

*Supplementary Submission to Committee on the Rights of the Child (CRC) on  
the Child's Right to Life and Health in India.*

**INDIA**

**Convention on the Rights of the Child**

**Supplementary Submission from**

**Edmund Rice International (ERI)**, based in Geneva and New York, and  
**Students' Empowerment, Rights and Vision through Education (SERVE)**,  
based in Kolkata, India.

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### *Introduction*

This report is a response to the *List of issues in relation to the combined third and fourth periodic reports of India* published by the committee on the Rights of the Child (CRC) on November 25, 2013<sup>1</sup>. It identifies a major area of adolescent health, clearly of concern to the Government of India in its combined third and fourth periodic reports to the CRC. Suicide is the second major cause of death of young people in India after accidents. The child's right to life and health deserves a concerted and effective national strategy, and the CRC is well placed to recommend this to the government of India.

This report relies on the data and best practices provided by Students' Empowerment, Rights and Vision through Education (SERVE), which is a local NGO with an India-wide operation, based in Kolkata. This report also uses recent research on youth suicide in India. It is a supplementary submission to an earlier report by ERI to the CRC<sup>2</sup>.

The report is aware that research has highlighted the positive impact education and development more generally has on suicide rates among Indian youth (see below), especially those from more vulnerable groups. But the research and SERVE's data suggests that the education system itself, as well as more general social pressures, can impact negatively on young people's health, including suicidal ideation, suicide attempts and suicide.

### *Situation Analysis*

India recognizes in their *Third and Fourth Combined Periodic Report on the Convention on the Rights of the Child* that youth suicide is a matter of concern stating that '35% of the total suicidal deaths belong to the 15-24 age group'.<sup>3</sup> They noted that a competitive education system, family and societal pressures and the lack of counselling services in schools were possible reasons for the increasing rate of suicide in young people.<sup>4</sup>

In fact, India has one of the highest suicide mortality rates in the world. Approximately 170,000 deaths every year in India are due to suicide. A national representative survey, conducted in June 2012, found that a large proportion of suicides in India occur in the age group of 15-29 year olds.<sup>5</sup> There has been

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<sup>1</sup> CRC/C/IND/Q/3-4.

<sup>2</sup> Edmund Rice International (ERI) 2013 *Submission to the Committee on the Rights of the Child by a team of 10 young people working with 51 children from the slums of New Delhi*.

<sup>3</sup> CRC/C/IND/Q/3-4, 61.

<sup>4</sup> CRC/C/IND/Q/3-4, 61.

<sup>5</sup> Patel V, Ramasundarahettige C, Vijayakumar L, Thakur JS, Gajalakshmi V, Suraweera W, Prabhat J for the Million Death Study Collaborators, 2012, 'Suicide mortality in India: a nationally representative survey,' *The Lancet*, Vol. 379, No. 9834, 2343-2351.

considerable attention from media and global news outlets about the increase in youth suicide in India. Many reports have associated the prevalence of youth suicide with increased stress levels and depression in young people during school and examination periods and other factors, and have questioned the state of India's public health system and its preventative strategies to reduce the incidence of youth suicide.<sup>6</sup>

Reports have identified other reasons for increased prevalence in youth suicide. 'Copycat suicides' have been noted as a serious problem in India. A suicide of a celebrity or a well-known politician in India gathers much publicity. The glamorization of such deaths, often has led to suicides in a similar manner by young people who often look up to these figures as role models. Additional risk factors are associated with rapid social change as well as embedded social structures in India that impact quality of life.<sup>7</sup>

There is also a variation in the rates of suicide occurring across India. The southern States of India have higher rates of suicide. This includes Kerala, Tamil Nadu, West Bengal, Andhra Pradesh, Maharashtra and Karnataka.<sup>8</sup> The southern states of India are associated with higher socio-economic status and literacy rates and high levels of education and expectation. Residency in the south of India and a higher level of education is therefore associated with an increased risk of suicide, particularly in young people.<sup>9</sup>

This supports SERVE's contention that the school system is itself to blame for some of these higher reported rates of suicide. SERVE cites figures on suicides in 2000 from the National Crime Research Bureau, with 35.6% in the age group 15 – 29 and 'FAILURE IN EXAMINATIONS' as the main cause of suicides among children, where causes were specified<sup>10</sup>. Patel also thinks that social change may be a driver of youth suicide.<sup>11</sup>

India's third and fourth reports to the CRC cover youth suicide as a serious problem, affecting the child's right to health. They also outline government responses to this. The CRC needs to be satisfied that these measures are having the desired impact.

