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Abstract

Human Migration is increasingly becoming as one of the most important social phenomena in 'time' and 'space' across all human society in this globalizing world and thus has changed the demographic-structural landscape at the receiving destination. It is also both great opportunities and challenges through the forces of globalization and urbanization which bring more ethnic migrants or newcomers into the fold of economic, political, social, and cultural contact with each other at the destination making the capitals and cities more multiculturalism in the world in general and particularly multiethnic country India. A large number of Northeast young population out-migrate to other cities of India in seeking for higher studies and work purposes due to lack of good educational facilities and job avenues for many years in the region. Though the migration generally helps ethnic minority migrants and their social networks from low-income households to access urban labor market for improving their economic well-being, still the challenging questions of their ethnicity, lived experiences of alienation, prejudices, discrimination, stereotyping, stigmatization and whether there is upward mobility at their place of destination are in questioned. Empirical studies show that out-migration and destination's physical and social new environment determining factors are closely related to migrants' health and well-being. The paper seeks to understand migration and ethnicity as determinants of health and well-being from a public health perspective in the context of Northeast Migrants in the National Capital Territory Delhi and need for public health policy and planning for migrants. The paper concluded that a policy framework is needed for the welfare and safety of the Northeast communities in Delhi, and also other cities in India.

Keywords: Migration, Northeast migrants, Prejudices, Discrimination, Determinants of health and Well-being, Public Health.

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Migration and Ethnicity as Determinants of Health and Well-being: A Public Health Perspective

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1. Introduction

The contribution of a public health perspective to the understanding of migrants' health and well-being will help to formulate public health policy and planning especially for people on move in the country. This paper focuses on the Northeast communities who have out-migrated in search of higher educational attainment and employment coming from the North Eastern Region of India[1] (NER) which comprises of eight states namely Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura. The Region is home to hundreds of ethnic minority mostly Mongoloid race and spread an area of 2, 62, 179 sq.km with 45.5 million of people constituting 7.9 percent of the total geographical area with 3.8 percent of the total population of the country[2]. The NER is quite different with the rest of the country in terms of employment situation due to geographical, socio-economic, cultural, and political reasons. Above all, NER is largely agrarian in nature and due to lack of industrial development and lack of political will and overall infrastructural development for many decades have caused the emerging issues of push-pull factors and its daily challenges face by the Northeast migrants in various parts of the country including the National Capital Territory Delhi. As migration is increasingly becoming a part of Northeast communities' lives for their education, livelihoods and even healthcare treatments, the health implications of migration and the health of migrants need to be recognized as an important agenda in health policy and planning. The definition of health according to WHO is that "health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity"[3].This classic definition centered around three components of health aspects of an individual i.e. 'physical', 'mental', and 'social well-being'. In the process of migration, migrants in their destination go through several lived experiences, which directly affect these three components of health. Some of the determining factors face by migrants is a combination of legal, social, cultural, economic, behavioral, and language barriers in the new environment. Thus, understanding the concept of social determinants of migrants' health and well-being in the context of Northeast migrants is paramount for accommodating and framing policy and planning for the welfare of the Northeast communities in different cities of India including National Capital Territory Delhi.

1 For more a sociological understanding of 'NER', please refer to Dubey, S. M. (Ed.). (1978). North East India: a sociological study. Concept Publishing Company.

2 Please see the Census of India, 2011.

3 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no.2, p.100) and entered into force on 7 April 1948.

2. Understanding Migration

Migration is one of the most important components of demographic structural changes in the urban areas, besides the other determinants such as fertility, mortality, and recognition and inclusion of adjoining areas for expansion of the urban areas. The impact of migration is drastic as it may change the size and composition of the population. Migration distributes and redistributes the population within an area at the level of a village, city, state or the country as a whole. Migration also influences and determines the growth of the labor forces at the destination areas (Omran, 1971). There is no universally accepted definition of migration as different scholars have tried to define it differently. Literally the term migration means settlement or shifting of an individual or a group of individual from one cultural area or physical space to another, more or less permanently (Ali and Shamshad, 2014). However, with the passage of time, the meaning of migration is continuously changing. At present, the meaning and scope of migration have become complicated. Mobility in physical space alone cannot define the complex process of migration. In this regard, several other social scientists have defined migration. Among them, Baker (1978) defined 'migration as the act of moving from one spatial unit to another'. However, the definition given by Weinberg (1961) appears relatively simple as according to him 'human migration is considered as the change of a place permanently or temporarily for an appreciable duration'. Lee defined "Migration as a permanent or semi-permanent change of residence" (Lee 1966: 49). According to this definition there is no restriction on the distance of the move or upon the voluntary or involuntary nature of the act of migration and no distinction is made between internal and external migration. Migration is a process of moving either across an international border or within a state or country. It is a population movement encompassing any kind of movement of people, whatever it length, composition and causes. Migration can be a long-term or short-term, internal or international (International Organization for Migration, 2006). While evaluating the definitions of different scholars we found that most of them have stressed upon 'time' and 'space', and 'socio-economic' implications of 'push' and 'pull' factors of migration. Considering the socio-economic consequences of migration, a new definition emerges which should also include the dimensions of health and well-being.

