

# Negotiating reproductive health needs in a conflict situation in the Kashmir Valley

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# Executive summary

Kashmir has been in conflict with the Government of India over the issue of an independent state for the last 16 years. The years of turmoil have resulted in a breakdown of the state machinery, especially the health infrastructure. This breakdown is more visible in the villages, where development has come to a grinding halt.

Kashmir has tough mountainous terrain that creates problems of access and connectivity. The years of conflict also virtually halted life after sunset with curfews after dark being routine for many years. Though these restrictions no longer exist, people are careful even now not to go out after dark. The years of conflict have physically and emotionally scarred the people of the state, especially the women. The number of patients suffering from psychological problems has grown manifold, as has the dependence on sedatives and anti-depressants.

Health care suffered a major setback with the breakdown of peripheral facilities and the migration of doctors. The doctors who are available now are concentrated in the cities. People in the villages have thus become dependent on “local doctors” who have mushroomed all over. Their professional qualifications do not matter. Their one qualification, which was most important during the years of conflict, was reliability. People preferred them to the professionals because they were available at all times. On their part, these “local doctors” were careful not to try to treat what they thought was beyond their powers. Still they caused a lot of harm, especially among women.

Over the years of conflict women had to face many restrictions from both the family and society. The threat of sexual harassment, abduction, and rape, was ever present. They had to bear the cross of “family honour,” resulting in many hardships. Women were not allowed to move out of the house alone. They had to conform to strict social etiquette. They were not allowed to pursue education beyond a point, or consult a gynaecologist. Parents would arrange their marriages as soon as possible.

Along with these social restrictions came the dicta of the fundamentalists banning family planning services. Women were left with no choice but to depend on the “local doctors” and illegal abortion centres or fall back on traditional systems of medicine. As religious beliefs became stronger women started depending on seers more than in the past.

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At times like these, women's health, especially reproductive health, was not thought of at all. Reproductive health would start and end with pregnancy. Women who participated in the study said they were well taken care of during pregnancy. But at all other times, as long as they could move about and do their work they were considered fit.

This study tries to look at the ways in which Kashmiri women coped with the restrictions placed on them by society, the family, and circumstances. How did they survive in spite of the negligible medical options?



# Chapter 1

## Introduction

News of my cousin's pregnancy delighted one and all in the family. My cousin lives in a small village in Anantnag district, about 45 kilometres from the state capital Srinagar, which houses the state's only maternity hospital. The nearby town of Tral has only one government health centre along with a few private nursing homes.

As the big day approached, we rejoiced, but the joy evaporated rapidly as a complication developed. Normally this should have been nothing to be perturbed about. After all, the doctors were there to take care of it all, were they not? But on the day of delivery, in the dead of night, my cousin had to be rushed to the Lal Ded Hospital, Srinagar, for emergency surgery. The private nursing home where she was to be delivered did not have the infrastructure to handle her complication. Had it not been for a neighbour's guest who happened to have a car, my cousin would have lost her life and the child. This was a woman from a middle-class family, who could afford a private nursing home. Yet, at the end of the day, her plight was no better than that of any woman living in a remote part of the valley. This incident woke me up to the realities of life in an area ravaged by conflict.

The welfare state exists in Kashmir but only minimally and peripherally. On the other hand, the security apparatus fails to elicit the trust of the people. Forging DNA samples hardly endears the State to the people. This is in addition to the violence that accompanies "normal" search operations, and the numerous curtailments of people's movements in the name of security. The excesses of the militants match the State's terror. Barely does one get accustomed to one tyrannical whim when another comes up. From the insistence on the *burqa* for women to the monitoring of the curricula of schools and universities, the list is never-ending.

Caught in the crossfire of the militants and the government, the people live a life of fear. Lack of public transport, a ban on private vehicles, curfews after dark, unsafe conditions for women, and the

uncertainties of daily existence, have made an already difficult life unbearable. This research was taken up against this backdrop. It attempts to study, through a collection of 25 case histories, how women in the valley have negotiated their way through the prevalent social and health conditions and survived in such hostile conditions.

### 1.1 The State of Kashmir

Jammu and Kashmir covers an area of 84,571 square miles. Within this is the valley of Kashmir covering 8,639 square miles. The valley has a distinct culture, language, and customs that have remained distinct on account of the mountains cocooning it. Records of ancient Kashmir trace their origin to an old historical text, *Rajatarangini*, by the historian Kalhana. The chronicles of Kalhana record Kashmir's various stages of religious change, from Vedic Brahmanism to Buddhism to Islam. [1].

Kashmir is bordered on the west by Pakistan, on the south by the rest of India, and on the north and east by China. The region is divided between the Indian state of Jammu and Kashmir (2001 provisional population 10,069,917), 39,179 square miles (101,437 square kilometres), with its summer capital at Srinagar, the state's historic capital, and its winter capital at Jammu; the Pakistan-controlled areas (1981 estimated population 1,980,000) of "Azad" Kashmir, 2,169 square miles (5,619 square kilometres), with its capital at Muzaffarabad, and the Northern Areas, 27,991 square miles (72,496 square kilometres), with its capital at Gilgit; and the largely uninhabited areas controlled by China, 16,481 square miles (42,685 square kilometres), within Xinjiang and Tibet.

#### 1.1.1 Conflict in the valley: The historical context

In the late 14th century, after years of Buddhist and Hindu rule, Kashmir was conquered by Muslims who converted most of its population. It became part of the Mughal Empire in 1586, but by 1751 the local ruler was independent. After a century of disorder the British pacified Kashmir in 1846 and

installed a Hindu prince as ruler of the predominantly Muslim region.

When India was partitioned in 1947, Muslim forces from Pakistan invaded Kashmir. The Hindu ruler fled to Delhi and agreed to place Kashmir under the dominion of India; the region was given semi-autonomy. Indian troops were flown to Srinagar to engage the Pakistanis. The fighting was ended by a UN ceasefire in 1949, but the region was divided between India and Pakistan along the ceasefire line. A constituent assembly in Indian Kashmir voted in 1953 for incorporation into India, but this was delayed by continued Pakistan-India disagreement, and UN disapproval of the disposition of any portion of the region without a plebiscite. In 1955, India and Pakistan agreed to keep their respective forces in Kashmir six miles (10 kilometres) apart.

A new vote by the assembly in Indian Kashmir in 1956 led to the integration of Kashmir as an Indian state; "Azad" Kashmir remained under Pakistan's control. India refused to consider subsequent Pakistani protests and UN resolutions calling for a plebiscite. The situation was complicated in 1959 when Chinese troops occupied the Aksai Chin section of Ladakh district. India-Pakistan relations were inflamed further in 1963 when a Sino-Pakistani agreement defined the Chinese border with Pakistani Kashmir and ceded territory claimed by India to China.

Serious fighting between India and Pakistan broke out again in August 1965. A UN ceasefire took effect in September. In January 1966, President Ayub Khan of Pakistan and Prime Minister Lal Bahadur Shastri of India met at Tashkent at the invitation of the Soviet Union and agreed to a mutual withdrawal of troops to positions held before the war. In the December 1971 war between India and Pakistan, India made some gains in Kashmir. In December 1972, India and Pakistan agreed to a new ceasefire line along the positions held at the end of that war.

In the late 1980s, Muslim resistance to Indian rule escalated, with some militants supporting independence and others, union with Pakistan. A rigged election in 1987 sparked violence, and the legislature was subsequently suspended. In 1990 direct presidential rule was imposed. Plans to hold elections in 1995 were abandoned following the

burning of an important Muslim shrine and surrounding town, and riots in Srinagar.

Fighting erupted again in May 1999 when India launched air strikes and ground action against infiltrators from Pakistan. After heavy losses on both sides, a ceasefire was called in mid-July. Kashmiri legislation restoring the state's pre-1953 autonomy and negotiations between India, and a dominant militant group proved short-lived in 2000. Kashmiri guerrilla attacks in 2002 threatened to spark a broader conflict with Pakistan. Yet, credible elections were held in October, leading to a new government that favoured negotiation with the separatists.

Before the onset of the insurgency, tourism played a pivotal role in the valley's economy. The year 1988, which marked the beginning of trouble in the valley, saw 720,000 tourists arrive in Kashmir. The number fell to 24,029 by 1990 and to zero a year later. This decline affected not just tourism but allied industries like transport, handicrafts, houseboat owners, pony owners, etc.

### **1.1.2 Impact of conflict on health, health care systems, and medical institutions**

The total male population of Jammu and Kashmir was 53,00,574 and the female population was 47,69,343, with a sex ratio of 937 as per the provisional results of Census 2001. Women and children suffer the most in a situation of conflict. A comprehensive paper titled 'Promoting psychological well-being among children affected by armed conflict and displacement' [2] reveals that in conflict situations anywhere in the world 80 to 90 per cent of the victims are civilians, mostly women and children.

According to conservative estimates, 60,000 people have been killed and several thousand more injured in the bloody conflict in the valley. Women and children are the most affected groups. Though there are no accurate records, reliable estimates put their number at 16,000 to 20,000. [2].

The many years of turmoil have left their mark on the health of the valley's inhabitants with the complete collapse of the rural health infrastructure, resulting in increased pressure on the city-based secondary and tertiary health care facilities. [3]. The insurgency led to the exodus of a large number of medical and paramedical professionals,

creating a vacuum in the provision of basic health care and leaving people vulnerable to disease. Making matters worse were the endless curfews and bandhs, which had become part of life for people in the valley.

People in the rural areas were hit the worst by this situation. Two decades ago, Jammu and Kashmir was the only state to provide 50 per cent reservation for training women as doctors. Today it is almost impossible to find a woman doctor in the remote areas like Kalakor, Banehal, or Ramban. The Government Medical College, Srinagar, faces an acute shortage of teaching staff and 109 faculty posts out of 209 remain vacant. The Medical Council of India has threatened to derecognise four departments – physiology, microbiology, pharmacology, and paediatrics – and the blood bank because of this shortage. As most of these departments also do clinical work, the staff shortage has affected the training of medical students and, hence, the quality of doctors that the college produces.

In 1997, only 57 students were admitted to various postgraduate and diploma courses though there were at least 75 seats in different postgraduate courses in the college and 18 for the diploma courses. Of these 57, only 23 could specialise in medicine and surgery because enough guides were not available. In the last seven years the postgraduate

medical exams have been held only twice, aggravating the shortage of specialists in the valley. The paediatrics department has only one professor (against two sanctioned posts), no associate professor (against one post), no assistant professor (against three posts) and one lecturer (against three posts). This limited faculty has to teach 100 undergraduate students and take three teaching and six clinical classes a week, besides organising seminars and symposia. [3].

Children's Hospital, the only specialised children's hospital, and Lal Ded Hospital, the only maternity referral hospital for the entire valley, both in Srinagar, are overloaded and understaffed. The former has a capacity of 175 inpatients but caters to almost twice that number. The maternity hospital caters to almost three times its inpatient capacity of 450. Nafiza Ali's study, for which 360 children were surveyed, found that only 36 per cent benefit from the supplementary nutrition programme. [4]. Further, only 41 per cent of the 180 pregnant women surveyed and 39 per cent of 180 nursing mothers used the supplementary nutrition services. Twenty-seven per cent of the 50 doctors included reported that the supply of medicines in various medical institutions was irregular.

**Table 1.1 District-wise distribution of health institutions [3]**

District/ population	Srinagar 1,183,493	Budgam 632,338	Anantnag 1,170,013	Baramullah 1,166,722	Pulwama 648,762	Kupwara 640,013	Total
District hospital	1	1	1	1	1	1	6
Sub-district hospital	2	4	4	5	4	3	22
Emergency hospital	-	-	1	-	-	-	1
Allopathic dispensary	22	12	25	25	23	11	118
Medical aid centres	2	6	18	24	10	51	111
Sub-centres (health and family welfare)	67	125	197	177	112	125	803
Subsidiary health centres	-	-	1	4	1	2	8
Leprosy hospitals	1	-	-	-	-	-	1

At the Lal Ded Hospital there are times when the labour room has 60 admissions against 30 beds. Due to the breakdown of peripheral maternity health services, the hospital receives patients from remote areas. Their attendants live on the premises, adding to the unhygienic conditions. The hospital had a full-fledged family planning unit until 1989-90, when violent threats from fundamentalist militant groups stopped all such activities. This ban on family planning has led to illegal septic abortions, also known as "*patri* terminations," carried out by quacks, which often damage the uterus. Also seen on a larger

scale are surgical complications like gut and bladder injuries. An increase in early pregnancies has also been reported. [3].

With sterilisations banned, there was an increase in the use of intra-uterine devices for family planning, the reason being that once the device is installed the user does not have to visit the doctor from time to time. The safety problems with this device are not unknown to the people. But where is the choice, with the fundamentalists dictating the lives of one and all, especially those of women?

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**Table 1.2 Patient load at Lal Ded Hospital [3]**

Year	Outpatient department	Inpatient wards
1990-91	30916	17061
1991-92	47966	22090
1992-93	62154	23639
1993-94	68115	23401
1994-95	91752	26253
1995-96	91299	26389
1996-97	77459	27680
1997 (till October 1997)	40888	15417

# Chapter 2

## Literature review

This chapter attempts to understand how conflict affects the health of women, particularly their reproductive health. The Heidelberg Institute for International Conflict Research defines conflict as a clash of opposing interests or positional differences over national values and issues like independence, self-determination, borders and territory, access to or distribution of domestic or international power. [5]. It further states that a conflict has to be of some duration and magnitude involving at least two parties (states, groups of states, organisations, or organised groups) that are determined to pursue their interests and win their case. At least one party is the State. Possible instruments used in the course of a conflict are negotiation, authoritative decisions, threats, pressure, passive or active withdrawal, and the use of physical violence.

Women's Human Rights has recorded that there are more than 30 undeclared wars and internal conflicts taking place in the world at present. [6]. Close to 90 per cent of the casualties are civilians, mostly women and children. At least 20,000 women and girls between the ages of 7 and 65 were raped during the conflict in the former Yugoslavia in 1992 alone.

The conflict in Kashmir, which began 16 years ago as a struggle for freedom, has over the years become a struggle for the life for the people. It has resulted in the degradation of their health, particularly that of women. In the valley, as elsewhere in the world, women have become indirect victims of the arrest, torture, disappearance, and loss of loved ones. At the same time they have become direct victims of physical violence in the form of rape, abduction, and murder. No house in the valley has been left untouched by the protracted curfews, crackdowns, arson, and violence. In an independent survey of the Government Mental Hospital in Srinagar in July-August 1999, Prabal Mahato found that post-traumatic stress cases rose from 1,700 in 1990 to 17,000 in 1993 and to 30,000 in 1998. [2].

The women of Kashmir, both Muslim and Hindu, have lived with conflict for so long that many

of the things they took for granted earlier have been taken away from them. Hindus live as refugees with few facilities, if any, in cities far away from their homes. The women have been pulled out of education.

Things are no better for the Muslim women back in the valley, for they are fair game for any number of players: the militants, security forces, their own men. And as these realities have sunk in, more and more women have had to face severe depression, fear, and loss of confidence. Similarly, while laws stipulate that a man may claim compensation from the State if he loses a limb as a result of conflict, there is nothing that allows a woman to claim any compensation if she is, for example, raped in a conflict situation. [7].

### 2.1 Social changes in conflict situations

Armed conflicts greatly alter the lives of women and completely change their roles in the family, community, and public domain. They result in separation, loss of family members and livelihood, and increased risk of sexual violence. [8]. They also mean that women have to take up the role of breadwinner. Ana Julia from El Salvador summed this up eloquently: "Before the war women were not taken into consideration. Women were only working in the home. But when the war came, women came out of their houses to demonstrate their capability. In part it was a war which meant that women could be taken seriously and that they could do a lot of things." [9].

This change in role brings with it increased sexual vulnerability. Throughout history, women and girls have been routinely raped in war. But of late ethnic cleansing and the changing patterns of conflict that target civilians have only made them more vulnerable. Most displaced women remain without access to reproductive health care, safe birthing conditions, contraceptive services, or counselling. [10].

In Kashmir political violence has seen the men withdraw, go underground, and/or join the

militants, while the women stay behind to run the family. After the first year of economic dislocation caused by violent upheaval, the state's economy adapted rapidly, establishing direct market outlets for the valley's fruits, handicrafts, shawls, and carpets in the rest of India. But in households that lost male earning members, women and children were faced with a sharp drop in income, even destitution.

The insurgency left women vulnerable to male predatory violence and the worst kind of social and economic exploitation. Many were divested of their land. Others were forced to seek employment as cleaning women, something unheard of for them earlier. Educated middle-class women were forced to take up professions such as nursing, which used to be frowned upon. For illiterate women with children, the choice was stark – they could place their sons in orphanages or in carpet-weaving factories. There are some 30,000 orphans in Kashmir, with no support structure.

The emergence of households headed by women did open up space for some power shifts in gender relations and opportunities to learn new skills and take control of their lives. But cultural violence as symbolised in the veiling of Kashmiri women was used to limit these opportunities. Also, the gun culture destabilised interpersonal relations between generations, especially between mothers and children. [11].

Domestic violence often grows with societal tensions, and is more common and lethal when men carry weapons. Sarah Maguire's research showed that in the build-up to the war in the former Yugoslavia, groups providing support to women victims of domestic violence in Belgrade reported that demand for their services increased significantly. Violence occurred especially after television programmes hyping "national honour" in preparation for war. [12].

The build-up is accompanied by renewal of a patriarchal familial ideology, deepening the differentiation between men and women, masculinity and femininity, preparing men to fight and women to support them. Women are reminded that by biology and tradition they are the keepers of hearth and home, nurturing and teaching children "our ways." Men by physique and tradition are there to protect women, children, and the nation, often

represented as "the motherland." Through this retelling, women are readied to sacrifice their husbands and sons, and men to sacrifice their lives. [13].

In such situations birth rates assume strategic importance. Women are urged to leave paid employment and attend to their "natural duties." Maja Korac has written, "The first instances of control and violation of women's rights during the transition from state socialism to ethnic nationalism were restrictions on their reproductive freedoms." [14].

## 2.2 Fundamentalism and the need to control women

The need to control women and their reproductive choices has many faces. "Fundamentalism" is just one of them. The term is currently used to describe a range of movements and tendencies in all parts of the world. These movements aim to impose what they define as tradition – whether religious, national, cultural, or ethnic – on societies they consider to be in danger of straying from their basic tenets. In the name of religion, fundamentalists all over the world are pressing people, especially women, to "return" to traditional gender roles. Control of women's sexuality and reproduction is at the heart of many a fundamentalist agenda.

For instance, the Vatican accused the United Nations of "causing moral and intellectual confusion" and "promoting irresponsible sexual relations." The Vatican's ire was directed at a manual issued by the UN in 1999 on reproductive health in refugee situations. The manual promoted the distribution of the morning-after pill. But the Vatican saw this as an attempt to introduce young men and women to an individualistic, irresponsible use of sexual pleasure. The Vatican approves only of natural methods of birth control.

Religious fervour does prevail upon women not to opt for sterilisation, which is legal in Bangladesh. Women are prohibited from contact with non-kin even in health matters. Secondly, most doctors who perform sterilisations are male. [15]. In Argentina the supreme court banned the morning-after pill as a form of abortion. [16].

Abortion is fiercely debated across the world. The issues are complex and emotional. Many

opponents argue against abortion on the grounds that it breaches a foetus's right to life. They maintain that human life begins at conception. [17]. Others hold a different view, as spelt out by Sonia Correa: "There is neither clear scientific nor theological determination that before viability, foetal life is human life." [18].

In the Persian Gulf conflict, bishops, using the "just war" theory, did not condemn its perpetrators. Yet they condemn abortion daily as an absolute moral evil. The just war theory accepts the taking of human life if that of another is threatened. A just abortion theory would therefore permit a woman whose life is in danger to have an abortion – an act now prohibited by church law. The foetus, they point out, is innocent. But as we have seen, even in hi-tech modern warfare, innocents are killed. One cannot help but wonder why religious leaders readily give presidents and generals wide latitude in decisions that affect many while seeking to prohibit a woman from making an individual decision. [19].

A Chilean woman has no recourse to legal abortion in any circumstance, including if the pregnancy endangers her life or was the result of rape. The consequences of having an abortion are severe: the law recommends a prison term of three to five years. In Ireland abortion is legal only when there is a real, substantial risk to the life (as distinct from health) of the mother. [20].

While states make laws, women have abortions, legal or otherwise, according to their needs and circumstances. The philosophy and the reality sometimes diverge. "I would say that in much of Africa, public position and private action with respect to abortion are not the same. Whilst the majority of persons, both male and female, would publicly state that abortion is a sin and should not be undertaken, many, perhaps the majority, would not hesitate to avail themselves or their wards of abortion services when the need arises." [21].

In July 1995 President Alberto Fujimori of Peru announced that the State would provide legal sterilisations as a method of family planning. But what started as a welcome family planning initiative in a country where religious doctrine discourages it deteriorated into a quota-driven bounty hunt where women were misinformed, bribed, and coerced into being sterilised. Women's groups say 15 women died

as a result of unsafe sterilisations conducted by overzealous doctors, and hundreds more claim to have sustained injury or been operated upon without consent. There were reports of women as young as 19 having been sterilised. [22].

Globally, 120 million couples have unmet needs for family planning, and each year women around the world experience 75 million unwanted pregnancies. As a result there are approximately 50 million abortions each year. Some 20 million of these are unsafe. Two hundred women die daily as a consequence and there are untold levels of severe morbidity as a result of abortion-related complications. [23].

Unwanted pregnancies can be reduced by improving access for men, women, and adolescents to high-quality gender-sensitive information and services that offer a range of contraceptive methods appropriate for people at different stages of life. [23]. Yet the Bush administration announced that it would disregard its obligations under an agreement on family planning adopted by 179 nations in 1994 at the International Conference on Population and Development. [24]. The US said that unless the terms "reproductive health care" and "reproductive rights" were "withdrawn or modified," it would not reaffirm its commitment. This position will have serious repercussions on women's rights to health choice, autonomy in reproductive health decisions, and access to safe abortion all over the world.

### 2.3 The symbol of honour

Because women are often seen as symbolising the integrity and honour of an entire community, in times of conflict the "enemy" subjects them to rape, sexual and physical abuse, and harassment. For the same reason, women are subjected to gender-specific constraints within their own communities and these controls are intensified in times of conflict or displacement. [25].

In 'Where are the women in South Asian conflicts' Rita Manchanda argues that rape is not an accident of war. Violence against women gets magnified as conflict promotes macho values that legitimise misogyny. Men compensate for their loss of power by hitting out at women. Moreover, with women seen as symbolic and physical markers of community identity, there is pressure (on both men

and women) to embrace identity constructs that undermine the women's autonomy of being, as in the veiling of Kashmiri women. [11].

Controlling women's sexuality is central to demarcating ethnic and national boundaries. Barkha Dutt in 'Nothing new?' stated that women were the central characters in the Gujarat carnage and their bodies the battleground. She argued that it was not the death of 58 Hindus in Godhra that aroused passions, but reports of the rape of Hindu women, for it is in their bodies that the community's *izzat* (honour) vests. The murder and rape of Hindu women, emblazoned in banner headlines across the language press, became the excuse, the emotional rallying point, the justification, for the unprecedented brutalising of Muslim women and children. [26]. Aziz Tankarvi, editor of Gujarat Today, said in an interview that when someone is murdered you are hurt, but a man can bear it quietly. It is when his mother and daughters are violated that he definitely seeks revenge. [26].

Wartime sexual violence against women not only occurs but also is a necessary aspect of conflict. History has demonstrated the link between war and the control of women's sexuality and reproduction. Through the rape of their women communities are humiliated and men emasculated. Rape in situations of conflict is now recognised as a war crime.

Rape in conflict is neither incidental nor private. In Kashmir, both the security forces and militants have systematically used it to punish, intimidate, coerce, humiliate, or degrade. [11]. Mass rapes in Kashmir by security forces were first documented in the Chanpora (Srinagar) incident of March 7, 1990. Though the forces called it a "wild" allegation, human rights investigators felt that mass rape had begun to be used routinely in search operations. Investigation of incidents in Pazipora (August 1990), Kunana Poshpora (February 1991), Chaj Saidpora (October 1992), Theno Budpathery Kangan (September 1994), and Wavoosa in Srinagar (1997) established rape by the forces as a collective form of punishment. [11].

An investigation was conducted into the mass rapes because of international pressure. After less than half an hour in the affected village three months after the incident, the investigators

concluded that the allegation was an invention. What convinced them was that some of the girls who lined up to be interviewed giggled and seemed "unashamed." Those who reported rape or assisted in filing complaints were intimidated. Medical practitioners were threatened. In November 1990, a surgeon in an Anantnag hospital asked for a gynaecologist to examine seven women who claimed to have been raped. The Central Reserve Police Force detained him for four days.

But the separatist ideologues failed to take on the challenge of locating rape in gender politics. Instead they reinforced the notion of feminisation of honour, thus condemning the raped women to social ostracism in a patriarchal society. In Kashmir and in Assam, studies have shown that victims of rape were later liable to be violated by their own patriarchy. Anis Haroon of Pakistan has questioned patronising quick fixes like the leadership calling on boys to come forward and cover "her shame" with marriage. [11].

## 2.4 Conflict and health

A 1994 study of Rwandan refugees in Tanzanian camps found that 60 per cent of the women had reproductive tract infections. Refugees from the former Yugoslavia who were treated and documented in London showed a 34 per cent rate of sexually transmitted infections. More than 20 per cent of births at a Burundi refugee camp in Tanzania in 1998 were below average weight, and infant deaths rose sharply from pre-war levels. Of Rwandan women who reported rape, 17 per cent were HIV-positive. [27].

In March 2002, the Shalman refugee camp in Pakistan had 20,000 Afghan refugees sharing 3,576 tents, 865 latrines, 373 washrooms, and five doctors in three health clinics, plus the aid of three "lady health visitors" to attend to pregnant women in labour. It also had four new primary schools for boys and one for girls. [28].

Social constraints restrict women's access to care even when it is crucial. In Pakistan there are cases "where a woman, in the last stages of pregnancy, dare not leave her home in her husband's absence... [If complications arise] such women haemorrhage to death," said Hilda Saeed, a founding member of the women's rights organisation Shirkat Gah. Women are not allowed to move outside



without the *burqa*. And the terror of the religious police prevents them from seeking medical aid.

