

Abstract

The Peruvian Truth and Reconciliation Commission (TRC), formed in 2001, turned national attention toward the serious mental health consequences of the country's 20-year internal armed conflict. The TRC prioritized reparations in mental health, using a legal justification that provided victims-survivors of the war with a rights-based framework for demanding that the public sector attend to their mental health needs. Since the majority of victims-survivors come from historically poor, rural, and marginalized populations and have tended to not exercise their right to health for a variety of social, economic, and cultural reasons, framing mental health in terms of rights helps to empower these people to impact the development of appropriate policies in mental health. The authors suggest that this process contributes directly to improving the mental health of this population.

La Commission Péruvienne Vérité et Réconciliation (PVR), créée en 2001, a tourné son attention sur les graves conséquences sur la santé mentale des acteurs du conflit armé interne qui a duré 20 ans dans ce pays. La PVR a désigné la santé mentale comme priorité, donnant une justification légale aux victimes-survivants de guerre, avec une structure de travail basée sur les droits des victimes-survivants au secteur public d'adresser leurs besoins en santé mentale. Puisque la majorité des victimes-survivants sont issus de populations pauvres, rurales et marginalisées et ont tendance à ne pas exercer leur droit à la santé pour diverses raisons sociales, économiques et culturelles, le fait de présenter la santé mentale en termes de droits permet à ces personnes d'influencer le développement des politiques appropriées en matière de santé mentale. L'auteur suggère que cette démarche contribue directement à l'amélioration de la santé mentale de cette population.

La Comisión de la Verdad y Reconciliación (CVR) del Perú, constituida en 2001, llamó la atención nacional hacia las serias consecuencias que el conflicto armado interno de 20 años de duración en el país tiene sobre la salud mental. La CVR priorizó la indemnización por daño de la salud mental, al usar una justificación legal que proporcionó a las víctimas sobrevivientes de la guerra un marco basado en derechos para exigir que el sector público atienda sus necesidades de salud mental. Dado que la mayoría de las víctimas sobrevivientes proviene de poblaciones históricamente pobres, rurales y marginadas, y ha tendido a no ejercer su derecho a la salud por diversas razones sociales, económicas y culturales, enmarcar la salud mental en términos de derechos ayuda a otorgar poder a esas personas para que influyan sobre el desarrollo de políticas apropiadas sobre salud mental. Las autoras sugieren que este proceso contribuiría directamente a mejorar la salud mental de esta población.

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THE PERUVIAN TRUTH COMMISSION'S MENTAL HEALTH REPARATIONS: Empowering Survivors of Political Violence to Impact Public Health Policy

Lisa J. Laplante and Miryam Rivera Holguin

The Peruvian Truth and Reconciliation Commission (TRC) put mental health on Peru's national agenda. Formed in 2001 to study the causes, consequences, and responsibilities of Peru's 20-year internal armed conflict, the TRC called special attention to the devastating psychosocial damage caused by the war. These findings led to the TRC's recommended Integral Plan of Reparations (PIR), which included a mental health component. In particular, the TRC set the stage for creating a more expansive approach to mental health, recognizing that each rural community, deeply impacted and often divided by the war, faced unique challenges to mental health recovery. Thus, it proposed a *communitarian* approach that moved beyond an individualized clinical- and medical-based model and identified a diverse representation of local participants who needed to be involved in diagnosing and determining the most appropriate ways to attend to their own mental health needs. Given the challenges of introducing new innovations into conventional health care, however, victims-survivors need to be empowered to demand that the gov-

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ernment adopt mental health policies appropriate for their particular needs.

In this vein, the authors suggest that the TRC served as a critical intervening event that provided victims-survivors of political violence a new advocacy tool for demanding appropriate public mental health services and programs.¹ Framing the right to mental health in terms of *the right to reparations* has provided a rights-based platform that empowers survivors, a historically marginalized population, to counteract traditional economic, social, and cultural barriers to exercising the more general right to mental health. While not articulating a violation of the right to health *per se*, the result of this political agitation nevertheless helps to shape the content of mental health programming, which aids in strengthening the general notion of the state's obligation to attend to the mental health needs of this population.² As a result, the Peruvian Minister of Health has begun to develop public health policy that more adequately responds to the specific needs of victims-survivors, thus addressing a longstanding public health failure.

Peru's Internal Armed Conflict: The Undeniable Presumption of Mental Suffering

It has become an undeniable presumption that armed conflict and political violence cause mental suffering and long-term mental health consequences for individuals and communities caught in episodes of mass violence.³ In war-torn countries like Peru, the profound effects of war form a significant public health concern that includes the physical destruction of states' infrastructures and the social destruction of familial and friendship networks.⁴ Truth commissions validate this presumption by bringing to the foreground the stories of victims-survivors.

Indeed, truth commissions can put mental health on national agendas and refocus post-conflict reconstruction toward the human suffering caused by political violence, and not just the damaged economic, political, and legal infrastructures.⁵ This shift reflects the realization that institutional reform of democratic institutions fails if the citizenry is not able and prepared to use these participatory channels.

Successful post-conflict recovery requires that citizens trust themselves, their neighbors, and their government, since a country's social and political stability depends on the mental health recovery of its war-affected population.⁶

The establishment of the Peruvian TRC represented important initial steps in Peru's post-conflict reconstruction efforts by revealing the mental health concerns of its victims-survivors through the investigation of the country's most prolonged and fatal war (1980–2000). The war began in 1980, when the self-declared Maoist group, *Sendero Luminoso* ("Shining Path" or SL), initiated its violent campaign to create its own version of a utopian society. Although arising out of similar ideological contentions, such as communism, Peru's conflict differed from others in the region. This was in part because most of the violence took place in the countryside and involved whole communities, and also because Sendero was responsible for up to 54% of the estimated deaths caused by the war.⁷ Three democratically elected governments sought to combat the terrorist threat but instead permitted brutal state terrorism at the hands of the armed forces.

Harvard anthropologist Kimberly Theidon notes that the conflict dissolved into "matando nuestros prójimos" (killing our own), as members of the same community joined different factions, including SL, the military, and self-defense committees ("ronderos"); the rest were caught between these combatants.⁸ The brutal strife turned neighbors, friends, and even family into deadly enemies. Meanwhile, the government and the powerful elite looked on with indifference or ignored the events entirely, reactions that are typical of those groups toward historically marginalized populations.

Finally, in 1992, terrorist leaders were captured, and the violence began to subside. In the midst of these promising developments, however, President Alberto Fujimori resorted to authoritarian policies that led to new types of serious human rights violations, such as arbitrary imprisonment and torture. Almost a decade later, his administration was tainted by corruption scandals, and he was forced to flee the country. His departure finally opened the way for a democratic transition, which included the TRC as part of a new commitment to building a peaceful democracy.

