Troubling Suicide:
Law, Medicine and Hijra Suicides in India

by

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Abstract

Attempting suicide is a criminal offense in India, although in the recent past there have been many public and legal discussions considering decriminalizing suicide attempts. How is suicide conceptualized within criminal law? What are the knowledges that inform the complex and shifting views, claims, and legal decisions that constitute the legal regulation of suicide, in India today? Informed by Foucauldian works on governmentality and biopolitics, postcolonial studies, sociolegal scholarship, and queer theory, this dissertation attempts to answer these questions by tracing the discourses that inform the regulation of suicide in India and showing how they are put together (or kept apart) in various legal and governance networks. In addition to a systematic, original study of how suicide appears in criminal court decisions, law reform documents, and proposed laws, this dissertation also studies the framing of suicide within psychiatric and psychosocial public mental health programming.

Along with studying the framing and the governance of suicide within law and medical systems, I also study a kind of suicide that exists at the edges of both medical and legal rights systems: hijra suicides. “Hijra” is a gender/sexual identity specific to the South Asian region that
does not necessarily fit well under the label of ‘transgender’ (a label that has come into prominence in Indian rights law in recent years). Based on my fieldwork in Bangalore, I study hijra suicides to demonstrate that these experiences exist at the edges of both public health programs and rights/legal discourses. In existing at the fringes of all current forms of governmentality, I demonstrate that hijras continue to exert their personhood through expressing their experiences with suicide, which makes the more general point that sociolegal studies of medical-legal assemblages should not be reduced to studies of successful governmentalization.
Acknowledgments

This dissertation was possible because of the help and support I received from many people throughout my PhD. My fieldwork experience was filled with joy and kindness I had not anticipated. For this I am immeasurably grateful to all my hijra and kothi friends and acquaintances in Bangalore who opened their homes and welcomed me with immense fun and warmth. Sometimes, it was an odd friendship because it was a temporary one. In these temporary relationships I received immense affection and trust. I would like to particularly thank Sonika for adding the much-needed giggles through our long bus and car rides across the expanding city of Bangalore.

I am immensely grateful to my PhD supervisor Mariana Valverde. She pushed me to think deeper and outside my comfort zone. She constantly encouraged me to observe the contradictions and complexities inherent in my project. I thank her for teaching me to see creativity in what I was otherwise reading as mundane legal documents. These documents came to life through my conversations with Mariana. Furthermore, I thank her for her mentorship, which is often missing in academia. I find it very difficult to express in words the extent to which she has been an influence and inspiration through the process of this PhD.

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grateful for Beatrice Jauregui for her meticulous reading of my dissertation drafts. She often saw significance in small details in my writing and nudged me to think further. Her feedback through the process of writing has been immeasurable. I was lucky to have such an amazing group of academics as my doctoral committee.

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think. Throughout my life, he has made it possible for me to explore various paths and has been a constant unwavering support. For this, and so much more, I am forever grateful.

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
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<tr>
<td>AFSPA</td>
<td>Armed Forces (Special Powers) Acts</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>A.P</td>
<td>Andhra Pradesh</td>
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<tr>
<td>CRPD</td>
<td>Committee on the Rights of Persons with Disabilities</td>
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<td>DIC</td>
<td>Drop-in Centers</td>
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<td>ECT</td>
<td>Electroconvulsive Therapy</td>
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<td>HC</td>
<td>High-Court</td>
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<tr>
<td>HIC</td>
<td>High Income Countries</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IASP</td>
<td>International Association for Suicide Prevention</td>
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<tr>
<td>IPC</td>
<td>Indian Penal Code</td>
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<tr>
<td>KHPT</td>
<td>Karnataka Health Promotion Trust</td>
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<tr>
<td>LAMIC</td>
<td>Low and Middle Income Countries</td>
</tr>
<tr>
<td>LCI</td>
<td>Law Commission of India</td>
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<tr>
<td>LCIR</td>
<td>Law Commission of India Report</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual, and Transgender</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender, and Queer</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>MGMH</td>
<td>Movement for Global Mental Health</td>
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<td>MHC</td>
<td>Mental Health Care</td>
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<td>mhGAP</td>
<td>Mental Health Gap Action Programme</td>
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<td>MPA</td>
<td>Medico Pastoral Association</td>
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<tr>
<td>MSJE</td>
<td>Ministry of Social Justice and Empowerment</td>
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<td>MSM</td>
<td>Men who have sex with men</td>
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<td>NALSA</td>
<td>National Legal Services Authority</td>
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<tr>
<td>NCRB</td>
<td>National Crime Records Bureau</td>
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<tr>
<td>NCWB</td>
<td>NIMHANS Center for Well Being</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NIMHANS</td>
<td>National Institute of Mental Health &amp; Neuro Sciences</td>
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<tr>
<td>NMHP</td>
<td>National Mental Health Programme</td>
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<tr>
<td>OBC</td>
<td>Other Backward Class</td>
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<tr>
<td>PIL</td>
<td>Public Interest Litigation</td>
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<tr>
<td>PUCL</td>
<td>People’s Union for Civil Liberties</td>
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<tr>
<td>PUCL-K</td>
<td>People’s Union For Civil Liberties-Karnataka</td>
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<tr>
<td>PWD</td>
<td>Person with Disabilities</td>
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<tr>
<td>RPD</td>
<td>Rights of Persons with Disabilities</td>
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<tr>
<td>RSS</td>
<td>Rashtriya Swayamsevak Sangh</td>
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<td>SC</td>
<td>Scheduled Castes</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SC</td>
<td>Supreme Court</td>
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<tr>
<td>SCRB</td>
<td>State Crime Records Bureau</td>
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<td>ST</td>
<td>Scheduled Tribes</td>
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<tr>
<td>SUPRE</td>
<td>Suicide Prevention</td>
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<tr>
<td>TG</td>
<td>Transgender</td>
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<tr>
<td>UNCRPD</td>
<td>United Nation’s Convention on the Rights of Persons with Disabilities</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UoI</td>
<td>Union of India</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Introduction
Regulation of Suicide in India

“[t]he meanings of suicide itself are so protean across time and space that it is not so clear that there is one thing, suicide”
- Ian Hacking (2008, p. 1)

“The value of a man was reduced to his immediate identity and nearest possibility. To a vote. To a number. To a thing. Never was a man treated as a mind. As a glorious thing made up of star dust. In every field, in studies, in streets, in politics, and in dying and living”
- Rohith Vemula

Anyone familiar with India will be aware that various “kinds” of suicides are frequently visible in the mainstream news and social media. Women, farmers, students (specifically Dalit students in higher educational institutions), suicide bombers, those who self-immolate, those who go on hunger strikes and religion-sanctioned suicides are a few examples of the kinds of suicide that circulate in popular media today. While each of these allegedly separate kinds of suicides have their own set of interventions, discourses and politics, there are also some efforts undertaken to address all suicides through a unified lens. In this dissertation, I study historical and contemporary discourses that have resulted in the concurrent presence of heterogeneous efforts to govern suicide within legal and medical realms.

Section 309 of the Indian Penal Code (IPC) states: “Whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both.” The code defines suicide as the “intentional ending of life” and provides three tests that a death must meet to be classified as a suicide: (a) it should be an un-natural death, (b) the desire to die should

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1 This quote is taken from the letter Dalit student and activist, Rohith Vemula wrote before he committed suicide in January 2016 in University of Hyderabad, Hyderabad, India.
originating within him/herself, and (c) there should be a reason for ending one’s life. Attempting suicide has been in the Penal Code since the British colonizers introduced it, but in the past three decades there have been legal debates regarding decriminalizing suicide attempts, which might soon occur. Simultaneously, there is an increased prevalence of psychological and psychiatric/mental illness discourse surrounding suicide and suicide prevention in India. During the early days of my research, I was interested in questions such as: Is there a shift in larger discourse regarding suicide? Has suicide been transformed from a criminal issue to a psychiatric/medical concern? I began my fieldwork in Bangalore, India, with these questions in mind. My aim at the time was to study the assemblage of legal mechanisms, rules and suicide prevention activities and institutions in Bangalore.

In the past decade, Bangalore was often reported as a “suicide capital of India” with a suicide “epidemic” in the city (Nanjappa, 2008; Mehta, 2011; Joy, 2014). Several suicide prevention NGOs were established and there was an increase in mental health professionals such as psychologists and psychiatrists who were talking more about suicide and suicide prevention in the city. While gaining information on the assemblage of legal and medical suicide prevention institutions in Bangalore, I stumbled upon a kind of suicide that did not have a dominant legal, psychological, psychiatric or public health institutional presence – hijra suicides. In a city where suicide was a topic of everyday conversations, hijra suicides were invisible in mainstream public

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2 Several countries in the past criminalized suicide acts and attempts to commit suicide. Hungary, Singapore, Ghana, Kenya, South Sudan, Tanzania, Uganda, Bangladesh, amongst others, have laws that criminalize attempt to commit suicide. Often these laws came into being with British colonial rule and continued to be adopted by the postcolonial states. Several European and North American countries have decriminalized suicide attempts but debates continue about assisted suicides.

3 The Mental Health Care (MHC) Bill 2016 was passed in the Rajya Sabha on August 08th, 2016. This Bill frames all suicide attempts as a mental health concern. It has been reported in the Indian media that since the passing of MHC Bill 2016, Section 309 IPC is decriminalized. But legally, Section 309 continues to exist in the Penal Code until it is revised. I trace the debates around the MHC Bill in Chapter Two.

4 Hijra is a particular gender/sexual identity in South Asia. I will explain hijras in more detail later in the Introduction.
discourse. Until I began work on hijra suicides, I was under the assumption that virtually all kinds of suicides in India were now being framed at least partially within a psychiatric discourse. And I thought that if there were an absence of psychiatric discourse, there would be the presence of criminal law, as is the case of individuals undertaking hunger strike as a protest and being arrested under Section 309. In the context of hijra suicides, I found an absence of both legal/criminal discourse as well as psychiatric/mental illness discourses. It was these absences that persuaded me to research hijra suicides in Bangalore.

As part of this dissertation, I study suicide in criminal law debates as well in the more recent mental health care laws. In most studies on suicide in India, Section 309 IPC becomes only the background. Unlike other studies on suicide in India, I conduct a detailed study of judicial decisions and legal reform initiatives to analyze the discourses that circulate in the debate to criminalize or decriminalize suicide. Suicide within the law has its own complex story to tell. It reflects the existing discourses that circulate within the larger society. It also demonstrates the complexity and heterogeneity of legal regulation of suicide.

To understand the complexity of social and legal governance of suicide, I bring together a range of literatures. This dissertation works broadly at the intersection of four different, sometimes overlapping, sets of scholarship: (i) Foucault’s theory of power and Foucauldian works on regulation of death, particularly suicide, as well as scholarship on governmentality in India; (ii) anthropological literature on health, life, and death, including ethnographic works on suicide in South Asia, ethnographies of the public health care system and indigenous healing practices; (iii) Indian colonial history of regulation of self-inflicted death; and (iv) scholarship on queer politics and affect. In the rest of the Introduction I provide an overview of each of these

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5 See Chapter One for a discussion on the arrest of Irom Sharmila under Section 309 IPC for undertaking hunger strike as a protest against the presence of the Indian army in the state of Manipur.
bodies of scholarship and its significance to my work. Following this, I explain my research process and the key themes and chapters that make this dissertation.

I begin with a brief summary of Foucault’s conceptualization of power, with a particular focus on sovereignty, discipline, governmentality, and biopolitics (Foucault, 1978b, 2003a, 2007; Hacking, 1990; Rose, 2001; Curtis, 2002; Rabinow & Rose, 2006; Valverde, 2016). There are multiple regulatory systems through which suicide is understood in the Indian context. Hence, Foucauldian notions of power provide a framework to understand the heterogeneity in regulation of suicide. I also trace key Foucauldian works that have studied the history of suicide in the West (Bayatrizi, 2008; Marsh, 2010). Importantly, these works have traced the emergence of suicide as a biopolitical entity in the West. There is little scholarship on regulation of suicide in India and so these works, although specific to the West, provide a history of modern forms of knowledge on suicide, especially statistics. Although, in this project I do not study statistical knowledge on suicide, I do study other knowledges that influence the meaning and thereby regulation of suicide in India. Understanding statistical knowledge on suicide helps to contrast other forms of knowledges such as religious doctrine or autobiographies on suicide that I analyze in my work.

As I mentioned earlier, the regulation of suicide has not gained scholarly attention in India thus far; however, other questions regarding power/knowledge have been analyzed extensively both historically and in contemporary contexts. In the section titled ‘Governmentality in the East’, I briefly study the historical works that have traced the emergence of governmentality during British colonial rule in India (Scott, 1995; Cohn, 1996; Appadurai, 1996; Legg, 2007; Kalpagam, 2000b; Chatterjee, 2016). In addition, I also study the scholarship on ‘governmentality from below’, which have contributed to governmentality studies, by tracing efforts undertaken by grassroots organization which use techniques of governmentality.
To further illustrate this idea, I provide a brief introduction to farmer suicides in India (Sainath, 2009, 2014, 2015; Nagaraj, 2008; Vasavi, 2012; Münster, 2015). Farmer suicides are one of the most prominent kind of suicide in India, and also a case of governmentality from below (Sainath, 2009, 2014, 2015; Nagaraj, 2008). The scholarship on farmer suicide demonstrates the possibilities and limitations of governmentality, specifically statistical knowledge (Povinelli, 2011; Münster, 2015). Furthermore, understanding agrarian suicides also helps get a deeper understanding of kinds of suicides that have not emerged as a political or social category, such as hijra suicides. However, my focus in this dissertation is not on farmer suicides, rather I study regulation of suicide within criminal law debates and mental health care reform efforts. In addition, as I mentioned earlier I study hijra suicides to understand in some detail how certain kinds of suicides do not have a prominent place within legal or medical discourses on suicide prevention.

1 Foucault on Power

My work on the governance of suicide in India is influenced by Michel Foucault’s conceptualization of power/knowledge. In my research on regulation of suicide in India I found that it is often difficult to trace clear-cut shifts from one form of power to another, and often Foucaudian studies have tended to trace a linear trajectory of one mode of regulation to another. In this section I will provide a brief overview of Foucault’s work on power/knowledge, particularly sovereignty, discipline, governmentality and biopolitics. In addition, I will also contextualize Foucauldian scholarship on power/knowledge regarding death, particularly suicide in Western history.
Foucault paid significant attention to relations of power, knowledge and the subject in his work. Importantly, he did not distinguish between power AND knowledge. For Foucault, knowledge is an exercise of power and power always a function of knowledge. Any systematic, rational knowledge project wields a certain power in itself, even before being put to use. He used the term power/knowledge to signify a “systematic collection of discourses and practices that share a particular logic, with the overall premise being that any form of power that has some intellectual justification…. is inextricable from a particular type of knowledge” (Valverde, 2016 p. 21-22). In my work on governance of suicide I trace a variety of knowledges that circulate within the legal and public health discourses on suicide in India. I analyze in some detail the relations of power/knowledge with respect to the heterogeneity of discourse on suicide within both legal and public health realms. In this work, my aim is to understand what kind of power is being exercised and what techniques are used to regulate suicide in contemporary India. Before I explain my work in more detail, I would like to briefly draw out the three modes of power/knowledge that are crucial to Foucault’s ideas: sovereignty, discipline and governmentality.

1.1 Sovereignty, Discipline and Governmentality

Foucault uses the concept of sovereignty to describe a mode of power that is top-down and static. Within this form of power, the sovereign is not interested in reforming the subjects; the focus is primarily on maintaining the authority of the ruler. Sovereignty exists by prohibiting certain acts and punishing, or taking power away from subjects who break rules or threatens the authority of the sovereign (Valverde, 2016).

Discipline, on the other hand, is a form of power that is not concerned with preserving the top-down authority. Instead, the idea is to reform people, control and maximize spaces and
Disciplinary power is focused on what one must do herself rather than an imposition of power from external sources. In *Discipline and Punish*, Foucault showed how sovereign violence was replaced with institutionalized supervision for the criminal. Various forms of supervisions such as time-tables and divisions of space, were incorporated to reform the inmates of the prison (Foucault, 1977). Disciplinary power requires knowledge of individuals who are measured and ‘normalized’ through different mechanisms, and these mechanisms “differentiate people from one another rather than treating everyone in a territory as abstractly equal subjects of an earthly or spiritual kingdom as sovereigns do” (Valverde, 2016, p. 23-24). Since seventeenth century in Europe, such disciplinary techniques were used in society with the hope of creating economically efficient and politically compliant subjects. Despite the differences in the nature of power between sovereignty and discipline, the two are not necessarily incompatible. The state could use disciplinary mechanisms to meet the objective of sovereign power. Foucault has demonstrated the coming together of disciplinary and sovereign power in the context of Nazi genocide (2003a, p. 260).

Governmentality refers to ways of governing that focus on managing risks, maximizing resources and planning for the future (Valverde, 2016, p. 24). Unlike sovereign power, which is predominantly concerned with maintaining authority, governmentality is focused on managing risks for the future. Thus risk assessment emerges as an important form of knowledge within governmentality. Unlike disciplinary forms of interventions, where the aim is to create particular forms of subjects by reforming individuals, governmentality manages risks at the level of population via knowledges such as statistics, probability calculations, and aggregates.

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6 I return to Foucault on Nazi genocide in the section on biopolitics.
7 I return to the topic of governmentality and statistical knowledge production specifically in the Indian context in the next section titled ‘Governmentality in the East’
According to Foucault, governmentality refers to three things: (a) an ensemble of institutions, procedures, calculations and tactics that allow the exercise of a form of power whose object of regulation is the ‘population’; the major form of knowledge is political economy, and apparatuses of security are an essential technical instrument. (b) Governmentality in the West, has become pre-eminent over other forms of power such as sovereignty and discipline; and (c) governmentality is a result of a process of transformation from a medieval state of justice to the modern administrative state (2007, p. 108-109). The emergence of ‘economy’ and ‘population’ were key ideas within governmentality. The rise of capitalism and liberal political economy went hand in hand with the emergence of “the population”.

Population does not simply refer to people, but rather to the phenomenon that emerged with statistical calculations. Statistics provided a vision of “the population” as a concrete and palpable reality in the form of a tabular representation. These populations are regulated through mundane institutional practices such as registering and recording, all of which attach individuals to new kinds of administrative and “epistemological spaces, turning them into ‘cases’, elements in series, that could be rank-ordered and subjected to practices of ‘optimization’” (Curtis, 2002). For Foucault, population is only visible at an aggregate level, an entity that is “more than (and different from) the sum of the subjects of the sovereign” (Valverde, 2016). In The Taming of Chance, Ian Hacking builds on Foucault’s notion of population by tracing the emergence of statistical and probabilistic ways of thinking in the West. Hacking explains that through the “avalanche of numbers” regarding mortality, crime, madness, disease, and suicide collected in nineteenth century France, concepts of ‘normality’, ‘social class’ as well as the ‘population’ were created (1990). I return to the question of statistics as a technique of governmentality in the next section on governmentality during British colonial rule and in contemporary India.
Foucault explains that by the middle of the eighteenth century in Europe, the purpose of rule was not just the defence and expansion of sovereign’s wealth and territory, but, rather, the provision of security. By security or governmentality, he refers to an all-encompassing centripetal form of power, which emerged alongside the othering or centrifugal disciplinary and sovereign forms of power. Governmentality, Sovereignty, and Discipline form a triad through which, Foucault argues, modern forms of power are exercised. But Valverde warns us that these are by no means the exhaustive list on power/knowledge that Foucault provided (2016). In the next section I give a brief overview of another mode of power Foucault studied—biopolitics, which is specifically relevant for this study of suicide in India because I trace how some kinds of suicides are addressed through biopolitical interventions whereas certain other kinds remain outside established forms of knowledge/power.

1.2 Biopolitics

Biopolitics is a form of power that is exercised over populations without necessarily aiming to reform individuals or control deviants. In *The History of Sexuality*, Foucault argues that modern Western power shifted from the right of sovereign power over death to a *biopolitical* exercise of power over life. He explains that while sovereignty was the right to *take* life or let *live*, biopolitics is the power to *make* life and *let* die (Foucault, 1978b). Foucault explains that in the eighteenth and nineteenth century, Western civilization discovered life as a subject of control and intervention (1978b, p. 142-143). With this shift to studying life, there was a shift towards managing and protecting life rather than ruling through coercive mechanisms. By the end of eighteenth century, Foucault argues that states used biopolitical tools over populations to address illness conditions. This was unlike epidemics which killed large numbers of people in a short duration of time. Through biopolitical management, there was a gradual loss of life (Foucault,
Life was regulated through knowledges such as statistical estimates within medicine, epidemiology, and insurance. Within Foucault’s conception of biopolitics, life was actively regulated but portions of the population were allowed to die.

Studying contemporary biopolitical management of life in the West, Nikolas Rose explains the evolution of biopolitics as that which was “inextricably bound up with the rise of life sciences, the human sciences, clinical medicine” (Rose, 2001, p. 1). These disciplines were engaged in systemic data collection on various aspects of society, especially life itself. In their discussion of “biopower today” Rabinow and Rose argue that biopolitics does not involve the “wholesale management of populations”; the logic is different. Biopolitics today “attempts to develop and maximize targets for pharmaceutical markets and other health care interventions which entail enrolling individuals, patient groups, doctors and political actors in campaigns of disease awareness and treatment in the name of the maximization of quality of life” (2006, p. 211). Once again, as Valverde cautions, it is important to note that biopolitics is not solely exercised within liberal governmentality as it is often understood in Foucauldian works. Other non-liberal contexts, such as communist states also engage in biopolitical strategies that impact the population, for example, China’s one child policy or Nazi Germany (Valverde, 2016).

Specifically in the context of Nazi genocide, Foucault has traced the complex connections between sovereign, discipline, and biopolitical forms of power (1978b, 2003a). In Foucault’s argument such occurrences of mass genocide were an exertion of sovereign power to protect the lives of citizens in the population (1978b, 2003a, p. 137). The brutal regimes that inflict holocaust upon their own populations were unlike the wars that were fought on behalf of the sovereign; these were genocides in the name of the population. Postcolonial scholarship has
demonstrated the coexistence of biopolitical power over life and necropolitical power over death (Mbembe, 2003; Haritaworn, Kuntsman, & Posocco 2014; Berlant, 2007).

Biopolitical power is unlike sovereign or disciplinary power. As mentioned earlier, Foucault draws a contrast between the ancient sovereign right to kill traitors and enemies and the modern state’s developing interest in maximizing life via the health of the populations. The sovereign had the right to take away freedom, even kill any person who it perceived as a threat to the monopoly of its power. Sovereignty is upheld by ensuring that nobody diminishes or steals any of the sovereign’s political power (Valverde, 2016). Post seventeenth century, sovereign power gradually reduced and modern states developed a form of political power that circulates at the level of population. For example, in most modern states, epidemiological data is collected with an aim of lowering the population’s risk or increasing the population’s health. Such an approach is qualitatively different from sovereign power, which is coercive on the individual. More significantly, it is different from disciplinary power, which is largely to reform or psychologize individuals.

Unlike disciplinary power, biopolitical projects are not necessarily aimed at the individual. Valverde explains that even if biopolitical measures or interventions have to be taken up and implemented by individuals, their target is the whole population or a sub-population. The aim is not necessarily to preserve sovereignty, but to modify and change the characteristics of ‘the population’ (Valverde, 2016). Hence, over time, states began to govern their citizens through aggregate data such as birth and death rates, rates regarding specific health and illness conditions, suicides rates etc.

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8 Berlant, (2007) in the conceptualization of slow death demonstrates the concurrent existence of biopower within contemporary capitalism regimes along with sovereign power accumulated by the terror state.
In the context of my research on regulation of suicide in India, I found that certain kinds of suicide are perceived through a biopolitical lens and certain other kinds of suicides do not exist at the scale of population. Notably, farmer suicide in India has emerged as a major “kind” of suicide via the production of statistical knowledge on agrarian suicide. This category of suicide is often addressed at the level of the sub-population of farmers. Within leftist political economy discourse around farmer suicides (which is one of the most prominent discourses on farmer suicide) the individual farmer is not as significant for suicide prevention intervention as is the farming population. However, as I discuss farmer suicides later in the Introduction and in Chapter Two, there is an emerging impetus for individualized, disciplinary form of power to prevent agrarian suicides, namely public mental health.

The prominent approach to prevent farmer suicide is through biopolitical interventions. But certain other types of suicides, such as hijra suicides, have not emerged as a separate category either through biopolitical lens or other established forms of knowledge/power. This results in substantial differences in the nature of regulation of each of these kinds of suicide. This study not only demonstrates the impact of biopolitical interventions on suicide prevention but also shows us that while some kinds of suicides are heavily regulated, other kinds of suicide remain outside the purview of institutions such as law and medicine. The fact that I highlight a kind of suicide that has not emerged as a social fact is not the point of this work. My aim is to demonstrate that even in contexts where a kind of suicide has not emerged as a separate social category for biopolitical interventions, people continue to express their experiences of suicide at the margins of biopolitics.

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9 I return to the topic of statistical knowledge production on suicide later in the Introduction.
10 I study hijra suicides in greater detail in Chapter Three and Four.
1.3 Suicide as a Biopolitical “Problem” in the West

Foucault’s work on biopolitics resulted in extensive scholarship on relations of knowledge and power that aim at the management of life and consequently death (Rose, 2001; Bayatrizi, 2008; Marsh, 2010). In *Suicide: Foucault, History and Truth*, Ian Marsh conducts a Foucauldian study of power/knowledge in relation to suicide in the West (2010). In this work, Marsh chronicles the process through which suicide is pathologized via ‘psy’ disciplines, psychiatry in particular. He is interested in understanding the “regimes of truth” regarding the “compulsory ontology of pathology in relation to suicide that has come to be so dominant” in the West (Marsh, 2010, p. 5). Marsh explains how in nineteenth century Europe suicide came to be exclusively explained by pathological factors, using medical terms such as “pathological anatomy” followed by the idea that suicide was “arising from an internal impulse” and finally was a “symptom of degeneracy” (2010, p. 116). A fundamental principle instigating the pathological understanding of suicide, Marsh argues, was the notion that suicide was madness. He explains that in the twentieth century, this focus on the suicide’s link to mental illness expanded and resulted in the psychiatrization of suicide. Prior existing religious, legal, moral explanation or condemnation of the act of suicide were marginalized and medical confinement and treatment was provided to those who were at risk of suicide. Marsh explains that although moral regimes of truth were marginalized, and the psy discourse expanded, medical men did not completely reject moralistic views on suicide. In addition, he explains that as medical/psy powers replaced legal, religious powers in relation to suicide, the medical professionals were saddled with new responsibilities for appropriately diagnosing the symptoms and preventing/confining and treating the suicidal person. In order to circumvent such a responsibility, the day-to-day responsibilities of suicide prevention was passed on to the asylum attendants or lower level staff (Marsh, 2010, p. 150-155).
In my study of regulation of suicide, I found that unlike Marsh’s narrative of compulsorily pathologized or psychiatrized narrative of suicide in the West, in India, there are several parallel discourses on suicide, for example, suicide as: 1) a result of political economy; 2) as part of religious rituals that permit certain forms of self-killing, 3) as a form of protest against the state; as well as 4) as a function of psychological and psychiatric disorders. In the criminal law debates that I analyze in Chapter One, we see the ongoing circulation of all these discourses, sometimes simultaneously and sometimes with one discourse obscuring the others. A purely psychiatrized discourse on suicide does not exist in the Indian context, although as I show in Chapter Two, a social momentum to psy/medicalize suicide does exist and is growing.

In another important work, *Life Sentences: The Modern Ordering of Mortality*, Zohrah Bayatrizi studies the history of mortality in the West. She argues that Foucault’s study of biopolitical discourses was excessively focused on life, thereby leaving the issue of death largely unanalyzed (2008, p. 15). In this work, Bayatrizi responds to Foucault’s claim in *The History of Sexuality, Volume One*, that with the rise of biopolitical management of populations, there was a gradual increase in secrecy over death, a decrease in death penalties and a decline in death rituals (2008). She argues that the rise of biopolitics did not result in increased secrecy over death: instead, it resulted in an increased interest in “how, why, and when people die” (Bayatrizi, 2008, p. 15). Although Foucault was primarily interested in power to “make live”, he did point to the fact that in the nineteenth century, suicide shifted away from being perceived as a crime, since prior to this period, the sovereign alone held the right over death of the subjects and the act of suicide was read as the subject usurping sovereign power. He explains that suicide was one of the first acts to enter sociological analysis (Durkheim, 1897). In such a shift, suicide was acknowledged as an individual and private right to die (Foucault, 1978b, p. 138-139). Bayatrizi
traces how death emerged as a sociological concern through statistics and thus produced knowledge at the scale of population on questions of how, why and when people die.

Specifically, Bayatrizi analyzed the statistical knowledge produced by John Graunt and William Petty in the seventeenth century to argue that unlike other studies on history of population via statistical knowledge, Graunt moves “beyond simple probabilistic calculations of the chances of death for each age group and instead, presents premature death as a preventable socioeconomic and political issue” (Bayatrizi, 2008, p. 56). Graunt and Petty explain that the prosperity of the nation depends on the size of the population, and its growth is maximized not so much by care for the newborn, as by the minimization of ‘premature death’ (Bayatrizi, 2008, p. 50-88). Within this actuarial knowledge, death was no longer an event that had any positive social significance. Rather it emerged as a negative, a social fact to which other information such as age, sex, social class etc. could be added to better manage the risks to maintain the wellbeing of the population. Bayatrizi demonstrates that as death emerged as a risk through statistical knowledge, it resulted in public health management of causes of death. This trend continued through seventeenth century onwards to contemporary public health management of mortality in the West.

Bayatrizi studies the emergence of management of suicide in the modern history of the West and explains that until the nineteenth century suicide was condemned, but it was understood as something that could be prevented (2008, p. 92). As suicide became a statistical object of study, it emerged as a biopolitical, sociological, and consequently public health entity that was required to be prevented. Significantly, she explains that the prior moral views on suicide, which led to the condemnation of the act of self-inflicted deaths, continued to exist alongside statistical knowledge on suicide in seventeenth, eighteenth, and nineteenth century (Bayatrizi, 2008, p. 92-93). The statistical knowledge on suicide, posed a challenge to
statisticians during nineteenth century, since unlike other causes of death that were avoidable, suicide was perceived as a result of individual’s free will (Bayatrizi, 2008, p. 93). The medical, sociological, and legal discourses that emerged at the time, were preoccupied with overcoming this free will with respect to suicide. Eventually, suicide moved from the category of free will and morality to a social and medical problem that resulted from external forces that were agreeable to control, management, and aggregated prevention (Bayatrizi, 2008, p. 93). This resulted in the modern suicidal subject being stripped of any rationality, symbolic or subjective meaning or intention with regards to the self-inflicted death. Post nineteenth century, Bayatrizi explains: “The individual may have gained the right to kill himself, but in the process, he lost his status of author of his own acts. If he killed himself, he was simply too incompetent to know what he was doing” (2008, p. 97). Medical discourse played an important part in conceiving suicide as a ‘problem’ rather than a sin or an immoral act (Bayatrizi, 2008, p. 103).

In my work on regulation of suicide in India, I demonstrate that unlike in the modern European history of suicide, which shifted from a sovereign power over the crime of self-inflicted death or a sin to a sociological, public health entity where the person lost their free will and thus emerged as medical subject, the suicidal subject in India exists (sometimes simultaneously) within all these multiple realms. In the legal and public health discussions on suicide in India, the suicidal subject is sometimes perceived as a threat to sovereign power, at other times a psychiatric subject with no free will who requires medical treatment. Further in other situations, the suicidal subject has the right to death through religious doctrine. And some kinds of suicides have emerged as a biopolitical entity, as in the case of farmer suicides. Furthermore, certain other kinds of suicide (including hijra suicides) have remained at the edges of governmentality and outside biopolitical forms of power. Even solely within criminal law debates, one sees that the suicidal subject is not always a criminal who has lost their right over
self-inflicted death. Instead, discussions within the criminal legal arena demonstrate the circulation of multiple discourses around suicide. For example, within the criminal legal arena, one sees questions on sovereign right over self-inflicted deaths such as hunger strikes, religious approval or disapproval of certain forms of self-killings etc. In the Indian context, all self-caused deaths or attempts at self-killing are not perceived as negative. This is most evident in the legal discussion on Jain ritual of self-killing—Santhara—that is understood by certain practitioners of Jainsim as way of cleansing oneself before death. To give another example, in certain modes of self-inflicted deaths, such as hunger strike or self-immolations, self killing is not perceived as negative by all; it is a show of resilience, of strength against a much stronger entity – the state.

The regulation of suicide in India does not follow the path from suicide as a ‘sin’ to suicide as a symptom of mental illness. In fact, there is no single meaning of suicide. Various forms of self-caused deaths are understood through a myriad of discourses including mental illness. To contextualize the presence and implications of these heterogeneous rationalities through which suicide is regulated in contemporary Indian context, I turn now to the scholarship on governmentality in India.

2 Governmentality in the East

Contemporary national statistics on suicide in India are still primarily collected as part of crime statistics. Since large-scale epidemiological knowledge on suicide is limited in India, most available information draws from the National Crime Records Bureau (NCRB), New Delhi, or the State Crime Records Bureaux (SCRB), which are situated in state capitals. Largely based on these crime statistics, contemporary suicides events are sometimes read as epidemics in parts of the country. Analyzing statistical knowledge on suicide in India, anthropologist, Jocelyn Lim
Chua states “The enumeration and classifiability of suicide by proximate cause and other demographic markers were crucial to the ontological sleight of hand that helped to transform suicide from social abstraction to controllable behavioral reality” (Chua, 2012, p. 209).

Suicide is being understood (at least partially) at the level of population. In this section, I will provide a brief history of the emergence of ‘population’ in colonial India, which will contextualize statistical knowledge production on suicide in contemporary India. I begin by tracing a brief overview of colonial governmentality. Following that, I focus on statistical knowledge, through which the population was/is constructed in the Indian colonial and postcolonial contexts. My aim in tracing governmental rationalities during British rule in India is not to privilege the colonial past in my analysis; instead, it is to better understand the history of the present, specifically with regards to regulation of self-inflicted deaths in contemporary India. With this aim in mind, I provide a brief introduction to the use of statistics as a tool of governmental rationality in the contemporary political economy movement concerning agrarian suicides. I demonstrate how farmer suicide in India has emerged as a category for regulation via statistical knowledge, demanded by the political economy activists, thereby emerging as a case of governmentality from below.

### 2.1 Colonial Governmentality

In the previous section, I have traced Foucault’s concepts of knowledge/power and Foucauldian works that are evidently genealogies of suicide in European contexts. These genealogies have generally ignored European history of colonialism. Foucault himself has often been criticized for not engaging with colonialism in his analysis of modern Europe; but various other scholars have studied Foucauldian conceptions of power/knowledge in colonial and postcolonial contexts
In this section I will focus on governmentality scholarship in the Indian historical context. Let me begin by providing a brief overview of colonial governmentality.

David Scott explains colonial governmentality as the governmental rationality of colonial power that redefines and transforms colonial society through the destruction and reconstruction of pre-colonial subjects in order to exert governing effects on colonial conduct (1995, p. 204–205). Scott argued for colonial governmentality as a lens to move post-colonial analysis beyond textual representations of authority and the institutional mechanisms of colonial control (1995). He did not deny the importance of these approaches for understanding how the colonized were included and excluded. However, he argued that it was necessary to study the ways in which colonial power was organized, thereby suggesting colonial governmentality as a framework for studying colonial and consequently post-colonial conditions of governance.  

An important governmental technique that emerged with European colonialism in India was recording and regulating various attributes of the population. Colonial governmentality required as its target the indigenous population, which had to be enumerated and classified according to a range of properties, thereby transforming subjects into members of sub-populations. In a study of origin of colonial census in India, Bernard Cohn argued that the role of modern knowledge production about the population was to exert colonial authority, not

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11 See Loomba (1998) Colonialism/Postcolonialism on the difference between Post-colonial and postcolonial. The hyphenated term ‘post-colonialism’ refers to the idea that the colonial encounter has ended and what exists today in those spaces are the ‘post-colonies’. The term ‘postcolonial’, refers to the idea that colonialism has not ended as one might argue but carries on to this day in various different forms.

12 For other works on colonial governmentality in India see Prakash, (1999); Legg, (2007); Chatterjee, (2016).

13 In my work I focus on the making of population, but there is also extensive scholarship on the emergence of ‘the economy’ with colonial encounter. For more works on emergence of ‘economy’ during colonial governmentality see Mitchell, (2002). Specific to the Indian context see, Birla, (2009). Birla explains that economy as practice of governing existed even prior to British rule in the Indian context, while economy as a science emerged with colonial rule, post nineteenth century (2009). See also, Kalpagam, (2000b).
through force but through “officializing” procedures that established and extended their capacity to govern (Cohn, 1996, p. 57-75). The civilizing mission of the colonial powers was coupled with and performed through various “investigative modalities” (Cohn, 1996, p. 57-75). These modalities defined what was to be relevant knowledge, established procedures by which knowledge was gathered, and paved the way for transforming knowledge into “usable forms such as published reports, statistical returns, histories, gazetteers, legal codes and encyclopedias” (Cohn, 1996, p. 5). These investigative modalities created the framework for asserting an enlightened form of governance, based on defining, classifying, and registering space; recording transactions and tracing the circulation of property and goods; counting and classifying populations through the registrar of birth, marriage, and death; and licensing some activities as legitimate and suppressing others as immoral or unlawful. The documentation involved, normalized a vast amount of information as the basis of governance. The capacity to govern depended to a great extent on “the reports and investigations of collisions, the compilation, storage, and publication of statistical data on finance, trade, health, demography, crime, education, transportation, agriculture, and industry” (Cohn, 1996, p. 3). Cohn argued that the census collected in colonial India was not an exercise in passively collecting information; it created categories and through these categories, influenced identities. Although Cohn was not building on the Foucauldian governmentality thesis, he was focused on relations of power and knowledge in colonial India.

Specifically, statistical knowledge produced by British colonial administration played an important role in classifying and enumerating people in order to create populations (Appadurai, 1996; Cohn, 1996; Kalpagam, 2000a). Arjun Appadurai argues that the British administration collected vast amounts of numbers regarding land, fields, crops, forests, castes, tribes and so forth, and used them to charge agrarian taxes, resolve land disputes, and decide on other policy
decisions. He explains that the statistics were generated in vast amounts that exceeded any unified bureaucratic purpose. An important point Appadurai makes is that the generation of numbers became an important “part of the illusion of bureaucratic control and a key to colonial imaginary in which countable abstractions, of people and resources at every imaginable level and for every conceivable purpose, created the sense of a controllable indigenous reality” (1996, p. 117).

Pointing to the qualitative difference in enumeration and classification in the rule prior to British colonization, Partha Chatterjee explains that the British put in place a system of surveillance that was continuous and permanent, which was unlike the pre-existing system of governance, where surveillance was intermittent and sometimes only emerged as a response to social calamity. It did not have a long continuous institutional memory (Chatterjee, 2016).

Similarly, Appadurai also describes the Mughal systems of enumeration: “Enumeration of various things was certainly part of the Mughal state imaginary as was the acknowledgment of group identities, but not the enumeration of group identities” (Appadurai, 1996 p.129). Enumeration of various things was occurring in India prior to the British colonial encounter. But the quantifying and the consequent making of the populations seem to be a product of colonization.

2.2 Governmentality from Below

Governmentality studies of the contemporary Indian context have importantly shown that the knowledge formed through governmental technologies is at times appropriated ‘by the governed’ (Legg, 2007; Appadurai, 2002; Kalpagam, 2000a, 2000b). Appadurai studies a group of

14 Appadurai (1996) like other scholars critiquing post-colonial literature on caste identities, explains that some of the classifications incorporated in British generated statistics were incorrect and there were several technical errors in the data collected. On categorization of caste in colonial statistics see Rawat (2016).
grassroots NGOs—Alliance—concerned with slums in Mumbai, India. These grassroots organizations produced knowledge about themselves through self-surveys and self-enumeration. The knowledge they produce is used to hold the state accountable and gain policy changes from the state. This form of production of knowledge, Appadurai terms as ‘governmentality from below’ (2002). Such an impetus for governmentality from below is also evident with regards to farmer suicide in India. In this section I provide a brief introduction to agrarian suicides and a critique of statistical knowledge on farmer suicides in India. Understanding the emergence and politics of agrarian suicides in India demonstrates the significance of statistical knowledge on conceptualizing and responding to one important kind of suicide and, more importantly, it helps to comprehend other types of suicide which have not yet emerged as a separate category.

Farmer suicides came to the fore in the Indian public sphere in 1997 when reports were published regarding farmers committing suicide in the Vidarbha region of Maharashtra. Following this, several similar reports were published about districts such as Warangal in the then Andhra Pradesh, Bidar in Karnataka, Sangrur and Mansa in Punjab, and Idukki and Wayanad in Kerala. Between the years 2000-2007, there were three hundred and seventy one suicides by agriculturalists in the plantation regions in Kerala and between 1997 and 2008 the state of Maharashtra alone recorded a total of 41,404 suicides by agriculturalists (Vasavi, 2012).

These large numbers of suicides were read as a political failure at both global and national levels. There were critiques of policies such as the introduction of multinational agro-business corporations’ genetically modified (GM) seeds (especially BT cotton). The impact of neoliberal policies like the integration of Indian agriculture with world markets also received severe criticism (Shiva & Jafri, 1998; Patnaik, 2006). Some scholarship on cotton cultivation

15 BT Cotton is a genetically modified cotton variety that produces an insecticide to bollworm. BT cotton was produced by the corporate giant Monsanto.
highlighted the historical as well as contemporary factors associated with cotton cultivation leading to these suicides (Prashad, 1999; Parthasarathy & Shameem, 1998). Speaking against global capitalist agendas, activists also raised a voice against the high cost of Green Revolution initiatives.\(^\text{16}\) Arguing specifically against the state’s apathy towards the negative effects of agro business, some scholars focused on indebtedness, unemployment, and loss of agricultural produce due to inadequate state policies to support the use of appropriate technology, institutions and investments (Dev, 2004; Sarma, 2004). Researchers have pointed out that the government has blamed farm related suicides on weather conditions rather than on increased costs of agricultural production, which demonstrates the government’s indifference to agrarian suicides (Mohanty & Shroff, 2004). Other scholars have highlighted political and economic struggles where the state has worked against the farming community or has ignored the growing crisis of farmer suicide (Vasavi, 1999; Sarma, 2004; Assadi, 1998; Revathi, 1998). Overall, in this literature the occurrences of farmer suicide are explained as the failure of the Indian state to protect its agricultural labor.

In the case of farmer suicides in India, the demand for statistical knowledge came from leftist activists who demanded the farmers be included as a separate category within the NCRB suicide statistics, and have since been vigilant about the accuracy of the data presented by NCRB each year (Sainath, 2009, 2014, 2015; Nagaraj, 2008). With respect to farmers, statistical knowledge has played a very significant role in three ways: (a) making farmer suicide a category to fight for better agrarian policies; (b) providing statistical proof of the failure of neoliberal state

\(^\text{16}\) Green Revolution refers to the introduction of mechanization and chemicalisation of agriculture in many developing countries in the 1960s with an aim of achieving food self sufficiency and food security. There have been several critics of this move, with scholars like Vandana Shiva (1991) arguing that the Green Revolution has made small land holders more vulnerable, increased the inequality between small and large farmers and destroyed the local eco systems.
policies and its appalling impact on farmers; and (c) demonstrating the state’s apathy towards its people (Sainath, 2009, 2014, 2015; Nagaraj, 2008; Vasavi, 2012; Münster, 2015).

Speaking about the settler-colonization of Indigenous lands and peoples, Elizabeth Povinelli explains that so much suffering by native communities on colonized lands is “ordinary, chronic, and cruddy, rather than catastrophic, crisis-laden, and sublime” (Povinelli, 2011, p. 3). In such a context, statistics turns uneventful suffering into an event by aggregating suffering in ways that make it visible. Povinelli develops this point to argue that while statistics has the potential for making “events”, it also has the potential to restrict alternative ethical formations (Povinelli, 2011, p.153). Statistics in the case of the leftist farmer suicide activists have transformed the chronic and cruddy instances of farmer suicides into a globally recognized event. The leftist activists’ struggle for statistical knowledge on farm suicide is a manifestation of “governmentality from below” (Appadurai, 2002). During his ethnographic research with the widows of farmers who had committed suicide in Wayanad, Kerala, anthropologist Daniel Münster explains that the widows he spoke to narrate a well-rehearsed narrative of agrarian crisis based on the circulation of statistical discourse on farmer suicides crisis (Münster, 2015, p. 1602-3). Aggregating farmer suicides has enabled it to emerge as a distinct crisis and while this crisis gains attention, it also has the ability to restrict the validity of other discourses and experiences that are part of suicide in those regions. The point I want to highlight is that the efforts at governmentality from below have also resulted in eclipsing other readings of suicide that exist outside governmentality frameworks.

While leftist political economy activists used statistics to make these suicides visible for political purposes, such a statistical visibility has also inspired a different form of regulation – psy/public health. Several state governments have initiated psychiatric and psychological research and therapeutic efforts to address the problem of agrarian suicides. One solution to
farmer suicide provided by proponents of Movement for Global Mental Health is decreasing access to pesticides and increasing access to anti-depressants (Patel, 2007). Within epidemiological studies, most farmers who have small land holdings are considered to be at-risk. In identifying such a population as being at risk, the whole farming population is being subjected to public health suicide prevention strategies. In another context, a minister in the south Indian state of Telangana called upon members of the Indian Psychiatric Society to conduct research on the reasons for farmer suicide in the state (“Conduct a survey”, 2016). In this context, psychosocial and psychiatric public health initiatives on farmer suicides are significant because such a medicalized discourse has the potential to eclipse other (for example political economy) frameworks to understand the problem of agrarian suicide. Both political economy as well as the psy frameworks when used as a sole explanation for the farmer suicide has the ability to restrict a well-rounded understanding of suicide.

These discussions of farmer suicides not only demonstrate the generation of statistical knowledge production as governmentality from below, but also shows the pathologizing potential that exists within such a governmental rationality. This dissertation builds on the pathologizing impetus of farmer suicide discourse to argue that such an effort could potentially ‘depoliticize’ suicide. In addition, this project also builds on Povinelli and Münster’s argument on limits of statistical knowledge, in order to look for ethical possibilities that exist outside governmental rationalities, to understand this in greater depth, I study hijra lives as repositories of knowledge that exist at the fringes of governmentality.\footnote{I return to this point again in more detail later in the Introduction.}

\footnote{I explain this point further in Chapter Two.}
3 Anthropological Scholarship on Health, Life, and Death

Ethnographies of suicide and medical systems in South Asia have delved into a range of concerns that not only relate to questions surrounding multiple meanings of suicide, but also understand suicide within health systems (both modern and indigenous) (Halliburton, 2004; Chua, 2009; Staples, 2012; Münster, 2015; Widger, 2015). Critically analyzing these works helps us to understand the regulation of suicide within psychiatric and psychosocial public health care systems. Suicide prevention within public mental health care in South Asia has received little scholarly attention (Halliburton, 2004). However, there are some ethnographic works that provide a nuanced understanding of the diversity within psychiatric care in India (Jain & Jadav, 2008, 2009; Ecks & Basu, 2009a; Pinto, 2014). Consequently these works have informed my study of psychiatric suicide prevention public health discourse and programs. In addition to anthropological works of public health systems, ethnographies of traditional healing spaces in India also demonstrate the complex relationship between indigenous healing systems and modern psychiatric care (Halliburton, 2004; Davar & Lohokare, 2009; Ranganathan, 2014). I will explain this in some detail in the next two sub-sections.

3.1 Suicide in South Asia: Ethnographic Studies

Even though studies on suicide as public health concern are limited, suicide has been studied extensively in the Indian context. In the recent past, there has been an expansion of anthropological scholarship on suicide in South Asia. These works have made a concerted effort to pose questions regarding the different meanings of suicide (Staples, 2012; Chua, 2009; Münster, 2015; Widger, 2015). While these studies are focused on specific regions, the literature also engages with issues such as the agency of the person who attempted or committed suicide (Broz & Münster, 2015), intent and motivations for suicide (Staples 2012, Broz & Münster,
2015), locally specific meaning of suicide in the context of global political and economic conditions (Staples, 2012; Münster, 2015; Chua, 2014), shame in the context of self-harm (Widger, 2009), and psychiatric pluralism and treatment for suicide (Halliburton, 2004). As Staples and Widger explain, these ethnographies are interested in, “…how suicidal behavior does not begin with the ‘precipitating factor’ and end with the ‘suicidal act,’ but extends deep into individual and collective pasts and futures” (2012, p. 199). These anthropological works study suicide not as a separate category of action, but in relation to experiences and social practices which such an act manifests. I am to an extent, interested in one ‘precipitating factor’—hijra loss of love—resulting in the suicide act, but I position these explanations for the suicide act to understand the wider question regarding the regulation of suicide.

3.2 Anthropology of Health and Healing

Since my aim is to understand the regulation of suicide, I also study mental health care systems that advocate for suicide prevention, especially the expansion of psychiatric and psychosocial suicide prevention discourse in contemporary India. In the recent past, suicide prevention has been advocated both nationally in India as well as transnationally as a public mental health problem requiring large-scale psychosocial and/or psychiatric interventions.

Ethnographic studies of public mental health care in India have shown psychiatric care to be often inconsistent and highly diverse (Jain & Jadav, 2008, 2009; Ecks & Basu, 2009a). Most cities in India are said to have shortage of psychiatrists, but biomedical psychiatric practitioners, who are often unofficial or illegitimate, are readily available. These practitioners include pharmacists, general physicians, and other practitioners who are all willing to treat psychiatric or mental illness conditions (Ecks & Basu, 2009a,b). Psychiatric care in India has relied on biomedical interventions. In a study of psychiatric care in India, Michael Nunley explained the
culture of over-reliance on biomedical interventions for mental illness, arguing that psychiatry in India grew in accordance with allopathic medicine, which had its best success with mass campaigns against infectious epidemic diseases (Nunley, 1996 p. 174). This resulted in Indian psychiatry taking an “epidemic view” of psychiatric pathology, which consequently led to large-scale psychiatric public health interventions. I contextualize psychiatric suicide prevention discourse within this scholarship. There is an overwhelming reliance on psychiatric biomedical treatment for depression, which is then expected to prevent suicide, in contemporary India. I find that in accordance with the history of biomedical treatment for psychiatric condition, suicide prevention strategies are advocating for biomedical interventions.

This advocacy for pharmacological care with regards to suicide prevention emerges from a transnational mental health care discourse propagated by the World Health Organization (WHO) and more recently the Movement for Global Mental Health (MGMH). Psychiatry, (sans suicide prevention as a separate mandate) entered the public health system in India following the WHO’s recommendations in 1970’s. The WHO guidelines on mental health care have been influential in nudging the direction of public mental health care in India (Jain & Jadav, 2008). Similarly, in my study of transnational suicide prevention discourse, I trace the emergence of suicide as a public health concern to the WHO recommendations, which were then adopted in the Indian context. The WHO as well as the MGMH continue to make a concerted effort to frame suicide as a psychiatric and/or psychosocial public health concern in India. However, ethnographic studies have also demonstrated that the WHO and the MGMH guidelines work in a top-down fashion, thereby missing out on nuances of local conditions. In a study on community psychiatry in a North Indian village, Sumeet Jain and Sushrut Jadav find that community psychiatry remain a “top-down” system, where there is little interest in local practices (2008, p. 562).
The WHO and the MGMH mandates need to be seen in relation to indigenous practices of healing. Traditional healing practices for mental health problems have gained anthropological attention in India (Kapur, 1979; Halliburton, 2004; Davar & Lohokare, 2009; Ranganathan, 2014). These ethnographies have studied healing spaces such as Hindu temples and dargas (Muslim shrines) (Ranganathan, 2014; Davar & Lohokare, 2009) as well as indigenous forms of therapy such as Ayurveda (Halliburton, 2004) to understand non-biomedical systems of treatment and Western psychiatric system’s interactions with indigenous practices of therapy. This scholarship can help reach a better understanding of the politics of regulation of suicide within transnational public mental health discourse and its interactions with indigenous and traditional practices of healing.

3.3 On Good/Bad and Natural/Unnatural Death

Although suicide prevention within medical discourse is an important part of my study, it is not the only focus. The key aim of this project has been to demonstrate the multiplicity of directions, meanings, and discourses that contribute to the regulation(s) of suicide in India. To understand this in greater detail, I turned to ethnographic works on death.

This is relevant for legal regulation because the High court and Supreme Court repeatedly try to differentiate between notions of natural/unnatural or good/bad deaths. In *Twice Death*, Margaret Lock does a comparative study of brain death and organ transplant in North America and Japan to understand how death has been redefined by medicine to read brain death and consequent organ transplant as “natural” in North America, whereas in Japan, brain death has not gained similar levels of acceptance due to substantially different understandings of life and death (2002).
In *Death in Banaras*, Jonathan Parry studies notions of good death as understood by the Hindu Priests in Banaras. In this work, Parry explains that according to some priests, certain forms of suicides are sanctioned by Hindu religious texts, but they distinguish between ‘self-murder’ as bad death and ‘self-immolation’ as a form of good death (1994, p. 22-23). Within this worldview, the fact that death is self-caused is not automatically perceived as something negative, as is the case with psychiatric discourses. In Parry’s work, the Hindu priests explain that self-inflicted death that is motivated by desire (even if it is a desire for death) is understood as bad death. By contrast, a good self-caused death is when a person is indifferent or is giving up on worldly desires (1994, p. 163).

