VIOLENCE AND HEALTH - AN EXPLORATORY STUDY

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CERTIFICATE

This is to certify that this dissertation entitled 'Violence and Health - an exploratory study' submitted by Ms. Ruchi Sinha in partial fulfilment of the requirements for the award of the degree of Master of Philosophy. This dissertation has not been previously submitted for any other degree of this or any other University and is her own work.

We recommend that this dissertation may be placed before the examiners for evaluation.

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CHAPTER - I

INTRODUCTION

INTRODUCTION:

Violence is a theme most bandied about by the mass media, as "Gunshot wounds labelled as epidemic" or " violence - the toughest epidemics of all". Violence is targeted as it violates basic human rights and its cost is large, unquantified and mysterious[1]. Media sees violence as the absence of peace and the presence of conflict implying that violence has a monolithic character. However, what has been portrayed is the proverbial tip of the iceberg, a phenomenon, scratched only on the surface. The major emphasis is on manifest, rampant, degrading nature of violence and it's bizarre outcomes.

In America, in the wake of epidemic of violence, the study of life threatening behaviour was undertaken and it was seen that violence is not a unitary phenomenon but a spectrum of behaviour which has a continuum of socially acceptable to unacceptable behaviour[2]. Violence is historically a human phenomenon. Man's development and evolution according to Ardrey are due to his inborn aggression. He traced violence back to anthropological evidence of bone weapons to the knife of ancient man to recent human delinquent[3]. Violence is an outcome of norms, values, attitudes, material traits, socialization processes, inter-personal relationships etc. Historically, however little attention has been

given to violence as a social issue/problem and much less as one relevant to public health.

Violence has been a subject of philosophical inquiry by many, (Jean Marie, Dominach, Diderto, Sartre, Lalande) and has been only seen as an illegal exertion of force[4]. It has been referred to as all types of behaviour, either threatened or actual that result in damage or destruction of or injury to property or individual[5]. Thus, overlooking the fact that violence is a behaviour which differs in a number of ways and includes force, aggression etc. Marx's term of "alienation" emphasized on insidious violence through structural features of society with reference to the distribution of power and the exploitation of the working class through misappropriation of income generated[6]. Mao also advocated the use of violence for change and attainment of goals.

Violence serves as a maintenance mechanism of the society which is used to legitimatize domination so that power and authority are vested in the dominant group only. This further gives them access to economic resources, power and prestige and this once concretized by legal rights and cultural norms becomes institutionalized. This is a disturbing trend of replacing personalized, face to face impassioned violence, as structural violence gives the allowance that state can kill,

maim, exploit in the name of development, science and national security[7]. Modernization, instead of assuring dignity of individual, health, education and meaningful employment has had a dehumanizing effect on the individual which has led to an increase in violence[8]. Besides this, socio, political, religious justification lead to violence[9].

Violence is such a major problem that America and Australia set-up a National Commission of Violence in 1968 and 1987 respectively. They stated that the diagnosis of violence in its causes, justifications and remedies in all strata is problematic[10,11] and needs to be integrated with federal expenditure to get a true picture of the quantum of violence. They state that violence is a social problem[12] and needs to be understood in the context of social movement and change[13], political goals and conflicts and needs to be studied from the social structural perspective searching for the source in differential access to power since violence is no longer restricted to streets and low socio-economic strata, but has moved into the home to all strata[14]. Violence can hence, no longer be ignored. Thus, there appears to be an increasing concern with an apparent rise in violence in developing countries (Asia, Middle East, Africa, Latin America) where there is rapid urbanization and

industrialization. This has led to increasing complexity in social life with new values conflicting and replacing old ones.

In spite of this, little or no efforts has been devoted to tackling the underlying cause of violence. The conceptualization of violence primarily as a judicial/legal issue and lack of data on the dimensions of violence have hampered understanding and the development of appropriate intervention. The priority has always been on protection initially which overlooks the need to understand the cause and effect relationship. There are many legal and social definitions of violence but each definition does not consider some as victims which another might recognise. Violence is a complex phenomenon which needs to give attention to all subtypes and exploration into causal factors.

The research in this area is in its nascent stage, dominated by individual phenomenological understanding of the individuals own violent experience. The fact that violence can be predicted by the historical, socio, economic, political, cultural trends and legal scenario is overlooked. Once this is recognized it would be helpful in providing protection to vulnerable groups even though it involves questioning power relationships and hierarchy both in the social and cultural context.

Most literature portrays medicine as a body of knowledge with no internal checks to its cognitive imperatives. This justifies use of violence to achieve a medical goal. Thus the doctors get caught in a self created image of being omniscient and omnipotent. This brings out the links between knowledge, power and violence, in practice in the modern system of healing. In the thesis, an attempt has been made to discuss violence in health from this angle as well.

The present thesis, aims to explore the nature and forms of violence, its complex nature and its linkages with health services. The thesis has lead to more questions than answers, which reinforces the fact that this is an area to be explored further. It has tried to see violence from the health professional's and victim's view point and their perception of health services capacity to handle violence.

DEFINITIONS:

The word violence has its root in the Latin world 'Vim' and Sanskrit word 'Vyas' implying thoughtlessness and willed ignorance[15]. National Commission of Violence in America recognized institutional violence to be responsible for high IMR, deaths due to preventable diseases but tackled only physical violence. Violence is a multi - dimensional concept which involves many intricacies as it is dependent

upon cultural norms. The problem of defining violence was best put by P.J. Goldstien and Megargee[16] who stated " We all know what violence exactly means but the problem is that our definitions may not agree with anybody else's. There is simply no universally accepted definition. Most definitions include causing or threatening to cause physical violence or are content with the legal definition of crime and violence which include categories involving physical injury or the potential for such injury to occur. The only point of agreement is that most definitions agree to the presence of other directed or self directed violence. "

Violence is a phenomenon that is manifested in a variety of ways. It can include war, fights between individuals[17] or interpersonal violence (which includes serious and non-serious forms of violence). Hence, one has to be cautious of unreflective acceptance of legal definitions of violence as it discounts harmful and oppressive social practices as environmental pollution and safe working conditions, sexism, warfare etc. Thus legal definitions are of limited utility for a genuine comprehension of violence. It's because of this one cannot equate gassing of citizens of Bhopal and death of Asbestos workers with insane criminals and psychopaths. The former is seen as unhappy by -

products of civilization and the latter acts to be condemned. Thereby underplaying the effects of violence[18].

Violence is seen on a continuum which moves from the microcosm to macrocosm and may be directed towards self or others. Violence is seen as being aggressive or defensive and intended or unintended[19].

	Violence as		
		Event	Permanent
Violence as	Action	I	II
	Non Action	III	IV

The above table classifies violence into type I, II, III, IV according to the situational factors.

Type I - Classical violence (aggressive / defensive)

Type II - Insidious violence (developmental)

Type III - Sudden violence (accidental)

Type IV - Structural violence (institutional)

Hence violence is recognized as a human phenomenon and is seen as the use of force whether overt or covert to wrest from individuals what they don't give on their own. Violence concerns not only a person's property or physical being but the very essence of his

being[20]. Hegel saw violence as an integral part of the very genesis of consciousness and as a prerequisite to the humanization of interpersonal relations[21]. Hence violence is inseparable from human conditions.

Violence has been defined differently by various groups. The ethnological basis of violence views it as being part of nature of ones total being, with its function being selection of the best and the strongest genes, defense of the young ones and formation of hierarchies[22].

Viewed slightly differently violence is seen as a problem of power used against a person in which force is an instrument. It is an asymmetrical relationship which stems from the imbalance of power and greater the inequality, greater the potential for violence. When violence is used against an existing power structure to disrupt existing order, it is an antiaction, a counterpart to this is proaction, that is when one tries to establish a new power order[23].

Legally violence is seen as directing physical force and assaulting an individual by transgressing legal boundaries and endangering the life of an individual. Wolin's definition of violence as force exercised with unnecessary intensity violating the body, psyche

and livelihood fall within the judicial purview. Some see violence as "an act carried out with the intention of or perceived as having the intention of physically hurting another person"[24]. Thus, legally violence[25] is seen as the brutalization of the individual through physical injury, threats of coercion and subtle acts of disciplining aimed at pressurising them to act in a manner conducive to the dominant group. It includes exploitation, discrimination and creating an atmosphere of terror.

From the health perspective violence is seen as any act of verbal or physical force or life threatening deprivation directed at an individual that causes physical or psychological harm, humiliation and that perpetrates subordination. It may include structural forms of discrimination or deprivation that affects a class such as poverty or lack of access to education[26]. Ana Lia Kornbilt saw violence as being indissolubly linked to the exercise of power and includes[27] :

(1) Action or omission of behaviour which results in damage produced.

(2) Intentionality

(3) Negative incidence on the subjects perception about self.

(4) Negative incidence on the subjects psychic or physical health.

Thus from the health perspective, violence is seen as a factor which affects the psychic and physical health of an individual.

These definitions are basically individualistic and restrict themselves to manifest violence only. They restrict themselves to hostile aggression. Hidden violence is not even indicated here. Hidden violence refers to dormant hostility which when activated is very destructive[28,29].

Structural violence thus moves from the behaviour matrix and arose out of the realization that in certain circumstances people are not killed by direct violence but by social order[30]. This was brought in the open at the conference of bishops in Latin America held at Medellin in 1969, where it was stated that, "the expression endeavours to mask completely that of imperialist system as imperialism is linked to a whole set of latent or operational repressive practices and leads to injustice and death". Thus the structure leads to violence on individual and not vice versa.

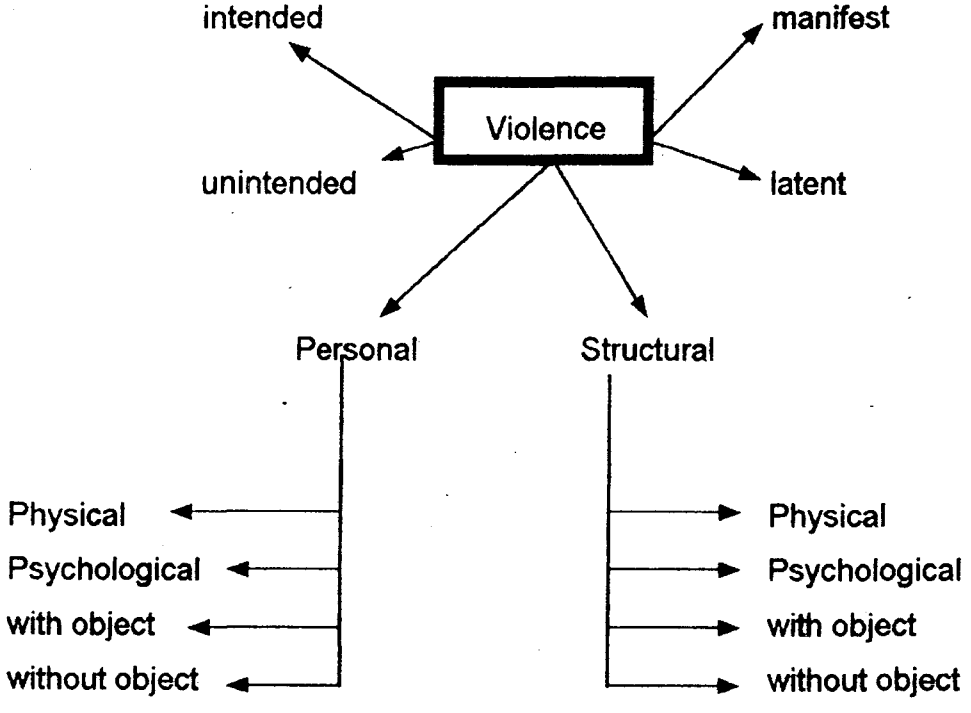
Violence thus is an act and condition which obstructs the spontaneous unfolding of innate human potential, the inherent drive

towards development and self actualization. Such acts which violate the process of human development may occur at interpersonal, institutional and societal level and differs in scope, intensity and consequences. On interpersonal level individuals act violently towards one another using physical and psychological means. They may also establish and enforce conditions which deprive, exploit and oppress others and consequently obstructs their development. At the institutional level organisations such as schools, hospitals welfare agencies may through their policies and practices disregard developmental requirements of people and subject them consequently to conditions which inhibit unfolding of the potential of an individual. At the societal level, institutional patterns and dynamics are established and legitimised resulting in phenomenon such as poverty, illheath etc. which inhibit the development of groups[31].

Since violence is such a broad phenomenon it can be emotional or collective in nature. Emotional violence is individualistic violence. Collective violence can be further divided into primitive, reactionary and modern violence[32]. Violence can be predatory, sexually motivated, retaliatory, ideologically motivated, assertive and senseless in nature[33]. The National Commission of Violence of Australia recognised this dual

nature of violence and defined violence as "any unjust or unwarranted exertion of force or power as against rights and law. It includes threat along with the physical use of force both physical and psychological."

Thus, violence has psychological, social and political aspects which harms the living organism[34]. and could be sexual, interpersonal, instrumental, material and political[35]. The concept of violence described by Galtung diagrammatically encompasses all aspects of violence as stated in the definitions above.



Since violence, includes aggression, abuse, molestation, torture, incest and homicide they too have been defined here.

Aggression is a behaviour motivated by anger, hostility or over competitiveness and is directed towards harming, destroying other people or in some cases the self. It is a behavioural trait consisting of self assertiveness with a tendency towards hostility. Thus it is an assertive, destructive and dangerous behaviour[36].

Abuse refers to actions which are harmful for the victims both physically as well as mentally, committed or resulting from omission, carried out intentionally. Abuse indicators are classified as physical symptoms, illness with psychic sources and social inadequateness symptoms. It includes maltreatment (physical, sexual and emotional aspects) and neglect (physical, educational or affective)[37]. Thus abuse has elements of threat and coercion[38].

Molestation is defined as the nonconsensual, non-coital sexual contact[39]. Incest is the prohibited relationship between parties of specified consanguinity[40] where as torture is legally defined as the use of physical coercion to obtain evidence for use in judicial proceedings against accused criminals[41].

Torture as defined by the UN in the Convention against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (Dec. 10, 1981) is "any act by which severe pain or suffering, whether

physical or mental is inflicted on a person for such purposes as obtaining from him or a third person information / confessions, punishing him for an act he or a third person has committed or is suspected of having committed or intimidating or coercing him or a third person or for any reason based on discrimination of any kind. When such pain or suffering in inflicted by or at the instigation of or with the consent of a public official or other persons acting in official capacity, it does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions"[42]. Thus torture can be both physical and mental in nature.

Homicide is the killing of another person and is divided into criminal and non - criminal homicide. The former comprises of murder and voluntary and non - voluntary manslaughter[43,44]. Non-criminal homicide is excusable or a killing in self defence and justifiable homicide is performed as a legal duty by a peace officer or executioner[45]. Homicide is largely an unplanned act but still certain regular uniformities and patterns are visible[46].

Justifiable Homicide is an intentional killing either commanded or authorized by the law. The difference between justifiable and excusable homicide is that the former is committed in self defence and in the latter,

the slayer is regarded to be in fault to some extent for becoming engaged in affray[47] where as in the former the slayer is not blamed at all.

Homicide occurs in dangerous but not illegal institutions in which people participate at their own acknowledged risk. A second type of homicide, non-culpable, is institutionalized in jural and ritual areas (jural by officials of the state, ritual killing by tribals of an adulteress etc.)[48,49].

The definition thus raises more questions than it answers. Presence of peace, is seen as absence of violence. The fact that peace founded on injustice and violation of human rights cannot last and leads to violence is not recognized. This shows it is a normative definition, and takes no account of trespassing of human rights as violence. Violence thus is not restricted to conflicts only but to a whole range of behaviour.

Conclusion:

We call a behaviour violence when it is unacceptable and when it breaks the implicit social contract and upsets accustomed arrangements, when it is unsanctioned and offends the general sense of morality[50].

Thus, violence comprises of conditions and actions originated by humans which obstruct the unfolding of human development throughout the life cycle. Violence, as defined here, may be a result of societal dynamics - 'structural violence', of acts of individuals - 'personal violence' and of interactions between societal and individual dynamics. Unfolding of human development tends to be obstructed when inherent biological, psychological and social needs are frustrated and cross beyond a level of tolerance. Whether and to what extent human needs are met in a particular society depends on its policies concerning resources, work production and rights which determine the quality of life and human relations in societies. When societies normal institutional processes consistently frustrate human needs and obstruct human development energy is blocked, this results in personal violence which leads to general violence[51].

PATTERN OF SOCIAL DISTRIBUTION OF VIOLENCE

Literature on violence shows that class, ethnicity, occupational status and other social variables are effective for predicting the incidence of violence besides individual traits such as age, sex etc. These variables are also useful in determining the perpetrators and the victims of violence.

Age: Almost universally it can be asserted that the highest incidence of violence is committed by young offenders most of whom are in the age - group of twenty to thirty. Violence is rarely committed by children or persons above forty[52]. This trend has been noticed in suicides and accidents also[53,54].

Sex: A review of literature indicates that males and that too youthful males show the highest association with violence. This is mainly blamed on the socialization pattern of the males on the masculine ideal of aggressiveness. Maleness and overt aggression are normally equated thus his commitment to violence comes naturally whether physically or psychologically[55]. Even suicide is three times more in men who use surer methods compared to women[56].

Socio - Economic Status: In the past the lower class due to their social structure and their value system which emphasises on aggression suggests an existence of a sub-culture of violence. The overt physical violence becomes an integral part of the subculture and gets integrated in the personality structure of the individual[57]. The important fact that different social circumstances have different life styles and different risks of victimization are generally underplayed and hence the notion of the lower class being more violent is floated[58].

Henry and Short concluded after a review of studies that higher the class status higher the incidence of suicide and lower the class status higher the incidence of homicide. Majority of violent crimes are committed by persons of lower status (blue collar workers)[59] not because the higher class are not aggressive but because of differences of ego involvement. The lower class has a culture transmitted, of exhibiting physical force as the repertoire of responses is limited for them. Though there seems to be some relation between economic class and violence, the findings are not conclusive.

Culture: A culture milieu does exist where violence is a more common mode of interpersonal action. Thus, violence occurs in diametric opposition to the set of values embraced by the cultural society of which they are a part[60]. The man from a cultural value system that denounces the use of interpersonal violence will be restrained from using violence because of his positive perspective that conforms to his value system and not because of a negation of it. The absence of that kind of value system is hardly likely to be a vacuous neutrality regarding violence. Instead it is replaced by a value system that views violence as tolerable, expected or required. As we approach that part of the cultural continuum where violence is a requisite response, we also enter a

subculture where physically aggressive action quickly and readily can bleed into aggressive crime. The man from this culture area is more likely to use violence, similarly because of a positive perspective that requires conforming to his value system. Thus a whole culture may accept a value set dependent upon violence, demand or encourage adherence to violence and penalise deviation. During the war, hence the whole nation accepts the principle of violence and restraint from using violence then may be frustrating, ego deflating, even a guilt ridden experience[61,62,63].

Thus, the oppressed classes (race, economic, political, and caste) are perceived to indulge in violence by the dominant classes definition of violence. Many studies in USA have emphasized on the ethnopsychiatric dimension[64] of culture but it fails to hold ground as the realities are not accounted for. Cross cultural patterns of violence show women and children always have been the most likely victims as they are the "vulnerable" within the oppressed classes also.

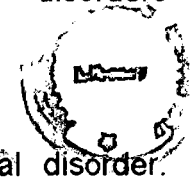
CAUSES

Although there are still gaps in our knowledge of causes of violence, review of studies show, factors which contribute to violence

are many and varied comprising of individual personality, behavioural and situational factors.

Mental Illness: Society has long been captivated by the professed association between mental disorder and violence. Images of inexplicable frenzy of unprovoked mayhem of wild beasts and maniacs gone berserk have circulated widely throughout the history of public culture, social theory and jurisprudence[65]. However, mental illness cannot be juxtaposed against violence in isolate bivariate analysis devoid of context or interpretation. The association between madness and violence is a full social process, dependent on transitory, political and cultural definitions mediated by prevailing medical and legal norms and grounded in the relative authority of various groups to enforce their particular versions of criminological and clinical reality. Simply stated what is deemed to be violent, what constitutes mental disorder is a product of social, political and professional contexts. One has to establish the epidemiological pattern of mental pathology among the populations to come to a conclusion[66] as one sees that what first appeared to be demonstrable convergence between mental illness and violent crime turned out to be an epiphenomenon, a fabrication of institutional realignment at the systems level[67]. Only when violence is

highly pronounced, the extraordinariness of the crime may suggest mental disorder such as cannibalism, mutilation of corpses, vampirism etc.[68]. This link between violence and mental illness is more apparent in the profession of forensic medicine, psychiatry and other medico - legal officials work. Within the psychiatric group schizophrenia, paranoid state and paranoia, chronic brain syndrome, acute brain syndrome, mania psychiatric depression and in the non - psychiatric group, passive aggressive personality, sociopathic personality, hysterical personality, paranoid personalities, neurotic behaviour etc.[69] disorders are prone to violence.



Homicide is an infrequent consequence of mental disorder. Many mentally ill people may commit serious assaults but fail to kill by inadequate design, the result of mental illness[70]. Hence, mental illness too needs to be treated carefully in the context of the existing scenario[71].

Medical and Biological Reasons: Medical and Biological studies have contributed only partial and incomplete data to the problem of violence. They are based on criminal population and hence are unreliable. Mesomorphs appear to predominate in the homicide populations and a variety of biological disturbances from hyper-thyrodism to hypoglycemia may cause an aggressive reaction. Some

endocrinological abnormalities and neuropsychiatric syndromes may occasionally be provocative of aggression and violence in normal subjects. This behaviour seems to be unrelated to systematic or unique biological differences. ECG elicits a greater proportion of abnormalities often of an aspecific type in violent offenders showing motiveless violence. Again no consistent biological disturbances can be isolated and this lack of consistency reflects the uncertainty of our knowledge about the underlying neural mechanism of emotion in general and specifically of anger.

This lack of evidence leads to an important consideration in the chain of causation of aggression which traces back to causes outside the organism and although there may be individual differences in the reactivity to external stimuli evoking aggression these inner characteristics do not by themselves explain aggressive behaviour[72,73].

Neurophysiological Reasons: Evidence on the heredity of violence and aggressiveness is contradictory and has never overcome the nature vs nurture methodological problem[74]. Thorne has studied their epidemiological transmission and he emphasises that the outward phenomenology of anger involves other persons in establishing an epidemic of negative reaction and the end result will be a vicious

situational psychopathy. Since 1929 physiologists and endocrinologists have located, several neurological and endocrinological structures and mechanisms which are said to be closely linked to the expression of anger and fear. Neurologically, aggression appears to be controlled by the hypothalamus and the neocortex. The amygdala also controls rage and their unilateral destruction produces long lasting rage reactions[75].

