KASHMIR: VIOLENCE AND HEALTH

A quantitative assessment on violence, the psychosocial and general health status of the Indian Kashmiri population

November 2006
FINAL VERSION

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EXECUTIVE SUMMARY

The Kashmiri population living in India has been both witness to and victims of violence, involving a number of groups with different aims over the past few decades. Since 2000, MSF-Holland has been working in the region, providing mental health care and support in the management of medical waste disposal in the capital Srinagar and outlying rural areas.

To identify needs and support project planning, a survey consisting of 510 semi-structured interviews was executed in two violence-affected, rural districts in Indian administered Kashmir during mid-2005.

The period of violence considered was defined by the local population as starting in 1989, continuing until the time of the survey. At the time of interview, almost half (48.1%) of the respondents said they felt only occasionally or never safe. In the period 1989-2005, people frequently reported crackdowns[A] (99.2%), frisking by security forces (85.7%) and round-up raids in villages[B] (82.7%). In the same period, damage to property (39%) or the burning of houses (26.3%) was considerable. Interviewees reported witnessing (73.3%) and directly experiencing themselves (44.1%), physical and psychological mistreatment, such as humiliation and threats.

In addition, people were forced to perform labour (33.7%) or to give shelter to combatants (18.4%). In the same period, one in six respondents (16.9%) were legally or illegally detained. A shocking finding is that torture appears to be widespread among those detained (legally or illegally): 76.7% said they were tortured while they were in captivity. The high levels reported suggest a strategy of intimidation and fear employed by the warring parties.

Violence is associated with human loss. In this period nearly one in ten people (9.4%) lost one or more members of their nuclear family[C] because of the violence. A third (35.7%) indicated that they had lost one or more extended family members.

Violence or the threat of physical violence seems to have had a significant effect on the mental health of people in this region. In the past 30 days one in ten (9.6%) people mentioned mental problems as their primary health concern. In the past month the respondents suffered from high levels of anxiety such as nervousness, tension, extensive worrying (62.7%); using a self-reporting survey tool that has been validated for use in India, 33.3% suffered from psychological distress in the past 30 days. Just under half of those interviewed reported that they were unhappy to the extent that a substantial number of people interviewed admitted to having thoughts about ending their life (33.9%). Such a high percentage of suicidal ideation, within a population holding strong religious beliefs that condemn the act of suicide, is a worrying indicator of the level of despair and hopelessness.

Physical health is also affected; a substantial number of the people reported their physical health as being bad (22.7%) or very bad (7.1%) in the 30 days prior to the survey. Over a similar period high rates of physical complaints including headaches (23.5%), body pains such as joint and back complaints (20.5%), and abdominal complaints (16.9%) were mentioned. Such high levels of non-specific health complaints suggest high levels of stress and psychosocial problems. Poor

[A] Houses are surrounded and all family members are asked to stay in one room while the houses are searched.

[B] All inhabitants of a village are gathered in the central square while security forces search for "terrorists" often using informers who name "suspects".

[C] Spouse, mother, father, brother, sister, child.

health placed a substantial burden on the area's health facilities, with most people saying they visit health clinics frequently (63.9%); some even four times or more in the past 30 days (15.3%). Medicine consumption was also high, with over one-third taking six or more medicines in the previous 30 days (37.9%).

Poor physical and mental health clearly affects daily functioning. Nearly half (49.0%) of those interviewed report being unable to carry out their usual activities for four or more days in the past 30 days; a similar number (49.8%) reported having to cut back or reduce their activities or work in the past month because of ill health.

Sexual violence is a common strategy used to terrorise and intimidate people in conflict, but in Kashmir it is an issue that is not openly discussed. Nevertheless, 11.6% of interviewees said they had been victims of sexual violence since 1989. Almost two-thirds of the people interviewed (63.9%) had heard over a similar period about cases of rape, while one in seven had witnessed rape.

In children, the major effect of the violence reported in this survey is fear (24.6%). School-related problems also scored highly, such as being unable to attend school (15.5%) and having problems studying (16.3%) due to the lack of professional teachers and study material.

Respondents tell people deal with stress by isolating themselves (22.3%) or becoming aggressive (16%). These dysfunctional coping mechanisms are reported often as a consequence of exposure to violence. While people think that talking confidentially to someone they trust is helpful when confronted with tension (89.4%), over two-thirds (68%) do not know what counselling is.

The findings of the study are of considerable concern. While the level of violence has decreased since 2004[1], the events reported here were still occurring in mid-2005 when the survey was done, indicating an ongoing and unacceptable continuation of violence. Kashmir remains caught in a cycle of violence despite efforts by governments to break the cycle. Further, our findings indicate that mental and physical health needs are high, while the coping mechanisms of individuals are predominantly dysfunctional. Even with a definitive end to violence, it could be expected that a substantial number of people would need support to overcome their problems. This assumption is confirmed by our findings of high mental health needs despite the decrease of violence since 2004.

Mental health problems in Kashmir need to be addressed with urgency. In areas where MSF works, we have implemented community based mental health services. In all other Kashmir districts community-based mental health services are non-existent, despite the intentions set out in the Indian Mental Health Policy. Based on the findings of this survey, MSF calls on the health authorities to implement their stated policies and to prioritise the immediate implementation of community based psychiatric and counseling services in Kashmir.

Summary Table

Living Circumstances (n)	510
Estimated mortality per day over the past two months	0.3/10,000/day
Currently feeling unsafe	48.1%
High or total dependence on outside financial/practical assistance	24.9%
Insecurity (since 1989)	
Crack downs	99.2%
Frisking	85.7%
Round-up raids	82.7%
Damage to property	39%
Burning houses	26.3%
Physical/psychological mistreatment/ witnessing mistreatment	44.1% / 73.3%
Forced labour	33.7%
Housing combatants	18.4%
(Il)legal detention / being tortured during (Il)legal detention	16.9% / 76.7%
Experienced / witnessed / heard about sexual violence	11.6% / 13.3% / 63.9%
Mental Health Situation in the past 30 days	
Mental health problems mentioned as major first complaint	9.6%
Anxiety	62.7%
Unhappiness	50.0%
Thoughts about ending his/her life	33.9%
SRQ 20 score indicating psychological distress (cut off 12)	33.3%
Physical Health Situation in the past 30 days	
Physical health very poor or poor	29.8%
Major physical complaints: *Headache*	23.5%
Body pains	20.5%
Abdominal complaints	16.9%
Health clinic frequently visited	65.1%
Medicine consumption (>six in past 30 days)	37.9%
Daily Functioning in the past 30 days	
Unable to do activities more than four days	49.0%
Reduce activities	49.9%
Loss	
Nuclear family	9.4%
Other family members	35.7%
Effect on Children	
Fear	24.6%
Problems with studying	16.3%
Unable to attend school	15.5%
Major Coping Mechanisms	
Isolate themselves	22.3%
Aggressive	16%

The Kashmir Context

A multi-layered conflict

The Kashmir Valley, surrounded by the snow-clad Himalayan mountain range, has been disputed territory between India and Pakistan since the birth of both nations in 1947. During partition, the Kashmiri population - a majority of which is Muslim - was promised a choice of joining either India or Pakistan, through a popular vote. This plebiscite never took place. For many Kashmiris this resulted in a denial of their democratic rights and institutions, an injustice still felt today.

After the first war between India and Pakistan in 1948, the Kashmir territory was divided into Indian-administered Jammu and Kashmir and a smaller area under Pakistani control, without consulting the Kashmiri population. The ceasefire line between Pakistan and India, named the "Line of Control" in 1972, still exists today. Both India and Pakistan have made control of a unified Kashmir an essential cornerstone of their national identities and have fought several wars between 1947 and 2002 on this issue.

Both Kashmir regions have a very complex and diverse society. Indian administered Jammu and Kashmir is predominantly Sunni Muslim and has a distinct regional identity based on Sufi traditions. Other parts of Indian administered Kashmir contain sizeable Hindu and Sikh populations, whilst in Ladakh, Buddhist and Shia Muslims are the dominant groups. Large parts of Pakistan-controlled Kashmir have strong Punjabi cultural influences. Each of these different groups and regions has different political aspirations. In general, non-Muslim minorities strive for a Kashmir that is an integral part of a secular Indian state. Others strive for an independent secular Kashmir or a Muslim Kashmir joined with Pakistan. Therefore, it is necessary to view the Kashmir conflict from a broader perspective and not only as a cross border conflict.

In Indian-administered Kashmir, from the late 1980s onwards, an independence movement led by young fighters of the Jammu and Kashmir Liberations Front (JLFK) fought a guerrilla war against what they perceived as government violence and human rights violations. This guerrilla movement, supported by fighters and arms from Pakistan, aimed at an independent and reunited Kashmir. A spiral of retaliation against militants by the Indian Army and vice versa quickly started and continues up to today. In later years, other militant groups arose that moved away from the JKLF's secular independent demands in terms of ideology to a global Islamic struggle. Many of these groups are said to have received support from Pakistan-based organizations.

The Kashmir conflict remains highly volatile although moderate opposition politicians in Indian-administered Kashmir, who are willing to negotiate the concepts of autonomy and self-governance within the states of India and Pakistan, seem to be gaining strength. The militancy however is far from silent, which in the view of the Indian army justifies a continued military presence in Kashmir.

