Identities in Motion;
Migration and Health In India

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The Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

First Published in October 2006

By
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Website : www.cehat.org

ISBN : 81-89042-46-7

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

FROM THE RESEARCH DESK

Health and Human rights has explicit intrinsic connections and has emerged as powerful concepts within the rights based approach especially so in the backdrop of weakening public health system, unregulated growth of the private sector and restricted access to healthcare systems leading to a near-total eclipse of availability and accessibility of universal and comprehensive healthcare. A rights-based approach to health uses International Human Rights treaties and norms to hold governments accountable for their obligations under the treaties. It recognises the fact that the right to health is a fundamental right of every human being and it implies the enjoyment of the highest attainable standard of health and that it is one of the fundamental rights of every human being and that governments have a responsibility for the health of their people which can be fulfilled only through the provision of adequate health and social measures. It gets integrated into research, advocacy strategies and tools, including monitoring; community education and mobilisation; litigation and policy formulation.

Right to the highest attainable standard is encapsulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It covers the underlying preconditions necessary for health and also the provisions of medical care. The critical component within the right to health philosophy is its realisation. CEHAT's main objective of the project, *Establishing Health as a Human Right* is to propel within the civil society and the public domain, the movement towards realisation of the right to healthcare as a fundamental right through research and documentation, advocacy, lobbying, campaigns, awareness and education activities.

The Background Series is a collection of papers on various issues related to right to health, i.e., the vulnerable groups,health systems, health policies, affecting accessibility and provisions of healthcare in India. In this series, there are papers on women, elderly, migrants, disabled, adolescents and homosexuals. The papers are well researched and provide evidence based recommendations for improving access and reducing barriers to health and healthcare alongside addressing discrmination.

We would like to use this space to express our gratitude towards the authors who have contributed to the project by sharing their ideas and knowledge through their respective papers in the Background Series. We would like to thank the Programme Development Committee (PDC) of CEHAT, for playing such a significant role in providing valuable inputs to each paper. We appreciate and recognise the efforts of the project team members who have worked tirelessly towards the success of the project ; the Coordinator, Ms. Padma Deosthali for her support and the Ford Foundation, Oxfam- Novib and Rangoonwala Trust for supporting such an initiative. We are also grateful to several others who have offered us technical support, Ms Sudha Raghavendran for editing and Satam Udyog for printing the publication. The cover page design and the photograph has been provided by Jhanvi Graphics. We hope that through this series we are able to present the health issues and concerns of the vulnerable groups in India and that the series would be useful for those directly working on the rights issues related to health and other areas.

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Identities in Motion; Migration and Health In India

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INTRODUCTION

Human spatial mobility started about two decades ago for various systemic, economic and individual reasons, but there is a lack of systematic information and health-risk assessment among the mobile population. The specific socio-demographic structure, that is, age, sex, education, attainment, occupation and income, determines the context in which migration takes place and their health-risks are predetermined by certain factors at the destination areas. They are

- Government-related factors such as national policies, public service system, community development, development and housing;
- Employer-related factors such as work site safety, living conditions, insurance coverage, women worker's maternal and reproductive health benefit, etc;
- Health-sector related factors such as health/preventive network, service coverage and approaches, service items and prices; and
- Individual-related factors like social support at the destination, health awareness, health beliefs, health behaviour and help seeking behaviour, impacts the individual and collective health risk of migrants.

This paper addresses the issue of migration and its public health implications within the human rights framework. Disaggregated information on the types of migrants in India, their magnitude and their vulnerabilities impacting their health and access to healthcare has been presented. The migrants are vulnerable at the source, throughout the migratory process and at the destination areas. The degree of vulnerability of migrants in India is different in different situations and so are the challenges that migration poses for health policy-makers. Understanding migration through a human rights framework helps explain the health needs of migrants in the context of the current migration patterns.

1. Migration and Health

At the start of the new millennium, spatial movement of the human population has become more pronounced. Migratory movements characterized by increased quantitative growth and qualitative differentiation along the lines of migratory patterns, nature of migrants, their quality and final destination have facilitated a differentiated development pattern creating spaces of vulnerability. The unfolding of the socio-political dynamics of different countries and the persistent economic growth along the individual and

collective complexities of societies has introduced instability at all levels. This has increased the migration of populations within and across the geographical contours of the nation-state. In the globalization debate, movement of people received scant attention. Yet the sheer magnitude of migration- forced and voluntary, regular and irregular, clearly suggests that migration has the potential to pose a potential public health challenge. Migration can expose individuals and groups in many settings at health risks. Many individuals and groups, in certain kinds of settings, remain excluded from the benefits of health and healthcare.

General Comment 14 of the International Covenant on Economic Social and Cultural Rights comments on the right to the highest attainable standard of health (Committee on Economic Social and Cultural Rights, 2000). This has been largely translated as a right to health care and has enabled focus on ensuring that the rights of individuals are not violated through the creation of structural and other barriers to the access to healthcare facilities. The application of principles in international law reminds governments and relevant authorities of their obligations to their populations. But the rights of migrants have always been a problematic area with many challenges. While globalization, conflict and disasters have contributed to the need for populations to be mobile and governments, particularly those of the developed countries, have promoted globalization for economic and development reasons, they have become increasingly reluctant to accept migration as one of the consequences of opening up markets for the exchange of goods and services. Restrictive migration policies in many countries have resulted in different kinds of human right violations on migrants and refugees. The marginalization and health of migrant populations are a growing public health concern as they represent one of the most 'at need' groups in the world.

Migrants have always been conceptualized as *problematic* in the context of policies both nationally and internationally. This mindset has led to complex public health issues posed by migration. Migrants and their human rights have to be understood from the existing contradictions within and across countries between skilled and voluntary migrants at one end of the spectrum to the other end comprising of the poor and unskilled migrant population destined to be excluded and obscured from the fabric of the host societies. For the latter, the intersection of human rights and migration is a negative one, with bad experiences throughout the migratory 'life cycle', in areas of origin, journey or transit in case of international migrants and destination. The intersection of migrants and human rights becomes even more complex when irregular or illegal migration clashes with the interest of the area of destination. Cases of exploitation of migrants by employers, smugglers or traffickers in such cases never meet justice. All these directly impact the rights of individual migrants.

The focus of this section is on the health implications for poor unskilled/semi-skilled migrants, both internal and international, in the context of public health as well as in relation to the health of the individual and the existing barriers of access to health services at the host

destinations.

1. A. Degrees of Vulnerability along Types of Migrants affecting Health-An Exploration of their health impact

Vulnerability can be understood as a state of being exposed to or susceptibility to danger or abuse. It comprises of weakness of physical and mental strength, defenselessness, unprotected ness, fragility and exposure to undesirable conditions/ factors. In addition to the health environment in the place of origin, transit and destination (including disease prevalence), they include patterns of mobility (regular, circular, seasonal, etc) that define the conditions of journey and their impact on health; the status of migrants in destination areas that determines their access to health and social services; and familiarity with the culture and language of the host community. Vulnerability is a relative term. Similarly, factors leading to vulnerability are varied and relative. In the case of migrants, the common factor that justifies their vulnerability is perhaps the fact that their origin differs from their present residence. The difference is not merely limited to the experience of change of space but extends to other experiences of differences of culture, language and people. The vulnerability which is primarily premised on the *alien status* [1] of the migrant gets complicated by the combination of factors at the area of destination. Limited choice and reduced capacity to negotiate results in increased discrimination in life chances. The migrant is considered an 'outsider'.

Various survey and studies have shown that migrants are disadvantaged relative to the native population regarding employment, education and health. These circumstances are not formally separable into causes such as deficient education and health, initial prejudice, and effects such as poor wages, inferior healthcare provision and sustained discrimination. But they mutually reinforce each other. For

Box 1

Vulnerability among Migrants

- *Migrants are disadvantaged relative to the native population*
- *They often have a low socio-economic status with no access to either healthcare or social services*
- *They suffer from mental and emotional vulnerability and low self-esteem*
- *Lack of provision of social goods, education and health, impedes the integration of migrants into the local population.*

[1] This is more evident in the case of international migrants

instance, a bias against the migrants may translate into health provider neglect which in turn perpetuates poor migrant health.

The degrees of vulnerability in which migrants find themselves depend on a variety of factors, ranging from their legal status to their overall environment. In the case of international migrants, one of the most important determining factors that pose barriers to accessing health services is the question of their legal status in the host area.[1] The discussion on health and human rights issues of migrants is most pertinent in the case of the mass exodus of poor population from the areas of origin to the areas of destination for economic and socio-political reasons internally and undocumented or irregular migration from outside the country. Laws and policies are either redundant or prevent migrants from accessing social services, including healthcare. The hiring of migrants in an irregular situation (both internal and international) allows employers to be exempt from providing health coverage to them as the labour force then becomes cheaper than recruiting locals/natives.

