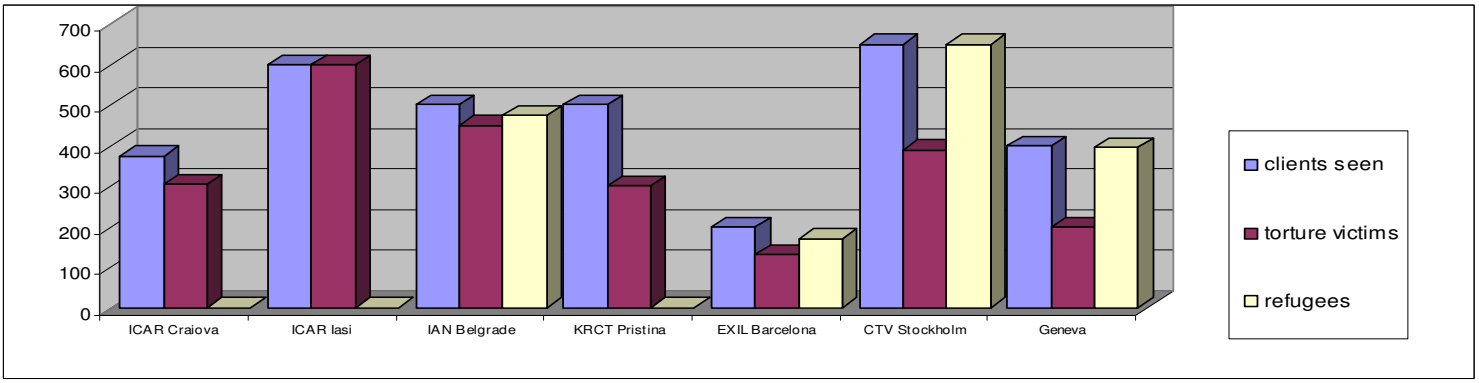


Who are the clients of current European Centres? (Continued)

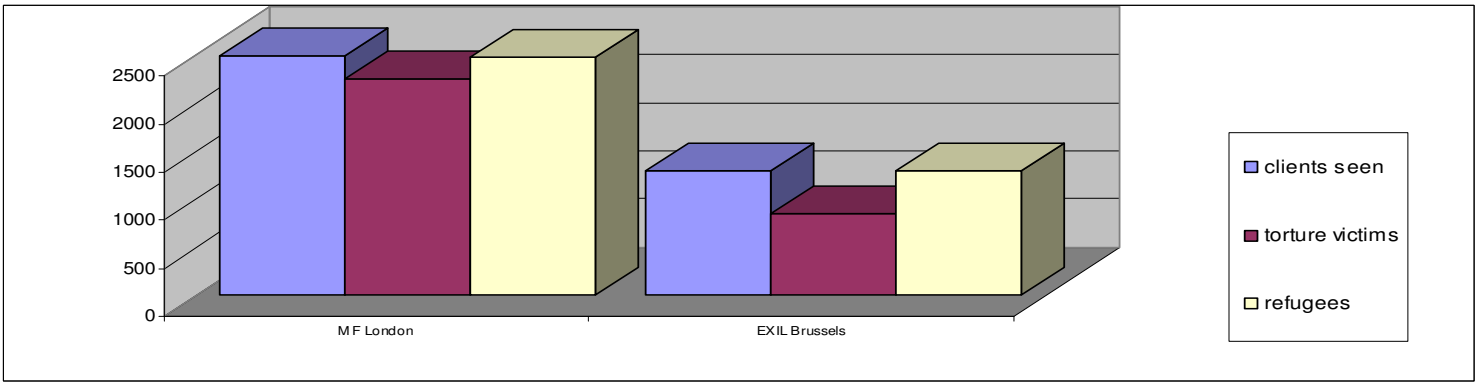
Graph 3



Graph 4



Graph 5



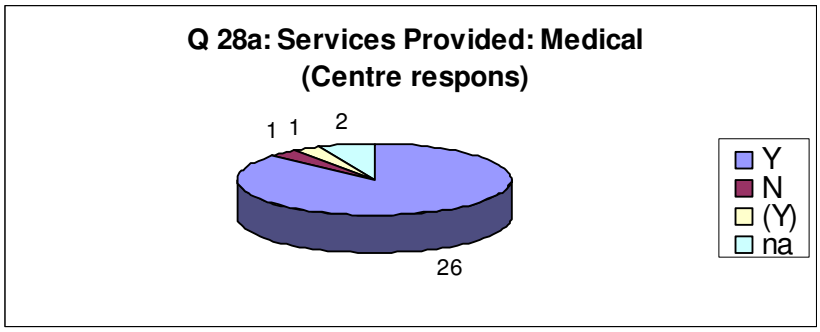
The total **number of clients** seen annually by the 29 centres responding to this question is **13.365.**

The percentage of **torture victims** among clients vary between 20 and 100 per cent with an mean of **78 per cent** (in EU countries 72 %) while the percentage of victims of other human rights violations correspondingly vary between 0 and 80 per cent with an mean of 22 per cent

The percentage of **refugees** among clients vary between 0 and 100 per cent with an mean of **70 per cent** (in EU countries 99 %) while the percentage of nationals correspondingly vary

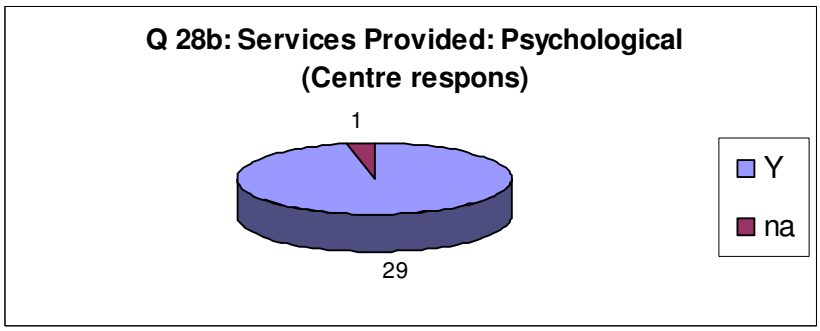
between 0 and 100 per cent with an mean of 30 per cent among the 28 centres responding to this question

WHICH KINDS OF SERVICES ARE CURRENTLY PROVIDED BY THE CENTRES?



YES				(Y)	NO
ACET Sofia	EXIL Barcelona	ICAR Iasi	PTRSN Kr.sand	MF London	
ARCT Tirana	EXIL Brussels	IRCT Zagreb	RCT Cphagen		Refugio Bremen
CAVITOP Lisbon	GRCT Tbilisi	KRCT Pristina	RCTV Chisinau		
CIR VITO Rome	HUG Geneva	MRCT Athens	Refugio Munich		**na**
CTV Sarajevo	IAN Belgrade	ICAR Bucharest	Oasis Cphagen		PCR Frankfurt
CTV Stockholm	ICAR Craiova	Pr. Levi Paris	Xenion Berlin		Pharos Utrecht*
			Zebra Graz		

Almost all centres responding to this question provide medical services to their clients.



YES					Na
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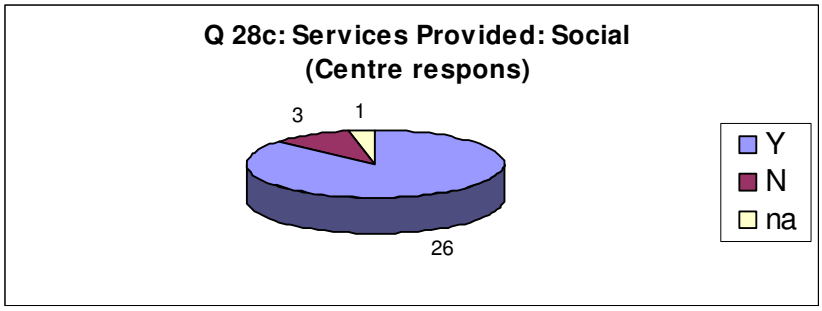
CTV Sarajevo	HUG Geneva	KRCT Pristina	Pr. Levi Paris	Xenion Berlin	
	IAN Belgrade	MF London	PTRSN Kr.sand	Zebra Graz	

All centres responding to this question provide psychological services to their clients.

*Since 2004 the Pharos centre only act as expert advisor to services for victims of torture and other human rights violation and no longer provide direct services. However there are a number of independent centres in the Netherlands still providing direct services to victims of torture and other human rights violations

TYPES OF SERVICES CURRENLY PROVIDED BY THE CENTRES (continued)



YES					NO
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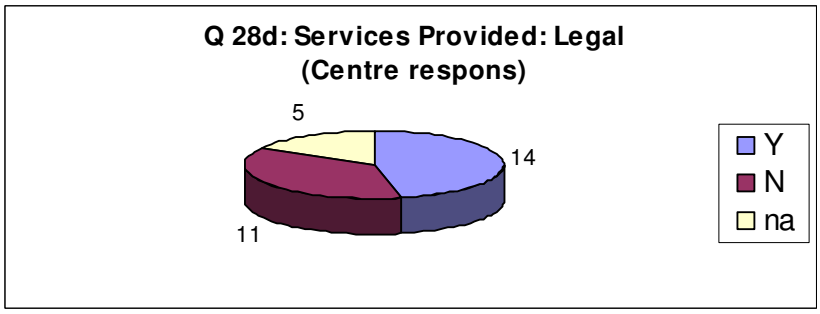
CAVITOP Lisbon	EXIL Brussels	KRCT Pristina	PTRSN Kr.sand	Zebra Graz	Parcours Paris
CIR VITO Rome	GRCT Tbilisi	MF London	RCT Cphagen		**na**
CTV Sarajevo	IAN Belgrade	MRCT Athens	RCTV Chisinau		Pharos Utrecht*
	ICAR Bucharest	Oasis Cphagen	Refugio Bremen		

Most of the centres responding to this question provide social services to their clients.



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CIR VITO Rome	KRCT Pristina	Zebra Graz	EXIL Barcelona	PTRSN Kr.sand	Oasis Cphagen
GRCT Tbilisi	MF London		EXIL Brussels	Refugio Bremen	PCR Frankfurt
IAN Belgrade	MRCT Athens		HUG Geneva	Refugio Munich	Pharos Utrecht*
	Pr. Levi Paris			Xenion Berlin	

Only 56 per cent of the centres responding to this question provide legal services to their clients.

