UNDERSTANDING REFUGEES: A PROFILE OF MOVEMENTS; POLICIES AND THEIR LIVING CONDITIONS WITH SPECIAL REFERENCE TO TIBETANS IN INDIA

Dissertation submitted to the Jawaharlal Nehru University
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MASTER IN PHILOSOPHY

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CERTIFICATE

This dissertation entitled **'Understanding refugees: A profile of movements; policies and their living conditions with special reference to Tibetans in India'** is submitted in partial fulfillment of the requirements for the award of **Master of Philosophy (M. Phil)** of this University. This dissertation has not been submitted for any degree of this University or any other University and is my original work.

Mina Toko

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

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'From one man he made every nation of men, that they should inhabit the whole earth; and he determined the times set for them and the exact places where they should live'.

Acts 17:27

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Finally, this is my prayer to the Lord my Saviour: bless me and enlarge my territory. Let Your hand be with me, and keep me from harm so that I will be free from pain and can be a testimony of Your wonders because You are good, and Your love endures forever.

As for the errors that remain in this dissertation, the responsibility is solely mine.

29/07/2008 *Mina Toko*

ABBREVIATION

AIIMS	All India Medical Institute of Medical Sciences
ANC	Antenatal Care Centre
APPSU	All Arunachal Pradesh Student Union
BCG	Bacille Calmette-Guerin
CAR	Central African Republic
CAT	International Convention against Torture and Cruel, Inhuman or Degrading Treatment or Punishment.
CBM	Confidence Building Measures
CEDAW	Convention for elimination of all forms of discrimination against women
CERD	International Convention on the elimination of all forms of racial discrimination.
CIA	Central Intelligence Agency
CMR	Child Mortality Rates.
CRC-I	Chin Refugee Comittee
CTA	Central Tibetan Administration
DALY	Disability Adjusted Life Years
DoH	Department of Health
DMK	Dravida Munnetra Kazhagam
DPT	Diptheria Tetanus
DRC	Democratic Republic of Congo
EPG	Eminent persons Group
GBV	Gender based violence
GOI	Government of India
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
ICCPR	International Convention on Civil and Political Rights
ICESCR	International Convention on Economic, Social and Cultural Rights
ICRC	International Council of Voluntary Agencies
ICMH	International Centre for Migration and Health
ICMR	Indian Council of Medical Research
IGCR	Intergovernmental Committee on Refugee
IMC	International Medical Corps
IMR	Infant Mortality Rate
IRO	International Refugee Organization
NGO	Non-governmental Organization
NHRC	National Human Rights Commission
OAU	Organization of African Unity
PHC	Primary Health Centre
PTSD	Post Traumatic Stress Disorder
RTI	Respiratory Tract Infections
SAARC	South Asian Association for Regional Cooperation
SAFHR	South Asian Forum for Human Rights
SC	Scheduled Caste
SLIC	Socio-Legal Centre
ST	Scheduled Tribe
TDS	Tibetan Demographic Survey

TMAI	Tibetan medicine and Astronauts Institution.
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNGA	United Nations General Assembly
UNHCR	United Nations High commission for Refugee
UNRRA	United Nations Relief and Rehabilitation and Administration
UNRWA	United Nation Relief and Work Agency
UNSC	United Nation of Security Council
USCRI	U.S committee for Refugee and Immigrants
USORR	U.S Office of Refugee Settlement
USA	United States of America
VHAI	Volunteer Health Association of India
VHAD	Volunteer Health Association of Delhi
WHO	World Health Organization
YMCA	Young Men Christian Association

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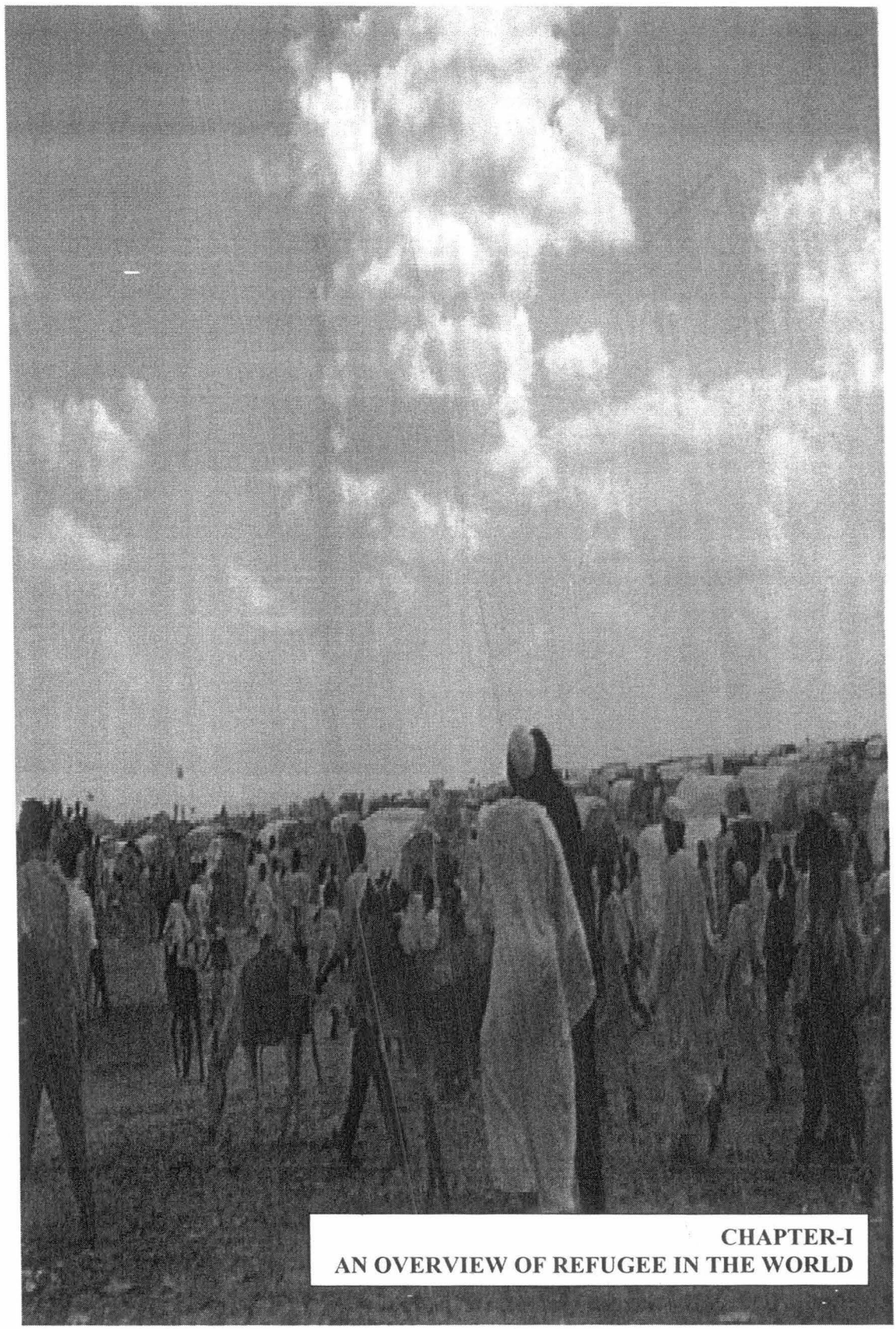

CHAPTER-I
AN OVERVIEW OF REFUGEE IN THE WORLD

CHAPTER-I

AN OVERVIEW OF REFUGEE IN THE WORLD

1. Introduction- Understanding Refugee

Refugees are people displaced from their origin habitat or place of residence. They are called 'refugees' , 'asylum seekers', and 'displaced persons' but no matter how they are referred to these are always the names of 'others'[1]. The process of 'others/othering' is inevitable with refugees. Movement of people from one place to another has been an age old phenomenon. But forcing people to move out from their established and known habitat emerged with the birth of nation state, gradually assuming religious racial or ideological character and identity. In the very process of the emergence of such identity, minorities and those groups of people who refused to confirm to the ideological and religious identities of the dominant nation state were persecuted and pushed out. Thus the phenomenon of refugees is as old as the emergence of nation state (Baral and Munni 1999). The problem of refugee has became enlarged and complex. The number of refugee is increasing world wide posing one of the greatest challenge. History records many aspects of tragic story of the refugee. When the UNHCR was established by the UN General Assembly to protect and assist refugees and find solution to their problems there were one million refugees but today as per USCRI Report on World Refugee Survey 2006 the total numbers of refugees and asylum seeker world wide is 13, 948,800.

2. Global distribution of refugee

UNHCR Statistical Yearbook shows, in 2006, the refugee population increased by 1.2 million persons (+14%) with an increase being recorded in North America (+89%), Asia (+30%), Latin America and the Caribbean (+8%), and Oceania (+5%). Europe and Africa experienced a decline of 8 and 6 per cent respectively. International Medical Corps

[1] It has been used in Social Science to understand the processes by which societies and groups exclude 'Others' who they want to subordinate or who do not fit into their society. For example, Edward Said's book *Orientalism* demonstrates how this was done by western societies—particularly England and France—to 'other' those people in the 'Orient' who they wanted to control.

(IMC) identifies that the number of refugee has fallen by one third but internally displaced people were increased by 22%. Refugee mainly as large groups in Africa and Asia , but generally as individual family units in Europe, Latin America and Caribbean. This was 31 percent fall compared to 2000 (UNHCR 2006). Repatriation fell 40 % compared with the previous year. Developing country produces 86% of the world's refugee in the last decade, but also provided asylum for seven out of ten of those fleeing. Female comprise of 48% of the uprooted people 7 out of ten asylum seekers is male. 32 countries showed, how ever that 76 % of females compared with 68 percentage of male were granted refugee status. Biggest refugee populations are 2.2 million Afghan populations in Pakistan and Iran. Asia is hosting the largest number of refugees (46%), followed by Africa (26%), Europe (16%), North America (10%), Oceania (1%), and Latin America and the Caribbean (0.4%) (Ibid).The fastest growing refugee population are Iraqi's in Syria i.e. 2 million. it is also identified that the five largest refugee movements are :

1. leaving TOGO for Benin or Ghana,
2. Leaving Sudan for Chad and Uganda,
3. Leaving DRC for Uganda , Burundi, Rawanda,
4. leaving Somalia for Yemen,
5. leaving CAR for Chad.

Table 1.1. Countries hosting the largest number of refugees

Country hosting refugee	Number of refugee in %
Asia	46%
Africa	26%
Europe	16%
North America	10%
Oceania	1%
Latin America and the Caribbean	0.4%

Source: UNHCR Statistical Year Book 2006

3. Defining Refugee

The term refugee is derived from the Latin word 'refugium' meaning "shelter, security, heaven". Its means one who flees from untenable situation to something hoped to be better else where across an international border. In France in late seventh century, the word refugee is regarded as having been used in 1573, referring to the grating of Asylum and assisting foreigners who were escaping persecution (Ahmed 2004). This popular conception of a refugee includes an element of emotion and the term refugee arouses the instinct of pity and brotherly feeling in the collective conscience of mankind and inevitably provokes spontaneous gesture of human sympathy (Vernant 1951).The field of 'refugee studies' has grown dramatically over since later part of twentieth century and deal substantively with refugees as its subject but still there is no clear terminological debate about who is and who is not refugee .And hence what is and what is not refugee studies (Black 2001).

The first international agreements defined a refugee as person who no longer enjoyed the protection of their government and had not acquired another nationality. In fact, the definitions come into play when countries and organizations attempt to determine who is and who is not a refugee. According to the humanitarian definition, a refugee is someone who has fled his country because he has a well-founded fear of persecution if he remains. While the definition in the Refugee Convention has been used by international organizations such as the United Nations, the term continues to be misunderstood and is often used inconsistently in every day language. Media stories, for example, often confuse refugees with people migrating for economic reasons ("economic migrants") and persecuted groups who remain within their own country and don't cross an international border ("internally displaced persons").For further explanation to avoid overlap and unnecessary confusion following are the key terms: **a) Refugee** – someone who has left her or his country or is unable to return to it owing to a well founded fear of persecution for reasons of race, religion, nationality, membership of particular social group or political opinion. **b) Asylum seeker** – someone who has fled from her or his country and is seeking refugee status in another country. **c) Economic migrant** – someone who has left her or his home to look for better work and a higher standard of living in another

place. **d) Immigrant** – someone who has entered a new country to settle. **e) Internally displaced person** – someone who has left her or his home in fear of persecution, but has not crossed an international border.

Table 1.2. Key Terms

TERM	DEFINATION
Refugee	Someone who has left her or his country or is unable to return to it owing to a well founded fear of persecution for reasons of race, religion, nationality, membership of particular social group or political opinion.
Asylum seeker	Someone who has fled from her or his country and is seeking refugee status in another country.
Economic Migrant	Someone who has left her or his home to look for better work and a higher standard of living in another place.
Immigrant	Someone who has entered a new country to settle.
Internally displaced Person	Someone who has left her or his home in fear of persecution, but has not crossed an international border.

3. a. Refugee- Operational definition

Early definition of refugee evolved between 1920 and 1950, included three distinctive approaches- **Judicial, Social and Individualist** (Chimni 2000, Baral and Munni 1996).

Table 1.3. Distinctive Approaches to define Refugee

Year	Approaches	Definition -refugee	Facilitation
1920-1935	Judicial Approach	Person effectively deprived of the formal protection by the government of its state of origin	This definition facilitated the international movement of persons who find themselves abroad and unable to resettle because no nation is prepared to assume responsibility for .them
1935-1939	Social Approach	Refugees are helpless causalities of broadly based social or political occurrences which separate them from their home society	To continue to assist persons without formal national legal protection;
1938-1950	Individualist Approach	Refugee is a person in search of an escape from perceived injustice or fundamental incompatibility with her home state.	To facilitate international movement for those in search of personal freedom

From 1920 until 1935 refugees were define largely in judicial terms. They were treated as refugees because of their membership in a group of persons effectively deprived of the formal protection by the government of its state of origin. This definition facilitated the international movement of persons who find themselves abroad and unable to resettle because no nation is prepared to assume responsibility for them. This definition was formulated in response to the international legal dilemma caused by the denial of state protection. In contrast to judicial focus the definition of refugee embodied a social approach during 1935-1939. It defined refugee as helpless causalities of broadly based social or political occurrences which separate them from their home society. The essence of this approach was to continue to assist persons without formal national legal

protection; to assist the victims of social and political events which resulted in a de facto, if not a de jure, loss of state protection.

During the third phase, 1938-1950, the term refuge was defined by individualist standards. It is a person in search of an escape from perceived injustice or fundamental incompatibility with her home state. This definition basically means to facilitate international movement for those in search of personal freedom. Several attempts to define the term "Refugee" have been made. UN convention on the status of refugees held in 1951 defined refugees as *:"any person who owing to well founded fear of being persecuted for reasons of race, religion , nationality, membership of a particular group or political opinion, is outside the country of his nationality an is unable , or owing to such fear in unwilling to avail himself of the protection of the country"(*Muni and Baral 1996).The definition contained in different international instruments, the 1951 convention is on status of refugee , the 1967 protocol followed the same but it just removed temporal and geographical limitation contained in the 1951 convention and the 1969 QAU convention and Cartagena Declaration governs the specific aspect of refugee problems in Africa, Chimni (2000). In everyday speech the word refugee is used to describe a person who is forced to flee his or her home for any reason for which the individual is not responsible. It can be persecution, public disorder, civil war, famine, earth quake or environmental degradation. In this sense, then it includes the Tibetans who fled because of Chinese political invasion. However in international law, a refugee is a person who is forced to leave home for certain specified reasons and who, furthermore, is outside the country of his or her origin and does not have its protection.

The definition of a 'refugee' in international law is of critical importance for it can mean the difference between life and death for an individual seeking asylum. Ferris (1985) defines refugee as those, 'who are victim of political violence and who seek refugee outside the border of the state whose national they are. It includes those who are persecuted for their political and religious beliefs, their ethnic and racial background, as well as those fleeing their homes because of war, whether or not they are individually singled out for persecution. In the literature on refugees various terms are used to refer to various categories of refugees. Some such terms are national refugee, International

refugee, convention refugee (Roy 2001).**National refugee or internal refugee'** are those persons who have been displaced in their own country. They usually enjoy national protection, for instance Kashmiri Pandits in India who had to leave Kashmir due to ethnic strife and terrorist violence. **'International refugee':** it means the person out side their country of origin. They are designated refugees in legal terminology when they lack the diplomatic protection granted to national abroad(Giri 2003) and **'Convention refugee' :** it means you are a Convention Refugee if you are outside your home country, or the country where you normally live, and can't return to that country because of a well-founded fear of persecution based on race, religion ,political opinion ,nationality or membership in a particular social group, such as women or people with a different sexual orientation.

According to UN High Commissioner of Refugee, the refugees are involuntary migrants, it means every refugee is migrants but not every migrant is refugee. Further it elaborates that there are three categories of refugee, the first category is internal refugee as mentioned above. The second category consist people who have not been specially persecuted, but have a result of generalized violence or economic deprivation within their own societies and succeeded in fleeing to another country. For instance, Sri Lankan Tamil refugees sought refugee in India during 1980's (Giri 2003). The third category of refugee is those who have generally economically better and have urban backgrounds; and they are often not register with the United Nations agencies as refugees. But, they also get asylum in other countries as their safety is threatened by events seriously disturbing public order. Refugees are often projected as **'Victims',** the helpless subjects who cannot but depend on the charity of the state and various agencies for their survival. Thus, according to Samaddar (1999) the term 'Illegal aliens' which has a broader coverage than the term refugee. Bose (2000) has considered as **'Active agent'** of social transformation. While Samaddar (1999) phrased that once refugee come out of the initial turmoil and start playing to their true selves they are often turn out to be "Active Agent' of economic development or the catalyst of social and political transformation. Norbu (2001) also emphasized role of **'Self effort'** in the successful rehabilitation of the Tibetan refugee in India. Further, Hazarika (1999) 'Environmental **refugee'** caught the attention

in some parts of the world and among some organizations. But the definition of the term 'refugees' is not extended to include this new amorphous group. Nation-states like India will be officially burdened by the task of taking care of many millions of such displaced groups. No one wishes to be a refugee, but sometimes flight to another country is the only available option left for those who become refugees. When people decide to leave their home country they often see no future in their country and their only experience is that the present has become unbearable for them.

4. Literature Review

The refugee phenomenon is as old as time and as recent as today. **The Bible tells of the exodus out of Egypt to the Promised Land[2];** the daily press in headlines and the weekly news magazines in vivid colors portray the flight of persons from natural or man-made disasters around the world-in Central America, Africa, the Middle East, and Southeast Asia. Today one may point almost anywhere on a spinning globe and put a finger on a refugee situation (Huyck and Bouvier 1983). There are refugees in every part of the world as a by-product of every serious crisis. Each time we hear of new situations of armed conflict or of serious repression somewhere in the world, we can imagine that some people are going to become uprooted. Today more than 21 million refugees are a concern of international community. Refugee situations are not merely problems calling for humanitarian concern. These can pose a potential threat to social, economic and political fabric of host states and threat to peace (Gil and Laila 1989).Year after year, millions of refugees are forced to leave their homeland and are compelled to live in hazardous places (Huyck and Bouvier 1983) which add to the illness and persistent health problems (Allotey 2003).

Through out the human history, human beings have always been moving from place to place. Sometimes they moved in small numbers, but often in large groups. It is as much a natural phenomenon as birds nesting from tree to tree or animals demarcating their

[2] The analogy is used in terms of, to understand how person moves voluntary or involuntary, directed to seeking a better future, greener pastures security and dignity. In the chapter of Exodus (Bible) it has highlighted how Israelites were oppressed, persecuted and put into slavery to Egyptian and later Israelites had to leave Egypt under the God's covenant to Moses to "The promised Land" for better future, security and dignity.

territories from place to place .Human beings moved with members of their own families, in large groups of several families, or religious community. Their travels were voluntary as well as involuntary, directed to seeking a better future, greener pastures, security and dignity. Even after the creation of modern nation states in the nineteenth century, with their defined borders, people continued to move from one country. Since there was hardly any organized protest from the host countries the problem of refugees and migrants did not arise (Hassan 2006). But in recent times, the flow of persecuted and dislocated people has increased and this flow has become a flood contemporarily. Millions have fled from reigns of terror in their homeland seeking refuge and a new life in another society and culture. Most have no other choice but to escape from intolerable threats and danger, to break with the bonds of their heritage and try to become part of different national tradition contributing some of their own values to the new country of their choice, where they are isolated and impoverished .These forms of marginality and exclusion add to the burden of illness in refugee populations and contribute to persistent health problems. The health status of refugees reflects upon conditions the illness that impact on their health in their countries of origin and those to which they are exposed in asylum countries (Alottey 2003). For instance , Tibetan refugee in India has major problem Tuberculosis resulting from unhygienic conditions, malnutrition and the change in environment, particularly the relatively polluted air in the cities when compared with the clean environs of the Tibetan Plateau (DoH, CTA 2003) .

According to Gurr, Marshall, Khosla (2000) violence, ethnic conflicts, wars, repressive regimes, from part of frame work within which millions of people flee for their safety. The cold war left a clear mark on every conceivable international problem which included the refugee problem too. In the post- cold war era, resurgent nationalism together with the economic and social consequence of the collapse of the world order, had led to multiplication of conflicts based on ethnicity, tribal and religious tensions. Millions of refugees in the world have been created by East-West rivalry, in the horn of Africa, Indo-China, Central Asia, the Middle East, South Asia, Southern Africa and Central Africa. After a steady increase in war and violence since the 1950s, the aggregate level of conflict began to decline in the 1990s following the end of the Cold War. These

trends differ by regions, with sub-Saharan Africa maintaining high levels of conflict during the 1990s. While fostering a trend towards greater democratization and decentralization in most former Soviet Republics, the end of the Cold War led to the continuation of old social and ethnic divisions in much of Africa; little international effort was made to promote a peaceful transition after the demise of communism.

In addition to deaths, some of the painful results from those conflicts are:

- increases in orphans, people incapacitated to work, refugees and displaced population;
- destruction of infrastructure;
- increases in food insecurity and malnutrition in the medium term because agricultural land was rendered useless due to land mines;
- and exacerbation of health problems, such as the spread of HIV/AIDS and different infectious problems. Direct DALY[3] losses from war and violence amount to about 2.6 per cent of all total causes among the poorest 20 per cent of the world population, but the indirect losses are far greater (Gwatkin and Guillot 1999).

Plight of refugee is symptomatic of the imperfections which continue to characterize the anarchical structure of the international system today. In many countries, violence and war should not be seen only as a domestic responsibility that can, be left alone to be solved internally by the countries suffering from it (Ibid).

The refugee problem today has assumed truly gigantic and global proportions and become a matter of acute international concern. The present century has been described as the "century of homeless man and century of uprooted" because of tremendous increase in the number of refugees In other word, the recent times, is marked by its refugee crisis, the number of refugees are raising world wide, posing one of the greatest challenge to humanity. The governments, international organizations and the public have

[3] The Disability Adjusted Life Year or DALY is a health gap measure that extends the concept of potential years of life lost due to premature death to include equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability.

become increasingly aware of the problems faced by refugees. The problem of forced displacement is not new. International efforts to alleviate the sufferings of such people have also been made. But the fact is that the international community has not fully succeeded in combating prejudice, persecution, poverty and other root causes of conflict and displacement (Ahmed 2004).

The formidable problem of refugees exodus is not new. Refugees have had to abandon their homes and seek safety else where to escape persecution, armed conflicts, or political violence and in search of life free from fear and wants. This has happened in different regions of the world, and millions have had to flee their homes. Through the length and breadth of Asia, Africa, South America, Central America, Europe and North America is unprecedented in the history of migration, gigantic in scale and often very tragic, most as it was victims of circumstance, misgovernance, war, conflict, violence and ethnic campaigns. These were people plucked from their native environs and forced to flee. They ultimately formed part of transferred populations.

History records many aspects of refugees. Hundreds of thousands of refugees, in need of protection and resettlement remained dispersed throughout Europe at the World War I& II .Although, the problem of refugee is as old history, it is only at the end of World War I that the international community began to take serious note of it. However when a league of nations was formed, the refugee problem was given the due attention. It is until the beginning of the twentieth century the nation prided themselves on their humanitarian approach to refugee/asylum seeker, as follows by various treaties from 1920's onward began to define the rights of particular categories of refugees to seek asylum in specific situations for instance the American refugees and persons of Russia origin. After the Second World War, the UN focused on the issue of post –war displacements. The first formal refugee specific organization set up after the formation of the United Nation (UN) was the United Nation Relief and Work Agency (UNRWA) for Palestinian Refugees, mandated by a UN Security Council resolution in 1949. The UNRWA has been responsible delivering basic services including food, shelter, health and education to Palestinian refugees since 1950 and given the continuing unrest in the region, its mandate

continues to be renewed by the UN General Assembly. Later the UNCHR was established by the UN General Assembly in 1951 to protect and assist refugees and find solutions to problems faced by refugee and differs in providing a generalized and individualized definition of a refugee. The UNHCR in particular was concerned with flight of people from the former European colonies in Asia and Africa. In the long drawn out Algerian war of independence, the widespread use of torture by the French forces provoked many Algerians to flee the country. They took refugee in Tunisia and Morocco in the late 1950's and early 1960's.According to a UNHCR report some 30,000 people had fled the country with the short span of two years. Similarly after the breakup of former Yugoslavia and dissolution of the Soviet Union and Czechoslovakia, millions of people were forced to flee their home. More over after the genocide in Rwanda in 1994, over two million Rwandans fled to Zaire, Tanzania, Burundi and Uganda. According to a UNHCR report 2, 50,000 Rwandans fled Tanzania in 24 hours (Giri 2003).

South Asia has also witnessed some of the largest population flows in the post world war period. South Asia is the fourth largest refugee-producing region in the world. The partition of British India 1947, described as the largest brutal uprooting of 15 million refugees in the sub continent .during the liberation war of Bangladesh, some 10 million refugees from the erstwhile East Pakistan fled to India. In aggregate, however India remains the principal country hosting refugees from all over south Asia and its adjoining regions. According to UNHCR figures, at the beginning of 2000,there were 2,92,000 refugees in India of whom 1,11000 were from Tibet; 42,000 from Myanmmar;14,5000 from Afganistan;15,000 from Bhutan and 1,10,000 from Sri Lanka. Over one percent of the total world populations today consist of refugees. More than eighty percent of that number is made up of women and their dependent children. An overwhelming majority of these women come from the developing world (Report of Refugee Populations in India 2007).