National health-care plans often discriminate against temporary migrants and especially undocumented ones by making only emergency care available for non-citizens. This forces migrants to delay health-seeking till the condition is sufficiently hazardous to justify going to emergency clinics. Another factor which prevents irregular international migrants from seeking healthcare and treatment is the fear of their illegal status being discovered (WHO 2003). In the case of internal labour migrants, their fluidity in terms of movement and their working conditions in the informal work arrangements[2] in the city debars them access to adequate curative care.

The vulnerability of the migrants and their health and human rights has to be assessed from the framework of

- *accessibility* of health and health services in relation to the availability of services; stigma and discrimination, discrimination on the basis of sex and gender roles and economic affordability,
- *quality* of available services and the prior conditions of health like right to safe and healthy working conditions, right to adequate food, physical accessibility of health services, culturally sensitive and good quality health services, and the right to seek and receive health related information.

Local bias stigmatizes migrants and may be used as an excuse by host communities to supply inferior care, impede integration, restrict the migrant's career and educational mobility and ultimately act as a socially and culturally indenturing force. Bias also acts as a self-perpetuating force, sustaining the migrant's negative

[2] Refugees and illegal migrants often get caught up in the internal geopolitics of the host countries and have no legitimate right that can protect them. They are denied basic rights.
[3] Delay in health-seeking is also due to associated costs, inability to miss work, problems of transportation. Many are unfamiliar with the local health-care systems and have linguistic or cultural difficulties communicating their problems.
Source: Census India, 2001

conditions and thus allowing for more bias to continue.

Broadly speaking, migration is of two different types—internal and international. Both the types can be either *voluntary* or forced. Migration is voluntary or forced on the basis of the factors that propel migration at the point of origin. In the case of voluntary migration, the decision to migrate is taken as a part of an informed choice made by the prospective migrant, while in the case of forced migration, conflict, political violence, armed conflict, development-induced displacement, are major reasons for migration. From the vulnerability point of view, the conditions prior to migration are important.

1. B. i) Internal Migration in India

Internal migration by place of birth has increased in India, from 1991 (838.5 in millions) to 2001 (1,028 in millions). In almost every category[4] barring the intrastate migration, there has been an increase in migration in the 2001 census as compared to the 1991 census data. The Figure 1 clearly shows that there has been an increase in the internal migration between the two census periods.

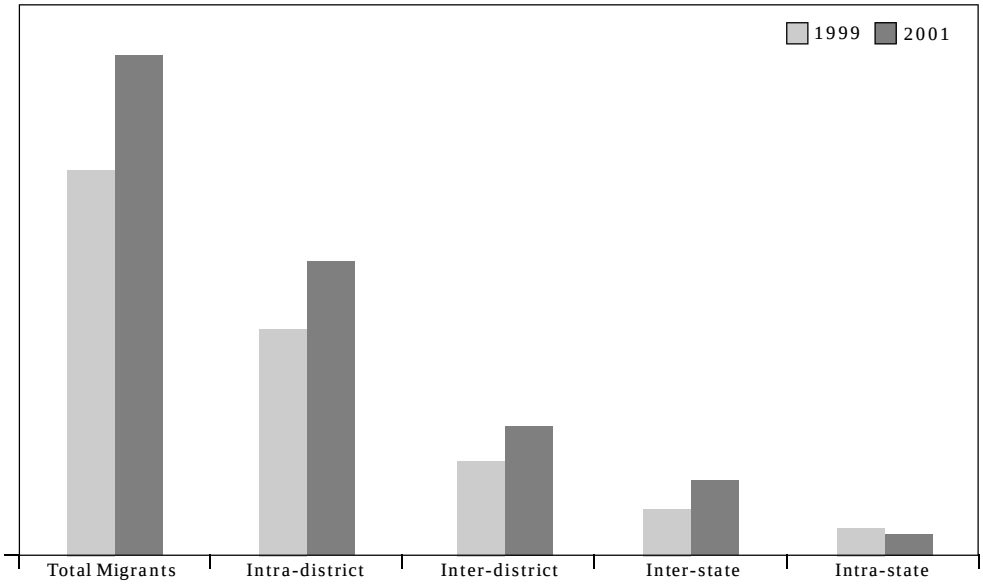
[4]

Migrants	1999	2001
Intra-district	136.2	181.7
Inter-district	59.1	76.8
Inter-state	27.2	42.3

Source: Census India, 2001

Figure 1

Increased Internal Migration by Place of Birth in India



Source: Census, Government of India, 2001[5]

During the 2001 census period, 14.4 million people migrated within the country for work purposes either to cities or areas with higher expected economic gains. The National Commission on Rural Labour (NCRL) estimates the number of internal labour migrants in rural areas in India alone at around 10 million (including roughly 4.5 million inter-state migrants and 6 million intra-state migrants). The 2001 Census has recorded about 53.3 million rural to rural migration within the country. According to the NCRL, a large number of migrants are employed in cultivation and plantations, brick-kilns, quarries, construction sites and fish processing. A large number of migrants also work in the urban informal manufacturing construction, services or transport sectors and are employed as casual labourers, head loaders, rickshaw pullers and hawkers (Dev, 2002).

Migrant workers predominate in the lower income labour market with higher risks of exposure to unsafe working conditions.[6] Migration for labour among the poor has a peculiar characteristic. It can be voluntary in the sense that the prospective migrants in most cases take the decision to migrate based on their expectations of estimated gains from the movement and in some cases, the same movement could be considered as forced migration where often

[5] Jammu & Kashmir has been excluded in both the Census

[6] Allotey Pascale (2003), *Is Health a Fundamental Right for Migrants*, Guest Editorial Column in the journal Development, Vol 46, No 3, September.

poverty, landlessness, debt, unemployment act as the push factors for mass exodus.

Globalisation and the associated casualisation of work have favoured the migrants who are absorbed in all forms of low paying, low or unskilled jobs with higher prospects of potential health hazards. Employers prefer to employ migrant labour with lower wages and they are steadily replacing local labourers (Breman, 1994). The mobile existence of the migrant labour further affects their sustainability in the urban industrial system in India (Breman, 1985; Singh, 1995; Grewal and Sidhu, 1979; Sidhu et al., 1997,Rogaly, 1996). Thus, the economic vulnerability of the migrant is kept alive by the informal work arrangement from the employers' end. Seasonal and annual migrant labourers from the rural areas working in the urban areas are denied voting power and are therefore not allowed to develop any stakes in the destination areas. They are not allowed to participate in the planning and governance processes thereby perpetuating political vulnerability. Social vulnerability is perpetrated by the experience of discrimination, social distance and feeling of alienation in the host area/destination.

The other type of internal migration which is purely forceful is due to political and ethnic conflicts. Here, there is a need to differentiate *migration* from *displacement.* Migration may include both voluntary and forced movement of people. Displacement implies the use of force or generation of conditions that displaces people from their source of origin. Because of political crisis and ethnic clashes, reasons of development or natural or man-made disasters, people are forced to flee their homes to new destinations. So while migration implies both voluntary and forced migrants, and includes the element of 'choice' or pull factors alongside the possibility of 'force' or push factors, displacement is solely dependent on the push factors. It takes away the *voluntarism* from the individual and the collective. Internally Displaced People (IDPs) are a product of displacement and are different from refugees in the sense that their areas of destinations are not across the borders. They resettle in a different place but within their country of origin. Again, while refugees are eligible to receive international protection and help under the 1951 Refugee Convention and the 1967 Protocol, the international community is not under the same legal obligation to protect and assist internally displaced people. National governments have the primary responsibility for the security and well-being of all displaced people on their territory.

Box 2

Categories of Internal Displacement in India

- *Political causes, including secessionist movements*
- *Identity-based autonomy movements*
- *Localized violence*
- *Environmental and development-induced displacement*
- *Religion-based violence and displacement*

Globally Asia is the second largest region having IDPs close to 2.8 million after Africa (12.1 million).In India, the internally displaced people are estimated to be around 6 lakhs (IDMC, 2006). Even among the neighbouring countries, the available estimates of IDPs in India are quite high. See Table 1 below for details.