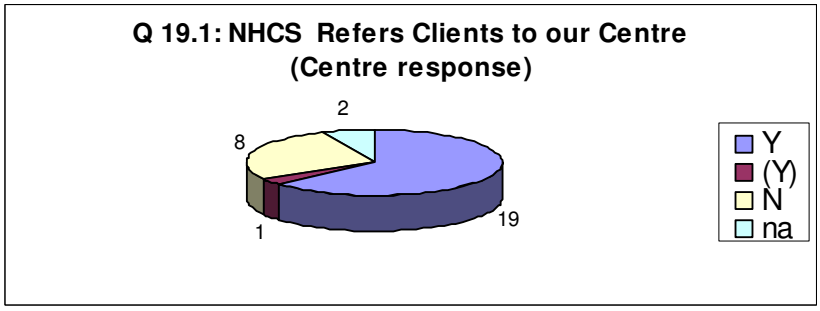
*Since 2004 the Pharos centre only act as expert advisor to services for victims of torture and other human rights violation and no longer provide direct services

WHAT IS THE POSITION OF THE CENTRES IN THE GENERAL HEALTH SERVICE SYSTEM?

YES		NO			
CTV Stockholm	PCR Frankfurt	ACET Sofia	EXIL Barcelona	IRCT Zagreb	RCTV Chisinau
HUG Geneva	Pharos Utrecht*	ARCT Tirana	EXIL Brussels	MF London	Refugio Bremen
ICAR Bucharest	Pr. Levi Paris	CAVITOP Lisbon	GRCT Tbilisi	MRCT Athens	Refugio Munich
ICAR Craiova	PTRSN Kr.sand	CIR VITO Rome	IAN Belgrade	Oasis Cphagen	Xenion Berlin
KRCT Pristina	RCT Cphagen	CTV Sarajevo	ICAR Iasi		Zebra Graz
Parcours Paris					

Only eleven of the 30 centres responding to this question consider themselves part of the national health care system

WHAT IS THE INTERACTION BETWEEN THE CENTRES AND THE GENERAL HEALTH SERVICE SYSTEM



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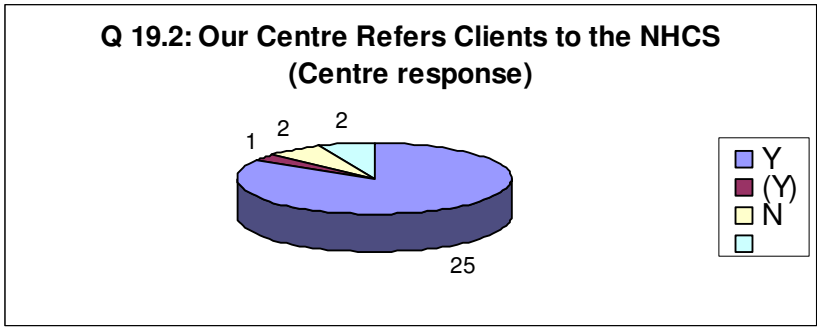
CAVITOP Lisbon	IAN Belgrade	RCT Cphagen	IRCT Zagreb		ICAR Iasi
CIR VITO Rome	ICAR Iasi	Refugio Bremen	GRCT Tbilisi		
CTV Sarajevo	KRCT Pristina	Refugio Munich	MRCT Athens		
CTV Stockholm	MF London	Xenion Berlin	RCTV Chisinau		
EXIL Barcelona	Oasis Cphagen	Zebra Graz	Pharos Utrecht*		
EXIL Brussels	Parcours Paris	(Y)	ICAR Bucharest		
	Pr. Levi Paris	Xenion Berlin			

Two thirds of the centres indicate that they receive referrals from the national health care system



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CTV Sarajevo	ICAR Craiova	PCR Frankfurt	Zebra Graz		na
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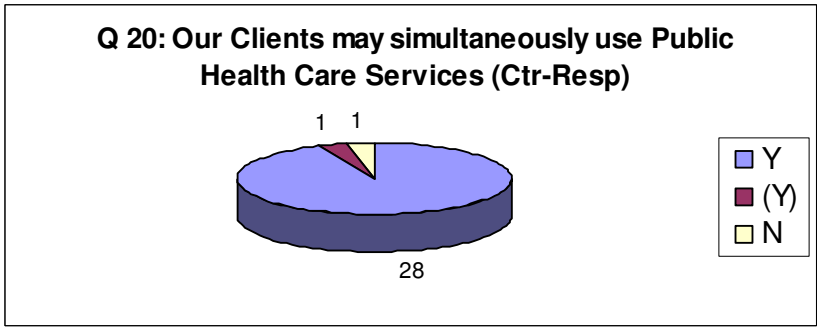
The majority of centres indicate that they refer clients to the national health care system



YES					(Y)
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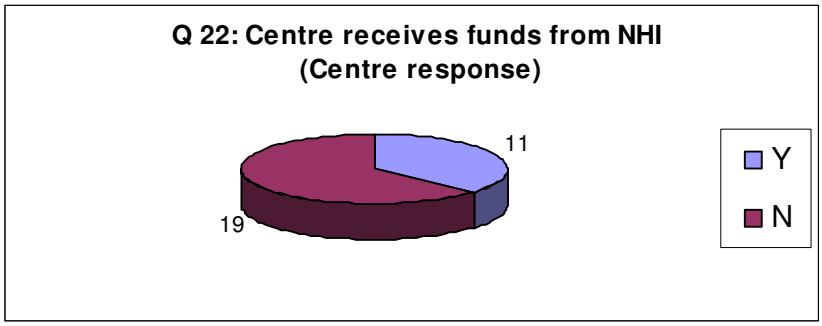
CTV Sarajevo	IAN Belgrade	MF London	PTRSN Kr.sand	Zebra Graz	na
	ICAR Bucharest	MRCT Athens	RCT Cphagen		Pharos Utrecht*

Almost all centres indicated than their clients may simultaneously use national health care services

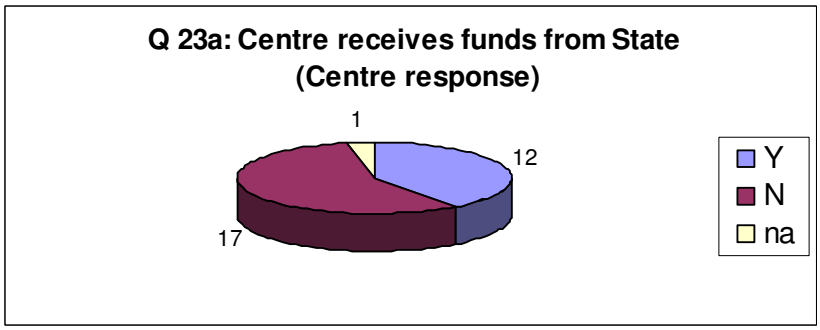
*Since 2004 the Pharos centre only act as expert advisor to services for victims of torture and other human rights violation and no longer provide direct services

HOW ARE OUR CENTRES FUNDED



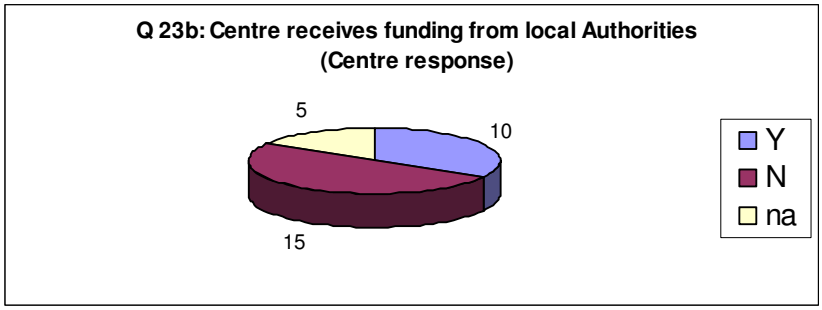
YES	Parcours Paris	**NO**	EXIL Barcelona	MF London	Xenion Berlin
CTV Stockholm	Pr. Levi Paris	ACET Sofia	GRCT Tbilisi	MRCT Athens	Zebra Graz
EXIL Brussels	PCR Frankfurt	ARCT Tirana	IAN Belgrade	Pharos Utrecht	
HUG Geneva	PTRSN Kr.sand	CAVITOP Lisbon	ICAR Bucharest	RCTV Chisinau	
IRCT Zagreb	ICAR Craiova	CIR VITO Rome	ICAR Iasi	Refugio Bremen	
Oasis Cphagen	RCT Cphagen	CTV Sarajevo	KRCT Pristina	Refugio Munich	

Eleven centres receive funding from the national health insurance, including centres in the EU, Norway, Switzerland as well as Croatia and Romania. This usually has the character of fee for service, but may also entail basic contributions to clients registered with the centres.



NO	GRCT Tbilisi	KRCT Pristina	**YES**	Oasis Cphagen	Zebra Graz
ACET Sofia	HUG Geneva	MF London	CIR VITO Rome	Parcours Paris	
ARCT Tirana	IAN Belgrade	RCT Cphagen	CTV Sarajevo	Pharos Utrecht	
CAVITOP Lisbon	ICAR Bucharest	RCTV Chisinau	EXIL Brussels	Pr. Levi Paris	
CTV Stockholm	ICAR Craiova	Refugio Bremen	IRCT Zagreb	PTRSN Kr.sand	**Na**
EXIL Barcelona	ICAR Iasi	Xenion Berlin	MRCT Athens	Refugio Munich	PCR Frankfurt

Twelve centres indicate that they receive direct contributions from the state mainly as direct percentage or lump sum contributions to the core budget.