In criminal law debates on (de)criminalizing suicide attempts, notions of good/bad or natural/unnatural death are very important. Since practices of dying are closely tied into religious ways of life, the courts often reach out to religious (Hindu, Islamic, Jain, and Christian) doctrine to decide what kinds of deaths are considered good or natural. It is important to note that religious ideas on good/ bad or natural/unnatural deaths are used to argue for both criminalizing and decriminalizing suicide attempts. Perceptions of religious approval or disapproval of self-caused deaths play an important role in the criminal legal arena concerning suicide. In the next section on colonial legal regulation of self-inflicted deaths, I will further discuss the tensions between religious codes and legal regulation over the right to take one’s own life.

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19 Banaras is a North Indian city. This city is a significant space of death and dying for practicing Hindus. It attracts pilgrims and mourners from all over the Hindu world.
Criminalizing suicide attempts can be traced back to the British colonial regime. In 1833, Lord Thomas Babington Macaulay, an English lawyer influenced by Jeremy Bentham, proposed to codify Indian laws. The codification resulted in the Code of Civil Procedure in 1859, the enactment of the Indian Penal Code in 1860, and the Code of Criminal Procedure in 1861 (Tambe, 2009). However, Queen Victoria’s government had guaranteed noninterference in religious beliefs in 1858 and, as a result of this guarantee, the Code of Criminal Procedure-1861 did not interfere with the Hindu and Muslim Personal laws and agreed not to codify them (Tambe, 2009). This non-interference guarantee gave rise to separate religion-based laws that governed marriage, divorce, and inheritance, among other aspects. Up until this time, the East India Company had administered different parts of the Indian Subcontinent using a plurality of legal sources, including Hindu and Muslim Personal Law, Regional Regulations, Acts of Parliament, and Islamic Criminal Laws (Kolsky, 2005). The criminal law that existed prior to Macaulay’s ambitious project of codification has been termed the Anglo-Muhammadan system, which consisted of various modifications of Islamic law and its subsequent alterations by the Company (Singha, 1998 p. vii). Historian Radhika Singha suggests that, according to the British magistrates and judges, the Islamic law used for criminal justice focused only on the consequences of the criminal act and on claims (compensation or retaliation) made by the injured parties. In contrast, the British wanted to communicate that criminal offenses affected everyone

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20 Macaulay and other British commissioners criticized the penal law system because it was imprecise and it varied from region to region. They also found working with Islamic law inconvenient. See Singha (1998) and Kolsky (2005) for a detailed study on codification of laws in India. See Kolsky (2005) and (2009) for a detailed study of the impact of codification of laws in the colonies on legal changes in Britain.
and not just individual parties, and hence it was the state’s responsibility to represent public interests (Singha, 1998).

4.1 Tensions between Law and Religious Codes

The legal history of India is a vibrant field of scholarship. However, the history of suicide law has not gained much attention within it, with a few exceptions, specifically, Singha’s work on the colonial state’s complex relationship to taking life in India. In her study of homicide law in colonial Bengal and other parts of India, she argues that criminal law provided the colonial state a legitimate authority to take life. However, British judges were less confident about being able to understand the motive behind a homicidal act. The question of motive was the point of negotiation between new terms of authority defined by the colonial state and the sensibilities of the Indian subjects (Singha, 1998 p. 80). Singha explains, “the question of motive, whether interpreted as superstition or religious belief, defence of honour or contumacy, material gain or spiritual benefit, forced itself to the attention of colonial courts and influenced the definition of the offence and the scale of heinousness by which it was judged” (1998, p. 80). This lack of clarity about any universal standard for understanding motives led to several negotiations between the colonial rulers and the colonized subjects. One such point of confusion for the judges occurred in cases where defendants invoked certain sources of authority, such as religious beliefs or patriarchal rights, to argue for exoneration for the homicidal act (Singha, 1998 p. 81). This confusion regarding motives was particularly relevant to cases related to “self-murder” or suicide. One of the major concerns was whether suicide posed a challenge to the juridical authority of the state or could, instead, be relegated to the realm of the personal. In such cases, the colonial judiciary sought to find religious sanctions to curb suicide incidents. Singha tells us
In England, the eclipse of religious and magical beliefs which justified penalties for self-murder has prompted coroner’s juries to deliver verdicts of *non compos mentis* from the eighteenth century. In India, colonial officials were usually ready to accept the religious or ‘superstitious’ motive behind forms of ritualized suicide, attributing it to the low value placed on life, particularly by the tenets of the Hindu religion. (Singha, 1998 p. 81)

Singha argues that while the colonial criminal law staked a claim for state monopoly over the right to take life, it was met with glaring conflicts in other ‘traditional’ codes of authority (religious or patriarchal), which claimed competing privilege in matters of right to death. Thus the state law also drew upon these traditional codes of authority to make juridical claims, which were acceptable to the subject population (Singha, 1998 p. 80-120). Singha’s account demonstrates that complex negotiations transpired between the colonial government and its subject population regarding who had what kinds of power to take life. In my analysis of court judgments in Chapter One, I similarly demonstrate the tension arising from suicide law’s complex relationship with religious codes, which has continued to shape criminal law debates on suicide in India till today.

### 4.2 Legal Regulation of Sati

One form of self-inflicted death that has gained scholarly interest amongst legal historians is sati.\(^{21}\) However, it is debatable whether sati is indeed a ‘self’-inflicted death. It can, and has, been argued by feminist scholars that the ritual of sati was coercive to women in many ways. My interest in the scholarship on sati is specific to the tension the ritual of sati highlights with regards to the courts’ engagement with religious rituals on death.

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\(^{21}\) Sati refers to the immolation of living widows on the funeral pyre of their husbands.
In her influential work on colonial discourse and sati in India, Lata Mani argues that Indian tradition was reconstituted in various ways under colonial rule through a religious reading of sati (Mani, 1999). Women were taken to be emblematic of tradition, and the reworking of tradition was largely conducted through debating the rights and status of women in society (Mani, 1999, p. 90).²² Mani argues that debates about sati were a mode through which colonial powers were both enforced and contested, and colonial officers shaped the nature of this discourse (Mani, 1986). Singha questions this one-way power relation in Mani’s formulation of sati in criminal law debates, and argues that while colonial laws and procedures of governance were influenced by powers of colonial officers, colonial laws were also under constant pressure by several alternative versions of tradition presented by various sections of Indian society (Singha, 1998). Using the case of Bengal, Singha shows that the colonial magistrates did not wish to be seen as being opposed to religious principles, nor did they want their role as a monitor of sati to be interpreted as an endorsement of the rite (Singha, 1998). At the time, the colonial government maintained a position of non-interference in religion. Hence the magistrates provided specific instructions based on religious principles to indicate the government’s extent of tolerance of sati, while not criminalizing it. But sati also did challenge the state’s monopoly over taking life, and hence could not be ignored by the British.

In the contemporary legal debates on suicide one sees a similar tension. In Chapter One, I demonstrate the Law Commission of India officers, and judges in their decisions constantly feel the pressure from traditional, i.e. religious, interpretations of suicide to justify their judgment either when criminalizing or decriminalizing suicide attempts. Sometimes in the court judgments

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one also sees the judges not wanting to oppose certain religious ideas regarding suicide while also not be perceived as endorsing the act of suicide.

5 Scholarship on Queer Affect and Politics

Another important body of scholarship that has informed this thesis is the literature on queer affect and politics. My interest in hijra suicides emerged from discovering the manner in which sexuality (specifically transgender) rights discourse as well as public health/epidemiological interventions have ignored narratives of hijra tragic love. I find answers for this silence in my work via queer scholarship. Scholarship focused on lesbian politics and affect has engaged with issues surrounding activism, sexuality and love (Cvetkovich, 2003; Dave, 2012; Mokkil, 2010; Vanita, 2005). This body of work taught me to see potentialities and queerness in affective practices that fall outside institutional domains. In An Archive of Feeling, Ann Cvetkovich is concerned with questions surrounding trauma that she reads as aiding the creation of lesbian counterpublic spheres in USA (2003). Cvetkovich undertakes the task of documenting lesbian public cultures so as to “illuminate the forms of violence that are forgotten or covered over by amnesiac powers of national culture which is adept at using one trauma story to suppress another” (2003, p. 16). The lesbian sites of trauma Cvetkovich documents are not the stories that find a place within mainstream media. She explains that these cultures often exist within the space of the everyday and include groups of people who are not making claims to the state as citizens. Cvetkovich is focused on situations and cases that offer “unpredictable forms of politics that emerge when trauma is kept unrelentingly in view rather than contained within an institutional project” (2003, p. 16). Cvetkovich’s work responds to Wendy Brown’s critique of identity politics. In States of Injury, Brown argues that groups that see themselves as injured
victims demand redress from the state by basing their struggle on politics of ressentiment (Brown 1995 as quoted in Cvetkovich 2003). Cvetkovich archives articulations of trauma that are not looking to the state or the identity to provide a resolution. She is interested in understanding how affective experiences that fall outside the “institutional or stable forms of identity or politics can form the basis for public culture” (2003, p. 17).

In *Queer Activism in India*, Naisargi Dave studies the ethical and affective practices of queer activism in India. She explains that a lesbian network—Sakhi—curtailed the expression of feeling in their politics, and argues that this was a response to the institutional neglect of lesbian politics (both within certain sections of the feminist movement and sexuality rights movement in India) (Dave, 2012 p. 35). In understanding the space of ethics within lesbian activism, Dave responds to Cvetkovich’s notion of “archive of feelings” (Cvetkovich, 2003, p. 7). According to Cvetkovich, emotion is ever-present in queer history. She reads affect as being central to gay and lesbian archives as a corrective to institutional neglect (Cvetkovich, 2003, p. 241). Diverging from Cvetkovich, Dave explains that dulling of affect within lesbian activism in Delhi does not in anyway diminish ‘feelings’. The archive Dave finds is not only an archive of feelings, but more a *history* of emotion (2012, p. 35). I build on this discussion to study hijra suicides.

Although hijra suicide attempts are largely invisible within large-scale public health interventions, hijras themselves speak about the presence of suicide within the larger community – not through the lens of biomedicine, psychiatry, or human rights, but as universal experience of loss of love.23 I study two hijra autobiographies as archives of feelings (and knowledge) on experience of suicides. Building on Dave and Cvetkovich I argue that unlike lesbian activism in India, which restrained itself to gain political respectability, affect in the context of hijra suicide

23 I use the word ‘community’ rather loosely. There is no single, homogenous hijra community in Bangalore. I use this word while referring to hijras as a whole in Bangalore.
is both highlighted as well as subdued. Within transgender rights discourse, certain hijra affective experiences of suffering are highlighted to gain rights and recognition from the state. Whereas, within the same rights discourse, hijra experiences of loss of love resulting in suicide attempts are not represented. By studying key autobiographical texts in the context of civil liberties/rights literature, and epidemiological programs, I demonstrate the selective display of affect both within civil liberties/rights discourse as well as a more rounded expression of affect within hijra autobiographies.

5.1 Hijra Life Beyond Sex/Gender Difference

My approach to understanding hijra life is influenced by a shift in literature on hijras. A majority of early scholarly work on hijras comes from the Western academia, which focused on studying hijra lives to disrupt Western notions gender and sex categorization (Nanda, 1989; Jaffrey, 1996; Vyas & Shingala, 1987). This literature read hijra lives as subversive to Western notions of sex and gender and hence hijras were celebrated as non-normative sexuality but always in comparison to the Western world. Anthropologist Gayatri Reddy terms this the “Third-sex analysis” and argues that they are not just a sexual or gendered category (Reddy, 2005a).

In With Respect to Sex: Negotiating Hijra identity in South India (2005a), Reddy provides a holistic view of hijra lives. Unlike the scholarship that came before, Reddy is not preoccupied with undoing the West-versus-the-rest binary. Instead her book opens up the issue

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24 The scholarship on transgender identity, politics, activism is vast. In my work, I largely build on scholarship that focused on hijras in India. For literature on transgender see Valentine (2007) and Stryker & Whittle (2006). On indigenous Two Spirit critique see Driskill (2010) and Driskill, Justice, Miranda & Tatonetti (2011).

25 In most academic scholarship on hijras, they are prominently defined as ‘neither man nor women’ Nanda (1989), Vyas & Shingala (1987); I explicitly avoid this definition of hijras. In all my conversation with hijras in Bangalore, I never once heard any of them describe themselves as ‘neither man nor woman’. What I found most frequently was that they referred to themselves as hijras or women or sometimes hijra women. Such descriptions of one’s gender/sexuality might be a reflection of the changing conversation around sexuality in Bangalore, but I would like to stay true to their self-description in my work. It is because of this, you might find that I sometimes refer to the hijras as women or hijra.
of thinking about cross-cultural sexuality beyond the language of disrupting dual categories. She explains, “Like the members of any other community in India, their identities are shaped by a range of other axes. Though sex/gender is perhaps the most important of these axes, hijra identity cannot be reduced to this frame of analysis” (Reddy, 2005a, p.2). Reddy historically traces the manner in which hijras have always been fetishized bodies through which sexuality, in the form of an exotic third sex or a transgendered difference, travels out from India to the West (Reddy, 2005a, p. 4-16). Thus, Reddy’s ethnographic work marks an important shift within the scholarship on hijras. Reddy shifts the conversation from hijra’s sexual and gendered difference to the complex interplay of religious practice, kinship relations, gender performance, sexual desire with a focus on the hierarchies of izzat (respect) in hijra lives (Reddy, 2005a). Similar to Reddy, Lawrence Cohen collapses the term sex and gender while studying hijras. He explains that, while listening to and representing the stories of hijras in Banaras, he is “confronted with narratives and language which resists any a priori divisibility into embodied sex and expressive gender” (Cohen, 1995, p. 278). A significant aspect of Reddy’s work is that she shifts the focus from hijra bodies and focuses on hijra personhood and relationships. By doing this, she presents a complex affective picture of the lives of the hijras she writes about. Similarly, Cohen also makes an explicit call not to essentialize hijras as third sex/ gender (1995).

Influenced by Reddy and Cohen, in my work here, I move away from understanding hijra lives solely through the lens of sexual or gendered difference. I am interested in hijra lives (and death), their personhood and not only their bodies.26 As I mentioned earlier, narratives of hijra suicides that I analyze are largely narratives of love. However, I neither imply that these narratives are unique to hijra lives nor do I intend to exceptionalize hijra bodies or emotions.

26 It is difficult to separate ‘life’ and ‘death’. As I demonstrate in Chapter Three and Four, suicide in an important aspect of hijra lives.
Instead, my aim is to study the relevance of love and suicide in their lives. Hijra experiences of suicide are both universal and distinct. They are universal because narratives of loss of love that hijras recount are similar to other several peoples’ experiences of suicide in Indian society irrespective of class, caste, religion and gender/sexuality. Hijra suicides are simultaneously distinct because unlike many other kinds of suicides that exist in Indian public sphere, hijra suicides are invisible within both medical/public health/psy discourses as well as within legal/rights discourse.

I write my analysis of hijra suicide in this dissertation with some trepidation, since my aim is not to create a new category of suicide, which then gets taken up by one or the other discourses to consequently discipline the conversation on suicide. But I also have an ethical responsibility to take seriously hijra narratives of suicide that I repeatedly encountered. Often, the contemporary literature on hijras emphasizes the lack of rights or the violence prevalent in hijra lives. Through my study of hijra suicides I hope to push the discussion on hijra lives towards questions of love and death and not, as I mentioned earlier, solely be focused on their gender/sex difference.

I have two major goals in studying hijra suicide. First, is to demonstrate the discursive spaces occupied by hijra experiences of suicide that exist at the margins of legal regulation. Second, I hope the study of hijra suicides will also demonstrate the limits and possibilities regarding governance and regulation of suicide in India more generally.

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27 Gayatri Reddy has been the only scholar who has studied hijra love in India. In Reddy (2006), she studies hijra love in some detail. However, in this essay, hijra love suicide is the background to understanding notions of intimacy and marriage amongst hijras and love suicides is not its sole focus.
6 Research Process

Fieldwork for this project was conducted from June 2013 to August 2014 in Bangalore, the capital city of Karnataka. I selected Bangalore for several reasons, one of the main reasons being that it was the place I began to observe the increase in psy discourse on suicide when I was in the city in 2005. Another important reason is the fact that Bangalore is my hometown. I grew up in Bangalore and I understand the language – spoken languages such as Kannada and Hindi, as well as the unspoken language of gestures and silences. While understanding how to interpret what was occurring around me was easier because of my familiarity with the city, I was also pushed in several instances to reassess my assumptions about the city during the course of my fieldwork.

The chapters that make this dissertation come together through a study of broadly three areas: (a) legal reform and case law regarding Section 309 IPC, (b) national and transnational medical/psy suicide prevention interventions and (c) hijra suicide narratives. Each of these areas required a different methodological approach, namely: Document analysis, Interviews, and Participant and Non-Participant Observations.

6.1 Document Analysis

Since my general aim was to understand governance of suicide, I focused on the debates that circulated regarding de/-criminalizing attempt to suicide (section 309 IPC). I analyzed the Law Commission of India reports that argued for reforming law, i.e., decriminalizing suicide attempts. Similarly, I reviewed the key judgements from High Court and Supreme Court of India cases where a person or persons were accused under Section 309 IPC. Until now, there has been no concerted effort to study the legal governance of suicide in India or understand the knowledges that are used to rationalize particular forms of governance. My detailed study of
Law Commission’s report and Court judgments highlights the heterogeneous discourses that are present in the legal regulation of suicide in India.

I also analyzed recent legal reform efforts, such as newly proposed mental health care laws, and analyzed their impact on defining and regulating suicide. There have been other studies that have critiqued the Mental Health Care (MHC) Bill 2013 and 2016, but there have been few studies that are focused on the impact of MHC Bill on the regulation of suicide. I bring the criminal law debates in conversation with mental health care laws to understand whether they have led to any qualitative difference in governing suicide in India.

To understand in greater detail the mental illness discourse, I also analyze reports published by transnational public health organizations and movements, such as the WHO and the MGMH. I study publications by the WHO and proponents of MGMH to understand the extent of circulation of psychiatric and psychological discourse surrounding suicide and suicide prevention. I also analyzed key epidemiological studies that have encouraged mental illness suicide prevention programs in parts of India.

In addition, I also analyzed one epidemiological study that focused on hijra mental health in Bangalore by a large public health NGO – Karnataka Health Promotion Trust. This was the only public health initiative focused on hijra mental health I encountered in Bangalore and studying it illustrated the continuations of HIV/AIDS framing of hijras and also the quasi-medicalization of suicide prevention. 28 To understand hijras within civil liberty and human rights frameworks, I analyzed reports published by civil liberties organization, specifically, the Peoples Union for Civil Liberties- Karnataka (PUCL-K), as well as publications by United Nations Development Programme (UNDP). I also studied the reports published on transgender issues by

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28 I explain quasi-medicalization in more detail later in the Introduction and also in Chapter Two
the Ministry of Social Justice and Empowerment as well as the 2014 Supreme Court of India judgment in *National Legal Services Authority v UoI*, which introduced the legal category of “third gender”. To understand these legal reform efforts in some detail I studied commentaries published by sexuality rights activists, some of who celebrated, and some of whom decried the third gender categorization. Most of these commentaries were published on LGBTQ online forums such as the *Gaylaxy Magazine* (www.gaylaxymag.com) and *Orinam* (www.orinam.net). I also studied a commentary published on an online Dalit activist forum: *Round Table India* (www.roundtableindia.co.in). Some of these opinions were published on facebook, and while these opinions are public I choose to maintain the anonymity of the authors. I also studied commentaries published in prominent English newspapers such as *The Hindu, Times of India, The New Indian Express, and Deccan Herald* by prominent sexuality rights activists, on the benefits or demerits of third gender categorization.

In addition to analyzing legal, epidemiological and sexuality activist literature, I also analyzed well-established English news reports that reflected the psychiatric impetus to suicide prevention published in *The Hindu, Times of India, The New Indian Express, The Indian Express* and *Deccan Herald*. I also studied news reports published in English news sites such as www.scroll.in, www.thewire.in and www.ndtv.com.

### 6.2 Interviews

I conducted interviews with fifteen psychiatrists, psychologists, and individuals working in suicide prevention NGOs in Bangalore. Often, these were not formal, recorded interviews because many times, the psychiatrists and psychologists had to get permission from their superiors in the hospital before speaking to any outsiders. Since they were not keen on doing that paperwork, I was told not to record our conversations. In other circumstances, when
psychologists worked independently, they were comfortable with more formal interviews. I interviewed psy experts in two contexts: (a) to understand psy suicide prevention interventions in Bangalore and (b) to understand the role of psy experts in hijra mental health support initiatives. Although these interviews do not figure prominently in this dissertation, it gave me great insight into the circulation of psy discourse in Bangalore.

Another important set of interviews I conducted was with hijras in Bangalore. This was by far the most significant part of my fieldwork. I conducted thirty-eight interviews with hijras. A few of them were working in various capacities in sexuality rights or HIV/AIDS prevention NGOs. I largely focused on hijras who worked as sex-workers and lived in hamams and other independent homes. 29 Most of these hijras knew of and had visited these NGOs but were not themselves activists or NGO workers. Usually, these interviews happened in mid to late afternoon, before they left for work. Sameera helped me immensely with my research. 30 Sameera is a hijra who had previously worked in a HIV/AIDS prevention program in Bangalore and so knew many hijras across the city. We traveled to various hijra households and hamams in many parts of Bangalore and spent four to eight hours in these homes. Often, I asked for a recorded interview and most times they agreed and were keen to speak to me. We would then find a quiet space in their home where I would begin by asking some basic questions about their lives and soon the conversation would flow seamlessly. The interview duration was dictated by how much they felt like sharing with me; it lasted anywhere between 45 to 140 minutes. If Sameera or I felt like visiting the same hamam or a hijra home again, we went back and spent more time. There were times I did not conduct any formal interviews and the day was spent chatting and hanging out as a group. In these group conversations, I only encountered general discussions regarding

29 Hamams are bathhouses where hijras who work as sex workers conduct their work.
30 Names of all the hijras I interviewed have been changed throughout this dissertation to maintain their anonymity.
suicide incidents in the hijra community. But in my one-on-one interviews and informal conversations, the hijras I was speaking to often narrated their personal experiences with suicide attempts. Importantly, I never asked any hijra I interviewed or had informal conversations with, about their personal experiences with suicide; my questions were always regarding hijra community as a whole. Significantly, in all my interviews, they brought it up themselves. I had the Office of Research Ethics, University of Toronto approval for all the interviews I conducted with psychiatrists, psychologists, and people working in suicide prevention NGOs in Bangalore as well as all the hijras.

6.3 Participant and Non-Participant Observation

Although I predominantly rely on interviews and conversation to get a better understanding of suicide amongst hijras, during the course of my fieldwork I did have the opportunity to engage in participant observation. In an attempt to provide something in exchange for requesting interviews and meetings with hijras and kothis in various NGOs, I offered to do some paperwork such as complete grant application forms, and translate funding documents from English to Kannada or from Kannada to English for some hijras and kothis working in NGOs. Although this work does not feed into my dissertation directly, it gave me a deeper understanding of the NGO work-life of hijras and kothis in Bangalore.

Part of my research was engaging in non-participant observation. During the initial period of my fieldwork, I visited two drop-in-centers (DIC) in Bangalore.\(^{31}\) I visited these DICs

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\(^{31}\) As part of the HIV/AIDS programs, DICs were set up as safe spaces for vulnerable communities such as Men-who-have-sex-with-men (MSM), including hijras and other transgender individuals. DICs are usually situated in lower-middle class neighborhoods in Bangalore, sometimes near the cruising areas or neighbourhoods where street based sex work happens. Typically, DICs offer a range of services such as HIV/AIDS counseling, which entails the communication of information regarding HIV/AIDS and other sexually transmitted diseases. These counseling services also encourage people to get tested for HIV/AIDS. They also distribute condoms and answer any questions regarding HIV/AIDS. Apart from this, they are also supposed to provide psychosocial support. The idea here is to
firstly to meet with some prominent hijras and kothi activists to understand suicide within the larger community. But often, since they were busy, I would hang around having tea in the DIC just chatting with people who were visiting. Researchers studying various aspects of sexuality are common in Bangalore, especially researchers from universities in the West. And so my presence in these DICs was not thought of as unusual. My presence raised some curiosity, probably because of my obvious upper-caste, upper-class aesthetic, which meant I was sometimes asked to explain my presence in their safe space. Often seniors in the HIV/AIDS programs had been interviewed by several researchers and this impacted our initial conversations. They usually perceived me as a translator of human rights abuses to the larger world and so they narrated instances of violence in the lives of sexual minorities. While these narratives of abuse and violence are a significant aspect of hijra lives, I was also curious about narratives that were not already circulating within the NGO circles. Spending time not doing formal interviews in these DICs helped me understand the hierarchies within the hijras who participated and/or visited the DIC. I also gained greater perspective regarding the support systems that play a role in hijra lives in Bangalore. Sadly, when I visited Bangalore in August 2016, I learnt that only one DIC still exists in the city. The others have suffered from the reduction in funding for HIV/AIDS prevention programs and so have been closed. Many hijras who worked in these NGOs are now out of work and are in a dire situation.

help sexual minorities (as they are known in HIV/AIDS and sexuality rights framework) come to terms with their life situations.
7 Chapters and Themes

7.1 Suicide in the legal arena

Chapter One, “A Multifarious Law: The (Im)possibility of Criminal Regulation of Suicide in India”, traces the multiple discourses on suicide within the criminal law that not only demonstrate the obvious fact that suicide does not have a single definition, but also that legal ideas about suicide are constantly shifting. The chapter shows that, unlike the modern Western, largely pathological approaches to suicide, in the contemporary Indian context, suicide entails a diversity of acts. The act of self-inflicted death, or to use a more positive term self-accomplished death (Marsh, 2010), is read as spiritual, religious, political, psychiatric, ethical as well as illegal and criminal. I demonstrate that in the legal arena all these discourses operate, sometimes simultaneously albeit with some tension. I use the metaphor of a “legal arena” to capture the tension between multiple discourses on suicide that exists within criminal law debates.

Arena, according to the Oxford English Dictionary, is “A place or scene of activity, debate or conflict”. Thinking of the numerous discourses and institutions gathering together in a legal arena helps shed light on the seemingly chaotic story of suicide vis-à-vis the law in India. By approaching the debates on suicide through the lens of the legal arena, rather than posing a single legal discourse, one can make sense of the fragmented rationalities and the multiplicity of discourses at play. I build on Rose and Valverde’s conceptualization of the term “legal complexes” (1998):

There is no such thing as ‘The Law’. Law, as a unified phenomenon governed by certain general principles is a fiction. This fiction is the creation of the legal discipline, of legal textbooks, of jurisprudence itself, which is forever seeking for the differentia specifica that will unify and rationalize the empirical diversity of legal sites, legal concepts, legal
By legal complex, the authors refer to an “assemblage of legal practices, legal institutions, statutes, legal codes, authorities, discourses, texts, norms, and forms of judgement” (Rose & Valverde, 1998, p.542). This assemblage, as Valverde suggests elsewhere, is an “ill-defined, uncoordinated, often decentralized sets of networks, institutions, rituals, texts, and relations of power and of knowledge that develop in those societies in which it has become important for people and institutions to take a position vis-`a-vis law” (Valverde, 2003b, p.10). This conception of the legal complex draws its inspiration from Foucault’s lectures on the genealogy of European legal system and its governmentalization (Foucault, 2007). In these lectures, Foucault highlights the relationship between knowledge and power in a legal complex, with a specific reference to its hybridity. The workings of a legal complex, that is, its practices, regulations, deliberations, and techniques of reinforcement, Foucault suggests, were influenced and supplemented by different forms of knowledge and expertise that are not necessarily legal, but rather positive knowledge claims from medical, psychological, psychiatric, and criminological sciences. Composed of elements with very diverse histories and logics, this hybrid legal complex, at an overall level, had “become welded to substantive, normalizing, disciplinary and bio-political objectives having to do with the re-shaping of individual and collective conduct in relation to particular substantive conceptions of desirable ends”, which is to say, had been governmentalized.” (Foucault, 1978a in Rose & Valverde, 1998, p. 543). Rose and Valverde’s seminal conception of legal complex helps understand the hybridity of its elements and its relationship to governmentality.

I prefer to use the term arena and not complex as in Rose and Valverde’s work to highlight the tensions that are at play within the multiple sometimes contradictory discourses that
circulate regarding suicide in India. In the context of suicide regulation, legal and non-legal knowledges have different histories and logics, since medical, psychological, psychiatric and religious knowledges and expertise all make claims about suicide in India. These efforts are occurring at different scales. For example, the expansion of psychiatric and psychosocial public mental health care agenda is occurring at a global scale, while religious demands to define certain acts as suicide and certain acts as a ritual are national or regional. Furthermore, these different actors and discourses do not arrive at the arena with an equal footing and strength. Thus, the legal arena becomes the space where an assemblage of actors, discourses, institutions working at different spatial scales, with different rationalities, and positions of power, negotiate, challenge, and contest definition(s) and the legal rules about suicide. I use legal arena as a metaphor to emphasize the tension and contradictory discourses that operate within legal deliberations on suicide.

Furthermore, while the criminal law debates demonstrate the circulation of varied, discourses, they also reveal the gradual expansion of psychosocial and psychiatric, biopolitical discourse regarding suicide. Psychiatric and psychosocial discourses circulate along with other discourses in the legal arena, thereby creating a hybrid space for legal regulation of suicide. But psychiatric/mental illness discourse outside the criminal law debates has a different story to tell.

7.2 Quasi-Medicalization

An important aim of this dissertation is to understand the medical regulation of suicide. Chapter Two, “Attempted Medicalization: Mental Health Care Laws and Suicide Prevention in India”, traces the emergence of Mental Health Care laws that frame suicide attempts predominantly

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32 See Chapter Two to understand the transnational efforts made by large public health organizations such as WHO as well as national level mental healthcare organizations and practitioners who are working towards a public health care model for regulation of suicide in India. See Chapter One to understand the religious demands to define certain acts of self-inflicted deaths as not suicide.
through a mental illness discourse. Along with the legal reforms tending towards a psychiatric formulation of suicide, transnational and national public mental health systems of care also propagate the notion that suicide is a mental health concern that requires prevention efforts by psychological and/or psychiatric experts. To understand the expansion of psychiatric/mental illness discourse, I began with a question: Is suicide medicalized in India? What I found was that medical/public health regulation of suicide in India is occurring within a complex web of discourses that cannot solely be understood through the lens of medicalization.

Biomedical/pharmacological psychiatric discourse around suicide prevention does exist in the Indian context as I demonstrate in Chapter Two. However, public health suicide prevention efforts also include non-biomedical, psychosocial interventions that are not medical in nature. For example, to prevent farmer suicide, one of the methods advocated is to regulate farmer’s access to pesticides. These are largely pragmatic programs designed to address sociocultural context with the narrow aim of suicide prevention. Public health care systems are themselves not purely medical entities; therefore, understanding suicide prevention within public health care as medicalization would be incorrect. Nevertheless, it is also important to recognize the expansion of a forceful transnational discourse that emphasizes biomedical/psychiatric care for suicide prevention. This phenomenon, that is, the expansion of biomedical psychiatric suicide prevention discourse alongside non-biomedical psychosocial interventions, I term quasi-medicalization.

7.3 Suicide at the Edges of Governmentality

In Chapter Three, “Hijra Suicides: Love at the intersection of Law and Medicine” and Chapter Four, “A Life Worth Telling: Registers of Knowledge on Hijra Suicide”, I study narratives of suicide that I encountered in many conversations. As I mentioned earlier, these were often
narratives of loss of romantic love. Self-inflicting death or suicides for the sake of love are not an unusual phenomenon in India. Killing oneself for love is a fairly common trope in the Indian public sphere. One often encounters instances of inter-caste, inter-religious heterosexual couples or lesbian couples choosing joint suicide rather than be torn apart because of the pressures of society or family. In such a context, however, hijra love suicides have not gained large-scale institutional attention. In Chapter Three, I study sexuality rights activism that has engaged with the notion of “right to love” to demand rights and recognition from the state. But even within this nation-wide movement, hijra love has not gained attention.

It is not only the sexuality rights conversation that has largely sidelined hijra love suicides. Even with the increasing presence of a psychiatric and psychosocial discourse on suicide and suicide prevention, they have remained at the fringes of public health interventions. As I mentioned earlier, hijras have been both subjects and objects of large public health programming (HIV/AIDS prevention), but these structures have done little in terms of addressing hijra suicide attempts. In this chapter, I contextualize contemporary narratives of hijra suicide attempts within the history of hijras as subjects of legal and medical systems. I use hijra love-suicide narratives to trouble public health and rights discourses formulation of hijra subjectivity.

Although there is relative silence within criminal law discussion, sexuality rights struggles and psychiatric and psychosocial interventions, individual hijras often talk about their attempts at suicide. The narratives of loss of love that I encountered in my conversations and interviews with hijras were not available in that form in any legal/rights or psychiatric and psychosocial publications on hijra suicide. However, hijra narratives of suicides were in circulation within other registers of knowledge such as public speeches, informal conversations and hijra autobiographies. In Chapter Four, I study two hijra autobiographies to understand the
presence of suicide narratives outside the legal or medical discourses on suicide. The two autobiographies are (a) A Revathi’s *The Truth About Me: A Hijra Life Story* and (b) Living Smile Vidya’s *I am Vidya: A Transgenders Journey*. In the contemporary context, when there are efforts to frame all suicides through a mental illness discourse, these autobiographical texts exist as “archives of feeling” on suicide (Cvetkovich, 2003). I study hijra autobiographies because of their presence at the fringes of both legal/ rights and medical discourses. In addition, in Chapter Four, I bring hijra suicide narratives into conversation with scholarship on lesbian suicide in India to understand the aspects of love suicide attempts in hijra lives that do not have the capacity to make it poetic or political. Chapters Three and Four, together, center hijra suicides within other large institutional discourses that impact hijra lives.

Overall, in this dissertation, I hope to capture how certain suicidal deaths come to matter within regulatory systems whereas some others remain at the edges of governance. But I will also show that no one system (legal, medical) is internally consistent: the unresolved dilemmas found in both legal and extralegal practices for governing suicide tell a larger tale about the internal contradictions and epistemological ambiguities of governance today.
Chapter One
A Multifarious Law: The (Im)possibility of Criminal Regulation of Suicide in India

This chapter explores one question: In a country where there have been numerous efforts to both criminalize and decriminalize suicide attempts, what can the study of suicide teach us about law and law’s interactions with other social systems such as medicine, religion, and social justice struggles?

Section 309, Indian Penal Code (IPC) criminalizes attempts to suicide.33 However the interpretation of the word suicide within the legal arena is fraught with tensions and contradictions. It has been an impossible task to find a single legal definition of suicide. The courts and legal reform efforts have consistently tried to legitimize criminalizing or decriminalizing suicide attempts by defining suicide based on a host of knowledges and discourses—religious doctrine, psychiatric explanations, state control over life and death, to name a few. These various discourses and knowledges demonstrate the liminality, rather than a singular definition, of suicide in India. Suicide is constantly in the process of being defined within the legal arena. In this chapter, I analyze this repeated making and remaking of legal definition of suicide to demonstrate the multifarious nature of suicide within the law. I study the legal provision which criminalizes suicide attempts in three ways: first, I trace chronologically the various debates and tensions that have risen in the efforts undertaken by different actors to criminalize or decriminalize attempt to suicide in India; second, I pay attention to the different

33 At the time of my completion of writing this dissertation (January 2017), the law that criminalizes attempt to commit suicide holds a blurry space. Only recently the attempt to suicide law is said to be decriminalized via a mental health care bill, but the criminal law provision continues to remain as I write this dissertation. In later parts of this chapter, I explain the complexity of criminalizing and decriminalizing attempt to suicide.
rationalities that these actors draw on to define suicide, which include religious doctrines, deliberations over state power on citizens’ life and death, psychiatric and psychological reading of suicide attempts, among others; and third, I identify multiple directions along which the discussions on suicide and law have branched out in the process. In doing so, my aim is to highlight the multifarious, contradictory, and hybrid character of the legal regulation of suicide.

In a study of pragmatist and non-pragmatist legal practices in American law, Mariana Valverde explains that legal networks combine a variety of disparate knowledges to legally justify any particular human concern (2003a, p. 87). Valverde responds to Bruno Latour’s theorization of modernity where he argues that since the scientific revolution, most knowledge networks are characterized by their effort to “suppress, minimize, or repress epistemological heterogeneity in the pursuit of pure, methodologically coherent analysis (Latour 1993, as cited in Valverde, 2003a). She explains that unlike modern knowledges where heterogeneity and hybridity are rejected, law “does not wish to be modern” (2003a, p. 87). Law is not burdened by the rational or modernizing logic. Law is not always burdened by truth seeking either. In Law’s Dream of Common Knowledge, Valverde builds on empirical studies of law in everyday contexts to explain that while seeking truth is an important dimension of law, it is not always its primary drive (2003b). Similarly, in my analysis of the court judgments, I demonstrate that law is not necessarily or consistently seeking truth regarding suicide. Law’s preoccupation with respect to suicide in India is not to find a single truth either with regards to the meaning of suicide or with regards to the legal regulation of suicide. The legal discussion on suicide is an ongoing negotiation, sometimes juggling multiple discourses that demonstrate little consistency. What we see is law’s ability at eclectic interpretations of the suicide act.

In the Introduction, I suggested that although the literature on suicide is vast and expanding in India, the scholarship on suicide law is limited. Legal scholarship has primarily
analyzed certain key court decisions that have criminalized or decriminalized suicide attempts to demonstrate the court’s progressive or conservative understanding of suicide. Apart from these studies of specific court cases sociolegal scholarship on the subject is limited. My work attempts to fill this gap in the existing literature through a detailed study of key court decisions, legal reform efforts as well as a thorough analysis of the implications of these decisions on suicide regulation in India. By studying key court decisions together, I gain a wider perspective to understand suicide within the law. By bringing together crucial court decisions along with other legal reform efforts that have occurred from the 1970’s until 2000’s I trace the multiple discourses that have operated to argue for and against criminalizing suicide attempts.

Most legal studies on suicide, of the few that exist, are focused on the debates on the merits or demerits of criminalizing suicide. My interest in the criminal law debates on suicide does not stem from a desire to argue for or against criminalizing or decriminalizing the act of suicide. Neither is my aim to understand suicide within the law. Instead I am more concerned with what a study of suicide in the legal arena tell us about law’s multifariousness and hybridity. In Bodies of Law, Alan Hyde analyzes American law’s approach to the body as it is legally constructed, fetishized and commodified (1997). He studies the proliferation of discursive constructions of the body within the law thereby opening up law to multiple readings. Hyde builds on critical theory, feminist and queer theory to demonstrate that legal truths about bodies are not always sexual or racial (1997). By choosing to analyze legal mechanisms closely, Hyde de-centers, for example, questions of gender, sexuality, and instead shows us other legal ‘truths’ (1997). Similarly, my work on regulation of suicide demonstrates the dismantling or de-centering of homogenous legal logics.

In Justice as Improvisation, a book on jazz and law, Sara Ramshaw draws parallels between legal judgment and bebop music to theorize the nature of improvisation within both law
and music (2013). Ramshaw explains that particularly in bebop, improvisation is a liminal space between tradition and invention, repetition and transformation. More importantly, bebop is “marked by responsiveness —between performers and audience—by intense and sensitive listening, and by a dialogic and collaborative development that remains faithful to the general past and the singular present” (Manderson, 2014). For Ramshaw, improvisation is not simply ‘freedom’, nor ‘constraint’, but a complex interchange between them. In this work, improvisation is not only a metaphor for law, but instead a model for it (Ramshaw, 2013, p. 1-14). In my analysis of suicide within the legal arena, I found that the legal meaning(s) of suicide was constantly in the liminal zone, as Ramshaw explains between tradition and invention, repetition and transformation (2013). A large part of multifariousness of law in the debate on suicide emerges from its ability for constant improvisation. In the analysis of court cases in this chapter, I demonstrate that the legal debates are shuffling several knowledges to provide a judgment regarding suicide thereby constantly juggling the meaning(s) of self-inflicted death. This reflects two things: one, there is no absolute meaning of suicide within the legal realm; and two, the law itself is not a homogenous entity.

1 The Heterogeneous Nature of Suicide Regulation

One of the key themes that runs through the dissertation is medicalization (or lack thereof) of suicide. Within the realm of law reform as well as court judgments, one encounters (albeit perfunctorily) the desire to create a mentally ill/medical suicidal subject. In the scholarship stemming from Foucault’s “governmentality” framework, the impetus has been to trace the shift from the legal to the medicalized subject. The literature on suicide that engages with medical/mental illness discourse often traces this shift in governance of suicide from legal to the
medical.\textsuperscript{34} When I began studying suicide in India, I expected that my research would take me in this predictable direction—that is, a narrative of the slow, but inevitable, medicalization of suicide. I anticipated that suicide, once located within the legal/criminal discourse, was gradually shifting towards a medical/psychiatric discourse and I intended to trace this shift and construct a classic Foucauldian argument about medicalization of a social problem. But as I delved deeper into the field, the issue presented itself as far more complex. It stopped being a story of one-directional medicalization and became a story of multiple contradictory trajectories, especially within criminal law debates. It became clear that the word ‘suicide’ carries multiple meanings; different forms of self-inflicted deaths are being treated and/or addressed differently, and multiple authorities and discourses are attempting to define, control, and classify ‘suicide’.\textsuperscript{35} Often there is a struggle between different actors and discourses to define suicide, leading to a tension that the courts then attempt to address. In such an attempt, the courts shuffle, juggle or combine various knowledges to define suicide. Once a court has defined suicide, it is yet again questioned by another set of actors and knowledges. Such a situation, as I will demonstrate points towards an (im)possibility of a single regulatory framework to address suicide within criminal law.

In contemporary India, the most evident examples of this heterogeneity of discourses in circulation with respect to suicide are: economic discourses concerning farmer suicides; discourses of caste-based violence in the case of Dalit student suicides in elite higher educational Indian institutions; inter-caste and inter-religious couples committing suicide; religious

\textsuperscript{34} See Hacking (1990), Marsh (2010), Bayatrizi (2008). Critical disability activism has also critiqued the latest Mental Health Care Bill 2013 for medicalizing suicide. See Chapter Two for a more detailed study of disability scholarship and activism on medicalization of suicide in India.

\textsuperscript{35} While suicide within criminal law demonstrates the eclecticism of law, it is also important to acknowledge that there is a transnational push to treat suicide as a medical/mental health problem. See Chapter Two for a more detailed study of quasi-medicalization of suicide in India.
discourses with respect to religious rituals such as Santhara that result in self-inflicted deaths; and discourses of state violence against political activists performing hunger strikes and self-immolations to protest against the state. I look at some of these examples in this chapter, in relations to the broader debates to de-/criminalize attempts to commit suicide. In this chapter, I show how a unified meaning of suicide is produced, repeatedly, in order to regulate suicide attempts, as well as how the regulatory framework continues to remain plural and heterogeneous, despite the legal reform impetus for uniformity.

Before I get into deeper analysis of suicide within criminal law, let me provide a brief historical framework. The colonial legal history has demonstrated the complexity of religious codes and their relation to law, as I explained in the Introduction. This complexity is evident even today in the contemporary debates on governing suicide. In the next few sections, I will draw out the tensions between law, religious codes, and notions of secularism in India that have had an impact on the regulation of self-inflicted deaths.

2 Postcolonial Relationship between Law, Religion, and Secularism

The difficulties faced by the colonial state with regards to religious rituals of taking life, which I briefly explained in the Introduction, have persisted in contemporary debates on suicide regulation under the postcolonial state. We see this most prominently in the recent public debates on Santhara—a Jain ritual of cleansing oneself by fasting or starving until death, which I study later in this chapter. Religious discourses have had a consistent influence on the legal opinions on suicide regulation in both colonial and postcolonial contexts. In the next three sub-sections, I expand on this relationship between religion and law in order to show how the Indian state
negotiates the dual task of religious even-handedness and religious reform while maintaining its commitment to secularism.

2.1 Religious freedom and Personal Laws

British rule in colonial India constructed its legitimacy by simultaneously claiming and not claiming interference in religious affairs of the colonized (Singha, 1998). This resulted in a complex relationship between the colonial state regulatory mechanisms and native religious practices. This approach was carried into the postcolonial context, and adopted by the Indian state. On the one hand the law maintains a distance from religious personal laws, and on the other hand the Indian courts continue to cleanse religious systems of their ‘superstitions’, in order to modernize and rationalize personal laws.

After India’s independence from the British, personal laws were imagined as way of maintaining community identity and respecting religious differences. Each religious community was permitted its own personal laws; Hindus, Muslims, Christians, and Parsis each had their own personal laws and other religious groups such as Jains, Buddhists and Sikhs were subsumed under the Hindu law. These laws allowed each religious community to regulate personal matters such as property inheritance, marriage, divorce, maintenance and custody of children, according to its religious laws and customs. This fragmentation was associated with the idea that India was a secular state. Any reform or removal of personal laws is perceived as a threat to religious identity.

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36 Secularism in India is unlike secularism in France, where there is an absolute separation of state and religion. It is not state neutrality as it is in France, but it is a different brand of secularism. I will explain Indian secularism in more detail later in the sub-section ‘Secularism, Law, and Religion in India’.

37 To give an example: In 1986, the Supreme Court of India ruled that Shah Bano, an aged Muslim woman who had been divorced by her husband, was entitled to maintenance payments to prevent her from complete destitution. This decision challenged the Muslim personal law. There was a furor from the Muslim conservative leadership which
2.2 Essential Religious Principles Doctrine

Although state interference with personal laws can be met with resistance, there exist provisions in the Indian constitution that allow state regulation of religious activity. Article 25 of the Indian Constitution guarantees equal entitlement to freedom of conscience and the right to profess, practice, and propagate religion. The right is subject only to public order, morality, health, and other recognized fundamental rights in the Indian Constitution. This provision has permitted the state to regulate and restrict any “economic, financial, political, or other secular activities which may be associated with religious practice” (Article 25). In addition to Article 25, the state via the Indian Constitution has also attempted to modernize religious practices. For example, untouchability, which is a Hindu practice, has been legally prohibited, however, unfortunately it continues to be practiced extensively in Indian society.38

Apart from modernizing aspirations, the Courts have also taken up the task of interpreting religious doctrine (Derrett, 1968; Galanter, 1997; Dhavan & Nariman, 2000). Essential religious principle doctrine refers to the practice where a judicial inquiry can determine whether or not a practice is essential to the religion.39 The Indian judiciary has used the ‘essential practices’ policy in a variety of cases. For example, in S P Mittal vs Union of India, the court denied the

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38 Article 15(1) of the Indian Constitution states: “The state shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them (4). Nothing in this article or in clause (2) of Article 29 shall prevent the state from making any special provisions for the advancement of any socially and educationally backward classes of citizens or for the Scheduled Castes and Tribes,” and Article 17 states: “Untouchability is abolished and its practice in any form is forbidden. The enforcement of any disability arising out of ‘Untouchability’ shall be an offence punishable by law.”

39 Essential principles was first invoked in the Commissioner, Hindu Religious Endowments Madras v. Sri Lakshimindra Thirtha Swamiar of Sri Shirur Mutt in 1954 and since then the courts have examined specific religious practices to determine what constituted as an essential religious practice.
status of religion to the followers of Aurobindo whose teachings were recognized as philosophy, and not a religion. In another case Acharya Jagdishwaranand etc. vs Commissioner of Police, Calcutta and ANR, the Anand Margis’ were recognized as a religious denomination. However, the practice of tandav dance (which was performed by the Anand Margis in public places by using human skulls and lethal weapons) was understood by the court as not an essential practice for this group. This verdict was appealed and the appeals court found that tandav dance was an essential practice to the religious beliefs of Anand Margis, but continued to restrict it for maintenance of public order. In these examples, the courts decided which religious practices are eligible for constitutional protection and which are not. In addition, the courts also judge the limits of freedom that can be enjoyed by religious groups, and they also test the legitimacy of legislation for managing religious institutions (Sen, 2010a, b; Padhy, 2004). In this process, the judges have emerged as custodians of faith by deciding the various limits of religious practices. Legal scholars have argued that the doctrine has allowed the state continued interference in matters of religion. In his reflections on court interpretations of religion, Marc Galanter poses a rhetorical question whether the constitutional provision has provided the Court a mandate to actively participate in the internal reinterpretation of Hinduism (Galanter, 1997 p. 251). In regular engagements with different religions, Indian laws often re-fashions religion in modern

\[40\] In the recent past several Hindu religious practices have entered the Indian Courts. For example, women between the ages of 10 to 50 are not allowed to enter a specific temple in Kerala. The rule is aimed at keeping menstruating women away from the temple, saying the deity, Lord Ayyappa, is celibate. A case was filed by activists stating that this custom was a form of gender discrimination and the Supreme Court gave a verdict that such customs infringe on one’s constitutional rights of women. Jallikattu (bull fighting) is another such example. Jallikattu is an event that occurred in the southern state of Tamil Nadu during the Hindu festival of Pongal. The Animal Welfare Board of India filed a case in the Supreme Court of India asking to ban this event citing that it is extremely cruel to animals. In May 2014, the Supreme Court gave a verdict banning Jallikattu. In January 2017, there was a widespread protest against the Supreme Court verdict in Tamil Nadu.
terms rather than always accept religious doctrine as represented by its practitioners (Sen, 2010b).41

I delve into this discussion here because religion, as I show throughout this chapter, has an overwhelming presence in court judgments and other legal documents on suicide law. Most criminal law related legal arguments on suicide regulation use religious doctrine to make their case for criminalization or decriminalization, hence making it important to contextualize these debates and discussion within past and present relationships between law and religion. As mentioned earlier, both approaches to religion—personal laws and essential religious principles doctrine—used by Indian courts are ways of interfering as well as not interfering in religious matters, while maintaining the Constitutional commitment to secularism. While my research does not specifically focus on the question of colonial and postcolonial history of suicide regulation or suicide within secular ideals in India, the literature on secularism will be briefly reviewed in the next section to provide a nuanced cultural context.

2.3 Secularism, Law, and Religion in India

During the Indian independence struggle from the British and immediately after, secularism was an inextricable part of the imagination of the Indian nation-state. India defines itself today as “secular nation”. Almost all discussions of secularism have been based on the idea of equal respect of all religions. The definition of secular in India is different from Western conceptions of the term. In the West, secularism meant a separation of church and state. For example, France does not allow a system of personal laws or personal expression of religion in public life. French secularism or laïcité, is the absence of religious involvement in government affairs, and the

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41 While Galanter and Sen’s comments have an undertone of critique of the judicial power to interpret religious doctrine, maybe even overturning the practices and beliefs of the practitioners of the religion, the courts have also played a role of protecting people against certain discriminatory religious customs.
absence of government involvement in religious affairs, especially the prohibition of government influence in the determination of religion. *Laïcité* relies on the division between private life, where adherents believe religion belongs, and the public sphere, in which each individual ought to appear as a citizen equal to all other citizens, devoid of ethnic, religious or other particularities. \(^{42}\) Turkey’s first President adopted a similar ideology of secularism. Followers of Ataturk, the Kemalists interpretation of secular is to have freedom *from* religion. Along with this idea of secularism, there is another notion of secularism in Turkey, i.e. the Islamists in Turkey, who seek freedom of practicing religion. \(^{43}\)

Indian secularism is different from either of these models. The Indian state is supposed to play a dual role of maintaining religious even-handedness (that is treating different minority and majority religions fairly) as well as intervening in religious reform efforts. This approach to secularism does not require a total separation between religion and state, but instead equal respect to all religions in both public and private spheres. Gandhi is said to be the proponent of such a governing mode of secularism. \(^{44}\) A noteworthy feature of secularism in postcolonial India is the constitutional mandate that the state can intervene in religious matters. The scholarship on secularism that has attempted to understand the relationship between state and religion in India can be divided into broadly three schools of thought. \(^{45}\)

One school of thought argues that religion and politics belong to different realms.

Proponents of this idea read the rise of hindutva politics in 1980s as a failure of the secular state.

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\(^{42}\) The recurring controversy in France regarding women wearing hijab or burkini is an obvious reflection of France’s aggressive secularism.

\(^{43}\) See Navaro-Yashin (2002) for a detailed ethnography of conflict over secularism in Istanbul following the victory of Islamists in the city’s municipalities. Also see Asad (1993) and (2003).

\(^{44}\) For more on this see Engineer (1995)

\(^{45}\) Freedom of religion was one of the core components of the Indian constitution, but the practice of religion was to be personal and private. But this gradually changed in India. For a more detailed study of secularism in India see Bhargava (1998). Also see Madan (1998); Nandy (1998); Bilgrami (1998). Also see, Engineer (2003); Sen (1996); Nigam (2000).
They argued that religion had to be within the private space of individuals and did not belong in the public politics. For the advocates of this line of thought, secularism represented liberty and progress (Tejani, 2007 p.7-8). According to another school of thought, secularism was never indigenous to the Indian subcontinent and hence has never worked efficiently (Nandy, 1998; Madan, 1998). This scholarship argues that religions in India have always practiced tolerance and so the focus ought to be on tolerance rather than on secularism. Thus, Indians need to draw from their own civilization and not look to Western ideas on secularism. In his analysis of tolerance, Partha Chatterjee argues for a public recognition of religious plurality or ‘tolerance’ (Chatterjee, 1994). He argues that secularism in India is concerned neither with the legal separation of political and religious institutions nor the extent of religiosity of people, but rather the recognition of difference, especially difference regarding minority religious communities. Chatterjee thus advocates for the formation of an autonomous forum that represents minority religious interests. By doing this, he suggests that religious affiliations will not be subsumed within larger democracy. Distinct from these lines of thought, the third stream of scholarship argues that assuming a division between ‘secular’ and ‘religious’ is incorrect in India. Specifically, political philosopher Rajeev Bhargava asks whether it is possible to take the spiritual and ethical elements common to all religions and reframe them as a secular, non-doctrine framework for human behavior. Bhargava proposes a form of secularism where various religious values are brought together in a way that they can be embraced by everybody (Bhargava, 1995 p.341). This last form of secularism has a specific resonance with the legal debates on suicide that I analyze below. As I will demonstrate, the court judgments draw on

46 Also see Verma (1990); Iyer (1976); Chaudhry (1978)
47 For more on the rights and recognition of minorities in the context of secularism in India see Nigam (2006); Chandhoke (1999)
readings of various religious principles, as well as modern medical-psy discourses to legitimize a specific reading of suicide.