5. Conceptual framework:

There is instabiiity, conflicts, generalized violence, gross and persistence violation of human rights, repression of minorities and the violence entailed in the breakdown of law

and order in all human society and all societies have systems for regulating it. But once it fails to regulate and function there is large number of uprooted population or movement of mass population which seek shelter in other's land for the mere survival and those population are legally defined as *Refugee*. Refugee who are often presented as an un differential mass constitute one of the most powerful labels currently in the repertoire of humanitarian concern, national and international policy and social differentiation. In order to tackle the problem of refugees there are broad based international and national organization and various law and policies, which would deal with refugee problem in its totality. Refugees are vulnerable throughout the phases of the refugee experience i.e., preflight, flight, claimant, settlement and to adaptation. During these phases refugees encounter economic hardship, social disruption, political oppression and physical violence, triggering a need to leave their home, hazards include imprisonment, death or disappearance of family members, loss of property and livelihood, physical assault, witnessing assaults or murders of loved ones, fear of unexpected famines and starvation. Thus it indicates that their rights to survival are abused in every sphere and the violations of their rights occur in vacuum. [4] Even after implication of major assistance in international and national level the problem of refugee remained dispersed and refugees continue to face following key conceptual issues: a) Socio –Cultural Changes: Refugee as a cultural community which takes place among the refugees in their new host countries. b) Community disorganization: There is break down of social relations, inability of social institution and lack of general cohesiveness of social structure in refugee community.

c) Institutional, Political, Legal and physical segregation

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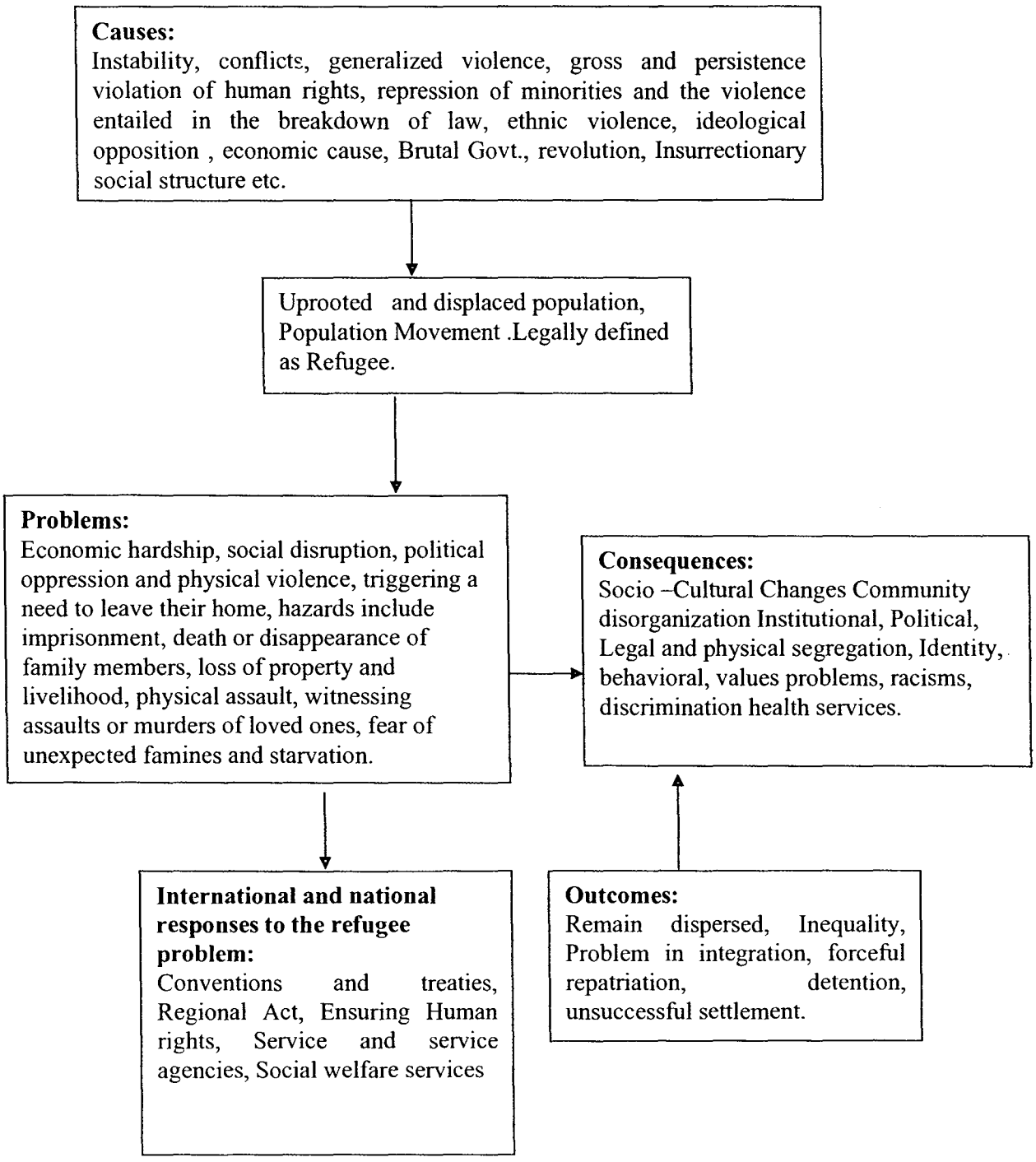
[4] Encyclopedia.of.Medical.Anthropology-accessed on 7th June 2008

Frame work for understanding refugee problems



6. Rationale of the study

Refugees are the most vulnerable group among the world's down trodden. The problems of refugees wear many faces, it ranges from violation of their human rights, their liberty, their nationality etc. if we talk about from Maslow[5] point of view of human need, we can say in the process of migration from one part to another part, or a group of people is forced to migrate. Such condition poses assault on their basic need from physiological needs to social need and self-esteem need. The problems of refugees can be broadly categorized as: Legal problems, Health problems, mental health problems and Human right violation. Health problems are serious concern of refugees. Common refugee experiences include torture, war or civil unrest, the loss of family and friends through violence, and prolonged periods of deprivation. These experiences can have major implications on health status. Thus, it is evident that health problem are one of major concern for refugee population after legal intervention for their human right safety. Deteriorating health and mental condition are direct result of their encroachment of basic life pattern. Social deprivation and exposure to violence are such life event factors.Even after the resettlement in the countries other than their countries of origin refugees have to face lots of problem (Alottey 2003).

Studies on refugee health have pointed out that faces lots of problem because of low access to health care facilities in relation to the availability of services; stigma and discrimination, culture alienation, discrimination on the basis of sex and gender roles and economic affordability i.e., very poor living condition and low socio economic status as it is found that health status of refugees are more vulnerable to illness and health problems. Secondly , *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. All these are rooted with their cultural alienation from the local communities, the discrimination where they have to face and universally poor condition of life in the new home. There are certain possible mechanisms of refugee.

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[5] Abraham Harold Maslow (April 1, 1908 – June 8, 1970) was an American psychologist. He is noted for his conceptualization of a "hierarchy of human needs", and is considered the father of humanistic psychology.

Process of migration: Event around the process of migration itself for example prolong waiting, social deprivation may cause several kind of stress related disorders.

Post migration factors: Social adversity, racial discrimination, breakdown of traditional culture, Loss of self esteem, loss of social support. Because most refugees have lost everything, they also want everything to change at once upon arrival. Often it takes several months before the refugee can realize that this is not possible. For instance, though there are studies on successful settlement of Tibetan refugees in Indian but it is to point out that even after 40 years of living in India, due political tensions within Tibet continue to erupt, it is estimated that approximately 2,500 Tibetan refugees per year cross the Himalayas into Nepal, seeking asylum there or in India. One-third of these refugees are children and 90 percent of those children are without parents. Not only have these children been victimized in an environment lacking in respect for human rights, but their escape from Tibet to India through the perilous Himalayas is full of risk and trauma (Admin2008) In 1959 to escape Chinese persecution His Holiness Dalai Lama fled to India along with other 60,000 Tibetans to seek shelter in India. Since then the issue became topic of debate. Tibetan refugee, have a strong desire to uphold their identity as a Tibetan. It prevents them from coming to terms with the situation prevailing in the host country which create some difficulties for them and which is particularly noticeable in health and health related behavior. Culture and traditionalism guides the attitude and activities of refugee which consequently results in deterioration of their health and unwillingness to their access to health facilities (Bera 2004 and Patel 1980).For instance most of the Tibetan refugee women in India suffer from joint pain because of their traditional occupation origin of Carpet weaving. Cirrhosis of the liver figured especially high in the North-eastern region where the drinking of the fermented millet brew called '*Chaang*' is widespread. Adult member of the migrant Tibetans Family frequently consume Chaang in their daily life. It has social and religious value as it is taken especial during ceremonies, religious functions and other ceremonial festivals. As continuation of the tradition food habits (higher quantity of meat, mostly mutton, pork, salted butter tea etc) of the native Tibetans at high altitudes where they are engaged in to physical activities, the migrant Tibetan in India continue to take the same diet as well where they

are rarely engaged into hardcore physical activities of which most of the migrant Tibetan suffer of Obesity. Availability of medical facilities from the local Tibetan health centers is accountable for gradual improvement .This health centre situated in their own settlement or colony control by the Tibetan doctor and health workers. As a result the common Tibetans easily communicate with this health worker. In contrast, they usually try to keep Away from Indian hospital due to language dilemma. If thought the better medical facilities are available nearby there identity seems to have effect in the seems that they are rather reluctant to take better advantage of those facilities no doubt the traditional beliefs still hold attraction. The acceptance treatment or healing methods among the Tibetan community in India depends on the nature of diseases and one's own choice of perception and most of the cases, which are directed by their traditional beliefs and customs. Both natural and supernatural means are considered for curing of illness. If one is sure that the illness either physical or spiritual, one immediately consults a traditional Tibetan doctor or a modern medical practitioner or spiritual or faith healer or Lama. Many Tibetans believe that previous negative Karma and bad spirit as oppose to microbes cause illness, and then he or she refers consult a spiritual healer or lama before consulting a medical practitioner because they have misgiving about the modern medical treatments. The traditional treatment is well accepted among the Tibetan refugee like the native Tibetans. They believe that the Tibetan medicine could cure the diseases from it's without any side effects and these is more economical then allopathic medicine s as well. A large number of Tibetan adults (29.0%) used traditional medicine for various illnesses because they considered it to be more effective in chronic or long term diseases like joint pain and arthritis, stomach pain, gastric, peptic ulcer, jaundice and head ache. The migrants Tibetans in India usually allopathic treatment in emergency and also for immediate relief .they belief that this kind of medical system only provide instant relief other total cure (Bera 2004).The Tibetan govt. in exile in India administers over eighty schools, not only in India but in Nepal and Bhutan as well. The Indian-run Central Tibetan Schools Administration funds and oversees approximately thirty of these schools in India. This has resulted in some tension between the Tibetan population and the Indian host culture: support is necessary and appreciated, but there is concern that the Tibetan schools, if run by non-Tibetans, will teach fewer Tibetan cultural values. Imbuing

children with a Tibetan sense of respect and compassion, maintaining the Tibetan language, and teaching Tibetan cultural arts are all vital aims for a people living in exile.Identity forged by the Tibetans in their stateless condition emphasizes the Tibetan Buddhist values of compassion, patriotism, ethnic and linguistic unity, and a focus on two main Tibetan rallying symbols, the Dalai Lama and *Rangzen* (self-power).

Thus, the study will attempt to locate this specific group of refugee (Tibetan) within the total global picture of refugee.

Purpose of the study

The present study intends to understand the issue of international refugees, focuses on the refugees in India with special references to Tibetan refugees and the problems faced by them in India. It profiles the Tibetan refugee in India and how they are adjusting themselves; and what type of health problems and health threats they face. The study will be used as a tool to justify the oppression of refugee and implication of national and international instruments for the protection of refugee worldwide.

Specific objectives of the study

- To understand the problems faced by Tibetan refugees in India.
- Health problems among Tibetan refugees in Indian
- To examine the factor which enhance and restrict access to health care among Tibetan refugees.

Research question:

- Why there is failure in implication of instruments to protect rights of refugee?
- What are the divisive issues of refugee health, health service facilities and delivery and why it has become highly contested?
- What determine the health status of refugee?

Hypotheses:

The following working hypotheses have guided the study:

In the recent years the current global situation has changed the dynamics of refugee experience. There are broad range of humanitarian, human rights and developmental agencies to provide protection, assistance and reintegration of refugee worldwide and all these have moved from Euro centric approach to problem solving to a more third world oriented. In these circumstances, while refugee health has gained major attention but it is getting deteriorating further more in all spheres.

Methodology

The study is based on secondary data and published material such as studies, report, official documents etc. An extensive literature survey has been carried out for compilation of existing information on the problems, conditions and health of the refugees who have come from Tibet into India. The second part of the study has to understand the statistical used information available from the following sources:

a) **Reports**: Reports and documents of different agencies for instance:
   - Voluntary Health Association of Delhi (Dwarka, New Delhi)
   - Voluntary Health Association of India (Qutub Institutional Area,New Delhi)
   - Socio-Legal Centre (Vikas Puri ,New Delhi)
   - Gender and health resource centre (Nariana,New Delhi)
   - Young Men Christian Association(Vikas Puri ,New Delhi)
   - Tibetan house (Lajpat Nagar,New Delhi)
   - Centre of gender study (Canuaght Place,New Delhi)
   - Nehru Memorial Library (Teen Murti, New Delhi).
   - And books and articles published from time to time, newspaper coverage and internet source

b) Data:

- Internet Source.
- Published books and articles.
- Interviews with Pradhan and members of Tibetan Welfare Association, Tibetan Women's group, Welfare Officer of Majnu Ka Tila[6], New Delhi, Tibetan traditional Medicine Practitioner, Doctors, Tibetan faculty member in JNU.

Outline of the chapters

The dissertation is divided into six chapters:

First chapter provides an introduction to definition and conceptual issues of refugee. And why is it important to study them as in the rationale of the study which highlight not only with poor condition of living, prolonged deprivation result into health but also attempt to study relationship of refugee and health.

Second chapter, is to study health of refugee both national and international by review some of the available literature related to Refugees and Health. And also make honest attempt to look into the matter of health status of refugee what are the factor that determine the health status of refugee.

Third chapter, present an overview of world refugee movement .The attempt of the study will bring out the problems of being uprooted. Since it is well aware that there is various reasons behind the flight of refugee. So in this chapter the causes of refugee movement will be discussed and the consequences.

Fourth chapter, This chapter presents some discussion on the international and regional instrument of protection of the refugee and also makes an attempt to study the different law, policy and practice of refugee protection in India .

Fifth chapter, examines the distribution of Tibetan refugee in India .It begins with a discussion of the condition of Tibetans refugees here in India further the discussion percolates down to look into the matter how India law and policy affected their life and particularly their health status in India and also their condition and position. The study

[6] Tibetan Refugee settlement in Delhi.

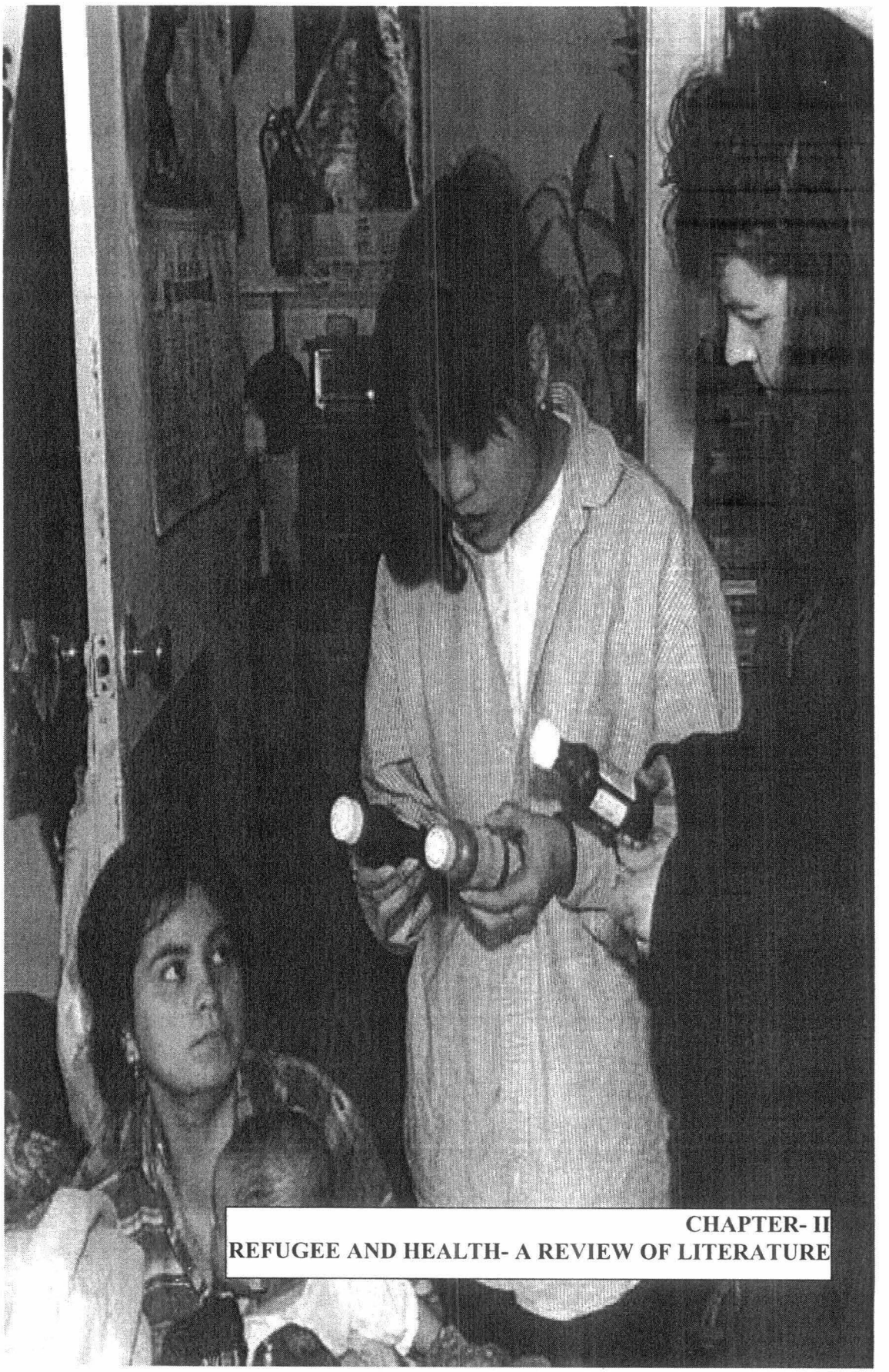
also attempts to develop socio economic profile of the Tibetan refugees their life style, nature of work they do, their awareness regarding health issues such as services available to them, health issues including health facilities and their perception of their health problems, health culture, health seeking behavior. And to explore the kind of health problems they have faced in the migration process and being refugee, the problems they are facing now and how satisfied they are here with the existing health services.

Sixth chapter is the conclusion and discussion which summarizes the principal result of this study. It discusses various issues and aspects of dealing with refugee problems and also points out the findings of the study.

Limitation of the study:

There is paucity of data on health of the refugee populations, particularly Tibetan Refugees has constrained the study in the following ways:-

- No quantitative analysis could be undertaken.
- Distribution of Tibetan refugees in India cannot be analyzed.



CHAPTER- II
REFUGEE AND HEALTH- A REVIEW OF LITERATURE

CHAPTER-2

REFUGEES AND HEALTH-A review of Literature

Every one has the right to a standard of living adequate for the health and well being of himself and his family including food clothing, housing and medical care and necessary social services a, and the right to security in the event of employment ,sickness, widow-hood, old age or other lack of livelihood in circumstances beyond his control.

Article 25:1 UDHR

1. The refugee experience

Refugees- Unless you have lived these names it is hard, if not impossible, to know how difficult your life could be, or how detrimental this state of being could be to one's survival. Asylum seekers are people who have been forced to flee from their homes and countries of origin to seek refuge elsewhere for reasons that may involve the difference between life and death. When their plight is officially recognized through processes that have been set up by the United Nations and the countries that offer temporary or permanent refuge, the 'label' is changed from asylum seeker to 'Refugee'. The predicament of refugees is a steady reminder that we live in an age of upheaval. The current global situation has changed the dynamics of refugee experience (Alottey 2003). The constitution of World Health Organization (WHO) of 1948 declares that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". It defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and prohibits discrimination on its enjoyment. The World Health Organization recognizes the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance as presenting a unique opportunity for the development and adoption of a new approach to addressing the health impact of racism, racial discrimination, xenophobia and related intolerance (WHO 2001). But large numbers of refugees residing in different countries continue to suffer instability, with few resources for health care and other basic necessities and no opportunities to re build their lives and communities (Alottey 2003). They face an acute sense of being uprooted, the difficulties of situational adjustments and adaptation to environmental changes, the frustration of unfulfilled expectations, the competition for acquiring a job and other problems like insecurity and lack of housing

etc. Migrants and refugees are often subjected to discrimination and prejudice, denied human rights and also exploited as cheap labour(WHO1981).These kinds of marginality and exclusion add to the burden of illness in refugee populations and contribute to persistent health problems (Alottey 2003).As health is dependent on the various socio-economic and political factors. Health status of everybody is inevitably decided by physical and social environment they live in and their economic status. Therefore, we need to know does "refugees" have a good health status and what are the factors that determine the health status of refugee? They often have inadequate access to health care facilities, the most obvious obstacle being linguistic, cultural and economic barriers, many of them do face racism and discrimination within the health system which in turn reduces their accessibility to health services. Finally some groups may also have reduced entitlement to these services because of their legal status in the receiving counties and have no preventive or curative services apart from emergency care (Kumari 1974). As Janzen (1998) also agreed that health is the result of a complex interplay of socio-economic factors and stated, research needs to explore how social, economic, behavioral and psychological factors are associated with changes in the health status of immigrant and refugee over time.

Alottey (2003) has studied Refugee Health from the public health perspectives and discussed that the term 'Refugee health' often has a very specific meaning depending on the context in which it is being used. In *humanitarian emergencies*, it usually refers to the acute management of the health issues involved in massive population movements as a result of natural disaster or complex humanitarian crisis created by conflict and war. In the context of *displacement*, a situation that often occurs within the national borders of the affected population, it refers to public health management to control the spread of infectious diseases that are rife in the condition created by poor hygiene, over crowding and lack of health service infrastructure. In the process of *resettlement,* refugee health involves rigorous health screening and assessment to identify exotic communicable diseases that might threaten the public health of host nation and following resettlement it refers to the management of health and health service to control the potential of marginalization of minority resettled population, spanning the provision of cultural

competencies for health service staff to addressing the specific physical and mental needs of torture and trauma survivors. Currently it has also been identified that the refugee health includes role of *advocacy* to ensure a more equitable distribution of the resources that enable health and access to health care particularly to the marginalized and vulnerable.

Gifford et al (2007) argues that more studies need to be conducted that address the refugee experience over time and combine a range of methods to capture meaning and experience, as well as more about health, wellbeing and settlement outcomes. By engaging with new and innovative approaches to refugee research is the only way to begin to build a strong evidence base for how best to promote health, wellbeing and successful settlement over time. They firmly believe that research approaches are especially needed when working with people who have overcome perhaps some of the most formidable challenges of their lives. The refugee experience is inherently one of change and resilience, of finding new solutions for life; and refugee research should be equally responsive and courageous.

There are numerous studies of refugee and migrant health. Many of these studies record cultural definitions of health perceptions, or the differences between migrant health and that of the host population. Some try to compare migrant health with health of non-migrants in their communities of origin. One of the difficulties about the first kind of study is that the migrants/refugees experience a range of complications to the initial dislocation, and commonplace destitution. Refugees who migrate by crossing international state borders will often have to: use a new language; live in an unfamiliar society; face labor market disadvantage/discrimination/downward mobility; face forms of racism and denials of their legitimacy (Loizos 2007).

Chatterjee (2001) in her paper "Identities in motion: Migration and Health In India" also discussed that 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.

Refugees have an added complexity of nationalism, ethnicity and social norms. 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. 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. They predominate in the lower income labour market with higher risks of exposure to unsafe working conditions. Many often do not approach the health system of the host countries in the fear of their status being discovered. 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 and delay in health-seeking is also due to associated costs, inability to miss work and problems of transportation. Many are unfamiliar with the local health-care systems and have linguistic and cultural difficulties communicating their problems. Thus it is mandate to assess and report on how voluntary and involuntary migration effect health, and how the health of migrants/refugee and displaced people can be protected and actively promoted. International centre for Migration and Health (ICMH) sees healthy migration as a basic human right that is fundamental to human, social and economic development. In one way or another ways movement of people affects the lives of people every where and as a worldwide phenomenon, it calls for a global response (Kumari 1974).

While studying health of refugee both national and international we will review some of the available literature related to Refugees and Health.

2.Refugee and Health Challenges

Refugee studies have always been connected with policy developments. But later in 70's the concern shifted to more problematic aspects of refugee experiences such as 'psychological adaptation and dysfunction' or difficulties in linguistic or occupational adjustment and by 80's it was refugee mental health. Now some of the current literature on refugee health shows two clearly marked main trends. The first is largely bio-medical, derived from humanitarian interventions in the early phases of refugee displacement, and it particularly concerns infectious diseases, such as cholera and typhoid, tuberculosis and nutritional status. Much of this literature concerns people who have come into refugee camps, or feeding centers, and remained there for weeks and months, sometimes years (Black 2001).

Ackerman (1997) says with the exception of studies of Southeast Asian refugees, there are few clinical trials on the health problems of refugees after arrival in the United States. Tuberculosis, nutritional deficiencies, intestinal parasites, chronic hepatitis B infection, lack of immunization, and depression are major problems in many groups. There is great variation in the health and psychosocial issues, as well as cultural beliefs, among the refugees. The second trend involves psychological consequences of displacement, and of the violence which too often goes with it: experiencing or witnessing torture and rape, and for survivors, loss of close family members or friends by violent death. This literature is concerned with psychological conditions, including Post Traumatic Stress Disorder (PTSD), and sometimes depression. The general thrust of the PTSD literature is towards refining diagnostic instruments and treatments, and with the all-important matter of cultural differences and cultural meanings in perceptions of and management of psychosocial illness. But attempts to understand causes of serious psychological illness have developed a strong interest in social and contextual factors for instance the trauma experienced by refugees children can cause a range of symptoms including anger, hostility, nightmares and severe dysfunctional behavior and delayed development .If they are not addressed, the results are long lasting and debilitating and are often compounded by the unwillingness of refugees from some ethnic background to seek or accept

treatment for what they regard as mental illness. The attached stigma breeds shame and humiliation. This may lead to delayed and dysfunctional psychosocial and emotional development in children. (Loizos 2007).

Fedrick (2005) in his study "The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation" propose a model of ecological treatment, focus on political violence and displacement issues such as separation, discrimination, hunger, lack of shelter and medical care, the loss of family and social support, etc., and their effects on individual, family, and community well-being. While these effects include trauma, grief, depression and anxiety in individuals and families, they also alter the supportive fabric of the community, dissolving institutions and destroying ties and supports that bind people together. Several critical factors are addressed. Mental health services to refugees are scarce and when available are often inaccessible. Many countries and cultures do not have a tradition of mental health care and may depend more on traditional measures offered by the village doctor or medicine man or woman. Another factor is the relevance and appropriateness of Western mental health approaches that may be culturally foreign to most refugees. A key question is whether there are universal emotional responses to forced migration and conflict, or whether these are shaped and influenced by local cultures. The author argues that clinical approaches are not sufficient to address the plethora of displacement issues that refugees face on a daily basis. These points to the need for a new and much broader approach to mental health care of refugees, namely 'ecological approaches to healing and adaptation'. He proposed strategies for a child-focused, community-based intervention programme, mental health services to reduce the effects of violence, an approach for empowering war widows, family interventions, and community-based advocacy and learning intervention. It also addresses methods for measuring the effectiveness of ecological interventions with the goal of exploring both process and outcome evaluations in conflict and non-conflict situations. The use of both qualitative and quantitative measures is recommended. His work also deals with challenges and critical issues in the utilization of ecological approaches to mental health. A series of useful principles are cited that deal with community involvement and participation in assessing refugee's need, designing interventions, and implementing

services as well as building community capacity, respecting local values and interventions, and emphasizing prevention. Each reflects a belief that psychological problems are often caused by the mismatch of one's community structure and the demands placed upon it.

Another study conducted bye Ruawanpura et al (2006) on mental health which has explored the constructions of mental distress/illness, its causation and coping strategies amongst a group of Tibetan refugees living in Dharamsala, North India. Constructions of mental distress and the associated coping strategies of Tibetans in exile were intimately linked to cultural, religious and political factors, principally relating to the philosophy and practice of Tibetan Buddhism. Family support and religious advice and support were key cultural coping strategies. Almost every interviewee stressed the importance of traditional coping strategies in treating mental distress. The belief that traditional coping strategies were more appropriate for treating mental distress, however, was put into question by the lack of real access to many of these coping strategies, especially for the newcomers. Many new refugees lacked both family support and detailed knowledge and understanding of Buddhism (and thus have limited 'access' to the associated local spiritual support systems in Dharamsala), and the counselling service was seen to fill an important niche. Not all of those interviewed were positive about 'western approaches' to mental illness, but those using the service seemed to do so in a pragmatic and integrative way. In general, holding fundamentally different beliefs about causation but seeking a form of treatment which did not coincide with those beliefs did not seem to cause any problems for the Tibetans who were interviewed. This may in part be due to the cultural sensitivity of the staff involved with the project and the time and effort spent by the western staff, living in the Tibetan community in exile in Dharamsala, to better understand the Tibetan culture.