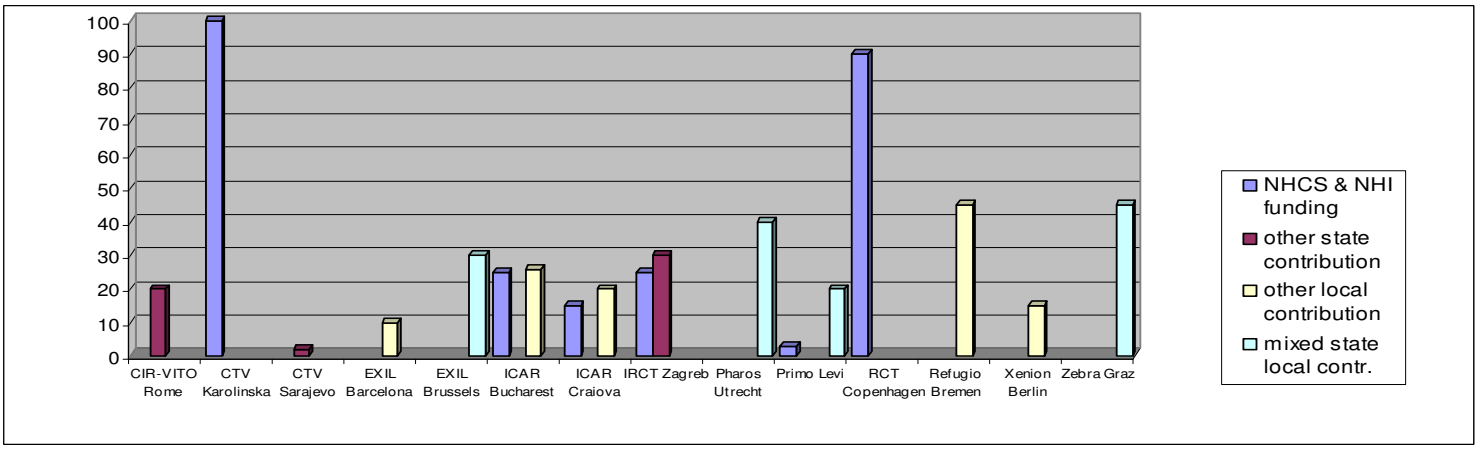


YES		NO			Na
EXIL Barcelona	Pr. Levi Paris	ACET Sofia	HUG Geneva	MRCT Athens	CIR VITO Rom
EXIL Brussels	PTRSN Kr.sand	ARCT Tirana	IAN Belgrade	Oasis Cphagen	CTV Sarajevo
ICAR Bucharest	Refugio Bremen	CAVITOP Lisbon	ICAR Iasi	Parcours Paris	KRCT Pristina
ICAR Craiova	Xenion Berlin	CTV Stockholm	IRCT Zagreb	RCT Cphagen	PCR Frankfurt
Pharos Utrecht	Zebra Graz	GRCT Tbilisi	MF London	RCTV Chisinau	Refugio Munich

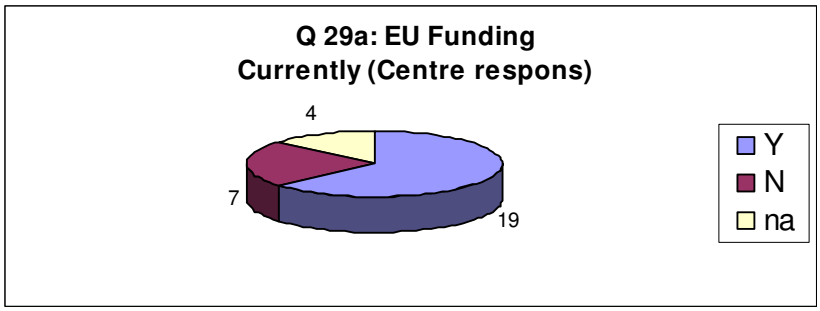
Ten centres receive contributions from local authorities in some cases as contributions in kind e.g. in the form of free premises as is the case for the three centres in Romania.

PERCENTAGE OF CENTRE BUDGET COVERED BY STATE OR LOCAL AUTHORITIES

The total value of funding by the NHCS (or the NHI) and the direct contributions in cash or in kind by state or local authorities vary widely: from close to 100 % (RCT Copenhagen and CTV in Stockholm) to 30 % or more (Exil Brussels, ICAR Bucharest and Craiova, IRCT Zagreb, Pharos Utrecht, Refugio Bremen, and Zebra Graz) to less than 5 % (CTV Sarajevo) among the 14 centres that have reported the percentage that such contributions cover of total operational cost

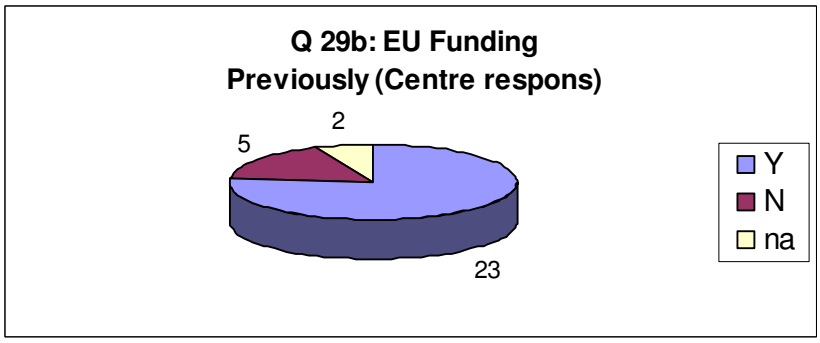


INTERNATIONAL FUNDING OF CENTRE ACTIVITIES

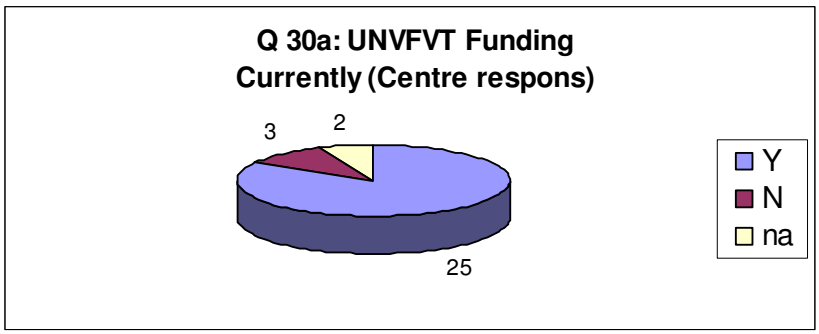


YES			NO		na
CIR VITO Rome	MF London	RCTV Chisinau	ACET Sofia	RCT Cphagen	ARCT Tirana
EXIL Barcelona	MRCT Athens	Refugio Bremen	CAVITOP Lisbon		CTV Sarajevo
EXIL Brussels	Parcours Paris	Refugio Munich	GRCT Tbilisi		CTV Stockholm
ICAR Bucharest	PCR Frankfurt	Xenion Berlin	HUG Geneva		ICAR Iasi
ICAR Craiova	Pharos Utrecht	Zebra Graz	IAN Belgrade		
IRCT Zagreb	Pr. Levi Paris		Oasis Cphagen		

19 of the 26 centres responding to this question indicate that they are currently receiving funding from the European Union. 13 of these centres are in EU countries.
Centres in 5 non-EU countries in the European region (Croatia, Moldova, Norway, Romania and Serbia / Montenegro) indicate that they are currently receiving EU funding.
Centres in Albania, Bulgaria, Bosnia-Herzegovina and Georgia no longer receive EU funding.

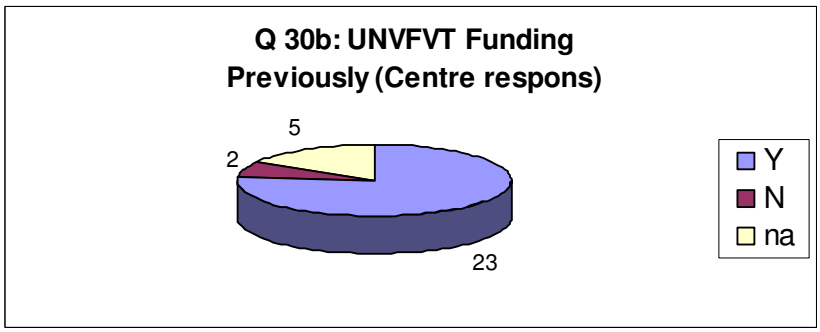


YES				NO	Na
ACET Sofia	GRCT Tbilisi	Oasis Cphagen	Refugio Bremen	CAVITOP Lisbon	ICAR Craiova
ARCT Tirana	IAN Belgrade	Parcours Paris	Refugio Munich	EXIL Barcelona	IRCT Zagreb
CIR VITO Rome	ICAR Bucharest	PCR Frankfurt	Xenion Berlin	HUG Geneva	
CTV Sarajevo	ICAR Iasi	Pharos Utrecht		RCT Cphagen	
CTV Stockholm	KRCT Pristina	Pr. Levi Paris		Zebra Graz	
EXIL Brussels	MF London	PTRSN Kr.sand			
	MRCT Athens	RCTV Chisinau			



YES				NO	na
ACET Sofia	IAN Belgrade	MRCT Athens	Refugio Bremen	CAVITOP Lisbon	ARCT Tirana
CIR VITO Rome	ICAR Bucharest	Oasis Cphagen	Refugio Munich	CTV Stockholm	Pharos Utrecht
CTV Sarajevo	ICAR Craiova	Parcours Paris	Xenion Berlin	PTRSN Kr.sand	
EXIL Barcelona	ICAR Iasi	PCR Frankfurt	Zebra Graz		
EXIL Brussels	IRCT Zagreb	Pr. Levi Paris			
GRCT Tbilisi	KRCT Pristina	RCT Cphagen			
HUG Geneva	MF London	RCTV Chisinau			

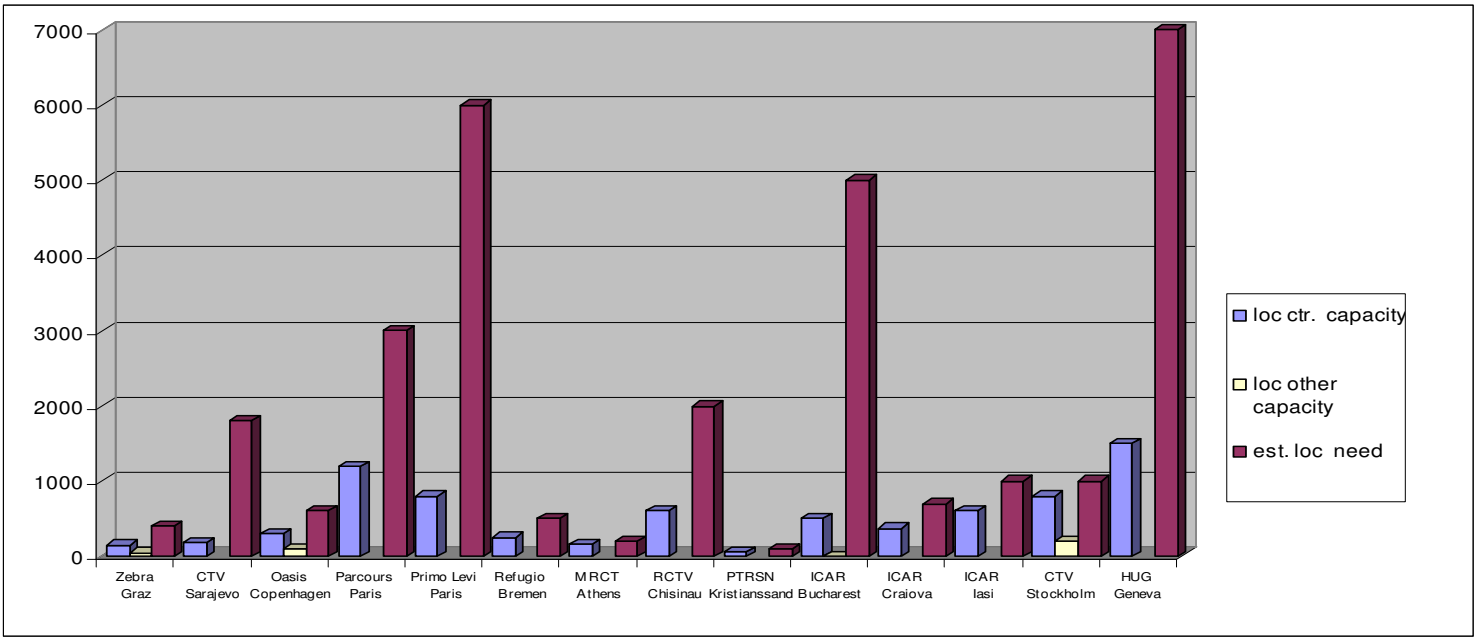
25 of the 28 centres responding to this question indicate that they are currently receiving funding from the UN Voluntary Fund for Victims of Torture (UNVFVT).
14 of these centres are in EU countries – an increase from 13 indicating they have previously received UNVFVT funding.
11 centres in 8 non-EU countries in the European region (Bosnia-Herzegovina, Bulgaria, Croatia, Georgia, Moldova, Romania, Serbia / Montenegro and Switzerland) are currently receiving UNVFVT funding – an increase from 9 centres in 7 non-EU countries in the European region indicating previously receiving UNVFVT funding.



