CHAPTER 9

SUMMARY FINDINGS AND DISCUSSION

The use of sex-disaggregated analysis to understand patterns of disease and deaths is an acceptable practice in health research. However, feminist and health equity oriented researchers have gone beyond this and looked at gendered patterns in morbidity, access, utilization and treatment of various illnesses. The high incidence of burn injuries and deaths in India led to the National Programme for Prevention of Burn Injuries (NPPBI) acknowledging that over 7 million burn incidents take place in India and 1,40,000 burn deaths every year, making burn injuries the second largest group of injuries after road accidents. The programme document states that burn deaths in women are higher as compared to men. (Gupta et al, 2010). Despite such compelling evidence and acceptance that burns mortality is high in women, the questions that remain unanswered are why so many young women die in kitchen accidents and what is happening at the hospital level in caring and responding to burn injuries.

This research examines the phenomenon of burns from a gendered public health perspective and not limit it to a bio-medical one by attempting to understand who suffers burns injuries, why women suffer burn injuries more than men, and how responses are influenced by gender at the individual, societal and system level. It enquired into the nature and patterns of burns injuries and the response of health systems. As described in chapter 3, the conceptual framework for the study uses the Liverpool School of Tropical Medicine's gender and health framework to public health and further the Haddon Matrix to understand burn injuries in terms of factors contributing at the level of the individual, the physical and social environment before the event (incident of burns), event (during and immediately after the incident) and post event(after the incident of burns) as indicated in Figure 3.1 Applying this framework, detailed interviews with survivors/victims, and/or family members, were carried out to understand the victim's environment. Twenty two such interviews with survivors/ their families, twenty six interviews with health providers in burns care and eight key informants in the hospital setting were conducted.

The chapters 4 to 8 present the findings of the research. This fills in an important gap in current literature on the subject as it unravels the circumstances surrounding the incident, the reporting

of cause of burns, the pathway to care, the response of health system and the role of the family in care and recovery. The study uncovers critical gaps in information gathering at a hospital setting and the lack of will to enquire into the manner of burns, by a systematic analysis using gendered public health approach. The research highlights how these gaps hinder the development of any prevention strategies as there is no reliable data on causes of burns. The study is important as it highlights the systemic avoidance/reluctance to enquire into the cause of injury which is further compounded by a tendency to trivialize the matter. The study also highlights the lack of clinical and medico-legal protocols for caring for burns survivors thus affecting their access to the even minimum standard of burn care and access to justice.

The various gaps pose a big challenge in a comprehensive understanding of the issue hindering the development of any systematic approach to address burns. The doctors, nurses, police, and natal family are silent spectators as they watch the women die due to the patriarchal notions of family honour, private matter and the acceptance of domestic violence as normal behaviour**.**

Most importantly the links between burns injuries and experience of domestic violence are established through this work. But the health system has no mechanism for documenting experiences of domestic violence. Most often than not, domestic violence is considered as a personal issue that no one wants to get into. Hospitals and health professionals too perceive it as a private matter that they should not intrude into. The thesis strongly argues for recognizing the gendered nature of burns injuries and need for a gendered public health response to it that recognizes steps to be taken at all levels of the health system.

India has committed to implement the Global Plan of Action to strengthen the role of the health system to address interpersonal violence, in particular against women and girls and against children at the 69th World Health Assembly in May 2016. (http://who.int/reproductivehealth/topics/violence/action-plan-endorsement/en/) The global plan recommends actions for

- strengthening health system leadership and governance through provisioning on the issue
- strengthening health service delivery and health workers'/providers' capacity to respond to violence, in particular against women and against children,

- strengthen programming to prevent interpersonal violence, in particular against women and girls, and against children
- improve information and evidence

This provides an opportunity for the Ministry of health to develop a comprehensive plan for a health systems response to VAW.