In recent months, Pakistan and India have shown a determination to reach a solution to the dispute in a peaceful and concerted manner, with the two governments trying to demonstrate their willingness to improve the situation of the Kashmiri population.

After the October 2005 earthquake in the region, the world was expecting the two countries to intensify their cooperation. It seems, however, that progress has come to a halt despite the opening up of the border to facilitate relief distributions. A sustainable political solution to the problem seems far away despite recent efforts by the international community and moderate

Kashmiri politicians and separatists. The continuing independence struggle, oppression and intra-state wars have already led to tens of thousands of victims, human rights violations, torture, extra-judicial killings, kidnappings, disappearances and rape, perpetrated by all actors in the conflict. The conflicts have also led to displacement of Kashmiri Hindu or Pundits from Kashmir Valley. In addition to the displaced Hindus, a sizeable Muslim population has chosen to leave the Valley and the state to escape the consequences of the conflict. They are, however, not recognized by the State as displaced persons. The wounds inflicted on Kashmir society are deep and go well beyond the socio-economic problems of neglect and poverty.

Mental Health Services in Kashmir

The Indian Ministry of Health decided to implement a policy of community based mental health care in the whole of India in August 1982.[2] An important objective was "*to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and unprivileged sections of the society*". In 2003, The National Institute of Health & Family Welfare in India stated about the achievements of implementing the mental health policy: "*The targets set for the programme are not achieved till today after lapse of more than one decade. This indicates that there is a poor commitment of the government, psychiatrists, and community at large*".[3]
The background of the conflict, high psychosocial and mental health needs and non-existent community based services triggered MSF to give support to the people in Kashmir.

MSF Activities in India

The MSF mission in India provides medical assistance to people who have limited access to health services due to conflict, and maintains an emergency response capacity for natural disasters and epidemics. Currently MSF teams work in northeastern Manipur state, providing primary health care services in the conflict zones with special emphasis for people living with HIV/AIDS, tuberculosis and sexually transmitted infections. In neighbouring Assam state, MSF carries out a large primary health care programme with emphasis on malaria treatment at various locations, for civilians caught in ethnic conflict there. A large component of the programme includes prevention through emergency water and sanitation facilities and bed net distribution. In the southern part of India MSF provides medical care in Bombay, Maharashtra state and in Tamil Nadu state. MSF is in the process of handing over mental health work started after the latter region was hit by the 26 December 2004 tsunami.

In Kashmir and Jammu state, MSF is providing psychosocial support and mental health counselling for patients integrated in 11 healthcare facilities in rural areas as well as the capital Srinagar. MSF also provides outreach and support to others in rural areas. In addition, MSF has assisted in the rehabilitation of the infrastructure of the psychiatric hospital in Srinagar, and the implementation of health care waste management systems and basic health care components in some hospitals and primary health centres. To increase knowledge and comprehension of mental health MSF operates a weekly radio program in Kashmir.

After the 8 October 2005 earthquake that killed more than 1,400 people and injured 6,000 in the Indian Kashmir part of the disaster zone, MSF provided emergency assistance to people living in the most heavily hit areas. Teams focused on distributing required relief materials and providing psychosocial help. Other types of medical assistance were found to be less necessary. After the period of acute assistance ended (late December 2005), MSF broadened its existing project, which provides psychosocial help to civilians to include those living in areas severely affected by

the earthquake and its aftermath. MSF continues to monitor the local population's medical situation in order to be able to respond quickly to any possible epidemic outbreaks.

Survey Methodology

Introduction

MSF started its psychosocial program in Kashmir in August 2000. Following initial assessment[4] and program implementation, this quantitative population survey aims to assess current health needs and assist in determining the future direction of MSF's medical humanitarian assistance. The survey was also used as an opportunity to evaluate the impact of MSF's three year-old radio program in Kashmir.

This survey is therefore focussed on assessing psychosocial and general health status, as well as psychosocial coping mechanisms. The extent to which the past and actual suffering contributes to or exacerbates health problems is difficult to define in a causal way. The questionnaire used does not intend to establish diagnostic levels of mental or physical health disorders. However, through combined questions on violence and health the survey aims to give a good indication of the severity of the problems encountered by civilians trapped in this conflict.

The survey was executed in two Kashmiri rural districts: Badgam (Beerwah medical block) and Kupwara (Kralpora medical block). Both areas were chosen based on informal assessment of needs and the fact that the survey findings would inform MSF further about the future direction of its programme activities in the selected areas. The official population number in both survey areas is 145,500[5]. In both areas many violent incidents have been reported since 1989 (the date defined by the population as the start of the ongoing violence in Kashmir).

Survey Implementation

Survey staff and questionnaire

Four senior survey staff was recruited from the existing MSF psychosocial project, to support the survey and technically supervise the additional 20 interviewers who were recruited from the Srinagar University Department of Psychology and Sociology. The interviewers received a salary for their work. An international mental health professional supervised the survey staff during their daily activities. All staff members were advised to stop their activities at any moment if they judged their activities to be counterproductive to the program, or if they were worried about their own safety or that of the population. This did not occur during the survey.

Training was done over a period of three days and included the nature and purpose of the survey, confidentiality of the data and information, survey techniques, data registration and assignation of individual tasks. Members practised interviewing skills on each other. Four female staff members withdrew from the training course because they did not obtain permission from their families to work in Kupwara district.

Special attention was given to dealing with extreme emotions. Both direct care and follow-up support was available to all survey participants. Counsellors were present for immediate support. Also, follow-up appointments with counsellors were possible. During the survey, MSF staff also received a daily debriefing during which emotional issues could be raised.

Selection & sample size

Once the appropriate health and civil authorities gave permission, the survey was conducted over a period of eleven weeks, from 4 June 2005 to 16 August 2005 in Badgam and from 4 July 2005 to 18 August 2005 in Kupwara.

The population of Kupwara (Kralpora medical block) officially comprises 72,000 inhabitants living in 35 villages. Badgam (Beerwah medical block) is officially made up of 73,000 people living in 66 villages. The sampling methodology was based on well-established methodology for health surveys.[6] A two-stage cluster design was chosen. For the calculation of sample size a prevalence of trauma-related psychological problems of 20%[7] was assumed, with a desired precision of 5% (confidence interval 95%). With a cluster effect of 2, the minimum sample size was set at 492. A two-stage cluster sampling with 30 clusters resulted in 17 interviews per settlement[D]. In total, 510 interviews were conducted among 30 randomly selected villages. Within these villages, households were randomly selected. All teams worked in one village at a time. As it was agreed that every village household should have an equal chance to be included in the survey, all of the research teams started at the centre of the village, spun a bottle, and started the interviews from the direction in which the bottle pointed. The first encountered household was selected, and after the interview, the next household in the same direction was approached. Each team executed the same procedure until 17 households were selected. In each selected household, one adult was asked permission to interview a person over the age of 18 years in the household. The adult assisted the interviewer in making a list of all household members above 18 years of age. From the numbered list of household members, one person (the respondent) was selected randomly. If the selected person was not at home, another person in the household was chosen using the same method.
The respondents were only those who were home during the time of the survey, with a possible bias in 'home-bound' participants who might be more likely to be suffering from mental or physical disabilities, although this methodology was deemed necessary for security reasons.

The interview

Five survey teams of four students were organized. Interviews were done in pairs, each pair conducting two to three interviews each day. The average time for interviewing was 50-60 minutes. Counsellors (specifically from areas other than where they normally worked) supervised each team. Questions were put as factually and simply as possible, with a short explanation given if anything was unclear. All participants were asked to respond to the questionnaire during the interview; they were not allowed to fill in the questionnaire later, nor were they permitted to study the questionnaire in advance. Short answers were sought and extra discussions or conversations avoided. Interviewers were permitted to stop or interrupt when they deemed the questions to be too emotionally upsetting.

A number of ethical issues were taken into consideration. Interviewers had to respect confidentiality at all times; survey results were given under anonymity, and guarantees of anonymity were given to each participant, together with a clear explanation of the purpose of the survey and the uses to which survey results would be put (including using the data to write a public report). It was made clear to participants that they would not receive any compensation for participating in the survey, and that they could decide at any moment to stop the interview without giving a reason.

[D] In a relatively homogenous population a random (clustered or stratified) sample can be generalized to the entire population regardless the size of that entire population. The sample size itself is matched to a precision of 5%.

Forms were registered anonymously. Data were entered in an EXCEL program spreadsheet and data were analysed by the programs EXEL and EPIINFO-6.

During the survey, the team detected a misinterpretation of the question about "the distance to the closest health centre". Many respondents indicated time by means of public transport; others estimated the time necessary to reach the health post by foot. For this reason, the question was not further analysed.

Development of the questionnaire

The survey questionnaire, adapted from assessment tools used by MSF in other conflict settings,[8] looked at various subjects; baseline demographics, indicators of psychosocial status, confrontation with violence, consequences of violence, and general health. A final section of the questionnaire contained general questions.

Baseline demographics
Questions focused on age, education and information on mortality in the past two months.

Psychosocial status
People living in contexts of ongoing violence are often faced with a number of practical problems. The physical environment in which people need to live and survive has a direct bearing on their health, including mental health[9], and related questions were therefore included in the assessment. Feelings of control and safety influence positive coping with adverse (traumatic) experiences.[10] Furthermore, ongoing (chronic) stress caused by feelings of insecurity and dependency can deplete physical and psychological resilience, resulting in chronic physical and mental problems.[11] Questions about feelings of physical safety and dependency on external resources such as finances and food were included to assess this area of concern.

