CAT Alternative Report: Peru

- Torture in Peru seen through the eyes of the victims

Introduction

Article 14 of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment provides victims of torture and ill-treatment with a right to redress including *"the means for as full rehabilitation as possible"*. In Peru, the number of victims is very high partly caused by the prolonged internal armed conflict and partly caused more recent acts of torture and ill-treatment. Due to a combination of severe physical and psychological consequences of the torture and ill-treatment they have suffered, many of these victims have difficulties reintegrating into society and leading a rewarding life. This has far reaching consequences for these individual, their families and society in general. It is therefore not only a human rights obligation but also in the best interest of the State to ensure that they receive *"the means for as full rehabilitation as possible"*. As part of the transitional justice process following the internal armed conflict from 1980 to 2000, the Peruvian Government did provide some reparations including rehabilitation services for victims of armed violence including torture and ill-treatment. While these initiatives are often flagged by the Government of Peru as good practice, there are several shortcomings in the effective access for victims of torture and ill-treatment to quality rehabilitation services.

The present report seeks to assess the torture rehabilitation services provided by the Peruvian Government with the objective of providing concrete recommendations for how the system can be improved to the benefit of all victims of torture and ill-treatment in the country. The report will provide information on the characteristics of torture in the country, the biopsychosocial consequences it leaves on the victims and the situation of rehabilitation of torture victims and their relatives in the public sphere and civil society. This information is necessary to be able to assess the quality of current services. An important source of information for this report is the testimony of hundreds of victims and their families who have been treated and documented by our institution, the Center for Psychosocial Care (CAPS).

This report complements other alternative reports prepared for the CAT by the Human Rights Commission (Comisión de Derechos Humanos - COMISEDH) and the Working Group against Torture of the National Coordinator of Human Rights (GTCT). This report is mainly directed at analysing the public rehabilitation services for biopsychosocial consequences and the way in which psychological evidence of torture is documented. It is organized along these five lines:

1. The profile of torture victims and the psychosocial consequences for the victims and their relatives in Peru
2. Specialized attention required by torture victims
3. Comprehensive attention to torture victims in the public sector
4. Recommendations
5. Annex: Documentation of psychological evidence of torture prepared by the Institute of Forensic Medicine.

The report has been prepared jointly by the Center for Psychosocial Attention (CAPS) and the International Rehabilitation Council for Torture Victims (IRCT). CAPS is a non-profit civil association which was established for humanitarian and scientific purposes for the promotion of mental health and human rights, with the objective of contributing to the psychosocial recovery, mental health and overall wellbeing of the persons affected by political and social violence. The IRCT is a health-based umbrella organisation that supports the rehabilitation of torture victims and the prevention of torture worldwide. Its members comprise more than 140 independent organizations in over 70 countries, which govern its work. Today, the IRCT is the largest membership-based civil society organization to work in the field of torture rehabilitation and prevention.

1. The profile of torture victims and the psychosocial impact on the victims and their relatives in Peru

Peru has ratified the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment as well as the Optional Protocol to the Prevention against Torture and the crime of torture has been clearly defined in the Peruvian Criminal Code since 1998. However, in spite of the commitments made by the Peruvian State, in practice torture was systematically practiced during the internal armed conflict (1980 – 2000) and at present torture continues to be practiced, principally in police stations, prisons and barracks.

The Final Report of the Truth and Reconciliation Commission (TRC) established that the number of cases of torture attributed to State agents represent 75% of a total of 4,625[1], showing that torture was not an isolated event but a systematic, generalized and institutionalized practice by the State. Likewise, the Ombudsman's Office Reports No. 42, 91, 112, 128 and 139[2], indicate that torture is the gravest and most widespread form of human rights violation in Peru, and that this Office has received 702 complaints of alleged torture and ill-treatment during the period between 2003 and 2011. The Ombudsman's Office registered 62 complaints of torture in 2011.

In contrast to the decades of the internal armed conflict, when the mere suspicion of participation in terrorism motivated torture, disappearance or unlawful imprisonment, the torture that occurs today is related to the suspicion of a crime against personal integrity and private property, as well as to social protest against unjust situations, the claim for a dignified life and/or the depredation of natural resources. In spite of this, the Peruvian State does not do enough to prevent and punish it and does not guarantee the victims and their relatives access to justice and integral and specialized rehabilitation.

