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PREFACE

Dear Readers and well wishers,

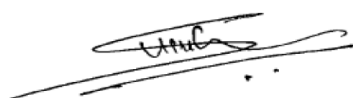
ICSW is in its pinnacle of its engagements in promoting global social policies for social protection, social welfare and social development. ICSW on completing 90 years of relentless work in the field of global social policy, its South Asia regional committee considers that inequalities among communities, welfare deficits among and invisibilisation of certain social groups such as gender minorities and migrant workers poses critical challenges for achieving SDGs. Maternal mortality too remains a serious challenge in the days to come for a better gender sensitive and inclusive society. Considering these, the current issue of Regional Cooperation Newsletter presents some interesting approaches and way forward towards our collective endeavour in promoting sustainable and inclusive communities.

Gayathri Krishna's special article on "The complexities of realising transgender identity in South Asia" presents a compelling description of current policies for protection of transgender rights in the region. The need to locate the gender rights and advocate for an inclusive approach for the community in the gender continuum is emphasised through her arguments. The policies adopted by the south Indian state of Kerala through a consultative approach and through field research is highlighted as a potential direction in which social and political rights of gender minorities can be ensured by the state. This discussion is particularly important in highlighting the need for enlarging social protection for the community which is otherwise missed in global social protection debates.

Abid Faheem in his commentary on "Verbal Autopsy as a tool for generating evidence on Maternal Death" provides a methodological framework for understanding and analysing maternal mortality. While enumeration of maternal death is complicated by lack of access and poor reporting mechanisms, particularly in developing world, the reasons and contributing factors to it remain elusive due to lack of a proper methodological approach. Using the study conducted in an Indian state of Bihar, verbal autopsy is presented to give first hand evidence on the factors leading to maternal death. Achieving the SDG target of reducing global maternal mortality ratio to less than 70 per 100,000 live births by 2030 is possible only if such a critical realistic analysis is done. Faheem's study paves some way forward.

While analysing another set of excluded group of migrant domestic workers and their vulnerability in their workplace Aswathy Krishna presents through her commentary on "Traumatic Journey of Asian Migrants to GCC" highlight the lack of decent work and humane conditions for them. Taking care of a variety of tasks such as cleaning, cooing, taking care of older people and even children and so on, the workers views and challenges are not expressed to the public, neither it is discussed with the authorities or it is visible in the media. She emphasise that the protection of the migrant workers need to be analyzed, interpreted, implemented and properly enforced through a human rights framework.

I am sure these very insightful articles provide some useful frameworks and action trajectories for ICSW and other actors in the development sector.



P.K. Shajahan PhD
Regional President (South Asia) and Editor

SPECIAL ARTICLE

THE COMPLEXITIES OF REALISING TRANSGENDER IDENTITY

IN SOUTH ASIA

Gayathri Krishna

Abstract

The transgender community in South Asia has been fighting for their legal and political rights for more than two decades now. Their enduring struggle have resulted in progressive judgements in favour of them in some of the countries, while they continue to challenge the draconian laws in some other. The unrecognition of transgender as another gender through relevant policies or statutes have huge implications on their day to day lives- in accessing public facilities, applying for jobs, accessing health care facilities, marriage, adoption, coverage of social policy, protection against violence and moreover results in a significant breach on the fundamental rights of the transgender individuals. The article tries to understand these complexities faced by transgenders which are an essential requirement for framing policies.

Introduction

Transgender is an umbrella term to refer to individuals whose expression of gender is different from the sex assigned to them at the time of birth (Levitt & Ippolito, 2014). The diverse sub-groups in this group are people who identify themselves as *transwoman* (MTF- transitioning from Male to Female), *transman* (FTM- transitioning from Female to Male), *transsexuals*- securing surgery and/or hormones, *gender queer*- not identifying with ‘male’ or ‘female’ and many others (Singh, Hays, & Watson, 2011). In short, a transgender person does not conform to the societal norms of binary gender. Generally, deviation from traditional socialisations of gender- man and woman are frowned upon, confronted and stigmatised in our society. The evidence from history and mythological transcripts, especially in the context of South Asia, point out that transgenders have been challenging the concept of binaries and celebrating gender continuums for centuries. Yet, the stigma faced by

transgender identities in the society proves why a “normal” life is still an aspiration for transgender individuals.

It can be understood from the mythological books, manuscripts and historical renditions that transgenders used to enjoy a significant role in the society. According to Taparia (2011), the presence of “eunuchs” (meaning castrated men, now used derogatorily) as slaves, brought by the masters to contribute to the labour force to build the empire, in India can be traced back to the time of Delhi sultanate i.e. the thirteenth century. The self identified transgenders who are organised into communities are known by the urdu/hindi name *hijra* and is a word used generally in South Asia to identify a transgender. It is the royal patronage that institutionalised hijras as third gender; the evolution of an inhumane act of castration that was forced upon vulnerable and young males to create eunuch slaves later combined with religious underpinnings came to be practised as a ritual by the

hijras (Taparia, 2011). There are both Hindu and Muslim lineages amongst *hijras* and they have over the years developed a social system which is organised into guru-cela (teacher-disciple) relationship and worship particular goddess, follow rituals and so on. Their traditional livelihood was to dance at various auspicious functions including marriages and birth of a child and beg for alms after offering blessings as they are believed to have powers to bless or curse according to the Hindu myths. The *hijra* identity was given a new dimension of caste or tribe with the coming of the British as part of ‘the systemisation of diverse forms of social identity in India’ (as argued by Nicholas Dirks) (Dutta 2012). The colonial rules have had an important role to play in ostracising the transgender communities. As Sood (2010) suggests, fear of sexual immorality of few castes or communities forced the colonial state to criminalise certain tribes and enact anti-sodomy laws in the colonies, especially in Asia. While section 377 of the Indian Penal Code condemned “carnal intercourse” and suppressed the sexual expression of ‘non-traditional’ genders (Levitt & Ippolito, 2014), labelling the “eunuchs” as criminal tribes who kidnap and castrate children (Criminal Tribes Act, Part II, 1871) wiped them away from the mainstream.