Although the underlying neurological mechanisms are of modest importance for the study of violence, the importance of central neurological lesions due to traumas, infections or congenital anomalies have been emphasised in violence studies. Papez states that irritative lesions in the sub callosal gyrus and in the medical frontal cortex produce aggressive and uncontrolled activities. Denis Hill reported occurrence of marked destructiveness and impulsiveness combined with primitive aggressiveness and sexual impulse of both auto and etero directed character which followed recovery in children who suffered from encephalitis lethargia in the 1920 pandemic. With age both EEG patterns and violent behaviour decrease. But the studies have also emphasised the importance of environment in the development and maintenance of violence. Central neurological lesions can of course be caused by a variety of etiological agents ranging from

infections to neoplasm. It is possible that children of lower social class and in developing countries where sanitary conditions at child birth are inadequate, organic causes are operative. Kinberg however states that these lesions are often undetectable by normal neurological procedures.

EEG's have not satisfactorily proved the existence of violence. But many studies have been conducted and EEG signs of an aggressive personality are found to be similar to a person exhibiting epileptic symptoms. A number of violent personalities reveal endocrinological disorders. The study of the male sex hormones in the development of aggressive behaviour has been discussed but to no avail as role expectations play a major role. Hormones of thyroid and gonads are the most researched upon in this area. Wilder states violence is more common when one is in a hypoglycemic state[76]. An exploration of the nexus between biology and aggression serves to show the complexity of an etiological study of violence from a biological stand point. There are individual differences in the reactivity to external stimuli evoking aggression, and these inner characteristics by themselves cannot explain aggressive, violent behaviour.

Drugs: Dai (1970) while studying criminal records of over a thousand opiate addicts in Chicago said, "It is interesting to note that comparatively few of them resorted to violence in their criminal activities. On the contrary our figures suggest that most of the crimes committed by addicts were of a peaceful nature that involve more the use of wit than of force."[77] Psychopharmacological violence suggests that some individuals as a result of short or long term ingestion of specific substances may become excitable, irrational and exhibit violent behaviour such as alcohol, stimulants, and barbiturates and in this either the offender or the victim may be the user. But reluctance of victims to report is a problem hence under reporting has prevented understanding of this nexus. Systemic violence refers to the traditionally aggressive patterns of interaction within the system of drug distribution and use, disputes over territory, rivalry in drug dealers, hierarchy, cleansing for reinforcing normative codes et. al. In economically compulsive violence the drug users engage in economically oriented violent crime to support drug use and not because they are violent[78]. The microsystem or interpersonal events appear to generate violence. Alcohol and drugs are seen as being not the only causal agent for violence, which is stressed by Coleman and Straus[79]. Systematic

understanding of drugs or alcohol's role in violence is hindered by the cultural phenomenology[80].

Race: Whenever a culture is racially heterogeneous with a minority that is subservient, suppressed or in some other manner superordinated by a ruling majority[81], the minority group is likely to be viewed as socially inferior and to have high proportions of its people in the lower social and economic class. Thus restricted and isolated from the institutionalized means to achieve the goals of the dominant culture they are caught in what Merton and Ohlin refer to as the differential opportunity structure and hence are likely to commit crime or indulge in violence[82]. Hence it is the environment which makes the oppressed violent and not the race, caste and class as it is generally believed.

Urbanization: The economic and social forces in urban areas are not self balancing. Imbalance in job, housing, social services and other aspects in urban life is abetted by public policies and relative ineffectiveness of the efforts of the urban government to respond to urban problems. The government is least responsive to people displaced to urban areas from rural areas[83] and as they are the ones most affected by urban marginalization, employed in unorganised sector with no cultural identity they tend to be more violent due to

discontent and frustration[84]. Urban violence and crime has increased by 3% to 5% and many studies are pointing towards an urban crisis which leads to violence[85,86], one of the reasons why the 1993 riots had maximum toll in urban areas[87].

Marital status and Broken Home: Studies reveal that people who are single are more likely to be violent[88] and more susceptible to suicides[89]. Individual who come from broken homes learn violent norms of behaviour and discordant values[90] which results in greater indulgence in violence. Broken homes transmit aggressive behavioural patterns which lead to internalization of antisocial aspects and dependence on violence as a mode of expression[91].

Educational status and Media influences: A lower educational level frustrates an individual as it blocks avenues for further growth which can be a factor for greater tendency to indulge in violence. Increase in portrayal of violence in media to solve problems or to achieve goals through violence, according to many social scientists has led to an increase in violence[92]. Popular literature emphasises violence and even the science dominated fictions show how a system of knowledge becomes a source of violence, once it has acquired power or the capacity to bestow power[93].

It appears valid to suggest that in a heterogeneous population differences in ideas and attitudes towards the use of violence exists. A middle class child is more likely to turn his aggression inward and commit suicide and the lower class sees it as an attacked - attacker relation, thus target is external and aggression is directed towards others[94]. Thus, they reveal and experience manifest violence. Residential propinquity simply reinforces the impact. An internal need for aggression and readiness to use violence by the individual have not been empirically verified where as social conditions have been accepted to have an authority on this as they recognize that In spite of similarity in situations it is the external situations which lead to violence. Violence is by no means evenly distributed across the population.

The causes are useful only in so far as identifying the high risk groups who are likely to be perpetrators and victims. In urban areas where the density of population is high, an increase in infectious disease and IMR, frustrate an individual which gets aggravated when there is little or no access to health services, which results in violence as a mode of expression of discontent.

THEORIES OF CAUSATION

INTRODUCTION :

Much of the general literature particularly of psychological character deals with violence from a descriptive atomistic viewpoint and has only marginal bearing on an integrated socio-psychological theory of violence. They view aggression and violence as being synonymous. Examining the theories, reminds us of the classic case of several blind men separately examining the elephant and separately discovering distinctly different parts. This is the kind of picture one gets when theories are evolved within the disciplinary insularity. Violence initially was seen as originating from the individual which then moved to causes in external environment. Causes of individual violence are studied at the biological and genetic level, group violence is studied on the immediate environment and institutional violence at a political and economic level[95].

CAUSES OF DIFFERENT LEVELS OF VIOLENCE UNDERTAKEN BY DIFFERENT THEORISTS

			Method of intervention		
System	Causality	Control Practice	1	2	3
Individual	Biology / Genetics	Medical	Eugenic	Therapeutic	Euthanasia
Group	Psycho-sociology	Police	Prevention	Surveillance	Repression
Institutional Organisation-al	Sociology	Political	Political Struggle	Political control	Legislation
Nation state politico-economic structures	Sociology of international relations	Diplomatic Military	Consultative Recruitment	Negotiation Manoevre threat	Agreement Alliance operation
Trans-National systems	Peace Research Studies	Generalised Military	Consultation	Control of flow	Economic military intervention

The table explicitly shows the different levels/ systems at which violence erupts and the corresponding causality, control practice and intervention.

The biopsychiatric model identifies predisposing risk factors of violence which can be blocked by medication. The psychological model sees violence as an instinctual reaction in the personality. The

sociological approach sees it as a logical outcome of structural tensions which frustrate an individual and creates group conflicts.

PSYCHOANALYTICAL THEORY OF AGGRESSION

Psychology has dominated the field of violence especially psychoanalysis which explains violence in terms of uncontrollable impulses, mental illness or disease, momentary losses of control produced by unusual circumstances. These explanations avoided the need to study the problem beyond the individual offender or victim and also removed the necessity of investigating the elements within a society which precipitates violence.

Aggression is the actualization of the death instinct, a somatically based instinct towards hatred and destruction[96] which can create disorder. Aggression is a behavioural response characterised by the exercise of force in an attempt to inflict injury or damage to a person[97]. Psychiatric literature has received a major boost, due to medico-legal requirements but since the collected evidence for a consistent personality pattern of violent persons is scarce, it is unreliable, and hence lacks confirmation and has received only scarce response.

Frustration Aggression hypothesis has been readily accepted by many sociologists and psychologists. This theory presupposes, a

frustrating situation to any aggressive situation. Berkowitz's definition of frustration produces an emotional state, or anger which heightens the probability of occurrence of drive specific behaviour on the presence or absence of restrainers against aggressive reaction. This formulation with its awareness of the importance of outside stimuli can be equated to social determinants of the learning process[98,99]. Dollard maintains that the primary source of human capacity for violence appears to be frustration and aggression as anger induced by frustration is a motivating force that disposes man to aggression which has a cathartic effect. Thus, frustrations resulting from deprivation are the main instigators of violence and relative deprivation is the main instigator[100,101].

The heuristic value of the frustration and aggression hypothesis is important in the area of psychology but has failed to hold value in other fields as it is virtually axiomatic that frustration is inevitable and necessary in the socialization process[102]. Feirabands and Nesvold blamed systematic frustration as the frustration collectively experienced within societies responsible for group violence[103]. The need to obtain power is ingrained in everyone and is a learned part of aggression. Man's aggression, thus, is partly instinctive and partly learned. The

roots of our violence thus lie in unresolved hostile aggression, the sign of which is our personal and social ambivalence[104]. Consequently our fears and frustrations become intensified through the environmental condition depending on which violence erupts.

SOCIAL LEARNING AND CONDITIONING

Provides a theoretical bridge between an individual's violent behaviour and individual value allegiance[105]. This emphasises the extent of individual differences in the strength of allegiance of those values and the fact that not all individuals with ecological propinquity share value and motive identity with the surrounding culture. The process of social learning through a number of mechanisms ranging from repetitive contacts to the subtler form of imitation and identification, involves the acquisition of value systems in early childhood and their integration in the complex personality, trait value and motive system which makes up global individuality[106].

Social Disorganisation Social change, conflict and violence go hand in hand[107]. Coser, theorised that violence provides mechanisms for conflict resolution when other channels are closed, which happens in a rapidly changing society. It is during these times that social disorientation and snapping of the network which binds people together

occurs[108]. This results in disorganisation, isolation and discrimination which when politicised gets emphasised as social inequality and immobility, which then errupts as violence[109].

Theory of Anomie by Merton[110] states in continuation to social disorganisation, that social structures exert pressures on individuals to behave in non-conforming ways to achieve goals which gets aggravated due to culture conflict. Thus, when goals are unattainable by conforming means, violence is resorted to as a last resort.

These theories have paved the way to subculture theories.

Cohen's Middle Class theory Cohen stated that the lower class child is constantly measured by the middle class measuring rod, but since the deprived child cannot attain the goal by socially approved channels, violence is resorted to[111].

Cloward and Ohlin's theory of Differential Opportunity talk of three subcultures namely-criminal, conflict and the retreatist. In the criminal subculture since the role model is violent, the child performs and practices violence. In the conflict subculture a manipulation of violence as a method of status achievement is seen. It is only in the retreatist subculture, where restriction on the use of violence exists, that inner - directed violence errupts[112].

THEORY OF RELATIVE DEPRIVATION

Discrepancy between value expectation and value capabilities leads to violence. The former are beliefs an individual holds they are entitled to where as the latter is what they are capable of attaining, given the social means available to them. The gap between the two leads to discontentment which is a precursor to violence[113].

The subculture theories try to explain the high violence rates in the lower class and emphasize the importance of middle class values which respect the laws and norms of the community, hence are biased against the violence committed by the lower class. These theories do not take into account institutionalized violence perpetrated by the upper class. Different kinds of violence is not referred to in these theories. Durkheims' sociology of violence recognised homicide and suicide as two forms of violence. He said the former is indicative of lower and the latter of a higher stage of development[114]. The fact that violence does exist in the upper class which is inner directed and hidden is not even recognised. Violence should be viewed in terms of both the cultural and social context to get a holistic picture. This is the approach that Wolfgang and Ferracuti have devised in their theory of violence where

an emphasis is on subcultural affinity to violence principally present in large urban cities, in the adolescent population[115].

SUBCULTURE OF VIOLENCE

Wolfgang and Ferracuti say[116], violence is a reflection of basic values that is stated apart from the parent culture. They state:

1) No subculture can be totally different or totally in conflict with the society it is a part of

2) to establish the existence of a subculture of violence does not require that the actors sharing these basic value elements should express violence in all situations

3) the potential or willingness to resort to violence in a variety of situations emphasizes the penetrating and diffusive character of this culture theme

4) this is shared by all ages, in a subsociety but this ethos is most prominant in a limited age group ranging from adolescence to middle age

5) the development of favourable attitudes towards and use of violence in a subculture involves learned behaviour

6) the use of violence in a subculture is not viewed as illicit conduct and the users therefore do not deal with feelings of guilt.

CONCLUSION

No single theory explains the variety of observable violent behaviour from both the psychological and sociological constructs nor do they aid in the explanation of violence. Even the subculture of violence postulated by Wolfgang and Ferracuti does not explain the genesis of violence. They have used the conceptualiation of a subculture of violence as a point of theoretical departure from an integrated socio and psychological approach[117].

The concern of distinguishing different kinds of violence and assigning value to them shows that the epistemic space of violence is prey to tyranny of the norms[118]. Thus, research into causes of different levels of violence undertaken by the theorists of different disciplines throws up the need of a multi causality approach. The structure of brain or social conditions alone cannot explain the concept as we can't see causality of violence in linear terms. One has to see the complex intrapsychic, interpersonal and sociological interactions[119].

DIFFERENT TYPES OF VIOLENCE

The assessment of the different forms of violence is much less developed and almost non-existant. A framework for guiding clinicians in the field is now emerging as one can see concepts of child abuse, wife abuse, elderly abuse, incest, and sexual abuse creeping into the medical circles. The different kinds of abuse tend to shatter the myth that family is the ideal place for life, society enhances an individual's potential for self actualization or that nation states give peace, protection and security to the citizens[120].

Child Abuse : Child abuse as an issue has been well documented in the west, but in India, the concept has yet to be recognized. Child abuse is defined as "any type of sexual exploitation of a child by any older person for stimulation or gratification of the person which is not confined to physical contact and which may range from exhibitionism or involvement with pornography to full intercourse or prostitution where the developmentally immature victims lacks the authority or power to prevent himself /herself being coerced into activities to which she/he is unable to give informed consent and which one does not comprehend properly at the time". The National Centre on Child Abuse and Neglect defined child abuse as "the physical and mental injury, sexual abuse,

negligent treatment or maltreatment of a child by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened"[121]. The latter is a more holistic understanding of the problem of child abuse. Abuse of children has been recognized only relatively recently as a serious social problem[122]. Many of our social customs favour or promote child abuse like child sacrifices and female infanticide and foeticide. Indian society makes a relative under estimation of girls and views them as a burden, thus contributing to a high female infant mortality rate. Child abuse covers maltreatment, child battering, failure to provide for the child, refusing medical attention, child labour and any other act which affects the well being of the child. The predisposing factors for child abuse are-

Child factors	:	illegitimate, unwanted, unwanted sex etc.
Parent factors	:	unreasonable expectation, abusive parents, lack of support, illness etc.
Social factors	:	financial problem, marital discord, unemployment, industrialization, urbanization etc.[123]

Clinical diagnosis proves to be difficult due to a perplexing variety of symptomatology (withdrawn, subdued, over reactive, etc.) along with psychosomatic problems. The psychological and physical scars are inseparable[124]. The severity of the physical consequences of abuse and neglect are more readily identifiable than those of an emotional and moral nature and only the cases closer to extremes are identified. Terms like endangering health, adverse effects, mental suffering, well being are left undefined which makes it difficult to locate when the abuse started. Thus getting accurate data on the magnitude of the problem is more an ideal than an attainable goal[125].

Elderly Abuse : Violence against the elderly is on an increase in America and yet studies of effects of victimization against them is surprisingly less. Abuse of the elderly is a serious problem with the life expectancy increasing. Humiliation, degradation, and social isolation are also forms of abuse. Just like child abuse, elder abuse does not denote a legal category nor a homogeneous class of behaviour. The lack of a standardized definition has led to a wide operationalizations which (like violence!) has rendered both fruitless and frustrating attempts to compare the findings of studies. Thus again no reliable estimate of incidence is available. Violence against the elderly differs in

some respects from violence against younger persons. The major findings are :

a. elderly abuse is perpetrated by family members and caretakers.

b. elderly abuse is committed at home thus being clubbed with "domestic victims".

c. Elders are more frequently and seriously assaulted.

d. Since females outnumber males in the older age groups, it was expected to see a gender bias. However this was not seen[126].

Thus neglect, physical assault, material abuse, violation of rights are forms of elderly abuse[127] and with decreasing mortality rates, the population of older persons is going to rise, thus one needs to probe further into the various dimensions of the problem.

Violence against women: Violence against women has recently been recognized by the UN as the fundamental abuse of women's human rights. Gender based violence includes a host of harmful behaviours that are directed at women and girls because of their sex and includes wife abuse, sexual assault, dowry related murder, marital rape, selective malnourishment of female children, forced prostitution, female genital mutilation and sexual abuse of female children. Sexual violence (rape, attempted rape, sexual molestation) is not a special subset of assault

but, as they are related to the sexual values of the society, they are crucial.

Domestic Violence : The most endemic form of violence against women[128] is abuse of women by intimate male partners both physical (includes sexual) and psychological (ongoing emotional abuse included). Mahajan in a sample of 50 per cent of SC households and 50 per cent of non ST households and an equal distribution of men and women (n=109 each) from a village in Jullandur (Punjab) found that 75 per cent of SC men admitted to beating their wives, 25 per cent non SC men admitted to beating and 75 per cent of SC wives admitted they were beaten - "frequently". Still women are reluctant to disclose abuse, because of feelings of self blame, shame, loyalty or fear. Women in many cultures are socialized to accept physical and emotional chastisement as part of the husbands marital prerogative making them less likely to self identify as abused[129].

Domestic violence has both physical and mental health consequences. Abuse related injuries include bruises, cuts, burns and scalds, concussions, broken bones, penetrating injuries from knives and other objects as well as miscarriages, permanent injuries such as damage to joints, partial loss of hearing or vision and physical

disfigurement from burns etc. These when aggravated, the severity increases and results in the death of the victim. Besides injury, battered women frequently experience a variety of less well defined somatic complaints such as chronic headaches, abdominal pains, muscle aches, recurrent vaginal infections and sleep and eating disorders. Researchers[130] suggest an association between domestic violence and delayed physical effects particularly arthritis, hypertension and heart disease. The psychological impact however seems to have a more debilitating effect than its physical sequele. This includes mental torture, living in fear and terror and the physical violence itself. This could have long term mental health consequences for women and they are more likely to commit suicide or attempt suicide and be alcohol dependent. The link between abuse and psychological dysfunction has been useful to understand the reasons for increased mortality through increased risk of suicide. Marital violence[131] in a cross cultural study was found to be a major defining feature in female suicide[132]. It was found that the peak age for suicides by married women were in 15 - 20 years of age group. Link between marital violence and homicide is particularly evident in India. Cases of dowry related deaths are a mute testimony to this[133]. The interesting fact is that these cases of

"homicide" are converted into cases of suicides and accidents which tells upon the "hierarchial system" and patriarchy existant today. Domestic violence is often a precipitant of murder by women. They are often preceded by a history of physical abuse directed at the woman.

Rape : Sexual violence is structural violence. These cases are notoriously under-reported. The legal definition of rape, includes forms of penetration other than penis-vagina. Data (whatever little is available) shows and explodes the myth of rape as a stranger perpetrated crime. In many cases majority of the perpetrators are people known to the victim. Historically rape has been perpetrated during episodes of organised violence as a means of breaking the structure of communities, demoralizing "the enemy" and energising the troops. Women are frequently regarded as a legitimate "spoils of war". Bangladeshi authorities estimate that in 1970-71 over 2,00,000 Bengali women were raped by Pakistani soldiers during the nine month war. "Mass rape" is seen as being good for the army morale.

The psychological and physical impact of rape on women is severe and leads to severe health disorders - both physical and mental. Majority of the victims reveal depression, alcohol abuse, drug dependence, generalised anxiety, OBCD and post - traumatic stress

disorder. The added possibility of becoming pregnant or contracting a sexually transmitted disease (HIV) is also high. When linked with family honour, the possibility of being killed in even higher. Sex within marriage is also forced. The physical and emotional fallout of rape by an intimate is greater than that of a stranger, as the former is seen as a betrayal of faith. Even decision of when or if to have sexual intercourses is a prerogative of men which is a sign of violence at a personal level. Thus sex is used as an instrument of violence[134]. Rape is violence inflicted by men on women. Rape is a crime that can be understood in its socio-cultural context and particularly in the context of power-relationships between males and females. Traditional socialization encourages men to associate masculinity with power, dominance, strength, virility and superiority and feminity with submissiveness, passivity, weakness and inferiority. Males also acquired certain cultural expectations about their sexual needs and access to females. Thus rape is an extreme form of male aggression and hostility towards women. There is an absence of social science theory and what has been developed, has been developed by practitioners, social workers and psychologists in treating molested women or offenders. But they lack comprehensiveness and are not sensitive to many socio-cultural

factors. Victims suffer from a range of clinically significant and persistent health problems including anxiety, fear, depression and sexual dysfunction and the trauma experienced by rape victims is more severe than victims of other violence. The rape victims can be helped by police, prosecutors as well as health professionals to deal with the trauma[135]. The measures should be designed to alleviate the effects of victimization and enhance the process of apprehending and prosecuting offender.

The lack of comprehensive theory and the peculiar difficulties of obtaining essential research data on sexual assault is limited and increasing. Thus, sexual violence tells us a lot about the values our society enspouses and the quality of life we hope to enjoy. The Sixth and Seventh Plans have an objective of NRR of 1 which is an underhand way of approving amniocentesis. It is a blatant yet hidden confirmation of female foeticide, infanticide, malnutrition, repeated pregnancy, dowry and high maternal mortality rate. Thus women are the appropriate victims for the state also[136]. Thus not only is domestic violence rooted in societal roots but also in political circles. The extent of domestic violence is also difficult to estimate as the behaviour is

widespread almost to the point of being a normal expected pattern in many homes[137].

A pan cultural feature of all patriarchal societies is the subordination of women, and that too is rationalised through structural organisations. Thus right from witch hunting, remarriage, sati, fidelity to birth of a daughter are phenomenon perpetuating violence[138,139,140]. However surprisingly, even in Kerala, a matrilineal society, violence against women is no less than anywhere in India[141]. Many reviews of newspapers[142] show a nexus between political leaders, police, judiciary and the insensitivity of doctors in government hospitals in perpetuating a slow insidious violence against women. Violence during childbearing years and after birth is quite high[143] and hence in the World Development Report (1993), a particular notice of violence against women and health consequences has been taken. Thus, unnecessary hysterectomies, abortion, death due to ruptures, infections due to IUD and the insensitivity of health care services of seeing a women only as a potential mother are all forms of medical violence and shows its role in perpetuating gender violence[144].