Confrontation with violence
The start of a violent episode is often difficult to define, especially when it stretches over many years. We asked people living in Kashmir, including key informants, when they defined the start of the violence. The majority defined 1989 as the start of the violence in Kashmir. We used this local definition not necessarily because it is a historical fact, but to avoid confusion during the survey.
The relationship between people's traumatic experiences and their health problems (physical and mental) in Western settings is well established.[12] To obtain the prevalence of potentially traumatising confrontations among our interviewees, respondents were asked to share their exposure to violence with us. We used different factors to assess the gravity of violence:
Proximity: The questions distinguished between general exposure and exposure through personal or witnessing experiences. The separation is important because research shows that the proximity to the event influences the prevalence of psychological problems negatively.[13]
Chronicity of violence**:** A number of studies have shown that multiple exposures to traumatic events (either the same or different events) are associated with higher levels of mental health problems including post-traumatic stress disorder (PTSD).[14] The questions on general exposure and personal or witnessing experience include the period from 1989 until time of interview. To check whether the violence still continued we repeated the questions on general exposure and personal experience in questions covering the last three-month period.
Nature of the violent event: The intensity of a traumatic event,[15] the severity of the incident,[16] and the extent of the physical injury can all contribute to the development of mental health or psychosocial problems.[17] Survey respondents were questioned about exposure to a set of

predetermined violent events. These events were chosen in close collaboration with local key informants and our own observations over the past five years. The respondents self-defined events such as torture and maltreatment.

Consequences of violence

To assess the consequences of violence we distinguished between human and material loss because of the violence, and other consequences.

Physical health People suffering from chronic or traumatic stress often report non-specific complaints such as headaches, stomach problems, general body pain, dizziness or palpitations.[18] Open questions were used in this survey to assess the type and order of priority of health complaints reported in the last 30 days. Answers were grouped according to prevalence. Closed questions were used to find out about the availability and accessibility of medical services, and use of drugs in the past month. Answers to these questions were registered using a Lickert[E] scale.

Mental Health The Self Reporting Questionnaire (SRQ)[19] is an instrument developed by the World Health Organization to measure general psychological distress, especially in developing countries. The SRQ consists of 20 questions about complaints suffered in the past 30 days, to which a "Yes/No" response is required. It can be used both as a self or interviewer-administrated questionnaire. SRQ can be used for adults and older adolescents (ages 15 and older). The questionnaire has been translated into many languages, including Hindi. For this questionnaire, the "Yes" response is scored as 1 and the "No" category as 0. A total score is obtained by adding the item scores. Question number 14 was adapted to: Do you feel you are usefully contributing in life?, for the Kashmir population because field-testing showed that people did not understand the original question (Are you unable to play a useful part in life?). For question number 14 the "No" was scored as 1 because Yes-answer was indicative for having no problems.
No universally applicable cut off score can be applied, but in most settings five to seven positive responses on items 1-20 indicate the presence of significant psychological distress. For India, various studies[20] have validated the SRQ. Currently, a cut off score of 11 or 12 is accepted[21] although this has been critiqued as being too high.[22] In our study, we used a cut off score of 12, meaning those respondents scoring 12 or higher are considered as suffering from psychological distress. The reference period for all questions in the physical and mental health section was the 30 days preceding the interview.

General Questions

Perceptions of mental health are culturally influenced. Coping methods, expectations about functioning, self-help and self-control mechanisms, as well as terminology and language differ between cultures. These issues were addressed in this section. We used open questions to identify the three most important ways of recognising people who are upset or tense, and also about culturally appropriate male and female functioning. Answers were grouped according to prevalence. Some evaluation questions on the MSF radio program were included in this section.

Translation

An experienced translator translated the survey from English to Urdu and phonetic Kashmiri, and a second translator back-translated from Urdu and phonetic Kashmiri to English. Differences were discussed and agreed upon. The counsellors tested this first draft by filling in the questionnaire themselves (most counsellors are multi-lingual (English/Urdu and Kashmiri)). Their questions and remarks on the content and translation of the questions were registered and

[E] The Lickert scale is used to nuance the answer beyond a dichotomy of yes/no. The answers of choice are: not at all, rarely, sometimes, and more often.

discussed with the translators and survey coordinator. The 20 survey interviewers tested the second phonetic Kashmiri and Urdu draft. Difficulties with questions and interpretation were reported to the translators, survey coordinators and the project co-ordinator. The third draft was further revised with feedback gathered by testing the questionnaire in a community close to Srinagar. The questionnaire was also shortened as a result of this piloting.

Survey Results

General

Survey remarks

The survey was interrupted on several occasions due to security incidents or official strikes. The number of incidents that occurred was not considered exceptional for the area. In total, the survey was stopped for 10 days in eleven weeks for such reasons. All respondents were asked for verbal consent (n=510). All interviews were held in private and confidentiality was stressed. Twenty-five times people refused to participate, mainly because they were single females in the house or because of a lack of time. Those who refused were replaced by the immediately adjacent household.

Survey staff reported that the majority of the population were glad to help, although a degree of distrust was apparent in some settlements. Thirteen interviews were stopped for varying reasons: lack of time, understanding or trust. For some, the interview was too painful and the interview was continued as a counselling session. When the counsellor believed that the participant needed follow-up support, referral to professional counsellors was facilitated. No direct referral appointments were made.

Demographics

The average age of respondents was 37.7 years old. More males (53%, 270) than females (47%, 240) participated in the study, not a significant difference (P>0.05). The gender distribution is representative for the household composition of the survey area in which the number of males dominate (53.4%, 2447). Households in the survey area consisted of nearly nine persons on average (8.94, number of households = 4,581). Nearly all respondents were originally from the Jammu and Kashmir area (97.6%, 498). The majority of the respondents were married (75.2%, 379); some were widowers (3.5%, 18). The level of formal education among those interviewed was low; more then half (52.6%, 266) had no formal schooling and only a few had attended college[F] (3.8%, 19) or university (1.2%, 6).

Mortality

In all, the respondents reported 29 family members having died in the two months preceding the survey. Approximately half (13) were part of the nuclear family (husband, wife, children). Crude mortality in the area was estimated at 0.3/10,000[G] per day, below emergency alert thresholds,[23] and mostly attributable to natural causes. Violence was indicated as the cause of death in only two cases.

[F] This includes education for those from 16-18 years and vocational schooling.
[G] Calculation used on basis of nuclear family denominator and numerator 10,000: 6979 x 13: 60= 0.31 Normal is 0.5/10.000/day and alarming is > 1/10.000/day

Safety and dependency

Living circumstances of the respondents are difficult. At the moment of interview nearly half indicated that they feel never (8.7%, 44) or only occasionally (39.4%, 200) safe. Nearly a quarter of the people are highly or totally dependent on financial and practical aid (24.9 %, 127) from authorities or religious and social charity. Nearly all respondents have at least two meals a day, three to five days a week (95.4%, 487).

Violence

General exposure to violence

Nearly all interviewees reported a general exposure[H] to violence since the start of the conflict in 1989, for example, through crackdowns[I] on villages (99.2%, 506), frisking (85.7%, 437) and round-up raids[J] by security forces (82.7%, 422). In the same time period, exposure to cross fire (85.7%, 437) and the explosion of mines/grenades (64.5%, 329) was high. Some people were exposed to damage to property (39%, 199) or the burning of houses (26.3%, n=134).

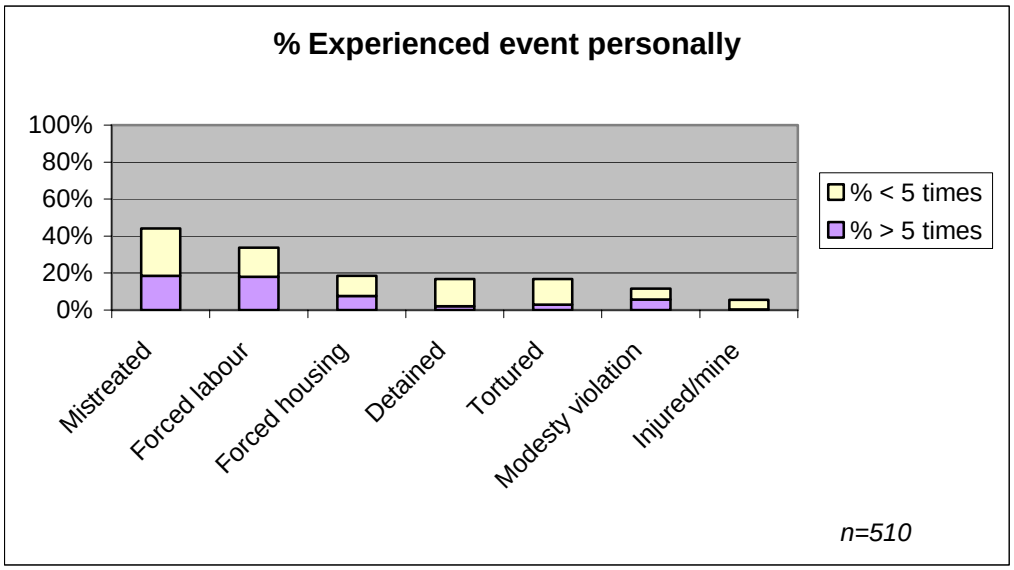
Personal experience

The violence in Kashmir that is inflicted by both security and rebels factions still continues. People reported violent personal experiences in the three months prior to the interview[K]. In addition, the chronicity of personal experiences of violence in the period 1989-2005 are described below (Graph 1). Physical and psychological maltreatment[L] in the form of threats or humiliation of civilians occurred frequently (44.1%, 225), for many in excess of five times (18.6%, 95). The fighting parties, both security and rebel forces, were reported to violate civilian rights frequently. Interviewees said people were forced to perform labour (33.7%, 172); one fifth of the respondents (18.2%, 95) were forced to work regularly (more then five times). The respondents were forced to accommodate fighters from one of the parties (18.4%, 94); nearly half of them said this occurred six times or more (7.5%, 38) since 1989.

