

**BUILDING A NEW
SUPPORT ECOSYSTEM
FOR WOMEN BURN
SURVIVORS OF
DOMESTIC VIOLENCE**

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International Foundation for Crime Prevention
and Victim Care (PCVC)

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ABSTRACT

The present study conducted in four states of Tamil Nadu, Telangana, Maharashtra and Delhi is directed towards gaining insight into the prevalence and incidence of burns as well as existing mechanisms of support. It further aims to identify the challenges and promising practices in each of these four states followed by gaining an insight into existing integrated responses. The project adopted a Cross Sectional Descriptive Research Design on a target population that includes hospitals and health care institutions and associated personnel, both medical and para-medical, law enforcement sectors/agencies, civil society, government run rehabilitation homes, government departments such as social welfare, women and child development and health and burn survivors of domestic violence and their care-givers. Data was collected across all four states using primary research tools; semi-structured stakeholder-customized interviews, case studies and focus group discussions to interrogate the four major themes: Incidence and prevalence, existing support mechanisms, challenges and promising practices and integrated responses. The key findings include the nature of cases, severity of burns, mortality rates amongst men and women, substance used, skewed reporting and documenting of the cases (different for men and women). It further outlines both the availability as well as the lack of infrastructural and institutional support (hospital, state and non-state i.e. family, NGOs/CSOs) for the victims/survivors. The study also highlights the existing structural and attitudinal hurdles for the victims/survivors, medical and para-medical practitioners and care givers face. In addition, the promising prospects in the form of support within institutions like the nurses and dressing attendants, and external support through organisations and community building are also looked into. With regard to the integrated response, there was again a possibility to identify mechanisms and practices in institutional settings as well as outside institutions. Through these findings, it is possible to identify the key points and areas that can help build a holistic and comprehensive ecosystem for the burn survivors.

INTRODUCTION

Burning (from acid, chemicals, kerosene, gas, alcohol) is one of the most horrific forms of violence against women/girls (VAWG). This underserved and underrepresented category of violence unique to South Asia cause tremendous physical and psycho-social trauma to survivors. Many succumb because of an inadequate, unresponsive support ecosystem, overwhelmed by more than just physical injury. Even if one looks at the conservative estimates, it becomes evident that female deaths from burning are over 100,000 a year; most under suspicious circumstances and often remain un-investigated by the police.

Tamil Nadu, by far the worst affected with 100-150 burn cases in the state capital every month, followed by other states such as Delhi, Telangana and Maharashtra. Current legislation offers limited protection for acid survivors but none for burns, worsened by poor recording/reporting of actual burn incidence. Even 3rd degree ‘burns’ are treated merely as ‘grievous injury’. Complicated by victim’s family/social compulsions; perpetrators, often in-laws/husbands who persuade victims to record violence as accidents or withdraw complaints. Although more cases are being reported nowadays but the support ecosystem isn’t improving when it can, in fact, encourage further reporting.

For those who survive, this violence remains visible (deformity/disfigurement, affected bodily functions) often permanent, significantly reducing their chance of normal life/livelihood compared to other forms of ‘invisible or temporary’ violence. The resultant deformity or disfigurement is also excluded, and therefore unprotected by the Disabled Act.

There are, thus, a multitude of challenges for survivors (medical, rehab, legal, psychosocial, economic) which are difficult to overcome given the ill-informed, dis-jointed, counter-productive support systems which add to a cycle of violence beyond the initial act.

There is very little research or data available in current literature that provides us with an accurate understanding of the incidence and prevalence of burns in India and the immediate causes and consequences of these injuries to the body and the psyche. Whilst academic and policy research on the subject is minimal, even state sectors/agencies such as the National Crime Records Bureau (NCRB) do not have clearly defined data specifically on burns. Currently, acid attacks have a separate category in NCRB data post their inclusion as a cognizable, non-bailable offence under sections 326A&B of the Criminal Law Amendment Act (2013) but the same cannot be said of kerosene or alcohol burns which make up a large percentage of all burns cases.

The International Foundation for Crime Prevention and Victim Care (PCVC) is the only organization of its kind working at the intersection of gender violence and burn injuries. PCVC has been supporting the rehabilitation of women burn survivors for the past 15 years and with a Government Order (GO) to work in the Kilpauk Medical Hospital in Chennai (the only hospital with a specialized burns ward in the State of Tamil Nadu), has been in a unique position to engage with crucial stakeholders including health care workers, law enforcement, policy makers

and other civil society organizations to arrive at a holistic model of care that focuses on both physical and psycho-social healing and recovery.

From anecdotal, experiential knowledge from years of working in the field, what is very evident is that a majority of burn cases are also cases of domestic and inter-personal violence and whether these injuries are self-inflicted or inflicted by others (spouse, in-laws, family) the fact that the root cause of such violence is the patriarchal, unequal structures that enforce boundaries and polices women and their bodies cannot be divorced from reality.

In seeking policy and advocacy changes so as to build a more holistic, multi-sectoral/multi-agency, evidence-based eco-system of support for women, it is imperative to back up PCVC's experience on the ground with more comprehensive data from across the country. Therefore, it is essential to

The present study is, thus, directed towards gaining insight into the prevalence and incidence of burns as well as existing mechanisms of support in the 4 target states (Tamil Nadu, Telangana, Maharashtra and Delhi). It further aims to identify the challenges and promising practices in each of these four states followed by gaining an insight into existing integrated responses.

Objectives of the study:

The main objectives of the study are to:

- Identify incidence and prevalence of burn injuries to women in four states – Tamil Nadu, Telangana, Maharashtra and the NCR.
- Identify existing support mechanisms across sectors/agencies (Family, Health Care Providers, Law Enforcement, CSOs, Govt. Departments, Legal System) for women impacted by burn injuries.
- Identify state specific challenges as well as promising practices within the existing support mechanisms across sectors/agencies (Family, Health Care Providers, Law Enforcement, CSOs, Govt. Departments, Legal System) for women impacted by burn injuries.
- Identify integrated responses to burn injuries on women across sectors/agencies (Family, Health Care Providers, Law Enforcement, CSOs, Govt. Departments, Legal System) and understand their effectiveness (in terms of nature, scope and functioning).

RESEARCH METHODOLOGY

Research Design

The project adopted a Cross Sectional Descriptive Research Design. A descriptive approach to the study helps to define and delineate the characteristics of both the population (stakeholders involved in providing or seeking burn care) and the phenomenon under observation (the prevalence and incidence of burns in the target states). A cross-sectional design allows for the examination of the various variables of interest in the study (the incidence and prevalence of burn injuries, the availability of support mechanisms, integrated response from support structures etc.) and their relationship with the rehabilitation of burn survivors. In the absence of official data and with the limitations imposed by time and resources, keeping in mind the nature of information to be collected, a qualitative method turned out to be the most apt for this project.

Research Tools

The tools used in data collection include a semi-structured stakeholder-customized interview, case studies and focus group discussions to gain insight into the present ecosystem of support. This data was supported by the addition of secondary sources such as hospital records, police records, newspaper reports where available, experiences of civil society organizations working on the ground, information available with state and national sectors/agencies and any academic or policy research that have preceded this one.

Population and Sample

The target population for this study includes hospitals and health care institutions and associated personnel, both medical and para-medical (doctors, nurses, first responders, ward attendants, physiotherapists etc), law enforcement sectors/agencies (police at station level, lawyers), civil society organizations (organizations with a focus on violence against women and/or burn injuries), government run rehabilitation homes, government departments such as social welfare, women and child development and health and burn survivors of domestic violence and their care-givers. Semi-structured, in-depth interviews will be conducted with all stakeholders; focus group discussions will be organized with survivors, care-givers and para-medical staff. A few in-depth case studies will be presented in each state to illustrate the process of care from incident to rehabilitation

Research Themes

Based on the objectives, the main themes of the research are the identification of incidence and prevalence and documenting existing support systems. Based on these, it would be possible to identify the challenges and good practices within the support ecosystem as well as the level of integrated response that exists. The research themes are further delineated in the figure below and will form the basis for the creation of the research tools.