Psychological Abuse is a concept which very few people accept exists. The mere definition of such an act or a behaviour as

maltreatment and oppression calls for some action as they impede the normal functioning of an individual. Hence the impact on the individuals emotional, intellectual and physical health are equally important. Psychological abuse are frequently perpetrated in the most violent forms such as isolation, humiliation, denial of support and threats of injury. Very little literature or research is available in this category.

Communal Violence : People with different backgrounds that is, educational, traditional, religious, political and professional are discriminated against and assaulted solely and primarily because of their membership in a social category. Hence social violence is structural in nature and takes different forms. that is rural, urban, class, ethnic, caste, racial, and communal violence.

Communal Violence is perhaps the most frightening form of social conflict. When the members of one ethnic or religious groups turn on the members of another, atrocities are inevitable. The relationship between such violence and mass displacements can be seen in India. With the partition of India in 1947, clashes between Muslims and Hindus forced eight million people to move to the new state of Pakistan, while more than six million people made the journey in the opposite direction. During the conflict that surrounded the independence of

Bangladesh in 1971, millions were displaced and even now 2,75,000 non-Bengalis in Bangladesh are still homeless. In 1983, tension between local Hindus and newly arrived Bengali muslims in Assam errupted in violence, leaving 3,000 people dead[145]. The death toll of the recent Ram-Janambhoomi episode (1993) is yet to be correctly estimated. Hence the incidence of communal violence is very high and needs to be recorded objectively[146,147].

Racial and Caste Violence : Both these categories of violence are a struggle for power which are rooted in imagined superiority[148] and is generally perpetuated most when the socio-economic scenario is fluid in any society. In India, violence against SC/ST has gained much attention from various quarters and though legal and constitutional provisions provide safeguards against discrimination, atrocities go unabated. Discrimination spreads not only in social context but also in economic, political and legal contexts[149].

Rural and Urban Violence : Seeing the demographic characteristics of India where 80 per cent of the population is rural, difference in violence in rural and urban areas is important to be studied. With failed agrarian land reforms, migration to urban areas and limited political access has led to an upheaval of violence is both rural and urban areas. What

needs to be examined is how the nature of violence differs in these two areas[150]. This would help to identify causal factors and to evolve preventive strategies in the present political scenario in India.

Political Violence : According to C.W. Mills, "The link between political power and violence is self evident"[151]. Marx said "state is an instrument of oppression in the hands of the ruling class" where as Weber postulated violence as a means specific to state and it alone possesses the exclusive right to use violence." Wars involve violence and homicide on an unparalleled scale. The mortality of wars are well known and documented. In general, however violence by the state is strangely absent from studies of the problem of violence. This omission reflects a widespread tendency not to define any acts of "official" violence that is war, capital punishment, political submissions etc. This was also evident as the National Commission on the Causes and Prevention of Violence of America excluded war and other official violence from the research agenda[152]. The state in an "official" violence episode ceases to play the role of a benefactor, assumes a repressive policy under the "Doctrine of National Security". Public liberties are curtailed systematically, torture, disappearances, execution, deprivation, exile, searches, threats to life and censorship along with no avenues for

public expression are the "normal accepted" forms of violence. The effects of all this on the psyche, illness and health is not even seen to be as being important[153]. Chile, Argentina, Sri Lanka, Pakistan and a few states of India are all victims of political violence. The state thus instead of providing protection for its citizens uses its power in the form of draconian rules and use of force which proves costly both in terms of human and economic resources.

Political Violence is often termed as a form of generalized violence with elements of political persecution and oppression. These include failure to guarantee equitable distribution of food, land, jobs, education and other resources to the marginalized or discriminated social groups. When they rebel, the government then launches repressive campaigns to assert their authority and root out opposition[154]. State violence is exhibited in policies and actions of the state which directly or indirectly affects adversely human life in terms of nature and type of disease and death, through food, housing, health and general economic policies. Thus political violence can be direct or indirect. If mortality and morbidity are not shown in isolation, the true quantum of political violence would be more noticeable[155].

Violent upheavels and civil disturbances have blotted India's chequered history since the dawn of independence. After subjugation was achieved, colonial government routinely attempted to determine the distribution of people under their control. Attempts were made to regulate uncontrolled settlement in the expanding urban centres. Regional inequalities were created. Politically important regions were favoured and others neglected. Large sections of arable land were brought under indigo, tea, rubber estates which had far reaching consequences and one had to import major items of food consumption. This led to tenancy and more exploitation. The production of commercial crops forced the development of service industries and destroyed self sufficiency. After independence, partition, assasination, wars (China, 1962, Pakistan 1965 and 1971), linguistic wars, internal strife, emergency, Mandal Commission, Babri-Masjid et al are just a few examples of violence politically generated. Victims of civil war and governmental counter-insurgency operations are often marginalised groups. Many of the world's poorer countries are locked into a vicious circle of repression. Their governments rule not in the interest of the nation as a whole, but to serve a small ruling elite often drawn from one region, religion or social group.

Finding no constitutional means of expressing their opinions, opposition groups turn to terrorism in guerrilla warfare, frequently backed by foreign powers. In response governments launch repressive campaigns to reassert their authority and to root out the opposition. In doing so, they use state terror, torture and indiscriminate killing which invites escalating waves of violence and counter violence. Political violence is seen as violence for change at the micro and macro level as an outcome of institutional functioning and structural change.

Political violence is a systematic and persistent strategy of violence practised by the state political groups against another state or political groups through a campaign of or act of violence with the intent of creating a state of terror or of public intimidation to achieve political goals[156]. Political violence is associated with terrorism. Terrorism is a variation of man's perennial use of violence. A form of political violence less extensive and more controlled than war - kidnapping, killing or looting is a part of it and its foundations are in anarchism and nihilism. It is a form of violence which is not governed by laws or rules[157]. Political violence has intellectual violence inherent in it and information, knowledge along with media are controlled[158]. Police violence also aggravates[159]. Violence is seen as a means to intimidate adversaries.

Jails become "torture centres". Even in normal circumstances police and judicial torture continues unabated on the poor in jail[160, 161].

Developmental Violence : The nexus between development, science and violence is evident by the fact that eighty per cent of scientific research is devoted to the war industry. The reductionist nature undergirds the economic structure based on exploitation, profit maximization and capital accumulation. Institutions of learning selectively train people in a reductionist paradigm and take refuge by saying application of science is violent thereby absolving self of introducing new forms of violence.

The relationship between violence and modernization therefore, needs to be explored. One has to be aware of the fact that science encodes a structure of domination and violence which is not confined to the laboratory. It is a pathology which resides in the banality of everyday life[162]. Development is an outcome of scientific discoveries, ingrained in the logic of modernity as technocracy. Development has four theses:

1) The Hobbesian project, - the conception of society based on the scientific method. The Hobbesian project was a schema for science and society. It forges links between science and power and links it to the issues of fear, death, terror and violence.

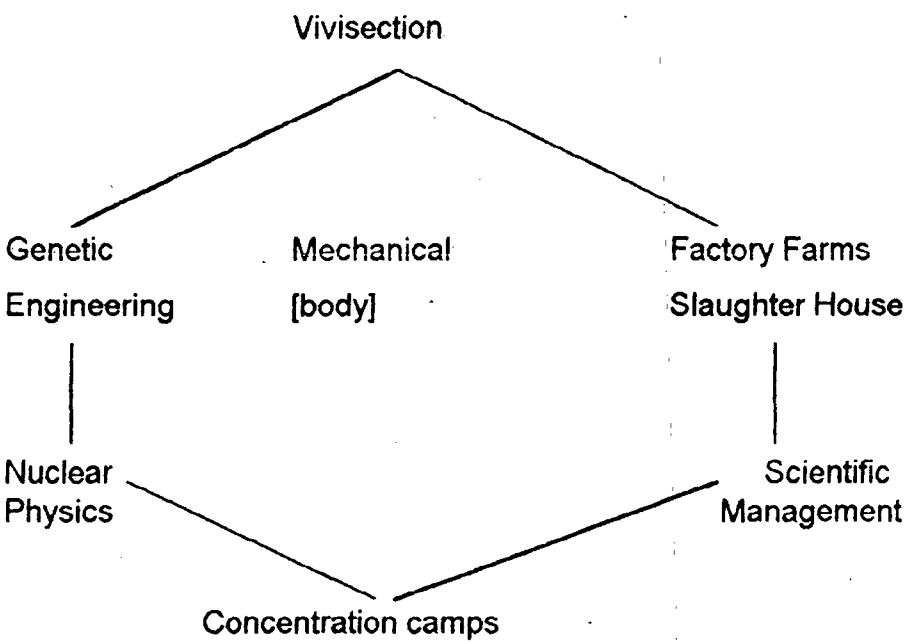
2) Imperatives of progress - which legitimizes the use of social engineering on all those objects defined as backward or retarded.

3) The vivisectional mandate - where the other becomes the object of experiment which in essence is violence in which pain is inflicted in the name of science.

4) The idea of triage combining the concept of rational experiments, the concept of obsolescence and of vivisection whereby a society, a subculture or species is labelled as obsolete and condemned to death because national judgment has deemed it incurable. [Triage in medical terms means determining priority of treatment particularly when treatment outruns the supply of medical facility].

Thus modernity was a vision of conquest. Progress and modernization as scientific projects automatically legitimize any violence done to the third world as objects of experimentation. The classic example is that of Marx who indirectly justified the British colonial presence in India as a trigger for India's movement towards modernity. The violence of modernity arises not merely from the violence of the state, but from the violence of science seeking to impose its order on society. Thus, scientification of a problem carries within it seeds of vivisection violence where, vivisection is the infliction of pain

for experimental purposes. The socialization of vivisection in science has become normal and underlies the violence implicit in science as evident in the scheme below[163].



Modern science and management thus has its origin in the vivisection of the animal body. The first assembly lines were developed in the slaughter houses. Modern management and science are all based on disassembling of the body. Thus, violence in science has an inherent paradox. To eliminate backwardness, violence is used as Frantz Fanon in the "Wretched of the Earth" stated violence is the only solution to free the enslaved and act as a catalyst of change[164]. However, once that backwardness is eliminated and development is

adopted[165] which too is based on violence. That could be a reason why history has been a chronicle of various disasters, wars, famines, epidemics, Chernobyl, Bhopal etc., which show the link between violence, development and change.

In a society in transition where pre - modern forms of socio - economic life continue in existence with the most modern, the processes of identity formation constitute an area of intense conflict. The peculiar nature of capitalist development in India is not based on the destruction of feudalism nor on the basis of confrontation with the feudal ideology as in Western societies but is based on a compromise. This provides the framework within which the battle of identities is waged. The state itself is an area of conflict and intense struggle between the two classes with each trying to dominate the other.

The result is a hybrid growth with a superimposition of the modern on precapitalist forms within which agriculture remains the primary sector in our Indian economy. This leads to an increasing prevalence of forced movements of population and the emergence of a vast number of uprooted people called variously as refugees, displaced persons, expelles, returnees and asylum seekers. Millions of people are obliged to move against their will. Some are uprooted as a result of

deliberate government policy and a larger proportion are displaced by intolerable conditions of insecurity and poverty. The slave trade of the fifteenth to nineteenth century, is one of the largest ever forced movements of populations and a classic example where people were used for enrichment of people elsewhere. Colonial expansion involved brutal mass displacements as a new territory was occupied. The indigenous population was cleared to make way for new settlers. Military conscription and forced labour uprooted many more. Large number of indentured labourers were transferred between continents to satisfy colonial demands for manpower.

In the first half of twentieth century involuntary migrations were concentrated in Europe. The two world wars and subsequent territorial realignment produced a series of mass displacements, refugee movements and forced repatriations involving suffering on a massive scale. A hundred new states emerged from colonial subordination. Boundaries, fragile national unity, brittle political systems and distorted economies, political and economic instability led to an unprecedented proliferation of tensions and conflicts. These development had immediate, disastrous consequences for the growing population of many developing countries. Expectations of the 1960's were steadily

eroded, scarce resources were depleted by arms spending, inappropriate development projects and economic mismanagement, mass poverty and insecurity increased. Millions of people were deliberately uprooted giving variety of reasons such as population growth, economic stagnation and ecological deterioration. Added to this the burgeoning arms trade, increased militarism and intolerance led to an increase in violence. International recession and terms of trade for primary exports have declined sharply. The oil price hike of the 1970s led to a huge increase in expenditure on energy by non - oil producing countries and growth rates plummeted. Debts increased by the developing countries encouraged by the banks they have become massive burdens. They turned to IMF for staiving off balance of payment crisis and are now following austerity programmes.

When displaced, people are unemployed, face xenophobia, physical assaults, harassment, distrust, suspicion, nostalgia, increasing psychological and physical hardship. They face hazardous conditions and artificial nature of life in camps. They are deprived of their ability to make any real choices about life. They face poverty, social tension and tend to participate in militarism.

Development leads to the breakdown of social structures and people most affected by it are the poorest and the most powerless members of the society (marginal farmers, urban squatters and landless labourers) as land is being appropriated in an attempt to fuel economic growth. Massive infrastructural development programmes such as construction of dams, highways, pipelines, construction projects are regarded often wrongly as a sure means of promoting growth. In the drive to maximize export earnings, commercial concerns are often preferred over production of food for the hungry. Policies are made by urban people and the majority that is the poor are made to pay for it. They are forcibly evicted from land and resettled on marginal sites with poor soil, steep slopes or poor rainfall. An NGO - Survival International has estimated that two million tribal people in India are threatened with displacement by hydropower projects alone. Impoverished new comers compete for scarce resources such as food, water, land and jobs[166]. Deforestation, soil erosion and infrastructural breakdown follow eventually. So they become victims of oppression and insecurity and face starvation, disease, death and contagious disease which take on an epidemic form. Physical assault is not uncommon. Besides this, psychological trauma, feelings of insecurity, depression, no self respect

add to the stress of the individuals. The technological change has reduced demand for labour. Wage rates decrease, poor labour are non-unionized who tolerate poor condition and harsh work routine, stay in slums which are routinely " removed" by local authorities. This unequal development has led to rural impoverishment, generating or exacerbating inequalities[167] .

Violence gets perpetrated by the division of labour, new social relations of production and new productive forces. The transformation of men into a working force, marks the genesis of the capitalist mode of production. The atomised individual is seen as a factor devoid of any human aspects, in an enterprise who has a little hold on the end product[168]. The nexus between maldevelopment and violence from colonial days with the role of elite is quite apparent. Green revolution and its role in increasing the gap between the have and have nots, perpetuating inequalities is well known[169]. In the name of science and development one can demand enormous sacrifices and inflict suffering. Violence includes new and strange forms of mutilation "with the growth of civilization" Ivan Illich stated that the current economic development based on modern science and technology can be seen as war activity[170]. Science is inherently violent and its use for violence is

assured for it has been accepted that science can emancipate the third world population. Thus physical environs can be changed which leads to disasters, decrease in welfare spending, increase in arms cost which are justified in the name of development[171]. Thus poverty which affects well - being and affects life expectancy is an outcome of development and science[172]. Hence paradoxically, science and development demands sacrifices, inflicts sufferings, perpetuates violence and yet lack of access to benefits of development in science is also seen as violence.

Examining this paradox, reveals that at the base is the appalling problem of poverty, inherited inequality and the lack of equal opportunity. This was not only prolonged by the colonial system but new forms of exploitation were also introduced by them. The local elite were transformed into a strata of collaborators who further perpetuated the colonial exploitation. With the dawn of independence, the colonial exploiters were exchanged with the "power elites" as exploiters. Thus the issue of violence in relation to development is like the double edged knife, that is not only is violence the byproduct of the developmental process, it is also the disequilibrium in the access to "fruits" of development that results in violence. As development serves the

interest of only the elites, it becomes the breeding ground of discontent which eventually leads to violence.

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CHAPTER - II

VIOLENCE AND HEALTH NEXUS

Any discussion on health and it's related topic confines itself to the technical domain and treats health as purely individual or personal, biological phenomenon where problems are to be solved at the individual level through medical technology. The truth however is that health is a product of biological, physical, social, economic and political realities.

The popular WHO definition of health, tends to focus on the ideal rather than on the actual since it assumes the notion of an absolute well being of an individual. The defining of health as "A state of complete physical, mental and social well being and not just the absence of disease and illness" fails to examine the relations of the individual with the social environment[1].

Thus, 'Health' is a social concept and its parameters differ from community to community like the concept of violence. Both are determined largely by the socio - economic, political and technological forces. Both have an element of exploitation of one class by the other and the struggle of the exploited against exploitation. However, both the terms health and violence are normally restricted to the physical aspect as that is how they can be classified in statistics. Hence, few people are able to, or are willing to perceive the violence which today is inseparable from modern medical science. The present chapter

attempts to explore the violence and health nexus from three aspects viz. (a) from the public health dimension, (b) the medical care for victims of violence and (c) medical violence.:

VIOLENCE & DISEASE

Violence is a widespread phenomenon with great hazards to the health and well being of those concerned. Not only does it affect health directly but it also affects notifications and recording of other diseases. Yach, shows notifications in infectious diseases such as TB also decreases during violence which is a drawback and prevents full quantification of the disease. It has a detrimental effect on the development of children and literally shortens the lives of socially marginalised or defenceless groups[2]. Violence is a cause of 'non health' and death. It affects the health of an individual by threatening life, altering health, producing disease and presenting death as a reality[3].

Disease is defined as a negative alteration in bodily integrity or its organic or emotional function. Violence produces disease as it mutilates, causes fluid or organic imbalances, lacerates, limits or impedes cell function, organ and system function and produces pain. Thus violence can be physical, psychological and biochemical. Physical manifestations are further exacerbated by individuals or collective psychological or emotional altercations. Its effects on

morbidity is both temporary as well as permanent. This is a disturbing effect as the distribution of victims of violence is not homogenous in terms of sex, age, race etc. Hence, epidemiology of violence is complicated and essential.

Since epidemiology of violence has always focused on mortality rather than morbidity, the quantum available or visible is misleading and unreliable. The fact that 1% of population in Central America has been maimed, 296.6 of 1,00,000 population tortured in Cali, 41 of every 1000 paediatric patients were abused children in Columbia shows that the problem is not being assessed and perceived by health departments. Violence negates the supreme right of an individual, that is the fundamental right to life, it transgresses all laws and clearly presents a threat to the health scenario. Placing the violence and health nexus in perspective, one has to look into the implications and demands that problems of violence represent for health institutions. The impact of violence can be thus seen in three different ways : (a) to asses the direct victims of violence, (b) effect of stress and tension during high levels of confrontation and violence, (c) the pathological increases and it's negative impact on medical care and research[4].

Due to violence, mortality and stress related diseases increase, maiming and spread of infectious disease aggravates. These are the

direct effects of violence. The kidnapping of medical professionals and looting of hospitals results in undue pressure on health workers and forces the doctors to use their authority and skills in support of violence, thereby hampering constructive use of medical care and research[5]. Violence imposes an enormous burden on the already overtaxed health care system. Recent World Bank estimates of the global burden of disease indicates that the cumulative impacts of violence on health is substantial[6]. Proper and timely attention to the end product of violence (injury, abuse, rape etc.) places demands on the health services for resources, infrastructure, working dynamics and as it is ill-equipped to do so, violence is demanding that health institutions provide reorientation of health services and ensure adequate policies and increased resources. Since violence has fatal consequences, it requires relocation of health centres. Violence as a cause of premature mortality claims potential years of life lost, and the World Bank estimates that in established market economies, gender based victimization alone is responsible for one out of every five healthy days of life lost to women of reproductive age.

Gumber in his article "Burden of injury", states injury as a public health problem lacks public awareness and is grossly under - recognized as a serious public health threat in both developed and

developing countries[7]. In the world today, injuries alone kill more than 4 million persons each year, which accounts for nine percent of total deaths. According to the World Development Report of 1993, injury is the fourth important cause of death. The share of injury in total deaths in contrast to diseases does not differ between developed and developing countries (share of communicable and non - communicable diseases are 5 per cent and 87 per cent respectively for developed, 41 per cent and 51 per cent for developing countries). If burden of disease is measured in terms of disability adjusted life years lost compared to years of potential life lost, the burden increases phenomenally as it takes into consideration both premature death and loss of healthy life resulting from disability. Gumber found the younger population (age-group of 5-44 years) is more prone to injury and results in more disability than other disease categories, with males being more affected.

In India, the share of injury was 3% and 4% in rural and urban areas, respectively but this low figure may be due to a variety of factors. Comparing this with hospitalization rates, injury ranked second in rural areas and third in urban areas. Thus injury according to him is a major cause of illhealth, which could be used to generalise safely that violence too contributes to the disease and death statistics phenomenally.

VIOLENCE & MEDICINE :

The medical world slowly is misinterpreting the concept of health. It is slowly taking health away from the social conditions and this insidious violence is being precipitated by the drug industry. The traditional medicinal practices which were people friendly have been pushed to obscurity by Allopathy[8,9]. According to Hirsh, "It is frightening to think that physicians generally without the knowledge of the patient are prescribing a therapy or medication without having any expertise in the area[10]. In fact we are a surgery happy society. Not only are many operations unnecessary but also an alarming number of physicians of questionable competency are causing death. If patients were well informed a large number of suffering can be reduced".

The family planning drive in India during emergency[11] and the lopsided expenditure on health all point towards the need to question ethics and morality in medicine which if not checked would be concretised as institutionalised violence. The application of health policies which are influenced by undemocratic political consideration are used to perpetuate existing inequalities in health and social service, this too is violence. Medicalization of life and politicization of socio - cultural roots of personal suffering become an institution for control and health care system is used to reinforce this[12]. The case of Olle Hanson

where attempts to highlight the malpractices were overlooked, shows violence in medical research is widespread. Hanson showed" attempts to hide facts, deny facts and attempts to convince doctors not to publish their negative experimental findings by Ciba Geigy led to crippling of 10,000 people in Japan with SMON (Subactive Mylo Optic Neuropathy) and yet the company functions in many countries.

The plague of 1896 in Bombay lasted for 12 years and 8 months with the toll going upto thousands and health officials depended on Haffkine. Simultaneously the plague in Egypt ended in 6 months with the death toll of only 45 by emphasizing on sanitation only. There is increasing evidence that medicine itself has become a source of disease and death. According to Ivan Illich disease brought on by doctors are a greater cause of mortality than traffic accidents. Iatrogenic illness causes 60,000-1,40,000 deaths in America alone besides the hidden mortality burden. Medical Violence is a curious product of the physician's arrogance and trappings of techniques. Despite all the sophisticated gadgetry health remains a dream. In fact so expensive has modern medicine become that it is far receeding from the people who need it the most.

