

CARE AS JUSTICE

Medical and psychosocial support as a response to North Korean human rights violations

KoreaFuture

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Care as Justice: Medical and psychosocial support as a response to North Korean human rights violations

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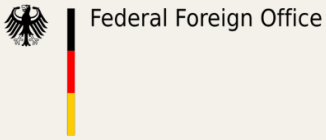

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Contents

EXECUTIVE SUMMARY 1
THE CASE FOR CARE AS PART OF JUSTICE 3
RESEARCH METHODS AND LIMITATIONS 5
WHAT SURVIVORS WANT FROM JUSTICE AND SUPPORT 6
WHEN CARE CAN CONTRIBUTE TO REPARATION 9
MAKING MEDICAL AND PSYCHOSOCIAL SUPPORT ACCESSIBLE 12
WHO SHOULD PROVIDE AND FUND SUPPORT 14
RECOMMENDATIONS FOR ORGANISATIONS AND FUNDERS 17
CONCLUSION 19

Executive Summary

Efforts to secure justice for North Korean human rights violations must address the harm survivors continue to experience, alongside the question of accountability for those responsible. This report examines whether medical and psychosocial support can provide a form of justice outside judicial proceedings and how it might help survivors who wish to participate in efforts to secure justice.[1]

The research draws on ten initial interviews with North Korean survivors and second-generation North Koreans, as well as counsellors and professionals providing organisational and community support within the diaspora. These interviews concern experiences in the two largest diasporas, the United Kingdom and the Republic of Korea, and were supported by follow-up interviews and consultations with four of the largest organisations that provide counselling or help survivors obtain medical care.

The central finding is that survivors value medical and psychosocial care as an outcome of justice in its own right when it responds to the continuing effects of violations and reflects their needs and wishes, whether or not it also helps them participate in efforts to secure accountability.

Realising that reparative purpose requires organisations and funders to recognise medical and psychological care among the outcomes of justice that survivors seek, while confronting the cost of providing it in a field already struggling financially. This cannot rest on an assumption that human rights organisations, counselling providers or community organisations can absorb additional costs within their existing budgets. One professional working between North Korean clients and counsellors explained that, once clients began counselling, they wanted regular appointments that the service's funding could not sustain.

International reparation principles recognise rehabilitation, including medical and psychological care, as a form of reparation, connecting assistance with acknowledgement of the violation that made it necessary. For the North Korean human

[1] In this report, medical support means healthcare to assess and treat physical or mental health problems, together with practical help to obtain that care, such as arranging appointments or meeting treatment costs. Psychosocial support means help with the emotional and social effects of harmful experiences. It includes counselling and support that helps people manage everyday life and maintain relationships.

rights field, this supports acknowledgement of a wider spectrum of justice responses, in which criminal proceedings and targeted human rights sanctions can be pursued alongside medical and psychosocial care. Giving care a substantive place among the outcomes sought would allow survivors' priorities to exert greater influence over what justice delivers in their lives.

Human rights organisations and governments should use this wider spectrum to guide the justice outcomes they pursue and the resources they commit to them. Integrating medical and psychosocial care would mean judging progress partly by whether survivors can obtain help for the consequences of violations, alongside advances in holding those responsible to account. It would also recognise that a survivor's decision to seek care without giving testimony can express a claim to justice that deserves a response.

The case for care as part of justice

For North Korean survivors living outside the Democratic People's Republic of Korea (DPRK), the pursuit of justice takes place alongside the continuing consequences of violations. The prospect of future accountability may matter deeply to someone whose health has been damaged, while offering little immediate assistance with the difficulties that injury creates. A credible account of justice must be able to explain what can be done about those difficulties now, without making the value of that response depend on whether the person contributes to an investigation, advocacy, or other justice intervention.

Korea Future's *A New Justice Framework* examined the outcomes that survivors and affected families associated with justice, including the importance they attached to recovering their health and rebuilding their lives. Its findings supported a broader understanding than is currently held of what a response to violations should accomplish.[2] This report develops the practical implications of that position by examining how medical and psychosocial support might acquire reparative value, and what organisations would need to undertake for people to obtain it.

