ARMED CONFLICT, VIOLENCE AGAINST WOMEN AND RIGHT TO HEALTH

Consultation with Health Professionals and State Women's Commission from Kashmir

15th-17th April, 2011

A Report

Between 15th-17thApril 2011, CEHAT organized a consultation with a team of health professionals and State Women's Commission, a total of nine participants from Kashmir. It was organized in continuation of our successful three day training programme in Delhi on "Responding to Violence against Women: Role of Health Care Providers, December 2010" with participation from Kashmir, Manipur, Jharkhand, Chhattisgarh and Maharashtra. Two of the key highlights of the training were: the absence of counselling services, especially for women in Kashmir given the nature and scale of violence and; the denied right of conflict affected populations to undisrupted- affordable- quality health care.

Aim of this consultation was to facilitate an exchange of experiences, learning, challenges and workable solutions associated with work on violence against women (VAW) and to deliberate on practical ways of engaging with Right to Health in situations of Armed Conflict. Consultation used a combination of presentations made by resource persons and participants, discussions and an exposure visit to DILAASA, Crisis Intervention Center for Women, K.B Bhaba Hospital, Mumbai[1]. Although there were main speakers for each of the themes, the sessions were highly interactive with ample debates and discussions.

Consultation was begun with participants spending an entire day at Bhaba hospital interacting with Health care Providers, Dilaasa staff and Training Cell[2] members who have been engaged with the issue of violence against women for several

[1] Dilaasa was set up in 2001 in K.B Bhaba hospital, bandra (as a collaboration between Municipal Corporation of Greater Mumbai and CEHAT with the aim of equipping the public health system to respond to the issue of " domestic violence". The venture has been replicated in K.B Bhaba hospital in Kurla, Cooper Hospital, Vile Parle and Rajawadi Hospital, Ghatkopar and M.T Agarwal Hospital, Mulund .

[2] Training Cell is a team of 40 health professionals across MCGM who are engaged in equipping health professionals with skills required to respond to the issue of Domestic violence. They provide regular trainings to across the five hospitals.

years. Participants were taken around the hospital and to Dilaasa to familiarize them with the setup in which the center is placed. An interaction with the Medical Superintendent, Dr Seema Malik followed, which provided an insight into the challenging process of establishing and maintaining such a center in a public hospital in a politically diverse city with a huge space constraint[3]. Dr Seema, a gynecologist has been a driving force behind the center whose motivation to work on this issue as a HCP emerged from her own experiences with women in her practice. A more detailed account of the functioning, day to day maintenance and challenges, was provided by Dilaasa team and training cell members. Sangeeta Rege who has been associated with the centre ever since it was established, introduced the group to the institutional structure of Dilaasa along with roles and responsibilities of those involved and an overview of the center's work so far. Guiding principles of maintaining confidentiality, being non-judgmental, and respecting the survivors decision to file legal complaints were reiterated.

Constant inputs were made by the participants in the form of questions, comments and constructive argumentation. Presence of a psychiatrist from Kashmir could bring out the debates on including psychiatric care[4] as part of the health response to survivors. It was further revealed that at present there are a total of 16 psychiatrists practicing in Kashmir, all concentrated in the capital city of Srinagar. Counsellors are usually not trained and there is a dearth of female counselors especially. There are no psychosocial services available in the peripheries and access to the city is constrained with movement restrictions arising out of instability.

It was recognized, that under such conditions, the first contact; who is usually the nurse needs to be sensitive towards the issue of VAW. If she is equipped with skills for screening the women facing violence and providing them with immediate support, much of the damage will be curtailed in terms of health consequences. A need to develop a tool for psychiatric evaluation of survivors to be used by counselors was discussed.

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[3] For more details on the process of establishing Dilaasa, please refer to our free publication on "Establishing Dilaasa, Documenting Challenges" which is available on order.

[4] An attempt is being made on the part of Dilaasa team to encourage psychiatrists to provide feminist counseling to survivors alongside an evaluation of their mental status. CEHAT has recently launched a national course on feminist counseling inviting counselors, psychiatrists, social workers and others.