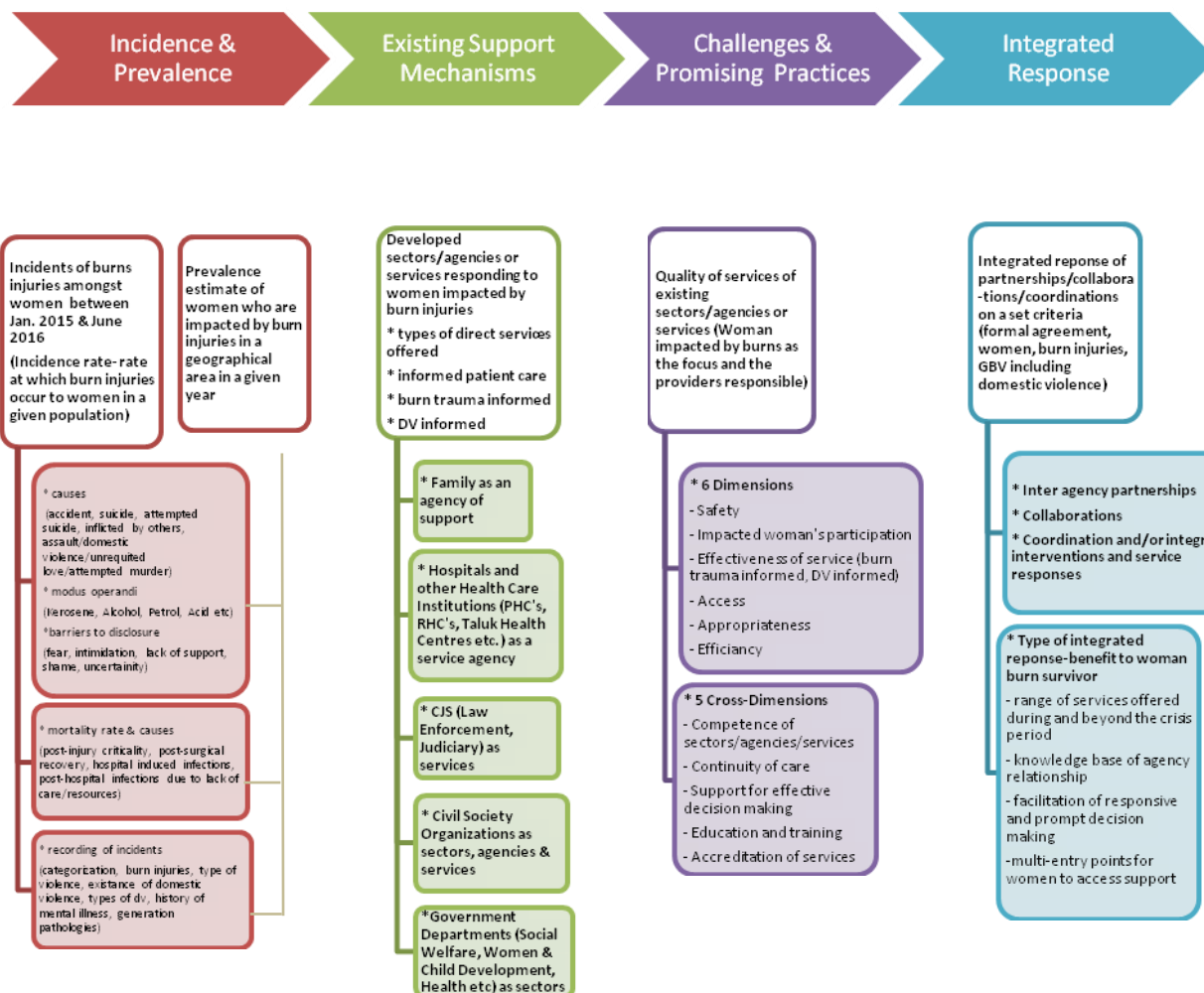


Fig. 1

Research Sites

Delhi, Maharashtra, Tamil Nadu, Telangana

TOTAL NUMBER OF INTERVIEWS:

Delhi - 73

(No of Doctors Interviewed: 22; No of Nursing Officers Interviewed: 11; No of Police Personnel Interviewed: 10; No of Government Officers Interviewed: 3; No of Burn Survivors: 9; No of people from CSOs: 10; No of people from Companies: 6; No of Counselors in Govt agencies: 3)

Maharashtra - 1

Tamil Nadu – 27

Telangana – 14 (number not clear in the report)

(Number of doctors – 10; CSOs – 1; Police personnel – 3)

TOTAL NUMBER OF FGDS:

Delhi – 2

Maharashtra – 1 (with Nurses)

Tamil Nadu – 2 (With nurses and with survivors)

Telangana – 1

KEY FINDINGS OF THE STUDY

THEME 1: INCIDENCE AND PREVALENCE

On the basis of the data received from the four states, viz. Delhi, Maharashtra, Tamil Nadu and Telangana, following points have emerged.

STATE STATISTICS

The burn data is only available for the below mentioned hospitals

- 1. Ram Manohar Lohia Hospital, Delhi** – Total no. of admissions in the burns and plastic department

Year	No. of cases*
2013	1111
2014	1450
2015	1414

*sex and age wise data is not available

- 2. Thiruvavarur medical college, Thiruvavarur**

Year	No. of cases*
2011	221

2012	66
2013	165
2014	144
2015	141

*most of the cases were suicidal and accidental burns

3. Govt Vellore medical college, Vellore

Year	Male	Female*	CH
2006	164	238	6
2007	152	200	3
2008	198	254	1
2009	247	179	2
2010	229	208	5
2011	241	192	3
2012	268	210	0
2013	227	146	1
2014	232	122	0
2015	199	89	0

*It can be noted that from the year 2006-2008, the no. of burn cases for women is higher than men, however, from the year 2009-2015, it is less than the number for men.

4. Govt Theni Medical College, Theni

Cause of burns – accidental, suicidal

Year	No. of cases*
2005	42
2006	45

2007	57
2008	50
2009	95
2010	74
2011	57
2012	72
2013	45
2014	50
2015	55
TOTAL	642

*no data available from the year 2000-2005

5. Thoothukudi Medical College Hospital, Thoothukudi

Year	Male	Female	CH
2005	33	51	29
2006	41	78	23
2007	29	74	20
2008	55	81	5
2009	50	70	7
2010	81	91	12
2011	62	85	5
2012*	98	97	18
2013	75	88	31

2014*	92	81	34
2015*#	64	53	40

*years when male burn patients are more than female burn patients

#no of women patients discharged between Jan 2015-Dec 2015 – 19

ABOUT THE CASES

Types: The cases are homicidal, suicidal, accident and acid attacks

Number - The number of cases ranges from 4-5 to 25-30 per month.

Registering of cases: Most cases are registered as Medico-legal cases¹. And if for a woman, the incident has happened within 7 years of marriage, legal institutional procedures are a must.

Treatment of the cases: Almost all major hospitals receive cases not just from the city in which they are located but also from the nearby areas. Across the TN districts and Pondicherry that were studied, incidence or prevalence of burns are found across geographical space and most big hospitals receive referrals from many surrounding districts and a high number of admissions with bigger hospitals with burns wards receiving more cases. Similar were the findings in other three states. Many a time, owing to the distance to the hospital and lack of proper first aid, case becomes more complicated and severe leading to the death of the patient.

Background of the patients: Most cases are from lower socio-economic strata. Also the number of cases from rural areas is higher than those from urban areas.

Cases include men, women and children, although incidents amongst children are much lesser.

There are equal categories, we get children who have been burnt by hot tea, some suicidal ladies who have family issues, others are homicidal, husband did it. Many times they do not open up, they lie about the cause because they are scared.

The reasons amongst the children are comparatively few; as one doctor in Delhi said

During the winter season the number of children patients is more. They get burned due to the hot water spillage, mainly in rural areas, slum areas they use water heater rods in the

¹ can be defined as a **case** of injury or ailment, etc., in which investigations by the **law**-enforcing agencies are essential to fix the responsibility regarding the causation of the injury or ailment. ... "Any **case** of Injury or ailment where some criminality is involved is called a **Medico-Legal Case** (MLC)".

bucket and sometimes they touch the water and get burned and sometimes while transporting the hot water from the kitchen to somewhere else they get burnt by spillage.

RATE OF INCIDENCE AND MORTALITY RATE

In three states, MH, TN and Telangana, no. of women patients is higher than the men. In Delhi, however, most doctors stated that number of cases for both men and women is equal. However, one of the doctor informed that “*women intake in *** is approx. 1:1.3*”

However, across all states, it was agreed upon that the mortality rate amongst the women is higher than those amongst men. Survival rate depends upon percentage of burns, people with upto 40% burns survive.

In Telangana, along with the information shared by the informants during the interviews, few studies have also corroborated the inference - two studies done earlier by Dr. Mohan Krishna and Jyothi Ande conducted for a period of 10 years between 2001-2010. It was further corroborated by another study done by Dr. Jyotsna Devi and others at MGM hospital, Warangal conducted for the duration, 1st January -31st July 2013. The data gathered from the newspapers have also reinstated the same. Although in Telangana, one informant opined that

It could be due to high percentage of burns and lack of psycho-social support from families to the women survivors.

But in other places, it did emerge that the pattern of injuries amongst women is often more severe, more widespread (burn surface area) and more critical than men. This can be directly related to the substance used/responsible for the burns and the circumstance under which the event happened, which often is the incidence of DV, but is not reported so. How far the mortality rate is high due to the lack of proper treatment in the government hospitals cannot be discerned unless there is a mechanism to keep some kind of check on doctors and management in the government hospitals. Added to that, their willing to critically reflect on this is also needed.

In one hospital in Delhi, it was shared that there has been a slight reduction in mortality rate due to change in the treatment procedure which is still in its initial stages, hence hasn't been followed everywhere. Additionally the procedure is dependent on the burn percentage of the victims. A doctor from a Delhi hospital said

...now a days we have started immediate excision of the burns. Within 5 days say the leg has been burned, so all the burned areas are excised and skin graft is put, so that by the 10th day the patient is fit for discharge. So morbidity becomes less. This process can't be carried out on more than 30% burn area due to lot of blood loss. It takes around 3-4 unit of blood

This was corroborated by the doctors in one hospital in Tamil Nadu who shared that the mortality rate has reduced after they have shifted to a new building. Infections are less and hygiene is maintained.

Substance Responsible For Burns

In all four states, the substance responsible for the burns for both men and women are similar – kerosene, gas leakage (from non-ISI branded small cylinders), accidents in kitchen, *diyas*, etc. In two cases, Pune and TN, crackers and children getting burned during diwali was also mentioned. But as it emerged in the data collected, these substances come to affect men and women differently. One doctor shared that men get

burnt while cooking is due to the ill-knowledge about cooking procedures , apart from them generally men who come with burns usually meet with accidents in work place and majority of them are of low income zone working in factories where there is no proper safe guard to check fire accidents

Cases of Kerosene burns in Delhi have apparently gone down as was shared by a doctor, who said that

Previously the burn cases were with kerosene oil, but now Delhi is Kerosene free so most of the burn cases are due to gas leak

Although, it also emerged that kerosene is easily available in the state as was found through a sting operation in Delhi. Additionally, getting kerosene in Delhi may seem difficult but it is easily available in neighboring cities like Noida.

Unlike the abovementioned factors which may be found for both men and women, acid attacks are almost exclusively faced by women. One doctor from delhi, gave very fixed categories in her responses and said

Homicidal is kerosene only, acid attack is different, it is acid.

She also added that that burns from diya are

...accidental, we still have women cooking on the floors in the kitchen with no gas, in no light, only with one diya. It happens, the kids were running around, they tripped and by mistake dropped the diya on her, she got burnt.