The following section looks at specific questions that arise from the findings and contextualizes this within the patriarchal institutions of family, community, institutions (medical and police justice)

The following issues emerging from this study are discussed in detail:

I. The burns burden- how data gets reported?

II. What are the circumstances around incidents of burn accidents?

III. What is the hospital response? What can improve in clinical and forensics response?

IV. How can a gender informed approach improve the response to burns?

V. What needs to change to make hospitals gender sensitive?

Each of the above questions that emerge from the research is examined further in the context of evidence available on the issue and deeper interpretation of the findings of the research.

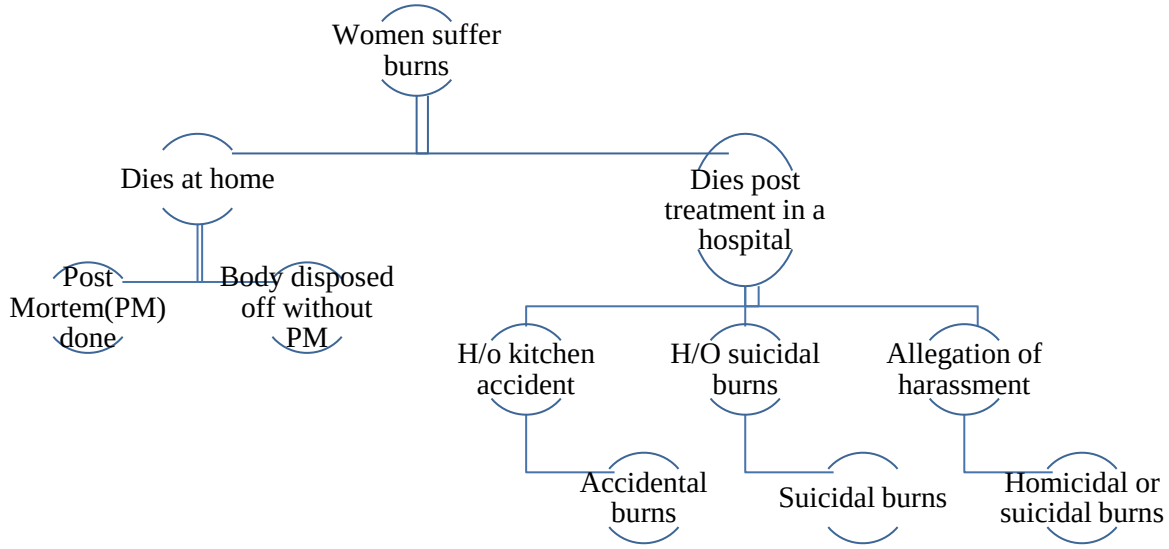
9.1 Inadequacies and inconsistencies in Recording Burns

One of the most critical aspects of any public health planning and policy is reliable and accurate data. Such data on burns injuries is simply not available. India does not have a national injury surveillance system or a burns registry and the only official source of information about the incidence of burns morbidity and mortality is from police records. Hence, if there is underreporting that leads to lower incidence of burns morbidity and mortality. The cases of burns deaths are categorized as "bride burning" or "dowry deaths" in NCRB (police records) and for the year 2014, this number was 8455 for India. Dowry deaths may be due to burns, hanging or poisoning but for purpose of this discussion, all these cases are being considered as caused by burns. The report on Accidents and Suicides by NCRB 2014 provides information on fire accidents in kitchens noted as cooking gas cylinder/stove which was 2582 females for entire India for the year 2014.Taking these two data together (dowry deaths and fire accidents in the kitchen) the number of such deaths is 11037 or 12% of the estimate of 91000 burns deaths per year arrived at by the researcher in Chapter 4. The estimated figure of 91000 possible burn deaths is eight times that of the police records indicating the huge gap in official statistics. Sanghavi, et al in 2009 have reported that their estimate on fire related mortality based on causes of death (male and female) was six times more than the police records.

