Beyond Burns ...surviving to thriving



International Foundation for Crime Preventio and Victim Carr British High Commission New Delhi

Supported by

Beyond Burns ...surviving to thriving

Guidance for practitioners and policy-makers in India on empowering women burn survivors through their journey of recovery and discovery of life beyond violence

Supported by The British High Commission in India

Contents

Introduction 7		
	Burns as a form of Violence Against Women	9
	1.1 Violence against women	
	1.2 The Nature of Domestic Violence	.12
	1.3 Burn injuries as a form of Domestic Violence	.13
	1.4 Government's Programme for Burn Injuries	
	The Work of PCVC on Burn Care and Rehabilitation	19
	2.1 PCVC and the Vidiyal Project	
	2.2 PCVC's Theory of Change	
	2.3 Approaches Underpinning PCVC's Model	. 26
	2.3.1 Solution Focused Empowerment Model	. 28
	2.3.2 Trauma-Domestic Violence-Informed Service System	. 30
	Rationale for Psychosocial Support	33
	3.1 Types of clinical policies and protocols recom mended	
	for Health facilities	
	3.2 Barriers to effective Health services – the perspective of	
	survivors and Health care professionals	. 38
	3.3 Normalisation of Violence	
	3.4 Health consequences of gender-based violence on women	
	3.5 Some Do's and Don'ts for Violence Informed System	. 42
	Integrating Psychosocial Support into Hospital Services	43
	4.1 Enablers of PCVC's Model - Center for Excellence,	
	Burns & Plastic Reconstructive Surgery Ward, KMC	

	4.2 On Arrival in Hospital	. 48		
	4.3 Psychosocial Support			
	4.4 Supporting Other Aspects of Hospital Care			
	4.5 Supporting and Providing Caregivers			
	4.6 Medico-legal Arrangements			
	4.7 Awareness Raising Activities in the Community			
	4.8 Prior to Discharge			
	Integrating psychosocial support in rehabilitation services			
	5.2 Returning Home – phone follow up and home visits	. 62		
	5.3 PCVC's Recovery and Healing Center for			
	Women Burn Survivors	. 65		
	Wider social and economic empowerment			
	······································			
	Coordinated Community Response for Holistic Support			
	Services for Women Burn Survivors	79		
	7.1 Key Elements & Strategies of a Coordinated Com			
	munity Response	.02		
		0.2		
	Conclusion	.03		
Case Studies				
Annexes				



Introduction

This Handbook aims to raise awareness on the issue of burns in the context of violence against women and to make the case for providing high-quality psychosocial support to women burn survivors to complement existing medical and rehabilitative services.

The Handbook draws on the experience of International Foundation for Crime Prevention and Victim Care (PCVC), a non-profit charitable trust based in Chennai and includes good practices from psychosocial support to women burn survivors across India. It is written for people delivering services to, and seeking to empower, women burn survivors, particularly those affected by violence. The following groups are likely to find this handbook of relevance:

- Girls and women surviving burns
- Caregivers of survivors
- Medical, nursing and other burn-care professionals treating survivors
- Social workers/NGOs supporting survivors in/out of hospitals
- Police and legal professionals responding to cases involving women burn survivors
- Those involved in policy and other aspects of service delivery related to survivors

The Handbook is the result of a PCVC-led initiative supported over 2016-17 by the British Deputy High Commission Chennai who saw merit in our model of holistic support to women burn survivors in Chennai and supported sharing of this model across India. This UK-backed initiative

included state-level research and knowledge sharing among burn-care practitioners in four target states (Delhi, Maharashtra, Tamil Nadu and Telangana) followed by regional-level policy discussion in these states and national-level discussion in New Delhi. The Handbook draws on insights and case studies shared by public and private, state and central government representatives over these discussions.

Several state governments have supported long-standing burn-care medical infrastructure in their states; these teams of doctors, nurses, physiotherapists, and dieticians have worked tirelessly for years to provide first-response care to thousands of women survivors. The Government of India's Ministry of Health whose ambitious National Programme for the Prevention and Management of Burn Injuries (NPPMBI) is strengthening the burn-care infrastructure across India. The National Burns Center, Indian Journal of Burns, National Academy of Burns India and several centers of excellence have, over the years, strengthened the academic, research and skills base of India's burn-care professionals. And civil society/social work organisations like us have supported burn survivors in their circles. We thank all these (and so many un-named) individuals and institutions whose time and thoughts have enriched this Handbook offering guidance to those working toward more holistic support for women survivors of burn violence.

> Dr. Prasanna Gettu, Ph.D. Criminology Founder & CEO, PCVC, Chennai, India



Burns as a Form of Violence Against Women

1.1 Violence against women

The United Nations, in its Declaration on the Elimination of Violence Against Women (1993), defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

Violence against women is a global issue, it happens in all countries and all social classes. It is rooted in discrimination and inequality and stems from a belief that women are of less value than men.

> Violence against women is a leading cause of injury and disability, as well as a risk factor for other physical, mental, sexual and reproductive health problems.

Factors that encourage violence against women include those at an individual level - low levels of education, having experienced physical or sexual abuse as a child and may be exacerbated by harmful use of alcohol. There is also a growing recognition of the importance of community and societal risk factors including traditional gender norms, unequal social, legal and economic status of women, the use of violence to resolve conflict more generally, and weak community sanctions against violence.

Violence has long-term consequences for women and their children, as well as social and economic costs for all society.

Many international agreements, including the United Nations Universal Declaration of Human Rights and the Declaration on the Elimination of Violence against Women, have recognized women's fundamental human right to live free from violence.

One of the most common forms of violence is domestic violence, which includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner. Other forms of violence against women include dating violence, sexual assault, human trafficking and violence against women in particular minority groups.



1.2 The Nature of Domestic Violence

- o Domestic violence is where one person tries to control and assert power over their partner in an intimate relationship. It can be physical, emotional, financial or seaxual abuse. These often overlap. Any woman can be affected and it can happen in any home.
- o The overwhelming global burden of domestic violence is borne by o women.
- o Domestic violence is harmful to a women's mental and physical o wellbeing.
- o Physical violence can include hitting, beating, kicking Psychological violence erodes a woman's sense of self-worth and may include harassment, threats, verbal abuse such as name-calling, degradation and blaming; stalking and isolation.
- o Evidence suggests that women who are abused by their partners suffer higher levels of depression, anxiety and phobias than non-abused women. In a 2005 WHO multi-country study, reports of emotional distress, thoughts of suicide, and attempted suicide were significantly higher among women who had ever experienced physical or sexual violence than those who had not.¹
- o Whilst domestic violence is a problem world-wide, the social customs and attitudes that support violence against women are particularly

entrenched and institutionalised in society in South Asia, at all levels – home, family, community and the State. In a nation-wide survey in India, nearly 50 per cent of women reported at least one incident of physical or psychological violence in their lifetime.²

- In India many cases of domestic violence involve burns, typically fire and occasionally acid burns.
- The act of domestic violence is illegal within Indian law, under the Protection of Women from Domestic Violence Act of 2005, as well as a human rights violation. However this has not had the effect of significantly reducing the incidence of domestic violence nor of reducing the number of burns cases.



¹ Garcia-Moreno C et al. WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization, 2005. ² International Center for Research on Women (ICRW) (2000), 'Domestic Violence in India: A Summary Report of a Multi-site Household Survey'.



1.3 Burn injuries as a form of Domestic Violence

- The incidence of serious burns in India is exceptionally high.
- The rate of young women experiencing serious burns in India is three times that of young men.
- Burns are most commonly caused by kerosene being set alight and are often explained as 'kitchen accidents'.
- Many of these burns are related to domestic violence.
- A high proportion of burn victims belong to lower socio-economic groups.
- Burns may be inflicted by a husband or in-laws or by the girl or women herself driven to desperation by sustained domestic abuse and violence.
- Whilst burns are very often a consequence of domestic violence, they can also cause further violence as the survivors family responds angrily to her disfigurement or disabilities.

Unlike acid attacks, which most often occur in public spaces as a form of street sexual harassment, burns by kerosene, alcohol or petrol happen more frequently in the domestic sphere. This manifestation of violence against women often occurs as part of a long period of abuse, harassment and violence within households and is mostly perpetrated by the husband or his family. However there is a high incidence of women burning themselves.

When a young woman burns herself, it is often in a moment of desperation, trying to find some way to have her husband, or his family, stop abusing her, stop heavy drinking associated with abuse or sometimes in response to accusations about her virtue. Women who experience sustained domestic violence tend to have greater overall emotional distress, as well as high occurrences of suicidal thoughts and attempts. According to a study by the National Center for Biotechnology Information³, suicide attempts in India are correlated with physical and psychological intimate partner violence.

In the absence of a national injury surveillance system in India, the actual incidence of burn-related injuries and deaths is not known. However, a 2016 study⁴ notes that of an estimated 7 million burn injuries in India



³ Vizcarra, B. Partner Violence as a Risk Factor for Mental Health among Women from Communities in the Philippines, Egypt, Chile, and India. National Center for Biotechnology Information. Department of Psychology Universidad De La Frontera, Temuco, Chile, 2013.

⁴ Gendered pattern of burn injuries in India: a neglected health issue (Padma Bhate-Deosthali and Lakshmi Lingam, 2016)

annually, 700,000 require hospital admission and 140,000 are fatal. According to the National Programme for Prevention of Burn Injuries (NPPBI), 91,000 of these deaths (65%) are women; a figure more than double that for maternal mortality⁵ in India.

The paper notes that in 1998, India was the only country in the world where fire was among the 15 leading causes of death, according to WHO. (The paper also points out that it has never been explored why so many young girls die of burns from 'kitchen accidents' after marriage, but cook safely in their natal homes.)

A study by Prachi Sanghavi and colleagues published in The Lancet $(2009)^6$ produced an estimate of 163,000 fire-related deaths in 2001. This was six times higher than police reports of fire-related deaths for the same period. About 106,000 of these deaths occurred in women, mostly between 15 and 34 years of age.

This age-sex pattern is consistent across a number of studies in India, indicating that in India, women of child bearing age are three times more

When women are subjected to a sustained period of abuse and violence, particularly where a woman has experienced violence in her natal home as well as in her married home, violence becomes normalized. A woman starts to believe that violence is normal and accepts the escalation of violence until it may tragically culminate in an effort to kill her - or she tries to harm herself as a desperate effort to escape the terror of life in a violent home.

likely to die because of burn injuries than men. According to WHO, South Asia has the highest rate of burn deaths amongst women.

Burn-related injuries and deaths amongst women in India are often reported as 'kitchen accidents' involving kerosene or cooking oil and flammable garments. Fire burns are far more common than acid burns - in 2012, 225 acid attacks were reported in India⁷.

⁵ According to WHO, nearly 45,000 mothers die due to causes related to childbirth every year in India.

⁷ Acid Survivors Foundation India



⁶ Fire-related deaths in India in 2001: a retrospective analysis of data (Prachi Sanghavi, 2009)

Highlights from some research studies done on burns in India

Recent research by public health professionals, Padma Bhate-Deaosthali and Lakshmi Lingam, noted deaths due to burns are four times higher among women aged 18-35 years and burns as one of the main causes of death in the 15 to 44 age group.⁸

Dr. Madhuri Gore, former head of the Department of Surgery at Mumbai's Sion Hospital, citing a study she had conducted, said 40% of the 200 burns cases she analysed were homicidal or suicidal but police cases were registered only in 5% of these cases.⁹ Dr. Mangai Natarajan, Professor, John Jay College of Criminal Justice, New York, in her study (2014), established that the majority (65%) of intentional burns cases were women and, among cases with the most severe burns, more women than men died. The study further stated that women's families did not want the police inquiring into their domestic problems and hence reported suicides and homicides as accidents. The victims were afraid of the perpetrators, often their husbands, and feared that if their husbands were arrested their children would be left stranded on the streets.¹⁰

Another analysis of cases conducted by Dr. Vinita Puri, head of the Department of Plastic Surgery at Mumbai's King Edward Memorial Hospital also found that many cases of attempted suicide or injuries inflicted by family members were reported as accidental burns. She has observed; "It is unlikely for a person to suffer 60 to 80per cent burns if it is accidental."¹¹

According to Dr. Padma Bhate-Deosthali, 'Busting the Kitchen Accident Myth: Case of burn injures in India (2016), of the 22 cases of burn injuries in women studied, 15 were reported as accidents to the police. However, when counsellor records were examined, only three of these were really accidents. Others were cases of burn injuries inflicted by a partner, self-inflicted burns or cases of accidental burns with a history of domestic violence.¹²

Dr. B.R. Sharma et al, in a 2006 study which analysed over 600 cases of burn related deaths in India over the period 1996 – 2005 found that the number of cases involving women was more than four times that of men; that the majority of women victims sustained burns in their in-law's house, (61%); and 76% belonged to a lower socio-economic strata (with an income of less than INR 10,000 per month).¹³

A study in Tamil Nadu, India, published in 2004, showed a suicide rate amongst young Indian women (15 - 19 years) 70 times higher than the equivalent rate recorded in the UK.

⁸ Bhate-Deosthali P, Lingam L. Gendered pattern of burn injuries in India: a neglected heath issue. Reproductive Health matters (RHM) Journal. 2016;24:96—103.

⁹ http://www.thehindu.com/opinion/op-ed/These-figures-aren%E2%80%99t-cooked-up/article14492775.ece



¹⁰ Natarajan M. Differences between intentional and non-intentional burns in India: implications for prevention. Burns. 2014 Aug;40(5):1033-9.

¹¹ http://www.thehindu.com/opinion/op-ed/These-figures-aren%E2%80%99t-cooked-up/article14492775.ece

¹² Bhate-Deosthali P. Busting the Kitchen Accident Myth: Case of burn injures in India. International Journal of Innovation and Applied Studies, Volume 17, Issue 2, July 2016, Pages 388–393.

¹³ Sharma B R. Harish D. Accidental burns in Indian kitchens: Are they really accidental? JIAFM, 2006: 28 (1) ISSN:0971-0973.

For women from poorer households, their financial insecurity means they may have to continue to be dependent on their husband and his family even after an attack and a sustained experience of domestic violence. This also explains why many choose not to reveal the actual nature of the incident.

Thus, there is clear evidence that burns in young women in India are very commonly a consequence of domestic violence, whether self-inflicted or inflicted by a husband or member of the husband's family and that such cases are massively under-reported – most often because the burn survivor is fearful to implicate her husband and his family.