In March 2008, India's Central Board of Secondary Education (CBSE) made it mandatory for all affiliated schools to employ counsellors, with the purpose of helping young people cope with stress and psychological pressures. Schools were also instructed to provide planned and effective counselling to promote self-image, acceptance and self-confidence in young people as well as learning techniques on how to cope with pressures. The CBSE also set up counseling helplines during exam periods to help students cope with pressure and fear of failure.<sup>12</sup>

In a recent survey conducted by Associated Chambers of Commerce and Industry of India (ASSOCHAM) it was found that only '3% of the private schools in Delhi-NCR have counsellors in

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<sup>6</sup> Kumar D & Talwar R, 2014, 'Determinants of psychological stress and suicidal behavior in Indian adolescents: A literature review,' *Journal of Indian Association for Child and Adolescent Mental Health*, Vol, 10, no.1, 49.

<sup>7</sup> Vijayakumar L, 2007, 'Suicide and its prevention: The urgent need in India'. *Indian Journal of Psychiatry* Vol. 49, Issue 2, 81-84.

<sup>8</sup> CRC/C/IND/Q/3-4.

<sup>9</sup> Patel V et al, 2012, 2348

<sup>10</sup> MacCarthaigh, B, 2006, 'Where the Child is Without Fear: the SERVE system of education,' Earthcare Books, Kolkata, 4.

<sup>11</sup> Patel V, 2012, Invisible health risk that stalks India's youth,' *The Hindu*, Available at: <http://www.thehindu.com/opinion/op-ed/invisible-health-risk-that-stalks-indias-youth/article3555531.ece>.

<sup>12</sup> CRC/C/IND/Q/3-4, 63.

their schools.’<sup>13</sup> The majority of private schools have been violating CBSE educational rules and procedures regarding this policy<sup>14</sup>. It seems there has been a failure in the successful implementation and regulation of counsellors in the education system. The CRC may wish to take this up with the Indian Government as a matter of urgency, as a failure to implement a key government policy on adolescent health.

In general, there has been a lack of research on youth suicide in India, including research on the causes and prevention of suicide. This is due to a number of factors that relate to the legal implications of suicide, which is still considered a crime in India, and the sensitive and controversial nature of the subject in Indian society<sup>15</sup>.

The exercise of several rights of the child is directly or indirectly threatened by government inaction on this serious risk to children’s health in India. They include those dealing with the child’s right to life, survival and development (art.6), the right to protection from all forms of injury (art.19), the right to the highest standards of health and access to health services (art.24), the right to an education developing the child’s full potential (art.29) and the right of children in minority or Indigenous groups to enjoy their own traditions (art.30).

General Comment No. 4 of the CRC (2003) elaborates on the rights of adolescents to health and a well-balanced development, including preparation for adulthood and constructive community engagement (articles 6 and 24 of the Convention)<sup>16</sup>. Any programmes, activities, expectations, or pressures that lead a child to consider suicide (and the number considering suicide is much greater than those who make successful attempts at this<sup>17</sup>) denies the child this right to a well-balanced development. Appendix One provides reflections on General Comment No. 4 and its relevance to preventing youth suicide in India.

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<sup>13</sup> Associated Chambers of Commerce and industry of India (ASSOCHAM), 2014, ‘Only 3% private schools in Delhi-NCR have counselors: ASSOCHAM,’ Press Release, Available at: <http://www.assochem.org/prels/shownews-archive.php?id=4362>.

<sup>14</sup> ASSOCHAM 2014.

<sup>15</sup> Vijayakumar L, 2010, ‘Indian Research on Suicide,’ *Indian Journal of Psychiatry*, Vol.52 (suppl 1), 2.

<sup>16</sup> See Appendix One, for comments on selected sections of General Comment No. 4.