However, informant from other informants in Delhi as well as in other states revealed that citing *diya* as the cause of accident is the most common answer given by the women.

Another factor that can be seen as affecting the chances of their survival of the patient/ victim is the family care and support that is given to them. Many informants opined that mortality rates

are lower amongst men than that amongst women. When asked about the reason for such assumption, many answered that because men are better looked after in their families because of the care and support they get from the women. One can find it echoed in the following response from a doctor in Telangana

for a male person (husband or son) his wife or mother is able to take care and therefore the survival rate of male is high.

The reasons for women not receiving proper care and support can be found in three factors: one, in some hospitals because the women ward is separate where men are not allowed,

For the women there are no continuous care takers and moreover in female wards men/ husbands are not allowed resulting in woman getting dependent on her natal family which at times becomes very difficult.

Another is that many a time, the women are abandoned by their husbands and affines. Sometimes their natal families too are not able to support them due to their financial conditions which do hamper their treatment. One doctor said,

dealing with women burn patients are little complicated compared with men cause generally they are abandoned by their husbands and his family due to burn disfigurement and sometimes the parents also abandon the women patient when they are poor and due to financial crunch these women are left on their fate. So opportunities are needed to break the taboo

This lack of support from the family sometimes has a psychological impact on the women patients wherein they may not respond very well to the treatment given to them. In many cases it was shared that family support helps the patient to respond faster to the treatment. In one interview, it also came out that men are also abandoned—

There are few cases, the female then goes to her parent's house. The men also get burnt, their wives leave them too. I have seen cases where the wife has left the man.

Third, many women do not receive/ avail proper treatment post-injury leading to infections, caused by no follow ups, lack of proper hygiene and care after discharge and lack of awareness about the need for sustained physiotherapy and nutrition. Almost all doctors across the four states opined that follow up rate is very low; hence they are not well informed about the health of most of their patients. They added that proper medicines, care, nutrition and supplements are given during the treatment but if the patients do not come for follow ups, they can't do much.

Recording of causes

For men and children, it was a widespread belief that the reasons cited during interrogation are “real” and “genuine”. Thus, almost all informants agreed that majority of children and men are

mostly admitted due to accidents and there is no reason to suspect otherwise. This point is corroborated in the following answers:

I think the reasons for a child's burns are genuine, because they are not that severe. It will either be a part of the arm that is burn, or a patch on the leg. And it is usually because they had been playing around fire or fell into the chulha

The complication mostly arises when one looks at the cases amongst women. Most women are unwilling to report the incident as homicide or suicide, hence they most of them get reported as accidents. As reported by some doctors, it is evident from the pattern of the burn that whether the incident is an accident/homicide/accident.

a women was admitted in the hospital with 95% burn and was 6 months pregnant told the police the usual story of accident that she was in 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 some domestic violence. She died - a Doctor from one of the hospitals in Delhi

Another doctor stated,

*If it is a small burn and can be patched up and she can go home then she will not tell us the actual reasons for the burn but if it is a life threatening then in the presence of her parents she may tell us the actual reason. Very rarely we get a history of the actual reason of burns. **First**, it is very difficult to extract the history from the patient because many times even when the parents accompanies patient she does not tell us the truth. **Second**, no one is actually bothered about the history of the burn, in any case whether accidental, homicidal or suicidal, we have to inform the police*

This reveals that there is a long history of misrepresenting self-inflicted or homicidal burns in women as kitchen accidents or as diya incidents as is evident in this information shared during FGD with nurses,

The main causes of accident among women are accident and domestic violence. Love affair is the most common cause of burn patients that come here, there are acid attacks again due to love affairs and then there are dowry related. And the reasons they give are burnt by gas, sometimes by diya.

A doctor corroborated this by saying

They mostly say it was an accident, they were cooking in the kitchen and their saree caught fire and they did not realise, hence the burns. Or that they were working and a diya fell on them. These two are the most common reasons they give us.

They know that most of the cases are because of regular episodes of domestic violence, doctors as well as police personnel, hence, have acknowledged that mostly, these women are not revealing the real cause as is evident in the following statement. Like one doctor said that

“when the inlaws are there they hide things when inlaws are away then they tell us the details.

Another one informed on similar lines

We get cases of suicide by women, argument or fight between husband and wife, love affairs of young couples. We get to know the cause of burns by seeing the pattern of burns, whether the petrol is used, kerosene is used. We also get to know if it is a case of suicide or homicide by seeing the pattern of burns. Petrol is used more often as everyone has vehicles at homes. In some cases women put themselves on fire, and in an attempt to save her, the husband also gets injured. But they never tell the exact cause. They make stories here in the hospital, like my stole caught fire or kerosene stove explode

A similar remark was made by a police officer in Delhi,

No one tells the real reason. They always call it an accident, always a burn caused by diya or in the kitchen while cooking. Even the suicide attempts after a fight with the husband are called an accident. A little easy to gauge which is the suicide attempt and which is the accident.

Another added that

90% of the cases are called accidents due to burn Diyas, the others may sometimes tell us the truth about the burns

Thus, even when the medical practitioners in the field are well aware of the cause, they have no formal mechanisms to address it, as opined by one doctor in Delhi,

In such cases we do not know what to do, nor we are aware that legally can we intervene or not. And even if we want to, professionally we may not be permitted as each such case may take lot of our time in terms of going to court for legal proceedings.

The main reason for not revealing the real reason is fear at different levels: one, they are scared for their children and their sustenance, both while they are in the hospital as well as post their death, evident in this statement,

Most of the time we know they are lying, but as doctors we can only rely on their statements. Sometimes they lie for their children, fearing that the in-laws will harm her children they lie.

Two, due to the lack of financial independence as well as societal pressure and stigma, they may not reveal the real reason

Mainly its family pressure because most of them are from lower socio economic group and they are not independent; they are dependent, economically they can't survive on their own for long time and the social pressure they have on them. They can't take their

own decision separately unless they are compelled so they don't take those drastic decisions and even their own family pressurizes the victim to tell it was an accident, said a doctor in Delhi.

In TN, during a FGD with nurses, they opined that

Survivors go back to the husband because they don't have any exposure and the society does not accept them. Hence they are dependent on their husband.

Three, they may also be under threat while in the hospital as was revealed during a FGD with nurses in Delhi,

Sometimes patients are very serious when they are brought in and in the state of grievance they speak in the favor of the culprit thinking she may die so what's the use, and often thinking of her child's future women patient sometimes don't admit of domestic violence on them. When women patients come here the relatives often tell that it was a accidental case, but after some recovery of the female patients we give moral support and them and they often confess about the domestic violence she faced either for dowry or other, so then we call the police again the patient gives their statement again. For these cases where relatives or husband may face jail we remain very cautious for the patients. So generally we always keep the backdoor of the ward locked because there is always a danger of shooting². So we have to do our duty with extra vigilance.

Many a time, even the nurses are threatened by the family members as revealed during a FGD with nurses in TN, thus safety becomes an issue for both the victims as well as the medical practitioners.

Sometimes, the hospitals try to create a conducive environment for the women to declare the real cause. This was done in MH where *the hospital, tries to make efforts by not allowing any family members during recording of statement by the police* as shared during the FGD with the nurses.

Although, most of them do not talk about the real/genuine reason as they are either scared for themselves or their children, yet it was found that sometimes longer period spent in the hospital may lead them to develop a rapport or an emotional bond with nurses, and dressing assistants, which may result in disclosing the real reason responsible for their burns. One doctor said

Sometimes they do, but mostly they are scared. Sometimes if they have been admitted in the ward for a long period of time, then they start to open up and talk to us since we see them everyday. Or they will by mistake, in a conversation, talk about their family life, and hint at the abuse that they are going through.

But, none of this reflects in the records of the patients.

² Here the informant is referring to attempts at shooting (murdering) the burn survivor as well as the care givers in the hospital, mainly to make sure that the patient doesn't divulge the real reason behind the burns.

Additionally, it was also found in many cases that the women do not have the requisite information to address these issues and report them to the concerned authority. This was addressed as an issue during both an interview with a doctor and also in FGD with the nurses in TN.

THEME 2: EXISTING SUPPORT SYSTEMS

HOSPITALS - INFRASTRUCTURE AND AVAILABILITY OF SERVICES

The infrastructure in the hospitals and other health care centres vary on the basis of two aspects – region (city, town, district) in which the hospitals are located and nature of the hospitals i.e. Govt or private. Treatment in the govt hospital is free of charge, hence, most burn cases are handled by the govt hospitals as the patients are usually from the lower socio-economic background who cannot afford treatment in a private hospital. A doctor from govt hospital in Telangana opined that

He felt that government hospitals are well equipped to deal with the survivors and it is a misnomer that private hospitals are well equipped to deal with the burn survivors. Almost 10-12 doctors visit the patients (an inter-disciplinary team of orthopaedicians, nephrologists including duty doctors and interns) giving them the best medical care. Post-operative care /problems do exist in government hospitals but that should not be sole criteria for assessing the care in hospitals.

Additionally, it is mandatory for the govt hospitals to admit any case of burns that either come to them directly or as referrals. But such is not the case with private hospitals, one doctor in a govt hospital in Telangana stated,

Most of the private hospitals refuse to admit the patients due to the medico-legal nature of the case and also to due lack of facilities.

In one private hospital in Telangana, the doctor informed that they have only received 50 patients till date, unlike an average of 20 every month in a govt hospital. Another added,

Poor patients at times after getting admitted into the private hospitals will finally land in the government hospitals as they cannot afford the costs of private hospitals.

From the data collected, it is clearly evident that most govt hospitals in major cities (with exceptions, one hospital in Hyderabad receives most number of patients, but is lacking in infrastructural facilities) are better equipped to treat burn patients than those in small cities and towns, as they get a number of referral cases. Consequently, most patients are either taken to or referred to the big hospitals that are supposed to have better facilities. Sometimes it also happens that a hospital may receive patients from districts from the neighbouring states which may not be equipped to handle burn cases. This was pointed out by a doctor in a govt hospital in Hyderabad who informed the researcher that persons from neighbouring states like Karnataka and

Maharashtra, especially from border districts like Raichur(Karnataka) Nanded (Maharashtra) also come to Hyderabad.