After two years of work, the TRC published its 8,000-page *Final Report* in August 2003, shocking the nation by estimating that approximately 69,280 people had been killed during the conflict, tripling earlier estimations.⁹ It also called attention to the thousands of widow(er)s and orphans left by the dead and disappeared, as well as the thousands of other people who had been displaced, tortured, raped, incapacitated, and unjustly and unlawfully imprisoned.¹⁰ Significantly, the TRC offered a comprehensive analysis of the socio-psychological impact of the conflict, thus revealing the challenging task of post-recovery conflict that awaited the nation in its quest for national healing and reconciliation.

Challenges of Post-Conflict Recovery: Poor Communities Marked by Fear and Distrust

Based on the almost 17,000 private and public testimonies in the early post-conflict period, the TRC devoted an entire chapter to the “destabilizing and destructive” psychosocial effects of Peru’s war that “challenged and exceeded the capacity of psychological defenses.”¹¹ The TRC emphasized a host of psychosomatic problems that the conflict-weary population were experiencing, including feelings of insecurity, helplessness, impotence, loss of confidence in oneself and others, generalized anxiousness, fears and phobias, impulsiveness, and aggressiveness. The TRC also confirmed that political violence had left an indelible mark on the well-being of the communities in which these suffering individuals resided, affecting “social functioning and limit[ing] the possibilities of a dignified life.”¹²

The unique nature of Peru’s conflict had created an intense climate of fear and distrust that ruptured social bonds and solidarity due to community conflict and interpersonal violence.¹³ It halted pre-existing local customs and norms as people tried merely to survive.¹⁴ The deliberate and primary tactics of repression and terror used during the conflict (public executions, disappearances, and arbitrary detention) had caused “a sharp sense of vulnerability” within the population.¹⁵ This terror imposed an atmosphere that made speaking out too dangerous, resulting in anxiety that created the “perception of imprecise, but always imminent, risk that disturbs daily life.”¹⁶

Peruvian Psychologist Vivi Valz Gen, who directed the TRC's Office of Mental Health, explained that fear became transformed into distrust, often bordering on feelings of anger and revenge.¹⁷ Thus, the TRC warned that these psychological consequences not only challenged individuals, but also posed "a constant obstacle for the possibilities of reconstruction and recomposition of communal life."¹⁸ They also affected the relationship between the population and institutions of the state, which had failed to respond to people's cries for help.

Thus, post-conflict recovery in Peru required healing at all levels: people had to deal on a personal level with painful repercussions of the war, but they also had to come to terms with feelings of betrayal and mistrust toward members of their community and those within the government. Indeed, a recent study conducted by the public Specialized Institute of Mental Health in Peru found that approximately 80% of Peruvians still lacked trust in all forms of authority, including politicians and police; approximately 65% of them did not trust their own neighbors.¹⁹ Rebuilding social solidarity, community well-being, and citizen protagonism entails overcoming these mental health barriers that threaten sustainable social reconstruction.²⁰

Ironically, the post-conflict recovery's focus on asking victims to become active participants in rebuilding their communities and to engage in political and legal processes to enforce their rights goes to the core of the greatest psychosocial consequence of the war. States of mind—and mental health issues—often prevent active participation in defending human rights. Moreover, distrust prevents some victims from seeking resources that could address these same mental health issues.²¹ For instance, in the same study conducted by the Institute of Mental Health, 36.9% of those surveyed stated that distrust had dissuaded them from seeking the state's mental health services.²²

This tendency not to use public mental health facilities had begun before the internal armed conflict started, however. Indeed, to understand the challenges of transforming victims-survivors into activists capable of lobbying for social programming in mental health requires understanding their historical passivity in relation to the act of demanding and exercising the right to mental health.

Victims-Survivors of the Conflict: Disempowered Second-Class Citizens

The Peruvian TRC raised the profile of victims-survivors of the war. Specifically, three out of every four lived in a rural region, were poor and illiterate *campesinos* (farmers), spoke a native language other than Spanish, and belonged to a marginalized, excluded, and discriminated-against population of Peru. The brunt of the violence took place in the least developed regions of the sierra and jungle.²³ In particular, 40% of the deaths occurred in the remote, mountainous countryside of the Ayacucho region, which only in 1999 acquired a paved road to the urban coast, reducing a three-day trip there to eight hours. Of Ayacucho's estimated 550,000 residents, 70% are indigenous and speak the native language, Quechua; 64.2% suffer chronic malnutrition; and the infant mortality rate is 84.8 per 1,000 live births.²⁴ These are communities whose origins trace back to the Incas, a population that was dominated throughout the Spanish conquistadores' oppressive and deadly rule.²⁵ Thus, deeply rooted inequalities thread back some 500 years.

Thus, the majority of victims-survivors had suffered from poor living conditions even before the war, conditions only exacerbated by the political violence.²⁶ Before becoming "victims" of the war, they had been "victims" of historical, social, and economic conditions that deprived them of basic social services such as health. In effect, this population had experienced a double violation of their rights: both civil and political rights, and economic, social, and cultural rights.²⁷ Certainly, the TRC identified these conditions as being responsible for the frustration and disempowerment that the terrorist groups had commandeered to serve their violent cause. Years of neglect and discrimination contributed to a *caldo* ("broth") out of which the conflict had arisen. Unequal relations of power and opportunities preceded, provoked, and then were exacerbated by the political violence.

It is critical to ask why this population disregarded legitimate democratic channels to alter social and economic conditions, and instead chose SL and violence. Social, political, economic, and cultural factors, in part, explain their reasons for not using legal and administrative mechanisms to

contest violations of their social, economic, and cultural rights. Next, we seek to look at this trend in the realm of health care in order to later propose how a truth commission process may help reverse it.

Factors Explaining Lack of Use of Complaint Channels

Complaint channels exist in Peru's public health sector. The country's domestic protection mechanisms seem to comply with the recommendation of the United Nations Committee on Economic, Social, and Cultural Rights (CESCR) for effective measures to ensure accountability and transparency, including "judicial or other appropriate remedies."²⁸ In 2002, the Highest Court of Peru invoked Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) while ruling on the right to health of prisoners, demonstrating the justiciability of the right to health.²⁹ Meanwhile, the Minister of Health (MINSA) has created administrative complaint channels such as the *Oficina Ejecutiva de Transparencia y Defensoría de la Salud*, the equivalent of an Ombudsman's Office, and a free complaint line, InfoSalud ("HealthInfo").³⁰ Complaint records held by MINSA reveal, however, that the population of victims-survivors rarely employs existing administrative mechanisms, at least not for seeking more appropriate care in mental health.³¹ Nor did we uncover national jurisprudence on the right to mental health for survivors of the war.

The apparent lack of use of these complaint channels, however, does not translate into an absence of need for mental health services. On the contrary, a large majority of participants in the TRC process complained of mental health issues. Of approximately 5,000 people who testified in Ayacucho, 49% complained of mental health problems related to their personal, family, or community life, yet only 3.2% had made specific demands for public mental health services.³² Similarly, in a sample of 407 testimonies used by the TRC to develop PIR, 71% of respondents used language expressing signs of depression and mental health suffering, yet only 10% had made specific requests for psychological counseling.³³ The lack of demand for these services cannot be assumed to reflect a lack of desire for attending to these mental health issues.