The place of care within reparation is already recognised in international principles, and the case for connecting psychosocial support with North Korean human rights work has been made before.[3] The question requiring closer attention is how that connection should operate from the perspective of the person receiving support. For example, a human rights organisation may regard a referral of an interviewee as evidence that it has addressed someone's needs, although the person referred may still have no appointment or little understanding of what the service offers. Recognising care as part of justice therefore requires attention to what happens after an offer has been made.

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[2] Korea Future, A New Justice Framework: a guide for civil society and governments working on the Democratic People's Republic of Korea (2026), pp. 1–2 and 6–8.

[3] United Nations General Assembly, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, resolution 60/147, adopted 16 December 2005, annex, paras. 18 and 21. Elizabeth Salmón, Special Rapporteur on the situation of human rights in the Democratic People's Republic of Korea, Situation of human rights in the Democratic People's Republic of Korea, A/HRC/55/63, 26 March 2024, paras. 51, 55 and 58(a).

Care has a reparative purpose when it is offered in recognition of an injustice and directed towards the harm that follows from it, with the recipient involved in determining an appropriate response. Its value on those terms can endure independently of participation in traditional human rights documentation or advocacy. Someone who wishes to receive counselling without appearing publicly has expressed a preference about how they want their circumstances addressed, and that preference should inform the arrangement through which support is provided.

Consultations with service providers suggest that some useful arrangements can be built around care that already exists. They also show why cooperation requires more than knowing which organisations offer counselling, since providers differ in the needs they can address and their capacity to sustain a relationship. The relevant task is to establish whether available assistance fits the person's circumstances and to identify what help, if any, is needed to obtain it.

The resources required for this work form part of the proposal from the outset. Small human rights organisations may have grants that cover documentation or advocacy that engages survivors without providing for continuing support, and a recommendation cannot reasonably assume that additional funding will follow merely because the need has been recognised. Even cooperation with an independently funded provider involves work that somebody must undertake, and that work will often be unpaid. A defensible allocation of responsibility must therefore distinguish commitments an organisation can meet through its existing activities and funding from provision that depends on resources it does not control.

The report uses the interviews and consultations to examine that allocation, while keeping their evidential limits in view. These accounts explain experiences of seeking help and participating in human rights work, but they do not measure the effects of treatment or establish that care produces greater participation. Their contribution is to clarify what a credible offer of support would entail, allowing recommendations to be judged against what survivors could actually receive and what the institutions involved can reasonably promise.

Research methods and limitations

This report draws on an initial set of ten interviews, supplemented by follow-up interviews that examine particular experiences in greater depth. Participants included North Korean survivors and members of affected families, alongside people whose work involves providing care or helping others obtain it. Their accounts concern experiences in the United Kingdom and the Republic of Korea, where the circumstances of settlement and the services available differ. These differences inform the analysis without providing a basis for judging either country's system as a whole.

Consultations with service providers supply additional evidence about how assistance is organised and the difficulties encountered in connecting people with it. Published research and *A New Justice Framework* provide context for interpreting the accounts, while international reparation principles inform the assessment of their implications for justice. These sources serve different purposes within the argument.

The interviews addressed what people wanted from a response to violations and how their experiences of seeking assistance shaped those expectations. Follow-up interviews examined the relationship between participation in human rights work and the support participants understood themselves to have been offered. They also considered whether describing care as a response to injustice changed its significance for the person receiving it. Where that possibility arose only after reparation had been explained, we treat the response as a reaction to the proposal, without implying that the participant had previously understood care in those terms.

The evidence supports conclusions about reported needs and obstacles to obtaining assistance, with recommendations directed towards the responsibilities those experiences reveal. It does not establish the prevalence of a particular difficulty across North Korean communities or measure whether treatment increases participation in justice. The argument for care's reparative value therefore rests on its proposed response to continuing harm, informed by participants' own accounts of what they would find useful.

What survivors want from justice and support

The interviews place the continuing consequences of violations at the centre of what a response should accomplish, including where a survivor has no wish to give evidence in a formal judicial process. Participants described needs that could be addressed through care, alongside demands that required other forms of assistance or a change in how organisations treated them. Their accounts strongly support a place for medical and psychosocial support within justice, while requiring the purpose of that support to be defined by the person's circumstances.

