EMPHASIS
Learning Series

Towards Safety, Dignity and Better Health of Migrants

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Note

The names of all migrants (and any identifying details) have been changed throughout the *Learning Series*. Actual names are used for EMPHASIS project staff.

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EMPHASIS

Learning Series

Towards Safety, Dignity and
Better Health of Migrants

ACKNOWLEDGEMENTS

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The EMPHASIS *Learning Series* was written by Dr Graeme Storer with valuable contributions from the Regional Secretariat (Kathmandu), CARE project teams in Bangladesh, India and Nepal, and staff of the implementing partners in Bangladesh, India and Nepal.

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Quotations and case stories were drawn from case studies developed by project staff teams, stories written by Women Power Connect; and from field visit interviews that informed this learning series.

Special Thanks

We acknowledge the collective efforts of the Steering Committee Members, Regional Advisory Group Members, CARE International-UK Team, Regional Secretariat Team, Team Leaders, and All EMPHASIS staff, Partners and especially Peer Educators in Bangladesh, India and Nepal, during the journey of EMPHASIS

A Few words...

In the recent years, the discourse on migration has clarified new perspectives in terms of both challenges and opportunities. Owing to various 'pull' and 'push' factors people are on the move and this will continue; migration is a reality of the current world. So within migration contexts, it is important to recognize and ensure the rights of migrants, and their safety and dignity is upheld at all times. This is not happening and migrants, especially labour migrants, face harassment and exclusion; the status of women labour migrants is even more critical due to patriarchal systems, structures and practices. In the midst of these challenges, it is important to note that there are efforts to recognize the rights of migrants and treat migration as a development agenda; what is urgent is to aggregate these efforts, and secure the political will of state and non-state actors.

With the support from BIG Lottery Fund, UK, CARE International led a five year regional project, EMPHASIS on cross- border migration, which was implemented in Nepal, India and Bangladesh. At a time when the latest discourse on migration is seeking strong data, evidence and a comprehensive program model on migration, EMPHASIS has emerged as one of the few comprehensive programs on migration working on all 'source', 'transit' and 'destination' contexts. This learning series is the outcome of our five years intensive operations on the ground where we have reached over 340,000 migrants and their families. The learning series includes : a) Overview: EMPHASIS at a glance; b) Reducing HIV vulnerability; c) Migrating Safely; d) Women Empowerment; e) Advocacy and Influence. Within these sections, there are stories of pain, change, transformation, success and inspiration. Some encouraging innovations in the continuum of mobility are also articulated in the document. The objective of this learning series is to share our work, innovations and learning with development stakeholders, including the governments, so that it can be used to transform the lives of migrants and their families. Though EMPHASIS focused on mobility within South Asia, we hope this learning series will be useful to migration programming globally.

This project has been a part of a unique combination of efforts from migrants and their families, peer educators, outreach workers, partners, and EMPHASIS colleagues at regional levels and country levels, EMPHASIS Steering Committee, the Regional Advisory Group, colleagues from CARE Country Offices and CARE International UK. We appreciate the support we got from governments, UN agencies, civil society, media and the entire chain of partnership that we worked with. This document is the outcome of these collective efforts. We acknowledge the effort of Graeme Storer, the consultant who did the research, collated information, and wrote these learning series, and Nabesh Bohidar, Regional Monitoring and Knowledge Manager who coordinated the work on behalf of EMPHASIS. Similarly, special thanks to project team leaders Abu Taher, Prakash Pandey and Navneet Kaur for their constant support and coordination. Finally, we are indebted to the BIG Lottery Fund whose funding and continued support and good will allowed us to implement EMPHASIS.

We hope you find the learning series useful.

Sincerely yours,

Navaraj Gyawali, Regional Director-Asia
CARE Regional Management Unit

Prabodh Devkota, Senior Regional Project Director
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What is inside...

The Learning Series showcases the cumulative experience of numerous volunteers, frontline staff, project partners, stakeholders and above all the migrants and their families. The 5 year journey of EMPHASIS has been fascinating, bringing vulnerabilities and strengths of migrants to the fore and facilitating ways in which migrants and their families are able to address these issues on their own.