YES				NO	na
ACET Sofia	EXIL Brussels	KRCT Pristina	Pr. Levi Paris	CTV Stockholm	ARCT Tirana
CAVITOP Lisbon	GRCT Tbilisi	MF London	RCT Cphagen	PTRSN Kr.sand	ICAR Craiova
CIR VITO Rome	HUG Geneva	MRCT Athens	RCTV Chisinau		IRCT Zagreb
CTV Sarajevo	IAN Belgrade	Oasis Cphagen	Refugio Bremen		Pharos Utrecht
EXIL Barcelona	ICAR Bucharest	Parcours Paris	Refugio Munich		Zebra Graz
	ICAR Iasi	PCR Frankfurt	Xenion Berlin		

WHAT IS THE ESTIMATED CAPACITY OF CURRENT SERVICES COMPARED TO ESTIMATED NEED

LOCAL CENTRE CAPACITY, OTHER LOCAL CAPACITY AND LOCAL NEED ESTIMATED BY 14 CENTRES

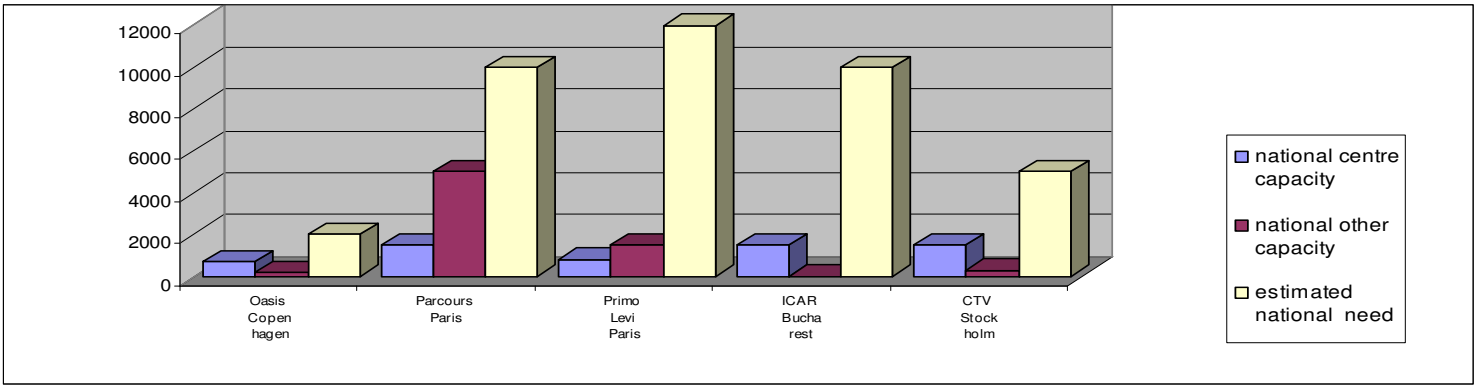


Only 14 centres have given their estimate of the local capacity of services for victims of torture. These estimates include capacity in specialised centres as well as other local service capacity. The centres have further provided their estimate the capacity for such services needed in their local area.
Only 4 centres indicate that there is a capacity besides the specialised centres in their area. And in all cases such capacity is estimated as smaller than the capacity in the specialised centres.
The estimated existing local capacity range from 10 % (Sarajevo and Geneva) to 100 % (Stockholm) of the estimated local need - with an average of 45 % - (65 % for the centres in EU countries and 31 % for the centres in non-EU countries)

Two of the responding centres operate in the same local area (Paris), which allows a comparison of two independent estimates. There is a difference in the estimation of existing local capacity (1250 Parcours vs. 2300 Primo Levi) as well as difference in the estimate of needed local capacity (3000 Parcours vs. 6000 Primo Levi)..

The overall impression is that the great majority of the centres in 14 European countries responding to this question consider the existing local capacity insufficient – in some cases highly insufficient - to cover the actual need for such services.

NATIONAL CENTRE CAPACITY, OTHER NATIONAL CAPACITY AND NATIONAL NEED ESTIMATED BY 6 CENTRES

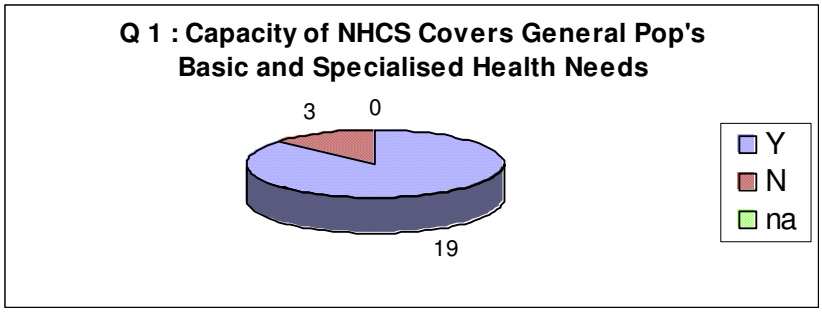


Only 5 centres have given their estimate of the national capacity of services for victims of torture ands other human rights violations. These estimates include capacity in specialised centres as well as other national service capacity. The centres have further provided their estimate of the capacity for such services needed nationally.
3 of these centres indicate that there is an existing capacity besides the specialised centres in their area. And one case (Denmark) such capacity is estimated as smaller than the capacity in the specialised centres, while in two cases (both in France) such capacity is estimated as larger than the capacity in specialised centres
The estimated existing national capacity ranges from 4 % (Romania) to 50 % (Denmark) of the estimated national need - with an average of 11 % - (24 % in 3 EU countries (Denmark, France, Sweden) and 4 % of the total national need estimated by ICAR Foundation for Romania)

Two of the responding centres operate in the same local area (Paris), which allows a comparison of two independent estimates. There is a considerable difference in the estimation of existing national capacity (5000 by Parcours vs. 1500 by Primo Levi) but a much smaller difference in the estimate of needed national capacity (10.000 by Parcours vs. 12.000 by Primo Levi)..

The overall impression is that the centres in 4 European countries responding to this question consider the existing national capacity insufficient – in one case highly insufficient - to cover the actual need for such services.

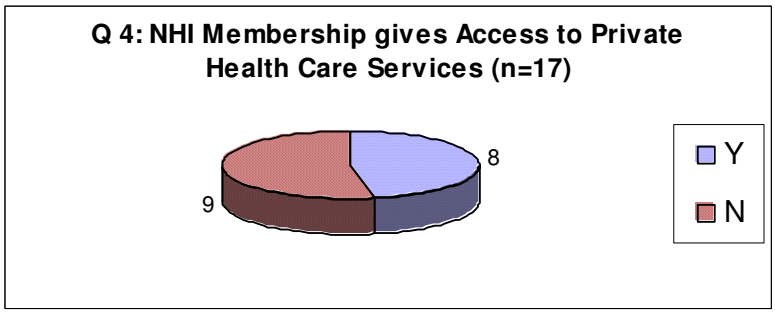
DO THE NATIONAL HEALTH SYSTEMS HAVE CAPACITY TO PROVIDE THE GENERAL POPULATION WITH APPROPRIATE CARE?



YES				NO
Austria	France	Norway	Switzerland	Albania
Belgium	Georgia	Portugal	U.K.	Bosnia-H.
Bulgaria	Germany	Romania		Moldova
Croatia	Greece	Serbia-M		
Denmark	Italy	Spain		
	Netherlands	Sweden		

The National health care system in19 of the 22 countries from which responses have been received is considered by the responding centres to have sufficient capacity to provide the general population with appropriate care. However, the health care system in 3 countries (Albania, Bosnia and Moldova) is considered to have insufficient capacity to meet the health care needs of the population.

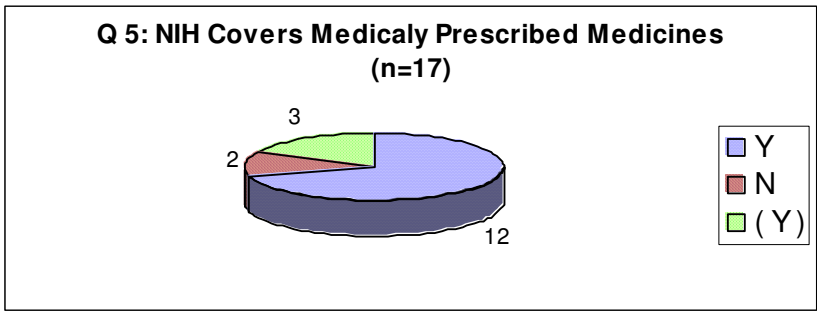
DOES THE NATIONAL HEALTH INSURANCE CONTRIBUTE TO THE PAYMENT OF PRIVATE HEALTH CARE SERVICES?



YES		NO	
Belgium	Greece	Austria	Portugal
Bulgaria	Italy	Bosnia-H.	Romania
Denmark	Spain	Croatia	Moldova
France	Switzerland	Germany	Netherlands
			Serbia-M

In 8 of the 17 countries reported as having a National Health Insurance System the National Health Insurance covers or contributes to the payment of private health care services.

DOES THE NATIONAL HEALTH INSURANCE COVER THE COST OF MEDICINE?