1 Truth and Reconciliation Commission Final Report Lima, 2003. 23% were attributed to the Shining Path and 1% to the Túpac Amaru Revolutionary Movement

2 http://www.defensoria.gob.pe/informes-publicaciones.php

1.1. Demographic profile of torture victims[3]

Torture victims have the right to rehabilitation and other forms of reparation as established in article 14 of the Convention Against Torture (CAT). In order to assess whether the Peruvian State is fulfilling this obligation adequately it is necessary to know the profile of the victims and their needs. Information regarding the torture victims' demographic profile as well as the biopsychosocial consequences allows us to show the characteristics, including age, sex and level of education of the torture victims that attend a rehabilitation center. Further, it can indicate the most frequent consequences and the rehabilitation services that need to be implemented and thus provide a good background for assessing the professional and financial resources needed.

The CAPS register of cases of torture victims and their relatives should be understood as a source that complements other related documents such as the Ombudsman's Office Reports, those of the Public Prosecutor's Office or those of human rights organizations that document and prosecute torture cases.

In order to prepare this register the total of 399 direct torture victims attended by the CAPS services between 2004 and 2011 have been evaluated. Of this total a representative sample of 75 cases has been used. The validity of the register is based on the testimonies of the victims and those of their relatives that have undergone treatment at our institution.

Table 1
Number and total percentage of torture victims and relatives attended at CAPS (period 2004 – 2011)

Condition	No. of people	Percentage
Torture Victims	399	21.68 %
Relatives of torture victims, of assassinated and disappeared persons	1441	78,32 %
total	1840	100 %

Table 2
Number and total percentage of torture victims differentiated by pre and post internal armed conflict periods

Condition	No. of people	Percentage
During internal armed conflict	331	83%
After internal armed conflict	68	17%
total	399	100 %

3 Find attached in annex 1 the document *La tortura en el Perú a través de sus Víctimas* (2010), prepared and edited by CAPS.

Table 3
Total number of torture victims by sex

Sex	No. of people	Percentage
Men	227	57%
Women	172	43%
total	399	100

Table 4
Total number of torture victims by age

Age	No. of people	Percentage
0 - 10	0	0
11 – 20	5	1%
21 – 30	24	6%
31 – 40	95	24%
41 - 50	159	40%
51 – 60	75	19%
61 and over	41	10%
total	399	100

Table 5
Level of education

Level of education	No. of people	Percentage
None	24	6%
Primary education completed / not completed	91	23%
Secondary education completed / not completed	107	27%
Higher education completed / not completed	125	31%
No information	52	13%
Total	399	100

1.2. Psychosocial effects on torture victims and their relatives

The physical, psychological, sexual and social effects are devastating in people that have suffered torture. In the large majority of cases it has had a chronic impact affecting different areas of their personal and psychosocial lives (partner, family, sexual, social, work and/or academic) and has changed their life plans, often irreversibly. Because of this, attention to and integral rehabilitation of torture victims and their relatives, who are affected by the traumatic experience of a close relative are so necessary.

In the simple studied at CAPS, torture victims reported the following biopsychosocial effects between 2004 and 2008:
With regard to physical consequences[4], the most recurring were, in this order: headaches (21.7%), chronic lower back pain (16.5%), chronic pain in other parts of the body (feet, hips, ribs, joints, chest) (15%), changes in the gastrointestinal system (12.7%), scars (7.5%), respiratory problems (6,7%), decreased visual field (5.25%), tumors (4.5%), different types of trembling in hands and upper limbs (4.5%).

With regard to psychological consequences, the most frequent signs and symptoms are: depressed mood (32.25%), anxiety (28.5%), mistrust (24.7%), insomnia (22.5%), fears (22.5%), irritability (19.5%), low self-esteem (19.5%), isolation (15.7%), nightmares (12.6%), memory impairment (12.6%), dissociative episodes (9.8%), outbursts of anger (9%), suicidal ideation/attempts (7.5%).