A few PCVC women have talked about how they saw burning themselves as a way of crying for help and that they did not understand how 'a few drops' of kerosene once ignited could be so dangerous and cause such devastating burn injuries. This lack of awareness needs to be addressed alongside options being made available for women trapped in violent homes.

See Annexe for links on media reports of burn incidents across India.

As part of the UK-backed initiative in 2016-17, PCVC led research to better understand existing burn-care support mechanisms and challenges in the 4 target states of Tamil Nadu, Telangana, Maharashtra and Delhi. The full research report is available with PCVC but a few main findings are:

- Mortality among women is higher than among men burn survivors.
- Burns are from a range of sources: fire (kitchen or 'diya'), kerosene, petrol, alcohol, gas, acid. The vast majority of cases involving women relate to fire, kerosene.
- Most women are unwilling to report incidents as 'homicide' or 'suicide', leading to higher rate of recorded 'accidents'. Reluctance is heightened because care-givers are often present during recording of the woman's statement or because of fear of abandonment/rejection, of losing her children, of not being treated because of her financial dependence, that her children will be targeted by in-laws, of retribution violence
- Caregiver and family support is higher for men (especially support received from women in the family sister, wife, daughter or mother) than for women burn survivors, contributing to a higher survival rate among men.
- Women survivors are more quickly and more consistently abandoned by families because of high cost of and prolonged need for burn treatment, before and after hospital discharge.
- Women face greater family/social rejection, than men, on account of burn disfigurement.
- The level of family support has a psychological impact on women that affects how quickly and positively they respond to even good and timely medical treatment.
- Within burn-wards, patient rounds by psychiatrists and mental-health workers are rare/absent. In the majority of cases physical healthcare is not complemented by psychological healthcare. Where services (individual/family counselling) are available they are not proactively offered/insisted on (to support physical-care) or sought.
- By default many nurses take on the role primary care-giver and offer psycho-social support but while they have been trained on handling physical trauma, they feel the need for specialised training in handling psychological trauma and on domestic violence issues.
- Most burn-data has historically been recorded and managed manually. The National Programme for Prevention and Management of Burn Injuries, been implemented under the aegis of Ministry of Health and Family Welfare, is in the process of developing a National Burn registry.
- State Commissions for Women provides support but it is inconsistent across states. Some provide 24x7 help-lines, special cells for women others have no contact with women burn survivors at all.
- Several civil society/social work organisations offer psycho-social and/or economic empowerment support women survivors of violence (domestic violence, sexual assault). Some support acid survivors but only a handful across India work with burn survivors.
- National Crime Records Bureau (NCRB) do not have clearly defined data on kerosene/alcohol burns, but do record acid attacks.
- Ganga Hospital in Coimbatore, Chaanv Foundation in Delhi, Grace Kennett Foundation in Madurai are some non-state initiatives that support burn survivors with economic empowerment, training, rehabilitation.



1.4 Government's Programme for Burn Injuries

In 2010, the Government of India announced the National Programme for Prevention of Burn Injuries (NPPBI), which aims at prevention, burns injury management and establishment of a central burn registry. It is now called the National Programme for Prevention and Management of Burn Injuries (NPPMBI). Under the 12th Five Year Plan, 67 Burn Units are to be established in State Government Medical Colleges and 19 Burn Units in District Hospitals. This will add value to the existing network of largely public sector, and select private sector, healthcare infrastructure serving burn survivors. Over time, this ambitious programme should help to



provide more and better treatment for burn patients and much more detailed information about burn injuries and their management in India.

http://dghs.gov.in/content/1357_3_NationalProgrammePreventionManagement.aspx

> The National Programme on Prevention and Management of Burn Injuries (NPPMBI), approved by the Government of India (2014) Over a five year period the programme aims to:

- reduce incidence, mortality, morbidity and disability due to burn injuries
- improve awareness of burn injuries
- establish adequate infrastructure to change behaviours
- manage burns and offer rehabilitation and carry out relevant research into behavioral, social and other determinants of burn injuries.

The Work of PCVC on
Burn Care and Rehabilitation2





posture while doing daily chores. Do not overstrain.

🔆 vidiyal - begin anew

1

Many Free face

Ũ







2.1 PCVC and the Vidiyal Project

The International Foundation for Crime Prevention and Victim Care (PCVC) is a non-profit, registered charitable trust based in Chennai, India. PCVC was founded in 2001 to provide services to women survivors of domestic violence.

The mission of PCVC is to help rebuild lives damaged by abusive family relationships and to support the self-empowerment of women survivors of domestic violence.

In 2003, PCVC initiated Vidiyal (*Dawn* in Tamil) : A Project for Women Burn Survivors of Violence who were discharged from hospital (KMC) the Burns Ward, at Kilpauk Medical College Hospital (KMC), Chennai.

In 2008, PCVC received a Government Order to provide assistance and support services on the Kilpauk Burns Ward at KMC. Thus, PCVC have been able to embed a range of services within the Burns Ward at KMC.

Many of the patients in the Female Burns Ward, KMC are survivors of fire or acid attacks resulting from domestic violence. PCVC supports survivors whilst in hospital and after discharge with a focus on psychosocial services. The overarching goal of Vidiyal is to empower women survivors of burn injuries to lead quality lives free from domestic violence. To this end PCVC provides rehabilitative burn care, especially psychosocial care, supporting women to lead quality lives as well-adjusted individuals free from violence. The project plays a pivotal role in women's lives, exposing them to choices that can lead to an end to violence.

In 2012 PCVC established a Recovery and Healing Center for Burn Survivors in Chennai, providing psychosocial and physical rehabilitation services on a residential and day care basis.

In 2013, PCVC entered into a three-year cooperation project with the Ministry of Foreign Affairs of the Republic of China (Taiwan), along with Sunshine Social Welfare Foundation (SSWF), Taiwan, to develop a comprehensive approach to address the rehabilitation needs of women burn survivors.

The Center significantly expanded its burn-related services, establishing a comprehensive system to facilitate the physical and psychosocial rehabilitation of women burn survivors, fulfilling an unmet need.

PCVC runs a number of other programmes to prevent and respond to domestic violence and other interpersonal violence issues. As the Tamil



Objectives of the Vidiyal Project

- To assist 'in-hospital recuperation' of the burn survivor by providing psychosocial support, psychotherapy (cognitive-behavioural and family therapy) and help the survivor cope with the trauma.
- To support hospitals to integrate psychological rehabilitation as an institutional policy and practice of the hospital through bringing a shift in the attitudes, mindsets and practices of the hospital towards women burn survivors.
- To encourage and support hospitals to become trauma informed and domestic violence informed in their services to woman burn patients.
- To enhance self-esteem, self-worth and confidence of the survivors through building their skills and making then economically independent.
- To bring a positive shift in the attitudes and behaviours of family and community towards the women burn survivors as an enabler for speedy recovery and healing of the burn survivor.
- To support family in managing their trauma and stress as a result of the incident, so that they are able to deal better with the situation and provide quality care to the survivor.

Nadu lead for Oxfam GB's We Can Campaign since 2004 they have developed considerable expertise on changing attitudes and beliefs about gender equality.

The organization is well networked with government, private and notfor profit agencies across India working on domestic violence and on treatment of burn injuries. This Handbook is part of a nation-wide initiative to raise awareness of the scale of the problem of burn injuries and deaths amongst young women in India and to work with others to prevent such incidents and to support women survivors to live quality, independent lives free from violence.

22

2.2 PCVC's Theory of Change

PCVC's Approach to its 'Theory of Change' has developed over years of experience working with women affected by domestic violence and burns and critically thinking about how to bring about the changes women want to make in their lives. PCVC supports women through a complex change process from 'victim to survivor to thriver'.

The women identify exactly what should change, over what period of time, and by how much, at every step in the process. The PCVC Team helps them explore how and why they expect change to happen in a particular way and how they are going to marshal their resources in creating immediate and intermediate steps of change that can lead, eventually, to their ultimate goal.

Each woman's recovery process is a 'pathway of change', a relationship between actions and outcomes throughout the 'victim-survivor-thriver' journey. A women's pathway of change typically involves psychosocial, physical and economic goals. PCVC creates services and interventions with the overarching aim of enabling women burn survivors to live full and positive lives free of any form of violence.

For a burn survivor this support can cover the journey from arrival at the Burns Ward at KMC through her hospital stay, her post-hospital rehabilitation (at the PCVC Recovery and Healing Center in Chennai or on an outreach basis), through to skill building training and help to find employment and, if she chooses to live independently, affordable accommodation.





Every survivor has her own unique needs. Based on her needs and driven by her own choices, goals for recovery and healing are mutually agreed between the survivor and the PCVC team.





ASSUMPTIONS

- A Women in abusive situations may not commit immediate
- B Women in abusive situations may not be able to attend regularl
- C Women in abusive situations may find it challenging to deal with others
- D Women in abusive situations may not be emotionally ready

Note: These statements can reflect understandings of the change process taken from research, or they can be taken from practical experience

INTERVENTIONS

- 1. Provide immediate need support like disposable sheet, disposable gowns, drinkiing water, nutritional supplements
- 2. Set up caregivers sessions at hospital
- 3. Education on need for physiotherapy, psychosocial therapy, wound care, high protein diet
- 4. Provide residential facility
- 5. Provide training of their choice
- 6. Develop curricula & experiential learning situations on gender & GBV
- 7. Education suppo
- 8. Capacity building on work ethics, rights etc
- 9. Connecting with employment opportunities
- 10. Support children's education and schooling



2.3 Approaches Underpinning PCVC's Model

Pathway of Change

A pathway of change is a map that explains how long-term outcomes can be achieved by setting out the preconditions

for change at each step in a process of change. It is the skeleton around which interventions are built. It summarizes the theory but does not tell the whole story.

Mapping this pathway works best when the process is done backwards from the first stages of intervention. Backwards mapping focuses on the question "What must occur before our outcome can be achieved?" instead of asking, "What can we do to bring about the outcome?"

Everything on a pathway of change can be understood as a precondition, or requirement, for the next outcome on the map. Preconditions must be achieved in order for the next step in the change process to be achieved. Preconditions can be identified by asking "What are the conditions that must exist in order for our outcome to be achieved?" This question is posed for long-term and intermediate outcomes on the map during the process of backwards mapping.



- A 'pathway of change' can support the 'victim-survivor-thriver' journey by helping women and other stakeholders to
- Develop a clear plan for recovery
- Explore resources and identify activities or actions necessary to reach the desired goal
- Develop a realistic picture of the complexity of the change process required
- Build consensus on how success will be defined, measured and documented
- Develop a shared understanding of what one is trying to accomplish

Family members may be included in the process, depending on presence of domestic violence and comfort level of the woman involved.



2.3.1 Solution Focused Empowerment Model

PCVC's work on domestic violence is informed by the solutionfocused- empowerment model which starts from valuing each woman's experiences and beliefs in her own ability and resourcefulness to establish and achieve her desired life goals. PCVC team does not offer solutions but rather support each woman to identify and construct her own solutions by engaging in open dialogue. The overall goal of a solutionfocused approach is recognizing and stopping the violence, establishing safety, healing and empowerment. Underpinning all aspects of PCVC's work is the belief that women must make their own decisions, based on clear information. The empowerment process aims to provide the burns survivor with:

- An internal locus of control
- A positive sense of self
- More awareness of her own needs and resources
- The ability to develop viable solutions appropriate to her needs and life context
- Self determination
- The ability to decide to stay with or to leave her partner.

This is not a linear process and it begins with understanding each woman's unique situation and viewpoint. A survivor's perspective is informed by her experience of violence, her culture, family and life circumstances, and for some, her role as a parent. Many burn survivors, overwhelmed by the fear of violence and feelings of powerlessness and helplessness, become paralyzed and withdrawn. As the PCVC team member builds a rapport with and starts to understand the survivor's experience and situation, she is able to share relevant information, talk about risks and options, and respond to the decisions each survivor wishes to make about her life.

The two work together to develop and implement recovery strategies, modifying them as the survivor's life and circumstances change. This approach is not simply listening and doing what a survivor wants. Rather, it requires a dynamic information and resource sharing process that creates and improves options for each survivor.



It is not uncommon for a counselor to spend many sessions educating a woman about her rights and supports available, only to find her returning to an abusive partner. Reasons might include coercion, financial dependency, and love for her partner. The approach used does not make any assumptions about what is best for a women, nor does it educate her as to what is the 'right way'. Rather it believes in the uniqueness of each woman's experience. It works on the belief that the solution is an individual's construction and comes from within. This validating process of discovering, connecting with, and amplifying life goals appropriate to her unique life context, builds each woman's own resourcefulness.

The result of this solution-focused approach is a comprehensive plan to end the violence and make life better for the survivor and any children. Survivors are rarely safe until they are free from violence and can provide for themselves and their families. For survivors without financial resources, plans often need to cover not just their physical recovery and psychosocial support but also their economic empowerment.

Ultimately, PCVC aims to support women to move from victim to survivor and on further to becoming a 'thriver'. This involves moving from a state of unawareness of the 'power within' her and her right to a life of dignity and respect, to a state of awareness of this inner strength and her potential to 'thrive', negotiating a violence free and equal life for herself.

Thus, healing is fully achieved when the burn survivor is able to lead a full life, free from any form of violence.

Strength Perspective

Problem focused

- Based on understanding of the problem of violence
- Focus on problems, deficits and pathology
- Engage in problem talk

Þ

solution focused ('doing what work')

- Based on positive change
- Focus on solutions, strengths and competencies
- Engage in solution talk

Women Frame their own Goals

- the woman is the only "knower" and the "expert" of their unique experiences, realities, and aspirations
- theere is n one "optimal" solution or one "best"
- define the goals and they fully "own" the efforts for a more satisfactory life



2.3.2 Trauma-Domestic Violence-Informed Service System

While each individual's experience of trauma is different, it is important to understand how it can impact the individual's coping resources and influence survival strategies. Trauma may be the result of a single event (like witnessing or experiencing a violent act) or a series of ordeals (longterm domestic violence).

PCVC has developed, over a number of years, a trauma and domestic violence-informed service system, which is a vital part of its work and essential to PCVC's mission of rebuilding the lives of women impacted by violence.

It is imperative that all members of the PCVC team understand trauma and how trauma affects the women's response to support services and the medico-legal process: how women begin to see themselves ("I am helpless," "worthless"); their worldview (the world is dangerous, no one can protect me), and relationships ("I cannot trust anyone"). These beliefs affect how women respond to health care, justice and other services and their confidence in the ability of these services to help them.