3 A Multifarious Law
The remaining sections of this chapter focus on the legal debates on the validity of Section 309 IPC. Since the early 1970s there have been several court cases challenging the constitutional validity of the attempt to suicide law. These cases are significant because they show how, in certain instances, the legal fight to criminalize or decriminalize suicide leads to particular actors, communities, or institutions fighting to define the meaning of suicide, and in others, fighting to define certain kinds of self-inflicted deaths as non-suicides. They also highlight how suicide constantly fragments into various issues or concerns, thereby leading to a heterogeneous representation of suicide and its regulatory framework. In doing so, I will illustrate that rather than a chronological shift from one discourse to another, suicide law is moving in multiple directions simultaneously.

3.1 Law Commission of India on Suicide Law (1971)
One of the first efforts to decriminalize suicide occurred in 1971 in the Law Commission of India Report (LCIR). The Law Commission of India (LCI) does not wield any actual powers in changing laws in the books; it is at best an advisory and a research group, which comes together when there is a need for legal reform. It is constituted of legal experts such as Attorneys General, former Supreme Court judges or Chief Justices, who head a regular staff of around twelve research personnel for a term of three years. The agenda or topics are defined internally by the commission. The reports are generally produced to reform law in the context of changed social circumstances. The reports published by the LCI are sometimes used in court judgments where
the courts are stepping in to fill certain gaps that might exist in the laws. So while the LCI might not exert actual powers to change laws, it has been influential in court judgments in the past, which in turn has resulted in legal changes. This specific LCI was constituted in March 1968, and its task was to make revisions to the existing IPC. To complete this task, the commission decided that it was important to get public opinion on ‘certain broad questions’ with regards to IPC, and hence met with various High Court Judges, representatives of the bar, academic lawyers, and government officials (LCIR, 1971). Based on the information collected, the LCI presented a report (Report 42) with a set of alterations and additions to the Section 309 IPC amongst other sections. The report made arguments against criminal prosecution of individuals who attempt suicide, and stated that the penal provision is “harsh and unjustified and that it should be repealed” (1971, p. 244). In making these arguments, the LCI drew on many different texts and discourses.

One of these many sources was the ancient Hindu text – Manu Smriti or The Laws of Manu. They cite: “…Or let him walk, fully determined and going straight on, in a north-easterly direction, subsisting on water and air, until his body sinks to rest” (LCIR, 1971, p. 243). This quote is used to demonstrate that Manu Smriti permits a man to give up on food and allow himself to die. Further, the LCIR also cites two commentators on Manu, Govardhana and Kulluka, who say that “a man may undertake the mahaprassthana” (great departure) on a journey which ends in death, when he is incurably diseased or meets with a great misfortune, and that,

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48 Prior to this commission coming together, a previous Law Commission, in 1959, had announced its intention to make revisions of the Penal Code and the Criminal Procedure Code. But this did not happen till later when the Law Commission, which was constituted in 1968, collected public opinion and submitted a report in 1971.

49 Manu Smriti is said to be an ancient Hindu code of legal doctrines and ethics. It is one of the most studied Hindu legal texts. It was translated from Sanskrit to English in 1794, during the British rule of India, by Sir William Jones and was used to formulate Hindu law by the colonial government. Manu Smriti has been criticized for being extremely brahminical and propagating casteist ideals. Apart from being casteist, Manu Smruti has also been criticized for being misogynistic. See Ambedkar (1916/2013) and (1891-1953/1990). For a more detailed study of the system of caste in India, see Dumont (1970), Dirks (2001), and Rawat & Satyanarayana (2016).
because it is taught in the Shastras, it is not opposed to the Vedic rules which forbid suicide” (1971, p. 243). Besides Manu Smriti, the LC also cites Max Muller on Jain religious texts:

From the parallel passage of Apas tambha II, 23, 2, it is however, evident that a voluntary death by starvation was considered the befitting conclusion of a hermit’s life. The antiquity and general prevalence of the practice may be inferred from the fact that the Jain ascetics, too consider it particularly meritorious (1971, p. 243).  

These Hindu brahminical as well as Jain religious interpretations were used to argue that suicide was permissible in certain circumstances in ancient India and hence attempt to suicide should be decriminalized. While Hinduism’s relationship to suicide is outside the scope of this study, it is important to point out that the Hindu interpretation of suicide which the LCI cites via Manu Smriti is an upper-caste or brahminical interpretation of Hinduism. Although the LCI does not seem interested in the larger politics of Hinduism, historically, an upper-caste interpretation of religion has taken precedence, and has been understood to be synonymous with all Hindu beliefs. By reaching to upper-caste Hindu and Jain acceptance of suicide, the LCIR draws its authority to decide on matters of death by arguing that the act of suicide is acceptable in Hindu society. Such selective interpretations of religious texts and rituals, by certain experts, have been a fairly common method to make legal changes.

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50 Jainism is said to have emerged as a revolt against the Vedic preoccupation with the supernatural in Hinduism in Eastern part of India (Bihar). Most Jains today trace their lineage to the teachings of Lord Mahavira (499-427 BCE). The term Jainism and Jain are derived from the jīna—‘the conjurer’ of one’s physical self and thus of karmic action (Madan, 2004, p. 210). One of the important tenets of Jainism is to forever be engaged in self-purification, through suppression of all bodily appetites and refraining from injury to others (ahimsa). Within this framework, renunciation of worldly pleasures is highly valued. For a Jain ascetic, ending one’s life through abstinence from food and drink is considered an ideal and for a layman, the ideal life is when he is guided by numerous rules and regulations (Madan, 2004, p. 211). Paradoxically, in India today, Jains are a minority community who are largely involved in businesses. They are mostly a wealthy community and share many religious practices with upper-caste Hindus. Hindus often claim Jains to be a part of Hinduism, rather than a separate religious community. For a more detailed study of Jainism see Dundas (1992), Babb (1996).
Apart from Hindu and Jain religious interpretations, the LCI also refers to decriminalization of suicide in Britain in 1961. The British Parliament, they explain, approached people who commit suicide as deserving of sympathy rather than social condemnation or punishment, and hence decriminalized attempting suicide in 1961 (1971, p. 243). In addition to the British legal reform, the LCI also cites the English writer and diplomat H. Romilly Fedden’s 1938 book *Suicide: A social and historical study*.

It seems a monstrous procedure to inflict further suffering on even a single individual who has already found life so unbearable, his chances of happiness so slender, that he has been willing to face pain and death in order to cease living. That those for whom life is altogether bitter should be subjected to further bitterness and degradation seems perverse litigation (Fedden, 1938 quoted in LCIR, 1971, p.243).

Thus, in the LCIR, one sees a use of Hindu and Jain religious views along with ideals of British benevolent modernity. Such a synthesis of ‘traditional’ and ‘modern’ discourses or modern interpretation of traditional practices is not unusual in the Indian legal context. In a study of Indian court rulings, Ronojoy Sen argues that, in the process of citation and interpretation, court rulings have the effect of homogenizing and rationalizing religion and religious practices, particularly in the context of Hinduism (Sen, 2010a). In line with Sen’s observation, we see that the LCI also attempted to find a homogenous Hindu and Jain interpretation of suicide. And while it homogenizes Jain and Hinduism’s view on suicide as a religious acceptance of suicide, it also draws on a modern secular reading of suicide by citing British ‘modern’, ‘non-religious’ views on suicide, as seen in quotation by Feddens and British parliament’s legal reform which addresses people who attempted suicide with sympathy. I come back to this secularizing impetus when I analyze court decisions later in the chapter.
4 Suicide Interpretation in High Courts

4.1 Case I: Political, Psychological, Social and Economic Explanation (1985)

Although the LC made a forceful argument to repeal Section 309 IPC and decriminalize suicide attempts, the bill drafted to amend the IPC did not pass in the Parliament. This lapse had nothing to do with the alteration of Section 309 IPC but was due to completely unrelated political reasons. Following this episode, the validity of Section 309 IPC was debated at the state-level (provincial scale) during specific cases in various Indian High Courts (HC).

In 1985, the Delhi High Court gave a strongly worded judgment in *State v. Sanjay Kumar Bhatia*. Sanjay Kumar Bhatia was arrested for attempting suicide due to “over emotionalism” (1985). He was arrested on October 5, 1981 for consuming Tik Twenty, an organophosphorous poison used to treat bug infestation, and the charge sheet was filed only on June 4, 1982. The court made a powerful comment that it took too long for the investigation to take place in such a simple case. The judges found that the respondent (Bhatia) had suffered a traumatic experience

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51 The House of the People was dissolved in 1979. The Bill, though passed by the Council of States, lapsed because the Parliament dissolved due to other political reasons. The Parliament was dissolved due to the political instability of the coalition party that was in power post-emergency in India. The emergency period in India refers to the 21 month period between 1975-1977. A state of emergency was declared throughout the country by the then Prime Minister Indira Gandhi. This gave the Prime Minister the authority to rule by decree. During this time, Indira Gandhi suspended elections, and curbed civil liberties. Following the withdrawal of the state of emergency in March 1977, several political parties contested elections and finally Janata Party won the elections and a government was formed which was headed by the Prime Minister Moraji Desai. However, due to infighting within the government, it did not remain in power for the whole term, which led to the Parliament being dissolved in 1979.

52 I only take up cases here that were referred to again in subsequent legal debates and court cases.

53 Attempting suicide is a cognizable criminal offense. If an offence is cognizable, police has the authority to arrest the accused without a warrant and to start an investigation with or without the permission of a court. Otherwise police does not have the authority to arrest the accused without a warrant and an investigation cannot be initiated without a court order. It is also a bailable offense, which means that the accused can claim to be out on bail as a right as long as s/he is subject to certain conditions. If an offence is bailable, police has the authority to release the accused on bail on getting the defined surety amount along with a duly filled bail bond at the concerned police station. Otherwise arrested person has to apply for bail before a magistrate or court. My research does not focus on the actual policing of suicide attempts, but it has been shown that in Karnataka alone 961 cases have been booked under Section 309 in 2007. See Gopal (2014).
and hence should not be penalized (State v. Sanjay Kumar Bhatia, 1985). Arguing against criminal prosecution of individuals who attempt suicide, Judge Sachar pointed out:

It is ironic that Section 309 IPC still continues to be on our Penal Code...Strange paradox that in the age of votaries of Euthanasia, suicide should be criminally punishable. Instead of the society hanging its head in shame that there should be such social strains that a young man (the hope of tomorrow) should be driven to suicide compounds its inadequacy by treating the boy as a criminal. Instead of sending the young boy to psychiatric clinic it gleefully sends him to mingle with criminals.... The continuance of Section 309 IPC is an anachronism unworthy of a human society like ours. Medical clinics for such social misfits certainly but police and prisons never. The very idea is revolting. This concept seeks to meet the challenge of social strains of modern urban and competitive economy by ruthless suppression of mere symptoms this attempt can only result in failure. Need is for humane, civilized and socially oriented outlook and penology.... No wonder so long as society refuses to face this reality its coercive machinery will invoke the provision like Section 309 IPC which has no justification to continue to remain on the statute book. (State v. Sanjay Kumar Bhatia, 1985)

Unlike the LCIR report analyzed earlier (and the other cases that I discuss ahead) this verdict does not refer to any religious texts. The judgment rationalizes the act of suicide as a result of social strains resulting from city lifestyle and competitive economy. It brings together a hybrid discourse by referring to socio-economic conditions resulting in psychological strains. And the solution the judge suggests is to send the boy to a psychiatric clinic and not a prison. By staying clear of any religious references, this judgment proposes a modern, secular approach to suicide. As the quote above demonstrates, the judgment frames suicide as a symptom of a psychosocial problem rather than a criminal problem deserving of punishment. It further states that a modern
penology must not have such non-humane statutes in the books; instead the need is for a more ‘civilized’ penology. Here, the push is to modernize, and psychiatric treatment is understood as modern and hence a form of progress. This judgment does not overwhelmingly pathologize suicide, but it was one of the first judgments where psychiatric treatment was suggested for suicide behavior.

4.2 Case II: Right to Life and Death (1986)

Following the 1985 case in Delhi HC, the Bombay (today Mumbai) HC stated the unconstitutionality of Section 309 IPC in 1986 in the Maruti Shripati Dubal v. State of Maharashtra case. Maruti Shripati Dubal was a police constable with the Bombay City Police Force for about nineteen years. In 1981, he met with a road accident and suffered head injuries that led to mental illness. Post-accident, Dubal was under psychiatric treatment for “Giddiness, Chabrat (fright), reduced sleep and appetite, nervousness, confusion, etc.” (Maruti Shripati Dubal, 1986). In August 1982, he was diagnosed with schizophrenia. The 1986 judgment explains, “He suffered from auditory and visual hallucinations. He used to sit lonely in bed, had a vacant look and was confused. He was given electric shock-treatment till September 1982 and was also put on a dose of heavy tranquilizers” (Maruti Shripati Dubal, 1986).

The incident that led to Dubal’s arrest occurred on April 27th 1985, when he tried to light himself on fire outside the office of the Municipal Commissioner of Greater Bombay. The judgment states that the immediate cause of his suicide attempt was a delay in his wife’s application for getting a license for a vegetable stall near Colaba Market, Bombay. The delay had

54 It is important to mention that attempting suicide in front of bureaucratic offices is an oft occurring, yet under studied phenomenon in India. During my research, I often found news reports on families or individuals attempting suicide by consuming poison or self-immolating in front of the police commissioner’s office, or other bureaucratic office spaces as in the case of Dubal. Certain forms of political protests have gained attention – such as hunger strike by Irom Sharmila, self-immolations by students in Telangana and Tibet – these are large political struggles and not individual or familial protests.
occurred despite the fact that a minister of State Government had given Dubal a letter addressed to the Municipal Commissioner to look into Dubal’s case sympathetically as he was mentally ill. It is said that Dubal wanted to meet the Municipal Commissioner in person with this letter but was sent away by the security guard who was rude to him. This led to him attempting suicide by pouring kerosene over himself and trying to light himself on fire outside the office of the Municipal Commissioner. Following this, Dubal was arrested under Section 309 IPC and released on bail, after which he continued to work as a constable in the police force (Maruti Shripati Dubal, 1986).

Following his arrest, Dubal asserted a constitutional challenge to Section 309 IPC. His lawyer made three arguments: first, Section 309 violates Article 19 (Freedom of Speech) as well as Article 21 (Right to life) of the Indian constitution. Second, Section 309 treats all cases of attempt to commit suicide equally and prescribes punishment for them arbitrarily by the same measure. And lastly, Section 309 violates Article 14 on equality before the law. With regards to this last point, the lawyer argued that even if an attempt to commit suicide is assumed to be a criminal offense, the punishment meted out is barbaric, cruel, irrational, and self-defeating (Maruti Shripati Dubal, 1986). In response, the Union of India countered all three points. It argued that neither Article 19 (freedom of speech) nor Article 21 (protection of life and liberty) “creates or recognizes the right to life as such” (1986). It argued that these two constitutional provisions prevent the Indian state from depriving an individual of his right to life by a just, fair,

55 Article 19, Indian Constitution: Protection of certain rights regarding freedom of speech etc. All citizens shall have the right (a) to freedom of speech and expression; (b) to assemble peaceably and without arms; (c) to form associations or unions; (d) to move freely throughout the territory of India; (e) to reside and settle in any part of the territory of India; and (f) to practice any profession, or to carry on any occupation, trade or business. Article 21, Indian Constitution states “Protection of life and personal liberty No person shall be deprived of his life or personal liberty except according to procedure established by law”
56 Article 14, Indian Constitution states “Equality before law The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India Prohibition of discrimination on grounds of religion, race, caste, sex or place of birth”
reasonable procedure established by the law (*Maruti Shripati Dubal*, 1986). A second argument was made with regards to Article 14 of the Indian constitution: “there is no obligation cast on the State to make classification of the offenders and, therefore, Art. 14 of the Constitution is not violated” (*Maruti Shripati Dubal*, 1986). Lastly, the Union of India responded to the argument about uneven sentencing by stating that “it is the prerogative of the State to prescribe the sentence, and the nature and the quantum of sentence prescribed for the offence cannot be said to be barbaric, cruel, irrational or self-defeating. The sentence prescribed is to deter the prospective offenders” (*Maruti Shripati Dubal*, 1986).

Disagreeing with the governments’ arguments, the court in *Maruti Shripati Dubal v. State of Maharashtra* ruled for the unconstitutionality of Section 309 IPC, and explained that it is violative of Article 21 (right to life) and Article 14 (equality before law) but *not* violative of Article 19 (protection of certain rights regarding freedom of speech). The judgment forcefully stated that Article 21 (right to life) will include within it a *right not to live or not to be forced to live*. The judgment stated:

> There is nothing unnatural about the desire to die and hence with the right to die. Whatever the circumstances which induce a person to end or terminate his or her life, the act of termination of life is the act of that individual. It is no less his than his act of living. The confusion between the circumstances which impel or urge a person to end his life and the termination of life often leads on to the mistaken conclusion that the desire to end one's life itself is not natural. The unnatural cause of death must also be distinguished from the natural desire to die. The means adopted for ending one's life may be unnatural varying from starvation to strangulation. But, the desire which leads one to resort to the means is not unnatural (*Maruti Shripati Dubal*, 1986).
This judgment, similar to the LCIR (1971), references doctrine from various religious texts to rule against criminalizing suicide attempts. It goes beyond Hindu and Jain texts to include Christian, Islamic, and Buddhist texts. It briefly explains that neither the New Testament nor the Old Testament of the Bible condemn suicide explicitly, although suicide is denounced as a form of murder in Christianity. In its brief reference to the Quran, the judgment states that suicide is explained as being worse than murder in the Quran. In addition to Christian and Islamic views on suicide, the judgment also makes a brief reference to Buddhism. It explains that although Buddhism encourages suicide under certain circumstances, such as in the service of religion or country, the attitude of Buddhism has been ambiguous with regards to suicide (Maruti Shripati Dubal, 1986). While the other religions are drawn on briefly, the judgment elaborates extensively on Hinduism’s views on self-inflicted deaths (Maruti Shripati Dubal, 1986).

Unlike LCIR 1971, which referred only to Hindu and Jain scriptures to make sweeping arguments for decriminalizing suicide, this particular judgment provides a detailed explanation on specific conditions under which suicide is acceptable according to Hindu scriptures. To do this, they refer extensively to interpretations of Dharmashastrakaras, Vedas, and Manu Smriti, to provide a detailed explanation regarding the acceptable and unacceptable situations for attempting suicide.57 To cite one example of an unacceptable situation:

The Dharmashastra writers generally condemn suicide or an attempt to commit suicide as a great sin. Parasara (IV. 1-2) states that if a man or woman hangs himself or herself through extreme pride or extreme rage or through affliction or fear, he or she falls into hell for sixty thousand years. Manu V. 89 says that no water is to be offered for the benefit of the souls of those who kill themselves (Maruti Shripati Dubal, 1986).

57 Dharmashastrakaras, Vedas, Manu Smriti, are all brahminical texts of Hinduism.
The judgment then refers to Hindu brahminical text Manu Smriti to explain that in certain circumstances suicide was permissible. For example:

In spite of this general attitude, exceptions were made in the Smriti’s the epics and puranas. When a man was guilty of brahmana murder, he was allowed to meet death at the hands of archers in a battle who knew that the sinner wanted to be killed in that way as penance or the sinner may throw himself head downwards in fire (Manu XI. 73. Yaj. III 248). Similarly the drinker of spirituous liquor expiated his sin by taking boiling wine, water, ghee, cow’s milk or urine and dying thereby (Manu XI. 90-91, Yaj. III., 253, Gaut. 23. 1, Vas Dh. S. 20.22). (Maruti Shripati Dubal, 1986)

The judgment reiterates that according to Hindu and Jain religious scriptures suicide is disapproved in certain circumstances, while in others it is not only approved, but also celebrated.58 In stating this, the judgment states: “What is instructive to note is that the exceptions made were more or less in conditions similar to those which are pleaded today as circumstances extenuating suicides or attempts to commit them” (Maruti Shripati Dubal, 1986). Importantly, the judgment ruled that while the methods used to end one’s life might be unnatural, the desire to die is natural.

As mentioned earlier, it is important to highlight that in this judgment brahminical Hindu religious discourses play an important role. A second point of significance here is that these judgments are based on scriptures or texts, and a selective interpretation of these texts, rather than on religious norms as practiced within different communities. Lastly, this judgment draws

58 It is significant that the example the judges choose from Manu Smriti is that of a person killing a brahmin. This is not only indicative of the Manu Smriti being brahminical, but also the brahminical nature and casteist tendencies inherent in many court judgments.
on the doctrines to read into the Article 21, which guarantees citizens right to life, citizens’ right to die or not live a forced life.

4.3 Case III: Right to Life Does Not Include Right to Die (1987)

The judgment by the Andhra Pradesh HC in the Chenna Jagadeeswar v. State of A.P. case (1987) changed the course of the conversation. In this specific case, the Court observed that Section 309 IPC was valid and *not violative* of Articles 21 and 14 of the Indian Constitution. The case pertained to Dr. Jagadeeswar and his wife Saroja who were tried for several charges. Amongst these, four charges were under Section 302 IPC against both the accused for having killed their four young children, and one charge under Section 307 IPC against Dr. Jagadeeswar for attempting to murder his wife Saroja. Both were also accused under Section 309 IPC for attempting to commit suicide. In the Sessions court, Saroja was acquitted of all charges except for attempting suicide, but was found guilty under Section 309 and released on probation. Dr. Jagadeeswar was found guilty of all four charges under Section 302 and was sentenced to imprisonment for life. He was also convicted under Section 309 and sentenced to undergo simple imprisonment for six months. These sentences were to run concurrently. The judgment I study here from the Andhra Pradesh HC was an Appeal in the case. The HC judge was to study whether the sentence imposed by the Sessions court was justified, and whether the prosecution proved the guilt of the accused beyond all reasonable doubt. The HC judgment reduced the sentence under Section 309 from six months to three months, however, it upheld Section 309 as being valid and relevant.

Speaking to the Constitutional validity of Section 309, Judge K Amareswari P Rao referred to Justice Sawant’s words in Maruti Shripati Dubal v. State of Maharashtra judgment, where it was ruled that Article 21 (Right to Life) also held within it the right to end one’s life.
Speaking against such a reading of Article 21 as well as Article 19, Judge Amareshwari rationalized,

From these Articles, it is seen that the right to life is not specifically mentioned. But, in a broader sense, unless a man is assured of physical existence there can be no other fundamental right and since the State exists for the common good of the citizens, no Constitution can ignore the right of the citizens to life though it may not be explicitly explained. In these circumstances, it is rather difficult to hold that the right to life impliedly guaranteed by the Constitution includes the right to die…..Can the parents who are responsible for the life of their children be said to have a right to dispose of the life of their children because they have created it. Then there are cases of hunger strikes, threatened self-immolations and other potentially employed (sic) situations. If S. 309 I.P.C. held to be ultra vires, no action can be taken against the people resorting to these practices, on the ground that they have a right to dispose of themselves (Chenna Jagadeeswar, 1987).

Judge Amareswari explains that Section 309 IPC does not mandate punishment; it is up to the courts to decide whether any punishment is to be meted out. Furthermore, the judgment mentions that in certain situations a person who attempts suicide is to be treated and not punished. In regards to the latter, there are other provisions that provide the court with the discretion to decide whether a person who has attempted suicide requires psychiatric care or is to be released with admonition (Chenna Jagadeeswar, 1987).\(^{59}\) This decision responded to the concern that if

\(^{59}\) The judgment explains other provisions in the Code of Criminal Procedure, 1898 which permits the courts to use discretion. The judgment states: “Sections 3, 4 and 13 of the Probation of Offenders Act, 1958 confers a wide discretion on Court either to bind such a person to Psychiatric care or release him with an admonition. S. 12 of the Act enables court to ensure that no stigma or disqualification should attach to such a person notwithstanding anything contained in any other law.” (Chenna Jagadeeswar, 1987)
Section 309 is to be held illegal, it might lead to Section 306 IPC (which refers to the abetment of suicide) being removed as well as render the state inactive in cases of hunger strikes and self-immolations. But a larger concern was that the dismissal of Section 309 and decriminalization of suicide would render any form of self-inflicted death, regardless of its motive, as being outside the purview of the court. The judgment states:

> It is a paradox that society will neither provide sustenance nor allow the sufferer to die. In this complexity of social mal-adjustments, the best safeguard is the Court which should exercise and temper its judgment with humanity and compassion. In a Country like India, where the individual is subjected to tremendous pressures, it is wise to err on the side of caution. To confer a right to destroy one-self and to take it away from the purview of the Courts to enquire into the act would be one step down in the scene of human distress and motivation. It may lead to several incongruities and it is not desirable to permit them. We, therefore, hold that S. 309 I.P.C. is valid and does not offend Arts. 19 and 21 of the Constitution (Chenna Jagadeeswar, 1987).

This statement indicates that the court imagines itself as an entity that can be compassionate and humane. More significantly, this judgment suggests that by decriminalizing suicide, and providing the right to “destroy oneself” to the citizens, the court will be aiding the already existing ‘human distress’ in India. Interestingly, in stating in a country like India, where the individual is subjected to tremendous pressures, the judgment acknowledges social conditions that might be resulting in people attempting suicide. This reference to the social situations is similar to the judgment in State v. Sanjay Kumar Bhatia. In Sanjay Kumar Bhatia case, the judge states that there are several stressors in society and thus Section 309 IPC ought to be decriminalized and people should instead be provided psychiatric treatment. Unlike the judgment in Bhatia case, Judge Amareshwari ruled that precisely because citizens of India are subjected to
social pressures, the court must continue to hold power and responsibility over self-inflicted deaths. This judgment seems to suggest that keeping suicide attempts as a criminal offense will dissuade Indians from attempting suicide.

Before moving on to the next set of cases, I want to briefly highlight the various discourses that are at play in the arguments for and against criminalizing suicide attempts. The LCIR (1971) explicitly states the need to decriminalize suicide attempts. By citing Hindu, brahminical texts and interpreting religious texts, the report supplements its argument based on the claim that the act of suicide is not punishable according to Hinduism. In the Maruti Shripati Dubal v. State of Maharashtra (1986), the judgment delves extensively into Jain and Hindu scriptures to make a case for the unconstitutionality of Section 309. In both these instances, religious discourse is used to exert pressure to decriminalize suicide attempts within the legal arena. In the latter case, while the judgment refers to other religions frowning upon the act of suicide, it gives precedence to brahminical Hindu and Jain interpretations to supplement its case for decriminalization as well as reading into Article 21 of the constitution a citizen’s right to die or not live a forced life. In contrast to these two cases, religious doctrines do not play a major role in the Judgment in State v. Sanjay Kumar Bhatia (1985). Here the focus is on reading suicide as a symptom of a modern psychosocial problem that requires psychiatric care rather than imprisonment.

The Chenna Jagadeeswar v. State of A.P. (1987) verdict, unlike the above three, ruled for maintaining suicide attempt as a criminal offense. Here, the emphasis is not on religious interpretation of suicide, because the aim is not to get religious legitimacy for the act of self-inflicted deaths. Instead, the focus is more on the state’s responsibility and legal control over a citizen’s right to life and death. The issue of medical/psychiatric treatment receives less attention, with the judgment leaving the power to decide about treatment to the courts. These
judgments, as well as the cases that I will discuss next, all bring to the fore different sets of problems. In some instances suicide is to be addressed through treatment and pity; in other instances suicide is understood as an offense deserving punishment; when seen through yet another perspective, some suicide acts gain religious approval (albeit only in the Jain and Hindu religions). In yet other contexts, suicide is a psychosocial problem. Suicide in the realm of law entails all these aspects I listed above.

In the next section, I analyze two important Supreme Court of India judgments. One temporarily decriminalized suicide attempts by stating that right to life included the right to death. The second case, (re)criminalized attempt to suicide by deciding against the idea of right to death being a part of right to life. These two cases further add to the hybridization and heterogeneity of suicide in the legal arena.

5 Shuffling Suicide Narratives: Supreme Court Judgments

5.1 Case I: Right (not) to live a forced life (1994)

The HC decisions discussed above influenced the important Supreme Court (SC) verdict of 1994, which decriminalized suicide, temporarily. In P. Rathinam/ Nagbhusan Patnaik v. Union of India case (1994), the SC struck down Section 309 IPC in order to “humanize our (Indian) penal laws” (P. Rathinam/ Nagbhusan PatnaikI, 1994). The judgment posed several questions, and in answering these questions decided that attempting suicide is not a criminal offense. I do not take up all these questions in my analysis here, but these questions highlight a variety of concerns that have emerged within discussions on suicide in the legal arena.

The questions that the judgment intends to address cover a range of topics both broad and narrow in scope. For example, questions such as: “Is suicide a non-religious act?” “Is suicide
immoral?” highlights the spiritual and religious aspects of self-inflicted deaths. Other questions such as: “Has a person residing in India a right to die? Why is law enacted? What object(s) it seeks to achieve? How can crimes be prevented? Why is a particular act treated as crime/what acts are so treated? Does commission of suicide damage the monopolistic power of the State to take life? Has Article 21 any positive content or is it merely negative in its reach?” demonstrate the court’s struggle with difficult concerns regarding state control over life and death. Further questions such as “Why is suicide committed? Who commits suicide? How suicide-prone person should be dealt with? Does suicide produce adverse sociological effects?” show us the courts concern with understanding or addressing sociological factors in a suicide act. In addition, the court also aims to position India within other modern countries with respect to regulation of suicide. This is evident in the question “Global View: What is the legal position in other leading countries of the world regarding the matter at hand?” (P. Rathinam/ Nagbhusan Patnaik, 1994). As I mentioned earlier, these questions themselves reflect a range of discourses that have entered the court debate. Unlike the HC judgments which often focused on one or two of these concerns, the Supreme Court addresses all of them concurrently.

In this specific case, the SC judges rejected the challenge to the constitutional validity of Section 309 based on Article 14 (equality before the law) of the constitution but upheld the challenge based on Article 21 (right to life). Similar to the Dubal case (1986), the SC judgment stated that Article 21 of the Indian constitution allows for the protection of ‘right to life’, as well as the ‘right not to live a forced life’ (P. Rathinam/ Nagbhusan Patnaik, 1994). Hence Section 309, it stated, violates Article 21. This SC judgment was a significant step in the discussion around suicide as a criminal offense, not just because it read Article 21 as right to die, but it also drew a clear distinction between suicide attempts, abetment of suicide, and euthanasia.
Abetment of suicide is a criminal offense in India.\(^6\) This SC decision makes a strong, but obvious point about differentiating between abetment of suicide and attempt to suicide by arguing that conceptually self-killing is different from abetting another person to take their life (\textit{P. Rathinam/ Nagbhushan Patnaik, 1994}). In emphatically making this distinction, this SC judgment disagrees with the HC judgment in the \textit{Chenna Jagadeeswar} case (1987), where the HC judge decided that decriminalizing suicide attempt would legitimize abetment of suicide. Furthermore, this SC judgment also makes a distinction between euthanasia and suicide to explain that public discussion on legalizing euthanasia is a separate concern from suicide and should not interfere with decriminalizing suicide (\textit{P. Rathinam/ Nagbhushan Patnaik, 1994}). Until recently, euthanasia was addressed under abetment of suicide law. Only in 2011 did the SC permitted passive euthanasia, which refers to the withdrawal of treatment or food that would allow the patient to continue living (\textit{Aruna Ramchandra Shanbaug v. Union Of India 2011}).

There have been extensive debates regarding euthanasia in India. Public discussion on euthanasia was at its peak in the case of \textit{Aruna Ramchandra Shanbaug v. Union Of India 2011}. In 1973, a 23-year-old nurse named Aruna Shanbaug working in a Mumbai hospital was brutally raped, had severe brain damage, and was paralyzed and thus became completely bedridden and dependent on her caretakers for her needs. Her parents died many years ago and she had no relatives to take care of her, but she received medical care in the hospital where she had worked for almost 39 years. When Shanbaug was about 60 years of age, her friend and an activist-journalist, Pinky Virani, filed a petition in the SC asking for permission to allow discontinuation of feeding and to allow Aruna Shanbaug a dignified death (\textit{Aruna Ramchandra Shanbaug, 2011}). In this decision, the SC turned down the mercy killing petition, but allowed for ‘passive

\(^6\) Section 306 IPC refers to the abetment of suicide law which states: “If any person commits suicide, whoever abets the commission of such suicide, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine”.
eutanasia’. The court provided guidelines for what constituted passive euthanasia. According to these guidelines, passive euthanasia involves the withdrawal of treatment or food that would allow the patient to continue living. In May 2016, the Government proposed a bill that permits passive euthanasia following the SC judgment in Aruna Shanbaug case.

In *P. Rathinam*, the court made a persuasive case against conflating euthanasia with suicide attempts. The judgment states: “…in euthanasia a third person is either actively or passively involved about whom it may be said that he aids or abets the killing of another person. We propose to make a distinction between an attempt of a person to take his life and action of some others to bring to an end the life of a third person” (*P. Rathinam/Nagbhusan Patnaik, 1994*). The judgment further explains that euthanasia is not related to suicide, and in the case of passive euthanasia, in parts of the world where it is permitted (at the time of this decision, passive euthanasia was not permitted in India), there is a requirement of getting consent either of the patient or their relations (*P. Rathinam/Nagbhusan Patnaik, 1994*). Thus withdrawal of life support, the court decided, does not amount to suicide. In making a distinction between abetment of suicide and euthanasia, the court ruled against the judgment in *Chenna Jagadeeswar* (1987), which held that Section 309 was valid and did not violate Articles 14 (Equality before the law) and Article 21 (Right to Life), as well as partially accepted the decision in *Maruti Shripati Dubal*

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61 For a more detailed reading on this case see Rao (2011).
62 In this bill the government recommended that passive euthanasia be permitted on ‘competent’ patients, that is those who can take informed decisions themselves. This draft bill states that competent patients need to inform their doctor to withhold medical treatment or life support and both the patient and the doctor will be protected from criminal or civil liability. For ‘incompetent patients’, those who are unable to take informed decisions, a case has to be filed in the local high court by the patient’s relative, friend or doctor and the high court is expected to pass a judgment within a month. This has raised red flags among disability activists. They are concerned how persons with intellectual disabilities or persons with mental illness will be dealt with within this proposed euthanasia bill. Disability rights activists read this bill as opening a Pandora’s Box regarding what life is worth living. For more on the proposed euthanasia bill see: ‘Passive Euthanasia gets lifeline from the government’, (2016); ‘Mercy Killing: It’s an Act of Humanity, not a crime’, (2016); Kaul, (2016).
(1986), which ruled that Section 309 violated Article 21. In doing this, the court was able to rationalize the right not to live a forced life, allow for future laws on passive euthanasia, as well as maintain abetment of suicide as a crime.

In addition to the discussion of right to life and death, the verdict also gave significant attention to religious views on suicide. The judgment meditated on the question: Is suicide a non-religious act? This engagement with religious views can be ascribed to the history of Indian law’s complex relationship to religion explained earlier. The legal system both attempts to maintain its position of non-interference and even-handedness towards different religions, and it displays its will to modernize both religious and secular discourses on various subjects. We have seen this form of relationship play out in the LCIR 1971, the colonial state’s position on Sati, as well as the previous HC judgments on Section 309. In the case of LCIR 1971 and the HC judgments, the commission and the courts, gave precedence to elite religious views on suicide. Hence, it is not surprising that in P. Rathinam, the SC posed the question, ‘is suicide a non-religious act?’ (1994) and subsequently drew on a host of different religious registers of knowledge to provide a secular view on suicide. This form of secularism, I argue, resonates with Bhargava’s approach to secularism, that is, to take the spiritual and ethical elements common to all religions and reframe them as secular, non-doctrinal framework for human behavior. Here, various religious values are brought together in a way that they can be embraced by all.

The judgment begins to answer the question by citing law professor G.P. Tripathi’s work on right to life. The ideas that Dr. Tripathi explicates are based on Hindu brahminical philosophy. The judgment states:

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63 As I mentioned earlier, some recent cases of law’s role in deciding on religious ritual are: banning of Jallikattu (bull fighting) in Animal Welfare Board of India vs. A Nagaraja and Others 2014, women’s entry into Sabarimala temple in Indian Young Lawyers’ Association vs. The State of Kerala and Ots 2006.
every man lives to accomplish four objectives of life: (1) Dharma (religion and moral virtues); (2) Artha (wealth); (3) Kama (love or desire); and (4) Moksha (spiritual enjoyment). All these objectives were said to be earthly, whereas others are to be accomplished beyond life. When the earthly objectives are complete, religion would require a person not to cling to the body. Shri Tripathi stated that a man has moral right to terminate his life, because death is simply changing the old body into a new one by the process known as Kayakalp, a therapy for rejuvenation (P. Rathinam/ Nagbhusan Patnaik, 1994).

In addition, the judgment also references Hindu mythological stories of Lord Rama and his brothers choosing Jalasamadhi (a form of water burial). In citing these ideas as reflective of all Hindu beliefs, the SC judgment not only homogenizes Hinduism’s view on suicide, but also privileges a brahmanical view of suicide within Indian law. In addition to Hindu mythologies, the SC judgement cites the examples of Buddha and Mahavira attaining voluntary death, as well as the writings of Pope John Paul II. It cites from John Paul II’s “Sacred Congregation for the Doctrine of the Faith Declaration on Euthanasia”:

> when inevitably death is imminent in spite of the means used, it is permitted in conscience to take decision to refuse forms of treatment that would only secure precarious and burdensome prolongation of life, so long as the normal care due to sick person in similar cases is not interrupted..... (P. Rathinam/ Nagbhusan Patnaik, 1994)

Furthermore, the judgment also refers to Encyclopedia of Religion (1987) on the meaning of life. The encyclopedia is said to have based its case after studying the subject of meaning of life in
Judaism, Christianity, Hinduism, Islam and Buddhism along with other ‘primitive societies’ (1994).  

Drawn from the Encyclopedia, the judgment cites that life is an:

…inexhaustible storehouse of mysteries, a realm of endlessly self-perpetuating novelties, in which the solution to any given problem gives rise to a plethora of other questions that beckon the always restless, never contended mind of Homo Sapiens to see further for additional answers or, at least, to search out more intellectually refined, morally elevating, and spiritually salutary ways of pursuing the quest. So, life does not end in this world and the quest continues, may be after the end of this life. Therefore, one who takes life may not really be taken to have put an end to his whole life. There is thus nothing against religion in what he does (P. Rathinam/ Nagbhusan Patnaik, 1994. Emphasis mine)

The fact that the judgment refers to an Encyclopedia of Religion to get the meaning of life and death demonstrates law’s ability to derive its truth from practically any source. In this case, the encyclopedia is amalgamating various religious beliefs into one singular idea of life and death. The court, without an explanation, uses this source as a legitimate defense of its judgment. The reference to the encyclopedia demonstrates law’s epistemic creativity.

Unlike LCIR (1971), which restricted itself to Hindu and Jain religious ideas as well as Western modern, secular discourses, this SC judgment engages with different religious views on self-inflicted deaths in a secular fashion. It brings together different religious views on suicide to conclude that taking one’s life is not against many religious principles. The judgment ignores

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64 The citation for the Encyclopedia of Religion referenced in the judgment is incomplete. There are several Encyclopedias of Religion and so it is difficult to know which one precisely the judgment was referring to. But irrespective of that Encyclopedias on Religion are elaborate surveys of religions across the world. Typically, these publications are not very detailed, but give a brief overview of the topics that are discussed. Also typically, these encyclopedias only reflect the brahminical conceptualization of Hinduism.
particularities of different religious philosophies. Thus, one does not find references to the highly criticized brahminical Hindu text Manu Smriti, or the Bible and the Quran, which are against suicide. What is significant here is the selective reading of religious texts in relationship to a desire for a secular approach. Here, the judgment is able to essentialize religious notions on suicide and avoid any contradictions that might exist amongst different religions.

The judgment then moves on to the aspect of self-inflicted death as a form of protest. Here, it discusses anti-British activists who chose hunger strikes as a method of protest. The judgment states, “modern history of Independence says about various fasts unto death undertaken by no less a person than Father of the Nation, whose spiritual disciple Vinoba Bhave met his end only recently by going on fast, from which act (of suicide) even as strong a Prime Minister as Indira Gandhi could not dissuade the Acharya” (P. Rathinam/ Nagbhusan Patnaik, 1994).\(^65\) By referring to Mohandas Karamchand Gandhi the judgment reasons that suicide as a form of protest is not only approved, but also celebrated as a sign of strength. Also the reference to Vinoba Bhave is significant. Bhave did not die from undertaking a hunger strike. After falling seriously ill, Bhave decided to stop consuming food or medicine until his death. In this judgment, such a form of self-inflicted death is celebrated in a similar fashion as hunger strikes.

In addition, a running theme in the judgment is the need to humanize the laws. It takes up an example of a woman who commits suicide because she has been raped and persuasively states:

Would it not be adding insult to injury, and insult manifold, to require such a woman in case of her survival, to face the ignominy of undergoing an open trial during the course of which the sexual violence committed on her which earlier might have been known only

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\(^{65}\) Mohandas Karamchand Gandhi is referred to as the ‘father of the nation’.
to a few, would become widely known, making the life of the victim still more intolerable. Is it not cruel to prosecute such a person? … And why persecute the already tormented woman? Have we become soulless? We think not. What is required is to reach the soul to stir it to make it cease to be cruel. Let us humanise our laws (P. Rathinam/Nagbhusan Patnaik, 1994).

The above example is one among many that the judgment undertakes to forcefully rule against criminal prosecution of individuals who attempt suicide. I will not delve into the victimizing rhetoric that is evident in this example. But it is important to note that one of the important themes running through this judgment is that in certain instances, such as the raped women, or student who has failed an exam and so attempts suicide, or an individual who is attempting suicide to avoid arranged marriage – are all perceived as needing help and sympathy and not criminal prosecution.

Although the judgment addresses citizen rights, religious approval, and suicide as political protests, the judgment then goes on to claim that “true” suicide is a psychiatric problem. It suggests that suicide should not be perceived as a manifestation of criminal instinct but as a problem that requires psychiatric care. Quoting Dr. Dastoor, a psychiatrist, the court points out that attempting suicide is basically a ‘call for help’ and that law is being cruel by demanding punishment for people who are attempting suicide (P. Rathinam/Nagbhusan Patnaik, 1994).

“(W)hat is needed to take care of suicide-prone persons are soft words and wise counselling (of a psychiatrist) and not stony dealing by a jailor following harsh treatment meted out by a heartless prosecutor” (P. Rathinam/Nagbhusan Patnaik, 1994. Emphasis mine).

What is significance in this SC judgment is the desire to isolate one “true” suicide. The judgment brings together various knowledges, experts, contexts, texts and discourses on suicide from subjects such as religion, medical/psy, freedom struggle, state control over life and death.
While it acknowledges various connotations and complexities within different kinds self-inflicted deaths, it chooses to highlight one true suicide, that which is a “call for help” requiring psychiatric treatment and not criminal punishment. The judgment differentiates between self-inflicted deaths that are sanctioned by religion, political protests such as hunger strike which gain moral approval and then a form of suicide that requires psychiatric care.

The causes of suicides are many and varying inasmuch as some owe their origin to sentiments of exasperation, fury, frustration and revolution; some are the result of feeling of burden, torture, and sadness. Some are caused by loss of employment, reversal of fortune, misery due to illness, family trouble and thwarted love. Sometimes killing is in opposition to society and sometimes in opposition to particular persons. This happens when the person committing suicide nurses a feeling of unjust treatment, maltreatment and cruelty (P. Rathinam/ Nagbhusan Patnaik, 1994).

Although the judgment distinguishes between different motivations for a suicide attempt, the only ‘solution’ it provides is psychiatric treatment. It would be unfair to read this judgment as if it is suggesting that psychiatric treatment is a solution for all kinds of suicides, but there is definitely a strong perception that psychiatric framework is a better treatment for some kinds of ‘true’ suicides. Hence, there is a desire to identify a certain true suicide, which is not the kind of self-inflicted death that is a political protest or sanctioned by religion. But it is unclear in the judgment whether it perceives the woman who is a ‘victim’ of sexual assault, or a student who is attempting suicide require psychiatric treatment. By quoting a psychiatric expert, who frames “true” suicide attempts as a call for help requiring psychiatric care, the judgment claims that everyone does and does not have a right to not live a forced life. In this formulation of suicide,
some individuals who attempt suicide are thought of as having agency, while some others who are perceived as having a mental illness require treatment.66

5.2 Case II: (Re)Criminalizing Suicide: Suicide as Un-Natural Death (1996)

The *P. Rathinam* judgment made a significant impact on the legal discussion on suicide. However, this did not last long. Another SC judgment passed two years later superseded it. In 1996, the SC overruled the *Rathinam* decision in *Gian Kaur v. The State of Punjab* and made attempt to suicide a criminal offense once again.

Gian Kaur and her husband, Harbans Singh, were convicted by a Trial Court under Section 306-IPC for abetting the commission of suicide by Kulwant Kaur. The primary concern in this case was the constitutional validity of Section 306-IPC, which deals with abetment of suicide. The argument made by Gian Kaur rested on the *Rathinam* judgment. They argued that anyone abetting suicide of a third person is merely assisting in the enforcement of a fundamental right under Article 21. Therefore Section 306 IPC (abetment of suicide) violates Article 21 of the Constitution. This argument compelled the judges to reconsider the *Rathinam* decision (*Gian Kaur*, 1996).

The *Rathinam* decision had extensive discussions on religion, medical/psy, and global debate regarding criminalizing suicide attempt. The *Gian Kaur* decision dismissed these discussions as being irrelevant. The judges in the *Gian Kaur* judgment acknowledged the *Rathinam* decision, the *Dubal* decision, the LCIR 1971, as well as the references made to Hindu scriptures in the two judgments, which were used to reinforce the argument for an individual’s

66 In the next chapter, I trace the implications of mental health care legislation on suicide regulation in India where there is a threat of people with mental illnesses being understood perceived as having no agency and therefore the treatment is decided for them.
right to take one’s own life. But such a line of argument, that is, self-inflicted death is acceptable according to some religions, the SC judges ruled, does not alter the fact that it has nothing to do with constitutional validity of Section 309 IPC. Any reference to religious doctrine or a global debate regarding suicide, it ruled, is immaterial to the discussion because it does not prove that right to life includes right to take one’s own life (Article 21) or Equality before the law (Article 14). The SC in the Gian Kaur judgment ruled that the constitutional right to life enshrined in Article 21 cannot be interpreted as a right to take one's own life. Section 309 can be held unconstitutional only if it violates particular provisions in the Indian Constitution. Thus Section 309, it claimed, does not violate Article 21 or 14.

This judgment focused on analyzing the meaning of ‘life’ within Article 21. They stated, Article 21 must protect life and a person’s right to life contains within its ambit the right to live with human dignity up to the end of one’s natural life (Gian Kaur, 1996 emphasis mine). The judgment made a distinction between natural and unnatural termination of life, and held that suicide is an ‘unnatural’ end to one’s life. The judgment contended:

Article 21 is a provision guaranteeing protection of life and personal liberty and by no stretch of imagination can ‘extinction of life’ be read to be included in ‘protection of life’. Whatever may be the philosophy of permitting a person to extinguish his life by committing suicide, we find it difficult to construe Article 21 to include within it the right to die' as a part of the fundamental right guaranteed therein. ‘Right to life’ is a natural right embodied in Article 21 but suicide is an unnatural termination or extinction of life and, therefore, incompatible and inconsistent with the concept of right to life’. With respect and in all humility, we find no similarity in the nature of the other rights, such as the ‘right to freedom of speech’ etc. to provide a comparable basis to hold that the ‘right to life’ also includes the ‘right to die’ (Gian Kaur, 1996. Emphasis mine).
The rationale behind reading ‘right to death’ within right to life (Article 21) in the Dubal and Rathinam decision was because other fundamental rights such as freedom of speech (Article 19) includes within it freedom not to speak, similarly freedom of association and movement includes freedom not to join any association or to move anywhere. And freedom of business and occupation includes freedom not to do business. So in the Dubal and Rathinam decisions, the courts applied the same principle to Article 21, because what is true of one fundamental right was assumed to be true of other fundamental rights (Hansaria, 1993, p 48). Differing from this above logic, the Gian Kaur decision did not read ‘right to die’ within ‘right to life’. It could make this ruling by framing suicide as an unnatural death. The logic was that one could have right to natural death but since suicide was an unnatural death, Article 21 does not provide protection for such actions.

Furthermore, the judges found the word ‘life’ in the ‘right to life’ to include ‘life with dignity’, and this dignity they reasoned, cannot be something that extinguishes life:

‘The right to life’ including the right to live with human dignity would mean the existence of such a right up to the end of natural life. This also includes the right to a dignified life up to the point of death including a dignified procedure of death. In other words, this may include the right of a dying man to also die with dignity when his life is ebbing out. But the ‘right to die’ with dignity at the end of life is not to be confused or equated with the right to die an unnatural death curtailing the natural span of life (Gian Kaur, 1996).

The notion of ‘dignified life’ has been addressed in various court decisions prior to this. In Francis Coralie Mullin v. Union Territory of Delhi (1981), Judge Bhagwati recognized extent of Article 21 and stated: “...The question which arises is whether the right to life is limited only to protection of limb or faculty, or does it go further and embrace something more. We think that
right to life includes the right to live with human dignity and all that goes along with it, namely, the bare necessities of life such as adequate nutrition, clothing and shelter over the head and facilities for reading, writing and expressing oneself in diverse forms, freely moving about and mixing and co-mingling with fellow human beings” (1981). In another judgment, *The Board of Trustees, Port of Bombay v. Dillip Kumar* (1983), a three-judge Bombay High Court bench explain, ‘life’ does not merely mean animal existence. It has a wider meaning and includes “some of the finer graces of human civilization, which makes life worth living” (1983).67

Unlike these previous judgments that expanded the meaning of life to include and specify certain qualities, the *Gian Kaur* decision drew the boundaries of dignified life by defining the meaning to dignified death. Such a dignified death needed to have a conception of ‘natural life’ and consequently ‘natural death’. Within this judgment any death that ‘curtails the natural span of life’ is unnatural and undignified. They explain that only in certain circumstances, such as when a person is terminally ill or in persistent vegetative state, s/he may be permitted to terminate their life. Speaking about such cases, the judgment rationalizes:

This category of cases may fall within the ambit of the ‘right to die’ with dignity as a part of right to live with dignity, when death due to termination of natural life is certain and imminent and the process of natural death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced (*Gian Kaur*, 1996).68

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68 It is outside the scope of this work to study the legal or medical understanding of the moment at which death occurs or begins. But it is important to acknowledge that locating a temporal moment at which death commences is not universal or absolute. For a detailed analysis of this in the context of North America, see Lock (2002, p. 78-100).
Ideas of natural and/or unnatural death are a recurring theme in some of these judgments. In the *Dubal* decision the Bombay HC stated that the desire to die is not unnatural, it is as natural as the desire to go on living. This judgment ruled that the means used to die might be unnatural, but the desire to die is natural. Stating almost the opposite, in the *Gian Kaur* judgment, the court explains that attempting to curtail one’s “natural span of life” must not be equated with right to die. What is significant in this decision is that it is primarily concerned with the termination of life by “unnatural causes”, i.e., suicide. To die through the act of suicide, the court decided, was unnatural and hence not an aspect of the fundamental right of Indian citizens. This decision brought attempt to suicide back within the state’s control over life and death, and in turn, rendered Section 309 IPC as a criminal offence. Here, the meaning of suicide is sought not through religious texts or psy experts, but rather through the notion of natural and unnatural deaths; by extension, natural and unnatural lives.\(^{69}\)

The *Gian Kaur* judgment is occupied with a sense of obligation or a duty towards protecting life. And an important aspect of protecting life includes controlling death, especially preventable death that is decided by the individual and is not state mandated. While it refuses individuals the power to take their own life, it permits certain forms of ‘dignified’ deaths, as in cases where death is imminent, such as terminally ill individuals, and thereby leaving open future deliberations on euthanasia. The verdict claims that a person who is terminally ill or in persistent vegetative state is living an “unnatural”, an “undignified” life, and hence has the “right to die”.\(^{70}\)

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\(^{69}\) Although the judgment does not explicitly make connections to any religious codes, its argument regarding the unnaturalness of death by suicide resonates closely with certain Hindu notions of good and bad death that I discussed in my analysis of the Dubal judgment. For a more detailed reading of complexity of good and bad death according to certain Hindu practices, see Parry (1994).