Rosemary Skaine, 2000, reported in 'The women of Afghanistan under the Taliban' that fear of public beatings and arrest prevented women from seeking health care. They were also turned back from hospitals, as "their modesty could not be preserved in a crowded ward." [29]. Male doctors were not allowed to examine women. Though women were allowed to practise medicine, they still feared the religious police stopping them. Then the health ministry's permission would mean nothing. A female medical practitioner in Afghanistan told Skaine, "Each morning when I leave my house for work, I pray to god for my safe return."

Women's stories "constantly point to the gendered nature of outcomes as a result of the conflict: for example, the collapse of primary health services obviously affected women differently, leading to appalling rises in maternal and child mortality and morbidity. Gendered mobility is most evident in the differentiation between the male and female population in rural areas (90 per cent of the total population in the early 1980s) where men, with sufficient warning, were able to flee to provincial towns and the capital. Women, encumbered by dependents, were more likely to stay in situ producing 'taxes' in the form of food and providing domestic services to occupying forces (including those of government)." [30].

## 2.5 Reproductive health

Swapna Mukhopadhyay and R Savithri [31] have categorised reproductive rights as a human right and defined it as a woman's right to regulate her sexuality, to conceive when she wants to, as often as she wants to, and to terminate unwanted pregnancies and carry desired pregnancies safely to termination. Further they quote Pachuria and Ravindran, who state that it is the right of a woman to her own sexuality and reproductive health.

According to the HERA Health Action, Empowerment, Rights, and Accountability) definition, reproductive health "requires good basic health and nutrition, protection from violence, and reduction of occupational and environmental health hazards throughout the lifespan. While the concept of reproductive health applies to both women and

men, it has far greater impact on women and as such requires preferential allocation of resources to women's health, particularly to reduce health risks that only women face."

Elaborating, HERA defined reproductive right "as the right of all individuals to control their own bodies, to have sex that is consensual, free from violence and coercion, and to enter marriage with the full and free consent of both parties. Reproductive health is essential for women to exercise their right to health and includes the right to comprehensive, good quality reproductive health services that ensure privacy, fully informed and free consent, confidentiality and respect." [32].

Clearly, reproductive health is more than just the reproductive organs, or just reproduction. It is about how social and sexual behaviour and relationships affect health and create ill health. It is true that women bear by far the greatest burden of reproductive health problems and that biological, social, cultural, and economic factors increase their vulnerability to reproductive ill health. But reproductive health has to be understood within the context of man-woman relationships, communities, and society, as sexual and reproductive behaviour is governed by complex biological, cultural, and psychological factors.

The Health for Women, Women for Health programme initiated in 1992 looks, in particular, at women between the ages of 15 and 49, especially adolescent women. [33]. But the World Health Organisation states that reproductive health requires that care be provided to meet the needs of individuals throughout their life. [23]. It believes that good reproductive health starts from childhood. A female child who is malnourished from birth or subjected to harmful traditional practices enters adolescence and adulthood with anaemia, physical anomalies, and possible psychosexual trauma. This can increase the probability of obstetrical problems during pregnancy and childbirth. It may also contribute to sexual problems, fear, and abuse in a relationship. Effective reproductive health care addresses these problems from birth with appropriate and culturally sensitive education and health care programmes.

This study uses the definition of reproductive health offered by WHO. WHO defines health as a state of complete physical, mental, and social well-being,

and not merely the absence of disease or infirmity. Reproductive health is described as a condition in which reproduction is accomplished in a state of complete physical, mental, and social well-being, and not merely the absence of disease or disorder of the reproductive process.

What these two definitions mean is that: (a) people have the ability to reproduce as well as to regulate their fertility; (b) women are able to go through pregnancy and childbirth safely; (c) the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; (d) couples should be able to have sexual relationships free from the fear of unwanted pregnancy and disease.

The present research was based in a conflict situation where basic health was at times beyond a person's reach. In such a situation seeking reproductive health was next to impossible. The World Bank's World Development Report 1996 [34] found that reproductive ill-health accounts for approximately 36 per cent of the total disease burden among women in the reproductive age. Three groups of diseases account for this – pregnancy-related deaths and disability, sexually transmitted infections, and HIV.

Further, conflict affects reproductive health needs in many ways. First and foremost is the impact on health in general associated with malnutrition, micronutrient deficiency, injuries associated with warfare, spread of communicable diseases, mental trauma, psychosomatic disorders, and stress-related diseases coupled with lack of food, water, and sanitation. There is a breakdown in health facilities, which leads to a resurgence of harmful birth practices. And there are the psychological impact, social ostracism, unwanted pregnancies, unsafe abortions, abandoned children, infanticide, and neglect/stigmatisation of children born as a result of rape.

There is also an increased burden on women due to changing gender roles and norms related to sexuality and marriage. Conflict often breaks down the extended family and community support networks. Nushina Siddiqui describes how the conflict in the valley led to the exodus of a large number of doctors leading to the collapse of the health infrastructure. She has discussed the shortage

of technical staff, health facilities, and medicines. This collapse led to a breakdown of the supplementary nutrition programme, poor immunisation services, and the reluctance of specialists to work in rural areas.

Siddiqui has further discussed how the insurgency coupled with the breakdown in health facilities led to an increase in the patient load of hospitals in the cities. Lad Ded Hospital saw an increase in OPD patients from 30,916 in 1990-91 to 77,459 in 1996-97. The psychiatry ward saw a tenfold increase in this period. Further, there was post-traumatic stress disorder among children. Siddiqui has pointed out the increase in prescription of psychotropic medication. It is no surprise that most households store liberal quantities of sedatives and painkillers. [3].

Another aspect of reproductive health in conflicts was put forward by the Asian Women Research Exchange Group, which stated that women's reproductive health is seriously damaged by weapons-testing and other pollutants introduced into their environment by military activity, often causing cancers in women and birth defects in infants. Other assaults on reproductive health result from the pregnancies and abortions forced by military forces for military purposes. [35].

Essential health care and the meeting of other needs fundamental to survival and well-being are constantly delayed and systematically denied by the priority given to the military. Such denial of basic and reproductive health care also results from the limitation of access and restrictions on mobility imposed in cases of armed conflict. This study explores the reproductive health needs in the valley in this context and tries to understand how women negotiated their way through the situation to lead a "healthy" life.

### **2.5.1 Conflict**

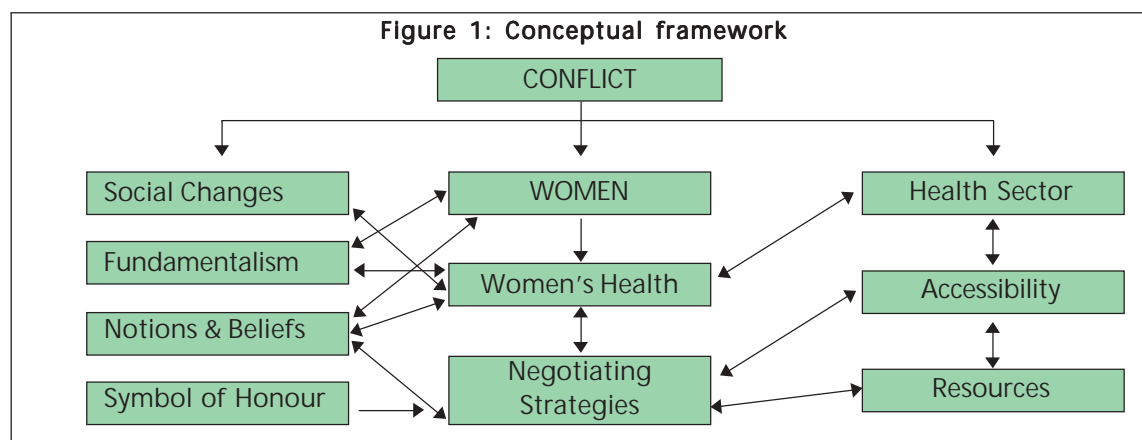
Conflict is defined as a clash of opposing interests or positional differences over national values and issues like independence, self-determination, borders and territory, and access to or distribution of domestic or international power (Heidelberg Institute for International Conflict Research). [5].

Kashmir has been in a conflict situation for 16 years. As in other countries women have become

indirect victims of the arrest, torture, disappearance, and loss of loved ones and direct victims of the physical violence of rape, abduction, and murder. Continuous armed conflict has caused disruption and displacement, leading to a profound negative impact on the reproductive health of women, men, and adolescents. Poverty, loss of livelihood, disruption of services, breakdown of social support systems, and acts of violence combine to destroy health. It was this destruction of health and health facilities in a conflict that this study proposed to explore.

homes and fend for themselves. Instability is not just economic but also psychological. On the one hand women are forced to fend for themselves. On the other they have to obey society's dicta.

The joint family system is breaking down because of economic instability. Women are unable to fall back on this secure system anymore. Yet, when they move out to fend for themselves, society frowns upon them. Women as doctors and teachers are respected, but not everyone can enter these professions. The environment is not conducive for



### 2.5.2 Social changes

The armed conflict has greatly affected the lives of women and changed their role in the family, community, and public domain. The breakdown or disintegration of families has forced them to assume new roles. It means separation, loss of family members and livelihood, and the increased risk of sexual violence. [8]. It also means that women take over the role of breadwinner of the household.

In Kashmir political violence has seen the male members withdraw, go underground, and/or join the militants while the women stay on to run the family. These women not only have to manage basic survival, they also have to survive societal changes. In a predominantly Muslim society, this means they have to deal with the growing fundamentalist fervour, which places all kinds of restrictions on them and seeks to control their lives totally.

Women face conflicting situations daily. The traditional social system is changing. There is a growing population of widows, of families headed by women, of young orphan girls without any support. These women are forced to leave secure

work, leave alone for working women. This study looks at such social changes to understand how they have affected women in general and their health in particular.

### 2.5.3 Fundamentalism

The term is currently used to describe a range of movements and tendencies in all parts of the world, which aim to impose what is defined as tradition – whether religious, national, cultural, or ethnic – on societies that they think are in danger of straying from their basic tenets. In the name of religion, fundamentalists all over the world are pressing people, especially women, to “return” to traditional gender roles. The control of women’s sexuality and reproduction is at the heart of many fundamentalist agenda. Kashmir in the past 16 years has witnessed this phenomenon in the form of the *pardah* (veil), restrictions on women’s movement, prohibition of western education for girls, and a ban on the use of contraceptives and abortions. These dicta have repercussions not only on physical health but also on mental health. The past 16 years have seen a progressive state regress with the fundamentalists trying to pull it further back.

#### **2.5.4 Notions and beliefs about women**

The hardening of identity-based roles ascribed to men and women within the community often has disastrous consequences for the latter. It restricts their mobility and freedom, imposes dress codes, confines them to the domestic sphere, brings them under the rigid control of male members of the family and community and, most critically, places them in the role of “bearers of the community’s honour” and traditions. These result in the women being subjected to rape, sexual and physical abuse, and harassment at the hands of the “enemy” as a strategy of war. For the same reason, they are subjected to gender-specific constraints within their communities.

#### **2.5.5 Symbol of honour**

Sexual violence against women is often used as a weapon in conflict. History has demonstrated the link between war and the control of women’s sexuality. Through the rape of their women, communities are humiliated and men emasculated. Rape of women in situations of conflict is now recognised as a war crime. This rape is neither incidental nor private. In Kashmir, both the security forces and militants have systematically used it to punish, intimidate, coerce, humiliate, or degrade. [11]. This study looks at how women have been made symbols of honour and forced to endure unjust restrictions, and how these restrictions have adversely affected their health, particularly reproductive health.

#### **2.5.6 Health**

The WHO constitution defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. This study was based in a conflict situation where basic health facilities were often beyond a person’s reach. In such a situation seeking reproductive health was next to impossible. The study not only looked at the deplorable health scenario, but also how it affected reproductive health.

Reproductive health implies a satisfying and safe sex life, free from fear of disease, coercion, and violence. It is the capability to reproduce, and the freedom to decide if, when, and how often to do so. It includes the assurance of going safely through

pregnancy and childbirth, and the right of access to appropriate health care, safe and affordable abortion facilities, and, above all, to services for the prevention and care of sexual and reproductive health problems. [36].

The challenge was to understand, first, how men and women perceived reproductive health, if it was perceived at all, and to what extent serious thought was given to reproductive health as against simple care during pregnancy. The study also explored whether reproductive health was understood in the rights framework.

#### **2.5.7 Reproductive rights**

This implies the rights of all individuals to control their bodies, to have sex that is consensual, free from violence and coercion, and to enter marriage with the full and free consent of both parties. Reproductive health is essential for women to exercise their right to health. It includes the right to comprehensive, good-quality reproductive health services that ensure privacy, fully informed and free consent, confidentiality, and respect. This study aimed to understand whether this concept was understood in Kashmiri society and if so what rights were available for the women. Reproductive health and rights are not feasible for any member of society, especially women, without the power to make their own decisions.

#### **2.5.8 Access to health care**

This issue covers not only the opportunity and capacity of women to reach and use the available health facilities, but also the choice of usage of the facility, and the control to decide when, where, and how she should access the facilities. This choice is further dictated by:

**Mobility:** The freedom of the woman to control and negotiate her movement within and outside the house, the freedom to move without social bindings, with the assurance that her movement will be safe. Kashmir’s predominantly Muslim culture does not allow freedom of movement to women. In addition there were the dicta of the State and the fundamentalists, which regulated people’s movements through curfews and *bandhs*, restrictions on movement after dark, restrictions on the size of the group, and so on. Even

doctors and trained health workers were not spared interrogations.

The public transport system in a region with an arduous mountain terrain, where the majority resides in far-flung villages and the minimum commuting time is an hour and a half, is unreliable. In certain areas the public transport system just does not ply. After dark it is difficult to find transport other than private vehicles, which are very costly. In such a scenario mobility is a big issue, especially in times of emergency.

**Control over economic resources:**

Who controls the monetary assets in the family? How easily are finances available to women, especially in connection with their health needs? Who decides how much is to be spent on whose health? Accessibility and mobility are directly linked to the availability of resources. A woman, despite being her family's breadwinner, may have little control over her finances. An agrarian society coupled with a situation of conflict does not permit much cash or ornaments to be kept at home. This reduces the woman's bargaining power when it comes to decisions about her health. She has to depend on her family for every *paisa*.

Control over economic resources is vital to access health care facilities, as the ultimate decision rests with the financial controller. Economic control also gives the woman the choice of when and where she wants treatment. Often it is seen that women's health is last in the family's list of priorities, unless it is during a pregnancy.

**Availability and affordability of services:** The turmoil in the valley has not only affected the availability of health services, but also their quality. The six districts in the valley each have a hospital, but it is only in Srinagar that the hospitals are geared for emergencies. Apart from Srinagar only one district hospital has provisions for anaesthesia, which means that even for minor operations patients have to be sent to Srinagar. Further, availability is linked to financial viability. There are times when women have to move not only across town but also to another state to access basic health facilities. How viable is this?

**Negotiation:** The numerous survival techniques used by women to deal with their health problems. Health infrastructure is almost invisible,

medical emergencies are a way of life; economic freedom and freedom of movement are nearly absent. Where they do exist, women are unable to exercise them because of the political institutions in the state. Do the male members of society also face a similar struggle? Or is negotiation a skill that only women have to learn? The study aimed to understand these skills.

## 2.6 Objectives of the study

- To look at the effects of 16 years of conflict on the state's medical system and its repercussions for the people in general and women in particular.
- To understand women's perspective on reproductive health in three districts of the valley.
- To understand how women across age groups negotiated their way around these realities.
- To try and explore the concept of reproductive rights.

## 2.7 Overview of the report

This report began with the catalyst for this research followed by a description of the geographical location of the state and a brief background to the conflict. The preceding second chapter gave the literature review from which emerged the conceptual framework, followed by the objectives of the research. The third chapter gives a detailed working methodology and the ethical issues that emerged during the research. Chapter four gives a profile of the of the 25 research participants interviewed formally for the study. The researcher interacted with close to 70 women and made an effort to also use these interactions in the report, especially in the discussion chapter.

The report after this has been divided into chapters using the conceptual framework as a basis. Five chapters put forth the concepts and the last discussion chapter tries to summarise the report. The report carries four annexure: a note from the researcher, a glossary of terms used by the research participants during the course of the research, the interview guide, and the geographical map of the state of Jammu and Kashmir.

# Chapter 3

## Methodology

This study aimed to look at the ways in which the people of Kashmir were coping with life in a situation of conflict. The methodology found most appropriate for this purpose was qualitative research. This method was chosen primarily for the flexibility it allows in data collection. It allows for an issue to be seen as far as possible through the respondent's eyes. It also allows space to explore any new issues that may emerge from the interview.

### 3.1 Research team

Initially, the research team was conceived of as the Principal Investigator and a trained Research Associate. But this decision had to be altered and the author as the Principal Investigator conducted the research alone, for two reasons. One, the need for safety required me to be as obscure as possible. Two, keeping in mind the delicate nature of the research, I was not comfortable with an associate collecting data. I felt that the response of the respondents to me vis-à-vis the assistant could vary and hence preferred to work alone. I did briefly hire a Research Assistant for feeding the translated data into a computer.

### 3.2 Field of work

The initial month and a half of the study was spent in the Lad Ded Hospital and the Children's Hospital in Srinagar, and the villages of Anantnag district, trying to establish a foothold. This proved to be a futile exercise because of the problem of acceptability. Even if I was able to converse in the local language, it was next to impossible to break down the barriers of authority, doubt, and suspicion.

After a month and a half of grappling in the field, I was introduced to an NGO working in district B. It was with the co-operation and assistance of this NGO that I was finally able to enter the field. At this point I had to change one of the field areas from Anantnag to District B. The three districts in which the study was finally conducted were:

- District A: A border district with tough terrain. At the extreme end of the state with bad roads and transport, it is virtually cut off from the rest of the state. Parts of this remote district are inaccessible in winter. Fear of the security forces and the insurgents is omnipresent amongst the people, making life difficult.
- District B: One of the lesser-known districts of the state, it is also remote, with few places of attraction and hence not as important as the other districts. Before the militancy began, this district had a health infrastructure. The district is covered with forests and hills, which provide hideouts for terrorist organisations and result in a lot of hardship for the people. Certain parts of this district remain cut off for months from the rest of the state due to heavy snowfall in the region.
- District C: the state capital, is the hub of all activities. It is here that the entry point to the research, the Lal Ded Hospital, is located. Most of the other institutes are also either located in the town or nearby. The district also houses the affluent class, which was one of the focal groups of the study.

### 3.3 Selection of the sample

The study was initiated in District B where the first 15 interviews were conducted. The selection of most of the participants was purposive, based on a brief medical sketch of the women in the villages by the community health worker (CHW). Due to a paucity of time in the field to interact with every woman in the village, I met almost 70 women and, from my conversations with them and the medical histories narrated by the CHW, chose women who had either undergone a medical emergency or were closely related to someone who had.

Some of the participants were selected on the basis of references from a previous interview.

While interviewing a young girl, I got a lead to interview her mother, who had gone through a horrific medical experience during the peak of conflict. Her case was not registered with the health worker as it had taken place before the NGO came to work in the village. Also, the woman in question did not like to interact with people.

The remaining 10 interviews were conducted in Districts A and C. Five interviews were conducted with the help of a female doctor of the primary health centre (PHC) in a village, while the other five were conducted in the district town of District A. Here again the selection of most of the participants was purposive. They were chosen on the basis of references given by the doctor and staff at the PHC.

The first 15 respondents for the interviews were short-listed during the first two months spent in the field. I interacted with almost 70 women across five villages. The CHW helped short-list the respondents. After briefly meeting the women in the villages I earmarked those who I thought would be suitable for the research. After this exercise I held a discussion with the CHW as she had been working in the area for four years and knew each household personally. Most of the candidates chosen by me were vetoed by the CHW, who gave her own recommendations. Of the short-listed women all but two agreed to be interviewed.

The first woman who did not agree was the young wife of a militant, pregnant with her third child. Her husband no longer played an active role in any militant group, but he was still well-connected. His lack of active participation was probably because of his ill-health. He was suffering from cancer that had reached a terminal stage. I met the girl four times, but each time I was asked to leave on one pretext or the other. Although the girl never refused to be part of the study, she never encouraged me either. After the fourth visit I gave up.

The second woman was the wife of the village *maulvi* (clergyman). They had six children. It was believed in the village that the woman underwent an abortion almost every three or four months because her husband did not favour litigation. In this case I was not able to even broach the topic with the woman because she was always surrounded by people. It is difficult to say whether this was

because I was an outsider or that was the way of the house. Seeing the difficulty in getting the woman alone for an interview, I decided not to pursue her.

While selecting the participants I took care to ensure enough variation in the age and financial background. Education levels in the village depended on the age. Middle-aged and older women were mostly uneducated, while the younger girls were educated at least up to the tenth standard. Thirty two per cent of the respondents had received some level of education. The ages of the women interviewed in these villages varied from 16 to 60 years.

Most people in the villages are farmers; a few are professionals. Many work as labourers on daily wages within and outside the village. Thirty six per cent of the women interviewed were employed. But this figure is not representative of the larger population. Interestingly, most of the employed respondents were working close to their houses or villages. One of the respondents, Badila, said the reason she was not harassed by the militants was that she was working in her own village. This was in stark contrast to the treatment meted out to her colleague, who travelled to the village from a nearby town. The colleague eventually tired of the harassment and applied for a transfer.

Kashmir is a Muslim-dominated state with Hindus, Christians, and Sikhs comprising the minorities. The years of insurgency have seen the migration of a large number of the minorities. Two of the villages in District B at the onset of insurgency housed a few Hindu families. But with the insurgency these families left the state. Their vacant houses were dilapidated. District A housed the maximum number of Sikh families in the state, but the villages that were short-listed for the study had no Sikhs. The 25 respondents of the study were all Muslims. I tried to get respondents from the minority communities. But lack of time and the effort needed to enter new fields within the state prevented me from pursuing this.

### 3.4 The process

I am based in Delhi, where I did my initial reference work for the study. I travelled to and from the field throughout the study. At the onset, I planned to divide my stay in Kashmir among the three districts to build a rapport and make efficient use of my time.

But once in the field I realised that this was not possible for reasons of safety. So the most viable district, District C, was chosen as the base. I travelled to and from the other districts and villages in the study. Most villages visited for the study were a minimum of 25 kilometres away. A private taxi with a reliable driver was hired on a daily payment. I spent more than nine months in the field.

Once I was introduced to the CHW, I spent about a month visiting the villages everyday, observing and familiarising myself with the local conditions. This also helped the people of the village to get comfortable with me. I spoke to about 70 women in these villages. It was out of these 70 that the first 15 respondents were short-listed. Though the conversations with the other women have not been used in totality, some parts have been used in the research, especially in the analysis.

During this one month, I not only had to respond to a lot of professional questions about the study but also personal questions. In fact there was more curiosity among the people about me than about my work. This initial time in the village as an observer was also spent in identifying people for interviewing for the study.

During this initial phase there was an inquiry about me from a local militant group. They wanted to know the reason for my visiting the villages. The NGO was asked for a formal letter of clarification and authentication. Work had to be stopped for two weeks while the NGO organised the clarification. Work resumed only after the NGO drafted a formal letter of authentication and circulated it to the health centres. I was also told to carry the letter with me to the field, just in case, and to try and finish my work as soon as possible. I was also advised to avoid “sensitive” topics during my conversations.

After spending two months in the villages and short-listing people, I began the interviews. In the first meeting, I informed the potential participant about the nature and scope of the study. It was difficult for them to understand why anyone would leave her comfortable life in Delhi and travel to their far-flung villages to conduct a study. They frequently asked questions about the usefulness of the study. This was a difficult question to answer because there is to be no direct result from the study. So, I explained to them that the aim was to collect voices from these

far-flung areas and make them heard where they would never otherwise be heard.

It was made very clear that the individual participant would get no direct benefit from the study. I offered no monetary or material benefit. What I did offer was assistance of any kind that was within my power to provide. This took the form of referring people to specific doctors in and around Srinagar for free treatment. Many people availed of this facility.

One factor that worked in my favour was that I am a native of Kashmir and had left my family in Delhi to come and talk to the people. This was something most people admired and respected and it opened avenues that might have otherwise remained closed. In spite of having obtained permission for the interviews from the respondents in the first phase, I obtained fresh permissions in the second phase.

### 3.5 Development of the study tool

The tool used for this study was the in-depth interview schedule. The process engaged in the development of the final schedule was an important aspect of the study. The interview schedule was refined over and over again as the study progressed to accommodate its changing demands.

The first draft of the schedule was prepared while drafting the proposal. This was based on the research conducted before submitting the proposal and on my personal experiences. This schedule was extensive and covered most aspects of the lives of the respondents with their medical history. This schedule was tested in the field and I realised that questions about the financial status of the respondent were not received too well.

On the basis of the interview schedule and the experience of two months in the field, the concepts of the study were developed. A conceptual framework was drawn with the help of the reviewer. Then the concepts were defined. This enriching experience gave the study its direction. The conceptual framework also helped to improve the interview schedule.

The second draft of the interview schedule was used to conduct the first five interviews. The interviews went off well, but the data that came in led to the realisation that some areas in the schedule were unnecessary. Information about the



reproductive health of the respondent, though necessary, was not needed in depth. Similarly the health pattern of the village was required, but not in as great detail as was being generated. These aspects were left out of the final schedule. With the help of the first five interviews the concepts were further developed to generate coding for the analysis of the final data.

### 3.6 The interviews

Each interview was conducted over two or three sessions. The first session was devoted to informing the potential participant about the study, the researcher, the areas of discussion, confidentiality of the data, and the freedom to opt out at any time. She was told that the report would be written without her name or any kind of identification being mentioned. The interview was conducted only after getting the participant's consent. The final participants had no objection to being interviewed, but they refused to allow the interviews to be recorded or to sign a letter of consent. Only one respondent allowed her interview to be tape-recorded.