A trauma and domestic violence-informed service system is one in which all stakeholders involved recognize and respond to the impact of trauma (due to domestic violence or other forms of violence against women, including burn injuries) on women, caregivers, and service providers. The system infuses and sustains trauma and domestic violence awareness, knowledge, and skills into PCVC's organisational culture, practices, and policies. It helps the PCVC team understand potential pathways for healing and also facilitates and supports the recovery and resilience of the woman and her family. Avoiding victim re-traumatization, increasing the safety of all, and increasing the effectiveness and efficiency of interactions with the women survivors is the primary goal.

For example, a woman brought to the hospital with burns did not want to talk or give any statement when the police arrived. When the police met her the next morning she was groggy, angry, and only gave one-word answers to the officer. The police officer felt frustrated, wondering why the patient was wasting their time. However, when the NGO's Medical Social Worker asked the same questions to the woman in a caring and nonjudgmental way, she learned that the incident was not an accident nor self-inflicted and there was a history of violence at home. Using a trauma/ domestic violence informed lens, the Social Worker asked the woman patient to let her know when she was ready to talk. This small change gave the woman a sense of increased control and decreased vulnerability, which greatly improved the efficiency and effectiveness of interactions between the woman and the enablers (NGO, law enforcement, hospital teams). The starting point for all such interactions should be: "How can I create a situation in which she feels safe, makes her own choices, and feels understood?"

Trauma informed approach begins with not just understanding the physical, social, and emotional impact of trauma on the individual, but also on the professionals who help them.

Lack of understanding of trauma, its deep seated and long-lasting effects and the specific needs of women who have experienced violence and burns, can lead to serious misunderstandings of the survivor's needs and responses amongst healthcare team and other service providers. Key aspects of domestic violence trauma informed care include:

- Trauma is acknowledged.
- Vulnerabilities and sensitivities are respected
- Survivors are never blamed
- Potential triggers are avoided, so survivors are not re-traumatised
- Personnel of service providers are trained to:
 - o Understand symptoms
 - o Build trust
 - o Avoid blame
 - o Ensure safety
 - o Build the strength and confidence of survivors
 - o Always recognise the possibility of undisclosed or unaddressed trauma
 - o Recognise link between past trauma and current behaviour







Rationale for Psychosocial Support

In many cases the burn survivor is disfigured and often disabled by her burn injuries.

Less visible than the physical damage experienced by burn survivors, the psychological damage experienced is often deep-seated and long lasting. In this regard, the vulnerabilities of women burn survivors are quite different from that of men.

Loss of Confidence and Self Respect

As a result of her injuries, and in a society that places great value on an attractive physical appearance, a women disfigured by burns often struggles with high levels of distress related to her body image. Her physical ability to care for others and to do housework may also be limited by her injuries. She may feel a deep sense of insecurity about her physical condition and level of disability (it is common that 'kitchen accident' burns extend to the eyes) and her level of dependency on her family or that of her in-laws.

Sense of Burden to Family

In many cases a woman burn survivor feels she cannot fulfill the roles that society expects of her – as a wife and sexual partner and as a mother and family caregiver. Her health issues may also place additional financial burdens on a family.

Insecurity

It is quite common that a burn survivor is deserted by her husband in the hospital and once a police report is made. She may be blamed by the family and coerced to take responsibility for the incident, claiming it to be an accident or suicide attempt. This leaves the survivor insecure about losing her main support system – her marriage.

Guilt

After the immediate trauma of the incident begins to settle, a survivor may start to feel guilty and blame herself for the incident and to worry about possible legal implications. The family's feelings may shift from fear to anger, exacerbated by the need to care for the survivor during the hospital stay, often over months.

Studies show that the effects of disfigurement and disability caused by burn injuries can include grief, guilt, anger, depression, withdrawal, social anxiety, altered sense of self-esteem and self-identity, lack of confidence and difficulty in developing relationships.

International research has demonstrated that as many as 50% of burn survivors suffer psychological distress (Klein, 2009). And that 30% of burn survivors meet the criteria for having post-traumatic stress disorder as a result of their injuries (Ballinger, 1998).

Normalisation

A survivor who has experienced sustained violence, and thinks it normal, rarely understands that the burn incident was part of a cycle of domestic violence perpetrated against her.

Psychosocial support for women burn survivors is crucial to help survivors counter the social conditioning that risks portraying the incident as 'all her fault'; and to help a survivor recognise the domestic violence she has lived with, build her self-esteem and confidence and develop her capacity to lead an independent life free of violence.

Currently psychosocial support is only available to burn survivors through the activities of not-for profit groups such as PCVC. Whilst the more forward thinking hospitals recognise the value of this support to the recovery of burn survivors, they must rely on the not-for profit sector as there are very limited resources available in the government system for such support.

In some hospital contexts, team do not understand that women burn patients are the victims of domestic violence and may lack empathy - or actually blame women survivors for the burns they have experienced. Psychosocial support is critically needed for burn survivors in such contexts to counter a culture of victim blaming. Furthermore team in hospitals need to fully understand this context of domestic violence and adopt a 'domestic violence and trauma informed' approach to the care they provide (Section 2.3.2).
3.1 Types of clinical policies and protocols recom mended for Health facilities

Type of policy or protocol	Why this type of policy or protocol is important and what it needs to contain
Sexual harassment policy	 Every health care organization should have a written policy that prohibits sexual harassment by staff members against other staff members and against clients. The policy should: state the types of actions that are prohibited, provide a clear definition of sexual harassment, specify the procedures for reporting a case of sexual harassment, and specify consequences of violating the policy. Health care organizations cannot adequately address the issue of GBV if they cannot ensure re- spect for the rights of their own staff members and clients. A sexual harassment policy that has a clear procedure for handling violations is therefore an essential part of this
Policies and protocols about client privacy and confidentiality	 Every health care organization should have written policies that explain how staff should protect client privacy and confidentiality. These policies should address issues such as: where in the clinic and under what circumstances staff members are allowed to discuss information about clients with other staff or with clients themselves, the circumstances under which providers are allowed to share information about clients with other people, including family members, confidentiality of medical records, whether or not providers are required to get parental consent for certain services, and whether or not adolescents can keep their personal and medical information confidential from their parents.
Protocols for treating cases of violence against women, including sexual abuse and rape	Ideally, health care organizations should develop protocols for caring for women who experience GBV, including rape. These protocols can help providers know how to respond to a woman's disclosure of violence in a caring and supportive way, that preserves her legal rights. In cases of sexual violence, for example, the protocol should include guidelines about the provision of emergency contraception and testing for STIs. Such protocols may increase the chances that women will receive adequate treatment, especially when health care professionals have misconceptions about issues such as sexual abuse, emergency contraception and STIs/HIV.
Protocols for handling situations of risk and crisis	 Health care organizations that want to strengthen their response to the issue of violence against women should develop protocols for caring for women who are in situations of crisis or high risk. This includes clients who appear to be at high risk of suicide, homicide, injury or extreme emotional distress. A protocol for situations of risk and crisis should include a discussion of: how to identify risk factors, how to ensure that women get at least the basic assistance that they need, and among who the staff can provide emotional counseling and safety planning.

Source: IPPF 2010



3.2 Barriers to effective Health services – the perspective of survivors and Health care professionals

a. Barriers faced by women survivors in accessing health services and disclosing violence

- The following reasons may prevent women who experienced GBV from accessing health care and disclosing violence to health professionals:
 - o Shame, guilt, and the feeling to be solely or partly responsible for the violence suffered: A woman who experienced violence from an intimate partner may be convinced that she can stop the violence if she obeys the perpetrator's wishes and "betters" herself.
 - o Fear of reprisals from the perpetrator: Women who live in violent relationships may fear an escalation of
 - o Violence and further threats, as violent partners usually forbid women to talk about the violence with any other person and threaten with further violence.
 - o Fear of stigma and social exclusion by their families and communities.
 - o Social isolation and the feeling of having to deal with the experienced violence all by themselves.
 - o Long-term experiences of mistreatment that can damage women's self-confidence and self-esteem to such an extent that the search for and the acceptance of support becomes difficult.
 - o Lack of safe options for their children and fear of losing child custody.
 - o Fear of drawing attention to irregular immigration status or of losing status following separation from a violent spouse.
 - o Lack of realistic options, e.g. for financial resources, housing, employment or safety.
 - o Even though these barriers operate at the levels of partner relationships, families and the wider community and therefore require interventions beyond the health care system, health professionals nevertheless need to be aware of them, in order to be able to provide effective care and referrals to relevant service providers, such as shelters, crisis Centers or counseling Centers. These organizations may assist women in addressing some of these barriers, for instance through providing accommodation, legal counseling or other support.
- Other barriers faced by women can and should be addressed by health care systems, including the following:
 - o Lack of physical access to health care services for women living in remote areas;
 - Fear of negative responses from service providers and of being blamed for not separating from the abusive partner, in particular when the woman has received inappropriate and victim-blaming responses from other service providers in the past;
 - o Not knowing which steps health care professionals will take, for instance whether police will be informed or whether the perpetrator will be approached;
 - o Language and cultural barriers faced by migrant women and women belonging to ethnic minorities; and
 - o Situational aspects of the counseling and treatment situation, such as inappropriate physical conditions of the facility or insensitive behaviour of doctors and nursing staff.

38

b. Barriers faced By health care professionals in providing effective services provider Barriers to an effective health care response to survivors of GBV

- Insufficient knowledge about causes, consequences and dynamics of GBV: If health professionals do not ask about or do not recognize symptoms of GBV, they may misdiagnose survivors or offer inappropriate care.
- Own attitudes and misconceptions about GBV that may result in perceiving intimate partner violence as a private matter or blaming the survivor for the violence.
- Own experiences of GBV in the past.
- Lack of clinical skills in responding to GBV. As a consequence, health care professionals may be reluctant to ask about GBV, so as to avoid "opening Pandora's box" (McCauley et al 1998, cited in PRO TRAIN 2009). Lack of knowledge and skills may also put the patient's safety, life and wellbeing at risk, for instance when health professionals express negative attitudes to a patient who has been raped or by discussing a woman's injuries in a way that can be overheard by a potentially violent spouse waiting outside.
- Lack of information about existing support services and appropriate professional contacts, which could serve as basis for referral.
- Lack of time for medical care, as well as inadequate funding of counseling. It may be difficult to estimate how time-consuming a conversation would be and health care professionals are worried about having to cut back on the time needed for other patients.
- Missing intra-institutional support such as standardized protocols, documentation forms or staff training on dealing with survivors of GBV.
- Uncertainties about legal obligations, such as confidentiality rules or reporting obligations.
- Absence of standard procedures, policies and protocols to ensure that health professionals' response to all survivors of GBV follow standards of good clinical care.

Sources: Adapted from Ganley 1998 and Hellbernd 2006, cite in PRO TRAIN 2009, IPPF 2010, Warshaw/Ganley 1996



3.3 Normalisation of Violence

Women in domestic violence situations fail to recognise and define their own experiences as violence. Living with an abusive partner changes their interpretation and understanding of violence. They normalise violence, and perceive the relationship as a manifestation of their own failure. Most women are reluctant to identify themselves as a 'victim' and the partner as an 'abuser'. As a coping strategy they tend to define the violence as 'caring', 'love' or 'normal'. Research has shown that only after the woman has left the violent relationship, when she no longer faces isolation, control and risk of further violence from her former partner, the process of "denormalisation" of violence begins, which enables her to name her experiences as violent.

Expected Reactions

- feels in a mood of anxiety or nervous
- angry about what happened
- shows emotions of being scared or worried

3.4 Health consequences of gender-based violence on women



Source: Hellbernd et al 2004, CHANGE 1999, all cited in PRO TRAIN 2009



3.5 Some Do's and Don'ts for Violence Informed System

Do's

- Take the initiative to ask about violence do not wait for the woman to bring it up. This shows that you take a professional responsibility for her situation, and it helps to build trust.
- Explain that the information will remain confidential and inform her about any limitations to confidentiality.
- Use eye contact and focus all her attention on her. Avoid doing paper work at the same time.
- Be aware of your body language. How you stand and hold your arms and head, the nature of your expression and tone of voice all convey a clear message to the woman about how you perceive the situation.
- Show a non-judgmental and supportive attitude and validate what she is saying.
- Use a sympathetic voice to reassure the survivor.
- Carefully listen to her experience and assure her that her feelings are justified.
- Show her that you believe her story.
- Be patient with women and girls survivors of GBV, keeping in mind that they are in a state of crisis and may have contradictory feelings.
- Emphasize that violence is not her fault and that the perpetrator is responsible for his behaviour.
- Use supportive statements, such as "I am sorry that this happened to you" or You really have been through a lot," which may encourage the woman to disclose more information.
- Underline that there are options and resources available. Try to find adequate services together with her. Leave "the door" open for her to come back to you.

Don'ts

- Don't ask about violence in the presence of her partner, family member or friend. Remember that the patient's safety is paramount.
- Avoid passive listening and non-commenting. This may make her think that you do not believe her and that she is wrong, and the perpetrator is right.
- Don't blame the woman. Avoid questions such as "Why do you stay with him?", "Did you have an argument before violence happened?", "What were you doing out alone?", "What were you wearing?" Instead, reinforce that GBV cannot be tolerated.
- Avoid body language conveying the message of irritation, disbelief, dislike or anger toward the survivor.
- Do not judge a survivor's behaviour based on culture or religion.
- Don't pressure her to disclose. If she does not disclose, tell her what made you think about violence. Document your doubts and the evidence they are based on. Explain her that she can come back for further assistance. Bring up the issue at the next appointment.

Source: Adapted from Perttu/Kaselitz et al 2006, Warshaw/Ganley 1996, WHO 2003, WHO 2013

42

Integrating Psychosocia Support into Hospital Service

Psychosocial care is part of a holistic patient perspective and allows patients to seek information and emotional support from care givers to help them cope with their trauma. Hospital staff, especially nurses and social workers, play a unique role in supporting patients by building dialogue with patients, understanding their fears and concerns, knowing what is important to them and what relationships and other factors may influence their decisions, in their treatment and beyond. Through good communication and assessment skills, rapport can be built with the patients and their family. Adequate psychosocial care benefits the patients by reducing both psychological distress and physical symptoms and enhances coping skills and the will to live.