Instead, the same social, cultural, economic, geographic, psychological, and political factors that have caused this population not to seek public health care are often similar to those factors that also cause them not to complain when they do seek care and find it to be unavailable, inadequate, or of low quality.³⁴ This tendency reflects and reinforces resilient behavioral patterns and beliefs in relation to this population's right to mental health. Some examples are:³⁵

- *Lack of knowledge of the right to mental health.* The knowledge of one's right is a prerequisite to exercising this entitlement.³⁶ Few Peruvian victims-survivors, however, know that the right to mental health is protected by international treaties, or that the government has both a "negative" duty to refrain from harming a person's mental health and a "positive" obligation to respect, protect, and fulfill the right to mental health by assuring the availability, accessibility, acceptability, and quality of mental health care.³⁷ Everyday experience makes it unimaginable that mental health counts as a right, especially since one often hears the sentiment, "Si la vida no fue un derecho, menos lo será la salud" ("If life was not a right, even less so will be health"). A more common attitude is, "Ojala que el gobierno nos atendiera" ("We hope that the government will respond"). Survivors of the war do not perceive that they are rights holders, and brutal attacks against their physical and mental integrity were simply "how it was." Thus, they make general appeals for help that rarely convert into rights-based demands.³⁸
- *Low expectations and resignation.* Even when actual experience — such as discrimination — amounts to violations of patients' rights, this population expresses high rates of approval for objectively poor service. They regard low-quality services as normal, and even the most minimal service is viewed as a luxury.³⁹
- *Perception of health care seen as a favor or gift of charity.* Health care is seen not as a state obligation, but rather as an act of charity. If the very presence of a doctor is "an act of goodness," complaining becomes an act of disloyalty. Extremely poor communities with very few resources or services fear that complaints might result in

a doctor's leaving or refusal to offer services. A culture of "clientelismo" makes personal connections and ability to pay more important than equal, non-discriminating treatment. Those unable to participate in this power dynamic employ a tactic of acting as victims to evoke sympathy, presenting themselves as "pobrecitos" (poor ones), rather than as holders of rights.⁴⁰

- *Submission to authority.* One illustrative anecdote involves a victim-survivor with psychosomatic symptoms who had sought help from a hospital, only to be told by the doctor that there was nothing wrong with her. The doctor did not refer her to a mental health specialist. The patient deferred to the authority of the doctor, never realizing that his diagnosis was inadequate.⁴¹
- *Mental health not a priority.* Ill-health, including mental health problems, is merely a part of daily existence. As one Peruvian psychologist explained, "It is a luxury to be able to imagine a situation of better emotional equilibrium when your life is so hard, even before the violence, difficult because of poverty and exclusion."⁴² Thus, all-consuming challenges involved with the daily struggle for survival leave people little if any energy to assert their rights. Needs such as housing, food, and education take priority. In this sense, people "give up" on mental health, (although the aforementioned practical items could improve their mental health). A lack of time and resources, combined with an agrarian schedule, makes complaining unlikely. Significant geographic distances between centralized offices far from outlying communities also discourage people from making administrative or judicial complaints.
- *Lack of incentive or knowledge of how to exercise a right.* The tendency not to use public health services and programs in the first place leaves the right to mental health dormant. Dr. Alberto Perales of the University of San Marcos in Lima, Peru, explains, "in order to enforce the right you have to be conscious that you have the right, and at the same time conscious that you need to employ that right for yourself."⁴³ Victims-survivors may avoid the public sector because of prior

bad experiences or mistreatment, either through first-hand experience or that of a family member or friend. Even if a violation exists (such as a patient's right to be free of abuse), protest almost always takes the form of "no yendo mas" (not going) to the public health facility. Moreover, a heavy reliance on human rights specialists throughout the years of conflict and continuing today has created a paternalistic relationship that leaves this population less empowered in the absence of professional assistance, especially if those needing services are not native speakers of Spanish or are illiterate. Complaint mechanisms are therefore of no help if those needing them are unable to use them. Similarly, even the most empowered of victims-survivors have limited knowledge of how to enforce health rights through traditional legal and administrative channels.

- *Perception of an absent, non-responsive state.* Past experiences show that the state is not responsive to demands for social programs. If a person does not believe that the state will dutifully assume its obligations, initiating a complaint or organizing a movement is a waste of time, especially at the cost of family and work obligations.
- *The belief that mental health is for the "locos" (the crazy).* A stubborn stigma that mental health services are only for the weak and crazy often prevents members of this population from seeking help. Associating mental health with sickness, rather than rights, makes people less likely to seek these services or fight for their mental health rights.⁴⁴
- *Demands that do not match the services.* The mental health demands of this population may not fit neatly within conventional concepts of mental health services, particularly those related to biomedical-psychiatric clinical care.⁴⁵ The absence of culturally appropriate mental health services, such as doctors who speak the native language or approaches to "salud mental comunitario" (communitarian mental health) make the public health sector less adapted to local needs.

Thus, to understand mental health recovery in post-conflict settings, attention must be given to what victims-

survivors consider as necessary to attain their mental health. Peruvian physician Danilo Fernández, who worked with the Peruvian Ombudsman's office's health program, explains that "the theme is how to explicitly define the content of the right to mental health" and then be able to evaluate whether services and programs offered by the public health sector match this perception.⁴⁶

For instance, mental health recovery may come more readily through comprehensive community programs integrating components of prevention, promotion, and rehabilitation that also consider economic, political, and social causes of mental health problems.⁴⁷ Valz Gen describes her constant internal lobbying to educate the TRC commissioners to understand that "the *social* cannot be separated from the *psychological*," which includes attending to issues of poverty, discrimination, and exclusion.⁴⁸ Here, one finds resonance with psychologist Ignacio Martín-Baró from El Salvador, who observed that psychosocial trauma is produced socially, and therefore, "understanding and resolving it require [sic] not only treating the problems of individuals but also treating its social roots, in other words, the traumatogenic structures or social conditions."⁴⁹

If what survivors consider appropriate for recuperating their mental health falls outside of the normal gamut of state services, goods, and programs, then demanding their right to these services requires political lobbying. Their lack of presence as seasoned political actors, however, and their minimal voice in the development of mental health policy explain, in part, why MINSA has not prioritized mental health for this population over the years. Through the lens of a public health analysis, the practical consequence is a breach between demand and offer. Until now, however, the government has not felt the political pressure to take measures to protect victims-survivors' right to mental health, or to allow beneficiaries' direct input on the components of this care. In the next section, the authors suggest that PIR's health reparations may provide a new channel through which victims-survivors can begin to demand appropriate mental health programming and thereby help to address this public health failure.