\(^{70}\) For a more detailed reading of the emergence of ‘dignified’ death in Western societies see Bayatrizi (2008). Also see Lock (2002), for a study of natural and unnatural death in USA, Canada and Japan.
The judgment’s notion of dignified and undignified death is connected closely with certain Hindu brahminical ideas of good and bad death. Anthropologist Jonathan Parry studies Hindu priests and other “sacred specialists” in Banaras who perform rites that ensure the deceased attain a “good state” after death. Parry studies notions of good and bad death that circulated among priests in Banaras to explain that religious suicides are sanctioned by certain Hindu texts (Parry, 1994, p. 22-23). The priests explain the difference between ‘self-murder’ (bad death) and ‘self-immolation’ or ‘burning up of the self’ (good death). Bad death, according to the priests in Banaras, is death that is “ensnared by desire” (1994, p.163). “Suicide is a surrender to the disappointed desires of this life and this evinces an acute involvement with it” (1994, p.163). By contrast, good death, while it might be self-inflicted is a “testimony to an absence of worldly desire and a calm indifference to mundane existence” (1994, p. 163). It is interesting that one of the interpretations of bad death that Parry recounts is precisely the kind of self-death that is motivated by desire to die. According to the Hindu priests in Banaras, a good Hindu self-death could occur through unnatural means such as self-immolation but a desire to die would not be considered as good death. Religious suicide has been practiced amongst Hindus for centuries although there continues to be some ambivalence in how extensively this practice is accepted among Hindus (Parry, 1994, p. 23). But Parry finds that people who go to Banaras to await their ‘natural’ death by living as an ascetic in Banaras, or people who are carried to Banaras on their death-beds to live out their last hours are extensively rewarded through rituals after their deaths. Allowing oneself to die is understood as a form of sacrifice and hence a good death. Similarly those who have a ‘right to die’ a ‘dignified death’ according to the

71 Banaras, as I explained in the Introduction, is a North Indian city, which is a significant space of death and dying for practicing Hindus.

72 It has been shown that since seventh century A.D. there has been the tradition of religious suicides in pilgrimage centers Chauduri (1979); Bharadwaj (1973) as quoted in Parry (1994). The practice of religious suicide is sanctioned in the Hindu texts of Skanda and Padma Puranas. For more on this see Kane (1973) as quoted in Parry (1994).
Gian Kaur judgment is: “when death due to termination of natural life is certain and imminent and the process of death has commenced. These are not cases of extinguishing life but only of accelerating conclusion of the process of natural death which has already commenced.” (1996, emphasis mine). So certain bodies for which death is imminent, are understood almost as a sacrifice and only these individuals are permitted the right to death. Whereas deaths that are, as a response to disappointment in one’s life is read as self-centered and so not a sacrifice, hence does not acquire the legal right to die.

Unlike some other previous judgments, this decision was not noticeably referring to religious discourses (although there are obvious references to certain Hindu notion of good and bad death). This decision instead attempted to define legal boundaries for self-inflicted death. It clarified what kinds of deaths ought to be considered dignified and thus natural and what kinds are deaths are undignified and unnatural. In studying all these different judgments together it is evident that what constitutes as natural or unnatural death shifts from judgment to judgment. For example, as I mentioned earlier the Bombay HC in the Dubal decision explained that the desire to die is as natural as the desire to live whereas the Gian Kaur judgment ruled the opposite, by stating that only certain kinds of ‘unnatural’ deaths deserve the right to die. I point to this, not to highlight a contradiction, but instead to demonstrate the heterogeneous ways in which suicide is perceived within the legal arena.


After the Gian Kaur verdict, the next significant discussion occurred in October 2008, when the Law Commission of India (LCI) presented a report titled Humanization and Decriminalization of Attempt to Suicide. The LCI, as mentioned earlier, is an advisory or a research group, which
comes together when there is a need for legal reform. So while the LCI might not exert actual powers to change laws, it has been influential in court judgments in the past, which in turn has resulted in legal changes. This particular report was produced under the eighteenth LCI.

In the report, *Humanization and Decriminalization of Attempt to Suicide*, one sees a strong psychiatric and psychosocial argument for decriminalizing Section 309. Prior to this report, the 1985 HC judgment in the *Sanjay Kumar Bhatia* case had made a similar recommendation that was rooted in recognizing the socio-political circumstances and also recommending psychiatric treatment instead of criminal punishment. A few years later the SC in *Rathinam* (1994), similarly stated that a person’s suicide attempt is a call for help that needs psychiatric treatment. The psy discourse has been a small part of the hybrid legal discourse on suicide, but it gained more attention and primacy in the 2008 LCIR. The report states:

> it is felt that attempt to suicide may be regarded more as a manifestation of a diseased condition of mind deserving treatment and care rather than an offense to be visited with punishment (LCIR, 2008, p. 38 emphasis mine).

Based on recommendations from different organization, including the World Health Organization, International Association for Suicide Prevention-France, Indian Psychiatric Society, suicide prevention NGOs, the report makes an argument to encourage the Government to repeal the “anachronistic” Section 309 IPC (LCIR, 2008, p.7). For example, the report states:

> It constitutes of legal experts such as Attorney Generals, former SC judges, or Chief Justices, who head a regular staff of around twelve research personnel for a term of three years. The agenda or topics are defined internally by the commission. The reports published by the LCI are sometimes used by court judgments when the courts are stepping in to fill certain gaps that might exist in the laws.

> In the 1990’s and early 2000’s WHO and other transnational health organizations undertook mental health as a public health concern. Suicide emerged strongly as a public health problem within this new psy paradigm. The 2008 LCIR’s emphasis on suicide as mental health concern is part of this larger expansion of psy discourse in India. In Chapter Two, I analyze this phenomenon further.
Many who resort to suicide and who manage to survive do not seek medical help for fear of being arrested and penalized. Suicide is a “cry for help”. People who attempt suicide need extensive and sometimes long-term psycho-social support. The panacea for them certainly cannot be imprisonment (LCIR, 2008, p.34).

Within this report, suicide is largely constructed as a psychosocial concern and not a criminal concern. Most significantly, the report says: “They even need compassion, emotional support and sometimes even psychiatric help. If the act of attempted suicide were to be decriminalized it will make things more workable and easier for all to extend their hand and support in reducing suicide in India” (emphasis added). I emphasize ‘sometimes’ because this qualifier demonstrates that the LCI does not perceive all suicides as a psychiatric problem. This report focuses on social problems as well as individual mental illness.

The 2008 LCIR report makes a powerful case to decriminalize suicide attempts. It clearly states that, whether it is constitutional or otherwise, Section 309 needs to be removed from the statute book (LCIR, 2008, p. 39). In making this claim, the report does acknowledge that the SC decision in the Gian Kaur (1996) case had found Section 309 IPC to be constitutional since Article 21 cannot be construed to include within it the ‘right to die’ as a part of the fundamental right. The report also cites arguments made in other HC and SC cases that were based on religious acceptance of suicide. However, it does not follow the same line of thought. It states:

Section 309 of the Indian Penal Code provides double punishment for a person who has already got fed up with his own life and desires to end it. Section 309 is also a stumbling block in prevention of suicides and improving the access of medical care to those who

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75 In Chapter Two I demonstrate how the recent Mental Health Care Laws are constructing all suicides as a mental health problem.
have attempted suicide. It is unreasonable to inflict punishment upon a person who on account of family discord, destitution, loss of a dear relation or other cause of a like nature overcomes the instinct of self-preservation and decides to take his own life. In such a case, the unfortunate person deserves sympathy, counselling and appropriate treatment, and certainly not the prison (LCIR, 2008, p.39).

Once again, as the statement above indicates, the emphasis in this report is both opening up space for psychiatric treatment as well as framing suicide as psychosocial concern. As I mentioned earlier, such a framework was proposed in the Sanjay Kumar Bhatia decision in 1985. After that decision, the courts and the law reform efforts largely debated on religious approval or disapproval of suicide as seen in the LCIR 1971, Dubal and P. Rathinam decisions. The courts also debated the meaning and legal limits of control over natural, unnatural, dignified, undignified deaths as seen in the Gian Kaur judgment. But the 2008 LCIR pays significantly more attention for psychosocial and psychiatric concerns regarding suicide. This inclusion of psychosocial and psychiatric frameworks is a reflection of a discursive shift that is occurring in India. Since the late 1990’s and early 2000s there has been an expansion of psychosocial and psychiatric discourse regarding suicide prevention. The forceful emergence of these frameworks is a significant shift in the debate on suicide within the legal arena.

### 6.1 Control Over Life and Death

Following the 2008 LCIR, a non-governmental organization, Mental Health Foundation, filed a Public Interest Litigation (PIL) in the Delhi High Court, seeking removal of Section 309 (Mental Health Foundation v. UoI and ORS, 2011). In response to the petition, the HC questioned the

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76 In this chapter I focus on the case law and legal reform efforts focused on Section 309 IPC, and so I do not analyze the emergence of psychosocial or psychiatric discourse on suicide in great detail here. In Chapter Two I study the Global Mental Health Care movement, which played a major role in providing a medical/psy discource for suicide prevention.
central government regarding the steps it had taken as a response to the recommendations made by the LCIR in its 1971 and 2008 reports.

In response, the central government approached all twenty-nine Indian state-governments, and the seven union territories to seek their approval to decriminalize attempt to suicide. Eighteen of twenty-nine states, and four of the seven union territories, supported decriminalization. Some of the state-governments, specifically, Madhya Pradesh, Sikkim, and Delhi, argued against decriminalizing attempt to suicide. Such a move, they argued, would curtail law enforcement agencies’ power to deal with those who protest against the government through hunger strikers or self-immolation. If suicide attempts were to be decriminalized then people who go on hunger strikes could no longer be force-fed and prosecuted (Jain, 2014).77 The Home Ministry dismissed such fears by arguing that other legal provisions exist to police those who protest against the government.

It is interesting that the conversation between the HC, the central government, and the state governments was not regarding the limits of state control over life and death. The majority of the state governments supported decriminalizing suicide attempts. Only a few governments argued that decriminalizing suicide attempts would restrict law enforcement agencies’ power to regulate protests against the government that are demonstrated via actions of self-inflicted death. The Home Ministry’s response to this resistance is not to restrict state control over life or death, but instead to remind the state governments that there are other legal provisions that they might use to control protests such as hunger strikes or self-immolations. Legal control over management of life and death especially in the context of self-death as a form of protest against the state continues to exist. A concern similar to that of the state governments’ regarding loss of

77 One of the cases mentioned in the Rajya Sabha was that of Irom Sharmila who had been on a hunger strike protesting against the state and she had been arrested under Section 309. I will discuss Irom Sharmila’s case later in this chapter
legal control over management of hunger strikes and self-immolations was expressed by Andhra Pradesh HC in *Chenna Jagadeeshwar* (1987). In the case of *Chenna Jagadeeshwar*, the court held that it is important to retain Section 309 IPC as a criminal offense because otherwise it might restrict state power in controlling hunger strikes and self-immolations. Within this conversation there is no disagreement within the government regarding state control over certain kinds of self-inflicted deaths such as hunger strikes and self-immolations. I will now slightly deviate from the court discussions to understand the threat of suicide protests on sovereign power.  

### 6.2 Understanding Suicide Protests

Acts of suicide protest have been frequent in many parts of South Asia. The first instance of modern self-immolation is often dated to Vietnam in 1963, when Thich Quang Duc lit himself on fire in the busy streets of Saigon. The most recent incidents that have gained public interest are the self-immolation protests in Tibet. It has been recorded that since March 2009 more than 140 people have set themselves on fire inside Tibet as a protest against the Chinese occupation. In 2012 alone, more than 80 people lit themselves on fire as a form of protest. Since 2013, there

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78 I use the term suicide protest to mean forms of protests where an individual intentionally kills themselves (or attempts to kill oneself) for a political purpose. I do not delve into suicide bombing in my analysis since suicide bombings have not emerged prominently within the discussions on Section 309 IPC. But there is an obvious qualitative difference between self-immolations, hunger strikes and suicide bombings. The first two are forms of self-killing where there is no intent to cause damage to other lives but only on oneself. Whereas suicide bombings display a clear political intention to kill oneself as well as cause damage to other human lives. For a discussion politics of suicide bombing see Asad (2007).

79 Although acts of fasting and self-immolations have cultural significance within Hindu, Muslim and Christian religions, the use of these practices as political acts can be traced back to early twentieth century. Modern Western incident of hunger strike is traced back to nineteenth century when the Russian anarchists undertook fasting to death (Michelsen 2016). Suffragettes in North America and Europe are said to be one of the first users of political hunger strikes, followed by Northern Irish prisoners who also undertook hunger strikes a part of anti-British protests. Self-immolation is thought to have originated in 1960s in Vietnam (Lahiri 2014).

80 Quang Duc was protesting the persecution of Buddhists by the South Vietnamese government led by Ngô Đình Diệm. In the subsequent two years ten more Vietnamese monks followed Quan Duc’s lead and immolated themselves. For a further discussion on this see Michelsen (2016).
have been fewer instances of self-immolation protests, but they are still a feature of Tibetan resistance.  

Specifically in India, self-immolations and fasting to death have emerged as frequent forms of political expression/protest. For example, between 2009-2012 there were several instances of self-immolations by student protestors who were demanding statehood for Telangana. Another important political incident of self-immolation was by Rajiv Goswami, who set himself on fire during an anti-governmental protest in New Delhi in 1990. He was protesting along with other upper-caste students who were fighting against the implementation of the Mandal Commission report, which would increase the number of reserved spots for Dalits in public sector jobs. The most prominent use of fasting to death as a form of political protest in Indian history has been by Gandhi during his anti-British protests. Gandhi’s conceptualization of fasting to death as protest against the state has been incorporated by several contemporary political protests. For example, Irom Sharmila, (who I discuss in some detail in the next section) was on a hunger strike for sixteen years protesting the presence of Indian army in the state of Manipur. In 2011 Anna Hazare undertook a hunger strike to exert pressure on the Indian government to enact a stringent anti-corruption law. All these above mentioned incidents had disparate political goals and some of these goals were achieved and some were not. Irrespective of the political objectives, suicide protests symbolically are perceived as a threat to the sovereign power.

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83 Over 159 cases of self-immolation occurred in the month following Goswami’s attempt and 63 succeeded (Dirks, 2001, p. 275)
84 I return to Gandhi’s conception of hunger strikes and satyagraha in the next section.
85 For a study of suicide protests and whether it achieved its goals see Lahiri, (2014).
Self-inflicted political deaths or attempts at death have acquired many meanings. For example, Gandhi’s hunger strikes have been analyzed as not being a purely political strategy, but it as an example of religious and ethical sacrifice (Lahiri, 2014, p. 26-35). In *Suicide Protest in South Asia*, Simanti Lahiri argues that despite Gandhi’s own framing of his fast as a purely moral act, it was also evidently a political move (2014, p. 30). In the study of self-immolations by Tibetans who are protesting the Chinese occupation of Tibet, Tsering Woeser argues that people who choose self-immolation intentionally employ an “extreme form of suffering, unbearable for the average person, so as to embody the most powerful form of protest and recapture their human dignity” (2016, p. 85). She further explains that the word ‘self’ in self-immolation is misleading since most of these acts are not tied into personal goals, but for collective change (2016, p. 86). Similarly, Allen Feldman in *Formations of Violence* argues that the prisoners, most prominently Bobby Sands, who undertook hunger strike and consequently died in Long Kesh Prison in Ireland did so to “return to the prepolitical body through a highly politicized action” (Feldman, 1991, P. 244). Feldman explains that Bobby Sands translated the republican tradition of endurance into a political protest. In this context, the “good” republican death was “inserted into the transcendent domain of nature which imbued death by hunger strike with an autonomous trajectory. The body denatured by prison conditions would be renatured in hunger striking” (1991, p. 244). Feldman explains that the goal of the hunger strike was to reclaim the external

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86 Later in the chapter, I demonstrate how Irom Sharmila resists the state formulation of her hunger strike as attempt to suicide. She reasserts that she wants to live and loves life and hence is not attempting suicide, but is instead protesting state violence. Irom Sharmila explains that she is following Gandhi’s satyagraha and similar to Gandhi Irom Sharmila’s hunger strike is both an ethical sacrifice as well as political strategy.

87 Woeser further explains that since the Chinese government has blocked the term “self-immolation” on the Internet, young Tibetans are using other terms such as “lamp offering” or “a lamp has been lit” to refer to self-immolations (2016, p. 86-87).

88 In Ireland, hunger strikes had a long history as part of the anti-British struggle. The most visible instance of Irish hunger strike was in Long Kesh Prison. This culminated in the death of Bobby Sands and nine others in 1981. These hunger strikes were preceded by several years of “Dirty Protest,” during which time they and other prisoners systematically smeared the walls of their cells with their own excrement Feldman (1991).
body from all institutional objectifications through a radical process of self-consumption (1991, p. 245). He further states “While the starving body absorbed the power of the state, its sacralization with death transferred this power from the state to the republican community” (1991, p. 236). In all these analysis of suicide protests, there is an implicit, sometimes explicit, threat to political power. But why is suicide protest such a political threat?

An integral aspect of suicide protests as seen in the above examples is the fact that the violence is exerted onto the self with an aim to exert agency on the sovereign power. Taking one’s own life or threatening to take one’s own life as a protest is sometimes a quest for justice, sometimes a threat to the status-quo, sometimes shaming society’s imperfections. The symbolic power that is inherent in asserting one’s suicide protest allows the protestor to claim moral and symbolic authority that is difficult for the sovereign to challenge, but the sovereign nevertheless attempts to control suicide protests. The responses from the central and state governments to the Delhi HC indicate that the symbolic threat of suicide protests is immensely powerful.

In The History of Sexuality: Volume One, Foucault analyzes the shifts in sovereign power with regards to “right of death and power of life” (1978b, p. 135-159). He explains that in its modern form, sovereign power in the West is situated and exercised at the level of life (1978b). Foucault takes up the question of death penalty and through that explains how power gave itself the function of administering life (Foucault, 1978b, p. 138). In his analysis, power could not exercise its highest prerogative by putting people to death, especially since its main role was to ensure, sustain, and multiply life, “For such a power, execution was at the same time a limit, a

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89 For more detailed study of suicide protests, see Andriolo (2006); Feldman (1991); Michelsen (2016); Lahiri (2014).
scandal, and a contradiction” (1978b, p.138). Death, particularly suicide has gradually disappeared from everyday lived experience in the public sphere and has instead reappeared as a subject of scientific, medical, political, sociological entity (Foucault, 1978b). Regarding shift in power over suicide, Foucault explains that it is not surprising that suicide which was previously considered a crime—which meant the sovereign alone had the right to death during the nineteenth century -- was one of the first behaviors to enter the realm of sociological analysis.

This shift for Foucault “testified to the individual and private right to die, at the borders and in the interstices of power that was exercised over life. This determination to die, strange and yet so persistent and constant in its manifestations, and consequently so difficult to explain as being due to particular circumstances or individual accidents, was one of the first astonishments of a society in which political power had assigned itself the task of administering life” (Foucault, 1978b, p. 138-139).

Although suicide as a subject of study might to a certain extent have entered disciplinary power in India, the reassuring exercise by the Home Ministry to the State governments regarding its continued control over protest suicide demonstrates Foucauldian sovereign power.

In *Homo Sacer: Sovereign Power and Bare Life* (1998), Giorgio Agamben brings together the two distinct directions he identifies within Foucault’s later works: one, the political technique used by the sovereign state in the promotion of biological life of populations, and two, the technologies of self through which the individual is bound to both a particular subjectivity and to an external power. According to Agamben techniques of individualization and regimes of totalizing power cannot be separated and the two meet at a point where the voluntary servitude of the individual comes into contact with dominant, objective power (Agamben, 1998). It is at this intersection that the inclusion of what Agamben calls “bare life” into political sphere “constitutes the original – if concealed – nucleus of sovereign power” (1998, p. 6). Bare life, exemplified by
the figure of roman law known as homo sacer, is that which may be killed without the commission of homicide and without the celebration of sacrifice (Agamben, 1998). In the contemporary moment, Agamben announces, bare life is capable of being killed off or abandoned to death for the protection and promotion of those populations allowed to live. To explain this further, Agamben focuses on Nazi death camp. For Agamben, the most extreme expression of homo sacer is that of the Muselmann, the camp inmate no longer considered human he is so close to death. Restricting the space between human and inhuman, ethical and unethical, the living and the death, the Muselmann: “marks the end and the ruin of every ethics of dignity and conformity to a norm. The bare life to which human beings were reduced neither demands nor conforms to anything. It itself is the only norm; it is absolutely immanent. And ‘the ultimate sentiment of belonging to the species’ cannot in any sense be a kind of dignity” (Agamben, 1999 p. 69). I refer to Agamben, not to argue that the Indian state perceives people on hunger strikes or the protestors who self-immolate as figures similar to homo sacer or Muselmann, but to demonstrate the desire of the sovereign to continue to maintain brute force over certain kinds of self-inflicted deaths with complete disregard for notions of dignity, rights, or will of the person who is protesting. The state is demanding brute power over certain kinds of deaths, while it is simultaneously permitting other kinds of self-inflicted deaths to disciplinary or biopolitical techniques. The LCI in 2008 argues for psychosocial as well as psychiatric approach to address suicide attempts and not criminal law. But it also argues for maintaining the power to exert brute force when self-inflicted deaths have the potential to either threaten or shame the state.

Apart from concerns regarding policing protests, two state-governments, Madhya Pradesh and Delhi, also raised concerns that decriminalization of attempt to suicide would dilute the law on abetment of suicide. The rationale was that once attempt to suicide was outside the
purview of the juridical system, an abettor could no longer be prosecuted in the case of a failed suicide attempt. Furthermore, the state-government of Punjab did not oppose the move but insisted that the government should stipulate rehabilitation for people who attempt suicide by providing medical/psychiatric care, as well as other forms of public assistance in cases of unemployment, old age, sickness, rape victims and distressed farmers. Although there was some resistance to decriminalizing Section 309, it did not hold much traction. The primary rationale behind its acceptance was that people who attempted suicide needed ‘care’, ‘sympathy’, and ‘psychiatric help’. After 18 states and 4 Union territories accepted the recommendation by the LCI, the central government announced in December 2014 that it would decriminalize Section 309 IPC. If the bill for decriminalization passes in the Rajya Sabha, attempting suicide will no longer be a criminal offense. However, as of January 2017, Section 309 IPC continues to exist in the Criminal Code.

7 Hunger Strike as Suicide: Difficult Conversation

The power to exert state control over suicide protest is most evident in the case of Irom Sharmila. Sometimes referred to as the Iron Lady, Irom Sharmila is a human rights activist who was on a hunger strike since November 2000 until August 2016. She was protesting against the presence of the Indian army in Manipur—a state in north-eastern India. Specifically, she has been demanding the repeal of Armed Forces (Special Powers) Act (AFSPA, 1958), which has been an instrument of severe violence used by the Indian army against the people of Manipur. The

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90 In August 2016, Irom Sharmila decided to end her fast and participate in Manipur elections.
91 For a more detailed analysis of Irom Sharmila and the Armed Forces (Special Powers) Act, see Mehrotra (2009); Dobhal (2009). Also see a short film titled ‘Legal Lives in the Postcolony’ on Irom Sharmila and her life within the legal system in Roy (2015).
Manipur government repeatedly arrested Sharmila under Section 309 IPC for several years and force-fed her through a tube (until recently when she decided to end her hunger strike). For sixteen years, Sharmila was taken to court every fifteen days for a court hearing where she was asked by the judge to either accept bail or end her fast; she refused to do either. She was then taken back to jail and continued to be force-fed. By March 2016 she was said to have made over 300 such appearances in the court (Roy, 2015).

In 2006, Sharmila was on a hunger strike in Delhi once again demanding the repeal of AFSPA. The Delhi police filed a case of attempted suicide at this time. In March 2013, the court framed charges against Sharmila and she pleaded not guilty to the charges. The Delhi court told her that the maximum punishment in the case was a few months to a year, and since she was in custody for more than six years, the case would be settled if she pleads guilty. Sharmila refused to plead guilty and said she had undertaken a non-violent protest similar to Gandhi (“Irom Sharmila asked,” 2014). In an interview with a prominent English news channel, Sharmila said she loves life and does not want to die. When asked by the interviewer, what does she love about life? Sharmila replied, “I want a life with reason, dignity” (“Never Attempted to,” 2013).

There is much to be said about Sharmila, but I am going to focus on the legal dilemma of arresting her under Section 309 IPC. She described her hunger strike as a non-violent form of protest based on Gandhian ideology. For Gandhi, such a hunger strike, a self-inflicted pain in the service of a quest for justice, was righteous. Gandhi held fasting as a show of strength - a sacrifice for something greater. The idea(l) of 'living by dying’ is what Gandhi found compelling (Skaria, 2010). In his study on Gandhi’s conceptualization of life and death in relation to
Ajay Skaria suggests that for Gandhi a satyagrahi is not someone who simply dies for a cause; rather it is someone who is “abandoning the fear of death” (Skaria, 2010, p. 212). It is about “living the proper life to swaraj—a word that can be glossed as “freedom,” “independence,” or the “rule of the proper” (Skaria, 2010, p. 213). Building on Gandhi’s notion of abandoning the fear of death, Sharmila continued to deny that she was ‘attempting suicide’. According to Sharmila, she was protesting by refusing food and being on a hunger strike. She was undertaking an ethical protest against state power by exerting pain on herself.

In Burning Bright: Irom Sharmila and the Struggle for peace in Manipur, Deepti Priya Mehrotra explains that Sharmila has yielded her body as a weapon and “[b]y fasting without end, she is asserting her right to deploy her body as she sees fit. She is expressing her resistance to injustice and the ‘lawless law’ through defiant inversion of the norm—of eating food” (2009, p. 100). In doing this, Sharmila is nudging the state to engage in a dialogue with her, but it refuses. Instead the state arrests her, force-feeds her to keep her alive. In exerting suffering on herself, Sharmila is creating psychological and symbolic discomfort in the state (Mehrotra, 2009, p. 101). This symbolic threat to sovereign power is evident in the state government’s resistance or concern with regards to decriminalizing Section 309 IPC, as demonstrated in the previous section. While the symbolic threat is evident in Sharmila’s protest, it is important to mention that the legal provision of Section 309 gave the state power to define Sharmila’s action as attempted suicide. Her hunger strike was not perceived by the court through the lens of ‘dignified death’. Sharmila’s dignity is not a preoccupation for the court as it was in other cases such as Rathinam and Gian Kaur. Her hunger strike, not surprisingly was solely read as protest against

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92 Satyagraha broadly refers to a policy of passive political resistance advocated by Gandhi against British rule in India.

93 The sentiment of abandoning fear of death is recurring both in the debate regarding the practice of Santhara. A similar sentiment is also found in Parry’s work on Hindu conceptions of good death in Banaras (1994).
the state, with the court responding by forcing her to continue living. In analyzing the use of Section 309 in the case of Sharmila’s hunger strike, I want to highlight the layers of powers inherent in this criminal provision.

8 Religious Ritual or Suicide?

In 2015, the limitations and complexities of the attempt to suicide law were widely debated once again in public sphere as a result of a Rajasthan HC judgment to ban the Jain practice of Santhara or Sallekhana—a religious ritual practiced by the Shvetambaras group of Jain religion, which involves abstinence from food until death to attain salvation (Nikhil Soni vs Union of India & Ors, 2015). In this court case, a PIL filed by the lawyer and human rights activist Nikhil Soni, the judge made Santhara a punishable offence under penal codes Sections 306 (abetment of suicide) and 309 (attempt to suicide). Soni originally hails from Charu district in Rajastan. This district has had the reputation of having the highest per capita incidents of Santhara in recent history. Growing up in Charu district, Soni is said to have witnessed several such ceremonies which eventually led him to file the PIL (Hattangadi, 2010).

The case began with the death of Vimla Devi Bhansali, a sixty-year-old woman. She was suffering from cancer of the brain and liver, and had died in October 2006 after a thirteen-day fast. There were allegations that Vimla Devi was coerced into accepting Santhara. The incident made headlines in Jaipur, a city in the state of Rajasthan. Following this, Soni filed a PIL in the Jaipur HC asking the court to declare Santhara illegal. He argued in court that many older people were being encouraged to believe that Santhara is the only path to salvation, and there was a moral pressure (or abetment) to commit to Santhara. He produced seven examples (from 1993-2003) of instances where older people in families were encouraged to commit Santhara. At the
time, he as well as others activists compared Santhara to sati. Further, Soni argued that the practice of Santhara is like any other kind of suicide and hence needs to be stopped. He stated:

…voluntary fast unto death is an act of self-destruction, which amounts to suicide, which is a criminal offence and is punishable under section 309 IPC with simple imprisonment for a term which may extend to one year or with fine or with both. The abetment of suicide is also punishable under section 306 IPC with imprisonment of the term which may extend to ten years and also liable to fine. Suicide means an intentional killing of oneself. Every act of self-destruction by a human being subject to discretion is, in common language described by the word suicide provided it is an intentional act of a party knowing the probable consequence of what he is about to do. Suicide is never to be presumed. Intention is the essential legal ingredient under section 309 IPC (Nikhil Soni, 2015).

Having termed Santhara as a form of suicide criminalized under Section 309, Soni recalled the previous SC verdicts to argue that Article 21 provided a right to life and not a right to death, thus implying that Santhara is a form of suicide that is illegal and criminal (Talukdar, 2015). The Rajasthan HC found the practice of Santhara illegal. The judgment was based primarily on two points: (a) the Gian Kaur verdict that Article 21 provides a right to life and not right to death, and (b) that Santhara as a religious practice was not an essential part of Jainism as per the essential principles doctrine, and hence not protected under Article 25, which guarantees a person’s right to religious freedom and conscience.

Following the verdict, there was uproar within the Jain community. There were protests, marches, as well as debates on television and print media, where followers of Jainism proclaimed
that no state or law has a right to prevent a person from taking their own life. A former judge at the Rajasthan HC, Panachand Jain was actively fighting the HC judgment in the media. He argued that Santhara had nothing in common with suicide or even sati. He stressed, “Suicide is usually done when people are in depression. Here people are not in depression - they give up food of their own accord, for days on end, to attain spiritual salvation” (Talukdar, 2015). He further stated: “A person is allowed to take Santhara only in case of old age or if he is suffering from an incurable illness…People who take Santhara do it to shed their negative karma” (Johari, 2015). Seemingly responding to the Jain protests, the Supreme Court of India stayed the HC’s decision banning Santhara on August 31, 2015.

A critical reading of the judgment in *Nikhil Soni vs Union of India & Ors*, shows that advocates fighting to retain Santhara as a religious ritual had submitted references to scriptures, testimonies by monks, and research articles explaining that Santhara is “a death with equanimity in pursuit of immortality. It is a victory over death or rather than fear of death. Persons taking vow of Santhara face it bravely and boldly whenever death comes to them. They are spiritual aspirants, who retain their equanimity in the face of death and their death does not remain fearful but becomes peaceful” (*Nikhil Soni*, 2015). Further, the advocates argued that it is a form of “voluntary death taken step by step to achieve moksha, with full wisdom and insight. It is not a violent method of death and is permissible in the Jain religion” (Nikhil Soni, 2015). The judgment however denied all of these arguments to state: “We do not find that in any of the scriptures, preachings, articles or the practices followed by the Jain ascetics, the *Santhara*…has been treated as an essential religious practice, nor is necessarily required for the pursuit of

94 Also see the documentary film *Santhara: A Challenge to Indian Secularism* by Shekhar Hattangadi. This film discusses the difficulty of conceptualizing santhara and suicide in the context of Indian secularism. Another important film that discusses Jain notion of good death and Santhara is *Ship of Theseus* (2013), directed by Anand Gandhi.

95 Moksha loosely translates as emancipation or liberation in Hindu philosophy.
immortality or moksha” (Nikhil Soni, 2015). As I have argued earlier in this chapter, despite its broader approach of non-interference in religious matters, and guaranteeing certain religious customs under personal laws, the Indian judiciary often makes claims regarding what constitutes an essential religious practice, and can hence fall under the freedom to practice religion guaranteed under Article 25. In this particular case too, the judgment dismissed the interpretations provided by supporters of Santhara, and claimed that Santhara is not an essential religious practice, and hence a form of “suicide under the garb of religious beliefs” (Nikhil Soni, 2015).

In addition to dismissing Santhara as not being an essential practice in Jainism, the judgment also analyzed the notion of dignified death. It states that the “right to human dignity does not include the right to terminate natural life” (Nikhil Soni, 2015. Emphasis mine). In the Gian Kaur decision, the SC made a similar distinction between natural / unnatural death, as well as dignified/undignified death. It claimed that a person who is terminally ill or in a persistent vegetative state has the right to a dignified death. Despite the SC judgment, the Rajasthan HC read the Gian Kaur decision as saying that “no person has a right to take his own life consciously, as the right to life does not include the right to end the life voluntarily” (Nikhil Soni, 2015). The verdict stipulates that the right to dignity and right to death come into play only when the person is unable to do so voluntarily. With regards to the distinction between natural and unnatural, the judgment states, “the ‘right to die’ with dignity at the end of life is not to be confused or equated with the ‘right to die’ an unnatural death curtailing the natural span of life” (2015). Drawing on the Gian Kaur verdict the Rajasthan HC judgment defines dignity in life as:

Any aspect of life which makes it dignified may be read into it but not that which extinguishes it and is, therefore, inconsistent with the continued existence of life
resulting in effacing the right itself. The right to die, if any, is inherently inconsistent with the right to life as is death with life (Nikhil Soni, 2015).

As I mentioned earlier, notions of dignified, natural or good deaths exist in most societies. In the North American context, the notion of dignified death without medical technological assistance is largely an accepted idea as shown by anthropologist Margaret Lock in the study of organ transplant (Lock, 2002). Lock does a comparative study of brain death and organ transplantation in North America and Japan. She finds that in North America, death has been redefined to include brain death and it has emerged as “natural” within medical systems. In Japan brain death has not gained similar levels of acceptance. Lock argues that in Japan, brain death has been understood as an affront to “natural” death (2002). She explains that in Japan, the identity, essence of a person is not located in their brain and consequently death is not located in one’s brain. Lock explains that in Japan the boundary between life and death is vehemently disputed which resulted in medicine not achieving hegemony in defining death, as brain death (Lock, 2002, p. 45).

Similarly, the idea of dignified death is consistently plaguing the judges who decide for criminalizing self-inflicted deaths in India. Both in the Gian Kaur judgment by the SC as well as the HC judgment regarding Santhara, we see the judges stating that certain forms of deaths are dignified and certain others are not. In the Gian Kaur judgment, the SC drew their definition of natural death with dignity as any death that is imminent such as in cases of terminal illness, etc. This court was comfortable with accelerating certain kinds of deaths which it considered as ‘natural’ to maintain the person’s dignity. Differing from the Gian Kaur judgment, while simultaneously building on it, the Rajasthan HC in Nikhil Soni case ruled that Santhara was not a dignified death. The Rajasthan HC, despite arguments by propagators of Jainism that Santhara is practiced by elderly people or people who have an incurable illness, dismissed them and termed
Santhara as a form of undignified death. Further, Santhara was interpreted by the court as not being essential to the practice of Jainism. The court further ruled that although Article 25 of the Indian Constitution states that every individual is “equally entitled to freedom of conscience” and has the right “to profess, practice and propagate religion” this does not include the right to take one’s own life. It stated, “Even in extraordinary circumstances, the voluntary act of taking one's life cannot be permitted as the right to practice and profess the religion under Article 25 of the Constitution of India” (Nikhil Soni, 2015).

What is of significance here is the affront to legal pluralism. Unlike personal laws that allow for a legal pluralism in matters of property, marriage, inheritances, we see three forms of relationship being established between religion and criminal law. First, the court selectively cites and homogenizes interpretations of religious texts to make claims that suicide is permissible in all religions. Second, the court dismisses religious approaches by giving precedence to psychosocial, psychiatric/medical, and natural laws as being above the religious doctrines on suicide. And lastly, as we see in the Santhara case, there is here a vehement dismissal of certain religious views, by arbitrarily rejecting some religious views. In regards to the latter point, we see that despite previous judgments (Rathinam in particular) and reports (LCIR 1971) having ruled that Jainism approves self-inflicted deaths, the HC claimed that religious rituals such as Santhara is a form of suicide parading as a religious belief. In doing this, the court reinforces its power over interpreting religious rituals as well as over religious practices. In addition, such a practice by the court has highlighted sovereign power in deciding what constitutes a religious practice. In Articles of Faith: Religion, Secularism, and the Indian Supreme Court, Ronojoy Sen argues that in cases on Hindu practices, the courts have often taken a modernist position rather

96 It is important to understand that even in Rathinam judgment and the LCIR 1971, the interpretation of Santhara as suicide could be a result of essentialist understanding of the practice of santhara or even Jain philosophy.
than accepting religions as represented by practitioners (2010b). The approach has been to use this doctrine as a vehicle “legitimizing a rationalized form of high Hinduism, and delegitimizing usages of popular Hinduism as superstitious” (Sen 2010b, p. 41). The Santhara decision differs from Sen’s argument regarding court interpretation of Hinduism. The HC decision on Santhara demonstrates the courts’ power over deciding practices that are essential to Jainism. But the HC is not claiming to modernize Jainism, nor is it relying on elite interpretations of Jainism to rule against Santhara. According to the Rajasthan HC judgment, Santhara is a form of suicide, and not because high scholars on Jainism are arguing for this, but instead because the court decides to apply the Section 309 – attempt to suicide – literally to define Santhara as suicide. The SC has stayed the judgment, and hence we do not yet know if religious rituals such as this one will legally be considered suicide or not.

9 Conclusion: Multifarious Meanings of Suicide

The assertion of sovereign control over suicide is evident in the debates regarding criminalizing and decriminalizing suicide attempt. As I explained earlier, the Indian state has repeatedly expressed its discomfort in decriminalizing suicide attempts. In response to the central government’s initiative to decriminalize attempt to suicide, specific state-governments clearly stated that this law is used to control and/or prosecute individuals protesting against the state, and hence should not be decriminalized. In the case of political protests, where the citizens’ protest against the state is demonstrated through threats of self-inflicted death, it is also framed by the Courts as a suicide attempt. In the Santhara case, the court made an argument to control suicide

97 Sometimes Jainism is read as a part of Hinduism and sometimes it is read as a separate religion.
by interpreting the ritual as not a essential practice to Jainsim and as ‘suicide under the garb of religion’. In the Gian Kaur decision, the court focused on explaining the extent of natural and unnatural life as well as dignified and undignified death. This decision ruled that ‘right to die’ could be provided for people only when death was imminent. In such circumstances, an individual had the ‘right to die’ with dignity. This judgment provided certain contexts where one has a right to choose death.

Although there is a desire to control suicide, there is a difficulty in knowing what is the meaning of suicide. For example, Irom Sharmila states she wants to live and loves life, and by stating this, she is denying the court’s assertion that she wants to take her own life. For her fasting is a form of suffering where she asserts pain over her body and uses it as a weapon against sovereign violence. She denies that she is attempting suicide and asserts that she is protesting against sovereign violence. Similarly, certain voices from the Jain community argue that Santhara is not suicide. It is instead a religious ritual to cleanse oneself before death.

All the court judgments and the LC reports use the word suicide, but suicide is fragmented repeatedly into heterogeneous categories. Suicide is simultaneously a psychosocial and psychiatric concern as well as religious ritual. Within the legal arena, suicide is concurrently a citizen’s right to death, a way to attain ‘dignified’ death, and criminalized. Suicide is both unlawful and has religious approval. Attempting suicide is an indication of mental illness requiring treatment, a result of social stressors of Indian life, as well as an unlawful protest against the state.\textsuperscript{98} Within the legal arena, suicide is constantly being fragmented and remade, sometimes by citing religious scriptures, and other times by using medical expertise. Each time

\textsuperscript{98} It is important to mention that within the legal reform discussions on Section 309 IPC, psychiatric treatment for suicide does not hold a prominent place, but it is seen as one of the possible treatments for mental illness resulting in suicide attempts. But there is a large emphasis on social problems in India that are leading to suicide attempts. In the next chapter I demonstrate the tension between psychosocial discourses and psychiatric discourse regarding suicide prevention.
the limits of legal regulation of suicide are determined, suicide is dismantled and another meaning of suicide is produced. This dismantling and restructuring of suicide occurs because the courts draw on different knowledges and draw the line between forms of self-caused death that are legally acceptable and forms of self-death that are to remain criminalized.

There are a host of knowledges, disciplines, and discourses at play in the legal debate on suicide. However, the legal actors in the arena are also preoccupied with finding a single truth with regards to the discussion on suicide. In the work on law and power of knowledge, Valverde makes a point that law is ontologically thin; it does not have to say the truth to make a point. She explains, “Some scientists aspire to create “pure” scientific knowledge; some ethical philosophers dream of a purely rational knowledge of norms. Legal actors and institutions, however, care little about epistemological purity and derive great benefit from being epistemologically creative” (2003b, p.26). Similarly, the Judges in most of the court cases cited earlier selectively use certain interpretations of religious doctrine to make a case for a legal truth. This creativity is found not only among the Judges, but also the petitioners (as in the case of Santhara debate), who creatively use multiple discourses to argue their case. They combine religion with other discourses to argue for or against the constitutionality of Section 309.

The discussions within the legal arena bring together various knowledges to constantly classify different acts of self-caused death. Because the attempt to suicide is framed as a criminal offense, various knowledges enter the legal arena to be used in the definition of illegal suicide. Valverde points to the fact that law adapts various knowledges into its own framework and transmutes certain alien knowledges into legal formats and frameworks and this “highlights the ways that law shapes the world that it then claims to adjudicate” (2003b, p.6). Similarly, legal discussion on suicide (a) shuffles various knowledges (religious, psychosocial, psychiatric, criminal law) and (b) within those knowledges, decides which one holds more value or meaning
over others. In doing this certain knowledges are reformulated into legal frameworks. The legal discussions on suicide in India have brought together various frameworks into the legal arena to be constantly available for decision making.
Chapter Two
Attempted Medicalization: Mental Health Care Laws and Suicide Prevention in India

Suicide News

I. At an October 2016 symposium, organized by the Goa commission for protection of child rights in collaboration with the psychiatric society of Goa, noted psychiatrist and a proponent of the Movement for Global Mental Health (MGMH), Vikam Patel, made a call for the inclusion of suicide within the national health priority. He stated:

India is one of the few countries where suicide is often treated as a socio-political issue rather than a fundamental health issue, where instead of acting to reduce suicide, time is spent on insinuations and allegations about caste ideology, politics and other issues (“Recognize suicide,” 2016).

II. Following the death of Dalit student activist Rohith Vemula in January 2016, a noted writer/journalist, Manu Joseph published an article in a mainstream English newspaper titled “Depression or oppression: What led to Rohith Vemula’s suicide?” In this article Joseph stated:

Farmer suicide is a depression story, not an economics story. Tibetan monks who immolate themselves in protest against China are a depression story, not a political story. Suicide bombers are a depression story, not a radical-Islam story. Rohith Vemula, from all evidence in plain sight, is a depression story, not a Dalit story (Joseph, 2016).
In this chapter, I critically analyze (a) the social and political implications of framing suicide as a public mental health problem, and relatedly, (b) the legal implications of seeing all suicides as a mental health problem. In the first part of the chapter, I trace the efforts undertaken by large and small public health organizations to frame suicide as a psy concern. I use the word ‘psy’ to connote the coming together of psychiatric as well as psychosocial mandates with respect to suicide prevention. In public mental health care programs, there are several discourses that come together to frame suicide as a health concern. In criminal law debates, as demonstrated in the previous chapter, there was a heterogeneity of discourses on suicide. Similarly, within public health discussions, one sees a circulation of multiple discourses on suicide prevention. However, unlike discussions within the criminal legal arena, the number of discourses regarding suicide as a public mental health problem is reduced. Some of these discourses include psychology, psychiatry, biomedicine, socioeconomic conditions and cultural factors. Although public health organizations recommend solutions on these multiple fronts, the psychiatric/biomedical approach often takes precedence. In this chapter, I trace the historical conditions that have resulted in widespread use of psychiatric drugs as treatment for depression and consequently suicide. However, my aim is not simply to critique biomedicalization of suicide prevention in India, but to understand the role of psy discourses in “depoliticizing” certain kinds of suicides. Thus, I trace the emergence of psychosocial and psychiatric conceptualizations of suicide to argue that there is an attempt undertaken via the public health approach (as seen in Patel’s statement above) to depoliticize suicide.

In the second half of the chapter, I trace the history of, and contemporary changes to legal provisions on mental health care to demonstrate how these legal provisions define suicide, and in doing so, directly and indirectly inform legal regulation. I argued in the previous chapter that actors and institutions in the criminal legal arena are not preoccupied with truth while deciding
the validity of a legal provision. Unlike those deliberations, the mental health care legal reform, I argue, is interested in making truth claims regarding suicide. The Mental Health Care Bill 2016 (and 2013), which has been submitted to the parliament to be passed as law, draws heavily on psychiatry to define all suicide attempts as a mental health concern that requires medical treatment. The mental health care legal and medical reform debates do not make direct claims for decriminalization of suicide attempt (Section 309 IPC), but in framing all suicides as a mental health concern, suicide attempts no longer remain a criminal offense.

Mental illness explanations for a suicide act are not a recent phenomenon in India. As evident in the previous chapter, several court judgments and criminal law debates related to Section 309 IPC were informed by the mental illness discourse, albeit to a limited extent. In the 1970s and 1980s, some of the legal actors—judges and the LCI members—suggested psychiatric treatment instead of criminal punishment for people who attempt suicide. A recurring notion within the criminal law deliberations was the idea that the suicidal subject requires care, specifically psychiatric care. Some of the court judgments I analyzed in Chapter One mentioned the need for psychiatric treatment, not criminal prosecution, for a person who attempted suicide. In these discussions, psychiatric care and treatment was one of many methods discussed to address suicide. Some of these legal debates framed suicide as a problem resulting from social conditions in India rather than an individualized psychiatric problem. Although psy discourse has been present in the legal debates since the 1970s, psy discourse on suicide expanded significantly since the 1990s. The legal discourse on regulation of suicide is not restricted to criminal law; legal reform efforts focused on mental health care have also addressed the issue of suicide. There has been a gradual merging of legal with psychiatric and psychosocial

99 See the discussions in Chapter One on State v. Sanjay Kumar Bhatia 1985 and P. Rathinam / Nagbhushan Patnaik v Union of India 1994. In the same chapter, also see the analysis of the 2008 LCI report
public health discourses. The term ‘psychosocial’ refers to the interrelation of social factors and individual thought and behaviors. Thus, psychosocial interventions are often designed to reduce individual mental health concerns by addressing psychological as well as social conditions. Psychiatric public health care, in contrast, aims at treating individual mental health problems, often by using biomedical/pharmacological treatments. The expansion of psychiatric and psychosocial discourse on suicide did not occur in India alone; it was part of a larger global mental health agenda, where large international public health organizations and psychiatric experts played a significant role. I will trace this expansion later in this chapter.

My aim in this chapter is not only to trace the medical system’s approach to regulation of suicide, but also to demonstrate the eclecticism of criminal law with respect to suicide, especially when compared with medical discourses. As I argued in the previous chapter, there is a multiplicity of discourses within the legal arena, which are in constant tension with one another. Unlike that scenario, the medical system's approach has been to repeatedly legitimize suicide as a purely health concern. However, as I explain in this chapter, such an effort to frame suicide as a mental health concern is also wrought with tensions.

1 Introduction to Foucauldian Medicalization

The term medicalization is broadly understood as the “process by which medical definitions and practices are applied to behaviors, psychological phenomena, and somatic experiences not previously within the conceptual or therapeutic scope of medicine” (Davis 2010, p. 211). Foucault wrote several essays in the mid-1970s that addressed the issue of medicalization. In his 1974 lecture “The Birth of Social Medicine” he spoke of the “medical intervention” in “biohistory” that first occurred in the eighteenth century (Foucault, 2001a). He introduced the
term “medicalization,” stating that “starting in the eighteenth century human existence, human behavior, and the human body were brought into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape” (Foucault, 2001a, p.134-135).

“State medicine,” in his account, developed first in Prussia was aimed at enhancing the collective power of the state through the administration of a medical police (Foucault, 2001a). In urbanizing France, Foucault identified a different development. Here, the experiences of plague and quarantine provided the “politico-medical ideal” for a city-scale sanitary organization, which involved individualizing and observing sick individuals, and regulating the physical elements—water and air—that carried disease (Foucault, 2001a). Finally, speaking of Britain, Foucault demonstrated the nineteenth century origins of “labor force medicine,” a kind of class project designed to ensure both a healthy workforce and the political security of the bourgeoisie (2001a, p.151). According to Foucault, these three distinct changes helped develop modern social medicine and allowed for a medical understanding of the social.

By the late 1970s, Foucault had incorporated the notion of governmentality into his concept of how the modern state ruled the “social body”. In discussing the arts of government, Foucault abandoned the notion of an essentialized and willful state in favor of a conception of governance that was not based on a juridical notion of sovereignty acting on citizens, but on a set of practices that operated on populations. In his conceptualization, medical practitioners were no longer enforcers or servants of the state but experts in the service of a discourse that, as Foucault put it, was already “in some sense immanent to the population” (1991, p. 100). The aim of governance was thus “the welfare of the population, the improvement of its condition, the increase of its wealth, longevity, health, etc.,” (Foucault, 1991, p.100). In the essay titled, “About the Concept of the Dangerous Individual,” Foucault argued that the security of the whole and the health of the social body were also advanced in the nineteenth century by the development of
psychiatry and forensic medicine. These disciplines formulated the concept of the “dangerous individual,” whose civil rights could be abridged in the name of a higher collective principle and with a medical judgment (Foucault, 2001b, p.196-197).

In recent years, scholars have extended Foucault’s critique of medicalization in the European context to include a critique of pharmaceuticalization. The latter concerns excessive reliance on pharmaceutical interventions (Ecks, 2005; Healy, 2006; Abraham, 2010). Biomedicalization is another term used to describe technoscientific and individualistic forms of medicalization (Clarke, Shim, Mamo, Fosket & Fishman, 2003). Scholars have argued that medicalization has a tendency to individualize causes, thereby pushing social/structural problems to the back (Clark, 2014; Mills 2014). Suicide prevention in the contemporary West has also been critiqued for becoming excessively psychiatric and biomedical (Rose, 2006; Hacking, 1990; Marsh, 2010).

Unlike Foucauldian works on medicalization or pharmaceuticalization, the story of public health regulation of suicide in India (probably anywhere in the world) cannot simply be studied as an isolated mode of governance. Medicalization of suicide in India does not solely belong to the medical field. It is simultaneously a psychiatric concern as well as a psychosocial, public health, economic and legal concern. Suicide in India has not been successfully medicalized, but one does see glimpses of such an impetus to medicalize/psychiatrize/pharmaceuticalize it. However, even the medicalizing framework is trapped by public health mandates that have to take into consideration other sociocultural, economic, political, as well as individual factors. To understand public mental health care in its historical context, I will provide a brief history of psychiatry in India.
A Brief History of Colonial Psychiatry in India

Although suicide is relatively new within psychiatric public mental health mandate, psychiatry itself is not new in the Indian context. It came into India with the British as an assertion of their moral and scientific superiority (Ernst, 2007, 2010). Waltraud Ernst explains that in the mid-nineteenth century, lunatic asylums, along with schools, dispensaries, hospitals, court rooms, and jails were perceived by the British as showpieces of Western colonialism at work in India (2010, p. 47). The mere existence of these institutions was understood as proof of the superior character of Western civilization and Western society’s moral and social progress (Ernst, 2010).

The asylums that were built in India housed the ‘natives’ (separated according to caste and class) and British in separate quarters (Ernst, 2007). In “Madness and Colonial Spaces – British India,” Ernst explains that although the asylum maintained racial separation through physical distance, the aim of psychiatry in India was not to maintain social control over native populations as it was in Europe or other British colonies (2007). On the contrary, colonial authorities perceived the burden of responsibility for the mad native to be on their family, communities or native-run asylums (Ernst, 2007, p. 223).

After India’s independence, the old asylums, which were now called mental hospitals, remained central spaces of care and treatment (Pinto, 2014, p. 17). From the 1950s onwards, there was a gradual shift away from mental hospitals to increased psychiatric care in general hospitals, but even in these general hospitals there was a decrease in in-patient stay. Post 1970s, there was a further shift towards community care thereby largely deinstitutionalizing psychiatric care. In the 1970s, the WHO had an important role to play in this shift towards community psychiatric care, as I will explain in the next section.
3 Origins of Public Mental Health in India

Although psychiatric care existed in the Indian context since British rule, it did not expand as extensively as other Western forms of medicine. Even today, psychiatry is still not an available form of medicine for most people in India. The major growth for psychiatry in postcolonial India began when the WHO’s International Pilot Study on Schizophrenia was initiated in the 1960s and 1970s in some African countries and India. At the time, the aim of the WHO was to provide humane and cost-effective forms of care for mental health patients. In “A Cultural Critique of Community Psychiatry in India,” Sumeet Jain and Sushrut Jadav explain that although there were extensive formal discussions among several mental health organizations, both nationally and internationally, there was no clear consensus on the development of mental health services (2008). In such a context in 1975, the WHO published a seminal report titled “Organization of Mental Health Services in Developing Countries”. In this report, the WHO made an important recommendation to integrate mental health services within primary health care and decentralize public health services to local levels. Integration of mental health services meant, “mental health component should be incorporated into the work of the primary health worker, the community health centre, district and regional health centres and hospitals” (WHO, 1975, p. 32).