Some interviewees said security forces or rebels had legally or illegally detained them since 1989 (16.9%, 86). Of them, 66 (76.7%) indicated that they had been tortured[M] during their detention. Some people were injured because of the violence, including landmines (5.7%, 29).

[H] Exposure refers to the event happening in the environment though not necessarily experienced by the interviewee.
[I] After an announcement from mosque loudspeakers all men have to assemble at an open place and then the houses are searched.
[J] A few houses are surrounded and all family members are asked to stay in one room while the houses are searched.
[K] The questionnaire distinguished between violence since the start of the conflict (1989) and the violence of the past three months.
[L] Maltreatment: cruel inhumane treatment.
[M] Torture: unbearable physical pain deliberately inflicted by others who have complete control.

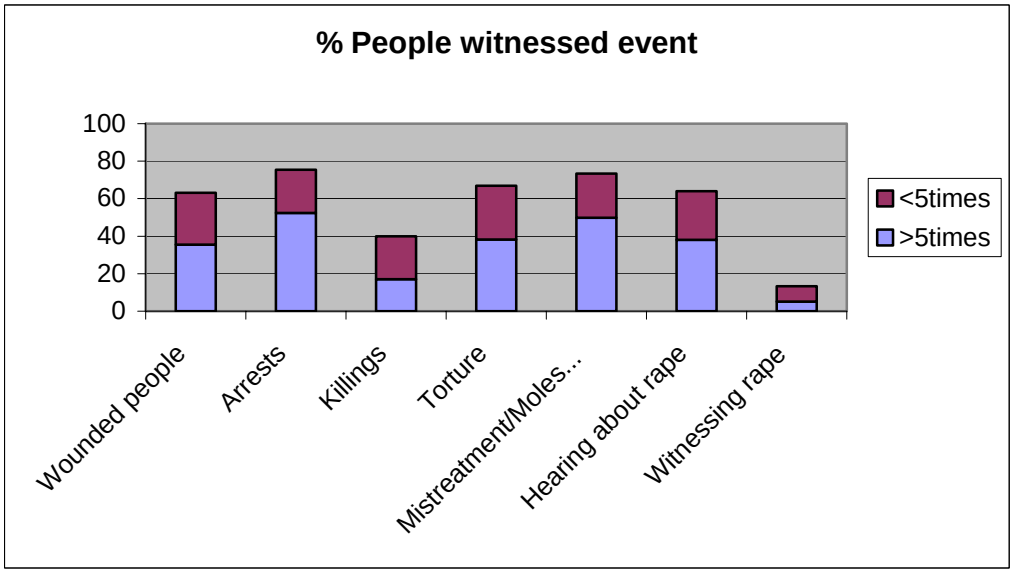
Graph 1: Overview of personal experience of traumatic events inflicted by all fighting parties since the onset of the violence in 1989



Witnessing

Witnessing traumatic events is potentially traumatising. We asked the respondents to tell us what events they had witnessed since 1989 (Graph 2). A large majority of the respondents had seen people being arrested (75.5%, 385); half of respondents had seen this more than five times since the start of the violence (52.9%, 270). The witnessing of physical and mental mistreatment is high (73.3%, 374). Half (50.0%, 255) of respondents reported witnessing this type of incident more then five times since 1989. Similar numbers were reported on witnessing torture (66.9% (341), one third of respondents (38.4%, 196) more then five times since 1989.

Graph 2: Overview of witnessed events since 1989



Sexual violence

For most Kashmiris, sexual violence is considered an inappropriate and difficult to discuss topic. Nevertheless, a rather high percentage of respondents (11.6%)- in comparison to other conflict areas[3] - said they had experienced a violation of their modesty[N] since 1989. Of them, more than one in ten experienced this in the last three months (8 of 59). Since 1989 many people had heard about cases of rape (63.9%, 326). Most had heard about more than five incidents of rape (59.9%, 195)[O]. The number that had actually witnessed a rape since 1989 was also high (13.3%, 68) in comparison to other conflict areas.[3] One in twenty (5.1%, 26) of the respondents had witnessed rape more than five times.

Consequences of violence

In the period from 1989 until the survey interview, almost half (46.3%) of those interviewed had moved because of the violence, saying that they couldn't deal with the situation anymore. One in six (17.3%) had been forced involuntarily to relocate due to measures or threats by one of the warring parties. The material loss reported is substantial: damage to property (39%), loss of possessions (25.5%) and loss of a house (5.9%). Approximately one in ten interviewees reported being made disabled because of the violence (9.8%, 48). Such disability covers physical, auditory or visual impairments and was based on personal accounts of those interviewed- no medical verification was carried out.

Table 2: Overview consequences of violence (n=510)

Consequence	**%**	**Count**
Chose to move for safety reasons	46.3%	236
Lost possessions	25.5%	130
Lost house	5.9 %	30
Displaced (forced to leave)	17.3%	88
Disabled	9.8%	48

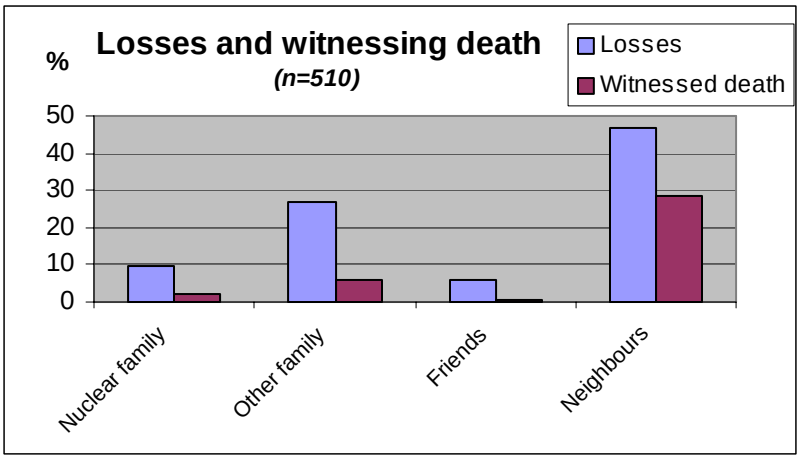
Many Kashmiris have lost family, friends and neighbours as a result of the conflict (Graph 3). In addition to the immediate loss, friends, family and neighbours are important sources of support when Kashmiris are confronted with tension and stress. Nearly one in ten (9.4%, 48) people interviewed had lost one or more members of their *nuclear*[P] *family* because of the violence. A fifth of those who had lost a nuclear family member had actually witnessed their death.
In addition, over the period 1989-2005, a third of the respondents (35.7%, 182) indicated that they had lost one or more *extended family members* (total 228) due to violence. Nearly half reported having lost a neighbour in a violent way (47.1% (240), and in 20.8% of these events, the respondent reporting having witnessed the death. Only a few reported having lost a friend (5.7%, 29).

[NN] In Kashmir, a violation of modesty is associated with an act of sexual violence that varies from rape to inappropriate touching (which is considered very stigmatising for the women and family involved). This definition is in line with the World Health Organization's definition of sexual violence (World Report on Violence and Health, WHO, 2002).

[O] It is possible for more than one person to have reported the same event.

[P] Nuclear family was defined as parent(s), brother(s), sister(s)

Graph 3: Reported deaths and witnessing of violent deaths since 1989.
(The " witnessed deaths" is the proportion of persons who witnessed deaths to total number of persons experienced in each category)



Consequences of violence on children

Respondents were asked to state three important effects they perceived violence to have on children in the communities (Table 3). Over 1,500 answers were obtained (n=1,521). A small minority (2.4%, 37) said there were no problems. The others saw fear as the major effect (24.6%, 374). School-related problems scored highly, including being unable to attend school (15.5%, 236) and having problems with studying, because of a lack of school materials or the absence of qualified teachers (16.3%, 248); schools have difficulty to find staff as nobody wants to work in a conflict area.

Behavioural changes amongst children that were noted included isolation, aggression, drug abuse, lack of respect for elders, loss of morality/values, and hopelessness.

Table 3: Consequences of violence on children (% taken from total number of responses, n=1,521)

Effects	Frequency	Effects	Frequency
Being afraid	24.6% (374)	**Lack of respect for elders**	5.7% (86)
Problems with school/studying	16.3% (248)	**Loss of morality/values**	3.7% (56)
Unable to attend the school	15.5% (236)	**Loss of Hope/mistrust**	5.0% (76)
Behavioural changes (e.g., isolation, impatience, irritability, aggression)	10.0% (152)	**No sleep**	1.5% (23)
Drugs or alcohol abuse	8.0% (121)	**No friends**	0.4% (6)
More frequently ill	6.1% (93)	**Other**	0.9% (13)
		None at all	2.4% (37)

Health Consequences of Violence

All mental and physical health related questions refer to a period of 30 days before the interview.