One survivor described an arm that had been broken during forced labour and had healed without appropriate treatment, leaving her in pain and restricting the work she could obtain. She linked that restriction to her reliance on prostitution for income, which she wanted to leave but felt unable to replace with another livelihood. Although the appropriate treatment would require clinical assessment, the connection she drew between the original violation and her present need was direct. She described treatment as "repair" because it would address damage and injustice she still lived with. Her account suggests that a response to the harm she described should also consider assistance with finding another livelihood, if she wanted it, since treatment cannot be assumed to remove the economic constraints she faced.

Her account also demonstrates why the availability of counselling cannot be taken as evidence that suitable support has been received. She reported that counsellors had questioned her account of exploitation and spoken as though the circumstances she described had been freely chosen, after which she no longer wished to confide in them. She nevertheless remained open to counselling from someone who understood trafficking and sexual violence, with a clear preference for a woman practitioner. Her criticism concerned the care she had encountered, rather than a rejection of psychological support in principle.

Another survivor described disturbed sleep and a continuing expectation of danger despite knowing that he was safe in the Republic of Korea. He had no wish to attend court or engage with the United Nations, yet welcomed the possibility that support could address the consequences of what the DPRK had done to him. When asked about care as a form of repair, he explained that "if medical or psychosocial support is a form of repair in itself, then that would be my justice". His answer gives a clear basis for treating care as valuable independently of further participation, because the outcome he sought concerned his own life.

The relationship between care and participation was different for a survivor who described continuing trauma associated with experiences in childhood. She regarded feeling safe and psychologically supported as important to being able to share her experiences, and wanted her violations to be more widely publicised. Her account supports the possibility that care could help someone pursue a justice activity they value, while the previous account makes clear that the same expectation cannot be imposed on everyone. Neither participant had prior experience of the justice activities discussed, so their answers express preferences and anticipated needs rather than demonstrated effects of support on participation.

For some interviewees, the reparative significance of care emerged only when that possibility was explained. One participant welcomed the idea that justice could involve restoring wellbeing, provided that receiving assistance did not require a public appearance or involvement in a human rights organisation's work. Their description of this possibility as "real justice" conveyed the importance of obtaining something tangible in response to the consequences of an injustice. It was a response to an idea introduced during the discussion, which suggests that a person's initial understanding of justice may not encompass every outcome they would value.

Other accounts require us to distinguish the harm for which someone seeks care from the way an organisation responds to a request for assistance. One participant described engaging with a civil society organisation and public representatives in the hope of finding a sister who had been arrested in China. They understood that help had been promised, but reported receiving no replies when they later sought information about what had been done. A subsequent invitation to speak publicly intensified their feeling that their account was useful to others while their own purpose in giving it had been neglected.

That participant already received counselling and would have welcomed help meeting its cost, without wanting an organisation to establish a new service. They also made a connected demand to be paid fairly for participation, describing a previous payment for an interview as useful in helping meet the costs of counselling. This request has a distinct meaning within the analysis. A contribution towards treatment costs would help sustain care, but would not by itself amount to full reparation for the original violations.

Another account challenges an assumption that discussing painful experiences is necessarily the principal difficulty survivors encounter in human rights work. The participant described hardship and distress as features of daily life and did not regard

the interviews as exceptionally troubling against that background. What they wanted from the interviewer was an attentive, unhurried encounter in which their feelings were taken seriously. Their account sits alongside explanations from counsellors who explained that some clients experienced distress after interviews that made continuing care more difficult. These experiences concern different people and give grounds for responding to individual needs, rather than assuming that testimony has a uniform emotional effect.

The participant seeking help for their sister also explained why the ability to stop an interview did not feel straightforward. They believed that the organisation needed information from them and that they needed the organisation's assistance, leaving something at stake if the exchange ended. They explicitly rejected describing this as pressure and understood it as the reality of the situation. Respecting that interpretation still leaves a question about how expectations of assistance affect a person's choices, particularly when the organisation has not clearly defined what it can deliver.