The interview started with general questions about the person, her family, and the society around her. The in-depth portion began only after the participant became comfortable with the researcher. The second session, which consisted of the main body of the interview, was normally held the following day to maintain continuity with the previous day's thoughts. Most interviews in District B were conducted in this manner. But the interviews in District A had to be concluded in a single session, as it was inadvisable to stay in the area for long.

The interviews were conducted mainly in Kashmiri. Though I am fluent in understanding and speaking the language, I cannot write in it. So the field notes were primarily in English. I was alone with the CHW, and was dependent mainly on these field notes. The CHW was a great help with the local dialect, which at times was difficult to understand. At the end of the day I made it a point to have a brief recap with the CHW, to make sure that I had understood what the respondent had said. If there was any confusion, or I felt that something had been left out, I filled in the gaps with the CHW's help. This practice proved beneficial, especially in District A, where there was no time for a second interview.

The interviews lasted between 45 minutes and two hours. They were conducted in Kashmiri and then translated into English. One interview was a combination of Kashmiri and English and another was a combination of Kashmiri and Hindi. Women who knew Hindi did not find it comfortable to converse in Hindi for a long time, especially when talking of serious issues. So although some women did start the interviews in Hindi, they ultimately switched to Kashmiri.

### 3.7 Problems with data collection

#### 3.7.1 *Acceptability*

The first problem was gaining trust in the field. The initial month and a half of the study was spent in the Lad Ded Hospital and the Children's Hospital in Srinagar, and the villages of Anantnag district, trying to establish a foothold. This proved to be a futile exercise. It was next to impossible to break down the barriers of authority and doubt. All conversations floundered on the question of my identity – was I part of the medical system or was I from the government? A negation of both aroused a doubt of identity that became impossible to clear. A person from the medical staff or the government signified authority that was to be avoided; a person not associated with either was a figure of doubt not to be spoken to. The problem was eventually sorted out by associating with the NGO.

#### 3.7.2 *Consent*

After gaining a foothold in the field, the biggest problem was the question of consent. The respondents had no hesitation in sharing information and experiences. In fact they were keen to talk and share their hardships. But they would not agree to a taped interview or give written consent. Only one respondent agreed to a taped interview. Another respondent, halfway through the interview, asked for the recording to be stopped. She was apologetic, but refused to continue with the audio interview, saying she had not imagined the interview would get so intense. She also asked for the recorded tape to be given to her. Most respondents said the reason for their reticence was not distrust of the researcher but fear. They had seen many hardships and were unwilling to take any more risks. I could ask any question and they would try and respond honestly,

but they would not give any consent that could be traced back to them.

### 3.7.3 *Gatekeepers*

The men were curious about the research. Some of the interviews had to be postponed because husbands or sons would linger around on some pretext. One strategy that was evolved was to allow the men to be around and to continue with the mundane topics of daily life. This was suggested by the CHW, and it worked. After a few minutes of talk the men would lose interest and move out.

Another problem was of women gathering while a respondent was being interviewed. This was resolved by moving indoors on the pretext of having tea. Getting women to talk about their health and the medical infrastructure in the area was not difficult. They were more than willing to share their hardships during the years of turmoil. What was difficult was to talk about the control of the Islamists and the patriarchal Kashmiri society over women. This was a topic that most women preferred to avoid. Those who spoke made only fleeting remarks. Another topic of discomfort was the economic control exerted by the family. Though most women said that things were not so bad in their families, the manner in which this was said suggested that they remained financially dependent.

The research was carried out in two phases because of the onset of winter, which makes travel into the interiors difficult. In the first phase of data collection I spoke to 67 women in five villages. Though I had short-listed the women I wanted to interview and obtained permission from them, I could only manage five interviews. The rest of the interviews were conducted during the second phase of data collection.

### 3.7.4 *Compensation*

Some staff of the NGO wanted the researcher to contribute for their surgical aprons. This was a problem as the NGO had made it clear that there were to be no material contributions. Since three of the respondents were from the staff this would also have been unfair to the other respondents.

## 3.8 Data management and analysis

The data generated from the interviews was qualitative. An effort was made to generate

quantitative data on the basis of the qualitative data. Field notes were taken in English during the interviews and filled in with details immediately thereafter. At the end of the day I would spend time with the CHW to recap the day's work and fill in any gaps caused by my inability to understand certain nuances.

I used the 90-minute taxi ride back to base to expand on the field notes. The interviews were translated into English and fed into a computer. I did the translation myself, normally on the same day. This was not always possible, but an effort was made throughout the study to keep to this pattern. This became difficult towards the end when the study was being conducted in District A. Here I was only able to maintain field notes because there was not enough time to translate them the same day. The last 10 interviews were translated only after my return to Srinagar.

The interviews were made computer-readable using a word-processing program and checked for consistency of spelling of non-English words with the help of a student at the state university. They were then coded according to the different concepts of the study and analysed under each concept. The analysis involved several close readings of the interviews, grouping and classification of the data in relation to the main research questions, and systematic work with the data to answer the main research questions.

## 3.9 Ethical issues

- All but one of the 25 respondents refused to allow a tape-recorded interview. And none was willing to sign a letter of consent. I asked the CHW to sign on their behalf as was suggested by the review committee. But the CHW was uncomfortable with this because she represented an NGO and any document signed by her would represent the NGO's consent. The NGO was also unwilling to do this.
- A major concern for all respondents was anonymity. They worried about their identities becoming public. So the study has used pseudonyms for the participants. The names of the villages have not been used

and letters of the alphabet represent the districts.

- At the outset, it was made clear to the NGO and the respondents that I would make no material contribution. Yet the NGO staff at various points asked for surgical aprons. This was a big concern as three of the respondents were employed with the NGO. If the other respondents learnt that some people were getting a material reward for being part of the study, it could have created an awkward situation. So I ignored the request and told the staff that I could not give them any material reward. I did, however, forward their request to the director of the NGO, who promised to look into it.
- In District B the NGO had the medical history of each household. In the initial stage of the study, the CHW suggested I go through the records and shortlist my candidates. This would have saved time. After much consideration I decided against it.
- The interviews at times generated emotional outbursts from the respondents. These were uncomfortable times for me as I was in no position to be of any assistance to them, especially Chand, who had faced mental and physical torture from the day she was married. I wanted to help, but was unsure if I should, or could. After much debate I discussed her case with the CHW and the NGO director, who promised to help.
- Privacy during the interviews was a major concern. It was extremely difficult to find women alone, especially married women living in joint families. Two interviews had to be rescheduled for this reason. The CHW was a great help; she would engage the family members in conversation, allowing me to conduct my interviews.

# Chapter 4

## Profile of the participants

A total of 25 respondents were interviewed. Of these, 24 were from Kashmir and one was from West Bengal and had migrated to Kashmir after marriage. Twenty-three respondents lived in far-flung rural areas and two lived in cities. Sixty-eight per cent had never been to school. Among the rest the minimum educational qualification was fifth standard and the maximum was an MBBS degree.

Thirty-six per cent were gainfully employed. Eighty per cent were married. Of the rest, three were widowed and two were unmarried girls. Most of the women had married early. Most of those above 45 were married even before the onset of menstruation. Only two women were married after the age of 25. Both belonged to educated, upper-class urban families.

**Table 4.1 Demographic profile of research participants**

S. No.	Name	Age	Residence	Economic status	Education	Occupation	Marital status
1	Amanat	32	Urban	High income group	MBBS	Doctor	M
2	Assiya	38	Rural	Lower income group	NA	Labourer	M
3	Azra	43	Rural	Lower income group	NA	Labourer	M
4	Badila	44	Rural	Middle income group	10	Aanganwadi teacher	M
5	Bano	16	Rural	Lower income group	10	Student	UM
6	Chand	25	Rural	Lower income group	NA	Housewife	M
7	Fateh	45	Rural	High income group	NA	Housewife	M
8	Fatima	60	Rural	High income group	NA	TBA	M
9	Fauzia	28	Rural	Middle income group	12	Health worker	M
10	Kaiser	40	Rural	Lower income group	NA	Housewife	M
11	Kasheer	65	Rural	High income group	NA	TBA	Widow
12	Mahad	36	Rural	High income group	Graduate	Housewife	M
13	Mariam	45	Urban	Middle income group	NA	CHW	M
14	Minnah	38	Rural	High income group	NA	Housewife	M
15	Nadeema	31	Urban	Lower income group	NA	Housewife	Widow
16	Nazar	22	Rural	Middle income group	NA	Housewife	UM
17	Noor	31	Rural	Middle income group	12	Housewife	M
18	Roshan	40	Rural	Lower income group	NA	Housewife	M
19	Ruksaan	46	Rural	Middle income group	NA	Housewife	M
20	Sahida	16	Rural	Lower income group	5	Housewife	M
21	Saleema	24	Rural	Lower income group	NA	Housewife	M
21	Saleema	24	Rural	Lower income group	NA	Housewife	M
22	Shaheen	70	Rural	Middle income group	NA	Housewife	M
23	Tahira	33	Rural	Middle income group	12	Housewife	M
24	Uzma	25	Rural	High income group	NA	Housewife	M
25	Yasmeen	45	Rural	Middle income group	NA	Housewife	M

**Amanat:** A general physician, Amanat had worked in sub-district hospitals in remote areas of Baramulla and Pulwama districts in her seven years in service. Her interview was aimed at getting feedback from a doctor and an upper middle-class woman. She ascribed the poor attendance of medical staff in hospitals solely to the prevalent *halaat*. Narrating her own experience, she gave examples of innumerable occasions when she had to return home halfway from her duty station after having spent hours on the road trying to reach the place.

**Assiya:** The 38-year-old was a mother of five and a housewife. Her husband, a farmer, worked as a labourer in the non-farming season. She helped her husband on their farm. The family had moved away from the village and closer to their farmland by the riverside. There was only one other house in the vicinity. Being away from the village, the family was even more scared of the army and the militants. At the height of the militancy there were times when they would not leave their house for days.

The ban on contraception in the valley almost cost Assiya her life. She was forced to approach a local doctor who, without examination, injected her with contraceptives. This led to haemorrhage and she had to be rushed to hospital where doctors diagnosed that she had been three months pregnant and the contraceptive had caused the haemorrhage.

**Azra:** A 43-year-old mother of three, Azra belonged to a very poor family and lived in a dirty single room in her mother's house. She had been through three abortions, the last one recently. She had not had the ligation operation due to a lack of money. Before the onset of militancy her husband, a labourer, used to make enough for them to live comfortably. Militancy resulted in restrictions on movement, confining her husband to the village, where work was not easy to come by. Even with both of them working, they were unable to make ends meet. Azra's elder daughter, aged 16, was badly affected by her mother's recent conception. She was embarrassed that her mother was still bearing children at this age. She tried twice to commit suicide and Azra was scared to leave her alone.

**Badila:** This 44-year-old village *aanganwadi* teacher had studied till the tenth standard. Her polio-

afflicted husband used was a farmer. She had two school-going sons, one 19 and the other 16. Her husband was unable to do any work and she ran the household. Badila did not face any problems because she worked in her own village. Militants would come and inquire about her work but they never tried to stop her. But a colleague, who travelled from the town, was often harassed and threatened. The threats finally forced her colleague to apply for a transfer to a school closer to her house.

Badila was against the militants' stand that women should not work outside the home. If she had not been working, she said, her family would have starved. She believed the militants were trying to control people's lives, particularly those of women. "They wanted to subjugate us completely," she said. Badila decided to undergo the ligation operation at the peak of militancy. She approached a doctor in the district hospital. The operation was conducted at night and she was back home by morning before anyone found her missing.

**Bano:** This 16-year-old, the only girl in a lower-middle-class family of five children, was studying in the tenth standard. Bano's memories of the days of insurgency were of being trapped in the house for days, of not being allowed out alone, of the restrictions placed on her because she was a girl. She regretted being a girl and strongly supported the terrorist dictum of wearing a *burqa*. The hardships and torture of the years of insurgency had made her believe that the *burqa* was good because it left no scope for attracting trouble for both the woman and her parents.

**Chand:** This 25-year-old lived in a shabby one-room house with her husband and son. She was from West Bengal and came to Kashmir after her marriage. She had survived four miscarriages and two dead children. From seven pregnancies she had only one surviving child and was pregnant for the eighth time at the time of the study.

She said that life was different in Kashmir. Comparing the conditions with her hometown she described the situation as depressing. She recalled the constant fear among people that she did not initially understand: "There was a sense of terror hanging in the air." She remembered days when she was alone at home with the army and militants all

over the village. She believed that God looked after her; otherwise, in a village where women were harassed and abducted from houses full of family members, why was she never touched?

**Fateh:** The 45 year-old lived with her husband and three children. The high-income family owned apple orchards. Her in-laws lived close by and were respected in the village. Fateh has cleared her tenth standard. Her husband was a graduate. The state of the dispensary in their area had not improved though the situation in the state had. The doctor still came only thrice a week and the assistants managed the show at other times. Fateh preferred to go to the doctor if s/he was available, but did not hesitate to visit the "local doctor" at other times.

**Fatima:** The 60-year-old was a traditional birth attendant (TBA) in her village. Her family, comprising a husband, four sons, and a daughter, owned land. Cultivation was their main source of income. In the non-agricultural season the family members worked as labourers. The family belonged to the middle-income group.

Fatima was bitter about the militant ban on family planning methods. She said it was a facade. According to her the militants needed these facilities as much as the people. Some were even run by them. "They have done so much harm to us women," she said. "The people who carried out those abortions were butchers with no knowledge whatsoever." Women were forced to revert to traditional contraceptive methods or travel outside the state for operations and abortions. Fatima believed the turmoil of the last 16 years had set Kashmir back many centuries. There was no transport at night. The army would not allow people to move unless it was a matter of death, and not even then at times. Doctors were scarce. Hospitals were used as hideouts. There were times when militants forced patients to vacate beds so that they could rest. In those days only the gun spoke. One would pray that one never fell ill, she said.

**Fauzia:** The 28-year-old woman from a rich family was married six years ago and had a three-year-old daughter. She was a health worker. She took the job to counter the depression of not being able to conceive a second child. Her first delivery was normal. But her troubles began thereafter. A piece of

the placenta was left behind in her uterus, almost leading to her death. In spite of her anger at the doctors and the hospital, she said she understood that such incidents had become more common because of the increased caseload. She recollected a time when the district hospital in their village was so good that they never needed to refer a case outside. Today it was little more than a dispensary.

**Kasheer:** She was a 65-year-old traditional birth attendant. Her husband died some years ago of ill-health. She had two sons, two daughters-in-law, and five grandchildren. The well-to-do family owned fields. Both her sons were craftsmen. In all her years as a TBA, she said she had never seen days as horrifying as during *tarikhi*. Even TBAs were not spared interrogation, she said. "So many times we had to beg and plead with the security forces to let us go. They wanted proof that we were going to visit a patient. What proof could we provide?" Every time she had to leave her house at night for a delivery she used to bid her family farewell as though she would never see them again. She thanked her family, which supported her through all the hardship.

**Kaiser:** The 40-year-old belonged to the poor nomadic community of Gujjars who rear sheep and goats in the hills in summer and return to the valley in winter. Her entire village was inhabited by Gujjars. She lived with her two school-going daughters in her family house. Women, according to Kaiser, could not take any independent decisions due to the lack of finances on the one hand and the unofficial ban on movement on the other. Kaiser was scheduled to undergo an operation at the district hospital but was unable to go for lack of a reliable guardian for her daughters.

**Mahad:** This 36-year-old housewife lived in a big town and was from the upper middle-income group. Her husband was an engineer in the state government. She had three daughters. This researcher met her two weeks after her third delivery. She was recouping from a difficult pregnancy following which her baby had suffered from acute jaundice. In spite of being from a rich family that included two doctors, she faced a tough time in hospital, making her wonder about the plight of the poor in government hospitals. She said the years of militancy had ruined the once sought-after medical facilities

of the state. People from all over the state were now dependent on the few hospitals in Srinagar resulting in the sort of situation she had to undergo. She knows things were improving slowly, but she also knew that it would be many years before the hospitals reached the level they were at when the troubles began.

**Mariam:** The 45-year-old was born in a village, but moved to Srinagar about five years ago. Her husband was in government service and she was a community health worker with an NGO. She belonged to the upper middle class. At the time of her first delivery, doctors advised her to get admitted in hospital after two days. But aware of the situation in the state, she decided to get admitted the same day. She was willing to stay with her cousin in the city if necessary. Having seen the death of her childhood friend due to a lack of means to reach a medical facility in the middle of the night, she was unwilling to take any chances.

She described night as a time of "*dehshyat*." "In Srinagar it really did not matter if it was day or night, but in the villages a person would not even curse his enemy to have a medical emergency at night," she said. Conditions were so bad that people were willing to camp in hospital for days on end and even give birth in bathrooms there, but they would not take the chance of coming to the hospital the next day.

**Minnah:** She belonged to a rich family of apple traders. She and her sister were both married and continued to live in the maternal house. She had four children and was considering sterilisation. When I met her she was accompanying her sister, who was admitted to the Lal Ded Hospital for observation after suffering bleeding in the fourth month of pregnancy and losing the foetus.

Minnah felt that the biggest drawback of the militancy was the loss of freedom for women, especially in the villages. In her house women were not even allowed to move out alone beyond the gate. She accompanied her sister to the hospital solely because there was no male in the family who could go and stay in the hospital all day. But at night one male family member would come to the hospital. Their village was about two and a half hours by bus.

**Nazar:** The 22-year-old, second in a family of five children, was a community health worker.

Despite being the daughter of a schoolteacher, she could not pursue education beyond high school. All colleges were in the district town and it was not safe to travel. Nazar tried to justify this restriction of movement by arguing that the woman had to save her "honour." If something had happened to her, people would have blamed her instead of sympathising. "They would have questioned my movements and said that I must have done something to attract attention," she said. To save her family and herself from this humiliation Nazar gave up studies. "I used to cry all the time and curse God for making me a girl," she admitted. Nazar said health was being neglected in the villages. With people preoccupied with basic survival, health had become an issue to be dealt with as and when the need arose.

**Nadeema:** This 31-year-old widow of a militant lived alone with her daughter and two sons. Her in-laws were waiting to usurp her property. Her only support was her parents, but because of her in-laws' malicious intent she did not want to move in with them. Nadeema said life was very comfortable as long as her husband was around; but after his death things took a turn for the worse. Her nightmare was going to the army camp for her husband's death certificate. She said nothing could be as bad as the glares of the soldiers there, and it was only then that she understood what other women must have gone through in the days of militancy.

**Noor:** This newly married 31-year-old lived in a village 42 kilometres from Srinagar. I met her in the Srinagar hospital where she was nursing her husband who had been shot accidentally in the leg when soldiers were trying to capture a militant travelling in the same taxi as he was. He was left on the road because people mistook him for a militant, and was taken to hospital only after much pleading. Noor said that if the same incident had taken place a few years earlier her husband would have been left to die. No one would have dared to move him. Doctors said that if he had been brought to hospital earlier he might have recovered without any operation. Now they were unsure if even a third operation would help.

**Roshan:** She was from a village atop a hill and surrounded by forests. She was in her 40s and had five children. Her family was from the lower

middle-income group. Their occupation was farming. The village was in an area known for militant activity. The hilly terrain and forest cover provided good hiding places. People here lived in constant fear of the army and the militants. Roshan blamed the militancy for the high blood pressure of pregnant women. She ascribed this to emotional stress and anxiety.

**Ruksaan:** She was a middle-aged woman who lived in a small village with her husband, mother-in-law, and three children. Her husband's brother, a militant, used to live with them, but after his death his wife moved to her maternal house. Ruksaan's husband was a government employee. The family owned agricultural land, which they tended collectively. Their house was located at the base of an army camp, which made it virtually impossible for the women to move out. Ruksaan's sister-in-law had offered to take her for a ligation operation to clinics run by her husband's outfit. But Ruksaan preferred to take medicines bought by her husband from the local medical shop and had aborted two pregnancies in this manner. The third abortion caused a lot of bleeding and she had to be admitted to hospital.

**Saleema:** This 24-year-old, married for six years, had a four-year-old daughter, and was pregnant with her second child at the time of the survey. She lived in a village in the hills about 50 kilometres from Srinagar. Till a few years ago the only mode of transport here was the government bus plying twice a day. The winter months would disrupt even this service.

Saleema described the days of *tarikhi* as a terrible time for people in the hills. The villages were cut off. The bus service that used to connect them to the rest of the state stopped. The villagers had to walk to the nearest village down the hill or use horses. Militants had hideouts in the forests nearby and would often walk in and out of the villages. Because of this army camps were based around the villages. Any trouble in any nearby area would result in raids on the villages. Not many people from outside visited the area. "For months we would not see an outsider," she said. "Our outings used to be to the hospital in the district. We used to actually look forward to falling ill or accompanying a person to the doctor."

**Shaheen:** This 70-year-old widow lived with her two sons and their families in their ancestral house in a small village tucked away from civilisation. They were farmers from the middle-income group. Shaheen herself was too old to work, but helped in bringing up the children, especially her younger daughter-in-law's son.

Shaheen rated the migration of Hindu Pandit doctors as the biggest loss for the people of Kashmir. "We had a lot of good Pandit doctors. But when the militancy started and the Pandits started migrating, the doctors also left. Earlier we thought it was good that they left, as it would bring opportunities for Muslims. We did not realise that experience was leaving with them. Younger doctors replaced them, but they had no one to guide them."

**Sahida:** This 16-year-old, who has been married for a year, was pregnant and had come to her mother's house for the delivery. She stopped going to school after the fifth standard because her parents did not think it was safe. Her husband, 22, was a farmer. They lived in a joint family with her in-laws, her husband's two elder brothers, and their wives. The family, which belonged to the lower-income group, worked together in the fields. Sahida's mother-in-law headed the family.

Sahida's child was overdue and she cited this as an example to explain the change in the situation. According to her, had she been in this condition four or five years ago she would already have been admitted to hospital. Now doctors were advising her to wait a few days more. Now, she said, even if an emergency arose, she would find some transport to take her to hospital.

**Tahira:** She belonged to a business family in a small village. Her family owned a general store in the nearby district town. She lived with her in-laws and had two children. Her husband was a graduate. She had completed schooling. At the time of her first delivery she was unable to reach the hospital. The local midwife was called and she had a safe delivery, though the midwife ran out of gloves and had to use a bedspread. To avoid such problems the next time, Tahira moved to Srinagar 15 days early and stayed with her cousin. She was lucky; other people rented accommodation around the hospital or camped on lawns or in mosques.



**Uzma:** This 25-year-old was brought up by her childless maternal uncle. Her parents died when she was a baby. She was married and lived in a joint family with her in-laws, brother-in-law, and his family, 11 members in all. They owned apple orchards and farmland in the village. Uzma had a son and a daughter, and was expecting a third child. She said the years of militancy changed things, especially for women. The increased levels of sexual harassment and torture led to women becoming suspect. Uzma had to abort her first foetus as she conceived within a few days of marriage and was unsure how her in-

laws would take the news. Her being an orphan only heightened her fears. So she consulted her adopted mother and aborted the child.

**Yasmeen:** The 45-year-old lived in a small village with her husband, four sons, one daughter-in-law, and grandson. Her husband was a government employee. The middle-income group family also had fields that her sons cultivated. The ban on family planning forced Yasmeen to travel to another district for her ligation. Visiting a gynaecologist in the village was not only unsafe for fear of militants, but people would suspect her character.

# Chapter 5

## Conflict: Reality from the women's perspective

The conflict in Kashmir has gone through many phases over the last 16 years. This chapter presents the women's perspective of the situation and some of their experiences, which resulted in changing people's attitudes towards the conflict. Although the media outside the state proclaim a return to normalcy with the revival of tourism, newspapers in Kashmir are filled with casualties every day. A leading Urdu daily even publishes a scorecard of people killed.

### 5.1 Perceptions of conflict

The years of conflict in Kashmir have seen many phases not only in its execution but also in the support the secessionist movement received from the people. None of the 25 women interviewed for the study said they did not support the movement, but all were in some way disillusioned. The years of struggle without any result had taken their toll.

"I am not saying that the independence movement is wrong. I completely support it," said Tahira. "But the movement has changed in nature over the years. We had thought that it will last a year or so, maybe a little longer, and then we will have our independence. But this has not happened. It is almost 16 years now of pure bloodbath. Our work, our lives, and our livelihood are affected."

Noor, recollecting the early days of conflict, said that even though she was only 15 at the time she remembers it all. "We all believed that independence was a few yards away," she said. "But things changed slowly and as the army and their control grew things changed. The face of militancy also changed. Different groups came up." Indeed, where the militants were earlier regarded as heroes, today the mere mention of the word frightens people.

Most of the research participants said they had supported the independence movement without realising that they were bartering their right to live with dignity. As Tahira said, most people thought freedom was a matter of a few years, if not days. Had they known that it would be such a long battle, they might never have supported it so overwhelmingly.

Discussing the change in attitude, Mariam said, "Initially the movement was sincere, so people respected it. Then things changed. It became a *goonda raaj*. Things became unbearable and people realised that this was not for their good but for the good of the perpetrators." She believes the militants' downfall was their failure to practise what they preached. Citing the example of the ban on modern education for girls, she said people would have obeyed it if the militants themselves had not sent their children to universities abroad. "They educated their girls in London and told us poor, illiterate people to send our girls only to Islamic schools. Why? So we are in no position to earn even a few rupees?"

### 5.2 Experience of conflict

Talking of the days of *tarikhi* is often not very easy. Each time the word is mentioned it brings back memories of hard times and vulnerability. "We were trapped. Militants would come at night for food. The army would follow in the day questioning us who had visited at night. Both had guns. We were scared of both and could not refuse anyone," one woman said.

People were scared even to use candles in the house after dark. Fatima said they would light a candle well hidden behind curtains or inside a cupboard so that the light would not show outside. Militants would visit the villages at night and it was believed that any house that had a light burning would be their first preference, though all were aware that darkness was no deterrent and whoever they visited could not refuse them entry.

Kasheer said, "We were lucky if a day would pass peacefully. Every day there was some disturbance somewhere or the other. The militants would come by night and the army by day. We were caught in the middle. If we were to listen to one, the other would kill us. Those were days of *dehshyat*."