The data in the public health field largely based on hospital-based records of burns patients as described in Chapter 2 indicate that burn injuries and deaths are a major public health problem and more women than men die due to burn injuries. However, there are several gaps in reporting of deaths caused by burns amongst women.

The following figure provides a snapshot on how data on burn deaths is collected and categorized.

Figure 9.1: Data recording in cases of burn deaths



Women who undergo burn injuries are brought to the hospital that has specialty care ward directly or through delayed referral. Providing the necessary care, recording the episode and reporting the same is linked to the way key institutions like family, police and health systems operate. Within this, the role of the family is vital as they may just report the incident of burns as an accident. This may be due to several factors; husband and conjugal family may be guilty of causing the burns or may be inflicting violence that led to a suicidal attempt. The natal family may not know about the abuse faced by the woman or may have advised her to bear it. Families may not want any police investigations since there is a concern about the future of the children who may be abandoned by the father and his family. These are aspects rooted in patriarchal structures that overlook violence against women within the family.

This ensures that there is no record of domestic violence and no investigation into the cause of burns, resulting in these being erroneously recorded as accidental burns in kitchens. Further, there is no mechanism for collating data between hospitals and police or for that matter within

the various levels of the health system. This results in an overall undercounting of burns under Crimes Statistics in India.

Recommendation

Need for injury documentation and national registry: There is an urgent need to document and collect accurate data on burn injuries and deaths from health facilities, police records, and cause of death registers. Currently, there is no mechanism to collate this data. The national injuries registry that has been proposed under the NPPBI must include critical information about circumstances of the burns incident and history of domestic violence so that a better public health response is developed.

9.2 Busting the kitchen accident myth

The medical literature reports on the high incidence of burn deaths in young women as being due to kitchen accidents and the NPPBI document also mentions this as the cause of burn injuries and deaths for women. This research brings into question the myth of "kitchen accidents" through a detailed study of perspectives of women patients/their families, experiences of health care providers currently engaged in burns care and experts in the field of public health, women's movement. The findings point towards the collusion of patriarchal attitudes across the institutions such as family, health system and the police. Domestic violence in all its forms physical, emotional, sexual and financial was reported by 18 of 22 women spoken to in the study. Experiencing domestic violence was one of the most significant risk factors for suffering burn injuries contrary to the reported stove and/or cylinder blasts or the perception of *saris* and *dupattas* that are likely to cause burn injuries.

What emerges from the narratives of women are the societal compulsions that made them record what was clearly the consequence of domestic violence as 'accidents'. The looming fear of arrest of husband and fear of police investigation pushes the facts under cover and the story of 'kitchen accidents" became the dominant narrative. Women said that they deliberately reported incidents of homicide and suicide as accidents as they did not want any police investigation lest their partners are arrested. Even those who reported suicide did not mention domestic violence to the hospital or police for the same reasons. Women are conditioned not to speak about domestic violence to preserve the honour of the home, caste, and community. The strong link between burn injuries in women and experience of domestic violence is established through the study

The decision to report the incident as 'accidental' was taken by women who knew they will survive and also by those who were not so sure of their survival. Women succumbed to family pressure and their concern for their children and husband prevented them from speaking out against the abuse faced by them. There is evidence of women reporting burns incidents as accidents to protect their abusers from direct work with burns victims as well as research**.** (Bhate-Deosthali, et al 2016, Belur 2014, Sharma 2002, Fernandes 1999, Rao 1989)

The studied silence about the actual cause of the incident, investigation, and documentation in cases of burn injuries and/or deaths in women is intriguing. The doctors, nurses, police, and

natal family are silent spectators as they watch the woman die due to the patriarchal notions of family honour, concern for their children and the acceptance of domestic violence as a private matter and normal behaviour.