Reparations in Mental Health

In their relatively recent history, truth commissions have come to be largely associated with balancing the needs of truth and punitive justice.⁵⁰ The Peruvian TRC, however, has shown that they also serve to reinforce notions of restorative justice. That is, they reinforce the principle that violations of human rights give rise to the state's obligation to provide pecuniary and non-pecuniary reparations in response to the harm caused, as recognized in both treaty and customary law.⁵¹ Indeed, the TRC offered ethical, moral, and *legal* justifications for PIR.⁵² Since then, civil society campaigns have presented legal arguments for why the state should fully implement PIR, including recommendations for symbolic, individual, collective, educational, health, and economic reparations. The TRC breaks down mental health into both community and clinical intervention.⁵³ Indeed, the pervasive mental health problems that challenge community life largely justify PIR, which seeks to help victims-survivors recuperate mental and physical health, reconstruct social support networks, and strengthen their capacities for personal and social development. This will favour the necessary autonomous development of the victims to reconstruct their individual and collective life plan ("proyecto de vida") that was cut off by the conflict.⁵⁴

Moreover, although the TRC does not frame health reparations as a response to a violation of the right to mental health *per se*, the practical results translate into substantial adaptations of public policy to accommodate the mental health needs of this population. The TRC implies that PIR also responds to previous unjust economic and social conditions and is intended to "improve the quality of life of the people and open possibilities of cultural, social, and economic integration for those who many times *not only suffered poverty and exclusion* but also had to directly suffer the consequences of the violence"⁵⁵ [italics added].

Framing the state's mental health obligations in terms of reparations for violations of political violence eliminates considerations related to the "progressive realization requirement" found in the ICESCR, which excuses delays in health programming.⁵⁶ This legal angle insulates PIR from

attempts to dilute or leave to the state's discretion the issue of reparations. Instead, notwithstanding the lack of political will, reparations for violations of civil and legal rights are an immediate state obligation, not subject to budget considerations or arguments of socioeconomic entitlements among competing interests in poor countries like Peru.⁵⁷

PIR includes two critical components that make it a novel enterprise in the realm of post-conflict reconstruction. By framing mental health in terms of rights and then by accommodating the victims-survivors themselves in policy and program development, the TRC has created a critical tool for individual and community empowerment.

Reparations in Health: Tools of Empowerment

The authors sought confirmation that PIR truly serves as an empowering tool in making demands for programs and services in mental health. Indeed, Peruvian mental health professionals working with war-affected populations expressed to the authors the "absurdity" of expecting this population to suddenly change their ingrained behavior of passivity with regard to the public health sector. We asked: does PIR actually encourage victims-survivors to develop an awareness of being citizens with rights and knowledge of how to exercise those rights? Does empowerment counteract the historical behavioral patterns of passivity with relation to the public health sector?

As discussed above, Peruvians historically have encountered the types of challenges identified in a recent World Bank report on health, including prolonged social exclusion, discrimination, prejudice, and internalization of low expectations.⁵⁸ Importantly, the World Bank proposes *empowerment* as an appropriate remedy "to campaign against the informal cultural, social, and economic practices that sustain unfairness in access and utilization [of health]."⁵⁹ To this end, empowerment theories become useful for examining factors that promote or thwart the process of owning and exercising the right to mental health. Given that powerlessness is one of the principal after-effects of massive political violence, it is important to examine how models of empowerment like those proposed by Brazilian educator Paulo Freire's "Radical Pedagogy" or Martín-Baró's "Liberation Psychology" might

provide the means for "supporting a community in identifying and realizing its needs."^{60,61}

While it is outside of the scope of this article to present an exhaustive examination of specific theories of empowerment, key concepts offer a preliminary exploration of how the TRC and PIR might help victims-survivors confront conditions of injustice and insert themselves as participants in the political post-conflict recovery process. We argue that the TRC has promoted empowerment by reframing a need as an entitlement, integrating the right to participation, and promoting a civic process that heals.

Reframing a Need as an Entitlement

Language is particularly important in transforming health from a need into an entitlement. Alicia Ely Yamin explains that "defining a social good, such as health, as a right might confer upon it the power of a 'trump card' with respect to the allocation of resources and the coercive enforcement power of the state."⁶² Embracing the power of "rights rhetoric" serves to label health as a right and makes beneficiaries "incipient rights-bearers."⁶³ This shift in perspective changes how an individual views a rights claim by raising awareness that rights grant "entitlements that give rise to legal, social, and political obligations."⁶⁴ This formula is relevant to Peru, where the lack of rights knowledge rendered war victims passive in the face of violations of their most basic rights to health. Indeed, the TRC provided new incentive for victims-survivors to organize themselves to present their recommendations regarding reparations.⁶⁵

One such group is the Asociacion Reflexion de Inocentes Liberados ("Reflection Association of Liberated Innocents," or ARIL), a group of Peruvians who were unjustly imprisoned for terrorism during the war and later liberated upon vindicating their innocence.⁶⁶ The majority of ARIL's members suffered from mistreatment and torture for as long as 15 years of maximum security imprisonment. Upon their release, they faced broken homes, interrupted study, and lost work opportunities. Most critically, they displayed debilitating physical and mental health problems.

Under the professional guidance of social worker Veronica Molina, ARIL began in 2001 in a psychosocial center in Lima, Peru, as a self-help group to address these compelling issues.⁶⁷ Initially, the group concentrated on the therapeutic processing of mental health suffering. In response to the formation of the TRC, however, they gradually acquired political aims, organizing in solidarity to seek reparations and make rights-based demands for mental health. In 2004, the group registered itself as an association and began to represent victims with other similar grievances; today its members number approximately 250 nationally.

ARIL's initial demands for reparations from the government eventually developed into a rights-based argument.⁶⁸ For example, members of ARIL held a series of meetings with the Seguro Integral de Salud (SIS, the public health insurance for Peru's poor, which the Minister of Health extended to cover reparations), to argue specifically for mental health coverage, which had previously been excluded from SIS altogether. ARIL referred to the legal basis for mental health reparations, citing both the TRC and cases from the Inter-American Court of Human Rights.⁶⁹ As a result, SIS presented a proposal to the Minister of Health to integrate mental health into its public insurance program, and ARIL's continued lobbying eventually resulted in the implementation of this proposal.⁷⁰

Since then, ARIL has occasionally partnered with the Minister of Health on other efforts. SIS invited ARIL's president to give talks to other victim-survivor groups on how to affiliate themselves with SIS. Similarly, SIS invited ARIL's members to form special committees to monitor and report problems with these affiliations. Indeed, SIS made ARIL a recognized accrediting body for new affiliates — one of only three civil society organizations and the only victim-survivor group among state agencies.⁷¹

Reframing health care as a question of right shapes victims-survivors' conviction to "take a stand as subjects of rights" and thus not as charity recipients.⁷² In ARIL's general assembly meetings, members speak of mental health as a right, an uncommon occurrence just five years ago, when the group was first formed and before the TRC published its Final Report.