“Decentralization” referred to the transfer of skills and delegation of tasks, which was to be achieved through training of local health workers. This report provided credibility and coherence for public mental health programming in India that resulted in Indian psychiatrists and policy makers accepting its recommendations uncritically (Jain & Jadav, 2008). The WHO study also resulted in psychiatry being included as part of the National Mental Health Programme (NMHP).
for the first time in 1982 (Nunley, 1996). NMHP has continued from 1982 to this day with certain policy shifts.\footnote{100}{For a critique of NMHP’s community psychiatry see Jain & Jadav (2008).}

In the early NMHP policy, mental health care was largely aimed at catering to severe forms of mental illnesses. Within such a conception, suicide had not emerged as a separate mental health problem that needed attention. It is only in the early 2000s that psychiatrists in India began to write about including suicide prevention as part of NMHP goals (Sinha & Kaur, 2011). This push for inclusion of suicide prevention within public mental health policy in India coincides with the WHO's inclusion of suicide prevention within its mandate.\footnote{101}{For an analysis of WHO’s symbolic power over psychiatric policy see Jain & Jadav (2009)}

The point I want to make in tracing a brief history of psychiatric care in India is to demonstrate its close association with public health programs. Public health mandate in India, as in most parts of the world, is not purely medical or, in this context, psychiatric. These programs are designed to include sociocultural, economic, and political contexts while addressing health concerns. Often, however, public health programs sideline the social aspects to provide technical and technological solutions (Amrith, 2007; Jain & Jadav, 2008, 2009). In a study on the culture of public health in India, Sunil Amrith argues that post-independent India’s initial commitment to the welfare state emerged from a complex combination of motives that included concerns regarding equity along with “quality” and “quantity” of the population. Due to lack of infrastructure support and resources, the Indian state ended up with programs targeting specific diseases via technologically oriented interventions that were largely supported by foreign aid (Amrith, 2007). Similarly, in this chapter I argue that as suicide prevention entered public health frameworks it resulted in designing technical solutions, just as public health programs have done for decades in India. In this work, my aim is not to study allocation of resources but instead, to
analyze the political and regulatory tensions that have arisen with suicide being framed as a public health problem. To contextualize this further, I trace, in the next section, the emergence of suicide as part of a global mental health advocacy and its influence in India.

4 Expansion of Global Mental Health

Mental illness and psychiatric care as I have demonstrated in the previous sections, have been a part of public health mandate in India for several decades. However, it is only in the recent past (since the early 2000s), that suicide has emerged as a separate category for public health intervention. The 1990s and early 2000s saw a growth in global mental health discourse. Until this time, the WHO and other large public health organizations were mainly interested in specific public health needs in certain developing countries. Post 1990s there was growth in understanding health concerns through a transnational and a human rights framework.

The book *World Mental Health: Problems and Priorities in Low-Income Countries* (Desjarlais, Eisenberg, Good, & Kleinman, 1995) was one of the first publications to discuss global mental health. It was a significant intervention since it expanded the scope of mental health beyond a narrow biomedical focus to include social conditions such as economic changes, ethnic conflicts, violence, and displacement as determinants of mental health problems. This book was followed by the publication of the WHO report *Global Burden of Disease* (Murry & Lopez, 1996), which included estimates of mental disability for the first time, thereby bringing mental disorders under global health issues. In 2001, the WHO published *The World Health Report- Mental Health: New Understanding, New Hope* (WHO, 2001) on mental health needs in low and middle-income countries (LAMIC) and initiated discussions on mental health specific to ‘developing’ and ‘underdeveloped’ countries. The 2001 report stated that “[m]ore than 40
percent of countries have no mental health policy and over 30 percent have no mental health programme” (WHO 2001, p. xvi and 3). Furthermore, over “450 million people worldwide are estimated to be suffering at any given time from some kind of mental or neurological disorder” (WHO, 2001, p.6). The 2001 report brought together biomedical treatment for mental health along with psychosocial factors that need to be factored in while addressing mental health concerns. With regard to biomedical interventions, the report stated:

Essential psychotropic drugs should be provided and made constantly available at all levels of health care. These medicines should be included in every country’s essential drugs list, and the best drugs to treat conditions should be made available whenever possible. In some countries, this may require enabling legislation changes. These drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse. They often provide the first-line treatment, especially in situations where psychosocial interventions and highly skilled professionals are unavailable (2001, p. 110).

The report also highlighted socioeconomic factors that result in mental and behavioral disorders in LAMIC. For example, the report comments on the relationship between poverty and mental health problems and stated:

….individuals may be predisposed to mental disorder because of their social situation and those who develop disorders may face further deprivation as a result of being ill. Such deprivation includes lower levels of educational attainment, unemployment and, in extreme cases, homelessness. Mental disorders may cause severe and sustained disabilities, including an inability to work. If sufficient social support is not available,
which is often the case in developing countries without organized social welfare agencies, impoverishment is quick to develop (2001, p. 14).\textsuperscript{102}

These statements demonstrate the emphasis on both social determinants for health as well as biomedical/pharmacological treatments as recommended by the WHO. It has been repeatedly argued that although psychosocial aspects of mental illnesses are mentioned in public health care programs and recommendations, these often take a back seat while pharmacological interventions gain prominence in India. Jain and Jadav, in a study of community psychiatry and circulation of psychotropic drugs in India, find that community psychiatry has, in practice, become an “administrative psychiatry focused on effective distribution of psychotropic medication. While it initially embodies ideas of accessibility and participation, the ‘pill’ eventually achieves the opposite: silencing community voices, reinforcing existing barriers to care, and relying on pharmacological solutions to address psychosocial concerns” (2009, p. 61).\textsuperscript{103}

Suicide prevention was an important part of this discussion on global mental health. Suicide prevention organizations and helplines had existed in India prior to the global mental health agenda.\textsuperscript{104} But during the late 1990s and early 2000s, global mental health discussions, specifically suicide prevention, were infused with a new energy. Today, mental health is an expanding field of development intervention in India. It involves several new and old, small and large organizations, which implement programs and undertake different activities in order to provide psychosocial and psychiatric public health care to prevent suicide. New organizations and new suicide prevention initiatives designed on the basis of global mental health mandates

\textsuperscript{102} For a critique of the mental health-poverty nexus and psychiatrization of poverty see Mills (2015).
\textsuperscript{103} I return to the question of biomedical treatment for mental illness later in the chapter.
\textsuperscript{104} In my study of suicide prevention organizations in Bangalore, I found that prior to the WHO suicide prevention mandate, the organizations that were focused on suicide prevention were largely agencies associated with churches.
are constantly emerging in this developmental field. In the following subsections, I study some of the significant programs and agencies involved in suicide prevention via public mental health in India.

4.1 Suicide Prevention within the WHO Global Mental Health Program

The WHO included suicide prevention within its larger mental health care mandate in the 1990s and in 1999 it launched a worldwide initiative on Suicide Prevention (SUPRE). The WHO-SUPRE’s 2003 report explains that suicide is one of the leading causes of death in the world. Each year almost one million people die due to suicide—a global mortality rate of sixteen per 100,000, or one death every forty seconds.\(^{105}\) The 2003 WHO-SUPRE report points out that suicide rates have increased by sixty percent worldwide in the last forty-five years, and it is one of the three leading causes of death among 15–44-year-olds and the second leading cause of death in the 10–24-years age group (WHO, 2003). In the early 2000s, the WHO-SUPRE developed a mandate to address suicide by designing strategies for restricting access to common methods and tools of committing suicide, such as firearms or toxic substances like pesticides, and by addressing the problem of depression and substance abuse, which in turn will reduce suicide rates. It then expanded its initial plans to include objectives such as reducing mortality and morbidity due to suicidal behavior,\(^{106}\) breaking taboos surrounding suicide, and bringing together national authorities and the public to overcome challenges.\(^{107}\)

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\(^{105}\) For more information, see WHO-SUPRE website. Retrieved from: http://www.who.int/mental_health/prevention/suicide/background/en/

\(^{106}\) In the public health/epidemiological literature on suicide, mortality refers to suicidal deaths and morbidity refers to suicide attempts.

\(^{107}\) For more information, see ‘SUPRE Prevention of suicidal behaviors: a task for all’, retrieved from http://www.who.int/mental_health/prevention/suicide/supresuicideprevent/en/
By 2014, the efforts became more intersectional. The WHO’s 2014 mandate suggested carrying out suicide prevention work at various scales to address different target population groups. Thus, suicide prevention strategies conducted in every country were divided into three categories based on three target population groups: Universal, Selective, and Indicated.

“Universal” prevention strategies, which are designed to reach an entire population, may aim to increase access to health care, promote mental health, reduce harmful use of alcohol, limit access to the means for suicide or promote responsible media reporting. “Selective” prevention strategies target vulnerable groups such as persons who have suffered trauma or abuse, those affected by conflict or disaster, refugees and migrants, and persons bereaved by suicide, by training “gatekeepers” who assist the vulnerable and by offering helping services such as helplines. “Indicated” strategies target specific vulnerable individuals with community support, follow-up for those leaving health-care facilities, education and training for health workers, and improved identification and management of mental and substance use disorders. Prevention can also be strengthened by encouraging protective factors such as strong personal relationships, a personal belief system and positive coping strategies (WHO, 2014, p. 8. Emphasis added).

In these efforts, one sees an urge to universalize suicide prevention work, and make it both a national and a global effort, as well as an urge to target specific groups and individuals. The idea that mental illness is both universal and individualized, and can be treated, is integral to this framework. The WHO World Health Report states: “We know that mental disorders are the outcome of a combination of factors, and that they have physical basis in the brain. We know they can affect everyone, everywhere. And we know more often than not, they can be effectively treated” (WHO, 2001, p.x).
The 2003 WHO-SUPRE recommendations were adopted in the context of Bangalore by the leading mental health organization – National Institute for Mental Health and Neurosciences (NIMHANS). Psychiatrists and epidemiologists at NIMHANS published training reports aimed at teaching appropriate response to suicide for media professionals, health professionals, police, NGOs, and educational institutions (Gururaj & Issac 2003a, b, c, d, e, f). An interesting aspect of these reports is that they felt a need to justify the health sector’s role in suicide prevention. In these publications, Dr. Gururaj, an epidemiologist, and Dr. Issac, a psychiatrist, explain that various sectors play a role in preventing suicide, such as: Education, Agriculture, Industry, Drug industries, Economics and finance, Traditional systems of medicine, Local governments, NGOs, Media, Police, Law, and Social welfare. Most importantly, holding the reins, is Health (Figure 1

Figure 1: An Intersectoral Approach to Suicide Prevention (Gururaj and Issac 2003b)
in Gururaj & Issac 2003a, b, c, d, e, f). They state, “[H]ealth sector has to take a lead role in developing, implementing, and evaluating suicide prevention programme as it is a matter of life and death and hence, a health problem. Health ministries and professionals have to take major responsibilities in guiding and leading other sectors and professionals towards a framework of action for suicide prevention” (2003a, p.20).

Within this medical framework, a fundamental yet significant assumption is that matters of life and death are a concern for the health sector, thus reinforcing the notion that public health has to be the primary respondent to suicide, over other disciplines, discourses, and belief systems. Unlike the criminal law discussions I analyzed in the previous chapter, where the courts deployed a variety of discourses, including religious doctrine, questions on state control over life and death, psychosocial and psychiatric explanations, the WHO’s suicide prevention mandate relies on explanations for suicide acts that are less eclectic, tending to privilege psychosocial conditions and pharmacological treatment for suicide behavior.

However, psychosocial interventions are themselves heterogeneous and hybrid. For example, the WHO’s recommendations argue that suicide is a health concern, but its suggestions for suicide prevention involve a wide array of non-medical social institutions and actors. Even though NIMHANS doctors and researchers might insist on centering the health sector in suicide prevention, we also see other non-medical actors—police, media, and educational institutions—being included within public health suicide prevention programs. The point I want to highlight is that while health (psy) systems are attempting to frame suicide as a public health psychiatric or psychosocial concern, suicide is not solely a medical/health concern. To further contextualize suicide prevention within public mental health discourse, I will trace, in the following subsection, the emergence of and interest generated by the Movement for Global Mental Health.
4.2 Movement for Global Mental Health

Extending the WHO’s efforts is the Movement for Global Mental Health (MGMH), an international network of individuals and organizations (including the WHO) which was formed in 2007 after a publication series on global mental health in the UK medical journal *The Lancet* (Prince, Patel & Saxsena, 2007; Patel et al., 2007; Saxena, Thornicroft, Knapp, & Whiteford, 2007; Jacob, Sharan, & Mirza 2007; Saraceno et al. 2007). Following this, there were two MGMH Summits and a second *Lancet* series in 2011 (Global Mental Health, 2011). One of the main concerns of the MGMH movement is to provide mental healthcare provisions for people in LAMIC (Patel, 2007). MGMH makes a call for global equality in access to psychiatric medication. The larger goal of the MGMH is to scale up psychosocial and pharmacological services for mental disorders (Eaton et al., 2011). The proponents of MGMH explain that such a move ought to rely on evidence-based decisions and human rights principles (Patel & Eaton, 2010). By evidence-based decisions they mean a standardized compilation of internationally comparable information on mental health problems (Murray & Lopez, 1996). Patel and Eaton explain that until recently there were no internationally accepted guidelines for improving access to evidence-based care and over the past few decades there has been a growth in evidence on “burden, impact, and unmet needs of care for people with mental disorders in low-and middle-income countries” but the effective treatments for mental disorders have been generated only from high-income countries (Patel & Eaton, 2010). Thereby, contextual factors, specifically “mal-distribution of human resources for mental health in LAMIC,” limit the potential to

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108 For more information on MGMH, see their website. Retrieved from, [http://www.globalmentalhealth.org/](http://www.globalmentalhealth.org/)
109 Also see the series on MGMH in other prestigious academic journals: *Transcultural Psychiatry* (2012) and *Harvard Review of Psychiatry* (2012).
generalize treatment from high-income countries (Patel & Eaton, 2010). This lack of information, they argue, made it difficult to generalize programs to large groups of people or to scale-up mental health services across countries. However, with the growth of global mental health, they argue, there is more evidence on the burden, impact, and unmet needs of care for people with mental disorders from LAMIC, and this evidence can help design appropriate programs in these countries (Patel & Eaton, 2010 p.343).

Patel is also of the opinion that mental disorders account for 11.1 percent of the total disease burden in LAMIC, and that there is a severe shortage of mental health practitioners in these countries (2007). Arthur Kleinman, an eminent cross-cultural psychiatrist, describes such a lack of mental health services as a ‘failure of humanity’ (2009). The assumption underlying MGMH for not using High Income Country (HIC) data to speak to conditions in LAMIC is that there is a mal-distribution of human resources for mental health in LAMIC.

As I mentioned earlier, public health in India has been often criticized for mal-distribution of resources (Amrith, 2007; Jain & Jadav, 2009). However, ethnographic accounts have found that it is not simply the lack of mental health care practitioners that is leading to failure of policy objectives but, instead, there is a disconnect between the ambitions of planners and the realities of poor infrastructure and resource constraints. Jain and Jadav study a community mental health program in North India and argue, “Despite poor outcomes and limited evidence, mental health professionals and bureaucrats maintain rhetorical fidelity to a dominant health model while implementing something quite different…. Psychiatric professionals in northern India operate in a national and international professional environment dominated by

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110 According to the WHO’s World Health Report (2006a), Human Health Resource is defined as “all people engaged in actions whose primary intent is to enhance health” (2006a). Human resources for health are identified as one of the core building blocks of a health systems: they include direct health providers such as physicians, nurses, midwives, dentists, community health workers, as well as support personnel who do not provide direct health care such as health service managers, medical secretaries, etc.
biological approaches to psychiatry” (2009, p. 75-76) and this disconnect, between the interests of the practitioners and the local contexts, results in failure of the health care provisions as envisioned by the policy makers.\textsuperscript{111}

Another important aspect of the MGMH agenda is to scale-up services. Currently, the WHO and the MGMH suggest scaling-up psychiatric treatments for all mental health problems, specifically, access to psychiatric medication. The Lancet MGMH series explains this aspiration and the position held by the WHO clearly (Global Mental Health, 2011). It states that every year up to 30 percent of the global population will develop some sort of mental disorder. These mental disorders represent a substantial “though largely hidden” proportion of the world’s overall disease burden. To address severe mental health problems across the world (predominantly in LAMIC), the WHO aims to develop “community mental health services” (Prince, Patel & Saxena, 2007). While the mandate is for all countries, there is a special emphasis on LAMIC, where, the organizations argue, 75 percent of people do not receive the required mental health services (WHO, 2008).\textsuperscript{112} The aim of this movement is to address the so-called treatment gap between the HIC and LAMIC,\textsuperscript{113} and in this process of scaling-up, the members of the MGMH advocate for exporting Western models of mental illness, and want treatment for such illness to be thought of as a fundamental human right (Mills, 2014).

MGMH has received criticism from disability scholars, critical psychologists, and survivors of psychiatry from various parts of the world. These critics argue that such global

\textsuperscript{111} I return to the discussion on pharmacological treatment for mental health concerns later in the chapter.

\textsuperscript{112} See the discussion on the WHO’s Mental Health Gap Action Program (mhGAP) in this chapter to get a detailed understanding of the nature of programs that MGMH propagates. It is also important to note that there are claims made in many of the high-income countries regarding over-prescription of medication. Mills points to the fact that in the Western countries there are voices which are making a call to abolish psychiatric diagnostic systems and also acknowledge the harmful effects of psychiatric medication (2014). An irony in this context that Mills points out that both the call for increased psychiatric interventions as well as the arguments exposing the harm caused by these intervention are based on human rights principles (2014, p. 3).

\textsuperscript{113} See the discussion on mhGAP later in the paper for a more detailed examination of the idea of ‘treatment gap’.
programs are based on alarmist data, which ends up creating cultures of sickness and simultaneously disempowers communities from cultivating and maintaining other forms of well-being practices (Campbell & Burgess, 2012). They also critique the professionalization and excessive medicalization of everyday life by such large-scale universalizing programs. In regard to the latter, Derek Summerfield, a prominent opponent of MGMH explains, “[I]n what has been called the ‘culture of therapeutics’, citizens are invited to see a widening range of experiences in life as inherently risky and liable to make them ill” (Summerfield, 2012 p.520).\(^{114}\)

Prior to MGMH, disability scholars in India had emphasized the negative implication of psychiatric labeling of women (Dhanda, 1987). Amita Dhanda, a leading human rights lawyer and critical disability studies scholar, pointed out the complicity of the state with psychiatry to maintain patriarchy by using a psychiatric labeling of assertive women (Dhanda, 1987 and 1996). Dhanda presents several cases where the label of ‘insanity’ was repeatedly applied to divorced and incarcerated women (1987). She explains:

Insanity labeling… disproportionately victimizes women on a male-defined double standard of mental health which assigns them to the highly stigmatised status of the psychiatric patient, especially if they behave in ways that challenge masculine stereotypes of female propriety. Psychiatrists approach women with assumptions about female mentality that condition what they see, and influence how they respond (Dhanda, 1996).

Specifically with regards to MGMH, scholars have shown that India began to design policies, following the WHO's mental health mandate, which led to an “explosion of mental disorders” (Davar, 2015). Disability activist and scholar Bhargavi Davar gives an example of the impacts of mental health programs stemming from a global mandate on women in India:

\(^{114}\) For a further critique of MGMH see Ingleby (2014).
Several women’s ailments considered hitherto as *public health failures* by women’s health activists, now became elevated to primary health care topics, redefined as ‘mental disorder’ requiring psychiatric treatment. For example, ‘chronic fatigue’, ‘vaginal discharge’, ‘genital complaints’ and ‘medically unexplained’ pain were analyzed as masked depression in large sample point prevalence studies conducted in India on women. Such findings led to the development and validation of psychiatric diagnostic tools that can be easily administered at the PHC level, and to advocacy for anti-depressant medications being made available in primary health care (Davar, 2015).

Davar’s argument highlights the process by which psychiatric diagnosis translates public health structural problems into purely psychiatric problems. Similarly, Dhanda explains the negative impact of psychiatric diagnosis and labeling of women. Such phenomena are not unique to the Indian context. In the ethnography of political, social and scientific circumstances following the Chernobyl nuclear reactor explosion, anthropologist Adriana Petryna points towards a similar impetus to apply psychosocial medical categories to individuals. This impulse, she argues, created a biomedical regime wherein a majority of political claims made on the state by people affected by the tragedy could be avoided (Petryna, 2002). There is an overwhelming concern amongst critiques of MGMH that there is an excessive reliance on pharmacological care for mental health problems. Excessive biomedicalization has a longer history in India. In the next section, I explain the history of over-reliance on pharmacological treatment for psychiatric concerns, which consequently demonstrates the reasons why, in spite of social issues being present in the discussion on suicide, public health programs soon turn to excessive pharmacological treatments.
5 Assemblage of Suicide Prevention Programs

In India today, there are several public health organizations, individual psychiatrists and psychologists, NGOs working on mental health problems, and volunteers, who have come together to form an elaborate assemblage that aims at preventing suicide using a psychosocial and psychiatric perspective. In 2002, one of the leading mental health institutes in India, NIMHANS, Bangalore, collaborated with the WHO to set up the Centre for Injury Prevention and Safety Promotion in Bangalore. This WHO Centre also designed capacity building programs for police, media professionals, NGO workers, and volunteers (Gururaj & Issac, 2003a, b, c, d, e, f). These programs claim to be important for three reasons: First, the police are the first responders in most suicide cases and, as suicide is a criminal offence, they need to conduct a criminal investigation. This might change if and when the legal status of attempting suicide in India changes. Second, there is a consensus that the media often sensationalizes suicide news, which might encourage other suicides. And lastly, NGO workers and volunteers work with individuals who are suicidal and hence require training to deal with such individuals (Gururaj & Issac, 2003a, b, c, d, e, f). These capacity building programs aim to sensitize all these groups to respond appropriately. However, it is unclear whether this Centre continues to function as it was intended in 2002. I could not find evidence that this Centre is functioning as of 2016.

Suicide was not the only concern for the doctors at NIMHANS. They were also involved in advocacy and research in areas such as road traffic injury and violence against children and women. As a part of its work on suicide prevention at this Centre, NIMHANS aimed to collect in-depth data on suicide. Currently, the NCRB, India, collects this data annually for the entire country. However, some of the doctors at NIMHANS believe that the data available are unreliable and not detailed enough to direct any real interventions. Hence, one of their primary aims has been to collect reliable data on the rates of suicide. NIMHANS' concern about lack of good data on suicide is not unique. WHO publications on suicide also share a similar sentiment regarding the unavailability of reliable data on suicide in various parts of the world (see WHO, 2001; WHO, 2014). Since this information is in the process of being collected, researchers at NIMHANS have been relying on the suicide statistics collected by the NCRB. I touch upon the politics of statistical knowledge on suicide in the Introduction.
However, other centres linked to NIMHANS have now emerged which also deal with suicide prevention.

In 2011, NIMHANS launched the NIMHANS Centre for Well Being (NCWB) in Bangalore, in collaboration with the White Swan Foundation. The White Swan Foundation for Mental Health is a not-for-profit organization that is a collaboration of individuals, such as suicide prevention activists, psychiatrists, psychologists, corporate heads, as well as NGOs. Its aim is to offer knowledge services in the area of mental health (including suicide prevention). Suicide prevention is a major part of the NCWB and its mandate is to provide mental health care support by being close to the community. In 2013, the NCWB, building on the WHO directives, launched the Gatekeeper Training for Suicide Prevention. According to the NCWB, a gatekeeper is a person who believes that suicide can be prevented and is willing to give time and energy to work towards suicide prevention. This gatekeeper can be a teacher, parent, warden, boss, colleague, or a community leader. They are trained by a senior psychiatrist, a psychiatrist nurse, and a psychiatrist social worker to: (a) offer psychosocial support to individuals who are contemplating suicide, (b) assess suicide risk in individuals, and (c) direct at-risk individuals to mental health services. Over 500 gatekeepers have been trained since February 2013. These gatekeepers are not necessarily psychologists or psychiatric experts, but act as nodes in the expanding mental health care system. They are trained in the specific areas of assessing suicide risk in individuals and encouraging these individuals to reach out to mental health care services, which then address the suicidal behavior.

It is significant to point out that the above-mentioned strategies for suicide prevention undertaken by the NIMHANS and the NCWB are not purely psychiatric/biomedical in nature.

The gatekeepers, for example, are trained by psychiatrists to assess risk of suicide, but they are also trained to provide non-biomedical, psychosocial support to the suicidal individual and, if this is not sufficient, to direct the person to psychiatric care. Such a psychosocial approach has been complemented by the work of several NGOs that work towards suicide prevention, both in Bangalore as well as across India. A few examples of suicide prevention NGOs are: Sneha (translates to friendship) in Chennai, Maitri (also friendship) in Cochin, Befrienders India in Chennai, Aasra (translates to support) in Mumbai. In Bangalore, Sahai (translates to help or support) is a prominent suicide prevention helpline that was established in 2002 by the mental health NGO Medico Pastoral Association (MPA) in collaboration with the Rotary Club of Bangalore. Similar to the NIMHANS-NCWB Gatekeepers program, Sahai also trains volunteers to respond to people who call on their helplines. These volunteers are trained by psychiatrists from the NIMHANS to listen pro-actively, recognize and assess signs of stress and depression. Furthermore, the MPA and NIMHANS psychiatric experts organize workshops for police and teachers to sensitize them regarding mental health concerns affecting people with suicidal tendencies. These NGOs, suicide helplines, volunteers, mental health institutions such as NIMHANS, individual psychologists and psychiatrists form a complex assemblage aimed at suicide prevention.

As is now evident, varied kinds of actors and organizations play a role in the suicide prevention assemblage in Bangalore and elsewhere. However, not all these actors in the assemblage have similar levels of authority to decide the direction of suicide prevention programming. For example, it is the psychiatrists associated with the WHO and the NIMHANS

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117 MPA is one of the oldest NGOs in Bangalore. It emerged as an NGO while being affiliated with a Catholic Church in Bangalore. I point to this detail because it highlights the various kinds of players who are involved in suicide prevention work in India.

118 See more about Sahai Helpline at their website. Retrieved from: http://www.sahaihelpline.org/about.html
who are training the police, media professionals, and NGO workers to respond “appropriately” to suicide incidents. Similarly, in the work undertaken by the NIMHANS-NCWB and the White Swan Foundation’s Gatekeeper training program, it is once again psychiatrist experts who are training the gatekeepers. These programs suggest that psychiatrists (along with psychologists) are leading the way with regard to suicide prevention. My aim in pointing this out is not merely to argue that suicide is or is not a psychiatric concern, or to trace medicalization of suicide. Instead, I would like to understand the implications of psychiatric and psychosocial interventions regarding suicide prevention. In the next two sections, I will study two important aspects related to suicide prevention within mental health care discourse in India. First, I will analyze the system of over-reliance on pharmacological treatment for depression (consequently suicide) in India. Second, I will study a psychosocial, non-biomedical farmer suicide prevention program and its implications. Specifically, my interest in studying a psychosocial farmer suicide prevention program is to understand the limitations of shifting the discussions regarding farmer suicide away from a political economy discourse (as I explained in the Introduction) to a public health discourse.

6 Over-Reliance on Pharmacological Treatment

In July 2009, I was in Bangalore conducting preliminary research. My aim at the time was to study suicide prevention interventions in Bangalore. As part of my interviews, I met with psychologists and psychiatrists who provided free counseling sessions in medical institutions and NGOs in Bangalore. One such venue is run by one of the oldest Hindu right-wing organizations.

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119 Later in the chapter, I also analyze the top-down framework adopted by psychiatric and psychological actors that drive mental health care programs.
called the Rashtriya Swayamsevak Sangha (RSS). The RSS in Bangalore had also taken up mental health care, along with other ‘social problems’. The clinic I visited provided free mental health diagnosis for people twice a week. I visited this clinic four times and I always found a long line of (about 50-60) people waiting to meet the psychiatrist.

In one of my visits, while I was waiting, the receptionist shouted out my name and asked loudly in Kannada (one of the local languages of Bangalore), whether I was the one who was visiting from Canada to study suicide. The receptionist’s call caused a murmur amongst the others waiting with me. Soon after, Uma and her husband walked up to me and introduced themselves. Uma said to me in Kannada that she had overheard I am studying suicide and would like to speak to me about her son’s suicide. She briefly explained that her second son, a happy 20-something man with a comfortable job had hanged himself more than a year ago. The psychiatrist, whom Uma had been visiting for a year, had reasoned to her that her son must have been depressed and hence decided to end his life. Uma, who was herself on depression medication for a year, asked me a series of questions: “What is depression? Why do people get it? How can it be detected?” Much to her disappointment, I had no answers to these questions and was there to understand the same. We went on to speak about her family and my work. After a while Uma and her husband thanked me and left. To me, this brief conversation with Uma is illustrative of the complexity of suicide prevention in India. Uma, despite undergoing medical treatment for depression for a year, continued to not have the answer to her question what is depression? But this had not stopped her from returning to the psychiatrist for further treatment.

After my conversation with Uma, the receptionist took me to meet the psychiatrist who was volunteering at this counseling center. I was asked to enter the room, and as I entered I saw

120 Name has been changed to maintain anonymity.
that the psychiatrist was still speaking to one of his patients. I was a bit embarrassed to be
listening in and so awkwardly offered to wait outside. However, the psychiatrist did not mind
that I walked in, and on the contrary he ushered me to take a seat on his side of the table while he
continued to diagnose that patient. After a couple of minutes of conversation, he wrote a
prescription and the patient left.

He then turned to me and asked me a few questions: Did I like Toronto? Will I be coming
back to serve my country or do I prefer to settle down in America? I answered his questions to
the best of my knowledge at the time. I explained that I was interested in suicide prevention work
in Bangalore. He immediately turned to his bag and retrieved three books he had written on
mental health and mentioned that all of them had sections on suicide prevention. He continued to
explain that many patients he receives in this clinic and other clinics where he works are
suffering from depression. He explained emphatically, “depression is the most common
problem”. Similar to conversations with other psychologists and psychiatrists I had had, he too
said “…people don’t understand depression. It is our job to teach them and to treat them. The
problem of suicide will automatically come down”.

By this time, another woman patient was ushered into the room. I offered to wait outside
for him to finish, but he insisted that I stay on, explaining that it will not take him much time.
Once again, I awkwardly watched him consult his patient. The psychiatrist simply asked the
woman patient in Kannada, what was the problem? To which the patient responded that she had
been to see him a few days back because she was feeling very sad (in Kannada: tumba beejaru)
and was again not feeling good. She then showed him the medication he had previously
prescribed. To which the doctor asked her if she had been taking the medicine daily. She nodded
yes. He then looked at me and then at her and told her that he would increase the dosage, to
which she nodded once again in agreement. The psychiatrist wrote a prescription while
mentioning aloud the name of the medicine – Prozac. He turned to me and said: “this is the
treatment they all need. Depression is a real problem”. The patient took the prescription and left
the room.

This psychiatrist’s reliance on pharmacological treatment for mental health problems is
not unique. Mental health concerns of varying severity are often treated with medication in India
(Nunley, 1996). High rates of prescribing psychotropic drugs are largely due to easy accessibility
of drugs, their relatively low cost, as well as leniency in regulation of medicines (Nunley, 1996).
Pharmacological treatment is imagined by patients to be evidence of care, with an idea that it
will offer immediate results (Nunley, 1996). Ethnographic studies in North India have found that
there are fewer psychiatrists in rural areas than in urban centres, nevertheless a range of other
medical practitioners such as chemists, uncertified doctors, and general practitioners all diagnose

Jain and Jadav study the circulation of psychotropic pills from the policy makers to the
patients in a village to argue that “psychotropic medication has become the essence and
embodiment of India’s community mental health policy” (2009, p. 61). While conducting an
ethnography of psychiatric care of women in North India, Sarah Pinto mentions that she
encountered psychiatrists who explained that drugs were more culturally appropriate treatment
for mental illness, whereas psychotherapies imposed Western notions of self which were
incompatible with Indian realities (2014, p. 19). In addition to a long history of excessive
prescription of psychotropic drugs, there are also several layers of sociocultural significance to
prescribing drugs. Prescribing drugs sometimes reflects medical authority. Jain and Jadav
explain “the implementation of a biologically-oriented psychiatry appeals to health professionals
as a way to both achieve desired professional outcomes (e.g., satisfied patients, income, and
credibility among peers) and cement linkages with the dominant discourses and institutions of
international psychiatry” (2009, p. 76). Similar to my observation at the counseling center, Michael Nunley also found that psychiatrists predominantly rely on prescriptions as well as electroconvulsive therapy (ECT) (1996). This focus on ECT and prescriptions, Nunley argues, is due to an “epidemic” view of psychiatric disorders and also the need to legitimize psychiatry both for the larger public as well as their medical colleagues (1996).

Within such a context of over-reliance on pharmacological treatment in India, the WHO’s conception of a “treatment gap” for depression between developing and developed countries and the pharmaceutical solutions for such a gap is significant. One of the primary aims of the WHO’s mental health efforts, as mentioned earlier, has been to close the treatment gap between developing and developed countries. To achieve their primary aim of closing this gap, the WHO started the Mental Health Gap Action Programme (mhGAP) in 2008 with the objective of integrating mental health within health systems across the world, and scaling-up services for mental, neurological, and substance use disorders, especially in LAMIC. The WHO-mhGAP’s first report—a large multi-country survey — states that “35–50 percent of serious cases in developed countries and 76–85 percent in less-developed countries had received no treatment in the previous 12 months. A review of the world literature found treatment gaps to be 32 percent for schizophrenia, 56 percent for depression, and as much as 78 percent for alcohol use disorders” (WHO, 2008, p.7). Based on this epidemiological evidence, the WHO identified “priority conditions” such as depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children (WHO, 2008).

Since the 1990s, the WHO has been counting depression as one of the world’s most pressing health problems and has predicted an increase in depression related suffering in years to come. Depression is a significant point of focus within the transnational mental health discourse.
Many psychologists, psychiatrists, and suicidologists believe depression to be a major cause for suicides, and providing antidepressants is seen as a natural course of action. The WHO itself is of the view that the increased distribution of antidepressants would reduce mental health problems in India and consequently reduce the number of suicides (WHO, 2001, p.61). In doing this, the WHO and its mental health discourse combines biomedical and developmental frameworks—if the existing gap in public health between the global north and south represents a treatment gap between “developed” and “developing” countries then wide distribution of antidepressant drugs become the cure. Further, the mhGAP designs “packages” consisting of interventions for prevention and management of each priority condition. These packages are designed to be adopted by LAMIC according to their local contexts. With regards to depression, the WHO-mhGAP report suggests interventions such as treatment with antidepressants and psychosocial interventions. With regards to suicide, its suggested interventions include: restriction of access to common methods of suicide, prevention and treatment of depression, alcohol and drug dependence (WHO, 2008, p.11).

6.1 On Depression in Global Mental Health

In global mental health literature, depression is discussed in two ways. One approach suggests that economic globalization is associated with the increase of depression around the world. The stressors of a globalized life, such as urbanization, migration, and large income gaps between the rich and the poor, all lead to an increase in depression (Bhugra & Mastrogianni, 2004). The

121 Examples of such interventions to address depression include (a) treatment with older or newer antidepressants by trained primary health-care professionals, (b) psychosocial interventions such as cognitive behavior therapy or problem solving, (c) referral and supervisory support by specialists (WHO, 2008, p.11).

122 Examples of such interventions to address suicide include multi-sectoral measures that relate to public health, such as restriction of availability of most toxic pesticides, and storage of supplies in secure facilities. The report also states that intervention for depression can also be used to address suicide (WHO, 2008, p.11). I study one such intervention to prevent farmer suicides in the next section.
second approach argues that through the process of globalization itself, western notions of ‘depression’ along with its pharmaceutical therapies spread to the rest of the world (Kirmayer & Minas, 2000 as quoted in Ecks & Basu, 2009a). This second argument stems from an idea that globalization of antidepressants is the work of pharmaceutical marketing rather than due to an increase in depression. Kirmayer and Minas hold that the global spread of psychiatric disease classifications and diagnostic routines explains the increase in the use of antidepressants (2000).

This school of thought argues that the increase in demand for psychopharmaceuticals across the globe is a result of pharmaceutical companies marketing notions of health and illness including depression (Healy, 2006). In a study of the spread of psychiatric treatment and discourse in the West, Nikolas Rose argues that that diffused state of sadness, which earlier went without therapeutic intervention, is now becoming increasingly medicalized and treated with drugs (Rose, 2006). The first approach to understanding globalization thus proposes that economic globalization is the root cause of mental disorders including depression and the treatment ought to be psychopharmaceuticals. Whereas the second school of thought argues that the demand for antidepressants and other psychopharmaceuticals is a creation of multinational corporations.

The WHO fits within the former of these two broad approaches. It has repeatedly contended that social inequality leads to a higher prevalence of mental disorders. Individual poverty and other macroeconomic conditions, it suggests, lead to increased depression, and the lack of appropriate care pushes people to be less productive in society (WHO, 2001, p.26-27). The WHO explains that a decrease in economic growth, and lack of appropriate treatment, along with an increase in social inequality leads to high prevalence of mental disorders and so it is not necessarily surprising that there is an increase in the sale and consumption of antidepressants (Ecks & Basu, 2009a).
The mental health framing of depression has further led to an increased focus on pharmacological care and particularly the use of antidepressant drugs and serotonin reuptake inhibitors (SSRIs) (Ecks, 2005; Healy, 2006). The increased acceptance of antidepressant drugs as a medical and developmental solution to the mental health gap has made pharmaceutical companies one of the major actors working towards redefining suicide in India. As I explained earlier, psychiatry in India largely works within a biomedical framework (Nunley, 1996). In his critical analysis of public mental health initiatives in India, K.S. Jacob argues that the exorbitant costs involved in generating evidence gives the pharmaceutical industry monopoly over evidence-based medicine. He explains:

… mhGAP is very sophisticated compared to past approaches. It employs research evidence of proven successes in low and middle-income countries. However, a closer look at evidence-based medicine suggests that the evidence fades over time and is not generalizable. For example, established evidence that the newer antipsychotic medication is superior to conventional drugs took over a decade to disprove…. The industry softens the Indian market by sponsoring physician education, advertising and selling newer drugs without doing effectiveness or efficiency trials in India (Jacob, 2015, p.23).

It is nevertheless interesting that when we shift the lens to local circumstances, it becomes evident that global pharmaceutical companies are not the beneficiaries of excessive pharmacological interventions. In the ethnographic work on pharma industries in India, Stefan Ecks shows that the Indian pharmaceutical industry is one of the biggest producers of generic medicines, which in turn has led to a widespread use of antidepressants within the country (2005). Ecks and Basu also find that contrary to the claim that big pharmaceutical industries in

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123 On the role of biomedicine in mental health care practice, see Jain & Jadhav (2009), and Pinto (2011).
the West are profiting from the sale of anti-depressants in India, the industries that are profiting are small Indian pharma industries that solely produce generic medicines (2009a). Ecks and Basu demonstrate that antidepressants are widely overprescribed or given out without prescriptions, often leading to their use beyond the control of licensed service providers. Despite this overuse, they argue that it is unclear whether this spread of antidepressants will ever lead to the outcomes desired and predicted by the WHO (Ecks & Basu, 2009a).

The point I want to make in tracing the elaborate discussions on biomedical interventions in mental health care is to argue that while global mental health programs and interventions might be recommending psychosocial intervention as well as psychiatric treatments, the local histories and social conditions in India push for excessive reliance on pharmaceutical treatment for depression. The ‘treatment gap’ and the need to ‘scale-up’ only legitimizes the already excessive pharmacological intervention with respect to mental health.

Nevertheless, in the space dominated by pharmacological treatment for mental illnesses, there are also other psychosocial programs designed to prevent suicides. In the next section, I take up one such intervention that aimed at preventing farmer suicide in Tamil Nadu, India. Studying such psychosocial interventions demonstrates that even non-biomedical suicide prevention interventions also have political implications.

7 ‘Depoliticizing’ Suicide

In many of their publications, the WHO’s Department of Mental Health and Substance Abuse, SUPRE, and the International Association for Suicide Prevention (IASP), have put forward
interventions for suicide prevention.\textsuperscript{124} Suicide through pesticide consumption is a predominant method identified by the 2006 WHO-SUPRE report (WHO & IASP, 2006b). As per the report, sixty percent of suicides in the world are due to pesticide consumption. The report also states: “in many low and middle-income nations pesticides are the most readily available and frequently used method of self-poisoning” (WHO & IASP, 2006b). In accordance with its twofold mandate for suicide prevention, SUPRE recommends the following community interventions:

i. Designing safer storage facilities to regulate access to pesticides, and educating farmers and rural populations regarding harmful effects of pesticide consumption

ii. Designing psycho-social interventions by local community level doctors who attend to people who have attempted suicide by consuming pesticides

iii. Formulating regulatory policies for pesticide production, sales and pesticide substitution (WHO & IASP, 2006b)

In India, where the rates of farmer suicides are very high, NIMHANS, following the WHO, prescribes two specific recommendations: (1) promoting manufacturing of less harmful pesticides, and (2) banning all lethal pesticides from routine availability. In 2010, the Tamil Nadu Health Minister inaugurated a community pesticide storage project—the Kattumanar Koil project. The project was initiated by \textit{Sneha: A link with life}, a suicide prevention NGO based in Chennai, Tamil Nadu, and was funded by the WHO. A centralized location was identified in two villages, where every farming family would have a locker for pesticide storage. The larger aim of the project was twofold. One, to study the effect of centralized pesticide storage facility on suicide rates in the district. Two, to examine the feasibility and acceptability of a centralized pesticide storage facility as a way of reducing suicide by pesticide consumption (Vijayakumar et

\textsuperscript{124} These documents are published and distributed to nations that have high rates of suicide. Although these publications are universal, in that they address the suicide problem for countries across the globe, they suggest that each country should adapt specific interventions to match local socio-cultural conditions.
al., 2013). The initiative was designed as a model project, on which future projects would be based.\textsuperscript{125} The researchers found the pilot project to be useful in reducing suicides by pesticide consumption.

The focus was solely on controlling access to pesticide. This resulted in marginalization of discussion around farmers' affective, social, political, cultural, and economic contexts, and their relation to suicide.\textsuperscript{126} WHO-SUPRE’s focus has been to regulate the methods and tools of suicide rather than addressing other sociopolitical, economic, cultural or individual aspects that might be resulting in a farmer committing suicide (WHO & IASP, 2006b).

A similar approach has been used in responding to suicides in other contexts. In a 2003 workshop with the Bangalore police, NIMHANS doctors and other expert participants, such as suicide prevention activists, drafted recommendations and guidelines for local police. These guidelines recommended surveillance of ‘high-risk’ places such as high-rise buildings, public parks, and ponds, to prevent people from attempting suicide. Similarly, hotels and lodges were also identified as spaces that need policing, since couples that elope often rent rooms there to commit suicide (Gururaj & Issac, 2003d).\textsuperscript{127}

In these proposals for regulating suicide, one sees the impetus to move away from a political, economic, or religious explanation, and, in its place, control the risk of suicide through regulation of a wide range of behaviors and spaces. Such a mandate chooses to pay attention solely to the act of suicide, almost as if it exists outside other social, affective considerations. I do not intend to suggest that by isolating the act of suicide in order to control it, that other

\textsuperscript{125} Scaling-up, as I mentioned earlier, is important for projects designed under MGMH and WHO directives.\textsuperscript{126} See the Introduction to understand the history and politics of the leftist, political economy based social movement regarding agrarian suicides in India.\textsuperscript{127} Inter-caste, inter-religious, same-sex couples often face severe harassment from their community and family for transgressing accepted social boundaries. One often hears narratives of such couples choosing joint suicide over a life of harassment. I refer to such suicides once again Chapter Three in the context of lesbian suicides in India.
policing methods do not exist. Suicide was, and continues to be, regulated through religious norms, expectations, criminal law and several other familial and community policing practices. But the significance of the new public health initiatives are their insistence on focusing on the method used to commit suicide. Such suicide prevention approaches govern risk more than individual acts or broader conditions of possibility. They focus on reducing the rate of suicides.

In his seminal work on the development industry in Lesotho, James Ferguson (1990) argues that development discourses have the capacity to ‘depoliticize’ certain integral aspects in society. He states, “(although) poverty, hunger, and unemployment are fundamentally political issues, the routine discourses and practices of ‘development’ machine render them apparently susceptible to technical solutions…The ‘development’ machine thereby depoliticizes these fundamental issues” (Ferguson, p.270). Tania Li also argues that, by identifying a problem through a particular framework, the development apparatus immediately links it to the availability of a solution, a practice she terms “rendering technical” (Li, 2007). This way of approaching issues confirms expertise and constitutes a boundary between those who are positioned as trustees to define the problem and those who are subject to their expert direction. These experts, she argues, are trained to frame problems in technical terms, which allow them to address the problem through technical means. Questions that are rendered technical get simultaneously rendered non-political.

Following Ferguson and Li, I posit that, in their efforts to prevent suicide, development organizations and professionals have attempted to remove suicide from all its other contexts and meanings and re-signify it as a development issue that needs psychosocial attention. By studying suicide as public health/psychosocial problem and addressing it through control of substances and spaces, the development apparatus frames suicide as being at the fringes of political, economic, cultural, and social spheres, and predominantly within the realm of public health.
Suicide thus gets depoliticized and, subsequently, becomes susceptible to technical solutions such as pesticide control. By using the term ‘depoliticize’ I do not intend to suggest that suicide, framed as a public health concern, is not political. Nor do I want to suggest that political or economic situations, however dire, are sole causes of suicides. Instead, I want to show how the psychosocial public health discourse frames suicide predominantly as a psychosocial public health problem, and obscures other aspects to the act of suicide. Programs such as the ones I mention above are supposedly reducing the rates of farmer suicides (Vijayakumar et al., 2013). Since the aim within public health mandate is to prevent suicide incidents and lower suicide rates, it is apparently achieving that goal. However, the result of framing farmer suicide as a public health concern has implications on other political discourses.

As mentioned earlier, psychosocial programs are also hybrid entities. As we see in these above mentioned interventions, psychologist and psychiatrists might be spearheading these interventions but most of the recommendations made, for example, regulating access to pesticides or recommending the police to have more surveillance of ‘high-risk’ spaces in the city involve non-medical, non-psy actors. Nevertheless, the discourse regarding farmer suicide is no longer solely revolving around questions of political economy.

In the recent past, there have been reports in the media addressing the psychology of the farmers. The Government of Maharashtra proposed relief efforts such as ‘psychological healing sessions’ for farmers (Harvesting Despair, 2009 p.4), and the former chief minister of Andhra Pradesh sent a team of psychiatrists to visit farmers to dissuade them from committing suicide (Sharma, 2004, as quoted in Mills, 2014). A minister in Telangana called upon members of the Indian Psychiatric Society to conduct research on the reasons for farmer suicide in the south Indian state of Telangana (“Conduct a survey”, 2016). In 2007, the Indian government responded to a spate of farmer suicides by launching a study to probe genetic links to farmer suicides in
Vidharba, Maharashtra. The aim was to study whether there were genetic factors that made people in particular communities more prone to suicide (Arya, 2007).

In contrast to the leftist political economy narrative that focused on structural conditions that were pushing farmers to commit suicide (as I explained in the Introduction), these psychological and psychiatric discourses frame farmer suicides as an individualized problem and disconnect the acts of suicide from larger structural conditions that would put the responsibility on the government. Several politicians and media outlets have proposed that farmers suffer from mental illnesses and that is a major cause for suicide (Mayer, 2016). A more recent surge of literature stemming from the psychiatric perspective claims that focusing on structural problems with regards to agrarian suicide is too political thereby not acknowledging the need for psychiatric treatment (Mayer, 2016; Sen, 2016). Vikram Patel explains that rather than the government providing compensation for farmers or families of farmers who have committed suicide, suicide should be seen as a mental health problem (Pandya-Wagh, 2015)

Biomedical and psy discourses on all suicides are expanding in India. But these recent psychological and psychiatric public health interventions on farmer suicide are significant because the state agencies are promoting this discourse by ignoring studies that have indicated structural factors that have led to agrarian suicides. This turn to psy and genetic discourses by the state has received criticism by leftist, political economy farmer suicide activists (Harvesting Despair, 2009 p. 4; Mills, 2014). Once again, I do not intend to argue that the political economy argument captures all the problems leading to farmer suicides. Political economy driven social movement surrounding agrarian suicide have also narrowed the potentiality of meanings associated with the suicide act. As I explained in the Introduction, a large part of the social movement surrounding farmer suicides in India has aimed to keep the state accountable and provide for its most marginalized citizens (Sainath, 2009, 2014, 2015; Nagaraj, 2008), thereby
silencing other narratives regarding agrarian suicides (Münster, 2015). A significant difference, however, is that, unlike the political economy discourse that held the state accountable, the emerging biomedical and psychological discourse on farmer suicide conceptualizes these acts as individual psychiatric or psychological problems. I do not intend to argue that the political economy discourse has a higher moral authority to decide on the meanings associated with farmer suicides, instead I want to point out some of the limitations of each of these singular narratives.

In the following section, I study the authority of psy experts in relation to depression and suicide to understand the complex relationship between psy discourse and other discourses around mental health care in India.

8 Ignorant Patients and Curing Psy Experts

In the early days of my fieldwork, I met with a psychiatrist researching suicide in Bangalore. He was based at NIMHANS, Bangalore. During my visit he spent an hour explaining the problem of suicide in Bangalore. He spoke about high-stress lifestyles, family pressure on students to excel in academics, lack of financial resources that results in men feeling like they cannot buy the latest model of cellphone or a car, the role of the media in sensationalizing suicides by movie stars, which results in more people committing suicide. While he was referring to these very disparate kinds of suicide acts, he also mentioned time and again that “depression is the root cause of suicide” and “people do not understand the meaning of depression, we need to spread more information about the impact of depression on people’s life” (Interview, 2013).
Many months later, I met with a psychologist Hema Ramchandra, who has previously worked as an HIV/AIDS counselor for hijras and other Men-who-have-sex with-men (MSM).\textsuperscript{128} In addition, she also had an undergraduate psychology student who had conducted a small study on hijra mental health. At the time I met her, she had stopped working with hijras and moved to working in a mental health organization called Richmond Fellowship Society (India).\textsuperscript{129} Hema explained to me, “I no longer work in sexuality, I now work in mental illness”. When I got in touch with Hema, she invited me to meet at her home office in an affluent neighborhood in Bangalore. She was cordial and we had a long conversation about her work with hijras in Bangalore and Chennai. Hema explained in detail the methodology she used to train HIV/AIDS counselors. At one point in our conversation, I asked her opinion about why so many hijras were attempting suicide. She explained that the abuse they suffered from family members, boyfriends/ husbands/partners was often a problem. She also explained that the police brutality they suffered also pushed many of them to suicide. While she was explaining this, she mentioned, “depression is a big problem among hijras, but they don’t understand it”. This sentiment that depression exists but “people who are suffering do not understand it” was a recurring trope in several of my conversations with psychologists and psychiatrists. Many of them articulated various social reasons for individual suicide acts, but their primary lens was that of ignorance of mental illness among people in India. Similarly to my conversations with the psychiatrist and psychologists recounted above, Jain and Jadav, in their study of clinical ethnography of a community psychiatry program in north India, find that there was a tendency

\textsuperscript{128} Name Changed. See Chapter Three and Four for further analysis of hijra suicides in Bangalore.

\textsuperscript{129} Richmond Fellowship Society (India) is an NGO working for psychosocial rehabilitation of people with mental illness. Its mission is to “provide accessible and quality psychiatric rehabilitation, reduce stigma surrounding Mental Illness, network with various organizations for training and sensitization activities, develop manpower in the field and make relevant research contributions” (\url{www.rfsindia.org}). Richmond Fellowship is also part of the National Suicide Prevention Alliance, UK.
amongst mental health care professionals (clinical psychologists, social workers and other mental health care practitioners) to perceive patients who did not visit the clinic or were non-compliant with medication as ‘irresponsible’, i.e., rural, uneducated (2009, p. 71).  

The point I want to emphasize is that the psychologists and psychiatrists I interviewed during my fieldwork in Bangalore all stated either that ‘suicide is a mental health problem and people do not understand this’ or that ‘they are ignorant about the effects of depression’, and hence appropriate programs must be designed to spread knowledge regarding depression and consequently, suicide through health care workers, NGOs, and other experts such as the police. Non-medical experts such as the NGO workers and the police are also thought to be ignorant about the “appropriate” response to suicide and they too have to be trained to (re)understand suicide in psychiatric or psychosocial terms. The assumption here is that there is no prior knowledge through which people could make sense of suicide. No efforts are made in any of the global mental health literature or programs to understand whether any prior knowledges on suicide exist in society.

One particular tragedy and its aftermath illustrate the complexity inherent in the assumption of lack of knowledge regarding mental illness in India. In August 2001, a fire broke out in a mental asylum affiliated to the Erwadi dargah (shrine) killing anywhere between 25 to 28 people who were severely mentally ill and who were chained to their beds. There was a widespread public outrage following this incident that led to heated debates about human rights violations in the mental health care system. The Supreme Court of India ordered the closure of several unlicensed mental asylums attached to shrines and insisted that state governments

130 Paul Farmer (1999) also forcefully argues that it is the poor and the marginalized who are often stigmatized and blamed for being “noncompliant”. Further, Farmer argues that it is the conditions of poverty which makes it difficult for patients to comply with prescription therapies and it is even more difficult in situations where the patient requires prolonged treatment.