The persisting conflict has left its mark on every individual in the state. It is a matter of spending time with people to know of their experiences. One person I was unable to interview in spite of meeting her almost every day of my stay in the valley was

Irma, an orphan of 14 years. She befriended me in the market. She lived in an orphanage close to where I was living. She made it part of her routine to come and meet me two or three times a week. She was from Kupwara (a militant-infested border district) and used to live in a village on the Line of Control. Her father had died in shelling in her village. She has three sisters and one brother, all in the village. Her aim was to be able to support her family one day.

Irma had one of the most cheerful faces I have seen in the valley. In spite of the tragedies she had been through, she believed in being happy. She believed in hard work and god and was determined to succeed. This was her coping mechanism. She never allowed anything to come between her and her goal. Each time I saw her, I understood how deeply the conflict had affected the people of the valley.

**Nazar:** *I know I should not be talking about these things, but then this may be my only chance to speak and, frankly, I do not care anymore. I do not support the army or the militants. For me both are equally bad. Both did things that cannot be pardoned. The militants were initially good people who believed in free Kashmir, but slowly things changed. The once good people changed and it was we, especially the poor women, who had to face the brunt of it all. (Wraps her chunni around her tightly). The militants also started torturing poor people for money. Had it been just this it would have been okay, but they started harassing people, especially women. I know of militants who abducted girls and kept them for months in their camps. (Pauses). These militants spoke about freedom and jihad and what not and see what they did to us. Can the women to whom this happened ever forgive them? Their lives are ruined forever. And when these women were sent back it was these very militants who would ridicule them and talk of banishing them from society. Were the women at fault? No, but who would give them justice? The poor women could not even whimper about what had happened with them. If they ever tried to open their mouths they were silenced with threats to them and their families. They were so scared that they would not even want to see a doctor for check-ups. They were aware that the doctors would ask all kinds of questions. To avoid that humiliation they preferred to visit the local doctor or suffer in silence.*

Noor got very emotional while talking of her growing years. She remembered the days when she would roam like a free bird. That changed with the onset of militancy. All kinds of restrictions were imposed on her behaviour, attire, and education. She had to abandon her studies. She described the initial militants as “*khudah ke bandey* (militants, men of god) who believed in a free Kashmir.” But slowly they changed into men who would abduct and rape girls. As the atrocities increased, Noor’s admiration for the militants diminished. She said, “As long as they were not interfering in our daily lives, the movement had our support. But once our lives were affected we started praying for an end.”

Nazar was bitter that her parents did not allow her to continue her education. Commenting on the irony, she said, “No one could have thought that a schoolteacher would not permit his daughter to study. But that is exactly what happened to me.”

### 5.3 The terror of darkness

One aspect that left no one untouched was the terror of darkness. Mariam’s statement, that “those were times when after four not a bird would move, what to talk of human beings,” captured the sentiment. Bano said that all movement came to a halt after sunset, especially for women. It was considered unsafe to move out, no matter what. I repeatedly heard how life would come to a standstill after dark. In the initial years of conflict curfews were imposed after sunset. People still obeyed the deadline though curfew was no longer imposed. If they could not get home before sunset, they stayed with a relative or in a mosque-----.

“Night time is *dehshyat* time” is what Mariam stressed, saying she would not even curse her enemy to fall ill or face an emergency at night. She knew how difficult it was to make any kind of arrangement at night. She had witnessed the death of a close friend for lack of transport. The family was unable to take her to hospital in time. “The terror of the night is so strong that at the slightest movement we get heart attacks,” she said.

Tahira said that earlier there was at least freedom of movement, be it day or night. “The helplessness that we feel now was not there. In those days we may have had to walk 20 kilometres, but we would do it happily, for we knew this was our land

and no one would question us. There was a sense of security. Today we are helpless and completely controlled by the clock.”

Traditional birth attendants in the villages were asked to carry lanterns instead of torches at night. This was a restriction imposed on all. Torches were banned. Mariam said, “If you were out with a torch you could be shot without warning, no matter what the reason for your moving out.” (The ban was a result of the fact that powerful torches were used by militants to temporarily blind soldiers at checkpoints and also as weapons.)

Kasheer, narrating her experiences of going out for emergency cases in the middle of the night, remembered the innumerable times she was stopped and questioned. “We do not mind the inquiry, but when they ask us to prove that we are going to visit a patient, we feel angry and helpless. What proof do we give? It is not possible to bring the patient to them,” she said. Noor questioned the identity cards provided to TBAs. “What is the point of issuing the identification cards when the government itself is not willing to recognise them?”

So people had to perform what many of the research participants called a balancing act. They had to learn to accept the situation and to change themselves. Roshan said, “Life for us changed completely.” Even weddings were shifted to the day. All ceremonies had to end well before sunset so that guests could return home before dark.

#### 5.4 Military crackdowns

Equalling the terror of the darkness was the terror of military crackdowns; all research participants spoke about these crackdowns. These were essentially intensive and extensive searches that sometimes lasted for days. The area to be searched was cordoned off and people were made to move out of their houses. Bano said, “People were taken out of their houses, men, women, children; old, young, even ill people were not spared. If anyone tried to stay on they were beaten.” Though women were not beaten as a rule, Chand said that if a woman tried to intervene there was no telling what would happen. People described crackdowns where even the sick and invalid were not spared. All were made to move out and stay out until the search was completed. No one was allowed to speak or protest. Misconduct was severely punished.

Mahad narrated how, at her younger sister’s wedding, jewellery was stolen by security personnel who were stationed in their house for a week during a crackdown in the area. They could not turn to anyone for justice. They could not even lodge a police complaint.

#### 5.5 The uncertainty of life

Uncertainties were visible in every aspect of life. Kasheer recollected that even a mundane task like going to work each morning was filled with fear. “Each day when people went out for work, those left in the house would pray for their safe return. How many times it has happened that we have not seen our loved ones again.” Her own work necessitated her to be available at any time. Whenever she left for work, she would bid her family farewell, not sure if she would see them again. It was her family’s support and encouragement that enabled her to continue working in this situation.

Huma’s daily exercise of buying groceries could have cost her and her son’s life. She had left him in the car with a cousin and was across the road buying vegetables. She did not even realise that something was wrong till the firing began. All she remembered is that people were pulling her towards a shop to shield her from the bullets while she was running towards the car to rescue her son. “It took two hours to get some sense in me. I was a nervous wreck. Finally someone on the road slapped me to bring me back to reality. They told me that I was holding my son while crying that he was trapped in the car.” Huma later realised that though she had saved her son from the bullets, she could have killed him by choking him.

Trouble between the militants and the army could occur anywhere, anytime. Curfews, *bandhs*, *hartals*, all were part of life. No one could say what would happen next. Nazar had gone to Srinagar with her parents. That day there was a bomb blast in the city. Firing continued for an hour. Thereafter curfew was imposed. No one was allowed to move. Nazar and her parents were forced to take shelter for two days with relatives. She considered herself lucky that she had relatives in Srinagar, but what about people who had none? “Where did they go? What did they do? What is visible today is not what was in those days. It’s very strange, but as I grew up in that

environment it seemed natural to me. But as things are changing I can see the difference now and realise what hell we were living in."

Fauzia said that in those days there was a lot of checking on the roads. One was considered lucky if one was not stopped en route. "I remember a particular day when we were made to get down thrice and our whole bus was searched. That day it took us almost three and a half hours to reach home." The hardships increased at night, as no vehicles were available. People and vehicles needed special permission to move around after dark. "We were, and for that matter in the villages still are, at the mercy of the security forces. There were times when we were made to feel worse than animals. Life used to come to a standstill. Yet we survived."

Livelihoods in the unorganised sector were badly affected. One community trapped in the turmoil was the nomadic Gujjars, who live in the hills and forests with their herds. They are familiar with the terrain and the happenings. The army often used them to trace militants hiding in the hills. Kaiser's husband, a Gujjar, was killed in the crossfire while helping soldiers track down militants hiding in the forest. But the Gujjars have little choice. If they do not assist the army, the soldiers will stop them from going up to the hills and that is a direct blow to their livelihood. At the same time there is the threat from the militants. "But they also know that if we do not help the army they will punish our families and us," said Kaiser. "We just have to live in this jam. They both have power and we perform a balancing act."

## 5.6 Return to normalcy?

In the last few years the Indian government has been propagating the return of normalcy in Kashmir. Yet each time I even whispered the word "conflict" I was met with silence. "What do I say; I am being very honest. The situation in the villages was very bad. When we look back on those days we shudder." This was a statement I heard regularly in my days in the field.

People in the valley were warm and inviting as long as the years of conflict were not part of the conversation. Research participants often pretended not to have heard the question. One word that was often used to describe those days was "dehshyat." The terror is still noticeable in the sudden change of tone and body language. I was often asked to lower my voice and be careful of who might be overhearing the conversation.

The participants said that while things were coming back to normal, conditions were not as good as they were being portrayed. Kasheer summed up the persistent terror when she cautioned me: "They are here, amongst us. Only now we cannot recognise them. Earlier they would roam around freely. They are more dangerous now. Let's not talk of them."

At 22, Nazar described the conflict as a part of growing up. Only recently as things began changing, she saw a world different from the one she knew. But she remained cautious. "The army and the militants surrounded our lives completely. There was no security in our lives. The situation is improving slowly, but fear still exists." Nazar envied

**Azra:** *When trouble started it brought bad days for us labourers. We work on a daily basis and the number of days that we do not work means that much loss to us. And conditions were bad. There was curfew, bandhs, searches, what not; it became impossible to move out of the house. My husband used to go to the towns to work, for you get better wages there. But with the regular disturbances, this was not feasible. After all, life is more important. So he was forced to look for work within the village. And work in the village is seasonal. There are months when there is no work. Earlier he used to earn more than enough to run the house; I would work only if someone requested me to. But then as the halaat deteriorated I was forced to move out and work on a regular basis. Do you think I like the fact that there is no one to look after my children when they come back from school? My house is neglected, there are so many repairs to be done, but who has the money or the time? I hope to God that someone benefited from this struggle, for I definitely did not.*

*I was not always like this. I was a healthy person, who never saw a doctor. The only time I went to a doctor was for my delivery, that too to the local midwife. But the tension of the past years has killed my health. The doctors tell me that I worry a lot and that is why I am losing weight. They tell me that I should concentrate on my house and my children. The irony is that it is my house and children that I worry about.*

the freedom women outside enjoy. It was her wish to attain that freedom. In a soft voice she said, "I wear jeans in Delhi."

The struggle for survival was not easy for Noor's husband, who was badly wounded in crossfire. He was lying on the road with no one willing to help. He had to plead with people to help him. Only when someone recognised him as a civilian was he taken to hospital. Noor was happy that someone at least had the courage to help. If the incident had taken place a few years ago no one would have dared and he would have died on the street.

Mahad, emphasising the perils of travelling in the state, said that even now it was uncommon for one to be able to travel without being stopped for a security check or by a bandh en route. Just a day before we met, her sister had been caught in a bandh and had to walk seven kilometres to reach her mother's house, where she waited till traffic was allowed to move again. "This is the scenario in times when things are supposed to be returning to normal," Mahad remarked.

Most of the research participants, though not completely happy with the state of affairs in Kashmir, described it as "jannat" in comparison to the past years, and prayed that the days of terror would never return. Bano said, "Right now I am sitting in my cousin's house without my parents' knowledge. In those days this would just not have been allowed."

## 5.7 Conclusion

People's perception of the conflict had changed. Over the years the nature of the movement for independence had also changed and the actors in the drama had lost their credibility. The people believed these players were no longer committed to the cause. People had also not imagined that the conflict would last this long.

The general population was left feeling trapped between the militants and the security forces. They felt betrayed. Not only was the freedom they dreamt of nowhere near being achieved, they had lost all hope for their own futures. They would still like to dream of freedom, but not at the cost of their lives. People wanted control of their lives back.

# Chapter 6

## Conflict, social changes and effects on women

Society undergoes many changes during a prolonged conflict. One of the most prominent changes is in the status of women. Women are often seen as a symbol of honour and protection of this honour becomes the focus of the society caught in the conflict, with the onus being on the women themselves. This responsibility manifests itself in various restrictions imposed on them. This chapter studies these social restrictions and the impact they have on women's lives.

### 6.1 Social changes

Mahad, explaining the repercussions of the conflict on women, compared Kashmir to the rest of India and to Muslims outside the state. "We are a very forward-looking community," she said. "Before the onset of militancy our girls were doing well. Things were different in the villages, but still it was better compared to the rest of the country." Women in Kashmir were respected and had a say in their household. But the onset of militancy set the state back by a century, "from a time when we were free to pursue any career and study as much as we liked to a time when we are asked to forgo all western education in the name of Islam." The change was especially bad in the villages where girls had only just begun to come out and take up jobs when the trouble began, and the first thing it did was end this independence.

Most research participants who were parents spoke of their helplessness. Minnah, a mother of four, compared her childhood to the last 16 years. She spoke of a time when they were free to go all over the village. Now she was not allowed to step out of the main gate of her own house alone. The times were changing, however, and she was trying to get all her children, especially the girls, educated. "They are allowed to go out in groups. There are schools close by and all the children from the village go and return together." But parents still worried. Some had made their children miss a year if there was no one else going with them to school or college.

Azra said she felt bad scolding her daughter if she returned home late. But she justified her anger because of the *halaat*. "Times are not the same anymore. There is army all over, and they are not good people. We cannot trust them," she said.

With this responsibility of preserving their "honour," women also lost all rights to privacy. "A woman in the village would never travel alone, come may what. She would beg and plead for company. Two women together would do, but not alone," one participant said. Taking kids along was the norm if no one else was available. Even within the village moving around alone was avoided. It did not matter where one was going. People believed there was safety in numbers. So they would wait for days for company to go to the doctor in town, and not go if there was no company.

### 6.2 Fundamentalism

The rise of Islamic fundamentalism has wrought major social changes. In Kashmir the phenomenon has manifested itself in the form of the *purdah* (veil), restrictions on the movement of women, prohibition of modern education for girls, and ban on the use of contraceptives and on abortions. These dicta have resulted in not only physical ill-health but also mental problems. The past 16 years have seen a progressive state come to a standstill.

Most of the research participants correlated the advent of fundamentalism with these restrictions. They said these dicta had caused more grief for women than the conflict. They repeatedly questioned the validity of the dicta, especially the ones against modern education and family planning. "They said family planning is against Islam," Nazar said. "What Islam are they talking about? I have also read the Quran, but I have never read anything like this."

Fatima accused the fundamentalists of trying to subjugate women. She questioned their action in banning family planning while not only allowing illegal abortion centres to flourish but also using them for their own gain. Her question: where

in Islam is the justification for rape? "They wanted to subjugate women to have more children. They wanted to keep women under their control."

Mariam said the community at large may well have adhered to the dictum against modern education, but the problem was that the people imposing the dictum were themselves disobeying it. All that the fundamentalists were trying to do was break the economic power of the people, especially women.

The research participants repeatedly said that their own lives did not matter, but young girls living through the years of conflict were badly affected. Nadeema, Ruksaan, Fatima, and many other mothers voiced concern for their daughters. Nadeema, who was trying to get over her young husband's death, also had to cope with her daughter's anxiety and depression. The girl, whose menstrual cycle should have started by now, showed no sign of it. Doctors said there was no medical problem. But Nadeema knew that all is not well.

Azra's daughter was a bright student, but suddenly lost all interest in education and developed suicidal tendencies. Azra blamed this on the lack of opportunity for her daughter to grow up in a normal environment. Kaiser worried about her daughter who did not want to continue her education for she was conscious and ashamed of the changes in her body.

### 6.3 Women and honour

Conflict has always left women vulnerable to sexual violence. Throughout history, women and girls have routinely been assaulted and raped in times of war. Recently, ethnic cleansing and changing patterns of conflict that target civilians have made women and children even more vulnerable. Most displaced women remain without access to reproductive health care, safe birthing conditions, contraceptive services, or counselling. [37].

Sexual violence against women is an inevitable adjunct of conflict. History has demonstrated the link between war and the control of women's sexuality and reproduction. Through rape, communities are humiliated and men emasculated. Rape and sexual assault in conflict are now recognised as war crimes. Rape in conflict is neither incidental nor private. In Kashmir, both the security forces and the militants systematically used

it to punish, intimidate, coerce, humiliate, or degrade. [11].

**Kaiser:** *What was I to do? She told me that I would have to be in hospital for almost a week. But how can I leave my daughters alone? I have to make arrangements for them. They cannot be left alone in the house. Someone has to be here. So I cannot leave till I send them to a relative's house or get one of their aunts to come and stay here. Though my neighbours have offered to stay over, I prefer to have someone from the family. It is not that I do not trust my neighbours, they are very good and I know they will look after my daughters well, but my heart does not agree. Daughters are daughters. Had it been a son I would have never thought so much. But I have to be careful about my daughters.... These past years of the gun have made us see things that we would have never even thought of. We have roamed all these mountains and know what is happening here and we also know what happens when girls are abducted. I do not want my daughters to go through any of it. It has become very difficult to raise girls, especially for a single woman. I pray for the day when I will have safely married off both my girls. It will be the day of Hajj for me. Till then I will never leave my daughters without making arrangements. Nothing is as important to me. Even if it is my own mother dying I will not leave my daughters alone.*

Women across the state voiced their concern at the rampant sexual violence by both sides. Bano pointed out that there were no age restrictions; the aggressors only had to fancy someone. If you were a girl you were at risk. Sahida said both the soldiers and the militants had no respect for women. "They make lewd remarks, try to get fresh, and God forbid if they take a liking to you. Then no one can save you." She said she could not describe her helplessness when these men stared at her. "They literally stripped you with their eyes. We were young, but I can still remember those eyes. I was tall and my body changed earlier than my friends. So I would always stand out in our group. It was very humiliating. At first I did not understand the glares. It was my cousin, to whom I told these experiences, who explained these things to me. I felt even smaller!"



With the growing number of cases of sexual harassment and no protection from the government, women became a symbol of honour for the family and society and protection of this “honour” at any cost took prime importance. The atrocities created a fear psychosis among people. The izzat of the woman became more important than the woman herself.

The restrictions on movement arose not so much from fear for the girls’ lives as from fear of loss of their izzat. The prime responsibility of parents was to safeguard their daughter’s izzat till she got married. Once married, this responsibility shifted to the husband and his family.

**Fateh:** *(Laughing out loud) I am sorry, but this is such a funny question. Who cares for women’s health? No one, believe me. You may wonder how I can say this with so much conviction. If you were listening to me carefully till now, I told you about how the “izzat” of a woman is above everything. You were surprised when I told you that my sister-in-law did not go to the hospital for check-ups during her pregnancy. By God’s grace we are well off and can afford the best doctors in the state. Yet no one in the family agreed to take her to the doctor for check-ups. Don’t you find it strange? I do. But then who would have listened to me? Finally the family honour cost the poor girl her life. How can I say that equal importance is given to the girl’s health when my own sister-in-law died because of this?*

## 6.4 The effects on women

### 6.4.1 Restrictions on mobility

Roshan spoke for most women in the state when she said the militants dictated everything. She said even their movements were controlled. “It was no life. We were not allowed to walk alone or leave our village alone. Even in emergencies we could not go out alone.” Talking of the days of peak militancy Roshan said girls were always kept in another room away from the eyes of men. “My husband would not allow even me to come into the room, what to talk of my daughters. We were scared to send our daughters to school. But how long could we keep them at home? Finally we allowed them, but only if they went in a group. There was no way they could go alone anywhere, even to school.”

Tahira got married just as the militancy began. Remembering those days she said she would feel claustrophobic. The only place she was allowed to visit was her parents’ house. The restrictions on women’s movements were not only mentioned by all the research participants, but also stressed repeatedly, because these restrictions changed their lives, especially in the villages.

Kasheer said it was almost a novelty after the militancy to sit and talk with friends. “It is very rare that we get a chance like this,” she said. “Earlier we would all sit together in the evenings and chat till late or go to the river together to wash utensils or clothes. Those were good days. These past years have spoilt all that. A slight delay in coming home and everyone worries. We used to curse going to the forest to collect wood. Now we miss those things. That was the only time you were alone, without your in-laws. How much we used to talk!”

The restrictions on movement cost women not just their freedom but also their privacy. They stressed over and over again the need for a companion, no matter where they were going. Mahad said, “One would hardly find women out in those days, especially alone. Women would not move out unless they had some work. Then too they had to be accompanied. A woman could not think of going out alone or without telling anyone.”

These restrictions came about because families were scared after hearing tales of harassment and abduction. Nadeema said there was no formal ban on women’s movements. “Just the fact that it was unsafe to go out alone meant that women would not venture out alone.” Roshan said people feared for their women. “What if something were to happen? What if someone abducted them? Who would be responsible?” To avoid these situations, women were asked to stay indoors or go out only in groups.

**Shaheen:** *Right now you are here in our village almost 60 kilometres from your home. You are brave and your parents are courageous to allow you out on your own like this. Who knows what might happen en route? Just yesterday there was firing on the highway and I believe it took almost three hours before the traffic was allowed to move. I would have never allowed my daughter to go out like this all alone. I am not passing judgement on you or your parents, but a fact is a fact.*

Shaheen said going out alone was unthinkable for a woman, whether young or old. "She will not go. It's as simple as that. There can be no emergency bigger than the honour of a girl or her family. If things are really bad, others are there in the village." A woman only had to ask for company and no one in the village would refuse if it were an emergency. "We are living in times when we cannot afford to refuse help to anyone. What if it happens to us tomorrow?"

#### 6.4.2 Lack of education

The constant fear led to drastic changes for women in those years. Girls were no longer allowed to pursue an education. Nazar, in spite of being a schoolteacher's daughter, was not allowed to continue her studies. Badila felt that she was lucky to be allowed to complete her tenth standard. So was Fateh. Sahida had to go to the next village for middle school, so her parents simply stopped her education. She was disappointed at not being allowed to continue beyond the fifth standard, but she came to terms with it, for she was not alone. All her cousins

and friends had to stay at home after the fifth standard.

It was not as if parents did not want to educate their daughters. Girls who were lucky to have schools close to their houses faced no problem. It was the travel that prevented parents from educating their daughters. Minnah said no woman in her family had been to school. Things were changing, but girls were still allowed to go out only in groups. Many families in her village did not allow their daughters to travel alone for education, and even made them drop a year rather than go alone.

Sahida had to give up her studies after the fifth standard and was married at 14. No one asked her opinion or gave her any explanation. She was just told to stop her education and then told that she was being married. "We did feel bad for a few days," she said, "but it happened with every girl, so we took it as a part of life. The militancy had created a fear psychosis. Parents wanted the safety and well-being of their daughters, so the minute they found a good proposal they plumped for marriage."

*Sahida: I studied till the fifth grade. After that my parents did not allow me to go to school. I had to go to the next village for middle school, so they stopped me from going. They were scared of the army. There was an army camp near our village and the men used to stare at the women. Also in those days there were a lot of stories of girls being abducted by the army, so my parents decided it was safer to stay at home. No one explained anything. There was nothing to explain. We all knew it. We were disappointed, but then those were days when nothing much could be done, so after grumbling for a few days all us cousins got used to it and life continued. Soon we were married off, so then it really did not matter. (Laughs) Who plans a baby? It just happens. I would have ideally not wanted one, but then if it has to come it will come. No one in the village plans a child. You get married and you get pregnant. If you do not get pregnant, then there is a problem. People talk and wonder about you. In the first two, three months no one says anything, but after that people talk. Why are you not pregnant? Is there a problem with you or your husband? Is there a problem between the two of you? All kinds of things are talked about. After the first child one can think of planning, but not before that. Before the onset of militancy people used to educate their children and wait for some time before getting them married. Now things are very different. Girls are married off as soon as possible. The militancy has created a fear psychosis. Parents want the safety and well-being of their daughters, so the minute they find a good proposal they deem it fit for marriage. The areas where we are living, things during militancy were bad. The men, both army and the militants, really disrespect women. I know it for I have experienced it. They will pass lewd remarks, want to get fresh with you, and God forbid if they take a liking to you. Then no one can save you. Who can do anything in front of a gun?*

*I cannot describe the helplessness of a woman when those men stare at you. They literally strip you naked with their eyes... It was difficult for us girls to move out alone. We were trapped in our houses. I used to long to go out and play with my friends. Even to go to the village shop or, for that matter, to go to the river. I was so innocent when I got married that I was actually happy that I was going somewhere finally. All the arrangements and the shopping elated me for I got an opportunity to go out of the house. I never knew that I was going for good.*

#### **6.4.3 Early marriages**

Sahida's narrative shows that it was not only women's education that suffered. A deeper repercussion was the lowering of their age at marriage. "Thankfully things are changing again and girls are getting an education and marrying a little later," she said.

Fateh, remembering her unfortunate sister-in-law, said people used to fear for the safety of girls. "In the villages girls were married off as soon as they turned 14 or 15. Before the onset of militancy girls were being married at 20 or even later. But all this changed with the onset of militancy. The minute parents felt their girl was old enough physically they would marry her off. My sister-in-law was married off at 14. By 15 she was dead."

Noor said that those days were so unsafe that even the head of the security camp near their village used to warn the women to move around in groups, especially after dark. Fateh said marriage was a very important occasion in the villages and if daughters were not married at a respectable age to a respectable groom, tongues start wagging. A girl could not get married if there was the slightest scar on her character. Parents had to really struggle and sometimes even settle for a less worthy groom.

#### **6.4.4 Dress code**

Restrictions were not only placed on the movement of women, but also on how they were to move. No woman was allowed outside the house without a *burqa*. In the villages this restriction was not strictly adhered to, but in the cities acid was thrown on women found exposing any part of the body. Women could not think of going out alone. Visits to the fields or even to the neighbours were only possible in groups. Families imposed this restriction to safeguard the women from the eyes of militants and soldiers. Looking back at the restrictions on society in general and women in particular, Badila felt that the militants wanted to spread terror. "Today when I look at it, I think they really wanted to send us women back to the dark ages. Their first ban was on the kind of clothes women wore. They banned all western clothes and asked women to wear clothes in strict adherence to Islam. *Burqa* was imposed."