The family interviews further limit any account that makes psychological injury the defining feature of North Korean identity. One participant described her mother's experience as a source of determination and responsibility, while objecting to the pity directed towards North Koreans and identifying scholarships as a useful form of support. Another described the emotional effects of family history and the importance of security in her own life, including the prospect of a stable home. She also understood her mother's resilience as something that had helped her. These accounts allow harm and strength to be recognised together without presuming that the experiences of an older generation determine the needs of their descendants.

Taken together, the interviews require a response that begins with an intelligible account of what assistance could offer and allows the person concerned to judge its relevance. Medical and psychosocial support acquire their value within this process through the harm they can address and the purposes they serve for the recipient, which may have little connection with what an organisation hopes that person will contribute.

When care can contribute to reparation

Describing care as reparative makes a claim about why it is being provided and how it responds to a wrong. Treatment may address an injury regardless of the circumstances in which it arose, while a reparative approach also recognises the connection between that injury and a violation of the person's rights. This connection matters to the interviews examined here because some participants understood their present needs as consequences of what had been done to them, and wanted those consequences addressed as part of justice.

The international framework provides a basis for that understanding. The United Nations Basic Principles and Guidelines on the Right to a Remedy and Reparation recognise rehabilitation among the forms of reparation for gross human rights violations, expressly including medical and psychological care. They situate rehabilitation within a wider response to harm, so the provision of treatment cannot be assumed to settle every claim arising from a violation.[4]

For victims of torture, the Committee against Torture's interpretation of the Convention makes clear that access to rehabilitation should not depend on pursuing judicial remedies.[5] It also recognises that states parties may meet rehabilitation obligations through services they fund, including those administered by civil society organisations. A civil society organisation can therefore provide care as part of a reparations arrangement, although assistance it funds independently does not, by itself, show that a state has fulfilled its obligations.

For the arrangements proposed in this report, the term "reparative value" describes the contribution that support may make when it is deliberately directed towards the consequences of a recognised injustice. This permits organisations to act on needs they can help address without claiming to provide a complete remedy. It also requires accuracy about what has been accomplished, since an offer of assistance by a civil society organisation may express a reparative intention while leaving the survivor's

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[4] United Nations General Assembly, Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, resolution 60/147, adopted 16 December 2005, annex, paras. 18 and 21.
[5] United Nations Committee against Torture, General comment No. 3 (2012): Implementation of article 14 by States parties, CAT/C/GC/3, 13 December 2012, paras. 15 and 37.

circumstances unchanged. The claim becomes more substantial when the offer results in appropriate support that the survivor can use.

Recognition within such an arrangement need not require public disclosure. The participant who welcomed care while rejecting public appearances identified a condition under which assistance would be acceptable, and there is no reason for an organisation to make recognition of their experience depend on abandoning that preference. A service can explain privately that it is responding to harm associated with a violation. It should ask for information needed to establish eligibility and arrange suitable assistance, while distinguishing those purposes from collecting material for an investigation or publication.

The language of reparation should also remain available for the recipient to accept or decline. Some interviewees found that language useful because it connected their present difficulties with an injustice for which they had received little response, but this does not establish that every person seeking care will want to understand it in the same way. An organisation can explain why it regards its work as reparative without requiring recipients to adopt that interpretation or present themselves publicly as victims. Otherwise, a framework intended to recognise the person's experience would begin prescribing how that experience must be understood.

Independence from testimony must be reflected in the terms on which support is offered. One counsellor interviewed for this report explicitly separated the purpose of care from making someone more willing to provide evidence, and maintained that a decision to stop participating should leave access to counselling intact. That position accords with the survivor accounts in which support was valued for what it could change in daily life. It means that refusal of an interview, or disagreement with an organisation about advocacy, should not become a reason for withdrawing assistance offered to address continuing harm.

This principle does not imply an unlimited commitment to treatment. Available resources and professional assessment will affect what a service can provide, and those limits should be explained when assistance is offered. A defined period of support with an agreed review has a different basis from support that ends because an organisation has obtained the testimony it wanted. The distinction concerns the reason for the decision and whether it is consistent with the purpose represented to the recipient.

Where clinical treatment is involved, decisions about its content must remain with the appropriately qualified provider in consultation with the person receiving it. A

civil society organisation's role in arranging or funding care does not give it a general entitlement to counselling information, nor should it allow the organisation's documentation priorities to determine treatment. A survivor may wish to connect aspects of their care with a justice process, but that requires a specific agreement about what information is needed and how it will be used. Receiving care should expand the person's choices without placing their private life under the direction of another institution.

