The Role of Health Systems in Responding to Communal Violence in Delhi

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A report by volunteers involved in facilitating access to healthcare for victims of violence between 25 February to 1st March 2020

BACKGROUND

From the night of 24th February 2020 till date, North East Delhi has seen unprecedented violence, directed especially against minorities in the areas of Ashok Nagar, Mustafabad, Jafrabad, Seelampur, Maujpur and Shiv Vihar. Mosques have been attacked, houses burnt, and people hunted down in the streets by mobs. As in any incident of mass violence, in this situation too, the role of the health system has been critical. From the 25th of February onwards, we have been attempting to coordinate the public health system response to survivors and victims of the violence that erupted in North East Delhi. Far from providing healing from the trauma that victims have faced, we have found that the public health system itself has ended up inflicting secondary trauma through acts of commission and omission. In this report, we are documenting the challenges that were faced by victims in accessing and seeking health care in this time of violence, and the steps that the Delhi Government needs to take to ensure that the system plays a constructive role in helping survivors heal from trauma and get justice.

NARRATIVES OF VIOLENCE FACED IN THE RIOTS AND RESULTING INJURIES

Patients narrated gruesome experiences of violence from the night of 24th February 2020 onwards. Some reported being chased by mobs and beaten with lathis, their vehicles being stopped and passengers being attacked with swords, mobs burning shops and houses. Assailants were said to be people not belonging to the area, but had come from outside. The police's role has been particularly highlighted by all patients. In one case where a missing family was searching for their son, the police told them they had taken him to a hospital. They refused to disclose which hospital. Later, the family reported that an eye witness had told them that when the boy ran to the police for help, he was pushed back to the mob which dragged him away and he has been missing since then. In three cases, the patients reported being attacked by the police themselves and beaten by lathis. In addition to gunshot wounds, sharp and blunt trauma, we were also told of and shown pictures of burns. One woman whose husband and daughter are admitted in a tertiary public hospital told us that they heard ruckus on the street, looked out to from their house to see what was happening, and acid was thrown on them by an unknown person in a mob.

RESPONSE OF HEALTH SYSTEMS AND PROBLES ENCOUNTERED THEREIN

1. Accessibility to Health services:

    a. Insecurity: While the conflict was ongoing, injured had no means to reach hospitals even when they were able to escape the violent mob alive. In the case mentioned above, the two persons burnt by acid escaped and hid in a mosque and then walked almost three kilometers to a point where they could find a private vehicle to get to the hospital. The time lapse between the assault and reaching the hospital was about 8 hours - precious time in cases of burns. Further, it has already been reported that mobs were not allowing ambulances to reach hospitals, and so some patients who needed to be referred to tertiary care from small private health establishments closest to the site of violence, were not able to seek care. This situation was relieved after the Delhi High Court order of 26th February. A charitable hospital that has been proactively providing care to injured persons is struggling to provide free care, as they have no received an official notification from the Delhi government regarding the extension of the Farishtey scheme to riot victims. Families are struggling to raise finances through volunteers and well wishers to ensure admission.

    b. Fear of state institutions: Another barrier to accessibility was the lurking fear of the state in the minds of victims. One resident of an area that saw large scale mob violence on 25th February called us on the phone in need of medical help but told us that she was afraid to come along with injured to GTB hospital as the police would then file an FIR and may prosecute them as rioters. Another woman, whose 14 year old son had a shrapnel injury on the back told us that they sought care at a small private clinic near their house instead of going to GTB Hospital, because of the same fear of being picked up by the police later on. When the pain became unbearable, only then did the woman bring her son to the hospital, more than 24 hours after the injury. Similarly, a man who was also attacked by the police and had a forearm fracture came to the LNJP casualty and told the doctor that he had had a fall from the stairs. He was afraid that an MLC would eventually lead to an FIR being filed against him by the police, which would mean a loss of his employment. In another case, a young man with a bullet injury in his hand refused care and almost fled from the LNJP hospital because he was told that he would need to file an MLC and would need to speak with the police. After much persuasion by a volunteer he agreed to seek care at LNJP. The fear of state institutions extends to ambulances with families reporting that they are reluctant to call on 102 for government ambulances and instead feel safer accessing private/ charitable hospitals using private vehicles or auto rickshaws.

