Self-immolation: An exploratory study
Acknowledgements
APPRO, EPD and Cordaid wish to express their sincere gratitude to individuals and organizations that continue to offer their time and commitment to this project. We are particularly indebted to the individuals and organizations who participated in this research and shared their views and insights about women’s peace and security in Afghanistan.

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This report is based on an earlier, incomplete report by Khalid Siddiqi. Lucile Martin and Saeed Parto authored this version.

About MWPS
Monitoring Women’s Peace and Security (MWPS) was conceived by APPRO, Cordaid, and Equality for Peace and Democracy (EPD) and funded by Cordaid to monitor and assist the implementation of the United Nations Security Council Resolution 1325 (UNSCR 1325), and Afghanistan’s National Action Plan for the implementation of UNSCR 1325 (NAP 1325), at the local level in 15 provinces throughout Afghanistan. APPRO is responsible for the research component of this project while EPD and Cordaid conduct outreach and advocacy at the national and international levels based on the findings from research at the local level.

About APPRO
Afghanistan Public Policy Research Organization (APPRO) is an independent social research organization with a mandate to promote social and policy learning to benefit development and reconstruction efforts in Afghanistan and other less developed countries through conducting social scientific research, monitoring and evaluation, and training and mentoring. APPRO is a non-profit non-government organization, headquartered in Kabul, Afghanistan with regional offices in Mazar-e Sharif (north), Herat (west), Kandahar (south), Jalalabad (east), and Bamyan (center). APPRO and its individual researchers have undertaken projects in Central Asia, Pakistan, India, Africa, China, and Turkey. APPRO is also a founding organization of APPRO-Europe (ASBL), registered in Belgium and based in Brussels.

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About Cordaid
Cordaid, based in the Netherlands, has a focus on international development and collaboration in vulnerable regions and areas of conflict. Its mission is to build flourishing communities in fractured societies. Monitoring the transition in Afghanistan is part of Cordaid’s program on Women’s Leadership for Peace and Security (WLPS). This program aims to increase the capacity of women’s networks, give a voice to women at the local level in processes of peace and security, and promote the women’s agenda in national and global arenas.

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About EPD
Equality for Peace and Democracy (EPD) is a nonprofit, non-governmental organization founded to empower women and youth at the community and policy levels in Afghanistan. EPD works to build the capacity of women and youth in order for them to be the front face in presenting their needs in development, peace building and democratic processes of the country. EPD further aims at mass mobilization of women and youth to contribute to overcoming the challenges of instability that Afghanistan is facing. EPD has platforms for women and youth to come together, establish networks, build trust and confidence to transform Afghanistan into a democratic country, free of all forms of violence and discrimination. EPD has peace and security, good governance and human rights as its three strategic areas.

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APPRO takes full responsibility for all omissions and errors.
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Executive Summary

Monitoring Women’s Peace and Security (MWPS) aims to strengthen the voice of women in fifteen Afghan provinces by supporting their ability to share their security situation with other women and work together to advocate for change. Throughout monitoring of the situation of women as it relates to the four pillars of the Women, Peace and Security agenda, one issue identified was the occurrence of self-immolation.

The aim of this case study was to provide an update to what is know about the drivers and consequences of self-immolation and inform the work of Provincial Women Networks as part of the MWPS project. The findings are based on qualitative data gathered through key informant interviews with victims, their families, medical and police personnel, representatives of Family Response Units, and women’s rights activists and specialists. Administrative records of cases of self-immolation from two leading hospital burn centers were also reviewed.

Self-immolation is an assertive choice committed by the victim in the presence of others to protest about mistreatment including severe physical and psychological abuse in a domestic environment. The treatment of the survivors of self-immolation is inadequate due to inadequate facilities, minimal effort to investigate the causes of self-immolation, lack administrative systems to collect data on the victims, and lack of post-treatment care for the victims.