A reparative purpose also requires an honest account of what care can achieve. One practitioner described frustration where clients expected a definite improvement and practitioners understood counselling as a process with uncertain results. Presenting treatment as justice would make that disagreement more serious if the description were understood as a promise that the harm would be reversed. Providers should explain the intended contribution of support and give the recipient opportunities to review whether it remains useful, without making recovery a condition that the person must satisfy to demonstrate the programme's success.

Receiving assistance must likewise leave room for other demands arising from the violation. Someone may value counselling while continuing to seek information about a missing relative, and accepting treatment does not mean that they regard the wider response to their experience as adequate. The interviewee's phrase "real justice" expresses the appeal of obtaining something tangible, but it should not be used to suggest that care exhausts what justice could require. Its significance lies in identifying a response that matters now while other claims remain unresolved.

A credible reparative approach therefore connects recognition of the wrong with assistance that has a defensible prospect of addressing its consequences. Its legitimacy depends partly on the recipient's freedom to shape that response and partly on the provider's honesty about what is available. These considerations direct attention to the practical arrangements through which support is obtained, because the language of reparation can strengthen an offer's significance only if the commitments attached to it can be kept.

Making medical and psychosocial support accessible

An offer of support becomes useful when the person receiving it understands what is available and can obtain assistance that responds to their circumstances. The intermediary interviewed for this report described a difficulty that could persist even when clients and counsellors spoke the same language. Some clients expected counselling to produce a definite improvement or provide direct advice about their lives, while practitioners understood their role differently and could promise neither outcome. Explaining the service more clearly may help, although explanation alone cannot make a service appropriate for someone seeking a different kind of assistance.

This account places a responsibility on providers to make their work intelligible without treating acceptance of counselling as the required outcome of the conversation. Someone needs to understand what an appointment involves and have an opportunity to explain what they hope it will accomplish. Where those expectations cannot be met, that difference should inform the response. A person seeking practical help should not have to accept psychological treatment as the nearest available substitute.

One participant described a reluctance to seek counselling because of embarrassment or concern that others would find out. In those circumstances, advertising a service's availability leaves an important obstacle unresolved. Information about confidentiality needs to explain how someone can make contact and who will know that they have done so, including any relevant limits on privacy. The purpose is to allow an informed decision about seeking help, with room for someone to decline without their choice being treated as a failure to understand their own needs.

Medical support raises related questions about whether a service can be used effectively. In one consultation, a participant described accompanying North Korean women to hospital because unfamiliar terminology made it difficult to understand diagnoses and medicines. Their account shows how speaking the same language can coexist with substantial difficulty obtaining useful information from an appointment. Assistance with that communication may be a necessary part of access, depending on what the person wants and can manage independently.

The suitability of a referral also depends on the extent of support a provider can offer. Another participant explained that emergency priorities could limit continuing assistance for people presenting with historical and complex harm, even where initial counselling was available. This account concerned the particular service described and

does not establish a general exclusion rule. It nevertheless identifies a distinction that a referring organisation needs to understand, because acceptance for an initial conversation does not establish that longer support will follow.

Continuity was a concern in the interviews, including an intermediary's account of clients wanting regular appointments that the funding model could not sustain. Some providers suggested how continuation might be considered from the outset. One service described free counselling for North Korean clients, with an initial allocation of sessions followed by reassessment and possible extension. Another service offered the use of remote appointments for clients living at a distance and the possibility of referring someone to a nearer service.

Published research reinforces the importance of the relationship through which support is provided.[6] In their qualitative study of eight North Korean women, Shin, Kim, and Song found that greater awareness of mental health did not necessarily result in obtaining care. One participant valued assistance from a provider's staff but described repeated staff departures and the absence of an enduring relationship. This account suggests that continuity concerns the people involved as well as the number of appointments offered.

Existing relationships also matter when someone already receives care they wish to continue. The survivor who requested help paying for their own counsellor identified a specific obstacle to sustaining an arrangement they valued. Where funding permits assistance with those costs, that possibility deserves consideration before another service is proposed. An organisation should establish what help is being requested without assuming that its contribution must take the form of a new referral.