Nurses and social workers in KM Hospital, Mumbai and KMC, Chennai and clinical psychologists in National Burns Center, Mumbai and KMC

Dilaasa is a public hospital-based Crisis Center established to address the psychosocial needs of women facing domestic violence. It was established at Bandra Bhabha Hospital, Mumbai, India, in 2001. It is a joint initiative of the Center for Enquiry Health and Allied Themes (CEHAT) and the Municipal Corporation of Greater Mumbai (MCGM). The programme locates domestic violence as an issue within the larger societal context of gendered inequalities and violence and is pushing for recognition of domestic violence as a public health concern.

The focus of the programme has been training of hospital teams – both medical and paramedical – to be sensitive and responsive to the issue of domestic violence. Core groups of trainers have since been formed in five hospitals and a second crisis Center intervention has been set up in another public hospital, the Kurla Bhabha Hospital. Dilaasa also provides emergency shelter and legal counseling for survivors of domestic violence. It is a comprehensive approach that could be replicated in other public hospital settings in India.



Hospital, Chennai, engage with patients and their families to help them cope with the psychosocial aspects of burn related trauma. They build a relationship of trust and often have patients come to see them after discharge. They also do referrals for psychological counseling, physiotherapy or employment.

In each of the eleven districts of Delhi there is a Crime Against Women (CAW) cell, which, in addition to police personnel, has two counselors from Tata Institute of Social Services (TISS).

This is part of a joint initiative between TISS and the National Commission for Women, which is placing trained counselors and social workers within the police system with a clear understanding that violence against women is a crime and with the responsibility to provide women with psychosocial as well as legal support.

PCVC's experience in seeing women burn survivors and their family throughout the 'victim – survivor – thriver' journey strongly validates the need for integrating psychosocial support into burn care. The healthcare providers and social service providers are in a unique position to recognise the patients' distress and psychosocial needs. Empowering women burn survivors through support and education enables them to have some feeling of control. Research confirms that health care professionals who use empathy, understanding, and reassurance contribute to positive psychological outcomes for patients (Lin and Bauer Wu 2003)¹⁴.

Women survivors need sustained psychosocial support to recognise they are not to blame for the incident but to see it as part of a cycle of domestic violence; to develop their confidence and self-esteem and ultimately become empowered.

¹⁴ https://www.researchgate.net/publication/10581361_Psycho-spiritual_well-being_in_patients_with_advanced_cancer_An_integrative_review_of_the_literature



4.1 Enablers of PCVC's Model - Center for Excellence, Burns & Plastic Reconstructive Surgery Ward, KMC

With the support of the Tamil Nadu Government, the Burns Block at Kilpauk Medical College & Hospital (KMC) has become the Center for Excellence and Reconstructive Surgery Block, the largest dedicated burn-care center in South India. Due to the vision of Padma Shri Dr. Mathangi Ramakrishnan and the dynamism of her students such as Dr. V. Jayaraman, a fully equipped Burns Block has been established, ensuring that specialist knowledge, equipment and supplies are available, round the clock, to provide the timely care crucial in treating burns. Burn care facilities at KMC include: Burns Intensive Care Unit, Male and Female Wards, Pediatric and Post-operative Ward, Laboratory, X-Ray Room, Physiotherapy, Dietician, Blood & Skin Bank and, most importantly, a dedicated team of highly experienced burn-care professionals, Dr. Nirmala Ponnambalam, Dr. Angeline Selvaraj, Dr.G. Karthikeyan, plastic surgeons and nurses.

Kilpauk Medical Center treats over 2,500 burn patients every year. An average of 100-120 women are admitted to the KMC Burns Unit every

month. The majority are from low income households. Most of the burns are from kerosene with a few cases of acid burns.

PCVC estimates that close to 90% of these admissions are a consequence of domestic violence, either self-inflicted or inflicted by the husband or his family.

Tragically 50-60% of women admitted to the Intensive Care Unit at KMC die due to their burn injuries or to infections. Those that survive transfer to Kilpauk Medical College, Tertiary Burns Care Unit.

With the support of KMC and approval of the Government, PCVC have a full-time team presence on the Burns Unit and provide burn patients (survivors) with a range of psychosocial supports and physical inputs to complement the treatment provided by the Hospital.

http://www.gkmc.in/dept_platicsurgery.asp



4.2 On Arrival in Hospital

Immediately on admission to a major hospital, most burn patients will be taken to the Intensive Care Unit (ICU) - where available.

Patients typically spend several days in an Intensive Care Unit. Tragically many patients who have serious burns (more than 60% burns) do not survive beyond this period. Those that do survive will be moved to a specialised Burns Ward after several days or weeks.

The hospital inevitably focuses on physical treatment of the women, as with most patients, but in reality the needs of women burn survivors and their families are much more than just the physical treatment. Effective psychosocial support is essential at every stage of the journey through hospital and post hospital.

Initially the woman is traumatised and in a state of shock after the incident. Family members also go through trauma.

In most cases women survivors arriving at the Burns Ward are married and are either accompanied by their own family members (a parent, a sibling, occasionally their children) or by their husband and his family. In some cases they may be scared of potential criminal implications. It is not unusual that family members suddenly desert the survivor at this stage.

In situations of domestic violence, the partner and his family may convince her not to report the true facts of the incident, whether it was self-inflicted or a homicide attempt. In most cases, the incident is reported as an accident. The survivor is often convinced that it was her fault; that her actions led to the incident. Given her physical condition and concerns about her children and family, she is often coerced into

forgiving the partner and reporting the incident falsely following which her spouse and in-laws often abandon her.

Many patients will stay in the Burns Ward for between two and six months. There are many opportunities over this period for the PCVC team to support burn survivors in the Burns Ward at KMC to develop the self-esteem, self-worth and confidence they will need in order to fully recuperate and to build a life free of violence.

> PCVC is exploring the possibility of developing Regional Outreach Centers in and close to Chennai to provide burn survivors with some of the services currently available only at the Recovery and Healing Center, recognising many women find it difficult to travel to and stay at the Center for months at a time. Such Outreach Centers would allow PCVC to reach many more women burn survivors, at a more modest cost, and support their rehabilitation and transition to a violence-free life.

4.3 Psychosocial Support

Supplementing hospital services with psychosocial support to help women survivors to deal with this stress and trauma – and to recognise that their situation is a consequence of domestic violence - can be of huge benefit to the recovery of burn survivors.

PCVC has two team members based in the Burns Ward at KMC - a medical social worker and a welfare officer.

- The Welfare officer takes charge of the physical support (providing food supplement, disposable clothes, attending to her physical needs in the absence of the attender, providing support in taking care of the minor children)
- The medical social worker provides a range of supports to women burn survivors on the Ward. As a first step she conducts an initial intake assessment with each new patient on admission, covering personal details and impact on the survivor, details about the burn incident and support likely to be required from PCVC and starts to build up a file about her.

PCVC team begins the process of confidence building and empowerment using a range of tools and strategies.

One to one counseling

The medical social worker offers each burn survivor one-to-one trauma counseling based on the Solution Focused Empowerment Model (see section 2.3 above) supported by high-quality and interactive communication tools to help the survivor identify the effects and cope with her trauma.

The goal of one to one counseling is to start to address her fears (e.g. about the impact of the injury on herself or her children and about possible retaliatory behaviour towards her or her children or wider family, because she declared the true nature of the incident). The counseling sessions are also an opportunity to educate woman about the services of PCVC and the Vidiyal programme. Medical procedures and the crucial role physiotherapy plays in recovery are also explained during counseling sessions.

Communication tools

The communications material, entitled 'I have the right to begin anew' is an activity book for burn survivors developed by a non-profit social communications agency. It is designed to be used by social workers with burn survivors and their carers. It has information and activities to address physical and emotional aspects of burn care and rehabilitation. There are games and techniques to help healing and to deal with pain and emotions related to anger and fear. Each page has an affirmation for the survivor.

Interacting with survivors

PCVC organise visits to the ward by burn survivors who have been through a similar situation and are now successfully leading quality, violence-free lives. These survivors act as mentors and help to instill hope and positivity and acts as a catalyst for the recovery of burn patients on the Unit. Survivors can help women admitted to the Burns Unit to better understand medical procedures, the rehabilitation process, the importance of nutritional supplements The patients are usually very receptive to inputs received from other survivors.

PCVC also employ a number of survivors who provide a positive role model for patients.

Family counseling

PCVC team also engage with families of burn survivors to help them manage stress and emotions through group and individual therapy. PCVC's team facilitate sessions in such way that the family is able to share their anxieties and feelings of stress and gradually move from victim blaming to recognizing and accepting the woman as a survivor. This encourages them to empathize with the patient and be a support at this crucial stage when the burn survivor is distressed and fearful - about her children, her body and her future.

Art Therapy

50

Many forms of therapy continue to emerge for people who have suffered severe trauma. Art therapy is proven to be effective in the after effects of trauma, especially with survivors of abuse.

Commonly after the experience of trauma such as burns, there is a hesitancy or inability to discuss the incident openly. The impact of trauma is such that articulation of thoughts and feelings is very oppressive even with a therapist or a social worker. In the presence of domestic violence it is even more complex. Repressing all thoughts and feelings is one reason this can happen. In art therapy, much can be achieved without words. Expressive arts therapy moves the client and therapist from the traditional talk therapy roles and into a process that may be less triggering. The medium serves as a bridge between the woman and the therapist, allowing exploration to occur at a comfortable pace.

PCVC has been using expressive art therapy with women and children witnessing violence at home, and sexual abuse for many years. Different mediums are selected by the therapist to support giving voice to their experiences. Women do not have to worry about finding words as the medium speaks and acts as a support for their experiences. Most emotions

are better expressed through art than through language. Viewing their work after completion contributes to healing.

PCVC has recently introduced art therapy sessions with women survivors at the Burns Ward. These sessions help women express and share their feelings of trauma and in many cases provide testimony about how and why the incident occurred.

Play Therapy

Traumatic events such as witnessing a mother burning, or a parent inflicting burns on the other or themselves, or burns being inflicted on the child by the parent, can all be too stressful, debilitating, painful, and confusing for a child. Play therapy, using directive and non directive techniques, can help in recovery and healing.

PCVC are raising funds for a play area for women and children on the ward to create a comfortable, stimulating space in which to conduct play therapy, art therapy and other sessions to stimulate and enliven survivors.

Raising awareness on gender & gender-based violence

PCVC team help burn survivors to begin to understand the causes and consequences of domestic violence; helping women to recognise the cycle of domestic abuse and violence in which they may have been caught. This is a process that enables women to imagine and create more choices for themselves.



SNEHA (Society for Nutrition, Education and Health Action), a Mumbai-based nongovernment SNEHA organization provides counseling and crisis

intervention services for survivors of violence. A multidisciplinary team assists women through psychosocial support, police consultation, and legal processes. SNEHA collaborates with the Mumbai hospital to discuss and support referrals for survivors of violence, run a women's outpatient clinic, and provide counseling services in the burns unit.

http://www.snehamumbai.org/our-work/sanjeevan-mobile-health-van-siemens-and-sneha.aspx

4.4 Supporting Other Aspects of Hospital Care

In addition to providing psychosocial care to burns survivors, PCVC has developed a range of other services to complement those provided by KMC. These services focus on improving the physical wellbeing of burn patients. Such inputs help the medical team to improve patient outcomes, provide PCVC team with a valuable opportunity to build rapport with survivors and also instill in survivors a sense of being cared for and valued, in turn helping them to start to value themselves.

Hygiene

It is critically important to avoid infection of burn wounds. This requires wounds to be kept clean. Dirty sheets and bedclothes are a common source of infection of burn wounds.

A valuable addition to core hospital services, offered by PCVC on the Burns Unit at KMC, is the provision of new disposable gowns and bed sheets to burn survivors on a daily basis. This helps to maintain personal hygiene and so lessen risks of infection. The clean, white disposable gowns and sheets also make the patient and the bed look and feel clean which has a positive psychological impact. Practically it is also easier for medical team to notice stains and secretions from burn wounds and to treat these.

Nutrition

After the trauma of being burnt, survivors need a high protein diet and plenty of fluids to prevent infection, weight loss and malnutrition. Burn injuries can lead to tissue damage and severe blood loss. Survivors need a balanced diet rich in iron and protein to help heal wounds, create more blood and lead to a faster recovery. Likewise it is essential that burns survivors drink large quantities of clean water every day. Such a diet may be unaffordable for the family and carers of burn survivors from low socio-economic groups.

PCVC team provides female patients in the Burns Ward with a daily protein supplement, ENSURE, and other nourishing and tasty foods (including fruits, cheese, ice cream, dates, jam) and several litres of mineral water each day. They also advise women about the importance of a balanced diet and fluid intake.

During the process of handing out these items, there are many opportunities for PCVC team to develop a rapport with women and their carers, to facilitate the provision of psychosocial support.



Physiotherapy and exercises

Burn survivors are given a regime of exercise and other physiotherapy support by hospital physiotherapists whilst on the Burns Ward. However such services are not always well resourced and the physiotherapist on duty may not have sufficient time to spend with each patient.

PCVC team support this service by informing burn survivors of the importance of physiotherapy, often using photo albums and brochures, and giving them personal encouragement to perform the exercises advised by the physiotherapist.

In addition, caregivers are taught how to help survivors do simple exercises, move their limbs to prevent bed sores and keep mobile.

Discouraging early discharge

Some women are discharged early from the Burns Ward against medical advice. Typically the carers of the survivor can no longer manage to stay at the hospital to provide care - often because of a lack of money and because of care demands in their home.

It is not unusual that the family want to have the burn survivor back at home so she can take care of her children and do housework on their behalf.

PCVC team try to encourage each survivor and her caregivers to remain in the Burns Ward until medical team judge her fit to be discharged.

Where a woman is discharged early against medical advice, this fact is noted by the PCVC medical social worker on the Ward. She alerts PCVC team involved in home visits after discharge (see section 5.2 below) so that team can connect to the patient quickly and visit her. If, during a home visit, they find the woman uncared for or with infection she is encouraged to return to the hospital or attend an outpatient clinic.



National Burns Centre, Mumbai has psychiatric management as part National of Psychiatrist and clinical Psychologist aim to reduce the distress and Burns Centre improve the psychological well-being of patients. They use psychological methods and medications to make positive changes to their patients'

lives and offer various forms of treatment. Clinical psychologists often work alongside with psychiatrist in multidisciplinary teams in order to tackle complex patient problems.