Claude Alvares[13] introduces medicine as a form of warfare, with the frustrated physician wrecking his vengence on disease and death

with the patient as the battlefield. He gives an example of staphylococci to show how modern medicine only damages the situation. Staphylococci has a symbiotic relation with the body, but the germ theory advocates its destruction whereas what is required is to restore the balance. This only leads to a new resistant strain of staphylococci[14]. Otula Owuor states that AIDS virus was introduced in Africa by western researchers just as was Ebola Zaire[15].

Manu Kothari and Lopa Mehta sum up by saying "It is a sobering thought that after several decades of research .....the problem of human malformation remains essentially unchanged." Mckeown proceeds to chastisise modern medicine further by stating that medical knowledge "on human malformation ..... etiology unknown, rate unchanged, relative contribution to IMR greatly increased ....."

Man's treatment of his own organism is violent and thus will provoke a biological backlash as violence is cyclical. The widening gulf between medicine and performance brings to the forefront the issue of iatrogenic mortality burden being imposed on the patients with professedly good therapeutic intentions, This double speak by medicalmen is dangerous. According to a global estimate 9 out of every 10 prescriptions are unwarranted financial disasters. A doctor inflicts violence on the patient through aetiology, diagnosis, investigation,

treatment, prognosis, research and image building (i.e. health as a business)[16].

Thus violence in hospitals and medicine is a phenomenon in the health services which has come to be dominated by the concept of dangerousness and hence can be seen to emerge and dominate the language and practice of medico - legal decision makers. Dangerousness is an especially legitimatising and enabling construct. It is pivotal to all clinical, cultural and scientific understanding of insanity and violence. In brief, it provides a rationale for conflating mental illness, and criminal violence. It lends scientific credibility to clinical and judicial claims about the confluence of madness and violent crime. It is from here that the concept of medical torture grew and now is seen as crime of medical hegemony[17].

The fact that drugs such as Baralgan, Analgin etc. are banned in developed nations as they perpetrate other medical problems more fatal than the diseases, it is prescribed for by the doctors, is violence. Producing useless drugs which are hazardous to people's health in the long run and which pollute our natural resources is medicalised institutional violence. Prescribing Anabolic steroids which stunt growth, unnecessary prescription, undue tests, not instructing the patient about medicines, giving treatment for a disease not existing, prescribing

substandard drugs (lured by M.R cuts), giving contaminated vaccinations, toxic glucose, are all violence against the body which are conveniently overlooked.

The effects of contraception on the body, such as blood clots, birth of deformed babies, formation of stone is well known. The Lancet January, 1983 brought out the nexus between unscrupulous pharmaceutical firms and gullible doctors with the story of Benoxaprofen and sixty avoidable deaths. Thus the collusion between doctors, media and the government bodies has caused numerous deaths. The story of thalidomide, the use of young girls and inmates of mental institutions in medical experiments is known to every one. The drug industry is increasingly commercializing health thereby destroying health and increasing deformity. This has led to the commercialization of medical practice which has been socially accepted. Thus making money at the cost of human life is blatant example of institutional violence.

VIOLENCE & DOCTORS :

In America, where doctors are easily sued for malpractice and misdiagnosis, doctors are more aware of the need to diagnose torture, abuse and violence[18]. In India response of professionals comes across as dismay or bewilderment, about what to say and what to do. Many feel

isolated and helpless when faced with an abused case due to lack of knowledge, understanding, interest and prejudiced attitudes. They feel patients, when asked directly about bruises, deliberately covered up the cause of battering either because they are ashamed or because they are scared. Many feel, that patients especially women, come basically with the possibility of a sympathetic response, which reveals the pervasive "privatization" of violence against certain sex, class, caste etc. This cultural value is so deeply absorbed by health professionals that it prevents them from recognising distress signals. This failure to heed signals for help, fits well in the concept of selective inattention and highlights their lack of training in crisis intervention (and possible burnout). It highlights that the empathy by professionals decreases as the length of time from their original training increases. This points towards the fact that non-professional crisis counsellors are required to provide support needed by distressed people[19].

The health professionals have been largely oblivious to violence. The prevailing explanation contribute to this neglect by emphasizing biological and psychiatric factors thereby negating the importance of violence. Doctors feel that a doctors job is only to treat illness of those who come and have no role to play in the social evils[20]. It is understandable that doctors are hesitant to play a direct role in the

social dimensions of the victims of violence as they are in all other types of health problems. But it is noteworthy, that they often become accomplices in perpetrating violence when they don't hesitate to issue fake documents, overprescribing, disclosing clients confidentiality and showing serious lapses in medico - legal cases.

During the riots[21], it was clear that communalism was practiced within the hospital and doctors harboured anti-minority sentiments. Doctors artificially increased the death figure for the majority caste and denied basic treatment to the minority. The film "Bombay's Blood Yatra", shows that some doctors used, their expertise to discern between mindless police firing and helped in controlling mindless killings[22].

The physicians role in violation of human rights, torture, judicial and extrajudicial punishment[23,24] are blatant examples of violence. The political abuse of medicine violates medical ethics. Torture is increasing as a method of control by political heads and what is disturbing is the involvement of doctors. The fundamental aim of medicine to protect and promote health is slowly being sidelined. Scientific medical torture with medical precision is worse than beastiality[25]. As the knowledge of physiology increases Amnesty International reports newer and more painful forms of torture[26]. In report on torture, Amnesty International identified sixty countries in which torture was being given by doctors,

and India was one of them[27]. Thus one has to be aware of the double edged nature of medicine just as one should be aware of the Baconian truth as clinical iatrogeny is worse than insane criminality.

RECENT RESPONSES OF THE HEALTH SYSTEM TO VIOLENCE:

Despite a growing awareness of links between violence and health, the short sightedness of traditional public health community is surprising. Violence needs to be recognised as a cause of "illhealth" which contributes phenomenally to the morbidity and mortality statistics. Since "violence" is not recognised as a cause of illhealth, research in this area has not been initiated. The review of literature shows that violence does have a major share in death and disease but it yet has to be recognised as a "cause". This has happened because "Health" is gradually being extracted from its social context and is being portrayed simply as "the absence of disease". Thus, till health is not seen as a holistic concept, the chances of seeing violence as a cause of illhealth is very low. In America, National Research Council and Institute of Medicine in its survey of injury in America failed to mention physical violence in general as a major cause of injury. It gave rape undue coverage when deliberate assault was a more common cause of injury to women. It is important to recognise that violence can take many forms and includes mental and physical assault. It can be prolonged as well

as life threatening[28]. This demands training of professionals, epidemiological analysis, development of criteria, attitudinal change and skills to integrate violence into the content especially in areas of psychiatry, epidemiology, traumatology, forensic medicine, rehabilitation, paediatrics, geriatrics and gynaecology among others.

Seeing the high incidence of violence and the possibility of a "contagion effect" the Centre for Disease Control in Atlanta has recently begun to study "violence" as a special kind of disease and are attempting to examine the statistical pattern of violent behavior as a function of various variables. They argue violence is a public health issue which needs to be treated within the medical model as a contagious disease[29].

Violence as an issue has led various medical associations to assess the consequences of torture, organised violence and its management. World over, especially in Africa, Brazil and Sri Lanka, work in this area was spearheaded by Danish doctors under the aegis of the International Council for Rehabilitation of Victims of Torture (IRCT). The Indian Medical Association (IMA) also held a seminar on counselling of torture victims in October 1995. The IMA has started a correspondence course on the management of violence victims, however due to lack of infrastructure facilities and resources available,

the future of this programme is also being questioned by doctors[30]. Violence as an issue was contemplated upon in the fiftieth World Health Assembly. They instructed WHO to press ahead with developing a public health approach to this universal problem and to come up with preventive measures. Thus, there is still an immense gap between the pace of ongoing research and understanding of the problem especially when compared to other health problems like AIDS

The first aspect of violence contributing to illhealth in terms of death, and injury has been recognised to an extent by individual doctors only. But since violence has been seen essentially as a social problem these has been no conscious attempt to deal with it at the institutional level hence medical care to the victims is limited to symptomatic treatment. Violence perpetuated by "medical institutions" is another aspect of the violence and health nexus. This medical institutionalised violence is not even recognised by the medical profession, thus no steps are taken to minimise it .

Violence is a term that suffers from a surfeit of meaning as a cursory glance thorough the definitions shows the bewildering medley it is trapped in. An operational definition of violence is needed which would cut across the iron cage of ideologies, systems of values, socio-

cultural, institutional environments and professional interests of criminologists and doctors.

We have therefore come to a full circle in this chapter. In conclusion, we return to the familiar paradox that permeates social conceptions of violence in contemporary society. The fact however to be noticed is that though violence is a culturally affected term, it needs to be recognized as a basic human trait which affects ones health.

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CHAPTER - III

METHODOLOGY

INTRODUCTION

Studies on the Violence and Health Nexus are limited and very little work of precise nature is available. Thus, it has remained a neglected field for research in India, especially in the area of health. The objective of the present study is only to explore the Violence and Health nexus. To work towards this objective, data at two levels (macro and micro) have been collected to get a holistic view of the problem.

At the first level, data from secondary sources have been collected. Data published by the office of Registrar General (Vital Statistics Division),Central Bureau of Health Intelligence and National Crime Records Bureau were collected. For this, visits to different libraries and statistical offices of different departments of the government were carried out. The aggregate statistical data was collected to get a picture of incidence of violence at the macro level.

At the second level, an attempt was made to see the kind of violence cases coming to the health services through data collected from one hospital. This was done in two phases. In the first phase, the hospital's emergency case records for a month were analysed to see the different kinds of violence cases coming to the hospital. These are the cases officially recognised and recorded by the health systems as victims of violence. In the second phase, twenty cases recognised by

individual doctors as "violence" were explored. These indicate the perception and the "informal" response of health professionals. The experience of the victims has also been explored to understand both sides of the interaction within the health services. For this, open - ended interviews with the doctors were carried out and case studies of the victims were done. Thus, an attempt has been made to link the macro and micro level data to get a coherent picture of the violence and health nexus.

DATA COLLECTED

SECONDARY SOURCES

(a) CRIME DATA

The major source of information on violence are police statistics which are often unreliable due to many lacunae in reporting, recording and processing. Crime in India is the most publicised source which provides data on various aspects of crime in India and it's states. It is compiled by National Crime Records Bureau (NCRB) and published annually. Data on violent crime has been analysed for India, Maharashtra and Bombay for the present work. Objections have been raised that statistics may not be accurate as law can be interpreted differently from state to state and better reporting may lead to an actual

increase. It contains aggregated data, of crime known to police which brings out the major drawback that since violence is not a focus of inquiry it does not bring out the true picture but gives a total of offences, thus victims are a yawning dark figure in these statistics. The crimes which form a part of violent crime are (a) Offenses against Public Tranquillity (Riots), (b) Offences against person (Murder, Attempt to Murder, Culpable Homicide, Kidnapping and Abduction and Rape), (c) Offences against Property (Robbery, Dacoity, Preparation and Assembly for Dacoity).

Another source of information was Accidental Deaths and Suicides which also is a publication of NCRB. It gives information on the inopportune mortality rates recorded in police stations. Since suicide is not tabulated in Crime in India, this source was also tapped. Accidental deaths are classified into natural and unnatural categories but for the present study deaths due to unnatural causes is only studied.

(b) HEALTH DATA

There is no violence and injury surveillance data available. The official registers record all violent death to be all deaths listed on death certificates as being due to external causes. This in itself is a broad and

vague recording category. It makes it virtually impossible to determine whether the victim was related to a violent incident or not. The Health Information of India, an annual publication of Central Bureau of Health Intelligence has been used for this purpose.

(c) VITAL STATISTICS

Since no comparative data on rural and urban areas with regard to violence is available, Survey of Causes of Death (Rural) and Mortality Statistics of Death (Urban) have been used. So the inference in indirect and deduced from these two data sources.

Survey of Causes of Death is an annual publication, where data is collected through paramedicals of PHC on information on cause of death. Mortality Statistics of Death gives data on the medically certified causes of death in conformity to international classification of diseases by age and sex. The data is collected from select hospitals in urban areas selected by Chief Registrar of Birth and Death. Thus deaths in medical institution in urban areas is tabulated only (but would include death of people residing in rural areas as they come to hospitals in urban areas).

LIMITATIONS OF THE DATA

This macro data is used to give as complete a picture as possible regarding incidence of violence. However just as there is a lack of specificity in the studies reviewed in defining violence, the same vagueness was observed in the data source. This differential classification makes it difficult to compare data sources. The continuum criteria is too vast, from simple assaultiveness to death. The emphasis is only on specific events of physical violence thus the data lacks direct evidence on severity of violence. One can also see that the nature of reporting by different agencies differs. Hence, the data is used only to highlight the differences in reporting on "violence" by different agencies and then an attempt has been made to see the scale of incidence of violence.

HOSPITAL RECORDS

Hospital Records were analysed to get an idea of the nature of victims of violence actually reaching the health services and to see whether they were recognised as being "victims." The data was collected from Lokmanya Tilak Municipal General (LTMG) Hospital more commonly known as Sion Hospital in Bombay. Sion Hospital was selected as it is one of the major trauma Municipal hospitals in Bombay.

The records for the month of September 1996 were taken, as data collection started in October 1996. Hence getting access to records was easier and less time consuming.

Ideally both general records that is OPD and indoor admissions and emergency records should be analysed, but for this study only the latter for a month was collected.

INTERVIEWS

Because of the complexity of the problems and limitation of time and resources, no extensive qualitative studies or surveys have been conducted. Since, this is a preliminary and exploratory study of violence and health nexus, we began from the doctors interview which led up to the victims who are presented as case studies.

Ideally doctors from all the departments should have been interviewed. However due to time constraints, a few departments based on studies reviewed were identified and then the doctors were interviewed. Initially an attempt was made to interview doctors of all levels that is, Head of departments, professors, lecturers and residents. However, due to doctors inability to give time, this could not be followed. Thus a minimum of two doctors at least were interviewed from different levels whenever possible. The emphasis of different levels was given to

see whether years of practice sensitized the doctors to cases of violence or not. A total of twenty - one doctors from six departments were identified and finally interviewed. The departments identified for the study are:-

- PREVENTIVE AND SOCIAL MEDICINE (PSM)	3
- ORTHOPAEDIC	3
- PAEDIATRICS	3
- FORENSIC MEDICINE	2
- PSYCHIATRY	3
- SURGERY	2
- GYNAECOLOGY AND	2
- MEDICINE	3

CASE STUDIES

The "victims" of case studies were identified through the doctors. They are twenty case studies of victims. The case studies give an insight into the kind of treatment the victims get and the doctors

response to them. They also highlight the problem of "violence" from different angles and the varied experience each victim had.

To sum up, the present study is exploratory in nature which attempts to bring out the violence and health nexus through the secondary data available, hospital records collected, interviews of doctors and the case studies of the victims.

CHAPTER - IV

DATA ANALYSIS

In the present chapter, data on violence for the year 1991, 1993, 1994 available from various sources for India, Maharashtra and Bombay have been analysed. The data as mentioned already, pertains to health and crime statistics. Hence Crime in India and Accidental Deaths and Suicides give us the figures for violence as recorded in the police station, a part of the Criminal Justice System. Survey of Causes of Death, Mortality Statistics of Death and Health Information of India give us the figures for the Health Care System. In this chapter an attempt has been made to analyse the coherence between them and to build as complete a picture as possible through them. The data deals with deaths due to violence. Data on violence not ending in death is not available which is a major limitation. Data on violent crimes, though likely to be grossly under - reported and misreported, has been examined to throw some light on this dimension. Emergency intake records for a month at a major municipal hospital in Bombay also indicate the nature of such violence.

Table 1 - POPULATION, DENSITY AND SEX RATIO, 1991

	Population	Density	Sex Ratio			Urban Population %	Male		Female	
			Rural	Urban	Total		Rural	Urban	Rural	Urban
INDIA	84,63,00,000	267	941	893	927	25.72	32,31,05,149	11,47,00,656	30,40,41,448	10,24,76,969
MAHA-RASHTRA	7,89,37,187	257	972	875	935	38.73	2,44,27,060	1,62,59,194	2,38,24,803	1,42,37,158
BOMBAY	99,25,891	16,461	—	818	818	100.00				

Source: Primary Census Abstract, Census of India, series 14, Government of India.

Primary Census 1991, Census of India

Demographic Profile :

Table 1, presents the demographic profile of India, Maharashtra and Bombay. According to the 1991 Census, India had a population of 84,63,00,000. The corresponding figures for Maharashtra and Bombay was 7,89,37,187 and 99,25,891 respectively. Bombay thus accommodates 12.57 per cent of Maharashtra's total population. The density of population of Maharashtra of 257 per sq. km. is slightly lower compared to the all India figure of 267. The density of population of Bombay with 16461 per sq. km. is very high which is mainly because of its metropolitan nature. Maharashtra is the third largest populated state and ranks first among the states in the total of urban population in India. About 38.73 per cent of the population in Maharashtra is urban against 25.72 per cent in India.

Out of the total population of 84,63,00,000 in India, 43,78,05,805 were males and 40,65,18,417 females. The number of females for every 1000 males population works out to be 927 in India against 941 and 893 in the rural and urban areas respectively. In Maharashtra, the female population per 1000 males is slightly higher than India with 934, where as the rural and urban figures are 972 and 875 respectively. The higher sex ratio of Maharashtra appears to be interesting specially in view of the fact that urbanisation in Maharashtra (38.73%) is much

higher than in India. The sex ratio in Metropolitan Bombay is 818 against 875 in urban Maharashtra. This variation in sex ratio is mainly because Bombay is a metropolitan city, where because of acute shortage of accommodation and limited paying capacity people prefer to leave their family behind. Keeping in view the adverse sex ratio in India Maharashtra and Bombay, it may be concluded that if there was no gender differential, the males would constitute somewhat larger numbers than females among the victims of violence.

VIOLENCE AS CAUSE OF MORTALITY :

The only cause head giving data on violence in "Survey of Causes of Death" is death due to accidents and injuries.(Table 2-9). Table 2 gives the total number of deaths by major cause group in India (Rural). A perusal of the table shows that from 1986 to 1992, accidents and injuries was the eighth major cause of death among the top ten causes and accounted for 6.5 per cent to 8.7 per cent of deaths. In 1992, the percentage share increased to 8.7 per cent and became the fifth major cause of death.

Table 2 - PERCENTAGES OF DEATHS BY MAJOR CAUSE GROUPS IN INDIA (RURAL) - 1985 TO 1992

SL. NO.	MAJOR CAUSE GROUPS (PROMINENT SYMPTOMS)	PERCENTAGES						
		1986	1987	1988	1989	1990	1991	1992
1.	ACCIDENTS & INJURIES	7.0	6.5	6.5	7.4	8.5	8.5	8.7
2.	CHILD-BIRTH & PREGNANCY (MATERNAL DEATHS)	1.0	1.0	0.8	0.9	1.0	1.1	1.0
3.	FEVERS	10.4	9.4	8.0	7.4	7.3	7.3	7.7
4.	DIGESTIVE DISORDERS	7.7	7.2	6.5	6.6	6.2	6.4	6.2
5.	COUGH (DISORDERS OF RESPIRATORY SYSTEM)	19.7	20.0	20.3	20.2	18.8	18.9	19.6
6.	DISORDERS OF THE CENTRAL NERVOUS SYSTEM	3.7	3.9	4.6	4.8	4.3	4.4	4.5
7.	DISEASES OF CIRCULATORY SYSTEM	9.0	9.5	10.0	10.9	11.1	11.1	10.8
8.	OTHER CLEAR SYMPTOMS	8.6	9.3	8.8	8.2	8.5	8.3	8.4
9.	CAUSES PECULIAR TO INFANCY	10.5	10.2	9.8	9.8	9.8	10.2	9.6
10.	SENILITY	22.4	23.0	24.7	23.8	24.4	23.8	23.5
	ALL CAUSES	100	100	100	100	100	100	100

NOTE: N.A. = Not available

Source: Survey of Causes of Deaths (Rural), 1991, 1992.

Table 3 - PERCENTAGE DISTRIBUTION OF DEATHS BY MAJOR CAUSE GROUPS IN SELECTED STATES AND INDIA - 1991

Sl. No.	States	Major Cause Groups										
		Senility	Coughs	Diseases of Circula-tory system	Causes Peculiar to infancy	Accidents & Injuries	Other Clear Sympto-ms	Fevers	Digestive Disorders	Disorder of Central Nervous System	Child Birth & Pregna -ncy	All Causes
1.	Andhra Pradesh	22.1	16.3	12.3	9.8	9.5	10.1	4.9	6.4	7.7	0.9	100.0
2.	Assam	21.2	20.4	9.9	7.3	5.1	9.1	6.6	17.5	2.2	0.7	100.0
3.	Bihar	24.8	16.2	10.5	4.7	8.7	9.9	11.2	8.4	3.0	2.6	100.0
4.	Gujarat	29.5	20.4	8.4	9.1	7.6	10.1	6.7	3.0	4.3	0.9	100.0
5.	Haryana	18.0	27.0	6.2	11.5	9.0	7.7	11.8	5.6	1.9	1.3	100.0
6.	Karnataka	25.3	19.7	12.3	11.2	6.5	10.6	3.7	5.0	5.4	0.3	100.0
7.	Kerala	7.2	17.3	22.1	4.2	11.4	19.8	0.6	3.2	14.6	0.6	100.0
8.	Madhya Pradesh	20.7	20.4	7.9	8.4	6.9	6.0	16.7	8.5	3.4	1.1	100.0
9.	Maharashtra	31.3	17.7	8.8	13.3	9.2	8.8	2.6	3.3	3.9	1.1	100.0
10.	Orissa	16.1	15.4	18.7	11.3	5.2	9.6	5.5	9.3	7.6	1.3	100.0
11.	Punjab	20.8	11.7	15.4	1.8	12.2	6.0	23.9	4.3	3.6	0.3	100.0
12.	Rajasthan	23.3	28.8	8.1	13.8	6.9	5.0	7.3	4.2	2.2	1.4	100.0
13.	Tamil Nadu	20.9	13.1	21.2	7.1	7.7	9.6	6.0	6.9	7.0	0.5	100.0
14.	Uttar Pradesh	21.7	22.5	6.7	13.3	9.9	5.9	7.3	8.9	2.2	1.6	100.0
15.	Dadra & Nagar Haveli	24.7	17.1	5.3	14.5	10.5	3.4	4.3	16.6	2.8	0.9	100.0
	INDIA	23.8	18.9	11.1	10.2	8.5	8.3	7.3	6.4	4.4	1.1	100.0

Source:Health.Information.of.India,1992.