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[6] Jee Soo Shin, Myeong Hee Kim and In Han Song, 'Qualitative study on the changes in mental health perceptions among female North Korean defectors in South Korea', Mental Health & Social Work, 50(3) (2022), pp. 77–99, especially pp. 83–85 and 91–92, doi:10.24301/MHSW.2022.09.50.3.77.

Who should provide and fund support

A recommendation to make care part of justice is incomplete unless it identifies who will undertake the work and how its costs will be met. For a small human rights organisation operating through restricted grants, a responsibility to arrange continuing support may arrive without any provision for the staff time involved. The recommendations in this report therefore proceed on the assumption that additional funding may remain unavailable, requiring decisions about what can be achieved within existing resources and what must remain beyond reach.

The intermediary interviewed for this report favoured continuing cooperation between human rights organisations and care providers with their own sources of funding. Their proposal recognised that the organisations performed different functions and could draw on funders interested in different outcomes. This offers a plausible basis for cooperation where suitable services already exist, although it cannot create appointments or treatment capacity that a provider does not have. A partnership acquires practical value through the assistance it makes obtainable, rather than through the existence of an agreement between organisations.

Human rights organisations should begin with responsibilities arising from their own conduct. They determine what they ask of participants and how they describe the likely results of participation, and should remain answerable for commitments made in that process. An organisation that cannot help locate a missing relative must make that limitation clear before someone participates in the expectation of such assistance. Where it agrees to make enquiries, it should define the undertaking and provide a response about what happened, including when the enquiry produces no useful result.

These responsibilities require time that should be included in the planned activity. A project budget that covers conducting interviews but leaves no capacity to answer subsequent enquiries makes dependable follow-ups difficult from the outset. The response should be to account for that work when agreeing the scope of the project, including the period after the last interview has taken place. Staff should not be expected to sustain commitments indefinitely through work that the organisation has neither budgeted nor assigned.

Cooperation with care providers should be proportionate to the organisations involved. A working relationship can begin with a named contact and an agreed way of establishing whether a proposed referral is appropriate. The provider should explain its

capacity and the information it needs, while the referring organisation should establish what assistance the person wants with making contact. This does not require every human rights organisation to build a clinical service or maintain its own extensive directory, particularly where another organisation already has the relevant expertise.

The costs of participation also deserve an explicit place in project decisions. The interviewee who demanded fair payment raised a question about the value of their contribution, alongside the financial difficulty of continuing counselling. A budget that recognises staff time while assuming participants can contribute theirs without consequence leaves that question unanswered. Organisations should adopt a clear approach to payment for time and reimbursement of expenses, with the terms explained before participation and no connection between the amount paid and the content of the account. Where resources limit what can be offered, those limits should be disclosed without presenting unpaid participation as inherently more credible.

Funders have a direct role in making these arrangements feasible. Where an existing grant finances documentation, a justified change to its budget may allow some resources to support the work required around participation. That change may also require a reduction in planned outputs, and the funder should assess whether the revised scope better reflects what responsible delivery entails. Requiring the original volume of activity while adding substantial support obligations leaves the organisation with a commitment that will become more expensive without becoming better resourced.

This argument does not assume that flexibility within existing grants will resolve every gap. Some budgets will be too small, while some required services will remain inaccessible even where an organisation can pay for help making a referral. In those circumstances, the proposed activity should be reconsidered in light of the particular person's needs and wishes. A necessary form of assistance that cannot be secured may require a change in the activity's scope or timing, rather than an assurance that support will somehow be found afterwards.

An absence of funded counselling should not, by itself, become a reason to exclude someone from human rights work. The interviews included survivors who did not experience participation as exceptionally distressing and whose concerns lay elsewhere. Requiring every participant to receive psychological care would disregard those accounts and risk making treatment a condition of having one's experience heard. Decisions about support must therefore remain responsive to the person and the proposed activity, with professional advice sought where the circumstances require it.

Care providers, in turn, need an accurate account of what cooperation is expected to involve. Accepting referrals from a human rights organisation should not carry an unstated obligation to absorb unlimited demand, particularly where the provider already works within a restricted service budget. The parties should agree the commitments each can sustain and review them when capacity changes. Any limits on continuing care should be explained to the recipient, while withdrawal from testimony or advocacy should remain separate from decisions about treatment.