'Migration is also defined as a movement from one place to another permanently or semi-permanently leading to cultural diffusion and social integration' (Black et al., 2011). However, in this definition also the very term 'social integration' is contested as how 'social integration' could be possible in multicultural societies like India for maintaining health and well-being of many newcomers or migrants in cities. It is only to accommodate and recognize the 'difference' between the 'newcomer' and 'host' for maintaining 'social well-being', which is one of the components of classic definition of 'health' by WHO.

3. The Determinants of Migration

The decision to migrate to urban centers have many contributing factors which include the dynamic changing of today's globalizing and urbanizing cities with their better amenities, new technologies, labor markets, competing educational institutions, competitive coaching centers, employment status, earnings, accumulated skills, skills development, health care facilities, career, marriage, age, sex, unemployment, underemployment, indebtedness, corruption etc., (Greenwood,1971; Oberai et al.,1989; Rosenzweig and Stark, 1989. ;Banerjee, 1991; Priya, 2000 and Chandra, 2012). According to an independent study, the determinants of out-migration of young

population especially from the state like Manipur are due to 'Unemployment' and 'Corruption' in recruitment for government jobs. At present, the registered unemployed in the state, whose literacy rate at 79.85 percent, which is higher than the national average of 74.04 percent, was 7, 49,935 by the end of February 2016 (Northeast Today, 2016). In today's rapidly globalizing and urbanizing cities of the world 'the model of life-cycle location choice helps for migrants for their out-migration periodicity, locational choice, and family considerations'(Greenwood 1985:528). In India, National Sample Survey Organization (NSSO) has been collecting data on "reasons for migration" in those rounds where data on internal migration were collected, particularly in the 14th, 18th, 38th, and 49th rounds. The "reasons of migration" have been divided into two groups; Voluntary and Sequential.

Voluntary reasons are those wherein migrating persons exercise their own discretion in deciding whether to migrate or not, and if decided in a positive way, what should be the destination. Whereas, in sequential reasons, there is some element of contractual or customary obligation and suggestion of other compelling circumstances. Voluntary reasons are basically employment, business, or studies, which have generally been dominant in male migration decisions while sequential factors are generally responsible decisions of females to migrate (Visaria & Gumber 1990:11). In the Indian Census data on "reasons for migration" for all migrants were collected for the first time in the 1981 census, which classified them into five; Employment, Education, Family moved (associational)[4], Marriage, and Others. The data are available according to the four migrations streams-rural- to-rural, rural-to-urban, urban-to-rural and urban-to-urban and by intra-district, inter-district, and inter-state movement and also cross-border migration from the place of last residence as also by the duration of residence at the place of enumeration.

4. Northeast Migration to Delhi

The present day pull factors of migration from North East Indian States to other Indian cities are due to the transformation of Indian cities as global cities characterize by structural forces such as global economy and new emergence of middle classes accommodating cheap labors at the labor markets and good educational institutions and competent coaching centers for competitive examinations and the push factors due to heavy militarization through the imposition of AFSPA, economic underdevelopment, lack of job opportunities, less number of good educational institutions both vocational and professionals (NESC &H 2011; McDuie-Ra, D. (2012) and Remesh 2012). In a research study conducted by NESC&H, (2011) over 314,850 populations migrated from North East India to other mega cities in search of higher studies and employment during 2005 to 2009. Migration growth rate from 2008 to 2009 is 13.62% and at this rate, approximate number of people migrated in 2010 is close to 100,000 populations, numbering total population over 414,850, which is 12 times higher in last six years. Delhi is the choicest destiny with over 200,000 North East Indian populations, which is 48.21%. The study reported that out of total migrants, around 85% numbering 275,250 migrants for higher education while 15% numbering 139,600 for jobs in government and private sectors. For example, the unemployment situation in Manipur is alarming. According to a reliable source, the registered unemployed in the state, whose literacy rate at 79.85 per cent is higher than the national average of 74.04 percent, was 7, 49,935 by the end of February, 2016 (The Times of India, 2016).