Table 3 gives the percentage distribution of deaths by major cause groups in selected states and in India for the year 1991. The table shows that Punjab tops the list in death due to accident and injuries followed by Kerala, Dadra and Nagar Haveli, Uttar Pradesh, Andhra Pradesh and Maharashtra. Maharashtra with 9.2 per cent of the deaths due to accidents and injuries, against the national figure of 8.5 per cent, secures sixth position among the ten major causes.

AGE AND GENDER DIFFERENTIALS :

Table 4, presents the percentage distribution of deaths for selected major cause groups by age and sex for the years 1991 and 1992. The majority of deaths in accidents and injuries occur in the age-groups of 15-24 and 25-34. This premature mortality is a disturbing phenomenon.

Persual of the table reveals that like most other cause groups females have a higher percentage of death from accident and injury upto the age-group of 15-24 and less in older age groups as compared to the male population. These are proportions internal to each sex and therefore do not show the comparative numbers of those affected.

Table 5 presents the distribution of death by age and sex due to injury and poisoning. In India, under this cause group, 34,447 deaths were recorded out of which 19,920 were males and 14,527 females.

The maximum number of deaths was recorded in the age-groups of 15-24 and 25-34. The total male and female population in India, according to the census is 43,78,05,805 and 40,65,18,417 respectively. A proportion of deaths due to injury and poisoning in India, hence works out to be .45/10,000 males and .36/1,000 females. Thus the number of males affected is more, with the difference being only partly accountable to the sex ratio. However, the females have a higher figure for death than males in the age-group of 15-24.

TABLE NO: 4: PERCENTAGE DISTRIBUTION OF DEATHS FOR SELECTED MAJOR CAUSE -GROUPS BY SEX AND AGE -1991 & 1992

Sl. No.	Major Cause Groups	Year	Sex Male/ Female	Age groups in years								
				> 1 YR	1-4	5-14	15-24	25-34	35-44	45-59	60+	TOTAL
1.	Accidents & injuries	1991	M	1.8	5.2	13.6	19.2	20.6	13.8	14.2	11.6	100.0
			F	2.2	5.8	14.3	25.0	20.4	9.1	11.0	12.	100.00
		1992	M	1.7	4.9	11.3	19.1	21.3	16.6	14.2	10.8	100.00
			F	2.6	4.5	12.5	27.6	20.9	11.8	6.7	13.3	100.00
2.	Fevers	1991	M	10.4	13.2	11.8	9.5	6.2	6.9	12.6	29.5	100.00
			F	11.9	17.0	15.3	5.7	7.7	6.7	9.3	26.5	100.00
		1992	M	13.9	15.3	13.0	8.3	5.4	5.5	13.4	25.1	100.00
			F	13.5	21.3	13.4	8.9	7.0	4.5	12.3	19.1	100.00
3.	Digestive Disorders	1991	M	8.9	10.8	11.7	6.5	9.5	9.6	18.7	24.5	100.00
			F	7.5	19.3	15.3	9.4	8.4	6.9	13.8	19.3	100.00
		1992	M	10.6	11.2	10.7	7.8	7.7	9.4	12.5	24.2	100.00
			F	9.1	18.8	13.4	9.2	10.3	7.4	10.3	21.8	100.00
4.	Coughs(Disorders of Respiratory System)	1991	M	10.9	7.6	3.0	2.5	5.4	8.2	19.1	43.2	100.00
			F	13.7	11.8	5.3	3.4	6.8	7.0	15.5	36.5	100.00
		1992	M	11.0	7.0	2.6	3.0	6.7	8.3	19.9	41.5	100.00
			F	16.1	13.1	4.4	4.6	7.3	6.6	12.0	35.9	100.00
5.	Disorders of the Central Nervous system)	1991	M	5.4	6.1	5.7	3.9	4.7	5.0	15.4	53.7	100.00
			F	5.5	8.0	6.4	5.7	4.8	5.3	12.6	51.8	100.00
		1992	M	5.5	5.9	4.0	4.9	5.7	6.9	17.1	50.3	100.00
			F	6.1	6.9	5.7	5.1	6.5	5.5	12.6	51.6	100.00

6.	Disease of Circulatory System	1991	M	3.2	3.3	2.7	3.7	6.7	9.9	26.8	43.7	100.00
			F	5.4	7.9	4.2	7.2	8.4	7.2	18.4	41.2	100.00
		1992	M	7.5	3.5	2.2	3.9	5.6	10.2	25.1	41.9	100.00
			F	6.2	8.2	4.1	7.7	10.9	8.6	16.0	38.3	100.00
7.	Other Clear Symptoms	1991	M	4.3	5.8	4.2	5.6	8.4	10.4	25.3	36.1	100.00
			F	4.6	10.6	7.0	5.6	9.2	10.1	23.8	29.1	100.00
		1992	M	5.9	5.5	5.7	4.6	7.4	11.0	24.2	35.7	100.00
			F	5.5	8.2	6.5	6.4	9.9	11.8	20.7	31.0	100.00

SOURCE: Survey of Causes of Death (Rural) 1991 & 1992.

TABLE 5 - DISTRIBUTION OF DEATHS DUE TO INJURY AND POISONING BY AGE AND SEX - ALL INDIA (UNDER THE SCHEME OF MEDICAL CERTIFICATION OF CAUSES OF DEATHS).

AGE IN YEARS	INJURY & POISONING	
	MALE	FEMALE
UNDER 1	294	227
1-4	716	541
5-14	1401	1071
15-24	3767	4585
25-34	4744	3981
35-44	3513	1697
45-54	2368	836
55-64	1503	632
65-69	491	258
70+	683	466
N.S.	440	233
TOTAL	19920	14527

SOURCE: Mortality Statistics of Causes of Deaths - 1987.

NATURE OF ACCIDENTS AND INJURIES :

Table 6 provides detailed information in respect of deaths due to accidents and injuries by 13 sub-cause (deaths by natural causes/calamity has not been classified as violence in the present study). The table reveals that at the national level, road accidents have recorded the greatest number of deaths followed by suicide, burns, drowning, snakebite and fall from height. The order slightly changes in Maharashtra with burns having the highest percentage followed by road accidents, drowning, suicide, snakebite and fall from height.

TABLE 6 - PERCENTAGE DISTRIBUTION OF DEATHS BY SPECIFIC CAUSES UNDER MAJOR CAUSE-GROUP 'ACCIDENTS & INJURIES' FOR SELECTED STATES AND INDIA - 1991

Sl. No.	States	Vehicular Accidents	Suicide	Burns	Drowning	Snake bite	Natural Calamity	Fall from height	Homicide	Rabies	Scorpian bite	Excessive Heat	Excessive Cold	Not Classifiable	Total
1.	Andhra Pradesh	14.4	27.5	13.2	14.4	7.2	0.6	6.0	1.2	4.8	1.8	0.0	0.0	9.0	100.0
3.	Bihar	21.7	2.6	7.8	17.4	13.9	6.1	3.5	10.4	5.2	0.9	0.0	0.9	9.6	100.0
4.	Gujarat	22.1	13.2	13.2	9.6	8.8	7.4	7.4	0.7	3.7	1.5	1.5	0.0	11.0	100.0
6.	Karnataka	8.5	32.2	6.8	22.0	6.8	1.7	6.8	5.1	0.0	5.1	1.7	0.0	3.4	100.0
7.	Kerala	24.1	53.7	0.0	11.1	5.6	0.0	3.7	0.0	0.0	0.0	0.0	0.0	1.9	100.0
8.	Madhya Pradesh	17.7	12.4	15.9	20.4	10.6	1.8	4.4	8.0	0.9	0.0	0.0	0.9	7.1	100.0
9.	Maharashtra	25.0	9.5	32.7	14.5	4.5	0.9	3.6	0.7	1.1	0.7	0.0	0.0	6.6	100.0
10.	Orissa	11.8	36.8	7.4	8.8	19.1	1.5	1.5	2.9	1.5	0.0	1.5	0.0	7.4	100.0
11.	Punjab	29.8	6.6	12.4	4.1	4.1	0.0	5.0	25.6	2.5	0.0	0.0	0.0	9.9	100.0
12.	Rajasthan	40.6	8.3	11.5	8.3	5.2	1.0	9.4	2.1	0.0	3.1	0.0	2.1	8.3	100.0
13.	Tamil Nadu	18.5	52.1	1.7	6.7	8.4	2.5	4.2	5.0	0.0	0.0	0.0	0.0	0.8	100.0
14.	Uttar Pradesh	20.7	5.3	4.6	4.6	8.4	26.7	8.8	5.3	2.5	1.4	1.4	1.4	9.1	100.0
	INDIA	22.6	16.6	14.1	11.6	7.5	5.6	5.5	4.9	1.9	1.1	0.4	0.4	7.8	100.0

Source: Health Information of India, 1992

TABLE - 7 TEN TOP SELECTED INDIVIDUAL CAUSES OF DEATH IN INDIA AND REGIONS

Specific Causes	India	Northern	Central	Western	Southern	Eastern
1	2	3	4	5	6	7
01. Bronchitis & Asthma	8.2	11.5	7.3	9.1	6.9	8.0
02. Heart Attack	5.8	11.0	2.4	10.5	3.7	4.6
03. TB of lungs	5.3	2.1	6.4	5.7	4.4	5.6
04. Prematurity	4.9	-	3.5	2.8	4.5	7.8
05. Pneumonia	4.6	4.0	7.5	-	3.9	5.7
06. Cancer	3.1	3.5	1.9	5.1	-	3.1
07. Anaemia	3.0	-	-	2.5	6.8	1.7
08. Paralysis	3.0	2.1	-	6.4	3.2	2.0
09. Vehicular Accidents	1.9	4.2	–	–	–	2.2
10.Gastro-enteritis	1.9	-	2.7	-	3.1	-
Typhoid	(1.7)	2.2	2.9	-	-	-
Malaria	(1.3)	4.4	3.9	-	-	-
Homicide	(0.4)	2.0	-	-	-	-
Acute Abdomen	(1.9)	-	2.9	1.7	2.0	-
Burns	(1.2)	-	-	-	-	2.1
Suicide	(1.4)	-	-	3.3	-	-
Respiratory infection of new born	(1.6)	-	-	2.4	-	-
Dysentery	(1.1)	-	-	-	3.0	-

Note: Figures given in bracket ( ) belonged to specific causes at regional level other than the 10 important causes. Central - Madhya Pradesh, Uttar Pradesh. Western- Goa, Gujarat, Maharashtra, Rajasthan, Dadra & Nagar Haveli. Southern - Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. Eastern - Arunachal Pradesh, Assam, Bihar, Manipur, Meghalaya, Nagaland, Orrisa, Tripura, West Bengal . Northern - Haryana, Himachal Pradesh, Jammu & Kashmir, Punjab and Delhi.

Source: Health Information of India, 1992

The top ten selected individual causes of death at regional and national levels have been presented in Table 7. Perusal of the table reveals that there is striking inter - regional variation in the occurrence of death in selected causes. Table reveals that vehicular accidents is among the top ten specific causes and alongwith homicide, burns and suicide records a high quantum of cases. Vehicular accidents account for 1.9 per cent of deaths in India, 4.2 per cent in the northern region and 2.2 per cent in the eastern region. Homicide accounts for .4 per cent of deaths in India and 2 per cent in northern region. Burns have a percentage of 1.2 and 2.1 per cent in India and eastern region respectively. Suicide has recorded a percentage of 1.4 with western region having the highest per cent of 3.3.

It may be inferred from the above that about 4.9 per cent of deaths occurs because of vehicular accidents, homicide, burns and suicide in India. Vehicular accidents and homicide together accounts for 6.2 per cent of deaths in northern region. About 3.3 per cent of deaths in the western region occur due to suicide alone whereas 4.3 per cent of deaths occur due to vehicular accidents and burns in the eastern region.

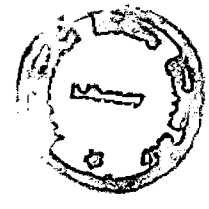

TABLE 8 - PER CENT DISTRIBUTION OF MAJOR CAUSES OF DEATH IN MAHARASHTRA DURING 1987 - 1991

	Causes	YEAR				
		1987	1988	1989	1990	1991
1	2	3	4	5	6	7
1.	Accidents & Injuries	8.0	7.3	9.5	10.7	9.2
2.	Child-birth and Pregnancy	0.6	0.7	0.7	0.7	1.0
3.	Fevers	2.9	3.1	3.1	2.2	2.6
4.	Digestive Disorders	2.9	3.1	4.5	3.8	3.4
5.	Coughs(Dis-oders of respiratory system)	17.8	19.7	20.0	17.6	17.7
6.	Disorders of the Central Nervous System	4.2	4.3	4.0	3.7	3.9
7.	Diseases of Circulatory System	8.0	6.9	8.2	8.8	8.8
8.	Other Clear Symptoms	13.1	10.7	6.8	9.1	8.8
9.	Causes peculiar to infancy	14.0	12.2	12.2	13.1	13.3
10.	Senility	28.5	32.0	31.0	30.3	31.3
	No. of reported deaths	3216	4957	4615	4449	4786
		100.0	100.0	100.0	100.0	100.0

Source: Health Information of India, 1992

TABLE 9 - PERCENTAGE DISTRIBUTION OF DEATHS BY AGE-GROUPS FOR MAJOR CAUSE-GROUPS, 1991, MAHARASHTRA

Major Cause Groups	Total No. of deaths	% of deaths to total deaths	Age groups in years: Below 1	01-04	05-14	15-24	25-34	35-44	45-59	60+
Accidents & Injuries	440	9.2	2.0	3.9	11.4	22.5	26.8	14.3	11.4	7.7
Child-birth and pregnancy	50	1.0	–	–	–	50.0	42.0	8.0	–	–
Fevers	125	2.6	1.6	19.2	24.0	12.8	15.2	4.8	11.2	11.2
Digestive Disorders	160	3.4	4.4	13.8	9.4	12.5	18.1	10.0	20.6	11.2
Coughs (Disorders of respiratory system)	848	17.7	13.9	11.7	5.0	3.5	6.1	8.8	14.2	36.8
Disorders of Central nervous system	186	3.9	8.6	9.2	8.6	9.1	5.9	9.1	14.0	35.5
Diseases of circulatory system	419	8.8	0.5	6.4	5.5	5.7	8.6	12.4	25.8	35.1
Other Clear symptoms	423	8.8	–	3.8	5.2	6.6	12.1	14.4	28.6	29.3
Causes peculiar to infancy	638	13.3	100.0	–	–	–	–	–	–	–
Senility	1497	31.3	–	–	–	–	–	–	–	100.0
No. of reported deaths	4786	100.0	16.6	4.6	4.1	5.4	7.0	6.2	9.9	46.2

Source: Health Information of India, 1992

Table No. 8 presents the percentage distribution of deaths by major cause group in Maharashtra from 1987 to 1991. Perusal of the table brings out that there has been a steady increase in deaths due to accidents and injuries in rural Maharashtra. The maximum number of deaths took place in the cause group of senility, followed by coughs, causes peculiar to infancy and then by accidents and injury. In 1990, there was an increase in deaths due to accidents and injuries which recorded a decrease in 1991. However, still the figure of 9.2 per cent is higher than the all India figure of 8.5 per cent and the position of accidents and injuries as cause of death has moved up from fifth place in 1987 to fourth place in 1991.

The percentage distribution of deaths by age groups for major cause groups (1991) in Maharashtra is presented in Table 9. A perusal of the table reveals that senility followed by coughs, causes peculiar to infancy and then accidents and injuries account for a major number of deaths. The same order of causes of death at the national level has been recorded for senility and coughs after which the order changes. Coughs is followed by diseases of the circulatory system, causes peculiar to infancy, other clear symptoms and then accidents and injury. Thus accidents and injuries are the fourth major cause for deaths in rural Maharashtra against the sixth major cause in India (Table 2). The

table also portrays a similar trend of the maximum number of deaths occuring in the age-group of 15-34 with females having a higher percentage upto the age of 34.

An attempt has been made earlier to present the picture of the causes of deaths in rural India (Table 2 to 7) where as table 8 to 9 presents the causes of deaths in rural Maharashtra. Perusal of the tables shows that during the years from 1987 to 1991 there is a considerable increase in deaths due to accidents and injuries, which accounts for the sixth and fourth major cause of death in rural India and Maharashtra respectively. The age-group 15-34 years is the most affected with females accounting for a higher percentage of deaths in this age-group.

It may be noted however that a great deal of ambiguity still exists since sources of information viz. Health Information of India provides information under the cause group of "accidents and injuries" whereas Survey of Causes of Deaths (Rural) provides under "injuries and poisoning" and are therefore not strictly comparable.

TABLE 10 - PERCENT OF MEDICALLY CERTIFIED DEATHS BY AGE AND SEX ACCORDING TO INJURY & POISONING CAUSE GROUP DURING 1989
STATE - MAHARASHTRA (NINTH REVISION OF I.C.D. LIST)

AGE IN YEARS	INJURY & POISONING(800-999)	
	MALE	FEMALE
UNDER 1	0.9	1.0
1-4	6.5	5.8
5-14	16.0	15.3
15-24	31.3	42.2
25-34	27.7	36.7
35-44	16.0	20.6
45-54	8.1	7.6
55-64	4.5	4.5
65-69	2.6	2.9
70+	1.7	1.6
N.S.	–	–
TOTAL	8.7	11.0

Source: Mortality Statistics of Causes of Death, 1989

Table 10 gives the per cent of medically certified deaths by Injury and Poisoning by age and sex in urban Maharashtra. The table shows that maximum number of deaths take place in the age-groups 15-24 and 25-34, with females having a higher percentage in share of deaths. Deaths due to injury and poisoning account for the fifth major cause of death in urban Maharashtra. Hence, deaths due to accidents and injury, injury and poisoning do account for a major cause of death in rural and urban Maharashtra.

TABLE 11 - NUMBER OF INOPPORTUNE DEATHS AND ITS SHARE AND RATE DURING 1991, 1993 AND 1994.

YEAR	1991				1993				1994			
	ACCI-DENT	SUICIDE	TOTAL	% TO DEATH	ACCI-DENT	SUICIDE	TOTAL	% TO DEATH	ACCI-DENT	SUICIDE	TOTAL	% TO DEATH
INDIA	**183558**	78450	**262008**	100	**181232**	84244	**265476**	100	**185998**	89195	**275191**	100
MAHA-RASHTRA	**38035**	8820	**46885**	**17.8**	**40186**	10338	**50524**	**19.03**	**32997**	10782	**43779**	**15.9**
BOMBAY	**6904**	1022	**7929**	**3.0**	**7652**	1105	**8757**	**3.2**	**8345**	1334	**9679**	**3.51**

Source: Accidental Deaths and Suicides, 1993, 1994.

DATA ON 'INOPPORTUNE DEATHS' (ACCIDENTAL AND SUICIDES)

This data allows a comparison of trends in violent mortality from 1987 to 1994. It also corroborates the findings discussed earlier from other data sources. Data of three years (1991, 1993, 1994) has been taken to ensure that no exceptional circumstances in a specific year influenced the analysis.

Table 11, portrays a comprehensive picture of the number of inopportune deaths in the years 1991,1993 and 1994. The total deaths under this category in India in 1991 were 262006, out of which Maharashtra and Bombay accounted for 17.8 per cent and 3.0 per cent of the deaths respectively. Bombay accounted for 17 per cent of Maharashtra's total deaths.

In 1993, there is an increase in the total with 265476 out of which Maharashtra's share increased to 19.03 per cent whereas Bombay's share recorded only a slight increase and accounted for 3.2 per cent of the deaths. Bombay's share in the total in Maharashtra was 17.33 per cent.

The total number of deaths again recorded an increase to 275191, in 1994 at the national level, but Maharashtra's share recorded a decrease as it accounted for only 15.9 per cent of the total deaths in

a decrease as it accounted for only 15.9 per cent of the total deaths in India. Bombay's share, however, showed a slight increase as it accounted for 3.51 per cent of the total deaths which amounts to about 22 per cent of the total deaths in Maharashtra.

The quantum of deaths, due to unnatural causes shows a steady increase over the three years for Bombay and a slight increase for India and Maharashtra.

TABLE 12 - PERCENTAGE OF ACCIDENTAL DEATHS IN INDIA IN TOP THREE STATES, 1991, 1993 and 1994

	POSITION OF STATES		
YEAR	1	2	3
1994	Maharashtra (17.5)	Madhya Pradesh (13.4)	Uttar Pradesh (10.2)
1993	Maharashtra (24.6)	Madhya Pradesh (12.8)	Uttar Pradesh (8.6)
1991	Maharashtra (30.6)	Madhya Pradesh (12.7)	Uttar Pradesh (11.2)

Source: Accidental Death and Suicide, 1993,1994

TABLE 13 - ACCIDENTAL DEATHS IN TOP THREE CITIES OF INDIA 1991,1993 and 1994.

	POSITION OF STATES		
YEAR	1	2	3
1994	Bombay	Delhi	Pune
1993	Pune	Varanasi	Nagpur
1991	Pune	Bombay	Delhi

Source: Accidental Death and Suicide, 1993, 1994

Table 12, presents a picture about the share in number of deaths by accidents in the three states having the highest share of deaths for the years 1991,1993 and 1994. Maharashtra followed by Uttar Pradesh and Madhya Pradesh tops the list with the highest share in the number of deaths due to accidents.

An analysis at the city level shows that Pune followed by Bombay and Delhi recorded the highest number of deaths due to accidents in 1991. Pune again topped the list in 1993 but was followed by Varanasi and Nagpur. In 1994, Bombay accounted for the maximum deaths in this category followed by Delhi and Pune. (Table 13).

Table 14 presents a distribution of accidental deaths by sex and age for the years 1991, 1993 and 1994 which shows that more or less a similar trend is found in India, Maharashtra and Bombay. The highest number of deaths was recorded in the age group of 18-30 followed by 30-50. The table also reveals that males have a higher incidence of accidental deaths.