Referral systems are in place across the states to send survivors to bigger, better equipped hospitals depending on the severity of the injuries. For example, in TN, survivors with more than 20-30% burns in smaller district hospitals such as Villipuram and Dindigul are referred to KMC, JIPMER, Madurai based in proximity.

Five government hospitals in Delhi have specialized wards. These wards are used for burn patients as well as for patients needing plastic surgery. There are many district headquarter hospitals in TN which have a specialized burns ward. For example, of the ones visited by the researchers, all but 3 have a burns ward and a full-fledged plastics team that provides care. The other 3 have sub wards as part of the general surgery ward that accommodates burn survivors.

Mostly there are separate wards for men, and women. A doctor in a Pune hospital said

we have separate wards for men, women and children.

In Telangana, it emerged that women have a separate ward for women which many a time is a hindrance in care giving by male family members of the patients. But not all places may have separate wards for men and women.

In most hospitals number of beds range from 25- 60, but those available for burn patients could be within the range of 4-10.

Most doctors in these hospitals have long term experience in their profession.

Hospitals reported that all the required medicines, clothes, etc are provided free of cost to the patients. However, during an FGD with the burn survivors in Delhi, many said that they had to pay for many medicines in government hospitals.

They are also given food as per the prescribed diet plan which is high in protein with supplements. This may also require the expertise of dieticians, usually available in most hospitals. Some services may not be available, as in Telangana, there are no provisions for forensic tests that can help identify the nature of the case.

Different measures are taken by hospitals to minimize hospital infused infections. Thus a doctor in Delhi shared the techniques used in the hospital he works in

We have some infection measure techniques in place like we have air chain system in the wards where burn patients are kept. Regularly 3-4 air exchange is done per hourly basis in the wards. The biggest source is the medical personnel and the support staff who try to minimize the infection chance by minimizing the entry of

outsiders. Every cubical has a hand wash outside. Changing of cloths is enforced in patients and visitors are advised to keep their shoes outside...

Most hospitals have a physiotherapy unit. They may also have psychiatry and/or psychology department. Sometimes even orthopaedic surgeons are required to treat the burn patients as shared during the FGD with nursing staff in Pune.

Medical practitioners across states confirmed that **Physiotherapy, psychiatric and psychological support** is necessary for an overall recovery of the burn victim. A doctor in Pune said,

We send people to physiotherapy center, as physiotherapy is very important for burn patients.... We do call psychologist when a patient is admitted.

Similarly some of the hospitals reported to have dedicated physiotherapy departments from where either the therapist makes regular visits to the ward and supports patients with exercises, or the burns wards refer the patients to the department. Also at the time of discharge patients are made aware of the importance of wearing pressure garments and physiotherapy. But TN data suggests that Referral ecosystems within hospitals are very limited. Unlike KMC which has in-house physiotherapists attached to the burns ward, most hospitals offer referrals to the physiotherapy department but there is a drastic fall in the number of people seeking services after discharge and many are lost to the system. Rounds by psychiatrists/mental health workers, social workers attached to the wards etc. are non-existent. Occasional referrals given to psychiatry department but there is no sustained collaboration.

The nursing staff in Pune, during the FGD further stressed the importance of psychological care,

Nursing care in burns is not limited to physical care. People feel unbearable pain sometimes

Thus, it emerges that one of the most vital **needs of the burn patients/survivors is the availability of mechanisms to deal with psychological stress.**

The main challenge is the psycho-social aspect which is all through neglected for patients because burn patients are treated as cut-offs from society especially women..., said a doctor in Delhi.

There are two perspectives, one is health perspective and another is psychological perspective when it comes to treatment of patients. Holistic approach is required, opined another.

At most occasions, although the services maybe available, but are not availed by the patients as there is a required procedure which needs to be followed. For instance, in Delhi, there are dedicated specialized departments for psychological and psychiatric support at the overall

hospital level. These departments provide services such as clinical treatment, individual counselling, family counselling, and therapies to patients who are referred to them by other departments. Such is the case with burns ward as well. They will extend support if any burn patient is referred to them. However, it was found in one hospital in Delhi that for the last two years no patient has been referred to the psychiatry department by the burns ward. This is an important revelation especially when most doctors and nurses opined that psychological support is extremely significant for the well being of the patient.

The department of Psychiatry has an in-patient program as well as an extensive out-patient program. We see large number of patients in a day. We are a staff of five people and yet we receive around 300 patients everyday. We have separate wards for men and women. We don't visit to Burn Ward. If doctors from Burn ward feel that the patient needs psychiatric help, they can refer the patient here. We have not got any referral from Burns ward in last many years...”, said a doctor in the psychiatry department in Delhi.

Some hospitals also try to rehabilitate the patients but the percentage is very small. Most hospitals have suggested that they do not always have the requisite means and resources for such an endeavour.

We try to rehabilitate the patient, giving them counselling and coaching, we try to make them independent. They receive massage treatment. We try as much as we can to help the wounds fade but the massages only work on superficial wounds, said a doctor in Delhi.

But this is not a very common phenomenon as shared by a doctor in Pune,

*In pune, there are only few rehabilitation centers. In pune there is one, *****. We treat only. We don't have any rehabilitation facilities.*

This was echoed in TN, it emerged that while most hospitals offer physiotherapy as part of the recovery process, post burn rehabilitation services which are very critical to full recovery are not present in a lot of hospitals. (For ex. Pressure garments, splints, access to physiotherapy, access to emotional support etc). It was further found that there are no government rehabilitation homes or other physical support structures in TN. Access to government schemes is difficult and such services are beyond the scope of government hospitals.

There is an ambiguity regarding the follow up by patients. In Delhi it was observed that coming back for follow-up checkups is overall very low amongst burn patients especially if they are not from Delhi. And within this group also, women coming back for follow-up is much less than men. Low turn-up follow-up can also be because of the procedures to be followed in a hospital. It was also observed that doctors from other departments attend promptly when they are called but follow up is very difficult where patients have to visit their OPD respectively. So Dr. ***** suggested if follow up is done in Burn ward only then it will ease the patients harassment and the

number of follow up will also increase which is very less at present after discharge. Similarly in TN, it emerged that there is no follow-up with any patients in any of the Government hospitals. However, in Pune, the nurses opined

Women come for follow up after discharge. They also come for plastic surgery. Our director is very good.

However, such a response was found only in one hospital in Pune. The nurses further added that

We give our 100% and try to save the patient. We change dressings everyday. We have to be strict with patients sometimes and don't allow relatives inside. The wounds are open and susceptible to infections. We feel happy when patients recover.

It, thus points out that in some places, doctors, medical practitioners and the nursing staff put in their best to provide treatment and care to the patients.

Training of the staff

Although most doctors were found to be highly experienced, it also emerged that specific training for the medical practitioners is not a norm. In MH, the nurses said,

We are not given special training but we learn while being on our duty in burn ward on rotation. We feel there should be special training.

This holds special significance as it was found that the patients bond easily with the nurses who become their primary care-giver and sometimes even confidante. In TN, it was inferred that Nurses often take on the role of psycho-social caregivers in most hospitals as they are the first point of contact and continue to be the sole point of daily interaction. But they are equipped only to handle the issues emerging from trauma but not much is told to them vis-a-vis the issue of DV. Even in Delhi, it was observed that Other than specialized trainings on various themes during NABICON every year, no other training specializing in burns is held for the staff. For instance WOUNDCON was held to provide training to nursing staff on wound care of burns. If a nursing staff is transferred to the burns ward, she/he shadows the senior staff and gets hands on training before taking on the responsibility.

But it clearly emerged that the nursing staff becomes a very vital point for the doctors as well as the patients. Nursing staff seems to have more information about the case history because they closely work with patient and gradually build rapport with them. As a result patients trust the staff and share with them the actual cause and details of the incident. Thus they can be identified as vital entry points and links with the patients.

Data recording and management

Data recording in the hospitals is not very satisfactory. It was observed in majority cases that the data is recorded and managed manually. In Delhi, it was shared that the data will soon be

digitised as the National Informatics Centre (NIC) premier science & technology organisation of India's Union Government is developing application/software to digitize data. But that will only be from current year onwards.

In some cases, data was also shared by the hospitals with the researchers.

Standard intake format is used by all hospitals to record information of patients. The form captures basic information of the patient.

Although, all cases are registered as MLCs but hospital's own system of recording the case and evaluating the case, sometimes forms the basis of determining the circumstances under which the incident happened, causative factors and the line of treatment. This is evident in the following response of a doctor in Delhi who shared that way information is recorded in the hospital.

Initially for the first 24hrs they are admitted in the emergency where the first aid, initial dressing and evaluation of the wound is carried out. We have a chart system where all the necessary details are filled which we later analyze also like the circumstances of burn, what type of cloths they were wearing etc., we are planning to incorporate include some more topics in the chart so that in every 4-5 years we can compile the reports.

In some cases, the log would be maintained in separate books as was divulged during a FGD with nursing staff in Pune, "We have admission book, analysis book, diet book and MLC book for patients here with us".