Integrating the Right to Participation

PIR emphasizes participation as “a basic criterion” and calls for the inclusion of the population of victims-survivors of the war “in decision-making and definitions of their own process of social, cultural, economic, and material construction and reconstruction.”⁷³ Thus, the TRC took as its starting point the necessities that the population prioritized.⁷⁴ Indeed, the TRC may have been the first official national initiative that engaged Peruvian victims-survivors in a process that allowed them to participate in the state’s attempt to understand their health needs: first, through its testimony-taking and later through consultative meetings and conferences during the development of PIR. The inclusive process helped PIR “[respond] to the demands of those who suffered the violence in the flesh.”⁷⁵ Perhaps for this reason, one finds a high rate of acceptance of PIR among survivors despite some compromises in its content.

The TRC, in effect, responded to the CESCER’s General Comment 14, which recognizes “participation of the population in all health-related decision-making” as critical to the right to health.⁷⁶ Similarly, one of the ten overall recommendations made by the World Health Organization (WHO) in *The World Health Report 2001 – Mental Health: New Understanding, New Hope* is that “communities, families, and consumers should be included in the development and decision-making of policies, programmes, and services” in order to *adapt* to the local needs that consider differing social, cultural, and economic systems, assuring that the content of the right to health matches the demand of the direct beneficiaries.⁷⁷ Participation of health beneficiaries reflects a growing trend of involving healthcare beneficiaries directly in the development of health policy in order to create appropriate and sustainable public health programs.⁷⁸ The direct involvement of individuals and groups in shaping health policy is thought to increase their control over their health, allowing them to “reach a state of complete physical, mental, and social well-being.”⁷⁹ Here, the intrinsic and instrumental importance of participation is multi-fold: as a valued right in itself, as the most effective means of ensuring that policy and programs adequately respond to the needs of beneficiaries, and as the most effective monitoring device to hold states accountable for the fulfillment of the right to health.⁸⁰

Participation assures respect for the intercultural dimensions of any society. For example, in Ayacucho, a concerted effort to teach women about their sexual and reproductive rights encouraged them to voice their discontent over services available to them. They were also inspired to make demands related to birthing methods and to require conventional doctors to adapt to the cultural preferences of indigenous women.⁸¹ In this way, traditional human rights workshops reshaped “the discourse of what is acceptable treatment of its citizens by the government.”⁸² These and other efforts made a significant contribution toward changing the practices of local doctors (for example, allowing women to give birth while squatting and not prone), and ultimately contributed to building a culture of rights among both service providers and recipients. Widespread participation has gradually helped, from the bottom up, to persuade the state to adjust policy and practice to the ideals of human rights. Unlike in reproductive health rights, however, participation in the development of mental health programming for victims-survivors of the internal armed conflict is thus far a novelty, even to most local nongovernmental organizations and health coalitions.⁸³

Promoting a Civic Process That Heals

Victims-survivors' involvement in civic participation projects also provides important opportunities for mental health recovery. Empowerment is a *dynamic process* with potential curative benefits.⁸⁴ Counteracting the psychological consequences of exclusion and violent repression entails gaining self-worth, control, self-efficacy, and personal security.⁸⁵ Mental health is a byproduct of being an “equal partner” in making decisions and having control over one's life circumstances and well-being.⁸⁶

PIR also contemplated “horizontal relations” in decision-making, calling for victims to be seen as “citizens,” thus addressing unequal power structures that undermine rights.⁸⁷ This approach sees “victims” as equals and acknowledges their dignity, liberty, and power.⁸⁸ Doing so counteracts the “dehumanization” of repression that often treated people “worse than animals.”⁸⁹ Carlos Martin Beristain, a physician who coordinated the Guatemalan truth commission's *Nunca*

Mas report, found that the indigenous women with whom he worked experienced an improvement of their mental health through realizing that they had human rights, because these rights made them *feel* human. Recognizing their inherent value as human beings led them to think and act in accordance with this new self-image.⁹⁰ Martín-Baró writes that one of the first steps in empowerment is to “demonstrate that they are people with rights, so as to recover their dignity and status as citizens and even as human beings.”⁹¹ Thus, empowerment should not be conceived merely as the awakening of consciousness and transference of knowledge and skills; it must also contemplate the actual mental transformation that convinces a person that she or he is worthy to be a subject of rights.

Challenges to Empowerment of Populations Affected by Political Violence

Rights rhetoric does not magically empower the formerly voiceless; it requires additional steps, such as transference of skills in defending one's rights, and ultimately the mental attitude and motivation to do so.⁹² While it is an important first step, consciousness-raising must be followed by preparation for taking action.⁹³ Theorists who propose the use of the rights-based approach run the risk of naively undermining the chance for change by not preparing the change agents.

Capacity Building for Victim-Survivor Organizations

Becoming an active citizen with a voice and vote in one's well-being does not happen automatically.⁹⁴ A rights-based approach may ignite the indignation and even desire to claim entitlements to health, but Freire warns, “none of this is easily accomplished. . . . Desire is fundamental, but it is not enough.”⁹⁵ One needs to learn how to fight politically with appropriate tactics.⁹⁶ Rights-holders must actually *see* alternatives for collective action and know *how* to use these channels to defend their rights.⁹⁷

For example, as mentioned, ARIL underwent almost two years of preparation in order to acquire the activist “know-how” to pursue its political demands. Engaging with state officials, presenting comprehensive and concrete pro-

posals, responding to government excuses related to economic and human resources, engaging public opinion, and demanding transparency and accountability, among other tactics, necessitated a level of sophistication requiring more than a knowledge of rights language.⁹⁸

This training requires sustained professional accompaniment. Until now, few human rights organizations in Peru have adopted this approach, leaving the majority of victim-survivor organizations weak and ineffective in defending their rights. Moreover, their inability to secure the economic and human resources to carry out a political struggle for justice and reparations directly threatens the viability of their political projects. As recognized in the Ottawa Charter, empowering beneficiaries of health policy requires enhancing self-help and social support, and also developing a flexible system that “requires full and continuous access to information, learning opportunities for health, as well as funding support.”⁹⁹ Historical dependency on human rights organizations paralyzes their growth as independent agents.¹⁰⁰ While victims-survivors ultimately carry the burden of pushing for the implementation of PIR, they are not viewed as “political actors” because of their weak organizational capacity to make their voices heard.¹⁰¹

The Paradox: Overcoming Challenges in Mental Health in Order to Lobby for Mental Health

Our initial positive findings regarding participation of victims-survivors in the development of mental health reparations must be tempered with some caution. In meetings with these groups, the authors still encounter high levels of fear, distrust, and interpersonal conflict, among other emotional obstacles, which present the greatest challenges to their helping build participatory democracies in post-conflict settings. Changing consciousness “requires fighting conditioned reflexes, literally asking people to think against themselves — to live in the third person.”¹⁰² It is necessary to recondition behavior by altering attitudes and perceptions.¹⁰³

The source and nature of a “culture of silence” — the way that it arises and the mentality that it generates — are where the empowerment theory must be adjusted to fit a

post-conflict setting.¹⁰⁴ Thus, building self-esteem and confidence and overcoming the consequences of repression are the constant aim — and at the same time challenge — of the empowerment process. Here, integration of the psychological angle in the empowerment theory reveals a paradox, in that mental health is actually a requirement for empowering people to defend their right to mental health.