131 Darghas are shrines built over the grave of a revered religious figure, often a Sufi saint.
provide psychiatric treatment to people residing in these shrines (who were now deemed ‘mentally ill’). In the aftermath of this tragedy, seeking mental health care in these healing centers was framed as a lack of knowledge regarding mental illnesses. The SC’s intervention led to the closing down of several traditional healing centers that were not covered under the Mental Health Act (1987). People with mental health problems were chased away from these spaces and some healing sites displayed banners instructing people with mental illness to go to the psychiatric hospital (Davar & Lohokare, 2009). Davar and Lohokare recount a case in Andhra Pradesh where the Directorate of Medical Education, along with the police, inspected a local dargah and carried out psychiatric examination of people using the dargah services. They diagnosed several people with mental illness and referred them to psychiatric treatment. Legal action was taken against the dargah for violating the Mental Health Act (1987) and a demand was made to transfer the mentally ill to psychiatric care (Davar & Lohokare, 2009). Following this, the healers at the dargah sent a letter to the Indian government stating that the dargah is not a mental hospital and hence there are no “patients” in this space. Thus, the question of sending patients to a psychiatric care facility does not arise (Davar & Lohokare, 2009). The dargah in this conceptualization remains a space of healing, but not for the “mentally ill”. In doing this, the dargah claimed that it worked outside the norms of the psychiatric, biomedical approach to mental health (Mills 2014, Davar & Lohokare, 2009).

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132 For more details on the Mental Health Act 1987, see the Section titled “Mental Health Care Laws and Suicide Regulation” later in this chapter.

133 The link between biomedical mental health discourse and traditional healing practices in the Indian context has been studied (see Ranganathan 2014, Kapur 1979). See Langford (2002) for a detailed study of the relationship between Ayurveda and other modern systems of medicine, including psychiatry, in contemporary India. Also see Kakar (1982), who argues that comparing healing practices in India and the West reveals not simply a separation between ‘Western’ and ‘Asian’, or ‘traditional’ and ‘modern’, but in fact a difference between people whose ideological orientation is more towards a biomedical paradigm of illness (something akin to a technician) and those whose idea of illness is metaphysical, psychological or social (Kakar, 1982, p. 274-275).
Prior to the Erwadi dargah tragedy, psychiatry worked with traditional healing practitioners. Due to the lack of psychiatrists in rural India and the popularity of healers in these areas, psychiatrists advocated for traditional healers since the 1970s (Kapur, 1979). More recently, scholars from NIMHANS, Bangalore, and the Schizophrenia Research Foundation, Chennai, have also explored the potential of healing spaces for community mental health (Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002; Padmavati, Thara, & Corin, 2005). In a study by anthropologist Murphy Halliburton on different forms of therapy—ayurvedic (indigenous) psychiatry, allopathic (western) psychiatry and religious healing—he finds that greater availability of all these distinct forms of therapy makes it more likely that people in ‘developing’ countries, even though they might be ‘ignorant’ about mental illness and might have several ‘misconceptions’ about mental illnesses, have more favorable outcomes than their counterparts in ‘developed’ countries. He attributes this more positive response to the availability of multiple therapeutic choices in developing countries (Halliburton, 2004 p. 81).

Interestingly, the MGMH has also been interested in traditional healing or “faith healers”. As I mentioned earlier, an essential aim of MGMH is to provide mental health care for people in LAMIC and bridge the treatment gap between high-income countries and LAMIC. With this aim, MGMH stresses the need to collaborate with ‘faith healers’ to reduce the treatment gap in mental illness (Mutiso et al., 2014 as quoted in Ranganathan, 2014). But the dangers of such collaborations is that by incorporating traditional healing shrines within a biomedical framework, diverse practices of healing will be streamlined into a homogenized standard of mental health care (Ranganathan, 2014). The larger mental health programs, some suggest, are usurping

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134 Anthropologist Stacy Pigg’s work on Nepal has shown the way in which development programs that aim to train Traditional Medical Practitioners and Traditional Birth Attendants accept a specific reading of “local perspectives,” based on which the whole program gets designed. She explains that the design reflects a specific set of development
traditional spaces of healing within a biomedical fold. In a WHO-sponsored NIMHANS publication on capacity building strategies for NGOs, an epidemiologist and a psychiatrist who worked on suicide prevention state:

It is generally agreed that there are misconceptions, lack of awareness, greater stigma and decreased response from the general public regarding suicide prevention.... Individuals in India have strong faith and affinity towards spirituality.... However, there are no programs to mitigate the same. Hence, NGOs should initiate and organize sensitization and design awareness programs on the nature, causes and prevention of suicide.... There is a need to involve spiritual organizations and their leaders in prevention of suicide by providing them with specific inputs (Gururaj & Issac, 2003c, p.34-35).

The mental health care (psy) discourse on suicide demonstrates a certain quality that is unlike criminal law discussions on regulation of suicide. In criminal law debates, we saw that there was heterogeneity of discourses that were incorporated to decide on the boundaries of legal regulation of suicide. Legal discussions were not interested in absolutely defining the meaning of suicide. The criminal courts were shuffling different discourses on self-caused deaths (religious doctrine, state control over life and death, right to life and death, etc.) to determine the nature of legal regulation of suicide. Unlike criminal law concerns, the public mental health care discourse consistently legitimizes psychiatric or psychological explanations for the suicide act and, in doing this, it tends to marginalize other non-psy discourses regarding mental health, as we saw in the case of the public health program that aimed at controlling access to pesticide to reduce desires—a desire not only for a certain kind of development practice, but also for a certain kind of “traditional” person to be first the object and then the product of development efforts (Pigg, 1997).
farmer suicides. In contrast to the citation practices within criminal law debates, where they draw on various knowledges, health care discourse is more self-referential, wherein mental health care discourses prioritize medical/psy forms of knowledge.

Suicide prevention within mental health care discourse is itself not a singular entity. As I have demonstrated throughout this chapter, psy public health discourse on suicide prevention includes psychiatric/biomedical, psychological and psychosocial interventions. But, unlike the discourses that entered criminal law debates, where there were no boundaries to what discourse could influence a legal judgment, in mental health care discussions there are certain boundaries. Mental health care programs, not solely psychiatric/pharmacological, but also psychosocial programs, consistently centered health discourse and experts in its suicide prevention mandate.

Mental health care discourse has influenced legal changes regarding suicide. There have been legal reform efforts to decriminalize attempt to suicide and frame all suicides as a mental health problem. In the next sections, I will briefly trace the history of mental health care legislation as well as analyze in more detail the contemporary inclination to medicalize suicide.

9 Mental Health Care Laws and Suicide Regulation

Post-independence, there were two important laws that impacted mental health care in India.135 The Mental Health Act -1987 (MHA) provided some legal protection for people with mental illness,136 and the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full

135 Prior to Indian independence from the British, there was the Lunacy Act of 1912. Under this Act, persons considered to be of ‘unsound mind’ were subjects under health/prison systems. This colonial act included both categories of ‘insane’ and ‘idiots’ who were subject to involuntary incarceration in mental asylums, jails, beggar homes and leper homes; see Mills (2014).
136 MHA 1987 is under review and the Mental Health Care Bill of 2016 is the latest national mental health policy that has been drafted recently and submitted to the Parliament to be passed as a law. I will discuss this in more detail later in this chapter.
Participation) Act - 1995 (PWD) provided a minimum protection for people with mental 
disabilities, by including mental illness under the bracket of disability. However, both these 
legal provisions have met with criticism from mental health care providers, human rights 
activists, and disability scholars.

9.1 Mental Health Care Act - 1987

The MHA 1987 was met with severe criticism because it concerned itself primarily with legal 
procedures of licensing, regulating admission, and guardianship of people with mental illness. 
Human rights concerns and mental health care delivery were not adequately addressed by the 
Act. Human rights activists questioned the constitutional validity of MHA 1987 because it 
permitted curtailment of personal liberty without the provision of proper review by any judicial 
body (Dhanda, 1996). Also, the act allowed for an involuntary commitment of individuals into a 
mental hospital, which meant that, unlike other health care patients, psychiatric patients under 
this law were constantly medico-legal subjects, where the admission into a hospital was more 
like a penal matter than a matter of providing care (Davar, 2012a).

9.2 Persons with Disabilities Act - 1995

While the PWD Act-1995 provided some protection for people with mental illness, it too was 
met with criticism. Some of the concerns raised were regarding the certification of disability 
within the law for people with mental illness (Math & Nirmala, 2011). More importantly, the fact 
that mental illness was not clearly defined to be under any government ministry was a concern. 
The two ministries that could have taken up mental illness—the ministry of social welfare and

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137 Other disabilities within PWD 1995 were hearing-impairment, blindness, locomotor disability, mental 
retardation, low vision, and leprosy-cure. The focus in PWD is more on physical manifestations of disability. 
Currently, there is a Rights of Persons with Disabilities Bill 2014, which has been drafted according to the United 

138 For a more detailed study of the implications of MHA 1987, see Minkowitz, & Dhanda (2006).
the ministry of health—assumed that mental illness did not come under their jurisdiction (Sengupta, 2010, as cited in Anand, 2015). There was also ambiguity in the definition of mental illness in the act, which led to severe confusion with regards to the understanding as well as implementation of the act (Kothari, 2014).\(^{139}\)

### 9.3 Rights of People with Disabilities

In the recent past, there have been significant changes to the MHA, 1987, and PWD Act, 1995. India showed its commitment towards addressing the concerns of people with disability by becoming one of the first signatories of the United Nations Convention on the Rights of Persons with Disabilities, 2007 (CRPD). Scholars and activists concerned with disability saw this as a promising move since it shifted the policy gaze away from a purely medical model to a wider understanding of disability, taking into consideration physical, mental, sensory and intellectual impairment, along with social, economic, and cultural barriers (Davar, 2012a,b).

The signing was followed by a long process of drafting a new bill in accordance with CRPD—Rights of People with Disabilities (RPD). The recently proposed RPD draft bill is meant to address some of the problems of the PWD Act-1995. Specifically, recognizing full legal capacity of people with psychosocial disabilities has been an important aspect of the bill.\(^{140}\) In a study prior to India signing CRPD, Dhanda analyzed the implications of psychiatric systems entering the legal determination of unsound mind and she argued that the psychiatric labeling affected life, liberty and other civil rights of persons who were diagnosed with psychiatric

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\(^{139}\) To understand the difficulties of people with mental illnesses under the Persons with Disabilities Act of 1995, see Kothari (2014), Anand (2015).

\(^{140}\) Since colonial times, around 200 legal provisions exist within Indian laws based on judicial determination of ‘unsound mind’. This category of ‘unsound mind’ enabled cancelling all civil and citizenship rights for persons. The rights that people with ‘unsound mind’ lost included the right to marry, right to vote, right to contract, right to self-represent in a court of law, amongst many others. For a detailed review of laws that included ‘unsound mind’, see Davar (2012a).
illness. Dhanda referred to several Indian legal provisions to demonstrate that a psychiatrically ill person could be disqualified from exercising her civil rights such as: to be employed or to retain employment, to transfer or manage property, to sue or to be sued etc. (Dhanda, 1996, p.348-349).

Talking about the RPD draft bill, Critical Disability scholar Shilpaa Anand explains, “Legal capacity means recognizing the legal status of a person before the law and is a significant move if adopted into the RPD Bill because that will then challenge the unsoundness of mind clause in all other legislations that has been detrimental to persons with psychosocial disabilities attaining personhood status before the law and rights to citizenship” (Anand, 2015, p.2). However, the RPD draft bill submitted to the Parliament includes within it a provision that allows ‘limited guardianship’ to all persons with disabilities, and applies ‘plenary guardianship’ to persons with psychosocial disabilities.\textsuperscript{141} This provision is similar to the one that was severely critiqued in the MHA, 1987. The first draft of the RPD Bill had expressly asked to repeal all other laws that obstruct the rights of persons with mental illnesses, but the final draft that was submitted in the parliament refers to the Mental Health Care draft Bill (MHC) of 2013. By doing this, Anand argues, mental illness is once again separated from disability as well as the CRPD mandate (Anand, 2015).\textsuperscript{142}

\textbf{9.4 Mental Health Care Bill-2013 and 2016}

The Mental Health Care Bill (MHC)-2013 is an attempt to reform Indian mental health care laws. Although the bill was drafted after India signed CRPD, the draft bill did not abide by several guidelines provided by CRPD. For example, Clause 97 of the MHC Bill-2013 allows  

\begin{itemize}
  \item \textsuperscript{141} ‘Limited Guardianship’ means that the ward retains some rights and decisions are taken based on mutual understanding between the ward and the guardian. ‘Plenary Guardianship’ means the guardianship is total and hence the guardian takes all the decisions with respect to the ward.
  \item \textsuperscript{142} For a detailed discussion regarding the RPD Bill which was submitted to the parliament see Salelkar (2014) and Kothari (2014).
\end{itemize}
treatment without free and informed consent of a person admitted through “supported admission”. This provision goes against the human rights norms in Article 25 of CRPD (Gombos, 2013). Overall, the MHC Bill-2013 emphasized institutionalization and provided for complete guardianship of persons with mental illness, thereby once again framing persons with psychosocial disabilities or mental illnesses within a medical model similar to that of MHA-1987. Bhargavi Davar argues that unlike pre-independence legal provisions such as the Lunacy Act of 1858, which in spite of being oppressive had the idea of providing a robust court procedure because the liberty of the accused was taken away, the MHC Bill-2013 frames an individual with mental illness as a person who requires support, is dangerously sick, and in doing so, permits any mental health doctor to carry out ‘treatment’ without the individual ever entering the justice system (Davar, 2014, p. 270-271).

With regard to the legal regulation of suicide, Section 124 of the MHC Bill-2013 states:

(1) Notwithstanding anything contained in Section 309 of the IPC, any person who attempts suicide shall be presumed, unless proved otherwise, to be suffering from mental illness at the time of the bid and shall not be liable to punishment under the said sections.

(2) The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having mental illness and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide” (MHC Bill 2013. Emphasis mine).

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143 Article 25(d) of the CRPD states: “Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care” (Emphasis mine). For a more such examples, see Gombos (2013).
In stating this, the bill does not repeal Section 309 IPC, but presumes that attempt to suicide is a sign of mental illness. In this phrasing of the Section 124, a person who attempts suicide will be exempted from criminal punishment but will be presumed to be “suffering from mental illness”. Many psy practitioners lauded the MHC Bill 2013 for framing suicide as a mental illness. First, they argued that this new conceptualization will provide relief to those people who attempt suicide because of stress; second, by not involving the police and instead placing them under the care of mental health practitioners, the new bill was seen as being more sensitive to the needs of individuals who attempt suicide (Bagcchi and Chaudhuri, 2013); and third, under the new medical framing of suicide, families where someone has attempted suicide would be more willing to report the incident since they no longer have to report to the police (Bagcchi & Chaudhuri, 2013). Despite these appreciations, the all-encompassing framing of people who attempt suicide as suffering from mental illness has received much criticism, particularly from critical disability scholars and activists (Salelkar & Davar, 2013; Davar et al., 2015, p. 36-37).

Proponents of MHC Bill-2013 argued that the benefit of presuming mental illness in every case of suicide attempt is that more people will be willing to report incidents of attempted suicides and not be wary of criminal prosecution (Bagcchi & Chauduri, 2013). Arguing against such a presumption, disability rights activists stated:

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144 While it is significant that a mental health care law contradicts a criminal law, it should be noted that the Health Ministry was in conversation with the Law Ministry, and both had agreed on this medical formulation of suicide. The plan was that the Law Commission of India would separately move to amend Section 309 IPC, which will eventually be approved by the Home Ministry. There continues to be a discussion in the mainstream English media suggesting that the parliament will remove Section 309 IPC. It has not yet occurred; see “New mental health bill” (2013).

145 The Draft Bill was introduced in the Rajya Sabha (Upper House) of the Parliament in August 2013 and in August 2016 this Bill was passed in the Rajya Sabha resulting in MHC Bill 2016. I will discuss MHC Bill 2016 later in the chapter.
In many cases familial and social relations that lead to the unbearable tension realign themselves to correct the situation and relieve the pressure. If social attitude follows the law, this will result in the suicide survivor being taken for psychiatric treatment and medication. On the one hand, the normal corrective process will be abandoned and the distress individualized as ‘mental illness’. On the other hand, this is a market for anti-depressants tailor-made for pharma (Davar et al., 2015, p.37).

Their critique of MHC Bill 2013 focuses on sociocultural support and healing practices that might already be in existence to address individuals who attempt suicide—what they refer to as ‘normal corrective processes’. Thus, critical disability scholars point not just towards the limitations of assuming the mental health formulation of suicide as ‘progress’, but also signal the significance of indigenous or community-based systems of healing that might be available to people who attempt suicide.

In addition to critiquing medicalization of suicide, the MHC Bill-2013 also received criticism for permitting institutionalization of people who attempt suicide. The history of mental health laws in India demonstrates the violent nature of forced treatment and institutionalization of people with mental illness. Issues regarding guardianship of people with psychosocial disabilities have been a concern within the mental health laws since colonial times. Psychiatrically ill persons’ liberty and other civil rights are frequently curtailed through mental health care laws and this often impacts women with mental illnesses more severely (Dhanda, 1996). According to MHC Bill-2013, in circumstances where a person with mental illness has “threatened or attempted or is threatening or attempting to cause bodily harm to himself”, a thirty day institutionalization is permitted even against the person’s wishes (MHC Bill, 2013). In

\[146\] For anthropological studies that look at everyday experiences of suicide and how suicide attempts are negotiated amongst families, see Staples (2016).
addition, the bill also mentions that the officer in charge of a police station has a duty to take under their “protection” any person whom the officer believes to be a risk to himself or others by reason of mental illness, and deliver the person to a public health care establishment. Salelkar and Davar argue that the process of institutionalization is adopted because of the presumption of mental illness in cases of suicide, (Salelkar & Davar, 2013). They give an example of its implication for women in the context of domestic violence:

A husband or family member may come forward asking for institutionalization of a victim of domestic violence, effectively silencing her for at least a while and subjecting her to additional suffering through the deprivation of liberty and self-determination, and through the likely infliction of forced psychiatric interventions such as electroshock or mind-altering drugs. Even if the victim seeks redressal in Courts under Family/Criminal Law for the domestic violence meted out to her, her evidence will be “tainted” by the legal presumption of mental illness (2013, p. 4).

With regards to the implications of Section 309 IPC, Salelkar and Davar explain that, as per MHC Bill 2013, a person who attempts suicide is exempt from punishment but not prosecution. Thus, the police continue to have the authority to remand a person who has attempted suicide into custody and produce them in front of the Magistrate. Since the law would assume that such a person is suffering from mental illness, s/he could be sent to a public mental establishment for assessment and treatment, or mandated to remain in a mental health establishment for up to ten days (Salelkar & Davar, 2013; Section 111, MHC Bill 2016). In such a context, the legal presumption of mental illness implies that the victim’s evidence regarding the matter would be insignificant. The threat of institutionalizing people who ‘attempt suicide’ has

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147 See Section 109, MHC Bill 2016
severe implications not just for individuals with mental health disabilities, but also political actors such as Irom Sharmila, whose hunger strikes against state violence can be controlled through institutionalization not in a penal system, but in a mental health system.

On August 2016, MHC Bill-2013 was unanimously passed in the Rajya Sabha. The Mental Health Care (MHC) Bill-2016 states that every person has the right to access mental health care and treatment from mental health services run or funded by the government. The MHC Bill-2016 used the same terminology as the MHC 2013 bill with respect to suicide, thereby framing all suicides as a mental health concern. The MHC Bill-2013 was celebrated in the mainstream English media because it permits adults with mental illness to choose a nominative representative who would take care them if and when they might be diagnosed with mental illness (“Rajya Sabha Passes”, 2016). It also provides access to public health care; and the bill guarantees every person access to government provided mental health care treatment. Overall, the bill was celebrated extensively for decriminalizing suicide attempts.

Subsequently, critical disability scholars and activists published articles critiquing the MHC Bill 2016 and people with mental disabilities argued that the bill frames mental health through a disease model and as a condition that needs to be fixed (The Schizophrenist, 2016). One concern was that while the bill allows a person to formulate in advance the treatment they choose, there is no mention in the bill that the doctors or the family is obliged to follow this directive (Dhanda, 2016; Sengupta, 2016). Dhanda explains “…both the doctors and the family can bypass the directive by following the procedure provided in the Bill. The discomfiture with

148 The Mental Health Care Bill 2016 will once again be reviewed by the Lok Sabha (lower house of the parliament) before it is approved as a law by the President of India.
149 At the time of writing this, MHC Bill-2016 was not yet available to all and so I do not have access to the Bill. I rely on the comments and opinions published in the English media both celebrating and critiquing the MHC Bill 2016.
150 For news reports celebrating the MHC Bill -2016, see Kala, (2016); Suraksha (2016); Srivastava (2017).
following patient preference also comes to the fore when the doctors are exonerated from any liability, which may arise if they follow the patient’s advance directive” (Dhanda, 2016). The concern with legal capacity of persons with mental illness is once again highlighted here.

Dhanda explains:

…legislation only refers to drugs and treatments devised in allopathy and other systems of medicine such as Ayurveda, Unani, and homeopathy and yoga. No reference is made to the recovery interventions devised by persons with psychosocial disability, be it peer support, open dialogue, family therapy or culture-based interventions such as faith and temple healing, which even the mental health programmes of the country have admitted to provide relief to some persons with psychosocial disability. The Bill does not bar these preferences; but neither does it permit them. And users relying on these services cannot be sure of their choices being respected as the Bill requires persons with mental illness, unlike the rest of the populace, to prove they possess legal capacity. Just the presence of mental illness does not mean that the persons lack legal capacity, but the presence of mental illness is sufficient to question the legal capacity to make contemporary choices or issue advance directives (2016).

In the quotation above, Dhanda is describing the Bill’s emphasis on biomedical interventions and its dismissal of other non-drug interventions and treatments that are often preferred by people. The emphasis on drugs, Dhanda argues, is aligned more with the preferences of medical professionals rather than people with disabilities. Thus, only people with disabilities whose preferences are in line with that of psychiatric professionals will benefit from these provisions (Dhanda, 2016).

The discussions regarding mental health care legal reform that I have traced above demonstrate a tension regarding a narrow medical conceptualization of mental illness and
consequently suicide prevention. As we saw in the quotes above, the critiques of Mental Health Care Bill 2013 are arguing for heterogeneity of mental health care support rather than a purely medical treatment for mental illness. Dhanda, in the quotation above, mentions the lack of cultural-based interventions such as faith and temple healing in MHC Bill 2013. Such a call for a more inclusive framing of mental health care is simultaneously a call for heterogeneity of discourses for mental health care and mental illness. Criminal law debates, as I have shown in the previous chapter, have demonstrated a scope for heterogeneity of discourses regarding suicide. I do not intend to argue that because of the heterogeneity of discourses on suicide within the criminal legal arena, it is necessarily superior. My intention in tracing these debates and arguments is to demonstrate the complexity that self-inflicted deaths/suicides present for both legal (criminal law or mental health care laws) as well as public mental health regulation.

10 Conclusion: Quasi-Medicalization

I demonstrated in the previous chapter that the knowledge produced on suicide in the criminal law debates does not have to correlate with any kind of rational expert knowledge. Following Valverde, I argued that law adopts various knowledges into its own framework. The mental health care law also operates within a similar logic, but less so. The Mental Health Care Bill 2013 insists on adopting certain psy knowledges to define suicide. It chooses a discourse, the mental illness/psychiatric discourse, while simultaneously, carefully not choosing other discourses on suicide circulating in India. Mental Health Care Draft Bill 2016, which might soon be passed as law, aims not just to regulate suicide but also to define all forms of suicides—religious, political, etc.—as mental health problems. Hence, mental illness discourses within the legal arena do make truth claims, while simultaneously, making these claims by carefully
choosing a particular discourse, the mental illness/psychiatric discourse, over the other discourses.

Although mental health care laws have relied on mental illness/psychiatric discourse to define suicide, it would be simplistic to argue that, with the passing of this Bill, suicide is medicalized in India. Public mental health suicide prevention efforts, as I have shown, have a more complex formulation of suicide prevention than mental health care laws. Although the public mental health care approach to suicide prevention has been to conceptualize suicide as primarily a health concern, it nonetheless engages with non-health, non-medical practices such as regulating access to pesticide, or encouraging surveillance of “high-risk” city spaces as strategies to prevent suicide. In undertaking such an approach, transnational and national public health initiatives are not framing suicide purely through the lens of mental illness. As I mentioned earlier, public health programs often take a psychosocial approach that account for social, cultural, and economic concerns while designing interventions. Including suicide as a public health problem, suicide prevention had to be thought of not solely as an individual mental illness but through other collective prevention methods. However, such a public health approach leads to its own set of complications.

The formulation of suicide prevention efforts through psychosocial interventions, such as regulation of pesticides, is part of depoliticizing certain discourses on suicide. There is a gradual expansion in the discourse on farmer suicide as a public health concern rather than other political discourses such as political economy. I would like to reiterate that I do not suggest that a political economy discourse on agrarian suicides captures all the subtleties of agrarian suicides. In fact, I argue that there are limitations to a political economy discourse on agrarian suicides. However, it is important to acknowledge the fact that the public health discourse regarding suicides could undermine other political discourses on suicide. It could result in lowering the government’s
responsibility to maintain the well-being of its citizens and place the onus of the act of suicide on the individual, thereby dismantling an existing social movement(s).

The psychiatric discourse and biomedical treatment are a typical modern form of power that has the ability to govern through the welfare of the populations. It is possible to make the argument that, in contemporary India, such a shift to psy care of the suicidal person is illustrative of the efforts to control the suicidal person through treatment. But, as we saw, the emerging mental illness discourse on suicide is only part of the story.

In the story of suicide regulation in India, there is no single shift from one form of control to another. Several techniques of managing life occur in parallel. Religious, legal (criminal and mental health care laws), disability, political, economic, caste violence among other discourses of suicide co-exist in India. Thus, the impetus for regulation of suicide does not lie solely within the criminal law, mental health care laws or the public mental health discourse. However, while several discourses are at play in discussions on suicide, the mental health discourse is spreading extensively. The mental health advocacy (from the global north as well as within India) has been framing suicide as a symptom of mental illness, which therefore should not be criminalized. I trace the Movement for Global Mental Health and the WHO’s suicide prevention efforts, and their manifestation within India to show the struggles within these ongoing efforts to ‘manage’ suicide. Responding to such a move, disability scholars have been arguing against an all-encompassing definition of suicide within a mental illness framework. I have attempted to illustrate, in this and the previous chapter the complexity of the issue of suicide regulation within and outside law. I read this complex interplay of discourses on suicide as quasi-medicalization.

151 While disability scholarship is a conceptually strong and growing field in India, at present the institutional and financial power they hold is marginal in comparison to the large mental health organizations, such as the WHO, which are influencing mental health programming in India.
I would like to end by returning to my conversation with Uma that I recounted earlier in this chapter. Uma’s questions: “what is depression? Why do people get it? How can it be detected?” are themselves illustrative of quasi-medicalization. As I mentioned earlier, Uma had been visiting the psychiatrist and taking medication for depression for about a year by the time I met her. But she continued to ask the question “what is depression?” Uma was not satisfied with psychiatric explanations for her son’s suicide or her own state of mind. Nevertheless, she continued to visit the psychiatrist and consume medication for her depression. Uma has not emerged as a completely medicalized subject of psy care, but she has also not abandoned it. Uma’s seemingly contradictory movement with and against psy treatment embodies one aspect of what I term quasi-medicalization.

In a study of alcohol regulation in North America, Valverde argues against artificially isolating a single mode of governance, “assuming that what is to be studied is medicalization, or professionalization, or the shift from disciplinary control to risk-based management” (Valverde, 1998, p.10). Valverde takes the question of medicalization away from the classic Foucauldian argument to show how Alcoholics Anonymous (AA) depends on the claim that alcoholism is a disease, but a disease that cannot be treated by medicine. She shows that the medical profession has accepted AA’s understanding by restricting itself to treating the physiological effects of alcoholism and referring the need for behavioral change to AA. Furthermore, Valverde’s account demonstrates that alcoholism has never been successfully medicalized, partly because no effective medical treatment existed, and because no one has been able to define the threshold levels of alcohol consumption that can concretely identify alcoholism. In doing so, Valverde’s history of alcoholism does not bear out a Foucauldian trajectory of a historical transition “from act-based governance of the criminal law to the more modern identity-based governance typical of disciplinarity” (Valverde, 1998, p. 68). Taking a cue from her work, I argue that it is
impossible to draw a clear trajectory of a transition from criminalization to medicalization with respect to governance of suicide in India. By tracing this long, winding, contemporary legal history of Section 309 IPC as well as the Mental Health Care Bill 2013 and 2016, I have demonstrated the tensions that exist in the regulation of suicide in India. There is an effort to decriminalize attempt to suicide, and simultaneously there is an attempt to assert certain kinds of religious suicides as a criminal offense. There is a concurrent effort to control political suicides that aim to shame the state, as well as a mental health movement to frame all suicides as a mental health problem. It seems that everyone is continually working towards defining what suicide means and how it should be governed by law. Thus, suicide holds within it, or to use Foucault’s term, is immanent with, many definitions that cannot be encompassed within a single category. Suicide in India is simultaneously fragmenting and in the process of becoming.

However, in a social context where suicide is heavily discussed as a public health problem and a legal concern, certain kinds of suicides remain outside these prominent and powerful discourses. In the next two chapters I study one such example of hijra suicides in Bangalore.
Chapter Three
Hijra Suicides: Love at the Margins of Law and Medicine

In the previous chapters, I studied the multiple discourses (psychiatric, religious, political, and others) that contribute to the constant making and unmaking of suicide within the legal arena. In this and the following chapter, I focus on a kind of suicide that has largely remained at the fringes of the law – hijra suicides. Hijras are a particular gender/sexual identity in South Asia. Hijras are transfeminine individuals and one of the many male-to-female transgender identities in India.¹⁵²

I spent fourteen months in Bangalore conducting interviews and having conversations with hijras. There was an overwhelming presence of suicide narratives in these interviews. In my naivety, I had thought I would steer the conversation towards the suicide incidents that had occurred in the community. I never intended to (nor did I) ask any of the hijras about their individual experiences with suicide. But to my shock, in most of the interviews, they brought up their own experiences with attempting suicide. In all these interviews they never expected me to provide solutions or advice (not that I had any to begin with). Often, they simply wanted me to record what they had to say. In many ways my presence in their homes, recording their stories in their voice, positioned me as a combination of friend and witness to their stories.

In this chapter, I aim to understand hijra suicides within the larger institutional narratives of rights/civil liberties, public health interventions and NGO responses (or lack thereof) to these

¹⁵² In the context of contemporary sexuality rights politics, the term ‘transgender’ is used as an umbrella term for all transgender identities. But transgender is not synonymous with hijras. Partly, within rights discourse, transgender is used as an umbrella term to include a variety of gender non-conforming individuals and communities, such as kothis, Female-to-Male trans people, Male-to-Female trans people, Hijras, Jogappas (also known as jogtas and jogins). I explain these gender/sexual identities in some detail later.
attempted and/or completed suicides.\textsuperscript{153} In Chapters One and Two, the legal question that intersected closely with suicide was the (a) criminal law debates and reform efforts, and (b) mental health care laws. As I have mentioned earlier, hijra suicides have not entered the conversation on suicide in either of these two above-mentioned legal realms. It is precisely because of such an absence that I was interested in understanding hijra suicides in some detail. However, hijras have been subject to legal regulation since British colonial rule in India. In contemporary contexts, the legal questions in hijra lives are predominantly approached through a human rights/civil liberties lens. The transgender rights movement has picked up pace in the last decade in India. It is in the context of this dynamic rights movement that I study the absence of discussions on hijra suicides. Within such a rights framework, I demonstrate the reasons for hijra suicides lacking political potential within rights discourse.

Before I delve into hijra suicides in greater detail, I will provide an introduction to hijra life and their cultural presence in contemporary India. I will also provide a brief colonial history of legal regulation of hijras.

1\hspace{1em}Introduction to Hijras

Hijras are transfeminine individuals. Most hijras are assigned a male gender at birth and some of them are also born intersexed. They express gender through typically feminine traits such as: using self-directed feminine pronouns, wearing feminine clothing, piercing their nose and

\textsuperscript{153} Rather crudely, by using the term attempted suicide, I mean to indicate that the person did not die with their attempt at suicide and by using the term ‘completed suicide’ I mean to indicate that the death occurred.
growing long hair, amongst others.\textsuperscript{154} Hijras usually are from working-class backgrounds and are ritually inducted into kinship systems with other hijras (Reddy, 2005a).

Typically, hijras in India live in groups that are traditionally organized into seven gharanas (houses). The main gharanas are situated in Hyderabad, Pune, and Bombay, and even hijras not in these big cities are affiliated to one of these gharanas. Each of these gharanas is headed by a nayak (leader) who then appoints gurus (guides, leaders) to train their chelas (disciples/followers) in dancing, singing, and blessing. The gurus have a responsibility to protect and mentor their chelas. The chelas can move from one guru to another.\textsuperscript{155} Disputes among hijras are resolved within the community by the nayak and senior gurus who act as lawmakers, and administer punishment such as imposing fines and expulsion from the community. Any person who wishes to become a hijra has to live in satla (female attire) in the community for at least a year and observe the rituals and obligations of the community, such as earning money for running the household and for the guru. If she is unable to adjust to the requirements of community life, she will not be allowed to go for nirvana (castration); nirvan kothis are often favored over those who don’t undergo castration (akwa/zenana).\textsuperscript{156} The nirvana ceremony in the hijra community involves both penectomy and orchiectomy (removal of penis and testicles).\textsuperscript{157}

\textsuperscript{154} Although growing one’s hair continues to be important within hijra culture in Bangalore, there have been a few hijras who have cut their hair short. In my understanding, this is specific to hijras who are involved in sexuality rights activism or some kind of NGO related work.

\textsuperscript{155} To make this transition official, a small ritual—\textit{rit}—is conducted (Reddy, 2005a).

\textsuperscript{156} Kothi (also transliterated as koti) is a person born male and who is feminine. Satla Kothis are a stage of transition in Hijra community where a Kothi lives full time in female attire (Satla). Nirvan refers to process of undergoing \textit{Nirvana} or salvation. It is the process of removal of both testes and penis (voluntarily/willingly) and then people who have undergone Nirvana can live as hijras. Nirvan Kothis refers to those individuals who have undergone the ritual of Nirvana. For a detailed analysis of the emergence of kothi identity see Cohen (2005) and Boyce (2007).

\textsuperscript{157} What I am writing here is a brief description of hijras to give a basic idea of who they are and what is their position in Indian society. I recognize that I am not doing justice to the complex socio-cultural system within which hijras live their lives in India. To get a more nuanced understanding of hijra life, culture and identity see, Reddy (2005a) and Nanda (1989). Also see Hinchy (2013, 2014a,b) for a colonial history of hijras in parts of North India.
Hijras, like many other communities, trace their origin to the Hindu myths of Ramayana and Mahabharata. The myth in which hijras figure in the Mahabharata involves Aravan, son of Arjuna and Nagakanya. During the Mahabharata war, Aravan offers to face Bhishma in battle knowing fully well that he will be killed. Aravan presents one condition for sacrificing his life: he wants to spend the last night of his life as a married man. Since no one offers to marry him, as she will be left a widow, Lord Krishna, assuming the female form of Mohini, marries him. The hijras in Tamil Nadu take Aravana as their progenitor and call themselves ‘Aravanis’. Along with these mythologies, hijras also invoke the image of the Shiv-Shakti, that is, the image of god Shiva, who in this form is half-male and half-female, representing a god who is ageless, formless and sexless.

In Ramayana, hijras play an important role when Rama is banished from his kingdom for fourteen years. When he leaves for the forest, he turns around to see a large number of his people following him. Rama appeals to ‘all the men and women’ to return to the city, but the hijras belonging to neither category don’t feel bound by his injunction and want to stay with him. Impressed with their devotion, Rama sanctions them the power to confer blessings on auspicious occasions like childbirth and marriage. This is partly the reason why hijras in India are considered to have the power to confer blessings or badhai on auspicious occasions such as childirths, marriages, and other inaugural ceremonies. The practice of badhai is more acceptable and recognized in northern parts of India; this custom and belief is not very common in South India. Many hijras I met in Bangalore complained about how they did not receive the respect they would have if they lived and worked in North India.

There are several other gender/sexual identities in India. To give one example of many: Jogappas are young male children usually from Dalit or other ‘backward’ castes, sometimes even from Muslim families in northern Karnataka, who are dedicated to the Goddess of Yellamma. They wear female clothes and act as mediators between devotees and the Goddess. They are forbidden to marry. The Jogappa is not an exclusively transgender category but rather a traditional space that permits cross-gender expression.
1.1 Hijra Work Life

In Bangalore, as in many other parts of the country, hijras largely work as sex-workers and/or go for *collections*. Many hijras live in hamams and/or private homes in various parts of Bangalore. Hamams are bathhouses where hijras who work as sex workers conduct their work. Sometimes they also reside in these hamams, but this is gradually reducing given that they tend to get violently attacked by hooligans in these spaces at night. What I found was that several hijras who were involved in sex work had moved into private homes, which were affordable, and in neighborhoods where they were not treated badly. These households operated similar to the hamams. In both hamams as well as the private homes, the guru was the head and she had many chelas live with her. The hijras who worked as sex workers in hamams sometimes had clients come to the hamam but more often they went out for street based sex work. In the hijra homes, it was not very common to have clients visit their homes; it was more common for all of them to conduct their work on the streets.

When I visited hijra homes, the gurus of these homes explained that they had left the hamams either because they wanted to set up a home for themselves and their chelas or because the hamams were not always safe spaces. I heard brutal stories of how drunken men would throw stones and attack the hamams at night. I once even heard a story that a gang of thugs tried to light a hamam on fire in the middle of the night, to get the hijras outside. In my conversations with hijras, few wanted to spend the night in the hamams, especially the hamams that were located on the outskirts of the city. However, while there is fear about hamams being attacked, there are also new hamams being set up. During my fieldwork, I visited three newly constructed

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159 ‘Collection’ is the term used by hijras who beg on the street. I frequently heard people use the English word ‘collection’ while referring to begging and I use the term collections interchangeably with begging in the context of hijra work life.
hamams in the outskirts of Bangalore and heard that there were many more being set up in different corners of the city. So it seems like there is simultaneously an expansion of the number of hamams as well as private homes. My understanding of the economy of the hamams is limited, but I did observe that the new ones were built in the outskirts of the city where new and large infrastructure projects were emerging, whereas the new private homes were largely within the city.

1.2 Hijras as Criminal Tribes

Until recently, hijras, along with other transgender identities, did not have an official recognition in India. Hijras had a prominent cultural presence in Indian society, but the state had not recognized hijra identity. In this section, I provide a brief account of the complex ways in which regulation of hijras has existed in India during the British colonial period.

The Criminal Tribes Act 1871 was enacted by the British to police certain tribes and communities. Certain communities were deemed criminal by their identity, and merely belonging to one of these communities rendered the individual criminal. This Act was amended to include “eunuchs”. This law assumed that the criminal was born that way. Gayatri Reddy explains, “The propensity for crime and its subsequent codification was, in essence, written onto the bodies of the so-called criminal castes” (Reddy, 2005a, p. 27). Initially, this act was applicable only in the Northwestern Provinces, Awadh and Punjab, but by the early twentieth century, many sections of the Act were extended to the whole of British India (Reddy, 2005a, p 26). Here, eunuchs was a catchall category, which clubbed hijras with several other “sexually deviant” groups. The Criminal Tribes Act defined eunuchs as ‘all persons of the male

160 Apart from the hijras, there were various communities that were recognized as ‘criminal tribes’. Thuggees, pardhis, kheria-sabars, vardis, bhils, bedars, kalkadis, kanjars, mangarudis, nir shikaris, tadvis are a few examples.

161 This amendment was titled, ‘An Act for the Registration of Criminal Tribes and Eunuchs’ 1871.
sex who admit themselves, or on medical inspection clearly appear, to be impotent’ (Hinchy, 2013, p.197). As Jessica Hinchy’s work suggests, “The singular English-language colonial category of ‘eunuch’ was internally diverse and encompassed a multiplicity of social roles. The term eunuch could be used variously to encapsulate male-identified and female-identified, emasculated and non-emasculated, socially elite and subaltern, politically powerful and relatively politically insignificant groups” (Hinchy, 2014b, p. 247). According to the British, hijras were “professional sodomites” who kidnapped, castrated, and exploited male children and “polluted” public space with their “obscene” performances and transvestism. The Criminal Tribes Act explained that any eunuch who was suspected of kidnapping, castrating or sodomy should be registered. Registration meant that the police recorded the individuals’ biographical details, which would then aid in their surveillance. Hinchy explains:

…officials attributed an enormous significance to the act of registration itself. Registered eunuchs were prohibited from performing in public or in a ‘public house’ ‘for hire,’ rendering their primary occupation illicit and forcing many into poverty. Wearing female clothing in public – a key marker of hijra and zenana identity – was also illegal as per this act. Magistrates removed children residing with eunuchs to prevent their castration and arranged for a surrogate parent. Registered eunuchs were denied several civil rights, including to write a will and be the guardian of a child, while police monitored eunuchs’ movements (Hinchy, 2013, p.197).

The genesis of these laws lies in the post 1857 shift in the British colonial rule where the colonial government intervened less directly in Indian religion and culture. With this shift in

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162 The most commonly cited turning point in the British rule in India is the indigenous soldier Revolt of 1857, which was followed by the dismantling of the East India Company and the start of direct Crown Rule in 1858.
the British colonial rule, it has been argued that social control increased. In 1868-71 a cluster of special laws (including the Criminal Tribes Act) were passed which gave the magistrate and the police special executive powers to regulate and manage certain target populations (Singha, 2003). As I mentioned earlier, these laws came out of a fear of a “scenario of young boys being kidnapped and emasculated by eunuch bands and initiated into ‘an organized system of sodomitical prostitution’ ” (Singha, 2003, p.93). Focusing on the North Western Provinces and Oudh regions, Singha argues that this “deviant fringe” was particularly targeted by the colonial powers as an experiment in “population management” (Singha, 2003, p. 97).

1.3 Rights and Epidemiological Interventions

The surveillance and regulation of hijras continues to this day. In contemporary history, hijras emerged as subjects within primarily two institutional interventions in civil liberties/human rights discourse and public health programs, particularly HIV/AIDS prevention. Commenting on the Criminal Tribes Act and its contemporary impact on the hijras, the People’s Union for Civil Liberties (Karnataka) (PUCL-K) in their 2003 report state:

Being a eunuch was itself a criminal enterprise, with surveillance being the everyday reality. The surveillance mechanism criminalised the quotidian reality of a eunuch’s existence by making its manifest sign, i.e., cross-dressing a criminal offence. Further, the ways in which eunuchs earned their livelihood, i.e., singing and dancing, was criminalised. Thus, every aspect of the eunuch’s existence was subject to surveillance, premised on the threat of criminal action. The police thus became an overt and

Ashwini Tambe points out that most historians agree that the revolt gave rise to increasing paranoia among British rulers and concern about consolidating their power (2009).
overwhelming presence in the lives of eunuchs. Further, the very concept of personhood of eunuchs was done away with through disentitling them from basic rights such as making a gift or adopting a son (PUCL-K, 2003, p. 45).

Since the early 2000s, there has been a powerful sexuality rights movement that has brought attention to the violence suffered by hijras in India. This campaign over two decades has recently led to the creation of the “third gender” category under which hijras are now officially recognized.

Prior to the sexuality rights campaign, hijras came under a large-scale state lens for the first time since the British rule through HIV/AIDS prevention campaigns. In the mid-1990s, large international aid organizations identified certain transgender groups (including hijras) as being at risk of HIV infection. This brought vast financial support to NGOs that addressed the spread of HIV. Within such HIV/AIDS prevention initiatives, hijras were read along with other male-same-sex sexual identities as men-who-have-sex-with-men (MSM). This category of MSM consolidated many distinct gender/sexual identities under one category.163 Through this large-scale epidemiological lens, hijras as MSMs became the subject and object of medical intervention.

Thus, since nineteenth century, hijras have successively been recognized as ‘deviant’, ‘criminal’, then carriers of HIV/AIDS infection and, most recently, as the third gender. Medical/epidemiological and criminal law/ rights have been a dominant discourse in hijra lives, but within such scenario I found that hijra suicide narratives were largely absent, apart from a few instances of epidemiological studies on MSM mental health. I will focus on these two interventions in hijra lives in greater detail later in the chapter.

163 See Chapter Four for a more detailed description of the impact of the rights discourse and MSM categorization, via HIV/AIDS prevention programming, on hijras in India.
2 Locating Hijra Suicides

2.1 Love and Suicide

I conducted thirty-eight interviews with hijras. Of these, only three hijras did not mention a suicide attempt. One of the thirty-five hijras who did talk about her suicide attempt was Kanchan.

I met Kanchan in one of the oldest hamams in Bangalore. The first time I visited this hamam, Kanchan was away. The next time I visited, she was happy to see me and keen to chat, because the other hijras in the hamam had all told her that they had had long conversations with me. She took me to one of the adjacent rooms where sex work happened at night. We sat down on the only furniture in the room, a bed, and Kanchan began talking. She told me various things about her childhood, mostly what she liked to wear and what games she liked to play as a child. Every few minutes, she would ask me something about my life; questions about my short hair, my marriage and family, and so on. At one point in our conversation, Kanchan described in great detail, accompanied by both pride and shyness, her love story. She began by explaining how she met her ex panti (husband/boyfriend/partner).

One day he saw her waiting for a bus and followed her to the hamam. For many days thereon he walked past their hamam trying to get a glimpse of her. After a week of simply walking about in the neighborhood he finally mustered up the courage to walk up to the hamam door to find out Kanchan’s name. The other hijras by then knew of his interest in Kanchan and as soon as he asked to speak to her, they teased him about it. He soon got very awkward and left; Kanchan thought he would not return anymore. But he did, only a few days later. She then

164 In the interviews I conducted, only eight hijras were associated with any HIV/AIDS prevention or sexuality rights NGOs in Bangalore. The other thirty hijras I spoke to worked as sex workers and/or went for collections and lived in hamams (bath-houses) and private apartments in various parts of Bangalore.
started talking to him and within days he expressed his love for her. He said he could not stop thinking about her and he really needed to be with her. They were very happy, she said. It was the best time of her life. But it did not last long; in less than a year her panti had started abusing her. He would say that she was ugly and no man would want to even see her naked. He beat her and took the money she earned by doing sex work. There were many days when she came back to the hamam with her face bruised and lips bleeding. Her guru and other hijras at the hamam tried to stop her from meeting this man, but she could not leave him. “He meant everything to me”, Kanchan told me. One day, he stole her money and left Bangalore to go back to his village. Kanchan was scared to go there looking for him. She mentioned that he had a family, a wife and children there. She did not want to disturb his family life, but she missed him terribly. She felt like she could not live without him. Then one day she tried to consume toilet cleaner in an attempt to commit suicide, but she was stopped in time by other hijras in the hamam. Kanchan ended our conversation in tears saying, “He left me, with no money and no love”.

I found such love related suicide narratives emerged repeatedly in my conversations with sexuality activists, hijras who were associated with NGOs, and hijras who were working in hamams inside the city or in the outskirts of the city. I found that the psychologists and psychiatrists who worked with hijras were aware of such narratives of suicide. I heard attempts of suicide narratives presented at protest meetings, at the transgender Memorial Day vigil, and in community Drop-in-Centers. If one listened intently, these narratives were everywhere. But there was also an odd silence about them. In one of my conversations with two queer rights activists in Bangalore, who are my friends and whose work I respect immensely, I asked them if they knew why so many hijras were attempting suicide. One of them immediately responded saying that

165 I narrate two more conversations that revolve around loss of love, told to me by hijras in Bangalore in the next chapter.
many of them take hormone medications, which are not prescribed by any doctor, and this erratic pill popping disrupts the hormone balance making many of them emotionally fragile leading to suicide. When I posed the same question to another psychologist who had previously worked with the hijras in Bangalore, she too mentioned that hormone intake as a major problem. Not to entirely negate this reading of the situation, it did strike me as significant that while activists and others focused on hormone intake, the explanation the hijras gave me in our conversations was something that was far more universal and far less medical—Love.

In this study of hijra suicide, I do not focus on hormone intake. Partly because none of the hijras themselves mentioned excessive or erratic hormone consumption leading to suicide acts, and partly because in focusing on explanations relying on erratic hormone intake for the suicide acts, I see a similar impetus to medicalize suicide as I traced in the previous chapter. In this context, the attempt to medicalize suicide does not occur through the discourse of mental illness, but instead through a narrative of hormone imbalance. In the context of farmer suicide I argued that such a medical/psy reading could depoliticize suicide. Resonating with that argument, focusing on erratic hormone intake also has the potential to detract from understanding hijra personhood—their ability to love, to be loved and feel pain when that love is lost.

The overwhelming number of love narratives I collected during my fieldwork demand that I analyze this affective expression in some detail. Love, as Elizabeth Povinelli explains, is political. Povinelli states “love is not merely an interpersonal event, nor is it merely the site at which politics has its effects. Love is a political event” (Povinelli, 2006, p. 175). Speaking to the settler colonial context in Australia, Povinelli argues how normative couple relationships are expected to produce good subjects for neoliberal capitalist democracy. Hegemonic liberal logics become evident in the context of ‘intimate couple’ love in the settler colonial context (Povinelli,
2006). Unlike love in Povinelli’s work, hijra love does not find a place in liberal politics, such as the sexuality rights discourse. My interest is precisely to understand this invisibility of hijra narratives of love within larger liberal political logics such as the sexuality rights discourse and public health programs where hijras are a subject of care. I focus on hijra love in this chapter with an intention of troubling the rights and medical discourses which play a prominent role in hijra lives.

2.2 Why Study Hijra Suicide Attempts?

Most kinds of self-inflicted deaths—by farmers, political activists, students—that I have discussed in my dissertation thus far, have gained national and international legal, political or psy/medical attention. Hijra suicide, on the other hand, is not a category for political or legal action. Sexuality rights activism and, specifically, transgender activism has gained momentum in the past decade in India. Yet in such a vibrant liberal rights political context, hijra suicides have not gained similar attention either by psychiatric or psychosocial public health initiatives or by human rights activists. While this might not be surprising in and of itself, it is significant for the study of the regulation of suicide in India. While more and more forms of self-inflicted deaths are being addressed as a psychiatric or psychosocial public mental health care issue, or becoming categories for political activism, hijra suicides remain at the fringes of these discourses. By studying hijra suicides, my aim is twofold: first, to highlight the discursive spaces outside the legal arena where hijra suicides are discussed, and second, to trouble the category of suicide within the legal arena in India. Hijra suicides, as I will demonstrate in this chapter, are both universal and distinct. Universal, because the narratives of loss of love pushing people to attempt suicide is not exclusive to hijra lives. This sentiment is found often in various contexts of class, caste, gender, sexuality and religion. But hijra suicides are also distinct because of the relative
lack of visibility of hijra suicide narratives within medical/psy/public health initiatives and in the transgender rights discourse.

To understand how and why hijra suicides have remained at the peripheries of large institutional interventions, I analyze legal reforms and medical interventions that have impacted hijra lives. Specifically, I study: (a) hijras within sexuality rights activism in India, (b) hijras in the HIV/AIDS prevention discourse and (c) a public mental health epidemiological study that was conducted following a spate of hijra suicide incidents in Bangalore. By studying these institutional ascendancies in hijra lives, I show that the public health initiatives (HIV/AIDS prevention and the epidemiological study of hijra suicide) have made hijras both subjects as well as objects of study, but have provided little as a response to hijra suicide attempts. The epidemiological mental health study, which included hijras (along with other transgender identities), has aided in creating a Foucauldian population of “transgender” that ought be governed. However, these studies have not yet translated into public health suicide prevention programs. Similarly, the rights discourse, which is a prominent mode of political discussion regarding hijras, has emphasized the accounts of violence and suffering but also silenced narratives of hijra suicide, especially suicide attempts stemming from failed romantic love. My point in studying rights and medical discourses in hijra lives is not simply to point out the fact that these frameworks do not validate hijra experience, but also to understand how hijras continue to speak about suicide outside prominent discourses and constantly assert their personhood beyond what was defined by HIV/AIDS or human rights frameworks. In the following chapter, I study hijra autobiographies to understand narratives of suicide that exist at the peripheries of rights and medical (psychiatric or psychological) discourses. This chapter provides an understanding of hijras within legal and medical interventions and the next chapter analyzes experiences of hijra suicide, as they exist at the fringes of these institutional discourses.
In the next section, I provide a detailed context to hijras within public health care programs in India.

3 Public Health Care Initiatives in Hijra Lives

The first large scale institutional attention hijras received was through the HIV/AIDS prevention discourse. In this section, I study public health/epidemiological interventions in hijra lives by analyzing: (a) the HIV/AIDS prevention discourse, and (b) the only epidemiological study on hijra mental health conducted in Bangalore. Although these two initiatives occurred in different time periods, studying them together demonstrates the repercussions and implications of public health discourse on hijra lives.

3.1 Hijras in HIV/AIDS Prevention Discourse

In the mid-1990s, international aid agencies, such as the United Nations Program on HIV/AIDS (UNAIDS) and the WHO, identified certain transgender communities as being at risk of HIV infection, which brought in a flood of financial support to the Indian non-profit sector. Within this HIV prevention sphere, hijras and others were categorized as MSM. MSM emerged as a key category within the global HIV/AIDS prevention discourse of risk management. This shifted the conversations surrounding male same-sex sexual relationship from moral and less legal standpoints to a medical/epidemiological one (Khanna, 2009).