Despite the prevalence of self-immolation in Afghanistan, addressing the issue is particularly challenging because of the taboo nature of suicide and speaking of domestic disputes and gender-based violence outside the home. In fact, communities, families, and even survivors tend to deny that the incident even took place in its aftermath.

The various government ministries and non-governmental organizations involved in addressing violence against women and self-immolation need to coordinate their efforts, including developing a single, uniform system for registering self-immolation cases, their causes, and establishing mechanisms to monitor post-treatment cases. At the local level, community and religious elders need to be engaged to facilitate dialogue on self-immolation as a community issue requiring community attention and efforts to overcome it.

Recommendations

Government of Afghanistan

- Promote an open dialogue on self-immolation as a tragic outcome of violence against women.
- Make prevention of self-immolation a policy priority and set up a dedicated structure to collect data, make recommendations for policy reform, and initiate proceedings to deal with self-immolation cases, including post-treatment psychiatric care and monitoring.
- Instruct hospitals to collect full patient data on victims of self-immolation.
- Allocate resources to specialist non-government entities to provide post-hospitalization psychiatric care to survivors of self-immolation as a means to prevent recurrence.
- The Ministry of Public Health and its provincial departments and the Ministry of Women’s Affairs should lead multi-agency and multi-stakeholder consultations to bring public attention to self-immolation and its drivers and ways in which they could be dealt with.
- Incorporate awareness raising on gender-based violence in religious, primary, secondary, and post-secondary education including changes in the curricula and skills training for teachers.
- Similar efforts should be made to re-educate the police, medical personnel at hospitals, family response units, and the judiciary on self-immolation being for the most part driven by gender-based domestic violence.

**Civil Society and National and International Non-governmental Organizations**

- Engage with state authorities through dialogue, lobbying, advocacy, and media on the need to pay specific attention to link between domestic violence against women and self-immolation by women.
- Engage with community and religious elders to address the issue of self-immolation.
- Demand, and provide where possible, support for the survivors of self-immolation.
- Organize gatherings and events around self-immolation and create opportunities for the survivors to share their experience the drivers and the consequences of self-immolation.
Introduction

Though no precise quantitative data exists about the incidence of self-immolation in Afghanistan, studies and records of patients in burn centers of Herat and Kabul indicate that, over the past fifteen years, cases of self-burning have increased among young Afghan women. Self-immolation in Afghanistan has generated serious concern among government, civil society and international stakeholders, resulting in efforts to document, explain and understand the root causes of the practice and devise interventions to prevent it. A link has been established between gender-based violence and self-immolation. The Elimination of Violence Against Women (EVAW) Law (2009) makes explicit reference to the link between gender-based violence and self-immolation. Despite these efforts, self-immolation continues in different communities throughout Afghanistan. In 2016 the Ministry of Public Health reported an increase in recorded suicide cases, including an unprecedented number of self-immolation cases.

Victims of self-immolation in Afghanistan are overwhelmingly female and young, with the vast majority between 12 and 35. Precursors most commonly identified are violence perpetrated by husbands, in-laws and other wives, forced marriage or engagement, child marriage, and practices of bad and badal.

Gender based violence and institutionalized oppression of women are central to understanding the phenomenon of self-immolation. The phenomenon of self-immolation by women in Afghanistan is traced back to the mid-1990s, during the civil war, when women suffered substantial abuse (including rape) from fighting factions. In contemporary Afghanistan, studies have shown self-immolation occurs after repeated failed attempts by the victims to overcome their plight. The use of self-immolation to commit suicide – a painful, violent and spectacular form of suicide – is a last resort act of defiance in a social context where women’s voices are not heard or are suppressed. In a context where violence is endemic and years of war and related disorders have broken down social structures of conflict resolution, violence has become an acceptable and widely used means to resolve conflicts. Women

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feature large in these violent forms of conflict resolution, and particularly suffer from early marriages, being exchanged in *badal* marriages for economic hardship reasons, or being offered as trophies for peace making by an offending family in the practice of *bad*.