In some places in TN, the data was recorded in tables

For instance in Madurai

2015-2016	Male- 83, Female- 62 Total- 145
2014-2015	124
2013-2014	119
2012-2013	176
2011-2012	149

In Dindigul, the data is only available for females

April 2015	5	January 2016	4
May 2015	5	February 2016	2
June 2015	13	March 2016	6
July 2015	8	April 2016	2
August 2015	6	May 2016	5
September 2015	7	June 2016	5
October 2015	8	July 2016	6
November 2015	5	August 2016	4
December 2015	4	September 2016	7
		October 2016	3

From the data available in TN,

DISTRICT & PRIVATE HOSPITALS	BURNS WARD	CAPACITY	MONTHLY AVERAGE ADMISSIONS
Kilpauk Medical College & Hospital	Separate burns block for men, women and children	60 beds	140 - 160 (majority women)
Coimbatore Government Hospital	No separate burns ward. One unit of the General Surgery Ward	15 beds	100 - 120 (majority women)
Ganga Hospital, Coimbatore	Acute burns ward, skin bank and contracture release/skin grafting patients are kept in general wards.	Acute ward - 5 beds Hope after Fire - Need based. Not restricted by numbers.	3 -5 in acute ward 277 beneficiaries under HAF
Salem	Separate burns	15 beds +	60 - 80

Government Hospital	ward for men, women and children	separate burns OT	(majority women)
Trichy Government Hospital	Separate burns ward for men, women and children	30 beds	50-60 (majority women)
Villupuram Government Hospital	No burns ward or plastic surgery department. Burns are treated in general ward and referrals are made.	None. Case by case basis.	10 (majority women)
Thanjavur Government Hospital	No separate burns ward. Treated in plastic surgery ward.	10 beds (5 for women and 5 for men)	20-30 (majority women)
Madurai Government Hospital	Separate burns ward for men, women and children	18 beds	50-60 (majority women)
Grace Kennett Foundation, Madurai	Separate burns ward for men, women and children	5 beds	12-15 (majority women)
Dindigul Government Hospital	No separate burns ward. Treated in general ward.	4 beds in General ward.	6-8 (only women)
Chengelpet Government Hospital	Separate burns ward for men, women and children	8 beds	8-10 (majority women)

Pondichery - JIPMER	Separate burns ward for men, women and children	20 beds	20-25 (majority women)
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State support to hospitals

All government hospitals in Delhi are either attached to a Police post or have a post inside the hospital. Like other medico-legal cases, burn cases are also brought to the post. The role of the personnel is to co-ordinate the filing of MLC and if the case is from outside Delhi then it is referred to the respective station for further investigation.

During a FGD with the Nurses, they stated

We have all the facilities here which are common for all central hospitals. We have advanced wound-dressing material; we have bed to bed suction. To reduce infections - We have anti bacterial flooring in wards, dressing room and in OT too. The lights in OT are UV lamps which help greatly in reducing infection risk

The Doctors in Delhi too shared

The biggest source is the medical personnel and the support staff who try to minimize the infection chance by minimizing the entry of outsiders. Every cubical has a hand wash outside. Changing of cloths is enforced in patients and visitors are advised to keep their shoes outside but it is seen that their shoes are being stolen so complains are a big headache for us. So we are trying to do something for that (this is a problem for us)

In all 11 districts of Delhi there is a Crime Against Women (CAW) cell, which apart from police personnel also has two counselors from TISS. This is as part of the joint initiative between NCW and TISS.

SUPPORT WITHIN THE HOSPITALS – SOCIAL WORKERS AND COUNSELORS

It was also observed that there is a need for **Social workers and counselors in hospitals** for a holistic treatment of the patients

“there should be a team approach. Every burn victim should be attended by a plastic surgeon, by a therapist, by a physiotherapist. There should be holistic approach.”, stated a doctor in Delhi.

Because in case of burns, medical care is just a percentage of the whole care needed by a burn patient, which is beyond the mandate and means of hospitals. As on doctor remarked,

“..no NGO who are working for women burn victims and it is very much needed because the government is only concerned with the treatment of the patients and the most significant thing is the psycho-social aspect which is neglected all through and even if the doctors want to do something they can't do much due to their heavy work schedule...”

However, it is also found that social workers and counselors are not a common phenomenon. In TN it was found that none of the hospitals except Ganga and Grace Kennett which are private hospitals have medical social workers in the ward.

Unlike TN, in Delhi, in one hospital it was found that there are Counselors who deal with all the incoming patients of domestic violence, whether coming from burns or OPD or frequent injuries, personal attempts. While in another, it was informed to the researcher that *“The MSW does not have much role here, she is basically working for destitute, old patients, these types of things. She is not involved in domestic violence”*. During the FGD, the Nursing staff too remarked *“They (social workers) are posted inside the hospital from the government but the social worker basically looks after those patients who have no family, or are unknown persons, belonging to the lowest rung of the society. The SW provides food and clothing to these unknown, very poor patients. He/she does not help in cases of women with DV”*

In Telangana, a doctor remarked that as doctors, their primary duty or responsibility is surviving the patient and he said that it is the nurses who do counselling to the patient and family members whatever in the limited capacities it is possible. Neither the burns ward nor the Gandhi Hospital have the full time social workers to cater to the psycho-social needs of the patients.

STATE SUPPORT/ED STRUCTURES AND MECHANISMS

One of doctor in Delhi shared that as per the High court ruling, no government hospital can refuse to attend a burn patient. Therefore if there are no beds available or there is no specialized burns ward in the hospital, the patient is given immediate first aid and then referred to another hospital.

All cases of burn are registered immediately for MLC³ (Medico-legal case) which means that there is a legal procedure that needs to be followed. One of the doctors shared that reason for doing so is to abstain the patient from changing her/his statement. Process of registering MLC varies from one hospital to the other, which may have an impact on the recording of the case by the patient.

*“In ***** hospital every burn cases are treated as Medico Legal Case(MLC). The person who does this is the Chief Medical Officer In ***** hospital all MLC cases are done in casualty ward but in ***** hospital there is a separate burn unit ward where*

³ can be defined as a **case** of injury or ailment, etc., in which investigations by the **law**-enforcing agencies are essential to fix the responsibility regarding the causation of the injury or ailment. ... "Any **case** of Injury or ailment where some criminality is involved is called a **Medico-Legal Case (MLC)**".

*the doctors who treat the patients makes the MLC's. So patients feel comfortable from the time of their admission in the hospital. This thing is needed in **** hospital, but different hospitals have different rules and methods” as stated by one of the doctors.*

During a FGD, nursing officers too said that *“For every burn case that comes in here, we have to inform at the police post. Then an MLC is made for the patients. If the woman who is burnt has been married for less than 7 years, then the SDM is called to take the statement and investigate”.*

In all four states, State women commission do provide institutional support but in varying degrees. For instance, in TN, No government rehabilitation homes or other physical support structures were identified. But Delhi Commission of Women (DCW) has a special initiative for rehabilitation of women acid victims called the Delhi Watch Cell. Rehabilitation includes supporting them with treatment, providing them skill building training and offering them employment within the commission and outside.

“..DCW has itself employed three women with acid attacks, one is placed as coordinator one as councilor and consultant and MTS (Multi Task Supervisor). Shalini who is an acid attack survivor is in charge of this cell who looks after the medical help, legal help which are needed to the victims...”

DCW provides other kinds of support services to women victims of domestic violence such as 24 hours helpline and the commission receives 1500-2000 calls in month. The commission also mobile van located in each district of Delhi, which can be accessed by women victims of violence thus ensuring their timely safety. They have also performed a sting operation on selling of acid in Delhi was carried out by DCW, as it is against the law to sell acid in Delhi as per Supreme Court order. At first cases of domestic violence was handled by Delhi Govt. office directly but from February, 2016 the responsibility has been transferred to DCW and DCW now oversees all the cases. DCW has a tie of DSLSA (Delhi State Legal Service Authority). So if someone under the DV act files a case, they can approach DCW, who will then prepares a letter and gives it to the victim. Victim can take this letter to the court and the court shall provide free legal support.

But in Telangana, State commission for women has not handled such issues at all. They also do not have any clear data as if now, on suicides including through burns, although they have future plans regarding the compilation of data in the Crimes records bureau about developing a category for burn survivors which was considered as feasible.

However, there is special budget allocation for health services in the year 2015-16 which is 1.6% increase from the previous year. There are also state govt schemes like Arogyasri scheme, wherein the BPL families will have access to quality medical care for treatment of diseases involving hospitalisation and surgery through an identified network of health care providers (Private and Corporate) and with insurance companies. Introduced by Congress Chief Minister

Rajasekhar Reddy, the scheme became quite successful and the ruling Telangana Rashtriya Samiti government is continuing the same. Discussions with the Doctors revealed that some of the burn survivors received surgeries under this scheme. The government tried to expand the Arogyasri cash less health scheme to all its employees, retired employees and teachers also but not successful. 108 Ambulance services is being continued, The government also has taken a decision to dismantle the present Osmania Hospital and construct a new building in its premises, and 3 more super speciality hospitals are being planned for Hyderabad city.

CIVIL SOCIETY ORGANIZATIONS

The key finding after interacting with many organizations across states was that some may and some may not work especially with burn survivors of violence, but all of them recognize that this group needs attention and has been neglected for a while. Some of them shared that their current focus of work may provide the scope to address the needs of this particular group of women survivors as well. Some of them also highlighted the lack of capacities in existing structures such as shelter homes to deal with cases of burn.

In Telangana Civil society organisations which are working with burn survivors are Dalit Stree Shakti, Shaheen Resource Centre for women, Burn survivor Trust. Many others like Prajwala, My Choices, Ankuram, Bhumika, Gramya, REDS, WINS, RADS do not address such issues.

No CSOs that work with women survivors of burn violence were identified in any of the districts visited in TN. In Madurai, Grace Kennett is a private hospital that offers post-burn rehabilitation services through their attached NGO which include wound care, physiotherapy, surgical intervention and social workers and psychologist are on staff.

In Delhi, *Jeevodaya Aashralaya, Jagori, Doctors without Border, Chaany Foundation, SAMA, Babu Ghar and Commonwealth Human Rights Initiative* were visited during the course of the study. These organization are extending support on various aspects of domestic violence to women- such counseling, referrals to shelters and legal counseling, short stay home, legal support, enabling them to become economically resilient and conducting research and advocacy on issues related to crime against women.

Thus, Jagori shared

“We targeted 15 hospitals in Delhi with ministry of health. Delhi state was not implementing new MLC guidelines. People were facing in MLC. The proper MLC guidelines were not followed. The new rules were not followed. Hospitals were not following that. Only few sensitive doctors were doing that on personal level.”