Table 1 : IDPs in Neighbouring Countries of India

Country	No of IDPs	Estimated Date	Source	Comments
Global	25,300,000	Dec,2004	Internal Displacement Monitoring Centre (IDMC)	Estimates based on analysis of available country figures and additional information on displacement and return trends
India	600,000	May-05	Internal Displacement Monitoring Centre (IDMC)	Compiled from various figures
Bangladesh	5000,000	2000	State Committee on Statistics, Chittagong Hill Tracts	
Pakistan	30,000-50,000	Sep-04	IRIN; Local Media	Estimates relates to South Waziristan. Most IDPs in Pakistan controlled Kashmir reported to have returned
Nepal	200,000	Jun-05	UN/NGO IDP Survey, IDMC	
Myanmar	540,000	Oct-05	Thailand Burma Border Consortium	Estimates relates to eastern border areas only and does not include significant number of IDPs in the rest of the country
Srilanka	341,175	July,2005	UNHCR/MRRR	

Source: http://www.internal-displacement.org, accessed 20 Feb, 2006

There has been no systematic documentation of IDPs both globally and nationally. The estimates are largely based on official estimates published and on analysis of additional information on new developments with regard to newer displacements returns and reintegration. Availability of IDP data has always remained a problem and there are enormous information gaps. In most countries, the scope of the displacement crisis is known with lower levels of accuracy. In such cases, detailed and specific information on the IDPs' total estimate, their living conditions and needs is always a problem. The figures used by the governments and international organisations are often rough estimates, and at times contradict each other. All these increase the vulnerability of the IDPs to human right violations. Large numbers of IDPs are caught in desperate situations amidst fighting or in remote and inaccessible areas cut-off from international assistance. Others have been forced to live away from their homes for many years, or even decades, because the conflicts that caused their displacement remained unresolved.

India at present has over half a million conflict-induced Internally Displaced Persons — 200000 consisting of the Adivasis, Bodos, Muslims, Dimasas and Karbis in Assam; 262000 Kashmiri Pandits from Jammu and Kashmir; 35,000 Brus/ Reangs from Mizoram and about 50000 displaced persons in Tripura (Norwegian Refugee Council, 2005). Insurgency and retaliatory operations by security forces are a major factor of displacement. Civilians have fled fighting and have sometimes been directly targeted by militant groups in Kashmir, the Northeast and in several states of Central India. Many people are known to be internally displaced due to conflicts in the Indian states of Jammu and Kashmir, Gujarat and in the North-east.[7] The largest situation of internal displacement however, stems from the conflict in the north-western state of Jammu and Kashmir.[8] There are no surveys to date that specify the extent of the problem and the actual number of people internally displaced by conflict could be much higher than the official statistics made available. A majority of the internally displaced people (IDPs) have not been able to return for several years either due to protracted conflict or unresolved issues related to land and property. One example is India's largest group of internally displaced, the Kashmiri Pandits who have been fleeing the Kashmir Valley since 1989 due to conflict in the Kashmir Valley. Table 2. provides an overview of IDPs in India and their nature of displacement.

[7] Assistance to IDPs remains inadequate, http://www.internal- displacement.org/8025708F004CE90B/(http Countries)/5762D122F45E14B0802570A7004BBA1F?opendocument&count=10000&expand=2&link=20.2&count=10000#20.2, Posted on 13 May 2005, accessed on 13.02.'06

[8] The status of Kashmir has been in dispute since the creation of an independent India and Pakistan in 1947, and the two countries have twice gone to war over the issue. Protection of the remaining Pandit population has been far from adequate, leading to further displacement during 2004 when 160 of the estimated 700 Pandit families remaining in the Kashmir Valley fled an upsurge of violence and killings (Central Chronicle, 4 January 2005

Table 2 : Overview of available Estimates of Internally Displaced due to Conflict in India

State	Who are IDPs?	Nature of Displacement	Reasons for Displacement
NORTHERN INDIA			
Jammu and Kashmir	1) Kashmiri Pandits 2) Residents LoC and border areas	Political Conflict	Conclusion of the ceasefire with Pakistan; due to shelling between India and Pakistan.
NORTH-EASTERN INDIA			
Assam	Santhals, Nepalis, Bengalis	Ethnic Conflict	Santhal-Bodo[9] conflict (2003), conflict between Karbis and Kukis (Oct-Nov 2003); violence towards Hindi-speaking people (Nov 2003); fighting between Dimasa and Hmar tribes; eviction of Muslims of Bengali origin; violence between Karbis and Dimasa tribes (2005) in Assam
Manipur	Kukis, Paites[10] and Nagas, Hmars	Ethnic Conflict	Conflicts between the tribes[11]
Tripura	Tribals, i.e., Reangs[12] and non-tribals, i.e., Bengalis.	Ethnic Conflict[13]	Clashes between tribes; security reasons [14]
WESTERN INDIA			
Gujarat	Religious groups Central	Communalism	Communal conflict
Chattisgarh	Villagers	Political Conflict	Clashes between naxalites and police[15]

Source: Internal Displacement Monitoring Centre, February, 2006

[9] The Bodos refer to themselves as Boros
[10] Paites refer to themselves as Zomis
[11] Around 1,000 were displaced in Mizoram and 5,000 in the Tipaimukh sub-division of Manipur.
[12] Reangs refer to themselves as Bru
[13] The official reports confirm about 47,742 people displaced between Jan 1999 and Nov 2003. More than 100,000 Bengali settlers have been internally displaced (BBC News, 6th May 2004). A large amount of Reangs have been displaced.
[14] Many people has also been displaced due to building of fence along Bangladesh border (Telegraph, 13, March,2005)
[15] Many villagers from nearly 420 villages in Chhattisgarh have fled for safety

In India, internal displacement has also resulted from natural disasters and development projects. Floods and other natural disasters displace many people every year. Recently, the tsunami in the Indian Ocean which hit southern India in December 2004, devastated the Andaman and Nicobar Islands and a 2,260 km stretch of the mainland coastline in Andhra Pradesh, Kerala, Tamil Nadu and Pondicherry affecting several households. An estimated 2.7 million people were affected by the disaster and some 650000 were displaced (World Bank, 3 May 2005). Kashmir, in the north of India, was badly affected by the South Asian earthquake in October 2005, which made thousands of people homeless. According to official records, 150000 people were homeless following the earthquake disaster.[16]

Available reports indicate that more than 21 million people are internally displaced due to development projects in India. India is the third largest dam builder country in the world. It now has over 3600 large dams and over 700 more under construction.[17] Large dams are the single largest cause of displacement in India. Of those who were displaced in India due to construction of dams, more than 50 per cent are tribal (HRW, January 2006). The estimates of IDPs due to development induced displacement lack authenticity of data. Lack of proper surveys on development-induced displacement excludes a large proportion of affected families out of the alternative schemes offered to the project-affected persons. This reduces their chances of resettlement and exacerbates their vulnerability impacting access to health and healthcare (Himadri et al., 1999). There are reports of lack of basic facilities like food, medical supplies and sanitation in the State government organized relief camps for the internally displaced people (HRW, April 2002).

Reports suggest that more than half of the IDPs are at risk of falling victim to physical violence threatening their lives (Norwegian Refugee Council, 2005). Many IDPs remain exposed to violence and other human rights violations during and after their displacement. Often they have no or only very limited access to food, employment, education and health care. Large numbers of IDPs are caught in desperate situations amidst fighting or in remote and inaccessible areas cut-off from international assistance. Others have been forced to live away from their homes for many years, or even decades, because the conflicts that caused their displacement have remained unresolved. Women and children often are particularly vulnerable to sexual and other forms of violence. As lack of security also affects humanitarian access, many of those stuck in dangerous situations also have limited possibilities of getting humanitarian assistance, which, in addition to immediate physical threats, makes them more vulnerable to malnutrition and diseases.

[16] USAID, 2005, Earthquake Estimates, December
[17] Taneja, Bansuri and Thakkar, Himanshu, On Dams, World Commission on Dams, accessed:5th April, 2006

1.B. ii) International Migrants in India

In India there are a large number of international migrants from other countries. In 2001 Census about 5.1 million persons were reported as *migrants by last residence* from across the International border. Neighbouring countries are the main source of origin of the international migrants to India. 4.9 million persons who migrated from the neighbouring countries constitute 96.9 per cent of the total migrants from abroad. The bulk of these migrants were from Bangladesh, followed by Pakistan and Nepal. But for the purpose of this paper, the main focus would be on low-skilled and unskilled internal migration to India and refugees.

Restrictions on legal entry at in most countries of destination, enforced through strict visa regimes and carrier sanctions, mean that a large proportion of migrants travel with illegal documents, often using long, torturous and dangerous routes to countries of destination. Since the movement of population is illegal, the estimates of entry of migrants to the countries of their destination remain largely undocumented. Restrictive approaches based on efforts to obstruct or deter people moving from one country and region to another, have had a negative impact on prospective migrants and asylum seekers violating their human rights principles and force them into the hands of human traffickers. Trafficking occurs in a wide range of situations and takes many forms. There are well-established trafficking routes of women and children from the neighbouring countries to India. Bangladesh, SriLanka and Nepal are common neighbouring countries from which women migrate to India as part of an organized trafficking network. The movement of trafficked persons is based on deception and coercion and its main purpose is exploitation. In the case of illegal international migrant, the issue of legality is the main cause of vulnerability. The vulnerability of undocumented migrants is multiplied by their illegal and clandestine condition. When migrants enter another country illegally and subsequently lose any legal immigration status, his or her vulnerability to abuse and exploitation increases sharply. In many situations, migrants do not know what rights they are entitled to, and still less how to claim them, hence the cases of abuse goes unrecorded.