With regard to social, family and/or work consequences: loss of work activity (10.5%), social stigma (7.5%), family breakdown (6.6%), difficulties in inter-personal relations (6.7%), relationship difficulties (6%), non-fulfillment of personal achievements (5.25%), disruption of life plans (5.25%), exclusion and/or marginalization (4.8%), family adjustment problems (4.5%).
With regard to sexual consequences the most frequent are: decrease in libido (2.3%), fear of sexual contact and intimacy (1.5%) and sexual inhibition (1.5%).

4 Sequelae or consequences are regarded to be physical, mental or social effects that last longer than 6 months.

These effects therefore lead to a situation where one or more of the victim's physical or mental abilities are more or less permanently altered. Notwithstanding that torture victims have the right to rehabilitation, the effects of torture and the consequent ill health, where rehabilitation services are not provided, also have an impact on the wider society. The mental and physical consequences of torture may lead to an impossibility to study and obtain an education; if the torture took place while in prison, valuable years have been lost during which the victim could have improved his or her opportunities for employment and education. Victims with physical and mental handicaps will have difficulties in obtaining work as well as in fulfilling a series of work duties. On losing their capacity for work, torture victims easily end up in a situation of (even greater) poverty. To this is added the stigma of torture that the victims bear, which leads to their marginalization and inability to act socially. Torture produces traumatic effects and mental suffering; it disrupts social networks and relations, as well as family ties. These social effects of torture weaken a society's moral fiber and create fear, which prevents effective leadership and resistance in civil societies. Torture thus discourages citizens from getting involved in public life and the fear it provokes spreads through the victim's social network and across generations. Taking into consideration that in Peru a large part of the population has been tortured, the lack of provision of adequate rehabilitation services has serious social consequences.

In the CAPS psychosocial work with torture victims and their relatives we have observed an increase in the patterns of violence as a result of the consequences of torture, patterns that are transmitted to the second and third generation in their family nucleus[5]. As was shown in table 1 (page 4), CAPS has attended 1441 relatives of torture victims and of assassinated and disappeared persons between 2004 and 2011. That is without taking into account the many victims and relatives of victims that have not yet received help. This places the members of these families in a vulnerable situation, increasing their risk of detention and potentially tortured due to problems related to antisocial behavior and/or social transgressions. There is no specialized area for attending the children of detained and imprisoned people that suffered torture in the public health programmes due to the fact that according to the PIR law (*Plan Integral de Reparaciones* - Comprehensive Reparations Plan)[6] the torture victims that participated in the Shining Path and the Túpac Amaru Revolutionary Movement and their relatives are excluded from these benefits.

CAPS carried out a study of the effects on the children of tortured women[7] and discovered that they present highly significant mental health problems in comparison with the population of young people of a similar socio-economic background, but without the "torture of a relative" variable. The study found a high percentage of violent ideation and intentional violent behavior, with suicidal ideation reaching 55% and suicide attempts 41%. Of the children studied, 68 % said that "as children they had told many lies" and 64% "stated that they still lie", while 50% said that they had stolen something at some time. It is also alarming that 36% of this population presents homicidal ideation. The significant percentage of antisocial behavior shows a high risk population with the probability of finding an outlet in another form of social violence. An important piece of information is that 24% of the detained mothers said that their children had witnessed the detention, that is, they were not only passive companions but were

5 Consecuencias Psicosociales en hijos de mujeres privadas de libertad durante el conflicto armado interno. CAPS, 2011. (Psychosocial consequences on the children of women deprived of liberty during the internal armed conflict)

6 Law 28592. Article 3

7 Wurst de Landázuri, Carmen & col. (2012) Reconstruyendo historias. Estudio sobre las consecuencias psicosociales de la detención durante el conflicto armado en el Perú. Lima: Ed. Roel (Reconstructing histories. Study on the psychosocial consequences of detention during the armed conflict in Peru)

also victims of the violent event.

The case of a family attended at CAPS can exemplify what has been said in the numbers above. Blanca lived with her parents and four siblings in a human settlement in Puente Piedra, in the North of Lima. Her father was a factory worker and his wages did not cover the family needs, he was a trade union leader, and the mother was a small-scale retailer. Blanca's parents were detained when she was 11 years old. At the time of the therapeutic interviews Blanca was 27 and living with her three children in a precarious room built in the patio of her mother's house. Her father was still in prison and her mother had been released after three years in prison.