- Assessing a patient's needs, abilities or behavior using a variety of methods, including psychometric tests, interviews, and direct observation of behavior.
- Working as part of a multidisciplinary team alongside doctors, nurses, social workers, education professionals, health visitors, psychiatrists and occupational therapists.
- Devising and monitoring appropriate program of treatment, including therapy, counseling or advice, in collaboration with colleagues.
- Offering therapy and treatments for difficulties relating to mental health problems such as anxiety, depression, addiction, social and interpersonal problems and challenging behavior.
- Providing consultation to other professions, encouraging a psychological approach in their work.
- Providing short-term and longer term scientifically-based treatments for issues such as grief, adjustment difficulties, stress, anxiety, trauma, depression, relationship problems, and stress secondary to medical diagnoses/illness.



The Department of Plastic Surgery at Ganga Hospital, Coimbatore, has been in the forefront of trauma reconstruction and microsurgery and has taken great initiatives for the care of burn patients. The project "Hope after Fire", for the correction of post burn deformities is a joint initiative of Ganga Hospital and the Rotary Club of Coimbatore Metropolis. Through this project over 200 major reconstructive surgeries with an outlay of over Rs 70 lakhs have been performed free to the patients and continue changing the lives of patients and their families. Setting up of the skin bank is an initiative

of Ganga Hospital to improve the outcome in acute burns. It has been done with the guidance of the National Burns Centre at Mumbai which pioneered skin banking in India.

http://www.gangahospital.com



http://www.burns-india.com/

4.5 Supporting and Providing Caregivers

Caregivers play a crucial role caring for women survivors on any burns ward. Caregivers are usually immediate family of the survivor (mother, sibling, sometimes children) or members of her husband's family.

PCVC team spend time with caregivers, one to one and sometimes in group sessions, giving them advice on how to best support their family member, both physically, (hygiene, nutrition) and how to best give appropriate emotional support to the survivor. PCVC team are available to answer questions and to help caregivers connect with doctors, nurses and other hospital staff.

For women in the Burns Ward at KMC, left without any family support, PCVC can also offer attender services and make care arrangements for her children, until a responsible family member is traced.

In some instances PCVC team have found children of ten years and younger as sole caregivers for their injured mother. In such cases PCVC

has provided a caregiver and made arrangements for the children to move in with a relative or to a home. PCVC has also supported children when their mother has died and their father abandoned them, placing them with relatives and taking care of their basic needs, schooling and providing children with psychosocial support to cope with their loss. For children who have witnessed violence, long term counseling support can be provided by an experienced child psychologist.

The pressure and stress on caregivers is immense – many women come from far-off districts, have no support system in Chennai and belong to low-income groups - often daily wage labourers. Expenses mount and time spent in hospital is time spent away from work, children and other responsibilities. Caregivers often go into debt. Involving them in the emotional life of survivors and helping them understand the trauma and its impact is crucial to ensuring that the women receive quality care.



4.6 Medico-legal Arrangements

A burns case is always treated as a medico-legal case. It is a legal requirement that the treating doctor report the case to the police immediately on completing any necessary lifesaving medical care. This is in accordance with Section 39 of The Code of Criminal Procedure, 1973. The need of informing the police in case of a suspicious burn injury is also a social and moral responsibility.

The existing laws make investigation mandatory for all unnatural deaths of married women within seven years of marriage. According to Ministry of Health guidelines, a panel of two doctors is required to carry out the post-mortem examination on the body of a married woman 'dying of burns (or other reasons)' within seven years of her marriage or if her age was less than 30 years at the time of her death in suspicious circumstances. According to The Dowry Prohibition (Amendment) Act, 1986, suspected suicide or suspicious death of a woman who has been married less than seven years must be subject to an inquest by a magistrate. If the family of the woman requests such an inquest, or if a police officer has any reason to think it necessary, an inquiry must also take place.

Practical implications

Many government hospitals, including KMC, have a police kiosk within the hospital. On arrival at hospital – and once the woman's condition has been stabilised – the doctor or other hospital team will inform the police about the case.

The woman or caregiver (s) will be asked to make a statement explaining how the burn happened and will have to complete a form confirming these details. An acknowledgement of receipt is taken for future reference.

The medico- legal assessment in burns cases should include

- Extent of burns degree, depth, % of body affected
- Reference to causative agents dry flame, chemical, electrical, kerosene
- Whether the person sustaining the burn injuries was fit enough to give a statement or was compos mentis to give a dying declaration
- Cause of death
- The time since injury and manner of injury
- Whether the burn injuries were sustained before or after death

54

A docket number is provided and is documented in the patient's records in case the patient wishes to follow up the case at a later date. The police will ask whether the patient intends to file a case. If at this stage a case is not pursued, the patient has the right to file a case at a later date.

In almost all cases, while giving these statements, women are in a state of physical and psychological trauma. They need time and support to understand their situation and to recognise the cycle of domestic violence they have lived with. Research studies show that counselor records are often very different and far more detailed than these official statement made to the police. It may be the case that after a period of psychosocial support, the survivor comes to understand that the kitchen accident was part of a cycle of domestic abuse and violence, and chooses to take action against her husband. A survivor can decide to instigate criminal proceedings at any point after the incident, providing the case has been properly documented and registered on admission.

Doctors involved in the knowledge sharing events recently held by PCVC report that it is often evident from the pattern of the burn whether the incident is a homicide or suicide attempt: "A women admitted in the hospital with 95% burn and 6 months pregnant told the police the usual story of accident that she was in the kitchen and a 'diya' fell from top and her cloths caught fire - though it was clearly evident that it was not the case and she was a subject of domestic violence. She died." Doctors at these events also report that they often feel helpless when they see a woman reporting the incident as an accident when they know it was not an accident: "In such cases we do not know what to do, nor are we aware legally if we can intervene or not. And even if we want to, professionally we may not be permitted as each such case may take lot of time in terms of going to court for legal proceedings".



4.7 Awareness Raising Activities in the Community

PCVC runs community awareness programmes with hospital doctors. Doctors from the Burns Unit deliver awareness sessions in schools and the community. PCVC's social workers, survivors of burn violence along with interns from social work schools also organise awareness programs in the urban slums to create awareness on burns and domestic violence. PCVC's crisis line number is also shared with the community.



Make Love not Scars (MLNS) is a non-government organization dedicated to provide acid attack victims an opportunity to regain their life on their own terms through recovery, rehabilitation, and reintegration.

https://makelovenotscars.org/

Comprehensive health promotion and domestic violence awareness raising programmes are needed in local communities, including through schools, addressing the lack of acknowledgement of the relationship between burns and domestic violence, the lack of awareness of how quickly a 'few drops' of kerosene once ignited can cause horrific burns and the lack of awareness of appropriate burn treatment.

Such awareness raising programmes are needed widely in Indian society.

Many women survivors, especially from disadvantaged backgrounds, have said that they would not have burnt themselves if they had known how life-threatening, often irrevocably, burns can be. But they had often been influenced, and misinformed, by neighbours, friends or family into using burns as a threat to end abuse and violence - only to discover that the damage can be intensely painful, disfiguring and life-long.

4.8 Prior to Discharge

Women often feel fearful and insecure at this point and may be in great pain. She may be bandaged over much of her body, incapacitated and reliant on others to clean and dress her wounds and help her with showering and feeding. She may be highly distressed thinking about who will take care of her once she returns home and also fear further abuse. She may fear that her physical appearance will impact on her sexual relationship with her husband and that her children will be scared of her disfigured face or body. She may be unsure if her husband and his family will want her in the house, because she can no longer play the role of caregiver and fulfill the sexual desires of her husband, but may have nowhere else to go.

Alternatively her own parents or siblings may be left with no choice but to care for her. But they may in turn worry about the social stigma of having

her, badly disfigured, in their home. They may also be burdened with thoughts about instructions from the doctors on wound care, hygiene, nutritious food, medicines, regular visits to the hospital, further surgeries and the financial implications this would have on them.

PCVC's team works closely with survivors at this anxious time, helping women share their fears and express their emotions. The social worker and welfare officer use positive stories and examples of other burn survivors to help women to understand how to manage their emotions and feel positive about themselves. They assure survivors that the PCVC team will remain in touch after discharge from hospital, through phone calls and home visits. Similar counseling sessions are undertaken with caregivers. The idea is to appreciate the caregiver who has tirelessly been

It is also very important that the burns survivor has adequat information on discharge concerning

- Dealing with trauma
- Nutrition needs
- Wound care
- Dealing with scars
- Physiotherapy and exercising
- Managing muscle contractions

The PCVC medical social worker discusses these matters in detail with each patient and, as far as possible, with her caregivers, just prior to discharge



in the hospital for weeks or months and explain the role she or he can play at home to help the speedy recovery of the burn patient. PCVC team also assure the family of the support PCVC will provide post discharge and the importance of rehabilitation. At times, joint sessions are held with the woman and her family prior to discharge, where each are able to share their concerns and fears so as to facilitate smooth transition from hospital to home. PCVC have also commissioned innovative communication materials for burn survivors and their caregivers to communicate key messages in an accessible way. This material is available to survivors to take home to help them and family members to be informed about care needs and to reflect on their experience and take positive action.





Support in Rehabilitation Services

SHOWT NURRA D

14.2

5.1 Overview

The rehabilitation process can be summarised as follows. These steps are expanded in the sections below:

Step I: Psychosocial support in Hospital

Step II: Home Visits (typically two or three visits, more as required).

Step III: Follow up by phone (typically once every two weeks over six to twelve weeks).

Steps IV, V & VI: Services at PCVC's Recovery and Healing Center (as required)

• Intake

- Assessment (Physical & Psychosocial)
- Service Plan developed, covering:
 - o Hygiene
 - o Nutrition
 - o Wound care
 - o Physiotherapy and exercise
 - o One to one counseling
 - o Group and family therapy
 - o Exposure trips and social events introduced
- Monthly Review (informs Service Plan and implementation)
- Discharge planning

Step VI: Discharge





5.2 Returning Home – phone follow up and home visits

Burn rehabilitation is slow, time consuming and often very painful for the survivor. Considerable support is needed at this time when survivors may be feeling frightened, lonely, neglected and in pain.

Once a burn survivor is discharged from hospital and returns home, it is very important she continues to receive psychosocial care as she learns to deal with the effects of her disfigurement and any disability and that she continues to have encouragement and guidance to take care of her wounds and undertake the physiotherapy, exercise and nutrition regime that will greatly aid her recovery.

Many women burn survivors return to homes a significant distance from the hospital where they have been treated and are then constrained in visiting the hospital for any follow-up treatment by the limitations of their injury, cost of transport, family demands and potentially social norms about women travelling. At the same time, the nature of outpatient services for burn survivors are limited.

In some cases, the husband and his family are fearful that the incident will be investigated and do not want to take the woman to the hospital again in case she, or they, are questioned.

It therefore falls on non-profit organisations like PCVC to provide home visits and other follow up support. In this section we set out the approach taken by PCVC in supporting the rehabilitation of burn survivors on

their discharge from hospital; in the hope that this model is of interest to other agencies working or planning to work in this area.

Phone Follow-up

PCVC team try to make contact with all patients discharged from the women's Burns Ward at Kilpauk Medical Center. Before her discharge, they will ask each patient for a phone number and proof of an authentic address through which they can make contact.

Phone follow up is undertaken by a social worker trained in phone etiquette (tone, pace, pause, hold) and counseling skills. She calls the patient, typically after one or two weeks, to find out about her physical and psychosocial recovery. Based on the information collected, a home visit may be planned. If the woman has open wounds and is still in the recovery process or if scar formation is at an early stage, PCVC's physiotherapist/wound care specialist will accompany the social worker on the home visit.

Home Visits

Occasionally when they cannot make contact over the phone, PCVC team will call at the home address when conducting visits nearby.

If the distance means it is not feasible for PCVC team to visit directly, they will try and locate and contact former women survivors in the area, briefing them over the phone and asking them to make an initial visit to the newly discharged patient and to give PCVC a report so they may decide on appropriate follow-up actions.

It is not uncommon that a woman burn survivor finds that her husband and his family refuse to take care of her on her discharge from hospital. Indeed some survivors are too fearful to return to their married home for fear of further abuse and violence. In many cases survivors move to the home of their parents or are taken in by siblings.

Whatever her home context, PCVC endeavours to offer ongoing support to a burn survivor once discharged from hospital.

PCVC offer almost all burn survivors discharged from KMC the opportunity to benefit from services provided at the PCVC Recovery and Healing Center, Chennai, on a residential or outpatient basis.

Many women initially try to manage at home without this support, believing they need to try and return to their former role of parent, wife, caregiver. Some find that the support of PCVC on a home visit basis is sufficient for their rehabilitation and recovery. Many find that they cannot manage the demands of rehabilitation in their home context and seek admission to the Recovery and Healing Center after a number of weeks or months. The services provided at the Center are set out in section 8.3 below.

During home visits, the PCVC team identify the physical, psychosocial and economic conditions of the woman at home, offer her guidance and support and to assess whether she wishes to be taken to the Recovery and Healing Center or if she needs re-admission at KMC (e.g. due to infection of wounds or contracture of scars). In situations where there is ongoing domestic violence, home visits by the PCVC Team gives the woman an opportunity to disclose if she is feeling unsafe or harassed. The team develop a treatment plan covering psychosocial needs of the survivor and physical requirements. A physiotherapist or wound care specialist accompanies the social worker for home visits if the woman is thought to have open wounds or scar formation, to advise on wound care, stretching exercises and other aspects of rehabilitation. If the woman needs reconstructive surgery, she can be referred to KMC and supported to undergo the surgery.

Psychosocial support builds on the interactions between the survivor and PCVC team during her hospital stay (see sections 1.2 and 4.2 above). It often includes one-to-one counseling with the survivor, working to build her self-esteem and confidence and practical problem solving with her to help her think through how to cope with the situation she is in and the options available to her.

Physical support includes dressing and taking care of wounds and guidance on physiotherapy and exercising to improve mobility and reduce the risk of contractures. This also helps PCVC team to build rapport with the survivor and so facilitates the provision of psychosocial support.

PCVC team will also, where relevant, engage with her family to acknowledge and strengthen their support to the survivor. This may involve encouraging the family to cope with physical and emotional stress of caring for the survivor and managing the financial implications of the injury and treatment. It may also involve helping the family to deal with the stigma associated with kitchen accidents, particularly where the injuries are believed to be self-inflicted.

Typically women receive two or three home visits although where there is a need, the number of visits can be much higher.

Advice provided by PCVC team during home visits has been documented in a set of health promotion materials. A selection of these materials are included in the annexe. Key messages are set out below:

Wound care

Wash wounds regularly in clean water. To ensure water is clean it should be boiled to purify and allowed to cool fully. Sooth scars and wounds with clean water. Do not scratch. Keep wounds dry. Change dressings daily or more frequently if they get wet. Do not burst blisters. Do not apply greasy lotion, ointments or other substance to wounds. Seek medical help if there is odour, pus or other discharge from the wounds. Wear loose fitting cotton clothes. Avoid sunlight on the wounds.