Another area where exploitation is rampant is forced labour which takes place in the illicit underground economy and so tends to escape national statistics. Irregular migrant workers are easy victims of abuse and exploitation by employers, migration agents, corrupt bureaucrats and criminal gangs. They often live on the margins of society, trying to avoid contact with authorities and have little or no legal access to prevention and healthcare services. Migrant workers predominate in the lower income labour market with higher risks of exposure to unsafe working conditions.[18] Many often they do not approach the health system of the host countries in the fear of their status being discovered.

[18] Allotey Pascale (2003), *Is Health a Fundamental Right for Migrants*, Guest Editorial Column in the journal Development, Vol 46, No 3, September.

Refugees are international migrants to India, who are understood as a fleeing stranger in need of sanctuary or someone who was received and treated as guests. Some refugees were integrated into the receiving society, while others may have chosen to return to their homes after a period of time (Samaddar, 2003). There have been several political developments and ethnic considerations which have resulted in a refugee problem in India. Because of ethnic violence in Sri Lanka, a large number of Sri Lankan refugees have crossed over to India since July, 1983 and their influx, though substantially reduced, still continues[19]. Displaced persons from East Pakistan who had come into India upto March 31, 1958 are known as 'Old Migrants'. They number about 41.17 lakh and the bulk of them, over 31 lakh stayed on in West Bengal. Following the partition, India received 2.55 million Hindu refugees from East Bengal. Again following the war of liberation in 1971, an estimated ten million refugees fled from Bangladesh to neighbouring India to escape from the atrocities of the Pakistan Army and their local collaborators. Within a month after the crackdown of the Pakistan Army on 25 March 1971, nearly a million refugees entered India. By the end of May, the average daily influx into India was over 100000 and had reached a total of almost four million. By the end of 1971, figures provided by the Indian government to the United Nations indicated that this total had reached 10 million. India quickly announced that all refugees who had entered the country after 25 March 1971 would need to return to Bangladesh by the end of February 1972. Remarkably, by the end of February 1972, over nine million refugees had returned back to Bangladesh.

A recent estimate of refugees in India amounts to 162687 (UNHCR, 2005). The number of refugees in India is declining from 1994 to 2004 (See Appendix 2). The total number of refugee population living in camps is 165292 of which 11493 stay in urban areas and the rest 153799 are dispersed across various regions. Refugees have an added complexity of nationalism, ethnicity and social norms[20]. Refugees may also face racism and xenophobia in the countries of destination. At times of political crisis, they may be the first to be targeted. In recent years, the linkages drawn between antiterrorism and immigration control in the context of the 'war on terror', has led to many governments having unintentionally encouraged discrimination against international migrants and refugees.

1. C. Migrant Women and Children

Migration among women and children (both internal and international) warrants special attention in the context of migration from the perspective of human rights. Migration among women and children and its associated vulnerability poses complex public health challenge. In the migratory pattern within India, women and children have always featured as

[19] Sri Lankan Refugees in India

Year	January	February	March	April	May	June	July	August	Sept.	October	November	December
1999	370	408	579	546	769	612	448	387	287	379	72	120
2000	92	181	257	198	288	200	138	45	29	41	46	105

Source: Ministry of Home Affairs, mha.nic.in/AR01CHP14.htm

[20] Bangladesh Documents, Vol. I, New Delhi, Government of India, Ministry of External Affairs, p.464

"associated" migrants with the main decision to migrate being taken by the male of the household. Internally migration within and outside the States of India, has always thrown out higher figures of female migrants citing, *'Marriage'* and *'Moved with household'* as the two most important reasons to move among women. This is primarily in consonance with the belief that man is the prime breadwinner of the household and is responsible to take important decisions. Women are largely care givers. This belief holds ground as is evident from the trend displayed in the subsequent censuses on migration.[21] According to the 2001 Census, 42.4 million migrants out of the total 65.4 million female migrants in India, mentioned marriage as the main reason to migrate within the country. As associated migrants, women suffer greater vulnerability due to reduced economic choices and lack of social support in the new area of destination. In the case of semi/ low-skilled or unskilled women migrants, this can translate into their entry into the low paying, unorganized sector with high exposure to exploitation and abuse.

But this scenario has changed globally. International migration of women for employment has increased over a period of time mainly with the changing vicissitudes of the global economy that has lead to the reversal of the income dynamics of individual households. Post 1990s, globally the identity of women as laborers became pervasive. Women migrant labour now accounts for 46 per cent of the overall international migration from developing countries.[22] In India, there are a large number of international women migrants. Female migration to India constitutes 48 per cent of the total in-migration from other countries. Migration among women has been high from Bangladesh and Nepal as compared to other neighbouring countries. Low/skilled or semi-skilled migration has an impact on their choice of occupation and the conditions of work. Many of the low/semi skilled female migrants work in the unorganized sector.[23] They work in hazardous conditions, live in shanty arrangements and are denied access to health and health care.

Trafficking also contributes to the cross-border movement of a large proportion of women into other countries. As mentioned earlier, there are established routes of trafficking in India used to facilitate the movement of women and children from across the borders in order to sustain the underground economy. Women and children in an irregular situation are doubly vulnerable owing to their lack of proper legal status and high risk of sexual exploitation.

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[21] In India, out of the total 82.1 million migrants by last residence during 1981-1991 about 36.1 million and 10.1 million were female migrants who migrated due to marriage and moved with family. In 2001 Census, about 42.2 million and 12.2 million were female migrants who migrated for marriage and moved with household respectively out of the total 97.8 million migrants. This estimate includes both skilled and unskilled female migrants.

[22] Citation available in Meenakshi Thapan's Series Introduction for Sandhya Arya and Anupama Roy edited, Poverty, Gender and Migration, New Delhi: Sage Publication, pg.9. The original citation is Susie Jolly, Emma Bell and Lata Narayanswamy,(2003), Gender and Migration in Asia: Overview and Annotated Bibliography, No 13. Bridge, Institute of Development, UK.

[23] Many of the migrant women work as domestic help, in beauty parlours as helpers, sweepers, prostitutes etc.

There are a large proportion of women and children refugees in the camps in India. There are 1, 22,078 Tibetan refugees in India, of which 43,708 are women and 23,122 children (0-14 age group)[24]. According to the UNHCR estimates, there are 12,760 Afghan refugees in India, of whom 9,417 are women, and children, which amounts to 74 per cent being women and children. Of these 4 percent are children below the age of five years.[25] Those in the refugee camps face large-scale atrocities. Very often, women in the camps, suffer sexual abuse during conflict. Women migrants have higher risks of being victimized at the work place and suffer sexual exploitation with its associated reproductive and mental health problems.

2. Health implications for those on the move

Public health threats arise in migrant populations when diseases are communicable and infected persons move or migrate. Cataloguing the morbidity reported among migrants makes the relation between migration and morbidity clear. Understanding the relationship is particularly important from the public health perspective. Different types of migration lead to diversified vulnerability among both internal and international migrants. The common possible determinants of health risks among migrants are the motivational factors (reasons for migration, occupational at the source of origin[27]), occupation related factors[27] and environment-related factors[28]. The factors that increase the health risks and health outcomes either directly or indirectly are not exclusive. Box 3. below gives several factors that affect migrant's health. The factors are inter-correlated.

Box 3

Causal Factors Affecting Migrant's Health

- *Overcrowded living conditions which facilitate increased transmission of infectious diseases*
- *Poor nutritional status(and consequent lowered immunity) due to lack of food before, during and after displacement*
- *Inadequate quantities and quality of water to sustain health and allow personal hygiene*
- *Poor environmental sanitation*
- *Inadequate Shelter*

[24] Tibetan Planning Commission, 1984, Tibetan Demographic Survey, Dharamshala

[25] UNHRC, 2001, http://www.UNHRC.CH, Women, Children and Older Refugee: The Sex and Age Distribution of Refugee Population with a Special Emphasis on UNHRC Policy Priorities, Geneva: Population Data, Unit Population And Geographic Data Section, United Nations High Commissioner For Refugees, p.10.

[26] These factors change and impact priorities at the destination areas. For example, perception and awareness of poor health; however, health expenditure depends on the socio-economic profile of the migrants at the areas of origin.

[27] Occupation related health hazards.

[28] Poor living conditions impact health.

The morbidity patterns among migrants vary with the type of migration and its scope for generation of health risk. For instance, in the case of internal migration among poor labourers, their susceptibility to health problems stems from their peripheral socio-economic existence in the host areas. Since they are absorbed in the informal economy, they exist as undocumented labour in most cases and fall outside the coverage of the labour-welfare schemes[29] and hence, the employer does not provide them their due. Poor living conditions such as lack of proper water supply, poor drainage system and unhealthy practices and deplorable sanitary conditions expose the migrants to various kinds of health risks predetermined by their standard of living and their choice of occupation (Sundar et al, 2000; VHAI, 2000, Ray 1993). These harm the migrants and increase the chance of their being prone to infectious diseases[30].