2. Quality of Treatment Provided to victims:

    a. Negligent care: There were instances where we saw that patients who had sought care at GTB and LNJP hospitals were not treated appropriately. In one case in which a man had been beaten by the police, he was taken to GTB hospital. He said he was treated

there hurriedly and was asked to leave even though he had trouble standing up and walking. Two days later he was in great discomfort and sought care at LNJP hospital. At LNJP he was not being admitted and instead being repeatedly told to go to GTB as that is where he had been treated at the first instance. The hospital also told him that they could not treat him as he did not have his discharge papers from GTB. He had never been admitted at GTB. Fed up, he said he would rather go home and bear the discomfort than be treated this way. After much insistence by volunteers and the family themselves, the CMO saw him, just checked his pulse and said that he is fine. He said that the man is probably feeling unwell because he has not taken medications. We then brought him to a charitable hospital where he was finally examined properly, investigations were done and he was admitted and treated. At the charitable hospital it was discovered that he has a forearm and leg fracture which was not treated at GTB or LNJP. These injuries were also not mentioned in the treatment summary given to him by GTB hospital.

b. Denial of Care: A common reason for denial of care was the lack of an MLC number and treatment records from previously accessed hospitals. Several patients were not given their MLC number or treatment record by hospitals. If they went to a different hospital, they were told that they cannot be admitted unless they bring the MLC number and treatment records. The doctors should have been responsible for doing this themselves, however they did not and this caused great harassment to patients. In two cases a lawyer and senior doctor's intervention was required to get two injured men admitted to LNJP hospital after a lot of delay. One of the men eventually died. It is possible that timely care could have saved his life.

c. Communal remarks by health professionals: Patients and volunteers both reported that injured persons being called "ugravadi" and "atankvadi" by doctors. Some said that when they requested prompt treatment, they were told "What will you do if we treat you? You will go back on the streets and be violent". These are also the exact words that a volunteer heard when he was waiting to take detainees from the police station to the hospital. A volunteer at a shelter who had been accompanying victims to seek care reported that doctors at casualty had asked some victims the full form of NRC and CAA. It is disturbing to see that health professionals are using this to shame patients in casualty, who have suffered grave violence.

d. Disregard for safety of patients: Patients reported that even in an atmosphere of great insecurity, they were asked to leave the hospital and go home, on their own. One man with a fracture on his leg without an accompanying person was asked to go home. He was not given time to contact his family to assist him in reaching home. Instead staff at the hospital put him in an auto rickshaw and sent him on his way. No ambulances were being provided to drop them home. No assessment of safety was done to ascertain where the patient lives and whether it is safe for them to go back or not. In times of crisis, the hospital itself can make arrangements for shelter until the law and order situation is controlled but this was not done, thus pushing patients back into insecurity.

3. Information and support to families of victims:

    a. Information on treatment and status of patient: Families of injured persons were not being provided information on what treatment is being provided or how their patient is doing. No liaison existed and families waited outside casualties for hours, not knowing if their patient had even been attended to. In one case a family member of a deceased man told us that he brought his brother in law alive to the hospital. He had been badly injured by a bullet and the family had rushed him to GTB hospital. Once he went into casualty, the family was just asked to wait outside. When they tried to intervene they were told, “Why dont you only come and treat your relative? Are you the doctor or I?” They kept waiting for many hours and finally went inside again to ask. They were told that their patient is no longer in casualty. Then after asking around they were told that the person is dead and the body has been shifted to the mortuary for post mortem.

    b. No help for identifying missing persons - During the violence, many persons were missing and families were desperately trying to locate loved ones in hospitals. Instead of being transparent and aiding families in finding their missing relatives, relatives were told to go from ward to ward, and room to room to check if their missing family members are admitted.

4. Medico-legal documentation and Post Mortems:

    a. No MLC number on papers: In several cases the patients did not have MLC numbers and were hence being denied treatment at other hospitals. In one hospital where we took a patient, the doctor called the previous hospital where the MLC was apparently made, and he was told that MLC numbers have not been “assigned” as yet due to the patient load. This will be done in two or three days, after which the MLC number can be attached to the subsequent hospital’s documents. While the high volume of patients can certainly be a challenge to manage in casualty, if the hospital knew that MLC numbers were being given retrospectively, this should have been informed to patients and not be made a requirement for admission.