With the 1990s came the pandemic of AIDS that raised alarms across the world and the government and the health department of the countries took immediate measures to raise awareness about AIDS amongst the public. International NGOs and civil society institutions worked with the vulnerable communities such as sex workers to raise

awareness. The spotlight shifted to Men having Sex with Men (MSM) amongst the sex workers as an extremely vulnerable group and the denial of their basic rights, including the right to self identify their sexuality or gender is brought to the forefront for discussion. In spite of having visible traditional transgender communities, very little has been documented or rather talked about their access to health, non-traditional livelihood or their living conditions in general. In the case of Indian sub-continent, Kole (2007) agrees that the AIDS epidemic and economic globalization of early 1990s influenced the queer mobilization and queer movement in some fundamental ways.

Policy Developments for Transgenders in South Asia

A society with heteronormative divisions of labour and power has been long accepted as “normal” that fluidity of gender (gender as a continuum) can seem threatening to the status quo and hierarchy established in the society. Men and women are socialised into performing their respective genders (see Butler, 1990) which aligns with the sex they are born into, while transgenders have no such parallel socialisation. Hence, they have to battle it out with themselves to come out as a transgender and realise their gender identity; with their family to accept their kinship rights and with the society to establish their socio-political and legal rights as an individual. This coming out process itself is stressful and so are the stages of transitioning. The high number of suicides in the transgender community itself testifies to their mental and physical struggle. The policy provides them a legal

and social protection in their journey.

The existing policies in the South Asian countries of India, Pakistan, Bangladesh and Malaysia retain the colonial laws that punishes carnal intercourse. The latest developments in some of the countries are as follows:

The Human Rights Watch reported that the lack of recognition of rights of transgenders and formal policy to protect them from harassment, violence in Bangladesh have created existential crisis for transgenders in the country in terms of bullying, harassment and exclusion from education, employment barriers, access to transition related healthcare, harassment and prejudice in family as well as public places. The article also tells that eventhough the Bangladesh government has taken measures to provide legal recognition to *hijras* as third gender, it has implementational hitches and it excludes transgenders, especially transmen who are not *hijras*. It also hints at the rising attack on the religious minorities in the country has double the danger on transgender individuals who belong to the minority religion.

In Malaysia, cross-dressing was banned under the Section 66 of Sharia law and a lower court on November 7, 2014 rejected the ban and thus affirming the rights of transgenders in the state. The lower court's ruling was overturned by the the Federal Court and it upheld Sharia laws prohibiting "a male person posing as a woman."

In India, the Supreme Court ruled in the National Legal Services Authority

(NALSA) v Union of India in 2014 that 'transgender' have to be recognised as a third gender and transgenders will be granted the fundamental rights under the Constitution of India. Transgenders also have the right to self identify their gender as male, female or transgender. As for the section 377 of the Indian Penal Code that punishes carnal intercourse, the Supreme Court bench upheld Right to Privacy and ruled that sexual orientation is an essential attribute of privacy and that only non consensual non vaginal- non penile intercourse would fall under the purview of Section 377. The state of Tamil Nadu has set up a Transgender Welfare Board in 2008 and preceded the discourse on transgender rights in the country. The state of Kerala unveiled a Transgender Policy in 2015 which upholds the rights of transgender individuals and also sets up a Transgender Justice Board. West Bengal also followed suit after the NALSA judgement.

Pakistan also passed the landmark Transgender Persons (Protection of Rights Act) that gives transgenders the access to legal, political and social rights and also the right to self identify their gender and protection against discrimination based on gender.

Transgender identity as a collective identity has multiple layers of stigma attached to it. As suggested by Beteille (2012), backwardness in India is an attribute of the community rather than an individual and hence is self-perpetuating. The members of "lower caste" in the caste system attempted to convert to other religion from Hinduism and choose livelihood outside their caste specific jobs to move out of their existing low social

status, and still could not escape the grips of oppression from members of “upper caste”. Parallels can be drawn from the caste hierarchy in India, as explained by Dumont, to the notions of gender binaries and its hierarchy that is entrenched in the societal life, with clear division of labour and other community practices which reinforce our gender identity with respect to the roles we carry out in our family and society. As he tries to contest in his book *Homo Hierarchicus: The Caste System and its Implication*, India emphasizes and reinvents the concept of “collective Man” (as cited in Reddy, 2006), through caste, where a system of hierarchy has been created in which people’s individual identity is overshadowed by the system where people are interdependent and work collectively because of the notion of ‘purity and pollution’. The underlying principle of this hierarchy based on division of labour is that the pure and impure occupations must be separated (Dumont, 1980). Livelihood is significant in determining the position of a community in the hierarchical structures, but traditional caste-like identities have more attributes to their identity than livelihood. Transgenders often have to strive harder to attain education, as they face discrimination and atrocities in schools, colleges and in public spaces and obtain a “worthy” livelihood to earn a better social status. Transcending the marginalities to move up the social ladder is a challenge for the transgenders like any other backward classes who have been carrying the baggage of years of oppression. Transgender communities also work towards positively valuing their identity and adopt measures to destigmatise it in their struggle for exercising their rights.