Carlson (2003) Issues facing the Tibetan community in exile regarding the problems of substance abuse prove extremely complex and difficult. There is increasing spread and impact of pharmaceutical addiction among older and second generation. In many ways problems regarding second-generation acculturation are unavoidable. No matter how much effort both parents and children make to be patience and understanding with one

another inter-generational conflict will inevitably occur. As long as refugee children are growing up in a different location and society than their parents did, a gap in expectations and realizations will remain. Through combined efforts, however, the gap can be shortened. Secondly unemployment another reason for pharmaceutical addiction among Tibetan refugee in India. Unemployment provides another difficult challenge for the Tibetan Government in exile. Although many jobs exist through the Tibetan government and education systems, but the opportunities for employment expectations into the Indian job market need to be expanded. However, these are the issues that ought to be addressed in responding to root causes of substance Abuse in the Tibetan refugee community (Carlson 2003 and Burke 2008).

Scant research has been conducted that systematically evaluates interventions to reduce micronutrient deficiencies in refugee populations, despite documentation of considerable prevalence and continued outbreaks of micronutrient deficiency among these populations. Refugees are especially at-risk for micronutrient deficiency given their circumstances of origin, current residential environment, and typical dependence upon food aid. Interventions promoting reduction of micronutrient deficiency in refugee settings, including food fortification and dietary diversification, are rarely systematically evaluated for impact in reducing micronutrient deficiency in refugee populations. As a result, little is known about the most effective prevention strategies for reduction of micronutrient deficiency in refugees. In fact, evidence suggests perhaps that nutritional interventions with demonstrated effectiveness in other populations and locales may not be readily adaptable to refugee situations. Sustainable prevention interventions aimed at reducing micronutrient deficiency in refugee populations need to be implemented and tested systematically to create an evidence base for good practice.

Refugee populations dependent upon external food aid continue to be at high risk for micronutrient deficiency resulting from insufficient food supply, despite increased awareness among international organizations of such micronutrient deficiencies among refugees and despite considerable organizational efforts to improve the micronutrient

content of food rations. Nutritional considerations are significant concerns for the provision of essential public health services to refugee populations and refugees typically face multiple nutritional risks relating both to their circumstances of origin and to their migration to another location. Traditional dietary patterns and environments within which cultures evolved over time, which already may have been nutritionally tenuous at best, are disrupted with the process of becoming a refugee. While macro nutritional issues, for instance adequate protein and caloric intake, are often of primary urgency to directly avoid wasting and stunting especially in children, micronutrient deficiencies (for instance, Vitamin C, iron, iodine, Vitamin A, and trace minerals) increasingly are of concern in longer-term refugee situations, among both children and adults. Food aid rations are typically formulated to provide energy (calories) and basic macronutrients (e.g. protein) needed for immediate survival; they are not designed to provide a long-term nutritional solution and sustenance for a population (Toole et al 1989). As a result, refugee populations are at considerable risk for micronutrient deficiencies (including very rare outbreaks of unusual deficiency diseases such as scurvy and pellagra and because they are removed from their traditional nutritional environment, refugees usually do not have access to staple foods that may historically have been providing them with sufficient micronutrient content. The standard approaches to prevention of micronutrient deficiencies—supplementation, fortification, and promotion of dietary diversity—which have been demonstrated as effective in other, non-refugee settings have been integrated in different ways into refugee settings with mixed or inconclusive results (Toole 1992). Few approaches to prevention of micronutrient deficiencies among refugees have been systematically and scientifically evaluated within the particular, unique circumstances of refugee residential environments or with refugee food aid programmes. As a result, effective practice around prevention of micronutrient deficiencies in refugees is unclear, leaving refugee populations at continued risk for unusual diseases caused by micronutrient deficiencies and death associated with inadequate micronutrient consumption. Very little research has been conducted around the systematic evaluation of interventions to reduce micronutrient deficiencies in refugee populations; as shown in only a few recent studies were located that reflected systematic evaluations that examined specific interventions in refugee settings. Micronutrient deficiencies are highly prevalent

among refugees as illustrated in camps. Low income countries, refugees and displaced population have commonly experienced high rates of communicable diseases and malnutrition resulting in significant excess mortality. Both refugees and internally displaced persons are often victims of land mine, particularly when they cross the international borders.

Many refugee children and women, in some camps in Algeria, Bangladesh and Kenya suffer from high levels of Anaemia (60%). Malnutrition including micronutrient deficiencies among women prior and during pregnancy limits the ability of the foetus to grow, leading to low birth weight, which is associated with increased mortality, impaired mental and physical development and increased susceptibility to diseases throughout the life cycle. Iron plays an important role in cognitive development during foetal development (UNCHR2006). Water and sanitation provision in UNHCR refugee operations (2003 to 2006) was reviewed to identify gaps in current service provision. Inadequate water and sanitation services will increase transmission of water-borne diseases and compound malnutrition problems. Indeed, malnourished individuals have compromised immunity and are not only more likely to contract many communicable diseases, but also suffer from more frequent, severe, and prolonged episodes of these diseases (UNCHR2006).Thus there is a need for humanitarian concern to provide immediate provision of macro nutrition (energy and protein) for refugee populations which often indicates ethical and/or practical immediate solutions to nutritional constraints. Longer-term aid programmes should be based upon sound practice with demonstrated impact to prevent micronutrient deficiencies in refugee populations that accounts for household- and individual-level factors in consumption and bioavailability of intended nutrients. Application of appropriate evaluation methods to assess effectiveness of products and implementation of operational research to enable efficient deployment of intervention is necessary to provide varied solutions for field practitioners (Dye 2007, Toole 1989, 1992, UNHCR 2003-2006).

Bisrat et al (1995) in his study "Morbidity pattern among refugees in Eastern Ethiopia" showed the population of refugees in eastern Africa and the health problems affecting them are enormous. The study was conducted to document the morbidity pattern among refugees in eastern Ethiopia. The study utilized a descriptive cross sectional design. Data were collected using a uniform format from all refugee camps in the eastern Ethiopia. Respiratory tract infection and diarrhoeal diseases were identified to be the major causes of morbidity, accounting for 31.8% and 27.3% respectively in children under five years, and for 34.9% and 8.5% respectively in the other age groups. In eastern Ethiopia, 1992 and 1993 health records from all 8 health units serving the refugees in refugee camps along the Somali border were reviewed in a study of the morbidity pattern among the refugees. The information was to be used to plan refugee health services. 156,050 of the people visiting the health units were at least 5 years old, and 139,267 were less than 5 years old (the under-5 group). The overall annual morbidity rate stood at 798/1000. 15% of all refugees in these camps were less than 5 years old. Refugees under 5 years old were more likely to visit the health units in 1 year than older refugees (5 vs. 1-2). Diseases did not discriminate by sex. All age groups were vulnerable to diseases. The leading causes of illness for the under-5 group and the older refugees were respiratory diseases and diarrheal diseases (31.8% and 27.3% for under-5s and 34.9% and 8.5% for older refugees, respectively). Other conditions prevalent in both age-groups were malnutrition, injury, eye infection, and intestinal parasitic infestation. The findings were consistent with other studies done in refugee populations elsewhere. Universality of the problems was noted and a coordinated multidisciplinary approach is recommended to alleviate the health problems of refugee population.

Burnham (2003) has discussed the 'Maternal mortality among Afghan refugee female'in Hangu area of Pakistan (NorthWest Frontier Province) Refugees face special risks. Women have difficulty in access to refugee health services, in receiving food and commodities, and in obtaining protection from sexual violence. Due to unfavorable environment to women it is difficult to translate this awareness into effective programmes. Report on crude mortality and maternal mortality data from 12 Afghan refugee settlements housing 134 406 refugees in the Hangu, found that they accounted for

crude mortality rate of 5·5/1000 is extraordinarily low. The comparable figure for Pakistan is 11 and for Afghanistan is 19, 1197 deaths in 1999–2000.Of the 66 deaths among women of reproductive age, 27 (41%) were due to maternal causes. For this refugee population the maternal mortality ratio was 291/100 000 live births, higher than that for Pakistan (i.e.200) but far lower than the 820 estimated for Afghanistan. More likely, deaths were under-reported.Although the maternal mortality ratios are similar to the Pakistan figures, maternal death ratio are notoriously hard to measure, especially in small populations. Reasons for preventable maternal deaths fall into three categories;

- Women had barriers in the category of household awareness and decision-making, transport to a referral hospital, and in receiving appropriate care after reaching the facility.
- Although antenatal services are provided to refugees at primary-health-care clinics, most refugee women give birth at home, attended by relatives and sometimes traditional birth attendants. Refugee settlements commonly have community health workers, whose duties include health promotion and care for sick children and pregnant women.
- Many Afghan refugee community-health workers are male and may spend much of their time out of the settlement looking for work. The female community workers who could provide the education and care needed is usually not empowered to move far beyond their own household. The largest number of barriers existed at the household-decision level is on cultural reasons.

It has also found that the first referral hospital is a neglected part of the health system, under-resourced, understaffed, and with its personnel demoralized. The level of the formal health system is commonly the one most affected by the refugee influx. Host governments openly blame refugees for social and economic problems. So often instituting forced returns to dangerous situations. The challenge of returning refugees to their homes and the challenge of rebuilding health care formidable .When refugee women present for emergency obstetric care to host-country hospitals, these negative perceptions, added to language and cultural barriers can result in second-class treatment. However, in

some circumstances, integration of refugee and host-country health systems has improved obstetric services.

Kemp &Kemp & Rasbridge (2002), from public health perspective have shown that there are various layers to refugee health and illness, and outreach must be broadly-based in order to address this range, from the acute to the chronic. In the refugee, illness from the refugee experience and morbidity as a consequence of resettlement are two distinct entities.

Kemp &Kemp & Rasbridge (2002) has also advocated for Reproductive health (RH) should be part of all refugee assistance programmes from the outset. A lack of awareness of the issues involved in protecting and promoting reproductive health may be found in all groups involved in a refugee setting, from the providers of health care to the community they serve. Lack of awareness may leave negative impact on reproductive health and responsible sexual behaviour. However advocacy that is undertaken on RH must demonstrate understanding of the culture, values and belief systems of the local population. Advocacy that is insensitive or disrespectful may be counterproductive and prompt rejection, or even reprisals, within the refugee community.

3. Refugees and gender based violence:

Gender-based violence is any harm enacted against a person's will that is the result of power imbalances that exploit distinctions between males and females. Violence may be physical, sexual, psychological, economic or socio-cultural, perpetrated in private or in public settings. Although not exclusive to women and girls, GBV principally affects them across all cultures. GBV can occur throughout a woman's lifecycle, from early childhood marriage and genital mutilation, to sexual abuse, domestic violence, legal discrimination and exploitation. In the breakdown of social and moral order that accompanies armed conflict, displaced women and girls are particularly vulnerable to GBV. Perpetrators may include others who have been displaced by conflict or disaster, members of other clans, villages, religious groups or ethnic groups, military personnel, rebel forces, humanitarian

workers from UN agencies or NGOs, members of the host population or family members. Sexual violence and torture of civilian women and girls during periods of armed conflict is a growing phenomenon. For instance, due to systematic and exceptionally violent gang rape. Doctors in the Democratic Republic of Congo now classify vaginal destruction as a war crime. Thousands of Congolese girls and women suffer from vaginal fistula—tissue tears in the vagina, bladder and rectum—after surviving brutal rapes in which guns, branches and broken bottles were used to violate them. A survey of rape survivors in South Kivu region revealed that 91 percent suffered from one or several rape-related illnesses. Employing rape as a weapon of war, the Burmese government has tried to violently suppress a local rebellion in the Shan state since the mid '90s. And displaced Sudanese women and men continue to report abduction and widespread rape of women and girls in Darfur, Sudan.When refugees and internally displaced persons are uprooted from their homes, their health, including their reproductive health, is severely compromised. They are exposed to violence as they flee and in the camps or communities where they seek safety. Health care is often missing or inadequate. Lack of reproductive health care is a leading cause of death and disease among displaced women of reproductive age"[7]. For instance, Thirteen Tibetans, including a newborn baby to one of the Tibetan women, are in prison in Katmandu. All are serving 10 year prison sentences for illegally entering and /or staying in Nepal. Human rights monitors have plead the Govt. (Nepal)to provide health care to mother and four month-old infant after learning of the mother's ailing health[8].In Tibet, there is forced sterilization and abortions which have traumatized the lives of countless women across Tibet (Bowe 1997) .

In addition, women are deliberately targeted for rape, torture and sex slavery, trafficking, forced marriages, and pregnancies. for instance refugee from Iraq war, in Syria alone an estimated 50,000 Iraqi girls and women, many of them widows, are forced into prostitution just to survive.The numbers of refugees rose from 2.5 million in 1970 to current figures of over 12 million (2000) registered through formal agencies; over three quarters of these are women and children. The most recent significant flows were from Afghanistan and the Former Yugoslav Republics. The populations destabilized by armed

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[7] Women's Commission for Refugee Women and Children, New York 2008

[8] Tibet Press Watch (2002).Vol.X.Issue no. 4, pp -11

conflict, natural disasters, and humanitarian emergencies are at increased risk of exposure to HIV infection because of sexual abuse, coercion, forced high-risk sexual behavior, and rape (UNHCR2000, Alottey2004).

Elizabeth et al (2006) has traced out the evolution and impact of implementing refugee health services in parallel to local systems using observations from Uganda, and offers Quality Design as a model for planning the local integration of services. The international community typically responds to refugee situations by establishing 'care and maintenance' programmes specifically for refugees. Limited resources may also be directed to hosting communities, but donors often channel the bulk of funding through UNHCR and its implementing partner NGOs, who in turn create service delivery structures that are operated in parallel to local structures. Although there may be cause for this approach in a short-term emergency phase, particularly if the host country systems are very weak, this eventually becomes financially problematic if refugees continue to live in exile for years at a time. In the short term, it can also engender an inequitable and inefficient use of scarce resources.

In the case of Uganda, the integration of health services has been problematic. The handover approach as described in Arua district resulted in confusion over a number of issues including the critical staffing function. Integration was perceived as the physical handover of equipment and facilities, and an overall shift in responsibility for staff and recurrent cost inputs from the international community to the district. In contrast, Quality Design is a planning tool that can help health managers tackle services integration through consensus-building, team work, the collection and application of data, and perhaps most importantly—viewing health service delivery as a set of *systems* rather than simply as health units, equipment, and staff. As described elsewhere, district and refugee health managers used Quality Design to plan specifically for the integration of immunization services in Adjumani district. If UNHCR is to pursue the objectives of local integration and refugee self-reliance in response to protracted refugee situations and

continued financial pressure, it is critical that both the agency and the international community as a whole look carefully at how these aims can be achieved in ways that ensure the best possible services for both refugee and host country populations.

4. Conceptual Models for understanding refugees

Mass migration and the movement of refugees are both a symptom and a cause of the turmoil in the world today. Millions of people are on the move for a multitude of reasons: as economic migrants, guest workers, internally displaced persons who are the victims of conflict, famine or drought and refugees. Refugees, currently thought to number 21 million, move for very specific reasons which distinguish them from other migrants. They flee from their homelands in fear of losing their lives or liberty. Today nearly 15,000 people a day become refugees; one in every 120 people in the face of the earth has been forced into flight. The situation of the world's refugees is not entirely one of unbroken gloom. Sometimes conflicts subside and it is possible for refugees to return home and to pick up the pieces of their lives. Meanwhile other solutions continue to be found for refugees unable to repatriate. Significant - if much smaller – numbers have been either to integrate permanently in the countries where they first sought asylum or to resettle in third countries where they have begun new lives. The total number of refugees continues relentlessly to grow. The international framework for meeting the needs of these people, which includes the Office of the United Nations High Commissioner for Refugees (UNHCR), is being stretch to meet the new demands of larger and more complex refugee situations. It has at its core a simple but powerful commitment: refugees must be protected and helped towards a lasting solution to their plight (Grove 1995, Uneoo 1995). Today, the problems of refugees raise not only humanitarian and human rights concerns but also fundamental issues of international peace and security .The four major root causes for creation of refugee are now well known which is discussed by Grove(1995)[9], Giri (2003)and Giri (1993):

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[9] Dr Robyn Grove is external relations officer with the United Nations High Commission for Refugees in Sydney 1995.

4.a Political Model

This is persecution based on who a refugee is (race, nationality, and membership of particular social group) or what he or she believes (religion or political opinion). Persecution usually takes place in the context of fundamental political disputes over who controls the state, how society organizes itself and who commands the power and privilege that go with political control. These disputes often erupt during periods of intense change, when entire social classes or ethnic groups may be perceived to hold political opinions in opposition to the state for instance, the professional classes in Cambodia under Pol Pot or the Kurds in Iraq under Saddam Hussein. Weak states are especially prone to internal violence, often lack representative political institutions, credible mechanisms for resolving conflicts peacefully, impartial law enforcement or free elections, for instance Mozambique, Afghanistan, Bosnia and Herzegovina, Rwanda. The vast majority of refugees today, as in the past, are fleeing not from targeted acts of individual persecution but from generalized violence that endangers civilians and radically disrupts everyday life.

4.b. Economic Model

Economic deprivation is a major factor in the instability of conflict situations which produce refugees. When the conditions of daily life, precarious to begin with, are disrupted by war, the ensuing famine and disease often become greater threats to the population then the fighting itself. Ethiopia, Sudan, and Somalia can be taken as example. Poverty inevitably compounds ethnic and communal tensions, with minority groups often providing convenient targets. More than one billion people worldwide live in absolute poverty.

4.c. Environmental Model

Millions of people have been forced to leave their homes because the land on which they live has become uninhabitable or is no longer able to support them. In some cases, the

cause is natural disaster; in others, the catastrophe is caused by humans. The disruption to habitat may be sudden or as gradual.

The terminology for describing environmentally induced migration is controversial. People displaced by environmental degradation or natural disaster need help. Occasionally, the destruction of habitat can equate to persecution ,if it occurs as the result of deliberate governmental action or gross negligence and no effort is made to assist or compensate the victims. In extreme cases, for example in Iraqi Kurdistan, destruction of a habitat may be used as a deliberate weapon of war. Long-term strategies of prevention should address environmental damage as a potential contributor to refugee flows.

4.e. Ethnical Model

Conflicts between ethnic groups have proliferated in recent years. Countries like Armenia and Azerbaijan, Bhutan, Burma, Ethiopia, Georgia, Iraq, Sri Lanka, Sudan and former Yugoslavia are examples. Ethnic tensions can be seen as a root cause of refugee flows for two reasons. First, they are highly susceptible to political exploitation. Second, in extreme nationalistic regimes, a minority ethnic group can be seen as an obstacle to nation-building, incapable of fitting into a homogeneous national identity, e.g. ethnic Albanians and Bosnian Moslems in conflict with "greater Serbia". Members of the minority group may be exposed to discrimination, forced assimilation, persecution, expulsion or even genocide for example Tibetans in occupied Tibet by Chinese. In Iraq, Bosnia and Herzegovina, Myanmar, Guatemala and Rwanda, ethnic minorities have to suffer human rights violations, enforced military conscription, and arbitrary arrest, detention without trial, torture, rape and murder. Thus, the need for refugee protection arises. But generally government's fail to defend its citizens against such violations. This failure by government is now frequently, and correctly, seen as a threat to international peace and security. The world's twenty million refugees are part of a complex migratory phenomenon. Global migration proceeds across a spectrum of motivation ranging from those fleeing persecution and serious danger, to those trying to escape misery and those who wish to leave behind a lack of opportunity.

The problem of refugee is one of the most serious problems all over the world. People move for many different reasons. To become a refugee is to experience a deep sense of loss. Becoming a refugee normally entails a lowering of ones social economic status. Even in countries with generous asylum policies, refugees are almost inevitably obliged to settle on the most marginal land and to accept the least desired and worst paid jobs. The loss experienced by a refugee also has important social, psychological and legal dimensions. When people are forced to leave they are separated from a familiar environment and cut off from friends, family and established social networks. Not knowing when they will be able to return to their homes, or what they will find when they get there, many refugees live in perpetual state of uncertainty .And wile some are able to settle down and integrate in another society, many find that they are obliged to live a second class residents in their country of asylum, deprived of rights, freedoms and benefits we hoyed by ordinary citizens of that state (Kumari 1997).Other then this ,much of the debate on the refugee issue has been dominated by a statistic perspective that views refugees as a disruptive of state order (Bose& Manchanda 1997). They are unwanted people at home as well as in the host country where they are seen as threatening scarce resources and fragile demographic balances (Samaddar1997). Manchanda's (1997) report on Chin-Burmese refugees in Mizoram brings out that they have become victims of a xenophobic campaign whipped up by local politicians. A sharp critique of Nair (1997) asserts the treatment of refugee is ad hoc and arbitrary. The restrictive 1951 definition does not provide protection to those who have been forced to flee because of ethnic strife civil disturbance, break down of law and order, denial of human rights and security of food land and water caused by forces beyond their control (Bose& Manchanda 1997). For instance, Lebanese constitution shows unique degree of socio-eco political exclusion of Palestine refugee, discriminatory law constraints Palestine refugees in Lebanon from those of wide range of skilled and semi skilled work as well as public sector employment and also their civic rights are constricted by laws which make life unbearable that many leave or live in a state of "ultra poverty". Chakma (2001) , easily apprehend that Chakma refugee are put under genocides, extra –judicial execution, arbitrary arrest, imprisonment without trail, rape, torture, burning of indigenous people's villages ,forcible eviction and relocation etc.

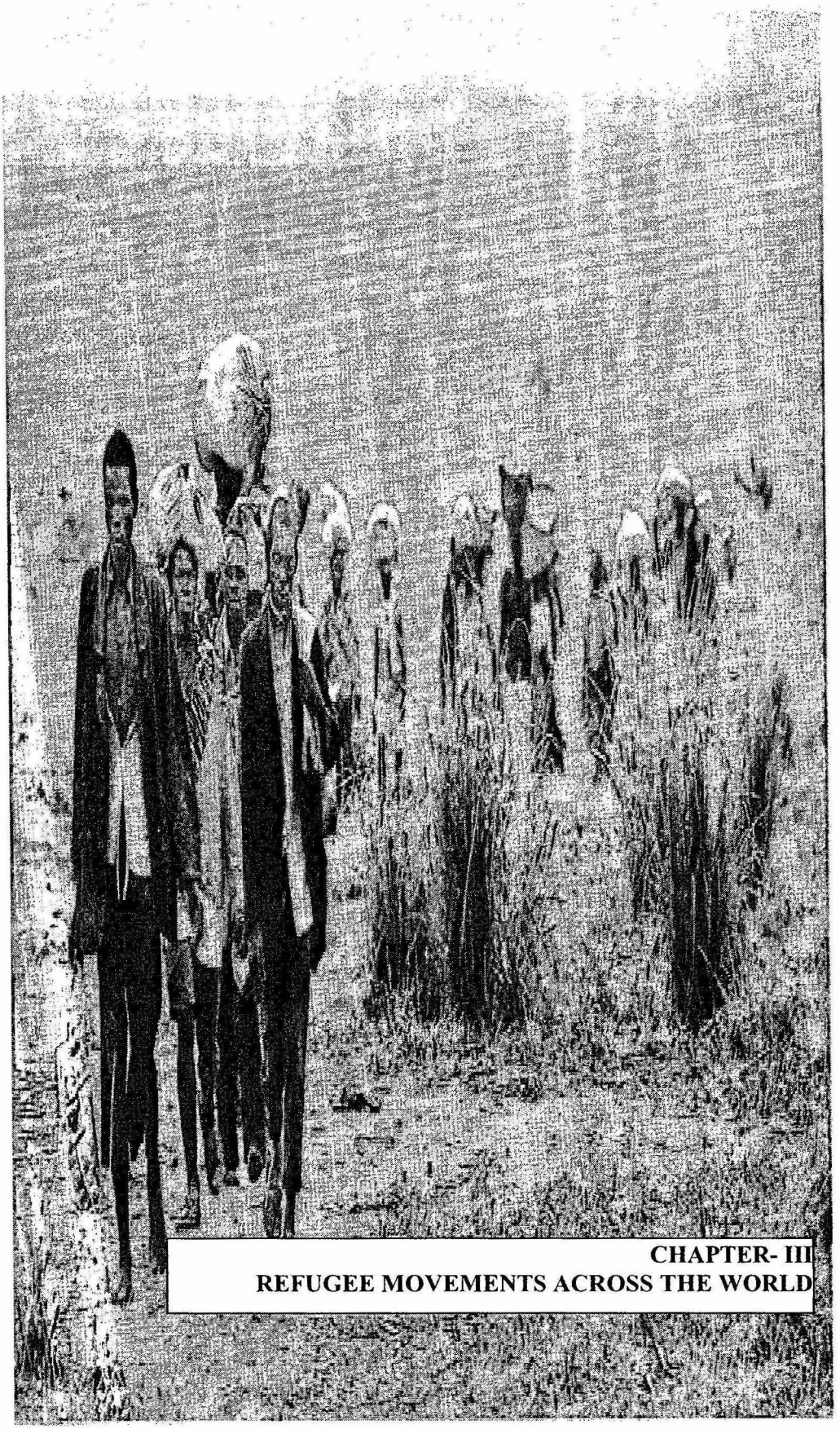
Alexander (2008) in his study of chin refugees in India and Malaysia highlighted that chin refugees take great risks, endure extreme hardships and confront dangerous challenges in the hope of finding refuge somewhere. However, there is a lack of legal recognition, limited access to protection, and difficulty in obtaining work, receiving an education and accessing health-care services and acceptable living accommodation. Allotey (2003), But often lost in this complexities are the specific health needs of this group (refugee) whose vulnerabilities are created by a combination of the out comes of the conflict ,displacement , poverty, natural disaster or violation of their human rights. And also lost is the heterogeneity of this population, the significant differences created by gender, culture, socio economic status and circumstances that provide the context for short and long term health outcomes in all population. Refugee problem is not only health centered it is also a plight of being an illegal intruder. Patel (1980), in his Anthropo-genetic study of Tibetan refugee in Orissa highlights refugees encounter many problems as they arrive at their temporary new homes loss of cultural support systems , psychological detachments, economic hardships and potential discrimination and hostility from the natives. They are seen as potentially dangerous to the economic welfare of the host population. Sometimes their cultural heritage varies so much from the host population that many myths regarding their belief and habits emerge .This contributes to resentment and fear on part of the native .Thus the stage is set for an uncomfortable encounter between refugees and their new neighbour. Further it is also studied that in some cases although the move to new society may be successful, it means the group passes through a cycle of contact, competition, conflict, accommodation and assimilation and finally they merge into the receiving group but many of them face difficulty in adopting new culture. This kind of cultural stress worsens their status (Kumari 1997).

5. Conclusion

All these studies reviewed led us to conclude that refugee have to face lots of problems. Refugees are often subjected to discrimination and prejudice, denied human rights and also exploited as cheap labor In case of women refugee, they are more vulnerable due to power imbalances that exploit distinctions between males and females. Health care is

often missing or inadequate. Often in refugee camps due to lack of reproductive health care is a leading cause of death and disease among displaced women of reproductive age. It is identified that environmental and socio-economic changes due to displacement are responsible for some major health problems among the refugees. With few resources for health care and other basic necessities and no opportunities they face an acute sense of being uprooted, the difficulties of situational adjustments and adaptation to environmental changes. Refugees are often entangled with issues such as identity and insecurity.

Though methodologically all these studies are varied so they can not be linked together but they all indicate that refugee are particularly vulnerable to diseases. It shows that there are various layers to refugee health and illness, from the acute to the chronic. It is also identified that refugees share health problem with the poorest section of the host population with whom they live and another health problems arising out of their health status which makes refugees health status more vulnerable as in many cases refugees are reluctant to seek health care due to their illegal status in the host country.



CHAPTER- III
REFUGEE MOVEMENTS ACROSS THE WORLD

CHAPTER-3

REFUGEE MOVEMENTS ACROSS THE WORLD

The refugee problem today has assumed truly gigantic and global proportions and become a matter of acute international concern. In fact the present century has been described as the " century of homeless man or century of uprooted" because of tremendous increase in the number of refugees (Ahmed 2004).In human history natural calamities religious and political persecutions have been creating continually a class of dispersed person who are uprooted from their native homelands. The classes of displaced and uprooted persons are referred to as refugees. History records many aspects of tragic story of the refugee. Hundreds of thousands of refugees, in need of protection and resettlement remained dispersed (Ahmed 1996).