As we started on the journey five years ago, we realized, the issues that cross-border migrants faced were numerous, and the challenges for addressing them was enormous. At times, project staff wondered whether engaging with the variety of issues, that migrants and their families asked us to facilitate and support, was a prudent one. However, the unwavering faith that the project put on migrants, as individuals and as groups in setting the agenda and leading the process, for addressing these vulnerabilities was the key in achieving the outcomes presented here in this learning series

The learning series starts with an executive summary, which provides a snapshot of the project activities. The first section provides an overview of the EMPHASIS project focussing on the strategies undertaken. Section two highlights on key accomplishments related to health and HIV and outlines the process by which cross-border migrants were able to access HIV services, including ART, in a seamless manner across the three countries. This section also describes the role played in strengthening health systems. Section three highlights a complex set of issues and changes relating to harassment and violence, including the underlying structures fuelling them and allies in bringing about change. This section also throws light on how it was possible to ensure safe remittances. Section four gives us glimpses of the issues faced by women at source, transit and destination. This section also captures the strengths of women as migrants at destination and as spouses at home (origin), reflecting upon the levels of empowerment achieved. The domains presented as standalone sections in this document may not do justice to the manner in which women groups played a central and catalytic role in addressing many of their own vulnerabilities, but is a key thread finding resonance across the document. Section Five highlights the efforts of the project in building knowledge and sensitising a large array of stakeholders at the local community level as well as at the regional and global levels. This was achieved through strategic research and advocacy.

Nabesh Bohidar
Regional Monitoring and Knowledge Manager, CARE

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ABBREVIATIONS

ART	Anti-retroviral therapies (also ARV medication)
ARV	Antiretroviral (as in ARV medication)
BGSVS	Bhartiya Gramotthan Seva Vikas Sansthan
BNP+	Bengal Network of Positive People
BSF	Border Security Force
BSP	Bengali-speaking Population
CARAM Asia	Coordination of Action Research on AIDS and Mobility in Asia
CB	Capacity building
DIC	Drop-in Centre
DNP+	Delhi Network of Positive People
EMPHASIS	Enhancing Mobile Populations' Access to HIV AND AIDS Information Services and Support
FHI	Family Health International
GaRDeF	Gangotri Rural Development Forum
HIV/AIDS	Human immunodeficiency virus / acquired immunodeficiency syndrome
HIV+	A person who has tested positive to the HIV virus (also PWHIV)
icddr.b	International Centre for Diarrhoeal Disease Research, Bangladesh
ICTC	Integrated Counselling and Testing Centres
IEC	Information, Education and Communication
IME	International Money Express
IOM	International Organisation for Migration
JUNIMA	Joint United Nations Initiative on Migration, Health and HIV in Asia
MARP	Most At Risk Populations
MOU	Memorandum of Understanding
MSM	Men Who Have Sex with Men (also, men who are sexually attracted to men)
NCASC	National Centre for AIDS & STD Control, Ministry of Health and Population, Nepal
NACO	National AIDS Control Organisation, Ministry of Health and Family Welfare, India
NASP	National AIDS/STD Programme, Ministry of Health Services, Ministry of Health & Family Welfare, Bangladesh
NEEDS	Nepal Environment and Education Development Society
NRs.	Nepalese rupees
PWHIV	People With HIV (instead of PLHIV - People Living with HIV)
Q	Quarter
SAARC	South Asian Association for Regional Cooperation
SBCC	Social and Behavioural Change Communications
SSB	Seema Suraksha Bal (Border Security Force)
STIs	Sexually Transmitted Infections
UN	United Nations
UNAIDS	United Nations Program on HIV & AIDS
UNDP	United Nations Development Program
UNGASS	UN General Assembly Special Session on HIV/AIDS
VAW	Violence Against Women
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

EMPHASIS (Enhancing Mobile Population's Access to HIV/AIDS Services Information and Support) was a 5-year, multi-country project funded by the Big Lottery Fund, U.K. The project was designed to address cross border mobility-related vulnerabilities, using an HIV lens and a specific gender focus. The project was implemented through respective CARE Country Offices working with local implementing partners in India, Nepal and Bangladesh. At the time of implementation, EMPHASIS was the only project in South Asia working with migrants on HIV across the mobility continuum (from source to transit to destination and back to source). Working on HIV and migration opens up pathways to a range of other vulnerabilities that more broadly relate to migration and development, including safety and dignity, workers' rights, violence against women, access to financial services, savings and remittances and stigma and discrimination. Building on this understanding, this Learning Series describes the EMPHASIS programme model for addressing the multiple vulnerabilities cross-border migrants can experience.