It was found that Blanca presented recurring depressive periods. The predominant symptoms were feelings of worthlessness as her sisters "are better prepared than she is". She considers that she is not very intelligent and "ignorant" and due to this feels that she is not able to have a better paid job. Other symptoms are sadness and irritability, which are expressed in her permanent bad mood and a lack of tolerance with her children. When talking about these symptoms she says: "I did not use to be so bitter, everything bothers me, I did not feel as unhappy as now. I was more passive, calmer; I liked to have friends, I had fun. Now anything they say bothers me, I get annoyed". Blanca feels insecure and fearful. Her lack of self-confidence does not allow her to deal with the problems of day to day life. She feels blocked in every situation and her avoidance behavior is characteristic of people that have gone through a traumatic experience: "My mother keeps on throwing me out and I realize that something is wrong with me as I can't go out. I'm scared of going out". Blanca shows a lack of impulse control and reacts violently with her children. She feels guilty and worried about the possibility of hurting them.

In terms of psychosocial consequences we observe that Blanca has lived in a family with little capacity for support and emotional and physical care, as a result of the parents' detention and possible torture. The mistreatment she received from her mother—and, subsequently, from her sisters— has led to violent relations between the family members. The father, recognized as the most loving and the most capable of containment, continues to offer support and advice in spite of being in prison serving a sentence. One of the consequences of the parents' detention was early sexual initiation, promiscuous behavior and adolescent pregnancy, given that there was not enough care or control at that stage of development. Situations of violence and mistreatment were reproduced during her married life. Another consequence is poverty due to a lack of education, which has not enabled her to be better prepared to provide herself with an income; this makes her feel frustrated as she is not able to satisfy her children's needs.

Blanca's case shows how torture has grave consequences that not only have an impact on the second, but also on the third generation and establishes tendencies, which increase violence in the family sphere and society. In order to prevent these tendencies the access to and availability of specialized and adequate rehabilitation is decisive for the development of a safe and secure society.

2. –Specialized attention required by torture victims

The right to rehabilitation is an established element of reparation for torture and ill-treatment under UNCAT article 14. Rehabilitation services must be easily accessible for torture victims. This includes physical and financial access and to information, non-discrimination, rapid and adequate attention and the elimination of State legal barriers, as well as special attention for vulnerable groups and populations.

The physical, psychological and social consequences of torture significantly disrupt people's life plans. In order to recuperate them, in the first place there is a need for public policies that regulate

the integral rehabilitation victims should receive. This includes the need to implement a coordinated set of health services for the treatment of persons affected by torture, with professionals that have incorporated a human rights, psychosocial, gender and intercultural focus (explained in the TRC Comprehensive Reparations Program). They are cases that require specialized rehabilitation that should be contextualized within the framework of this psycho-legal condition. In contrast to the suffering of a person with a physical or mental disorder which is expressed in the different areas of psychosocial functioning (partner, family, work, etc.), a person that has been tortured by State agents also requires comprehensive reparation measures from the State itself for his or her true rehabilitation.

Mental health and human rights institutions such as the Center for Psychosocial Attention (CAPS) attend torture victims and their relatives, mainly referred by people that have themselves received treatment in our center or by human rights organizations. It also receives some referrals from public offices such as the Ombudsman's Office, and occasionally from the Institute of Forensic Medicine. To this end, CAPS receives funding from the UN voluntary Fund for Victims of Torture. At an individual level, victims of torture need a variety of medical services (specialists, exams that range in complexity), medication, different types of psychotherapy (individual, family, group), physiotherapy, social work and psycho-pedagogical spaces to strengthen productive capacities. If the persons are going through prosecution processes they will require legal advice. In many cases there are chronic conditions that require follow-up sessions and periodic attention when there is an intensification of symptoms. But, above all else, they need to re-establish trusting relations with stable and consistent health staff that treat their psychosocial consequences.

3. Comprehensive rehabilitation for torture victims in the public sector

The Peruvian State seeks to fulfill the right to and need for rehabilitation of torture victims, through a set of public policies regarding reparations for the victims of the internal armed conflict and the national healthcare system.