The discourse on out-migration from North East Region

4 Associational migration is defined as the migration of dependent persons consequent upon the migration of the principal bread-winner.

to NCTD is most recent one and is associated with 'racial discrimination', 'better educational pursuits', and to improve socio-economic well-being as the literature review has shown it. A large out-migration of North East young population to other mega cities of India for higher education and employment in last one decade has been reported in this connection (NESC&H, 2011; McDuie-Ra, 2012 and Remesh, 2012). It is very obvious that the place of origin of North Eastern Region is facing serious problems such as armed conflicts, ethnic violence, militarization, unequal distribution of development, lack of infrastructure, less opportunities for jobs and higher education both professional and vocational which is known as 'underdevelopment' in the development discourses (Fernandes,1999 and Madhab, 1999).

5. Migration and Determinants of Health and Well-being

Migrants encounter many problems as they arrive at their temporary new environment such as loss of cultural support systems, psychological detachments, economic hardships and potential discrimination and hostility from the natives (Berry, 1997). Their problems are also due to so much cultural differences from the host population that many myths regarding their belief and habits emerge. Thus, the stage is set for an uncomfortable encounter between migrants and their New neighbors (Patel, 1980). Park and Burgess (1921) have put forward the thesis of race & relation cycles, which asserts that migrants pass through a cycle of contact, competition, conflict, accommodation and assimilation and finally they merge into the receiving group.

The most vulnerable groups among migrants are disabled people, children, the elderly, widows and other young women who attempt to bring up their children about the support of a partner (Bollini & Siem, 1995). Single, divorced and widowed women are at a greater disadvantage, lack of education, poor job skills, higher incidence of depression and increased vulnerability by virtue of their gender differentiation (Wilson, 2012). They have to face a new hostile environment, and the lack of protective and caring support, which is often a leading cause of major physical and psychological problems (Berry, 1997). Ensuring the survival protection and healthy development of these populations is an everyday challenge (Djeddah, 1995). Physical and psychological violence rates are high among the health risks faced by migrants. Wide scale rape in Bosnia and Rwanda perceived as a war crime that had brought to world attention on reproductive health as a fundamental part of the basic human rights of women and girls (Newman, 2004). In India, Northeast tribes and communities who belong to Mongoloid stock is not an exceptional as there are many cases of rape and murdered by armed forces in India, and also in the mainland India (McDuie-Ra, 2012; Sanajaoba 2014 and NESC &H, 2011). The consequences of sexual violence include special health problems posed by the risks of sexually transmitted diseases, HIV *I* AIDS, unwanted pregnancies, unsafe abortion, post traumatic stress syndrome & social criticism (Djeddah, 1995).According to Bollini and Siem (1995) several reasons explained the lower health status of migrants' out- groups in receiving new environment. They often have inadequate access to health care, the most obvious obstacles being linguistic barrier, cultural and economic barriers. Many face racism and discrimination within the health system, which in turn reduces their use of health services. Finally some groups may also have reduced entitlements to services because of their legal status in the receiving destination; the extreme situation is that of irregular migrants who have no access to any preventive or curative services apart from emergency care (Zhou, 1997).

Any discussion on the 'health status' of the ethnic minority migrants, raise an obvious question, "Do