1. Historical and contemporary refugee crises

The first and the most important refugee movement started after the first World War. Since World War I at least seventy millions person have led to move as a result of political, military or ideological disputed. The World War I and Bolshevik revolution of 1917 produced first massive refugees movements .After the Russian revolution and subsequent civil war in 1917-1923 created the first large group of international refugee. Over 1.5 millions Russian escaped persecution and saved their lives and personal freedom by fleeing to central and West Europe and to china. Another result of Russian Revolution was the expulsion of abort 350,000 Assyrians, Greeks, Turks, and other minority groups from southern part of Russia. They found asylum in Turkey, Greece and some other countries. The second important refugee movement took place during world war II caused the most formidable displacement of population. The conflict and political instability during War II led to massive amounts of forced migration. Hundreds of thousands of refugees, in need of protection and resettlement remained dispersed through out Europe at the end of World War II. Large new groups of international refugee were formed as result of racial religious and political persecution. There was mass movements of Germans, many of whom either fled or expelled with German defeat as were Germans in the territory that was ceded to Poland and Soviet Union after the war. Fascism forced 200,000 Italians to leave their country and about 150,000 Germans fled Nazi Germany,

both groups seeking protection and sustenance in Western Europe.East Europe to witness a massive dislocation of people during the World War II about 1.6 millions persons during 1939-45 (Nash and Humphrey 1987, Ahmed 2004).

Asia too witness massive dislocation of people .In 1947 creation o two separate stats India and Pakistan was followed by an exodus of about 85,00,000 Hindustani and Sikhs from East and West Pakistan. Of these 50,00,000 were from west Pakistan in the period of 1947-48 and 35,00,000 refugee from East Pakistan in the period of 1950-51.In addition to East and West Pakistan the Chinese occupation of Tibet in 1959 also led to inflow of additional 50,000 refugees led by the Dalai Lama followed by the Chakma influx in 1963. Even after the independence of East Pakistan the inflow of refugee did not subsidized due to outbreak of civil strife in East Pakistan in March 1971 . The Tamil efflux from Sri Lanka in 1983, 1989,and again in 1995, the Afghan refugees from the 1980s, the Myanmar refugees for a similar period and migration and refugee movements from Bangladesh over the years (Ahmed 2004)

2. Refugees across the world

The refugee problem today has assumed truly gigantic and global proportions and become a matter of acute international concern. In fact the present century has been described as the " century of homeless man or century of uprooted" because of tremendous increase in the number of refugees (Ahmed 2004).In human history natural calamities religious and political persecutions have been creating continually a class of dispersed person who are uprooted from their native homelands. The classes of displaced and uprooted persons are referred to as refugees. History records many aspects of tragic story of the refugee. Hundreds of thousands of refugees, in need of protection and resettlement remained dispersed (Ahmed 1996).Global refugee problem is largely a twentieth century phenomenon that until 1950s was largely European in nature. Today most of the world 's refugee populations are to be found in the poorest countries. There is wide spread acknowledgment that this problem is growing with seemingly no end in sight .there is also the recognition that such a problem poses a major humanitarian and political challenge. The scale of refugee movements has expanded dramatically in recent

years (Rajkumar 2001). Many scholars have identified the process and event of refugee movement. The following refugee movements are highlighted to provide the necessary framework by which to gain full understanding of the seriousness of the refugee problem around the world. Informations are collected from from studies done by different scholars at different time and period such as, Bligh (1998):Israel and the refugee problem from exodus to resettlement 1948-52,"Millions on the move – The aftermath of Partition (1987)",Ministry of Information and Broad Casting , Government of India, Datta (1999): "Refugee crisis; hanging Solution", Moosa, (2004): "Refugee, Conflict and Global Peace", Elmadmad,(1999): "Asylum in the Arab world-some recent instruments", Ogata, S(2000): "Africa's refugee crises", Zolberg,(1986): "International factors in the formation of refugee movements", Giri,T.N (2003): "Refugee problems in Asia and Africa-role of UNCHR and The state of the world's Refugees- A Humanitarian Agenda UNHCR (1998)

2.a- Refugee situations in the Middle East

2.a (i) Palestinian refugees: In 1948,the proclamation of the State of Israel, the first Arab-Israeli War began. Many Palestinians had already become refugees, and the Palestinian Exodus (*Nakba*) continued through the 1948 Arab-Israeli War. The final estimate of refugee numbers was 711,000 according to the United Nations Conciliation Commission. Palestinian refugees from 1948 and as of December 2005, the World Refugee Survey of the U.S. Committee for Refugees and Immigrants estimates the total number of Palestinian refugees to be 2,966,100.

2.a(ii)Jewish refugees: In Europe, Nazi persecution culminated in the Holocaust and the mass murder of many European Jews.Secondly,the refusal of the Arab world to accept the existence of a Jewish state led to discrimination and violence against the Jews. In 1948, the Arab League declared the Jews enemy citizens., Jews were arrested and fired from their jobs, roperty was confiscated and synagogues were attacked. Now very few Jews live in Arab countries today.

2.a.(iii) African refugees in Israel: Since 2003, an estimated 10,000 migrants from various African countries have illegally entered Israel. Israel refuses to recognize them.As due to the Jewish state's good relations with both African countries they receive temporary resident IDs, for "humanitarian" but not as refugees.The remaining infiltrators live in Israel illegally.

2.a.(iv) Refugees from the Algerian War: The Algerian War of Independence (1954-1962) uprooted more than 2 million Algerians, who were forced to relocate in French camps or to flee to Morocco, Tunisia, and into the Algerian hinterland.

2.a(v)Lebanese Civil War: It is estimated that some 900,000 people, representing one-fifth of the pre-war population, were displaced from their homes during the Lebanese Civil War (1975-90).

2.a.(vi)Western Sahara: It is estimated that more than 150,000 uprooted – due to territory dispute.

2.a(vii) Turkey: Between 1984 and 1999 Turkish military engaged in open war an estimated 3,000 Kurdish villages in Turkey were virtually wiped from the map, representing the displacement of more than 378,000 people.

2.a(Viii) Refugees from the Iraq wars: The Iran-Iraq war from 1980 to 1988, the 1990 Iraqi invasion of Kuwait, the first Gulf War and subsequent conflicts all generated hundreds of thousands if not millions of refugees. Iran also provided asylum for 1,400,000 Iraqi refugees who had been uprooted as a result of the Persian Gulf War (1990–91). At least one million Iraqi Kurds were displaced during the Al-Anfal Campaign (1986-1989). The current Iraq war has generated millions of refugees and internally displaced persons. As of 2007 more Iraqis have lost their homes and become refugees than the population of any other country. Over 4,200,000 people, have become uprooted. Of these, about 2.2 million have fled Iraq and flooded other countries, and 2 million are estimated to be refugees inside Iraq, with nearly 100,000 Iraqis fleeing to Syria and Jordan each month.

2.a.(ix)Religious minorities in the Middle East: Although Assyrian Christians represent less than 5% of the total Iraqi population, they make up 40% of the refugees now living in nearby countries. There is repression of religious minorities in the Middle East and in Pakistan such as Christians, Hindus, as well as Ahmadi, and Zikri denominations of Islam. In Sudan where Islam is the state religion, Muslims dominate the Government and restrict activities of Christians, practitioners of traditional African indigenous religions and other non-Muslims..In the Islamic republic of Iran, Iranian Christians decry minority religions' lack of freedom in Islamic countries , are fleeing religious persecution .

2.b- Refugee movements in Africa

Since the 1950s, many nations in Africa have suffered civil wars and ethnic strife, thus generating a massive number of refugees of many different nationalities and ethnic groups. The division of Africa into European colonies in 1885, along which lines the newly independent nations of the 1950s and 1960s drew their borders, has been cited as a major reason why Africa has been so plagued with intrastate warfare. The number of refugees in Africa increased from 860,000 in 1968 to 6,775,000 by 1992. By the end of 2004, that number had dropped to 2,748,400 refugees, according to the United Nations High Commission for Refugees. Many refugees in Africa cross into neighboring countries to find haven; often, African countries are simultaneously countries of origin for refugees and countries of asylum for other refugees. The Democratic Republic of Congo, for instance, was the country of origin for 462,203 refugees at the end of 2004, but a country of asylum for 199,323 other refugees.

Countries in Africa from where 5,000 or more refugees originated as of the end of 2004, arranged in descending order of numbers of refugees are listed below. The largest number of refugees are from Sudan and have fled either the longstanding and recently concluded Sudanese Civil War or the Darfur conflict and are located mainly in Chad, Uganda, Ethiopia, and Kenya.

Table2.1 Refugees in different states of Africa

Country	Population
Angola	228,838
Burundi	485,764
Cameroon	7,629
Central African Republc	31,069
Chad	52,663
Côte d'Ivoire	23,655
Democratic Republic of Congo	462,203
Eritrea	131,119
Ethiopia	63,105
Ghana	14,767
Liberia	335,467
Nigeria	23,888
Republic of the Congo	28,152
Rwanda	63,808
Senegal	8,332
Sierra Leone	41,801
Somalia	389,272
Sudan	930,612
Togo	10,819
Uganda	31,963
Zimbabwe	9,568

Source: UNHCR, 2004, Global Refugee Trends

2.c- Refugee movements in the Americas

More than one million Salvadorans were displaced during the Salvadoran Civil War from 1975 to 1982. About half went to the United States, most settling in the Los Angeles area. There was also a large exodus of Guatemalans during the 1980s, trying to escape from

the Civil War and genocide there as well. These people went to Southern Mexico and the U.S.From 1991 through 1994, following the military coup d'état against President Jean-Bertrand Aristide, thousands of Haitians fled violence and repression by boat. Although most were repatriated to Haiti by the U.S. government, others entered the United States as refugees. Haitians were primarily regarded as economic migrants from the grinding poverty of Haiti, the poorest nation in the Western Hemisphere.

The victory of the forces led by Fidel Castro in the Cuban Revolution led to a large exodus of Cubans between 1959 and 1980. Dozens of Cubans yearly continue to risk the waters of the Straits of Florida seeking better economic and political conditions in the U.S. In 1999 the highly publicized case of six year old Elián González brought the covert migration to international attention. Measures by both governments have attempted to address the issue; the U.S. instituted a wet feet, dry feet policy allowing refuge to those travelers who manage to complete their journey, and the Cuban government have periodically allowed for mass migration by organizing leaving posts. The most famous of these agreed migrations was the Mariel boatlift of 1980.

It is now estimated by the US Committee for Refugees and Immigrants that there are about 150,000 Colombians in "refugee-like situations" in the United States, not recognized as refugees or subject to any formal protection.

During the Vietnam War, many U.S. citizens who were conscientious objectors and wished to avoid the draft sought political asylum in Canada. President Jimmy Carter issued an amnesty Since 1975, the U.S. has resettled approximately 2.6 million refugees, with nearly 77% being either Indochinese or citizens of the former Soviet Union. Since the enactment of the Refugee Act of 1980, annual admissions figures have ranged from a high of 207,116 in 1980 to a low of 27,100 in 2002.

Currently ,ten national voluntary agencies resettle refugees nationwide on behalf of the U.S. government: Church World Service, Ethiopian Community Development Council, Episcopal Migration Ministries, Hebrew Immigrant Aid Society, International Rescue Committee, US Committee for Refugees and Immigrants, Lutheran Immigration and

Refugee Service, United States Conference of Catholic Bishops, World Relief Corporation and State of Iowa, Bureau of Refugee Services.

The U.S. Office of Refugee Resettlement (ORR) funds a number of organizations that provide technical assistance to voluntary agencies and local refugee resettlement organizations. The nonprofit organization assist refugee service providers in their efforts to help refugees achieve self-sufficiency. RefugeeWorks publishes white papers, newsletters and reports on refugee employment topics.

2.d-Refugee movements in Asia

2.d.(i) Afghanistan: From the Soviet invasion of Afghanistan in 1979 through the early 1990s, the Afghan War (1978–92) caused more than six million refugees to flee to the neighboring countries of Pakistan and Iran, making Afghanistan the greatest refugee-producing country. At the peak of the Soviet invasion of Afghanistan, close to seven million Afghan refugees sought refuge within Pakistan, making Pakistan the only country to have hosted such a huge number of refugees. The number of refugees fluctuated with the waves of the war, with thousands more fleeing after the Taliban takeover of 1996. The U.S. invasion of Afghanistan in 2001 and continued ethnic cleansing and reprisals also caused additional displacement. Though there has been some repatriation sponsored by the U.N. from Iran and Pakistan, a 2007 UNHCR census identified over two million Afghan refugees still living in Pakistan alone.Since late April 2007, the Iranian government has forcibly deported back to Afghanistan nearly 100,000 registered and unregistered Afghans living and working in Iran. The forceful evictions of the refugees, who have lived in Iran and Pakistan for nearly three decades, are part of the two countries' larger plans to repatriate all Afghan refugees within a few years. Iran says it will send one million by next March, and Pakistan announced that all 2,400,000 Afghan refugees, most living in camps, must return home by 2009. Experts say it will be 'disastrous' for Afghanistan.

2.d.(ii)Tajikistan Civil War: Since 1991, much of the country's non-Muslim population, including Russians and Jews, have fled Tajikistan due to severe poverty, instability and

Tajikistan Civil War (1992–1997).In 1992, most of the country's Jewish population was evacuated to Israel. By the end of the civil war Tajikistan was in a state of complete devastation. Around 1.2 million people were refugees inside and outside of the country.

2.d.(iii) Uzbekistan: In 1989, after bloody pogroms against the Meskhetian Turks in Central Asia's Ferghana Valley, nearly 90,000 Meskhetian Turks left Uzbekistan.

2.d.(iv) Communist takeovers in Vietnam, Cambodia, and Laos :In 1975, about three million people attempted to escape in the subsequent decades. With massive influx of refugees daily, the resources of the receiving countries were severely strained.

Large numbers of Vietnamese refugees came into existence after 1975 when South Vietnam fell to the communist forces. Many tried to escape, some by boat, thus giving rise to the phrase "boat people." The Vietnamese refugees emigrated to Hong Kong, France, the United States, Canada, Australia, and other countries, creating sizeable expatriate communities, notably in the United States.

- Survivors of the Khmer Rouge regime in Cambodia fled across the border into Thailand after the Vietnamese invasion of 1978-79. Approximately 300,000 of these people were eventually resettled in the United States, France, Canada, and Australia between 1979 and 1992, when the camps were closed and the remaining people repatriated.
- Due to the persecution of the ethnic Karen, Karenni and other minority populations in Burma (Myanmar) significant numbers of refugees live along the Thai border in camps of up to 50,000 people.
- Muslim ethnic groups from Burma, the Rohingya and other Arakanese have been living in camps in Bangladesh since the 1990s.

- The Korean War (1950–53) and the Chinese take-over of Tibet (1959) both caused the displacement of more than one million refugees.
- During the end of Chinese Civil War and Great Leap Forward thousands of Chinese escaped to Hong Kong in the 1960s.

2.e. India

2.e.(i) The Partition of 1947: The partition of the Indian subcontinent into India and Pakistan in 1947 resulted in the largest human movement in history: an exchange of 18,000,000 Hindus and Sikhs (from Bangladesh-65% and Pakistan-35%) for Muslims (from India). During the Bangladesh Liberation War in 1971, owing to the West Pakistani Army's Operation Searchlight, more than ten million Bengalis fled to neighboring India. Because of this partition, th city of Amritsar was set aflame and this event was noited it histories.

2.e.(ii) Inflow of Refugee from bangladesh 1971: As a result of the Bangladesh Liberation War, on 27 March 1971, Prime Minister of India, Indira Gandhi, expressed full support of her Government to the Bangladeshi struggle for freedom. The Bangladesh-India border was opened to allow panic-stricken Bengalis safe shelter in India. The governments of West Bengal, Bihar, Assam, Meghalaya and Tripura established refugee camps along the border. Exiled Bangladeshi army officers and the Indian military immediately started using these camps for recruitment and training members of Mukti Bahini. During the Bangladesh War of Independence around 10 million Bengalis fled the country to escape the killings and atrocities committed by the Pakistan Army. Following the war, the Bangladesh government and actively supported by the Indian military indiscriminately tortured and killed thousands of Biharis who were mostly against the independence of Bangladesh. Those who survived the massacre were forced into squalid camps were they live to this day. There are between 126,000 and 159,000 Biharis who have been living in camp-like situations in Bangladesh ever since the war.

2.e.(iii) The Tibetans : There are more than 150,000 Tibetans who live in India, many in settlements in Dharamsala and Mysore, and Nepal. These include people who have escaped over the Himalayas from Tibet, as well as their children and grandchildren. In India the overwhelming majority of Tibetans born in India are still stateless and carry a document called an Identity Card issued by the Indian government in lieu of a passport. This document states the nationality of the holder as Tibetan. It is a document that is frequently rejected as a valid travel document by many customs and immigrations

departments.In 1991-92, Bhutan expelled roughly 100,000 ethnic Nepalis, most of whom have been living in seven refugee camps in eastern Nepal ever since. As many as 200,000 Nepalese were displaced during the Maoist insurgency and Nepalese Civil War which ended in 2006.

2.e.(iv) Sri Lankan Tamils: The civil war in Sri Lanka (1983 to the present) has generated millions of internally displaced as well as refugees. Sri Lanka Tamils have fled to India, Europe (mostly France, Denmark, the United Kingdom, and Germany), and Canada (over 800,000 people).

2.e(v) Hindus of Kashmir (India) : Displacement of Kashmiri Hindus living in Kashmir due to the ongoing anti-Indian insurgency. Some 300,000 Hindus have been internally displaced from Kashmir due to the violence.

3. Factors affecting Refugee Movements

Considering above chronolpgical history of movements in world it is understood that the refugee movements stem from variety of causes .These causes m ay be combined with one another and are responsible in varying degrees for particular refugee flows. Some causal agents affect entire regions, other only specific localities .Some effect whole populations or at least entire ethnic groups, where as others only specific persons.

The root cause of refugee problems are manifold, national and international, individual and social, political and economic. In the theoretical studies of refugee phenomenon six broad causal factors have been identified as being responsible for creating refugees. They are (Giri 1993, Rajkumar 2001, Mohan 1999, Chimni 2000, Sen 2003, Munni and Baral 1996,Grove and Uneoo1995) :

3.a. Anti colonial wars: Wars of independence and self determination movements. The break down of colonial rule and the rationalization of some of the colonial legacies created refugee flows .A majority of third world countries have only gained independence in the 1950's and 1960's .In case of south Asia the largest of such flows ,

was between India and Pakistan , resulting from the partition of British India. (Munni & Baral 1996). The most of the world's refugee in the early 1970's were created by the wars of national liberation against in Angola, Guinea Bissau and Mozambique. Likewise, in Ethiopia, the struggle for independence in 1962 created thousands of refugee .The history also shows that even after achieving political independence in many countries, communal conflicts and territorial disputes took place and resulted mass population displacement (Giri 2003).

3.b.International conflict: War between two states or two groups of states generates refugee flows. Sometimes this flow has resulted in long absences, sometimes only in shorter displacement. There are many reasons for this flow for instance the government authorities, to prevent injury to civilians, may force them to change their place. Sometimes civilians, act on their own initiative in order to avoid immediate danger such as outpouring of people from the border areas occurred in Europe in the beginning of the Second world war., war between Somalia and Ethopia over Ogaden in 1977, soviet invasion of Afganistan ,Vietnam invasion of Kampuchea in 1978.

3.c. Revolution, coups and changes of governments: Generally it involve relatively small part of society where one elite exchanges for other. This results in exodus of senior political figures and military officers who were part of the replaced regime. Number of refugee depends on the aim of new regime, its repressiveness or violence. Each change in the regime has started new waves of refugee. For instance there is a case of Cuba, where since the victory of Fidel Castro in 1959 more than one million people have left the country and have settled in USA. The civil war in Nicaragua, brought the Sandinista regime to power, which forced 100,000 Nicaraguans to become refugees.

3.d.Ethnic and tribal conflicts: Ethnicity and tribal identity is a very important cause of conflict since the time immemorial such as fighting between Aryans and Dasyus (local inhabitant of Indian Sub continents) in early Rig-Vedic period. In present also ethnicity and tribal identity have led to many wars throughout the world and have created refugee problems. The history tells us that in two world wars there was move towards ethnic

homogenization in Europe. In Sri Lanka , inter communal violence which began in `1983 between Tamil minority and Sinhalese majority resulted in large number of refugee, more recently in Assam in India the ethnic riots in the form of Bodo Land movements, the still on going fighting with Afghanistan and Iraq. Thus ethnic and tribal conflicts are also important cause of refugee emergence.

3.e. Partition of states: Partition of states on the ground of religion ethnicity, language, culture etc involves movement of population in huge numbers because these demarcations are difficult to draw on land. Movement of people in search of new jobs, better opportunities, pilgrimages etc brings intermixing of population of different characters. Therefore, when partition of states on above lines are done and people with different character see each other as enemies, this result in large scale war, violence and death and movement of people from one area to another . This type of partition has given rise to large number of refugee. Indians have already suffered from this type of partition when India and Pakistan were created in 1947 on the lines of religion and also the war between Israel and its neighbour Arab countries. In 1954 decision to divide Vietnam into separate sectors, this resulted in one million refugee movement from North to South Vietnam.

3.f. Expulsion of minority groups population transfers: This category comprises political refugees forced to move by government actions such as, in recent case 40,000 Hindustanis and Pakistanis who were forced to leave Uganda, Keniya and Tanzania and later most of them were accepted by great Britain.

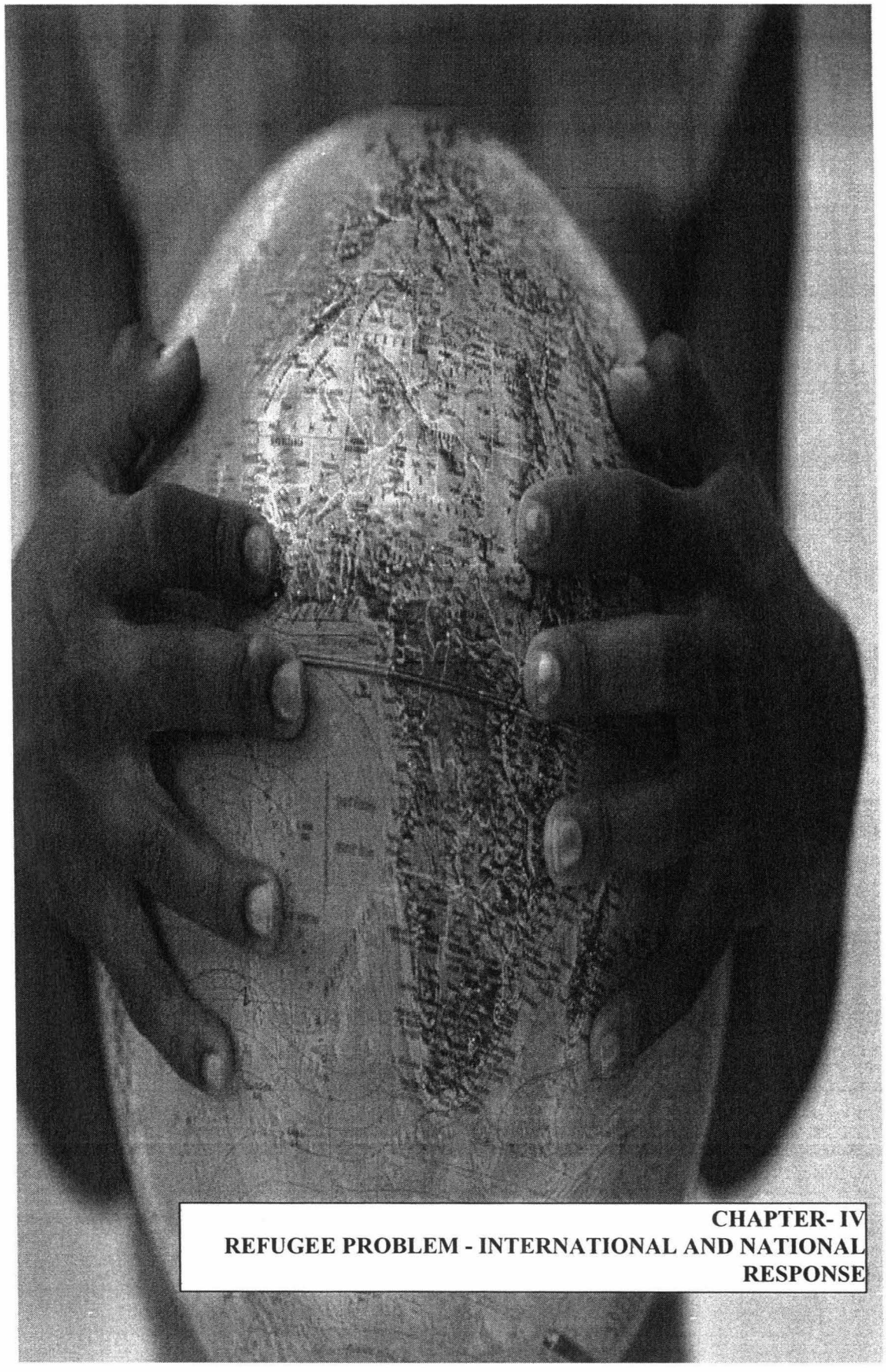
4. Outcomes of Refugee Movements

There are categories of refugee generating factors relate to the development outside the region and the flow of extra –regional refugee. So far such refugees have come from Tibet , Afghanistan and Burma . Generally speaking they relate to internal and external armed, ethnic or other conflicts, economic hardship of individuals and nations governmental policies of control and discrimination foreign interventions and interference and to natural and environmental disasters. Often several of these

components are interconnected and there is seldom one single cause for the decision to seek protection from outside the country of origin. In other words, the decision to leave is always a difficult one, jump to the one unknown, for instance before a peaceful adjustment of Tibetan refugee in India , the group has to go through episode of genocide, religious persecution, torture, forced sterilization, destruction of families an so on in their own country which compelled them to seek refugee in India (Norbu 2001). To become a refugee is to experience a deep sense of loss .becoming a refugee normally entails a lowering of ones social and economic status. Even in countries with generous asylum, policies, refugees are almost inevitably obliged to settle on the most marginal land and to accept the least desired and worst paid jobs. For instance, Cultural, linguistic and sharp physical differences still set the group (refugee) apart from host country. The Bantu refugee in Dadaab (Somali), their children were discouraged to school, denied any meaningful land tenure or political representation. They are not allowed to pick up dignified job. Bantus are filled with menial jobs, principally working on the land. Daily life is strictly regimented and boredom is a way of life. The Bantu refugee cannot travel out side the camp with permission. Violence is ever present threat such as sexual violence has been endemic in Dadaab in respecter of ethnicity and gender (UNHCR 2002). Gender might be one of big problems of refugees in Canada. It is recognized that persecution experienced by women are different forms from those experience by men. The evidence, that women refugee claim may be more difficult to be provide than that of men. Furthermore, difficulty in employment is one of them. A majority of immigrant women do work for wages. In addition, non-white and non-English-speaking women tend to be put in three occupational categories characterized by "low salaries, part-time, term-specific or temporary employment, low levels of unionization and few employee benefits." (Jo-Anne, 1999). Being a refugee implies discontinuity in all spheres of life both for an individual and for families. Termination of employment and professional advancement paths produces a traumatic effect and has great consequences because it leads to material dependence and poverty. In a situation when unemployment is a problem encountered by the majority of the refugee population in Serbia. They living in unsatisfactory conditions had forced many refugees to work in the 'shadow economy'. The survey results show that young people with lower education and women are in a

more disadvantaged position (Vukovi 2001). Some studies show that Colombian refugee lives in rebel-controlled areas and who were forced to pay a "protection" tax under duress to avoid immediate death. Many of the Liberian refugee get kidnapped by rebels, tortured, and forced to perform household tasks for their kidnappers (i.e. provide "material support" to a "terrorist organization"). Refugees and IDPs typically experience high mortality, especially in the period immediately after their displacement or migration (Alottey 2004). Deaths occur from malnutrition, diarrhea, and infectious diseases, especially in children, with recorded increases in communicable diseases such as malaria, tuberculosis, and HIV infection. Injuries from land mines and direct conflict-related violence typically affect adults. The prior health status of the population, their access to key determinants of health (housing, food, shelter, water and sanitation, health services), the extent to which they are exposed to new diseases, and the level of resource availability, all affect health status (World Health Organization, 2002). In this way the refugee faces problems of lack of food, cultural economic barrier. Many face racism and discrimination within the health system which in turn reduces their use of health services. Some time it happens that some groups may also have reduced entitlements to service because of their legal status in the host country.