Using pressure garments to limit scarring

Scars are thickened marks left after a burn has healed. Scars occur when burnt skin tissue is replaced by more fibrous tissue as it heals. Pressure garments help stop scars forming or progressing and need to be worn once wounds have healed. Survivors should be provided with pressure garments prior to discharge from hospital. During home visits, PCVC team will check that survivors have appropriate pressure garments and are using them properly.

In summary, pressure garments should be worn 24 hours a day even when asleep (but not when bathing or having wounds dressed). They should be changed every day for a clean garment (therefore survivors need to have at least two of each garment) and should be used with creams or oils advised by a physiotherapist or doctor. Garments should be washed in a mild shampoo and allowed to dry flat in the shade. They should not be rung out, ironed, dried in the sun or brushed.

Preventing contractures

Burn scar contractures are tightening of the skin after a serious burn injury. When skin is burned, the surrounding skin begins to pull together,

resulting in a contracture. It needs to be treated as soon as possible because the scar can result in restriction of movement around the injured area. Burn scar contractures do not go away on their own, although may improve with regular exercising of the affected area and with use of splints. If not managed in this way, the patient may need the contracture to be surgically released. It is not uncommon for burn survivors to have to return to hospital for this treatment, bringing additional demands on the survivor and her family.

Wearing a splint on a joint can help keep it straight and prevent a contracture. Splints should be worn on top of the pressure garment.

Range of motion (ROM) exercises help keep the muscles and joints of the burned limbs flexible. A physiotherapist will determine an appropriate exercise regime to best encourage the healing process. Exercises are very important to keep the scar area stretched and prevent a contracture developing.

Nutrition

Burn injuries cause tissue damage and usually cause large quantities of blood loss. A balanced, protein and iron rich diet is needed to heal wounds, help create blood and lead to a faster recovery. Small, easy to digest meals should be eaten frequently and the survivor must drink large volumes of clean water. Recommended foods include chicken, eggs, fish dhal, chana, bananas, spinach, orange, limes, dates and beetroot. Tea, coffee and spicy foods should be avoided.



5.3 PCVC's Recovery and Healing Center for Women Burn Survivors

5.3.1. Overview

The purpose of the rehabilitation process is to help the burn survivor effectively manage her physical needs as part of the recovery process and to help her explore her own strengths and potential, gain confidence and realise her own self-worth and to obtain skills that will help her move beyond the impact of the burn incident. PCVC team work closely with

Challenges in joining the center/continuing rehabilitation



each survivor on this recovery process, helping her to see the incident as a turning point in her life and to move on to a life free of abuse and violence.

PCVC's Recovery and Healing Center is fully equipped with necessary equipment and facilities for the physical and psychosocial healing of women survivors along with a residential facility.

The Center accommodates up to 15 women at any one time and stays are typically for periods of three to six months and sometimes longer depending on their needs. Accommodation is clean and simple and organised to balance the benefits of communal living with some private space. Women stay in small dormitories. There is a well-equipped kitchen and dining area. The main rehabilitation room has an extensive range of equipment for the physiotherapy and exercise needs of residents.

The Center is discreetly located in a residential area and unmarked to prevent unwarranted attention.

Women receive free accommodation and all their basic needs are met alongside the physical and psychosocial burn care.

There are a number of reasons that prevent or delay women burn survivors from attending PCVC's Center: belief that her long hospital stay was sufficient for recovery; lack of understanding about the need for

 $PCV_{2017}|_{65}$

and benefits of ongoing treatment; concern over losing the relationship with her husband and children should she stay in the Center for weeks or months; her family's unwillingness to let her go to the Center for another long stay, after an extended period in hospital; family demands such as household chores and childcare; in some cases her husband may not trust her to stay in an unknown place with strangers.

During the home visits and follow-up phone calls, the PCVC team help survivors to work through such issues and to make their own informed decision about whether a stay in the Recovery and Healing Center is the right thing to do. Many women come around to this view after a period of weeks or months at home. A survivor may start to realise that that the care she is receiving at home is not sufficient to aid her recovery. She, and her caregivers, may realise that she cannot take on childcare and other domestic responsibilities. She may start to see rapid scar formation and notice that she is becoming less mobile, that her movements are restricted – and connect that with information received in hospital about the need for continued physiotherapy. Caregivers may also realise that taking care of the survivor is a full-time job and they may not have the time, energy, resources or inclination to do so.

Psychosocial therapy..

rediscover and reconnect with their own resourcefulness in resisting avoiding, escaping, and fighting against the abuse

develop a vision of a life free of violence

empower women to reexperience their personal power in bringing positive changes to their lives

"The future exists in our anticipation of how it will be" (Cade & O'Hanlon, 1993

Assessment and Service Plans

In the first week of the woman's stay at the Center, a Service Needs Assessment is undertaken to assess the woman's needs in terms of physical and psychosocial care (including daily living needs, participation in activities, interpersonal relations, support for children, financial needs, legal assistance). A PTSD (Post traumatic stress disorder) assessment is also done to establish whether the woman has symptoms of PTSD which will inform her care. A physiotherapist also evaluates her needs and establishes a tailored exercise and physiotherapy regime as part of her service plan. The survivor's progress against this service plan is reviewed at least monthly.

Psychosocial Support

Counseling and Therapy

Women are usually very distressed and vulnerable when they first attend the Center. They are often worried about the well-being of their children, left in the care of parents or in-laws. They may fear the husband will remarry and that their parents will not allow them to return to their natal home and they will be homeless and destitute. They may worry about whether children will visit and if they do how they will react to their mother's disfigurements and how they are coping having witnessed violence and the burn incident.

They need considerable one-to-one and group support at this vulnerable time.

Women at the Center are supported with regular one-to-one counseling sessions by PCVC team using the Solution-focused Empowerment Model (Section 2.3.1) which aims to support women to understand their situation, the context of domestic violence they have lived in and to make their own decisions about how they wish to live their life.

Each survivor is supported to develop the skills and resources needed to achieve a life free of violence, which may include vocational training and employment so as to become economically independent.





One to one counseling is also supplemented by group therapy and art therapy sessions – led by a skilled team – to help women build selfesteem, self-acceptance and life skills. Dance therapy is also provided on an occasional basis. These activities encourage survivors to find and express their own creativity and help further strengthen group dynamics and opportunities for group support.

Support group sessions are conducted once a month and bring together survivors who have finished their rehabilitation and left the Recovery and Healing Center with those who are currently residential. Sharing of experiences, feelings and challenges faced at different stages in the rehabilitation process help women learn from each other and also build a strong emotional bond. Social workers and interns also use this opportunity to plan recreational activities, share useful information about government and other schemes, inform them about opportunities for skill building

Exposure trips and social events

Women go out together on a regular, at least monthly, basis, to get used to being seen by people and having to deal with stares and comments in response to their disfigurement. On return, a skilled counselor helps the women reflect on and learn from the experience. These trips help survivors to build confidence about their appearance and the ability to deal calmly with any reaction they may receive.

> "I used to fear to even step out of my home. When I was told we were going to the mall the next day I was crying with fear the whole night...I closed my face with a dupatta when I left the rehab. When we came back after the outing the dupatta was tucked in my bag, the time I spent in the mall and enjoyed so much with other women, I even forgot I had scars." – Kalpana, 22 years, works in a garment company

These trips and other social events held at the Center help survivors to begin to enjoy 'normal life' and to move on from seeing themselves primarily as burn victims but rather as confident women who can engage socially in a range of different settings.



Communal living

Staying together with other women who have been through a similar trauma also has a positive impact. The survivor begins to feel that she is not alone and starts to recognise that the experience of domestic violence is widespread. The element of self-blaming begins to diminish and she is able to build a support system for herself. Listening and sharing each other's stories and journeys has a healing effect on the women and a sense of solidarity develops.

"I used to cry all the time, when doing my exercises or having lunch. Nights were scary. I missed my three and a half year old daughter so much. Will I be able to see her again? In the evenings when we sat together we shared our day, and when it came to my turn I used to only cry. But gradually listening to the other women I felt I was not the only one, many had even younger children and we were here to put in our best to recover, find our strengths and 'begin anew'" - Shyamala, 28 years, works at a café

The women receive a daily living training and an individualised living program is built to address their physical condition and psychological needs. They share chores and take responsibility for certain tasks at the Center. This also helps in slowly getting back to independent living, like showering, wearing clothes, making her bed, folding her blanket, The women share work, encourage each other and are supportive to one another. Given the diverse backgrounds the women come from, they learn to value each other's differences and appreciate each other's strengths and competencies, be it cooking or cleaning, stitching, painting, drawing, poetry, singing, dancing, making music, acting, jewellery making Build a network of survivors at state and national levels to encourage better sharing of information, opportunities, challenges, case studies and good practice to improve the survivor experience.

A range of therapeutic strategies are used in the Center to help women come to terms with their body image and develop their capacity for independent living. Work with mirrors helps women to accept their disfigurement, explore how make up can enhance their appearance, and learn to speak positively to themselves in front of the mirror. A shared 'living room' allows women to watch television together and share stories, discuss skills or talents they would like to develop, explore business ideas and opportunities for independent living. A writing wall and boards allow women to display their art work, poetry,

The PCVC caretaker at the Center has a challenging role in helping women settle into a new living arrangement: living with others, building relationships, coping with Post Traumatic Stress or other emotional or behavioural disorders, disturbed sleep patterns, use of medications, She gives positive support and helps them through the recovery process.

Graduation events

The PCVC team typically organise a Graduation Event for women just prior to their discharge, helping them to recognise and celebrate the journey they have made, mentally and physically, since their burn

I was the happiest, my husband and daughter were there with me. It was a like a birthday, a cake too, and a gift for me. This was my first graduation ever and I deserved it. I was told in the hospital that surgery is the only way to release my neck. But see now I can move my neck. I was determined to follow the exercises. I reached the edge at times, wanted to give up. When I saw the results of the exercise and the pressure garments, my run to the goal increased each day. Here I was celebrating myself". - Parvathi, 28 years, Homemaker

incident. The event is also a motivation for other women in the Center to strive for their own graduation. Caregivers of the survivor are invited to take part in the event.

The PCVC Team and other survivors share positive experiences about the survivor. The survivor speaks about her journey, her dreams and goals for her future. Caregivers are also invited to share positive stories. Witnessing the graduation and hearing what people have to say often helps caregivers understand the journey survivors have made.

Other celebrations

"Any festival was a joy, we celebrated together, danced and sang songs, forgetting the pain, nothing in our minds just letting our bodies move to the music."

Birthdays and festivals are also celebrated at the Center. The women are involved in the planning, they prepare dishes and take part in cultural activities including music, dance and drama. This helps them to distance themselves emotionally from their trauma and gives them space to be themselves.

Other forms of physical therapy

Women are taught practical skills such as quilling for making jewellery and crafts. This has practical benefits in terms of using their hands and fingers which have often received burns and sometimes can be sold for modest income. Physical therapy like this, undertaken in groups, also provides an opportunity for women to be together and to talk about their experiences and learn from and offer support to each other.



Emphasis is needed on promoting healthy relationships between women and men that are built on mutual respect and understanding.

Understanding Domestic Violence

During all of these psychosocial interventions, women at the Center are helped to better understand the dynamics of domestic violence and how it has impacted their life prior to the burn incident and to comprehend the incident as part of these wider dynamics in society. Understanding the root causes of violence helps the women recognise all forms of violence and their right to a life free of violence - at home, in public spaces and the workplace.

> "I thought it was always my fault. He was nice to everybody, it was something I did that made him angry and hit me. The counseling, group sessions and sharing sessions made me recognise this was violence and not my fault. This realisation is like an 'awakening' I feel I can focus on my exercises, I am able to decide what kind of job I will enjoy and what I want to be. My growth is in my control." – Janaki, 32 years, works in a beauty parlour

Physical Support

Physical healing is important in itself and for its positive impact on the emotional wellbeing of survivors and in convincing their families of the benefits of remaining at the Center until treatment is complete. Physical Alongside tackling wider gender norms, there is a need for strong health promotion messages around how to minimise the risk of burn injuries and how to treat burn injuries when they do occur – there are many cases where injuries are made worse due to inappropriate immediate treatment (such as removing garments stuck to burnt skin or applying creams or ointments that may cause infections or other substances that further damage the skin).

rehabilitation covers the following areas:

Wound care

The care team at the Center ensure wounds are washed and dressed on a daily basis.

Showering

Women are helped to shower every day, helping to keep their wounds clean and free from infection.

Scar prevention and management

The team in the Center ensure that survivors wear appropriate pressure garments in order to limit scarring. Wearing a splint on a joint can help keep it straight and prevent a contracture. Splints should be worn on top of the pressure garment.

70 | PCV2017

"It's not easy. Seven hours and more of exercises, wearing pressure garments 22 hours, massaging the oil on the scars, it's all very hard. The physiotherapist would hold my hand and help me do the exercises, those words "you can do it, try" is what kept me going. While doing the exercises my thoughts were constantly on "where will I go from here? "will I be able to work again?" The therapist shared the experiences of other clients who are now living with their children and doing jobs. She even showed me their photos. It made me smile" – Danalakshmi, works at a café

Physiotherapy and exercise regime

Each woman at the Center has a personal physiotherapy and exercise plan developed with PCVC's physiotherapy team to help prevent scar contractures. Women can also avail of massages and yoga classes to help limit contractures and improve mobility.

Nutrition

The Center provides all meals for women. Meals are selected and prepared to ensure a diet rich in iron and protein.

Eye surgery

The Center is also able to offer some reconstructive eye surgery through speciality hospitals like Sankara Nethralaya, a not for profit eye hospital in Chennai (www.sankaranethralaya.org) and the support of philanthropists.

Outpatient support

"I did'nt want to leave my children at home and come and stay at the center. So, even though the social workers explained the benefits of coming to the center during the home visits and phone calls I did not go. Finally, I shared with them that I already left my children for 7 months when I stayed in the hospital and I feared they will not come back to me if I leave again. I learnt about the option of 'outpatient support'. Although I had to leave home early I still managed to finish my physiotherapy and come back to be with my family. I was part of the quilling sessions and now I make jewelry at home. I feel my time at the center has helped me 'open up my life', I attend leadership sessions and workshops and I'm confident my journey of success has begun." -Sulochana, 25 years, runs a business in her home town"

For burn survivors unable to stay at the Center or whose injuries do not require a full-time residential treatment regime, they can receive outpatient support from Center team.