The case of Transgenders in Kerala, India

The *hijra* culture is the prominent transgender culture in the Indian sub-continent. However, the transgenders in Kerala are not organised into a community like hijras. They gained visibility lately. On asked by Union Ministry of Social Justice and Empowerment about the issues faced by transgenders in Kerala in 2013, Govt. of Kerala responded that “there are no officially identified transgenders in the state” (Report of the Expert Committee on the Issues Relating to Transgender Person, 2014). Realising and negotiating their gender identity as well as creating a space for expression of their identity within the state of Kerala has been difficult for them. Their perception of identity has been shaped by the influence of the prominent hijra culture (as some were part of the culture outside the state), their individual experiences of education, family, seeking livelihood, rights based organisations working for them and so on.

A qualitative study was conducted to understand the life journey of the transgenders who politically assert their identity as individuals in the state of Kerala.

The transgender population was acknowledged for the first time in 2014 through the Transgender Survey conducted by the Social Justice Department of Government of Kerala with the support of NGOs such as Sangama and the Sexual Minority Forum, Kerala (SMFK). More than 4000 transgenders provided responses for the survey. The interaction of an individual with the society happens through various spaces such as schools,

hospitals, service providing institutions, state mechanisms for law and order and so on. A person's identity becomes important at these interactional spaces. These social institutions are a microcosm of the society they are established in. The survey data shows that these transactional spaces that are laden with the biases of the society are not in favour of transgenders expressing their identity. According to the survey, 58% of transgender students dropped out of school before completing Grade 10 due to gender related negative experience and severe harassment from peers as well as teachers. Most of them also had negative home environment which added to their suffering. Fifty percent of the respondents were denied equal treatment in hospitals. The lack of coherent knowledge about sex and gender, unavailability of facilities in hospital to do hormone therapy or SRS add to the woes of treatment facilities for transgenders. Many of the transgenders recorded in their response that they rarely visited hospitals. All the respondents reported that they were denied jobs due to their gender expression. Seventy percent have hence not revealed their gender identity at their present work place and hence act their assigned gender. More than fifty percent of the respondents had a monthly income of less than Rs. 5000/- and only 11.6% transgenders have regular employment. Eighty nine percent of the respondents experienced stigma and harassment at work place and were mistreated. The institutions of law and order in the state have been abusive and irrational towards transgenders. More than half of the respondents faced violence and harassment from police. Ninety six percent of the transgenders do not raise complaints of harassment and abuse because of fear of police mechanisms.

The state unveiled a State Policy for Transgenders in Kerala in 2015 based on the outcome of the survey. The policy stressed that the effort was to stress the constitutional acceptance of transgenders and guaranteed their rights as individuals and also made sure that it was inclusive of, but not limiting to Female to Male, Male to Female and Intersex people and thus acknowledging the gender spectrum. It explained the broad framework within which the transgender considerations will be integrated into development interventions in Kerala. It also laid out a comprehensive results -based framework based on constitutional rights for transgenders which will guide all institutional stakeholders in designing their contribution for transgender justice.

The stages in realisation of transgender identity as understood through experiences of the respondents can be categorised broadly as **self-realisation** that they identify themselves differently from the assigned gender, then **seeking out** for different means of gender expression to comprehend their gender identity better, **becoming** phase where their gender expressions become stronger and they yearn for freedom of expression and become their true self- the desire to have a congruent mind and body is strong and hence are forced to stay away from familiar circumstances due to lack of acceptance in the family and society and **establishing** their gender identity and perform their desired gender in the place they choose to and want to. Another important stage in the realisation of their identity is **coming out**.

to come out of the binary definitions and expectations of their identity and state their non-conformity to micro (people

within direct contact- family, friends), and macro (society, culture, law, etc.) systems. It is a process and hence may happen at any of the above stages.

These stages play out differently in a closely knit community with a culture to follow and rituals to perform such as *hijras* as there are positive affirmations from community members and established ways of socialisation in the community. The transgenders in Kerala are keen on pitching their rights politically to strengthen the individual as well as collective transgender identity in the state. It is to be realised that a transgender policy which understand the nuances of their stages of life and the requirements and demands of the community only would do justice to the transgender individuals in that particular state.

Conclusion

The lack of policy protection for a community denies them an array of opportunities to break away from the shackles of indignity. Dhall and Boyce (2015), in their research finds that people who belong to non-normative gender and sexual identities are not acknowledged institutionally and hence face difficulties in accessing the social security schemes such as NREGA and various housing schemes for poor and destitute women, etc. They observe that a major drawback of these policies issued in interest of protecting the socio-economic interests of

common man often renders useless to transgender persons as they may not partake in common institutions such as family and marriage in a way perceived by the general society and cannot enlist themselves to the gender binaries offered. Unless supported by special order as in Legal Services Act, transgenders are not acknowledged for the schemes for poor and marginalised. The findings also pointed out that lack of knowledge of government officials about the Supreme Court order of 2004 has also been a hindrance in the policy seeing a positive outcome for the community. The Non-Governmental Organizations (NGO) and Community Based Organizations (CBO) have played an important role in bridging this gap between the social policies and their implementation in reality.