3.1. In terms of coverage

3.1.1 Public policies in relation to reparations for the victims of the armed conflict

The Comprehensive Reparations Program (PIR) (Law 28592), recommended by the Truth and Reconciliation Commission in its final report (2003), establishes the principles, focuses, objectives, policies and actions that guide the State's action on matters of reparation for the victims of the process of violence our country went through between 1980 and 2000. Based on these recommendations the High Level Multi-sectorial Commission (*Comisión Multisectorial de Alto Nivel* - CMAN) was created in 2004, in charge of following up and coordinating the implementation of actions and policies in this area. Likewise, the Central Register of Victims (*Registro Único de Víctimas* - RUV) was approved and subsequently a Reparations Council was set up with the task of drawing up a list of individual and collective beneficiaries[8]. In Peru there are regulations for Mental Health reparations aimed at the victims of the armed conflict. In 2004, the Ministry of Health (MINSA) established the National Strategy for Mental Health and a Culture of Peace, incorporating important aspects of the Comprehensive Reparations Plan. Similarly, the Multi-sectorial Commission for the Follow-up on Reparations (CMAN) had a health reparations plan for the 2009 – 2011 period.

8 Ministerial resolution 012-2006/MINSA, where the victims of the internal armed conflict are included in the Strategy for Mental Health and a Culture of Peace http://www.minsa.gob.pe/portal/03Estrategias-Nacionales/10ESN-SaludMental/saludmental.asp Diagnostic of the Group on Reparations - CNDDHH 11 – 12-07 Sanitaria de Salud Mental y Cultura de Paz 2005-2010

The opinion of human rights organizations, endorsed by the Ombudsman's Office, is that the process of reparations and its implementation in the country, has only been partially developed as during the years of the Alan García government priority was given to collective economic reparations and there was no serious commitment to implement in a comprehensive manner, as stated in the law, the other programs of (individual) economic, health, education, symbolic and housing reparations and the restitution of rights.[9] Although there has been partial progress, the process of reparations still does not have a national public policy that is organized, inclusive and consistent, that commits to reparations in a comprehensive way, with a clear budget that goes hand in hand with the search for truth, the access to Justice for the victims and their relatives and the construction of a memory that may set precedents for the future.[10]

3.1.2 National Health System

In 2009, Universal Health Coverage (Aseguramiento Universal en Salud - AUS) was established through law No. 29344. AUS establishes the right of all Peruvians or residents in Peru to health insurance, irrespective of their age. In other words, AUS is aimed at ensuring the effective enjoyment of the right to health. The institution in charge of administering the funds for the application of this right is the Comprehensive Health Insurance (Seguro Integral de Salud - SIS).

There are also guidelines in the health sector that direct the processes towards the implementation of a model of community mental health, especially the contributions outlined in the National Mental Health Strategy Plan 2011-2012 (particularly in Strategic Objective No. 4), the Comprehensive Healthcare Attention Model (MAIS) and a recent amendment of the General Health Law (Law 29889). However, a shortcoming of the regulations is that there are no public policies that highlight the right to integral rehabilitation for torture victims and their relatives, which means that the need to have specialized programs for that population is not realised. Likewise, we should point out that the Mental Health Office has very limited resources to carry out a leadership role.

The mental health programs of the Ministry of Health, through the Comprehensive Health Insurance (SIS) and Universal Health Coverage (AUS) directed at people living in poverty and extreme poverty offer a set of basic health services (especially physical health) for the victims of State violence during the internal armed conflict. However, these SIS services are not available to people that have suffered torture after the 1980-2000 period. A person that has been a victim of torture since 2000 until now can have access to SIS if they qualify for it in due to their poverty but not on the basis of them being torture victims. This population is invisible in the public health services. Nor are these specialized services offered by ESSALUD, an insurance covering employees and their families, or at a municipal level.

When access is obtained to health services, these are highly inadequate both for victims of the armed conflict as well as for victims of the post-conflict period. For example, if breast cancer is diagnosed only two treatment sessions are offered. In order to continue with the treatment, the patient has to resort to supplementary treatment, which is almost impossible. With regard to mental health attention, the Health Coverage Essential Plan (Plan Esencial de Aseguramiento en Salud - PEAS) includes schizophrenia, anxiety and depression, but in terms of treatment offered, a person diagnosed as schizophrenic, for example, only receives four sessions. In cases of anxiety and depression, in theory 15-20 sessions

9 National Coordinator of Human Rights. Informe anual 2011
10 Idem.

should be offered respectively, but it has been reported that in practice a maximum of only four sessions are offered. In most cases, if access to health centers is obtained, people are diagnosed but never receive treatment. In addition, the quality of health services is very low; it often happens that the medication the person needs is not available.