Patriarchy of the family and state institutions operate in tandem with each other to build the story of 'kitchen accidents'. First, the social control of women is evidence of the widespread occurrence of DV from an intimate partner and marital family. Secondly, the refusal of natal family, community and state institutions to intervene contributes to worsening the situation by pushing women back into the same violent space or 'death". As reported in chapter 5, women spoke about experiencing various forms of violence and for long periods. This incident was not a result of a single episode. The private and public patriarchy as enunciated by Walby in 1990 can be seen to operate here in tandem. The interaction of informal and formal institutions within the public and private domains of women's lives reinforces their subjugation and reduces their credibility and legitimacy in both spheres (Weber, 1964) As reported in chapter 8, all the procedures laid down by law are carried out merely as a drill. Not a single woman reported a visit by the police to the place of incident. The role of the police is known to be problematic in dealing with domestic violence. The medical system too has known to connive with patriarchal attitudes as seen in their role in sex determination thus creating a market for the son preference and devaluing daughters, in commenting on the hymen and size of vaginal introitus and obsessing over past sexual history of rape survivors and in its reluctance to intervene in cases of domestic violence as it is a personal matter. (Gupte, M 2003, Deosthali P et al 2005, Bhate-Deosthali, 2013).

Recommendation

Investigate: There is a need to investigate the abnormally high number of accidental burns amongst young women aged 18-35 years. Verbal autopsies, which have been used successfully to identify barriers at community and health system levels in cases of maternal deaths, could be considered as a method to enquire into burn deaths. Issues such as the role of family members when such accidents take place, and immediate medical care, need to be explored and documented.

9.3 Shortcomings in Hospital response

The gendered pattern in burn outcomes show that they continue to be low particularly for women as seen from the empirical work in three hospitals. The various tensions within the existing service provision such as: who should treat? (General surgeon or Plastic surgeon), where should the treatment be provided? (General hospital or specialized centre), what should be the standards of care? (Uniform for all patients or 'comfort care or no care' for those reporting more than 50% burn injuries), need to be addressed through clear directions and guidelines.

The study highlights the positive impact of setting up specialized centres for burns care that offer a multi-disciplinary approach to burns care. At the same time, it found the routinely available care is fraught with apathy, poor standards, and ill-informed practice of categorizing patients as "non-salvageable" /'non-survivable", thus leaving them to die. Furthermore, systemic problems such as resource availability, rationing of material that ails the public system make it challenging for hospitals to prioritise burns care as it is highly resource- intensive. The numbers are high and the burn outcomes continue to be poor particularly for women. Providers and key informants further reiterated this and what emerges clearly is the need to equip the primary and secondary levels of health care system to "treat" burns and not "manage" or give "comfort care". All underscored the need for clinical protocols for resuscitation, treatment, and referral. Experience in other countries has been that introduction of clear protocols for resuscitation, quick and effective management of burn injuries with latest surgical interventions has resulted in survival for those with severe burns and reduction in post burns morbidity. Success in these areas involves a multidisciplinary team trained in current state-of-the-art interventions and therapies, with the ultimate goal of restoring function and allowing psychosocial reintegration. (Kasten, et al 2011) The protocol led patient care (both nursing and medical) in Australia has facilitated clinical audit and standardization of care. (Greenwood et al, 2010)

Of those who survived the burns, the support of natal families was pivotal in completing the treatment and follow up. The completion of treatment for burns, which is a long process, requiring several follow up visits for surgeries and physiotherapy is gendered with few women following up for these services. The post burns contractures require several rounds of surgery and physiotherapy which are costly. These are necessary to reduce the disfigurement caused due to burns. This essentially falls under the specialization of "plastic surgery" and India is

recognized as one of the best places for the management of post burn contractures. But it lags behind in acute care. As one of the experts aptly summed it up "*The fact that we are the best in the world when it comes to managing post burn contractures only highlights the sad truth that our acute care continues to be decades behind the rest of the world."* It was reported that women are then pushed into closed spaces to living in seclusion from public gaze and glare due to the scars.

