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Written statement* submitted by International Muslim Women's Union, a non-governmental organization in special consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[23 May 2023]

* Issued as received, in the language of submission only.

Physical and Mental Health in Indian Administered Jammu and Kashmir

Achieving socio-economic growth can be done by enhancing national health. The availability and provision of health infrastructure in an administrative territory affect the health of ordinary people. People's access to healthcare is inversely correlated with the availability of a region's health infrastructure.

The revocation of Article 370 on August 5, 2019, effectively dismantled the semi-autonomous status of the Indian Administered Jammu and Kashmir, leading to significant tension and unrest in the region. The revocation of the Indian Administered Jammu and Kashmir's special status, combined with subsequent lockdowns and communication blackouts, has had severe implications for the health of the public in general and the vulnerable women and children in the region. Access to healthcare facilities became increasingly challenging, particularly for those with chronic diseases. Strictly enforced curfews by security forces hinder transportation to hospitals and impede timely medical care.

Moreover, a recent study demonstrates the existence of inter-district disparities in the Indian Administered Jammu and Kashmir's health infrastructure. Regarding health infrastructure, Doda has the highest Health Infrastructure Index (HII) and has been designated a 'developed' district. Doda is followed by Jammu, Kishtwar, Udhampur, Ramban, Samba, Reasi, and Kulgam, which also fall into the 'developed' districts category. Backward districts include Kathua, Rajouri, Poonch, Budgam, Shopian, Kupwara, Ganderbal, Baramulla, Bandipora, and Anantnag. Srinagar district, with the lowest HII, was identified as the most backward district in Indian Administered Jammu and Kashmir. All of the districts of the Kashmir division, apart from Kulgam, are classified as being 'backward' or 'very backward'.

Nevertheless, healthcare facilities in these places are frequently insufficient and inaccessible, exacerbating the health inequities these populations suffer. Mainly caused due to the heavy militarization of this region where access is restricted. Establishing the health infrastructure and free movement of the public without security checkpoints and barricades will strengthen the medical infrastructure throughout to safeguard people's lives and provide the optimum medical care facilities possible. Thus, there is an urgent need to develop the healthcare infrastructure of Indian Administered Jammu and Kashmir to guarantee that marginalized and vulnerable groups have access to adequate healthcare services.

In comparison to India's doctor-patient ratio of 1:2000, Indian Administered Jammu and Kashmir has one doctor for 3866 people, compared to the WHO (World Health Organization) norm of one doctor for 1000 people,"

The upshot of poor health services in district hospitals of the Kashmir region, especially concerning the health issues faced by the women, is that the majority of the patients who need obstetric care and run even the slightest risk are referred to the region's solitary tertiary care maternity hospital – Lal Ded Hospital – in Srinagar. This puts a lot of strain on this facility don't perceive any difference even though so many district hospitals have been established to relieve the pressure on this tertiary care facility. As a result, putting the burden on metropolitan hospitals adds to the pressure on doctors who are overburdened with patients. Patients are often negatively affected by their waistlines, delays in consultation, and therapy, putting them in danger of aggravating the ailment they have, which can be cured/eradicated with appropriate intervention. According to the CAG's performance audit of 84 community health centers (CHCs) and sub-district hospitals (SDHs) across the Union Territory, only 270 expert medical officers were present in these health institutions, despite a sanctioned strength of 504 specialists. In these health centers, there was a 46 percent shortage of specialists.

Furthermore, healthcare delivery in rural areas needs a better technology infrastructure to improve and provide healthcare facilities, making it accessible to the most in need. Private dispensaries and hospitals, and private physicians (of questionable credentials) operating in and around the region are usually more of commercial nature and expensive beyond the reach of the rural community. Distance to cover to reach health facilities always poses a constraint. Expenditure incurred and time (resultant loss of day's wage) spent overreaching health facilities is always a constraint. In contrast, uncertainty about getting needed health services due to the absence of medical staff or the non-availability of drugs remains

There is an urgent need to address the menstrual and reproductive health crisis among Kashmiri women and take immediate action to uphold their rights to health and education. This lack of access to proper menstrual hygiene management significantly impacts women's health, increasing the risk of infections, infertility, and cervical cancer.

The perpetual conflict situation in Indian Administered Jammu and Kashmir compounds the reproductive health crisis faced by women in the region. The trauma resulting from the conflict has led to an increase in infertility rates and reproductive health problems. Fear of violence and the threat of conflict deter pregnant women from seeking regular prenatal care, resulting in maternal and fetal deaths due to the unavailability of timely treatment.

To address these pressing issues, clear government leadership in Indian Administered Jammu and Kashmir is needed. The establishment of a working group, involving practitioners familiar with the stigma related to menstruation and reproductive health in the region, is essential. This working group should develop an agenda grounded in human rights principles and engage international actors, such as UNICEF or UNFPA, to coordinate a multi-stakeholder response.

Evidence-based policy programs should be central to policymaking, enabling a comprehensive understanding of the impact of menstrual and reproductive health on various other human rights. Targeted and inclusive intervention programs are crucial to ensure women's access to adequate healthcare services and education. The international community must support and advocate for the rights of Kashmiri women, demanding the fulfillment of their right to health.

In conclusion, the revocation of Article 370 and subsequent events in Indian Administered Jammu and Kashmir have severely impacted the menstrual and reproductive health of women. Cultural taboos, compounded by lockdowns and limited access to healthcare, have created a crisis that demands immediate attention and action. The Indian government must fulfill its obligations as a legal duty-bearer and take effective measures to improve healthcare infrastructure and education in Indian Administered Jammu and Kashmir which are not possible amid the severe human rights violations. Collaboration with international organizations and the establishment of a working group can help develop targeted interventions and ensure the rights of Kashmiris to health and education are respected and upheld. The time for change is now, and the international community must stand in solidarity to support the well-being and empowerment of Kashmiris