While transgenders are negotiating their way into the mainstream, it is important to notice that their visibility in the society has to be backed up by acceptance from the society. Legal recognition is an important step towards societal acceptance and so is de-stigmatising transgender identities through awareness amongst the public. It is also to be noted that when the social policies being drafted for transgenders are over-arching, inclusive and in consultation with the community, it would imbibe the spirit of transgenderism and would consider in full, the complexities of how transgenders realise their identity in the respective countries, be in a community or as individuals.

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COMMENTARY

VERBAL AUTOPSY AS A TOOL FOR GENERATING EVIDENCE ON MATERNAL DEATH

Abid Faheem

Introduction

In January 2018 a study on Maternal Death was conducted in Madhubani district of Bihar, India which is a part of Darbhanga Division. The study was conducted to understand the causes of maternal deaths and to find out the possible solutions for the issue. A total of 82 maternal deaths occurred during this period, out of which 52 family members were interviewed. The district occupies an area of 3,501 km² and has a population of 44,873,799 (Census 2011). The district has a sex ratio of 925 females for every 1000 males, and a literacy rate of 48.3% for female and 72.53% for male (Census 2011).

Maternal death means, “*The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration or site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes*” (International Classification of Death (ICD) 10, World Health Organization). The most common cause of maternal death is PPH (Post-Partum Haemorrhage) which is 35%. Apart from that, other causes of maternal deaths include Hypertension 18%, Abortion 9%, Sepsis 8% other direct causes 12% and indirect causes are 18% (WHO, 2015). In India, 167 maternal deaths occur over 1,00,000 births in a year while 208 in Bihar (SRS, 2013). Also, 50.3% pregnant women between 15-49 age group are anemic which are 58.3% in

Bihar and in Madhubani 54%. Ante-natal check-up in 1st trimester in India is 58.6%, in Bihar 34.6% and in Madhubani 27.3% (NFHS 4, 2015-16).

The Three Delay Model:

Delay 1- Decision to access care – The first delay occurs due to lack of proper decision to seek care by the patient or his/her family. Socio-economic and cultural factors have a great impact on decision making to seek care (Calvello, Skog, Tenner, & Wallis, 2015). **Delay 2 – Identification of transportation** – The 2nd delay occurs when the patient or his/her family couldn't identify proper facility of transportation to reach facility for care (Calvello, Skog, Tenner, & Wallis, 2015). **Delay 3 – Receipt of adequate and appropriate treatment** – The 3rd and final delay occurs when the facility is not in a position to provide adequate and appropriate treatment to the patient. Here at this position patient is ready to seek care but the facility couldn't able to provide that. Thus, accessibility of facilities and quality of care is responsible for this delay (Calvello, Skog, Tenner, & Wallis, 2015).

This three-delay model illustrates that maternal mortality is not due solely to a lack of economic and human resources but was a product of numerous interwoven factors. A poor patient outcome is likely to result if any of these factors contribute to an undue delay. For example, in the ability to recognize an emergency may extend the

delay in the decision to seek care. While the ability of the patient or a caregiver to recognize an emergency is partially dependent upon the patient’s or caregiver’s level of education, studies have shown that true obstetric emergencies may not be perceived as emergencies in areas where they commonly occur. Additionally, in various cultures, women’s status can affect both the ability of women to decide to seek care and their subsequent ability to reach care (Calvello, Skog, Tenner, & Wallis, 2015).

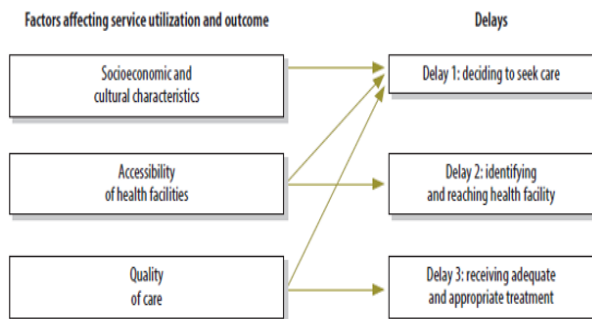


Figure 1: The Three Delay Model

Findings

The maternal deaths that occurred between April 2017 to January 2018 had 84% women who were less than 30 years of age and mostly they belong to SC and ST Community i.e. 53%. Apart from that 31.1% belong to OBC category and 15.6% from general category. Out of total women, 64% had less than 5 years of schooling and 71% of their husbands had less than 5 years of schooling.

The Study shows that the maximum number of maternal deaths occurred in the age group between 20-25 years which was 49% of total maternal deaths. Also, out of total maternal deaths, 55% women have 1-3 previous pregnancies while 27% has no previous pregnancy. The major causes of maternal deaths were PPH 46.6%, Eclampsia 13.3%, 6.7% Sepsis, 6.7%

Obstructed Labour, 8.9% Anemic and 17.8% were other causes. Study also shows that 16% women of total maternal deaths had no antenatal check-up which is very crucial for early preparation of safe delivery and for better maternal health.

The study shows that out of total deaths 49% has gone for delivery at public hospital, 24% to private hospital, 16% delivery at home and remaining for other facilities (Fig. 2). This reflects high number of delivery at home which may have been a barrier in managing the complication to avoid maternal deaths. Data support this statement which states that 13% deaths occurred at home and 4.5% occurred in transit, from home to facility 1 (Fig. 3 & Fig. 4).