Living arrangement, living conditions, and health behaviour are related to the incidence of infectious diseases. Malaria, hepatitis, typhoid fever, and respiratory infection are found with a higher incidence among migrants The occupation-related commonly reported problems among migrant workers working in the informal sector are cold- cough fever, diarrhea, tiredness, lack of appetite, giddiness, weight loss, stomach pain, hip pain, headache, pain in the neck, swelling of legs, swelling of hands, hair loss, skin diseases, injuries, chest pain, eye problems among others (Jeyaranjan, 2000). Migrant labourers avail themselves of curative care but they fall outside the coverage of preventive care largely due to their fluidity of movement caused by uncertainty of employment. The low health status of women can be seen from indicators such as antenatal care coverage, prevalence of anemia, prevalence of reproductive tract infections and violence against women (Kundu, 2002). Children suffer from malnutrition and low immunization when their parents are in perpetual low-income uncertain jobs that necessitate frequent shifts based on concentration of work (Sundar et al, 2000). Measles is found to be common among migrants mainly among children who do not have immunization (Harpham, 1994).

Migrant labour is more susceptible to HIV/AIDS infection. A study on the vulnerability of the workers in an industrial are in New Delhi that in the absence of proper observance of existing labour rights, the migrant labourers continue to live in squalid surroundings and have hazardous working atmosphere. They are not provided the basic needs. Most of the workers have multiple partners and indulge in high risk behaviour with a very low pattern of condom usage. They also reported high alcohol

[29] In cases of rural to urban migration where the push factors are essentially economic i.e., landlessness, debts, joblessness, etc., the need of the migrant is more than the employers need for labour. This gap in the level of *need* between the labourer and the employer reduces the time of bargaining for the right price of labour benefiting the employer who buys labour at his price irrespective of the market price. The *need* element of the migrant reduces his/her labour price.

[30] The World Bank and WHO has estimated that in India, 21 per cent of all communicable diseases (11.5 per cent of all diseases) are water related. The specific diseases are diarrhea, trachoma, intestinal worms, hepatitis and tropical cluster (schistosomiasis, leishmaniasis, lymphatic filariasis in India) of diseases (Parikh, 2000).

Box 4

Migration, Mobility and HIV/AIDS

Migrants and mobile people become more vulnerable to HIV/AIDS. By itself being mobile is not a risk factor for HIV/AIDS. It is the situations encountered and behaviours possibly engaged in during the mobility or migration that increases vulnerability and risk. Migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), health services. – International Organization of Migration, 2005.

consumption and drug use. All these place them at high risk for HIV/AIDS (Singh R., N Atteq, J.John, 1999 ; Lingam,1998). The most vulnerable sub-population is sex workers is found to be those who are trafficked from neighbouring countries or those from rural areas who lack education and migrate to cities as a surviving strategy.

There are health risks for people displaced due to development activities such as dam construction[31] and conflicts. Internally displaced people are usually housed in tents or one-room tenements or just spaces, bereft of basic amenities of life. Others are on the move in search of shelter and livelihood and lead a nomadic existence. The health, both mental and physical, of IDPs has been the greatest casualty. The trauma of forced exodus and the exposure to an alien and hostile environment are further compounded by the problems of acclimatisation, lack of basic amenities such as drinking water, drainage and sewerage, absence of proper lavatory facilities, poor housing, over-crowding, and extremes of climate, lack of healthcare, joblessness, idleness, depression, disease and death. A health survey among displaced Kashmiri Pandits reveals that the affected population shows multiple signs of deteriorating health like high incidence of serious and potentially fatal diseases (Norwegian Refugee Council, 2005).

The emotional stress of displacement and the toll that this takes can have a great impact on physical as well as mental health. Large numbers mental health problems are reported among IDPs. Stress disorder leads to cardio-vascular stress, psycho-trauma, endocrine stress, musculo-skeletal stress, stress-belly (ulcers etc) and cranial stress (tension headaches and migraines). Hypertension is common even among the youth. Stress diabetes is a new syndrome (Daily Excelsior, 3 September 2003). Psychological and mental disorders are epidemic in proportion. Reactive depression and nervous breakdown are very common in the youth. Males have overt

[31] Sometimes water impoundments increase favourable vector sites at times of the year offering to be a breeding site for mosquitoes. They transit a number of tropical diseases.

Box 5

Health Problems in the Context of Trafficking

Mental trauma
Physical trauma
Communicable disease
Violence, including sexual abuse

Source: International Organisation of Migration, 2005.

depression. Female complaints are more somatic in nature. Older people have retarded depression. Even schizophrenia is reported among IDPs. Constant uncertainty has created chronic, impending and ongoing phobias. Refugees like IDPs suffer from poor mental health. Cases of neurological disorders are also commonly reported in the refugee sites (Norwegian Refugee Council, 2005).

Refugees are placed at a high degree of vulnerability as far as their exposure to diseases is concerned and this exacerbates by their status in the host country and their uncertain future of relationship with the country of origin. They have restricted access to social goods in the host country. Many refugee camps lack sanitation, water, electricity and have little or no access to medical facilities (Norwegian Refugee Council, 2005). A report by the South Asia Human Rights Documentation Centre in 1994 described the conditions in the camps as abysmal (SAHRDC, 1994). The major causes of morbidity and mortality among refugees are measles, diarrhoeal diseases, acute respiratory infections, malaria and malnutrition. A direct causal relationship between malnutrition and mortality in the refugee sites is evident, and this is most pronounced among children under five years of age. Malnutrition is both a primary and secondary cause of death among children (Norwegian Refugee Council, 2005). The refugee camps lack basic medical facilities. The results are devastating in terms of morbidity and mortality among the children (Norwegian Refugee Council, 2005). Children also suffer as they grow in sometimes violent and insecure environment. The NHRC reported that children were one of the major sufferers in the refugee camps due to the neglect of their education and health[32].

Women like children have specific needs than others in the refugee camps. The gender dimensions of ethnic nationalism and the related struggle for identity formation, manifests itself in the form of violence on women in the case of refugee women. As women they are targeted for sexual violence because of the nation or the community they represent. Several cases of chronic vaginal discharge due to vaginal infection and ovarian failure related to sexual abuse are commonly reported by women in the refugee camps (International Initiative of Justice, December 2003, pp.64, 67).

[32] National Human Rights Commission, India, July 1996, 'Human Rights Newsletter'.

Various reports have underlined the importance of meeting the reproductive health needs of women and adolescents in the camps.[33] Cases of polymenorrhea (shortened menstrual cycles), dysmenorrhoea (painful menses) and menstrual irregularity are common among women and adolescent girls in the refugee camps. The most common cause for such health problems is violence on women and the associated psychological and physical stress. (International Initiative of Justice, 2003). There are also many cases of mental problems reported among women in the refugee camps. Skin diseases, nutrition syndromes, incidence of tuberculosis, renal stones, renal failure and asthma are among other commonly reported morbidity in the camps (Samaddar, 2003).

3. The Human Rights of Migrants

The Vienna Declaration and the Programme of Action (1993) attached great importance to the promotion and protection of the human rights of persons belonging to vulnerable groups, including migrant workers.[34] States were urged to create conditions to foster greater harmony and tolerance between migrant workers and the rest of the society of the State in which they reside. Refugees and migrants have been recognized as groups with special protection needs. Each government is allowed to exercise its national sovereignty to decide who to admit into its territory, but once the individual has entered the country, the national government is responsible for the protection of his or her rights. But between refugees and migrants, the former received more attention than the latter on the grounds that they lack protection by their own governments. A special protection 'regime' was created for the refugees to protect them from refoulement, to recognize their civil, social, economic and cultural rights, and place them under the protection of individual states and of the UNHCR.[35] The UNHCR was formed with enormous protection mandate for refugees.

Refugees and children's rights have been defined in separate treaties quite early but there was no legal text for migrants which included all the different elements and aspects of migration, and which was accepted as legally binding and authoritative by a majority of states. It was perhaps the move to prioritize the rights of refugees which has led the international community to give less attention to the rights of migrants and a much less developed human rights protection.

[33] A study was conducted to compare 400 females with menopausal symptoms after migration and an equal number who developed menopause before exile. It showed that 25 women in the age group 35-40 years developed menopause after exile compared to nine before migration. In the age group 41 to 45 years, 34 developed menopause after exile as against 26 before exile. More than 36 per cent women become infertile by the time they reach 40 years of age after Migration (Norwegian Refugee Council, 2005).

[34] In the last half century, human rights have been transformed from the abstract principles embodied in the Universal Declaration of Human Rights (UDHR), to become legal entitlements for individuals, and legal duties for states. The body of international law seeks to regulate the relationship between the state and individuals within its territory and jurisdiction. The central principal is nondiscrimination and equal treatment. In the context of vulnerable groups, governments have recognized that some individuals and groups are particularly vulnerable; although they enjoy the same universal protection as everyone, they also have special protection needs.