The medico-legal response requires complete overhauling so that the forensic role of health professionals in burns care is recognized and integrated into burn care in India. As reported in chapter 8, the lack of forensic documentation jeopardizes the access to justice. Figure 8.1 highlights the serious gaps between what is expected and what the current practice is.

Recognizing the gendered factors in current health service delivery and those operating at the household level, the experts recommend the need to innovatively place follow up services for women survivors of burns that ensure easy access to free surgical care, legal aid, psychological support and physiological and occupational therapy. The health providers spoke about the apathy and lack of interest in burns care while also highlighting its high cost. They underscored the need for state intervention and mandate for setting protocols for burns management and reviews. This calls for increased provisioning through adequate budgets for human resource and other material costs for running a burns unit

The material cost which only includes dressing material and medicine for one of the specialized units under this study was estimated as 2.5 crores a year for caring for 25 beds. There is a need to systematically study the cost involved in running good units in order to inform the actual requirement for setting up and running of the specialized units proposed under the NPPBI.

Recommendation

Clinical protocols for acute and chronic care: Need to implement protocols for management of burns care, increase the allocation of resources and conduct research on burn injury management. The psychosocial care also needs to be included within these guidelines

9.4 Need for a gender sensitive public health approach to burn injuries

Although medical literature repeatedly stated that burns are a major public health issue, a public health approach to burns management was found missing. There is no analysis of the causes of high occurrence of burns among women, no enquiry into the modes of information gathering in the hospitals. This lack of scientific enquiry into the causes of burning and the circumstances preceding the episode of burning, poor management, and outcomes of such cases indicates a lack of public health approach as well as a lack of recognition of the gendered patterns of burns injuries. An adoption of a gendered approach would have prompted the health system to raise questions, seek answers and organise systems to respond better. Questions such as:

- Why so many women suffer burns injuries?
- Why so many women suffer injuries when they are young?
- Why are women reporting accidents in kitchens? And so on.

There are no *investigations* into the causes of burns amongst women and no study on the quality of stoves or the lack of safety in kitchens. This is a serious omission as burn injuries are mostly preventable. There are no efforts to develop prevention strategies. This is most evident from the fact that, unlike road traffic accidents, despite so many women dying every day in so called "kitchen accidents", the issue has not prompted any campaign for making kitchens safe.

There is no exploration of why is it that so many young women die of accidental burns in kitchens after marriage when they are initiated into cooking as early as age 10-12. No question has been raised about why they cooked well in their parental homes but met with accidental burns in their marital homes, or why, when all women and girls cook wearing *sarees* or *duppattas*, do young, newly-married women end up with their clothes accidentally catching fire in the kitchen? There has been no effort to recognise burn injuries as a sign of domestic violence in health care settings. As pointed out by Karkal M (1985), if even one tenth of the burn deaths in women had occurred in any other industry, this would have attracted greater attention and a search for remedial measures. Since the victims are women, largely from lower socio-economic classes, such a large number of deaths remain unnoticed. Those who survive but are maimed or disfigured are left to face the social and psychological consequences on their own.

Based on this research, several new aspects were discovered which have implications for the understanding of the gendered patterns of burn injuries and more importantly for developing any response to it. The findings underscore the need to focus on socio-cultural problems versus non-human agents/hazards thus making a critical contribution to the field of burns prevention.

This research deconstructs the high reporting of "kitchen accidents" and provides an evidence base for developing a gender sensitive public health approach to preventing burns by focusing on changing gender norms, recognizing and detecting domestic violence cases within health settings, providing intervention services for survivors of domestic violence and improving the medico legal and clinical response to burns.