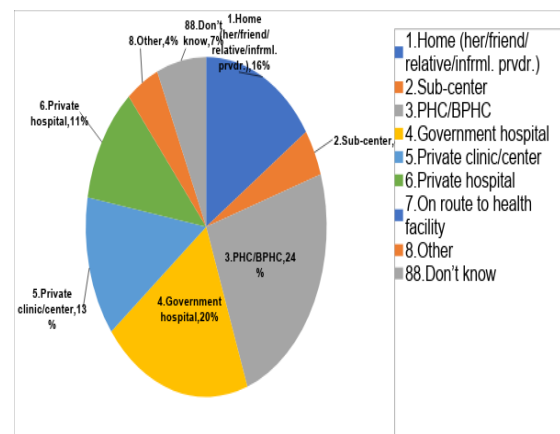


Figure 2: Place of Delivery

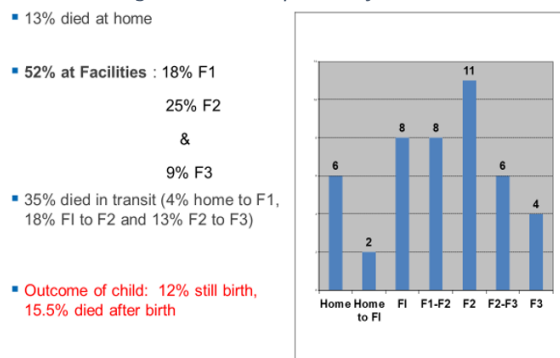


Figure 3: Place of Death and Outcome of Child

The study shows that out of 45 maternal deaths only 37 patients able to reach facility 1 and it took an average one hour to reach in facility 1 which shows lack of

proper decision making to seek care by the patient or his/her family (delay 1). It also showed that even 4.5% patient couldn't able to reach facility 1 (Fig. 4). This reflects the delay 2 where the patient couldn't able to identify proper transportation mode to reach the facility. Out of 37, 8 patients died at facility 1 and only 21 patients able to reach facility 2. This means 27.5% patient couldn't able to reach facility 2. The average time to reach facility 2 from facility 1 took 45 – 60 minutes. This shows the lack of proper and inadequate referral management, inappropriate treatment by facility staff and inadequate accessibility to health services (Fig. 4).

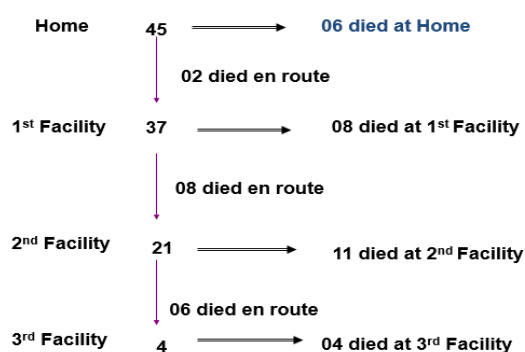


Figure 4: Pathway Analysis

Out of 21 patients, 11 patients died at facility 2 and only 4 patients able to reach facility 3. This means 60% patients couldn't able to reach even facility 3 and 4 patient died at facility 3. The average time to reach facility 3 from facility 2 took 30 minutes This again shows the improper and inadequate referral management, inappropriate treatment by facility staff and inadequate accessibility to health services (Fig. 4). From data, it revealed that from facility 1, 82% patients were referred to facility 2 and from there 57% were referred to facility 3.

Recommendation

From the study, it was revealed that maximum deaths that occurred could be saved as maximum deaths happened either due to lack of adequate services at facility level or lack of proper care-seeking decisions by the patient or his/her family. Hence, to reduce the chances of maternal death following points must be incorporated:

Quality of Service: - Quality and adequate care services to patients at the facility must be ensured. Immediate management of complication by trained service providers should be provided and if a patient has to transfer to the higher facility a prompt and informed referral decision must be taken by the service provider.

ANC Check-Up: “4” ANC check-up of all pregnant women & prior identification of High-Risk Pregnancy by ANM and follow up should be ensured by FLWs.

Birth Preparedness: “Prior birth preparedness” of all pregnant women should be ensured through FLWs.

PNC: Proper PNC counseling & check-up of all beneficiary must be ensured, so that beneficiary will be mentally prepared for the chance of complication, treatment & referral.

Referral Services: Quality of referral services must be ensured i.e., telephonic information to a higher facility, referral slip, 24X7 ambulance services should be available in all facility. Data has shown that 35.5% patient couldn't able to reach facility which resulted in en rout deaths. Moreover, due to delay in reaching facility timely care services couldn't be provided and deaths that can be saved couldn't be saved.

Facility Strengthening: Facility services should be strengthened by providing services through trained providers and by ensuring availability of basic medicines and consumables.

Friendly behavior by Facility Staff: Behaviour of facility staff should be friendly so that patient and their caretakers can discuss all complication with service providers without any hesitation and can seek care advice.

Apart from above activity, sensitization of community through FLWs about maternal and perinatal issues should also be ensured. Counseling and care during pregnancy like birth preparedness, maternal complication, FP, Immunization & Nutrition services should be ensured.

Acknowledgements

District Resource Unit (DRU), Madhubani is grateful to all relatives and family members who despite their great loss participated willingly in this study. We thank the Civil Surgeon Madhubani, the MO-I/Cs, Medical Officer of all block and their field staff for their enthusiastic involvement and efforts to ensure reporting of maternal deaths and for conducting the verbal autopsy.