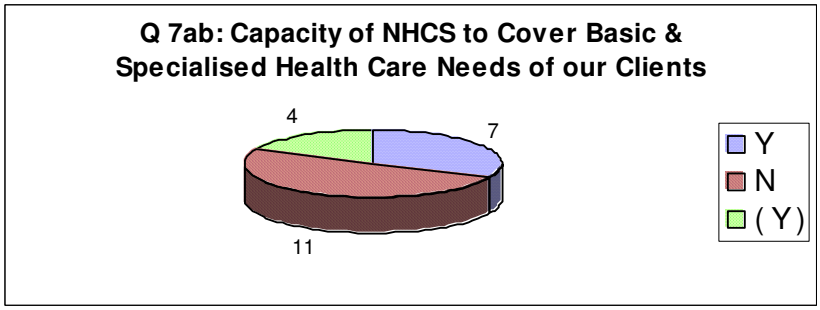


YES			(Y)	NO
Austria	Denmark	Netherlands	Bosnia-H.	Moldova
Belgium	France	Portugal	Romania	Serbia-M
Bulgaria	Greece	Switzerland	Spain	
Croatia	Germany			
	Italy			

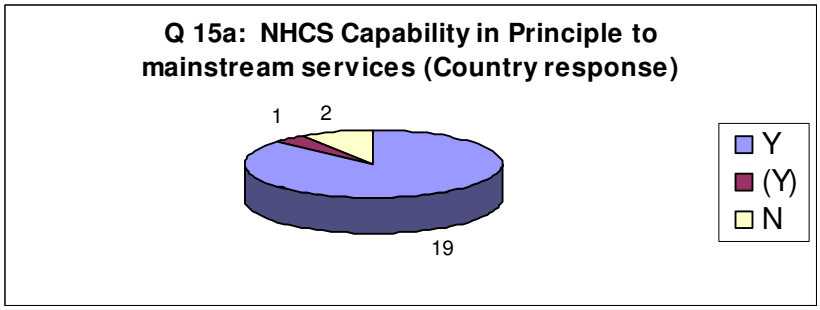
In 14 of the 17 countries reported as having a National Health Insurance System the National Health Insurance covers or contributes to the payment of medicine. In Serbia/Kosovo and Moldova the responses indicate that the National Health Insurance does not cover the payment of medicine,

Let us turn now to the general health system in the countries where these centres operate

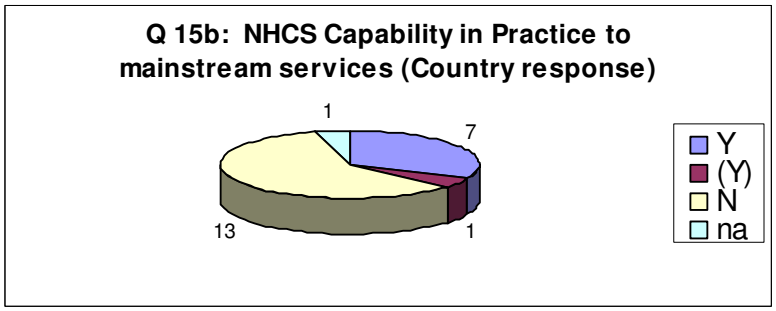
WHAT IS THE POTENTIAL OF THE CURRENT PUBLIC HEALTH CARE SYSTEM TO PROVIDE SERVICES NEEDED BY OUR CLIENTS



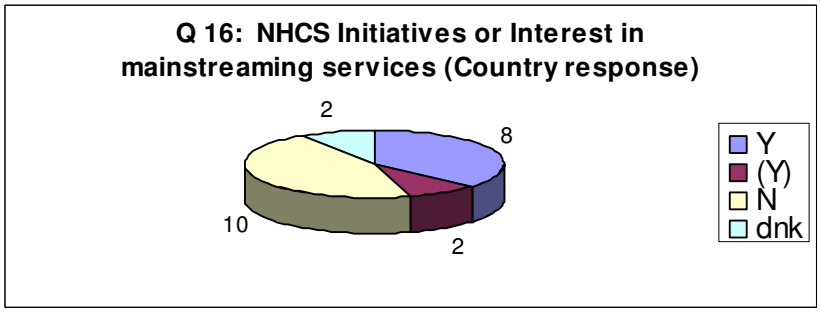
YES		(Y)	NO	
Belgium	Sweden	Bosnia-H.	Albania	Germany
Bulgaria	Switzerland	Denmark	Austria	Greece
Netherlands		Romania	Croatia	Italy
Norway		United Kingdom	France	Moldova
Portugal			Georgia	Serbia-M
				Spain



YES			(Y)	NO
Albania	France	Portugal	Serbia-M	Bulgaria
Austria	Georgia	Romania		Moldova
Belgium	Germany	Spain		
Bosnia-H.	Greece	Sweden		
Croatia	Italy	Switzerland		
Denmark	Netherlands	United Kingdom		
	Norway			



YES		(Y)	NO		na
Austria	U.K.	Germany	Albania	Greece	Sweden
Croatia			Belgium	Italy	
Denmark			Bosnia-H.	Moldova	
Netherlands			Bulgaria	Romania	
Norway			France	Serbia-M	
Portugal			Georgia	Spain	
				Switzerland	



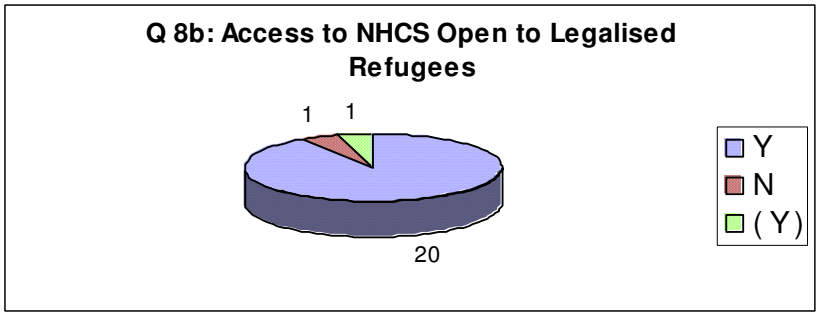
YES		(Y)	NO		na
Austria	Norway	France	Albania	Greece	Moldova
Belgium	Sweden	Serbia-M	Bosnia-H.	Netherlands	Portugal
Denmark	U.K.		Bulgaria	Romania	
Germany			Croatia	Spain	
Italy			Georgia	Switzerland	

IF THE NATIONAL HEALTH CARE SYSTEM HAS OR DEVELOPS THE CAPACITY TO PROVIDE THE SERVICES NEEDED BY OUR CLIENTS WE MUST THEN CONSIDER WHETHER OUR CLIENTS WILL HAVE ACCESS TO THESE SERVICES

THERE ARE A NUMBER OF CONDITIONS FOR ACCESS TO HEALTH SERVICES THAT MAY PREVENT MANY OF THE CLIENTS WE ARE SEEING AT OUR CENTRES FROM ACCESS TO APPROPRIATE SERVICES

POTENTIAL BARRIERS TO ACCESS (1)

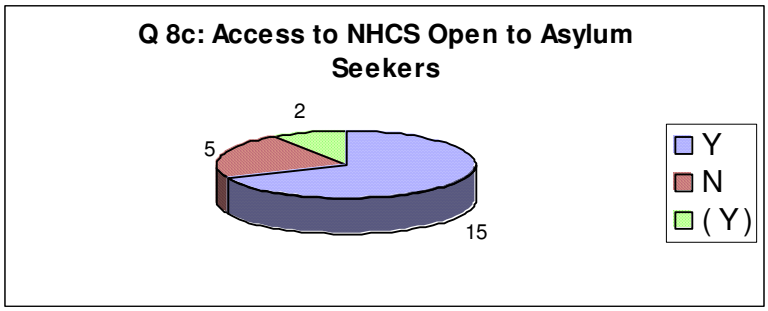
Access to the National Health Care System (NHCS)



YES				(Y)	NO
Albania	Croatia	Netherlands	Sweden	Germany	Georgia
Austria	Denmark	Norway	Switzerland		
Belgium	France	Portugal	U.K.		
Bosnia-H.	Greece	Romania			
Bulgaria	Italy	Serbia-M			
	Moldova	Spain			

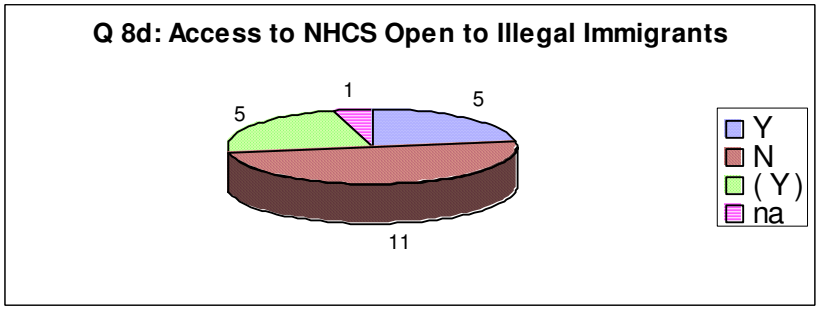
Centres from 20 of these countries indicate that **legalised refugees** have access to their health care system; legalised refugees in Germany have access in some areas; whereas they do not have such access to the national health system in Georgia.

Access to the National Health Care System (NHCS) (continued)



YES			(Y)	NO
Albania	Greece	Spain	Germany	Bosnia-H.
Austria	Italy	Sweden	Romania	Croatia
Belgium	Netherlands	Switzerland		Denmark
Bulgaria	Norway	U.K.		Georgia
France	Portugal			Moldova
	Serbia-M			

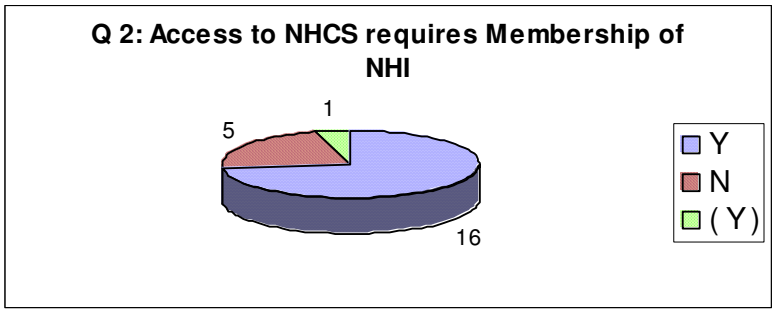
Centres from 15 of the countries indicate that **asylum seekers** have access to their health care system, in Germany asylum seekers have access in some areas, and in Romania they have limited access to the national health system. In the remaining 5 countries asylum seekers have no access to their NHCS.