Another important aspect that emerged was the need for care of caregivers especially in situations of conflict which affect health care providers as well.

Scope of CEHAT's work on violence against women has expanded from domestic violence to include sexual violence. Development of Sexual Assault Forensic Examination Kit (Safe Kit) which has been endorsed by the WHO, was a step in this direction. Dr Anita made a presentation on a comprehensive health care response to sexual assault including the use of SAFE KIT and its limitations. Doctors from Kashmir revealed that in the peripheral areas, close to the border, they are receiving 2-3 cases of sexual assault in each OPD as MLC cases. They reach them 2-3 days after the assault, seriously affecting the quality of evidence that can be collected. There are no forensic laboratories in such areas. Most of the cases involve the Security Forces; doctors conducting examination are pressurized to not produce findings that confirm assault. Even in cases, where doctors have confirmed rape, police and security forces have tended to resolve the matter among themselves, consenting to a certain amount of compensation to be paid to the survivor. This leads to frustration among the doctors who feel incapacitated by such incidents.

On the second day, Mr Amar Jesani, founder member of CEHAT and a pioneer in medical ethics and health research interacted with the group. His session touched upon the moral and ethical debates surrounding the role of health professionals extending beyond mere provision of medical treatment. Dr Binayak Sen's conviction was a topic of constant debate and discussions. One of the principles in medicine, provision of care to all or principle to maintain neutrality becomes highly problematic in conflict situations. Providing care to the non-state armed groups was a major ground for Dr Binayak's conviction and the question that was raised in the session was should doctors provide care to militants in Kashmir and should they ask for identification when an injured person has approached them? Participants shared incidents of arrest of doctors who were suspected to have provided care to militants. In principle a doctor must provide care to all and the reason that this is not practiced is because the medical profession has lost its independence. Dr. Binayak's bail resulted from the pressure that was built up by the civil society including medical professionals. There is a need for medical profession to be independent of any political influences. Medical professionals

nationwide, including especially those from conflict zones, have to collaborate to form a support network that upholds principles/ethics of medicine no matter what the situation. Not an individualistic but a professional structure is required. Participants with not much difficulty instantly associated Dr. Binayak's case to that of a doctor who first gave positive findings for rape in Shopian rape case 2009[5]. In this case however, in the absence of any civil society support, she has been suspended ever since and is likely to be terminated from service. Other personal experiences of having faced such a dilemma of choosing between ethics and one's own safety/security, were shared, wherein doctors confessed, not everyone is a Binanyak Sen. Throughout the session, the sense was that the task of performing one's ethical and moral responsibility is highly daunting and life threatening to health care providers in conflict situations. Armed Forces Special Powers act among other things provides for interrogation of any civilians including doctors. There is another major role conflict that arises in the case of Kashmir HCPS. While they have a loyalty towards patients, most are government servants[6], private sector is negligible and isn't strong enough for the purpose of lobbying. Rising against the state is seldom possible. A number of cases were shared wherein doctors under pressure by the police had to provide information about a patient suspected to be a militant which violates the patient's right to confidentiality.

The last point that was discussed in Dr. Amar's session emerged from the principle of non-discrimination on the basis of caste, class, region, religion, language and gender. There is a fine line between the personal and professional and health care providers find it challenging to follow such a distinction. On the question of medical ethics, participants were left with the thought that for how long and to what extent can health care providers allow their personal beliefs such as those of religion, to function in their professional practice of medicine. Religious beliefs can be used both in favour and against science of logic. For instance in the case of suicide attempts, doctors shared that the instant response to such a case was "why are you doing this, do you not know that this is a sin"?

[5] Alleged abduction, rape and murder of two women from Shopian district of Kashmir region, by the security forces in 2009. The case remains unresolved even after a series of investigations and inquiries including an inquiry by the CBI which ruled out rape and stated drowning as the cause of death.

[6] As per the law, state health professionals have to provide information to the police while the private sector is not obligated to do so.