Where provision remains inadequate, the unmet need should remain visible in assessments of the work. An organisation can accurately report that it identified a need or helped someone seek assistance without claiming that care was received. Funders should be prepared to consider those gaps alongside the activities completed, since a record of referrals alone cannot show whether the intended support became available. This allows responsibility to be examined at the level where decisions about resources are made, while keeping an organisation’s promises within the work it can undertake.

Recommendations for organisations and funders

The interviews justify requiring organisations to account for the support they promise, while the funding constraints require those promises to remain within what they can deliver. The following recommendations should be reflected in the design and funding of activities involving survivors, with responsibility agreed before commitments are made to participants.

1. Human rights organisations should define what participation can achieve and remain answerable for any assistance they undertake to provide. An invitation to give testimony should explain the organisation's purpose and the limits of the outcomes it can influence. Where a participant seeks help with a particular problem, the organisation should clarify whether it is accepting that request and what action it can undertake. Any commitment should have an agreed means of follow-up, including a response when enquiries produce no useful result.
2. Care offered on reparative grounds should remain independent of a person's willingness to contribute to documentation or advocacy. Organisations and providers should explain this separation when assistance is offered, so that declining an interview or withdrawing from public activities does not become a reason for losing support. The duration of care should be governed by the provider's assessment and the funding limits communicated to the recipient. Decisions about treatment should remain with appropriately qualified professionals in consultation with the person concerned, with specific agreement governing any information shared for a justice process.
3. Referral arrangements should establish whether suitable assistance can actually be obtained. Before presenting a service as an available source of help, the referring organisation should confirm that the provider can consider the person's circumstances and explain the likely limits of provision. Existing care that the person wishes to continue should be considered when deciding what assistance would be useful, including where the request concerns its cost. These arrangements should be proportionate to the organisations' capacity and should draw on existing services where they are suitable. Funders should support training on sexual violence where needed, while referrals should match practitioners' expertise with survivors' needs and preferences.
4. Organisations and funders should include the costs of responsible participation when agreeing budgets and outputs. This should encompass the staff time needed to honour commitments, alongside a clear policy on

payment for participants' time and reimbursement of expenses. Payment terms should be explained in advance and should not vary according to the substance or perceived usefulness of testimony. Where support requires a change to an existing grant, funders should consider a justified reallocation of resources and accept a corresponding reduction in outputs where necessary. A requirement to provide additional support should come with an explicit decision about how its costs will be met.

5. Projects should distinguish offers of assistance from support received and report material gaps in provision. With the person's agreement, a follow-up should establish whether the assistance offered became obtainable and whether further action falls within the commitments already made. A decision against receiving care should be recorded as a choice, rather than automatically treated as a failure of the programme. Where support remains unavailable, reporting should identify the obstacle without implying that making a referral resolved it. Funders should assess these results alongside documentation outputs, including cases in which care was obtained and the recipient chose no further participation in human rights work.

Conclusion

The interviews give grounds for recognising appropriate medical and psychosocial care as an outcome of justice because some participants understood the help they wanted as a response to violations whose consequences remained part of their lives. Taking those accounts seriously would give care a substantive place among the justice outcomes sought by human rights organisations and governments, while preserving survivors' ability to pursue other forms of redress.

For organisations offering care on this basis, the responsibility is to establish what a person can actually obtain and explain the limits before making a commitment. Existing services may provide suitable support, although their capacity to respond will depend on the resources available as well as the person's circumstances. Funders therefore need to allow for these costs within grants or agree changes to the work, since small organisations cannot reasonably be expected to absorb new responsibilities their funding does not cover. Where assistance remains unavailable, survivors should be told plainly, and their unmet needs should remain part of the assessment of what the response to injustice has achieved.

The research does not establish that receiving care increases participation in more formal justice processes, and organisations should not need that result to justify helping someone address the harm they continue to experience. A survivor who receives useful support and chooses no further involvement in human rights work or formal justice may have obtained precisely the response they wanted, and recognising that outcome would give their understanding of justice a consequence in how the field judges its own work.