This research was carried out to update what is known about self-immolation and identify entry points for addressing it at the local level through interventions legitimized under Afghanistan’s National Action Plan for the implementation of the United Nations Security Council Resolution 1325 (NAP 1325), which came into effect in June 2015.

The research was conducted in Kabul and Herat in early 2017, where the two main burn centers. Interviews were carried out with burn and forensic medical doctors and health specialists within the burn wards, survivors of self-immolation, families of victims, representatives of the Afghanistan Independent Human Rights Commission (AIHRC), women’s rights activists, Ministry of Women’s Affairs, and Family Response Units. See Appendices 1 for the full list of interviewees and Appendix 2 for the interview questions.

The next section provides an overview of the findings from this study and puts these findings in international perspective. The findings are organized under four headings:

- Drivers of self-immolation
- Choice of self-immolation as a suicide method
- Conditions for surviving victims and treatment
- Formal handling of self-immolation cases

### Drivers of Self-immolation

Data from this research and other studies of self-immolation in Afghanistan indicate that institutionalized discrimination, widespread violence against women, chronic conflict and its impact on mental health, and seclusion and stigmatization of women act are the key drivers of self-immolation. According to medical officials, the most common causes of self-immolation are forced and early marriages and domestic abuse. As a survivor of self-immolation in Herat summarizes:

> Girls are married off at a young age, without their parents thinking about the consequences of someone getting married at a young age...I was a very young girl, playing on the streets. I was married off as an exchange for a wife for my brother. We were engaged for three months and then got married...Life at my in-laws was hell. They would make me work all day. I was too young to prepare food; they would physically beat me everyday. The abuse and beating was so bad, that I would not be able to sleep at night because of the pain...They would not give me any food to eat and they would not get me clothes...these led me setting myself on fire. There might be women who burn themselves because they have mental disorders, but in most cases it is the torture that is unbearable.  

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9 KI-F-Her-5
Abuse and mistreatment can be related to and exacerbated by economic hardship, unemployment, and drug addiction, particularly affecting men as the perpetrators of violence. Combined with traumas of conflict and displacement these factors create a deadly cocktail of violence targeted at women. Traditional conservatism combined with illiteracy or low education and lack of awareness or recognition of equal or basic rights for women also contribute to violence against women and play major roles in a victim’s decision to commit suicide through self-immolation.

Violence-induced, severe depression and anxiety is listed as another driver of self-immolation:

One of the reasons given by our patients about why they chose self-immolation is the feeling of hopelessness and extreme sadness. They say that their environment offered them no escape and that they felt restless and could not bear it anymore. Many women face violence and discrimination, but a small percentage of them choose self-immolation as a method of suicide. We have no means to properly investigate the psychological reasons, but women who have self-immolated do show signs of depression.

There is little or no psychiatric help for the victims. There is also little evidence of post-discharge follow-up for survivors of self-immolation, making it difficult to ensure the safety of the victims once they return to normal life.

**Choice of Self-immolation as a Suicide Method**

One of the determinants of choosing self-immolation to commit suicide is the accessibility of flammable materials in the home environment and the high likelihood of certain death, regardless of the physical pain. According to one key informant,

There are different types of flammable fuels present in almost every kitchen and women know how to use them. [...] They do not know how to use weapons. Women think that if they hang or poison themselves, it might take longer and someone might save them. Therefore, they usually choose burning.

Another reason for the choice of self-immolation is the ferocity and visibility of the act. Instances of self-immolation often make it to the news and people in the community hear and talk about them. The urge to make a point and generate shock also explains the fact that much of self-immolation occurs in front of witnesses, despite typically being carried out indoors. The survivors had set themselves on fire in front of their husbands, in-laws and even children in the family. One survivor, for instance, stated that when she was setting herself alight her mother-in-law did not stop her. But, as soon as she was engulfed in fire, the mother-in-law started screaming for help as she tried to put out the fire.