Key learning that emerged from the project was:

a. Establishing an information network that reaches out to migrants across the mobility continuum leads to better outcomes than interventions that only operate at source or destination.

   37 service centres (Community Resource Centres, Drop In Centres and Helpdesks) established at strategic locations in the three countries provided meeting and recreational spaces and were instrumental in fostering community mobilisation. A network of 700+ outreach workers, peer educators and volunteers reached out to inform and empower over 340,000 migrants and their families with context-specific and multi-lingual Social and Behavioural Change Communication (SBCC) materials. A referral network embedded within the outreach strategy linked migrants and their families to existing public, private and non-government service providers. Mobilising existing service providers strengthened accountability and ownership.

   A project end-line study to measure change in knowledge and attitude of stakeholders showed an increase of over 100% over the baseline and that the project fostered behaviour change through its use of mass and folk media, campaigns and SBCC.

b. Ensuring HIV services across borders requires different strategies for open versus closed borders.

   An ART cross-border referral mechanism was operationalized between Nepal and India; access was increased to Voluntary Counselling and Testing (VCT) services in India, Bangladesh and Nepal. Training was made available to service providers on syndromic management of sexually transmitted infections (STIs), infection prevention, universal precautions, counselling and testing protocols and rationale use of anti-retroviral therapies. Referral mechanisms were strengthened. Health camps and mobile clinics were made available for migrant populations that were unable or unwilling to access health services. Special attention was given to the health and wellbeing of HIV+ migrants and stigma and discrimination were addressed through inclusion strategies.

c. Promoting safe mobility, security and dignity requires robust research and power analysis focused on specific corridors.

   The project was able to reduce the number of cases of violence and harassment at the Indo-Nepal border. Formats were developed to monitor and address harassment, violence and rights abuses, and the findings were widely shared. Stakeholders (nongovernment and community-based organisations; hoteliers and food stall owners; transport unions, bus drivers and rickshaw pullers; and border security and police officers) were enlisted as allies; and accountability mechanisms were activated.

   The project was also able to promote safe remittances and a culture of saving and ensure women had greater control over remittances. Banks and money transfer services in India and Nepal were lobbied to develop migrant-responsive banking procedures; trust was built in the use of official money channels amongst migrant populations; and the media was engaged to build wider public awareness and to bring about accountable responses from duty bearers.

d. It is possible to bring about these changes in ways that empower women.

   Ensuring women have access to information about migration and HIV and to referral and support services is key to reducing their vulnerability to HIV and STIs. Second, inter-spousal communication is key to reducing women's vulnerability to HIV and leads to more equitable family relationships.

   In all 55 community-led women's groups evolved in Bangladesh, India and Nepal and provided creative spaces for women to express themselves as agents of change. Additionally linkages were established with existing organisations to address violence against women and barriers to decision making related to migration and sexual and reproductive health. The women's groups played a significant role in addressing stigma and discrimination, as well as their own issues.

e. Regional cooperation and acceptance of cross border mobility is essential to ensuring inclusion and the protection of rights, dignity and the service needs of mobile populations.

Issues-based research and policy briefs informed policy dialogues across multiple levels (national, regional and local), alliance building, networking and campaigning. Sensitisation meetings were facilitated with policy makers, civil society organisations, service providers and security forces on rights and concerns. The media and other enablers were engaged to add weight to lobbying efforts.

Each of the parts in this EMPHASIS Learning Series describes in detail different facets of the EMPHASIS cross-border programme model. Each part is written as a stand-alone document, though the facets are closely interconnected, and the parts can be read in any order. They are:

Introduction	A description of the comprehensive programme model for working with cross-border populations.
1. Project Overview	Background to the project and the context in which the project was operating, governance and management structures; profiles of the migrant populations; the project's theory of change (project outcomes, pathways and enabling strategies); and the project's approach to capacity development and results-based management.
2. Reducing HIV Vulnerability	How the project addressed HIV-related vulnerabilities and promoted access to HIV and health-related services; increased uptake of services amongst male and female migrant populations; ensured HIV+ migrants and their families had access to HIV-related services and community-based care; and addressed stigma and discrimination.
3. Migrating Safely	How the project supported safe travel and reduced levels of violence and harassment at source, transit and destination; and promoted safe remittances through access to bank and financial services.
4. Women's Empowerment	How the project worked with community-led women's groups to provide spaces for women to contribute to action around HIV, safe migration and safe remittances; to address stigma and discrimination, support HIV+ women and promote inclusion; and to challenge traditional notions of women's roles, hierarchy and gender.
5. Advocacy and Influence	The EMPHASIS advocacy strategy in action – how the project worked across regional, national and community levels to influence wider political acceptance of cross border mobility; to promote safety and dignity, to reduce violence and stigmatisation; and to promote migrants' rights and entitlements to decent work and services.

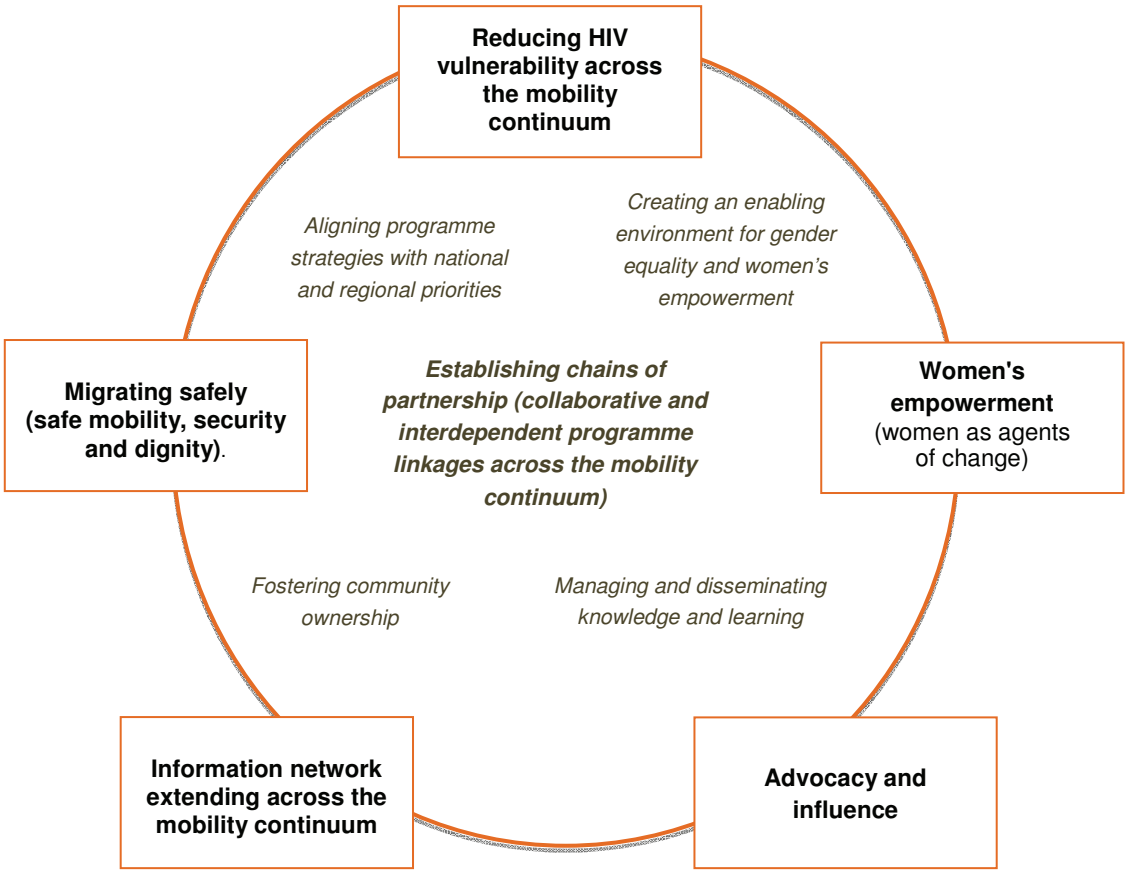
Introduction

A comprehensive model for working with cross-border populations

EMPHASIS (Enhancing Mobile Population's Access to HIV/AIDS Services Information and Support) was a 5-year, multi-country project funded by the Big Lottery Fund, U.K. The project was designed to address cross border mobility-related vulnerabilities, using an HIV lens and a specific gender focus. The project was implemented through respective CARE Country Offices working with implementing partners (local nongovernment organisations) in India, Nepal and Bangladesh. Women Power Connect in New Delhi was the strategic advocacy partner for the project. The Overseas Development Institute (ODI) provided support for policy research. A Regional Secretariat in Kathmandu provided overall leadership and coordination. Governance was provided through a CARE International Steering Committee and a Regional Advisory Group.