<sup>17</sup> Centre for Disease Control and Prevention 2014 ‘Suicide Prevention’ USA Government Available at. [http://www.cdc.gov/violenceprevention/pub/youth\\_suicide.html](http://www.cdc.gov/violenceprevention/pub/youth_suicide.html) Viewed 6 March, 2014. Mind Frame-National Media Initiative, 2012, ‘Facts and Stats about Suicide in Australia,’ *Hunter Institute of Mental Health and the Australian Government*, Department of Health . Available at <http://www.mindframe-media.info/for-media/reporting-suicide/facts-and-stats> Viewed on 11 March 2014.

### *Conclusions and Recommendations*

Edmund Rice International and SERVE are extremely concerned about the incidence of youth suicide occurring in India and sees the situation as needing urgent attention. They make the following recommendations.

That the Government of India:

- 1. decriminalise suicide.**
- 2. consult widely with children and involve them actively in programmes for preventing youth suicide.**
- 3. sponsor more research on youth suicide in India, including: causes of youth suicide; data on demographics; disaggregated data on youth suicide within vulnerable groups; the effectiveness of youth suicide prevention strategies, including school counsellors and school programmes.**
- 4. ensure regular and comprehensive monitoring of the Board of Education and their policies relating to health and welfare services to students and youth, including the monitoring of mandatory counsellors in schools.**
- 5. establish and resource a National Action Plan for Suicide Prevention in India, with a special focus on youth suicide prevention, involving children, their families and all school systems.**
- 6. research and trial models of education that reduce the stresses on children and students that predispose them to suicidal ideation.**

### *Appendix One*

#### ***Comments on General Comment No.4 of CRC relevant to Preventing Youth Suicide in India***

Commenting on articles 3, 6, 12, 19 and 24 (3) of the Convention, the Committee specifies that adolescent health can be damaged by harmful traditional practices in certain communities<sup>18</sup>. Given the evidence for parental, familial and social pressures on adolescents concerning exam performance as critical factors in youth suicide for students<sup>19</sup>, and evidence of gender imbalance in teenage suicides (with more young women suiciding than young men<sup>20</sup>), government action is needed. The General Comment recommends “awareness-raising campaigns, education programmes and legislation aimed at changing prevailing attitudes, and address gender roles and stereotypes that contribute to harmful traditional practices”<sup>21</sup>. This can be applied to those social and cultural groups whose children are subject to unreasonable and dangerous pressure to ‘succeed’ in exams, however such success may be defined by the group<sup>22</sup>.

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<sup>18</sup> CRC 2003 *General Comment no.4* CRC/GC/2003[24].

<sup>19</sup> MacCarthaigh 2006, 1.

<sup>20</sup> Patel et al, 2012, 2348.

<sup>21</sup> CRC 2003 [12].

<sup>22</sup> MacCarthaigh, B, 2006, 7 -16.

In regard to articles 19, 32-36 and 38 of the Convention, the General Comment insists that states parties must protect adolescents from ‘the specific forms of abuse, neglect, violence and exploitation’ they are affected by<sup>23</sup>. With fragile self-esteem and only a developing sense of self-worth, identity and belonging<sup>24</sup>, adolescents can be at risk from parents, families and school staff demanding too much of them. This insensitivity to their developmental needs can be characterised as both abuse (of their inherent vulnerability) and neglect (of what they need to receive from significant others). The Indian government has responsibility to research and monitor the negative impact its educational policies have on this group, especially the examination system, which SERVE points out is the most commonly named causal (or triggering) factor in youth suicide.<sup>25</sup>

The second part of this comment is also pertinent to the Indian situation. The CRC recommends that states parties ‘involve them [adolescents] in an appropriate manner in developing measures, including programmes, designed to protect them’<sup>26</sup>. The children of India are already active in advocacy for their rights, including submitting an alternative report to the CRC<sup>27</sup>. SERVE has found them to be willing partners in improving the education system in various Indian states and schools<sup>28</sup> and reducing pressures on adolescents at risk.<sup>29</sup> A programme aimed at youth suicide prevention must use their talents in detecting, monitoring, and supporting youth at risk of suicide<sup>30</sup>, as well as the public education programmes recommended above. The Committee’s recommendation of ‘proper role models’ in such education<sup>31</sup> will help counter-balance the undue influence of media portrayals of suicide, as mentioned above.