ethnic minority Migrants have a different health status than the dominant host population?" Several empirical studies have shown that that the 'health status' of one individual to another, one population to another, and even within the same population is different due to several determining factors such as age, sex, ethnicity, race, social disadvantages, language barriers, discrimination, differential quality of life, change in lifestyles, lack of social protections, differential income levels, socio-economic inequalities, lack of quality of health care provisioning and health care providers cultural insensitivities, perceptions of health and illness and types of health seeking behavior, unaffordability and unavailability of modern day human basic amenities, and physical and social environment conditionings (Hunt et al., 1981; Patrick and Erickson, 1993; Adler et al., 1994; Wilson and Cleary, 1995; Johansson and Sundquist, 1999; Krieger, 2001; Gee, 2002; Kaplan and Baron-Epel, 2003). These determining factors affecting health and wellbeing of ethnic minority migrants have serious concerned for public health in Indian subcontinent as well. The health statuses of ethnic minority migrants both national and international are subject to various types of diseases, illness and ill-being both from their sending and receiving destination. There are few empirical studies of the 'health status of ethnic minority migrants' and found in their studies that these migrants have higher rates of diseases, illness and ill-being than the dominant host population (Foxman et al., 1984; Vega et al., 1987; Rogler et al., 1991; Pinquart and Sörensen, 2000; Ponce et al., 2006; Hoyez et al., 2016). Migration in this context thus has both negative as well as positive aspects. The health status of these migrants could also be improved due to their effective coping mechanisms, availabilities of many options of medical facilities and at the same time they may also run out of pocket expenditures. However, 'health status' of an individual or population keeps on changing owing to various determining factors including personal, physical, social environments' conditionings and political decisions and thus there has not yet been a consensus parameters for health status but keeps on working for it through the parameters of wellbeing both in developed and developing countries. Exploring the determinants, which determine the 'health and well-being of the marginalized migrants in their past, present and future aspirations and hopes would be a meaningful study. As health is dependent on the various determining factors, the health status of anybody is decided by these major contributing determinants i.e., the physical, social environment they live in, working conditions, their socio-economic status, their perceptions of diseases, illness and wellbeing, resort patterns, political decisions, and availability and affordability of health care and accessibilities of basics human needs (Mehrotra, 2000). Thus, the context of 'health status' seems to have varying degree of determinants and accordingly have classified into two categories i.e., 'good health status' and 'poor health status'. In the context of certain construction workers the determinants of 'poor health statuses' would be interrelated with 'labour and diet', 'poor physical environment' and 'a stressful life owing to migration' (Mehrotra 2000:367). Evans and Baldwin (1987) have concluded that all migrants encounter health risk in their new environment destination. Colledge, Van Genus and S. Vensson (1986) in their book entitled 'Migration and Health : towards an understanding of the health care needs of ethnic minorities' have concluded the need for research policy to be redirected towards migrants perceptions of their health focusing on language and cultural barriers rather than race differences. Migration is a process of displacement, stress and loss in time and space (Bhugra, 2004). The migration process of pre-migration, migration and post-migration may cause several multiple determinants of stresses that affect the 'physical', 'mental', 'social' and 'spiritual' well-being of individuals (Bhugra, 2004 and Odegaard,

1932). The determinants that migrants are affected in the whole process of migration might be lack of social support system, changes in identity, concept about self and adjustment in the new culture. These factors play an important role for health and well-being among the migrants in their new destination (Bhugra and Ayonrinde, 2004). In different studies of migration show that migrants face positive life satisfaction as well as self-esteem negatively. In such situation, coping with cultural changes and adaptation to new circumstances may lower the levels of life satisfaction and quality (Gun and Bayraktar, 2008).

6. Dimensions of Othering Ethnicity and Race

In the multicultural city like Delhi, Northeast migrants who have the same citizenship rights under the Constitution of India but different in ethnic physical look because of Mongoloid physical features with different cultures and food habits have been reported to have faced 'racial abuse', 'multiple physical attacks' , and 'sexual assaults' in the National Capital Territory Delhi and NCR (NESC &H, 2011). Most Northeast migrants not only face racist attitudes and negative stereotypes but experiences in their daily activities in Delhi and NCR which directly or indirectly affect their health and well-being (Reachout Delhi-NCR Discrimination Survey, 2014). The most recent 'multiple physical attacks' on a 30-year-old man from Manipur in front of a woman friend in NCR-Gurgaon has been reported and he had suffered serious injurious and received 15 stitches on his head (NESC& H and the Indian Express, 2015). Such atrocities against Northeast Migrants in Delhi and NCR have caused insecure and vulnerable for the Northeast migrants living in the city and there is also a question of social marginalization and exclusion of identity as an Indian citizen in the mainland. This is more visible on the streets of parliament with the slogan 'We are Indians and not outsiders and foreigners' with the written pamphlets on their hands whenever North East Citizens are attacked in the city. It always shocks on the emotional and psychological well-being of the Northeast migrants living in different parts of the country (Singh, 2015).