At the time of implementation, EMPHASIS was the only project in South Asia working with migrants on HIV across the mobility continuum (from source to transit and destination and back to source). As such the project was able to contribute significant new insights to the domain of migration that have relevance in other contexts. This EMPHASIS Learning Series builds on the lessons that emerged over the course of the five years. It demonstrates how working on HIV and migration opens up pathways to a range of other vulnerabilities that more broadly relate to migration and development, including safety and dignity, workers' rights, violence against women, access to financial services, savings and remittances and stigma and discrimination. Building on this understanding, the Learning Series describes the EMPHASIS programme model (Fig. 1) for addressing the multiple vulnerabilities cross-border migrants can experience.

Fig 1. A comprehensive model for working with mobile populations across the mobility continuum



The model comprises a set of five interdependent and multi-pronged interventions. These are:

1. An information network that extends across the mobility continuum.

    1.1 37 service centres (drop-in centres, community resource centres and helpdesks) were located at strategic locations across the mobility continuum (source, transit and destination) in the three countries. (In Nepal, for example, the two transit sites were chosen because they were a confluent for migrants from 45 districts in Nepal.)

    The service centres provided safe spaces for migrants and their families to come together to seek out information and to ask questions about particular concerns and were instrumental in fostering community mobilisation and social cohesion.

    Mobile drop-in centres complemented the static centres, and were found to be more effective in reaching migrant populations.

    Community-led Management Committees helped to create an enabling environment, provided a gateway into communities and promoted ownership and sustainability.

    1.2 Standardised, yet multi-lingual and context-specific, Social and Behavioural Change Communication materials (SBCC) were disseminated across the mobility continuum.

    These provided migrants and their families with access to accurate and timely information about HIV and health; travelling safely; referral services and how to access; rights; and government policies and legal frameworks. Specific pre-departure information was also included.

    1.3 Project outreach workers and peer educators (recruited from amongst migrant communities and stakeholders from along mobility corridors) staffed the service centres. Community-led groups, mainly women's groups at source and destination, were integral to the information network. Together they ensured that migrants and their families were receiving and sharing consistent information about migration at source, transit and destination.

    1.4 A referral network was rooted in the outreach strategy and in the mobilisation of existing service providers (public and private sector, nongovernment organisations and other stakeholders along the mobility continuum). Supporting migrant-responsive services was a focus of the capacity building initiatives with service providers.

    1.5 Cross-border reflection and planning meetings identified synergies and shared innovations and lessons, to inform programme adjustments and to identify entry points for advocacy.

    - At the Indo-Nepal transit points, teams from the centres and stakeholders on either side of the border were able to cross over and meet face-to-face.
    - As the Indo-Bangladesh border is closed, these meetings took place by WEBEX and Skype.
    - NING – a community of practice software – allowed for constant information flow between and among staff, who were able to quickly share updates of activities, incidents, accomplishments and challenges, inviting feedback and joint solution making. NING helped to bridge technology barriers (for example, peer educators who had not used a computer before were able to blog), linguistic barriers (people could write in their native languages and then use Google translation for others to read). NING was also helpful for motivating staff that often had to work in difficult conditions and built team spirit across distances.

    1.6 Scope and scale was expanded through social mobilisation strategies.

    - In Nepal, migrant issues were publicised through, for example, the Nepal Chamber of Commerce and Industries Regional Expo and existing male and female migrant networks and youth groups.

- Across the mobility continuum, outreach workers/peer educators and migrant populations participated in National AIDS Day activities or Women's Day activities, as well as in religious and cultural events. Gathering together at the safe travel sites to celebrate these events allowed migrant populations to strengthen community relations and social capital.
- In India, the project drew on the strengths and presence of existing community-based organisations and cultural groups to expand awareness about HIV and migration. Nepalese community-based organisations and associations played an active role in lobbying for acceptance of Nepalese identity documents to open bank accounts in India, for simplification of remittance procedures and for formal employment contracts.
- In Bangladesh, the project extended its reach through linkages with transport/lorry union officials and sister organisations also working on migration-related issues and those working with men who have sex with men, hijra (third gender), injecting drug users and entertainment workers.