The CRC, in their comments on article 19, also strongly recommend that states parties collect disaggregated data on adolescent health<sup>32</sup>. As suicide is the second largest cause of mortality in Indian adolescents, the collection of such data is an urgent research priority. Increasing affluence in some social and cultural groups may expose their children to new pressures, including suicidal ideation, that the group cannot yet cope with. Unless the government of India funds such research to collect and monitor disaggregated data on youth suicide, they will have no objective basis for policies or action plans.

Regarding articles 2-6, 12-17, 24, 28, 29 and 31, the CRC recommends that governments ensure adolescents have ‘a safe and supportive environment’, both immediate (family, peers, schools and services) and wider (community, religion, media, state and nation). This requires

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<sup>23</sup> CRC 2003 [12].

<sup>24</sup> Saywer S, Afifi R, Bearinger L, Blakemore S, Dick B, Ezech A, Patton G, 2012, ‘Adolescence: a foundation for future health,’ *The Lancet*, vol. 37, 1632.

<sup>25</sup> MacCarthaigh, 2006, 4.

<sup>26</sup> CRC 2003 [12].

<sup>27</sup> Edmund Rice International (ERI) 2013 *Submission to the Committee on the Rights of the Child by a team of 10 young people working with 51 children from the slums of New Delhi*.

<sup>28</sup> MacCarthaigh, 2006, 104, 110.

<sup>29</sup> MacCarthaigh, 2006, 33-35.

<sup>30</sup> National Association of School Psychologists, ‘Preventing Youth Suicide- Tips for Parents and Educators,’ Viewed 6 March 2014, Available at: [http://www.nasponline.org/resources/crisis\\_safety/suicideprevention.aspx](http://www.nasponline.org/resources/crisis_safety/suicideprevention.aspx).

<sup>31</sup> CRC 2003, [12].

<sup>32</sup> CRC 2003, [13].

‘promotion and enforcement’ of these articles<sup>33</sup>. The Government of India is obliged to steer this public education campaign to sensitise individuals and especially groups to children’s rights, and the risk suicide poses to exercising these.

The CRC also specifies a further cluster of responsibilities governments bear, in relation to article 24 of the Convention<sup>34</sup>. Current research suggests some mental disorders (eg depression, some substance addictions) can provoke suicide<sup>35</sup>, yet suicide can also occur independent of mental health problems<sup>36</sup>. Most suicide is associated with stresses and pressures (as perceived by the young person), even when the young person initially seems resilient in the face of such factors. The Committee is clear that ‘States parties are urged to provide adequate treatment and rehabilitation for adolescents with mental disorders, to make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress’<sup>37</sup>. The later provision has important consequences for the Government of India, as both education systems and social forces can create pressures that are ‘undue’.

## ANNEXE A

### **Recommendations**

That the Government of India:

- 1. decriminalise suicide.**
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- 3. sponsor more research on youth suicide in India, including: causes of youth suicide; data on demographics; disaggregated data on youth suicide within vulnerable groups; the effectiveness of youth suicide prevention strategies, including school counsellors and school programmes.**
- 4. ensure regular and comprehensive monitoring of the Board of Education and their policies relating to health and welfare services to students and youth, including the monitoring of mandatory counsellors in schools.**
- 5. establish and resource a National Action Plan for Suicide Prevention in India, with a special focus on youth suicide prevention, involving children, their families and all school systems.**
- 6. research and trial models of education that reduce the stresses on children and students that predispose them to suicidal ideation.**

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<sup>33</sup> CRC 2003, [14].

<sup>34</sup> CRC 2003, [29].

<sup>35</sup> Vijayakumar 2007, 81-84.

<sup>36</sup> National Association of School Psychologists 2014. Viewed 6 March 2014, Available at:

[http://www.nasponline.org/resources/crisis\\_safety/suicideprevention.aspx](http://www.nasponline.org/resources/crisis_safety/suicideprevention.aspx)

<sup>37</sup> CRC 2003, [29].