TABLE 14 - DISTRIBUTION OF ACCIDENTAL DEATH BY SEX AND AGE GROUPS FOR 1991, 1993 AND 1994

		Below 18 yrs.			18-30 yrs.			30-50 yrs.			50 +yrs.			Total		
State		1994	1993	1991	1994	1993	1991	1994	1993	1991	1994	1993	1991	1994	1993	1991
India	M	18072	19420	19016	44280	43154	43338	48094	46184	45882	21795	21741	20906	132241	130499	129142
	F	11842	13204	12513	22704	23794	23548	15771	16936	15288	7877	7924	7512	58194	61858	58861
	TD	29914	32624	31529	66984	66948	66886	68665	63120	61170	29672	29665	28418	190435	192357	188003
	%T	15.7	17.0	16.8	35.2	34.8	35.6	33.5	32.8	32.5	15.6	15.4	15.1	X	X	X
	%F													30.6	32.2	31.2
	%M													69.4	67.8	68.7
Maharashtra	M	2777	4660	3189	6408	8150	7511	7442	10471	9277	4177	5804	5189	20804	29085	25116
	F	2362	3872	2596	5206	6492	5512	3337	5374	3628	1710	2541	1859	12614	18279	13595
	TD	5139	8532	5785	11614	14642	13023	10779	15845	12905	5887	8345	7048	33419	47364	38761
	%T	15.4	18.0	14.9	34.8	30.9	33.6	32.3	33.5	33.3	17.6	17.6	18.2	X	X	X
	%F													37.7	38.6	35.1
	%M													62.3	61.4	64.9
Bombay	M	677	621	501	1532	1387	1252	2037	1909	1859	1227	1198	1286	5473	5115	4890
	F	600	450	412	1137	1122	974	711	576	390	440	390	205	2888	2538	2043
	TD	1277	1071	913	2669	2509	2226	2748	2485	1588	1667	1588	1491	8361	7653	6933
	%T	15.3	14.0	13.2	31.9	32.8	32.1	32.9	32.5	33.2	19.9	20.8	21.5	X	X	X
	%F													34.5	33.2	29.5
	%M													65.5	66.8	70.5

Note: M-Male, F-Female, TD - Total Death

Source: Accidental Deaths and Suicides 1991, 1993 and 1994.

TABLE 15 - NUMBER OF ACCIDENTAL DEATHS IN INDIA BY UNNATURAL CAUSES DURING 1987 TO 1994

SL.NO.	UNNATURAL CAUSES	NUMBER OF ACCIDENTAL DEATHS DURING							
		1987	1988	1989	1990	1991	1992	1993	1994
1.	By Fire Arms	1672	1349	1923	2731	3169	3341	1980	2375
2.	By Explosion	289	351	392	556	606	512	318	487
3.	By House Collapse	1097	1825	1080	1472	2006	1903	1127	1190
4.	Total Road Accident	33884	36119	42075	43005	44930	49156	45769	51855
5.	Factory Accident	1021	703	591	658	539	549	550	606
6.	Railway Accident	12985	13099	14608	13796	16080	17834	16800	18340
7.	Air Crash	64	732	66	188	15	17	46	80
8.	By Fire	18574	18943	20288	20522	22306	22010	22395	23323
9.	By Drowning	22720	24851	22485	24383	23271	21960	21998	23050
10.	By Poisoning	8960	11005	11354	13164	13697	12773	13134	13752
11.	By Snake Bite	4288	3835	4071	4548	4842	4142	4768	4502
12.	Killing By Animal	928	1057	1111	1235	1108	1145	1099	974
13.	By Boat Capsize	415	260	198	675	422	277	346	371
14.	Mine or Quarry Disaster	663	648	436	690	519	776	403	506
15.	Accidental Electrocution	2408	2490	2542	2957	2933	3062	3488	3502
16.	Accidental Fall from Height	3310	3410	3524	3700	3650	3731	4049	4267
17.	Consuming Spurious Liquor	764	784	827	893	1199	998	871	961
18.	Suffocation Due to Smoke etc.	148	163	236	230	296	250	293	405
19.	Abortion	91	91	132	185	118	113	185	162
20.	Unspecified	34124	3790	36574	34252	41850	46178	41613	35288
	Total	148405	159205	164513	16984 0	183556	190727	181232	185996

Source: National Crime Records Bureau, 1991,1993 and 1994.

TABLE 15(a) - PERCENTAGE OF INCREASE OF ACCIDENTAL DEATHS BY UNNATURAL CAUSES OVER AVERAGE OF 1987-89 AND 1992-1994.

SL.NO.	UNNATURAL CAUSES	Average of 1987-89	Average of 1992-94	% of Increase / Decrease	Position according to % of increase
1.	By Fire Arms	1648	2565	+55.64	2
2.	By Explosion	344	439	+27.61	7
3.	By House Collapse	1334	1407	+5.47	15
4.	Total Road Accident	37359	48927	+30.96	5
5.	Factory Accident	772	568	-35.9	–
6.	Railway Accident	13564	17658	+30.18	6
7.	Air Crash	287	48	-497.9	–
8.	By Fire	19268	22576	+17.17	11
9.	By Drowning	23352	22336	-4.55	–
10.	By Poisoning	10440	13320	+27.59	8
11.	By Snake Bite	4065	4467	+9.89	14
12.	Killing By Animal	1032	1073	+3.97	16
13.	By Boat Capsize	291	331	+13.75	13
14.	Mine or Quarry Disaster	582	562	-3.56	–
15.	Accidental Electrocution	2480	3351	+35.12	4
16.	Accidental Fall from Height	3415	4016	+17.60	10
17.	Consuming Spurious Liquor	792	943	+19.07	9
18.	Suffocation Due to Smoke etc.	182	316	+73.63	1
19.	Abortion	105	153	+45.71	3
20.	Unspecified	36063	41026	+13.76	12
	Total	1,57,374	1,85,985	+18.18	

Table 15, gives the number of accidental deaths in India by causes from 1987 to 1994 by unnatural causes. The maximum number of deaths by other causes have been recorded under road accidents followed by fire, drowning, railway accidents, poisoning, snake bite and accidental fall from height. The total number of accidental deaths shows a consistent increase from 1987 to 1992. A decrease in the total number of deaths 1993 was seen which increases in 1994.

In Table 15 (a), the percentage of increase of accidental deaths by unnatural causes over the average of three years, i.e., 1987 to 1989 and 1992 to 1994 has been computed. The table shows that overall there has been an increase of 18.18 per cent in deaths due to unnatural cause from 1987 to 1994. The percentage increase by causes shows that deaths due to suffocation due to smoke, firearms, abortions, accidental electrocution, vehicular accidents, railway accidents, explosions and poisoning have increased substantially over the years. A further exploration in to the nature of causes is required to see

whether they are 'accidental' or 'intentional' to get a true picture of deaths solely accountable to violence.

Tables 11 to 15 give the number of deaths due to accidents for the years 1991, 1993 and 1994 where Table 15 shows that over time (1987 to 1994) there has been an increase in deaths occuring due to accidents. The trend in Table 14 shows (as in Table 2-10) that, the age group most affected is 18-30 and 30-50 with males having a greater share in the total number of deaths.

The major causes of deaths for males is road accident, poisoning, snake bite, suffocation due to smoke, animal bite and fire whereas for females the causes were poisoning, road accident, snake bite, animal bite, suffocation due to smoke and fire. The causes though similar differ in hierarchy and quantum for both the sexes.

TABLE 16 - INCIDENCE AND RATE OF SUICIDE, 1991, 1993 and 1994.

State	Year	Number of Suicides	% of total suicide
India	1994	89195	100
	1993	84244	100
	1991	78450	100
Maharashtra	1994	10782	12.1
	1993	10338	12.3
	1991	8820	11.2
Bombay	1994	1334	1.5
	1993	1105	1.3
	1991	1022	1.3

Source: Accidental Deaths and Suicides,1994,1993.

TABLE 17 - POSITION OF SUICIDAL DEATH IN TOP TWO RISK STATES FOR 1991, 1993 AND 1994

YEAR	STATE	NUMBER OF SUICIDE
1991	West Bengal	123574
	Tamil Nadu	9670
1993	West Bengal	11381
	Maharashtra	10338
1994	West Bengal	12389
	Maharashtra	10782

Source: Accidental Deaths and Suicide,1993,1994.

SUICIDES :

Table 16, gives the incidents and rate of suicide for the years 1991, 1993 and 1994. An analysis, of which shows, that the number of suicides in India, Maharashtra and Bombay is increasing even for this brief period.

Table 17, gives the position of suicidal death in top two risk states by percentage share for 1991, 1993 and 1994. In 1991, West Bengal and Tamil Nadu alone accounted for 15.7 per cent and 12.3 per cent of the suicides respectively in the country. In 1993, Maharashtra replaced Tamil Nadu, and West Bengal remained the top risk state, however, its incidence had reduced considerably. In 1994, the situation was the same with both West Bengal and Maharashtra showing an increase in incidence of suicides.

The distribution of suicidal deaths by sex and age for the years 1991, 1993 and 1994 in India, Maharashtra and Bombay is presented in Table 18. On analysing the table, one observes that more or less the same trend is exhibited for all the three years in India, Maharashtra and Bombay which is discussed below.

TABLE 18 - DISTRIBUTION OF SUICIDE BY SEX AND AGE GROUPS FOR 1991, 1993 AND 1994

		Below 18 yrs.			18-30 yrs.			30-50 yrs.			60 +yrs.			Total		
State		1994	1993	1991	1994	1993	1991	1994	1993	1991	1994	1993	1991	1994	1993	1991
India	M	4789	4564	4555	20852	19610	18654	19178	18219	16092	7933	7458	7023	52752	49851	46324
	F	5186	4905	5083	18206	16890	15786	2566	9303	7983	3485	3295	3274	36443	34393	32126
	Total	9975	9469	9638	39058	36500	34440	28744	27522	24075	11418	10753	10297	8915	84244	78450
	%T	11.2	11.2	12.3	43.8	43.3	43.9	32.2	32.7	30.7	12.8	12.8	13.1	x	x	x
	%F													40.9	40.8	41.0
	%M													59.1	59.2	59.0
Maharashtra	M	493	502	452	2406	2358	2051	2106	2121	1794	845	888	729	5850	5869	5026
	F	768	665	590	2418	2193	1971	1271	1190	855	475	421	378	4932	4469	3794
	Total	1261	1167	1042	4824	4551	4022	3377	3311	2649	1320	1309	1107	10782	10338	8820
	%T	11.7	11.3	11.8	44.7	44.0	45.6	31.3	32.0	30.0	12.2	12.7	12.6	x	x	x
	%F													45.7	43.2	43.0
	%M													54.3	56.8	57.0
Bombay	M	38	42	28	287	222	219	278	216	183	82	54	53	685	534	483
	F	87	87	81	352	307	298	156	129	110	54	48	50	649	571	539
	Total	125	129	109	639	529	517	434	345	293	136	102	103	1334	1105	1022
	%T	9.4	11.7	10.7	47.9	47.9	50.6	32.5	31.2	28.7	10.2	9.2	10.1	x	x	x
	%F													48.7	51.7	52.7
	%M													51.3	48.3	47.3

Source: Accidental deaths and suicide,1993,1994.

The table reveals that the highest deaths was recorded in the age group of 18-30 followed by 30-40 for all the three years. Males have a higher incidence than females in India and Maharashtra. In Bombay, however, a reverse trend, i.e., an increase in percentage of females over males in suicides was recorded for the years 1991 and 1993 which changed in 1994 to males having a higher percentage of incidence than females. However, the difference is not as high as in India and Maharashtra.

The table shows that the incidence of suicides was consistently higher in females in the age-group of below 18, for all the three years in India, Maharashtra and Bombay. In the age-group of 18-30, in Bombay for all the three years females have a higher incidence of suicide. This is however not revealed in the data available for India and Maharashtra.

Table 16-18 show that, incidence of suicides is quite high and as in accidental deaths the age group most affected is 18-30. The gender difference regarding suicides is clear in the data. Females compared to males upto the age of thirty years have a higher incidence of suicide and which decreases in the

older age-groups. The males thus have a higher incidence of suicide in the older age group.

VIOLENT CRIME :

TABLE 19 - VIOLENT CRIME IN INDIA, 1991, 1993 and 1994.

VIOLENT CRIME	1991	1993	1994
Murder	39174	38240	38577
Attempt to Murder	29778	29725	30020
Culpable Homicide	4243	3890	3946
Rape	10410	12218	13208
Kidnapping & Abduction	20079	19830	20983
Dacoity	10831	9357	9271
Preparation & Assembly for Dacoity	1393	1102	946
Robbery	26428	24354	23933
Riots	105309	93838	94344

Source: Crime in India,1993,1994.

TABLE 20 - VIOLENT CRIME IN MAHARASHTRA AND BOMBAY, 1991, 1993 and 1994.

MAHARASHTRA	1991	1993	1994	BOMBAY	1991	1993	1994
Murder	3044	3133	2787	Murder	473	687	354
Attempt to Murder	1414	1586	1325	Attempt to Murder	261	354	229
Culpable Homicide	79	150	136	Culpable Homicide	6	1145	1304
Rape	906	1145	1304	Rape	114	131	150
Kidnapping & Abduction	1278	1158	1171	Kidnapping & Abduction	332	220	234
Dacoity	884	794	693	Dacoity	115	117	113
Preparation & Assembly for Dacoity	109	89	84	Preparation & Assembly for Dacoity	109	39	57
Robbery	3779	3388	3180	Robbery	3779	824	754
Riots	4644	4892	4422	Riots	4644	772	233

Source: Crime in India, 1991, 1993,1994.

Table 19 and 20 give the incidence of violent crime for the years 1991, 1993 and 1994 as recorded by the police station and compiled by the National Crime Records Bureau for India, Maharashtra and Bombay. Therefore, it is likely to be unreliable as it reflects only the recorded cases in the police station. Inspite of this, Crime in India (1994) states that a 1.1 per cent increase in violent crime in 1994 over 1993 in India has been recorded. The percentage share recorded for violent crime in 1953, was 8.2 per cent which increased to 14.4 per cent in 1994. Thus showing that violent crime has been increasing steadily over the years.

In 1991, 1993 and 1994, at all India level robbery, riots, murder, attempt to murder and rape account for a major share of crime committed and harm to the body under the head of violent crimes. The total figure shows that in 1993, there was a great increase in the number of crimes under these heads which reduced in 1994 considerably.

In Maharashtra the same trend in forms and incidence of violent crime is noticeable.

In Bombay, in 1991, riots, robbery, murder, attempt to murder and kidnapping and abduction account for a major quantum of violent crime as against culpable homicide, robbery, riots, murder and attempt to murder in 1993. In 1994, culpable homicide and robbery remained the top two causes followed by murder, kidnapping and abduction and riots.

TABLE 21 - EMERGENCY INTAKES FOR ONE MONTH IN SION HOSPITAL

CAUSE	SEX	AGE								
		0-10	10-20	20-30	30-40	40-50	50-60	60-70	70+	TOTAL
Injury	Male	33	37	73	55	25	10	4	0	237
	Female	13	27	43	20	44	2	0	0	109
	Total	46	64	116	75	69	12	4	0	**346**
Assault	Male	10	51	190	100	34	22	1	0	408
	Female	1	13	46	29	11	7	3	3	113
	Total	11	64	236	129	45	29	4	3	**521**
Fall	Male	73	55	90	42	22	15	7	10	304
	Female	76	23	20	13	8	3	5	9	157
	Total	149	78	110	45	30	18	12	19	471
Accident	Male	27	58	148	76	47	30	13	3	402
	Female	16	15	25	12	12	5	2	3	90
	Total	43	73	173	88	59	35	15	6	**492**
Unknown	Male	18	26	55	26	15	15	9	2	166
	Female	17	10	28	18	11	4	1	1	90
	Total	35	36	83	44	26	19	10	3	256
Rape	Male	0	0	0	0	0	0	0	0	0
	Female	1	2	1	0	0	0	0	0	4
	Total	1	2	1	0	0	0	0	0	**4**
Medical cases	Male	11	15	36	41	13	11	3	4	134
	Female	10	7	6	15	2	2	2	3	47
	Total	21	22	42	56	15	13	5	7	**181**
TOTAL										**2231**

HOSPITAL RECORDS OF EMERGENCY DEPARTMENT :

Table 21, tabulates the information collected for emergency intakes for one month (September, 1996), in Sion Hospital, in Bombay. The information has been classified, to give age and sex variation for the different causes of emergency complaints. The causes are classified into injury, assault, fall, accidents (vehicular and railway accidents), unknown cases, rape and medical cases. These causes are mentioned by the doctors in the emergency record book. On clarifying from the doctors, it was seen that the recording of the cause depends on what the patient says and less on the doctors' own judgment or medical diagnosis. The data is therefore likely to reflect what the patients' want to tell (depending upon whether they want a medico - legal case or not and other social considerations) and not what really happened.

The maximum number of cases pertain to assault (total cases - 521), followed by accidents, fall, injury, unknown cases, medical problems and finally by four cases of rape. The table reveals that the age group most affected is 20-30 and 30-40, with males having a greater incidence than women in all age and cause groups.

TABLE 21(a) - PERCENTAGE SHARE OF CAUSES FOR ONE MONTH OF EMERGENCY INTAKES

CAUSE	TOTAL	PERCENT-AGE
Injury	346	15.2
Assault	521	22.9
Fall	471	20.7
Accident	492	21.7
Unknown	256	11.2
Rape	4	0.18
Medical cases	181	7.9
Total	2271	100

TABLE 21(b) - EMERGENCY INTAKE FOR ASSAULT BY DIFFERENT CAUSES FOR ONE MONTH

CAUSE	MALE	FEMALE
Stone	30	12
Fist	141	39
Belt	8	3
Stick	55	26
Sharp instrument	44	26
Knife	53	4
Fire arm	21	2
Police	12	1
Glass	19	–
Bite	7	–
Alcohol	18	–
Total	408	113

TABLE 21(c) - EMERGENCY INTAKE FOR FALL BY DIFFERENT CAUSES FOR ONE MONTH

CAUSE	MALE	FEMALE
Height	168	82
Cot	10	15
Stair	32	32
Unknown	78	20
Tree	7	3
Bathroom	9	5
Total	304	157

TABLE 21(d) - EMERGENCY INTAKE FOR INJURY BY DIFFERENT CAUSES FOR ONE MONTH

CAUSE	MALE	FEMALE
Poison	68	35
Suicidal burn	16	14
Accidental injury	26	9
Injury at work	42	3
Accidental burn	32	28
Electric burn	8	3
Bite	12	6
Fall of heavy object	13	5
Fall of cupboard	2	0
Unknown	5	1
Acid burn	11	3
Strangulation	2	2
Total	109	237

Table 21(b) classifies assault by weapons used. Sharp instrument and knife though could be in the same category are classified separately as they are mentioned separately in the medical records. For the females assault by fist, stick and sharp instrument was followed by stone and knife whereas for the males, fist, stick, knife, sharp instrument and stone were major tools used.

Table 21(c) shows the cases of fall by different reasons. Fall from height, tree, stair, unknown (reason), cot and bathroom was noticed as the major causes in decreasing order for females as against, fall from height, unknown, stair, cot, bathroom and tree for males.

Table 21(d) gives the causes of injury. For the females poison, accidental burns, suicidal burns, accidental injury and bite were

recorded as major causes in decreasing order whereas for males poison, accidental injury, accidental burn, suicidal burn and injury due to heavy objects were responsible for major case admits.

A perusal of the tables (Table 2-20) shows that deaths due to accidents, injuries and poisoning have a high incidence. Table 21(a) reflects this as it shows that out of 2271 of total emergency intakes recorded, only 181, (i.e., 7.9 per cent of the total intakes), are related to medical problems such as fever, backaches, asthma, etc. and 92.1 per cent of the cases were ascribable to some form of physical violence. The greatest share in the total emergency intakes was of assaults with a total of 521 cases which accounts for 22.9 per cent of the total intake cases. However, the hospital records do not reflect the same picture as the macro - data with relation to gender. The macro - data shows that females below thirty have a higher incidence than males whereas the hospital data shows that female cases are lesser for the same. This shows that female cases are missing from hospital records.

CONCLUSION:

The analysis of tables show that there are a phenomenal number of deaths occuring due to physical violence and this has so far lacked public awareness and is under-recognised as a serious public health problem. The data gives information only on "Mortality" and hence was

analysed to understand the magnitude of violence mortality. The main findings that emerged from the analysis are summarised below:

The data shows that from 1986 to 1992, the percentage share of accidents and injury in India has moved upto the fifth major cause of death in 1994 from being the eighth major cause in 1986. Maharashtra ranks sixth highest in the state in relation to deaths due to accidents and injuries. In rural and urban Maharashtra, deaths due to injury and poisoning account for the fourth and fifth major cause of death respectively. The violent crime data reveals an 18.18 per cent increase from 1987 to 1994. Thus, all the tables show that the incidence of violence seem to have increased phenomenally. Though some inter-regional variation in terms of causes of death can be seen, violence figures among the top ten selected individual causes of death at the regional and national levels.

In all the data sources, violence as a cause affects the prime age groups of below 18 and 18-30. The gender difference is more pronounced in the age-group of 18-30 and 30-50 with the females having a higher incidence over males. The males have a greater incidence in the latter years of life. A gender difference is also seen in certain types of subcauses such as deaths due to accidents. Since data is only on mortality, in-depth analysis of fatality, severity, disability

and morbidity is not possible. The hospital data shows that female cases are either not coming or are evading the cause of the visit to the hospital as males have a higher record of cases than what is evident in the macro data.

The picture that emerges after analysis of the tables, shows that the younger population (i.e., 30 and below) are a vulnerable group having a higher risk of being affected by "violence". The males though have a higher incidence, it is the females who have a greater percentage of share in incidence at the vulnerable age-group. Table 15(a) shows that the cause of males having a higher incidence is not attributable to the sex ratio alone. The data on morbidity due to violence, if available would be helpful to give a complete or holistic picture of the true quantum of violence. However, for this the doctors need to be given clear cut definition and guidelines for dealing with violence as a "cause". Inspite of the limitations of the data base, there is a clear indication of increase in violence, especially social violence.

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CHAPTER - V

RESPONSES OF HEALTH CARE PROVIDERS TO VIOLENCE AND ITS VICTIMS

THE VICTIMS:

The twenty case histories, presented here are of victims who came to the hospital for treatment. These cases were identified by the treating doctor as one related to violence. Therefore, they give an insight into the problems of victims of violence and also the response of the doctors. The cases vary from domestic violence, sexual abuse, generalized violence and child abuse.

Out of the twenty cases, thirteen are female and seven are male victims. The age category, which has the maximum number of victims, is twenty to twenty- five followed by twenty - five to thirty. There are eight cases of child abuse, four cases of domestic violence, two of sexual abuse and six cases of generalized violence. Study of the cases reveals that in most cases, the doctors deal with the problem symptomatically. In some cases, even when doctors identified the cause, they either overlooked the issue or handed the case to the psychiatric or social work department.

The victims coming to the hospital also seek immediate help and do not expect any help beyond "treatment". The victims come only when the situation becomes serious. Out of the twenty cases, seventeen were interviewed directly and information for three was gathered from other sources as the violent event had led to the death of the victims.

The bare outlines presented cannot capture the physical and mental torture these victims have undergone but may assist in assessing the effects of violence on the psyche and health of an individual.

DOMESTIC VIOLENCE:

Cases one to four deal with domestic violence. An analysis of the cases reveal that within domestic violence there is a wide variation. Cases show that domestic violence is not restricted to any particular religion or community. Women are harassed in different ways. The violence is mainly from the husband with the in - laws colluding and actively assisting in "torture".