The result is that

1. Torture victims that do not belong to the 1980-2000 period do not have access to specialized service
2. The relatives of victims that have been imprisoned do not have any right to any type of attention
3. The Peruvian State has not considered a fund to subsidize the rehabilitation services offered by civil society mental health and human rights organizations, which would considerably contribute to increasing the coverage, access and quality of the services for the victims, as recommended by article 14 of the Convention.

3.2 In terms of access

Registration in SIS entails a classification procedure for each family and there are often delays in the process of obtaining the certificates that give people without health insurance the right to free healthcare services. These delays have a negative impact on timely access to health services in general. In addition to this, SIS is stretched due to demand and, at the same time, is poorly funded and organized which makes for an extremely low level of healthcare service.

It is important to highlight that the victims experience difficulties in accessing physical health services, that the quality is poor and that there is discrimination. We are going to clearly state the SIS discriminatory practices to exemplify the attention given to torture victims. SIS policies establish the right not to be rejected or discriminated against by health centers due to socio-economic conditions, race, age, sex, etc. However, the first thing that the victims of the political violence, including people that have suffered torture, have to do is identify themselves as victims showing their certificate from the Central Register of Victims (RUV). On doing so, they are often stigmatized as "terrorists" and they have to leave the waiting line. They are made to wait longer than other people, and frequently have to deal with other discriminatory practices before they are attended. In this regard, there have been cases in which healthcare staff make "raped women" get into a line so that they may be seen to by women doctors, violating the women's dignity and intimacy. For these reasons, access to health care often depends on other factors such as, for example, the victim being able to pay for the services in order to access them when needed, the influential contacts the person may have or if he or she knows somebody in an NGO that could represent him or her or put pressure on the healthcare syste. Discriminatory practices are even more evident in the case of Quechua- speaking victims and those that come from rural areas. The case of María can illustrate what has been mentioned.

María is from Ayacucho. The mother tongue is Quechua although at present she speaks Spanish fluently. She was four months pregnant when she was imprisoned under the false accusation of being a terrorist. As a result of the torture and ill-treatment she received, she lost her baby and suffered a gynecological infection, which became chronic until she was released seven years later. When we interviewed her, María told us that after she left prison she had many health problems, that at the time of the interview she had cancer and needed an urgent operation on her gall bladder after having been misdiagnosed several times. At the hospital she was going to she was told that she could not be operated on immediately and that she would have to pay for the operation, including the medicines. In other words, the fact that she belonged to the RUV and her access to SIS did not help her. In order to obtain help, María contacted one of the leaders of a local non-government organization ARIL and called the CAPS social worker, who put pressure on the SIS so that she could have access to some type of health service. The result was a more

reasonable price and a faster operation.

President Garcia's government showed little interest in following up on reparations and the budgets allocated were grossly inadequate for the victims' integral health rehabilitation. The Ombudsman's Office Report No. 140 "Mental health and human rights. Oversight of public policy, the quality of services and the attention to vulnerable populations" ("*Salud mental y derechos humanos. Supervisión de la política pública, la calidad de los servicios y la atención a poblaciones vulnerables*") which showed the results of a study carried out between July 2007 and April 2008 in 15 regions of the country, concluded that: "mental health seems not to have left the marginal place it occupies in policies and on the national public agenda. Although the Peruvian State has fulfilled the obligation of formulating public policies on mental health, there are still problems in its implementation".

To the present day, people who are subjected to torture generally do not know their rights not to be mistreated; even when they are treated in humiliating or degrading ways by public officials, they are not fully aware that that practice violates their fundamental rights. There is a lack of awareness among many torture victims of their rights and the citizen's role in a democracy. In that regard, the documentation of the cases and people's access to health services due to torture, are under registered. In addition, 79% of the victims of the internal armed conflict were from rural areas, where non-government organizations in different areas of the country are the ones that impel the processes so that people may have access to health services. In remote areas where there is no support from NGOs the process is almost impossible.