On Staying Steadfast Despite Slow Progress

Personal transformation of victims-survivors becomes increasingly difficult when their political, social, and economic milieu stays the same.¹⁰⁵ Changing subjective states often must be reinforced by noticeable changes, even if slow, in economic, racial, cultural, and societal power structures. For instance, while the government has shown increasingly more openness to listening to and working with ARIL, in everyday life most of its members still encounter enormous problems in obtaining the health care that they need. These experiences, including a lack of response, the continued delay of reparations, and the outright mistreatment of victims-survivors seeking reparations, result in renewed situations of victimization — and further mental health suffering. In one meeting convened with SIS, ARIL's members expressed not only their frustration and anger about this situation, but also their sense of worthlessness and lack of power. Indeed, where this treatment resulted in fatal consequences (one member's infant died after the mother's repeated attempts to seek care were refused), we see, tragically, renewed human rights violations and victimization.

A critical point exists in the empowerment paradigm, in which, if nothing changes, those who should be empowered may become even more passive and defeated. There is a risk that “the oppressed interpret their impotence as proof that they themselves are worthless,” and thus accept the inevitability of an unequal social order.¹⁰⁶

Conclusion

The Peruvian TRC raised collective consciousness about the mental health impact of its internal armed conflict and informed victims-survivors that their grievances corresponded to the right to a government response. Framing mental health

as a right (albeit in terms of reparations), the TRC inspired an incipient political movement to demand policy that responded to their unique mental health needs. Creating formal opportunities for political participation, the TRC also empowered victims to begin to overcome behavioral patterns that had previously made them passive before the public health sector.

Experiences like those of ARIL, however, suggest that if health corresponds to relations of power in that victims tend not to have power to protect themselves from harm, then regaining health entails gaining power and control over one's life and well-being. Despite the promise of the rights framework presented by PIR, empowerment theories must include specific measures to address the psychosocial effects of the war and build trust before survivors can be expected to activate their rights.¹⁰⁷ Delving into mental health issues goes to the heart of disempowerment, and transforming "victims" into protagonists with rights is a complex and challenging process. Indeed, Peru's experience shows that empowerment does not come magically, but rather results from continued focused efforts and effective appropriation of resources.

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References

1. The author's observations shared in this article arise out of their sustained field work and participant observation during their work with the TRC as well as with victims-survivors, as well as through the funded research studies mentioned in our acknowledgments.
2. For the purpose of this text, "this population" is understood to pertain to victims-survivors, the majority of whom are poor, rural farmers.
3. See for example, I. Martín-Baró, *Psicología Social de la Guerra* (San Salvador, El Salvador: UCA Editores, 1990).
4. L. E. Fletcher and H. M. Weinstein, "Violence and Social Repair: Rethinking the Contribution of Justice to Reconciliation," *Human Rights Quarterly* 24 (2002): pp. 573–639.
5. A. Allan, "Truth and Reconciliation: A Psycholegal Perspective," *Ethnicity*

& *Health* 5 (2000): pp. 191–204, at 191.

6. *Ibid.*

7. Peruvian Truth and Reconciliation Comisión, *Hatun Willakuy: Versión Abreviada del Informe Final de la Comisión de la Verdad y Reconciliación* (Lima, Peru: 2004): p. 18.

8. K. Theidon, *Entre Prójimos: El Conflicto Armado Interno y la Política de la Reconciliación en el Perú* (Lima, Perú: IEP, 2004): p. 174.

9. Peruvian Truth and Reconciliation Commission, *Final Report* (Lima, Peru: 2003). Available at: www.cverdad.org.pe.

10. *Ibid.*

11. *Ibid.*: “Psicosocial Secuela,” Vol. VIII, p. 167. (Translation by author).

12. *Ibid.*: p. 169.

13. *Ibid.*: p. 354.

14. Personal Interview with J. B. Choque Q., President, Asociación de Heroes Civiles Fundadores y Protagonistas de la Pacificación del Peru (October 1, 2006).

15. TRC, *Hatun Willakuy* (see note 7): p. 355. (Translation by author).

16. *Ibid.*; and Psicosocial Secuela, *TRC Final Report* (see note 11): p. 167.

17. Seminar, *Salud Mental en el Proceso Post Comisión de la Verdad y Reconciliación (CVR)* (Asociación Peruana de Psicoterapia y Psicoanalítica de Niños y Adolescentes, Lima, Peru: October 4, 2006). [Hereinafter, Lecture *Vivi Valz Gen*].

18. TRC, *Hatun Willakuy* (see note 7): p. 355. (Translation by author).

19. J. S. Castillo, “Estudio Epidemiológico en Salud Mental en Ayacucho,” *Anales de Salud Mental XX* (2004): p. 29.

20. While more marked in rural villages, the authors have encountered these challenges in urban centers especially in communities composed entirely of people displaced by the war.

21. Fletcher, “Violence and Social Repair” (see note 4): p. 564.

22. Castillo, *Estudios Epidemiológico* (see note 19): p. 29.

23. TRC, *Hatun Willakuy* (see note 7): pp. 22–3.

24. Instituto Nacional de Estadística e Informática, *Censo Nacional de Población y Vivienda* (Lima, Peru: 1993). The United States State Department estimates Peru’s total population to be 27.2 million, according to a 2006 census. See Bureau of Western Hemisphere Affairs, available at: <http://www.state.gov/r/pa/ei/bgn/35762.htm>; Instituto Nacional de Estadística e Informática, *Compendio Estadístico Departamental* (Lima, 1995–96).

25. Peru’s situation fits into a general regional pattern as passionately detailed in the classic E. Galeano, *Open Veins of Latin America: Five Centuries of the Pillage of a Continent* (New York, NY: Monthly Review Press, 1997).

26. L. J. Laplante, “On the Indivisibility of Rights: Truth Commissions, Reparations and the Right to Development,” *Yale Human Rights and Development Law Journal* (forthcoming May 2007).

27. *Ibid.*

28. Committee on Economic, Social and Cultural Rights (ESC Committee), General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000), para. 59.

29. The Court held that the right to health requires not only that the

State refrain from putting a prisoner's health at risk but also that it "provide adequate and appropriate medical attention." Sentencia Tribunal Constitucional del Perú, Expediente, 1429-2002-HC/TC, paras. 13-15. (Translation by author).

30. See website of the Peruvian Minister of Health, available at: <http://www.minsa.gob.pe/portal/>.

31. For further examination of these mechanisms, see R. Castellon and L. J. Laplante, *Los Afectados por el Conflicto Armado Interno del Peru: Exigiendo el Derecho a la Salud Mental* (Lima, Peru: Consorcio de Investigaciones Económico y Social, 2005): Ch. 2. Available at: www.consorcio.org/observatorio.