Mental Health (Self-Report Questionnaire 20)

The items of the questionnaire were constructed to identify general psychological distress in populations and cover various categories (Table 4). Physical health items such as headache (53.6%, 273), and poor appetite (40.8%, 208) are indicative of high levels of somatisation. Two-thirds of the interviewed group felt nervous, tense, or worried (62.7%, 320). Signs such as being easily frightened (55.9%, 285), trembling hands (50.2%, 256), and sleeping problems (45.5%, 232) were reported frequently. Half the population said they were unhappy (50.0%, 254) and this was confirmed through high scores on increased crying (45.1%, 230), feeling tired all the time (62.5%, 319) or having lost general interest in things (45.1%, 230). Over one-third said they felt worthless (37.8%, 193). A trend of feeling miserable and disheartened may result in increased suicidal ideation, or worse, enaction. Among those interviewed we found an alarmingly high prevalence of suicidal ideation: one-third of those surveyed had had thoughts of ending his or her life (33.9%, 173) in the past 30 days. More then half (51.8%, 264) reported that their daily work was suffering because of their problems and that they did not enjoy their daily activities (50.0%, 255).

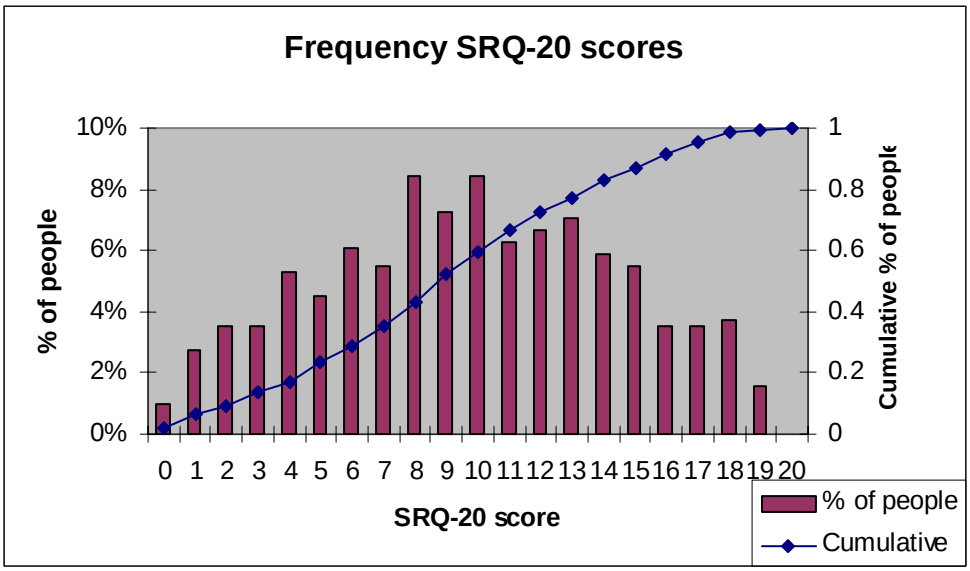
Table 4: Overview of responses on items of Self-Reporting Questionnaire 20. NB The complaints refer to the past 30 days before the interview.

(N=510)	**YES**		**YES**
Do you often have headaches?	273 (53.6%)	Do you find it difficult to enjoy your daily activities?	255 (50.0%)
Is your appetite poor?	208 (40.8%)	Do you find it difficult to make a decision?	202 (39.6%)
Do you have sleep disturbances?	232 (45.5%)	Is your daily work suffering?	264 (51.8%)
Are you easily frightened?	285 (55.9%)	Do you feel you are usefully contributing in life?	158 (31.0%)
Do you feel nervous, tense, or worried?	320 (62.7%)	Have you lost interest in things?	230 (45.1%)
Do your hands tremble?	256 (50.2%)	Do you feel that you are a worthless person?	193 (37.8%)
Is your digestion poor?	128 (25.1%)	Have you thought about ending your life?	173 (33.9%)
Do you have trouble thinking clearly?	256 (50.2%)	Do you feel tired all the time?	319 (62.5%)
Do you feel unhappy?	254 (50.0%)	Do you have uncomfortable feelings in your stomach?	203 (39.8%)
Do you cry more than usual?	230 (45.1%)	Are you easily tired?	340 (66.7%)

The Self-Report Questionnaire 20 has been validated for India.[24] A cut off score of 11/12 is accepted as appropriate for distinguishing between cases and non-cases. However, it has been criticized as being too high[25]. If the cut off score of seven (meaning those with a score of seven or higher are considered cases of psychological distress) is used, a large majority of the respondents suffers from psychological distress (71.4%; 364, CI: 66.1-76.7). If the higher Indian validated cut off of twelve (12 or higher is a considered a case) is used, more then one-third of respondents are

considered to suffer from psychological distress (33.3%, 170, CI: 28.3-38.4). See also Graph 4.

Graph 4: Overview of scores the Self-Report Questionnaire 20



Prevalence and effects of health difficulties on life and daily functioning

A large majority of those surveyed said that the conflict has caused stress in the family (81.4%, 316). Nearly half of the people indicated that their family members still suffer from tension/stress (46.7%, 238). Table 5 shows that in the past 30 days nearly half of the people reported that their health problems interfere with their life in a severe (31.5%, 156) or extreme way (16.6%, 82). When asked how many days in the past month the health problems interfered two-thirds of all respondents reported that they had such difficulties four or more days (67.7%, 335).

Work and daily activities were also found to suffer from the reported health problems (Table 5). Nearly half (49.0%) of those interviewed reported that they were "totally unable" to carry out their usual activities for four or more days in the past 30 days; only one-third reported they were able to carry out their daily activities every day in the last month (34.8%). Nearly half (49.8%) reported that they had to cut back or reduce their activities or work for health-related problems in the past month for four days or more.

Table 5: Effect of health problems in the past 30 days

	None	Mildly	Moderately	Severely	Extremely / Cannot Do
Overall, how much did these difficulties interfere with your life? (n=495)	11.9% (59)	17.2% (85)	22.8% (113)	31.5% (156)	16.6% (82)

	0 days	1-3 Days	4-10 Days	11+ Days
How many times do these problems occur (n=495)	16.2% (80)	16.2% (80)	30.3% (150)	37.4% (185)
How many days are you totally unable to carry out your usual activities or work because of any health condition? (n=491)	34.8% (171)	16.1% (79)	31.5% (155)	17.5 % (86)
How many days[Q] do you have to cut back or reduce your usual activities or work because of any health condition? (n=492)	33.3% (164)	16.9% (83)	31.9% (157)	17.9% (88)

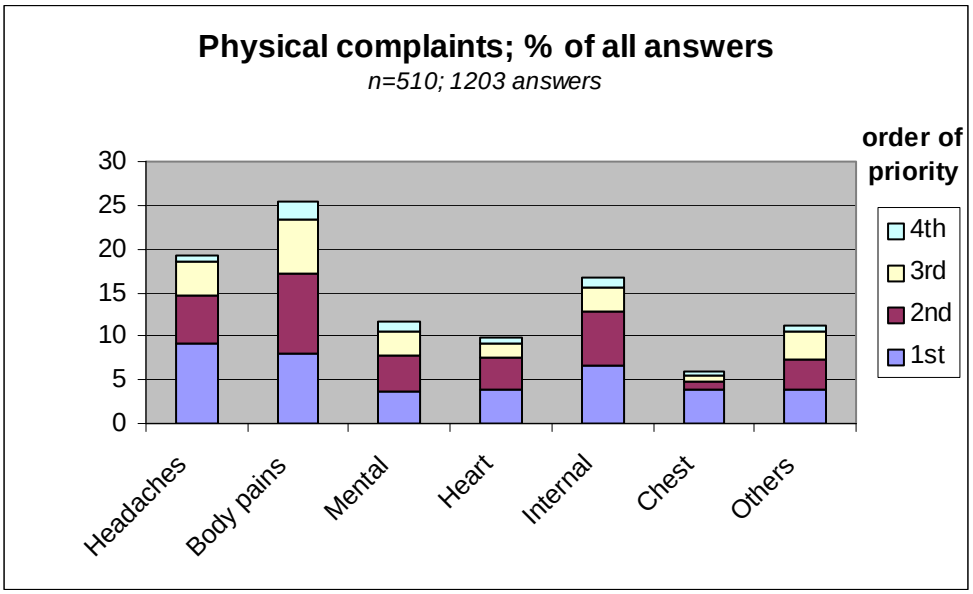
Physical Health

Nearly one third of the respondents rated their health as either bad 22.7% (116) or very bad in the past 30 days (7.1%, 36) (Tabel 6). Over the same period, more than half of respondents experienced greater than three health complaints (56.1%, 286). Respondents were asked to mention a maximum of four complaints in order of priority (Graph 5). The response categories were grouped by prevalence. Of all first mentioned complaints (n=470) headaches (23.5%, 110), body pains such as joint and back pains (20.5%, 96), and internal problems (mainly abdominal complaints, 16.9%, 79) were mentioned most frequently. One in ten people mentioned mental problems (tension, fatigue/weakness, anorexia) as their first major health problem (9.6%, 45). These health problems were also mentioned as second, third and fourth complaints.