Initially there were no revolts against these bans as the fundamentalists had terrorised women with their acid attacks. Women gradually revolted against dicta opposing modern education and imposing a dress code, but the terror remained. "Beauty parlours were shut down," Mariam said. "They would go and shoot any person trying to run a parlour along with the people found inside. Video shops were shut. Cinema halls were closed. There was no avenue of entertainment left. They wanted people to sit and pray the whole day."

#### **6.4.5 Financial vulnerability**

The vulnerability of women was accentuated by their financial dependence on husbands and families. In the cities some women were employed, but in the villages the percentage of such women was minimal, though most of the research participants said things were changing. Roshan said, "Financial independence depends on the family... as women are not employed they are dependent on husbands or fathers. Things are changing, especially in the cities, where more and more women are beginning to work."

Kashmir is primarily agrarian, with a strong joint family structure, making the income earned a joint income of the entire household and controlled by the head of the family. This structure makes women dependent on the family and their husbands. Fateh said, "Women are very vulnerable in the villages. The head of the family is in complete charge and he takes all the decisions. In a lot of families women hardly have any say, especially new brides."

Tahira said marriage for a girl meant a loss of even the little freedom that she enjoyed in her maternal house. "When she is unmarried she is in a position to at least speak to her mother, if not her father. But after marriage she cannot voice her opinion. If she is lucky to have a good husband or caring in-laws it is okay. Otherwise she loses all control, especially over her body." When Tahira looked at the state her friends and cousins, she felt that she was lucky that her husband was good to her and did not make her beg for every penny.

Noor said mere financial independence was not enough for a woman to make her own decisions; she also required her family's support. Talking of her mother's vulnerability, she said, "On the one hand

we had no financial resources. On the other we were not allowed to move out on our own. Even if we had money the fact that we could not move out without informing people at home made things tough... even if we had managed the resources from somewhere, we could not have gone to the hospital without my father's permission."

Amanat said a village woman's health was directly linked not only to her family's financial position, but also its will to get her treatment. In villages the trend was that if a woman was "well" enough to get up and work she did not need a doctor. This trend was more noticeable in the harvest season. "People postpone things until they finish their work in the fields. This may take three to four months by which time the patient may have reached her deathbed."

Kasheer said the lack of finances meant that women in the villages often continued to be their parents' responsibility even after marriage. Many a time you would see women being sent to their maternal homes for "a change of air." "Where girls are unfortunate to have bad in-laws you will often see them going to their maternal homes," she said. "When a woman is unwell, the in-laws willingly send her home for 'rest', but all know that it is for treatment."

Kasheer said this already bad situation was made worse by the militancy. "Families that were not keen on treating women now found a valid excuse," she said. "There was too much trouble outside, so it was not safe to travel to doctors in the city." Women were often taken to local doctors or

*hakims* and *pirs* till such time that there was no choice but to go to a qualified doctor. By then a small ailment would have developed into a serious sickness.

The only source of income for women in the villages was the money they saved, either from selling some crops or from gifts given by friends and relatives. Sahida said, "There are times when I come home and my parents give me some money. I save it... It is never a lot, but still I save it. By God's grace I have not needed to use that money till now, but it is there for me whenever I need it."

## 6.5 Conclusion

With their lack of education and lack of control over decisions relating to their lives like marriage and childbirth, the women were constantly fighting a losing battle, which was made tougher by the dictates of the militants and the army. Over the years they became a symbol of "family honour," which resulted in the loss of all their rights. Their education was stopped the minute it was considered a threat to the "family honour." They were made prisoners in the house till they could be married.

Their vulnerability was evident from the thoughts of Bano, who said, "What is the point bringing trouble on oneself? Look at all the hardships we have to face if we do not obey. Our parents are tortured. We are tormented. The threat of death hangs on our heads. Why not just cover up and save the trouble? After all, that's what even the Koran says." As the conflict gathered steam, so did the restrictions. Beginning with the imposition of *burqa* to the ban on modern education, the restrictions culminated in the ban on family planning.

# Chapter 7

## Conflict and health

This chapter looks at the repercussions of the conflict in Kashmir on the state's health sector. The chapter has been divided into four parts: (a) Condition of the health sector (b) People's experience of the health sector (c) Perceptions of treatment and quality of care (experiences) (d) Accessibility of health care services.

### 7.1 Condition of the health sector

Kashmir has a total of 1,169 government-run or sponsored health care centres along with innumerable private clinics, polyclinics, and hospitals. In isolation this is impressive. Yet, in Kashmir this infrastructure has proved to be inadequate. People are dependent on local doctors (quacks) whose only qualification is their "dependability" in times of crises. Describing these local doctors, Badila said, "Though they are not bad, the problem is that one is not aware of their qualifications. They have come up randomly. It is not that I do not go to them. I also patronise them, but for small ailments. I would not trust them with my life. But I can say that if they had not been there for us in those days of trouble, God knows how we would have survived."

Echoing this, Nazar said, "The local doctors are good and effective most of the times... and most of all they are dependable." This dependability in times of conflict was the main attraction for all the research participants. The uncertainty caused by curfews, *hantals*, or emergencies resulted in people favouring the inefficient but dependable local doctors. Kasheer, a TBA, said there was no point depending on regular doctors. "When one needs the

doctor most he is not there. Who in his right mind would have come those days? The government may have provided dispensaries, district hospitals, and everything, but what use are they when there is no one in them to take care of you? Empty buildings do not save people."

During my interview with Nazar, she had pointed to the village dispensary and asked me if I had seen anyone visiting it. I had worked in her village for two months, but realised that Nazar's observation was right. "The dispensary is dysfunctional," she told me. "If the staff is present there are no medicines. When the medicines come, the staff is not there."

When asked the reason for this degradation, research participants, especially from District B, talked of a time when the district hospitals were so good that even people from outside used to come to their hospitals for treatment. "The militancy in the state ruined whatever existed," Fauzia said. "Our district and sub-district hospitals were so good that we almost never had to send a patient to Srinagar. It was only if there was something very complicated that doctors would refer patients to Srinagar. All known doctors from Kashmir were in our hospitals. But now the situation is so bad that even for a simple referral we have to send the patient to Srinagar. The district and sub-district hospitals are not even geared for a simple Caesarean, what to talk of complicated procedures."

#### 7.1.1 Lack of medical staff

Most participants said the degradation of the village and district medical infrastructure was

**Assiya:** *It is not faith; it is the convenience and surety that they will be there for you when you need them. You may find it strange coming from me, who has had two horrifying experiences with them, but believe me, it was either them or God for us in those 10-12 years. People may be able to afford the best of doctors in the city, but what is the use if they are not able to access them? During the peak of tarikh, movement was restricted not only during the night but sometimes also in the day. In this situation it was these local doctors who could be depended upon. They may not be very good, but they were there to give at least consolation, if nothing else, that one had visited a doctor, which, I can assure you, in times of trouble can be all that you need to survive.*

due to a lack of staff. As Kasheer put it, empty buildings do not save lives. The troubles in the state led to the exodus of trained medical professionals, especially the Hindu Pandit doctors, resulting in a shortage of senior, skilled personnel. At the same time, younger doctors sought better opportunities outside the state, leading to a situation where it became difficult to find good doctors. The doctors left behind preferred to be based in the cities.

Talking of the empty dispensaries and district hospitals, Ruksaan said, "No one wanted to come. Whoever was posted would go on leave and get a transfer." Noor said she had never seen a doctor in her village dispensary. It is not that no doctor was ever posted there; they just did not come. "Instead, the assistant is there," she said. "Lately I have heard that the assistant has learnt to give injections, so now the doctor is needed even less. But if you ask in the village the people will say the doctor comes regularly because over the years they have got used to addressing the assistant as 'doctor'. It does not make a difference to them, as they do not visit the dispensary."

The lack of medical staff and supplies was visible even at the district level, especially at night. Mahad said the district hospitals were similar to the local dispensaries because neither had the staff nor supplies. "During the day the district hospital was still okay, but at night how long could one doctor and one anaesthetist stay on duty?" Even at the time of the research, only one senior doctor and one anaesthetist were posted at the hospital. Patients preferred to go to either the local doctors or to hospitals in the cities. They considered the district hospitals a waste of time, because they were not geared for any emergency. Even simple Caesarean sections were referred to Srinagar. The only comfort with the district hospitals was that some kind of medical assistance was available at all times and the hospital ambulance could be used to move patients to Srinagar, subject to availability.

"There are only two or three ambulances available with the district and two with the sub-district hospital," Mahad said, "and they are used round the clock. If the ambulance is available the hospitals will never refuse you, but the problem is availability. On days when things are really bad and some casualties have occurred, you will not even find the ambulance at the hospital."

Many of the research participants were blunt about why doctors did not come to the villages, asking who in their right mind would want to risk their lives. Fateh said it was, and still is, considered lucky if a doctor visited a far-off centre two or three times a week. Doctors and their assisting staff had developed a system whereby at least one of them would be available at the centre. "Even now the doctor in our dispensary comes not more than thrice a week. The assistant and the nurse manage the other three days," she said. Asked about the inspectors, Fateh said, "Who would come to check? After all even the invigilating officer has to come from Srinagar."

Although most of the research participants expressed anger at the missing staff, they also understood their problems. Mariam, while insisting that she wasn't defending the medical staff, said, "Being from these areas I know the difficulties they had to face to travel this far." Shaheen agreed. "It was not easy to travel. It could easily take two to three hours and it was not even safe. There were bomb blasts all over. Vehicles were targeted all the time. People were scared to leave their houses to even to go the local market, what to talk about coming this far."

Roshan, who lived in a small village cut off from civilization except for a highly irregular bus service twice a day, was not surprised when the doctors stopped coming. "Who would risk his life in these parts?" she said. "Even living here those days was a risk, so why should someone from outside come? There were militants all over. They used to move around freely with guns. Even the army was scared to come here."

This fear and the arduous journey kept most doctors away from the hinterland. As Mariam and Kasheer pointed out, life in the cities was different. There one could always find a solution. In Srinagar one could still walk to the hospital. But in the villages even a small ailment became an emergency. The very thought of moving out at night was impossible.

Thus people came to depend on "local doctors" who mushroomed all over the state. As Assiya and Badila said, they had little choice. "We waited for hours outside the hospitals in rain and snow for the doctors, but no one would come," Kasheer said. Noor said she had never visited the

dispensary either in her maternal village or her marital village in all her 31 years. Doctors were not there at either place, she said.

Chand, on the other hand, was forced to make innumerable rounds of the local dispensary because she could not afford to travel to the district hospital or to Srinagar. "Most people prefer to go to the district hospital or to private clinics, and the better off to Srinagar. It is only people like me who cannot afford those options who come here," she said. "The only time it is very crowded is when the doctor has not come for a day or two."

Saleema, when asked why she never availed of the medical facilities in the village and district, said the doctors, especially in the dispensary, were hardly ever present. "There have been times when I have had to make three to four rounds before I could find him there," she said. "The district hospital was not so bad, but yes, in the peak of militancy, even there the doctors were mostly absent. But at least the nurses and attendants were there." So, like most other research participants, Saleema found it easier to travel to Srinagar despite the distance, simply for the certainty of seeing a doctor.

Kasheer, the 60-year-old TBA, did not believe in doctors. She felt that the more one depended on them the more difficult it became to do without them. "The government may have provided us with dispensaries, district hospitals, and everything, but what use are they when there is no one in them to take care of you?" she said. "You need doctors, but where are they?" This question cropped up over and over again during the interviews.

Shaheen, who lived in the border area, said the militancy ruined everything. Even the district hospital was not spared. Some doctors ran away while others did not report for work. Eventually the hospital, which was once a model for the state, went to seed. Only over the last two years had doctors been attending the dispensary and the district hospitals regularly.

Nazar justified the absence of the doctors on the basis of the *halaat* then, but said lack of vigilance on the part of authorities made the situation worse. The invigilating officers were also based in Srinagar and would not risk their lives to check on their staff. Now, after long last, things were improving with the government getting tough on absenteeism.

The women were unanimous that the peripheral health services were ineffective primarily due to the lack of medical staff. Nazar laughed when asked about the local dispensary. "There is a government dispensary in this village," she said. "But you will never see anyone going there. It is dysfunctional. When the staff is present there are no medicines. When the medicines arrive the staff is unavailable. Sometimes both are available but the team does not work." All the 25 participants had similar experiences in their own villages.

This situation forced people to travel to the state capital for treatment. Yasmeen said it was a full day's task for her, as a result of which she tended to ignore the illness or consult the "local doctor." Kasheer said the situation proved convenient for those people who in any case did not wish to invest in treatment for their women.

Assiya and Azra said they would have opted for the doctors in Srinagar, but for daily wagers like them the trip would mean loss of a day's earnings, which their families could ill-afford. So they mostly ended up going to the "local doctor." Although these untrained personnel proved to be saviours in many cases, they also sometimes caused crises. Had Assiya not been found by her husband at the right time and taken to hospital, she would not have lived. Yet, she continued to depend on the local doctors because of the lack of qualified doctors in her area.

The absence of qualified doctors in the dispensaries and district hospitals also resulted in assistants and nurses assuming the role of doctor. Noor said that a doctor was posted to her village but she had never seen him/her; yet people in the village said the doctor came to work regularly. That was because they had become used to calling the assistant "doctor."

The absence of qualified medical professionals at the village and district levels resulted in many lives being lost. In Noor's case, the delay in her husband being taken to hospital in Srinagar resulted in him having to undergo three surgeries. Doctors said he may not have needed even one if he had been brought in on time. The delay was compounded because he was taken first to the district hospital, only to find that he could not be treated there. Mahad lost her sister-in-law because she was unable to reach Srinagar in time. Lack of transport

and lack of freedom of movement also contributed to the casualties, which could have been avoided if medical facilities had been available closer to home.

### **7.1.2 Lack of medical supplies**

The other major handicap the peripheral health infrastructure suffered from was a lack of supplies. Chand questioned the point of going to a dispensary if no medicines were available. If she had to buy all her medicines outside, she might as well visit a private doctor rather than wait for days on end for the government doctor to arrive, she said.

Badila said that when she calculated the cost and time difference between visiting a dispensary closer to home and going to a private doctor or the hospital in Srinagar, she preferred the latter because the costs were almost the same. "In the dispensary even if I find the doctor I will have to buy the medicines from outside, which is the same cost in which I would have reached Srinagar, got myself treated by a better doctor, and been assured of both medicine and medical attention," she said.

Nazar, referring to the dispensary in her village, said that even if the staff was available medicines were missing. Badila also said that the village dispensary and district hospital were useless. "The doctors were not regular; medicines were not available," she said. "Why only the dispensary, even the district hospital was not dependable." She said going to the district hospital was a waste of time because they invariably referred patients to Srinagar.

Assiya, in spite of her poverty, also favoured the hospitals in Srinagar. "The doctor in the dispensary is no good," she said. "In the district hospital, the doctor is good, but what is the use going to her? If the problem is complicated she will refer you to Srinagar, so you might as well just go there yourself."

### **7.1.3 Overcrowding and negligence in hospitals**

In spite of the dependency on hospitals in Srinagar, Kasheer said she advised her patients not to go there, especially to Lal Ded, unless it was a must. Had it not been for the fact that patients need to be registered in LD Hospital for emergencies, she would not have allowed any of her patients to go there, she said. The reason was simple: overcrowding and filth

in the capital's hospitals. There are times, she said, when you can barely find space to walk. Worse, there were cases of newborn babies being stolen. "The doctors advise patients to bring someone along to guard the infant," she said. "There have been so many cases where children have been stolen, especially boys. There have also been cases of child-swapping. I have seen mothers wailing for lost children in the hospitals and no one coming to their help."

Most research participants agreed. Because of the breakdown of the peripheral medical infrastructure, hospitals in Srinagar have become overcrowded and overburdened. Fauzia blamed negligence at the hospital for her inability to conceive a second time. "Deliveries are a matter of routine there," she said. "And the caseload is so heavy that everything is done at express speed. At times I wonder if they even know what they are doing. How do they manage to keep track of each case in the delivery room?"

Kaiser had never been to a hospital in Srinagar. It was too far for her. She prayed that she would never have to go there, citing the experience of a pregnant woman from her village who was admitted to LD Hospital. The woman had to lie on the floor due to a shortage of space. Later she was asked to share a bed with another woman. "Can you imagine the plight of a full-blown pregnant woman sharing her bed with another pregnant woman?" she said. "For two days she was like that. She requested the staff to allow her to stay on the floor, but they refused. Finally, fed up with the uncomfortable bed, she just went back to the floor. The attendants were rude to her, but when she just refused to move they let her be." After her delivery she had to stay in the hospital for three more days, when her infant had to share a cot with another baby. "My poor neighbour did not know what to do," she said. "She was just praying for discharge. And she prays to God that she never has to go back there."

The personnel at the Srinagar hospitals were given the thumbs down by most of the research participants. Fatima said she preferred to visit her district hospital because the staff there hailed from her village and were polite to her. The doctors and attendants in the big city hospitals did not pay much attention to a patient unless they knew him or her. Assiya's sister-in-law was given an ultimatum in the



middle of night when she was unable to arrange for the blood needed for her treatment. "She was told that they would leave me on the footpath till the blood could be arranged," Assiya said.

Nadeema's cousin was discharged from hospital, but the nurse forgot to tell her. The next day at five in the morning she was asked to vacate her room. Unfortunately the city was under curfew. All her pleas to the medical staff fell on deaf ears. She had to leave and it took her the entire day to reach home. By the time she reached home, whatever rest she had had in the hospital had been frittered. "It took her a week to recover, where a day's rest would have sufficed," Nadeema said. "This is how hospitals functioned not only then but even now."

Overcrowding in the hospitals in Srinagar also made doctors negligent and insensitive. Kasheer said that in a place where one could not distinguish one doctor's patients from another's, and lines stretched as far as the eye could see, who could blame the doctors. Amanat, general physician in a sub-district hospital, said that at times she had to treat cases for which she was not fully qualified, because she knew the patient would not be able to come again another day.

#### **7.1.4 Hospitals as hideouts**

Along with overcrowding and the excess workload, patients had to face another difficulty – the fact that militants used the hospitals as hideouts. Only two research participants were willing to talk about this. Mariam, who was admitted twice to hospital, said, "You don't know the power of the gun. They were everywhere. You will not believe it, but even today after dark there are people hiding in the hospitals. In a hospital where only one person is allowed with a patient, the corridors fill up after dark, but by morning there is no one. Who are these people and where do they go? No one ever asks."

Minnah said that even if someone questioned the strangers they only had to say that they were accompanying a patient. Who had the time to keep a check on who was accompanying whom? Even now, with things slowly returning to normal, her family would send a male family member every evening to keep her and her sister company. "What do I say? Right now all may seem normal, but at night even now there are people around the corridors

whom no one knows. They come at night and disappear by morning."

## **7.2 People's experience of the health sector**

"Health is a matter of concern only when the need arises." That is how most of the research participants described their need for health care. This section looks at their perceptions, beginning with the changes in the health sector, changes in the treatment-seeking pathways of the people, and their experiences of the sector.

### **7.2.1 Changes in the health sector**

Over the last five to six years things have been changing in Kashmir for the better. Although they are not back where they were 16 years ago, some progress has been made. Sahida had early memories of going to hospitals and not finding a doctor. Now, she said, there was at least a doctor even at the local dispensary. They may still not come every day, but they were there and they were qualified. People could move about without much trouble. They could even arrange for a vehicle in the night if need be. Commuting had become easier, though it remained expensive. Five years ago everyone had to depend on the bus, which was time-bound, slow, and unreliable.

Shaheen regretted the loss of qualified medical professionals who left the state with the onset of the turmoil. "We had a lot of good Pandit doctors, but when the militancy started and Pandits began migrating to other parts of the country the doctors also left. It was the biggest loss we have had to bear. We thought this would bring in opportunities for Muslims. We did not realise that experience was leaving with them. Younger doctors replaced them, but they had no one to guide them."

Amanat blamed the *halaat* of the times for the decay in hospital facilities in the districts. She remembered a time when there were such good doctors and facilities at the district and sub-district hospitals that they seldom had to refer cases outside. "Only cases that needed super-specialised attention were sent to the bigger hospitals," she said. "From senior doctors I hear tales of the famous doctors who have practised in our district hospitals and wish that I could at least once get a chance to see them. Today

we are at a juncture where even a simple Caesarean operation has to be referred to Srinagar.”

Mahad lived in the same district as Amanat. She said there was a time when many of their people did not even know the way to the Srinagar hospitals because their own doctors and facilities were so good. “But the trouble spoilt everything. Our hospitals became worse than dispensaries. For everything we had to go to Srinagar, and it was not easy. It takes an hour and a half in a private vehicle on a good day without any problems en route.”

Roshan said things were better in the pre-militancy days. “I don’t know why, but people used to fall ill less,” she said. “The hospitals were the same, but doctors were available. This little dispensary of ours sufficed. We would never even go to the district hospital.”

Fauzia agreed that the state’s medical infrastructure had stagnated in the last 16 years. “The militancy ruined whatever existed,” she said. “The district and sub-district hospitals are not even geared for a Caesarean, what to talk of complicated surgery. Now with the posting of new doctors to this area things are improving. The operation ward is again functional, but this is only in the last three to four years. Prior to this we just had to go to LD. And I am not talking only for our district; this is the case with all district and sub-district hospitals.”

Kaiser said, “In our village there is a woman who uses traditional methods of contraception and performs abortions. The people coming to her have increased manifold after the ban on family planning. And it is not only patients from our village or nearby villages, but also from far. I was talking to her just the other day and we got chatting about the number of people who come to her for treatment. She said she has never attended to as many customers as in the last eight or nine years.”

Kasheer said, “Look at health care today. Agreed, there are good doctors and hospitals now as compared to our younger days. But I still feel we were better off without them. At least we were not dependent on them. Today people are so dependent on doctors that they shun home remedies. Then what happens? When one needs the doctor most he is not there. The government may have provided the dispensaries, district hospitals, and everything else, but what use are they when there is no one in them to take care of you?”

Assiya said, “What do I tell you what it was like four or six years ago? Things are better now. We have seen bad times, both in terms of the situation here on the whole and the shortage of doctors. Today at least the dispensary is functional and the district hospital is worth visiting. Earlier this was not the case. We were dependent on local doctors or the hospitals in Srinagar. From my own experience I can tell you it was not a good situation.”

### **7.2.2 Pathways for seeking treatment**

The years of turmoil, which caused a virtual collapse of the peripheral medical infrastructure, left the people of Kashmir with limited health care choices. These were: (a) the hospitals in Srinagar and (b) the “local doctors.” Chand said only people like her were forced by extreme poverty to wait for days for the doctor to arrive at the local dispensary. All other patients preferred to either consult the district hospital or the hospitals in Srinagar. “Most people preferred to go to the district hospital or to private clinics or, even better, to Srinagar,” she said.

Uzma, despite living in a remote village from where travelling even to the nearest town was a task, said she preferred to go to Srinagar for treatment. “We waited for days at the dispensary for a doctor. When people got tired of waiting they started going to Srinagar.” The district hospital was not as good and the doctors would anyway refer patients to Srinagar. “Another thing was that in Srinagar if one did not get to consult a government doctor at least they could try with the private practitioners.” Clearly, while travelling to Srinagar was expensive, the cost was justified by the quality and choice of medical care available.

Yasmeen shared this view, pointing out that their district hospital was neither geared for an emergency nor did it stock important medicines. “What good is a government hospital if you have to buy medicines outside? And, believe me, it’s a waste of time going there, as you know that they will ultimately refer you to the better hospitals in Srinagar.”

Badila said going to doctors in Srinagar made financial sense. “I know people will say it is easy for me to talk as I can afford it,” she said. “But the dispensary hardly ever provides medicines. They are forever out of stock. So you end up buying from

outside. This means that though you are saving on transport, you are spending on medicines. It works out to the same.”

Minnah had been nursing her sister for two weeks in hospital in Srinagar. She had not seen her children or her house in these two weeks and was unsure when the hospital would discharge her sister. Any inquiry in this regard got little response. Yet she felt the hospitals in Srinagar were better. “The only hospitals where you can be sure of any treatment are in Srinagar,” she said. “So people would travel even if it meant spending the night at a relative’s or in the *masjid*.”

So, people were willing to bear all possible hardships for the sake of assured treatment. Mariam decided to get admitted to a hospital in Srinagar days before her delivery. So did Tahira, who did not want to risk a repeat of her first delivery, when the TBA had run out of gloves and used a bedspread.

Sahida, who was close to her delivery date, said that if she had been in the same condition five years ago she would have had to arrange to stay in Srinagar. Narrating the instance of her neighbour’s son who suffered a bullet wound and was in hospital for three months, she said that the family could afford to rent a place and move to Srinagar. “Poor people have no choice but to travel up and down or stay in the hospital,” she said.

Most of the research participants lived at least 25 kilometres from Srinagar. For the fieldwork I was stationed in Srinagar and my commuting time in a private vehicle was roughly an hour and a half on average. Many of the research participants pointed this out to me to bring forth the reality as it stands now and as it would have been in the days when arranging for a vehicle was next to impossible.

When asked about the proximity of the hospital in Srinagar, Sahida said it would take her at least two hours to get there. “Going to Srinagar at any point means the entire day is gone. In a condition like mine people had to make arrangements to stay somewhere there. For those who could not afford it, that meant camping in the hospital or a mosque.”

Tahira expanded on the hardships of travelling to Srinagar. “Yes, Srinagar is far, takes almost two hours by bus. But what could one do in situations where there was little option? When there were curfews or *bandhs*, even buses were not available.

And buses used to be searched en route, sometimes twice or thrice. It was an ordeal. For many years no vehicles were allowed on the roads after dark. Life was really tough.”

Fauzia recollected a day when a woman near labour and on her way to hospital for the delivery was made to alight from their bus on three occasions to allow security personnel to complete their search. Finally when she could take it no longer, they got special permission for her to stay on board.

Most research participants spoke of the number of deaths of patients due to the non-availability of vehicles or because traffic was stopped en route due to some trouble. Fateh’s sister-in-law died before her very eyes at a security check post outside the village when their taxi was not allowed to leave because a shoot-at-sight order was in force outside.