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10 KI-F-Kab-1, confirmed by ten key informants in Herat and five key informants in Kabul
11 KI-F-Kab-2, confirmed by four key informants in Herat and two key informants in Kabul
12 KI-M-Her-1, similar stories confirmed by three other key informants
13 KI-M-Kabul-1, similar points confirmed by eight other key informants
14 KI-F-Kab-4, confirmed by KI-F-Kab-1
15 KI-F-Her-4, KI-F-Her-5
16 KI-F-Her-4
Conditions for Surviving Victims and Treatment

Self-immolation patients tend to have very high mortality rates. Families and communities are afraid of their reputation being stained by self-immolation cases in their midst and hence do as much as they can to maintain secrecy, including letting victims die at home instead of taking them to hospitals. Those who reach hospitals are generally found to have severe burns and over a larger burn surface area, compared to burn victims who did not inflict their own injuries. The situation for survivors is further aggravated by the limited access to health centers for physical treatment, little or no psychiatric care following physical treatment, and the post-treatment stigmatization by family and community members.

Of the 38 female self-immolation cases 2011 and 2016 recorded at Istiqlal Hospital in Kabul only three survived. The victims were generally young, with a mean age of 26 years. The youngest patient was a 16-year-old girl. Istiqlal Hospital is the only facility in the province with a burn ward for adults, and often overcrowded and lacking medicine. The Areal hospital in Herat is also the only hospital in the province to have facilities to treat burn victims. Of all the self-immolation patients admitted to Istiqlal Hospital in Kabul, 34 were from Kabul and 18 came from provinces, as far away as Bamyan and Ghazni. Similarly, self-immolation victims in Herat come to Areal Hospital from across western Afghanistan, including Farah, Badghis and Ghor provinces. Covering such long distances increases the possibility of infections and subsequent death significantly.

No psychiatric care or post-release care is provided to survivors of self-immolation in either province. Nor are there efforts undertaken to monitor conditions for the victims after release to ensure that they are no longer at risk and that recurrence is prevented. There are no data available on the number of survivors who go on to attempt suicide again through self-immolation or other means.

Formal Handling of Self-immolation Cases

Whether or not the patient that arrives at the hospital is alive or dead is the first step in distinguishing between suicide and murder. If a patient can speak, doctors sometimes inquire about the conditions under which the incident occurred and if foul play is suspected, the police are informed. However, many doctors believe that their responsibility is to treat patients and fear that asking too many questions or informing the police could deter other families from bringing dying relatives to hospitals because of fear of prosecution.

Procedurally, cases of deceased patients are treated differently. In the autopsy, doctors look for signs of smoke inhalation in the lungs, which indicate whether or not the patient was alive prior to burning. Then the police and the hospital inquire about the victim’s domestic situation, with the aim of identifying potential suspects. If the inquiry indicates likely foul play then arrests are made, otherwise the case is closed. In practice, however, it appears that efforts to distinguish self-immolation from murder seldom occur. The purported presence of the ANP in hospitals is disputed and doctors tend to be too busy to actually conduct autopsies and identify the real cause of death.

References:
17 KI-M-Her-2, confirmed by two key informants
18 KI-F-Her-3, KI-F-Kab-2
19 KI-F-Kab-2, confirmed by four key informants
20 KI-F-Her-3, confirmed by five key informants
Conclusion and Recommendations

Self-immolation is grounded in the larger problem of tolerance for violence against women in society and generally rooted in domestic violence. As such, legislation alone cannot be expected to deal with the drivers of self-immolation though, arguably, legislative reform aimed addressing domestic violence against women can help.

In addition to thoughtful and context-sensitive legislative reform, government institutions and rights advocacy organizations need to work more closely with community and religious leaders so that interventions to prevent self-immolation are viewed as local initiatives and conducted at the local level and by local community leaders.