Conclusion: To conclude, by studying refugee movements world wide it is clear that refugee problem is a complex multifaceted and underlines the need to adopt a comprehensive approach focusing both on the causes and consequences of refugee problems. The international refugee movements however cause a serious geographical, political, financial obstacles and social disruption. Emergence of conflict, war, revolution etc make mass movement which makes them to under go physical hardship .The stresses of refugee and adjustment in the new surrounding are significant and make refugee vulnerable.



CHAPTER- IV
REFUGEE PROBLEM - INTERNATIONAL AND NATIONAL RESPONSE

CHAPTER-4

REFUGEE PROBLEM AND INTERNATIONAL AND NATIONA RESPONSE

Through out human history people have been forced by circumstances to flee their homes in search of life free from fear and wants. Millions have fled from reigns of terror in their homelands seeking refuge and a new life in another society and culture. Global refugee problem is largely a twentieth century phenomenon that until 1950s was largely European in nature. Today most of the world's refugee populations are to be found in the poorest countries. There is wide spread acknowledgment that this problem is growing with seemingly no end in sight .there is also the recognition that such a problem poses a major humanitarian and political challenge. The scale of refugee movements has expanded dramatically in recent years. It is until the beginning of that century the nation prided themselves on their humanitarian approach to asylum seeker, which clearly as follows by various treaties from 1920's onward began to define the rights of particular categories of refugees to seek asylum in specific situations for instance the American refugees and persons of Russia origin. The first formal refugee specific organization set up after the formation of the United Nation (UN) was the United Nation Relief and Work Agency (UNRWA) for Palestinian Refugees, mandated by a UN Security Council resolution in 1949. The UNRW has been responsible delivering basic services including food, shelter, health and education to Palestinian refugees since 1950 and given the continuing un rest in the region, its mandate continues to be renewed by the UN General Assembly. Later the UNCHR was established by the UN General Assembly in 1951 to protect and assist refugees and find solutions to problems faced by refugee and differs in providing a generalized and individualized definition of a refugee.

The international community, initially through the League of Nations, and subsequently the United Nations (UN), recognized that priority needed to be given to addressing the vulnerability of the many displaced population living within a context where governments were unwilling or unable to enforce laws and protect their basic rights. Refugee protection on a large scale first occurred with the setting up of the United Nations Relief and Works Agency in 1950 and culminated in the establishment of the

United Nations High Commissioner for Refugees (UNHCR) and the drafting and passage of the Convention on the Status of Refugees in 1951 (hereafter referred to as The Convention). The Convention and the subsequent Protocol in 1967, defined refugees as individualswho (1) face threats of or experience torture, trauma or other forms of persecution by virtue of their race, religion, nationality or membership of a particular social group, or their political opinion; (2) were outside their country of origin; and (3) for these reasons were unable to return (UNHCR, 1951, 1967). Governments that are signatories to The Convention have a number of obligations. These include supporting the work of UN agencies that deal with refugee crisis situations, to respond to people who request and are found to be in genuine need of asylum under The Convention, and to protect the human rights of refugees within their borders. A critical component of the obligation is not to return a refugee or asylum seeker to the country from which they fear persecution, a principle known as non-refoulment. he circumstances that lead to displacement today vary significantly from the circumstances held at the time the definition of a refugee was first drafted. Today, situations that create refugees are more likely to involve mass movements of people. In order to tackle the problem of refugees and co-ordinate relief and rehabilitation work in systematic and organized way, the need was felt to set up a broad based international organization which would deal with refugee problem in its totality (Alottey 2004, Ahmed 2004).

1. Evolution of International effort to protect refugee

The need for organized international assistance to refugees have become apparent during first world war when it was certain that more governments found themselves faced with arrival of thousands of refugees than ever before in both Europe and Asia minor especially. Very large number of people fled their homeland and passed on to one country to another country for the fear of persecution due to race, religion, nationality or political opinions. In the year of 1818-1922 about one million Russian refugees were moved out as result of Bolshevik armies[10], the Russian feminine, and the breakdown of

[10] Russian refugees fled from Soviet Union in the wake of the Bolshevik Revolution and the subsequent civil strife. They were spread over Europe and in the refugee camps in Turkey. Some went to China and the Far East.

white Russian resistance in Siberian Russia in 1922. In 1926 ,it was defined that that any person of Russian origin who did not enjoy the protection of the government of the Union of Soviet Socialist Republics and who has not acquired another nationality. A similar approach was adopted in 1936 arrangements in respect of those fleeing Germany , which developed by Article of 1938 convention (Giri 1993).

In Asia Minor the collapse of the Ottaoman Empire and the adoption by turkey of a policy of nationalism. Moreover, it was not only the plight of refugees that caused concern, many of the countries to which they had fled were themselves also destroyed by war. Their economic condition disrupted and their political situations were unstable and tense. Thus the countries of first asylum were not able to absorb the refugees into their economic life. The 'intruders' as they were regarded in many cases became a dangerous threat to political economic stability in the receiving countries (Giri 2003).

Prior to 1921, efforts to cope with refugee needs were undertaken mainly by private organizations, or voluntary agencies and were predominantly in the form of relief.But later due to increase flooding of refugee it has decided that vast refugee problem could be successfully tackled only by an internationally coordinated action. International action for refugees goes back to 1921 when League of Nations, the first international organization who undertook the problem of refugees, appointed Dr. Fridjor Nansen of Norway as the first High Commissioner for Refugees. His main job was to extend humanitarian assistance to Russian refugees. In fact, the first initiative to expand the base of refugee operations came in February 1921, from a gathering in Geneva representatives of private relief organization and these agencies are represented today in the International Council of Voluntary Agencies. Following this meeting, as ICRC suggested to appoint League of Nation's High Commissioner for refugee basically focused on Russian refugees and their problem of defining legal status, repatriation and immigration to other countries and did not include international aid and protection for refugee. The League of Nations took part in resettlement of refugees very actively and looks forward for permanent solution i.e., considering the primary need of the refugees by giving them legal status that would give them standing in the country of refugee and thus permit

employment or enable them to travel from one country to another in search of opportunity. Thus, in July, 1922 an international governmental conference was called in Geneva to consider a proposal for a legal status for registered refugees which would be acceptable within and between countries an issue of special certificate of identity to Russian refugees which later known as 'Nansen Passport' [11]. Following this, an arrangement of was laid down in 1928 for American and Russian refugee for securing legal and political protection.

In 1938, a new comprehensive organization" The international Nansen Office for Refugees" was established as an autonomous body . The post of High Commissioner was abolished and the supreme authority in the new office was exercised by a governing body whose president was nominated by League Assembly. However the office failed to carry out the original plan of settling the refugee problem due to world wide economic depression, League failed to provide collective security in the Sino-Japanese and Italo-Ethopian conflict, the entrance of Soviet Union into the League which reduced the activities of League and the arose of new refugee problem in Germany from 1933 onwards. The Assembly of League decided to re appoint another High Commissioner for Refugees coming from Germany including both political refugees and persons who feared persecution on account of their Jewish extraction. The mandate was confined to the improvement of the legal status of refugees and to finding refugees employment was extended to refugees coming from Austria following its annexation by Nazi Germany. The Assembly made both League and High Commissioner independent body as to avoid offence to the German government but subsequently Germany resigned from the League and High Commissioner was made responsible to Assembly and Soviet Union objected any kind of league protection to Few Russian refugee who fled Stalin's Purges and

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[11] 'Nansen passport' named after Dr. Fridtjof Nansen, the high commissioner on behalf of the t league of Nations Commissioner for refugee .It the first international identity paper , refugees of specified categories became the possessors of a legal and juridical status and it was certificate to identify Russian refugees but alter it extended to American refugees in May 31 , 1924 then to extended to Armenian refugees. In 1928, the provision extended to Assyrian, Assyro-Chaldean and Turkish refugees.

Collectivization Campaigns.The convention 1933, restricted the practice of expulsion of refugees, ensured the enjoyment of civil rights and secured most favorable treatment in respect to labor, welfare , relief and taxation. It ensured free and ready access to the courts, security and stability as regards establishment and work facilities in the exercise of the professions of industry and commerce and in regard to the movement of persons and admission to schools and universities.

In 1938, the Assembly decided to club the two refugee offices, the International Nansen Office for Refugees and the High Commissioner for Refugees under the protection of League of Nations. The new High Commissioner was entrusted with the task of co-ordination the humanitarian opportunities as humanitarian work was left to the voluntary agencies earlier, and supervising the application of the various arrangement and conventions in the field of international protection. However the new High Commissioner denied entering into any kind of legal commitment to League of Nations. Very soon High commissioner faced great difficulties created by World War II which hampered the activities of High Commissioner and immediately the mandate of High Commissioner was terminated. By the end of World War II millions of people were outside of their country and in need of assistance. Thus, the United Nations Relief and Rehabilitation Administration (UNRRA) was established by 44 nations in 1943 as an temporary In specialized agency to deal in comprehensive way with refugees and displaced persons but had limited mandate as UNRRA was working under Allied military command. Towards the end of 1946 US took action to kill UNRRA by stopping 70% of fund which comes from US itself. US remained strongly critical of UNRRA operation as US felt UNRRA is only to served to consolidate Russian political control over eastern Europe. So, US worked on to create a new organization to deal with resettlement of refugees and Displaced People uprooted by World War II and its aftermath. As the volume of refugee flow increased an international conference was held in 1938 in France on the initiative of President Roosevelt to formulate comprehensive plans for dealing with the refugees. An international body—intergovernmental Committee on Refugees (IGCR)—was set up with headquarters at London to coordinate relief work for refugees.

In January, 1, 1947, the Intergovernmental Committee on Refugee (IGCR) assumed outside the purview of League of Nations. The primary task of the Committee was to negotiate with Germany about Jewish migration. The mandates of IGCR and the provisions laid out for the refugees were similar to those of Nansen refugee and the convention of 1938. Despite the development of institutional framework for dealing the problem the plight of Jewish remained limited. The migration of Jewish to Palestine was sharply curtailed. And their exits from Germany and entrance to western countries were closed. So, the mandate regarding refugee was extended to Draft constitution of the International Refugee Organization which took all over responsibility for refugees on July 1, 1947. Previously the international organization had dealt with specific groups such as Russian or German refugee and governments had never attempted to formulate a general definition of term refugee. Therefore, here for the first time the international community made refugee eligibility depends on the individual rather than on the group and accepted individual's right to flee from political persecution and to choose where he wanted to live. When IRO took over the mandate and spread over a wide range of geographical area and made it possible to approach the refugee problems and its all dimension such as identification , registration and classification care and assistance and repatriation or resettlement .IRO accomplished such difficult operation only through join effort by the member government of the IRO, the government of asylum and of resettlement , the international and national voluntary agencies and several United Nations organization. They worked together in three phase effort towards the final settlement of refugees for instances by providing temporary relief activities of care and maintenance, the movement of refugees out of the countries of temporary hospitality through resettlement and establishment of refugee as a person possessing full citizenship and thus adequate legal protection and the means of earning livelihood. In setting up IRO, the UN members had considered refugee as post war problem and assumed it could be solved in limited time by international cooperation and financing in limited time but it could not , rather left some problem unsolved such as material assistance to certain categories of refugees for whom resettlement was not feasible and influx of new refugee. IRO faced difficulty in performance due to constant change in international politics, economics conditions and continuing influx of new refugees.

2.International and regional instruments for protection of refugee

The following international and regional treaties determine standards for the protection of refugees and displaced persons (Chimni 2000, Kharat 2003, Good-will 1986, Child Speak 2006[12] and Gallagher 1986):

2. a International

2.a.(i) Universal Declaration of Human Rights (1948) (article 14): The first international document that recognizes the right to seek and enjoy asylum from persecution.

2.a.(ii) Geneva Convention relative to the Protection of Civilian Persons in Time of War (1949) (article 44, 70): This treaty protects refugees during war. Refugees cannot be treated as "enemy aliens".

2.a.(iii) Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol 1) (1977) (article 73): It says "persons who, before the beginning of hostilities, were considered as stateless persons or refugees shall be protected persons in all circum stances and without any adverse distinction."

2.a.(iv) Convention Relating to the Status of Refugees (1951) : This was the first international agreement covering the most fundamental aspects of a refugee's life. It spelled out a set of human rights that should be at least equivalent to freedoms enjoyed by foreign nationals living legally in a given country and in many cases those of citizens of that state. It recognized the international scope of refugee crises and necessity of international cooperation -- including burden-sharing among states -- in tackling the problem. As of 1 October 2002, 141 countries had ratified the Refugee Convention.

2.a.(v) International Covenant on Civil and Political Rights (1966) (article 2, 12, 13): It says that states should ensure the civil and political rights of all individuals within its

[12] A Newsletter of the Organization for the Protection of Children's Rights

territory and subject to its jurisdiction (article 2). The Covenant also guarantees freedom of movement and prohibits forced expulsion.

2.a.(vi) Protocol relating to the Status of Refugees (1967): It removes the geographical and time limitations written into the original Refugee Convention under which mainly Europeans involved in events occurring before 1 January 1951 could apply for refugee status.

2.a.(vii) Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) (article 3): Article 3 (2) states that a consistent pattern of gross and massive violations of human rights are circumstances which a state should take into account when deciding on expulsion. The monitoring body of this convention, the Committee Against Torture, has established some fundamental principles relating to the expulsion of refused asylum seekers. It offers important protection to refugees and their right not to be returned to a place where they fear persecution.

2.a. (viii) Convention on the Rights of the Child (1989) (article 22): Article 22 of this convention stipulates that "States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refuge shall receive appropriate protection and humanitarian assistance in the enjoyment of rights. States Parties shall provide cooperation in efforts to protect and assist such a child and to trace the parents or other members of the family of any refugee child for reunification with his or her family. In cases where no parents or other members of the family can be found, the child shall be accorded the same protection as any other child deprived of his or her family environment'

2.a.(ix)Declaration on the Elimination of Violence against Women (1994): Recognizes the particular vulnerability of refugee women.

2.a.(x) Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the status of refugees: This handbook is widely accepted by practitioners and most governments as an authoritative interpretation of the Refugee Convention.

2. b Regional

2.b.(i)African Union (formerly organization of African Unity, OAU):

Convention Governing the Specific Aspects of Refugee Problems in Africa (1969) Accepted the definition of the 1951 Refugee Convention and expanded it to include people who were compelled to leave their country not only as a result of persecution but also owing to: external aggression, occupation, foreign domination or events seriously disturbing public order. This definition is a wider definition than the one found in the UN Refugee Convention and adapts the definition to the reality of the developing world. The African Union's definition also recognizes non-state groups as perpetrators of persecution and it does not demand that a refugee shows a direct link between herself or himself and the future danger. It is sufficient that the refugee considers the harm sufficient to force her/him to abandon their home.

2.b.(ii)African Charter on the Rights and Welfare of the Child (1990) (article 13): This treaty stipulates special provisions of refugee children that are unaccompanied by parents or guardians.

2.c Council of Europe

2.c.(i)Convention for the Protection of Human Rights and Fundamental Freedoms (1949) (article 3, 4, 5, 6, 8, 9, 10, 13, 14, 16): The European Convention on Human Rights does not contain any right to asylum and it makes no direct reference to asylum seekers or refugees. A very important case by the European Court of Human Rights (*Soering v. the United Kingdom*, 1989), however, established that states were indeed responsible, in certain instances, for the well being of individuals in other countries. The case concerned article 3 of the European Convention that "No one shall be subjected to torture or inhuman or degrading treatment or punishment". In recent years the European Court has again stressed the unconditional nature of the prohibition against ill-treatment and established the principle that a state wishing to deport even an individual found guilty of a serious criminal offence or constituting a threat to national security must first make an independent evaluation of the circumstances the individual would face in the country

of return. Although article 3 is most often called upon to protect asylum seekers and refugees, other articles may also be invoked to ensure that their human rights are respected. In particular article 4 (prohibition of forced or compulsory labour), article 5 (deprivation of liberty), article 6 (right to a fair and impartial hearing "within a reasonable time"), article 8 (respect for private and family life), article 9 (right to freedom of thought, conscience and religion), article 10 (right to freedom of expression), article 13 (right to the grant of an effective remedy before a national authority) and article 16 (no restrictions on political activity of aliens) can offer substantial protection.

2.d Organization of American States (OAS)

2.d.(i)Cartagena Declaration on Refugees (1984): The refugee definition of the Cartagena Declaration builds upon the OAU adding to it the threat of generalized violence; internal aggression; and massive violation of human rights. Unlike the definition in the refugee convention by the African Union, however, a refugee must show a link between herself or himself and the real risk of harm; all applicants must demonstrate that "their lives, safety or freedom have been threatened". This demand is similar to the UN Refugee Convention, which requires individuals to show that they risk persecution as a particular individual rather than in general. Although not formally binding, the Cartagena Declaration has become the basis of refugee policy in the region and has been incorporated in to the national legislation of a number of States.

2.d.(ii)Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women "Convention of Belem do Para" (1994) (article 9): Takes into account of the vulnerability of women and girls to violence by reason of, among others, their race or ethnic background or their status as: migrants, refugees or displaced persons. And also 'Asia Africa Legal Consultative Committee at its Eighth Session , Bangkok,1966' define the term 'refugee' under its Article I.

War, militarism, discrimination against minorities, revolution, partition of states, ecological consequences of development, emergence of a labour market - these and many other factors have contributed to large scale movement of refugees in the region. It has

also noted that how the phenomenon of statelessness and displacement has become more acute due to absence of a proper refugee care and rehabilitation system, lack of human rights of the refugees, and above all their protection. The lack of national laws and a regional instrument on refugees has accentuated the difficulties. As far as the countries of Latin America are concerned, they have the Cartagena Declaration on Refugees applicable to most countries in Latin America. Similarly for the countries of Africa, there is the OAU Declaration. But there is no Convention or Declaration for the countries of South Asia. Therefore it is important that all the countries of South Asia should come together for the protection of the refugees. Having a regional or national law would ensure the protection of refugees, uphold the constitutional mandate, and prevent discrimination with respect to particular group of refugees (Bose 2000).

2. e South Asian States

South Asian region has always been crowded with refugees , none of the countries in the region so far is party to the 1951 convention relating to the status of refugees or its 1967 protocol and nor do they have well spelt out national laws on refugees. In absence of this, the government over the years dealt with refugee problem chiefly through bilateral negotiations apart from other ad hoc solution. The refugees are more or like treated like aliens or foreigners and subjected to the law and regulations governing the entry, stay and departure of a foreigner. The "Draft model National law on refugees' was prepared in 1997 by a group of eminent persons from the region headed by justice P.N Bhagwati , the former chief justice of India. The purpose of the Act is to establish procedure for granting of refugee status to asylum seekers, to guarantee them fair treatment and to establish the requisite machinery to safe guards refugee rights. Under this Act the Articles 4,5,8,9,12,13,14,17 deals with different dimension of refugee problems. South Asia is home to one of the largest refugee populations in the world. This region has over 2 million refugees and has generous tradition of receiving refugees the post- colonial state in the sub –continent have faced the problems of divided communities, disturbed neighborhoods and almost unstoppable cross- border movements. The diversity of the refugee population in South Asia is certainly impressive: Tibetans, Sri Lankan's, Afghan's, Bangladeshi's, Pakistani's besides a fair number of Somalia's, Sudanese

Iranians and a motley group of various other nationals (Kumar 2001). South Asia is the fourth largest refugee-producing region in the world. As it is mentioned earlier, the partition of British India 1947, described as the largest brutal uprooting of 15 million refugees in the sub continent .during the liberation war of Bangladesh, some 10 million refugees from the erstwhile East Pakistan fled to India. In aggregate, however India remains the principal country hosting refugees from all over south Asia and its adjoining regions (Mandal 2006,Patil 2000, Baral and Munni 1996).

3. India's refugee Law and Policy

India's diversity, stability and relatively well established rule of law have made it a natural destination for people fleeing persecution and instability in their own countries. Within the South Asian region, India stands out as an exception of tolerant, democratic and secular government in a neighborhood of unstable and volatile states. India has historically faced numerous influxes over many millennia and the ability of these peoples to integrate into a multi-ethnic society and contribute peacefully to local cultures and economies has reinforced the perception of India being a country traditionally hospitable to refugees. India shares seven land borders and one sea border with countries in varied states of strife and war; and, over the years, has hosted large refugee populations from neighboring countries. India is neither party to the 1951 Convention on Refugees nor the 1967 Protocol rather repeatedly declined to join the convention. In addition, India has resisted demands for a national legislation to govern the protection of refugees. The lack of specific refugee legislation in India has led the government to adopt an ad hoc approach to different refugee influxes (Acharya 2004[13] and Ahmed 1996). The status of refugees in India is governed mainly by political and administrative decisions rather than any codified model of conduct. The ad **hoc nature** of the Government's approach has led to varying treatment of different refugee groups. Some groups are granted a full range of benefits including legal residence and the ability to be legally employed, whilst others are denied access to basic social resources. The legal status of refugees in India is governed

[13] Acharya, B (2006): "The law, policy and practice of refugee protection in India". He is a lawyer working on, inter alia, refugee protection issues and is the Assistant Director of the Public Interest Legal Support and Research Centre, New Delhi.

mainly by the Foreigners Act 1946 and the Citizenship Act 1955. These Acts do not distinguish refugees fleeing persecution from other foreigners; they apply to all non-citizens equally. Under the Acts it is a criminal offence to be without valid travel or residence documents. These provisions render refugees liable to deportation and detention. The United Nations High Commissioner for Refugees (UNHCR) is based in New Delhi. Once recognized, Afghan, Burmese, Palestinian and Somali refugees receive protection from the UNHCR. Many refugees receive a small monthly subsistence allowance and all have access to the services provided by the UNHCR's implementing partners in Delhi: the YMCA, Don Bosco and the Socio-Legal Centre (SLIC). Despite the support provided by these organizations, the majority of refugees in India experience great hardship, both economically and socially. The largest refugee populations in India do not fall under the UNHCR's mandate, but are nonetheless considered refugees by the government. There are no authoritative statistics on the number of people who have fled persecution or violence in their countries of origin to seek safety in India. But at present, there are over 150,000 Tibetans and 90,000 Sri Lankans who have fled violence and persecution and sought refuge in India. These groups are accommodated and assisted in accessing education, healthcare, employment and residence to varying degrees. However, because of India's porous borders and accommodative policies, India's documented refugees are allegedly outnumbered by Lakhs of unregistered persons who have entered the country from Nepal and Bhutan to escape violence and persecution in their countries. It is estimated that over 20 Lakh Nepalis fleeing from civil conflict have entered India undetected over the open border. There are also an unknown but large number of people displaced from Bhutan because of their ethnic-Nepali origins. However, India has repeatedly declined to join either the Refugee Convention or its 1967 Protocol. In doing so, India has met the many refugee influxes into its territory through an **ad hoc** system of executive action which is determined by the government's policy towards the country of origin. The relative success that India has had with this approach, which is guided by political instinct free from legal obligation, has led to an institutional complacency towards legal rights-enabling obligations to refugees. There has also been a hardening of attitudes about foreigners in recent years in light of heightened security concerns. This has resulted in genuine refugees paying an unfortunate price in a country that otherwise

has an impressive history of protecting refugees .In addition, India following the Law Commission's 175th Report of 2000, the law was made stricter to treat `illegal entrants' harshly, irrespective of the cruel circumstances that may occasion their migration(Hindu 2004). But by contrast, India agreed to the SAARC's Additional Terrorism protocol in 2004. Article 17 of the Additional Terrorism Protocol of the South Asian Association for Regional Cooperation of January 2004 permits SAARC nations not to extradite and, perforce, to protect those being prosecuted or punished on account of their race, religion, nationality, ethnic origin or political opinion. This stand is mystifying. Globally, India steadfastly refuses to join the Convention of 1951 even though it is on the Executive Committee of the UNHCR without being a signatory to the Convention under which the Committee is constituted. Indeed, from 1997, its envoys to the UNHCR have been pleading for a more equitable global regime to participate in a discourse that India does not carry any further.

For India the foremost reason for refusing to concretize a refugee protection policy is the threat of terrorism. But studies have shown that some pro-refugee jurisprudence argue that there is no reason for sustaining such a fear. Justice P.N. Bhagwati's Model Law, which the National Human Rights Commission is examining, and the SAARC Anti-Terrorism Protocol of 2004 ensure that suspected `terrorists' are not treated as refugees. Under the proposed model law, India may exclude even other undesirable persons provided they are not sent back to the country of persecution. The second reason for resisting the model law is that such liberality would precipitate a flood of migrants — especially from Bangladesh. This reason is also fallacious. In fact, a proper `refugee' law would distinguish between refugees and migrants by a fair, fast and stringent procedure.

3.a The law, policy and practice of refugee protection in India

It has a three –pronged mechanism to deal with refugee problem. Firstly, the Home Ministry deals with the formulation of policies for the rehabilitation and settlement of refugees. Secondly the state government is entrusted with the responsibility of protection and maintenance of refugee camps t the local level. Thirdly, the Ministry of External Affairs is empowered with the responsibility of bilateral negotiation and to deal with the

issue internationally. On the other hand, national Human Rights Commission, Minority Commission and SC & ST Commission are entrusted with the responsibility of ensuring overall human rights, fundamental freedom and equal opportunity to all at the national level (Kumar2001, Nair 1997 and Bhattacharjee2008).

3.a.(i)The Foreigners Act and its Application to Refugees

India relies on the Foreigners Act, 1946 to govern the entry, stay and exit of foreigners in India. Section 2(a) of the Act defines a 'foreigner' as "a person who is not a citizen of India", thus covering all refugees within its ambit as well. The practice of the Indian Government has been to deal with refugees in three main ways: (a) refugees in mass influx situations are received in camps and accorded temporary protection by the Indian Government including, sometimes, a certain measure of socio-economic protection; (b) asylum seekers from South Asian countries, or any other country with which the government has a sensitive relationship, apply to the government for political asylum which is usually granted without an extensive refugee status determination subject, of course, to political exigencies; and (c) citizens of other countries apply to the Office of the United Nations High Commissioner for Refugees (UNHCR) for individual refugee status determination in accordance with the terms of the UNHCR Statute and the Refugee Convention. Indian refugee policy is often guided by political compulsions, not rights enabling legal obligations. The first mass influx following the Partition of the country in 1947 was met with a number of legal, executive and administrative mechanisms designed to assist and eventually integrate the incoming Hindus and Sikhs into the national mainstream. The first 'foreign' influx of refugees occurred in 1959 from Tibet when the government, politically uncomfortable with China, set up transit camps, provided food and medical supplies, issued identity documents and even transferred land for exclusive Tibetan enclaves across the country for cultivation and occupation along with government provided housing, healthcare and educational facilities. In 1959, the Kripalani Committee set up the central relief committee of India for Tibetan refugees whose purpose was to coordinate various relief efforts and to channel all non-governmental aids through CRC-I. The CRC-I worked in close cooperation with the Ministry of External Affairs and through it the aid from major voluntary organizations

(Norbu 2001).As early as 1953 the then Prime Minister of India, Mr. Jawaharlal Nehru informed Parliament that India would abide by international standards governing asylum by adopting similar, non-binding domestic policies. Since then, the Indian Government has consistently affirmed the right of the state to grant asylum on humanitarian grounds. Based on this policy, India has granted asylum and refugee status to Tibetans and Tamils from Sri Lanka. The Sri Lankan Tamil refugees, having arrived in India in three waves beginning in 1983, have also been relatively well received in the geographically and ethnically contiguous State of Tamil Nadu where a large degree of local integration has occurred. In comparison, the Chakma influxes of 1964 and 1968 saw a subdued and reluctant government response (Chatterjee 1997,SAFHR 2000 and Singh 2003). Perhaps the largest mass influx in post-Partition history occurred in 1971 when approximately 16 million refugees from erstwhile East Pakistan sought safety in India. Enormous amounts of socio-economic and other resources were expended by the both the Central Government and the governments of the neighboring States to deal with the crisis. Although most of the refugees returned within a year, the experience left the Indian government both bitter at the non responsiveness of international organizations and complacent in the confidence of being able to deal with future mass influxes. Refugees who are not extended direct assistance by the Indian Government are free to apply to the UNHCR for recognition of their asylum claims and other assistance. UNHCR is mandated by its parent Statute to conduct individual refugee status determination tests and issue certificates of refugee status to those who fulfill the criteria of the Refugee Convention. The Refugee Certificates issued by the UNHCR are not formally recognised by the Indian Government, making them legally unenforceable in India. However, the authorities have, in general practice, taken cognizance of the UNHCR's Refugee Certificates to allow most refugees an extended stay in India in the absence of political opposition. Therefore, while a de jure system of refugee protection in India does not exist, there is a system of procedures and practices that serve to create a de facto refugee protection regime in India. The ambivalence of India's refugee policy is sharply brought out in relation to its treatment of the UNHCR. While no formal arrangement exists between the Indian government and the UNHCR, India continues to sit on the UNHCR's Executive Committee in Geneva. Furthermore, India has not signed or ratified the

Refugee Convention. This creates a paradoxical and rather baffling situation regarding the UNHCR where India sits on its Executive Committee and allows the UNHCR to operate on its territory, but refuses to sign the legal instrument that brought the organization into existence(Mohan 2003).