2. Promoting access to HIV and health-related services and addressing factors that contribute to HIV vulnerability

   2.1 ART cross-border referral mechanisms were operationalized.

   The project worked with local, state and national-level AIDS authorities and health service providers in India and district and national-level AIDS authorities in Nepal to establish an ART referral mechanism that allowed cross-border HIV+ migrants to maintain ARV medication without disruption.

   2.2 Health-service strengthening at source focused on existing structures.

   Working in collaboration with public health authorities, the project strengthened VCT (voluntary counselling and testing) services and mechanisms:

   - In Bangladesh VCT clinics were established in two district-level hospitals adjacent to the Indo-Bangladesh border; training was provided in STI (sexually transmitted infections) syndromic management and a chain of referrals was established from community-level clinics up to the district-level VCT clinics.
   - In Nepal STI syndromic management and anti-retroviral therapy case management were strengthened in an existing ART/VCT service centre; the approach was then replicated in other districts.
   - In both Bangladesh and Nepal, counselling services were aligned to address the needs of pre-departure and returning migrants and case management data are informing national surveillance data.

   2.3 Uptake of services was increased amongst male and female migrant populations:

   - Referral mechanisms were strengthened – first, the project mapped existing public and private service providers and nongovernment organisations addressing HIV, migration and related rights issues. The groups were then brought together to discuss how they could collaborate (e.g. by directing migrants with STIs to the government VCT facilities) and to discuss rights and response-abilities.
   - The outreach workers and peer educators were trained to make referrals to existing services.
   - Over time, an increased number of migrant/families came forward for VCT services at source and destination; and an increased number of migrant women gained access to pre-natal care and safe birth delivery at destination.

- Health camps and mobile clinics were established for populations that were unable or unwilling to access health services available in government settings at destination or who lived too far to be able to travel to government services (as in the more geographically-isolated districts of the Far Western Region of Nepal).
- Uptake of referrals by migration populations was encouraged via the information network.

2.4 Access of HIV+ migrants and their families to HIV-related services and community-based care was facilitated:

- Women's groups were evolved at source and destination to support HIV+ migrants and their families and to address stigma and discrimination within migrant communities (below).
- Service providers were sensitised to the specific needs of migrant populations.
- HIV+ migrants were linked to PWHIV networks and to other organisations that could provide needed support.
- Where required livelihood support was provided to PWHIV families in need (such as for women in Nepal whose husbands had died of HIV complications).

2.5 Stigma and discrimination was addressed through inclusion strategies:

- In Nepal, community support groups included HIV+ and HIV- women who worked together to provide community-based care and to address issues related to stigma and exclusion in the community.
- In Bangladesh, the community support groups included local elected bodies, influential persons, religious leaders and representatives of migrant workers. Their support created an enabling environment for the women's groups in what is otherwise a restrictive environment for women. The community support groups also addressed the discrimination and humiliation that is commonly experienced by migrant families.
- In Mumbai, a project-led HIV+ group provided a space for HIV+ migrants to come together, to talk and to provide each other with psychosocial support.
- In Kolkata, the Community Resource Centre Management Committee facilitated access to community members in Madhyamgram, North 24 Parganas. Similarly the Cossipur Masjid Committee in north Kolkata helped the community access the Bengali-speaking community when the Imam agreed to announce project activities through the public loudspeakers (that were also used for prayers).

3. Safe mobility, security and dignity

3.1 Monitor and address violence and harassment.

a. IEC (information, education and communication) messages about travelling safely were included in the information network (above):

- Simple formats were developed to monitor and address harassment, violence and rights abuses along the mobility corridors; numerical data were supplemented with case stories to illustrate the extent of and types of harassment and violence that migrants were experiencing.
- The findings were shared across multiple levels (through "sensitisation" meetings, through engagement with local media, and through national and regional consultative meetings).
- Media were engaged to publicise and name exploitation, harassment and violence that occurred.

b. Enlisted stakeholder as allies.