Most often than not, domestic violence is considered as a personal issue by hospitals and health professionals that no one wants to intervene. In fact, there is a systemic avoidance/reluctance to enquire into the cause of injury for women. It is observed in this study that women reporting burns reach this stage after a prolonged experience of violence and therefore strategies like querying about abuse as part of the clinical enquiry to identify violence at an earlier stage and provide necessary support services like counseling, legal aid, etc., needs to be put in place. This would enable women to resist and stop violence in their lives. The role of primary prevention strategies including awareness on the issue of domestic violence, changing existing beliefs that domestic violence is normal and integral part of families are important public health strategies. At the secondary level efforts to minimize harm already done and to prevent further injury from occurring such as a coordinated reporting system that protects the safety, confidentiality, and anonymity of women reporting violence and at the tertiary level, it refers to setting up of support services for responding to consequences of violence.

Recommendation

Need for going beyond sex disaggregated data analysis and bringing a strong gender perspective in research and planning on responding to burns. Need for researching gendered patterns in burn injuries going beyond retrospective studies and bringing in the voices of the survivors/victims.

9.5 Engendering the Haddon Matrix

The Haddon Matrix is used as a tool in Injury Research to understand the risk factors associated with various injuries and has been found effective in reducing road traffic accidents and other injuries. The framework for this research was informed by this matrix and specific questions were included in order to understand what happens pre event, event and post event. The WHO (2011), a document on Burns Prevention presents the epidemiology of burns and also presents the Haddon Matrix to indicate the focus on prevention. In this document, kitchen accidents assumed as an outcome of constrained cooking space or hazards endemic to cooking have not been deconstructed and thus the socio cultural factors contributing to the incidence do not find a mention. The research findings found different factors operating at the individual, agent, physical and social environment in the pre-event, event and post –event phases of incidents of burn injuries reported by women. The engendered Haddon Matrix shown in Figure 9.2 provides a perspective on preventing burn injuries in women and for improving response of the health system.

Pre-vent phase: This refers to factors that need intervention in order to prevent the occurrence of burns. The research highlights the factors such as age and early years of marriage, the experience of domestic violence (DV) at the individual level that made women susceptible to burn injuries. The lack of awareness about DV services of what to do and where to report DV was also a risk factor to burn injuries. Also, women had no positive coping mechanisms as there was a lack of awareness about what to do when one feels suicidal. With regard to agenda/vehicle of burns, the research identified only one single factor which is easy availability of kerosene for women at home. With regard to the physical environment, what was found was that women were alone in the domestic space when the incident took place due to their gendered roles that define domestic role especially cooking as their primary responsibility. With regard to the social environment, the WHO lists poverty, unemployment, lack of fire safety in buildings and the acceptance of acid throwing. The research has highlighted several additional factors in the social environment such as social norms that accept DV as normal including dowry, acceptance of DV as private, the cultural of silence around reporting of DV, lack of support from natal family post marriage.

Figure 9.2: Applying an engendered Haddon Matrix to burn injuries suffered by women

	Host (individual factors)	Agent/vehicle	Physical environment	Social environment-Gender roles and cultural norms
Pre event	• Age and early years of marriage • Experiencing DV • Lack of awareness about DV services to stop abuse and self-harm • Reduced kitchen safety as a mental health consequence of DV	• Easy availability of kerosene for women at home	• Small living space	• Uninterrupted access to gas/stoves for women due to gender roles • Social norms that accept domestic violence as normal including dowry • Acceptance of DV as private matter so no intervention by neighbours and community • Lack of support from natal family for married women experiencing DV
Event	• Lack of knowledge about what to do in case of burns	• Stored water in houses the only first aid available	• Alone so no one to intervene to stop fire • Time lapse for others to intervene	• Lack of knowledge about intervening in a burns incident • Reluctance to intervene due to fear of getting into "police case". • Lack of facilities for transfer to burns care facility • Lack of policy or law on prevention of kitchen accidents
Post event	• Poor knowledge of first aid and services for burn care • Access to treatment is gendered as seen in discharged against medical advice (DAMA), low follow up for ancillary care • Fear of arrest if the husband	• No report of damage in the house • No investigation into malfunction of stove/gas	• Low level of care in general- first aid, acute care and chronic care. • Access to acute care not uniform for all but based on percentage of burns • High cost of care	• Actual cause and history of domestic violence not registered in the health system • Conspiracy of silence over domestic violence by a woman, family, police, and hospital-- • Disability caused by Burn injuries not recognized in the Disability Law • No compensation for "kitchen accidents"