3.3 In terms of the quality of the services

While there is a group of mental health services for the victims of the internal armed conflict, the quality of these health services– when there is access to them– is inappropriate and often inadequate: they are insufficiently implemented, the coverage varies from region to region, mental health teams do not have trained staff that have incorporated a human rights, psychosocial, gender and intercultural focus as part of a program specialized in the rehabilitation of torture victims[11], and the budgets are very limited. Regarding the focus on gender, the high level of women victims (43% of the people that received treatment at CAPS between 2004 and 2011) shown in table 3 (page 5) highlights the need to include a gender focus in health services.

A key problem in the area of mental health in Peru is that the current hospital model is centralized and stigmatizing. For example, the third level (III)[12] Psychiatric Hospitals such as Larco Herrera or Hermilio Valdizán, in Lima, have limited resources for community interventions and are limited in their geographical range of action. What has been described for level III services, is also seen in supporting and general health centers (level II, Minsa, 2008) in which the attention system and mental health professionals tend to establish an internal and bureaucratic institutional culture. Furthermore, in Peru, mental disorders are to a large extent understood as madness, which means that general hospitals fear that they may be attacked by this group of patients[13]. Hospital culture is the main obstacle to a true implementation of a community mental health model. It is the case of general hospitals in Peru, which are unwilling to hospitalize patients with psychiatric problems due to the general stigmatization of persons that suffer mental health problems. At a community level, the current system of health attention for people affected by the political violence and torture in villages and rural communities and

11 There is no differentiated treatment offered to women victims of sexual violence, although guidelines for a gender focus have been brought before the State (Group on Reparations of the National Coordinator of Human Rights).

12 In Peru, health establishments are organized into different levels of attention according to their complexity. In general terms, the First level (I, II, II, IV) correspond to the health posts and centers; the Second level corresponds to Hospitals (I and II) and the Third level of attention corresponds to Hospitals (III) and Specialized Institutes (MINSA, 2008)

13 Interview with con Manuel Escalante and Rita Uribe, MINSA, 23 November 2010

peri-urban populations is based on the model of primary health attention with the person later being referred to health centers of greater complexity. These health centers have mobile teams that carry out work in the field. This centralised model for the specific attention to people affected by the political violence should be supplemented by the community model.

The current focus on mental health in Peru is not adequate to offer treatment to torture victims that need specialized attention. The specialized attention to affected people should be based on the creation of community spaces in order to work on the integral recovery of this population using a participatory and experiential methodology, adapted to the cultural and social characteristics of each collective and as part of their daily lives. As has already been mentioned, it is necessary to strengthen the community model of integral health attention with the key participation of regional and municipal authorities. A switch from the psychiatric hospital model to a community mental health model is also crucial because most of the people that suffer the psychosocial consequences of torture and the victims of the political violence during the internal armed conflict live in rural communities and the peri-urban and marginal areas in the poorest regions of the country.

Taking into consideration what has been mentioned with regard to coverage, access and the low quality of public health attention, torture victims, in most cases can access the limited health services should they have physical problems, but the psychosocial consequences are not attended in a consistent manner. The public programs specialized in the attention and rehabilitation of torture victims at a community level are currently almost non-existent in the country. It is particularly important to highlight the invisibility of torture victims, after 2000, in SIS and other health programs like ESSALUD.

4. Recommendations

In order to solve the deficiencies analyzed in this report, CAPS and the IRCT propose the following recommendations:

4.1. Regarding the specialized rehabilitation services for torture victims.

a) Improve the coverage, access and quality of comprehensive health services for people that have suffered torture, their relatives, as well as the communities directly affected by the political violence.

b) Articulate their specialized programs for torture victims with mental health and human rights organizations that have worked with them at a local level.

c) Create and organize a specialized program for the rehabilitation of torture that establishes guidelines for good quality attention. Attention should include a group of comprehensive services: medical consultations, examinations, medication, etc., to attend the physical consequences, as well as counselling, psychotherapy, psychiatry, physiotherapy, support groups, social work, home visits, strengthening of productive capacities, among other services.

d) Strengthen the capacities of the multidisciplinary comprehensive health teams that treat victims of torture and political violence at the different levels of health care considering the human rights, gender, psychosocial and intercultural focus put forward in the Final Report of the Truth and Reconciliation Commission.

e) Adequately take into account the long-term financial losses and the significant physical and mental suffering that many torture victims in Peru experience when determining reparatory compensations.

f) Strengthen the monitoring and evaluation system regarding the effectiveness of integral health interventions for people that have suffered torture or other forms of violence against their integrity.

g) Guarantee a rapid accreditation of the certificates issued by the Central Register of Victims (RUV) without delays, prejudices or discrimination.