International and Inter-state migration has brought formerly isolated ethno-cultural groups into contact with other social group members. In our fast changing human society, migration, urbanization, and globalization during the last few decades have given rise serious issues in the new destination environment (Sikri, 2009). One such crucial atrocities against the Northeast people, is reported to be 'racial discrimination' and 'physical attacks' in various parts of the country, particularly in National Capital Territory Delhi (NCTD) and adjoining National Capital Region (NCR) (Tausch, 2015 ; NESC &H, 2011 and Reach out Delhi-NCR Discrimination Survey, 2014). It is a heinous crime against humanity and dignity and is one of the outcomes of socio-political and economic disparities besides deeply entrenched mindsets of caste and race in past and contemporary modern Indian society (Ghurye, 1985). Understanding the nature of problems faced by North East Indian in their destination requires understanding certain terminology. This is because curing a 'disease', 'illness' or 'sickness' needs clear identification of the pathogenic agent both in physical and social environments. The concept of 'ethnicity' always revolves around the collective identity. It is derived from the ancient Greek word 'ethnos' connoting 'a range of situations in which a sense of collectivity of humans lived and acted together and which is typically translated today as 'people' or 'nation' (Jenkins, 1994).

Relationship between race and ethnicity is complex. The genesis of the term race are traced to Latin words such as 'generatio', 'ratio', 'natio', which is from the

latin word, meaning nation, people or tribe, and 'radix' to Spanish and Castilian 'razza', and old French 'haraz' with such diverse meanings as 'generation', 'root', 'nobility of blood', 'patch of threadbare' (Sollors, 1996). The term 'race' has been in popular use much before 'ethnicity' was adapted in popular and academic vocabulary. Race came into scientific academic parlance as a classificatory feature. In this regard, physical anthropologists used 'physical features' to classify what some may describes as 'human types'. Nevertheless, man's lust to conquer his fellow beings and 'subordinate' them resulted in tremendous 'abuse' of these so called classificatory studies that were prompted to facilitate scientific research (Anderson,1988). Magnus Hirschfeld and Paul in 1938 described 'racial abuse' as 'racism'. The genocide that was unleashed in World War II in the name of protection of 'purity of races' made academicians and politicians equally shy of using it in public domain (Tatz, 2003). The concept of 'ethnic group' introduced in the mid fifty's was an acknowledged attempt to provide a neutral system of classifying 'human groups' on the basis of 'cultural differences' rather than distinguishing them on the basis of 'racial characteristic' (Barth, 1998). It was argued that the terminology of 'ethnic group' would provide a value neutral construct and avoid prejudiced and stereotypical categorization of people in hierarchical and discriminatory categories (Van den Berghe, 1978 and Smedley & Smedley, 2005) Many scholars believed in the usefulness of this distinction but others thought there was hardly any merit in this distinction as 'race' is only one of the markers through which 'ethnic differences' are validated and 'ethnic boundary markers' established (Connor,1978 and Barth,1998). Those authors supporting the expediency of making this distinction would argue that 'ethnic social relations are no necessarily hierarchical and conflictual, albeit 'race relations' would certainly appear to be so (Barth, 1998). When 'race' is constructed and conceived in terms of 'physical' or 'phenotypical differences', prejudices and stereotypes accompanying this perception are socially articulated and perceived (Lopez, 1994). In this sense, many would argue that race is an allotrope of ethnicity (Spencer, 2014). Jenkins (1994) prefers to argue the other way suggesting that 'ethnicity' and 'race' are different kinds of concepts. Banton (1967:10) has argued that primary difference between 'race' and 'ethnic group' is that 'membership' in an 'ethnic group' is 'voluntary' whereas 'membership' in a 'racial group' is 'not' and this would imply that 'an ethnic group' is all about 'inclusion' whereas 'race' is all about 'exclusion'. In this theory, one ethnic group may willingly join another large or small ethnic group to strengthen the ethnic power relation. In this connection, the Northeast ethnic groups' consciousness and expansion of identity by merging together several ethnic groups to form pan Naga Nationalism is an example of its inclusion (Shimray, 2004). In case of racial group theory exclusion is always the mandatory point; racial assimilation through inter-marriage ties erupt diverse racial groups (Bates, 1995). Though, there have been some study on racial mixing in the past as Risley in Bates (1995) discussed about seven types of racial formation, the present Hindu hierarchical society clearly indicates that racial assimilation through inter-marriage is out of the caste system because there is always a mindset among the Hindus because of the very notion of 'purity and pollution' and the caste system is regulated through the customary laws of endogamy. Child marriage system was one of the means to prohibit inter-caste marriage among the Hindus (Ghurye, 1969). Nevertheless, "there is a form of institutionalized inter-marriage called hypergamy, where the upper caste men may marry women of a lower caste group, but not vice versa" (Davis 1941:381). Srinivas also clearly writes that "caste system is hereditary, endogamous having