And Sama,

“We have worked on initiating the linkages between gender based violence and health system. We should work towards strengthening the health system response towards survivors of violence”

Khaas Travel Agency in Delhi is an enterprise specifically setup to financially and socially empower women who are differently abled – particularly acid survivors and women with impaired vision.

Chaanv foundation on the other hand, works with acid victims to serve a dual purpose, help the survivors to attain financial independence and to create awareness amongst the general public about these women,

“The work at Sheroes Hangout is designed to give them the confidence to show their faces in public after being disfigured. And it goes the other way too. If customers haven’t met someone with acid scars before, they will have by the time they leave the cafe. Pictures of the women’s faces adorn the walls and their images are writ large in graffiti on the exterior. 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 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.

FAMILY AND WORKPLACE SUPPORT MECHANISMS

From the data gathered from all across the states, it was clearly evident that family support is most crucial for women burn victims and survivors. No amount of state institutional and medical support can replace the support that one gets from the domestic structural support. Veena Das⁴ has especially talked of this through her concept of domestic citizenship which holds particular significance for women in India where disfiguring of the face and body can be a deterrent to their normal social life. One can easily find evidences for her claim in the data collected for the study. Thus, in TN, family and workplace support mechanisms were found to be hugely beneficial to women when they were open and non-discriminatory. In cases where the family was found to be supportive (mostly natal as opposed to marital homes) and workplaces which offered options of re-joining work aided emotional healing and recovery. During FGD with acid attack survivors in Delhi, they mentioned that to boost the self esteem the moral support of the parents and it helps a lot.

One case study from Delhi, that describes how family support can help one to move from the stage of victim to that of a survivor –

⁴ Veena Das and Renu Addlakha (2001). “Disability and Domestic Citizenship: Voice, Gender and the Making of a Subject” in *Public Culture* Vol. 13 No.3 pp511-532

According to one of the girls who was treated in a private hospital, her experience is totally different as doctors were considerate enough in treating the wounds and it was far less horrifying than the girls who were treated in the government hospitals. She got all the support from her family and the doctors treated her with utmost care so her treatment was not traumatic like the others. Now she is doing dance training and also shows. The worst part of her accident was that she doesn't know who her actual attackers were, prior to her accident she was a dancer and actress in small budget Bhojpuri films and all things changed after her accident and this was one of the fact which affected her the most but now again regaining her ability to achieve her dream ones again.

Another one,

One of the victims is successfully running a salon in NCR and she was trained from Javed Habib institute and she is doing well in her life. With the support from her family, especially her father who boosted her moral to achieve her goal irrespective of the society speaking negatives against her, he boosted her moral and today she is successfully running a salon from her home, her future dream is to open chains of her salons throughout India. She even has adopted a girl child

In MH, it was found that in some cases, the Family supports during the treatment, but mostly, because with burns, disfigurement happens, women survivors face difficulty in getting social acceptance. With burns, Psycho-social stigma is there.

Workplace stigma and support

There is usually stigma attached to the victim, because of which she suffers especially when it comes to managing her survival,

During Dhan teras we went to shop in Lajpat Nagar and I met a lady selling balloons, she seemed different as she was selling the balloons with different attitude uncommon with the regular sellers. She was speaking in English and had two babies with her. When I went there to her, I saw she had acid burns all over her face. I asked what happened then she told that she worked as a security personal in a mall and some boys from the neighbourhood poured acid on her face and on her 3rd day her husband abandoned her. She also lost her job due to the disfigurement of her face. I generally asked why she is selling balloons and she can try other jobs, she told me a woman who has lost her job due to her accident , where in Delhi or India she will get a job. Though she had a MBA degree no one will hire her just because of her accident and disfigurement. So this compelled me to think that a mere accident can ruin someones life just due to the orthodox thinking of our society. So I started working to create a platform for these women so that their potential does not go in waste and they can lead a normal life. So I started with 2 girls and now I have employed 6 girls working successfully.

But sometimes, creating a structural support mechanism, may help them traverse the path from victim to survivor as is evident in the Story of Acid attack survivors working in Sheroes –

The main thing that they learned when they came here that they are not alone and they got the courage to face the fact and what they have to say is that to stay strong and face the fact as majority of the attacks are due to one sided love and mainly the face of the victim is targeted to let the victims disabled to work in future as face is the main aspect in the society to value a being so when the face is damaged they are automatically detached from the society and they are rendered useless which lowers the self esteem of the victims and many times they commit suicide and this is what the attackers want. So according to the girls if the victim accepts the fact that face has nothing to do with the ability and talent of the victims and they can do everything in life whatever they could have done before the accident and this will be a huge setback to the attackers that for what they attacked their victim did nothing and this will be the actual punishment to the attacker apart from the legal punishment to see the victim is thriving in life even with acid burns

THEME 3: CHALLENGES AND PROMISING PROSPECTS

CHALLENGES

There are many different kinds of challenges faced by the burn victims/survivors and various stakeholders. Thus it is important to list these challenges categorising them under separate heads before they can be addressed.

INFRASTRUCTURAL CHALLENGES

This section delineates the lack of infrastructural facilities and services in most hospitals which have a significant bearing of the treatment of burn patients and survivors.

1. Available services in the hospital are very limited in scope and range. Furthermore, it was also found that most of the available facilities were also not adequate and satisfactory.

For instance, the researchers in Telangana found that the conditions in the burns wards of two major govt hospitals in Hyderabad (Gandhi Hospital and Osmania Hospitals) are quite deplorable with no proper beds and post-surgery facilities. In many places, there are no special ward, as in the case of *****hospital in Telangana where burn wards are subsumed under the department/ward of Plastic surgery.

And one can see that such is not a problem in only one state, even Delhi's best govt hospitals are not satisfactorily equipped.

*No there is no separate beds for women in this ward said a Doctor at **** hospital in Delhi*

The only problem that we say is that there is less number of hand less OT timings and the patients have to wait, there is a waiting to be admitted in the hospital - HOD at a leading govt hospital in Delhi.

In India, there is inadequate infrastructure for burns. Under infrastructure, there are two things- gadgets and personnel. In public hospitals, you can order as many gadgets or machines you want. But in terms of personnel, the doctor patient ratio and nurses patient ratio is abysmally bad – doctor from MH

Shortage of staff as the main problem – remarked a dietician

*Some of the challenges include blood arrangements which is very crucial for blood transfusion in burn patients and delay in that causes death. The other is patient care, due to limited resources and area. Sometimes with limited seats and more number of patients it becomes difficult to treat patients but RML doctors and nurses do their best to meet the challenge stated a doctor in **** hospital in Delhi.*

2. Lack of clarity in terms of the treatment. As shared by a doctor who worked with burn treatments earlier pointed out

In KEM hospital, Mumbai burns were treated in two departments- general surgery and plastic surgery department. The convention at that time in the hospital was that anybody with above 50% burns was treated by general surgery department while one with below 50% was treated by plastic surgery department. This is because there was an understanding that those below 50% are “salvageable”. There was a very disturbing thing that used to happen at that time was whenever a patient with borderline burns percentage would arrive, general surgery residents would say 45% while plastic surgery residents would say 53%. There was a reluctance to treat burns from both sides

3. Lack of coordination amongst various departments of the hospitals which may lead the patient to drop follow up in the long run.

*doctors from other department attend promptly when they are called but follow up is very difficult where patients have to visit their OPD respectively – said a doctor from *** in Delhi*

4. The methods of storing Data in most hospitals across all states are inadequate as it is recorded manually, as informed by most medical practitioners. Although, one doctor in Telangana did share the possibility of digitising data about patients, in his words.

No, currently data that is stored in the record section is not fully computerized. They are trying to get good user friendly software, and then these data will also be updated

Since these are MLCs, there is a need for proper documentation of the evidence which can help in dealing with such cases. An UNFPA associate during a knowledge sharing workshop in MH, emphasized that it is important for all of us to work together and come up with a standardized protocol for providing treatment and collection of medico- legal evidence. The entire aspect of medico- legal evidence and taking cases of logical conclusion constitute holistic justice

Additionally it was found that in some places where SWs are positioned in the hospitals to work with and help burn survivors as in the case of MH, some women did speak to these SWs about the real cause of their burn which may times was intentional but the social worker documentation does not have the same significance as that of a medical professional in the court. They struggled with the medical professionals and the police to get that documentation done so that if a family decided to go to the court something can be done.

5. Treatment in the private hospitals is not easily available as unlike the govt hospitals where it is mandatory to admit and treat burn patients, private hospitals do not have to follow any strict guidelines. As mentioned by a doctor in Telangana,

Private hospitals refuse admissions

6. Sometimes, treatment of the patients cannot be completed for various reasons which is a hurdle for the full recovery of the patients.

Many times, treatment is not complete as the patients are taken away - Not specially domestic violence, a lot of them take away because they have other problems, we get them to sign on the LAMA form or many times on the DUPR form, Discharge upon Personal Request. DUPR is when the patient should stay back 1-2 days but is otherwise stable, LAMA is when the patient should not be discharged in any condition- doctor

7. Capacity/resources to provide holistic care is limited amongst individual stakeholders: It clearly emerged that burn patients need a holistic treatment (not only physical but also psychiatric and psychological) but it is not always achievable as there is lack of coordination amongst various departments

We have everything to help us in giving proper healthcare, the problem comes in coordinating with other departments – said a doctor from burns department

Thus it is important to ensure a comprehensive support for the patients, which is difficult. During an interview with a doctor in MH, he remarked,

in acute stage, we only take physical care. But we don't know what happens to those women in their families.

It also emerged that in many cases, **psychiatric help** is not sought unless referred by the doctors treating the burns of the patient and the incidence of patients being referred to the psychiatry or psychology departments are negligible.