32. M. Rivera, A. Reyes, and R. M. Cueto, *Ayacucho: Personas en una guerra, Apuntes desde salud mental* (Ayacucho, Peru: 2003). (On file with author).

33. The authors thank Jocelyn Getgen, Masters Candidate at Johns Hopkins Bloomberg School of Public Health, for providing assistance with this research. The archives mentioned are currently stored at the Information Center for Collective Memory and Human Rights of the Ombudsman's Office (*Centro de Información para la Memoria Colectiva y los Derechos Humanos*) in Lima, Peru.

34. For fuller discussion on the framework for analyzing the violation of the right to mental health, see L. J. Laplante and R. Castellon, "Expanding the Definition of the Right to Mental Health: Attending to Victims of Political Violence and Armed Conflict in Their Communities of Origin," *Essex Human Rights Review* 2/1 (2005): pp. 38-56.

35. The analysis in this section is based predominantly on interviews with local mental health professionals, representatives of the public health sector, and human rights professionals working with this population. While an exploration of these issues should be conducted in more depth with victims-survivors themselves, the observations of third party observers shed important light on some of the more subtle obstacles to a culture of rights with respect to health that run along a continuum and are interrelated.

36. See for example, S. E. Merry, "Rights Talk and the Experience of Law: Implementing Women's Human Rights to Protection from Violence," *Human Rights Quarterly* 25/2 (2003).

37. For a full discussion of the right to mental health, see Laplante and Castellon, *Expanding the Definition* (see note 33).

38. For example, I. Coral, who developed a program in reparations for survivors of the conflict for the Programa de Repoblamiento y Apoyo a Zonas de Emergencia (PAR) (Program of Repopulation and Development) of the Peruvian Minister of Woman and Development, indicated that she frequently received written requests for attention in mental health from the 163 victims organizations working with PAR. She said that the requests were based on complaints that their mental health problems prevented them from having a normal life. Personal Interview with I. Coral, current Director of Centro de Promoción y Desarrollo de la Mujer (CEPRODEP) (Center of Promotion and Development of Women), (Lima, Peru: September 9, 2004). (Transcript on file with authors).

39. Interview with D. Fernández, Coordinator of the Proyecto Fortalecimiento Institucional para la Protección de los Derechos Humanos en Salud (Institutional Strengthening for the Protection of Human Rights and Health Project), Peruvian Ombudsman's Office (Lima, Peru: September 27, 2004). (Transcript on file with authors).
40. Interview with M. E. Planas, Professor, University Cayetano Heredia (Lima, Peru) and civil society representative, Multi-Sectarian Committee of Mental Health of the National Council of Health of the Peruvian Minister of Health (Lima, Peru: October 12, 2004). (Transcript on file with authors).
41. For further discussion on the frequency of psychosomatic expressions of mental suffering observed in this population, see Theidon, *Entre Prójimos* (see note 8).
42. Interview with A. M. Rabasa, Executive Director, OXFAMPeru (Lima, Peru: September 14, 2004). (Transcript on file with authors).
43. Interview with Dr. A. Perales, Coordinator of the Masters in Bioethics of the Universidad Nacional Mayor de San Marcos (Lima, Peru: September 23, 2004). (Transcript on file with authors).
44. Interview with Sister Victoria, the Commission of Health of the Archdiocese in Ayacucho, Peru (Ayacucho, Peru: November 24, 2004). (Notes on file with authors).
45. D. Summerfield, "A critique of seven assumptions behind psychological trauma programmes in war-affected areas," *Social Science & Medicine* 48 (1999): pp. 1449-62.
46. Interview with Dr. D. Fernandez (see note 39).
47. For discussion see, Grupo de Trabajo de Salud Mental of the Coordinadora Nacional de Derechos Humanos, *Salud mental comunitaria en el Peru: Aportes temáticos para el trabajo con poblaciones* (Lima, Peru: AMARES, 2005).
48. Lecture Vivi Valz Gen (see note 17). Valz Gen's perspective follows a growing trend in Latin America to challenge traditional psychoanalytical approaches. See also N. C. Hollander, *Love in the Time of Hate: Liberation Psychology in Latin America* (New Brunswick, New Jersey: Rutgers University Press, 1997): p. 17.
49. I. Martín-Baró, "Toward a liberation psychology" in A. Aron and S. Corne (eds), *Writings for a Liberation Psychology* (New York: Harvard University Press, 1996): p. 125.
50. For discussion see, P. B. Hayner, *Unspeakable Truths: Confronting State Terror and Atrocity* (New York: Routledge, 2001); R. G. Teitel, "Transitional Justice Genealogy," *Harvard H. R. J.* 16 (2003): p. 69.
51. "Programa Integral de Reparaciones" in TRC, *Final Report* (see note 9): Vol. IX, sec. 2.2: 142-3. The TRC uses the framework of human rights to substantiate its legal arguments for reparations. Although the right to reparations exists within the framework of International Humanitarian Law (IHL) which applies during conflict, this argument was not used by the TRC, no doubt due to the fact that there was still controversy on whether to denominate the political violence in Peru as an internal conflict. This article focuses thus on the right to reparation within human rights law, although encourages further development of jurisprudence on

the right within international humanitarian law. For a full discussion on the right to reparations, see L. J. Laplante, "Bringing Effective Remedies Home: The Inter-American Human Rights System, Reparations and the Duty of Prevention," *Netherlands Human Rights Quarterly* 22 (2004): pp. 347-88, at 347, 351-61.

52. Here, the TRC invoked both national and international law. TRC, *PIR* (see note 50): pp. 141-2.

53. *Ibid.*: p. 157. (Translation by author).

54. Specifically related to health, PIR speaks of the need to respond to the "state of distrust, fear, insecurity, paralyses and pain generated by the violence." *Ibid.*: p. 168.

55. *Ibid.*: p. 146. However, the TRC makes clear that even if PIR alleviates some of these problems, it does not seek to resolve entirely the problems of poverty, exclusion, and inequality that arise out of economic and political structures, since these are problems that must be addressed through institutional reform and social development designed to "attack the roots of poverty and inequality" as recommended in other parts of the TRC Final Report. *Ibid.*: p.148. For further discussion see, Laplante, *On the Indivisibility* (see note 26).

56. See A. R. Chapman, "A 'Violations Approach' for Monitoring the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 18/1 (1996): pp. 23-66.

57. *Ibid.*

58. V. Gauri, "Social Rights and Economics Claims to Health Care and Education in Developing Countries," *World Bank Policy Research Working Paper 3006* (March 2003): p. 12.

59. *Ibid.*

60. R. D. Glass, "On Paulo Freire's Philosophy of Praxis and the Foundations of Liberation Education," *Educational Researcher* 30 (2001): pp. 15-25, at 15; Paulo Freire, *Pedagogy of the Oppressed* (New York: Seabury) 1970: pp. 12 & 21; and Martín-Baró, *Writings* (see note 49): p. 125.