localized group with a traditional association with an occupation and a particular social position in the local hierarchy of caste ladder. Relations among castes are governed through the concepts of pollution and purity and maximum commensality occurs in the caste. A caste is generally segmented into several other sub-castes and each sub-caste is endogamous in nature" (1994:13). The concept of hierarchical difference in the caste system is not synonymous with the concept of social stratification and the latter is ubiquitous in nature and is based on age, sex, birth, race, residence, achievement and appearance (Davis, 1941). Thus, inclusion of ethnic tribes in the caste hierarchy is out of the place. Even among the caste system the practices of 'othering' are still perpetuating based on their respective caste orders (Ghurye, 1969). This means that we are once again returning to the dominant theory of 'us' versus 'them', which is critical to our understanding to 'ethnicity' as well as 'race' but as perceived by Jenkins would argue 'ethnicity' is about 'group identification' whereas 'race' is about 'social categorisation' (Jenkins, 1994).

Pierre L.Van den Berghe (1978) is the one who offers systematic interpretations of differences between 'race' and 'ethnicity'. Berghe's much acclaimed work 'Race and Racism' written in 1996 suggests that four principal connotations of 'race' make it confusing. At the outset he rejects 'physical anthropological construction of three or four races arguing that this outdated connotation is no longer 'tenable'. The second connotation of 'race' that he prefers to be used in terms of 'ethnic group' is when we speak of the 'French race' or the 'Jewish race' etc. The third explanation argues race to be a synonym of 'species'. It is only the fourth construction offered by Berghe that he recommends we should use. According to this view:

> *"Race refers to human groups that define itself or is defined by other groups as different from other groups by virtue of innate and immutable physical characteristics and societies that put emphasis on biological traits to differentiate groups within it can be called racist" (Van den Berghe 1987: 29).*

Thus, sociological conceptions of 'race' take specific note of 'visible' and 'physical as suggested by Gordon or as described by Berghe that of 'innate' and 'immutable' distinctions from those described as 'cultural'. Hutchinson and Smith (1996) defined "Ethnicity as the feeling of kinship, group solidarity and common culture". While the anthropologist Eriksen (1993) defined, "Ethnicity as an issue of the relationship between at least two groups, with a conception of cultural differences between these two groups". More specifically, the group shares attributes of the membership regarding racial, territorial, economic, religious, cultural and linguistic uniqueness. Ethnic identity is essentially subjective, a sense of belonging and an ultimate loyalty (De Vos, 1982)

Identity is the individual self-conception (Romanucci-Ross, 1982) and the interaction between the individual and his surroundings (Jenkins, 1996). All identity aspects are social and are created in social interaction with the surroundings (Jenkins, 1996). Ethnic identity is an expression of ethnicity. Identity, ethnicity and culture are ongoing process of social interaction (Jenkins, 1996 and Hannerz, 1996)

The debate around 'race' and 'racism' are prominent among western scholars and it has been the subject of most extensive research, especially in social psychology. Our social relationship is affected by the notion of 'race', 'racism' and its relations (Bobo & Fox, 2003). Racism and discrimination have long-standing and pervasive effects on African Americans in every domain of life including health, education, housing,

politics, physical and psychological well-being (Braveman, 2011). These cases are not exceptional in a diversity country like India. Dalits are the most sufferers because of Hindu religious social order of caste system and untouchability (Thorat, 2004). The four major types of challenging discriminations which have extremely violated human rights and dignity that different ethnic groups and minorities including women face in our contemporary society are caste based discrimination, race based discrimination, gender discrimination and religious discrimination (Kishor, 1993; Thorat, 2004; NESC&H, 2011 and Thorat & Attewell, 2007). This is because the dominant minds of Hindu culture are based on the 'complete cultural assimilation' and 'cultural genocide' (Akmam, 2002).