The department of Psychiatry has an in-patient program as well as an extensive out-patient program. We see large number of patients in a day. We are a staff of five people and yet we receive around 300 patients everyday. We have separate wards for men and women. We don't visit to Burn Ward. If doctors from Burn ward feel that the patient needs psychiatric help, they can refer the patient here. We have not got any referral from Burns ward in last many years, remarked by a doctor from the psychiatry department.

Rehabilitation is also a very significant part of the holistic treatment of burn patients which, as found in most cases is difficult and unsatisfactory.

As far as rehabilitation is concerned, how can we control what is happening in their homes. Yes, our counselors follow up. But there are certain limitations, right now we have 3 male counselors and 1 woman counselor, the male counselors cannot intervene in the family issues. And if they do then there are marital discords. So the questions is how can we revert the marriages which arise out of our social situations. We can only help with psychotherapy – Doctor in Delhi

There is also lack of special training for the medical practitioners especially nurses who emerge as a vital point of support for the burn patients. The patients interact with them, confide in them and look up to them for support. Some nurses during an FGD did voice their concerns regarding this

We are not given special training but we learn while being on our duty in burn ward on rotation

STRUCTURAL CHALLENGES

- 1. Socio-economic background of the victims:** since most of the victims hail from low socio-economic background, they face problems at multiple levels, one, because of their financial situation most patients are unable to avail hospital services for themselves. This happens despite the govt. hospitals providing free treatment to burn patients. It, thus, leads to heightened mortality rates as pointed out by a doctor, who is also the HOD of a leading govt hospital in Delhi.

the patients are so poor that they do not have the money to come to the hospital; they are so poor. It is basically the poverty that kills the patient.

Two, most victims do not share the exact cause of their socio-economic background,

Mainly its family pressure because most of them are from lower socio economic group and they are not independent; they are dependent, economically they can't survive on their own for long time and the social pressure they have on them. They can't take their own decision separately unless they are compelled so they don't take those drastic decisions and even their own family pressurizes the victim to tell it was an accident, said a doctor in Delhi

2. State Support for the victims and the stakeholders

From the available data, it is fairly clear that it is important to look at policy changes and macro-level interventions as a significant support system for the people involved in the issue. There are no specific policies for burn survivors (only acid) and general welfare schemes are inaccessible and there is a lot of red tap-ism that needs to be navigated.

It is also important to look at the legal definition of disability which needs to include fire burn victims within the group.

Doctors have no proper mechanisms to address the issues of DV even when they know that the patient they are treating is a clear cut case of DV as expressed by a doctor in Delhi

In such (DV) cases we do not know what to do, nor we are aware that legally can we intervene or not. And even if we want to, professionally we may not be permitted as each such case may take lot of our time in terms of going to court for legal proceedings

Some also opined that there is a need to address the issue at its root, rather than trying to treat the patients who are a victim of much deeper malice in society. And this, as expressed by a some practitioners is only possible when the state steps in

The government should pay attention to the prevention of burns because it is more of a social problem, where in marital discords/conflicts are playing a major role.

Corroborating this, another doctor, Dr. Sanjog Sharma, in Delhi also remarked

Work needs to be done at the grass root level, to see where the problem starts. We here at the hospital cannot do more than just save them.

Another one from MH remarked,

It should be considered as a public health issue like trauma and emergency care

Another challenge is the lack of legal support for the patients –

The patient needs to be looked after in the hospital as well, so they can share their stories. I know a case of a girl who was burnt Her case was dragged on for 10 years in the court her doctor I was summoned in the court during the hearings. Ultimately the

man with the power will win. In our judicial system justice is never provided to victims, most of the times not provided – Dr. Bhandari. HOD of GB Pant hospital

He further added,

legal cases are difficult to pursue by the patients - As her doctor, I was asked to give my account and medical opinion about the patient in the court. And i did, they would call me once a month, or sometimes once in 3 months to come to the court, but then nothing happened. The case kept going on like this for years. There is no support for these women out there. The justice system is slow, the policing is lax, and the patients do not have any money to afford good lawyers, pointed out a doctor.

As it has been mentioned earlier, private hospitals do not usually engage with burn patients/victims and sometimes even when they try, it is difficult for them to address/treat the burn patients due to lack of state support. This was evident in the efforts made by a private hospital (Aakar Asha Hospital) in Telangana which tried for the govt scheme viz. Arogya Sri affiliation but could not manage to get it.

3. Lack of Social Workers/ Medical Social Workers And NGO Support

It also emerged that there is lack of integration between different structures like the family, state and non-state entities. It was found that very less number/sometimes no SWs within the hospital settings, which also hinder the holistic treatment of the patients. Sometimes, it is the nurses who do counselling to the patient and their family members but only in limited capacities. In Telangana, a doctor pointed out that neither the burns ward nor the **** hospital has the full time social workers to cater to the psycho-social needs of the patients.

And in some places, even when SWs are there, they do not address the issues of burn patients, as it emerged in one hospital in Delhi, where

*MSW does not have much role here, she is basically working for destitute, old patients, these types of things. She is not involved in domestic violence. – doctor at *** hospital*

It was also found that there are no NGOs and other organisations working with burn victims and survivors. When asked about if any NGO is working to help these women patients in Delhi, a doctor stated,

till date there is no NGO who are working for women burn victims and it is very much needed because the government is only concerned with the treatment of the patients and the most significant thing is the psycho-social aspect which is neglected all through and even if the doctors want to do something they can't do much due to their heavy work schedule.

Another doctor in MH remarked

There are no NGOs working on this issue here. It is a neglected field.

Sometimes, there are NGOs and civil society organizations working on providing support of different kinds and rehabilitation to domestic violence survivors but there seems to be lack of awareness at the hospital level on the existence of such organisations. On the other hand the outreach of these agencies does not include fire burn survivors. There seems to be lack of awareness on this particular group and there do not have the required skills and resources to cater to the need of women burn survivors.

4. Lack of family support

It was also found that most burn patients had very little family support. Either they were the victims of DV or in case of accidents, left by their families. Post the incidents, they become extremely vulnerable due to our social structure and mindsets. This, was in addition to the severity of burns which is higher in women than men.

...dealing with women burn patients are little complicated compared with men cause generally they are abandoned by their husbands and his family due to burn disfigurement and sometimes the parents also abandon the women patient when they are poor and due to financial crunch these women are left on their fat

It was clearly evident that most successful cases were because of the support that the women get from their families, which was also restricted in most circumstances because of the poor socio-economic situation of the families.

ATTITUDINAL/PERSPECTIVE CHALLENGES

Other than the infrastructural and structural challenges, another set of challenges were faced in the sphere of attitudes of patients/victims and various stakeholders.

At the level of the patients/ victims/survivors

Biggest challenge is to get the patients talk about the real cause of their burns. There is very less reporting of the actual cause which leads to the silencing of the voices of the women on the issue DV.

Women don't report the exact cause. They actually commit suicide but don't report that. They report that as accident. It happens very often and they do that because of their children. Often they go back with their husbands, sometimes even their own families don't accept them back – FGD with nurses

90% of women don't file a case as they are not financially independent. They are scared of their husbands. They care for their children –a Doctor from Noida.

The family should be honest to us, they do not share the actual details about the incident. We cannot force a confession out of them. There is no pressure from the hospital staff or

the police to know what happened. The FIR is filed only when the SDM asks us to, or if the parents want to, who in most cases don't – FGD with Police officers

There is also a lot of victim blaming as the family members who are with the patient constantly tell her that look what she has done to herself – pointed out during knowledge sharing sessions.

Secondly, it was also found that the patients may not cooperate during treatment as shared by a dietician in Delhi,

The patients are counselled to follow a particular diet, but many time they do not. Soups are provided twice a day. Those patients who have made 1/3rd recovery can consume food products which are rich in protein, 70% though still receive proteins nasally and 1/3rd can consume liquids orally. It all depends on the severity of the burns.

Follow up with the patients is another major problem. During two FGDs with nurses in two different hospitals, it came up that follow ups are rare, despite counseling.

Counselling is given to both the partners, and it helps them, it affects. Follow up is an issue with the patients. We cannot convince or reach out to patients who don't follow up - FGD with nurses

One doctor from Delhi suggested

if follow up is done in Burn ward only then it will ease the patients' harassment and the number of follow ups will also increase which is very less at present after discharge.

Many a time that could be because they are suicidal.

Yes, there are many patients who are suicidal and refuse to take their supplement, they will not eat their food. Mostly they show signs of aggression and anger, and they are hostile towards the staff. They choose to stay alone, by themselves. Many other skip meals because of the trauma and its mental effects.

As noted by a dietician in Delhi, most patients do **not even follow the given diet after getting discharged**

Before they leave, we counsel them on the importance of healthy diet, many of them do not follow it. They don't consume protein rich foods, or they don't come for follow up visits. They are supposed to have 50 grams of protein each day to make up for the loss they suffered because of their burn injuries.

Many practitioners also remarked that lack of awareness among patients has also contributed to the cases. The HOD of another hospital stated

there are many barriers, how do you even count them all. Illiteracy for one, many of the women do not even know that their husbands cannot beat them. They are not aware of their laws and rights, they have grown up all their lives listening that it is a ghar ka maamla. How will then they know that it is wrong? Second comes poverty, since they are not educated they don't have jobs, no jobs so no financial independence. Now, when these cases happen they only think about their children, if they complain, then the husband will take away the kids. They are scared most of the time

The biggest one is of course lack of reporting on the side of the patients about the real cause of the event which leads to diluting of the issue of DV and there are no supporting mechanisms that can ensure a cross checking of the statements given by the victims. It was pointed out during knowledge sharing session that disconnect between providers observation and what woman is saying is not recorded in the medical records. Consequently, there is no space in the protocol where all these things can be mentioned. There is also a huge time lapse between the forensic doctor meets the patient, usually after a week or more when a lot of medical intervention has already happened.