The category of MSM consolidates several, quite distinct, social identities under one single umbrella and interpellates them as a single ‘at-risk’ medicalized category. As HIV/AIDS prevention work expanded at the turn of the 21st century, and hijras began to be recognized under the MSM category, they became targets for HIV/AIDS prevention work (Khanna, 2009; Boyce, 2007). It was this particular HIV-driven medical gaze that turned hijras into MSM along with
gay men, with their links to other transgender identities and groups being therefore quietly severed. A different medical gaze, a psychiatric one, would have categorized hijras differently, but the MSM category was developed for HIV epidemiological purposes; in the MSM discourse inner psychic identities, to say nothing of cultural histories of meaning and popular recognition, are purposively ignored.

With the hijras finding a space of sorts within the sexuality rights movement as well as in the HIV/AIDS prevention discourse, hijras came to be perceived as sexual beings rather than asexual figures as was the case in the past. Reddy writes, “In the popular Indian imaginary, hijras have traditionally not been perceived as sexual subjects. They were viewed as either asexual, religious figures – blessed by a Hindu goddess through whose power they get their power to confer fertility—or more often, as objects of ridicule because of their asexuality and lack of any one gendered, religious, or caste affiliation” (Reddy, 2005a p.263). She (and Cohen, when he writes about the kothi identity) argue, that it is with the emergence of the HIV/AIDS epidemic that hijras, reimagined as MSM, were targeted as sexual beings. (Reddy, 2005a; Cohen, 2005). The HIV/AIDS discourse did interpellate hijras, but only insofar as they were thought of as MSM; it did not include within it the demand for transgender rights and indeed specifically excluded any ‘transgender’ connections.167

166 The kothis are a category of socioeconomically marginalized gender variant or ‘feminine’ same-sex desiring males. This identity gained attention in both the LGBT rights and HIV/AIDS programs in the 1990s. Some activists have argued that kothis was more indigenous or authentic to India than the term ‘gay’ – which was considered more Western and used by the English speaking Indians. Other scholarship has argued that this ‘indigenous’ narrative is not entirely true, and has shown that the kothi identity emerged with the increased interest in the human rights of ‘sexual minorities’ as well as governing programs associated with sexual health, especially HIV/AIDS prevention programs. Lawrence Cohen has argued that the term ‘kothi’ grew in parallel with the growth of the NGOs. For Cohen, although the term existed, it expanded as a “new social fact” in cities like Mumbai (Cohen, 2005). Akshay Khanna and Paul Boyce have shown that donor funded HIV/AIDS prevention programs played an important role in constructing kothi as a culturally authentic Indian category, a subcategory of MSMs, within the larger HIV/AIDS prevention discourse (Boyce, 2007; Khanna, 2009).

167 The transgender rights discourse only began in early 2000s. I discuss the transgender rights struggle in greater detail later in this chapter.
In recent transgender rights activism, hijras are read under the transgender and/or third gender category.\textsuperscript{168} Aniruddha Dutta argues, “I suggest that both hijra and kothi may be evolving through interrelated and active epistemological projects of naming, describing and classifying gender/sexual identities, through which their definitional boundaries are becoming more standardised in relation to each other. [. . .] hijra becomes defined in terms of gender variance as a transgender identity while kothi is defined with reference to (homo)sexual behaviour as a subsection of MSM, constructing an increasing separation between gender and sexual identities” (Dutta, 2012, p. 828). Thus, as a result of the HIV/AIDS discourse, hijras not only appeared as sexual figures, they also emerged as a male-to-female transgender identity. However, sometimes they continue to be perceived as a male gender/sexual identity. Later in the chapter, I will demonstrate how in other epidemiological studies on MSM mental health, hijras get compared with other male, and not female, gender/sexual identities.

3.2 Precarity in HIV/AIDS Prevention Work and the Impact on Hijras

During my fieldwork, it became apparent that the HIV/AIDS prevention infrastructure is no longer expanding to the extent that it did in the 1990s and early 2000s. Amongst other things, the international funding is being increasingly regulated by the Indian state. Previously, NGOs could get direct funding from international development agencies located in the global north, but now the funding has to be funneled through India’s National AIDS Control Organization. The Indian state is attempting to control the work NGOs do.\textsuperscript{169} This has led to a sense of precarity among

\textsuperscript{168} See sections ‘The New Third Gender’ and ‘History of hijras within the rights discourse’ to get a more detailed understanding of hijras being read as transgender and as the third gender.

\textsuperscript{169} This attempt to control funding cuts across NGOs working on a variety of social issues, not just HIV/AIDS prevention work. Receiving funds from outside the country is increasingly being framed as a security threat to the Indian nation-state thereby providing a nationalist rational for the State to control financial support for issues that it deems as a threat.
the remaining HIV/AIDS NGO workers. Many hijras and kothis I spoke to who are working in HIV/AIDS NGOs, moved from doing sex work to NGO work where they began working in HIV/AIDS prevention programs. This gave them a sense of respectability. In many of my conversations, hijra and kothi individuals working in sexuality rights NGOs, which are also heavily involved in HIV/AIDS programs, were of the opinion that NGO work is less lucrative, but they get more respect. Sameera, who helped me during my research, mentioned several times that people open their homes to us because she has earned respect in the larger community from her HIV/AIDS NGO work.

It is important to acknowledge that this is a transitional time for the HIV/AIDS programs in India but also to simultaneously understand the significance of HIV/AIDS epidemiological programs on the identity of hijras. Urmi, a kothi identified person who currently works in a sexuality rights and HIV/AIDS prevention NGO, compared her experience working in an HIV/AIDS prevention NGO with working as a sex worker. She explained to me in Kannada, “sex work was very nice, a lot of fun. We used to all dress up together every evening and go to Cubbon Park, Majestic or near Vidhan Soudha; till a customer’s car or bike slowed down, we would all be chatting and laughing, but then the police started coming around a lot more. Sometimes the police constables warned us before the senior police officers came, but sometimes we would get caught and taken to the police station and then had to suffer at the hands of the

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170 The biggest HIV/AIDS prevention NGO in Bangalore is called Sangama. This NGO not only does work on HIV/AIDS issues, but also works on sexuality rights for various groups of sexual minorities. Sangama has several sister organizations such as Samara, Aneka, Jeeva, Payana, Swatantra, Ondede, Sarathya and others. Most of these NGOs work on some aspect of HIV/AIDS prevention. And many hijras who entered the NGO circuit were hired by one of these organizations within this large NGO infrastructure.

171 For more on the HIV/AIDS industry and social mobility, see Khanna (2009).

172 In my work, I focus on hijra lives, but it is important to keep in mind that the conditions for Female to Male (FTM) transgender individuals are also extremely precarious. For one they do not have the cultural recognition that the hijras have in India. Secondly, unlike the hijras and other male born sexual identity groups, FTM people did not receive recognition of existence through the HIV/AIDS programs, since most of these programs were focused on male born individuals. There has been an increased critique of this from activists and individuals interested in Female to Male transgender identities.
police. If it were not the police problem, it would be customers who would treat us very badly. They would not pay us after sex and throw us out of the car, or would take us to remote places for sex and leave us there in the middle of the night without paying. It was very violent. But I also have fond memories of that time.” At that point I asked her if she missed sex work. She said, “Sometimes I do, but working in an NGO, I feel like I can tell everyone what I do. I feel like I have some respect in society and even in the community, people respect me. But this is difficult as well. Now HIV/AIDS funding is going down, I don’t know what will happen to us, we don’t get respectable jobs apart from in NGOs.”

Another significant consequence of the HIV/AIDS prevention intervention (which aided the sexuality rights movement) was that it helped build a sense of a collective, which included hijras along with other MSMs, at least within the activist circles. Partly intentionally and partly otherwise, hijras were incorporated into the larger gay world through HIV/AIDS programs as MSMs and they fought against Section 377 IPC. Public parks in big cities in India had become important spaces where HIV/AIDS prevention activities occurred. These were also spaces where communities of gay, bisexual and hijra people began to form (Narrain and Gupta, 2011, p. xxi).

As part of the HIV/AIDS programs, drop-in centers (DIC) were set up as safe spaces for vulnerable communities such as MSMs, including hijras and other transgender individuals.174

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173 This conversation happened prior to the ‘third gender’ bill being passed in the Lok Sabha. I suspect that that legal provision has given a lot of hope in terms of jobs for transgender people, especially the people associated with sexuality rights and HIV/AIDS NGOs, who have access to “respectable” jobs.

174 Section 377 of the Indian Penal Code states, “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to 10 years, and shall be liable to fine. Explanation – Penetration is sufficient to constitute the carnal intercourse. See the section titled ‘The Transgender Rights Bill 2015 and its critique’ in this chapter for a more information on the fight against Section 377 IPC. Also see Narrain and Bhan (2005) and Narrain and Gupta (2011)

175 DICs are usually situated in lower-middle class neighborhoods in Bangalore, sometimes near the cruising areas or neighbourhoods where street based sex work happens. Typically DICs offer a range of services such as HIV/AIDS counseling, which entails the communication of information regarding HIV/AIDS and other sexually transmitted diseases. These counseling services also encourage people to get tested for HIV/AIDS. They also
These efforts enabled a sense of collectivity with other marginalized gender/sexual identities that did not exist earlier. During a conversation with an activist from Sangama, an important sexuality rights and HIV/AIDS prevention NGO in Bangalore, when talking about the reduction in HIV/AIDS prevention funding in India and how it would affect the ‘sexual minorities’ working in the NGOs, she mentioned in passing, “AIDS killed a lot of us, but it also brought us together. Many of us were not even thinking of asking for our rights, with AIDS, we all came together and realized that gays, bisexuals, hijras…all of us can come together”. This statement is a reflection of the fight against Section 377 IPC.

This brief history of HIV/AIDS in relation to hijras highlights the complex history of public health intervention in hijra lives. In the next section, I first trace the implications of the hijra categorization as MSM in contemporary epidemiological programs on hijra mental health care, and then discuss a program that was undertaken in Bangalore to address mental health concerns among hijras (as MSM).

3.3 Hijra Suicides and Epidemiological Knowledge Production

In one of the oldest hamams in Bangalore, Kajal was telling me about her husband who she had loved immensely. By the time I met Kajal, her husband had left her for another hijra in the same hamam, which had led to a huge fight between Kajal and the hijra who was now with her ex-panti. But the man had chosen and nothing more could be done about it. Her ex-panti and his new hijra partner had rented another apartment and were now living together. She had distribute condoms and answer any questions regarding HIV/AIDS. Apart from this, they are also supposed to provide psycho-social support. The idea here is to help sexual minorities (as they are known in the HIV/AIDS and sexuality rights framework) come to terms with their life situations.
complained to her guru that the other hijra had stolen her man, and they had all met to discuss the problem, but nothing could be done. All this had occurred more than a year before I met Kajal. She repeatedly told me that there was nothing left for her in this world. Kajal mentioned that her family didn’t support her, people in the community were not trustworthy and she had nowhere to go for support. At some point in our conversation, I asked her if she had reached out to the counselors who were present in the HIV/AIDS and sexuality rights NGOs in the city. To which Kajal responded: “avarella yavagalu AIDS baggene maathu, condom bagge helthare, inna yathirbagge nu maathilla” “Those people always want to speak about AIDS, and tell us about condoms, they are not interested in speaking about anything else”.

In the larger focus on HIV/AIDS discussions in India, mental health concerns have not to found a prominent place. In the next few sections, I will study a few efforts that were undertaken to address mental health problems within the hijra community. Although these public health/epidemiological efforts have been short lived and small-scale, they are important because these are the only initiatives that have addressed hijra mental health, albeit with some obvious concerns that I will demonstrate in the next section.

### 3.4 Hijras as MSM within Mental Health Care

Mental health concerns among hijras have gained a little attention with the HIV/AIDS prevention discourse. An Issue Brief titled ‘Hijras/ Transgender Women in India: HIV, Human Rights and Social Exclusion” published by the United Nations Development Programme (UNDP), India, states:

Mental health needs for Hijras/TG communities are barely addressed in the current HIV programs. Some of the mental health issues reported in different community forums
include depression and suicidal tendencies, possibly secondary to societal stigma, lack of social support, HIV status, and violence-related stress (Chakrapani, 2010, p. 4).

This is one of the first publications where suicidal tendencies among hijras is recognized, although hijras are subsumed within the category of transgender, which includes various transgender/sexual identities. The report explains that mental health services should be included as part of HIV/AIDS prevention programs. Around 2010, there is a marginal growth of mental health discourse within the MSM and HIV/AIDS literature. For example, another epidemiological study was conducted in Mumbai which focused on suicidality, clinical depression, and anxiety disorders amongst MSMs. This study also made a similar argument as the UNDP Issue Brief, that is, mental health care ought to be included within the HIV/AIDS prevention programs (Sivasubramanian, et al., 2011).

Specifically in Bangalore, the Karnataka Health Promotion Trust (KHPT), a large public health NGO, conducted a study on mental health concerns among MSMs in Bangalore. In 2014, KHPT published a report titled “Addressing Mental Health Needs Among Male Born Sexual Minorities”. This epidemiological study was part of a pilot-program to address mental health needs for transgender people in Bangalore. The NGO Sangama, had been working with KHPT for several years on HIV/AIDS prevention work until both these NGOs began to take an interest in mental health issues among hijras, as a response to a spate of suicides by hijras and kothis in Bangalore in 2010. Sangama and KHPT, with support from the Bill and Melinda

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176 KHPT is a large public health NGO working in various parts of Karnataka. Apart from HIV/AIDS, the NGO works on maternal and neonatal health, adolescent health, violence against women, tuberculosis, and malnutrition among other issues. They also conduct empirical research to inform health policies.

177 The report explains: “Disturbingly, 39 unnatural deaths were reported from May 2009 to October 2010. The majority of the deceased were Transgender individuals, of which, 15 were clearly suicides. Also, 12 of the 39 deceased persons were known to have tested positive for HIV” (Dutta, et al., 2014 p. xi). In my conversations with sexuality activists and NGO workers, I heard a few different explanations for this spate of suicides. Some hijras activists mentioned that some of these suicides incidents were because of betrayal by pantis. Other activists
Gates Foundation, decided to initiate a one-year pilot project to understand mental health problems amongst transgender people in Bangalore. The aim of this project was to understand the underlying mental health conditions, such as suicide ideation, before providing mental health care services (Dutta et al., 2014 p. x).

As part of this project, they also trained a few peer counselors. Peer counselors are people from the larger transgender and kothi community trained by psychologists and psychiatric experts to act as counselors for others within their community. These counselors were typically previously trained as peer counselors in the HIV/AIDS programs. One of the first things that struck me while reading this report was that it compares the statistics regarding hijra suicidality with that of male suicides in India. This was momentarily surprising to me, considering the fact that hijras never identify themselves as men and sometimes historically they might have been identified as “neither male nor female”. But the reason KHPT understood hijras as men was because of the HIV/AIDS prevention categorization of hijras as MSMs. This reflects the links and continuations between HIV/AIDS prevention formulation of hijras as MSMs and the contemporary efforts to address their mental health needs.

There was an effort to understand suicide behavior among hijras and kothis in this study. For example, in the section on “Suicidality, self-esteem and relationships” the report states:

Alarmingy, 60% of the respondents reported to have made a suicide attempt once in their life. Among them 66% have low self-esteem on self-scale, 70% have medium level of mentioned erratic hormone consumption. Yet another explanation I heard was that these were copycat suicides; a prominent hijra committed suicide and so others followed. Sometimes the same person would give me a different explanation each time this spate of suicides came up in conversation. It was unclear to me how to read these multiple and changing explanations.
self-esteem on familial aspects, 67% have low self-esteem on social aspects. Surprisingly 82% have high self esteem on self scale, but 63% have low overall self-esteem and 68% have low relationship status (Dutta, et al., 2014, p. 22-23)

In a similar way the report discusses the correlation between “Suicidality and alcohol consumption” as well as “Suicidality, anxiety and depression” (Dutta, et al., 2014, p. 23-24).

This discussion on suicide assumes that certain correlations are indicative of causation for suicide. The study concludes that the friction caused with family, society and the self, due to their sexual identity and expression, results in low self-esteem among the hijras. The report also explains that excessive exposure to violence, due to hijras and kothis involvement in sex work, violence from the police, and also from the hijra community, leaves a scar on their mental health (Dutta, et al., 2014, p. 38-39). It also says that it is possible that due to experiences of stigma and discrimination, people in the LGBT community are vulnerable to higher rates of anxiety, depression and psychiatric disorders, including risk of suicide (Dutta et al., 2014 p. 39).

This epidemiological study makes a call for inclusion of mental health care for MSMs in HIV/AIDS programs. In my research, I found that this recommendation for inclusion of mental health care for MSMs within HIV/AIDS programs has not gone beyond acknowledging the problem. Public mental health care programs that address hijra mental health have not received adequate funding, which results in mental health care programs lasting only for very short durations of time. Even within these short-term mental health care programs that aimed to address MSMs, it is important to point out that hijras within this study were subsumed within the larger category of “male born sexual minorities”. The results presented combined the experiences of kothis, double-decker and bisexual individuals with hijras, thereby assuming the
same approach to all these different groups. Gayatri Reddy examines HIV/AIDS prevention frameworks in Hyderabad and argues that including various gender/sexual identities within one framing of MSM often fails to pay attention to the differential understanding of stigma and socio-economic underpinnings, thereby resulting in ineffectiveness of prevention programs targeted at these “at-risk” communities such as hijras (2005b). Similarly, in these studies on mental health care needs of MSMs, the particularities of experience of hijras are ignored. Factors that are not unique to hijras are also erased. The experience of loss of love that hijras narrated to me (which is not exclusive to hijra lives) is understood only through the lens of MSM experience. Significantly, the report ends with the statement:

…this particular study can lead to further suicide prevention research, campaigns and more effective targeted interventions with the transgender and sexual minority populations in India. Along with other similar research, it can help generate inclusive policies and need based service delivery relevant for global mental health (Dutta, et al., 2014, p. 40 Emphasis added).

I have discussed global mental health in the previous chapter, and as seen there, this statement reflects the impetus to provide treatment in accordance with the global mental health mandate. This epidemiological study is similar to the efforts undertaken by the WHO. The underlying assumption is that the epidemiological and psychiatric assessment and treatment is the path towards understanding and addressing suicide. Thus, the mention of mental health needs in the HIV/AIDS and MSM literature is a reflection of the expanding mental illness discourse I showed in the previous chapter. Until recently, mental health needs were not prominent in the HIV/AIDS

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178 ‘Double-decker’ broadly denotes a man who is sexually versatile in assuming penetrative as well as receptive roles during sex. In different regions of Karnataka, double-decker could also refer to a man who is married and who engages in bisexual behavior, or a man who is more masculine than a kothi, or it could also refer to being gay.
prevention discourse. The publication of these epidemiological studies is a reflection of the gradual increase of mental illness discourse within HIV/AIDS discussions.

But it would be incorrect to assume that these reports are a reflection of medicalization of suicide among MSMs. The KHPT project was discontinued after one year and no one I met associated with the project was interested in discussing it. I got a sense that for most involved, this project had moved to the realm of the past. During my fieldwork, in 2013, I traveled to Chennai to meet the author of this Issue Brief, Dr. Venkatesan Chakrapani. During my visit, I asked him whether there have been any shifts in focusing on mental health for transgender people since the publication of the Issue Brief in 2010. To this question, Dr. Chakrapani responded that he had conducted some research work on mental health care needs of transgender people in Tamil Nadu, but nothing significant had come of it in terms of policy changes. Thus, while there are a few public health/epidemiological interventions regarding hijra (as MSM or Transgender) mental health, none of these epidemiological studies resulted in psy/mental illness programming. While the stimulus to medicalize is apparent in these programs, the efforts are currently only partially successful. In Chapter Two, I focused on the attempts and the potentiality of psy discourse to medicalize suicide and termed this partial expansion of psy/medical discourse as quasi-medicalization of suicide prevention. In the context of hijra suicide, the effort undertaken by KHPT is once again an example of such a quasi-medicalization of suicide prevention. There is an effort to acknowledge hijra suicides as a public mental health concern, but also these programs have not survived beyond conducting a couple of epidemiological studies. While a psy/mental illness framework expands as an explanation for hijra suicides, it has not gained adequate financial or discursive support to medicalize suicide among hijras or MSMs.

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179 In spite of several efforts to get a reason for why this project ended or the details of the year long pilot, I never got clear answers from anyone I met who was involved in the project.
In the next chapter, I study the ways in which hijras continue to speak about their experiences of suicide outside the psy/medical framework.

Following the KHPT project, a less biopolitical initiative was undertaken to address mental health needs of hijras and kothis in Bangalore, which I discuss in the next section.

3.5 Art Therapy for Mental Health

Following the KHPT pilot project, a small art therapy project was initiated to address mental health care needs for hijras and kothis in Bangalore. The psychologist who headed this venture had experience working with hijras and kothis for over a decade and had a nuanced understanding of hijra mental health care needs. This experimental project was initiated by a small NGO called Jeeva (which translates to “life”). I met all the hijras and one kothi individual who participated in the art therapy sessions, as well as the psychologist who designed and conducted these sessions. The participants were asked to draw and create art objects and through this, express their feelings. The counselor who headed these sessions explained, “Once the feelings are well articulated, then we can begin to find solutions. There is a lot of pent-up feelings among hijras and kothis. They themselves need to understand it and through art they can express it well for themselves and then to others. And they process this together, not alone. But by helping each other” (Interview, 2014).

Some of the participants complained that although the sessions were fun, it was not helpful to address their problems. Others complained that these sessions were too few (there were only three sessions in total), because in the process of drawing, they brought out all their problems and then the sessions ended. Because of this, it did not help them cope with their

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180 There were in total only five people who participated in this project. Only one of them identified themselves as kothi, the others were all hijras.
situation and so it felt like it might have been more harmful than helpful. But all the participants who attended these sessions said that if given a choice, they would have liked to continue art therapy. Art therapy was meant to address various topics in each session, such as relationships, confidence, stress, and expression of feelings. Through the use of art the participants were instructed to put down on paper what they feel, and in doing so find support and begin to heal.

This approach was very different in its framework from the KHPT project. KHPT was connecting mental health problems among MSMs and suggesting services within the global mental health framework. By contrast, the art therapy program did not pathologize any emotions expressed by people attending workshops. Instead it made an effort to enable the participants to cope with their situation both collectively and individually.

In this section, I have highlighted two programs that were aimed at understanding and addressing mental health concerns among hijras in Bangalore. One was the KHPT initiated pilot program that resulted in the publication of the epidemiological study on hijra (as MSMs) mental health needs. The second project focused on art therapy. This was initiated by the NGO Jeeva and led by a psychologist. The KHPT project marks the beginning of medicalization or quasi-medicalization of hijra suicides, whereas the art therapy sessions mark the beginning of a non-pharmacological, less biopolitical healing practice. Apart from these two projects, I did not encounter any other (small or large) institutional interest in addressing hijra suicides in Bangalore and both these projects ended within a short duration.

The other important discourse that has greatly influenced hijras is the rights discourse. In the following section, I trace the history of hijras in the civil liberties and human rights discourse to provide a detailed study of the complex maneuvers hijra identity has made in relation to these large institutional programs.
4 Sexuality Rights Activism: A Focus on Hijras

4.1 History of Hijras within Rights Discourse

One of the first efforts to think of transgender rights in India was the 2001 fact-finding report published by the civil liberties organization, PUCL-K, titled “Human rights violations against sexual minorities in India.” The aim of this report was to study the human rights violations suffered by sexual minorities in India (with a specific focus on Bangalore). The report examines these violations under two broad sections: state and society. Violence and violations by the legal apparatus, such as the police were documented under the section of the State. Violations by family, workspace, public space, medical establishment, and in popular culture, came under the section - society. This report was based predominantly on testimonies by gay and bisexual people, but also included problems faced by hijras. The emphasis of this report was on state culpability in violence against hijras.

Following this, PUCL-K published another report in 2003, titled “Human Rights violations against the transgender community.” Unlike the 2001 report, this focused solely on problems faced by transgender people. Transgender people in this report primarily included hijras and kothis and there was no mention of Female-to-Male transgender individuals. This report incorporated gender-based demands into sexuality rights activism, mainly the right to define and express one’s gender identity. In addition, it illustrated that sexual orientation could no longer be the sole basis of sexuality politics, since the everyday violence recorded in this report demonstrated that other gender/sexual identities which challenged gender norms were also at risk of extreme violence. Lastly, this report demonstrated “mainstream society’s deep-rooted fear of sexual and gender non-conformity” which manifests itself in the “refusal of basic citizenship rights to these communities” (PUCL-K, 2003, p.11).
Generally, most hijras are from working class (probably not upper caste) backgrounds. These two PUCL-K reports, for the first time, highlighted the importance of class disparity that contributed to the problems faced by hijras. This acknowledgement nudged the larger queer rights movement to demand recognition for transgender people from the state in the form of voting rights and identification documents (Ration card, Voter ID, Aadhar card).\textsuperscript{181} The report ends with a charter of “action points” for human rights groups and the sexuality movement, with the goal of realizing the rights of citizenship and personhood of hijras and kothis (PUCL-K 2003, p. 11). It states:

The brutal stories of abuse and sexual violence documented in this report are really narratives of cruelty, a traumatisation of an entire community which negates the constitutional claim of equal citizenship and protection for all (PUCL-K, 2003, p. 12).

These two reports were the first significant steps towards transgender rights. My aim is twofold: first, to understand the articulation of rights discourse in these reports and, second, study the place of suicide within the hijra rights debate.

4.2 State Culpability in the Rights Discourse

In India, the civil liberties discourse historically was interested in exposing State excesses, which ranged from preventive detention to custodial violence to encounter killings (Upadhyay, 2014). With the emergence of the Universal Declaration of Human Rights in 1948, and later an upsurge around human rights during the post-emergency period in the 1970s, it translated in the Indian

\textsuperscript{181} Since hijras were not officially recognized by the Indian state, there were no legal/bureaucratic provisions to get documentation that reflected their lives as hijras. Most of the documents that a hijra might own would be based on their perceived gender as a boy. For a further discussion on the history of the struggle for the identification documents by transgender women, see Govindan and Vasudevan (2011).
context to “civil rights”. Amit Upadhyay argues that lexically it was a combination of international human rights and local civil liberties discourses, and this new expanded vocabulary of “civil rights” included issues of communal violence, (perfunctorily) caste violence and questions of gender violence. He poses the question, why did this expanded set of themes interest rights organizations? He then argues that they provided additional grounds to allege state culpability. For example, custodial rape (by the police and the security forces) was the first and foremost issue that was taken up to illustrate state culpability. Once these violations were introduced into a state culpability framework, they became norms to evaluate not just the state but also society at large (Upadhyay, 2014). When understood through this lens, we see why the PUCL-K reports emphasized both – (a) the aspect of state culpability such as brutal police violence or police custodial rapes, and (b) the lack of social acceptance and oppression of the hijras and transgender people by their families and larger public because of their non-conforming sexual identity.

Hence, oppression and violence found a place within the hijra rights discourse whereas other specific affective concerns were left out. Issues of police entrapment of the hijras, harassment by the police in public places, and rapes in jail get detailed attention in these reports. This particular “victim”-focused approach to state culpability in violence is a reflection of the civil liberties approach. In the next section, I turn to the significant legal changes that occurred between 2013-2015, partly as result of this civil liberties/human rights activism.

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182 The emergency period in India refers to the 21 month period between 1975-1977. A state of emergency was declared throughout the country by the then Prime Minister Indira Gandhi. This gave the Prime Minister the authority to rule by decree. During this time, Indira Gandhi suspended elections, and curbed civil liberties.
5 The New “Third Gender”

5.1 The Supreme Court Announces Transgender Rights

In August 2013, the Ministry of Social Justice and Empowerment (MSJE) organized a consultation to discuss problems relating to the transgender community. This meeting included representatives from the transgender community, expert researchers, concerned individuals from State and Central government departments, such as the Central Ministries of Law and Justice, and the Department of AIDS Control. MSJE brought these representatives together to form an Expert Committee which specifically studied the problems faced by transgender people and made recommendations to the government to ameliorate those problems. MSJE also requested the State governments and Union Territories to give their recommendations and the Expert Committee examined these suggestions before making its final recommendation. These discussions and recommendations made by the Expert Committee have influenced the Supreme Court decision on “third gender” as well as the Transgender Rights Bill 2014.

A division bench of the Supreme Court passed a judgment in April 2014 that constituted a veritable charter of transgender rights. This judgment arose from a Public Interest Litigation suit filed by the National Legal Services Authority (NALSA) (National Legal Services Authority v UoI) in 2012. In this judgment, the Court asked the Central Government to treat transgender people as socially and economically backward, meaning that the third gender individuals must

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183 For example, this was the first time within the national bureaucratic systems where there was a detailed discussion regarding questions of self-representation of one’s gender/sexual identity along with addressing other concerns, such as providing medical support like Sex-Reassignment Surgery (SRS) for transgender individuals, addressing police violence on trans lives, providing anti-discrimination laws that protect transgender individuals, deregulation of gender within the education system and many more (MSJE, 2014).

184 NALSA is a statutory authority constituted under the Legal Services Authorities Act 1987 to provide free Legal Services to the weaker sections of the society and to organize Lok Adalats (People’s Court) for amicable settlement of disputes.
now be recognized under the Other Backward Class (OBC) category of the Indian Constitution, and thereby be entitled to affirmative action policies by the Indian state.  

This judgment was celebrated as well as scorned by the activist community in India. One section of sexuality rights/social justice activists was suspicious about how the Supreme Court recommendation would impact different transgender identified people. One question that activists posed on queer social media platforms was: “would these provisions apply to upper class or caste transgender individuals, as it does to working class or Dalit trans people?” One constant complaint regarding reservation policies have been that they benefit the more privileged people within the SC/ST/OBC communities and the most disadvantaged people remain left out of these support systems (Semmalar, 2014). Speaking to this concern of being dealt with as both OBC and SC, a Dalit trans activist/ artist, Living Smile Vidya, states:

I definitely do not want to be OBC. And you will understand why as a dalit, I do not want to come under the OBC category of all things! Putting transgenders under an oppressed caste category erases the caste privileges that savarna transgenders have. It is better for us to have caste and gender based reservation so that dalit women and dalit transgenders get

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185 Backward class was a category that emerged as part of India’s affirmative action system, generally referred to as ‘reservation’ in public jobs, educational institutions, and even voting constituencies. This was introduced in the 1930s and expanded after India’s independence from the British. Marc Galanter terms this system ‘compensatory discrimination’ (Galanter, 1984). These positive discrimination policies were aimed at addressing historical discrimination that disadvantaged communities and groups suffered for centuries in Indian history. These communities were largely categorised as Scheduled Castes (SC)—mainly Dalit communities, and Scheduled Tribes (ST)—much of the indigenous or adivasi communities of India. Adivasi refers to the “original inhabitants;” it is used as an umbrella term for the Indigenous communities in India. Some Indigenous communities also use the term Tribal to identify themselves. Further reservations were later introduced for Other Backward Classes (OBC). OBC is not a clearly defined category and it includes several communities that did not come under the SC or ST category. The Indian constitution provided a legal framework for affirmative action and also named backward classes as being eligible for reservation. Since there were many different communities across the country that might qualify as socially and economically “backward” or “oppressed”, the constitution allows for Special Commissions in States and at the Centre to decide who comes under OBC in any particular region. Over the years, several Backward Class Commissions have recommended several communities to be included within affirmative action policies. Because of the nature of this system, new groups continue to be added under the OBC category. For a more detailed analysis of affirmative action and the Backward Class Commissions, see Galanter (1984) and Jafferlot (2003)

186 See footnote 191 on reservation policies in India.
representation. Otherwise reservations will only benefit savarna transgenders and dalit men (Living Smile Vidya as quoted in Semmalar, 2014).  

The judgment states that trans people are allowed to identify themselves as man, woman or third gender. Responding to this categorization, some hijras I spoke to expressed the desire to be simply referred to as women or hijras and not ‘third gender’. Although not officially recognized till recently, some hijras have managed to obtain a government identification document in their hijra name. This is important because many hijras run away from home at a young age and at the time all the official documentation (if any) would be in a male name. Most hijras do not carry these documents when they leave home. But over time, some hijras I met had managed to manipulate the bureaucratic system and obtain government documentation in their hijra names and the gender identity in these document indicate that they are women. Some hijras were concerned that the paperwork that identifies them as women will no longer be valid if they had to identify themselves as ‘third gender’. 

Others read this judgment as muddled and confusing. Gee Imaan Semmalar, a trans man and activist, writes in anger regarding the offensive generalizations that the judgment makes:

[.....] that claim that all hijras are third gender and do not identify as women because of a ‘lack’ of reproductive organs and menstruation that they are ‘emasculated men’. It (the

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187 Savarna refers to upper caste Hindus. As a response to this confusion, in April 2016, there was news that the new Transgender Rights Bill (draft) will mention that transgender people who do not belong to SC/ST category will be provided reservation under the OBC category; see (New Draft of Transgender Bill, 2016).

188 I intentionally do not explain the typically informal processes that hijras have followed to attain these documents here because I do not feel it is ethically correct to put in print these informal support systems that have emerged organically.

189 Another point that the hijras and some activists raised was the problem of ‘fake hijras’. The fear was that fake hijras would obtain benefits under provisions provided for third gender people. Fake hijras were a concern outside the bureaucratic system. I often heard stories of how men would dress up as women and pretend to be hijras and beg on the streets and thereby take away from livelihood opportunities for ‘real hijras’. This seems to be a concern for hijras who mostly beg on the streets for a living. I did not hear this concern often in the discussion on this judgment on queer social media. But some of the hijras who do not access the Internet mentioned this to me in person.
judgment) also includes cross dressers who might not have a gender identity different to the one they were assigned. Such references to the trans women as phantasmagoric beings who are neither man nor woman, gender being judged primarily on the presence or absence of reproductive capacity feeds into and reflects all the dominant transphobic stereotypes and beliefs (Semmalar, 2014).

Semmalar argues that the Court is attempting to make the transgender people a ‘manageable’ category with an intention to reveal the ‘truth’ about them (Semmalar, 2014). The judgment states that, “Such a person, carrying dual entity simultaneously, would encounter mental and psychological difficulties which would hinder his/her normal mental and even physical growth” (National Legal Services Authority v UoI, 2014). And “TGs face many disadvantages due to various reasons, particularly for gender abnormality which in certain level to physical and mental disability (Sic)” (National Legal Services Authority v UoI, 2014). Responding to such pathologizing instincts, Semmalar writes:

A pathologisation of trans people runs throughout the judgment with emphasis on the duality of mind and body and how psychological tests should be preferred over physical tests or sex reassignment surgery as a criteria (Semmalar, 2014).

Differing from these apprehensions, another set of legal activist voices celebrated the judgment. Applauding the principle of self-determination of gender in the judgment, Arvind Narrain, a human rights lawyer and a prominent sexuality rights activist wrote:

…the Indian Supreme Court in a historic first, takes the principle of self-determination of gender to its logical end by noting that persons can identify as either male, female or third gender. By doing so it recognises the complexity of gender identity and makes space for a range of possible ways of identifying oneself” (Narrain, 2014).
Another lawyer, Danish Sheikh, explains the potential that this judgment has opened up,

…the reiteration of a judgement as precedent doesn't necessarily need to happen within the Court. There is an expressive function that the judicial text has, over and above its enumerated directions. That expressive power is ultimately what activists rely upon in their advocacy; it's what state actors will use in political debates; it is what the media reports on and injects into public discourse. And at the level of perception, there is certainly much to be optimistic about when it comes to NALSA. It has entered the vocabulary of many LGBT individuals and activists, its promises invoked in protests, meetings, consultations and engagements with the media (Sheikh, 2015).

These legal activists also celebrated the fact that the judgment provides a comprehensive regime of rights for transgender people. It specifies that transgender individuals have the right to live with dignity, the right to equality and the right to freedom of expression. But this judgment does not include the right of transgender persons to form intimate attachments with those of their choice. This, Narrain explains, is the case because providing such a provision will be in conflict with the Supreme Court judgment, which upheld Section 377 IPC which criminalizes homosexuality (Narrain, 2014). The public debate regarding the quality of the Supreme Court judgment did not last long, and a year later, on April 23rd 2015, the Transgender Rights Bill was passed without protest in the Rajya Sabha (Upper House of the Parliament of India).

5.2 The Transgender Rights Bill (2015) and its Critique

The Rights of Transgender Persons Bill 2015 was passed unanimously, with people across different political parties affirming the need to address problems faced by the transgender people in India. The broad aim of the bill was to create a national policy for securing the welfare and development of the transgender community. The bill was expected to protect and provide a
number of rights to transgender people, while guaranteeing them reservations in education and jobs, financial aid and social inclusion.\textsuperscript{190} The response to this bill was similar to the Supreme Court judgment—mixed.

A significant point of the bill was that it allowed for transgender individuals to choose to identify themselves as either ‘male’, ‘female’ or ‘transgender’. It stated:

transgender person means a person whose gender does not match the gender assigned to that person at birth and includes trans-men and trans-women (whether or not they have undergone sex reassignment surgery or hormone therapy or laser therapy etc.), gender-queers and a number of socio-cultural identities such as —kinnars, hijras, aravanis, jogtas etc. A transgender person should have the option to choose either ‘man’, ‘woman’ or ‘transgender’ as well as have the right to choose any of the options independent of surgery/ hormones.” (The Transgender Rights Bill, 2015).

This provision to self-identify one’s gender/sexuality was largely celebrated. But there were a few activists who were against the usage of the term ‘transgender’, since it unified a variety of gender/sexual expressions under a single umbrella of ‘transgender’.

Another significant aspect of this bill was that it made a point to provide provisions, that is, reservations for transgender people in education and employment. But activists were cautious and pointed out that all the provisions made in the bill had to be taken up seriously by each state government for it to benefit all transgender people.\textsuperscript{191} In addition, the bill also demanded separate courts for speedy disposal of legal cases of transgender people. It was argued that this

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\textsuperscript{190} A bill has to be passed by both Houses of Parliament (Rajya Sabha: upper house, and Lok Sabha: lower house of the parliament) and obtain presidential assent before it becomes an Act. The Lok Sabha can make amendments to the bill after which it will have to be passed by the Rajya Sabha again before it goes before the President for assent.
\textsuperscript{191} For news reports which reflect the activist voices, see Srinivasan (2015) and Kolhatkar 2015.
\end{flushleft}
would ghettoize the transgender people (Ratnam, 2015). Another concern raised by activists such as Sheikh argued:

Since transgender is an identity term that many individuals adopt only at an adolescent stage, if not later, it will risk leaving a broad spectrum of children out of the bill’s protection. It is recommended that the term ‘gender non-conforming children’ be used along with the term ‘transgender children’ throughout the bill (Sheikh as quoted in Ratnam, 2015).

In the discussions on social media platforms, several queer activists expressed happiness regarding the new legal opening and provisions for transgender people. Some of these comments also expressed hope that this new transgender rights bill would initiate, once again, the conversation regarding Section 377 IPC that criminalizes homosexuality. The fight against Section 377 has been a source of much disagreement within the queer struggle in India. Some queer activists found the fight for legal recognition does not do justice to the various gender/sexual identities that exist in India and argue that the fight to decriminalize Section 377 focuses primarily on male same sex sexual relationships thereby ignoring other queer concerns. For example, problems faced by queer women were largely absent in the fight against Section 377. Queer activists posted opinions online arguing against bringing the issue of male same sex sexual relationships into every fight including the transgender struggle, in some sense appropriating the transgender struggle for the purposes of decriminalizing Section 377.

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192 The discussions about the bill occurred on Facebook; articles were posted on www.orinam.net, a portal dedicated to providing information on alternate sexuality and gender identities. Some of these discussions also occurred within the listserv of Coalition for Sexual Minority Rights.

193 For a more detailed discussion regarding the lesbian struggle in India see Dave (2012) and Thangarajah & Arasu (2011).
This debate regarding the pros and cons of the Rights of Transgender Persons Bill 2015 did not last long. On August 2\textsuperscript{nd} 2016, the Transgender Persons (Protection of Rights) Bill 2016 was introduced in the Lok Sabha (lower house of the parliament), which once again shifted the discussion on transgender rights in India.

5.3 The Disappointment of Transgender Persons (Protection of Rights) Bill 2016

This bill was building on the NALSA judgment and the Transgender Rights Bill (2015), however, certain significant aspects of the NALSA judgment were ignored in the 2016 bill. Unlike the NALSA judgment and the 2015 transgender rights bill, where there were differences of opinion within queer activists, the 2016 bill that was introduced in the Lok Sabha was scorned by almost all sexuality rights activists in India.

Some sexuality rights activists had celebrated the NALSA judgment and the 2015 transgender rights bill for being inclusive. The NALSA judgment and the 2015 bill had acknowledged people who wanted to break the male-female binary. It had also explicitly allowed people to self-identify their gender. However, the Transgender Persons (Protection of Rights) Bill 2016 completely eliminated the option of self-identification as either male or female. Instead the bill frames a transgender person as one who is: (a) neither wholly female nor wholly male, or (b) a combination of female or male, or (c) neither female nor male (\textit{Transgender Persons (Protection of Rights) Bill, 2016}). Such a formulation of transgender received severe criticism from the sexuality activist community primarily for perceiving transgender people as not ‘male’ or ‘female’, which once again reinforces the idea that being transgender is linked to the presence or absence of reproductive capacity. Another criticism that the 2016 bill received was for confusing intersex with transgender identity. In an initial response to this bill by trans and intersex people, they write:
Not all intersex persons may identify as transgender. And not all transgender persons need to be intersex. In fact, there are many intersex variations that do not manifest physically, and often those with intersex variations may not be aware of this themselves; they may identify exclusively with the gender they were assigned at birth (Nirangal, 2016).

An important critique of this bill was that to be identified as transgender, the individual has to apply for a certificate to the district magistrate, who will then refer the application to a district screening committee, which will issue a certificate of identity. This certificate will be the basis on which the person’s gender will be recorded in all official documents and will be the basis for conferral of rights as a transgender person. This procedure has been critiqued for being arduous and once again being in violation of self-identification as granted by the Supreme Court in its NALSA judgment (Nirangal, 2016).

Health care provision for transgender people was another point of concern in the 2016 bill (Nirangal, 2016). In the previous, 2015 bill, there was mention of the state’s obligation to set up trans health care centers in governmental hospitals, which would provide free sex reassignment procedures. This provision was dropped in the 2016 bill. An initial response to the 2016 bill states:

Transhealthcare is absolutely critical for trans people to go on living their lives. Key services like counseling, hormone therapy, various gender affirming procedures have to be made mandatory services that are accessible to all underprivileged sections of the trans communities (Nirangal, 2016).

Overall, the 2016 bill received overwhelming criticism from all sexuality activists, despite the fact that they, and the broader queer movement in India, have different political agendas.
To understand these differences it is imperative to understand the larger queer rights movement in India. The legal fight to decriminalize Section 377 IPC, which criminalizes adult same-sex activity, has been critiqued from within the movement since its inception in 1994. Till the 1990s, this legal provision was more symbolic and discursive rather than punitive. The first legal effort to challenge Section 377 was made in 1994 by an AIDS prevention and education NGO called AIDS Bedhbbav Virodhi Andolan (ABVA), and has continued to this day. In 2009, the Delhi High Court “read-down” Section 377, thereby decriminalizing “adult same-sex sexual activity in private” (Naz Foundation v. NCT, Delhi & Ors). This judgment was challenged in the Supreme Court of India, and in 2013, it set aside the Delhi High Court judgment and ruled that homosexuality is a criminal offense. As of October 2016, a Curative Petition is filed in the Supreme Court of India asking the Court to reconsider its judgment. This long legal battle against Section 377 has resulted in several critiques, which are similar to the critique of transgender rights activism. Concerns that legal activism selectively represents certain queer groups and makes invisible certain others is at the core of the disagreement. For example, it has been argued that the lesbian concerns were not taken into account in the fight against Section 377. Similarly, with regards to the fight for transgender rights, it is argued that concerns particular to Female-to-Male transgender people are not adequately represented in the fight for transgender rights. While some rights activist/lawyers, like Narain and Sheikh, read potential for future sexuality rights as they did in the Transgender Rights Bill 2015, other activists like Semmalar are critical of legal activism in India overall as they read it as centering

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194 For a detailed history of queer rights activism, see Narrain and Bhan (2005), Narrain and Gupta (2011), and Dave (2012). For a detailed review of the various High Court and Supreme Court judgments, see Orinam website. Retrieved from www.orinam.net

195 Much of the observations that I make are based on critiques that were presented in personal conversations, activist meetings or in facebook discussions. Since my work here does not focus on the tensions within queer activism in India, I explain these concerns very briefly.
on the Section 377 debate, which focuses on problems faced by elite gay men and is not necessarily of consequence to other queer groups.

This fight against Section 377 is significant for my study of hijra suicides, because the long legal fight against criminalizing ‘unnatural sex’ has brought up the question of love, not solely as a right for same-sex relationships, but as a universal right. In the next section, I discuss the sexuality rights discourse and show how it is unable to address the narratives of hijra love-suicides.

6 Limits of Rights Discourse
I began this chapter by narrating a conversation I had with Kanchan, where she emphasized her desire for, as well as the loss of, love in her life, which motivated her suicide attempt. I heard similar narratives of loss of love and suicide during interviews and conversations with many other hijras in Bangalore. A man did not reciprocate their feelings, or he cheated on them with another hijra, or he used them for their financial resources while pretending to be in love—these were the stories that I heard repeatedly. Many of them rhetorically posed the question “Don’t we deserve love?” It was evident that loss of love was one of the central concerns in hijra lives and it was closely connected with suicide attempts. But this sentiment of love (or loss of love) was not included in the transgender rights discourse. I am not suggesting that the rights movement ought to have taken up hijra suicide as a separate entity and addressed it; rather, I am interested in the limits and the effects of rights discourse and rights-oriented political and legal strategies.

Analyzing the boundaries of the language of rights in the context of feminist politics in India, Nivedita Menon argues, “that rights come into being within specific sets of shared norms of justice and equality. However, legal discourse, through which rights are sought to be
institutionalized, is marked by the movement towards certainty and exactitude. What are the implications for the liberatory potential of rights once their meaning is fixed by law?” (Menon, 1999, p. 263). In a similar tone, Wendy Brown discusses rights for women and argues that a rights discourse, albeit useful for the marginalized subjects in contesting oppression, simultaneously locks these marginalized subjects into being ‘oppressed subjects’ (Brown, 2002). She explains that with strategic essentializations of being oppressed, which are encoded in legislation, a rights discourse reproduces that which it sought to originally contest (Brown, 2002). The PUCL-K reports I mentioned earlier highlight the human rights violations against hijras in India. In doing this, the hijra identity is linked to these issues of suffering, abuse, and violence. Just as the hijras were categorized and addressed as MSMs within the HIV/AIDS paradigm, through the human rights discourse the experiences which gained prominence were the violence unleashed by the state actors and institutions such as the police custodial violence, rather than other forms of negative life experience, to say nothing of agency or desire. These efforts have been successful to gain legal recognition for the ‘third gender’ individuals. But, on the other hand, since the focus was on state culpability, rights discourses emphasized violence, abuse and humiliation faced by the hijras, not hijra agency or hijra desire. It is because of the significant position held by the human rights discourse, and its potential for social transformation, that it continues to be important to study the limitations of this discourse. The question of hijra love – i.e., need for love or the loss of love rhetoric – exists outside notions of victimhood. It is an assertion of their personhood. Hijra suicide attempts are stemming from a desire for intimacy and companionship that cannot be fought on the basis of basic needs and rights. And there lies the unique position of hijra suicide in the context of rights discourse.
6.1 **The Right to Love**

Sexuality rights activism in India has taken up the issue of love, albeit as a rights issue and as a critique of the idea of procreative sex. The fight against Section 377, IPC, which criminalizes male same sex sexual relationships, took up the question of ‘right to love’.\(^{196}\) Writing about the power of love in the context of decriminalization of Section 377, sexuality rights activists Arvind Narrain and Alok Gupta explain:

people who are moved by an emotion called love often question the assumption of existing structures which keep in place notions of caste and community. The desire to live with someone drives this questioning of societal structures….The feeling called love cuts through the rigid boundaries imposed by the samaj and renders the identities of caste, religion and sexuality vulnerable to difference….In India, lovers who have dared to transgress these boundaries by putting love before their community have been killed by orders of the samaj\(^{197}\) (Narrain & Gupta, 2011, p. xxxiv).

In making this argument, they state that the question of ‘right to love’ is not a unique battle for queer people, but is a battle for all cross-caste, cross-religion couples. The argument here is for the right to love. Love in this context is discussed within the rights framework. This once again focuses on the potentiality of the individual(s) involved to want to be in love publicly. In the case of the hijras, something more complex is going on.

The conversations I had with hijras in Bangalore were about the loss of love rather than about the right to be in love. None of them ever discussed the ways in which they could legitimize their marriages, by getting official recognition. Many of the hijras did not even expect

\(^{196}\) In July 2002, the Delhi High court in *Naz Foundation v. NCT, Delhi and O rs* gave a judgment that read down the Section 377 IPC and so decriminalized consensual sex between adults. This verdict was overturned in 2013 by the Supreme Court of India and so as of today homosexuality remains a criminal offense in India.

\(^{197}\) Samaj loosely translates to society.
to have any share in the husband’s property. They were looking for companionship, intimacy, love.\(^{198}\) Although hijras were in marriage-like relationships, they were not recognized by law. Many lived with their pantis in a separate home, and most times their partners had other families, which many hijras referred to as ‘real families’. I do not mean to imply that the hijras have no aspirations for heteronormative marriage structures; however, in the conversations I had, this was not their primary concern. The central concern that many of the hijras expressed in connection with their narratives of attempted suicide was the desire to be loved. This desire that leads to suicide attempts does not figure predominantly within the rights debates.

Love enters the rights debate, as Narain and Gupta argue, precisely because of the potential it has for breaking old systems and a potential for a new beginning. However, within such a rights framework, hijra loss of love (resulting in suicide attempts) does not have a similar potential for breaking societal norms and questioning societal structures. To a certain extent this is not surprising. Most communities that have to fight for their own rights will not bring up the issue of suicide (especially the issue of suicide because of love) to ask for rights from the state. Suicide attempts stemming from loss of love is not a category that the legal system can comprehend to provide recognition. Unlike other love-suicides (gay, lesbian, inter-caste, inter-religious), which are politically more efficacious, hijra suicide attempts due to betrayal and loss of love do not carry a similar potential for rights based politics. The former kind of love death makes a point that they are human beings worthy of being loved, whereas hijra love-deaths demonstrate a lack of love. These are not adequate tools to demand rights from the state or even sympathy from larger society. I do not intend to argue that hijra suicides cannot be a basis for demanding rights. My point is that hijra suicides attempts due to loss of love have political

\(^{198}\) For a more detailed discussion on need for companionship in hijra lives see Reddy (2006).
potentiality, however, not within a liberal rights framework. In the next chapter, I study experiences of hijra suicide attempts as narrated in two autobiographies where the authors forcefully assert their personhood, and in doing so, affirm that these experiences do have political potential albeit outside the boundaries of narrow liberal rights politics.

7 Conclusion

The chapter begins with Kanchan’s narrative of her experience with suicide. Hijras, as I have suggested, talk about their experience with suicide in different venues. Kanchan’s narrative, similar to that many other hijras I met, tells her story of loss of love that resulted in her suicide attempt. My aim in this chapter has been to highlight that this narrative of love and betrayal has remained at the margins of two prevailing discourses that have significantly affected hijra lives: medical discourse and sexuality rights discourse.

In the first part of this chapter, I briefly traced the impacts of legal and medical discourses and practices on hijras in India, and specifically in Bangalore. The study of public health/epidemiological interventions demonstrates that hijras were first interpellated as MSMs through HIV/AIDS prevention programs. This demonstrated a certain kind of violence, which was a result of framing hijras through a masculine lens of MSM. This formulation of hijras as MSMs was carried into the later epidemiological studies, which attempted to study as well as address mental health problems among hijras. However, the mental health/epidemiological efforts remained unfinished due to other structural concerns, particularly the lack of funding. In previous chapters, I demonstrated that there have been similar, but more concerted efforts to address suicide as a psychosocial or psychiatric concern among different groups, including farmer suicides. This psy/medical understanding of suicide has expanded within the legal realm,
as seen most evidently in the Mental Health Care Bill 2016. However, as I show, the psy/mental illness discourse was challenged by different political actors, who framed suicides through discourses of class, agro politics, political economy, and caste, among others, thus resulting in a quasi-medicalization. It is in relationship to these parallel occurrences that I have highlighted the cursory effort to medicalize hijra mental health concerns, including suicide, in this chapter.

In the second part of this chapter, I traced discourses on transgender and sexuality rights in India, which has had a close relationship to HIV/AIDS as well as civil liberties discourses. This has led to the identification of hijras as third gender – a state category that could potentially allow them to demand rights from the state. I have demonstrated that both medical as well as rights discourses have remained unaffected by hijra suicides. The reason is, I argue, that unlike the sexuality rights discourse that bases itself on ‘right to love’ and its political potential for universality, hijra suicide attempts are about *loss of love* and betrayal, which are not adequate for rights based political demands. However, as I have described earlier, the hijra assertion for the need to be loved, and the pain at the loss of love demonstrates the larger political potential in hijra experiences of suicide. In the next chapter I explore this point further by studying hijra experiences of suicide as registers of knowledge outside medical and rights discourses.
In the previous chapter, I traced the way in which hijras have become subjects and objects of state governance—initially, through HIV/AIDS prevention work and, more recently, through the Transgender Rights Bill 2016. The activist struggle for hijra rights has been to find a space to live as legitimate citizens of India. The effort to find legitimacy and support for hijras who have attempted or might attempt suicide has occurred (albeit perfunctorily and indirectly) through an epidemiological/public health framework. The only non-epidemiological effort has been by the use of art therapy sessions, which ended due to lack of financial support. The sexuality rights discourse, which is otherwise a predominant mode of discussion regarding the hijras, is relatively silent about suicide or love-suicides. As I have argued in the previous chapter, attempting suicide because of loss of love does not provide adequate legal capital for rights based politics.