61. Fletcher, "Violence and Social Repair" (see note 4): pp. 623, 633.

62. A. E. Yamin, "Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law," *Human Rights Quarterly* 18/2 (1996): pp. 398-438, at 402.

63. *Ibid.*

64. Sub-Commission on the Promotion and Protection of Human Rights, *The Social Forum: poverty, rural poverty and human rights*. Background note by the Office of the High Commissioner for Human Rights, U.N. Doc. E/CN.4/Sub.2/SF/2004/2 (23 June 2004).

65. According to a study conducted by Oxfam in Peru, during the two-year term of the TRC, 40% of the approximate 120 victims associations in Peru formed specifically to present their demands to the TRC, including mental health. R. P. Ruiz, *Mapeo De Las Organizaciones de Afectados por la Violencia Política en El Peru* (Lima, Peru: Oxfam, 2004): p. 33. (Working document on file with authors).

66. Author Laplante began observing ARIL in 2002, continuing until the present time of writing. Her observations of the group arise out of participant observation and from attending their weekly assembly meetings. In

addition, she has conducted in depth interviews with as well as surveys of its members. The results of this study can be found in Chapter 4 of Castellon and Laplante, *Los Afectados* (see note 31).

67. While ARIL's members reside in urban Lima, many come from the rural setting and/or share the types of characteristics described earlier in terms of their passivity in demanding their rights.

68. The Peruvian government began to implement reparations in health for members of ARIL following the work of a special commission whose recommendations preceded the TRC but which TRC folded into PIR. For more information see, Defensoría del Pueblo, *La Labor de La Comisión Ad-Hoc a Favor de los Inocentes en Prisión* (Lima, Peru: 2001).

69. *Loayza-Tamayo v. Perú*, Reparations, I/A Court H.R., Series C No. 42 (November 27, 1998).

70. Decreto Supremo No. 015-2006-SA, *El Peruano* (July 22, 2006): p. 325619.

71. Resolución Ministerial N° 591-2006-MINSA, *El Peruano* (June 29, 2006).

72. M. R. Garate, "Sensibilización del Personal de Salud Para la Atención de Casos de Violencia," in A. M. Guerrero (ed), *Derechos Humanos y Salud: Encontrando los Lazos* (Lima, Peru: 2002): pp. 74-6, at 74.

73. TRC, *PIR* (see note 50): p. 157.

74. *Ibid.* (Translation by author).

75. *Ibid.*: p.140.

76. General Comment No. 14 (see note 28): para. 11.

77. World Health Organization (WHO), *2001 World Health Report Mental Health: New Understanding, New Hope* (Geneva: WHO, 2001): p. 3. Available at: <http://www.who.int/whr/2001/en/>.

78. See for example, M. Minkler, and N. Wallerstein (eds), *Community-Based Participatory Research for Health* (San Francisco, California: Jossey-Bass, 2003).

79. *Ibid.*

80. E. Villar, "Empowering The Poor: The Politics of Health and Poverty Reduction Programmes," *Development* 47 /2 (2004): pp. 109 -14, at 110.

81. *Salud Sin Limites, Modelo de Atención de Parto con Adecuación Cultural* (2003). (Unpublished document on file with author).

82. A. E. Yamin, "Empowering Visions: Toward a Dialectical Pedagogy of Human Rights," *Human Rights Quarterly* 15 (1992): p. 653.

83. Only recently have local groups like ForoSalud, the Coalition of Health, the Peruvian Ombudsman's office and CarePeru, who have experience empowering grassroots rights movements in other areas of health, begun to examine the issue of mental health in this population in response to the recommendations made by the TRC. In fact, these various groups commissioned the study conducted by the authors that led to some of the observations being shared in this article for the purposes of informing their own development of programs on mental health, especially related to the victims-survivors of the war.

84. C. Hollander, *Love* (see note 48): p. 143.

85. Fletcher, "Violence and Social Repair" (see note 4): p. 633.

86. Yamin, *Defining Questions* (see note 62): pp. 425, 415.

87. TRC, *PIR* (see note 51): pp. 157, 170, 174.
88. Ibid: pp. 141, 157. (Translation by author).
89. TRC, *Hatun Willakuy* (see note 7): pp. 367-8. (Translation by author).
90. Personal Conversation with C. M. Beristain (Lima, Peru: March 25, 2005). (Notes on file with authors).
91. S. E. Alvarez, E. Dagnino, and A. Escobar, *Cultures of Politics, Politics of Cultures: Revisioning Latin American Social Movements* (Boulder, CO: Westview Press, 1998): p. 5.
92. Freire, *Pedagogy* (see note 60): pp. 12, 21.
93. Center for Economic and Social Rights, *Economic, Social and Cultural Rights: A Guide to the Legal Framework* (New York: CESR, 2002): p. 10.
94. A. E. Yamin, "EDHUCASALUD, Derechos Humanos y Salud: Encontrando los Lazos," in Guerrero, *Derechos Humanos y Salud* (see note 72): pp. 15-9, at 18.
95. P. Freire, *Teachers as Cultural Workers: Letters to Those Who Dare Teach* (Boulder, CO: Westview Press, 1998): pp. 50-1. (Translated by Donoldo Macedo, Dale Koike, and Alexandre Oliveira).
96. Ibid.
97. S. C. Wright, D. M. Taylor, and F. M. Moghaddam, "Responding to Membership in a Disadvantaged Group: From Acceptance to Collective Protest," *Journal of Personality and Social Psychology* 58 (1990): pp. 994-1003, at 995.
98. CESR, *Economic, Social and Cultural Rights* (see note 93): p. 11; A. G. García, "La Sociedad Civil y el Derecho a la Salud," in ForoSalud, *La Salud: Un Derecho para Todos* (Lima, Peru: 2003): pp. 80-5, at 85.
99. The Ottawa Charter for Health Promotion, First International Conference on Health Promotion, WHO/HPR/HEP/95.1 (November 21, 1986).
100. These types of civil society power struggles are not unique to Peru. See Alvarez et. al., *Cultures of Politics* (see note 91): p. 17.
101. J. Urrutia, former President of the Comisión Multisectorial de Alto Nivel Para la Seguimiento de las Recomendaciones de la Comisión de Verdad y Reconciliación, "Reconciliación y Democracia" (Conference convened by the Instituto de Democracia y Derechos Humanos and the Pontificia Universidad Católica del Perú, Lima, Peru Noviembre 30, 2004). (Notes on file with authors).
102. Yamin, *Defining Questions* (see note 62): p. 436.
103. Ibid: p. 432.
104. Freire, *Pedagogy* (see note 60).
105. Yamin, *Defining Questions* (see note 62): p. 413.
106. Martín-Baró, *Writings* (see note 49): pp. 215-6.
107. A. Mahtani, "The Right of Refugee Clients to an Appropriate and Ethical Psychological Service," *The International Journal of Human Rights* 7 (2003): pp. 40-57, at 51.