### 7.2.3 Local doctors

In times like this, people were left with little choice but to fall back on the “local doctors.” As Badila put it, “These doctors may not be medically trained, but over the years they have gained enough knowledge and experience to treat people for small ailments. In days of trouble it was these doctors who saved many lives. They were good, reliable, and cheap. Being in the villages they were available 24-hours. So people often preferred them to the regular doctors.”

Fateh had a different view. She said that if a trained doctor had been available she would never have gone to a quack. “But in emergencies, when there is no option, it is always him (the local doctor). Had he not been there, we would have not survived all these years. Not that people did not die. He is only a doctor, not god. In those days even if god were here he would have not been able to do much.” Badila agreed. She said she would any day prefer a trained doctor, but she did not want to spoil her relationship with the local doctor because experience had taught her his importance.

Tahira said she preferred to treat small ailments at home with over-the-counter remedies. Only if things got serious did she consult the local doctor or the district hospital. “But mostly we prefer the local doctor,” she said. “The government hospitals are overcrowded and the doctor does not give the patient much attention.”

**Nazar:** *We may be in far-flung villages, but there is no dearth of doctors here. No one is sure of their qualification and, to be honest, no one bothers. Look at the situation here. You come from Srinagar every day by car. If it takes you an hour and a half in a private vehicle, imagine how long it will take a villager in a public bus. Half the day will go to reach the city and then wait for the doctor. Who has the time or the energy? The local doctors are good and effective most of the time. If there is a serious problem they simply ask you to go to the city. They are at least honest. They will not treat you for something they do not understand. And most of all they are dependable. In those days of war, when there was no surety of anything, it was these doctors who were available at all times. Can you imagine trying to reach the district hospital or the city in the middle of the night or in a curfew without transport?*

Roshan, who lived in a small village on a hill, could not even think of going to the district hospital during the militancy. Even at the time of this research her village depended on the two daily government buses, which were unreliable. "All that we have here is a medicine shop," she said. "For the doctor we have to go to the village downhill. The hospital is so far off that to go for small ailments it is not feasible. First, it is expensive to travel that far. Secondly, one is unsure of getting transport, which can result in wasting the whole day. So we preferred the local doctor in the village down the hill. If nothing worked with the local doctor then our first option was to go to the district hospital. Srinagar was just too far. Only if there was no option would we go to Srinagar."

Fauzia, in spite of having travelled to the village where the government dispensary was located, also preferred the local doctor. "The doctor at the dispensary is quite unreliable," she said, "so I prefer to go to this one. At least I know he will be around in case something happens." Assiya said, "It is not faith; it is the convenience and surety that they will be there for you when you need them. You may find it strange coming from me, who has had two horrifying experiences with them, but believe me, it was either them or God for us in those 10-12 years. People may be able to afford the best of doctors, but what is the use if they cannot reach them?"

#### **7.2.4 Traditional healers**

The years of turmoil not only gave a boost to the local doctors, but also revived faith in traditional healers. Mariam believed it was because of the blessings of her family *pir* that she was able to deliver her second child without problems. The doctors were ready to operate, but the *pir's* blessings saved her. People in her area may visit all kinds of doctors, but their faith in the *pir* will always be stronger, she said.

This faith grew during the conflict, judging by the number of devotees coming to the *pir*.

Tahira agreed with this assessment, saying that when one had lost faith in everything then faith in religion helped you. Where she lived, conflict was still part of daily life. "We believe in him and it is not possible to be without him," she said. "He is our strength in these insecure times. For our mental peace we need his blessings. People travel long distances to meet traditional healers, especially when other options fail. Our family is a staunch believer in the shrine near the village and each year we have special celebrations. We have people flocking from miles away, and this is not only for our shrine. I have noticed this for all."

Shaheen, who lived in a nearby village, said that when people lose all hope they go to shrines. "There are a lot of people I know who will go to *pirs* and shrines even when doctors are treating them. They may stop the doctor's medicine, but they will not stop the medicine the *pir* is giving them. Such is the faith out here."

The monetary aspect may have been another reason for the popularity of these healers. Uzma said, "One thing good about them is that they do not charge any money. You can give what you want; there is nothing binding." This was particularly good for women who were not in a position to pay cash, but could give wheat, rice, almonds, etc. Chand, despite losing seven children, had not been to a doctor because money was a problem. But her belief in the local shrine was so strong that she never missed a single Thursday prayer.

Kasheer, also a strong believer in her family *pir*, said, "When life has shown you bad days one tends to establish faith in some strong being, whatever it may be." Individual *pirs* are highly revered, especially since the beginning of the militancy. Nadeema said Kashmiris have for generations had

strong belief in *pirs* and *hakims*. She felt the need for a professional doctor as well. "Maybe I am not such a strong believer, though I have seen and heard of miracles taking place at the hands of *pirs*, but I feel a doctor cannot be completely ignored."

Nazar said that because of a famous shrine in their area people's belief was stronger. Most times when people got tired of visiting doctors and clinics, they sought refuge in these shrines. People travelled great distances to their favourite shrine or holy man. Local shrines were worshipped and big days were celebrated with more devotion than the big festivals. "We have grown up with the clay of one or the other shrine being smeared on our foreheads for all kinds of ailments," she said.

### 7.3 Perceptions of treatment and quality of care (experiences)

Bano summed up the quality of care in the hospitals and clinics in one line: "It depends on your luck." According to her, at times the doctors were good, but mostly they were impolite. "The attendants in the district hospital are better than most doctors. They have to be as they are from these villages," she said. She blamed the bad behaviour of the doctors and their attendants on the large number of patients they had to handle. "What can the doctors do? Look at their workload, especially in Srinagar. There is not even space to stand in the waiting rooms. Queues stretch to the end of the corridors, especially with a senior doctor. I am sure a good doctor in Srinagar must be seeing not less than 200 patients a day!" Tahira spoke of occasions when there was no space to even walk in the hospitals. "It is so crowded. Every time someone says they are going to Lal Ded for something I shudder and make it a point to include them in my daily prayers."

Amanat did not disagree with these assessments. Without trying to defend her colleagues, she said it was not possible for the hospital staff to handle the overload of work coming in because of the breakdown of the peripheral medical infrastructure. Unfortunately, some doctors were taking advantage of the situation by running private clinics after duty hours. Many research participants said they preferred going to these private clinics and paying extra, for the doctor was accountable and paid attention unlike in the hospital where they could not devote more than two minutes to a patient.

Amanat said the overcrowding led to lack of proper care by doctors, resulting in wrong diagnoses and treatment. "I am ashamed to say this, but a lot of intra-uterine devices were installed without check-ups. I know of cases where they have resulted in pregnancies and complications. But there is no one the people can complain to."

**Ruksaan:** *Even now I cannot believe that such a young girl could meet with such a fate. She was my maternal cousin, the life of all gatherings. She was married for six years and had a four-year-old daughter. She conceived for a second time and all went well till her fourth month. One night she developed a pain in the abdomen, which soon became intolerable. Her husband took her to the local doctor who gave her an injection and asked them to go to the city hospital. At the hospital she was admitted and kept for five days. The doctors said they would have operated on her if she had been brought directly to them. But the injection had caused the swelling in the appendix to subside and they could not operate until the problem recurred. She was advised bed rest. Three months went by and we thought all was going to be fine. In her seventh month she again developed pain in the middle of the night. But an encounter was taking place in the next village. No one was allowed to move. Who could you blame? The army could not risk civilians walking in the middle of firing. By the time the encounter stopped and they were allowed to go it was too late. The appendix had ruptured. The doctors did their best but could save neither her nor the child.*

Yasmeen said she preferred to consult only the doctors in Srinagar for she believed there was no proper treatment available elsewhere. After the death of her son (who, she believed, died of medical negligence) she did not trust the doctors at the village or district level. "There is no proper doctor for miles," she said. "The doctors at the dispensary come as and when it pleases them. Even when they do God knows what they treat. Don't know where they get their degrees. They are hardly ever able to diagnose the illness."

Asked about the treatment in hospital, Chand was hesitant. "What can I say?" she said. "I am at their mercy. Everything else is okay, but I hate

the fact that the doctors smoke while they check the patients." When she tried asking them not to smoke, the doctors made her wait her turn endlessly and did not treat her well during examination.

Amanat said that at times the caseload was beyond the hospital's capacity. Then the staff had to make emergency arrangements because they cannot refuse admission to patients. "We have to either put mattresses on the floor or ask patients to share beds. What can we do? We cannot turn away a patient. You will not believe me, but on record we deliver about 100 cases a month, or an average of three a day, in a hospital which has not had a gynaecologist for the past 10 years."

Fauzia agreed, saying deliveries were a matter of routine in the hospitals. "The caseload is so heavy that everything is done at express speed," she said, wondering at times whether they even knew what they are doing. "How do they manage to keep track of each case in the delivery room?" When she was being delivered of her baby, 15 other women were waiting or giving birth at the same time. "In such a mad rush, how is it possible not to make mistakes?"

Such ghastly mistakes have been made that a full-term pregnancy was declared to be just four months old and the pregnant woman was not even allowed to question the assessment. Saleema was pregnant with her second child and did not want to deliver in the hospital for fear that the doctors would again tell her she had miscalculated her date of conception and put her life at risk. She barely managed to reach home after her first delivery.

#### 7.4 Accessibility of health care services

Accessibility of health care services in a situation of conflict is a major issue. Across Kashmir people have emphasised that there is no dearth of medical infrastructure, but conditions within and outside these structures have resulted in their ineffectiveness. Most villages have a dispensary close by and a district or sub-district hospital in the vicinity.

Referring to her village, Mariam said, "The closest dispensary here is about a kilometre away and is open till four in the evening. The district hospital is 15 kilometres away. The hospital is good, but it is not geared for an emergency. If after the initial check-up the doctors feel that they can handle the case, they will take it. Or else they will refer it to

LD. The district hospital is geared for minor emergencies, but it does not have the facilities required for serious problems." This is more or less the situation across the state. This infrastructure, according to most of the research participants, existed before the conflict began. The intervening years destroyed most of what existed.

Assiya, remembering her first-born, said that now the village dispensary was at least functional and the district hospital was worth visiting. In the past this wasn't the case. "We were dependent on the 'local doctors' or hospitals in Srinagar. From my personal experience I can tell you that was not a good situation." Assiya believed it was her inability to consult a good doctor in time that cost her first-born his life.

An effective health structure is even more important in a conflict situation. Some of the factors that have resulted in ineffective access to this structure in Kashmir are:

- Lack of medical staff and supplies (discussed earlier)
- Problems of mobility
- Availability of health infrastructure – easy and effective
- Affordability
- Control over economic resources

##### 7.4.1 Mobility

As the political situation deteriorated, the public transport system also went to seed. Kashmir has always depended on public transport. Most research participants said that while the transport system before the conflict was equally bad and there were areas where buses would not ply, they preferred the old days. People like Uzma, who lived in remote villages, or Saleema, who lived in the hills, described how before the onset of conflict they had to travel five to eight kilometres for a bus. The buses had a strict timetable and in most parts would stop running after dark. Yet it was better than what the days of *tarikhi* had in store. At least there was freedom of movement.

The days of *tarikhi* ended this freedom. Public transport in the remote villages and hilly terrain became irregular or it stopped. For a long time, sunset meant a complete halt of movement. Curfew was imposed. Mahad said, "There was hardly any private means of transport in those days. Most commuting

was dependent on government buses. These buses had fixed timings and would ply twice or thrice a day on a particular route. And the service would stop after sunset. One was dependent on these buses. If you missed one, you might have to wait two or three hours for the next. Private buses were hardly there, nor the Tata Sumos visible today."

Mariam said, "Movement was controlled. Both the militants and the security forces were keeping watch. Every time one moved out explanations had to be given, humiliation had to be borne. They were always watching. More than the militants it was the army that troubled us. Every step had to be measured. People lived in constant fear. No one was sure what would happen when. A simple knock on the door could mean death."

Free movement, whether of the common person or of medical staff, plays a major role in access to health infrastructure. Seventy-two per cent of the research participants said life was easier for the people of Srinagar because hospitals were accessible to them at all hours. An emergency in a village at night almost certainly meant death. Life was dictated by the light of day. After sunset it was impossible to take a patient to hospital unless one could arrange for a private vehicle. Patients had been carried on *charpoys* (beds) to hospital when nothing else was available. In daytime people even hitched rides on trucks to reach the city.

Freedom of movement was dependent on public transport, daylight, and peace in the neighbourhood. If any of these was not available, movement stopped. Asked why patients were not taken to the district hospital, Shaheen said, "What do I say? The buses coming here are regulated by time. If you miss one you have to wait for hours for the next. Even now when Tata Sumos are plying everywhere else in the state we are dependent on the morning and evening bus. After four in the evening there is no bus. If a person were to fall ill after dark he has to wait for daybreak before he can be taken to a doctor. There are hardly any private vehicles and in those days the drivers were scared to travel at night. One had to really beg and plead with them. And then we could only try the district hospital as Srinagar is too far away. At the district hospital one could not be sure of the availability of a doctor or ambulance. So it was better to wait till morning and take the patient to Srinagar."

Mariam said, "If pain arises in the daytime some arrangement can be made. If nothing else one can go on foot to the district hospital, or hitchhike with the trucks that pass through the villages. One can always do something in the light." Nazar said that though the hospitals in Srinagar and in the districts were centrally located, they were inconvenient to visit because of the lack of transport. In most districts the hospital was located at a distance of half an hour to an hour from most villages. The hospitals in Srinagar were about two hours away by public bus on a normal route. This term, normal route, occurred in most interviews in different contexts, but meant the same thing.

Citing her sister's example, Mahad said, "Even today travelling without being stopped en route for checking or a jam or a *bandh* is very uncommon. Just yesterday my sister was on her way from Srinagar to her duty station. She reached midway and there was firing in a town. All traffic was stopped. She could neither go back home nor go to her hospital. Finally she had to walk 7 kilometres to our mother's house where she waited till traffic resumed and then returned home. This is the scenario when things are supposed to be returning to normal."

A lack of transport was not the only hindrance to movement. Many of the participants said vehicles could somehow be managed as the days of conflict bound the people in the villages together. What proved a greater hindrance was the restriction on movement imposed by the security forces. They narrated instances when they were forced to beg and plead with army personnel to be allowed to move out of the village for an emergency. Sometimes the pleas worked, but if the *halaat* were bad, then nothing would work.

Kasheer said if there was a genuine reason the soldiers would let them travel, but after a lot of questioning. "We have been stopped so many times at night when called for deliveries... So many times we had to beg and plead with the security forces to allow us to go. They wanted proof that we were going to visit a patient. What proof could we provide?"

Such restrictions on movement inevitably resulted in casualties. Fateh and Sahida described situations where relatives lost their lives because of such restrictions. The *halaat* outside the village were bad and no amount of pleading worked with the men on duty.

Recounting her sister-in-law's case, Fateh said, "We arranged for a taxi and left for the hospital. But at the checkpoint just outside the village the army stopped us and would not let us pass. No amount of begging or pleading worked. It could not, for there was firing all along the route to Srinagar. Who would have allowed us out? We begged them, told them we would take responsibility if anything went wrong, but nothing worked. I can never forget that day. The local doctor tried his best, but she died in front of our eyes at the checkpoint."

Describing the case of a woman in her village, Sahida said, "The *halaat* were so bad that people could not move out of the village. There was a shoot-at-sight order in the city. No one was allowed out. She had to be taken back home. The doctor and the *dai* did all that they could, but it was of no use. She needed a proper doctor and hospital. She died in her bed with the baby inside." Incidents like these were a regular feature in the remote areas. Because of such experiences Mariam said she would not even curse her enemy to fall ill at night.

Women all over the state not only had to deal with these hindrances, they also had to negotiate with what Kaiser described as an unwritten restriction. "At all times women would have to have an escort, preferably a male, but even another woman or an older girl child. When women did not find any escort and had an emergency, they would go out alone. But this was very rare. Even today you will not find women travelling alone. Even a child is good enough as an escort."

Kaiser cited the example of her daughters, who at the time of the interview were out visiting friends. "My elder daughter wanted to visit her friend, but even now, when peace is returning, I fear for her safety, so I have sent my younger daughter with her. You will laugh if I tell you where her friend lives: four houses away. Yet I cannot send my daughter alone, so how will families send women outside the village alone?"

Kaiser had indefinitely postponed her own operation because she could not find a reliable guardian for her daughters. "They cannot be left alone in the house. Someone has to be here with them," she said. She would not leave till she could send them to a relative's house or get one of their aunts to come and stay with them. Although her

neighbours had offered to stay, she preferred to have someone from the family. "It is not that I do not trust my neighbours, they are very good and I know that they will look after my daughters well. But my heart does not agree. Daughters are daughters. I have to be careful."

All the women spoke of this restriction on movement. Minnah described it as the worst outcome of the militancy. Women in her house were not even allowed to go alone outside the gate. My interview with Minnah took place in the hospital where she was accompanying her sister. She was there because the family had no choice. Her sister needed a female attendant and the family could spare no one else. She said that if the hospital staff asked her to leave she would not even be able to find her way to the bus stand. By evening a male family member came to spend the night with them. Her village was at least two hours by bus. These restrictions had no age barrier. But Bano felt good that she could now move out on her own. "This is like heaven," she said. She hoped it would stay like this forever.

#### **7.4.2 Availability of health infrastructure**

Accessibility is not only linked to the mobility of people but also to the availability of services. In all 25 interviews the participants made it clear that there was no dearth of services. What needed to be studied was how easy and effective was their availability. All the six districts in the valley have hospitals, but only in Srinagar district they are geared for emergencies. Apart from Srinagar only one district has provision for anaesthesia, which means that everywhere else, even for minor operations patients have to be referred to Srinagar. On June 23, 2004, after almost 20 years, the sub-district hospital at Tankard officially reopened its operation theatre. More than the efforts of the State, this was possible because of the doctors posted there. Further, availability is linked to financial viability. There were times when women had to move not only across town but also to another state to access basic health facilities. How viable was this?

Expressing anger at the inefficiency of the local dispensaries and district hospitals, Mariam said she preferred to go to Srinagar. "What is the use of these hospitals? They are not geared for anything.



They may be good for small ailments, but in an emergency they are useless." In pregnancy cases these hospitals could only handle a normal delivery. For anything more serious the woman had to be rushed to Srinagar. So the district hospitals compulsorily required patients to be registered with Lal Ded for emergencies.

From the 25 interviews and other conversations in the valley it could be seen that most people in the days of conflict preferred to go to hospitals in Srinagar. In some instances people suffered more because they wasted precious time by not going directly to the main hospital in Srinagar. Noor, a newly married wife sitting on a Srinagar hospital bed with her husband, was an example. Her husband was shot in the leg and taken to the district hospital. After first aid he was transferred to Srinagar. "By that time he had lost blood and the poison had spread. He has already undergone two operations and may need a third one. Doctors said if he had been brought here directly he might not even have needed an operation."

Mariam said, "The district hospitals admit a patient only when they are convinced that they can treat him. If they are convinced that the case is beyond them, they simply refer it to Srinagar." So people preferred to go directly to the big hospitals to save time and money. The services and infrastructure at the local and district levels were insubstantial. A common thread running through the 25 interviews was this lack of service.

Bano asked of what use was such infrastructure when there were no personnel. People were willing to overlook the problem of distances. They had learnt to live with it. What they found hard to negotiate was the lack of medical staff. If there was no transport, they were willing to walk miles to reach a doctor. Then, after all the effort, they still could not find a doctor who gave good treatment.

Despite the hardships, most people stated their preference for the hospitals in Srinagar; this was not because of the quality of services, but only because availability of doctors was assured. Twenty-one out of the 25 research participants said the hospitals were overcrowded and the most a patient got with the doctor was two minutes.

The poor, however, had limited choice, as government hospitals were the only resource

available to them. Life was especially tough for daily wage earners. For them one trip to Srinagar meant the loss of a day's earnings. Bano, daughter of a labourer, explained their plight. "There was no

**Nazar:** *The district hospital is good and centrally located. There is a good lady doctor there to whom we refer all our cases. But the hospital, like all other district hospitals in Kashmir, is not geared for any operation. All operations have to be carried out in the hospitals in Srinagar. Even for a simple Caesarean operation women have to go to the Lal Ded Hospital. The traditional birth attendants can handle normal deliveries. Why do we need hospitals for them?*

*The problem is not only with operations; there is a problem of staff also, as at the dispensary. During the conflict years this problem was worse. There were times when no doctor would come for days to the dispensary or the district hospital. Who wanted to risk their lives? I would have not gone. The situation was bad, really bad. There was no certainty of anything. Trouble between the militants and the army could occur anywhere, anytime. Curfews, bandhs, hartals, all were part of life.*

*There was this time when I had gone to Srinagar with my parents. All went well till we were to come back. Suddenly there was a bomb blast in the city. Firing continued for an hour after which curfew was imposed. No one was allowed to move. We were lucky that we knew friends living close by and reached their house. We were stuck there for two days. Imagine the plight of people who knew no one. Where did they go? What did they do? You tell me, will you risk your life in a situation like this?*

*What you see today is not what it was those days. It's very strange, but as I grew up in that environment it seemed natural to me. But as things are changing now I can see the difference. I can see what hell we were living in. All those restrictions, checks, curfews, bandhs! I wonder how we lived in those days. There was no accountability anywhere. Who would come checking to see if a doctor in a remote village was reporting for work? It's only now that there are regular and surprise checks and things have improved.*

choice," she said. "The private doctors near the village were expensive. And there was no guarantee that they could cure you. So one was left with no choice but to go to Srinagar. But that takes the whole day. That is very hard for people who work as labourers; it means a day's wage is lost. Further one has to make provisions for the children, especially the girls. They cannot be left alone at home. There are times when people avoid going to the doctor because they have nowhere to leave their children."

Private doctors were available, but were expensive. Conditions in the valley were such that ironically, even though "people may be able to afford the best of doctors in the city, what is the use if they are not able to access them?" This statement of Assiya brought home the reality of those years when a rich person was as helpless as the poor.

#### **7.4.3 Affordability**

Affordability of services had become an issue over the years. In all 25 interviews the women said categorically that doctors, whether good or bad, were available, but a price had to be paid. Even if one decided to bear the hardship of travelling all the way to Srinagar for free treatment at government hospitals, the fare and the uncertainty about the number of days one may have to stay in Srinagar made up the difference.

Chand was pregnant for the eighth time. She had had four miscarriages and two of her children died within a month of being born. Yet she had never been to a doctor for a check-up or cleaning after her abortions. Asked why, she said, "We are poor people. We have no money for check-ups. Doctors are expensive. The government hospitals are far. The private clinics need money. Where will I get the money?"

Even if people were able to rustle up resources for the private doctors, that alone would not guarantee any respite. Nazar explained, "Firstly, most of these doctors are located in the big towns or in Srinagar, which means the same problem of access as with the government hospitals. Secondly, they are expensive. Lastly, even these hospitals are not prepared for an emergency. The infrastructure is inadequate. Ultimately they too depend on the big government hospitals. This is one of the reasons for the overcrowding of hospitals in Srinagar."

Private practitioners witnessed a boom, especially in the countryside, during the years of trouble. But they were good only for emergency and first-aid treatment. For proper treatment people depended on the hospitals in Srinagar. Saleema said that availability was not so much an issue as affordability. "Our village does not have any private doctor," she said. "In the district, yes, there are plenty, but they are expensive. We may as well go to the local doctors in the villages or visit our *pirs* and traditional healers."

### **7.5 Conclusion**

The peripheral medical infrastructure in Kashmir was disrupted by the conflict. Absent staff, lack of supplies, and the inaccessibility of the facilities became problems. When health needs forced people to seek medical aid, their first preference was to consult the unqualified local doctors in and around the villages.

The people, however, empathised with the absent doctors and understood their difficulties in view of the risk involved in travelling to villages in those days. They were happy if the doctor reported for work thrice a week. For their other needs they depended on the district hospital, not because it was functional but simply because some medical advice would be available there and, in an emergency, the hospital could arrange for an ambulance to Srinagar. District hospitals were a stopgap to avoid travel to Srinagar. Travelling to the district also meant that in case medical advice was not available at the hospital, there were enough private practitioners around who could be approached.

Care and treatment in the hospitals during the days of conflict were seen as a matter of luck. With long queues everywhere, patients considered themselves lucky if the doctor spent more than two minutes with them. Militants used the hospitals as hideouts. The maternity wards and children's hospital were known for child thefts and swapping. Doctors themselves would advise patients to bring a person along to look after them. Patients had to share beds or lie on the floor. Women delivered in corridors and bathrooms. With conditions like these it was no wonder that people tried to avoid hospitals as much as possible.

# Chapter 8

## Conflict and reproductive health

With people's health being affected, it was natural for reproductive health to be hit. Lack of access to health facilities coupled with the dictates of the fundamentalists and the conflict in the state affected women's reproductive health even more. Many deaths occurred not because of the original symptoms, but because of complications that arose due to delayed or wrong treatment by qualified and/or unqualified doctors. Research participants even narrated instances where they had to depend on veterinarians for treatment.

### 8.1 Sexual abuse, harassment and rape

Sexual abuse, harassment, and rape became rampant at the hands of both the security personnel and the militants. As a result the movement of girls was curtailed. Describing those days, Bano said she felt trapped in her own home. She felt ashamed of her bodily changes as she reached puberty and cursed her fate for being born a girl.

The sexual atrocities and harassment resulted in an odd phenomenon whereby even a routine check-up by a female doctor would arouse suspicion. This resulted in women falling prey to the local doctors. Girls had to silently suffer any medical complications related to the menstrual cycle and women had to tolerate all gynaecological complications because they were not allowed to consult a female doctor. It was believed that only an

“unfit” woman or girl would consult a female doctor. As a result of the rampant sexual violence in the valley a woman not legitimately pregnant and consulting a gynaecologist was looked upon with suspicion. It was presumed that she was either pregnant illegitimately or had been sexually assaulted by the militants or the security forces.

*Izzat* (honour) became very important for girls in the period of conflict. A belief persisted in the state, especially in the villages, that a woman consulted a gynaecologist only after marriage. An unmarried girl visiting a gynaecologist was looked at with suspicion. Nazar said that if an unmarried girl was taken to a female doctor there would be all sorts of talk about her. Naturally, no one wanted to risk it. “*Izzat* is very precious to us,” she said. “We can do anything for our *izzat*.”