Educational and psychosocial support for children of survivors

On discharge

"From under the sheet I saw my father push my mother's head down and pour kerosene on her and lit the matchstick. I hugged my little brother and cried silently till he left the room.
My grandmother took care of us for two years and now we are in a boarding school. I want to become a doctor I think sometimes, or a social worker and help many children like me who see their parents fight." - Kavitha, 12 years, her mother died in the hospital out of burns

PCVC also offer a comprehensive programme for children who witness violence at home (including attempted suicide by their mothers or attacks by their fathers or family) through the SMILES programme – see section 6 below.

"I used to get angry in the beginning, I was struggling to look after the kids and go to work. The weekly visits and counseling helped me realise she was not on a holiday here. When she was ready for discharge, I was ready too to understand the continued support she needs from all of us at home."- Ramesh, a survivor's partner

Once the survivor has achieved the goals agreed as part of her personal plan, usually after several months, arrangements are made for her discharge. A discharge meeting is held between her and the PCVC team involved in her rehabilitation. A meeting may also be arranged with her family to explain to them the regime she will need to continue after discharge (continuing exercises, wearing pressure garments, attending group support sessions, periodic reviews,) At this point women are very much encouraged to give feedback on their experience in the Center and to identify ways to further strengthen the service.


Wider Social and Economic Empowerment 6

and Lar

For many women burn survivors their worst fear is to return to the house of their abusive husband. Not only may domestic violence have been the cause of their burn injuries but survivors often find that domestic violence is a consequence of their injuries - as their disfigurement and disability prompts anger or disgust in their abusive partner or in-laws.

In many burn cases, women have reported that the need for them to ask for money from their husband or partner was one of the reasons why the incident took place.

The experience of PCVC has shown that women who are economically dependent on their husband are often forced to go back to an abusive situation and are unable to break free from the violence.

When individual goal plans are developed at PCVC's Recovery and Healing Center, women are asked to share what goal they aspire to. The majority of the women say that they want to earn money and to become financially independent. For women who do not want to return to an abusive relationship but have no other means of support, PCVC assists them to enroll in skills training with the goal of ultimately finding employment and being able to live an independent, fulfilled life.

> Involvement of men – particularly those with the status to change power structures and break the silence surrounding domestic violence – is needed. People should speak up when they witness violence and men should challenge men who subject women and girls to violence and violent situations.

"Whenever I ask him to give money for household expenses and for children's school fee he will beat me or shout at me"

" I always felt not valued and disrespected because I was not earning money"

"Because I was not contributing to family income, I had no say in any family decisions"

" …that day like any other day, I asked him for money to get rice for children, he shouted at me and refused…I felt very angry and humiliated…and decided to kill myself…"

Make Love not Scars (MLNS) is a non-government organization dedicated to provide acid attack victims an opportunity to regain their life on their own terms through recovery, rehabilitation, and reintegration.

https://makelovenotscars.org/



Experience of PCVC has shown that when a woman starts to earn money, the power dynamic and her ability to negotiate within the relationship change positively. It helps her to take more informed decisions.

Ultimately, women may choose to live independently or go back to the partner, in either situation their level of confidence and ability to assert themselves is enhanced by their financial security.

The emphasis is not just on earning and becoming independent but also on the survivor's personal growth, to explore possibilities and learn what she has always wanted to do or to become.

Forms of skill building training offered under the Vidiyal project include restaurant kitchen training and working as a 'chef' in 'Writer's Café.

Economic empowerment is a key pillar in PCVC's model. It is approached as follows:

- At the Recovery and Healing Center, there is often a mixed of women undergoing physical rehabilitation while others have moved on to training and skill building. Living together gives them the opportunity to interact, share experience, doubts, fears and to find solutions from within the group.
- Exposure visits and interactions are also organised with other women in training or employment.
- Thriver sessions are organised for the women including work ethics, employee responsibility, employee rights, awareness on laws related to sexual harassment at workplace,
- PCVC collaborate with several skill-building institutions, which offer women a range of opportunities and options. They provide non-traditional skills training opportunities and open up avenues for them to move into reasonably paying jobs.



The Writer's Cafe, located in Gopalapuram, Chennai, has bright, sunny interiors. Its large glass windows allow dappled sunlight to fall on the wooden tables enabling the inquisitive customer to peek into its kitchen. The menu covers a range of Swiss-inspired pizzas and pastas, and is easy on both the tummy and the wallet. The sunlit, airy feel of the space is reflected in the attitudes of the people who run it, a majority of whom are women burn survivors.

Started by M Mahadevan, the proprietor of huge restaurant chains like Hot Breads and French Loaf, the Writer's Cafe employs seven women burn survivors in its kitchens, and donates 100% of the proceeds to the The International Foundation for Crime Prevention and Victim Care (PCVC) – an NGO that works toward the rehabilitation of women burn survivors. More women are currently being trained to join the Writer's Cafe and its future endeavours. Plans are in the offing for a second outlet in Adyar,

76

Chennai and a third in Church Street, Bangalore. The association with PCVC began when Mahadevan decided that merely donating money every month wasn't a sustainable solution. So he set up the Writer's Cafe with the express goal of rehabilitation of women burn survivors.

At PCVC, training in a range of skills and disciplines including nursing, DTP, driving, IT and Optometry are provided through a collaboration with ANEW (Association for Non-Traditional Employment of Women).

ANEW offers FREE training and placements to economically challenged women in the following areas:

- Auto/Car driving (certified by Maruti ABT Driving school)
- Home nursing (certified by Sundaram Medical Foundation)
- Basic IT Skills (certified by NIIT Foundation)
- Desk Top Publishing Applications (certified by NIIT Foundation)
- Web Designing (certified by NIIT Foundation)
- TALLY & Accounting (certified by Veetech software solutions)
- Optometry (certified by Sight Care Foundation)
- Hearing Impaired IT Skills (certified by NIIT / Wadhwani Foundation)
- Career Readiness Program

Other women are supported to continue their education and to graduate – directly or through some form of distance education.

Another important support provided by PCVC in certain cases to assist survivors to maintain their economic independence and their emotional well-being is to contribute to the psychosocial health and costs of education of their children - through the SMILES programme. The programme also supports children who have been injured in a burns incident and/or who accompany their mothers to the Center as they have nowhere else to stay. In some cases, financial support is provided to help children continue with their education. The programme offers children a range of activities including support group sessions, team building through excursion trips, art therapy, vocational camps These initiatives not only help children deal with the trauma they have experienced or witnesses but also help in rebuilding their trust in relationships.

Women survivors who, after going through the Recovery and Healing Center, opt for an independent life, physically, emotionally and economically or who have been deserted by their families and have no

home to go to, can also avail of support from PCVC to help them find suitable and affordable accommodation.

Chaavn Foundation in Delhi initiated Sheroes, café shops or hangouts managed by women acid attack survivors. As well as providing employees with an income and the opportunity to be economically independent, the work gives them the chance to engage confidently with people in a public setting. This helps to break down their inhibitions about their physical appearance and to learn to deal with the reaction of others.

According to the Chaavn Foundation: "The primary focus has been to create awareness so Sheroes was opened in December in Agra. Then another was opened in Lucknow and one is going to be opened in Jaipur. This platform has given them [acid attack survivors] the boost in their morale as they are now meeting many celebrities at the café, even the normal people who are visiting the café change their perception after meeting these survivors."- Chaanv Foundation.

The Delhi Commission of Women (DCW) also has an initiative for the rehabilitation of women acid victims - Delhi Watch Cell – which includes supporting survivors with treatment, providing them with skill building training and offering them employment. DCW has trained and employed three acid attack survivors, one as coordinator, one as councilor and one as a supervisor.

Greater public (state and Center) and private, including CSR, investments in educational and vocational training opportunities for burn survivors will help them into employment and financial independence and so avoid them having to return to the home of the abuser due to lack of financial resources.





Coordinated Community Response for Holistic Support Services for Women Burn Survivors

Best practice internationally involves bringing together health, police, judicial and legal services, civil society groups, schools and other education institutions, religious or cultural groups, and others to ensure survivors of violence and their children receive the comprehensive support they need in a well-coordinated, timely and sensitive manner. A coordinated community response is the equivalent of employing a multi-sectoral approach at the local level.

Representatives from relevant government and civil society agencies are brought together in a 'team of professionals' (including health, police, social workers, counselors) to ensure a shared understanding of the anti-violence legal context, the concept and practical application of a community coordinated response and the respective roles and procedures to support such a response. In many instances, central-level agreements are secured first that can then be transferred to more local levels.

Coordinated community responses engage key individuals and agencies from different sectors to:

• Help women and girls access protection, legal assistance and meet other basic health and livelihood needs;

- Encourage survivors to report incidents of violence by ensuring a gender-sensitive and appropriate response and increasing trust in the police;
- Promote 'zero tolerance' throughout the community;
- Closely monitor women's safety programmes, where they exist; and,
- Increase prosecutions and convictions.

Need to raise awareness more widely in Indian society of the nature and scale of domestic violence and to change the gender norms that support it.

Sathyabama University in Chennai granted scholarships to acid survivors to pursue MBA and Visual Communication courses

http://timesofindia.indiatimes.com/city/chennai/Anafternoon-with-acid-attack-survivors-of-a-city-college/ articleshow/54393154.cms



7.1 Key Elements & Strategies of a Coordinated Com munity Response

Safety of the survivor is the core principle of the model, which needs to be instilled (through sensitization, training, protocols, procedures) among all key stakeholders and service providers.

Inter-institutional negotiations for cooperation leading to Memoranda of Understanding, protocols and other agreements. In the process of these negotiations, it is important to secure support from respected local authorities and decision-makers and work with actors that are trusted by the community.

Achieve systematic changes the purpose of inter-institutional negotiations and interventions is not only to improve responses for survivors, but also to achieve lasting changes in the attitudes, norms and practices within service delivery organisations. The intervention is focused on organisations as a whole, and not just individual representatives, reflecting a systems-based approach. This implies investments in training; ensuring minimum standards (e.g. for domestic violence or rape-related services); upgrading equipment and infrastructure; continuous quality control mechanisms to monitor the quality of services that survivors receive; and establishing data collection systems.

Multidisciplinary teams that bring together all relevant stakeholders specific membership depends on the local context, including any relevant legislation that may guide and establish roles and obligations for particular sectors and professionals.

Community mobilization and primary prevention efforts including through sustained local campaigns engaging the media and diverse organizations and sectors of the population to build zero tolerance and enable an overall supportive environment for survivors, and for furthering policy and legal reforms and securing resources.

Flexibility, adaptation and ongoing monitoring the coordinated community response is intended as a dynamic model that can respond and adapt to needs for improvement and changes in context based on continuous, participatory monitoring involving the key stakeholders and information based on women survivors' experiences. This should include monitoring of efforts to adjust policies and procedures to end impunity for perpetrators of violence.

Efforts should be made to develop such community coordinated responses in locations in India, bringing together hospitals, NGOs, police, legal services and potentially also the private sector to offer a more holistic and effective system of support for women burn survivors.

Prevention strategies to address discrimination against women and girls, and other social norms that make this form of violence regarded as normal and acceptable, should be a priority for investment. More people die in India each year of kitchen accidents than of road accidents. Resources need to be devoted to campaigns to end kitchen accidents in the way that resources are being invested to reduce road accident deaths.

Conclusion 8

Fire related injuries and deaths are a major public health problem in India - and a huge cost to the health system. Most of these injuries and deaths are preventable.

Indian society needs to recognise the exceptionally high level of burn injuries and deaths amongst young women (the number of young women dying in 'kitchen accidents' each year is more than double the number dying in complications from childbirth) and acknowledge that a large majority of incidents are a consequence of domestic violence and take action to tackle this injustice.

For cultural change in perceptions and practices regarding VAW to happen, change is needed at the individual, household and community level. Men and women's belief that VAW is a 'private' matter and culturally acceptable needs to be challenged.

The fact that women are over three times more likely to die from burns than are men points to the fact that this is a gender issue – and needs to be tackled as such.

This handbook aims to raise awareness of the relationship between burns and violence against women, to inform individuals and agencies of the psychosocial needs of burn survivors and to contribute to improvements in the treatment and care of burn survivors.

This handbook has drawn on the considerable experience of PCVC in working with women survivors of violence and in providing psychosocial

and rehabilitation support to women burn survivors. It has also been informed by the work of a number of other agencies in this field, most notably the dedicated burns professionals at KMC.

Some users may find it useful to work through the handbook section by section. Others may prefer to dip in and out, finding sections of greatest relevance at a particular point in time. It does not matter in what sequence the material in the handbook is accessed. Rather it matters that the material is used constructively to challenge prevailing attitudes and beliefs about 'kitchen accidents' and to provide survivors, health care, NGO and other professionals and relevant policy makers with a range of strategies, tools and practices that can be used to improve current services and encourage the development of new services for women burn survivors.

The handbook should assist women burn survivors to make the journey, with the support of their family, caregivers and a wide range of medical and other professionals, from victim to survivor to thriver.



Case Studies

14

(Names have been changed to respect confidentiality and protect the identity of the survivors)

Priya

Priya spent three months on the Burns Ward at KMC, in 2012. She was ashamed of her disfigured appearance and tried to keep herself covered up. She remembers the PCVC Social Worker telling her "I see other people like you" and being curious about other women in a similar situation.

She returned home for some months but found her condition was not improving. She had bad scarring and could not lift her arm or handle a spoon or other items properly.

She explains how she expected that burns would "easily heal". She "knew nothing about scars forming".

She heard about PCVC's rehabilitation centre from the PCVC Social Worker. She decided to go there as she hoped it would help her become more mobile. She found the physiotherapy difficult but she wanted to work hard at it so she could become more mobile and take better care of her daughter. She was also helped by the encouragement of PCVC staff and the other residents in the centre. She found it challenging to be separated from her daughter but she also believed that the support that she was receiving at PCVC would eventually allow her to support her daughter well.

The emotional weight of having to make decisions about the future and the decision to separate from her husband and leave the abusive relationship behind was a difficult one to make as she was feeling both physically and emotionally vulnerable, uncertain about the future, overwhelmed and scared. Counselling and talking and sharing with other women at the centre provided solace, support and strength.

She remembers the Art Therapy. She learnt to be able to put down her feelings on paper, things she had never been able to talk about.