In continuation with the thought process initiated in Dr. Amar's session, Mr Anand Grover, UN Rapporteur for Health Rights focused on the right to health framework in the international and national context. This framework provides all humans everywhere a right to best achievable standards of health care. The objective was to identify the ways in which this framework can be applied in conflict situations. At the outset, he clearly declared that the AFSPA is a draconian act and needs to be revoked. Legal rights were also discussed. He encouraged the participants to write to him about violations of health rights which was welcomed by them, but not without initial hesitation.

Post his session, HCPs from Kashmir and member secretary of State Women's Commission spoke about the Kashmir context. Conflict in Kashmir has affected all spheres of life having social, economic and political implications. Women have been the victims of different forms of violence at the hands of state and non state actors. Other than this, cases of domestic violence are increasing. At present State Women's Commission in Kashmir is handling 4000 such cases. Stigma associated with violence against women especially sexual violence and domestic violence remains a constant problem in reporting of such cases. Alcohol consumption and Drug Addiction are increasing rapidly. The latter is found to be increasing among females as well. A drug de-addiction center has been functioning in Srinagar for several years and as of today treatment for a new patient is waitlisted for three months.

In terms of health issues, deterioration of mental health was raised as a serious concern with a stark rise reported in the number suicidal attempts (99% women), PTSD and other depressive disorders. There has been no comprehensive research to look at the impact of recent violence in the valley. The most recent study was by MSF on Violence and Health, 2005. Meanwhile, several small initiatives are being undertaken such as establishing a stress management center with 24*7 helplines and counselors available and; counseling of women by doctors themselves in their personal capacity.

In terms of physical health, with curfews being a common phenomena, health access is constrained. This was illustrated by taking last year's example- 2010 protests marked by stone pelting. Several problems were encountered in health

care provision in terms of shortage of supplies and serious restrictions on movement. It was expressed that more people died as a result of non availability of services as opposed to direct deaths associated with violence. Although ambulances were allowed to ply, they had to stop at several check points and many a times were attacked by the stone-pelters. In addition, there is virtually no evidence linking the general health or morbidity rates to the protracted conflict, despite a situation where access to facilities having specialized care is highly restricted due to concentration of such facilities in the city. Impact on nutrition and child development is completely unknown.

On the last day, Dr Jagdeesh spoke more about some of the issues that were raised in the Delhi programme as well as on the previous days regarding the legal rights and role of health care providers in conflict situation such as that in Kashmir. He took up the Shopian rape case in detail expressing dissatisfaction with the files that he reviewed for the same. He shared that many things about the case remained ambiguous to this day despite numerous inquiries into the matter. For instance, he couldn't find the original findings given by the doctor.

A measure to protect oneself from such situations as permitted by law, he reiterated, is to make multiple copies of the report prepared by concerned doctor to safeguard against attempts at tampering of evidence. A doctor shared that she has begun keeping multiple copies of her findings and has urged her colleagues to do the same. She narrated a personal experience of harassment by the legal authorities in a case in which she gave positive findings for a rape examination despite being told not to do so by the police as the case involved the Security Forces. She was labeled to have accepted bribes by the survivor's family and was asked humiliating questions in court. The matter went unresolved to the extent that another doctor who was commissioned to conduct the examination too was accused of taking a bribe for confirming her findings. It was only after a third doctor from a major hospital in capital city of Srinagar too confirmed the findings that the case was resolved. Dr. Amar added to this experience stating that such cases can be found in many areas such as, the Gadchiroli district of Maharashtra, affected by Maoist insurgency.

Overall, this programme allowed for diverse issues and concerns surrounding right to health in an armed conflict, to be heard, discussed and debated. Through such an interaction the sense of injustice that participants had experienced and witnessed in their professional and personal lives, could be seen as channelizing towards action. As part of future planning, they identified a need to form a support group that will work towards addressing issues that emerged, such as initiating counseling services, training of health care providers on the issue of VAW and training for conducting autopsy and act as a lobby to provide protection to health professionals from external pressures/politics. They will be meeting soon to formulate their agenda and plan of action. CEHAT has extended its support in terms of research, training, capacity building and generation of funds.