Assiya had consulted the local doctor for her daughter's stomach pains. She had never taken her daughter along for examination. She just explained the problem to the doctor and he gave her some medicine. “I cannot take her along,” Assiya said. “She may have a problem, but no problem is that big as to take her to a lady doctor. What if someone sees her?” In the villages, she said, word spreads quickly and she could not risk rumours.

*Izzat* was valued more than even the woman's life. Fateh was angry with her in-laws for not taking her sister-in-law to the doctor for regular

**Assiya:** *This is normal with girls at this age. When she complains of acute pain I go and get medicine for her from the doctor at the bus stand. It is normal before marriage. These days everyone has it and most girls stop complaining once they get married and have children. She will too. If nothing else helps we will take her to hospital, but not for small stomach pains. What will people say? They will talk; all kinds of things will be said about my girl. I have had a tough time bringing her up safely to let all my hard work go waste. Times are different now. So much has happened in these past years that one is scared. All the bad things that were done to girls by the militants and the army result in talks if we go to a lady doctor. (Pauses) There have been instances of girls being taken and tortured and then left back to survive. They were dogs that did it and our girls lost their lives in the bargain. For no fault of theirs the girls have to face humiliation for the rest of their lives. Marriage may be a solution, but do you think the girls will forget all that took place? Society is not very helpful. If an unmarried girl is seen visiting a lady doctor, god save her. Society can hurt a person by what they say. I do not want my daughter to go through that.*

check-ups during pregnancy. "She was separated and did not want to go. She was scared that people would say that the child was not her husband's. Women in those days had to be very careful; the *izzat* of the house was dependent on them. It was their responsibility to guard it."

Her sister-in-law had returned home after about three months of marriage and no one had come to either ask her to return or to find out how she was doing. In these circumstances people would have easily deduced that she might be the one at fault. So it was best to keep the pregnancy away from everyone. She decided that she would go to a doctor only after the baby was born. "Finally the family honour cost the poor girl her life."

Ruksaan thanked her lucky star for not having a girl. She said it was almost a curse to beget a girl in those days. Things were changing slowly, but the destruction wrought had left its marks. Had it been just the fact that girls were not allowed to move out or get educated things would still have been okay, but it did not stop at that.

Uzma was pregnant in the first month of her marriage and felt pressurised by social norms to abort the child. "So much was happening with girls those days that a first month pregnancy would be doubted," she said. "Uzma had to abort her pregnancy because she was unwilling to give society the chance to talk since she had conceived so soon. She was also scared that her husband and in-laws would suspect that the child was not theirs."

Most of the research participants described the society of those times as 'bad'. No one empathised with another's misfortune in spite of knowing that the same misfortune could befall them. Once talk of a girl's "character" began there was no saying where it would end. Yasmeen said, "Good health is not as important as good honour. My daughter can avail of gynaecological treatment even after marriage, but if her *izzat* is tarnished before marriage she will be ruined for life. No one will marry her."

Saleema held society responsible for these problems. "We are a bad lot of people here," she said. "We all know that it can happen to any of us, yet we will blame the girl and her parents instead of the person who has done it. Any small problem or defect with a girl is associated with the belief that something must have happened to her."

## 8.2 Ban on family planning

If this was not bad enough, the militants imposed a ban on family planning. This ban was strictly imposed, with informants in almost all hospitals. Operations were banned, installation of copper-T was discontinued, and no method of prevention of childbirth was allowed. Women who could afford it travelled as far as Delhi for treatment, which was kept secret even from family members.

*Ruksaan: The militants banned abortion and they were extremely vigilant about it. For people who could afford it, nothing was impossible. It is the poor who have to bear the brunt of it all. Not only was abortion banned, all family planning programmes were banned. But those who have to get it done do it. A lot of people would travel outside the town for abortion as well as for family planning operations. It is not that they were not taking place here. They were, but it was risky. The operations were normally done under cover and at times in haste were not even conducted properly. Believe me, it was the same people who banned abortion who also ran the abortion clinics. (Lowering her voice) I am 100 per cent sure, my brother-in-law's wife used to take people for the operations. He was a militant and in one of the parties that banned it. His wife on the other hand used to take people and get them aborted or get operations done for not having children. She used to live with us and I knew what she was up to. We never used to interfere. We were all scared. Do you think the militants did not know of the underground clinics running all over the city? They knew each one and they were the ones running them. When I wanted to get an abortion done my sister-in-law told me that she would take me. But I was scared, so I refused.*

Badila ranked the ban on family planning as the toughest hardship for women in the state. "The ban resulted in hardships that really affected the health of the women; it became almost impossible for women to get any kind of safe treatment in the hospitals." The hospitals were watched, so women could not avail of the facilities offered. Even if a woman gathered courage to go to a hospital, the doctors would refuse her. "Everyone was scared".

All 25 research participants agreed that the ban on family planning was the worst outcome of the militancy. Fatima said it would not have been so bad had it been followed strictly. While there was a ban, an illegal network of doctors, nurses, and abortion centres was also running in the valley. These centres damaged women's health even more. Five of the participants said the parties banning abortion shielded the illegal centres and the network of doctors performing illegal sterilisation operations. Most of the other research participants also indirectly hinted at patronage of these centres or at least knowledge about them among the militants. Fauzia said that she had no proof, but was sure that the economics of the centres was so lucrative that the parties banning abortion were also running them. Ruksaan's brother-in-law was a militant and his wife used to take women for ligation operations and abortions. She even offered to help Ruksaan get her operation, but Ruksaan was too scared.

Fauzia said this ban drastically changed the lives of women in Kashmir. The ban did not result in a complete collapse of all family planning facilities, but the business now went to the expensive private practitioners. In many places unqualified doctors performed both sterilisations and abortions. "I have also witnessed the open sale of copper-T to people to either insert them or get them inserted. I know of people who travelled outside the state to avail of these facilities. But this was possible only if they had money. A lot of chemists were supplying medicines to women to induce abortions." She said this became a racket and its victims were the poor.

The ban on family planning and the insistence on Islamic law resulted in women being pressurised not only by society but also by their families. Women who wanted to oppose these bans were unable to do anything because they had no family support. After her second child Saleema wanted to get sterilised. But she was unable to

**Badlla:** *Only I know what I went through for that operation. No hospital, no doctor was willing and I was sure that I did not want it done by a local doctor. There is this one doctor from our village, who is very good. He is in Lal Ded Hospital in Srinagar. I know his family very well. I requested him to do something for me. At first even he was not ready. I literally had to fall at his feet to make him agree. If it had not been for him I don't think I would have ever managed the operation. He took pity on me and arranged for the operation. He arranged for an ambulance to come and collect me in the middle of the night. I was taken to some place I did not know. I was operated upon and before morning I was back home. No one knew of it except my husband and the doctor. For a very long time I did not tell my in-laws. They would have been very upset. They were, when they got to know of it. (Smiles) But by then it was too late for them to do anything. I was not the only woman who must have hidden it like this. We had no choice. The militants would have gunned us down if they had come to know about it. Now when things are better we have started talking about it. But even now one is careful about whom one talks to.*

**Saleema:** *I am sure there will be chaos at home, but once it is done it is done. They cannot undo it. All will be good by the grace of God (muttering a prayer). These people do not understand that the more children we have, the poorer we will become. Lives are not safe in these areas and tomorrow if we are not able to feed our children they will run and join the militancy and get killed like my brother-in-law. I do not want to kill my children. I am a mother and I have seen enough deaths (her eyes fill up). Let them throw me out of the house, but I will not listen to them. I was married to my brother-in-law. I did not know that he was a militant. It was only later that we got to know about him. He was a good man, but he was killed. My in-laws were good and instead of sending me back to my parents' house they got me married to their younger son. I am very grateful to them for this, but I do not want my children to become militants also. We have enough problems as the family of a militant. Every other day there is someone around to see what we are up to. This is no life. They killed the one who was involved, but they do not leave us alone. Both my husband and father-in-law are under constant watch. Any time they are late in coming home we worry. I want to protect my children from this life.*

convince her husband. She eventually decided to go ahead without his consent.

Sterilisation operations within the valley came to a virtual halt. The few that were conducted were done outside hospitals, without any records. The ban also resulted in women falling prey to the unqualified local doctors. Many women lost their lives, or came close to dying, while being treated by these “doctors.” The repercussions were still visible, with many women complaining of backache, heavy bleeding, anaemia, or uterine infections.

Many people also reverted to traditional methods of birth control, not all of them safe. Traditional methods of abortion were also used, which resulted in complications. Illegal abortions were a direct consequence of the ban. Local doctors would perform these operations at high cost, often in unhygienic conditions with no emergency backup. In many cases abortions were not done completely, resulting in infections and complications.

***Bano:** Abortions were carried out. So what if they were illegal? A lot of them were carried out. At times the militants took the girls for abortions... There were times when the child was killed... After the girl gave birth the grandparents would kill the infant or bury it alive. There was this girl in our village, I don't know whether the army took her or the militants, but she got pregnant. Once the baby was born the parents of the girl killed the child. Everyone knew this case, but the parents would deny it if asked. Parents would never say if their daughters were taken away. If anyone asked they would simply say that she is away visiting relatives. The girl herself would never tell anyone. But all knew. All knew where the girls were, but none dared to say a thing lest it is his daughter's turn tomorrow.*

After their third child, Roshan and her husband wanted to opt for sterilisation but were too scared. Roshan eventually went ahead and arranged for the operation, but was unable to get it done for want of money, which her husband was unwilling to give. If the government hospitals had been functional, she would not have had to depend on him for money, she said.

Mariam said, “They had banned all forms of contraceptives, saying it was against Islam. What Islam do they know? It was for their personal gain. They wanted to subjugate women to have more children. They wanted to keep women under control.” If not, why would they run illegal abortion centres while officially banning abortions, she asked. This question was asked again and again.

### 8.3 Infrastructure and the health sector

The health sector was badly hit by the conflict. The uncertainties of everyday life hit medical facilities the most. Assiya said the *halaat* were such that no doctor wanted to risk taking family planning cases. Militants had informants watching all over, especially in the government hospitals. People were forced to travel out of Kashmir for family planning procedures. But due to a lack of money Assiya was forced to depend on the local doctor for her medical needs. This almost cost her life. Her husband rushed her to hospital in time and saved her. When she recovered it was revealed that she was already pregnant when she started taking injections for birth control. The “doctor” had not bothered to conduct any tests. “When I look back I wonder how I survived,” she said. “From that day on I am scared of all family planning methods. You must be wondering how I managed to have three more children despite everything. I did not want to use any methods after this incident.”

Assiya was angry with the local doctor, but said she had to depend on the same doctor because there were no options. She continued to consult him for her unmarried daughter's treatment. She preferred him to the female doctor for fear of harming her daughter's reputation. She was clear that her daughter's *izzat* was more important than her health.

Many research participants like Assiya talked about their vulnerability in accessing medical treatment. Most said they had no choice but to go for illegal abortions. Even if a woman mustered courage to go to a regular doctor for treatment, the doctor would get scared and refuse the case, especially if it was an unmarried girl or a case of rape by soldiers or militants. “There has been many a controversial case in these areas. The doctors do not want to get involved as it means a lot of interrogation

if it is a police case and harassment if a sensitive case with the militants.”

Kaiser had never been to the hospitals in Srinagar because they were too far. After hearing the experience of her neighbour, she prayed that she would never have to visit one. Her neighbour had gone for delivery to the hospital in Srinagar. Due to a shortage of space the woman was asked to lie on the floor. When she was allotted a bed she had to share it with another woman. When the baby was born he also had to share his cot with another infant. Kaiser said that even as nomads they maintained better hygiene. “What is the point of going to hospitals like that?” she asked. Most of the research participants questioned the quality and standard of care in these hospitals.

#### 8.4 Safety in hospitals

The hospitals in Srinagar were the only ones that are fully functional. A breakdown of the peripheral infrastructure had led to overcrowding in these hospitals. Kasheer said that each time she visited these hospitals she prayed for all the patients there. They were so dirty. The minute you entered

the hospital lane you could smell the morbid atmosphere. Besides, they were overcrowded; people were everywhere.

“At times I wonder how so many people can fall ill at the same time,” she remarked. “Women are forced to share beds or to sleep on the floor. I wonder how the doctors recognise their patients. It’s no wonder that so many patients get treated for wrong ailments. Children are stolen in the wards; the attendants at the hospitals are known for this. They sell the children for money. The doctors are known to advise patients to bring someone along to guard the newborn child. There have been so many cases where children have been stolen, especially boys. There have also been cases of child-swapping. I have seen mothers wailing for their lost children and no one coming to help. Can you imagine the plight of a mother who had delivered a child only a few hours back to be told that it has been stolen, or that she has a girl instead of a boy? I have never seen such inhuman things as have been done in the past 10-12 years.”

Minnah, who was taking care of her sister in the hospital, waited every evening for a male family member to keep them company. Her village

**Kasheer:** *I do not think any of us was aware of this case. In the late evening I was approached for a delivery. I was a bit taken aback as I was not aware of anyone due for delivery then. When I enquired, her uncle told me who it was. I was shocked, as we had not seen this girl in the village for a long time. We were under the impression that she was with her aunt in Jammu. When I heard it was her I knew there was something wrong. I wanted to refuse but did not have the heart. I said my prayers and after bidding farewell to my family left for the girl’s house. One look at her and I knew we needed to take her to hospital; her delivery was going to cause a problem. I pleaded with the family, but no one was willing to listen. They pleaded with me to do whatever I could. After much arguing I asked them to at least arrange for a standby doctor. This too they were not willing to do until I said that I was not going to deliver the baby without a doctor. Finally they brought a doctor from somewhere. He was as scared as me. He also tried pleading with the parents to take her to hospital, but they just would not listen. Her labour was long and difficult. We were worried. It was way past midnight when there was a knock on the door. The whole household went into shock. The girl was in pain. Her mother came over and tried to silence her by putting a pillow on her face. I was aghast. I snatched the pillow and threw it away. The banging on the door grew louder. Finally someone opened it or they would have broken it down. Suddenly the room was filled with four men with guns. The doctor hid behind me. I was at the door and did not budge. I do not know what it was but they did not try and move me aside. Maybe it was my age. They stood pointing the gun at me for I don’t know how long; it seemed hours at that time. They finally moved back and motioned for the father and uncle of the girl to follow them. I do not know what happened between them, but after about an hour the militants left. We continued struggling with the delivery. The next morning the girl finally delivered a healthy boy. She was lucky to survive. It was later that we got to know what the problem was. The girl was pregnant with the child of a militant who wanted it aborted. But the girl refused and her parents supported her. She was hidden in the house and the militants were told that she had gone to Jammu for the abortion. But someone had informed the militants of the delivery and they had come to kill the family. The family finally negotiated with the militants and paid them a huge sum of money to let them live and promised to get the girl married as soon as possible.*

was at least two hours' drive away from the hospital, but each evening someone came to be with them. Minnah said that even now there were people around the hospital whom no one knew. "They come at night and disappear by morning," she said. "When we are not allowed out alone in our own villages, how will we be allowed to be alone out here all by ourselves with strange people all around?"

### 8.5 Abductions, rape, and abortions

Both the militants and the security forces have sexually molested, harassed, and raped girls and women in Kashmir. Bano narrated the case of five girls who were abducted and raped before being released three days later. "So much wrong was done to them that their internals (uteruses) were torn," she said. "They all died in hospital." Bano said such women often had to undergo illegal abortions. "A lot of them were carried out. At times the militants themselves took the girls for abortions," she said. At other times the newborn was killed. "After the girl gave birth, the grandparents would kill the infant or bury it alive."

Kasheer said that in most cases the militants wanted the girls to have abortions so as not to leave any trace behind. And if it were too late for abortion they would arrange for the girl to be married to someone in the area. If the girl did not agree, they would kill her and her child, if she gave birth. In her 40-year career as a TBA, Kasheer said the only time she was scared was when she was delivering the child of a woman who had been raped by a militant. The militant had wanted her to abort the foetus. The girl refused and her parents backed her. They hid her in the house and told the militant that she had gone to Jammu for the abortion. But the militants learnt of the delivery and came to kill the whole family. The family had to negotiate and pay a huge sum of money. They also promised to marry off the girl as soon as possible. This was done four months later. Some distant relatives adopted the child.

Nazar said the lives of women who were abducted were ruined. When these women were sent back, the same militants would ridicule them and talk of banishing them from society. If the women tried opening their mouths they were silenced with threats. The women were so scared and humiliated that they would not even want to see a doctor for

check-ups, because they knew the doctor would ask all kinds of questions. So they either preferred to visit the local doctor or suffered in silence.

These girls were married off at gunpoint to unworthy grooms, as Bano put it. Narrating the case of a girl in her village who was raped, Bano said, "It is sad; she is a very pretty girl of good nature from a good family. If fate had not interfered I am sure she would have been married to a very good person. Now she is married to a man not worthy of her. The groom lives with her family and works in their fields. She deserved better."

No wonder then that girls were married off, as Sahida was, as soon as they attained puberty. Sahida was married at 14. Her parents did not ask her if she was willing. "They found a match whom they deemed fit for me and I was informed. The *halaat* were so bad that there was no option for my parents either." Sahida felt good that things had changed now. Parents were educating their daughters and marriages were taking place after the age of 18.

### 8.6 Conclusion

The concept of women as the honour of the family led to an odd phenomenon whereby women, especially unmarried women, were not taken for consultation to a gynaecologist for fear of setting off rumours that would harm their chances of marriage. Even after marriage, until the girl was pregnant, she was not taken to a gynaecologist. Gynaecologists were acceptable only for legitimately pregnant women. In any other case it was always either the local doctor or the general physician, due to the concept of "honour."

Lacking education, or a say in marriage, or in deciding how many children to have and when, the woman constantly fought a losing battle, made worse by the dictates of the militants, the army, and their own families. The fear of abduction and harassment by the security forces and militants, coupled with the ban on family planning by fundamentalists, left women with hardly any choice. Chand put it bluntly, "Contraception? Do you think my husband will allow that? He is a *jallaad* (executioner). He feels I will become weak by using contraception and he does not want anything to come in the way of his needs. He will not bother even if I am pregnant."



# Chapter 9

## Gender power relations and vulnerability of women

The long years of conflict in Kashmir made women even more vulnerable than they had already been in a staunchly patriarchal society. This chapter looks at gender relationships and how conflict increased the women's vulnerability.

Twenty-eight per cent of the research participants had received some kind of formal education. Of them, only one woman of 40 and above from the rural sector had received any education. Most of the other participants, especially from the villages, said it was only in the past 20 years or so that education for women had been stressed upon. Fatima, 60, said education was not easily available for girls when she was young. Most of the participants said that just before the onset of militancy things were looking up for girls. Mahad said girls were progressing in spite of being in a Muslim-majority state. The militancy halted this progress.

Education for women was one of the targets of this tyrannical period. Nazar, Sahida, and many others like them suffered. Sahida was not given any explanation for not being allowed to continue with her education. Nazar, in spite of her eagerness to study, was asked to stop as soon as she was required to travel outside the village.

Although she had no opportunity to get an education, Minnah was making sure that her children, especially the girls, were able to study. This was no easy task, for the elders in the family would not allow the girls to travel alone even for education. As long as they were in a group, it was fine. Otherwise, they had to wait a year or two until they found company.

The association of the girl's *izzat* with the family made the situation worse. This had gendered access to health care. Bano said that girls were more important to the family because they worked more than boys. But she was unable to answer why, in spite of severe stomach ache, clotting, and excess bleeding during her menstrual cycle; she was not referred to a doctor.

Noor said not much importance was given to women's illnesses. Her mother was physically weak and after begetting four children the doctor

had strictly told her not to have any more. "But my father being a staunch Musalmaan would not allow her to go for an operation, nor would he get himself operated." Finally Noor's mother had to get operated without telling anyone at home. Until the time of the interview Noor was the only one in the household apart from her aunt, who helped get the operation done, who knew about this. She feared that even now if her father learned about it he would kick up a fuss.

The position of women within their marital homes became precarious also because of the concept of *izzat*. Sahida said she could only think of family planning after her first child, not before. If she had spoken to anyone, including her husband, about family planning before the birth of her first child, they would have suspected her character. In spite of not wanting a child at the age of 16, she was in no position to voice her opinion. On the other hand, Uzma, under the same societal pressure, had to abort her first pregnancy because she conceived too soon after marriage and was scared that her husband and in-laws would suspect her character.

Chand, even after six spontaneous miscarriages, was in no position to use contraceptives. She said her husband would not allow it. "He feels I will become weak by using contraception. He does not want anything to come in the way of his needs... The doctor has asked me to sleep without him. But do you think he will allow that? The day he wants to, who can stop him?" Yasmeen's doctor had advised her husband to go in for the ligation operation, but he was not willing. "He will become weak," Yasmeen said. "He has to work. What if something happens?"

Most research participants said contraceptives were the woman's responsibility, but they did not have the power to decide when or how to use them. Tahira, talking about the various dicta of the fundamentalists, noted that they were aimed solely at women. "Men were not affected, as they anyway never take responsibility for family planning. There is the strong myth that they will become weak,

and also women are at home so it is more convenient for them to get it done.”

Women thus had to fight not only men’s superstitions but also the dicta of the fundamentalists and society. “I did not want to have children when my daughter-in-law was having children,” said Yasmeen. “How shameful it would have been.” But her husband only agreed to her sterilisation after moving her out of his parental house, and after the realisation dawned on him that his daughter-in-law was pregnant and that society would not look very kindly on both his wife and daughter-in-law being pregnant at the same time. So, it was not Yasmeen’s health or wishes that finally prompted him, but the fear of society. While Yasmeen thus managed to convince her husband, she remained apprehensive about her son agreeing to his wife’s sterilisation after one or two children. “He is a staunch Muslim,” she said. “I do not think he will allow the operation. Let us see.”

Fateh said, “I remember when I wanted to get the ligation operation done, my in-laws just would not agree. They felt that it was against Islam.” Mahad, talking of herself and her sister, said that in spite of their education and family wealth, they were no better off than any uneducated poor woman when it came to reproductive decisions. Her sister’s husband was opposed to contraception and family planning. “No one can argue with him, for no one can argue against the Koran,” Mahad said. “I have had discussions with her and she says that had she been financially independent maybe she could have taken this decision on her own. But now she does not want to take the risk. She has to think of her children and their future. She cannot play around with that when she knows she cannot support them on her own. And she does not want to be dependent on our father.”

Mahad belonged to a family where boys were highly prized and women were under pressure to produce a male offspring. She said that over the years she could see the deterioration in the health of the women in the family. “It is not physical health that I am talking about. I know I am lucky that I do not lack anything, but this pressure is unbearable.” She already had three girls and doctors had told her not to have any more children, but she could not get sterilised. Her only hope was that her fourth child was born so weak that her husband might be forced to consider ligation. “I am trying my best to convince him but am not sure that it will work,” she said with moist eyes.

Roshan’s husband feared for their lives and so did not agree to the operation. Roshan wanted to go ahead with it and made all the arrangements but was not able to get the doctor’s fee of Rs. 5000. “My husband was against it for he feared for our safety. He was just not willing to agree, so finally I had to give up the idea and have two more children till he finally agreed. Women do sell jewellery and other precious possessions to get money, but I did not want to do that. At times I wished I had, but then I think maybe I did the right thing. Had I got it done and something had happened, what would I have done? My husband is everything. If he is not there what is the point of my existence?”

### 9.1 Control of economic resources

Kashmir is primarily an agrarian state with the head of the family controlling the resources. The state’s culture is patriarchal with the oldest male member heading the family. Women contribute equally to the workload, maybe more. They are responsible for the house, the children, as well as the fields during the farming season. But they do not figure in the family’s economic hierarchy. There is no better illustration of this than Minnah’s household.

*Saleema: I am sure there will be chaos at home, but once it is done it is done. All will be fine by the grace of God. These people do not understand that the more children we have the poorer we will become. Lives are not safe in these areas. Tomorrow if we are not able to feed our children they will run off and join the militancy and get killed. I am a mother and I have seen enough deaths. Let them throw me out of the house, but I will not listen. I was married to my brother-in-law. I did not know he was a militant. It was only later that we learnt about him. He was a good man, but he was killed. My in-laws were good and instead of sending me back to my parents they got me married to their younger son. I am grateful to them for this. But I do not want my children to become militants. We have enough problems as the family of a militant.*

Minnah and her sister were married to their cousins and both girls and their husbands lived with Minnah's parents. The family collectively looked after its orchards. But Minnah's father preferred to hand over the money to his two sons-in-law. The daughters, in spite of being in their own house, depended for money on their father or husbands. "We have to ask him directly or our husbands," she said.

Women in this primarily Islamic state are underprivileged, especially where education is concerned. Things were looking up just before the onset of militancy. But the years of militancy have pushed the state back. The ban on modern education and enforcement of the *purdah* resulted in women being trapped in their houses and deprived of employment opportunities, increasing their dependence on male kin.

This monetary dependence resulted in many hardships for women, especially in accessing medical care. Roshan was unable to get a ligation operation because her husband was against it. Women across the state had similar experiences. Noor talked about an aunt living in Delhi who she thanked for her current good health. Her aunt helped her mother with her ligation operation and got Noor treated for anaemia. Otherwise all decisions in their house were made by her father, who was against family planning, and forced his wife to bear children even when doctors had advised against it.

Noor had been married for a year and things were somewhat different at her in-laws' place, though the financial dependence remained. "Here all decisions are taken jointly though here also the final decision rests with my father-in-law," she said. "But women in this family are at least allowed to voice their opinions."

The lack of sources of income has made women in Kashmir dependent on the men. What is worse was that their health, especially in the villages, is not given any importance. These two factors combined to cause much hardship. Women were often forced to go back to their maternal homes for proper treatment. Kasheer had seen many a girl come home like this. "Most of the times the girl comes to her maternal house for treatment. Where girls are unfortunate to have bad in-laws, you will often see them going to their maternal homes. It is so unfair on the parents, but this is normal here. The in-laws

send the ill woman for 'rest', but all know that it is for treatment."