Event Phase: In the Event phase, the research uncovered several additional factors at various levels. At the individual level, the lack of knowledge about what to do in case of burns was found to delay the immediate first aid. At the level of vehicle/agent of burns, it was found that most households could access the limited stored water as first aid or a blanket to stop the fire. This is important to note as most are reportedly occurring in kitchens/ domestic space. In most of the cases, there was no one at home at the time of the incident and so no one to intervene or stop the fire, there was a time lapse between the incident and intervention to stop the fire by neighbours. But what emerged from the research were several factors at the social environment level that hindered an intervention such as reluctance to intervene due to fear of getting into a police case, lack of emergency service to reach burn care facility and a complete lack of policy or law on prevention of kitchen accidents.

Post-event phase: In the post event phase, the research found the gendered access to treatment as seen in women leaving the hospital against medical advice (DAMA) from the hospital, low follow up for ancillary care, and not revealing the actual cause of burns due to fear of arrest of husband as factors at the individual level. At the level of the vehicle/host, it was found that there was neither any report on damage in the house due to the incident nor any report of the investigation into malfunction of stove/gas. At the level of physical environment, the low standards of care in acute and chronic care, access to acute care not uniform but based on a percentage of burns. At the social environment level, the high cost of care, the actual cause and history of domestic violence not registered in the health system, conspiracy of silence over DV by woman, family, police and hospital, the lack of compensation by state for "kitchen accidents' and the Persons with Disabilities Act 2016 not recognizing flame burn injuries as disability. **Thus**, bringing in a gender perspective can go a long way in preventing burn injuries and effectively responding to them.

Recommendation

The NPPBI has a component on Prevention of burn injuries that must be informed by a gendered analysis. As depicted in Figure 9.2 .there is a need to develop a comprehensive plan to mitigate the risk factors such as to create enabling environment for reporting and recording of DV, develop mechanism for responding to DV within health sector and connect them with other sectors such as police, social services and justice and improve the acute and chronic burns care. Even in case of genuine kitchen accidents, investigation must be given same priority as investigation of road accidents and to make the family and community accountable for safety in homes.

9.6 Need to build gender sensitivity in hospitals

The failure to recognise burn injuries among women as a major concern is rooted in gender inequality. Health professionals and health systems need to recognise the gendered pattern of burn injuries in India. The existing role of health professionals in responding to burn injuries points to their failure to probe beyond what the woman says even when her history is not consistent with the injuries on her body. Even in cases of suicidal burns, to categorise harassment as reported by women as "maladjustment" or "quarrels", rather than as violence, points to the reluctance of the medical fraternity to go beyond medical aspects of care, and to the lack of understanding of VAW as a health care issue.

The health professionals have a key role on violence-related issues in a way that equips them to respond to the specific needs of survivors, documents the injuries and incident, and assists survivors in seeking justice. The research found that hospital staff was able to recognize the gap between the history provided by the woman and the injuries she had suffered by providing specific identifiers for the manner of burns based on the severity of burns, parts of the body that were burnt, and so on as mentioned in chapter 8. Though the law makes it mandatory for doctors to report all burn cases to the police the entire procedure is carried out in a mere drill as shared by staff and experts.