About District Resource Unit (DRU) – Madhubani: As a part of the agreement between GoB and BMGF, Bihar. TSU has established District Resource Unit (DRU) in all the districts to provide technical support in the field of Health. As a part of that DRU is working in Madhubani District from January 2014.

District Resource Unit (DRU) Madhubani has district level and block level team for successful implementation of the programme interventions at ground level. The District level team has Mahendra Singh as District Team Lead (DTL), Sumit Pande as District Facility Officer, Abid Faheem as District Technical Officer – Outreach & Nutrition and Krishna Bharti as District Programme Officer – Kala-azar.

About the author

Abid Faheem is working in Care India for the past one year as District Technical Officer – Outreach & Nutrition in Madhubani District of Bihar State. He was a student of TISS, Mumbai of M.A Social Work 2015-17 batch.

Also, sensitization of facility staff about their duties and responsibilities towards society should be one of the major priority.

Conclusion

Most mothers who died in Madhubani had access to care, but they couldn't be provided appropriate and quality care services. Thus, it is crucial that the quality of care received at the health facility level is to be improved. This includes a refocus on strengthening referral services, enhancing healthcare providers' knowledge, skills to recognize & manage complications and provide emergency obstetric care. The enabling environment must be in place as well a fully functional referral pathway between healthcare facilities need to be ensured.

COMMENTARY

A TRAUMATIC JOURNEY OF ASIAN MIGRANTS TO GCC

Aswathy Krishna K C

Introduction

Gulf Cooperation Council involves Kingdom of Saudi Arabia, State of Kuwait, Kingdom of Bahrain, Sultanate of Oman, State of Qatar and State of United Arab Emirates. The matter of migrant workers constitutes an important part of this collaboration. Among them Saudi Arabia and UAE are involved in the top 10 countries that accommodate the largest migrant population in the world. In Qatar and UAE, the majority of the population in these countries that is around 80% comprises of foreign laborers. The domestic workers and laborers in the construction sectors constitutes around 95% of the migrant population. The countries in GCC has been criticized for Human rights violations against the migrant workers in the States of GCC.

During the first phase of migration, the migrants were mainly from the Asian countries and even now it remains the same. It is mostly the trade relationship between the Gulf countries and Asian countries. Many laborers from India stayed in Gulf for years and generations, later they became the citizens of these countries. Later during the 1980s and 1990s, the Arab migrant workers were replaced with Asian migrants. The authorities of GCC feared that the low educated Arab migrants would lead to corruption and would become the culture of Gulf States. By taking the historical ties between Gulf countries and Asian countries, and abundance of workers willing to migrate to the Gulf regions, Asia became a better option for GCC countries,

especially India. India is one among the countries to make up the highest number of migrants travelling to the Middle east countries.

There are several human rights organizations who have reported lots of violations of labor and human rights of migrant workers in the Gulf countries. The migrant workers undergo violations like confiscation of their documents like passport, visa, etc., inaccessibility to health facilities, denial of benefits of the laborers, unavailability of proper food and accommodation, occupational health and lack of care for safety of the migrants, excessive working hours, non-payment of salary, and also sexual, physical and psychological abuse by the sponsor or the employer.

Fighting against the Khafala system

In GCC the major violations of human rights are been reported because of the Khafala system. Khafala system is a sponsorship system, where the employer or the sponsor is assigned with the whole responsibility of the migrant workers. The system also enables power to the sponsor over the migrant worker. The system has created a greater delinquent to the migrant worker as the sponsor or the employer has the ability to cancel the work permit any time. At the same time the migrant worker never is allowed to freely leave the employment without the employer's consent. Even though their contract period is completed or even when the worker is under pressure or in some problematic situation because of the sponsor, the

worker is not simply allowed to leave the country without the consent of the sponsor. If in case the worker leaves the country without the consent of the employer, the migrant worker would be seriously punished by the country. In such conditions, the worker will be banned to re-entry to the country, or sometimes he or she would be having difficulties in departing to the country of origin. In some case the migrant worker cannot leave their employment as their documents will be in the custody of the sponsor. As the issues of the migrant workers are increasing, some GCC countries like Bahrain, Kuwait, Qatar and UAE have agreed to a commitment to amend the legal framework of the Khafala system. This amendment will help the migrant workers and provide protection to migrant workers' rights.

Migrant domestic workers

The migrant domestic workers are entirely a different category with regard to the migrant rights violations. The migrant domestic workers are excluded from the protection of labor laws in GCC. As the domestic workers are not included in the laws, these workers are vulnerable and they are even abused by their sponsors. Some abuses include physical and sexual abuses, excessive working hours without providing time for rest, not providing the salaries or even partial payment of salaries, improper living conditions and unavailability of food and so on.

Some of the countries of origin have prohibited migration of domestic workers to some countries in GCC. But even if there are such prohibitions from the country of origin, there are high chances of illegal means to travel to the destination country or the Gulf country. The migrant

workers will definitely seek for other means to reach the country as the workers are covered with debt in their families. The illegal entry to the Gulf countries would gradually become a risk factor for increase in forced labor and later becoming the victims of trafficking.