The most common reason being expectations of implicit obedience from the wife with a minor infringement and failure to comply leading to punishment with severe mental and physical abuse. The husbands in all the four cases invariably appear to exercise authority and dominate the wife in every way. The women as a result have to face sexual abuse (Case 2) and harassment often of a violent, insensitive and sadistic nature (Case 3). Beating the children, torturing parents are additional forms of violence (Case 2) to induce compliance from the wife. In three cases the husbands were employed whereas in one (Case 2), the husband's alcoholic addiction rendered him unemployed. The women with the exception of one, were housewives.

The notion of a woman as a man's property and the subordinate position of a woman renders her powerless. The victimized woman continues to tolerate and adjust as long as possible (Case 2) but when things go out of hand, she goes (Case 4) for help either directly or indirectly depending on the alternatives available. A woman is often victimized when she resists unfair and unjust demands thereby negating her right to self - determination (Case 1). As discussed earlier, case one and two are cases of physical torture. In case one, the woman was victimized when she refused to accept the religious dictates which finally led to her being burnt. She sustained forty-five percent of serious degree burns. This along with the fear of being divorced played havoc with her self - esteem. In case two, the woman was subjected to what is considered perverted sexual demands and if she refused, the children and the mother would be tortured. Case 3 is a typical case of dowry demand and the torture related to it. Case four deals with the woman's inability to self - determination regarding her own reproductive capacity.

The doctors in all four cases have attempted to help at various levels. In case one and case four, the doctor referred them to the social work department. In case two, the doctor visited the patient at home to find out the root of the problem. The doctor not only treated the case but sent the husband for psychiatric counselling. In case three, the doctor

himself called the husband and threatened him with police action if he did not go for counselling. Thus it's apparent that doctors have tried to help in their own limited capacity.

Case 1, is of a 28 year old married female staying in Ghatkopar. She is staying with her husband (32 years), a travel agent earning approximately four thousand per month. She has two children a son ($6^{1/2}$ years) and a daughter (3 years).

The main bone of contention between the couple is that the husband is a sunni and the wife is a shia muslim. During the time of "nikah" and the first year of marriage there was no problem. Subsequently, the husband started to force her to conform to the rigid religious formalities. Soon they shifted to Sandhurst Road, a major muslim dominated area. The people residing here were very orthodox and the women specially were victimized. The case refused to conform to the religious rules as she was not accustomed to it. This is when her husband started abusing her physically, called her to be of loose character and threatened her with "talak", and was followed everywhere. She was not allowed to visit even her parents. It was only when she was burnt that she came to her parents house who admitted her to the hospital. The doctor referred her to the social work department after the treatment. However since her husband does not approve, she is scared

to contact any social worker. While this interview was conducted the case had marks of torture on her arms and her stomach. The case now wears a "burkha" and does not visit her parents. The case got symptomatic treatment from the doctor and visited the social worker only once.

Case 2, is of a 33 year old unemployed married female staying in Sion. She stays with her in-laws, husband and four children (two sons and daughters). Her husband is an alcoholic . The mother-in-law works as a maid where as the father-in-law works as a shopkeeper.

Since the case was staying in the same slum as her husband, they were known to each other before marriage. It was an arranged marriage with no objection from either side. After they got married, they went for their honeymoon to Mahabaleshwer. Her husband exhibited strange behaviour there and expected sexual favours which is considered perverted today. She yielded initially thinking that it would later fade away once the novelty of marriage faded. The case soon conceived and delivered their first child. She said that the husband was most considerate during her pregnancy. After the delivery, he reverted back to the same behaviour. This continued in the subsequent pregnancies. When the case started to resist, the husband started to abuse her physically and blackmailed her by abusing the children and

his elderly mother. The case would try to ward of her husbands advances by faking her illness which would keep him at bay. She would frequently visit the urban health centre with problems of acidity , pain etc.. The doctor suspected that something was amiss, so she made a home visit to the case's house. This home visit brought out the real cause, i.e., to avoid abuse at home, the case was faking her illness. The doctor referred the husband to the psychiatrist and dealt with the case herself. The progress of the husband is not known as both the times when the researcher made the home visit, he was not present.

Case 3 is of a 20 year old married woman staying in Sion Koliwada. She stays in a joint family which comprises of her mother- in - law, brother - in - law and sister - in - law and her child. The case has two daughters and her husband is working in a telephone company.

According to the doctor, the case came to the emergency accusing her mother - in - law of beating her with a stick. The next day, she was got to the emergency with cord compression and neck fracture. Initially, she told the doctor that she fell from the stairs but after a lot of probing, she admitted that her husband had dragged her by the hair and hit her head against the wall. When she tried to escape, he caught her and slapped her. The second time, the blow landed on her neck. The doctor, besides treating the case, sent the husband for psychiatric

treatment. The doctor threatened the husband of police action if he did not go for psychiatric treatment.

Case 4 is of a 25 year old married woman, initially working, now unemployed. She stays in Dharavi with her parents - in - law and brother - in - law. The former are earning members where as the latter is unemployed. The case has two daughters and one son. Her husband is a sweeper.

After marriage, the case's husband demanded that her parents buy a house for them. The father bought a "jhopada" in Sion and later a one room tenament in Dharavi. The case gave birth to three children. When the son was born, everything was okay but after the birth of two daughters, she was constantly harassed. She was forced to have an abortion before her second daughter was born. The mother - in - law wanted another grandson and hence would constantly harass the case to conceive again. The case however, didn't want any more children. While the case had taken her daughter for a health check - up, the doctor advised her to undergo a family planning operation. When the case suggested this to her husband, he physically abused her and threatened her with dire consequences if she did so. The case however, did not agree to the demands of another child from her mother - in - law, so she went to her mother's place and got herself operated in Sion

hospital. After she recovered, she went back to her husband's house. However, she soon developed an infection, for which she had to be admitted again. Her husband came to know of her operation and refused to take her back. They wouldn't even visit her in the hospital. It was after the social worker intervened on the doctor's advice, that the in - laws agreed to take her back. According to the case, "Abhi bhi roj sunna parta hai. Meri sas mujhe banjh bulati hai. Mujhe ghar main akele kone main rahna parta hai. Par rahna to mujhe yahin hai".

RAPE:

Case five and six are cases of sexual abuse, that is rape. They highlight the range of issue involved when dealing with problems of violence.

Case 5 is of a married woman in her early twenties staying in Jogeshwari. Since the case was not open to the idea of discussion, further details regarding the family are not available.

The case was brought to the emergency at about two in the morning. She was bleeding profusely. The diagnosis was rape but she and her husband kept denying it. Her vagina and anus were brutally damaged. However, the case kept insisting that she had slipped from the stairs and an iron bar had entered her. No explanation for the bruises over her body were given. After a week's treatment, she was

sent to the psychiatry department whereafter about a month, she admitted that she had been raped. According to case, during the Babri Masjid riots, they left their house in Chembur and went to stay with relatives in Bhendi Bazaar, a muslim majority area. Subsequently, when they returned to their house, they found it occupied by someone else and who, when asked to vacate, flatly refused. They spent that night at the neighbour's house. The next day, while the husband had gone to file a police complaint, members from a major political party at the local level came and threatened the case to stay away. However, since the police complaint was filed, they got possession of their house but were tortured everyday. Either the water or the electricity supply was cut and the rent was increased. One day, when her husband was not at home, some people came to collect the rent. The case told them to come later since her husband was not at home. They said that they would come at noon for their payment. They came promptly at noon and raped her. When the case's husband came back in the night, he took her to the hospital. In the emergency, the doctor refused to believe the story and called the police on duty. The husband was taken to the police station where he narrated the truth. The police asked him to keep his mouth shut. The husband on coming from there, told the doctor, "waqt pe

badla lenge, abhi kuch nahin karna hai". The doctor on duty kept trying to help them to file a case but the husband flatly refused. The case felt that the doctors in the ward were helpful and supportive.

Case five, shows, the repressive aspect of legal and judicial structures and how unequal power relations in society get reflected in the way the victim was treated. The woman approached the police for help but was not entertained. Apparently, this move led her to be victimised twice. The males prerogative to punish by torturing a woman in this case is evident. The refusal to lodge an FIR, the police threatening the husband and the subsequent recording of the case as an injury is clear. These issues are required to be addressed to ensure justice to the victim with full support from the medical and judicial personnel. In this case, the communal bias along with the gender bias of the police has led to a hostility in the husband and a feeling of apathy and indifference to the entire system.

The doctor on duty did try to get the truth out by intimidating the husband before recording. But the fear and apathy, kept the former from doing so as he did not expect any outcome for the better.

Case 6 is a 37 year old married woman staying in Dharavi, employed as a maid. She has two sons and daughters . Her husband is a casual labourer. The difference in the nature of cases is evident. This

case is of a woman who claims to have been sexually abused. However, the doctor feel that she is faking the case in order to implicate the neighbours.

The case came to the Gynaecology department complaining of rape by her neighbour. According to the doctor, there was no outward manifestation of any struggle or signs of rape. The case, however claimed that there were some differences regarding a drain blockage problem with the neighbours, who would pick up a fight any time on the same issue. She said when this incident happened, her husband wasn't at home and she had just come back from work and found the neighbour sitting outside her house. On seeing her, he started abusing her by calling her names. When the case told him to come later and talk to her husband, he got angry and went away. However, five minutes later, he entered the house and raped her. The doctor's feel that the case is trying to implicate the neighbour in a false case as her version is highly dramatised and gets distorted with every visit. The case was not open to the researcher visiting her house and did not answer the questions openly. In this case, even the doctor was reluctant to give medical details. This case is indicative of the further complexity of issues at hand. In this case, medical reports were not available as both the doctors and the case were reluctant to talk openly to the researcher.

STREET VIOLENCE:

Cases seven to nine deal with generalised street violence .The cases here are all males. Out of the three cases two were employed and one unemployed. These three cases are of violence of random nature. Cases seven to nine tend to confirm the explanations related to ghetto violence where violence is more blatant and commonly accepted as normal. The victims in these violent events are random (case 9) or picked at because they opposed the perpetrators in some way (case 7 and 8). In case seven thus the victim takes the assault in his stride where as in cases eight and nine, since the violent episode has led to a permanent disability, the trauma cannot be overlooked. In case nine ,the victim cannot place , as to why he was victimised. All the three cases show a distrust of the state machinery, i.e. the police. These experiences have left a bitter taste in the victims, especially for cases seven and nine who are now disabled. Though all three got "symptomatic" treatment from the hospital, they complain of being roughed up or ill-treated by the hospital staff.

Case 7 is of a 25 year old married unemployed male. He stays in Dharavi with his parents, sister, wife and son. His father is a vegetable seller and his sister works as an "ayah".

The case came to the OPD with multiple injuries and a broken knee. He was injured at around three in the night but was got to the hospital only at nine in the morning. This was done to avoid filing a police case. The case and his friends used to drink at night and generally loaf around. That day, he had a fight with a member of another youth group regarding, a festival matter. Taking offense to that, the other group came at night and beat them up with bamboo sticks. The case sustained multiple injuries whereas one of his friends was stabbed. The other two friends sustained minor injuries. The case is not worried about future handicaps or of the cost of treatment inspite of the fact that he is married with a child. In fact, the case was quite proud that "dada jaise fight hui aur ek dam film ke villain ki tareh fight hui". The case now is a pick - pocketer and blames his parents for marrying him to a girl who did not bring sufficient dowry.

Case 8 is of a 23 year employed male staying at Antop Hill with his parents and two sisters. The only earning member in the family is his retired father.

The case was a simple person who worked as a peon in a clinic. He was studying hard to get through the police constable examination. One day, when he was returning from work, he saw some of the boys troubling a girl who stayed in his vicinity. He scolded the boys and took

the girl home with him. The same night, when the case was coming back from the public toilet, he was brutally beaten with iron rods and chains. He claims that the rod was put on his knee and applied pressure to after which he was kicked and brutally thrashed. The case lost consciousness at that stage. Soon his family got alarmed and started to look for him. When they found him, they got him to Sion hospital. They told the duty officer that he had fallen from the terrace and since there was construction work going on, he fell on the stones. The case's leg was amputated and no police case was registered as the family is scared that the same people might cause further harm The case feels lost as he sees no future prospect for himself.

Case 9 is of a 23 year old married employed man. Since he is a reluctant interviewee details about his family is not available.

The case was got to the emergency at around eleven with a bullet injury in the knee and abdomen. His leg was crushed and he was hit with some blunt instrument on the head. After three days when he gained consciousness, he was shocked to hear that his leg was amputated. The case had gone to see Ganpati Puja in a nearby area and had just gone to relieve himself when he was caught by some people and brutally beaten. He doesn't remember being shot at. He doesn't even know why he was picked and tortured. The case was very

angry with the hospital authorities for not taking prompt action and informing his family. He claims that he was asked for money for the operation. He feels the doctor could have been more supportive in telling him where to get the crutches from and to help him get used to his disability.

INSTITUTIONALISED STRUCTURAL VIOLENCE :

Cases ten to twelve are victims of institutionalized violence. Case ten is a victim of communalism, case eleven of gender based institutionalized violence and case twelve a victim of socio - economic compulsions, a form of institutionalized violence. Case ten deals with a victim of the massive riots in Bombay due to communal tensions. Major devastation due to bomb blasts had taken place and police was openly showing a partisan attitude against muslims who bore a major brunt of the riots in terms of loss of life, property and self esteem. The experiences of this case shows that even the basic health services was not available. The experience of the victim shows that, one does not only experience physical assault but also mental agony in such situations. In such situations, rioting, looting, ransacking, beating, murdering and raping of women is common and the state machinery plays the role of mere onlooker. The victim lost his brother and father in the riots. His father did not even get first aid. The injured were dumped

along with dead bodies and injuries such as burns were not even addressed or looked into. The experience shows that the health services are not equipped with even the bare minimum infrastructure and facilities to handle such situations.

Case eleven brings to the forefront a case of power inequality. The case was an active woman who worked for the betterment of the community and women. A fight arose on the issue of vacating a "balwadi" with the local dadas. Acid was thrown at her as punishment and to teach a lesson to the people that they should listen and obey the "local dadas" or suffer. The husband is scared to report the case and the hospital records injury and burn due to manhandling of chemicals. The doctors tried to probe by asking as to which chemical was used and where the incident occurred, but got no response. The fact that the neighbours are more supportive than the family shows that the distrust of the people of state action can be directed to mobilization of public opinion to combat violence and the anti people approach of the power barons. Though case was badly burnt and her future is uncertain as her husband was threatened with dire consequences if he took her back, it was the community which was taking an active role in nursing her back to "health".

Case twelve, shows how the socio - economic conditions compel a person to take extreme steps. When the case murdered his children and committed suicide, he was rushed to the hospital but not the children. An in-depth interview was carried out with the wife which brought to light that the case in normal circumstances wouldn't have taken such an extreme step. This was confirmed by the neighbours also. In this case one death was recorded but the issue of the death of the two children was evaded by the wife.

These cases show how circumstances get institutionalized into different forms of violence which take a toll on the well being of an individual in terms of ill health and death.

Case 10 is of a 27 year old employed male living in Cheetah Camp with his mother a widowed sister and a brother.

The case said that initially there was no problem and everyone used to live in harmony. He used to work for a Hindu who did not employ him after the riots. His brother had gone to the public toilet and never came back. His father went to the police station to report his brother missing and for six hours he too was missing. Later on, someone informed him that his father had been shot dead and was lying in the lane. The case took his father's dead body to Inlak's hospital but no one paid attention or listened to him. He recounted how they

used to live in perpetual fear of Shiv Sena. He said food and kerosene was in short supply, women were raped, men were killed and houses were looted. He said that they were constantly hearing slogans such as "Pakistan jao, nahin to kabristan jao" He said "hum to mar mar ke jee rahe the". The case said that the people who were inflicting torture were from outside and not from the neighbourhood. Some neighbours at their own risk, however, did try to help them.

He admitted, he was very angry and could have killed people. His hand and leg got burnt when he was trying to put out the fire in his house. First three days, he did not even get first aid and survived with "haldi" on his burns. They got shelter in the nearby masjid from where they were shifted to a relief camp. It was there that he met his sister who told him that her husband and son were killed, their zari business establishment burnt. He was scared to go to the hospital since there was a rumour that police were killing people in the hospital. He also had the feeling that a Hindu doctor wouldn't help him. At that time, the injured and the dead were loaded together on the vegetable cart and dumped in front of the hospital. The case says, even today seventeen people he knew are missing.

Case 11 is of a 23 year old married woman staying in Siddarth Colony with her mother - in - law, sister - in - law and brother - in - law. Her husband is a peon.

The case was brought in the emergency with fatal acid burns on the face, frontal region, lower half of the body and arms by the neighbours. The case battled for life in the ICU for three days. She was the head of a Mahila Mandal group and was constantly working to improve the community. She would always be ready to take up cudgels for any woman who was being tortured. One day, she had a fight with the "local dadas" who wanted to set up a dye industry in place of the balwadi. A week later, the case was caught in the night while she was returning from a nearby shop and acid was thrown on her. On hearing her scream, the neighbours came out. Her husband was informed but surprisingly the neighbours took the case to the hospital. The case was badly burnt. She had lost her eyesight, and her face is totally distorted. Her family is scared to support her as they have been threatened. Thus, there is no police complaint and the medical report says that the case burnt herself while handling "some" chemicals. Her future is uncertain as her husband is reluctant to take her back because of the fear of inviting more trouble.

Case 12 is of a 30 year old employed man who was living with his mother, two brothers, one sister, wife and two children. He was the only earning member of his family.

The case committed suicide on 5th October, 1996 and before killing himself, he killed his two children. The details of the case were collected from his wife. The case was staying in Shivaji Colony for the past eighteen years. He was married for seven years and it was only after his marriage that there used to be fights on financial issues. His wife was from a rural area and the marriage was arranged through some relative of the case. A year after the marriage, the wife conceived and was sent home for delivery. Her first child died three months after birth due to some fever. His wife didn't return for one and a half years as she herself fell ill. The case would visit her as and when possible. It was after the wife delivered a daughter, she returned home. The wife had to constantly face her mother - in - laws demands for dowry. The case , however, would never demand anything, which would anger his mother. When the situation deteriorated, the case took to drinking. Things aggravated when the case's sister's engagement broke because they could not meet the dowry demand. The case took his wife's jewellery, sold it and that too couldn't suffice. That night, the case left home in great anger and came back drunk at two in the night. When he

came home, he threw everyone out of the house, strangled the children and then killed himself. The wife's experience at the hospital was most frightening. Whenever she would go to the MICU, the nurse or the peon would scream at her and ask her to get out. The night the episode happened, the case's brother got him to the emergency and the wife took the children to a nearby nursing home. In this case, the only case which has reached the hospital is of the case himself. The fact that the wife is being tortured everyday to leave the house and the death of the two children goes unreported.

CHILD ABUSE :

Cases thirteen to twenty are cases of child abuse. However, there are variations visible in all the seven cases. Cases thirteen to seventeen are all cases of child sexual abuse, case eighteen is a classic case of battered baby syndrome, cases nineteen and twenty pertain to physical abuse with elements of emotional and psychological abuse.

Cases thirteen to eighteen deal with the female child and nineteen and twenty with the male child. Out of the six cases of girl child abuse, five deal with sexual abuse and one with physical torture. Both the cases of male child deal with only physical torture. This is not to point out which form of abuse has more or less effect but to point that

the bias in the form or type of abuse does exist on the basis of sex. Case thirteen reveals how poverty forces young girls into the flesh trade by their own relatives. The absence of any support system only sees to the continuation of this abuse as the girls have no other alternative. Cases fourteen and sixteen deal with incest and its effect on the child. Both the cases have dealt with the situation differently. The former, ran away from home when the family blamed her and the latter is a homosexual who is now being tortured by her family for her preferred choice of women. Case fifteen shows how girls living in an impoverished area are sexually abused and way laid. Case seventeen, is the youngest victim and reveals the sadistic nature of child abuse. Case eighteen deals with a typical case of battered baby syndrome. Here the child was thrown and kicked. However, the family out of fear of police kept saying that the child choked on carrots. Cases nineteen and twenty, show that the children being the most vulnerable and unable to protect themselves from assault, are easily picked up and tortured.

These eight cases of child abuse reveal that children need to be protected from outbursts of anger which can lead to some disastrous forms of disability (both psychological and physical) and in certain situations and circumstances to death.

Case 13 is of a nineteen year old female staying with her uncle, aunt and two cousins in Dharavi. The case was working as a sales girl initially. Her uncle is a taxi driver.

The case lost her parents when she was very young. She was brought up by her maternal uncle. Her life till the age of fifteen was good. She was sent to an english medium school. The case was suspicious of her aunt who would invite strange men home at odd hours. When the case started with her menses she was asked to start working as a sales girl. She started selling things like clips etc. on the trains. But her aunt would complain that she was not earning enough and that she should get into a more lucrative business. One day, the case was asked to dress up as she was to go with so called her aunt's brother to see a film. The case had seen this man quite often coming to the house but the lure of movies egged her on. He took her to his "kholi" apparently to get tickets. That is when the case was first sexually abused. When the case came home and complained to her aunt, she simply ignored her. The case came to the hospital complaining of abdominal pain and itching in her private parts. After preliminary diagnosis, the doctor referred her to the social worker. The case does not want to lodge a complaint with the police as she has no one to look after her.

Case 14 is of a 20 year old female who was living with her parents, one sister and one brother. Her father is a retired teacher.

The case was brought to the emergency unconscious and the diagnosis was that she had meningitis. She was treated at the cost of the hospital for almost two months. She didn't respond to any question for a long time. After she gave her address, the parents were contacted, who told the doctor that the case had run away a month back. The parents admitted that the case was abused when she was fifteen years old and it was only after that she started to run away from home. The case confirmed that everytime the uncle who abused her came home, she would run away and come back when she knew that he had gone. The case would often go to her uncle's house and play with his children or they would come to her house. The case had just started her menses and thus had to wear a salwar. It was after that, that her uncle started abusing her and she started running away from home. This went on for five years. Once, she was sent with her uncle to the field to collect fodder for the goats. It was then that the case was sexually abused. When the case complained to her mother, her mother slapped her. The case then decided to run away. She caught a state service bus and came to Bombay. She lived on the street for a month. She remembers not feeling well for a few days and the next thing she knew she was in

the hospital. The case was scared to talk to the doctors initially but opened up when they showered her with love and affection.

Case 15 is of a sixteen year old female child staying in Sion with her parents, sister and brother. Her father is a labourer and mother a basket - maker.