The normalcy with which providers said that women hide the actual cause of burns and that they cannot do anything about it makes them a part of the conspiracy of silence. Their attitude that this is not their role thereby stating that their role is limited to clinical care, is rooted in the lack of understanding and sensitivity to gender and power relations affecting health. It also clearly shows apathy to existing legal obligations. Providers not only accepted the 'false story of kitchen accidents' but also seemed to justify them. They were able to list the various reasons that may prevent women from speaking the truth such as family pressure, concern for children. They do recognize this as an issue of domestic violence but most of them felt that they have no role in the prevention or in seeking justice for her.

Despite over three decades of focus and advocacy on VAW by women's movements, textbooks on medical jurisprudence followed in medical schools in India still do not provide any systematic guidelines for examination of burn injuries or the links between burn injuries and experience of

domestic violence. The review of the textbooks highlights the lack of scientific information, missing data on incidence and epidemiology of burns, the absence of guidance on dowry deaths and domestic violence as underlying causes of burn injuries. There is no guidance on the role and responsibility of medical professionals to investigate the cause of burns in order to inform prevention strategies and assist women's access to justice. These contribute to the mindset "it is not our job" "we record what she says" 'getting into the true cause of injury is not our job but that of the police". The forensic role of health professionals in burns care needs to be recognized and integrated into burn care in India.

India's draft National Health Policy 2016, states that "*One major concern is the health response to victims of gender violence—ranging from sexual assault to acid attacks on women. While measures to prevent these are the focus, the health system must also bear the costs and undertake whatever it takes to access the appropriate services for these victims. At another level, women's access to health care needs to be strengthened by making public hospitals more women friendly and ensuring that the staff has an orientation to gender-sensitivity issues."*

The biomedical approach trains doctors to focus on the physical symptoms and most believe that their role is only to treat the reported health complaints. The biomedical model that predominates in most health-care settings does not help with the disclosure of domestic violence by women or enable an appropriate response from providers. Violence is often seen as solely a social or criminal-justice problem, and not as a clinical or public health issue. There is also a lack of understanding about inequalities faced by women in particular. Health providers, share the predominant sociocultural norms that sanction male dominance over women and the acceptability of violence— precisely, the attitudes that reinforce violence against women. (Garcia et al 2014, Deosthali and Malik 2009). They do not recognise gender inequality as a social determinant and fail to recognise the situation of and barriers faced by women.

Moreover, the lack of gender-sensitive protocols for documenting the history of violence, circumstances, patterns and position of burn injuries, prevents doctors from recording relevant and crucial information. Despite the severe and long term impact of violence on physical and/or mental health, the health sector has barely begun to recognise its potential role and responsibility in responding to violence against women. It is pertinent to note that VAW is not recognised as a public health issue and it is absent in the health policy and programmes. Health providers often

fail to document the current and past episodes of violence and limit their role to treating physical symptoms. (Garcia et al 2014) Efforts at creating a health sector response to domestic violence and sexual violence are underway but they need to be upscaled. (Bhate-Deosthali 2015, MoHFW Guidelines 2014) The National health policy provides an opportunity to change this and build gender sensitivity in hospitals.

Recommendation

The MoHFW needs to recognize flame burns as an issue of gender based violence, thus going beyond acid attacks. Gender sensitivity needs to be integrated in hospital systems. The training on this should be part of in-service training and also in medical and nursing education

To conclude, the research was carried out in the city of Mumbai which is known to have one of the best health care facilities. The three hospitals under study represent what may be the best available response to burns. Two of the three hospitals were clearly providing specialized care to burn injuries. The findings of the research are therefore most significant in terms of improving the clinical and forensic care for women survivors/victims of burn injuries as the situation at the district level in other parts of the country is likely to be far worse. It is essential to create an ecosystem that is alert to VAW within the health system to be able to identify violence at an early stage, create an enabling environment for victims/survivors to speak up and create a comprehensive multi-sectoral response. Such an ecosystem will act as a deterrent to VAW. The critical role that the health system and health-care providers can play in terms of identification, assessment, treatment, crisis intervention, documentation, referral, and follow-up, needs to be integrated within the national health programmes and policies in India.