Awareness and recognition of rights, anti-violence values in religious and educational teachings, and equal and equitable treatment under the law regardless of gender, age and wealth are also necessary pre-requisites of dealing with the drivers of self-immolation.

Women’s access to the formal judiciary needs to better facilitated and protected to prevent victims of domestic violence from becoming further victimized by their family members or the police and the formal and informal judiciary systems. In sum, the protection of the potential and actual victims of self-immolation needs systemic change and systematic support.

Given that there is essentially no support for protecting survivors of self-immolation from making further suicide attempts, there is urgent need for establishing a system that can address the psychiatric, moral and spiritual issues of survivors. The victims often also need shelter to protect them from those who drove them to attempt suicide in the first place. If a victim continues to live with her husband’s family, the situation needs to be closely monitored to ensure the woman’s safety.

The general culture of impunity that dominates social relations in Afghanistan, and the minimal rights afforded to women, particularly by traditional conservatism, have given free reign to the perpetrators of violence against women as a most vulnerable group in society. A systemic approach to address the issue of self-immolation would entail concerted efforts to institute equal rights for women through legislative reform and re-education through religious and formal educational teachings aimed at challenging and changing gender-based biases.

The reform and strengthening of the judiciary is therefore crucial. A judiciary that endorses and enforces existing laws against violence against women is essential for prosecuting and punishing perpetrators of family violence and providing support for the victims.

At an administrative level, better and more complete data need to be collected on cases and drivers of self-immolation as the basis on which to develop preventive measures as the lack of sufficient or reliable data about the incidence of self-immolation in Afghanistan undermines the development of effective interventions.
Recommendations

**Government of Afghanistan**

- Promote an open dialogue on self-immolation as a tragic outcome of violence against women.
- Make prevention of self-immolation a policy priority and set up a dedicated structure to collect data, make recommendations for policy reform, and initiate proceedings to deal with self-immolation cases, including post-treatment psychiatric care and monitoring.
- Instruct hospitals to collect full patient data on victims of self-immolation.
- Allocate resources to specialist non-government entities to provide post-hospitalization psychiatric care to survivors of self-immolation as a means to prevent recurrence.
- The Ministry of Public Health and its provincial departments and the Ministry of Women’s Affairs should lead multi-agency and multi-stakeholder consultations to bring public attention to self-immolation and its drivers and ways in which they could be dealt with.
- Incorporate awareness raising on gender-based violence in religious, primary, secondary, and post-secondary education including changes in the curricula and skills training for teachers.
- Similar efforts should be made to re-educate the police, medical personnel at hospitals, family response unites, and the judiciary on self-immolation being for the most part driven by gender-based domestic violence.

**Civil Society and National and International Non-governmental Organizations**

- Engage with state authorities through dialogue, lobbying, advocacy, and media on the need to pay specific attention to link between domestic violence against women and self-immolation by women.
- Engage with community and religious elders to address the issue of self-immolation.
- Demand, and provide where possible, support for the survivors of self-immolation.
- Organize gatherings and events around self-immolation and create opportunities for the survivors to share their experience the drivers and the consequences of self-immolation.
Appendix 1: Research and Data Collection Tools

Research question:
What is the state of self-immolation among women in Afghanistan? How and why do the victims choose self-immolation as a preferred method of suicide and what are the available preventive and protective tools to combat self-immolation among women in Afghanistan?

List of interviewees
1. Survivors of self-immolation (2 X KII)
2. Focus groups with women’s rights activists (or 2 KIs)
3. Medical doctors and health professionals working in burn centers (2 X KII)
4. Department of Women’s affairs (1 X KII)
5. AIHRC (1 X KII)
6. ANP/FRU (1 X KII)
7. Family members of victims of self-immolation (2 X KII)

Questionnaires consist of a survey to identify risk factors and open questions to get the narrative.