She also talks about the exposure trips and how reluctant she was to go out of the centre, fearing people's attitude towards her. Her first trip was to a large shop mall – she talks about the 'Skywalk' outing. Going out as a group with the support of PCVC gave her confidence and helped her get over her reluctance to be seen. She now moves around "without reservations". She also mentioned that if she now sees women with burn scars in public places she will stop and talk with them and make sure they know about the support available.

Priya knew she needed to find work to be able to support her daughter. Before her marriage she had worked as a data entry operator. But she was worried about how potential employers would respond to her burn scars.

When she started applying for jobs, she would get called for interviews but would be rejected once they saw her in person.

She considered joining the Optometrist course offered through ANEW but decided on the training at Winners bakery, as this was paid training and she liked the idea of being part of a group of women burn survivors. She enjoyed the training and found the atmosphere at Winners "very supportive". She talks about how much she loves working in a supportive atmosphere with other women who have had similar experiences. Priya reflects on the change in herself and in those around her. After the burn incident she was not invited to family and community events. She felt that people were embarrassed to acknowledge her. But once she started to be confident in herself, to develop skills and have a job, then the attitude of others towards her started to change. She talks about how she developed self-respect and how this has influenced the attitude of others towards her. She talks happily about how she is now invited to and warmly welcomed at weddings and other family and community events.

PCVC also helped her daughter through the Smiles programme, paying for her school fees, uniform, bus and tuition whilst Priya was at the rehabilitation centre.

Priya still visits the rehab centre on a regular basis to meet with residents and talk about her own experiences. She also takes part in counselling support group sessions. PCVC also continue to give support for her daughter's education.

Asked to say what PCVC has meant to her, Priya says it's been a "re-birth" for her, giving her a new and more fulfilling life. "At PCVC everyone treats us equally".

Lakshmi

Lakshmi has been with PCVC for over a year.

She remembers her time in hospital: "The doctors and nurses didn't give me much attention...the wound care was done roughly...people asked for money to change wounds..."

The PCVC team member would sit with me every day...I kept thinking: "why does she sit with me...take an interest in me...?" "PCVC would bring me tasty things to eat...would bring fresh sheets. It really made me feel different."

There was a quilling session in hospital..."it was so colourful....it made me happy...I'd never done anything like that before..."

Lakshmi went home from hospital, "but I didn't do the exercises....I didn't understand the importance of exercising. At home people were scared of me, they wouldn't touch me. There was no help with exercises."

Lakshmi was persuaded by a local NGO to visit PCVC's Rehabilitation Centre.

"Everything seemed different went I came here. People are interested in me, talk to me." She explains how people are happy to share food with her and to touch her. This environment of support is very important to her. Lakshmi described it as 'like shifting from your mother-in-law's house to your mother's house'

"The wound care here is very different to the hospital. PCVC staff take two hours to dress wounds that would be dressed in 15 minutes in the hospital."

She says that she was asked how she was doing and if it hurt frequently and a lot of care was taken to address any questions or concerns she might have.

"Whatever you say here...people listen". PCVC team members say "what can we do about this?", they don't say "you must do this...". This was a new experience for Lakshmi who had rarely been consulted about her views

She has been able to work and care for her family. She says this would never have been possible without the support of PCVC.



Mahima

Mahima tried to burn herself after an argument with her mother who had accused her of being in a relationship with a neighbourhood boy as she was reported talking to him on her way back from school. She said she was very upset but had not expected that it would be anything more than a few, minor burns.

She found the pain unbearable and was very unhappy in the hospital. Her mother met the PCVC social worker and both Mahima and her came to the rehab centre as she was a minor. She has now been in the centre for over a year and has gone for multiple surgeries.

Initially she found it very difficult to accept that this had happened to her. She says she was devastated about not being able to graduate with her friends as she was in her last year of high school. Mahima found the wound care and the exercises hard to do and said that she was very sensitive and would cry all the time and felt that people were demanding too much from her.

Over time however, she says that she made connections with the PCVC team and began to share her feelings with the counsellors. She found the counselling sessions very helpful not only in addressing the trauma of the burns but also talk through her feelings toward her mother and work on improving their relationship. She also says that she understood why her mother made the decision to separate from her father better and after coming to PCVC, recognizes that she had made a very brave decision and that gave her brother and her a better life and they all deserved to live without fear.

She says she decided to set goals for herself and she was determined not to lose more than a year of her schooling. She is excited about re-joining school and is already thinking ahead to what course she would like to study in college.

She is very happy about her mother working in PCVC now and says that this really helped make the family financially stable as her mother had to stop working to take care off her in the hospital and beyond and they had to depend on extended family to support them and take care of her brother while she was recovering. The fact that everyone is so minutely focused on each person's needs and works hard to make sure that you are in a supportive environment is what makes staying in the residence special. It is a "home until we make a new one for ourselves."

She says she has worked hard to accept her appearance and small things are exciting – being able to wear earrings again, her first pair of jeans, trying on make-up, that no one questions her need to get dressed. She says she only wishes that hair will grow on the bald patch on her head again and says sometimes its ok to wish for shallow things if they would make you happy. She has some anxieties about returning to school and worries about how other students will respond to her but she is also quietly excited about returning to her life.



Kanamma

Desperate to avoid the violence of an abusive husband she poured kerosene on herself. She said she had no idea what devastating impact this action would have on her. She explains how the fire "got out of control very quickly" when her sari started burning.

She met PCVC's Social Worker whilst in hospital. And then received follow-up calls from her when she was discharged. Kanamma decided to join PCVC's rehabilitation centre as she wanted to improve her ability to look after her children. She had bad contractures which affected her ability to use her hands. She had no support from her family and her husband and his family continued to be abusive.

Through PCVC Kanamma got to know that Winners Bakery were offering training and employment. She was delighted to join the training. She had previously applied for over 20 jobs. The experience was "very humiliating". She was frequently asked questions like: "how will customers cope with you...?"

She enjoys her work and feels proud of the skills she has developed. She talks about her confidence and the satisfaction of being able to care and provide for her children. She says her husband's family avoid her and don't invite her to family events. But she is no longer hurt by this. She believes in herself. Her husband continues to be abusive and even though they live apart (different floors in the same apartment complex) he often shows up to create trouble and continues to threaten her. She says she is aware that there is help out there, whether it is PCVC or her workplace, and of how and when to seek help and this has given her a lot of confidence.

PCVC have helped her daughter and son through the SMILES programme, covering the costs of their education and helping them come to terms with her mother's injury. Kanamma talks about how her two children reacted badly to the burn incident. She was very sad when her daughter first saw her after the burn incident and refused to believe Kanamma was her mother. She is now able to manage on her salary and take care of her children with some ongoing support from PCVC for education costs.

Kanimozhi

"PCVCs Medical Social Worker would come and sit with me every day. At first I would not respond. I was too distressed. But after two weeks I was waiting for her...looking out for her. I started to look forward to her visits".

After a short hospital stay Lakshmi was discharged and Linda made a follow-up visit to her at home.

She had very little information when she went home. She knew very little about scarring and contractures.

The social worker encouraged her to come to the PCVC Healing and Recovery Centre and to "give it a try". At first she did not want to interact with anyone, she "avoided mingling". But the other women encouraged her and tried to involve her. After a couple of weeks she realised she was enjoying her interactions with them and "sharing stories". She could talk to them about her experiences and knew she would be understood and comforted. Living with other women with similar stories provided new perspectives and methods of coping. She feels accepted at the Centre. People are not afraid of her. She has made many friends.

At home people were doing things for her, like feeding her. At the Centre she has had to do things for herself. She understands this is better for her, helping her to improve her movement and to be more independent.

She also commented that at the Centre no one asked her "why did you do this?". No one blamed her. Over time she has been able to "let go of the guilt" and has stopped blaming herself. The staff at PCVC have given her "confidence and courage". She has been able to "work out her anger" through counselling and therapy. She has found the one to one counselling very valuable: "being able to talk through different options". She has "learnt patience and anger management".

She described the Centre as "an affirmative place" that has given her "a new life".



Annexure

Useful contact details of burn-support services (medical and non-medical) in Delhi, Maharashtra, Tamil Nadu & Telangana

Delhi

- Govind Ballabh Pant Hospital, 1, Jawaharlal Nehru Marg, New Delhi 110002, Phone: 011 2323 4242
- Burn & Trauma Research Center, 5th Floor, Vinayak Hospital, Captain Vijyant Thapar Marg, Sector 27, Noida, Uttar Pradesh 201301, Phone: 0120
 254 4000
- Guru Teg Bahadur Hospital (Burns and Plastic Surgery), Dilshad Garden, Delhi 110095, Phone: 01122586262
- Jay Prakash Narayan Apex Trauma Center AIIMS, Ring Road New Delhi 110029, Phone: 011 40401010
- Lok Nayak Jai Prakash Narayan Hospital 2, Near Delhi Gate, Jawaharlal Nehru Marg, New Delhi, Delhi 110002, Phone:011 2323 0733
- Ram Manohar Lohia Hospital, Ram Manohar Lohia Hospital, Baba Kharak Singh Marg, New Delhi, Delhi 110001, Phone No- 01123404286
- Safdarjung Hospital (Burns and Plastic) Beside Blood Bank, Ansari Nagar West, New Delhi, Delhi 1100160, Phone:0112616 5060
- Umeed Ki Kiran Clinic, A-20, G.T. Opp Metro Pillar no. 115, Shalimar Main Rd, Mahendra Park, Jahangirpuri, Delhi 110033, Phone No-1800 102 1075

Maharashtra

- B. J. Medical College, Jai Prakash Narayan Road, Near Pune Railway Station, Pune, Maharashtra 411001, Phone: 020 2612 8000
- Government Medical College, Aurangabad, Panchakki Road, Aurangabad, Maharashtra 431001, Phone: 0240 240 2028
- King Edward Memorial Hospital, Acharya Donde Marg, Parel, Mumbai, Maharashtra 400012, Phone: 022 2410 7000
- Kasturba Hospital, Saat Rasta, Sane Guruji Marg, Jacob Circle, Mumbai, Maharashtra 400011, Phone: 098670 09495
- National Burns Cenre, Sector 13, Airoli, Navi Mumbai 400708, Phone: 022 27796660
- Masina Hospital, Sant Savta Mali Mag, Byculla East, Mumbai 400027, Phone: 022 23714889
- Shri Bhausaheb Hire Government Medical College, Dhule, Samta Nagar, Dhule, 424001, Phone: 02562 239 407

96

Tamilnadu:

- Chegalpattu Government Medical College & Hospital, GST Road, Kancheepuram 603001, Phone: 044 27431225
- Coimbatore Government Hospital, Trichy Road, Coimbatore 641018, Phone: 08807523184
- Ganga Hospital, Coimbatore, 313, Mettupalaym Road, Saibaba Koil, Coimbatore 641443, Phone: 0422 2485000
- Government Rajaji Hospital, Madurai, Oanagal Rd, Goripalayam, Madurai 625020, Phone: 0452 2532535
- Government Hospital Dindigul, Teni Hwy, Begambar, Dindigul 624001, Phone: 0451 2430017
- Government Villipuram Medical College & Hospital, Mundiyampakkam, Villipuram 605602, Phone: 4146 232300
- Grace Kennett Foundation, 8 Kennett Road, Madurai 625016, Phone: 0452 2601849
- Kilpauk Medical College & Hospital, Kilauk, Chennai 600010, Phone: 044 26412979
- Salem Government Hospital, Shevapet, Salem 636001, Phone: 0427 2210563
- Trichy Government Hospital, Puthur, Thillai Nagar, Tiruchirapalli620017, 0431 2771465
- Thanjavur Government Hospital, Thanjavur 613004, Phone: 04362 240951

Puducherry:

• JIPMER, Dhanvantri, Gorimedu, Puducherry 605006, Phone 0413 2298288

Telangana:

- Aakar Asha Hospital, Kukatpally, Phone: 040 23050961
- Burn Survivor Trust, Phone: 08985884450
- Century Hospital, Banjara Hills, Phone: 040 33133333
- Dalit Stree Shakti, Phone: 040 27601557
- Deccan Hospital, Somajiguda, Phone: 040 23410640
- Gandhi Hospital, Secunderabad, Phone: 040 27505566
- Mahatma Gandhi Memorial (MGM) Hospital, Warangal, Phone:09963867620
- Osmania Hospital, Afsalgunj, Phone:040 24600146.
- Shaheen Resource Centre for Women, Phone: 040 24386994
- Sarvodaya Youth Organisation, Warangal, Phone: 09849346491



Burn incidents reported in the Indian media:

http://www.rediff.com/news/report/woman-who-kissed-rahul-gandhi-burnt-to-death-report/20140301.htm http://www.news18.com/videos/india/madurai-honour-killing-ob-anna-717782.html http://www.indiatvnews.com/crime/news/-yr-old-woman-burnt-to-death-by-servant-in-delhi-s-posh-area-6311.html http://timesofindia.indiatimes.com/city/dehradun/Woman-allegedly-burnt-alive-in-Rudraprayag/articleshow/53901048.cms http://www.newindianexpress.com/states/odisha/Woman-burnt-alive-by-husband-in-Rayagada/2016/09/06/article3613826.ece http://indiatoday.intoday.in/video/woman-gangraped-burnt-alive-in-etah-district-of-uttar-pradesh/1/142117.html http://timesofindia.indiatimes.com/city/patna/Woman-burned-alive-for-dowry-in-Muzaffapur/articleshow/53901384.cms http://www.thehindu.com/news/national/other-states/saharanpur-woman-burned-alive-for-resisting-rape/article8960546.ece http://www.hindustantimes.com/india/women-burnt-alive-by-brothers-for-marrying-outside-caste-in-rajasthan/story-B2K7hVirPd7PmsLqhV6eGO.html http://www.oneindia.com/kolkata/birbhum-22-year-old-woman-burnt-alive-by-in-laws-being-dark-skinned-2122860.html

http://www.firstpost.com/india/woman-burnt-alive-over-dowry-harrassment-succumbs-to-injuries-493613.html http://indiatoday.intoday.in/story/kannur-district-woman-burnt-alive-kerala/1/396909.html

http://newsfirst.lk/english/2014/02/indian-woman-baby-burned-alive-dowry/18183







International Foundation for Crime Prevention and Victim Care (PCVC)

www.pcvconline.org Phone: +91 44 43111143 24 hours crises line : +91 44 43111143 email: pcvc2000@yahoo.com Facebook.com/VidiyalPCVC

Twitter.com/PCVC2000