Of the total responses (max 3 per person, in total 1,203 answers) body pains were mentioned most frequently (25.4%, n=305) as a complaint over the past 30 days, followed by headaches (19.3%, n=232); mental problems were mentioned 140 times in total (11.6% of all answers).

[Q] The days people were totally unable to do activities were not included.

Graph 5: Health complaints in the past 30 days in order of priority (maximum of four answers per interviewee, % from total number of answers: 1203)



The majority of the respondents (65.1%, 326) visited a health post or clinic for their complaint (Table 6). A third (31.5%, 158) visited the health clinic two or three times, or even four times or more (15.4%, 77) in the past 30 days. Despite this, the overall impression of the health facilities was poor (49.8%, 253) or only acceptable (22.4%, 114). A minority rated the facilities as good (24.0%, 122) or excellent (3.7%, 19). Medicine consumption was high: over one-third (37.9% (189) took six or more medicines in the past 30 days. Less then a third (28.9%, 144) did not take any medicines. The type of medicine was not further specified.

Table 6: Overview of health responses. The reference period is the last 30 days.

Perception of own health (n=510)	**Very good**	**Good**	**Moderate**	**Poor**	**Very poor**
	11.8% (60)	23.3% (119)	35.1% (179)	22.7% (116)	7.1% (36)

Number of complaints (n=508)	**None**	**0-2 Times**	**3-6 Times**	**6+ Times**
	29.3% (149)	14.4 (73)	22% (112)	34.3% (174)
Visit health clinic (n=501)	**Not at all**	**1 Time**	**2-3 Times**	**4+ Times**
	34.9% (175)	18.2% (91)	31.5% (158)	15.4% (77)
Quality health facility (n=508)	**Excellent**	**Good**	**Acceptable**	**Poor**
	3.7% (19)	24.0% (122)	22.4% (114)	49.8% (253)
Medicine consumption (n=499)	**Not at all**	**1-3 Times**	**4-6 Times**	**6+ Times**
	28.9% (144)	14.6% (73)	18.6% (93)	37.9% (189)

Perceptions of Mental Health

How do respondents identify conflict-related psychological problems?

Those interviewed said the most important way to recognize mental problems were through facial expressions such as looking pale, upset, gloomy or weak (40.5%, 203). Withdrawal behaviour (such as being silent, lost in deep thought, not working, not talking to people or being lonely) was the second most common way (22%, 110). The third most important way was having a sad mood This was followed closely by a change in general behaviour, most notably, being restless (12.4%, 62). The answer categories we have identified were based on prevalence of responses and cover well the avoidance, anxiety and mood-change criteria.

Table 7: How to identify that a person is upset or feeling tense because of the conflict[R]?

	All first answers (n= 501)	**Second answers (n= 460)**	**Third answers (n= 291)**
Aggression/irritability	6.2% (31)	12.6% (58)	14.8% (43)
General behaviour change	12.4% (62)	22.2% (102)	22.7% (66)
Facial expression	*40.5% (203)*	14.1% (65)	8.9% (26)
Mood	15% (75)	11.3% (52)	13.8% (40)
Withdrawn attitude	22% (110)	31.3% (144)	34.7% (101)
Health problems	4% (20)	8.5% (39)	5.2% (15)

Coping mechanisms

Interviewees were asked to give three answers to explain what people do when they feel tension or stress (Table 8). It was reported that some people isolate themselves (22.3%), others act out through aggression (16%), stop talking to people (12.8%), numb themselves through drugs or alcohol (12.7%) or keep themselves busy (7.2%). Answers such as seeking support from family (4.3%) or talking to others (8%) were found to be relatively low. Religion was said to be the third most important coping mechanism (13.8%) among those interviewed.

Table 8: Overview of coping mechanisms.

Coping mechanism	**Frequency (n= 1,469)**
Isolation	22.3% (327)
Aggressive behaviour	16% (235)
Praying/meditation	13.8% (203)
Stop speaking to people	12.8% (188)
Drug and alcohol use	12.7% (186)
Talking to others	8% (117)
Keeping busy	7.2% (106)
Seeking support from family	4.3% (63)
Other	3% (44)

[R] *Three answers were permitted, in order of priority.*

Where to go for support?

To find out whom was regarded as a source of support, respondents could give three answers from 15 pre-determined categories Table 9). The largest proportion (23%) would seek help from friends, if they felt disturbed or upset. A medical doctor (17.4%) and family members (14.9%) were the second and third most frequently mentioned answer. Faith healers were also regarded as an important source of support (13.4%); counsellors or psychiatrists were less frequently consulted.

Table 9: Support mechanisms

Support mechanisms	**Frequency** (**Ntotal answers=1,447)**	**Support mechanisms**	**Frequency** **(Ntotal answers=1,447)**
Friend	23% (333)	**Psychiatrist**	1.5% (22)
Family member	14.9% (215)	**Nurse**	0.8% (12)
Doctor	17.4% (251)	**Health worker**	0.8% (11)
Faith healer	13.4% (193)	**Social worker**	0.6% (8)
Neighbour	10.9% (158)	**No one**	2.1% (31)
Kind person	8% (115)	**Fortune teller**	0.4% (5)
Counsellor	3.2% (46)	**Other**	1.2% (17)
Religious leader	2.1% (30)		

What does "functioning well" mean?

In Kashmir, men and women have different, culturally prescribed roles in both family and community life. The ability to fulfil these roles influences a person's perception of his/her functioning. Respondents were asked to give three examples of what they considered important traits for a well functioning male (n=1,375) and female (n=1,375). The categories were constructed during the data analysis, grouped by prevalence of response.

Those surveyed said a well-functioning male has a good character[S] (23.7%, 326); high moral values[T] and earns money (16.3%, 224). He is also sociable[U] (14.7%, 202), healthy (11.9%, 163) and educated (9.2% (126). His role in the family (caring and behaving well) defines a male's functioning only marginally (7.5%, 103). The perception of well functioning behaviour for females was more associated with her capacity to manage the household[V] (22.7%, 301), her behaviour[W] (18.8%, 250), her character[X] (17.7%, 235) and her moral values (12.6%, 167). Education (11.1%, 147), family (10.8%, 143) and health (6.4%, 85) were seen to be of lesser importance.

Providing Support

Most respondents reported that talking confidentially to someone they trust is helpful (89.4%, 456) when confronted with tension. The majority of respondents did not know what counselling was (68%, 347), but when the term was explained they considered it very (58.8%, 300) or moderately useful (31.8%, 162).

If psychosocial services were offered (this was explained as a combination of social activities and counselling) a majority said they would use such services (96.9%, 494). More specifically they

[S] Well mannered, honest, respectful, polite, courageous, kind, patient
[T] Religious, doing good deeds, praying, generous
[U] Helpful, friendly, sympathic, social, good with others
[V] Cleaning, hygiene, management, skills
[W] Sociable, helpful, hospitable, obedient, disciplined
[X] Well mannered, honest, respectful, polite, courage, kind, patient

indicated they would use the counselling service (39.3%, 275), listen to the radio program (21.1%, 148), use MSF knowledge about service providers in the community (19.9%, 139) or participate in community-oriented activities (13.9% (97).
MSF had just started its activities in the survey areas. Although many people knew about the MSF radio program (49.2%), a majority (80.2%) had never heard about MSF's other activities in the region (psychosocial care and water and sanitation activities). A small minority did have contact with MSF[Y] (4.5%, 23).

Respondents were asked to give MSF advice about its future activities in Kashmir. Some people (26.8%, 110) said they thought MSF should do more about providing education on topics such as general health, raising children, and hygiene. Some also asked for more information on stress and mental health (23.8%, 98), counselling (11%, 45) and family relations (3.2%, 13). Approximately one in ten (13.6%, 56) asked MSF to become involved in social issues such as dowry-related problems or poverty-related eradication programs.

[Y] MSF was starting up activities in the survey regions in 2004

Discussion

The survey executed in two blocks of Kupwara and Badgam districts in Kashmir (India) during mid-2005 was representative, with in total 510 people interviewed. The execution of a survey in such a violent context had security limitations. Despite this the completion rate of the survey was good (93%).
The major findings relate to violence and health condition of the population. Nearly half the respondents indicated at the time of the survey that they felt never or only occasionally safe. Violent acts continue, and had occurred during the three months preceding the survey.

Since the onset of the violence in 1989, the general exposure to violence experienced personally or witnessed by the respondents, such as crackdowns and round-up raids, indicate an ongoing climate of fear. The high number of people who experienced physical and mental mistreatment since 1989 further illustrates this.

A substantial number of respondents reported since 1989 that they had been detained -either by the authorities or the rebels - and among those detained, the majority reported having been tortured. In addition to this, parties to the conflict were also reported to have infringed civilian rights through forced labour or the forced sheltering of combatants. In this survey, torture and maltreatment were predefined and explained to the respondents. Despite this we cannot exclude that and to what extent people used their own definitions. We felt it was inappropriate and unnecessary to further enforce a definition on respondents because investigating torture or maltreatment as such was not an objective of the survey.