The case came to the OPD complaining of intense abdominal pain. The doctor assumed that it was a normal complaint of delayed menses and prescribed medicines accordingly. The case came back after a week with the same complaint. The doctor became suspicious and sent her for a pregnancy test. The results of the test and the check - up showed a case of pregnancy. According to the case, one day when she was alone at home, her brother's friend came and asked her to accompany him to a friend's house. The case admitted to have a liking for her brother's friend. It was on the same day that he seduced her for the first time. After that the case admitted submitting to him five more times as he would threaten her with dire consequences. The case is petrified of her parents and doesn't want them to know about her condition. The person responsible for her present condition is now avoiding her. The doctor cannot help her since for an MTP, the parents' consent is essential.

Case 16 is of a eighteen year old female. At present, she is staying alone, inspite of the fact that her family stays in Bombay. Her father is a manager, mother a teacher , brother a lecturer, sister teaches computers and her brother - in - law is a medical representative.

The case is now a confirmed homosexual and was brought to the psychiatric department for counselling. The case attributes her present condition to the abuse she had undergone when she was a child. When the case was small, during summer vacations, all the cousins would meet in Calcutta at their grandfather's house. She remembers that all the boys would often sneak up leaving all the girls downstairs. The case admits that her curiosity got the better of her and she too managed to sneak along with the boys to the terrace. It was then that her uncle caught her. He then made her undress and made her do all kinds of things like pinching, stroking etc. The case was only twelve years old at that time. The case admits that she was scared, confused and feeling horrible. The next day her uncle made her repeat everything and sexually abused her. The case did not confide in her mother as she felt that her mother wouldn't believe her. The case said it was from then onwards that she started hating men and fell attracted towards women. She was most condescending of the psychiatrist who kept telling her

that she was abnormal. She feels that the doctors and the psychiatrists didn't know how to deal with her.

Case 17 is of a two week old female child got to the hospital for a post - mortem. The case was raped and strangled to death.

The case was a construction worker's child. The construction worker was working on the hospital premises itself. The doctor was shocked to get the case. He said he had to sit and talk to the parents since they couldn't even register what had happened. The mother fainted on hearing that her child was dead. The case was registered as a police case but nothing happened.

Case 18 is of a one year old female child staying with her parents in Dharavi. Both the parents are employed.

The case was brought to the emergency at around three in the afternoon, with a complaint that the child choked on carrots. The diagnosis revealed multiple fractures and bruises on the body with the lungs absolutely clear. Initially, the mother refused to talk about the child's death. After four visits, the mother opened up and talked. She said, her husband was an alcoholic and would fight every night over money matters. He didn't like the child as the child would always fall ill. That day, the husband came back early, drunk and in an irritable mood. The child was crying as she was suffering from loose motions. This

irritated the father and he picked her up to quieten her. Apparently, then the child's finger went into the father's eyes and he threw her on the floor and kicked her. It was after some time, that the mother along with her mother - in - law brought the child to the hospital. They decided to fake the cause to avoid a police case. The doctors according to the mother were very rude and kept threatening them to tell the truth or they would be sent to the police. When they didn't give in, they delayed the handing over of the dead body by four hours.

Case 19 is of a eight year old male child, staying in Dharavi with his parents and sister. His mother is the only earning member.

The case was a happy and mischievious child. The case's father was unemployed for two years. The mother took up a job which was not liked by the father. These two facts would lead to fights everyday. The fights became worse when the father couldn't find a job. During one such fight, when the mother fainted and the case started crying, the father slapped him also. That was the first day the case was beaten by his father. The case stopped talking from that day and keeps falling ill regularly. The doctors have diagnosed this as a case of emotional abuse. The mother says, the doctors have been helpful and supportive.

Case 20 is of a sixteen year old male child staying in Goregaon with his parents and two brothers. His father is a peon in a private company.

The case was referred to the hospital by a private practitioner as he was not responding normally. The case needed psychiatric help. The diagnosis revealed that the case was a victim of emotional abuse. The case was pampered excessively by his mother and abused extensively by his father. This led to a lot of insecurity in the child. As a result, he grew up hating his brothers and father. During the riots, the case's mother expired. It was during this time the case stopped communicating with anyone and became violent Initially, his father would try to get him to talk by slapping him but when that did not work, he took him to a private doctor, who referred them to Sion hospital. The doctors response here is restricted to clinical work only.

The cases described here include only reported cases which the doctors felt were cases of violence. Yet these cases are reported in the medical records as cases of injury, burns etc.. The lacunae in recording the cases is thus evident. The interpretation of violence hence is subjective in nature and the case studies reveal the medical systems dependence on individual based view in cases of violence.

An analysis of victims case studies shows that they pertain mostly to children and then to women which shows that even among the cases coming to the hospital, doctors are more likely to see the vulnerable sections as victims of violence. Theirsg is a common social perception and response to victims with no professional knowledge or skills backing them. Each victim comes into contact with the health services for different reasons. The victims are quite reluctant to disclose the cause of injury to avoid filing a police case. Inspite of this, in seven cases, the doctors were very helpful and went out of their way to help the victims once they realised they were being victimised. In one case, the doctor showed some sensitivity to the victim while treating them but was unable to help beyond. In twelve cases however, the doctors restricted themselves to symptomatic treatment. The victims in these cases, complained of facing rude and unsympathetic behavior from the doctor. Due to overload of work, less time and lack of resources, most victims do not get recognised unless they are blatant cases of violence. In most of the cases, it was seen that violence does not only effect the victim alone but also the immediate circle which includes the family, neighbourhood and the community.

THE DOCTOR'S PERCEPTIONS :

The doctors initial reaction to the researchers opening remarks during the initial interview was of total confusion and most of them heard "Virus and Health" instead of "Violence and Health". Once this was clarified, most of them could not comprehend as to why this issue needed to be seen to when there were other more important problems to be tackled. Most of the doctors were cooperative but due to their busy schedule, they had to be contacted repeatedly. Some doctors refused and some couldn't be interviewed due to last minute emergencies. When asked to define violence, fifteen doctors saw it as a phenomenon with physical and mental aspects attached to it. Dr. Anjali from the PSM department said violence is a phenomenon to be seen on a wide spectrum as it has major and minor aspects with physical, mental and social correlates. Six doctors saw violence purely as a physical phenomenon. They belong to the orthopaedic, forensic and psychiatry department. Most of the doctors however specified, that in the medical profession, what they had to deal with was basically physical violence.

RIOTS AND THE DOCTOR'S ROLE :

One violent episode which almost all the doctors experienced was the communal tension and the bomb blasts in 1993. Thus, this

was taken as a reference point and explored. The doctors were questioned as to whether they were on call duty, their family's response, and the doctor's role during that time. During the riots, majority of the doctors were on duty and three of them were medical students, also on duty. When questioned as to how the family responded to their being on duty and not at home, most of them said "It's part of our profession and in a doctor's family, it is accepted as normal. Most of them, felt that it was not an irrational demand to expect doctors to stay on in the hospital in such situations. In fact, they felt it was normal. Dr. Changlani from the surgery department compared a doctors role to the army. He said that just as the citizens expect the army to fight, they expect the doctors to cure at any given time or situation. On further probing, however, a few felt such as Dr. Ghuge from the forensic department, and Dr. Goregaonkar from the orthopaedic department that at times, when this expectation gets converted into a demand, it is irrational. Dr. Meena from the surgery department said "It's irrational as we too have a family to take care of".

When the sensitive issue of refusing treatment on the basis of their communal leanings was questioned, it was met with three typical responses of:

- a vehement "no" with a look of disbelief

- no, not in Sion hospital, probably by private practioners
- we also heard of it, but they are all rumours or " Akhir time kahan tha, discriminate karne ko?"

This is in direct contradiction to some published works on how doctors allowed their communal leanings to affect their work during the riots. Changing the line of questioning, the doctors were asked whether, they themselves and the hospitals were safe during violent situations, to which all doctors responded in the positive. Most said hospital is one place where everyone feels safe. Dr. Changlani felt that a hospital was probably safer than a police station. Dr. Shanbaug of the PSM department was not so optimistic and said that hospitals were relatively safe but not immune to attacks. When questioned as to the attack on the Urban Health Centre (UHC) in Dharavi, most doctors said that major hospitals were safe and not the periphery units. The doctors from the PSM department said that since the UHC was in the midst of the slum, it was but natural that it would be attacked.

ON MEDICAL VIOLENCE:

The doctors initially, refused to accept that violence in hospitals as a phenomena exists. It was only after a lot of probing that they admitted that it probably occurs in private hospitals and not in public hospitals. Undue operations, not admitting AIDS patients, selling

kidneys, taking blood from people not fit to donate were few examples of violence given by Dr. Ghuge and Dr. Anjali. However, many tended to see violence as an issue of malpractice or ethics and felt, the two could not be equated. Dr. Nitin from the medicine department felt that ragging in medical colleges made a doctor insensitive to the issue of violence. He felt that the materialistic tradition penetrating the portals of medicine will lead to increase in violence or "malpractice". This seems to support the claims of other doctors that violence in terms of excessive operations etc. occur more in private practice. Many doctors from the orthopaedic, medicine, surgery and gynaecology department felt that the Consumer Protection Act (CPA) slapped on the doctors would help reduce the above mentioned. Dr. Neena from the psychiatry department and Dr. Bichile from the medicine department were two doctors who denied that violence is practised in hospitals. A few doctors justified malpractice by claiming to be humans too. Dr. Shah from the psychiatry department felt that the two percent of operations done on chance factors cannot be seen as violence. Another view was put forth by Dr. Vaidya from the gynaecology department, who said "If we don't send the patients through a battery of tests, they are dissatisfied and then go to private practioners who will spoil their health". These varied responses show that doctors

themselves are confused and that they would evade the issue of violence by terming it as malpractice. Some doctors talked of violence occurring in mental institutions in terms of chaining the patients, use of ECT etc. which was vehemently denied by the psychiatry department. The doctors, however, refuse to elaborate on this issue which clearly points towards issues beyond malpractice. The fact that a few doctors have referred to CPA as a solution to check "malpractices" shows that some doctors are aware of the problem of violence.

Responding to the question as to whether the doctors face violence in the hospital, most of them answered negatively. Dr. Anjali, who was in the UHC while it was attacked saw it as an aberration and of no consequence. Majority of the doctors said that though patients tended to be rude, aggressive and short - tempered, they overlook this. This was used to justify that just as patients waiting in queues lost their temper, they too at times due to high patient load tend to be rude. The psychiatrist and forensic experts felt that they had to face threats from relatives and patients themselves. The doctors, however, took it in their stride and said that on the whole they rarely faced violent situations in the hospital.

VIOLENCE AS AN ISSUE - SOCIAL/PERSONAL Vs PROFESSIONAL :

Majority of the doctors admitted that violence is a personal issue but felt that just as a judge has to have a non - judgemental attitude, they too had to be objective while dealing with patients. Doctors felt that for an issue like violence, they simply needed years of experience to deal with it. So when asked whether as doctors, they are equipped to deal with violence as an issue professionally, they all felt that they could. However, personally they felt it depended on the doctor's background and upbringing. Dr. Reddy of the PSM department said "If a doctor himself is a victim of child abuse, he is bound to be more sensitive than a doctor who has not been victimised". This shows that doctors feel on a personal and professional front they differ in their capabilities to deal with violence. The doctors admitted that they need to be sensitized to the issue of violence but felt that it shouldn't be taught in the medical curricula. When asked as to how the doctors could be sensitized, they themselves were confused on the issue. Dr. Badhvar from the gynaecology department felt that since as a medical student, the schedule is already packed, teaching sociology of violence would be impossible. Doctors admitted that in the course of their medical

education, violence as an issue was non - existent but after a few years of experience, they felt the need to recognise its existence. They seemed to recognise violence only in terms of their outcomes, i.e. injury, rape, suicide, assault, battered baby syndrome etc..

RECOGNITION AND HANDLING OF VIOLENCE :

When asked to identify the kind of violent cases coming to the hospital, the responses differed from department to department. Doctors in the PSM department identified cases of sexual abuse, assault, domestic violence, as against cases of fall from height, chopper and gunshot wounds, amputations identified by the orthopaedic department. Cases of emotional neglect, battered baby syndrome, child abuse, sodomy, peer abuse are common in the paediatrics department. Dr. Preeti felt that the female child as victims were more common than their male counterparts. The forensic department deals with cases of ruptured spleen, cuts, stabs, burns, poisoning, hanging along with victims of gangwar, riots, blasts, rape and dowry deaths. The psychiatry department felt that they dealt with all types of abuses as the patients were referred to them from all the departments. Cases of burns, assaults, stabs and acid throwing were common in the surgery department where as pregnant women physically assaulted, burns with cigarettes, glass injuries and sexual

abuse are dealt by the gynaecology department. The doctors in the medicine department felt that they dealt with all the above mentioned cases. The doctors were then asked whether they remembered any particular case of violence, they all responded after a moment's reflection. The cases identified by the doctors varied from domestic violence to child abuse to generalised violence, reveals that the doctors are aware of the issue of violence. The fact that some doctors have tried to go beyond "symptomatic treatment" shows that doctors can play a role in identifying and helping victims of violence. This was reinforced by Dr. Anjali, Dr. Shanbaug and Dr. Nitin. The doctors at times have tried to help by referring cases they identify as "victims" to the psychiatry and social work department. However, due to limitations in the system, the doctors felt they had little to offer. This shows that the health system does need to incorporate changes and institute guidelines to deal with victims of violence as they do approach the medical professionals for help. The victims, however, do not get the required support as the cause of the problem is not identified or is overlooked. When dealing with violence, the doctors admit that victims of violence perpetrated by social factors do approach the hospital but deny that violence within health institutions exists. They accepted that victims needed further care and required to be treated sensitively but

when it came to questioning their role, they felt that as professionals, they had a limited role to play.

Finally, the doctors were asked to mention three diseases which should get the top - most priority in terms of medical care. Here too, inter - departmental variations could be seen. The PSM department saw infectious diseases followed by sexually transmitted diseases and heart problems as being important where as the orthopaedic department identified accidents, injuries and assaults followed by infectious diseases. Diarhoea, malnutrition and anemia were mentioned by paediatrics department as against accidents, assaults and tuberculosis by the forensic department. The psychiatric department gave depression, psychosis and substance abuse while the surgery department mentioned infectious diseases, cancer and heart diseases. The gynaecology department felt infectious diseases, anemia, cancer of the cervix and ill - health due to repeated childbirth were the most important where as the medicine department saw infectious diseases, respiratory and cardiac problems as the three most important diseases. When asked to place violence in context to these diseases, the doctors felt that violence was inherent side by side in all of them. They felt that violence as a cause of ill - health needs to be addressed as its outcome is fatal. Many doctors felt that an effective

trauma ward with outreach services is a must for the hospital to be able to deal with victims of violence. They admitted that violence was a hidden problem which needed to be addressed in the medical circles but they could tackle the problem only if their work - load reduced and infrastructural facilities improved.

The victim's experiences and the doctor's responses show that violence does effect the health of an individual and gets addressed only if the doctor shows extreme sensitivity. Even when the doctors recognised the issue, they restricted themselves to the outward or physical manifestation of violence only. The cases where the doctor has gone beyond symptomatic treatment (as in case one and case eight), the victims have got some support from the doctors occasionally. This shows that the doctors can play an effective role in identifying victims, preventing repeated victimisation and providing rehabilitation either through self or other support services. Hence, violence as an issue needs to be recognised and dealt with within the medical context.

CHAPTER VI

SUMMARY AND CONCLUSION

Violence is a phenomenon that is manifested in a variety of ways. It has both psychological and physical aspects attached to it. It is not a unitary phenomena but includes a spectrum of behaviour which has a continuum of socially acceptable and unacceptable behaviour. It comprises of conditions and actions which obstructs the unfolding of human development. It can be on the interpersonal, institutional or societal level, and thus can be both latent and manifest in nature. Violence is a term that suffers from a surfeit of meanings. The lack of standardised definitions has led to widely varying operationalisations. This in turn has rendered both fruitless and frustrating any attempt to compare the findings of the studies and data available. Thus, still no reliable estimate of its incidence or prevalence is available. The elasticity of the term "violence" is such that it makes it possible for any researcher to downplay or overblow the incidence of violence simply by adopting a narrow or a broad definition of the concept. Thus most studies have restricted themselves to violence that can be objectively established and measured such as "physical" or :sexual" violence. This brings to the forefront the issue of identifying the wide range of behaviours which constitute violence. Attempts to explain violence in terms of causal factors such as age, sex, culture, drugs, race,

urbanisation show that in a heterogeneous population differences in attitudes towards the uses of violence exists.

Many of the theories dealing with the concept of violence show that initially violence was seen from an individualistic view point, hence its origin was seen to be determined by the individual himself. At this micro-sociological and psychological level, the study of causes of violence restricts itself to biological and genetic level. Violence by group is seen to have its origin in the nature of the group itself and thus is "institutionalised". Research into causes of different levels of violence undertaken by theorists of different disciplines shows that each of the interlocking fields involved in studying violence, are exploring only one aspect and neglecting the others. Hence there is a need to bring together such varied research, at so many levels of causality and of such different practical applications. One has to see the complex intra-psychic, interpersonal and sociological interactions to understand the concept of violence. This leads to the need to assess the different forms of violence such as child and elderly abuse, violence against women, domestic violence, psychological abuse, communal and caste violence, political violence, developmental violence etc. to comprehend the complex nature of violence. An analysis of these different kinds of violence shows that it is a complex phenomenon and brings to the

forefront that home, society and the nation states which traditionally are suppose to protect an individual are the main perpetrators of violence. This reality needs to be recognised, if violence has to be tackled effectively.

Violence, thus is a widespread phenomena which affects the health and well-being of an individual. The present study attempts only to explore the violence and health nexus. Three aspects of this nexus have been identified. The first aspect is seen as violence contributing to illhealth in terms of death and injury. An analysis of the official statistics reveal that violence is a considerable cause of mortality. Violence thus has a long lasting effect on the health of an individual. The age bracket which is most affected is the 20-30 age-group. But since the official statistics collected in the Criminal Justice System and Health Care System do not link acts of violence to the resultant injury, this data base has a serious limitation for the elaboration of the violence and health nexus. In the face of inadequate empirical data one can at the most arrive at a conservative approximation of an estimate and be restricted to "recorded" violent incidents processed in the official statistics. This aspect of violence where it affects the health of an individual by threatening life and producing disease has been recognised to a limited extent, that "medical care" for victims of violence

as an issue is being debated upon. Since due to violence mortality and stress related disease increase, maiming and spread of infectious diseases aggravates, violence is placing demands on the health services for resources, infrastructure and facilities as a "cause". The case studies of victims shows that, victims come into contact with the health services for different reasons but do not always get recognised as "victims". The fact that victims do not disclose the true nature of cause of "injury" and that doctors do not try to probe into the causal factor acts a great hindrance in identifying victims of violence. The doctors are aware of violence as a problem and at times do try to go beyond symptomatic treatment but in majority of the cases the doctors restrict themselves to "medical care" only. Thus, violence demands that in hospital policies and procedure guidelines for identifying and treating victims of violence which do not exist, should be instituted, especially those involving the provision of emergency care. This medical response to cases of violence is the second dimension in Violence and Health. The health service professionals need to develop procedures which can address the diversity of needs for victims of violence.

The third aspect of violence, perpetuated by "medical institutions", is not recognised by the medical professionals. Hence this area needs to be highlighted and researched upon as till now steps to

minimise it have not been undertaken. The fact that violence is rarely recognised as a cause of illhealth it is not seen fit to include it as a "public health" problem. Thus violence perpetrated by doctors, medical sciences and the drug industry shows that together they are misinterpreting the concept of health. They are slowly taking "health" away from the social conditions and isolating its meaning as merely the absence of disease. This commercialisation of health is leading to institutionalising insidious violence in the medical world.

This dissertation, thus raises a number of issues:

(a) Seeing the burden of violence from the Health and Criminal Justice System, a need for local cooperation between clinicians, social workers and police authorities needs to be evolved.

(b) Training of health personnel is required to help them diagnose and manage a case of violence for which guidelines for diagnosis need to be included in the medical curricula so that they are aware of the short and long term manifestations of violence on health.

(c) Public health workers need a fuller understanding of the impact of violence on health in terms of form, extent and impact of violence based on which methods of surveillance needs to be developed to monitor effects of violence on health.

(d) Hospital policies and procedures for identifying and treating victims of violence need to be instituted.

(e) Health planners and policy makers need to recognise the fact that violence is systemic and widespread and will continue to be so. Thus guidelines to avoid violence in medical institutions needs to be evolved.

Thus, since violence affects the determinants of health and health directly, resulting in increased morbidity, mortality and disability, the Violence and Health nexus needs to be recognised by health professionals and planners.

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APPENDIX 1 - LIST OF DOCTORS INTERVIEWED:

DEPARTMENT	NAME OF THE DOCTOR	DESIGNATION
Preventive and Social Medicine	Dr. Reddy	Head and Professor
	Dr. S. Shanbaug	Associate Professor
	Dr. Anjali Babbar	Lecturer
Orthopaedic	Dr. Ambaredkar	Head and Professor
	Dr. Goregaonkar	Associate Professor
	Dr. Ajay Puri	Lecturer
Paedriatrics	Dr. Kulkarni	Head and Professor
	Dr. Preeti	Associate Professor
	Dr. S. Upadhyay	Lecturer
Forensic	Dr. Dhakne	Lecturer
	Dr. Ghughe	Lecturer
Psychiatry	Dr. Nilesh Shah	Professor
	Dr. Desai	Lecturer
	Dr. Sujeet	Senior Resident
Surgery	Dr. Changlani	Head and Professor
	Dr. Meena Kumar	Professor
Gynaecology	Dr. Vaidya	Head and Professor
	Dr. Badhvar	Professor
Medicine	Dr. Chawla	Head and Professor
	Dr. Bichile	Professor
	Dr. Nitin Kartik	Associate Professor

APPENDIX 2 LIST OF QUESTIONS ASKED TO THE DOCTORS.

1. What is Violence?
2. During the course of your medical education, were you sensitised to violence?
3. Are there any changes in you perception of violence as a student and now as a practicing doctor?
4. Is violence a personal issue?
5. Can doctors deal with violence?
6. Do doctors need to be taught sociology of violence?
7. How many patients do you see everyday and how many are related to violence?
8. During the riots were you on call duty?
9. What was your family's response?
10. Do you think it is an irrational demand to expect doctors to be on call duty during violent situations?
11. Are doctors in hospitals safe during violent situations?
12. What do you think of violence in hospitals?
13. Have you ever faced violence in hospital?
14. What kind of cases related to violence do you deal with?
15. Do you remember any case of violence you have dealt with?

16. Make a ladder of disease with three diseases you think requires topmost priority.

17. Where would you place violence in this context?