Nonetheless, after a series of physical attacks on North East Indian citizens more particularly after the unfortunate tragic murdered of Nido Tania in Lajpat Nagar in the National Capital Delhi, the debate about 'racism' burst out in the national leading media and popular channels (Ngaihte, 2014; Ngaihte & Hanghal, 2015; McDuie-Ra, 2015 & Bhanjdeo, 2015). Since then, the challenging questions of 'identity', 'citizenship', 'integration of North East Region' and its people and culture to 'mainland' India have been the main discourses on popular channel such as 'the Big Fight: Are Indian Racist?'[5] Another 'pathetic mindset towards the Northeastern people is clearly seen when the Delhi Police officer told one of the students who were arrested on serious charges of sedition not to move without permission because the 'chinkis' do not understand hindi and they eat humans'(Northeast Today, 2016). Such types of casteist and racist mindsets have long been deeply entrenched in the dominant social group and in this regard Ghurye (1969) study succinctly brought out the very intolerable characteristics of caste and race in India in past and contemporary Indian society. Ironical to this type of allegation against Northeast people, is the fact that they have been participating in nation building in many challenging fields such as games and sports, serving in Indian army, in educational sectors, hospitality and Service sectors, Information Technology, Films, Medical sciences, Folk Medicine and healing practices, organic farming, Folk Dance and literature, human rights activists etc. The continuity of the depiction of the bad images of the region succinctly shows that the region and its diverse ethnic people and their rich cultural practices are not democratically integrated in the mainstream India.

7. Violence against the North East People

Most of the Northeast migrants are young energetic and vibrant with high aspiration. However, their aspiration and hope for the betterment of future has been shattered as most of the migrants have encountered 'racial discrimination' in their newly receiving environment. According to NESC &H (2011) research reported that crimes against Northeast girls are very high followed by beating boys. Out of the total 96 cases, 35 cases were of molestation, 4 raped, 7 beating girls, 8 girls trafficking, 2 attempt rape, 25 beating boys, 5 murder, 6 non -payment of salary, 2 rent non refund, 1 media bias, 1 missing. Out of these 96 cases of crimes against Northeast migrants, only 35 crimes were registered

5 The Big Fight: Are Indians Racist? www.ndtv.com/.../the-big-fight-are-indians-racist/308737. This debate is about racism in India which was published on February 8, 2014, duration 46 min, 44 sec on NDTV as an anti-outsider campaigns based on stereotyping just after the tragic murdered of Nido Taniam in Lajpat Nagar, a student from Arunachal Pradesh. The participants were BJP leader Subramanian Swamy, noted columnist Namita Bhandare, Rahul Narvekar of the Shiv Sena, writer-activist Binalakshmi Nepram, Professor Madhav Nalapat of Manipal University, journalist and author Samrat Choudhury and Leki Thungon of the Delhi School of Economics [Accessed on 8 December 2015].

as First Time Report (FIR) and 61 cases were not registered as FIR. The reasons behind this huge number of unregister FIR cases might be the reason of Delhi Police apathy or unwilling to risk life in the city as most Northeast migrants do not have a proper social and legal support here in Delhi. As per NESC & H (2011) findings of the state wise report of racial discrimination victims, Manipur stood the highest number of victims 41 followed by Assam 15, 11 Nagaland, 7 Mizoram, 5 Meghalaya, 3 Arunachal Pradesh and 2 Sikkim respectively. NESC&H, (2011) findings suggested that the root cause of racial attack, discrimination and sexual violence against North East Migrants living in Delhi and NCR is owing to 'social profiling'. The racial attacks in 2005-2008 were 34, 49 in 2009, 16 in 2010 and 7 in 2011. The rising number of attacks in 2009 might be owing to the lack of proactive and preventive measures taken by Delhi Police.

Reach out Foundation (2014) suggested that 63% discrimination were due to 'prejudice and lack of understanding' about North East Migrants in Delhi, 13% 'indifference', 20% 'lack of interaction'. The findings further suggested that 'racial discrimination' is higher than religion and gender discrimination against North East Migrants. By educational background, the most victims of discrimination were reported from undergraduate 50% followed by postgraduate 40% and by profession it was also reported from students 60% and working in private sectors 16% respectively.

According to the narrative of a young boy[6] of about 29 years working in an IT Solution in Udyog Vihar Phase-2 Gurugram, he was accused of data theft. He joined the company as a quality auditor 45 days back.

The incident took place on the 13th January, 2017 when the management authority hired four bouncers as an act of pre-plan for tackling a 2 crore loss on company revenue due to charge back received. The same day I was working as usual like any other days. However, I was kicked, thrashed with belts, walking sticks, baseball bat, and punched many times and even paraded me naked and poured cold water and beaten me blue and black in the third degree torture until I fainted due to my injuries and wounds. Even when I was taken to the local hospital they insisted me to report to the Doctor as if I fell down from the staircase. Thereafter, they dropped me up to my room.