Violence has had direct consequences on many civilians. In terms of human loss, the consequences are serious: many lost a member of their nuclear family or another family member since the onset of the violence and one in six had been forcibly displaced.

The respondents reported suffering direct violations of their modesty and/or the witnessing of such acts since 1989. It is possible that the actual prevalence is higher as many people regard it as inappropriate to talk about sex-related issues. The survey found much higher numbers of people whom themselves had experienced sexual violence in comparison to findings in other surveys and contexts: Sierra Leone (2%), Sri Lanka (2%), Chechnya (0%) and Ingushetia (0.1%).[26] This may be due to the fact that people in Kashmir feel freer to discuss a "violation of their modesty" than civilians living in those other contexts. Another possibility is that the definition of sexual violence varies among populations; in Kashmir, a "violation of modesty" includes inappropriate touching, which may contribute to the increased prevalence of sexual violence reported here if the other populations in surveys define sexual violence only as the act of rape. These differences suggest that the assumption of a universal definition is at least doubtful. In future studies, developing more explicitly questions relating to the World Health Organization's broader definition[Z] of sexual violence[27] should be considered. This definition includes, for example, "inappropriate touching" as reported in the current survey.

The health of the respondents is poor; a majority had visited the health clinic in the past month and one-third took six or more drugs in that period. The major complaints mentioned (headaches and body pain) are often stress-related. The health effects reported here cause potentially serious

Z Sexual violence includes, at least, rape/attempted rape, sexual abuse, and sexual exploitation. Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home or work".

economic losses. A majority reported an inability to work for at least part of the past 30 days because of their health condition.

The mental health of the interviewed is also poor. Approximately one-third could be regarded as suffering from psychological distress based on the responses to the SRQ-20 Indian-validated tool. This result is high in comparison to another Indian study[28], where 18% of probable mental ill health was found among low-income urban women, using a relatively low cut-off score (7/8). Our findings indicate a higher prevalence, while using the higher (more strict) cut off score of 12. This may mean that our findings on psychological distress are actually underreported. Our findings on coping mechanisms further confirm the gravity of the suffering, with the two most frequently mentioned (self-isolation and aggression) clearly dysfunctional.

In the past month many respondents reported anxiety and unhappiness, with a substantial number have entertained thoughts about ending their life. Our findings are in line with Margoob et al[29] who reported on high suicide rates in this region previously. These data are alarming especially in a predominantly Muslim culture that regards thoughts and acts of suicide as a grave sin. The overt expression of these ideas is a strong indicator of the despair and lack of future perspective among the predominantly Islamic population.

The relationship between people's traumatic experiences and their health problems (physical and mental) in Western settings is well established.[30] Our findings in the survey on the physical, mental health and the reported violence both since 1989 and in the past three months appear to confirm these findings.
Our survey did not intend to research a causal relationship between violence and health. Nevertheless, evidence increasingly suggests that the differences between Western and non-Western populations in terms of their experiences after traumatic circumstances are not major, and that there is a "universal" vulnerability to certain traumatic events. In a study on lifetime events and post-traumatic stress disorder (PTSD) in four post-conflict settings (Cambodia, Gaza, Ethiopia, and Algeria) it was found that conflict-related events after the age of 12 years were significantly related to PTSD[AA] in all four samples.[31] In another study, the health of a group of refugees who escaped from various conflict areas in the world was researched in their country of resettlement. Exposure to a physical traumatic component (experienced/witnessed physical violence and torture, experienced a life-threatening event), and separation from family was found to be a strong indicator for ill health.[32]
The population surveyed were cooperative and responded positively to the survey. Nevertheless, there were a number of limitations. The security conditions in the area are unpredictable and caused some delay in implementation of the survey. In some areas, the suspicion towards MSF was an obstacle, most notably in areas where MSF had only recently started its activities. Such distrust could have an impact on the way people answered questions on the exposure, self-experience or witnessing of violence. People may have felt reluctant to share their self-experienced or witnessed events because it might expose them to retaliation.

The survey was executed over a long period (eleven weeks). To ensure cooperation of the rural population the survey ended before the start of the harvest, but the length of the survey period

AA The diagnosis of psychological disorders, and in particular PTSD, should be assigned with care for several reasons. First, not all disorders after traumatic events can be described in terms of PTSD; it is far from being the only possible disorder after traumatic events, and the picture is complicated by the fact that co-morbidities are not uncommon. Second, Western conceptual frameworks on psychological stress and mental disorders cannot be automatically transferred to different countries and cultures.
(Kleber, R.J. (1997). Psychobiology and clinical management of posttraumatic stress disorder. In: J.A. den Boer (Ed.), Clinical management of anxiety: Theory and practical applications (pp. 295-319). New York: Marcel Dekker Inc.
Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. Social Science & Medicine, Vol 48, p. 1449-1462.)

may have influenced some answers on the questions. For example, especially when tension or violence increases in a region, answers on questions related to this may score higher. If the whole area had been surveyed in a shorter period, potential differences in exposure might have been reduced. However, MSF's wish to do thorough security checks, to inform many formal and informal authorities, and to communicate the objectives and intentions of the survey to the people in the communities thoroughly, meant this was not feasible.

This survey asked historical questions over a lengthy period (1989-2005), in addition to questions in the more recent past (30-60 days). Recall bias is always a potential confounding variable, particularly when reporting traumatic events. However, an important recent study[33] has shown that refugees remain consistent in reporting major traumatic events such as those we recorded, with more variability occurring in recall of minor historical details.

The respondent's level of education was low. The understanding of or differentiation between some questions was sometimes problematic. Interviewers were trained to check if the respondents understood the questions. During debriefing extra attention was paid to this issue, but misinterpretation of some questions cannot be fully excluded.

Six staff performed data entry. Although the data entry was standardised, some individual interpretations were observed and corrected; if flaws or differences were noticed all data on the question(s) were checked from the original file. As a last control 5% of the forms were randomly checked. We are confident that the control procedure was sufficient to ensure reliability of data, but it did result in some delay in the data entry and analysis.

Conclusions and Recommendations

The ongoing conflict-related events cause substantial suffering in the Kashmiri population. Once Kashmir was referred to as 'Paradise on Earth' - our findings show clearly that for many Kashmiris, it has become rather a nightmare of constant fear that affects all areas of life.

The impact on the physical and mental health and socio-economic functioning is alarming. Our data show a level of despair and lack of future perspectives that potentially endangers the long-term well being of many people (or worse, as many respondents had thoughts about committing suicide). Schooling and economic activities have suffered. Despite the political *détente*, violations of human rights and infringement of civilian rights by all fighting parties continue.

A cessation of hostilities, with a reduction in fear and intimidation will result in an immediate improvement of the population's physical situation. However, the effects of conflict do not always end the moment a peace agreement is signed. Many people will need some support to reduce their dependency on aid. Using a validated screening tool, we have shown that a substantial number of people suffer from serious psychological distress. Physical and mental coping mechanisms are exhausted, and the health system needs further strengthening.

The substantial needs for psychological and psychiatric support we identified in our survey can only be addressed through a strong community-based mental health system. This type of service is advocated in the Indian Mental Health Policy,[34] but in Kashmir, community psychosocial services are absent and psychiatric services outside Srinagar remain non-existent.

The failure of the Ministry of Health to implement its own Mental Health Policy in Kashmir and many other parts of India[35] contributes to increased and unnecessary suffering. Due to lack of services and/or medication, severely disturbed and ill people must travel long distances to seek care. The psychiatric hospital in Srinagar provides basic care and the number of patients is growing.[36] Others suffer in silence.

MSF asks the authorities to implement their own policies. Psychosocial support (including counselling) in the villages is needed, with basic psychiatric support, including medication, at health post level. MSF calls on the health authorities to give a high priority to the region of Kashmir. The findings of our survey show a serious mental health situation that is likely to have further deteriorated due to the recent earthquake that devastated some Kashmir districts. The mental health condition of the people must be given much greater attention.

References

1 http://www.satp.org/satporgtp/countries/india/states/jandk/data_sheets/annual_casualties.htm

2 Ministry of Health and Family Welfare (2004). *Mental Health: an Indian perspective 1946-2003*. Ed Agarwal, S.P.. Directorate of Health services. New Delhi: Elsevier

National Institute of Health and Family Welfare. *National Mental Health Programme*. http://www.ndc-nihfw.org/html/Programmes/NationalMentalHealth.htm

3 National Institute of Health and Family Welfare. *National Mental Health Programme*. http://www.ndc-nihfw.org/html/Programmes/NationalMentalHealth.htm

4 Jong, de Kaz (2000). *Kashmir, heaven on earth? Psychosocial consequences of a chronic emergency*. MSF internal report.

5 Indian civil authorities, Srinagar, India (2005)

6 Bennet, S., Woods, T., Liyanage, W.M. & Smith, D.L. (1991). A simplified general method for cluster sample surveys of health in developing countries. *Rapportage Trimestrial Statistical Sanitaire Mondiale*, 44, 98-104.

WHO (1994). *Household survey manual: diarrhoeal and acute respiratory disease control.* Division of control Diarrhoea, Acute Respiratory Disease. Geneva, Switzerland: World Health Organization.

Save the children UK (2004). *Survey manual. London*: save the Children UK, 2004

7 Kleber, R.J. & Brom, D. (1992). *Coping with trauma. Theory, prevention and treatment.* Lisse: Swets & Zeitlinger publishers.