3.a.(ii)The judicial treatment of refugees: Indian courts, while generally strictly interpreting the stringent legislation on foreigners by refusing to interfere with the powers of the executive, have, on occasion, evolved a wider and more humane approach to protect the rights of refugees in India. However, since this approach is unsystematic and dependent upon the exigencies of the situation, it must be seen as an exception to the normal rule. In 1996, the Supreme Court in National Human Rights Commission v. State of Arunachal Pradesh intervened with a liberal interpretation of the law to suggest that refugees are a class apart from foreigners deserving of the protection of Article 21 of the Constitution. Every person is entitled to equality before the law and equal protection of the laws. So also, no person can be deprived of his life or personal liberty except according to procedure established by law. Thus the State is bound to protect the life and liberty of every human being, be he a citizen or otherwise, and it cannot permit anybody or group of persons, e.g., the AAPSU, to threaten the Chakmas to leave the State, failing which they would be forced to do so."Courts have also provided a certain measure of socio-economic protection in special circumstances (Chakma, 2001). The role of the UNHCR in India has been given a limited recognition by the judiciary.

4. India's international commitments to refugee protection:

India being a non party to the 1951 convention, she has acceded to certain International Covenants, treaties and such other international instruments which by implication are also available to refugees and bind government of India to respect refugee rights. In April 1979, India acceded to the 1966 International covenant on economic, Social ,cultural Rights. Article 13 of the ICCPR instrument deals with the expulsion of a person lawfully present in the territory of the state. India has reserved it right under this article to apply it municipal law relating to aliens. In December 1992, India acceded to the 1989 convention on the rights of child; Article 22 of this convention deals with refugee

children and refugee family unification. The 1963 convention on the Elimination of all forms of Racial Discrimination was ratified by Indian in 1969 and the 1979 Convention of elimination of all forms of discrimination against women was ratified 1993 (Bhattacharjee2008).

Applicable non binding international human rights whose article 14(1) states that. 'Everyone has the right to seek and to enjoy in other countries asylum from persecution'. Also included are: The principle of non refoulement incorporated in the Asian –African Legal consultative committee's 1966 principles concerning the treatment of refugee (Bangkok Principles), which specifically includes non- rejection at the frontier. More recently the declaration and Programme of Action of the 1993 Vienna World Conference on Human Rights included a special section on refugees which re-affirmed the right of every person to seek and enjoy asylum as well as the right to return to one's own country.

India refuses to join the Refugee Convention, which it first found too 'Eurocentric' and then saw as a Cold War tool to criticize communist countries by accepting refugees from the eastern bloc into what was declared to be the 'free world'. Bound by the compulsions of real politik and the constant fear for national security, India does not want to be tied down by an international legal obligation that impinges upon its discretion to regulate the entry of foreigners into its territory. This concern must be understood in the context of South Asia's unstable geopolitics, not to mention its volatile ethnicities. India defends its stand on not joining the international refugee protection regime by arguing that the latter will impose ' largely one sided obligations on the refugee receiving states' in areas such as housing , education etc (Chatterjee,1997). The Indian government officially recognized three groups of refugee-Tibetans, Chakma's and Sri Lankans. Now refugees in India from Afganistan, Bhutan and Mayanmar are also included in legal immigrants. In India , the absence of a refugee specific legislation an the entry or treatment of refugees has meant different levels of assistance and facilities. The Sri Lankan refugee community in Tamil Nadu is a case in point. In the awake of Rajiv Gandhi assassination, the Jaylalitha Government suddenly clamped down heavily on the refugee in Tamil Nadu. The local administration had the power to deny refugee children access to basic education. But visibly with the return of Karunanidhi and the DMK government, the situation has

changed for the better for the refugee (Nanda 1997). Tibetan refugees who arrived prior to 1980 received adequate assistance from the Indian government, assistance to the Tibetan refugees who arrived after 1980 has declined greatly, forcing them to live in inhumane conditions. They were sent back after being detained for several months. Refoulement and sending back refugees against their will amounts to violation of human rights, if we keep the 1951 convention. Such refugees are faced with inhuman treatment both at the country of their origin and the country of asylum (Roy 2001). Mondal (2001) in his paper 'Tibetan Muslim refugees in India: the problem and prospect" stated that the Indian government initially refuge to grant asylum to Tibetan Muslims and said that " only those whose permanent domicile remained in the state of Jammu and Kashmir and who visited India time to time, whose parents or one of whose grand parents were born in undivided India are potential citizens of India' but later some time in 1959 Indian government suddenly came out with an statement that all Muslim Tibetans were Indian nationals and consequently a controversy and dispute arose in this matter between India and China. And the Muslim Tibetan refugee became sandwich between two governments and it affected their life in exile and made problematic considering many other reasons as well as. The housing in the settlement was not adequate. The allotted quarters were not provided with required bathrooms and toilets and the living space was also not sufficient for the growing population(Mondol2001). Though on 4 April 1959 Nehru stated in public that Tibetan refugees was high on India's Agenda and India has deep sympathy for the people of Tibet (Norbu 2001), the Tibetan Muslim failed to receive much help from the state government and the locals who in fact looked down upon them (Mondol2001).Many Tibetan Muslim refugee became Indian citizens in 1966 owing to their Indian ancestry. But until the visit of His Holiness Dalai Lama in 1975, they received very little help from the government. Even after years of stay they failed to integrate into their ancestral land. These inconsistent policies demonstrate that India should adopt basic standards of treatment for the refugees living inside its borders. India has an important role in the treatment of refugees because of its position as a leader in South Asia, setting an example for other states in the region, and it shelters one of the largest refugee populations in the world. India's lack of clear standards for the treatment of refugee groups, however, is resulting in violations of the international norms for the

treatment of refugees. Its policies are discriminatory and inequitable, even to members of the same group (Thames).India's foreign policies has always been criticized for being passive and reactive. No wonder that the pressure of the flow of refugees often had a fall out on Indian foreign policy. But on other hand, Indian and other commentators from developing countries the world today are vastly different from what they were when the UNHCR was created to deal with refugee situation. However, India has signed a number of international conventions that impinge upon its obligations towards refugees. These include the Universal Declaration of Human Rights, 1948 (UDHR) the International Convention on Civil and Political Rights, 1966 (ICCPR) the International Convention on Economic, Social and Cultural Rights, 1966 (ICESCR) the International Convention on the Elimination of all Forms of Racial Discrimination, 1966 (CERD), the Convention Against Torture and Cruel, Inhuman or Degrading Treatment or Punishment, 1984 (CAT), and, the Convention for the Elimination of all Forms of Discrimination Against Women, 1979 (CEDAW). Significant pressure to accede to the Refugee Convention and enact refugee protection legislation for the country is exerted on the Indian Government by the National Human Rights Commission (NHRC). The NHRC is a statutory body established under the Protection of Human Rights Act, 1993, and is mandated by Section 12(f) of that Act to "study treaties and other international instruments on human rights and make recommendations for their effective implementation". The NHRC's Tenth Report, its latest, continues to push the Indian Government and chastises it for failing to meet its international law responsibilities. On other hand the need for a stable and secure guarantee of refugee protection in India led to the establishment of an Eminent Persons Group (EPG). However, the process of drafting appropriate refugee protection legislation began earlier at the Third South Asian Informal Regional Consultation on Refugee Migratory Movements, where a five-member working group was constituted to draft a model refugee protection law for the South Asian region. The first draft of this proposed law was presented at the 1997 SAARCLAW Seminar in New Delhi, modified and then adopted by the Fourth Annual Meeting of the Regional Consultation at Dhaka in 1997. The India-specific model law was born out of this regional consultative process to provide statutory protection to refugees in the diverse South Asian region. Generally speaking despite technical or specific misgivings about the model law, there has been

unanimity about its necessity and widespread acceptance of its use as a framework for future protection.

5.Conclusion: The problem of refugee is one of the most serious problems all over the world. A large number of people are forced to leave their own country by some kinds of reasons. Even after starting new life, refugees might face other difficulties even though they expected much better life. Refugee had to begin to reconstruct not only a new life but also a new identity. The whole process of adjustment of the refugee into the conditions in the area of destination falls into several categories for instance , acquiring legal citizenship, absorption in the entire process of economic productivity, integration into the social structure and adoption of the values and customs in the place of destination. By looking at the distribution of refugee world wide it is also understood that the responsibility of industrialized states to share in international refugee protection. We thus see that the problem of refugee is a challenging and gigantic around the world and the situation of refugee itself is most vulnerable. Many international treaties have a mechanism to monitor the implementation of the treaty. The Refugee Convention does not have such a body that monitors state obligations and commitments towards asylum seekers and fail to recognize humanitarian need of refugees. In this global milieu, India known for its generous policy towards refugee really needs to look at the refugee and its related policies. India's long porous borders and stable democracy makes it an attractive destination for refugees in the region - home to one-tenth of the global refugee population. India is in such a neighborhood that generates refugees often. The absence of uniform legislation on refugee protection means that political interests are dictating the different administrative measures being applied for different refugee groups in India. In order for India to bring its refugee law into conformity with the international community, only improving its domestic laws is insufficient because it will continue to reject international assistance and monitoring of refugee groups. India should reform its refugee policies and accede to the Refugee Convention or its Protocol. The plight of refugees in India generally depends upon the extent of protection they receive from either the Indian Government or the United Nations High Commissioner for Refugees. India needs to review its ambivalent refugee law policy, evolve a regional approach and enact rules or

legislation to protect persecuted refugees. This is one step towards supporting a humanitarian law for those who need it. As a refugee-prone area, South Asia requires India to take the lead to devise a regional policy consistent with the region's needs and the capacity to absorb refugees under conditions of global equity.

CHAPTER- V
TIBETAN REFUGEES IN INDIA AND THEIR HEALTH STATUS

CHAPTER-V

TIBETAN REFUGEES IN INDIA AND THEIR HEALTH STATUS

As stated in earlier chapters throughout human history there has always been a flow of persecuted and dislocated people. Beginning with the twentieth century however, it has become a flood. Due to the reign of terror in their home land, people in various parts of the world are compelled to seeking refuge and a new life in another society and culture. They have no other choice if they wish to escape from intolerable threat and danger, but to break with the bonds of their heritage and to try and become part of different national tradition, contributing some of their own values to the new country of their choice. For most of them their past is gone, their present has changed under the pressure of new demands caused by the need for assimilation in their adopted land. In that sense, Tibetans in Indian are not ordinary refugees. They have taken refuge not as individuals alone, but rather as a national polity that has escaped the destruction taking place in Tibet and has sought and been given the protective mantle of a neighboring friendly country. Both people and cultural institutions have taken refuge in a host setting and have demonstrated both strength and survivability. That is the extraordinary and unique story of Tibetans in India, a story that demonstrates the vitality of the Tibetan culture and of the people - the thousands of who fled with their leader, the Dalai Lama, from Tibet - the land originally the major source of Tibetan Buddhism. India, the land of Gandhi and the land where the Buddha once lived, was the best sanctuary Tibetan polity could have found. Clearly the survival of Tibetan culture in India is a wonderful event. Fifty years ago, when the Dalai Lama arrived in India after his incredible escape from Lhasa over the High Himalayan mountain passes, followed by thousands of sick and destitute Tibetan men , women and children seeking refuge after their futile uprising against the Chineses invader, they may well have feared the worst for not only their own survival but also that of their community - its culture and traditions. Few would have foreseen that fifty years hence, the Tibetan story would turn out to be an outstanding example of continuance of an abiding, vigorous culture and its survival. It is a miraculous recovery from a grievous, seemingly disastrous blow. In India, the Tibetan polity, its settlements, its enterprises and its religio-political structure have not only flourished but have transformed and developed

from the prototype in Tibet into an active part of the modern world. And in turn this Tibetan has provided a beam of light and hope for the six million Tibetans remaining in Chinese-dominated Tibet and in the neighboring Chinese Provinces politically cut off from the Tibetan heart land (Michael 1985,Namgyal 2007and Tsering 2007).

1. The Tibetan community: A background

In the last fifty three years, India has received considerable refugee population from Bangladesh and Sri Lanka besides Tibet. The story of the Tibetan refugee community in India begins with the Chinese military invasion of Tibet in 1959 (Conway 1975). Tibet is a land in south – central Asia. It is called 'the roof of the world' because its snow covered mountains and windswept plateau are the highest in the world. The town of Ka-erh, in western Tibet, is believed to be located at the highest altitude in the world. Tibet is situated on the high plateaus and valleys of the Himalaya. It has an area of 1,221,600 square kilometers. It is famous as the centre of Lamaism which is a form of Buddhism. The people of Tibet maintain a culture quite distinct from that in other parts of China. As recently as 1914, a Peace Convention was signed by Britain, China and Tibet that formally recognized Tibet as an independent country. Representatives from the major monasteries governed the country with the Dalai Lama heading the government. The Tibetan people have a deep-seated faith in religion and Buddhism ruled every aspect of their lives. In 1949 China invaded Tibet. Two years later Chinese troops forcibly occupied Tibet; killing, detaining and arresting thousands of Tibetan citizens. At the time of invasion by the People's Liberation Army (PLA) of China in 1949, Tibet was an independent and traditionally theocratic state. Thus, Tibet has been part of China since the 1950s. In May 1951, the Tibetans were forced to sign a 17-point agreement with China whereby the Chinese government took control of Tibetan external affairs while pledging itself to respect the region's autonomy, religious beliefs and customs. However, their continued occupation of Tibet with the help of troops represents an on-going violation of international law and rights of the Tibetan people. Following the Chinese incursion in 1951, China continued to perpetrate human rights violation in Tibet despite pleas from the Dalai Lama and his government. The efforts of the Dalai Lama to find a peaceful solution to the ongoing violence proved futile and his personal security was threatened. Calls for help to the

international community went unheeded and the Dalai Lama was forced to flee from Chinese - occupied Tibet. His flight was followed by an exodus of Tibetan people unable to live under Chinese oppression. In 1959, approximately 80,000 Tibetans fled to India with a steady flow filtering into India in the years that followed. Today, there are approximately 150,000 Tibetan refugees living in India. The Indian prime minister, Pandit Jawaharlal Nehru, helped make land available for refugee settlements in several states of India, Nepal and Bhutan and the Dalai Lama established a government in exile at Dharamsala in the Himalayan foothills of Himachal Pradesh. In the mid 1960s, the Indian Government offered several areas throughout India where the refugees could settle together and protect their distinct culture and way of life. The state of Karnataka in the South formed the largest concentration of Tibetan refugees worldwide, today totaling around fifty thousand. These settlements were open societies and developed actively with help from the government of India and international non-governmental organizations. The infrastructure necessary for self contained villages was established within a few years, including agricultural and dairy cooperatives, handicraft and carpet weaving centers, schools, daycare centers, restaurants, and religious temples and monasteries founded by the large number of monks who migrated from Tibet (Awasthi 2008) .

1. a. Phases of Displacement

Often referred to as the model refugee community, the Tibetan problem, in terms of numbers is not so significant in comparison, with those forced migrants from Mozambique. Tibetans officially form the largest refugee group in South Asia (Norbu 1996). The first batch of Tibetan refugees crossed over into India on March 31, 1959, when 85,000 Tibetans followed their religious leader. They are an organized refugee group maintaining a unique culture and pursuing a peaceful struggle. The second exodus began in the early 1980s when Tibet was opened to trade and tourism. Between 1986 and 1996, nearly 25,000 people have taken refuge in India. Approximately 44% of them are monks and nuns. There has been a steady trickle of refugees to Some 2,200 Tibetan refugees arrived in India in the year 1999. Although all of them were allowed entry, most of the refugees have not been granted legal residence (Ahmed 2008).An explanation of the history of the problem is beset with problems and reflects the conflicting versions of the Chinese and the Tibetans. According to

the latter, Tibet is historically an independent nation and China is a colonial power exploiting them. The official Chinese version holds that Tibet is an integral part of China. And there is an external hand (CIA) behind the problem, which is aiding abetting, funding and internationalizing the issue. The Chinese Premiers Deng Xiaoping in 1978 and Li Peng in 1991 have emphasized that Tibet is an inalienable part of China. Despite these opposing viewpoints, the fact remains that there is a Tibet problem, which is reflected in the unprecedented number of people, displaced. The reasons for displacement based on studies conducted on Tibetan refugees have been identified as:

1. Religious persecution: The first and more general reason given was the popular feeling of acute anxiety about the future of their religion and culture under the communist regime. They were afraid that they would not be allowed to practice Buddhism and maintain their way of life.
2. Political repression: Atrocities , torture and humiliation in public committed by Chinese to anyone unwilling to embrace Chinese Communism.
3. Obstruction of endogamous marriages by the Chinese Government: The Chinese authorities were obstructing endogamous marriages among the Tibetans, who were forced to take a bride or a groom from the Chinese. It is explained that the main aim was to destroying their race of which the Tibetans are so proud.
4. Following their leader, the Dalai Lama: Tibetans followed their Leader the Dalai Lama who escaped to India in 1959.
5. Confiscation of property: Confiscation of property from propertied class. Moreover Chinese planned that the communities and the families were split among themselves, The children were used to spy upon their parents, the wife upon the husband which created a sense of insecurity and this insecurity in their daily life was at the bottom of the Tibetan migration (Norbu 1996).

Tibetans are probably the only refugee community who do not live in refugee camps, but in settlements. Initially, they resisted settling permanently but agreed later if the GOI would allow them to settle in large relatively isolated communities, so that they could maintain and recreate their religion and culture. It is so that Dharamsala the largest

settlement of the Tibetans and headquarter of the Dalai Lama is known as "The Little Lhasa".

1. b. Legal status of Tibetans in India

Since India has not signed the two major legal instruments on refugees, the 1951 convention and the 1967 protocol, nor is there any domestic regulation to the effect. Refugees therefore come under the Constitution of India and a refugee influx is dealt with at the political and administrative level . The Tibetan refugee therefore come under the normal laws of India. The Tibetan refugees were granted asylum by the GOI and the principle of non-refoulment (i.e. protection against compulsion to return to home country while the threats to persecution continue) has been strictly adhered to. Tibetan refugees born in India are entitled to Indian citizenship according to Section-3, of the Indian Citizenship Act; 1955.Tibetan refugees have been issued certificates of identity ie, residence permits, work permits, which enables them to seek formal employment take part in other economic activities and travel permits to travel in and out of the country. They are the only refugee group to receive travel permits from the Indian government i.e, they are stateless and small percentage of Tibetans bear foreign passport .Most of them hold Indian registration certificate. After 1961 a special sub division of the Ministry of Education for the Tibetan Schools Society, which was funded by the GOI[14]. Tibetan refugees in general are not allowed to be involved in politics; the GOI has tacitly tolerated the Tibetan refugees campaign for the freedom of their country from Chinese domination The GOI recognizes Tibet as a part of China. Officially the Tibetan refugees are not allowed to engage in political activities against China from inside India. Nonetheless Dalai Lama has been permitted to run a de facto Tibetan Government in exile from Dharamsala. This Government is also not recognized by the GOI(SAFHR2000).Tibetans who arrived in India in the late 1950s and early 1960s were accorded refugee status by the Indian government despite India not being party to either the 1951 UN Convention Relating to the Status of Refugees or the 1967 Protocol. These Tibetans were issued registration certificates, which must be renewed once or twice a year. Tibetans who were born in India are also eligible to obtain a registration certificate

[14] Tibetan refugees in India, http://www.ipcs.org. Accessed on 30 June 2008.

once they are 18 years old. Although the Indian government continues to allow Tibetans to enter the country, it has not afforded them the same legal status as the first wave of Tibetans. However, some Tibetans who arrived in the second-wave were able to obtain their registration certificates by claiming that they were born in India. Tibetans are given more rights than most other refugee groups in India (Report of Refugee Population in India 2007) .Thus, many Tibetans in India have achieved economic self sufficiency. However in the post-1980s period, an increasing number of Tibetan refugees coming into India resulted in an extra burden on India. So the Government of India (GOI) decided not to grant either legal status or financial assistance for the rehabilitation of the refugees but some, including elderly persons, women headed families and recent arrivals are still struggling. One important thing, initially the GOI allowed the UNHCR to assist the Tibetan refugee in India. However , after the entry of mainland China into United Nation, the UNHCR, unilaterally withdrew its financial support to the Tibetan refugees. This has soured India-UNHCR relationship. Moreover Prime Minister Rajiv Gandhi's visit to China in 1988 and the resultant CBMs agreement signed between the two countries in 1993 in New Delhi improved Sino-Indian relations. Later, when Chinese vice foreign minister Tang Jiaxuan raised the issue of Tibetan refugees and objected to the Tibetan parliament-in-exile headed by Dalai Lama, the senior Indian diplomat J.N Dixit said that Delhi officially prohibits the pro-democracy Tibetan exiles from political activity. The Indian Prime Minister P.V Narshimha Rao also promised that India would not allow any anti –Chinese activity on Indian soil (Karat 2003). Again in June 2003, Indian Prime Minister Atal Behari Vajpayee signed a joint Sino - Indian agreement and said that the Tibetan Autonomous region is a territory of the People's Republic of China[15] . Frankly speaking, the sudden change in the nature of India's policy towards Tibetan refugees must be seen in the context of its substantial improvement in India's relations with China as well as possible pressures from the local population in the vicinity of the settlements and the scattered camps, especially in Himachal Pradesh and Arunachal Pradesh (Karat 2003). In other word, India's relations with China have been a cause of great concern for the refugees as well.

[15] A Handbook on Tibet by His Holiness the Dalai Lama

1. c. Specific protection issues:

Despite the fact , Indians and Tibetans generally co-exist peacefully but there have been isolated cases of anti-Tibetan violence. There have been no cases where any specific groups within the Tibetan community have been targeted. But it is to reveal that though India did not support independence or autonomy of Tibet, the Dalai Lama and his followers were granted asylum in India. Transit camps were set up for them in Misamari in Assam and Buxa in West Bengal, though they later moved to Sikkim, Karnataka, Delhi Dehradun, Ladakh and Dharamsala. The relations with the host community can be understood at two levels. Firstly, at the governmental level, and secondly, at the community level. The government of India does not support autonomy, nor does it recognize the Tibetan Government in Exile. At the community level, Tibetans have been living in relative isolation from the local people with a view to preserving their distinct religion and culture. In places where there is interaction with the local people, relations have been harmonious and reciprocal. However, in the recent past there has been a gradual decline in this regard. The local population in Dharamsala feels threatened by the demographic and cultural impact of the refugees. It has also been alleged that Tibetans were buying up large tracts of land through *Benami* transactions[16]. There were incidents of violence also against the refugees in 1994, when a local youth was killed by a Tibetan youth. The relative prosperity of the Tibetans is also a cause of strain between the two communities (Ahmed 2008). With refugees competing with their hosts in business and labor markets, and with assistance provided to refugees but not hosts, tensions inevitably arise (Burnham 2003, Kharat 2003). In the Year of 1998(Jan-Feb),21 Tibetans were arrested in Dharamsala for not holding valid residence permit and later the detainees were released .It is said that the arrest were prompted by the Indian authorities concern for the security and safety of the dalai Lama in the wake of reports about Chinese authorities sending infiltrators to Dharamsala. But Tibetan advocacy group feared that India might be signaling a change in policy toward Tibetan refugees(SAFHR2000).It has also to state that their future is inextricably linked to two factors: firstly, events in the international political arena, since the cause is highly internationalized. Secondly, India's national interest and security concerns. Indian policy makers have been ambivalent on the issue. Though it is felt that help and assistance to the

[16] According to the Himachal Pradesh Tenancy Act only Himachalis can buy land in the state.

Tibetans should be continued for humanitarian reasons this should not be done at the risk of our national interest since the Tibetan question and India's response to it has been a thorn in Sino Indian relations. The other option that some policy makers have offered is that all humanitarian assistance should be given, but the refugees should not be allowed to run a government in exile. Tibetan refugees in India do not present a picture of uprooted ness like other refugee groups, but their future is not as secure as it may seem because they still remain refugees in an alien land.

Tibetans own a unique form of religion, social and political structure in the world. Many religions including Hinduism, Islam, Christianity and Bon-a folk religion is peculiar to Tibetans. But as it is mentioned above the Tibetan people have a deep-seated faith in religion and Buddhism ruled every aspect of their lives. The dominant religion of Tibetans is Mahayana Buddhism. Tibetan society is basically described as theocratic state because the Dalai Lama (the religious leader) is considered to be the incarnation of ***Avalokiteswara*** Tibet's patron Bodhisattva. The Tibetan society is based on religious order of hierarchical and highly authoritarian. Besides agriculture and animal husbandry, Tibetans economy comprises of trade and entrepreneurship which stratifies the society into distinct estates. They are highly skilled artisans such as Carpenters, Painters, builders and iron-smiths to make weapons(Awasthi 1978).

The majority of the families are nuclear and although polyandry is not prohibited most have preferred monogamous marriage. The family continue to be patriarchal and authoritarian with the eldest male being the head (Ibid). According to Tsunde (2000), TDS (1998) listed 17,935, Households in India and Nepal of which 45.5% or 8,167 are settlement households belonging to the category of rented and staff quarters respectively. Only 16.5 of the total households were owner -occupied houses where no form of rent was paid. The household pattern shows that the traditional joint family system is gradually being replaced by a nuclear family structure with medium family sizes(Table 5.1).

Table 5.1. Differing family sizes per household (including institutional households)[17].

No. of members	No. of households(India Nepal)	Percentage
Total	17,935	100.00
1-2	5,210	29.05
3-4	5,368	29.93
5-6	4,141	23.09
7-8	1,903	10.61
9 above	1,313	7.32

Source: Handbook onTDS by Kunchuk Tsunde2000,Dharamsala,CIA,India.

The Table 5.1 shows that 29.93 % of household have 3-4 family members and 29.05 % of households have only 1-4 family members. where as only 18% families have more than 7 members .

2. Socio demographic profile of Tibetan refugees in India:

After more then four decades in exile, there are now a total of 122,078 Tibetans living as refugees worldwide Tibetan population had reached from the initially estimated population of 80,000 in 1959 out of which 85,147 live in India. A majority of them are settled in approximately 52 settlements located in South Asia, with more than half in India, and the rest in Nepal and Bhutan. There are now 24 agriculture based settlements, 16 agro plantation based settlements and 10 handicraft units. Besides, there are Tibetans located in scattered communities in various towns and cities of India (TDS, 1998 and Tsundue 2000).

The distribution of the Tibetan population in terms of numbers is as follows: 85,000 people live in India, 20,000 in Nepal and 1,500 in Bhutan. So far about 12,153 Tibetans have moved to other parts of the world. The American continent mainly USA and Canada have the largest number of Tibetan refugees outside South Asia; the figure has reached up to 7000. The next

[17] Institutional households are households of unrelated persons such as monasteries, nunneries and residential schools etc.

largest concentration of Tibetan refugees population of about 2,243in Europe of which 68.8% are in Switzerland alone. There are 217 persons in Oceania. And the staff of Tibetan in Pretoria constitutes the Tibetan exile population in Africa (Tsundue 2000).

Table 5.2. Approximate Tibetan population world-wide.

Country	2001
South India	30,000
Central India	8,000
Uttar Pradesh	6,500
Himachal Pradesh:	21,000
North-east India	8,000
West Bengal and Sikkim	14,300
Ladakh	5,600
Nepal	20,000
Bhutan	1,500
United States	3,000
Canada	560
Switzerland	2,000
Australia and New Zealand	120
Japan	40
Scandinavia	90
Taiwan	1000[18]
Rest of Europe	640[19]

Source: (Bhatia et al 2002, DoH 2005 and Tsundue 2000).