YES	(Y)	NO		na
Albania	Austria	Belgium	Georgia	Serbia-M
France	Greece	Bosnia-H.	Germany	
Norway	Netherlands	Bulgaria	Italy	
Spain	Portugal	Croatia	Moldova	
Sweden	U.K.	Denmark	Romania	
			Switzerland	

Centres from only 5 countries (Albania, France, Norway, Spain, and Sweden) of the 21 countries responding to this question indicate that **illegal immigrants** have access to their health care system; in five countries (Austria, Greece, Netherlands, Portugal, and UK) they have limited access but in 11 of the 21 countries responding to this question they have no access to their health care system

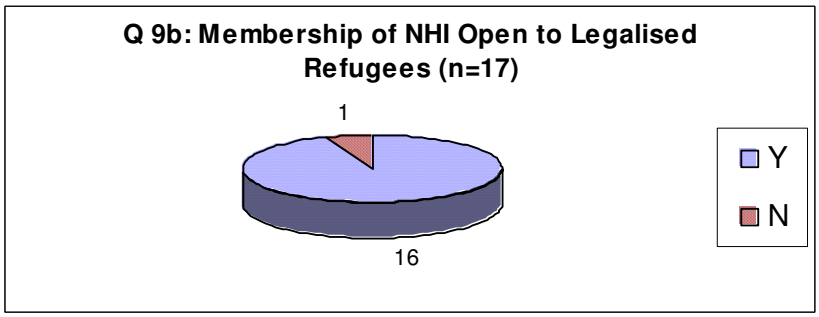
POTENTIAL BARRIERS TO ACCESS (2)



YES			(YES)	NO
Austria	Denmark	Netherlands	Portugal	Albania
Belgium	France	Romania		Georgia
Bosnia-H.	Germany	Serbia-M		Norway
Bulgaria	Greece	Spain		Sweden
Croatia	Italy	Switzerland		U.K.
	Moldova			

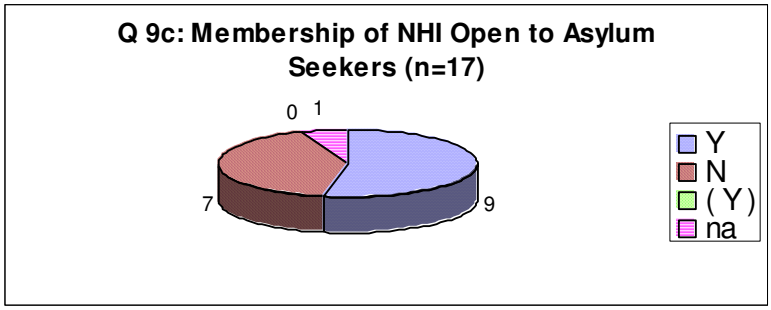
Access to the National Health Insurance System

Centres in all 17 countries reported as having a National Health Insurance System indicate that all nationals have access to their health insurance system.



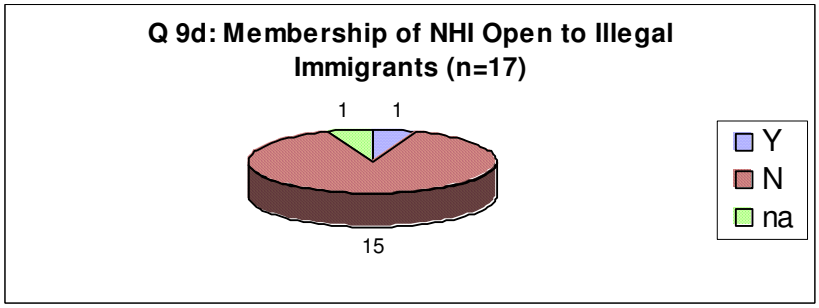
YES					NO
Austria	Bulgaria	Greece	Portugal	Switzerland	Croatia
Belgium	Denmark	Italy	Romania		
Bosnia-H.	France	Moldova	Serbia-M		
	Germany	Netherlands	Spain		

Centres in 16 of the 17 countries reported as having a National Health Insurance System indicate that **legalised refugees** have access to their health insurance system.



YES	Greece	Spain	**NO**	Denmark	**na**
Austria	Italy	Switzerland	Belgium	Germany	Serbia-M
Bulgaria	Netherlands		Bosnia-H.	Moldova	
France	Portugal		Croatia	Romania	

Centres in 9 of the 17 countries reported as having a National Health Insurance System indicate that **asylum seekers** have access to their health insurance system.



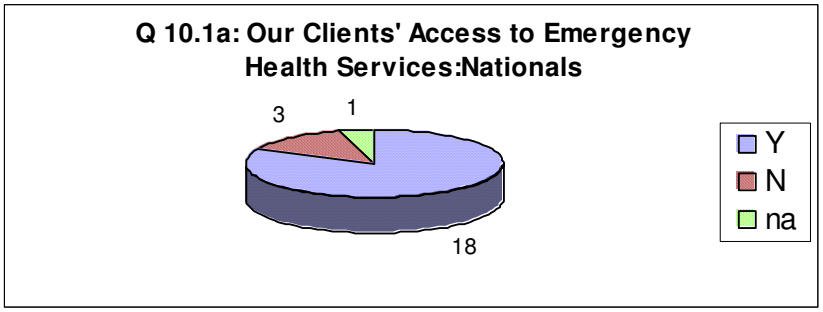
YES	**NO**	Croatia	Moldova	Switzerland	**na**
France	Austria	Denmark	Netherlands		Serbia-M
	Belgium	Germany	Portugal		
	Bosnia-H.	Greece	Romania		
	Bulgaria	Italy	Spain		

Centres in 1 of the 17 countries reported as having a National Health Insurance indicate that **illegal immigrants** have access to their health insurance system.

In16 of the 22 countries from which responses have been received membership of a national health insurance system is a condition for access to the National Health Care System. In Portugal access also depends on membership of the NHI except for emergencies Among the five remaining countries Georgia, Norway, Sweden and U.K. have National Health Systems that are variations of the Beveridge model i.e. free access to all forms of health care in a health care system with sufficient capacity to provide the general population with appropriate care.. Albania neither has a health insurance system nor a National Health Care System with sufficient capacity in their health care system to meet the health care needs of the population.

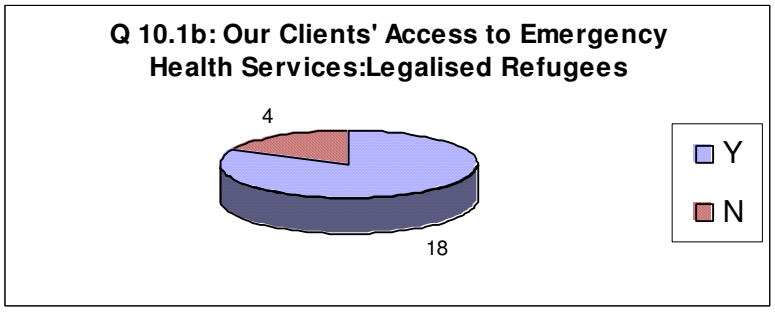
POTENTIAL BARRIERS TO ACCESS (3)

Victims Access to the Emergency Health Services



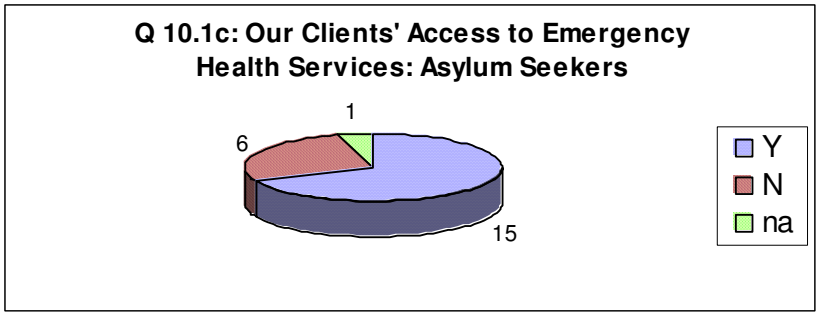
YES				NO	na
Belgium	France	Netherlands	Sweden	Albania	Austria
Bosnia-H.	Germany	Norway	Switzerland	Georgia	
Bulgaria	Greece	Portugal	U.K.	Spain	
Croatia	Italy	Romania			

Centres from 18 countries responding to this question indicate that all **nationals** have access to emergency health services.



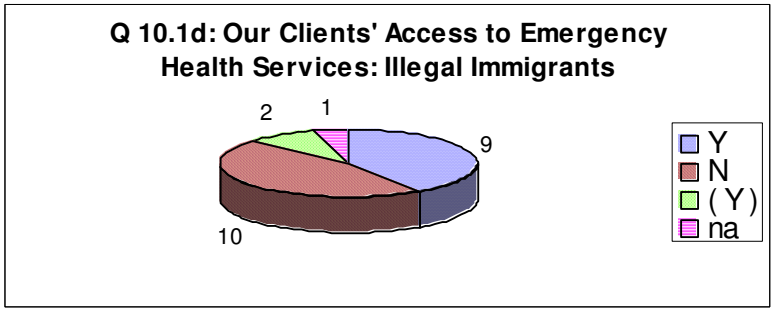
YES				NO
Austria	France	Netherlands	Sweden	Albania
Belgium	Germany	Norway	Switzerland	Croatia
Bosnia-H.	Greece	Portugal	U.K.	Georgia
Bulgaria	Italy	Romania		Spain

Centres from 18 of the 21 countries responding to this question indicate that **legalised refugees** have access to emergency health services.



YES			NO		na
Bosnia-H.	Greece	Serbia-M	Albania	Moldova	Serbia-M
Bulgaria	Italy	Sweden	Belgium	Spain	
Denmark	Netherlands	Switzerland	Croatia		
France	Norway	U.K.	Georgia		
Germany	Portugal				
	Romania				

Centres from 15 of the 21 countries responding to this question indicate that **asylum seekers** have access to emergency health services.

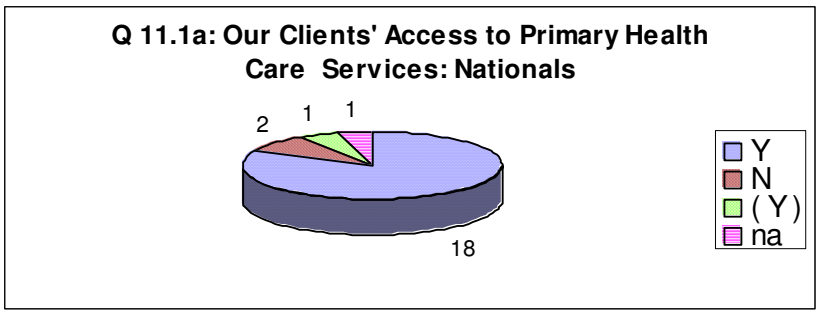


YES		(Y)	NO		na
Austria	Norway	Bosnia-H.	Albania	Italy	Serbia-M
Bulgaria	Portugal	Denmark	Belgium	Moldova	
France	Romania		Croatia	Spain	
Greece	U.K.		Georgia	Sweden	
Netherlands			Germany	Switzerland	

Centres from 11 of the 21 countries responding to this question indicate that **illegal immigrants** have access – in two of these countries only limited access - to emergency health services.