8 Jong K. de , Mulhern, M., Ford, N., Kam, S. van der & Kleber, R.J. (2000). The trauma of war in Sierra Leone. *The Lancet*, Vol. 355, page 2067-2068.

Jong, K. de, Mulhern, M., Ford, N, Simpson, I, Swan, A and van der Kam, S. (2002). Psychological Trauma of the civil war in Sri Lanka. *The Lancet*, volume 359, page-1517-1518.

Jong, K. de, Kam, S. van de, Ford, N., Hargreaves, S., Oosten, R. van, Cunningham, D. & Boots, G. (2004). Trauma of Chechnya's ongoing war on internally displaced people. *The Lancet*, 364, 1008.

9 Jong, J. de, Komproe, I.H., Ommeren, van M., El Masri, M., Araya, M., Khaled, N., Put, van der W. & Somasundram, D. (2001). Lifetime events and post-traumatic stress disorder in 4 post conflicts settings. Journal of the American Medical Association, *86 (5), 555-562.*

10 Creamer, M., Burgess, P., Pattison, P. (1990). Cognitive processing in post-trauma reactions: some preliminary findings. *Psychological Medicine*, 20, 597-604.

Creamer, M., Burgess, P., Pattison, P. (1992). Reaction to trauma: a cognitive processing model. *Journal of Abnormal Psychology*, 101, 452-459

Kleber, R.J. & Brom, D. (1992). *Coping with trauma. Theory, prevention and treatment.* Lisse: Swets & Zeitlinger publishers.

11 Selye, H. (1956). *The stress of life.* McGraw-Hill Book Company, New York.

12 Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, vol. 52, 1048-1060.

Solomon, Z., Laor, N. & McFarlane, A. C. (1996). Acute Posttraumatic Reactions in Soldiers and Civilians. In Kolk, van der B., McFarlane, A.C. & Weisaeth, L.. *Traumatic stress. The effects of overwhelming experiences on mind, body, and society*. Guildford press, New York.

13 Kleber, R.J. & Brom, D. (1992). *Coping with trauma. Theory, prevention and treatment.* Lisse: Swets & Zeitlinger publishers.

14 Killpatrick, D,G., Resnick, H.S., Saunders, B.E. & Best, C.L. (1998). Rape, the violence against women, and post-traumatic stress disorder: critical issues in assessing the adversity-stress-psychopathology relationship. In: Dohrenwend, B.P. (Ed.). *Adversity, stress, and psychopathology*. New York, NY: Oxford University press; 161-176.

Green, B.L., Goodman, L.A., Krupnick, J.L. et al (2000). Outcome of single versus multiple traumatic exposure in a screening simple. Journal of traumatic stress, *13, 271-286.*

Rosenberg, H.J., Rosenberg, S.D., Wolford II, G.L., Manganiello, P.D., Brunette, M.F. & Boynton, R.A. (2000). The relationship between trauma, PTSD, and medical utilization in three high risk medical groups. *International Journal of Psychiatric Medicine*, 30 (3), 247-259.

15 Foy, D.W., Rueger, D.B., Sipprelle, R.C. & Carroll, E.M.(1987). Etiology of posttraumatic stress disorder in Vietnam veterans: Analysis of pre-military, military, and combat exposure influences. *Journal of Consulting and Clinical Psychology*, 52, 79-87.

Breslau, N. & Davis, G.C. (1987). Posttraumatic stress disorder: The etiologic specificity of wartime stressors. American *Journal of Psychiatry*, 144, 578-583.

Basoglu, M., Paker, M, Paker, O., Ozmen, E., Marks, I., incesu, C., Sahin, D. & Sarimurat, N. (1994). Psychological effects of torture: A comparison of tortured with non-tortured political activists in Turkey. *American Journal of Psychiatry*, 151, 76-81.

16 Bowes, I.T., O'Gorman, E.C. & Sayers, A. (1991). Assault characteristics and post-traumatic stress disorder in rape victims. *Acta Psychiatrica Skandinavia*, 83, 27-30.

17 Abenhaim, L., Dab, W. & Salmi, L.R. (1992). Study of civilian victims of terrorist attacks (France 1982-1987). *Journal of Clinical Epidemiology*, 45, 103-109.

March, J.S. (1993). What constitutes a stressor? The criterion A issue. In J.R.T. Davidson & E.B. Foa (Eds.). *Posttraumatic stress disorder: DSM IV and beyond* (pp-37-53). Washington, D.C.: American Psychiatric Press.

18 Selye, H. (1956). *The stress of life.* McGraw-Hill Book Company, New York.

Van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F.S., McFarlane, A.C. & Herman, J.L. (1996). Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. American Journal of Psychiatry, 153, Festschrift Supplement.

19 WHO (1994). *User's Guide to the Self Reporting Questionnaire.* World Health Organization, Division of Mental Health, World Health Organization, CH-1211 Geneva 27, Switzerland.

20 Harding et all (1987). Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychological Medicine*, 10, 231-241.

Kishore J, Reddaiah V, Kapoor V, Gill J. (1996).Characteristics of mental morbidity in a rural primary health centre of Haryana. *Indian Journal Psychiatry*: 38: 137-42.

Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. (1997). Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*,170: 473-8.

21 Sen B, Williams P. (1987). The extent and nature of depressive phenomena in primary health care: A study in Calcutta, India. *British Journal of Psychiatry*, 151: 486-93.

22 Deshpande, S.N. & Sundaram, R. (1989). Psychiatric disorders among medical in-patients in an Indian hospital. British Journal of Psychiatry, 154, 504-509.

23 Epicentre (1999). *Rapid health assessment of refugee or displaced populations.* Paris: Epicentre.

24 Harding et all (1987). Mental disorders in primary health care: a study of their frequency and diagnosis in four developing countries. *Psychological Medicine*, 10, 231-241.

Kishore J, Reddaiah V, Kapoor V, Gill J. (1996).Characteristics of mental morbidity in a rural primary health centre of Haryana. *Indian Journal Psychiatry*: 38: 137-42.

Mumford DB, Saeed K, Ahmad I, Latif S, Mubbashar M. (1997). Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*, 170: 473-8.

25 Deshpande, S.N. & Sundaram, R. (1989). Psychiatric disorders among medical in-patients in an Indian hospital. *British Journal of Psychiatry*, 154, 504-509.

26 -Jong K. de , Mulhern, M., Ford, N., Kam, S. van der & Kleber, R.J. (2000). The trauma of war in Sierra Leone. *The Lancet*, Vol. 355, page 2067-2068.

Jong, K. de, Mulhern, M., Ford, N, Simpson, I, Swan, A and van der Kam, S. (2002). Psychological Trauma of the civil war in Sri Lanka. *The Lancet*, volume 359, page-1517-1518.

Jong, K. de, Kam, S. van de, Ford, N., Hargreaves, S., Oosten, R. van, Cunningham, D. & Boots, G. (2004). Trauma of Chechnya's ongoing war on internally displaced people. *The Lancet*, 364, 1008.

27 WHO (2002) *World report on violence and health.* World Health Organisation, Geneva.

28 Jaswal, S.K.P. (1995). *Gyneacological and mental health of low-income urban women in India.* Phd thesis: London School of Hygiene and Tropical Medecine.

29 Margoob,M.A., Singh, A. & Ali, Z. (1997). *A study of suicide attempts in Kashmir valley over the past six months (april-sept. 1997) experience from psychiatric outpatient population.* Indian Psychiatric Society North Zone.

30 Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M & Nelson, C.B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, vol. 52, 1048-1060.

Solomon, Z., Laor, N. & McFarlane, A. C. (1996). Acute Posttraumatic Reactions in Soldiers and Civilians. In Kolk, van der B., McFarlane, A.C. & Weisaeth, L.. *Traumatic stress. The effects of overwhelming experiences on mind, body, and society*. Guildford press, New York.

31 Jong, J. de, Komproe, I.H., Ommeren, van M., El Masri, M., Araya, M., Khaled, N., Put, van der W. & Somasundram, D. (2001). Lifetime events and post-traumatic stress disorder in 4 post conflicts settings. *Journal of the American Medical Association*, 86 (5), 555-562.

32 Lie, B., Lavik, N.J. & Laake, P. (2001). Traumatic events and psychological symptoms in a non-clinical refugee population. *Journal of Refugee Studies*, 14, 276-294.

33 Herlihy, J., Scragg, P & Turner, S. (2002). Discrepancies in autobiographical memories- implications for the assessment of asylum seekers: repeated interviews study. *British Medical Journal*, 324, 324-327

34 Ministry of Health and Family Welfare (2004). *Mental Health: an Indian perspective 1946-2003*. Ed Agarwal, S.P.. Directorate of Health services. New Delhi: Elsevier

National Institute of Health and Family Welfare. *National Mental Health Programme*. http://www.ndc-nihfw.org/html/Programmes/NationalMentalHealth.htm

35 National Institute of Health and Family Welfare. *National Mental Health Programme*. http://www.ndc-nihfw.org/html/Programmes/NationalMentalHealth.htm

36 Margoob,M.A., Singh, A. & Ali, Z. (1997). *Prescribing practices and outcome in anxiety disorders over the past two decades-experience from a sole provincial level psychiatric diseases hospital outpatient department.* Indian Psychiatric Society North Zone.