The victim of such inhumane beating and 'paraded naked' has reduced the dignity of a personhood as a human. From public health perspective, the physical injuries, the emotional injuries, and psychological injuries have not only affected the health and well-being of the victim but it also creates ill-being at the societal level among the migrant communities. The life of migrants in the Capital Delhi and NCR is at high risk including physical assault, molestation rape, and mental harassment. The pertaining question is that where is the safety for migrants in the Capital Delhi and NCR? Migration is increasingly becoming a social determinant of health especially for minority migrant social groups from the North Eastern Region of India owing to their difference physical appearance, ethnicity, language, and food habits (McDuie-Ra, 2015).

8. Understanding Migration as Social Determinants of Health

The conceptual framework of Social determinants of health is the conditions in which people are born; grow up, live, work and age (Commission on Social

6 This statement was given by the victim. Please see the Indian Express report on 2017 January 20 in the reference section.

Determinants of Health, 2008). Various forces such as political, social, and economic are responsible to have shaped these conditions. The following Fig 1 shows various layers of determinants that determine the health of a person such as age, sex, life style factors, social and community influences, living and working conditions, general socio-economic, cultural, and environmental conditions. These determining factors have implications for migrants in their new destination. The process of migration thus addresses the state of physical, mental and social well-being of migrants. Most of the literatures including the Bezbaruah Committee Report suggested that Northeast migrants felt and experienced the structural inequalities which have a significant impact on their everyday life including health and well-being. The unequal distribution of wealth, money, resources and development are intrinsically linked with the broader unequal distribution of social determinants of health. Northeast migrants include students, workers in public and private sectors in different occupations, and healthcare treatments seekers and these groups facedifferent health challenges at different levels in their course of lives during their stay in Delhi.

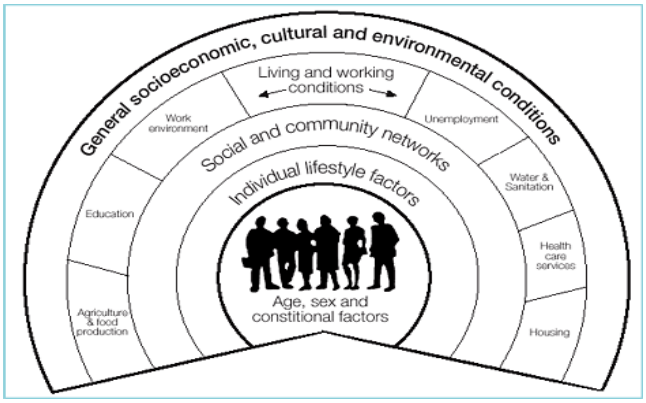

Fig 1: Social Determinants of Health adapted from International Organization for Migration (IOM)

9. Conclusion

Migrant populations are exposed to specific determinants of health and well-being. As defined by WHO, 'health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity'. This classic definition of health by WHO has a lot of implications for migrants in general and particularly northeast migrants living in National Capital Territory Delhi and other parts of Indian cities. It is also learnt from the literature that migrants access to public health and social services are hindered by the lack of legal documents and other determining factors. The health of migrants can be considered as a human rights and social equity agenda. In a right based framework the health of migrants could be addressed through the daily living conditions, working conditions, fair employment and decent work, social protect across the life course, social and legal support systems, health equity programs, development, and planning, gender equity irrespective of caste, creed color and race, and good governance etc.

As reported from the literature migration can be considered as social determinants of health and well-being for the minority ethnic migrants. As most of the cases of northeast migrant issues deal with physical assaults with severe beating, crimes against the northeast young girls including molestation, rape even murdered, trafficking, trust deficits, lack of proper social and legal supports. All these determining factors are broadly linked with the social determinants of health and well-being. While framing policy and planning for migrants especially for the Northeast migrants living in National Capital Territory Delhi, NCR, and other parts of Indian cities, multisectoral partnerships are necessary for social and legal supports for the victim survivors of the Northeast Migrants. It will enhance the development and implementation strategies in minimizing stigmatization, social exclusion, discrimination, and marginalization of migrant populations. Above all, offering language, cultural and other sensitive services

will ensure inclusion of marginalized migrants in the mainstream. The policy should also be concerned in view of the reports of the Bezbaruah Committee Report, 2014, Northeast NGOs, Civil Society reports, students bodies, Northeast lawyers and other bodies working for the welfare and safety of the Northeast communities living in Delhi and other parts of the country.

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