    b. No access to medico-legal records: Patients were not being given any records of medicolegal documentation or post mortem reports. This is the right of the patient and will be of use to them if they choose to pursue legal cases in the future. One family member told us “I brought a live man here to the casualty, and now he is dead. I do not know what the hospital did or what kind of injury he had. We have been waiting for his body and post mortem reports for more than 24 hours and we have only been given one paper that says that the police has handed over the body to us. What are we supposed to make of this?” In another case where a woman lost two sons, the family has been asking volunteers to help procure medico legal records. They said we do not know what injuries our sons had, what treatment they were given, and how they eventually died. Thus in all, we saw at least three cases of deceased in which the families had just been given one document from the police which was required for

burial. Other than that, no record of injuries or treatment were given to families. When they asked for it, they were told that they can only access them from the police, after two weeks.

c. Inadequate documentation - For patients who had a casualty case paper, we noted that the documentation was extremely sparse. No details of history were recorded - such as where the violence took place, with what weapon, who the assailant was and so on. Injuries were also recorded cursorily and some gross injuries such as fractures were not recorded at all. Hospital papers can serve as legal proof for victims to claim justice and all efforts must therefore be made to make sure that these are complete and accurate. While we understand that high volume of patient load can pose a challenge to documentation, the health department must find a way to deploy more human resources to accomplish this task given that it is a legal obligation.

5. Health care in communities: The violence has resulted in displacement of entire communities in the north east of Delhi. In one relief site that we visited, persons displaced from Shiv Vihar were living in the houses of relatives, friends and good samaritans in a safer area. People are living in crowded conditions with families separated from each other. There is a need for more space for people to live, with good hygiene and sanitation facilities and access to health care at the community level. Access to routine treatment for chronic illnesses has been affected, such as diabetes and hypertension, due to the disruption and displacement. Shiv Vihar, one of the most affected areas from where maximum displacement of people has happened, is situated in Mustafabad. Mustafabad has no Mohalla clinic. The primary health centre of the government has been lying shut since violence broke out on Monday and even basic services are not available. There is also a need for medical vans and ambulance services to provide healthcare and transport people from the community to hospitals since there has been a disruption in services in the community.

POSITIVE EXAMPLES:

It must be mentioned that there were a few doctors in this chaos who went out of their way to help patients. In LNJP hospital, two doctors intervened when a patient without an MLC number was being sent back and asked the police why they should not offer care. Doctors at a charitable hospital provided attentive care to patients who had been turned away from other hospitals for want of MLC or inadequate care. Moreover, in this time of great strife and distress, there have been various instances in which the medical community has also risen to the occasion and pulled resources together to respond to the crisis. Given the great sense of insecurity in sites where fresh conflict had broken out, it was a small private hospital - Al Hind - that provided first response medical care. It is commendable that the care was provided free of cost even before the Aam Aadmi Party government announced the extension of the Farishtey scheme to riot victims. Moreover, they also followed up on patients who had not completed treatment and ensured that they received care later on. In one instance, a relative of an

admitted patient told us how they could not transfer him to tertiary care on the night of 25th February because of the presence of mobs, and so they went home. But the next day after the Delhi HC order, Al Hind reached out to them and told them that the government had now guaranteed security to ambulances and so he could be taken to GTB. The family then returned and completed treatment. Similarly, although government ambulances apparently were not able to respond to violence victims, private ambulances did. Small private clinics also provided whatever care they could.

IMMEDIATE DEMANDS:

1. Station hospital liaisons in all government hospitals attending to injured persons to intervene if they or their families are facing issues in accessing care or treatment records.
2. Issue written orders to public and private hospitals to ensure injured people are not denied care or treatment records including MLC number.
3. Issue directions that treatment records including MLC numbers be made available to families and injured persons who have so far not received their treatment records.
4. Post Mortems reports should be made available to next of kin.
5. Issue written orders to all private and charitable institutions informing them of the extension of the Farishtey scheme to riot victims to ensure access to free care.
6. Set up a toll free number so that people can report instances of denial for treatment/admission for quick and appropriate action.
7. AAP should lead a team of people consisting of representatives of health rights groups to visit all affected areas and identify responses needed from the health system.
8. Operationalize primary healthcare services at all affected areas through Mohalla clinics or Urban PHCs. Ensure that paediatricians, gynaecologists and surgeon are stationed there.
9. Ensure availability of surgical facilities as people need surgical care and are scared to go to hospitals.
10. Designate mobile vans for affected areas and assign a team of medics and paramedics to provide healthcare outreach and referral services to injured people.