[35] Convention on the Status of Refugees (1951) and Protocol.

But the increased movement of people across the globe for labour and the serious concerns raised about the existing labour standards of individual states necessitated the need to protect the rights of the migrants by governments. The value of a rights based approach to migration lies in its ability to identify at an early stage laws, policies and practices which could lead to abuse of migrant's rights. The Hague Declaration focused on adopting a more humane approach to migrants and migration. Migrants now have rights under two sets of international instruments: first, the core human rights treaties such as the *International Covenant on Civil and Political Rights (ICCPR),* whose provisions apply universally, and thus protect migrants; and second the new *Convention on Migrant Workers (CMW)* and the *ILO Conventions* which specifically apply to migrants, and in particular to migrant workers. Despite several attempts, migrants continued to be protected under an amalgam of general internal law, human rights law, labour law, and international criminal law. But with the Convention of Migrant Workers (CMV), the provisions for the protection of the migrants received formal sanction. The CMW was adopted by the General Assembly at its 45th session on 18 December 1990.

The *Convention on Migrant Workers* brings together in a single text the rights of the migrants including the irregular migrants. Most of the rights set out in Part III, which applies to all migrant workers are related to the fundamental civil and political rights.[36] The Convention establishes a Committee to oversee implementation by the States.[37] The CMW treaty came into effect only in 2003. It has been accepted as legally binding by relatively few governments but no major employment country has thus far ratified it (*See Appendix 3 for Status of Ratification of the CMP* by countries). At present, the number of ratifications of the Convention is 25 (Steering Committee Report, 2003). The CMW lacks the legal authority of other human rights treaties as it has not been ratified by majority of states. But, the UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (UN Convention on Migrant Workers) clearly spells the global focus on the human rights of migrants

Migrant's rights in the most extreme situations, that is, war, genocide or crimes against humanity are protected under international criminal law, and international humanitarian law. Two protocols to the UN Convention against Transnational Organised Crime protect migrant's rights in situations of trafficking and to a lesser degree where they are smuggled. The mandate for the Special Rapportuer for Human Rights of Migrants was established in 1999.

[36] Part III contains that there has to be equal treatment between all migrant workers and nationals to their families, giving them equal treatment in respect of their basic economic and social rights, including remuneration, work and employment conditions, social security, emergency medical care, and access to education for the children of migrant workers. Part IV, is only for regular migrants and relates to access to educational institutions and service, vocational guidance and training, housing, social and health services, and participation in cultural life. They are given the right to form trade union and rights to political participation. They also have a right to family reunification.

[37] The Committee examines reports from States, and considers communications from individual and other states alleging violations. An ILO representative is to participate in a consultative capacity at the Committee's meetings.

There are only two international treaties that recognize health rights of irregular migrants: the *Convention on Migrant Workers (1990)* and the *Rural Worker's Organizations Convention (1975).* The right to health among migrant workers is encapsulated in Article 43 of the CMW about the protection of the rights of all migrant workers and the members of their families. It makes a reference to the access to social and health services by migrants in the host countries. (See Box 6 below for details.)

Box 6

International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families

Article 43

1. *Migrant workers shall enjoy equality of treatment with nationals of the State of employment in relation to:*
   a. *Access to educational institutions and services subject to the admission requirements and other regulations of the institutions and services concerned;*
   b. *Access to vocational guidance and placement services;*
   c. *Access to vocational training and retraining facilities and institutions;*
   d. *Access to housing, including social housing schemes, and protection against exploitation in respect of rents;*
   e. *Access to social and health services, provided that the requirements for participation in the respective schemes are met;*
   f. *Access to co-operatives and self-managed enterprises, which shall not imply a change of their migration status and shall be subject to the rules and regulations of the bodies concerned;*
   g. *Access to and participation in cultural life.*
2. *States Parties shall promote conditions to ensure effective equality of treatment to enable migrant workers to enjoy the rights mentioned in paragraph 1 of the present article whenever the terms of their stay, as authorized by the State of employment, meet the appropriate requirements.*
3. *States of employment shall not prevent an employer of migrant workers from establishing housing or social or cultural facilities for them. Subject to article 70 of the present Convention, a State of employment may make the establishment of such facilities subject to the requirements generally applied in that State concerning their installation.*

Advocacy for the protection of the health right of migrants have taken place through several platforms internationally. The Committee on Economic, Social and Cultural Rights (CESC), states that States have an obligation to respect the right to health 'by refraining from denying or limiting equal access-on economic, physical and cultural grounds-for all persons, including .....asylum seekers and illegal immigrants, to preventive, curative and palliative health services.[38] The Programme of Action of the 1994 *International Conference on Population and Development* made several references to migrants and their health.[39] The *Beijing Platform for Action* (1995) recognized the barriers of displaced immigrant and migrant women, including women migrant workers and urged governments to protect the human rights of women migrants and protect them from violence and exploitation and introduce measures for the empowerment of documented women migrants. The 1999 final document proposing key actions for the further implementation of the *Programme of Action of the Cairo Conference* urged governments of both the countries of origin and destination to "provide effective protection for migrants and provide basic health and social services, including sexual and reproductive health and family planning...." (WHO, 2003).

3. A. Migrants Rights in India

India has ratified many ILO conventions but is neither a signatory or ratified the CMW. The Indian Constitution contains basic provisions relating to the conditions of employment, nondiscrimination, right to work etc. (for example, Article 23 (1), Article 39, Article 42, Article 43) which are applicable for all workers including migrant workers within the country. Migrant labourers are covered under almost all labourers laws and policies. These laws include the Minimum Wages Act, 1948; the Contract Labour (Regulation and Abolition) Act, 1970; the Equal Remuneration Act, 1976; the Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act, 1996; the Workmen's Compensation Act 1923; the Payment of Wages Act 1936; the Child Labour (Prohibition & Regulation) Act, 1986; the Bonded Labour Act, 1976; the Employees State Insurance Act, 1952; and Maternity Benefit Act, 1961.The last two Acts cover only organized sector workers and exclude temporary migrants.

[38] The International Covenant on Economic, Social Cultural, General Comment No 14 (2000) paragraph 12 (a) mentions right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[39] It urged government to provide migrants and refugees with access to adequate healthcare services. I also urged governments to take care of the basic healthcare needs including reproductive health services and family planning of the internally displaced people.

Box 7

Existing Labour Laws in India Relevant for Migrant Workers

All Workers

- *Workmen's Compensation Act 1923*
- *Payment of Wages Act 1936*
- *Minimum Wages Act, 1948*
- *Contract Labour (Regulation and Abolition) Act, 1970*
- *Bonded Labour Act, 1976*
- *Equal Remuneration Act, 1976*
- *Building and Other Construction Workers (Regulation of Employment and Conditions of Service) Act 1996*
- *Child Labour (Prohibition & Regulation) Act, 1986*

Workers in Organised Sector

- *Employees State Insurance Act, 1952*
- *Maternity Benefit Act, 1961*

In addition to the above laws, Parliament passed the *Inter State Migrant Workmen (Regulation and Conditions of Service) Act 1979*, specifically to deal with malpractices associated with the recruitment and employment of workers who migrate across state boundaries. The Act followed the recommendations of a committee set up by the Labour Minister's Conference in 1976. The Act only covers interstate migrants recruited through contractors or middlemen and those establishments that employ five or more such workers on any given day. The Inter-State Migration Workmen Act, 1979, defines a migrant workman as one who is recruited by the contractor in the workman's home state. It clearly states that migrant workers are entitled to equitable money to dependent family payable by employers along with their travel expenses when they migrate.

Box 8

Inter State Migrant Workmen Act, 1979

- *Contractors and establishments are required to be licensed and registered by a notified registering authority.*
- *The Contractor is required to issue a passbook to every worker, giving details about the worker, including payments and advances, and pay each worker a displacement allowance and a journey allowance.*
- *Contractors must pay timely wages equal to or higher than the minimum wage; prescribed medical facilities and protective clothing; and notify accidents and casualties to specified authorities and kin.*

3. B. Existing Gaps Interfering with the Realisation of the Right to Health

The human rights deficit among migrants is a reflection of inept national policies and international politics between and within countries. Realisation of rights by migrants also suffers due to many other factors. *The most important factor that separates the rights from being realized is the gross underestimation of migrants both internal and international at the origin and destination*. This factor is of utmost importance in the case of international migration where lack of a proper system of registering either at source or destination areas has also been responsible for exploitation of migrants and their lack of coverage within any existing national or international policies and guidelines.