Tibetans still continues to enter India as refugees every year on an average of 2000 to 3000 Tibetans (Burke 2008). More than 44 % of them are teenagers and young adults belonging to the 14 – 25 years age-group. 33% are adults belonging to the 26 – 59 years age-group.

[18] www.whatAboutTibet_com - Tibetans in exile.htm. By office of Tibet.New york.accessed on 5th July 2008

[19] ibid

More than 17 percent are young children below 14 years of age. 5 percent of the refugees entering India are over the age of sixty (Tsunde2000).

3. Size and geographic distribution of the population

The Tibetan population registered in 1996 was 54,537 increasing roughly 1% per year from 1994 (53,293) and 1995 (54,047). The population was distributed across 37 settlements in six regions of India plus one settlement in Delhi .The largest concentration is in Himachal Pradesh with 13 settlements. The largest settlements are in Karnataka state, with a good farming area in the South India.

5.3. Demographic characteristics of Tibetan refugee population in India by region, 1994–1996.

Region	Population	Percentage of population	Number of settlements
South	23,247	42.6	5
Doon Valley	3,836	7.0	6
Central	5,524	10.1	3
Ladakh	5,804	10.6	3
Himachal Pradesh	6,926	12.7	13
North east	7,705	14.1	7
Delhi	1,495	2.7	1
Total	**54,537**		**38**

Source: TDS 1998, Bhatia et al (2002)

It is identified that the Tibetan government-in-exile has opened a reception centre in Delhi and Dharamsala for the new comers(Tibetans refugees). Young children below the age of 13 years and monks are rehabilitated easily in India by being sent to the schools run by the Tibetan government-in-exile, and monks and nuns are sent to the monasteries in different refugee settlements. The rehabilitation of adults above the age of 18 is a big problem, since

many of them are uneducated and unskilled. The Tibetan government-in-exile has set up an adult education centre for these adults where they are taught Basic English, Tibetan and Mathematics as well as arts and crafts. The CTA (Central Tibetan Administration) provides small grants to these adult refugees to start a small business. Many of them are engaged in small antique businesses and eateries on the roadside.

4. Socio-economic conditions of Tibetans in exile

Tibetans in India live in 37 different settlements and 70 scattered communities. Of the settlements, just under half are based on agriculture, while one-third are agro-industrial and a fifth are handicraft-based. There are scattered communities consist of smaller groups of Tibetans outside of the official settlements who have limited resources for their survival.

When the Tibetans came to India as refugees, most of them were starving or wounded, suffering from sickness due to the low altitude and stunned by the cultural shock of coming into the hitherto distant world. As a result, many died of disease, unable to acclimatize to the hot climate, compounded further by the trauma of having left their homeland. In the beginning, many of them found employment in road construction works in the hilly states of India. Gradually, they were rehabilitated in the newly created settlements in all parts of India. They were trained in cultivating local Indian crops like maize, millet, rice and mustard and soon after, agriculture became the main source of livelihood for many of them. At the same time a good number of them have taken up entrepreneurial activities. Tibetans selling winter garments, especially sweaters and shawls, is a common sight in many towns and cities in India but minority of them selling drugs to tourist or begging (Burke 2008). Today, selling woolens has become dominant economic activity for Tibetans in India although agriculture is a major primary occupation for those living in agriculture-based settlements in India.

Table 5.4.Percentage Share of Sources of Income

Economic Activities	% age share of income	% age share of workforce
Agriculture & allied activities	8.5	26.4
Artisans and crafts	4.2	5.7
Hotels and restaurant	3.3	1.9
Organized trade or business	30.7	16.2
Professional job	0.6	0.3
Salaried employment	23.0	20.1
Small enterprises	14.1	12.1
Unorganized trade or business	10.7	11.1
Casual work	4.8	6.2

Source: S. Bhatia et al. / Social Science & Medicine 54 (2002) 411–422 416

According to Bhatia (2002) , the Tibetan Demographic Survey shows (as mentioned in the table above) the largest percentage share of income comes from Tibetan engaged in trade and business, which includes sale of woolens and petty business. Salaried employment, which includes services in the armed forces, government and teaching, contributes twenty-three percent of the household income, whereas agriculture and allied activities account for twenty-six per cent of the total workforce but contribute a mere eight percent of the total household income. Apart from the primary sources of income, the Tibetan households also rely on subsidiary sources of income, which include income from sponsorships, government and foreign remittances. Many of the economically deprived households are either being looked after by the government or are supported by sponsors from abroad.

In the 1990s many Tibetans immigrated abroad, especially to the United States, as a result of which their families back home have started receiving remittances from them. According to official statistics, an average Tibetan household earns Rs.66,800 per year, which translates into Rs. 13,100 per capita per annum. At present, the general standard of living of the

Tibetan people is comparable to that of the surrounding native rural communities; in some areas, the economic conditions are far better than those of the native Indian villages. Almost all the settlements are provided with primary and secondary schools, primary health care centre and cooperative societies. There are also monasteries, nunneries and temples in the settlements. The cooperatives in the settlements play a vital role in the lives of the settlers. The cooperatives procure and advance seeds, fertilizers and pesticides, market agricultural produce collectively and provide common services such as tractors for tilling or transport, trucks for transport and warehousing for storage. Cooperatives also run small business ventures like carpet weaving workshops and small incense factories. Education of Tibetan children has been the top most priority of the Tibetan administration right from the beginning. Today more than 84 schools have been set up in India with the help of the Indian government and foreign aid. As the result, the literacy rate among Tibetans has reached a high 78 percent. The literacy rate in the 19-25 years age-group is 99%, a marvelous achievement indeed (Patel,Bhatia 2002).

Apart from the different UN agencies, its principal donors include Swiss Aid, Norwegian refugee council, Indo- German Social Service Society, Christian Aid (UK),American Enmergency committee for Tibetan Refugees, Tibetan Refugee aid society(Canada),Oxfam (UK), Arbeiter-Whohlfahrt (West Germany) and Deutsche Welhungerhilfe (West Germany).In comparison to other refugee group that receiving governmental recognition and patronage like the Tibetans are in a much better position than those recognized and assisted by the UNHCR (Mohan 2003)

About 27% of the Tibetan population is undergoing at various levels of school and university. Among the working population, farming is the most common occupation and 16% of the population engaged in this activity. This is followed by selling woolens, an activity that employs 6.4% of the population. 5.2% of the population comprises full-time housewives. 5.1% of Tibetans in India are involved in handicraft-making, especially carpets. 5% of the population is engaged in military service. Only 2.4% of the Tibetan community claims to be unemployed, while children and the elderly make up 16.4% of the community, and are outside the working population.

Table 5.5. Occupation distribution among Tibetan refugee population in India

Occupation	Number	Percentage
Student	14,784	27.1
Too young or too old	8,932	16.4
Farming	8,746	16.0
Sweater selling	3,461	6.4
House wife	2,834	5.2
Handicrafts	2,745	5.1
Military service	2,712	5.0
Petty business	1,917	3.5
Others	1,727	3.2
Monkhood	1,755	3.2
Retired or unemployed	1,328	2.4
Govt.staff	927	1.7
Teacher	742	1.4
Restaurant	582	1.1
Animal husbandry	489	0.9
Health workers	475	0.9
Office	269	0.5
Nun	116	0.2
Total	54,537	100.0

Source: S. Bhatia et al. / Social Science & Medicine 54 (2002) 411–422 416

4. a. Entrepreneurial activities of Tibetan refugees

Mahapatra (2006), in his study on Tibetan refugee settlement in Chandragiri (Orissa) highlights that Tibetan refugees are not only conscious of their physical and economic conditions but equally aware of protecting and preserving their own culture, traditions

and religion. Coming from an entirely different climatic and cultural background, adapting to the tropical climate in Chandragiri was a difficult proposition for the refugees in the primary stage. But with the passage of time and continuous endeavor to adapt to the environment, the Tibetan refugees succeeding a great deal in acclimatizing to their changed circumstances. Since a majority of the Tibetan refugees were originally farmers by occupation, agriculture seemed to be the most suitable occupation for them to follow in exile. By dint of their hard labour, they succeeded in transforming the barren land of Chandragiri into cultivable land. Apart from agriculture, the refugees were also engaged in carpet weaving and handicrafts. Carpet weaving is a century-old profession of the Tibetans. The carpets produced at Chandragiri are exported to European countries. Tibetan women and children who do not pursue their higher studies are mostly engaged in carpet weaving. Out of the two carpet weaving factories, started with Swiss Government collaboration, one is located at Chandragiri and the other at Lobarsingi. Apart from carpet weaving, Tibetan refugees are also experts in weaving textiles, producing clothes, wood carving, painting and metal work. In addition to these, Tibetan herbal medicines have also contributed significantly to the Indian society.

4. b. Contribution of Tibetan Medicine

Over the years, Tibetan medicine has proved most effective in curing various chronic diseases. Its effectiveness in curing hepatitis, according to some westerners, is miraculous. Tibetan medicine is also known for its efficacy in curing chronic sinus-related diseases, although one has to be on medication for a long time. [20] Over a period of 2,500 years Tibetans have perfected a sophisticated medical tradition based on the holistic concept of mind and body. It maintains that disease or disorders in the human body are caused when there is disequilibrium of psychological and physical energies (Dharmananda 2000). The healing efficacy and potential of Tibetan Medicine has been vouchsafed as much by many of its grateful beneficiaries as by those medical professional who have gained an insight into it. The GOI's Ministry of Health is willing to treat Tibetan medicine as a part of Indian Ayurvedic system and also willing to give recognition and resources. TMAI (Tibetan Medicine and Astronauts Institution) Dharamsala, pointed out that over 92

[20] http://www.tibet.com/dasaguide.html accessed 28th June 2008

percent beneficiaries of Tibetan Medicine were Indians (Moser1999,Dhondup2002). More and more people suffering from chronic ailments are today turning to Tibetan Medicine. Allopathic doctors and scientists are also turning to Tibetan medicine in their quest for answers modern science has so far failed to yield satisfactorily on various aspects of the phenomenon of human ailments. Even All India Institute of Medical Sciences (AIIMS) at New Delhi, the premier medical institutes in India, has a program referring its cancer patients to the TMAI's branch clinic in New Delhi. Tibetan Medicine is slowly coming out of its dogmatic cocoon to embrace modern concept. The TMAI has an active collaboration program in clinical, pre-clinical ,plant and library researches with government institutions, fully equipped private institution as well as renowned doctors, scholars and scientist from India and abroad. It has also has a programme to exchange students and experts with institutions of other systems of healing (Janes 1992 and Thinley 1997).

5. Tibetan Health System –An overview

The Tibetan culture is ancient; rich with wisdom and beauty. In these deeply troubling times, it is a precious gift to have as an example for the world, a leader and a people who despite a background of enormous hardship and extreme brutality have maintained a life of compassion and peace. With the flight of the Dalai Lama from Tibet to India came, over time, his followers, including a significant number of monks and nuns. Most of these refugees came to India with very little or nothing and continue to live in poverty (DoH 2003, 2005). A number of them are in ill health and mentally vulnerable due to violence and torture they faced back in Tibet (Mills 2005). Many of these refugees are senior teachers, monks and nuns. They are living in monasteries and nunneries with nothing – no family, no resources and in very poor health.Violation of Many organisations have worked diligently to organise services for this exiled community, dispersed throughout India and other countries. Health care services for destitute Tibetan refugees are among the most critical of their needs.[21] Health care is the basic need for the overall welfare and development of a

[21] Project on Tibetan health initiative (2002): Department of Health , Dharamsala, Government in exile India.

community. Recognizing the need for good health care for the Tibetan refugee community, the Tibetan government–in-exile has taken several steps towards creating curative and preventive health care services. The earliest rehabilitation projects included health care centers which were funded by non- governmental organizations. When these organizations handed over the administration of the health centers to the respective settlements, there was a need to establish an apex body within the Tibetan government-in-exile to finance and manage the health centers as well as to plan a comprehensive health care system for the Tibetan refugee community. The Department of Health of Tibetan government-in-exile was thus established in 1981.This department runs sixty one Primary Health Care Centres and six referral hospitals in almost all the Tibetan communities in India and Nepal. The Tibetan Medical and Astro Institute in Dharamsala is an autonomous body under the auspices of the Department of Health. The institute specializes in traditional Tibetan medical care and has set up thirty six branch clinics in various parts of India and Nepal.[22] But it is also to state that due to financial constraints, the overall health situation of the Tibetan refugee community in India and Nepal, especially for women, is still not satisfactory. This is mainly due to the stress and tension of refugee life, economic constraints, poor nutrition, poor hygiene, and poor sanitation, illiteracy among the older generation, the language barrier and an overall low level of health awareness in the community. 'His Holiness the Dalai Lama's Vision for a future 'Free Tibet', the Guidelines for future Tibet's Polity and basic features of its Constitution, which His Holiness issued on 26 February 1992 categorically declares that during the transitional period a public health care system will be established in order to provide adequate health care facilities to the people(DoH 2003,2005).

5. a. Trends of diseases

It is studied that Tibetan population are mostly suffering from tuberculosis (TB) is at its highest and TB is also the main cause of death in the refugee society. Among patients with TB the most common type of TB is TB of lung and there are also a few cases of intestinal and lymphatic TB(Nelson et al 2005). The second most common

[22] http://www.tibet.com/dasaguide.html accessed 28th June 2008

disease is ailments of the digestive system, but stomach ulcers are relatively rare (Tsering 2008)[23]

Diabetes mellitus is hardly ever recognized, but diseases of the thyroid gland, such as hypothyroidism in particular, and other hormone-related illnesses are sometimes recognized. AIDS is spreading in India and the Tibetan refugee medical personnel are paying close attention to identification and prevention. However, AIDS has been less identified among the Tibetan refugee. Leprosy is also seen as a social problem of the refugees and projects for examination of this problem and program for rehabilitating leprosy patients are also initiated recently by Department of Health, CTA. Leprosy has only been reported from Tibetan refugee settlement from South India. As for other infectious diseases, measles, dysentery, Type-A hepatitis, cholera and typhoid is quite common. Plague was reported to have struck mainly in Southern India but not even single case of plague has been reported till date from Tibetan refugee settlements. Due to hygiene problems, skin infections caused by yellow Staphylococcus, ringworm and scabies are quite common. In terms of surgery, treatment of hernia, removal of the prostate gland frequently performed[24].

Bera (2004) in her study *'Tibetan Refugee in India : Observations in the Field of Health'* highlights the extreme love for their own tradition and an inclination to continue their old customs, practices and habits create considerable difficulties for the migrant Tibetans in India. This is particularly noticeable in their health and health related behaviours. Tsering (2008) and Bera (2004) identified the migrant Tibetans have almost similar consumption pattern as their counterpart at high altitude. The calorie intake of this migrant population is sufficient but is not balanced in terms of proxemic principles viz., protein, fat and carbohydrates. The persistence of a diet with high protein and fat that is typical of populations living in high altitudes but reduction in the energy expenditure because of decreased physical work among the migrant

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[23] Dr. Phurbu Tsering –BTMS (Bachelor of Tibetan Medical in Science),Bhot-Ayurved Acharya,Tibetan University, Varanasi.Currently working in Majnu Ka Tila, New Delhi.

[24] http://www.jicef.or.jp/wahec/ful312.htm 28th June 2008

Tibetans in the lower altitudes is accountable for the comparatively higher body weight among them. Hence, the dietary pattern of the migrant population has increased the health risk among the women.

There are Common health problems such as upper respiratory tract infections, common cold, diarrheal diseases, dysentery and dermatological problems. In, particular the new comers from Tibet, which constituted a huge number, were prone to insect bites and other wounds. Other uncommon but more serious health problems that Tibetan refugee encounter is Malaria, Pneumonia, accident fractures, heart problems, uncontrolled diabetes and cerebra vascular stroke. Few Psychotic patients were also recorded. The numbers of out patients varied from 500 to 800 and in all more than 10,000 patients were treated effectively (Tibetan Health 2006).

As it is mentioned above Tuberculosis (TB) continues to remain as one of the major health problems for exile Tibetan community (Wares 2000). Unhygienic surrounding, refugee life, low nutritional diets, lack of awareness, stress and change in living conditions from the cold climate in Tibet to hot weather of the Indian subcontinent adds up to factors responsible for high numbers of TB incidence in the Tibetan community. Poor treatment compliance on the part of TB patients and their families are factors that account for high incidence of disease. [25]

6. Health status indicators:

6. a. Infant Mortality: Bhatia et al (2002) and Childs(2002), studied that in 1995 and 1996 the regional Infant Mortality Rate (IMR) among the Tibetan community present in settlements in the North East region of India stood at 20.7 for every thousand live births. In the settlements in Orissa (Central India) and Dickyiling (Doon Valley) the IMR was 22.3 and 31.2 respectively. The settlements in South India showed an IMR of 21.3 per 1000 live births. Thus, Infant Mortality is in the range of 20–50 per1000 live births. So, over all the infant mortality rate (IMR) for both male and female infants is twenty seven deaths per thousand live births. Child mortality rates (CMR) for both boys and girls aged from one to four years is twenty five deaths per thousand. The life expectancy for both men and women

[25] http://www.ciolek.com , Accessed on 20th April 2008

is above sixty[26]- sixty three[27] and it is longer than the average life span, 57[28]and 60-61[29] years, of Indians[30]. The reason for this difference is unclear. Malnutrition account for up to 40% of the deaths of children under five years of age and infant mortality is 162 for every 1,000 in 1990.This rate is reported to be higher than that of the Indians (Sowa et al 1991).

6. b. Maternal health and Antenatal Care: Antenatal Care Centre (ANC) records on pregnancies for live births1232 (1994) and in 2084 (1996). According to medical reports, 50% of pregnant women were found to be with hemoglobin level below 11 grams/dl[31]. As of September 1994, 90%of pregnant women were fully immunized against tetanus and other infections. Sixty percent of births were attended by trained personnel/midwives in clinics and forty percent of births were attended by experienced elder women or community health workers. Births were attended by experienced elder women or community health workers (DoH , 2003)[32]

6. c. Childhood vaccination: The childhood vaccination varied by region, by year, and by type of vaccine, but, overall, less than half of children were fully vaccinated. Vaccine coverage improved from 1994 to 1995, when it exceeded 40% for each DPT and BCG. However a decrease was recorded in 1996, to 30% (DPT) and 7% (BCG), respectively. The regional break down of these data showed marked differences between regionwithin the same year and across years. It may have improved due to vaccination campaigns funded by international donors in the 1990s (Bhatia 2002, Sowa et al 1991).

6.d.Clinic attendance and illness: Data compiled from the available sources showed that the common diseases of developing countries, especially skin ailments, upper and lower respiratory tract infections (RTI), fevers, diarrheal diseases, tuberculosis, parasitic and other infectious diseases abound in the settlements and accounted for 52,544 (60.3%) of the 87,109 clinic visits in 1996. While these illnesses are common in all age groups

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[26] Department of Health at a glance (2003), Hand book by Department of health, CTA.
[27] http://www.jicef.or.jp/wahec/ful Acessed on 20th June 2008
[28] Sowa et al (1991)
[29] Census of India (1991)
[30] But as of 2005, the Life expectancy for m/f is 62/64 (WHO).
[31] "gram per deci liter-some medical test give result in g/dl , a gram is equal to weight of one milli liter or 16 drops of water. It is about 1/30 of an ounce. A deci liter measures fluid volume equal to 1/10 of a liter. A liter is little bigger than a quart of fluid". *health .yahoo.com.*
[32] http://www.ciolek.com, Accessed 20th June 2008

and in both sexes, among the older population these illnesses are supplemented by joint pains, peptic ulcers, and cardiovascular conditions.

6. e. Hypertension and depression : Hypertension among Tibetan refugees residing in India is also quite high, although it is not immediately evident whether this poses a health concern for environmental reasons related to Tibetans nature as a high altitude dwelling people (Tripathy et al. 2006). Tibetan has higher levels of depression and anxiety than Tibetans born and raised in relatively stable exile communities in India and Nepal (Shetty 2008).

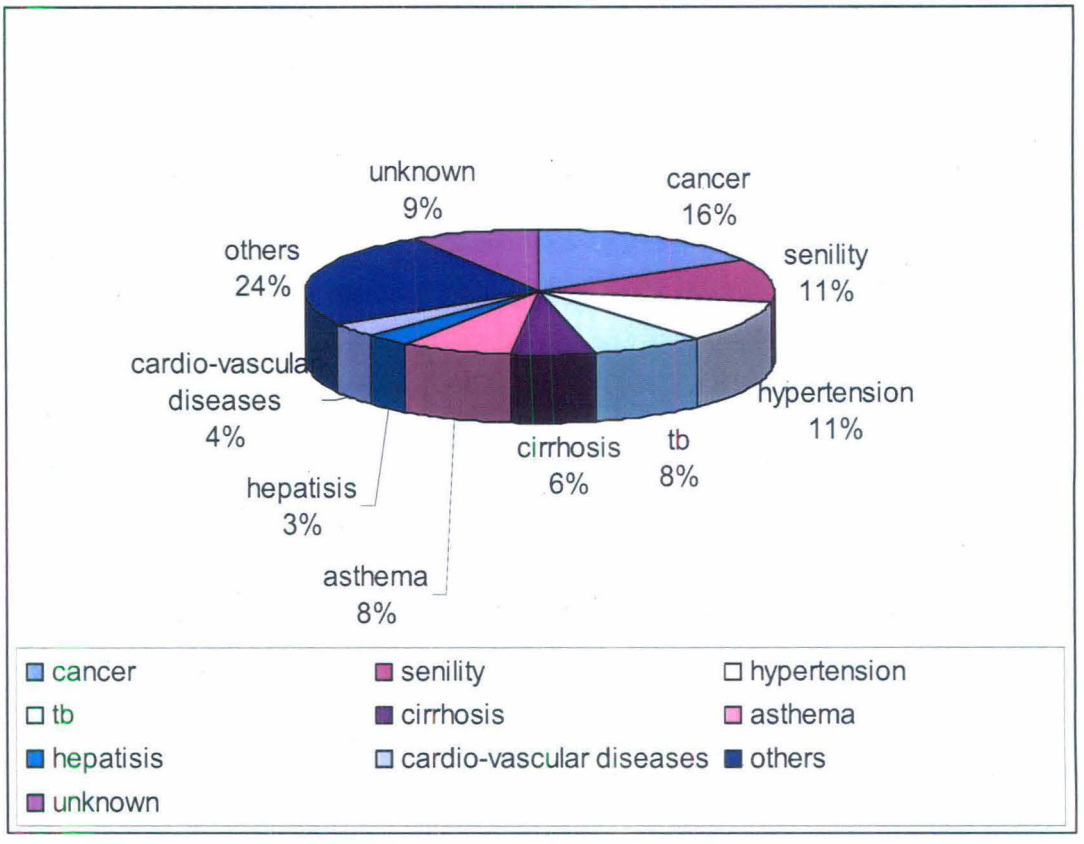
6.f. Obesity: High levels of obesity (11.7%) and overweight (27.9%) refugees are observed. Very few refugees were found to be underweight (4.8%) (Tripathy et al 2006 ,Bera 2004).

6.g. Causes of death: Cancers were the leading causes of death among Tibetan refugees in India, followed closely by pulmonary tuberculosis, of which 35% (characterized as drug resistant), were thought to be due to drug resistant strains. Accidental deaths (primarily "vehicular accidents, altercations, and drowning") and old age were the third most common specific cause, mainly due to vehicular collisions, altercations or drowning. Cirrhosis of the liver figured especially high in the North-eastern region where the drinking of the fermented millet brew called 'Chaang'[33] is widespread. Deaths from malaria were common in the North-Eastern and central regions where anopheles mosquitoes abound (Bhatia 2002, DoH 2003).

Sowa et al. (1991) report that 40% of child deaths in 1990 were characterized as being a result of malnutrition potentially explaining their elevated numbers.Similarly the Department of health of CTA[34] also recognized Cancer,TB, Senility ,Cirohsis and hypertension as major cause for death among Tibetans in exile.

[33] Rice bear made out of fermented rice which is very much popular among Tibetans.
[34] Department of Health at a glance (2003) ,Hand book by Department of health, CTA.

5.1. Causes of death in Tibetan exile community in India (2003)-CTA



Source: Department of Health at a glance ,Hand book by Department of health, CTA.

6. h. Birth and death rates: According to Bhatia (2002) the overall Crude Birth Rate on records of vital statistics in the community health centre in Tibetan refugee settlements in India was 16.2/1000 population, and the birth rate calculated from the number of children in the 0-4 year age group was 16.8 / 1000.There is large regional variations. In general the north eastern and Ladkah had higher rates while himachal and Doon valley gave the lowest rates as of 1995-1996.

6.i. Incidence of Tuberculosis:

Tuberculosis is a major problem. Over 33,000 cases within the Tibetan refugee community have been reported since 1959. A concerted effort with international assistance has greatly improved TB detection and treatment .Other health problems

include dysentery, diarrhea, hepatitis (Namdul,2000), skin disorders, and respiratory diseases resulting from unhygienic conditions, malnutrition and the change in environment, particularly the relatively polluted air in the cities when compared with the clean environs of the Tibetan Plateau. According to Department of Health, CTA (2003) highest new cases of TB was detected among 15-24 age group (Tibetan reefugee in India and Nepal), of which male population are suffering most.

5.7 Number of TB new cases in Tibetan refugees in India and Nepal (2003)[35]

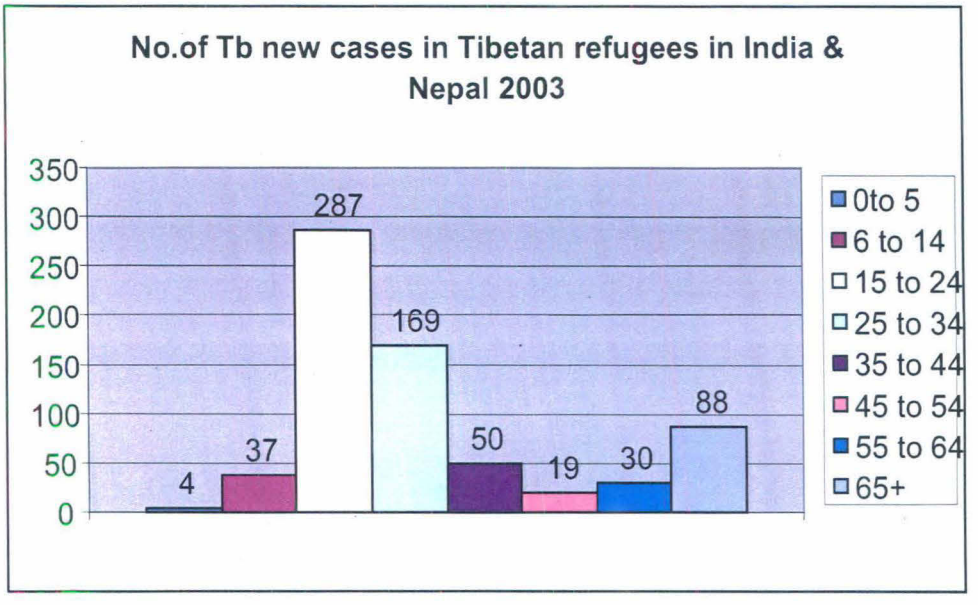


Table 5.8. No. of TB new cases by sex in India and Nepal.

No. of TB new cases by sex in India and Nepal.	
Male	**Female**
71%	**29%**

Source: Department of Health at a glance ,Hand book by Department of health, CTA.