Categories for the survey (30 survivals and 30 control group):

1. **Demographic**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban/rural</td>
<td>Parents’ employment</td>
</tr>
<tr>
<td>Occupation</td>
<td>Parent’s education</td>
</tr>
<tr>
<td>Marital Status</td>
<td>Family size</td>
</tr>
<tr>
<td>Birth Order</td>
<td>Number of children</td>
</tr>
</tbody>
</table>

2. **Socioeconomic, cultural and psychiatric risk factors**

<table>
<thead>
<tr>
<th>Religious preconceptions</th>
<th>Drug use by the victim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditionalism</td>
<td>Drug use by the family</td>
</tr>
<tr>
<td>Conflict</td>
<td></td>
</tr>
<tr>
<td>Displacement</td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
</tbody>
</table>

3. **Familial risk factors**

<table>
<thead>
<tr>
<th>Interpersonal conflict with spouse</th>
<th>History of mental disorders family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal conflict with in-laws</td>
<td>History of mental disorders victim</td>
</tr>
<tr>
<td>Interpersonal conflict with parents</td>
<td></td>
</tr>
<tr>
<td>History of suicide in Family</td>
<td></td>
</tr>
<tr>
<td>History of suicide of the individual</td>
<td></td>
</tr>
</tbody>
</table>
4. **Quantitative data:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women who have committed suicide</td>
<td>Year</td>
</tr>
<tr>
<td>Number of women who have done so through self-immolation</td>
<td>Per year</td>
</tr>
<tr>
<td>Percentage of self-burning victims that have survived</td>
<td>Per year</td>
</tr>
<tr>
<td>Number of self-burning victims that have survived</td>
<td>Per year</td>
</tr>
</tbody>
</table>

Open questions:

1. What causes the victims to burn themselves? Give general explanation.
2. What is the distinction between self-immolation and murder by burning?
3. Why do self-immolation victims specifically choose burning as a method of death? Why not hanging, or ingesting poison, for example?
4. What causes the victims to burn themselves? Name factors, give specific examples.
5. How can incidents of self-immolation be *prevented*?
6. How can potential victims of self-immolation be *protected*?
Appendix 2: Key Informant Interviewee Codes

All Provinces

<table>
<thead>
<tr>
<th>Interview type</th>
<th>Number of Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Informant Interviews</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>

Description of codes:
Each code consists of four units of information, the table below shows the types of the interview and interviewee as well as the province in which the interview has taken place. The affiliation of the interviewees is described in a separate table.

<table>
<thead>
<tr>
<th>Unit within the code</th>
<th>Description of the abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>KI</td>
<td>Key Informant Interviewee</td>
</tr>
<tr>
<td>F/M</td>
<td>Female or Male interviewee</td>
</tr>
<tr>
<td>Kab/Her</td>
<td>The first three letters of the name of the visited province</td>
</tr>
<tr>
<td>Number</td>
<td>The fourth unit indicates the affiliation of the interviewee, which can be found in a separate table</td>
</tr>
</tbody>
</table>

Affiliation of the interviewees

<table>
<thead>
<tr>
<th>Number</th>
<th>Affiliation of the Interviewee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Department of Women’s Affairs</td>
</tr>
<tr>
<td>2</td>
<td>Family Response Units</td>
</tr>
<tr>
<td>3</td>
<td>Burn Unit Medical Doctor</td>
</tr>
<tr>
<td>4</td>
<td>Survivor of self-immolation</td>
</tr>
<tr>
<td>5</td>
<td>Survivor of self-immolation</td>
</tr>
<tr>
<td>6</td>
<td>Family member of a self-immolation Victim</td>
</tr>
<tr>
<td>7</td>
<td>Family member of a self-immolation Victim</td>
</tr>
<tr>
<td>8</td>
<td>Women’s Rights activist</td>
</tr>
<tr>
<td>9</td>
<td>Women’s Rights activist</td>
</tr>
<tr>
<td>10</td>
<td>AIHRC</td>
</tr>
<tr>
<td>11</td>
<td>Forensic Doctor</td>
</tr>
</tbody>
</table>