The existing data on international migrants in India underscores the links between irregular migration, trafficking and smuggling; between irregular migration and exploitative labour, and generally between irregular immigration status and violation of human rights by national authorities or by private individuals, employers, and criminal groups. The data-gap has held back rights protection and research-based policy making. Methodological hurdles involving the inappropriateness of the use of conventional methods of data collection which cannot easily be adapted to situations involving illegality, where people fear to report abuse, further complicated the process of estimating the number of international migrants. In general terms, in the case of international migration in many countries, the failure to separate rights protection from immigration control, especially in relation to employment, has prevented migrants from reporting abuses to the authorities. This gap is has been further augmented by lack of awareness among migrants about their rights. Lack of consular access in cases of abuse has been a major impediment in the realization of rights by migrants especially in cases of victims of trafficking.

In India, in the case of internal migration among the poor labourers, the migrant's rights have remained elusive. Available studies clearly show that human rights are generally not well protected in informal sector employment. Most of the migrant workers cannot avail themselves of the existing schemes under the national policy

on migrant workers as the casualisation of work and the subsequent absorption in the informal sector beats the actual number of migrants working in the informal sector. The Inter State Migrant Workmen Act, has largely remained on paper and proved to be futile in the backdrop of helplessness, ignorance and desperation of the prospective migrants. In the case of the 1979 Act, few contractors have taken licenses and very few enterprises employing interstate migrant workers have registered under the Act. The record of prosecutions and dispute has been very weak. Migrant workers do not posses pass books, prescribed by the law, and forming the basic record of their identity and their transactions with the contractor and employers (National Commission of Rural Labour 1991).[40]

Several studies conducted on the migrant workers working in the unorganized sector in several states point out the violations of the Child Labour (Prohibition & Regulation Act 1986), the Minimum Wages Act (1948), the Contract Labour Act (1970), the Inter State Migrant Workmen Act (1979) and the Equal Remuneration Act (1976) (Breman, 1996; Biswas 2003; Gamber & Kulkarni 2003).[41] A recent tragedy of workers losing their lives due to lack of safety conditions during work, in the month of December, 2005 in Delhi, exposed once again the abysmal working conditions prevailing in the unorganized sector and raised the issue of safety of the workers in the unorganized sectors. In the first case, fire broke out in a garments factory in East Delhi, and in the second case 12 workers buried under the debris at a construction site in South Delhi. The commonality between two isolated incidents within the same month is that the workers who lost their lives were migrants from mostly West Bengal and Bihar. Living in shanty accommodations, these migrant workers were employed on a casual basis by the employer.[42] The rights of IDPs are even more neglected as there is lack of systematic information of the accurate estimate of people displaced due to conflicts, development projects and natural disaster.

4. Conclusion: Including the Excluded

Ensuring social, legal and human rights to migrants has been difficult. The rights-based approach to migration has indeed expanded the scope of understanding migration as an indispensable process in the scheme of globalization and identified migrants as an important part in the process of development. It resurrects migrants from the world of obscurity and peripheral existence to the core of society dynamics. The human rights approach to migration shifts the focus from how to

[40] The Unorganized Sector Workers Bill, 2003 has been drafted by the Central Government following the recommendations of the Second National Commission of Labour 2002, to identify workers employed in the unorganized sector and to provide them with basic social security (*See Appendix 4 for details*).

[41] This is more present among migrant workers in the brick kilns factories, construction industry, sugarcane plantation, etc. Different kinds of harassment are meted out to migrant workers by the employers, labour contractors, police during their journey, etc. Migrant labour is recruited from various parts of a particular state through contractors or agents for work outside that state in large construction sites and sugarcane plantations. This system lends itself to abuses –working hours are not fixed and workers have to work under extremely harsh conditions. Employment in the unorganized sector compounds their vulnerability.

[42] Basu Moushumi ,(2006), *Delhi's Twin Tragedy*, Commentary, Economic & Political Weekly, Vol. XLI No 9, March 4-10, pg. 784.

prevent migration to the rights of migrants, refugees and displaced within their new environment and their possibly permanent senses of loss of home, identity and citizenship rights in some cases. The focus on rights of migrants thus is inextricably linked to the concept of integration rather than exclusion. Integration in case of migrants is a much nuanced and difficult term to conceptualize and even harder to practice. Ultimately it is about a nation's and more importantly the international community's ability to tackle prejudice, respect the different histories and competing identities.

The 'rights based approach' to migration implies the interpretation of human rights principles and labour standards into policy making. Such an approach necessitates the use of commitments voluntarily made by the state- whether of origin, destination or transit – to protect rights and prevent serious human rights violations during the migration cycle. There is a need to introduce rights-based approach to frame migration policies which includes observance of international human rights norms, including equality and non-discrimination, standard setting and accountability, the recognition of migrants as subjects and holders of rights, the participation of migrant communities and the integration of gender, child's rights and ethnic perspective.

A rights based approach to migration includes the following elements:

- Before any new law, policy or practice is introduced; it should be reviewed to ensure its consistency with the state's national, regional and international human rights obligations, and international labour standards. There should be an assessment of the human rights impact to ensure that the policy measures, for instance anti trafficking measures, comply with respect for human rights
- There should be systematic data collection and its disaggregation by sex, geographic origin, age and ethnicity, to enable discrimination or potential discrimination to be identified, and eliminated
- Existing national laws should be reviewed to see if they protect migrants and citizens equally
- Employment contracts, made under bi-lateral agreements, should reflect labour and human rights[43]

4. A. Inclusive Healthcare for Migrants

Healthcare of migrants has suffered due to the presence of divergent models of how and when nations are responsible for the health and safety of individuals. This problem becomes pronounced in case of migrants linking two nations that endorse divergent models and irregular migrants who get trapped as they are not eligible to receive health service from either nations or finally falling prey to individuals exploiting this policy differences for their own benefit. There are three different legislative responsibility models currently in use to determine a country's healthcare obligations towards international migrants. The *Host Nation model* bases territorial responsibility of the state towards all

[43] Would refer to workers moving for temporary employment under GATS Mode 4 agreements

individuals, legal or irregular within their national boundaries.[44] The *Source Nation model* differs from the former in then sense that it is based on contractual obligation, where citizenship is the exclusive determinant for healthcare responsibility. In the third model the migrant benefits when there is a relationship between the sending country and the host country.

Historically, the needs of the host countries/areas and the receiving countries/areas have been pitted against each other. Health policies have focused selectively on protecting receiving nations form disease importation and costly post-migration utilization of health care resources through the use of quarantine and regulatory exclusion. This approach at times had lead to discriminatory, inadequate and ineffective migration health programmes. Despite these attempts receiving countries/areas remained at the risk of disease importation. For migrant populations, these policies led to restricted movement, poorer health status, lack of access to necessary healthcare, ethical or confidentiality problems, and stigma and alienation in host and resettlement communities. Health policies have through decades followed an exclusionary paradigm towards migrants. Focusing primarily on regulatory exclusion is harmful to both migrants and receiving countries/areas. Exclusionary statues may inadvertently encourage migrants to conceal or temporarily treat their disease, resulting in increased migrant mortality. Concentration on exclusion raises ethical or discriminatory issues and result in migrant stigma or alienation. Inclusive policies and statues can promote better health among migrants. Any inclusive policy addressing the healthcare of migrants has to understand the dynamic relationship and interdependence that exists between migration and health, and between the needs of the numerous populations involved in the migration process.

A major obstacle to policy-making on migrants both internal and international has been the lack of information-on types of violation, the places where they occur, and their characteristics. Violations on migrants have been generally under-recorded. Official awareness of the multitude of seasonal migration or the importance of it in the lives of poor is abysmally low. The State is not geared to dealing with migrant and regards them as external to the systems that they work with. Policy-makers have tended to perceive migration largely as a problem, posing threat to social and economic stability and hence there has been an effort to control it, rather than viewing it as an important livelihood option for the poor. There has been little or no effort of organized support made accessible for the poor migrants who face insecurity in their source location as well as the destination areas.

The most obvious challenge is to integrate the needs of both the host and migrant

[44] The Thailand's Ministry of Public Health (MOPH) works in partnership with IOM and WHO to tackle migrant health issues since 2000. The Royal Thai Govt. has implemented a massive irregular migrant registration programme aimed at the estimated 1 million undocumented migrant workers in Thailand. Advertised in the migrant's three principal languages and promulgated through consenting employers, undocumented workers who register are granted the right to primary and reproductive healthcare, communicable disease control services, a health examination and a work permit.

Box 9

Integrating Health and Migration- Achieving a Balance

Receiving Population	Migrant Population
Improved disease protection	*Timely and safe movement*
Better resource utilization	*Targeted health intervention*
Infrastructure support	*Reduced morbidity and mortality*
Improved health and productivity	*Better health care access- reduced stigma*

Source: International Organization for Migration (2005)

populations. On one side, there is a responsibility to protect the host community from the threat of diseases and take care of their healthcare needs, on the other side; migrants have health and welfare priorities that are associated with their basic human right, including the right to health. Lack of culturally sensitive care also acts as a barrier to access of available healthcare. At every stage of migration process (from the decision to the journey, integration in a new community and return to the country of origin), the physical, mental and social well-being of individual migrants, their families and their communities need to be considered in policy-making ands practice (WHO,2004). Any response to the challenges posed by migration has to be sensitive to the reasons and the process of migration. A comprehensive interpretation of migration health goes beyond infectious disease control to the inclusion of chronic non-infectious conditions, mental health concerns, and an understanding of health and human rights issues.