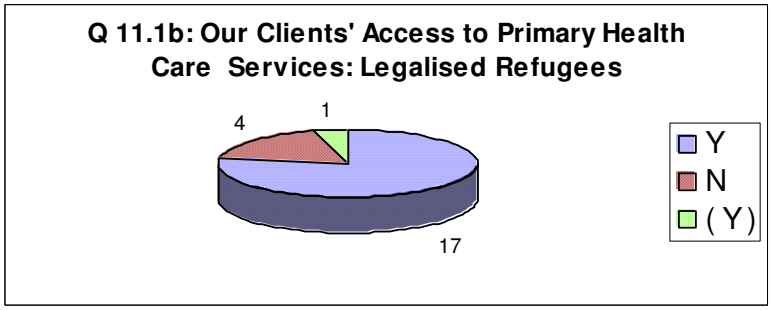
POTENTIAL BARRIERS TO ACCESS (4)

Victims Access to the Primary Health Care Services



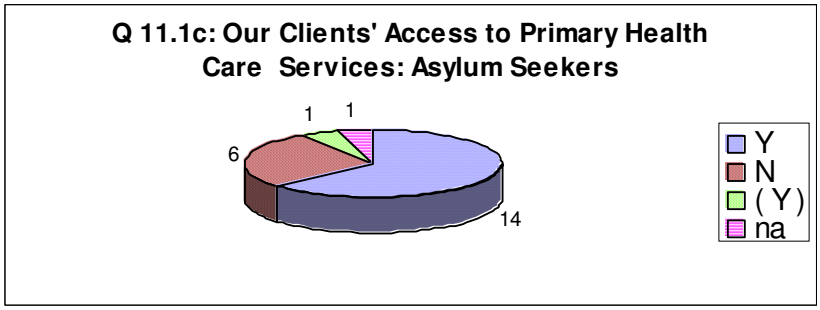
YES			(Y)	NO	na
Belgium	Germany	Serbia-M	Denmark	Albania	Austria
Bosnia-H.	Greece	Spain		Moldova	
Bulgaria	Italy	Sweden			
Croatia	Netherlands	Switzerland			
France	Norway	U.K.			
Georgia	Portugal				
	Romania				

Centres from 19 of the 21 countries responding to this question indicate that all **nationals** have access – one country only limited access - to primary health care services.



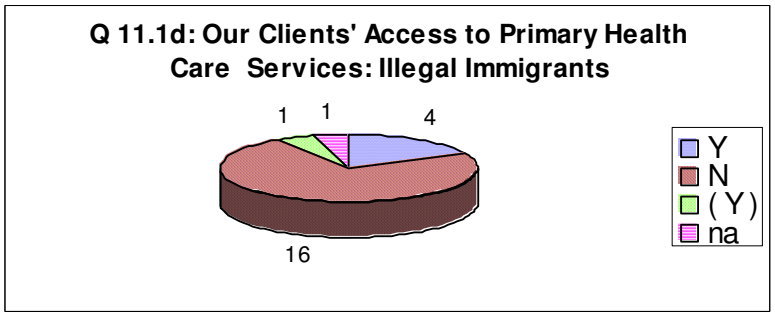
YES			(Y)	NO
Austria	Greece	Spain	Denmark	Albania
Belgium	Italy	Sweden		Croatia
Bosnia-H.	Netherlands	Switzerland		Georgia
Bulgaria	Norway	U.K.		Moldova
France	Portugal			
Germany	Romania			
	Serbia-M			

Centres from 18 of the 22 countries responding to this question indicate that **legalised refugees** have access – in one country only limited access - to primary health care services.



YES			(Y)	NO	na
Austria	Netherlands		Romania	Albania	Serbia-M
Bosnia-H.	Norway			Belgium	
Bulgaria	Portugal			Croatia	
France	Spain			Denmark	
Germany	Sweden			Georgia	
Greece	Switzerland			Moldova	
Italy	U.K.				

Centres from 15 of the 21 countries responding to this question indicate that **asylum seekers** have access – in one country only limited access - to primary health care services.

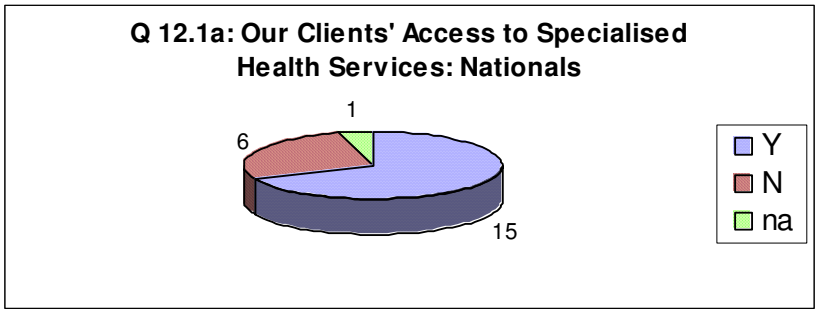


YES	(Y)	NO			na
France	Bosnia-H.	Albania	Germany	Sweden	Serbia-M
Italy		Austria	Greece	Switzerland	
Norway		Belgium	Moldova		
U.K.		Bulgaria	Netherlands		
		Croatia	Portugal		
		Georgia	Romania		
			Spain		

Centres from 5 of the 21 countries responding to this question indicate that **illegal immigrants** have access – in one country only limited access - to primary health care services

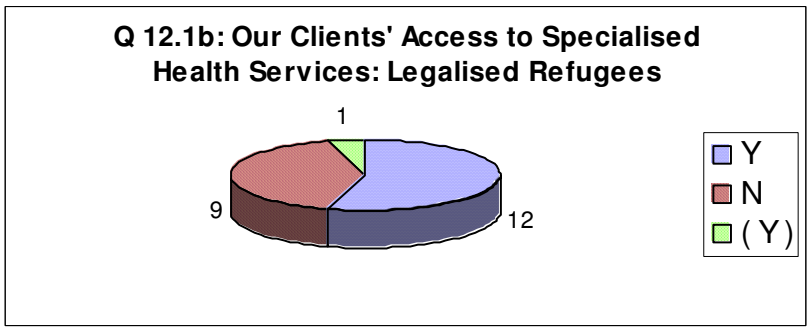
POTENTIAL BARRIERS TO ACCESS (5)

Victims Access to the Specialist Health Care Services



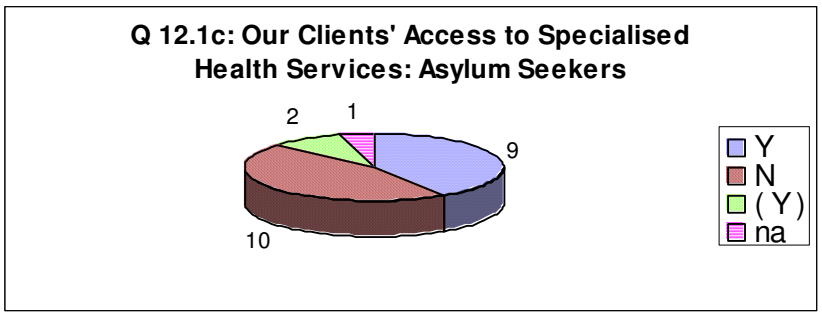
YES	France	Serbia-M	**NO**	Spain	**na**
Belgium	Germany	Sweden	Albania		Austria
Bosnia-H.	Greece	Switzerland	Georgia		
Bulgaria	Netherlands	U.K.	Italy		
Croatia	Norway		Moldova		
Denmark	Portugal		Romania		

Centres from 15 of the 21 countries responding to this question indicate that all **nationals** have access to specialist health care services.



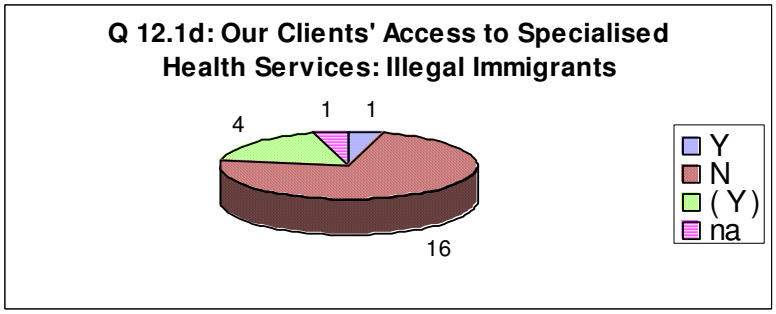
YES	Greece	U.K.	**(Y)**	**NO**	Moldova
Belgium	Netherlands		Germany	Albania	Romania
Bosnia-H.	Norway			Austria	Serbia-M
Bulgaria	Portugal			Croatia	Spain
Denmark	Sweden			Georgia	
France	Switzerland			Italy	

Centres from 13 of the 22 countries responding to this question indicate that **legalised refugees** have access – in one country only limited access - to specialist health care services.



YES		(Y)	NO		na
Bosnia-H.	Norway	Denmark	Albania	Italy	Serbia-M
Bulgaria	Portugal	Germany	Austria	Moldova	
France	Switzerland		Belgium	Romania	
Greece	U.K.		Croatia	Spain	
Netherlands			Georgia	Sweden	

Centres from 11 of the 21 countries responding to this question indicate that **asylum seekers** have access – in two countries only limited access - to specialist health care services

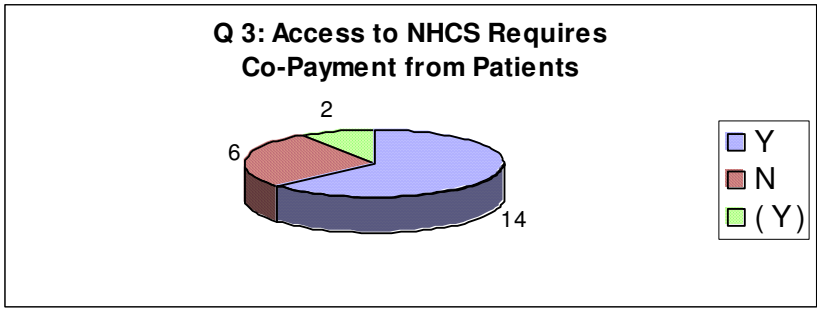


YES	(Y)	NO			na
France	Bosnia-H.	Albania	Denmark	Moldova	Serbia-M
	Portugal	Austria	France	Netherlands	
	Sweden	Belgium	Georgia	Norway	
	U.K.	Bulgaria	Germany	Romania	
		Croatia	Greece	Switzerland	
			Italy		

Centres from 5 of the 21 countries responding to this question indicate that **illegal immigrants** have access – in four of these countries only limited access - to specialist health care services

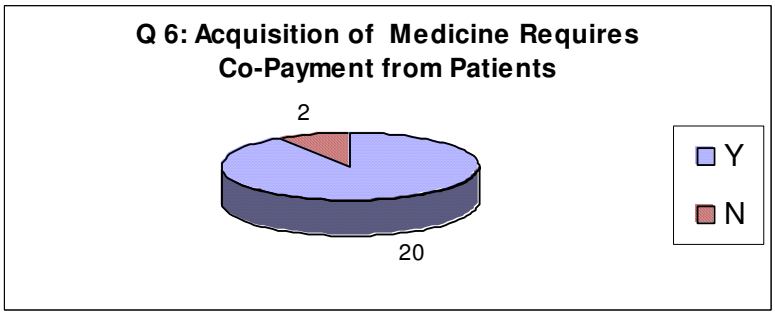
POTENTIAL BARRIERS TO ACCESS (6)

Co-Payment as Requirement for Access to Health Services



YES	France	Norway	**(Y)**	**NO**	Spain
Belgium	Georgia	Romania	Portugal	Albania	U.K.
Bosnia-H.	Germany	Sweden	Serbia-M	Austria	
Bulgaria	Italy	Switzerland		Denmark	
Croatia	Moldova			Greece	

In 14 of the 21 countries from which responses have been received co-payment by the patient is required for access to national health care services. In Portugal co-payment depends on income level. No patient co-payment is required in Albania, Austria, Denmark, Greece[2], Serbia, Spain or U.K.