Most of the Gulf countries have not adopted any minimum wage requirements. Thus the migrant workers are paid less for their jobs. In 2016 Kuwait became the first Gulf country to set a minimum wage for domestic work. Some other issues are concerns with delay in salary payment or partial payments etc. The issue regarding the payment of salary is also related to the Wage Protection system in the Gulf countries. According to the Gulf Government the aim of this system is to protect labor rights and to gather information about the wages and bank accounts of workers. The Government of Saudi Arabia is also reported to use the Wage Protection System to control the finances and spending of migrant workers.

Deportation of the Migrant workers

The deportation of both documented and undocumented migrant workers, has been because of implemented policies of large scale deportations over the years. According to Kuwaiti media, 14,400 migrants were deported from Kuwait between January and April 2016. In 2016, a total of 29,000 migrants were deported from Kuwait, in comparison to about 25,000 migrants in 2015. In 2013, almost a million migrants were deported from Saudi Arabia, according to Migrant-Rights Organization, in order to protect the employment of Saudi citizens and to protect their nations security. In 2013, 7346 undocumented migrants were

deported from Bahrain. In 2016, more than 600 migrants were deported from Oman in just seven days. The workers are often deported for disputes such as traffic violations, arguments in public spaces, complaints about working conditions, organizing strikes or violations of the terms of the residency and work permits. The arrested migrants often only spend three days to a week in prison before the actual deportation, leaving them without time or means to appeal the deportation decision. These mass deportations still lead to overcrowded prisons, as reported by Human Rights Organizations. It is argued that these mass deportations are part of the Gulf States' policies to increase employment of their nationals and to improve national security. About a million migrant workers left voluntarily. Between November 2013 and March 2014 around 370,000 migrant workers were forcibly deported from Saudi Arabia. It was also reported that crimes were committed by the Saudi police against these migrants, including extreme violence, torture, rape and killing.

Migrant domestic workers in Lebanon

The uncertainty of the Khafala system in Lebanon has resulted in migrant domestic workers facing many legal issues and violations to their basic human rights. The government has largely been inactive and ineffective in implementing laws to protect migrant domestic workers. The recruitment process of a migrant domestic worker into Lebanon is conducted by sponsorship system. The worker has to receive an invitation before being granted a working permit to enter the country. The invitation comes through a recruiting agency.

First, the Ministry of Labour issues preliminary work authorization to migrant domestic workers. In 2010, the Ministry of Labour issued an approximate 118,000 work permits to migrant domestic Workers. After that the Ministry of Interior issues entry visas through the General Directorate for General Security. Then the General Directorate of General Security authorizes the legal entry of migrant domestic workers and arranges work permission and residence when they arrived in the country. Lastly, the sponsor's name is located on the migrant domestic worker's entry visa, residence and work permit. The visa is for a three-month period and the name of the sponsor is included in the passport. When the migrant domestic worker arrives at the airport they are subjected to an immigration routine which includes the handing over of their passports to the Lebanese General Security in order to process the papers, while the migrant domestic worker waits to be collected by their sponsor from the airport. After this, the sponsor brings the migrant domestic worker to a local agency for a basic medical checkup.

There are no clear criteria set by the government in terms of the requirements needed to issue an agency license. In order to open an agency, an agent must place an amount which is non-interest-bearing guarantee in a Bank. There are an estimated 310 licensed agents in Lebanon. Out of this number, 44 are operating as genuine agents with office and staff while the remaining agents hold licenses, they do not focus on the obtaining and placing Migrant Domestic Workers in positions but sell them to active agencies.

In order to recruit migrant domestic workers, Lebanese recruitment agencies

collaborate with agencies in the countries of origin. Migrant domestic workers are required to pay a fee to the local agent fixed by the agent in their home country. Usually this will be a large sum of money which causes the family to incur a large debt. Once the fee transaction is complete the agency arranges the transportation for the worker. The employer is obliged to meet the migrant worker at the airport gate where a general security guard who holds the employee's passport will hand it over directly to the employer. A medical examination and the resulting report must be fulfilled before the work permit is issued and the insurance for the worker must be paid by the employer within three months. A standard unified contract is drawn up which is more in favor of the employer than the migrant worker.

The Khafala system in Lebanon

The Khafala system involves a sponsor who has the legal responsibility for a migrant domestic worker during a contract period, making the worker dependent upon the sponsor. The Khafala system is not legally binding in Lebanon because recruiters cannot act as a sponsor. Instead the system is made up of a number of administrative regulations, customary practices and legal requirements which bind the worker to the recruiter temporarily. Once in Lebanon, the migrant domestic worker is assigned an employer. A worker may not change employer or break the terms of the contract unless the employer permits for the same. This must be done before a notary public and Lebanese authorities give an official release. A worker becomes illegal if they leave without the consent of their sponsor and the official release from the authorities. The Khafala system in

Lebanon puts workers at risk of exploitation and abuse. The Anti-Slavery International has also said that the system is one of the major causes of vulnerability of migrant workers. The Khafala system means that the sponsor of the migrant domestic worker is legally responsible for the migrant and the states responsibility for 'surveillance' is then passed on to the employer.