Laws and policies protecting the rights of migrants during the migratory cycle should be set in the context of, and complemented by, development policies, which address the underlying causes of migration. The over-riding priority is to create a situation in which migration can take place in conditions of dignity, and become an informed choice rather than a strategy for survival in an economically asymmetric world.

Migrants' health extends to the underlying determinants including adequate nutrition, housing, healthy environment, and occupational conditions, access to health-related education and information as well as access to health care and education. The human rights framework facilitates an increased focus on the societal and contextual conditions within

Box 10

Priority Areas

- *Organisational reform/institutional development*
- *Primary health service provision for migrants/refugees*
- *Behavioral change of health providers and health seekers*
- *Research (collecting evidence on migrant's health)*

which migrants live and address the stigmatization and discrimination from the rights perspective.

Endnote

1. Census and National Sample Surveys (NSS) are two main sources of data on internal migration in India. NSS being a sample survey, the data has obvious limitations and is not helpful in knowing the district level pattern in the internal migration within each state. There is also a difference in defining migrants between Census and NSS. NSS adopted the *Usual Place of Residence*, to define migrants. A usual place of residence is defined as a place (village/town) where the person had stayed continuously for a period of *six months or more*. According to NSS, a migrant is defined if he or she had stayed continuously for at least six months or more in a place (village/town) other than the village/town where he or she was enumerated. Migration is measured in the two most common forms of data, that is, by events and transition. The census provides data on migrants based on *place of birth* (POB) and *place of last residence* (POLR). In the census, if the place of birth or place of last residence is different from the place of enumeration, a person is defined as migrant. Three types and four streams on internal migration have been identified. They are Intra-district Migration (i. *Rural to Urban, ii. Urban to Urban, iii. Rural to Rural iv. Urban to Urban*), Inter-District Migration (i. *Rural to Urban, ii. Urban to Urban, iii. Rural to Rural iv. Urban to Urban*) and Inter-Stare Migration (i. *Rural to Urban, ii. Urban to Urban, iii. Rural to Rural iv. Urban to Urban*). There is considerable criticism on the nature of data on migrants collected by the Census.

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Definitions and Concepts

Involuntary Migration is a result of extreme economic and often social hardships, and is undertaken mostly by landless or land-poor, unskilled and illiterate poor labourers or people displaced by socio-political crisis. Here there is no choice of the place or type of work that they undertake.

Forced migration refers to the involuntary movement of a person wishing to escape from armed conflict or a situation of violence and/or the violation of his/her rights, or a natural or man-made disaster. This term applies to refugee movements, movements caused by trafficking and the compelled exchange of populations among states.

Migrant Defined by Place of Birth is those who are born in the village or town where he/she is being enumerated.

Migrant Defined by Place of last Residence is those whose place of last residence is different from the place of the enumeration. The last residence may also be the birth place of the person incase he has not shifted to any other residence in between.

A refugee is a person seeking asylum in a foreign country in order to escape persecution. Some regional legal instruments further include those seeking to escape generalized violence in the definition of a refugee. Those who seek refugee status are sometimes known as asylum seekers and the practice of accepting such refugees is that of offering political asylum. The most common asylum claims to industrialized countries are based upon political and religious grounds.

Irregular migration refers to the movement of a person to a new place of residence or transit using irregular or illegal means, as the case may be, without valid documents or carrying forged documents. This term also covers trafficking in migrants.

Total migration/net migration is the sum total of the entries or arrivals of immigrants, and of exists, or departures of emigrants, yields the total migration, or the migration balance, resulting from the balance between arrivals and departures. The net immigration balance, or positive migration balance, refers to arrivals exceeding departures, and net emigration, or negative migration balance, to departures exceeding arrivals.

Trafficking in persons refers to the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

Internally Displaced Persons (IDPs) are forced to flee their homes because their lives were at danger, but unlike refugees they did not cross international borders.

Annexures

Annexure 1

Latest Census Questions on Migrants/Non-Migrants

A. Birth Place	B. Last Residence
i) Place of Birth	i) Place of Last Residence
ii) Rural/Urban	ii) Rural/Urban
iii) District	iii) District
iv) State/Country	iv) State/Country
C. Reasons of Migration (Last residence)	
D. Duration of Residence at the Village or Town of Enumeration	

Annexure 2

Status of ratification of the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families

Number of States parties as of 1 March 2004: 25

State	Signature	Ratification, Acceptance (A), Accession (a), Succession (d)
Azerbaijan		11 Jan 1999 a
Bangladesh	7 Oct 1998	
Belize		14 Nov 2001 a
Bolivia		16 Oct 2000 a
Bosnia and Herzegovina		13 Dec 1996 a
Burkina Faso	16 Nov 2001	26 Nov 2003
Cape Verde		16 Sep 1997 a
Chile	24 Sep 1993	
Colombia		24 May 1995 a
Comoros	22 Sep 2000	
Ecuador		5 Feb 2002 a
Egypt		19 Feb 1993 a
El Salvador	13 Sep 2002	14 Mar 2003
Ghana	7 Sep 2000	7 Sep 2000
Guatemala	7 Sep 2000	14 Mar 2003
Guinea		7 Sep 2000 a
Guinea-Bissau	12 Sep 2000	
Kyrgyzstan		29 Sep 2003 a
Mali		5 Jun 2003 a
Mexico	22 May 1991	8 Mar 1999
Morocco	15 Aug 1991	21 Jun 1993
Paraguay	13 Sep 2000	
Philippines	15 Nov 1993	5 Jul 1995
Sao Tome and Principe	6 Sep 2000	
Senegal		9 Jun 1999 a
Seychelles		15 Dec 1994 a
Sierra Leone	15 Sep 2000	
Sri Lanka		11 Mar 1996 a
Tajikistan	7 Sep 2000	8 Jan 2002
Timor-Leste		30 Jan 2004 a
Togo	15 Nov 2001	
Turkey	13 Jan 1999	
Uganda		14 Nov 1995 a
Uruguay		15 Feb 2001 a

Annexure 3

Key Provisions of the Unorganised Sector Workers Bill, 2004

- The scope of the Act will extend to all workers in the unorganized sector, whether directly or through an agency or contractor, whether a casual or temporary worker, a migrant worker or a home based worker (self-employed or employed for wages)
- Central and State governments shall constitute an 'Unorganised Sector Workers Central Board' and similar state boards for the administration and coordination of the Act at central and state levels.
- The boards shall set up 'Workers Facilitation Centres' for the registration of workers; issue of social security numbers and identity cards ; mobilization of workers to become members of the Welfare Fund; assistance in dispute resolution and in the conduct of inspections.
- Concerned governments could notify welfare schemes for any class of employment under the Act and establish a Fund for this purpose. It could also regulate the conditions of employment.
- The Welfare Fund will receive contributions from the government, employers and workers. Workers will have to make regular contribution to the Fund until age of 60.
- All workers, including self-employed or home-based will be eligible for registration.
- Lok Shramik Panchayats shall be formed for dispute resolution in the unorganized sector.
- The government will appoint persons known as 'Shramik Samrakshak' to carry out inspection and check

Centre For Enquiry Into Health And Allied Themes
Research Centre Of Anusandhan Trust

CEHAT, in Hindi means “Health”. CEHAT, the research centre of Anusandhan Trust, stands for research, action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses, for strengthening people’s health movements and for realising right to health care. Its institutional structure acts as an interface between progressive people’s movements and academia.

CEHAT’s objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

We are a multi disciplinary team with training and experience in Medicine, Life Sciences, Economics, Social Sciences, Social Work, Journalism and Law. CEHAT’s projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, Ethics and Patients’ Rights, (3) Women’s Health, (4) Investigation and Treatment of Psycho-Social Trauma. An increasing part of this work is being done collaboratively and in partnership with other organisations and institutions.

Previous publications

		Year of Publication
1	Review of Health Care in India: Country Health report	2005
2	Health and Health Care in Maharashtra: Health Status Report of Maharashtra (in English and Hindi)	2005
3	Health Facilities in Jalna: A study of distribution, capacities and services offered in a district in Maharashtra	2004
4	Health and Health Care Situation in Jalna, Yawatmal and Nandurbar	2004
5	Population Ageing And Health In India	2006
6	Gendered Vulnerabilities: Women's Health And Access To Healthcare In India	2006
7	Tracing Human Rights In Health	2006

This is one of background papers to the Establishing Health as a Human Right Project. It reflects solely the views of the author. The views, analysis and conclusions are not intended to represent the views of the organisation.

ISBN : 81-89042-46-7