4.2. Regarding the authority and the public mental health programs:

a) Strengthen the Health Ministry's Mental Health Office and increase its budget.

b) Establish as a public policy the right to the torture victim's integral rehabilitation and that of his or her relatives.

c) Increase efforts to decentralize mental healthcare services so that – improving the quality of the services – they may be extended to rural and remote areas in Peru. This is particularly important in relation to community mental health services and requires a reorganization of the model of mental health care and the training of professionals and community agents.

d) Decentralize the services of psychiatric hospitals and develop programs (that include infrastructure) which promote community mental health in a decisive manner.

5. Annex: Documentation of the psychological evidence of torture carried out by the Institute of Forensic Medicine

(CAT/C/SR.718, 2006Recommendation 16, paragraph c)

An important element that needs to be addressed is the strengthening of torture victims' access to justice and reparation through an adequate documentation of the evidence of the consequences of torture carried out by experts at the Institute of Forensic (IML).

In this regard, it can be observed that the experts do not cover the whole country in the same way, although in the last six years there has been a significant increase in the number of psychologists in the different regional offices. In June 2011, the Institute of Forensic Medicine had 253 psychologists and 15 psychiatrists[14]. However, not all of them are forensic experts or have the competence to determine the psychological damage produced by torture. The greatest difficulty can be found in the quality of the psychiatric and psychological expert reports, which continue to show serious shortcomings (these have been pointed out by the Ombudsman's Office). Two factors contribute to the poor quality of the reports: one factor is the demand for services by the people that go to the IML to obtain an expert's opinion, which means that the professionals have a lot of cases and little time for their interviews and reports, and the second factor is that they did not have a guide that enabled them to have standardized measures of psychological damage, or better training.

In their defense we can indicate that as from 2008 a "Guide to assess psychological damage in victims of family and sexual violence and torture" was being prepared by a technical committee made up by mental health professionals from the IML and civil society (Center for Psychosocial Attention and Manuela Ramos Movement), a document that was approved by the Public Prosecutor's Office in December 2011. This Guide, which is essentially based on the Istanbul Protocol, is directed at overcoming the failings found in the "Forensic Medical Examination Protocol for Detection of Injuries or Death Resulting from Torture", an instrument used by the IML for the documentation of torture since 1997 when assessing and evaluating the psychological consequences of torture. It is important to emphasize that to date this Guide to Assess psychological damage has not yet been incorporated into the IML computer system and training has only recently started. The implementation of this Guide is therefore a priority that is yet to be put into action. Likewise, it is necessary to continue increasing the number of Psychologists and Psychiatrists for a better coverage at a national level and so that they may have the necessary time to draw up their reports in a more consistent manner.

With respect to the training of healthcare professionals that document torture, as well as of the prosecutors of the Public Prosecutor's Office in the issue of human rights and torture, the Public Prosecutor's Office School has made efforts to work on these issues. However, the impact of these trainings on justice operators needs better evaluation, given that the quality of their reports and actions still show significant flaws making it difficult for the victims to achieve access to justice based on an adequate identification and documentation of the case of torture.

We would like to point out that the cases of torture that are in prosecution processes and that require support to cope with processes that take years, need the support of the services of the Public Defense system, which has recently been strengthened.

14 Register of health professionals of the Institute of Forensic Medicine, 2011.

5.1 Recommendations with regard to the documentation of torture carried out by the Institute of Forensic Medicine

a) Implement the Implement the Guide to assess psychological damage in victims of family and sexual violence and torture in the Institute of Forensic Medicine's computer system, train the experts in the use of this Guide and formalize the minimum number of hours required, established in the Guide, to document the psychological evidence of torture in an adequate manner.

b) Establish a monitoring and evaluation program of the training provided to the medical, psychiatric and psychological experts at the Institute of Forensic Medicine on the issue of torture, as well as the quality of their expert reports.