Mahad, who was from a wealthy family, spoke of a different dimension to the control of finances. Her sister was married into a rich family where money was no problem; yet she faced the brunt of a lack of economic independence. "Life was very tough, especially if you belonged to an orthodox or strict family like my elder sister," Mahad said. Her sister had five children, but did not use contraceptives. Her marital family did not allow family planning.

Summing up the politics of economic control, Ruksaan said, "Of course money plays a big role. The government doctors are good, but they are far off. Sometimes we get the government buses, sometimes not. Then we have to depend on the private buses. Not that government buses are cheap, but relatively they are. Plus tests and other treatment, though subsidised, require money. In such a scenario if I am dependent on my husband or father and they do not feel the need to get me treated, what can I do?"

## 9.2 Conclusion

Respondents across the state listed loss of freedom of movement for women as a major repercussion of the conflict. All respondents said that the fact that movement was curtailed not only for them but also for the men caused great hardships.

Tahira said that the various bans, especially the one on family planning, affected the women. "This ban proved to be a curse for all women," she said. "Men were not affected, as they never take responsibility for family planning anyway." Azra said the bans were meant to push women into submission. "They wanted to torture us by making sure we live in the house all the time," she said. Nadeema, a militant's widow, agreed that the bans hurt the women more. As long as her husband was alive, she did not feel the difference. But after his death reality hit her. "In those days I had my husband who was respected a lot and so I did not realise it. But yes, now I know how difficult it was."

Mahad said no one knew the exact reason for these restrictions on women. All she knew was that they did not benefit anyone. "They only led to hardships for us." Asked if the bans were meant for men as well, she said, "Who would target men?"

# Chapter 10

## Major findings

The 16 years of conflict in Kashmir changed life for one and all. This chapter tries to bring together the changes that took place in (a) the lives of the common people, (b) the health sector, and (c) the reproductive health sector, and how people negotiated their way through these changes to ensure survival.

- The biggest change was that a feeling of insecurity became a constant. Life lost all meaning. Not only did dreams of freedom fade, people tired of the insecurity, instability, and poverty that the long-drawn battle brought. Life became so insecure that people were not sure if they would return home safely in the evening after a day's work, or reach their destination when setting out for it. The biggest fear was reaching home to find that all was not well there. So men had to seek work closer to their houses and women often had to quit their jobs. Seventy per cent of the research participants said they did not even mind the non-availability of transport provided they could move around freely at all times.
- The sense of insecurity was greater for girls and young women who became virtual prisoners in their houses because of the ever-present threat of abduction and sexual violence. Their lives came to a virtual halt on attaining puberty, with all manner of restrictions being placed on them. Their education stopped and they were married off at the earliest opportunity.
- The education system was badly hit by the frequent curfews, *bandhs*, and strikes. It began to take up to three years to complete one grade, especially in professional courses like medicine and engineering, resulting in students migrating outside, which in turn caused a shortage of trained and qualified professionals in Kashmir.
- Restrictions on movement ranked as the single biggest problem brought on by the secessionist movement. Curfew was imposed after sunset across the state for many years. Even

now there are areas where curfew is imposed after dark. Such restrictions left the people feeling helpless in their own land.

- The fundamentalists sought to control every aspect of life, from what kind of books to read and schools to attend to what clothes to wear and how to live. The research participants said the fight for freedom had cost them their personal freedom. Even leisure was sought to be controlled by the fundamentalists, who banned almost all types of entertainment. Certain festivals and social functions had to be discontinued. Traditional social gatherings like the henna ceremony, which was earlier performed after sunset on the eve of a marriage, had to be rescheduled for the daytime.
- Health care, especially in the villages, was badly hit, first by the migration of trained medical professionals and then by the unwillingness of the remaining doctors to risk their lives to serve in the districts and villages. Most of them stayed in the cities.
- The bans imposed by the fundamentalists were initially obeyed, owing partly to the fervour of the movement and partly to the fear of retribution. But as people saw the fundamentalists themselves disobey their dicta, they became disillusioned. Thus the ban on modern education and the insistence on the veil eventually faded away.
- Only the ban on the use of family planning methods remained in force to some extent. Women across the three districts in which the study was conducted felt the reason for this ban was to subjugate them. Some also believed that the militants profited from it by running illegal abortion centres, which opened up all over the state.
- Abductions and sexual violence against girls and women resulted in the family "honour" being associated with them. People were scared more of losing their "honour" than their lives,

limbs, or emotional balance. So parents let unmarried daughters with serious reproductive tract ailments go untreated rather than risk talk about her "character." The hesitation to consult a gynaecologist applied to all women, especially in the villages, unless they were legitimately pregnant.

- Health went from being an essential requirement to one based on need. People ignored it, especially a woman's health, as far as possible. They were just too busy fighting for daily survival. As long as a woman could work, she was considered fit. More importance was given to the male earning member of the family. It was believed that his good health was important for the survival of the rest of the family. This was also the excuse given for men not opting for sterilisation.
- The conflict, especially in the villages, created a situation where a medical professional's qualification was not so important as his/her reliability and availability in an emergency. Even today, when health care in the districts and villages is improving, the villager holds on to his ties with the "local doctor" for fear that if the conflict flares up again they will have to go back to depending on these quacks.
- The increased emphasis on "honour" resulted in girls feeling trapped. Internalising this concept, young girls often said it was better for them to cover up and avoid trouble or to discontinue their education without murmur. Girls were married off at 14 or 15.
- This same concept did not allow women to think of planning a family right after marriage. It was believed that if a girl did not want a child soon after marriage something had to be wrong with her. Doubts were raised about her character. Family planning could be thought of only after the first child. Women also had to be careful not to conceive too soon after marriage, or tongues would start wagging.
- The ban on family planning methods forced women to fall back on traditional methods or the treatment offered by quacks, leading to complications later. Although women across the state pledged their faith in these "local doctors,"

they also blamed them for their current problems. Although there were no medical records to prove this, many said problems of heavy bleeding, backache, fatigue, and anaemia have become common among women over 30. They believed that most of these ailments have become chronic because they did not get proper medical aid at the right time. Even abortions were mostly carried out by local doctors in unhygienic conditions.

### 10.1 What does this study confirm?

Conflict brings all kinds of changes in the lives of people, but more so in the case of women. The biggest fear for women trapped in a conflict is loss of "honour." "Honour" is linked directly with a woman's reproductive health and rights, which she has to forgo. Girls and young women in Kashmir can only be thankful that parents are once again thinking of educating them before getting them married.

It was only when I spoke to young women who were born in the years of conflict that I realised how much life looks different to them. These girls, who have seen nothing but restrictions and strife, consider present-day Kashmir a heaven, which it is still anything but. Simply being able to visit a cousin in the same village without having to inform their elders is bliss for them. To even dream of wearing jeans is a transformation from the time when the veil was compulsory.

Women over the last 16 years have had to go through a lot and it is no wonder that today they do not even want to talk or think of those days. They want this peace to continue even if their dream of freedom remains unfulfilled. They are happy that at least their daughters will not have to go through what they endured.

In those years of conflict, women had no choice but to fall prey to quacks and illegal abortion centres. After some time they even started believing that an abortion was not a complicated or harmful operation. It is only now that women are realising what harm they caused to their bodies. Most married women with children today complain of lower backache that seems to have no cause. Almost all the women with such complaints had at some point been treated by the "local doctors" or had undergone an illegal abortion.

## 10.2 Negotiating strategies and coping mechanisms

### ***Dependence on traditional healers:***

Learning to live with the *halaat* took its toll. Research participants spoke of a growing dependence on sedatives and anti-depressants. Sixty per cent blamed this on the uncertainty in their lives. This uncertainty also led to a reinforcement of their faith in religion and seers. Participants often said that had it not been for “him” (the local *pir*) they would have perished like thousands of others all over the state.

While most of the participants said the *halaat* were bad in the days of strife, they were not comfortable when asked to explain. Most described their lives as having been worse than those of animals. “Yet we survived. I would say it is thanks to Allah and our faith in God...” Fauzia said.

Strong faith in seers has been part of Kashmir’s culture for centuries. Almost every village has its own shrine. Today these shrines are crowded and the *pirs* are mobbed. Earlier people would go to a *pir* or a *ziarat* only when in trouble. Now you find them in the *ziarats* at all times, if nothing else then simply to seek goodwill. People like Nadeema, who never believed in *pirs*, have also become believers. The peace and strength she gains from her faith give her the confidence to face life.

***Internalising of the conflict:*** Most participants did not want to talk about the “bad days” or the militancy in detail. They said that in comparison Kashmir is a paradise now. They prayed for this peace to continue. Any attempt to discuss the militants was met with strict resistance. They felt it was better to forget those days.

People have internalised the conflict to such an extent that even though no curfew was imposed after dark at the time of this study, they were careful to avoid any travel at night unless it was absolutely unavoidable. Everyone tries to get back home before sunset, and if they cannot they prefer to stay at a friend’s or relative’s house rather than travel at night.

***Support from the community:*** People said that one of their biggest strengths during the years of conflict was the support provided by neighbours. The participants noted several instances when they could trust their neighbours and approach

them for assistance at any time. People would not refuse, for everyone knew that it could be their turn next.

***Focus on family honour:*** Protection of “honour” became the family’s prime responsibility, with the women, especially unmarried girls, bearing the brunt. Every tiny problem with a girl had the potential of being construed to mean that something dreadful had happened to her. To protect the family honour, girls had to face a lot of restrictions, including on their movement. The minute girls attained puberty they could no longer go out alone, particularly after dark. They could not even go alone to the neighbour’s house.

Thanks to the widespread incidence of abduction and rape, any unmarried girl who consulted a gynaecologist came to be looked upon with suspicion. Rumours would spread quickly and mar her reputation. So parents avoided consulting even a regular doctor for their daughters unless it was unavoidable.

Girls were forced to discontinue their education if they had to travel to another village or town. Even at the time of the study some parents made their daughters skip a year if they did not have other students accompanying them to school or college. They justified this on the ground of safeguarding their daughters, pointing out that even security personnel in the villages cautioned women against travelling alone, especially in the fields or in the evenings.

Early marriages became another mechanism for society to safeguard women. Girls as young as 14 were married, especially in remote villages. Parents saw this as a way out of their own fear. The education, health, and well-being of girls stopped being matters of consideration. *Izzat* dominated society’s thoughts and marriage was seen as the only solution.

Marriage was also used as a mechanism to cover up a lot of the evil in the state. Sexual harassment and rape were rampant, with both the militants and the security forces as perpetrators. This left parents with two choices: abortion or marriage. “Girls have been married off within weeks,” Bano said. “In Kashmir we get boys from poorer families to marry girls and then live at the girl’s house. Many marriages were arranged like this.”

Marriages of girls who had been raped by militants were often arranged by the militants themselves to avoid a bad reputation. They would either marry them off to someone within their own group or to someone from the village, the latter under duress. The girls and their families, of course, had no say in any of this. And the families wouldn't object, because it would save them the humiliation of looking for a match themselves. Children born as a result of rape were either killed or given up for adoption.

**The nexus of quacks:** People had to depend on a network of quacks for health care, who set up shop all over the state in the absence of qualified medical professionals. Women paid the biggest price for the collapse of the state's healthcare infrastructure. Good quality reproductive health care became almost completely inaccessible, with the result that even at the time of the study, many women suffered from chronic sexual problems. The quacks did save many lives with their limited knowledge in times of crises. But in other cases their treatment left behind a legacy of constant sickness. With the militants' ban on family planning strictly implemented, women had little option but to depend on these quacks even though there were innumerable instances of misdiagnosis and wrong treatment. Participants spoke of the quacks selling intra-uterine devices for Rs. 34 and telling patients to insert the birth control devices themselves.

**Traditional methods:** Women all over the state had stories to tell of their personal experiences at the medical centres. The only other option for

them was to fall back on traditional methods of family planning, never mind their success rates or the safety aspect. Many women even grew to prefer these methods to the ones prescribed by the quacks because they believed that the traditional medical professionals were more careful with their prescriptions and treatments.

**Interstate travel:** Those who could afford it went to other states in India for medical treatment, especially for family planning. They had to be careful about never mentioning the purpose of the trip, even to family members. No one was trusted. This was especially tough for women because they were allowed hardly any privacy at all times. The women talked over and over again about how the notion of privacy no longer existed for them. There was no way that a woman could take a decision in complete privacy. She had to take someone in confidence. Yet illegal abortions and sterilisations were performed in complete secrecy.

Most research participants talked of people travelling outside the state for treatment. People travelled to Jammu, Delhi, Punjab and even Mumbai. The safest places were considered to be either Delhi or Ajmer, where one could be going for pilgrimage. The women said that it is only now that the reason behind these trips was being revealed. Although the option of travelling outside the state was available, it was not always feasible due to the costs involved. Not everyone could afford to travel. Women like Assiya were aware of the option of travelling out of the state, but said she had to depend on options available within the state.

*Mariam escorted her sister to the Lal Ded Hospital and begged a female doctor, a friend, to perform an abortion. "After much cajoling, the doctor agreed, but the operation was performed in a hired room close to the hospital with the aid of an assistant. After the abortion the doctor and the assistant left and asked us to come to the hospital for medication. In the hospital we were treated as fresh patients who had come for a regular check-up. There is no record of that abortion anywhere. Nor is there a discharge slip. The doctor simply assured us that she would take care of everything.*

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## Annexure 1

### Researcher's note

This study received several positive critiques over 18 months. One question that always posed a challenge and was a source of worry was how this study would be different from any other study about medical facilities conducted in any part of the country. In terms of the state of medical facilities, it has nothing new to contribute. But there is one difference, which is the ethos and context of this

study: the conflict in the state for 16 years, which made access to the near-defunct medical system even more difficult.

A second critique from prominent scholars wondered why reproductive health should be such a major concern in a conflict situation with plenty of other crises to address. The answer is, why deny women their rights when men don't have them taken away?

## Annexure 2

### Glossary of terms from the women's narratives

**Bandh** – Protest call by political groups for closure of all activities in an area.

**Charpoy** – A wooden single bed used in villages. Often used as stretchers to carry patients.

**Chula** – Clay stove used for cooking.

**CHW** – Community health worker.

**Dabaa key rakhna** – Subjugate.

**Dehshyat** – Terror, particularly the terror of the night at the height of the militancy. Even at the time of the study, when things were returning to normal, people would avoid being out after sunset, such was the terror.

**Goonda raaj** – Rule of thugs and thieves.

**Halaat** – The happenings of the times, a term used to describe negative events. In the research the term has been used to describe the bad situation during the militancy in Kashmir.

**Izzat** – Honour, of the woman or the family.

**Jannat** – Paradise. Respondents used the term again and again to depict their vision of Kashmir vis-à-vis the hell they were living in.

**Jihad** – Religious battle.

**Kharabi** – Term used by every respondent to signify rape, sexual harassment, or reproductive health problems caused by medical malpractice. Also used at times for the overall physical and mental degradation of women in Kashmir.

**Khudah ke bandey** – Militants; men of god.

**Lachaar** – Helpless. Respondents used the term to describe women's helplessness before the militants, security personnel, and society in general.

**Local doctor** – Literal translation of the term "doctor in the village" used all over the state. These "doctors" mushroomed during the years of militancy. Their qualifications were often unknown. In most cases they were either local medical storekeepers or doctor's assistants in government hospitals. In spite of their lack of training, they were revered for their dependability during the years of turmoil.

**LD Hospital** – Lal Ded Hospital, Srinagar, the only functional maternity hospital in Kashmir.

**Musalmaan** – Follower of Islam.

**Normal route** – In this study the term has been used to denote a person's commute on a particular route without unscheduled stops. From the days of the conflict to the present time travelling in Kashmir has always been risky as insurgents often target vehicles while security forces stop them for checks that can take hours. Even today a half-hour journey can take anywhere from an hour to the entire day depending on the *halaat* en route.

**Purdah** – Veil. In Kashmir's context it also refers to the distance women must keep from strangers. But the veil itself, introduced in the form of the *burqa*, was strongly opposed.

**Tarikhi** – The colloquial term, origin unknown, for the years of turmoil. Respondents would always look around before whispering it.

**TBA** – The traditional birth attendants, or *dais*, who assist pregnant women. In the last six years or so they are being trained by the government. Earlier experience was their only guide.

## Annexure 3

### Interview guide

#### LIFE HISTORY OF THE WOMEN WITH EMPHASIS ON MAJOR LIFE EVENTS

- Name
- Age
- Marital status
- Age at marriage
- Number of children
- Occupation/main bread-earner of the family
- Number of family members
- Education levels
- Nature of school – co-education or only for girls

#### MEDICAL HEALTH HISTORY OF THE INDIVIDUAL, FAMILY, AND VILLAGE

- What are the kinds of diseases the family suffers from?
- What are the kinds of diseases that women in the household suffer from?
- What are the diseases that women in the area suffer from? Which among these do you consider minor/major? Why? How do the women deal with such illnesses?
- Is there a difference in the kind of ailments that people are suffering from in the past 16 years?
- What are the kinds of illnesses that people used to suffer from in those days and what is the change now?
- What could be the reason for this change?
- What are the problems that women face before, during, and after pregnancy?
- How seriously are women-related problems looked at by the family and/or community?
- Is there a change in this perception in the past few years?

#### HEALTH FACILITIES AVAILABLE AT THE MICRO AND MACRO LEVEL

- What is the kind of treatment sought by the locals?
- Where is the treatment available (hospitals, doctors, *hakims*, home remedies)?
- How are the medical facilities that are available – functional/non-functional/partial?
- How are patients treated at the clinics? What is the attitude of the doctor?
- Are there differences in the kind of facilities available in the villages and the city?
- Was this difference present even before the troubles began?
- What are the kinds of problems faced in accessing reproductive health facilities?
- Is the existing health infrastructure adequate for the number of people in this area?
- What are the kinds of facilities available in the health sector, especially in emergencies?
- How are emergencies dealt with?
- The years of turmoil have led to a breakdown of the health sector. What were the kinds of facilities available before the insurgency began?
- Have the facilities improved or has there been degradation?
- Were they adequate for the population at that point in time?
- What were the health facilities available then? Were they adequate?
- Where were hospitals located before the insurgency and how easy was it to reach them?
- How were the medical facilities available then – functional/non-functional/partial?

### **ACCESSIBILITY TO THE HEALTH SECTOR**

- Where is the closest hospital/dispensary?
- Are you allowed to go on your own?
- Who decides when and to which hospital or doctor you need to go?
- Who accompanies you to the hospital?
- What happens if you need to go for follow-up treatment?
- Where were the hospitals located before the insurgency?
- How accessible were they before the turmoil?
- Were you allowed to go alone for health care services before the conflict began?
- What was the mode of transport in those days?
- How easily were private vehicles available then?
- How were emergencies dealt with in those days?

### **REPRODUCTIVE HEALTH HISTORY OF THE INTERVIEWEE**

- When was it that you realised there were some physical changes in your body?
- Were you aware of puberty and the changes it brings in one's body?
- How did you learn about puberty?
- What was your experience of the bodily changes before and after the onset of puberty?
- How old were you when your menstrual cycles began?
- Were you aware of menstruation?
- What was your first experience of menstruation? How did you deal with it?
- Were you menstruating by the time you were married?
- What were the physical or mental changes in you after marriage?
- How soon did you conceive after marriage? Whose decision was it? Were you part of it?
- Who decided on the number of children that you were to have? Did you have a say?
- What do you think of birth control methods?
- What about sterilisation?
- How are reproductive health emergencies dealt with at the local hospitals and in the city hospital?

### **UNDERSTANDING OF HEALTH, PARTICULARLY REPRODUCTIVE HEALTH**

- What is the reaction in the household when someone is unwell?
- When is the option of a doctor considered?
- What are the precautions/medications used before visiting a doctor?
- Are precautions taken to lead a disease-free life?
- Do you think you are healthy?
- What does health mean?
- What about reproductive health?
- Does it entail anything more than pregnancy?
- Is reproductive health looked on as a separate entity? Or is it part of the larger health structure?

### **INTERACTION WITH THE MEDICAL SYSTEM**

- How are patients treated in the clinics here?
- Is there a difference if a woman walks in alone to the hospital and if she is accompanied by a male companion?
- Are women's health problems taken seriously?
- Do women patients receive the same time and attention as male patients?
- How accessible are the senior doctors in the hospitals?
- Is there a change in the quality of health services in the past years?

- What about the doctors? Do you feel that there is a difference in the quality of doctors available, especially in the villages?
- What about the kind of doctors in the public and private sectors? Is there any difference in quality there? If so, was this difference always prevalent or is it recent?

#### **ROLE OF EXTERNAL AGENCIES (MILITARY, MILITANTS)**

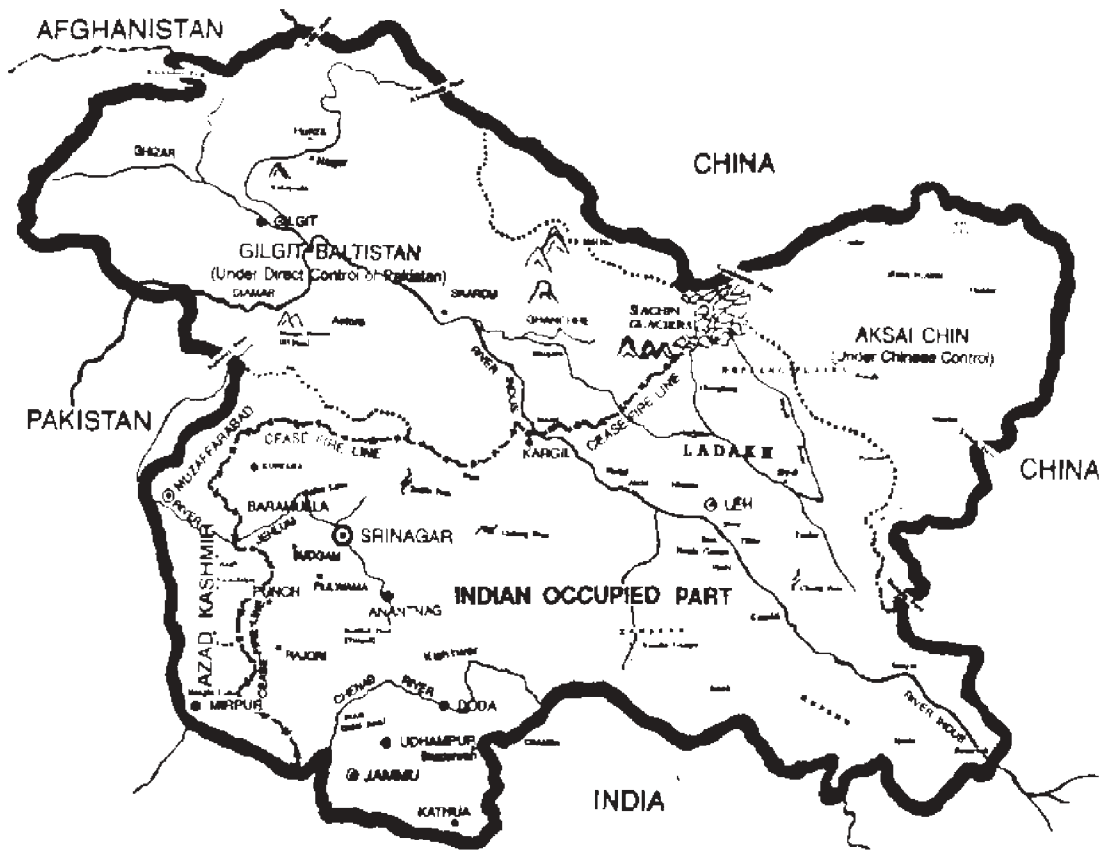
- Why is the situation the way it is?
- How has militancy changed life for the valley, especially the women?
- Has it in any way improved the lot of women in the context of health? How?
- How has the presence of security forces changed your way of life?
- How have people reacted to the various dicta imposed by the militants and the government, particularly by the militants, like bans on abortion, family planning, and education for girls, strict adherence to Islam, ban on entertainment, and so on?
- Is there any personal experience that you would like to share?

#### **GUIDELINES FOR ADOLESCENT GIRLS**

The guidelines remain the same till we come to the reproductive history of the person. Here the guidelines vary as adolescent girls today are becoming aware of their sexuality and want to explore it. Do they have any avenues? How does this affect their growth? These are a few of the questions that will be explored.

- When was the first time you noticed any physical changes in your body?
- Did you know of these changes? How did you know of them?
- What was your first reaction when you noticed these changes?
- Did you seek help? From whom?
- Once you learnt of these changes did it bring any change in your life, in the way you behaved in public, dressed, etc.?
- Have your thoughts about yourself and your being changed in any way since?
- You have grown up in an era where your life is dictated by conflict. Do you imagine a life without conflict? How would your life be different if there was no conflict?
- What do you think of the army and/or militants who surround your village and your life? Do they bother you in any way? How have they made a difference to your life?
- Would you like to share any incident with us about how these outside forces have changed your life?

# Map



**List of studies completed under the initiative:**

1. Gender, caste, class and health care access: Experiences of rural households in Koppal district, Karnataka  
**Aditi Iyer**
  
2. Correlates of high-risk sexual behaviour among never-married male industrial workers in Tirupur  
**N Audinarayana**
  
3. Involuntary childlessness among the middle class in Vadodara city  
**Bhamini Mehta, Shagufa Kapadia, Debjani Chakraborty**
  
4. Attitudes of adolescent students in Thiruvananthapuram towards gender, sexuality, sexual and reproductive health and rights.  
**Phillip Mathew KM**
  
5. Men's participation in reproductive health: A study of some villages in Andhra Pradesh  
**G Rama Padma**
  
6. The interface between mental health and reproductive health of women among the urban poor in Delhi  
**Ranendra Kumar Das and Veena Das**
  
7. The interrelationship between gender and malaria among the rural poor in Jharkhand  
**Sama**
  
8. Middle class sexuality: Construction of women's sexual desire in the 1990s and early 21<sup>st</sup> century Mumbai  
**Shilpa Phadke**
  
9. Delay in seeking care and health outcomes for young abortion seekers  
**Sowmini CV**
  
10. Interface of heart disease and reproductive health: An exploratory study of gender dimensions  
**R Sukanya, S Sivasankaran**
  
11. Negotiating reproductive health needs in a conflict situation in the Kashmir Valley  
**Zamrooda Khanday**