At the level of practitioners and other stake holders

From the data, it emerged that there is a need to differentiate between acid burns and fire burns. A doctor from MH pointed out that in cases of burns cases, acid burns have taken greater attention compared to fire burns. Because of the blurred distinction between the two types of burns, there is no clarity about the differentiation between violence in public space (resulting from acid burns) and domestic violence. Thus, it is important that when the patient is brought to the hospital there is a mechanism to record the history of the patient and the exact event, notify the police and record the dying declaration. This comprehensive recording of data is needed to develop the standards of treating the burn patients. And for this, it is imperative that there is a clear distinction between the reasons for different kinds of burns so that the cases can reach their legal conclusion.

The attitude of practitioners towards Domestic Violence is also a significant point to look into wherein they may not give due importance to the cases of domestic violence, thereby consciously or subconsciously making it a trivial point to look into.

*It is evident that the doctors were not paying attention to the domestic violence issue, supporting the women /family during the dying declaration process or in registering the legal cases properly - Ex forensic head in **** hospital in Telangana*

It was also found that sometimes the MSWs dissociates burn cases from DV cases as evident in the following quote

No, we do not counsel the burn victims, we do not meet with them also. We only see domestic violence victims and sexual assaults, MSW in Delhi.

or they when say

there is no follow up for DV cases, it is a family matter

Training is required for all stakeholders to deliver trauma-informed, DV-informed care. Otherwise there is evidence of re-victimization.

At the level of general public

Discriminatory attitude of the people towards burn survivors

The main challenge is the psycho-social aspect which is all through neglected for patients because burn patients are treated as cut-offs from society especially women and this often leads in non reporting of domestic violence by women as they know that if they survive the only place she can go is her husband's house, so many times they tell they met with accidents. Oppression of women prevents reporting domestic violence – doctor in Delhi

With burns, Psycho-social stigma is there. Disfigurement happens, especially females face lots of problem in society and acceptance is a problem –FGD with nurses in MH

Thus it is important to involve more people in helping with the treatment at their own level, an issue that arose during an FGD with nurses in MH,

For eye donation, people are ready but not for skin donation due to religious beliefs. More awareness needs to be created. We just take skin from thighs and back. Skin has a shelf life for 3 years. Skin can be stored. Skin is not only used for burn patients but also for diabetic patients.

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it was also pointed out that even if efforts towards the rehabilitation of survivors are made, it may not have the desired impact

***They need education, or some sort of vocational training,** but even then no one will employ a person with deformity in their homes as a domestic help. We would not like to take food from people who have deformed limbs, and this is about our outlook regarding these patients. We as doctors come across such patients and cases almost everyday, but as someone who does not, you won't give them a job – HOD of a gvt hospital in Delhi.*

The women can disfigured faces can be put to work in the kitchen and those with less disfigurement can work as waiters - HOD of another hospital in Delhi

People here are not very sympathetic with special people cause at first I was afraid and uncomfortable to meet the acid victims, but I understood that they are also like us but met with an accident – interview with Khaas

PROMISING PRACTICES

There is recognition amongst health care providers of the existence of DV/history of violence as a crucial factor in occurrence of an incident of burns.

There is recognition amongst health care providers of the importance of psycho-social care in the recovery process of burn survivors.

There have been a few attempts to provide such support within existing framework Ex 1: KMC Doctors follow the practice of taking multiple histories at different point of time to get a full understanding of the background and provide the patient with enough time to open up and share their experience. Ex 2: There have been attempts to connect survivors to government schemes and services such as providing disability certificates in Salem and KMC.

Ex 3: Some initiatives exist that try and connect survivors to economic empowerment schemes, training, employment etc in Ganga Hospital.

Ex4: NGOs like Chaanv foundation trying to create non-state support system by training and rehabilitating the burn survivors

There is willingness to connect with other services, expand services etc. Through the NPPBI, Salem and Trichy will soon be getting separate burn blocks. Government sanction has been provided to expand to separate 10 bedded burns ward in Dindigul and 12 bedded burn ward in Thanjavur as opposed to the current situation of being attached to general/plastics wards. These are great opportunities to develop a more integrated model. Telangana govt has increased the health budget for the year 2016-17 by 1-6%. There are also plans by to dismantle the present Osmania Hospital and construct a new building in its premises, and 3 more super-specialty hospitals are being planned for Hyderabad city. Furthermore, during the researcher's meeting with police officials (Mr.Mahesh Bhagwat, Commissioner Rachokonda, Mr.Amit Garg, Additional DG CBCID (Andhra Pradesh), Ms. Soumya Mishra, Additional DG CBCID (Telangana)), who shared that there are also talks regarding the compilation of data in the Crimes records bureau about developing a category for burn survivors, which can be achieved.

There is a possibility of a public and private partnership model - in one instance in Telangana, it is being implemented for patients who need Dialysis. Similar possibilities were found in poor people getting treatment for certain identified ailments in the private/corporate hospitals and the government would reimburse those costs to them and government hospitals also got money under this scheme as it is tied with Insurance Company. One of the other advocacy agenda for PCVC is how we can get compensation for the survivors of violence. It emerged that Central Government Victim Compensation Fund can be used for these women.

Similarly another MoU has been signed with United Care Development services to maintain the equipment in the Gandhi hospitals in Telangana. Because most of the equipment lies unused

because of minor problem and personnel hiring or maintenance agreements are not signed by the hospital management.

There are also organisations like *khaas* which employ people with disabilities. They also plan to have some new ventures - a two storied restaurant with another partner. One floor will be named Khas Matrimony and one Khas Kheer which will specialize on kheer a traditional dish of India and blind girls will be employed here to serve and prepare. And the Khas Matrimony will be for made for the blind girls, acid victims and for disabled persons. And the people who will operate the business will be HIV positive girls as they are also cut off from the society

THEME 4: INTEGRATED RESPONSE

The data from the four states have revealed certain **emerging points** for addressing the issues:

1. There already exist opportunities and willingness in the private sector for economic empowerment and their reintegration into the society. But all such efforts seem to be working in isolation. Therefore there is a need for a more co-ordinated approach of working, using which all actors like hospitals, support services providing NGOs, law enforcement agencies and private sector for a more holistic system of support for women burn survivors
2. Within the hospital there exist support structures for extending care to burn victims other than physical such as psychology department and psychiatry department. If resourced well with human power and skills, there is a possibility of establishing more comprehensive burn care within the hospital itself
3. There is a willingness amongst health care providers to extend support to women so that she is able to get justice but are not aware of the possibility and process for the same

Furthermore, there were certain **needs** that were recognised:

1. Burns treatment is a multi- modality treatment. It involves patients, doctors, nurses, relatives, physiotherapist, and counsellors. Everyone has to work in a coordinated manner so as to improve the outcomes. As suggested by one of the doctor for addressing psychosocial needs of burns, the major points are opening up of a Yoga/meditation center, facilitating burn survivors to meet burn patients to motivate the patients, give them mental strength to cope up with the situation, as mental support accentuates the healing process i.e. a need for peer cohort is essential. And most importantly a proper mechanism for follow-up for the patients after discharge needs to be put in place.
2. It is evident that health care providers recognize the relevance and criticality of comprehensive care for burn survivors, particularly women, which is more than just medical treatment. Out of the four states, it was found that although many stakeholders alluded towards a more comprehensive support system for the burn victims and survivors, such a holistic system was not found in all four states. As mentioned earlier, there are many challenges, towards building a more integrated system which can address

social, legal, economic and psychological needs of the survivors. A Yoga/meditation center in the hospitals may help in meeting the psychological needs of the patients.

3. This needs an integrated system which means addressing different issues vis-à-vis the burn survivors and DV victims through different platforms and integrating them into one. Thus there is a need to build a comprehensive system with collaboration between legal, state (police and health institutions), non-state (private hospitals and NGOs) and family institutions trying to address issues at the level of creating awareness, devising methods, firstly to contain the cases of DV and secondly, how to empower the survivors and devise long term goals if they have been victims of DV. But all this is possible when the survivor develops enough self-confidence to address the issue and deal with the circumstances.
4. There is also a need to create a community of survivors where they can help each other and give each other strength. Facilitating burn survivors to meet burn patients to motivate the patients to give them strength to cope up mentally, which in turn, may lead to faster healing process. So peer cohort is essential and needed.
5. In the discussion in Mumbai, it emerged that many doctors have tried to provide a more comprehensive treatment to their patients by coordinating between the different departments, at times even different hospitals for medical, surgical and psychological treatment. But it doesn't give out anything in terms of support outside the hospital once these survivors leave the hospitals.

The integrated model of care offered by PCVC is unique and nothing similar exists anywhere else in the state. It is also the **ONLY** model that focuses on psycho-social rehabilitation.

However, some other models of burn care that can be leveraged/expanded are as follows:

- ❖ **Ganga Hospital: Hope after Fire:** The Hope after Fire project is a collaboration between Ganga Hospital and the Rotary Club of Coimbatore Metropolis to provide holistic burn care to survivors of burns. Through this project, Ganga Hospital conducts free contracture release surgeries, post-burn rehabilitation including physiotherapy, pressure garments, splint. They also have 2 social workers and 1 psychologist on their team that work on providing some psycho-social services to survivors.
- ❖ **Grace Kennett Foundation:** A private hospital that provides surgical interventions, physiotherapy, pressure garments and splinting services to burn survivors, they also offer emotional support through counselling. All services are charged.
- ❖ **Salem Government Hospital:** Help connect burn survivors to government schemes by helping to issue disability certificates.
- ❖ In Delhi, Possibility to expand current NCW- TISS initiative under which counselors have been placed in all CAW cells. These counselors can be

equipped to provide legal awareness within burns wards, provide psychosocial support within wards etc.

- ❖ Nursing staff at the hospital emerges out to a potential stakeholder at the hospital for providing preliminary psychosocial support, awareness on legal aspects, rehabilitation opportunities and counseling, if given the required training and are well resourced in number
- ❖ There are public-private partnerships in Telangana with regard to the treatment of dialysis. There is also a MoU between hospitals and United Care Company. Something similar can be devised to include the burn victims and survivors.