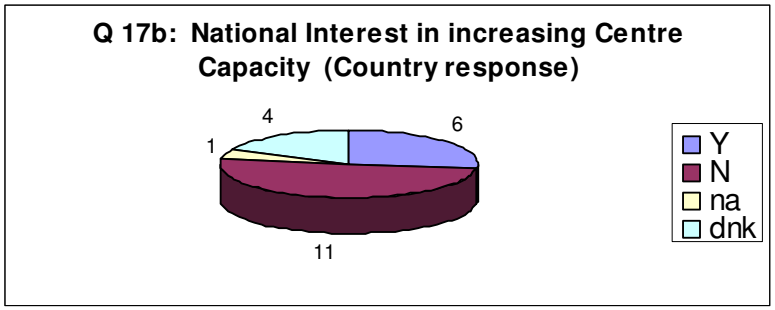
YES	Croatia	Italy	Serbia-M	**NO**
Albania	Denmark	Moldova	Spain	United Kingdom
Austria	France	Norway	Sweden	Netherlands
Belgium	Georgia	Portugal	Switzerland	
Bosnia-H.	Germany	Romania		
Bulgaria	Greece			

In 16 countries reported as having a National Health Insurance System the National Health Insurance requires patient co-payment for medicine. Responses from four of the five countries without a National Health Insurance System indicate that their National Health System also require patient co-payment for medicine. Only (Netherlands and UK) do not require patient co-payment for prescribed medicine.

[2] WHO-EURO indicates that unofficial payments are expected for most services

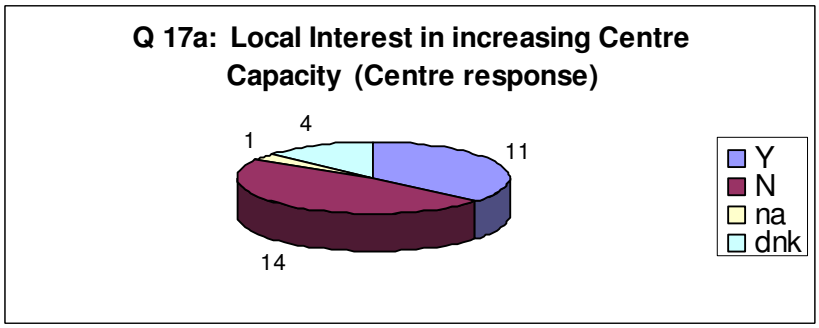
ALTERNATIVE MAINSTREAMING BY EXPANDING THE NUMBER AND THE CAPACITY OF EXISTING CENTRES AS PART OF THE NATIONAL HEALTH CARE BUDGET.

An alternative to integrating services in the national health system would be public funding of an expansion of the capacity of pluri-disciplinary treatment and rehabilitation centres operated as now by independent non-governmental organisations, semi-official bodies like the national Red Cross organisations, refugee organisations or charities



YES		NO		na	dnk
Belgium	U.K.	Bosnia-H.	Italy	Albania	Austria
Denmark		Bulgaria	Norway		Moldova
France		Croatia	Portugal		Netherlands
Germany		Georgia	Romania		
Spain		Greece	Serbia-M		
			Switzerland		

Centres in 6 countries - all in the EU - indicate that there is a national interest in increasing the capacity of centres for victims of torture outside the national health care system while centres in 11 countries do not think there is such an interest.



YES		NO		na	Dnk
CIR VITO Rome	Oasis Cphagen	ACET Sofia	ICAR Craiova	ARCT Tirana	Pharos Utrecht
CTV Stockholm	PCR Frankfurt	CAVITOP Lisbon	IRCT Zagreb		RCT Cphagen
EXIL Barcelona	Pr. Levi Paris	CTV Sarajevo	KRCT Pristina		RCTV Chisinau
EXIL Brussels	Xenion Berlin	GRCT Tbilisi	Parcours Paris		Zebra Graz
ICAR Iasi		HUG Geneva	PTRSN Kr.sand		
MF London		IAN Belgrade	Refugio Bremen		
MRCT Athens		ICAR Bucharest	Refugio Munic		

Centres in 11 countries - all in the EU - indicate that there is a local interest in increasing the capacity of centres for victims of torture outside the national health care system while centres in 14 countries do not think there is such an interest.

CONCLUSION BASED ON THE FINDINGS OF THE SURVEY

Since there seems to be general agreement that the existing capacity for treatment and rehabilitation of victims of torture and other human rights violations is insufficient, the first priority must be to address this problem as a matter of urgency - probably through a combination of the two approaches with a number of specialised units or centres of excellence spearheading a mobilisation and capacity building in the general health system where this is possible.

Centres are currently for the most part dependent on international funding for part of their budgets. In order not to reduce an already insufficient capacity this international funding must be maintained – and as needed increased – until credible national funding mechanisms have been secured and/or accessible alternative services have been created

Mainstreaming services for these victims does not only mean creation of the relevant specialised services as part of the public health services but also removal of all barriers preventing our current clients from access to such services.

This survey does not allow an assessment of country-situations, where past or continued human rights violations combined with impunity for perpetrators and general mistrust in public institutions and professionals working in these structures make mainstreaming of this kind of services impossible

Services for victims in these countries must continue to be operated as independent and trustworthy institutions by necessity dependent on external funding.

Indicators of the existence of such conditions in a country will be found in general human rights reports but it should be made clear to national and European politicians that just throwing the problem back to member states - especially this kind of member states - of the Council of Europe or the EU - disguised as mainstreaming - means deserting the victims.

Annex I

POSSIBLE MODELS FOR MAINSTREAMING TREATMENT AND REHABILITATION SERVICES FOR VICTIMS OF TORTURE AND OTHER HUMAN RIGHTS VIOLATIONS

1. The special treatment and rehabilitation activities needed by victims are provided by special units in the general health care system, the general social care system and a public legal counselling system.
2. The national health insurance system covers the cost of treatment and rehabilitation activities needed by victims from independent specialised providers of such services on a fee for service basis.
3. The special treatment and rehabilitation activities needed by victims are provided in integrated multi-professional units within the public health or social care system.
4. The special treatment and rehabilitation activities needed by victims are provided by integrated multi-professional units within semi-official organizations like the National Red Cross or the local UNHCR but funded by the state or local authorities
5. The special treatment and rehabilitation activities needed by victims are provided by uni-professional or integrated multi-professional units sponsored by private confessional organisations but funded by the state or local authorities
6. The special treatment and rehabilitation activities needed by victims are provided by uni-professional or integrated multi-professional units set up by or organised as independent NGOs but funded by the state or local authorities either on a total cost basis or on a fee for service basis.
7. The special treatment and rehabilitation activities needed by victims are provided by special units within any or all of these models.

ANNEX II

SUGGESTED NATIONAL STRATEGY FOR MAINSTREAMING SERVICES FOR VICTIMS OF TORTURE AND OTHER VICTIMS OF HUMAN RIGHTS VIOLATIONS (NORA SVEEASS)

Developing national health plans for rehabilitation and care of survivors of torture and other gross human rights violations should be a high priority and include ways of ensuring care both at specialized and local level

Services should be
- Multiprofessional
- Well coordinated
- Consist of a ”chain of intervention”
- With a long time perspective
- Developed in close collaboration with the persons involved
- Based on good assessment

Need for specialists and trained professionals
- At a local level
- At a national level
- This means training as well as supervision and collaboration
- This costs…..
- In the chain of interventions the public health care system in all host countries have a vital role to play

Continued need for specialized centres
that provide:
- Special expertise
- Wide experience with the group in question
- Ongoing evaluation and development

that are
- Prepared to give time
- Prepared to train and supervise public health care
- Motivated for systematization and communication

that maintain
- An independent position and special awareness of human rights principles
- International collaboration

Thus the survival of independent specialised centres is absolutely necessary – even after successful mainstreaming of services in countries where this is possible - but they will be much more effective if given secure conditions within the general health care system.

ANNEX III

SUGGESTED EU OR EUROPEAN STRATEGY FOR MAINSTREAMING SERVICES FOR VICTIMS OF TORTURE AND OTHER VICTIMS OF HUMAN RIGHTS VIOLATIONS (ERIK HOLST)

As is demonstrated in a number of countries the public authorities have to some extent accepted the challenge to develop appropriate services for victims of torture and other human rights violations. This has either been done directly through involvement of public health, social or immigrant services, or indirectly by financing fully or in part semi official or independent non-governmental organisations.

It is the general assessment of the majority of respondents that the national health services in their countries could in principle provide such services but also that in practice they are unlikely to take-up this task.

There are initiatives in this direction in some countries both at the local and at the national level either as through a mobilisation of the general health system or as an interest in providing such services indirectly through existing or new specialised centres.

If the EU Commission wants to follow up on the idea of mainstreaming services for victims of torture and other human rights violations in the 25 member states, there is a need for a specific EU initiative to promote such a development either alone or in collaboration with the Council of Europe.

This could be done in a Council of Europe organised conference on the subject involving ministries of health, social affairs, immigration, and justice that could result in a call for European and national strategies for assistance to victims of torture and other forms of human rights violations to be developed as a natural implementation of state obligations under international and humanitarian law.

The national efforts in this respect might even become subject to some form of international review under the auspices of the European Convention for the Prevention of Torture

While this is under discussion the Commission must ensure that the current level of EU financial and moral support for services for victims of torture and other human rights violations inside and outside the EU is maintained - or better increased in response to the very real uncovered need for such services.

ANNEX IV
Questionnaire
To be added