The environmental and socio-economic changes due to migration are largely responsible for some major health problems among the Tibetan refugees in India. The Tibetan adults

[35] Department of Health at a glance ,Hand book by Department of health, CTA.

suffer from various diseases. The most prevalent diseases among the adult Tibetans are chest diseases and digestive disorders. Among the Tibetan refugees upper respiratory diseases (36.8 per cent) might be associated with seasonal climatic changes as well as lack of awareness about the ways in which common cold and flu spread. TB was uncommon in traditional Tibetan society due to the sparse population and high altitude (Mansoer 2002). As a result, the indigenous population in Tibet had little natural immunity because there was no TB in Tibet before 1959. Tuberculosis is now a major health problem among the adult Tibetans (9 per cent) in India, particularly in the age group of 15-35 years. This figure can be compared to the overall incidence of TB in India. Where at least 50 percent of the Tibetan population above the age of 20 years is infected the current risk of infection for India is 1.7-2.0 per cent (Datta1995). The survey finding by ICMR revealed that the sputum positive pulmonary TB is about 4 per 1000 population and an estimated 1.5 million infectious cases spreading infection in the community (Bera 2003).Values for TB prevalence are estimated at 1200/100 000 in a 2002 study, 835/100 000 in a survey of 90% of the adult population over the period 1994-1996 (Tripathy et al. 2006). TB cases are reported to have arisen at a rate of 300 new cases per year in 1990 (Sowa et al 1991). Tibetan refugees to the United States and Canada throughout the 1990s showed high levels (98% and 97% respectively) of exposure to TB upon arrival (Nelson et al.2005). TB rates may have improved since the time of last survey due to expansion of a WHO anti-TB campaign in India known as the DOTS program HIV/AIDS has not been reported as a problem in refugee camps to date (Nelson et al. 2005, Tripathy et al.2006).

7. Medical programs and projects by Department of Health, Dharamsala, Government in exile

7.a. Immunization Programme: Immunization all under fives against the main communicable diseases are given to all the new born children (DPT, Polio and BCG vaccinations). Tetanus vaccine is administered to pregnant mothers through the existing hospitals & PHC centers. The new refugees coming from Tibet are also being vaccinated with tetanus, BCG and measles. Currently 95% of Children have been

immunized where as it's coverage in 1991 was only 40%.

7.b. Mother and Child Health Programme: The infant mortality rate is high in South India (Tibetan Settlement) i.e. 34.8 out of 1000 of which many are preventable. DoH has initiated many Programmes to reduce current infant mortality rate by 75% by the next five years by providing appropriate ante natal care and immunization for mothers and children. Through health education many mothers are now aware of the need for providing immunizations and proper health care for their children especially during pregnancy.

Table 5.9.Population change rates: (1988-91)

Population	Rates
Crude Birth Rate (per 1000)	18.6
Crude Death Rate (per 1000)	5.0
Infant Mortality Rate (per 1000)	34.8[36]-27[37]

Source: Department of Health at a glance , Hand book by Department of health, CTA (2003) , Bhatia et al (2002).

7.c. TB & Leprosy Control Programme: The incidence of TB in the Tibetan population is among the highest in the world estimated to be at least 20 per 1000 (Ahuja 2006). The number of TB patients is increasing. Thus Department of Health (DoH), CTA initiated programmes to bring down the TB prevalence rate to 10 per 1000 people by year 2000 A.D. But Tuberculosis (TB) is still a major health problem for the Tibetan Community. It is also to mention that 13 patients (Tibetans) are under treatment for Leprosy.

7.d. Drinking Water and Sanitation Programme: The Drinking Water and Sanitation is given priority in Tibetan settlements because Gastro enteric and Diarrhoeal diseases

[36] As of 1988-1991
[37] Studied by Bhatia et al (2002) as 1995-1996

together accounted for a large proportion of the disease incidence in the Settlements and the scattered communities. This is understandable that on an average the settlements are able to get only 64% of their drinking & washing water requirements. In view of these conditions, the Department of Home, has taken up the Programme for all drinking water and sanitation' projects.

Table.5.9.Disease incidence In 37 Settlements and 70 Scattered Communities

Disease	Percent Settlements	Percent Scattered Communities
Skin Diseases	22.2	20.2
Gastro-enteric & Diarrhea	35	22.7
Respiratory	10.5	31.7
Tuberculosis	6.5	7.7
Malaria	3	0
Blood Pressure	0.3	1.7
Others not specified	22.5	15.9

Source: Health Department, Tibetan Govt. in exile,Dharamsala, HP India,[38]

The Table(5.9) shows that there is significant difference in Tibetans living in settlements and scattered communities in regard to above mention health problems .Respiratory problem is higher in scattered in communities than settlements.

7.e. Health Education and Media Project: Health awareness within the Tibetan Community including schools, monasteries and nunneries has been very poor. Health

[38] www.tibet.com/Govt/doh.html accessed on 28th June 2008

Education and Media Unit, of Department of Health continue to conduct health education Programmes in all the Tibetan settlements. It has -published posters, Tibetan & English Biannual bulletins, pamphlets on dental health in Tibetan & English, and produced video cassette on TB. These are distributed to all Community Health Centers for public education. It is to continue to develop appropriate media to provide health education. Materials are also being translated from the WHO and other publications, as well as various pamphlets, books, comics, posters and video cassettes, into Tibetan.

7.f. Primary Health Care Programme: The Tibetan Settlements are located in remote areas where medical facilities are not available. Thus the DoH adopted PHC system to cover all the Tibetans in India and Nepal through setting up of PHC Centers. The DoH is trying to move towards to make the health care system more sustainable.

7.g. Disabled and Handicapped Project: In 1989, the Department initiated a special unit for treatment and rehabilitation of Disabled and Handicapped. The aim is to help disabled and handicapped to become self-supporting and lead as normal life as possible. At present there are 1006 cases of disability within the Tibetan refugee community.

Table 5.10. The Disabled in 37 Settlements and 70 Scattered Communities[39]

Disability	No. affected	Per 1000 of population
Deaf/Mute	144	1.7
Blind	163	1.9
Hands/Ann	81	0.9
Leg	215	2.5
Paralysis	102	1.2
Leprosy related	76	0.9
Polio	79	0.9
Other	72	0.8

Source: Health Department,Tibetan Govt. in exile,Dharamsala,HP India,

[39] with a population of 85,843.

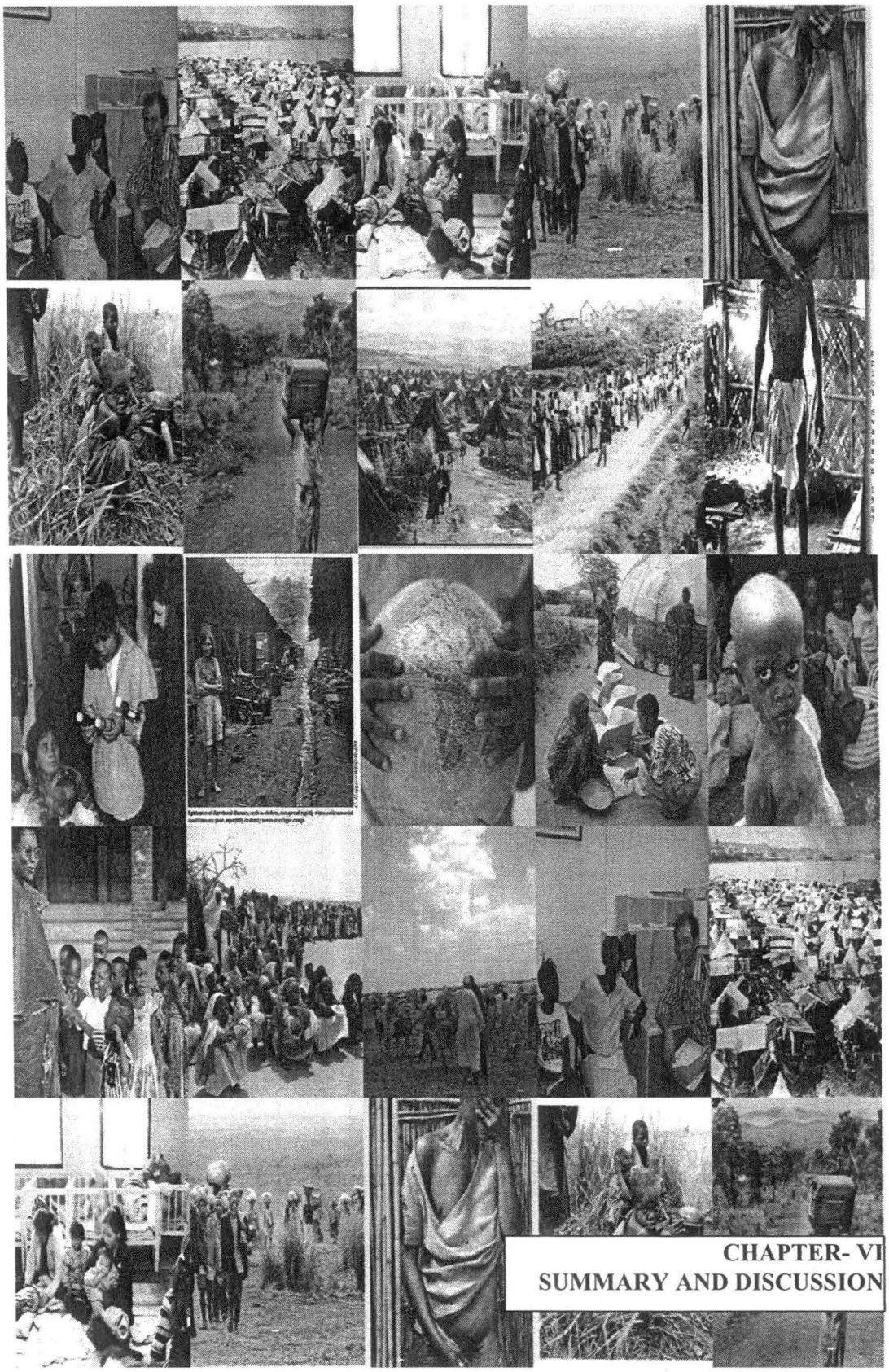
The Table (5.10) shows that among disabled, people having physical impairment are maximum in number.

7. h. Eye & Dental Care Programme: Education on prevention of dental diseases are given to the public in settlements and scattered communities. Dental therapy courses are given to Tibetans to train them in treating dental diseases. DoH, CTA conduct dental therapy training. Eye care and dental clinic camps are organized in the settlements & other communities from time to time.

7. i. Tortured Victims Survival Project: Many Tibetans to flee Tibet is that they have suffered from torture under the Chinese rule. While not all of them require medical treatment, a sufficient number need medical support. They need medical and counseling treatment to adapt to the new environment and earn their livelihood. Thus, DoH has initiated Tibetan Torture Survivors Programme.

8. Conclusion: Tibetans initially experienced problems in moving from what was a strongly traditional and almost closed society to the culturally diverse one of democratic India. In general, how ever, they have successfully maintained their cultural and religious practices in fact Tibetan refugee community in exile is considered as one of the most successful refugee communities in the world. They have managed to rebuild their lives in a completely alien environment achieving almost total economic self reliance. Despite these positive achievements, the majority of the Tibetan refugee in India still entangled with issues of security , identity ,cultural and language conflict which vice-versa affect their health status . Most of these still continue to live in poverty. They are living in monasteries and nunneries without family, no resources and in very poor health. Health care services among Tibetan refugees most critical of their needs. There experiences of being refugee is as same other refugee in the world. There major grievance is economic prosperity which create tension between them and the host population . They live in constant fear of being deported back and shift in Indian policy due to increasing good relation of Sino-Indian. Identity is also a problem within this small community. Many success in acquiring identity card to stay in India but still there are many who have no documents and no official identity.

With due to all hardship many of scholars have reflected that Tibetan refugee seems to be under great transition from those typical of least developed countries to the typical of middle income and more affluent societies. Tibetan refugee community is said to be the relatively more secure when it comes to financial assistance.



CHAPTER- VI
SUMMARY AND DISCUSSION

CHAPTER -VI
SUMMARY AND DISCUSSION

Refugees are global problem. Refugee problems are no longer hidden from the public eye tucked away inside refugee camps or settlements. In the name of country, nation and homeland, millions being thrown out and displaced and forced to move from one country to another country which has been an enduring feature of population geography and human affairs. Global refugee problem is largely a twentieth century phenomenon and it has left behind a massive legacy of refugees. The response to this legacy remains incomplete and inadequate. World War I, the Soviet Revolution, State partition in south Asia and other events led to `crisis responses' for the Russian refugees, Armenians, German, Afghani, Bangladeshi and Tibetan refugees. When the International Convention of Refugees was enacted in 1951, it was seen as Euro-centric and, essentially, anti-communist. The international community has attempted to provide refugees with protection and assistance. International covenants, protocols, regional mechanisms, laws and organizations have been established for the protection of refugees as well as the promotion of a lasting solution of the refugee problem. But the international refugee regime is facing difficulties in keeping pace with developments around the world .The bulk of the displaced people of the world today, belongs to the country of the south or the developing countries for instance South Asia and yet has not joined the international protection regime. Very few have developed laws, institutions and administrative structures for protection and rehabilitation of refugees. This lack of laws and policies has further deteriorated the situation. Today as per USCRI Report on World Refugee Survey 2006 the total numbers of refugees and asylum seeker world wide is 13, 948,800. UNHCR Statistical Yearbook shows, in 2006, the refugee population increased by 1.2 million persons and Asia is hosting the largest number of refugees.

1. Definitional and Conceptual issues

Refugees are vulnerable through out the phases of the refugee experience. Other than the causes which create refugee and problem they face as defined in conventional and current definition of refugee, they face much more and suffer beyond what is actually

defined within the framework of instruments created for their protection. It is not being argued that those who have been forced to flee their home and hearth because of political persecution and direct threat to their life should be equated with those who have been forced to move by loss of livelihood, man made disaster and natural calamities. At the same time it can not be ignored the fact that certain governmental policies have impoverished vast masses of population, particularly those belonging to minority communities and economically backward. For instance, in the case of Tibetan refugees in India, they have provided every opportunity to get education by joining the education institutions in India. But the opportunities for employment expectations into the Indian job market are less which needs to be expanded. Unemployment provides difficult challenge for the Tibetans in exile. Although many jobs exist through the Tibetan government and education systems, but it almost non existence of which most of the Tibetan youth are indulged into substance abuse (due to depression). Thus, clearly there is an urgent need to reconceptualise the definition of refugees and while defining refugees the emphasis should shift from the factors that created the refugees to defining a refugee circumstances that they are living in that is as stateless (e.g. Tibetans in refugee in India) and vulnerable to abuse. New and effective international instruments and national laws need to be created to protect the rights of these millions who have no legal existence in most countries of the world today.

2. Refugee movements and International and national approaches to refugee protection

The study shows the historical records and contemporary crisis of refugees around the world. And also detailed many aspects of tragic story of the refugee. Hundreds of thousands of refugees, in need of protection and resettlement remained dispersed and in fact the present century has been described as the "century of homeless man or century of uprooted" because of tremendous increase in the number of refugees. Today most of the refugee found in poorest countries. Refugees will continue to appear as most of the countries are involved in the throes of great social and political transformation that unavoidably entail types of social conflicts that generate violence, including classis persecution and which people seek to escape by fleeing to other country. The scale of

refugee movements has expanded dramatically in recent years, for instance refugee situations and movements in the Middle East, Africa, America and Asia. By looking at the distribution of refugee world wide it is understood that the problem of refugee is one of the most serious problems all over the world. Many international and national/ regional instruments, treaties and mechanisms implemented to deal with the refugee problem since 1920 onwards. UDHR (1948) is the first international document that recognizes the right to seek and enjoy asylum from persecution, then followed by 1951 convention and its 1967 protocol. Different countries have different policies concerning refugees. Countries of Latin America have the Cartagena Declaration on Refugees applicable to most countries in Latin America. Similarly for the countries of Africa, there is the OAU Declaration but countries in South Asia who host majority of refugee in the world , do not ratified any of the international convention .Therefore many scholars have reflected that international refugee protection is in throes of a crisis there is a serious north-south division in matter of refugee related issues and policies . In fact, it is claimed that the communication gap between states is the main cause of non- compliance of the Asian countries to International convention. Among the Asian countries India has traditional been a good host for refugees as it does not have any specific policy to deal with this refugee influx. Many factors in the recent years emphasized Indian governments to adopt and redefine their policies in regarding refugee population in the country such as assassination of former Primer Minister Rajiv Gandhi, Continuous influx of Tibetan refugee since 1959 ,Anti foreigner movement in Arunachal Pradesh (against Chakma refugee),Ethnic clashes between host population and Burmees refugees in north eastern Region of India etc. Though India is not a member of the international convention, but the country has acceded her commitment to the International sphere by being executive member of UNHCR and acceded many treaties and covenants for instance; International covenant on Economic, Social ,Cultural Rights(1966), Convention on the rights of child(1989), Convention on the Elimination of all forms of Racial Discrimination(1963) and Convention of elimination of all forms of discrimination against women(1979).From the study it is understood that world today is not what it used to be 50 years ago. Around the world people are moving .population movement between countries are happening voluntary or involuntarily. Therefore India can not do away with mere foreign policy,

judicial treatment and acceding some of international covenant. Scholars have again reflected many years India has not applied its mind to the world of refugees, their problems and discontents. It is the time now that India should recognize the constitutional values in the shape of a national refugee policy.

3. Causes for refugee movement and its consequences

No one wants to be displaced from the place of his origin resident.But the human history and contemporary crisis around the world shows there has been always some or other kind of instability in the human society from time immemorial of which resulted in mass movement (voluntary or involuntary) . Due to which millions have become refugee to other nations, directed to seek a better future, greener pastures security and dignity .Today nearly 15,000 people a day become refugees; one in every 120 people in the face of the earth has been forced into flight. The movements of refugees are symptom and a cause of the turmoil in the world today. Scholars have found out the root cause of refugee and it is also discussed in the study are: wars, political warfare, revolution, coup'd' etat, insurrectionary social structure, minorities, brutal government, deliberately undertaken change of social structure, economic cause, ideological opposition etc. Today the situation create refugees are more likely to involve mass movements of the people, for instance by ethnic wars , political insurgency, with few occurrences of natural and environmental disasters and increasingly changing nature of war where civilians are becoming the target for negotiating political agenda. Therefore, the refugee experience is not easy as it is portrayed today in international agenda as charity box. They are called 'queue jumpers' and always been referred with the names of 'others' but no matter how they are referred, unless you have lived these names it is hard and no possible to know how difficult once life could be. Refugees often encounter economic hardship, social disruption, political oppression and physical violence which compel them to leave their home. Every stage of their life they are marginalized and characterized by apathy, isolation dysfunctional attitude which make them more vulnerable. The out flow of refugee is dramatically increasing or in other word there is wide spread acknowledgment that this problem is growing with seemingly no end in sight but it seems to be no solution

to it and there is huge gap and miscommunication in the international and national policies to deal with refugee protection issues.

4. Refugee and health

Refugees are the most vulnerable group among the world's down trodden. The problems of refugees wear many faces; it ranges from violation of their human rights, their liberty, their nationality, legal problems etc. But often lost in these complexities is health problem. Health problems are serious concern of refugees. Refugees are among the most at risk populations for poor health status in the world. It is to state that refugee generally share the same health threats with the poor host population of the country but refugees are more vulnerable in way because of low socio-economic status and their 'refugee status /identity' of which they are reluctant and afraid to reveal in the process of obtaining any sorts of support. Low access to health care facilities, bad living conditions , insecurity of food , poor infrastructure which is very much due to culture alienation and makes them more prone to ill health. Refugees are often subjected to discrimination and prejudice, denied human rights and also exploited as cheap labour In case of women refugee, they are more vulnerable due to power imbalances that exploit distinctions between males and females. Health care is often missing or inadequate. Often in refugee camps due to lack of reproductive health care is a leading cause of death and disease among displaced women of reproductive age. Thus it is argued that there should be a broader definition of persecution to include non political but potentially life threatening events such as gender related persecution. The reviewed literature shows that health is the result of a complex interplay of socio-economic factors .Social; economic, behavioral psychological, cultural factors are associated with changes in the health status of immigrant and refugee over time for example Tibetan refugees in India.

The study shows that Tibetan refugee community in exile is considered as one of the most successful refugee communities in the world. They have managed to rebuild their lives in a completely alien environment achieving almost total economic self reliance.

5. Tibetan refugees in India

India today accounts for more than one lakh Tibetan refugees living in 37 settlements and 70 scattered communities ,which is spread across the different states of India. The majority of the families are nuclear and although polyandry is not .They are naturally trained in cultivating local Indian crops like maize, millet, rice, and mustard etc. Agriculture is the main source of livelihood for many of them. Tibetan society is basically described as theocratic state. Tibetans in India they have their own traditional medicinal system especially herbal medicines have also contributed significantly to the Indian society. It reveals that Tibetan refugees in India do not present a picture of uprooted ness like other refugee groups. But despite of these positive achievements, their future is not as secure as it may seem because they still remain refugees in an alien land and they have their own story to tell from the phase of plight to successful settlement.

5. a. Issues of insecurity , identity and culture conflict

Many scholars have reflected that Tibetan refugees in India are used as ping-pong ball or safety card for Sino-Indian relation. Even UNHCR stopped assisting the Tibetan refugee in India after the entry of mainland China into United Nation, the UNHCR, unilaterally withdrew its financial support to the Tibetan refugees. It is also identified that the Tibetan issue is getting sandwich in the world's politics. Some insight were gained in regard to fear of shift in Indian policy towards Tibetan refugees with the continue influx of Tibetan refugee to India, substantial improvement in India's relations with China as well as possible pressures from the local population in the vicinity of the settlements and the scattered camps, especially in Himachal Pradesh and Arunachal Pradesh. Many of the fresh arrivals are detent, imprisoned or sent back .Government of India (GOI) decided not to grant either legal status or financial assistance for the rehabilitation of these refugees. Elderly persons, women headed families of recent arrivals are still struggling. At the community level, Tibetans have been living in relative isolated from the local person with a view to preserving their distinct religion and culture which is gradually decline in this regard. The local population feels threatened by the demographic and cultural impact of the refugees. There were incidents of violence also against the refugees in 1994 .Relatively it is to say that there is tension between the Tibetan and host

communities. Most of these still continue to live in poverty. A number of them are in ill health. Many of these refugees are senior teachers, monks and nuns. They are living in monasteries and nunneries without family, no resources and in very poor health. Health care services among Tibetan refugees most critical of their needs.Recognizing the need for good health care for the Tibetan refugee community, the Tibetan government–in-exile has taken several steps towards creating curative and preventive health care services and have set up their own tradition medicinal system. But it is to state that due to financial constraints, the overall health situation of the Tibetan refugee community in India, especially for women, is still not satisfactory. This is mainly due to the stress and tension of refugee life, economic constraints, poor nutrition, poor hygiene, and poor sanitation, illiteracy among the older generation, cultural conflict, the language barrier and an overall low level of health awareness in the community.

5. b. Health status and Health care provisions

Many of the scholars reflected that Tibetan refugee seems to be under great transition from those typical of least developed countries to the typical of middle income and more affluent societies. But the study has revealed that it cannot be said that they have been particularly successful in doing this because there are certain areas where the new environmental and socio-economic features differ markedly from those prevailing in Tibet and on which they have absolutely no control. for instance ,tuberculosis is the major health problem among Tibetan refugee.The burden of illness in this society are mainly characterterised by diarrhea, skin infection, respiratory infection, fever, joints pain, cardio vascular problems. High levels of obesity and overweight refugees are observed. Very few refugees were found to be underweight. There is poor equipment and the limited the efficiency of the laboratory. One of the most important problems is the shortage of Tibetan allopathic doctors in the community, which is due to poor facilities, poor pay scales, and the limited level of medical technology and treatments. Another reason could be the acceptance treatment or healing methods among the Tibetan community in India as they are guided more by their traditional beliefs and customs.

Findings

Refugee movement is symptomatic of the imperfections which continue to characterize the anarchical structure of the international system today. International refugee regime is facing difficulties in keeping pace with developments around the world. Very few have developed laws, institutions and administrative structures for protection and rehabilitation of refugees. This lack of laws and policies has further deteriorated the situation. The bulk of the displaced people of the world today belongs to the country of the developing countries for instance South Asian countries. Yet South Asian countries have not joined the international protection regime. There are broad range of humanitarian, human rights and developmental agencies to provide protection, assistance and reintegration of refugee world wide and all these has moved from euro centric approach to problem solving which is more oriented third world countries. But still the solutions to the problem of refugee remain dispersed. India do not have any particular policy to deal with refugees in the country but have a partial commitment to international community by being executive member of UNHCR and acceding few of international covenant which ensure the basic facilities to refugee in the country on humanitarian ground. Refugees are often subjected to discrimination and prejudice, denied human rights, isolation and impoverished These forms of marginality and exclusion add to the burden of illness in refugee populations and contribute to persistent health problems. Thus, it is important to study refugee issues basically in the field of health. Tibetan refugees are the only refugee in India settled in proper settlement and run a parallel government in exile with cabinet minister and independent commission. With the continuous influx of Tibetan refugee in India since1959 and increasing substantial good relationship between India and China may lead to change in policy towards Tibetan refugees in India.There is relative tension between Tibetan refugee and host population on the ground of economic prosperity of the group (Tibetan refugee).The host population fear that the Tibetan refugee may not go back and demand for separate homeland., without understanding the gravity of the problem of some one who is forcibly thrown out of his homeland.Unemployment is the biggest challenge for the Tibetan community in exile.Tibetan refugee have strong dedication and is struggling in persevering their own identity and culture which makes them to disintegrate with the host population .It is very much visible in case of Tibetans reluctant

to take better advantage of modern facilities available. Thus it is learnt that refugees though may share common predicaments but come from diverse cultural backgrounds. The study in field of refugee health must tackle the cultural diversity. The health system of Tibetan is based on tradition medicinal system .It has contributed to Indian medicinal system. There is strong dissatisfaction among Tibetan refugee with the level of medical technology and treatments. Tuberculosis is highest among Tibetans in the world estimated as at least 20 per 1000. Like other refugees around the world Tibetan refugee has gone through all the phase of refugee experience: preflight to settlement and tolerated violence, cultural conflict, social disruption, economic hardship and political oppression. But it s their hard work and struggled paid them. Considering all the socio-demographic and health characteristic, it is noted that Tibetan refugee in India is under transition on the ground of improved health status. Besides Tibetan refugee India is accounts for refugee from different states of South Asia. Therefore , India need to Pass a national law for the refugees that will provide uniform treatment and regulation of all the refugees living in India.

The main findings can be summarized as follows:

1. Refugee is a global problem. It is dramatically increasing worldwide posing a great challenge to the human society not in terms of only humanitarian and human rights concerns but also fundamental issues of international peace and security.
2. There is an urgent need to re-conceptualization on the definition of refugees and while defining refugees the emphasis should shift from the factors that created the refugees to defining a refugee circumstances that they are living in that is as stateless.
3. New and effective international instruments and national laws need to be created to protect the rights of these millions who have no legal existence in most countries of the world today.
4. There is pressure on India to recognize the constitutional values in the shape of a national refugee policy. So ,to deal with the difficulty created by the absence of legal framework for refugee and asylum seekers is that there is no matter of

separating the really vulnerable who need the protection of a host state from the ordinary job seekers

5. The study on refugee as a population invites a multidisciplinary approach because their existence often is a result of history, politics economics, conflict and more recently globalization with its long term outcomes for example health . Refugee advocates have argued on gender based violence and persecution, which need to be considered in the process of making policies, law or refugee protection instrument.

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Annexure-I

Interviews and discussions held on:

1. 11th October 2007
   - Prof. Yeshi Choden -School of International Studies, Jawaharlal Nehru Uuniversity , New Delhi.
2. 12th October 2007,30th October 2007
   - Mr. Rinchin Phunstok-Pradhan of Tibetan Welfare Association, Majnu ka Tila, New Delhi.
   - Mr. Tsering Thaye- Secretary of Tibetan Welfare Association, Majnu ka Tila, New Delhi/ Welfare Officer deputed from Tibetan Government in exile ,Dharamsala,Himachal Pradesh
3. 10th Novemeber 2007
   - Mr. Tsering Thaye- Secretary of Tibetan Welfare Association, Majnu ka Tila, New Delhi / Welfare Officer deputed from Tibetan Government in exile ,Dharamsala,Himachal Pradesh.
   - Discussion with Women Welfare Association, Majnu ka Tila, New Delhi (10th Novemeber 2007).
4. 14th November 2007
   - Visit to Men-Tsee-Khang; A Tibetan Medical and Astronomy Institute of his Holiness Dalai Lama and discussion with the nurse and staff of health centre, Majnu ka Tila, New Delhi.
5. 15th November 2007
   - Dr.Phurbu Tsering –BTMS (Bachelor of Tibetan Medical in Science), Bhot-Ayurveda Acharya, Tibetan University, Varanasi.
   - Mr. Tsering Thaye- Secretary of Tibetan Welfare Association, Majnu ka Tila,New Delhi / Welfare Officer deputed from Tibetan Government in exile ,Dharamsala, Himachal Paradesh