The role of agencies is very crucial. They have three different roles in the process, such as recruiter, immigration consultant and mediator. A labor recruiter can be either public or private and offers labor recruitment services. These businesses profit from the recruitment of migrant workers from one country and their allocation in jobs in another. Agents charge fees and commission for their services to migrant domestic workers. Sri Lankan migrant domestic worker pay less amount to a Lebanese agent while potential workers in the Philippines and Ethiopia pay more than the amount paid by the migrant in Sri Lanka. The Lebanese agent will also earn some amount as commission in addition. This money covers travel costs, Lebanese government visa fees, and the agency fee. In some cases, the first three months' salary is signed as payment. The agency fees cover the cost of airfare, government charges for issue of visas and agency commissions. The residency, work permit, notary fee and annual insurance are not included in the initial sum and are the responsibility of the employer sum. There is a difference in the amount the agency receives for each group of workers depending on their country of origin. One example is the migrant workers from the Philippines who demanded higher costs and monthly salaries because they have a

good command of English. They are better educated and therefore are given a higher respect as maids than those from other countries. Some employment agencies contract migrant domestic worker out on short-term contracts. The high prices involved in recruiting a migrant domestic worker means that employers take precautions to make sure the worker does not leave their position before their contract is up. The migrant domestic worker is also required to make a deposit in a Lebanese bank in order to cover return ticket home, which is never available to the worker. Because of the conditions present in Lebanon, legal and illegal agencies flourish and due to the Khafala system a migrant has to rely on agencies to find a Lebanese sponsor and employer.

Under the Lebanese employment system, recruitment agencies are liable to provide a replacement within the first three months after a migrant domestic worker decides to discontinue his or her work. These first three months are a preliminary “trial period”. In order to minimize having to do this, agencies advice employers to take measures to limit the freedom of the migrant domestic workers through the confiscation of their passport and restrict their communication with the outside world which is sometimes similar in some other countries in the Gulf. Recruitment agencies have been known to encourage employers to place restrictions on migrant domestic workers which include the confiscation of their passport and confinement to the residence. Recruitment agencies in Lebanon receive very little state supervision. The workers are often made false promises about the country they are moving to, as well as the work they will do, and the conditions expected

in the workplace. They are also misled about the salaries they can expect to receive.

Role of country of origin

Many women migrating for domestic work pay fees to agencies in their home countries which sometimes means entering into debt or selling assets to cover the cost. Agency fees in the country of origin varies between countries. Migrant domestic workers from Sri Lanka and the Philippines are often offered training by the recruitment agency in their home country. The training involves lessons on using electrical appliances and cooking the traditional food of the country of destination.

The government of the Philippines established an Overseas Employment Administration in order to protect emigrant workers from exploitation. In Lebanon, especially, the agencies wishing to hire Filipinas for work are required to obtain “Master Employment Contract for Domestic Helpers” from the Embassy of the Philippines in Lebanon. The Philippina Worker Resource Center in Beirut provides training seminars to assist in skills upgrading and cultural activities.

Migrant Domestic Workers can be classified into three categories, they are live-ins, freelancers and runaways. Live-in migrant domestic workers live in the household of the sponsor for a number of years. During the time, the sponsor is responsible for all financial costs and has a lot of control of the worker. A freelancer is less controlled and lives on their own terms and works on an hourly basis for different employers. Some freelance workers may have originally entered through the Khafala system and decided to

remain when their contract finished. Freelancer are required by law to have a sponsor and some business men take this as an opportunity to earn money, sometimes charging very huge amounts. Runaway migrant domestic workers are former-live in workers who have left their sponsor for a variety of reasons. As soon as the migrant domestic worker leaves their place of residence they are automatically seen as an illegal. The migrant domestic worker must then either return to their home country or find a new sponsor.

Conclusion

The migrant domestic workers perform variety of tasks such as cleaning, cooing, taking care of older people and even children and so on, the workers views and challenges are not expressed to the public,

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About the Author

Aswathy Krishna is the Project Coordinator at CIMS (Centre for Indian Migrant studies), an NGO registered with the Government of India which uses the influence of Visual media to track down missing people with the assistance of viewers, social workers, and Migrant forums.

neither it is discussed with the authorities or it is visible in the media. The migrant workers also undergo fear of material losses in the work place, dehumanization of the workers, not showing empathy and not even desire to provide motivation for good work performances.

The protection of the migrant workers need to be analyzed, interpreted, implemented and properly enforced through a human rights framework. The migrant rights protection need to be with regardless of the country of origin, the level of work and even status of their family. The resolved issues need to be reinvestigated to bring a better understanding about the root cause of issues of the migrants. Always the biggest challenge remains with the understanding of the root cause.

NEWS AND EVENTS

❑ **ICPSP 2018 : 20th International Conference on Poverty and Social Protection**

Conference, 22nd to 23rd October 2018, Bali, Indonesia

The ICPSP 2018: 20th International Conference on Poverty and Social Protection aims to bring together leading academic scientists, researchers and research scholars to exchange and share their experiences and research results about all aspects of Poverty and Social Protection.

Organized by: The International Research Conference

Deadline for abstracts/proposals: 20 July 2018

Website:<https://waset.org/conference/2018/10/bali/ICPSP/home>

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Conference, 13th to 14th September 2018, Zurich, Switzerland

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Organized by: International Humanities and Social Sciences Committee

Deadline for abstracts/proposals: 20th June 2018

Website:<https://waset.org/conference/2018/09/zurich/ICSW/home>

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The word limit is between 5000 and 6000 words (including abstract, keywords, and references). The author(s) should submit the article in MS Word format. It should have a cover page specifying aspects like title, author(s) name(s), affiliated institution, communication address, and short bio (of 100 words). Article should have an abstract of not more than 150 words and five keywords. In case of multiple authors, the first author will be considered as the corresponding author. A letter of authorisation from all the authors to agree to the order in which the names appear will have to be submitted along with the article.

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