Locating hijra suicides within the context of larger politics on suicide in India highlights the convoluted nature of governance of suicide. In the previous chapter, I demonstrated the ways in which hijra suicides have existed at the fringes of both the epidemiological/psy/public health discourse as well as human rights/civil liberties activism. Epidemiological studies on hijra (as MSM) mental health are similar to other mental illness suicide prevention efforts, where there is a concerted push to frame suicide through a mental illness framework. However, this process has currently remains in the process of becoming and, as a result, hijras continue to be at the edges of the public mental health efforts. My aim in studying the rights and medical discourse in hijra lives is not simply to point out the fact that these frameworks do not validate hijra experience, but instead to understand how hijras continue to speak about suicide outside prominent
discourses and constantly assert their personhood beyond what was defined by HIV/AIDS or human rights frameworks.

While narratives of hijra suicides are relatively absent within rights activism, they are present in everyday conversations and autobiographical writings by hijras. As I mentioned earlier, I encountered many narratives of suicide in my conversations with hijras. There was a stark difference between my conversations with hijras associated with HIV/AIDS prevention and/or sexuality rights NGOs, and those hijras who lived in hamams and worked as sex-workers or went for collection. Hijras associated with the HIV/AIDS prevention programs or sexuality rights NGOs, immediately framed me as a human rights researcher looking for stories of abuse and harassment that the hijra community undergoes. These conversations changed as they got to know me a little better, but predominantly, hijras who were in prominent positions in NGOs assumed my role as being a conveyor of atrocities, with a hope that my work would contribute to gaining rights or legal recognition of hijras in India. In contrast to this, hijras who were not associated with any NGO were constantly surprised that I was even interested in them. Their stories often included experiences of suicide attempts. In this chapter, I aim to demonstrate the complexity of hijra lives and analyze suicide in hijras lives within the larger institutional contexts through which their lives are governed.

In addition to analyzing conversations and interviews, in this chapter, I also study two autobiographies written by hijras as forms of knowledge on suicide. I find the practice of archiving suicide experience to be significant because it has the potential of expanding the discussion on suicide, while simultaneously not defining it solely as either a mental health care concern and/or a human rights violation. I study these autobiographies, following the work of Ann Cvetkovich, as repositories of emotion or ‘archives of feeling’ (2003). These autobiographies not only do the work of producing knowledge on the violence and suffering in
hijra lives, they are also archives of feeling which are not necessarily correcting a societal injustice, but are highlighting affect. Cvetkovich also examines depression and its forces with an aim to “depathologize negative feelings so that they can be seen as a possible resource for political action rather than its antithesis” (Cvetkovich, 2012, p. 2). In saying this, she does not suggest that depression needs to be understood as a positive experience. Rather, she maintains that depression continues to be associated with inertia and despair, but suggests that such affect becomes sites of community formation (Cvetkovich, 2007). Influenced by Cvetkovich’s framework, I read hijra autobiographies as repositories of knowledge on suicide which are not found in any other large producers of knowledge on hijra lives. The pain that these autobiographies express can be seen as political, where they communicate their pain without being confined within a narrow liberal framework.

1 Love-Suicide Attempts in Hijra Lives

Couples committing suicide because of family and societal pressures is a common trope in India. Shakespeare’s Romeo and Juliet has been remade into several mainstream Indian movies, and there are several South Asian folk tales that are based on lovers not able to be together because of societal and familial restrictions.¹⁹⁹ Love in these stories usually fosters a sentiment of defiance of convention and a fight against injustice. Apart from fictional stories, one often encounters news reports of inter-caste and inter-religious couples committing joint suicide as a gesture of their love and defiance.²⁰⁰ In this section, I recount two (of many) conversations I had

¹⁹⁹ For Romeo and Juliet remakes see Hindi films Qayamat Se Qayamat Tak (1988), Goliyon Ki Rasleela...Ram-Leela (2013), Ek Duuje Ke Liye (1981) and the Malyalam film Chemmeen (1965). Heer-Ranjha, Mirza-Sahiban are two examples of such tragic romance stories from Punjab region.

²⁰⁰ Here are a few news reports on couples committing joint suicide: “Engineering students in love” (2013); “Lovers hang themselves” (2016). “Young lovers commit joint suicide” (2015); “Couple Ends Life” (2015)
with hijras in Bangalore where they narrated their experience with suicide because of loss of romantic love. Unlike the *Romeo and Juliet* narrative, these narratives of suicide do not stem from a sense of defiance towards society, nor are they the type of couple suicides which form the basis for ‘right to love’ discourse. In not being obviously defiant, these experiences of suicide attempts remain “quasi-events” that gain little attention in society (Povinelli, 2011). These are events that “never quite achieve the status of having taken place” (Povinelli, 2011, p.13). I recount conversations with Akanksha and Raveena to explain love and suicide in hijra lives.

### 1.1 Conversation with Akanksha

Sameera, a hijra who was helping me conduct research in Bangalore decided that we should go meet her friends in Mudalpalya, an area that used to be a village in the outskirts of Bangalore, but is today an urban village. Sameera told me it was not a hamam, but a hijra home, which was headed by her friend Akanksha. Akanksha was the Guru in that house and she had about six chelas living with her. The house was on the second floor in a three-storey apartment building. As we entered the house, I saw that a person was lying down on the floor and one of the younger hijras was pressing her feet, while the others were sitting on the floor watching Kannada day time soap-opera. I guessed the person whose feet were being pressed was Akanksha. She looked older than the others and she obviously commanded respect. As we entered, they all recognized Sameera and the younger chelas shifted around to make space for us to sit. Akanksha smiled and asked Sameera some questions about how she is doing, how is work going on, and as an aside she instructed one of her chelas to make some tea for us. Within minutes Sameera had introduced me to them and we were drinking tea and chatting. I explained that I would like to speak to them individually and Akanksha then asked her chelas if they wanted to talk. They all smiled.

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201 Both these names have been changed to maintain anonymity.
awkwardly at me and I made my little effort to encourage them saying that I was going to ask questions about their lives and their journey and they could stop anytime they wished. Finally one of the more senior hijras volunteered and we were given one of the rooms to have our conversation. Over the next several hours I spoke to all the hijras who were willing to speak but was still very much interested in speaking to Akanksha. She seemed to be in control of the house and was constantly instructing her chelas to do various things, so I was a bit intimidated to ask her. I asked Sameera quietly if there was a possibility that Akanksha would be interested in speaking to me. Akanksha overheard this and said to me in Kannada “You speak to the younger ones. Why speak to me? Their story is more important”. I responded by saying that I want to know her story as well. She needed a bit of coaxing but we were soon in the room with my recorder having a long conversation. Here, I want to focus on one part of this longer conversation. We were talking about the younger hijras in her home and Akanksha was telling me about how they are so desperate to fall in love. She said:

I keep warning them that men only say they will be with you forever, but they all leave. They marry you one day and they find someone else the next day. They will leave and you will be left all alone and then all you want to do is to die. It is better to depend on your guru, it's better to depend on your sisters. But these young girls always want to fall in love and get hurt and then they take poison or try to hang themselves. If there are no men, then no trouble only. I too was young once and I know what it feels like when a man makes promises and then leaves you and you are in so much pain that it feels like it's better to die than live. In the past I was also tired of my life and tried to end it all because of a man. I tell them (her chelas) it's better for us to be together than trust a man. But I can’t control them, they all go and fall in love. For people like us, getting attached to men is dangerous”.
She continued after a pause “...but I also understand, we all want someone to be with us, someone we can depend on, someone who cares for us. We also want to be loved.”

1.2 Conversation with Raveena

I met Raveena for the first time when I visited a DIC in Malleshwaram in Bangalore. The DIC is located behind a very busy main road. I wanted to spend some time there and get to know the people who frequented this center. I was sitting in a corner talking to one of the HIV/AIDS peer-counselors when Raveena walked up to me and bluntly asked me who I was. I introduced myself and she said in Kannada in an exasperated way, “oh one more researcher studying us!” I embarrassedly smiled and nodded in agreement. She then asked me if I wanted some tea, I nodded yes and we walked together to get tea on the opposite side of the room. As we started drinking tea, Raveena pointedly asked me if I would do an interview with her. I readily agreed. As a researcher, it was usually the other way around, me asking people for their time and information. We quickly found a space in the DIC. Raveena informed others not to disturb us and shut the door.

I began by explaining my area of research, my interest in the hijras in Bangalore, and asked her to tell me about herself. After that question, I did not ask any question for at least twenty minutes. Raveena spoke and I listened. She told me about the village she grew up in, which was in the outskirts of Bangalore. Ever since she was a child she felt like a girl. She liked to do women’s chores at home, such as cooking and cleaning. Her favorite activity was waking

DICs emerged as spaces for HIV/AIDS counseling for ‘sexual minorities’ as well as safe spaces for people from the queer community. They are mostly frequented by working-class queer people. This DIC is an apartment converted into an office space. It’s a pretty busy space. People come here for various reasons, ranging from getting help to fill forms for a government issued identity card to picking up condoms before they head out for sex work. A lot of NGO related paperwork also happens in this office space.
up early every morning and cleaning the front yard and drawing the rangoli.\textsuperscript{203} When Raveena was young, her family did not mind that she was doing household chores or that she liked to wear her sister’s skirts. They actually encouraged it and thought it was sweet. During this time, her sister was learning dance, and Raveena would accompany her to the dance class, learn some moves, and come back home and practice in front of the mirror or even sometimes perform for her family. She did not like to go out and play with other boys. Although her family encouraged her to play with boys, they were okay with the fact that she only had girls as friends. Raveena emphasized that this was the best time of her life. But this did not last long. Around the time that she turned thirteen, her family started complaining about her behavior. They had stopped her from wearing her sister’s clothes or from cooking and cleaning. Her brother had started beating her to get her to be more of a man. Raveena mentioned that this abuse only increased with time. By the time she finished her tenth grade exams, around the age of sixteen, the situation was very bad. Around the same time that Raveena met some hijras who worked as sex workers near the local bus station. She felt like they understood her and so she began spending a lot of time with them. Gradually, she too began to engage in sex work. Over time, without her being aware of it, several of her brother’s and father’s friends had become her clients. And it was through these clients, the news of her working as a sex-worker reached her family. One day when she went back home in the afternoon, her brother beat her and then attacked her with a knife, threatening to kill her if she did not leave home. She said her sisters and her mother just watched in silence as she packed and walked out of home in tears. A hijra friend of Raveena’s suggested that she leave for Bangalore because there was no hope for her in that village. Raveena left her family and village at the age of sixteen never to return. While narrating this incident, Raveena’s face

\textsuperscript{203} Drawing a rangoli is a ritual in Hindu homes in India. Rangolis are patterns created on the floor in living rooms or courtyards using materials such as colored rice, dry flour, colored sand or flower petals. Rangolis are traditionally drawn by the women in the household.
was streaming down with tears. She said, in Kannada, “avaginda bari hodadaatha nanna life nalli” “ever since then there has been only fighting and violence in my life”.

After leaving her village, Raveena came to Bangalore, where she met other hijras at the Majestic bus stand (Kempegowda Bus Station, the main city bus station in Bangalore) who helped her find a Guru in Bangalore. Soon she began to work as a sex worker. It is during this time that she met Ravi, a local autorickshaw driver who was her client.204 They fell in love and he asked her to marry him. They went to a temple and got married. They were happy for a while until Ravi started borrowing money from her. Raveena said it started as low as five hundred rupees and increased to fifty thousand rupees, which she had to borrow from her friends. If she didn’t pay him, he would beat her, with belts, kitchen utensils, or anything he could lay his hands on. Often he would keep her locked at home through the day, and let her out in the night to go earn money as a sex worker. Without emphasizing it, Raveena mentioned that Ravi was married to a ‘real woman’ and had two children. She said, “just because he was married to me, doesn’t mean that he should not have children and a happy life. I can’t provide him with all the happiness he needs. I loved him. I think I still love him, I would do anything for him” she said.

One day he stopped coming home, stopped calling her and ignored all her messages. Raveena reached out to his friends, but they too kept their distance from her. He had simply disappeared. Those days, Raveena would stay home all day and night drinking rum, hoping he would come back, but he didn’t. Her friends from the hijra community had distanced themselves from her ever since she started living with her panti. On hearing about her situation, some of her old friends reached out to her, but Raveena said to them that she wanted him or wanted to die. One night, after two months of waiting, she heard that he was living with another hijra, and had

204 Autorickshaws are a major form of public transport in Bangalore. They are three wheeled vehicles that are carry 3–4 people. Many hijras I met had clients, boyfriends and husbands who worked as autorickshaw drivers.
married her in the same temple he married Raveena. That night she drank *old monk* (a type of dark rum), tied her sari into a noose to the ceiling fan and tried to hang herself. Raveena looked away from me at that moment, and said sadly, “*aadhare naanu saayalilla*” “*but I didn’t die*”. We were both silent for a few minutes. Raveena continued, “*Ravi valle panti alla, avnu nannida duddu kithkonda, nannana madve madkondo aaamele bere hijra nu maduve aada, aadaru avanige naanu kaade. Namma life heege, yaavagalu loveu loveu antha namma thaleli…aadhare namage yaavathu sigalla*” “Ravi wasn’t even a very nice panti. He didn’t respect me, he took all my money and he cheated on me with another hijra. *But in a hijra’s life, we are always looking for love but we never seem to find it.*”

My conversation with Raveena was very difficult, but unfortunately the sentiments she expressed were not unique. In my interviews and conversations with other hijras, loss of love and betrayal by husbands/boyfriends was an oft-mentioned narrative of suicide. I heard many of them express similar sentiments: “I have always wondered, why live a life that is so painful?”; “I loved him and he used me, I would rather die than be without him”; in another interview, a hijra mentioned, “This life seems like a punishment, so thought why not simply die?”; “what have I done to deserve such a harsh life? With no love, then why try living it?” Throughout my fieldwork, I was surprised about how open hijras were to speaking about their experiences with their own suicide attempts as well as other suicide incidents within the larger hijra community. There was an overwhelming presence of suicide in most of my conversations with hijras. Almost everyone at some point in our conversation brought up the topic of suicide, and opened up about their life’s deepest emotions, feelings, and decisions. I heard them repeatedly say to me, “who is interested in our stories? Who thinks about people like us? No one cares if we live or die.”

As I mentioned earlier, love-suicides are not an unusual phenomenon in India. We constantly hear news reports of inter-caste and inter-religious couples choosing joint suicide over
life. Scholarship on queer suicides in India, mostly lesbian suicides, has seriously engaged with the idea of love driving lesbian couples to suicide. In this regard, Ruth Vanita examines the idea of ‘love-death’ and states: “If marriage is a public statement of a couple’s intent to live together, joint suicide or love-death, wherein a couple express their commitment by dying together, can also function as a type of marriage – a public statement of intent to be united forever…[d]eath may make visible and public on this earth a love that society would not permit to be consummated in marriage” (2005, p.124). Vanita makes the argument that same sex couples (mostly women) who have committed suicide in the Indian subcontinent have positioned themselves through notions of love and marriage, while simultaneously putting themselves beyond state interference (2005, p.125). Her argument is that either through wedding or through suicides women (mostly lesbian women) have made their relationship visible through a “cross-cultural language of love” (2005, p. 7). For Vanita, lesbian suicides have claimed a space for display of love through joint suicides, which she argues is a cross-cultural language of love. She reads into these suicide acts the poetics of love, marriage and defiance.

Similarly, Navaneetha Mokkil (2010) in her study of lesbian suicides in Kerala analyzes a series of interviews conducted by Sahyatrika (an organization working for rights of women-loving-women) on suicide by two young women Ammini and Meera, in a rural area in central Kerala in August 2001. Mokkil uses these interviews to understand ‘lesbian haunting’ and the manner in which this suicide incident and the memory of it fuel the demand for justice. Drawing on Avery Gordon’s work, Mokkil argues that lesbians who have committed suicide emerge as social figures that are produced at the site of violence and exclusion (2010, p.191). This social figure, she further suggests, is a mobilizable figure that haunts the public sphere of Kerala and hence it is necessary to examine this process of haunting to understand the complexities of sexual politics.
Lesbian suicides in India are mostly by young couples in non-urban areas. Many times they leave notes stating that their families had either tried to separate them or were trying to force them to get married to other men, or that they had to suffer abuse from the family because of their relationship.\textsuperscript{205} The scholarship surrounding lesbian suicides in India connects the poetics of love and suicide to sexuality, politics, family, rights and activism. Hijra suicides are different from lesbian suicides (or other inter-caste, inter-religious couple suicides). In my research, I often found individual hijras attempting suicide due to loss of love rather than for love. Hijra suicide attempts were not couples declaring their love publicly by attempting suicide. Individual hijras were often in despair due to loss of love and so attempting suicide. Another significant difference is that these were attempts at suicide. This is a rather crude observation, that the suicide incidents that hijras spoke to me were not incidents of completed suicides; they were attempts at suicide, which had not resulted in death. As I demonstrate below, the fact that these are individual suicide attempts is of significance.

Throughout my fieldwork, I was struck by the number of hijra love suicide stories but was not entirely certain how to deal with this preoccupation with love-suicides and do justice to these experiences while writing a sociolegal dissertation. It was only in writing the earlier sections that its significance became obvious: I did not find this narrative anywhere within the rights or the medical discourse which dealt (albeit to a limited extant) with the issue of suicide within the hijra community. And the only way love has entered sexuality rights activism is through the liberal rights (right to love) framework. Within this framework, love is understood as having the potential to break archaic and violent patriarchal social systems (Narrain and Gupta, 2011).

\textsuperscript{205} See Dave (2014).
Suicide attempts by hijras are neither overtly political acts that are directly connected to demands of rights from the state, nor are they actions that are exclusive to hijra lives. Hijra love-suicides are in many ways similar to any other person (irrespective of gender, sexuality, class, caste, occupation) attempting suicide because of failed love. Hijra suicide attempts are neither public demonstrations of defiance or strength as is the case in hunger strikes or self-immolation.

Importantly, hijra suicide attempts are unlike lesbian suicides or farmer suicides, which are to put it crudely, ‘completed’ suicides. The hijra suicide narratives I encountered are more about the suicide ideation (borrowing the term from the psy literature on suicide).\textsuperscript{206} By this I mean that many narratives I collected were stories of suicide attempts. These had not resulted in deaths. Unlike love-death described by Vanita, where the couple’s suicide is also functioning as marriage, a public statement of intention to be united forever, what we see in the context of hijra suicide attempt narratives is the impossibility of such a public statement of love. Here, death has been attempted, but the potential that a ‘completed’ suicide act carries, that of a future as “forever”, “the afterlife or future life” (Vanita, 2005), is curtailed in attempted suicide narratives.

Even in instances where certain hijra suicide incidents were ‘completed’, there too the future would not be a display of a “successful” love, having a potential for a public statement. It simply would exist as an incident indicative of suffering and isolation, whereby loss of love remains unacknowledged. In such a context, as I have mentioned earlier, hijra suicide attempts

\textsuperscript{206} I use the term ‘suicide ideation’ to capture a range of suicidal thoughts that were expressed by hijras I met in Bangalore. According to Centers for Disease Control and Prevention, USA, suicide ideation is characterized by individuals having suicidal thoughts that can range in severity from having passing thoughts about not wanting to live anymore through making plans to kill oneself. Similar definitions are used by several epidemiological studies to understand suicidal behavior.
remain “quasi-events” (Povinelli, 2011). Certain kinds of events, such as a crisis or catastrophes, Povinelli argues, demand an ethical response, but quasi-events do not (Povinelli, 2011).\(^{207}\)

Although hijra suicides remain as quasi-events, not recognized within liberal rights frameworks; archiving their experiences of loss of love and suicide also demonstrates a declaration of hijra personhood as I demonstrate in the study of hijra autobiographies in the next section.

2 Hijra Autobiographies as Archives of Feelings

In this section, I focus on accounts of familial abuse and betrayal leading to suicide attempts, as narrated by hijras in their autobiographies. I began studying these autobiographies while I was searching for hijra suicide accounts. These are key texts for two reasons: first, they have been written by hijras themselves and second, they are archives of experience with suicide that are not bound by legal or medical discourses. Thus, unlike the epidemiological/public health projects on suicide prevention, these autobiographical texts highlight and address the topic of suicide without making it a medical or a legal category for direct liberal political action.

One of the important functions such autobiographical texts perform is that they shift the hegemonic discourse. Mainstream society’s imagination of hijras is that they are shameless, dirty, and a nuisance. Hijras largely exist at the peripheries of middle and upper class social imagination. The idea that hijras are ‘dirty’ and ‘shameless’ is because a large part of hijra livelihood comes from street based sex-work and by going for collections to stores and/or at traffic signals. It is because of this that hijras are heavily policed, become targets of police

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\(^{207}\) The only instance where I see an acknowledgement of hijra suicides by the state is when these suicide narratives are used to describe the abject condition in which hijras live their lives. For example, see Ministry of Social Justice and Empowerment Report 2014, and the epidemiological project initiated by KHPT in Bangalore, which attempted to study hijra mental health that I analyzed in the previous chapter.
violence and are thought of as a nuisance. One of the most prominent threats that hijras use during collections is to expose their genitalia if their demands are not met. This behavior, along with the fact that they disrupt several middle-class sensibilities, leads to the idea that the hijras have no “sharam or shame” (Vyas & Shingala, 1987, as quoted in Reddy, 2005a, p.257). Further, for most upper and middle-class Indians, hijras barely exist in their everyday social life and only become visible during certain rituals. As mentioned earlier, hijras are seen to have the power to bestow blessings or to curse. So they become important during the birth of a child or during weddings. This phenomenon is much more prevalent in the northern parts of India and not so popular in Bangalore or in other parts of south India. During my fieldwork, many hijras I met in Bangalore traveled to Ahmedabad (a city in Gujarat, in the North-Western part of India) during the wedding season because they could earn more money there than doing sex-work or going for collections in Bangalore. Within these limited frameworks through which hijras are perceived in India, I see value in these autobiographies because they are registers of knowledge produced by hijras which alter mainstream derogatory public discourses.

Mariana Valverde discusses the relevance of autobiographical tales of intoxication as archives of minor discourses in the context of addiction and recovery (Valverde, 2002). She writes about Foucault’s interest in low-status texts as an effort to look for practices that were neither moralistic nor psychological, and suggests that by looking at these texts, Foucault “exposes the ways in which the work done on the front lines by those inventing, evaluating and trying out ‘minor practices’ has left a rich archive documenting, and often critically analysing, the main techniques of governance characterising advanced capitalist societies” (Valverde, 2002, p. 4). Specific to the Indian context, I draw inspiration from Dalit life-writing to study hijra autobiographies. Dalit literary studies have understood the potential of life-writing by people from severely marginalized communities. Scholarship on Dalit literature has engaged with Dalit
writing as an assertion of their voice within a violent history of forced erasure within Indian history and theory (Limbāḷe, 2004). Saranakumara Limbāḷe states “Dalit literature is precisely that literature which artistically portrays the sorrows, tribulations, slavery, degradation, ridicule and poverty endured by the Dalits. This literature is but a lofty image of grief” (Limbāḷe, 2004).

One significant aspect of the larger Dalit literature is the autobiographies or as some literary scholars have termed it, testimonio (Rege, 2006; Nayyar, 2006). Speaking about Dalit women autobiographies, feminist scholar Sharmila Rege explains testimonios as that “which forge a right to speak for and beyond the individual, and contest, explicitly or implicitly, the ‘official forgetting’ of histories of caste oppression, struggles and resistance” (Rege, 2006, p.13). The term testimonio gained popularity in biographical studies in the 1990s and it reflected first person narratives of abuse suffered by marginalized groups. An important characteristic of the testimonio was that along with narrating a first person account of suffering and survival, it also reflected the abuse and violence suffered by the whole marginalized community (Nayyar, 2006).

Hijra autobiographies, taking inspiration from Dalit literary criticism, can be understood as testimonios. Both hijra autobiographies and Dalit life-writing are not narratives that can be found in newspapers or in any human rights documentation of violence. These are nuanced records of grief and suffering in their lives. These narratives have reclaimed the narratives of abuse outside the human rights framework, or media representation of suffering, to reassert hijra or Dalit personhood (Rege, 2006). Debjani Ganguly has argued that terming Dalit life-writing as testimonio is inadequate to convey the complexity of Dalit personhood (Ganguly, 2009).

Ganguly argues that the term testimonios largely reflect human rights violations in Dalit lives,

208 It is important to mention that not all Hijras are Dalit. And Dalit literary criticism has argued that Dalit life-writing is a particular reflection of Dalit pain. And so in referring to Dalit life-writing to understand hijra autobiographies, I do not mean to equate Dalit suffering with Hijra suffering (although some might argue that they are very similar). My aim in referring to Dalit life-writing is to draw upon a similar theoretical framework to analyze hijra autobiographies.
whereas Dalit life-narratives often reflect concerns that are more complex than questions of citizenship and legal subjectivity (Ganguly, 2009). She takes examples from Dalit life-writing to demonstrate that these writings reflect the Dalit community’s experiences of suffering, but also highlight a particular Dalit pain, which by definition cannot be universal (Ganguly, 2009).

As Dalit scholars have argued, their suffering is particular to Dalits, a reflection of specific historical pain and suffering (Limbāle, 2004). But following Ganguly, I see hijra autobiographies as a reflection of complex struggles, which operate largely outside particular concerns of human rights abuses. It is outside the scope of this work to study these autobiographies in their entirety; I focus mainly on role of suicide attempts within them. Even within the limited scope of this question, hijra autobiographies are important and unique registers of knowledge on hijra suicides. This genre of writing, like the narrative of Raveena which I mentioned earlier, can be seen as an integral aspect of the emergence of the hijra personhood as a figure of survival.

In the autobiography, *The Truth about Me: A Hijra Life Story*, A. Revathi (2010) narrates an incident when she was about fifteen or sixteen years of age. She runs away from home to Delhi in search of a guru and to live as a woman. In Delhi, Revathi adorns herself with saris and jewelry and begins to beg on the streets. Her family soon finds out and she is asked to return home saying that her mother is very unwell. Revathi returns to Namakkal, her hometown, in Tamil Nadu in South India. Here, she once again has to wear trousers and shirt, and has to pretend to be a man because she is afraid how her family would react to her in a sari. As soon as Revathi enters her home, worried for her mother’s health, one of her brothers beats her black and blue:
As soon as I stepped in, he shut the door, grabbed a cricket bat, and began hitting me, all the while screaming, ‘That’ll teach you to go with those Number 9s. Let’s see you wear a sari again, or dance, you mother-fucking pottai!’ He beat me hard mindlessly, yelling that he wanted to kill me, I who had dared to run away. I tried to protect my face and head with my hands to keep the blows from falling. But nevertheless they came down hard, and I felt my hands swell. I was beaten on my legs, on my back, and finally my brother brought the bat down heavily on my head. My skull cracked and there was blood overflowing, warm. ‘That’s right. Beat him and break his bones. Only then will he stay home and not run away,’ I heard my mother say. (Revathi, 2010, p.55)

Revathi then goes and locks herself in a room and she writes “It seemed to me then that it was better to take my own life than let my brother beat me to death” (Revathi, 2010, p.55).

In the autobiography titled I am Vidya: A Transgender’s Journey, Living Smile Vidya (2013) explains a situation when she is tired of pretending to be a man in front of her family and friends. She explains this to her friend, who tries to dissuade her from coming out and instead encourages Vidya to continue her education, earn a PhD, get a job and take care of her family like “a good son” (2013 p.56). Vidya states, “No, I couldn’t live any longer as a man. If I could not become a woman, I’d rather die. I wasn’t confused now. I had come to a clear decision, and it burst out in words. Suicide has been an option in my mind over the last few days.” (2013, p. 56) She goes on to say, “I was going to try and live as a woman. If I failed, I was ready to die.” (2013, p. 56).

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209 “Number 9” is a taunt that is frequently hurled at hijras or transgender women. In parts of North India, “Number 6” is used to taunt hijras and other transgender women. I even heard that Number 69 is used as an insult as well. These are all derogatory terms. I could not muster up the courage to ask any hijra I met the etymology of Number 9 and so I am not yet certain about why these numbers act as derogatory terms.
In another instance in the book, Vidya narrates an incident of her suicide attempt. In the beginning of the book, we are a witness to the complex relationship shared by Vidya and her father. She describes how her father who would physically abuse her to push her to work harder and do well in school and to come first in her class. Their relationship contained love but was tainted with fear and physical abuse stemming from the pressure to excel at school. In a later part of the book, when Vidya meets her father in a sari, he refuses to meet her unless she changes into trousers and a shirt, and even then he has trouble accepting her for who she is. In this narrative we, as the readers, become witnesses to her pain. Vidya illustrates her father’s violence towards his family and explains the motivations for his abusive behavior. She grapples with being sympathetic to her father’s expectations and ambition for her as well as satisfying her own desires and aspirations. Throughout the book, Vidya explains her growing up years as traumatic since she had to hide the fact that she felt herself to be and wanted to live as a woman. She describes one instance when, as a seventeen year old studying in Class XI, she comes home with 74% in a public exams and her father punishes her for securing low marks. For the first time she stands up to her father – yells back at him and pushes him. This Vidya describes as “something no one had expected and something unforgivable” (2013, p. 30). Following this outburst, Vidya takes a sari lying close by and tries to commit suicide by hanging from the ceiling fan. A family member stops her in time.

In both these above-mentioned instances in the two autobiographies, we see the description of brutal physical violence, the sense of betrayal from the family and, in such a context, there is the act of attempting suicide. In Vidya’s writing, we see that she stands up to her father and is unable to come to terms with the violence of the situation. Later in the book, she describes this as “Shock, wailing and the shame of defeat turned the evening into some kind of theatre of the absurd” (2013, p. 30). Explaining the dramatic nature of events, but keeping true to
its bleakness, Vidya provides the complex reasoning for her suicide attempt. In Vidya’s description of her difficult relationship with her father, she not only focuses on the sex/gender concerns but also on the pressures of excelling in education and heteronormative notions of being “a good son”. These narratives explain the complexities of hijra life without the singular focus on sex/gender that traps other narratives on hijra lives. For both Vidya and Revathi, suicide does not exist as an exceptional category as we see often in public health suicide prevention programs. It exists as part of their complex lives and the violence within their lives. In Chapter Two, I analyzed a farmer suicide prevention program where the act of suicide by the farmer was identified as a problem; therefore, technical solutions such as regulating the access to pesticides were provided. Since the act of suicide was isolated from the farmer’s larger life in this public health model, a depoliticized program of pesticide control could be designed. Whereas, these autobiographies produce a narrative wherein suicide is not isolated and identified as a specific ‘problem’ that requires technical solutions. Instead, within these autobiographical narratives, the reader is pushed to understand the nuances of hijra life.

In an interview with Revathi, published in a prominent national daily following the release her book, she is asked about her interest in writing. She says, “Writing, for me, is a way of bringing together the two worlds that I am part of – the hijra community and my family…. [W]riting makes these two worlds talk to each other” (Manayath, 2010). In another interview, Revathi says, “I have not written this book to express bitterness or settle scores. I am just telling my story as it happened and hoping people would understand someone like me better” (Bageshree, 2010). As we see in Revathi’s interviews, she uses the medium of writing her life stories with a hope that people will understand her better. In both the autobiographies, there is an attempt to make the reader understand their lives as well as become a witness to the sufferings they have undergone. Here the reader is not a direct witness, but in reading and consuming the
knowledge of the book—their life trajectories and brutal experiences that are stated in the most blunt manner—the reader is now a witness to the suffering and humiliation. In stating some of the private and painful, violent instances of their lives, which are shrouded by public secrecy and morality, the reader is now a witness to the secret, and is transgressing certain social boundaries by gaining knowledge that is meant to be in the realm of the private. An aspect of being a witness is to also witness the experiences of suicide.

The two narratives of suicide mentioned in the autobiographies, do not exceptionalize the experience of suicide; it is merged with other experiences of pain. Suicide incidents seamlessly enter the narrative. In her work on queer activist lives in America, Ann Cvetkovich argues that “Affect is often managed in the public sphere through official discourses of recognition or commemoration that don’t fully address everyday affects, or through legal measures (ranging from the abolition of slavery and segregation to affirmative action) that don’t fully provide emotional justice” (2007, p. 465). In such a context, Cvetkovich explains that ‘archives of feeling’ are cultural texts that are repositories of emotion in their content, production, and reception (2003, p. 7). For Cvetkovich, emotion is ever present in queer history. Hijra autobiographies emerge at the fringes of the predominant rights discourse and public health discourse on suicide to provide an archive of affective knowledge on their lives including familial love, betrayal and suicide. These autobiographical narratives capture particular experiences of loss of love and familial betrayal leading to suicide attempts, not to demand rights from the state. The aim in these autobiographies does not seem to be to gain legal capital for a rights struggle but to assert their personhood through pain.

Naisargi Dave differs from Cvetkovich’s assumption that emotion is ever present in queer history (Dave, 2012). She argues that Cvetkovich sees affect as central to gay and lesbian archival practices as corrective to institutional and cultural neglect. But what Dave finds in
lesbian activism in Delhi is that precisely because of the institutional neglect of lesbian politics, and because of the desire to render that politics respectable, the lesbian activists worked towards limiting the expression of feeling. Dave states, “the dampening of affect need not render this archive any less an ‘archive of feeling’, but it might instead help to productively delimit what such an archive is: not an archive of emotion itself, but an archive of a history of emotion in its uneasy relationship to the political” (Dave, 2012, p. 35-36). In the context of lesbian activism in India, Dave argues that affect was both the necessitating condition for the emergence of the new radical world and also that which had to be disciplined into politically appropriate feeling in order for this emergent world to present itself, both to itself and to the social world, as a community (Dave, 2012). In lesbian activism, affect was restrained to gain political respectability. On the other hand, in the context of hijra suicides, affect is simultaneously subdued as well as highlighted to gain political respectability. Certain forms of affective expressions, such as suffering due to police violence, are highlighted in the civil liberties/human rights discourse to gain political recognition. Certain other affective experiences, such as betrayal by a lover or family leading to suicide attempts, are subdued in the rights discourse but are visible in the autobiographical writings. We find such narratives in the autobiographies mentioned above and in the conversations I quote. In these registers of knowledge, there is a constant presence of affect at the center of the discussion. As Cvetkovich argues, archives “must preserve not just knowledge but feeling” (2003, p. 241). In the hijra archiving practices such as autobiographies, emotion is at the center of narrative (loss of love, despair about love) and this is not necessarily “corrective to institutional neglect”, but provides an alternative, affective discourse which is unavailable elsewhere.

In building an archive of feelings, either by writing autobiographies or by participating in the interviews, where all the conversations or even the books are brimming with narratives of
humiliation, love, betrayal, sadness, the hijra women are not using this to demand some fundamental rights from the state. To give these efforts a precise purpose would be unfair. They are archiving their abject conditions. Supporting the rights discourse could be one aim of the autobiographies, but it is not solely that. It is an effort to archive their life. It is an effort to make society listen to their life stories. Such an archive has a larger political potential than liberal rights discourse.

I dwell on these archiving practices in detail, because I am interested in registers of knowledge that have the ability to exist at the fringes of governmentality. In the context of suicide prevention work, as we have seen in the context of farmer suicides (Introduction and Chapter Two) or the recent mental health care legislation (Chapter Two) which is attempting to frame all suicide attempts as a mental illness/clinical problem, these autobiographies are complex registers of knowledge which are produced not by an external agency or discourse but instead answer Gayatri Spivak’s famous question ‘Can the Subaltern Speak?’ with a definitive, ‘yes’.

3 Echoes of Suicide in Hijra Lives

In this and the previous chapter, I have demonstrated that hijra suicides exist at the edges of the transgender rights discourse. Due to their emphasis on loss of love and betrayal, hijra suicides have not emerged as a category within the liberal logic of rights, unlike Dalit student suicides or farmer suicides. Precisely due to the emphasis on loss of love, hijra suicides do not gain attention for being “exceptional” within either celebration of queer love or the right to love rhetoric.

In addition, the experiences of suicide as recorded in the autobiographies or in the conversations I recount, do not exceptionalize the act of suicide. Suicide attempts emerge within
a nuanced life-narrative, not as a separate health problem that requires technical solutions as we saw in farmer suicide prevention programs in Chapter Two.

I read these narratives of suicide in the context of the institutional discourses present in hijra lives. I think of hijra autobiographies (and to some extent interviews) as repositories of knowledge on suicide. Such narratives are not found in other large producers of knowledge on hijra lives. The pain that these autobiographies and interviews express is political, but without working within a narrow liberal political framework of rights and with an aim of communicating their pain as expression of personhood. Hijra narratives I have recounted in this chapter present hijra lives outside the liberal models of governance and care. Hijra suicides are both distinctive and universal. They are distinctive because in an environment where medical/psy regulation of suicide is gaining attention, hijra suicides are relatively absent in public health initiatives. In the vibrant context of sexuality (particularly transgender) rights activism, hijra suicides are once again relatively absent. Concurrently, I read hijra suicides as being universal because the concerns hijras are expressing are not necessarily exceptional to hijra lives, but common across gender, sexuality, class, caste, and religion in India. They have found a way to speak about suicide without exceptionalizing it to either their own lives or to the act of suicide. However, as is evident throughout this chapter, while hijras might have archives of feelings, a space for healing is clearly absent.
Conclusion
Suicide as an Elusive Target of Law and Governance

In concluding, I would like to highlight two important themes that run throughout this
dissertation. The first concerns the complex and constantly shifting roles played by different
representations of different kinds of suicide within Indian law and legal reform debates; and the
second concerns the political implications of the conflicts and inconsistencies documented in this
study of regulation of suicide in India.

1 Suicide in Law
Suicide, as the title of this conclusion suggests, is an elusive target of both state and non-state
governance. Attempts to regulate suicide have been undertaken by criminal law, mental health
care laws, and public health care efforts, to name a few. Within criminal law discussions alone,
one finds religious, psychological, psychiatric and other discourses that have been variously
deployed to help law regulate the act of self-caused deaths. However, such efforts have not
succeeded in completely regulating suicide or even drawing firm boundaries around 'suicide' by
separating it from other types of death.

1.1 Eclecticism of Law
It is commonly thought that the court system provides or should provide clarity on socially
disputed ideas, circumstances, or behaviors. However, instead of providing clarity, in regard to
the politically contested entity that is 'suicide', the courts in India have generated multiple
conflicting viewpoints. Studying how suicide is constructed and regulated within criminal law
has revealed several contradictory judicial discursive constructions of suicide, thereby leaving
law open to multiple readings. For example, suicide is understood as both natural and unnatural, a threat to the sovereign power, as well as an individual’s right to practicing religious rituals. It seems that instead of generating regulatory clarity, legal efforts to draw boundaries around 'suicide' and to separate criminal acts of self-inflicted death from non-criminal ones have only exposed and exacerbated existing contradictions and uncertainties—uncertainties that exist in judicial and legislative discourses as well as in the larger civil society.

Such diverse conceptions of suicide in criminal law are only possible because of law’s unique relationship with extra-legal knowledge systems. Law has the ability to absorb content from different knowledge systems as it seeks to provide a legal explanation or justification for a human action. Law, as Valverde reminds us, is ontologically thin and hence has the ability to easily choose from a number of knowledges and shuffle them as needed (2003b). It is because of such a characteristic that one finds creative and diverse interpretations for the act of suicide in India, especially in criminal law.

The recently introduced mental health care laws differ from criminal law in their approach to suicide. Mental health care laws attempt to define all acts of suicide as mental health concerns, in a way that is less flexible and internally contradictory than criminal law. (Although if these laws go on to being implemented we could well see inconsistencies and conflicts at the enforcement level, as the sociolegal literature would suggest). Studying suicide in law demonstrates not only the heterogeneity of meanings associated with self-caused deaths in India, but also the key sociolegal point that law itself is not at all homogenous.

In Chapter Two, I compare criminal law debates with public health suicide prevention programs. The evolution of public mental health suicide prevention efforts has shown that there is a growing support for psychiatric explanations and treatment for suicide acts. Such a support is closely connected to the history of public health care in India where there has consistently been
an over-reliance on biomedical/pharmacological treatment. However, not all public health suicide prevention programs are psychiatric/biomedical in nature. Public health programs are hybrid and take up the task of preventing suicide through non-biomedical, psychosocial approaches that merge with social work or community work approaches. Public health suicide prevention programs and discourses are thus more eclectic than the purely psychiatric/biomedical approaches; but they are not as openly eclectic as criminal court judgements.

2 Discourses of Suicide

While discourses are not autoeffective, specific discourses allow for specific practices of regulation. In Foucault’s work, discourse is, “not merely a surface inscription, but something that brings about effects” (Davidson, 1997, p. 4-5). For Foucault, power/knowledge is a systematic collection of discourses and practices that share a particular logic, where any form of power is closely linked with a specific form of knowledge. In this dissertation, I have traced not only the presence of multiple discourses on suicide that circulate within the legal and medical realms, but I have also demonstrated that certain specific discourses have the potential to permit a specific set of regulatory practices.

In the discussion on farmer suicides in the Introduction, I explain the role of leftist activists who struggled to make farmer suicide a political concern. They fought to make the National Crime Records Bureau, which collects annual statistics on suicide in India, include data on farmer suicides. After doing this, the high rates of farmer suicide that became visible in the statistics were attributed to the impact of the neo-liberal economy and the state’s apathy towards agricultural employment. The leftist activists, through a political economy discourse, provided a
framework to understand and address the crisis of agrarian suicides. However, in Chapter Two I demonstrate that political economy discourse is contested by public health discourse, which stays away from global political economy analyses and instead tries to pragmatically address agrarian suicide through limiting physical access to pesticides. Such an impetus, I argue, can amount to a depoliticization of suicide. By using the term ‘depoliticize’, however, I do not suggest that regulating access to pesticides or treating farmer suicide as an individual psyche problem is necessarily apolitical. What I argue is that the move away from a political economy discourse, where the state could be held responsible, towards a psychological or psychiatric discourse, wherein the individual farmer or the farming community is held responsible, depoliticizes the political economy framework for understanding the agrarian crisis. The political economy discourse allows for the state mechanisms to be held accountable, whereas public health suicide prevention programs lead to technical solutions such as pesticide control, solutions that are cast at the scale of the individual or the locality, not the nation-wide or even global scale favoured by the left-wing critics of farmer impoverishment. In highlighting the differences in regulatory frameworks, I have tried to avoid being prescriptive about the directions these political struggles ought to take; instead, my aim has been to highlight the limitations of different discourses with respect to regulation of suicide.

There is one particular high profile suicide-related story that demonstrates a similar discursive tension. In Chapter One, I consider Irom Sharmila’s sixteen-year hunger strike, which she undertook to demand the repeal of the Armed Forces (Special Powers) Act, a law that resulted in extreme violence unleashed by the Indian army in the state of Manipur. A prominent method used by the Indian state was to frame Sharmila’s actions as a suicide attempt, a criminal offense: such a framing gave permission to the state to force-feed her. She vehemently fought against the framing of her hunger strike as suicide by asserting that she loves life and would like
to continue living. In this context, one sees the struggle by the state to refashion the discourse of Sharmila’s hunger strike as that of a criminal suicide attempt. Refusing to decriminalize suicide (as had been suggested by law reform bodies) allowed for a discursive construction of Sharmila’s protest as ‘suicide’.

In the context of farmer suicides as well as that of Irom Sharmila, it is clear that particular discursive frameworks result in specific kinds of regulatory practices. However, I also take up another kind of suicide to show how certain kinds of suicides exist outside any of the mainstream discursive practices. Hijra suicides are unique in that they are not discussed in any of the prominent institutional discourses on hijras, and neither are they part of any of the established legal and medical framings for suicide analyzed in previous chapters. Neither the legal rights discourse nor the public health discourse, both of which have a prominent presence in hijra lives, have seriously engaged with hijra suicides. This is not surprising in and of itself; in mainstream middle-class Indian imagination, hijras continue to be perceived as ‘dirty’ or ‘shameless’, thereby not seen as worthy human lives requiring respect and attention. Within such a context, hijra suicides remain outside any significant regulatory systems: criminal law, mental health laws, and public mental health suicide prevention programs all ignore hijras. I argue that in remaining at the edges these discursive mechanisms, hijras speak about their experience of suicide without being drawn into either liberal rights discourse or psy discourses (which often appear as the only two alternatives for stigmatized identities).

Interviews and conversations with hijras in Bangalore suggest an explanation why hijra suicides have not emerged as a separate category for either legal or medical intervention or for political action within human rights/civil liberties discourse: experiences of hijra suicides are not ‘governmentalized’ by any of the available systems of power/knowledge, but are rather expressed and archived within registers such as autobiographies. I study two autobiographies that are
registers of knowledge of hijra lives. These texts provide insights into hijra lives without exceptionalizing their acts of suicide: suicide attempts, in these texts, appears as inextricably connected to other aspects of their lives. In discussing suicides in the concrete context of other aspects of their lives, hijras are not only asserting their personhood, but they are also implicitly resisting having their lives be framed and governed through the available mainstream systems of power/knowledge.

3 Limitations of this Study and Directions for Future Research

Writing this dissertation revealed a few limitations of the project, as is always the case. It is important to point out these limitations in order to point the way toward potential future research.

1. The planned fieldwork did not occur as anticipated. Although I began my fieldwork with a plan to do in-depth interviews, most psychologists, psychiatrists and suicide prevention NGO workers I encountered were hesitant to participate. They were often willing to have conversations (most often informal conversations) but they were not willing to allow me to do in-depth interviews to get a better understanding of the work they did. There was a bureaucratic reason for this. Often the psychologist and psychiatrists working on suicide prevention were associated with large mental health institutions that had elaborate bureaucratic procedures that curtailed access of researchers from outside the institution. In spite of such fieldwork difficulties, I had some success in that I held informal conversations with fifteen psychiatrists, psychologists and suicide prevention activists. I also had the opportunity to spend some time in one free counseling clinic. This gave me deeper understanding of psychiatric and psychosocial approaches to suicide prevention in Bangalore. However, an ethnographic study of the
assemblage of suicide prevention activities could provide a deeper understanding of the networks of suicide prevention, so this is a possibility for future research.

2. In this dissertation, I focus on High Court and Supreme Court judgments to understand how suicide is constructed within the legal arena. These court decisions are archived on the Internet and hence easily accessible for researchers, including those who do not reside in India. However, conducting a similar study at the scale of village and district courts might yield new insights and/or provide further depth. Studying village and district courts (whose decisions are not necessarily accessible online) might reveal regional variations or other important differences that are not visible in the writings of the senior judges. As I mentioned earlier, the lower courts documents are not as well archived on the Internet as the higher courts: hence, the researcher would have to spend time getting permissions to access judgments, attending trials, interviewing individual judges, and lawyers involved in cases concerning suicide in order to get a deeper understanding of how law constructs suicide and how managing and governing suicide shapes law. Studying lower court decisions could confirm what I have traced in higher court judgments: however, I suspect that there might be a variety of discourses on suicide circulating in lower levels that have not made it to the higher courts.

3. Similarly, I have studied several national-level legal changes, but given that nobody had previously studied even the national law, I have not been able to go on to document state level initiatives. During the time I spent writing this dissertation, many legal changes were occurring. The discussion regarding decriminalizing of Section 309, IPC, caught speed, and the new Mental Health Care Bill 2016 and the Transgender Rights Bill 2014 were introduced. These seemingly disconnected legal changes impacted the regulation of suicide and slowed down the dissertation process. Policy changes by state governments remain under analyzed. For example, following the 2014 Transgender Rights Bill, there have been other state-level efforts to establish
transgender rights. These efforts have resulted in more debates and struggles, not included in this
dissertation. My aim in tracing the national debates regarding transgender rights was to
demonstrate the dominance of rights discourse with respect to hijras. I think I have achieved that
modest aim. However, further research comparing different states would help deepen our
understanding of the contemporary evolution of rights discourse regarding transgender and hijra
rights, and also shed light on other suicide-related legal debates.

4. Since this research project is focused on regulation of suicide, I chose to emphasize one
recurring narrative that I encountered in my conversations with hijras in Bangalore. I analyzed
hijra experiences of loss of love leading to attempts at suicide. In this process, I have not
emphasized other aspects of hijra lives. Anthropologists Gayatri Reddy and Lawrence Cohen,
who have written on hijra and kothi lives in India, have justifiably critiqued the extensive focus
on gender/sexual difference in hijra lives in academic scholarship. Influenced by such a critique,
I did not focus solely on the gender/sexual aspect of hijra lives and instead aimed to highlight a
certain aspect of their personhood and their own assertion of their personhood. However,
because of the constraints of the thesis topic, I have not adequately represented hijra lives in
Bangalore in all its complexity—although of course that was not my aim. There is more to be
written about hijra lives than their gender/sexual difference, their victimhood and their
experiences of attempting suicide. One area for future research would be hijra personhood and
notions of belonging in hijra lives.

Despite these limitations, this dissertation has made original contributions to several areas
of research. First, until now, there has been no comprehensive study of legal conceptions and the
shifting legal regulation of suicide in India. There do exist a few commentaries on the key cases
that mark a shift in suicide law (Section 309-IPC), which analyze the judgments for their
political implications. However, no study has analyzed the case law systematically, and no study
has focused on the knowledges that inform the legal regulation of suicide. This dissertation shows that suicide regulation in Indian legal networks is made up of a diverse array of knowledges that are used or not used depending on the exigencies (often political exigencies) of the situation (as seen for example in the dilemmas raised by a religiously motivated form of voluntary death found in the Jain community). This in turn allows for the law of the day to be repeatedly challenged by different actors.

Second, this dissertation provides a comprehensive and critical analysis of suicide regulation within public health programs in India, which forms an original contribution to sociolegal scholarship. I show how public health programs aimed at suicide prevention are biased towards psychological and psychiatric explanations for the suicide act. However, critiquing these programs for “medicalizing” suicide would be incorrect since, similar to the legal realm, several heterogeneous discourses inform public health conceptions of suicide.

Lastly, a unique aspect of this research is that I analyze certain ‘kinds’ of suicides that have emerged as a category for political/public health interventions (most notably farmer suicides) along with a kind of suicide that is neither a political nor a health category—that is, hijra suicides. Placing hijra suicides within a larger study of regulation of suicide in India demonstrates the limits of the governmentalization of suicide. Hijra suicides exist at the edges of both public health programs and rights/legal discourse on suicide in India. In existing at the fringes of governmentality, I demonstrate that hijras continue to exert their personhood through expressing their experiences with suicide.
References


Chua, J. L. (2012) Tales of decline: Reading social pathology into individual suicide in south India. *Culture, Medicine, Psychiatry*, 36, 204-224.


Davar, B.V. (2014). Globalizing psychiatry and the case of ‘vanishing’ alternatives in a neo-colonial state. *Disability and the global south, 1*(2), 266-284


Mental Health Care Bill (2016), Retrieved From http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20health%20care%20as%20passed%20by%20RS.pdf


‘New Draft of Transgender Bill Makes Forcing a Transgender to Leave Residence an offense’


globalisation of agriculture. New Delhi: Research Foundation for Science, Technology and
Ecology.

University Press.


Sivasubramanian, M., Mimiaga, M. J., Mayer, K. H., Anand, V. R., Johnson, C.V., Prabhugate,
P., & Safren, S. A. (2011). Suicidality, clinical depression, and anxiety disorders are highly
prevailing in men who have sex with men in Mumbai, India: Findings from a community-
recruited sample. Psychology, Health & Medicine, 16(4), 450–462

Daud Ali (Eds.) Ethical life in South Asia (pp. 211-231). Indianapolis: Indiana University
Press.

http://www.thehindu.com/news/cities/chennai/turning-point-in-transgender-
rights/article7139875.ece

Srivastava, D. (2017, January 06). Mental Health Care Bill: A much-needed reform that still has
a long way to go. Firstpost. Retrieved From http://www.firstpost.com/india/mental-health-
care-bill-a-much-needed-reform-that-still-has-a-long-way-to-go-2952636.html

Staples, J. (2012) Suicide in South Asia: Ethnographic perspective. Contributions to Indian
Sociology. 46 (1&2), 1–28.

approaches to understanding self-harm and self-inflicted death. Culture, Medicine,
Psychiatry. 36, 183-203


Transgender Rights Bill (2015). Retrieved from:

Transgender Persons (Protection of Rights) Bill, (2016). Retrieved From:


Court Cases

Acharya Jagdishwaranand etc. v. Commissioner of Police, Calcutta and ANR, (1984), SCR (1) 447

Anand Margis Case, Jagdishwaranand vs Police Commissioner, (1984), AIR 1984, SC51

Animal Welfare Board of India vs. A Nagaraja and Others, (2014), 7 SCC 547


Francis Coralie Mullin v. Union Territory of Delhi, (1981), SCR (2) 516


Kehar Singh v. Union of India, (1988), SCR Supl. (3)1102


Mental Health Foundation v. Union of India and ORS, (2011), W.P.(C) 3135/2011

National Legal Services Authority v UoI, (2014), AIR 2014 SC 1863


Naz Foundation v. NCT, Delhi & Ors, WP(C) No.7455/2001

Ramsharan v. Union Of India, (1988), SCR Supl. (3) 870

Rathinam/Nagbhusan Patnaik v. Union of India, (1994), SCC (3) 394

State v. Sunjay Kumar Bhatia (1985) Cr L J 931

The Board of Trustees, Port of Bombay v. Dillip Kumar, (1983) SCR (1) 828