Over time the project enlisted the support of stakeholders – public and private sector health service providers; local nongovernment and community-based organisations; hoteliers and food stall owners; transport unions, bus drivers and rickshaw pullers; and border security and police officers – that had previously been in exploitive relations with the migrants. Activities included:

- Orientation and awareness building sessions were provided.
- The peer educator network was expanded to include rickshaw pullers, bus drivers, transport unions etc.
- At the Indo-Nepal border, transit-based interventions engaged police and border officials, transport unions and rickshaw drivers, hoteliers and the media in cross-border planning sessions.

c. The project worked with duty bearers to activate accountability mechanisms and to help them locate opportunities to play an active and productive role in addressing safe migration. For example, the Achham District Migrant Network (formed from among returnee migrants) provided a platform to lobby district authorities to initiate searches to trace missing migrants or to claim compensation for those migrants who have been injured / abused or lost their lives.

3.2 Promote safe remittances and a culture of saving and ensure women have greater control over remittances.

a. Banks and money transfer services were lobbied at source and destination to develop migrant-responsive banking procedures, such as, by simplifying identity-proof requirements and other procedures.

b. Trust was built in the use of official money channels amongst migrant communities, for example, through financial literacy and negotiation skills training. Early adopters were supported to open accounts and then enlisted to bring on board other migrants.

c. Created an enabling environment – the media was engaged to build wider public awareness and to bring about accountable responses from duty bearers.

4. Women's empowerment

In all, 55 community-led women's groups evolved in Bangladesh, India and Nepal and provided creative spaces for women to express themselves as agents of change.

4.1 Inter-spousal communication was encouraged.

- Training sessions enhanced the skills and confidence of women to speak out about their concerns (related to, for example, reproductive and sexual health, safe migration and violence and harassment) and to contribute to action around HIV and migration.
- Parallel sessions with men's groups (and mixed groups) facilitated an environment where men were willing advocates for women's rights.

Two significant lessons have been, first, ensuring women have access to information about migration and HIV and to referral and support services is key to reducing their vulnerability to HIV and STIs. Second, inter-spousal communication is key to reducing women's vulnerability to HIV and leads to more equitable family relationships.

4.2 Linkages were established with existing organisations to address violence against women in migrant communities and barriers to decision making related to migration and sexual and reproductive health.

4.3 Space was provided to identify and address other issues important to the women and to challenge expectations about their place alongside men.

4.4 Stigma and discrimination were addressed through strategies of inclusion (above).

5. Advocacy for wider political acceptance of cross-border migration.

5.1 Building on field-based experience – and in close collaboration with international agencies, governments and the South Asia Association for Regional Cooperation – specific advocacy strategies were developed to gain wider support for migrants populations; to promote safety and dignity; to promote migrants' rights (and thus access to services); and to recognise women as agents of change and economic actors.

5.2 Research was conducted and policy briefs were developed to inform policy dialogues across multiple levels (national, regional and local), alliance building, networking and campaigning.

Research findings were published and disseminated and included baseline and end line studies, mapping of migration corridors and the issues migrants experienced, analysis of existing laws and policies; and documentation of good practice models.

5.3 The media and other enablers were engaged through sensitisation meetings and workshops to create an enabling environment and to add weight to lobbying efforts.

Five essential enabling strategies complete the model. These are:

a. Establishing chains of partnership.

The project facilitated collaborative and interdependent programme linkages across the mobility continuum. For example, the referral mechanism rooted in the outreach strategy mobilised existing service providers (rather than creating parallel structures). The cross-border ART referral mechanism developed by EMPHASIS required the project to establish linkages and agreements between state and national AIDS authorities in India and district and national AIDS authorities in Nepal. Stakeholders (rickshaw pullers, transport officials, hoteliers and so on) that had previously been in exploitive relations with mobile populations joined hands in reducing violence and harassment.

It should be noted that establishing trust and credibility was often a slow and difficult process, particularly when working with undocumented migrants. One of the implementing partners in New Delhi described the difficulties faced by his team:

> Initially we faced many challenges... landlords would not give us space to set up the Drop-in Centre. House owners strictly warned outreach staff not to enter their premises. The local police were picking up our field staff for questioning without any reason. And in many cases, the migrant populations were not receptive to the information we were giving out on HIV and safe mobility [Pramod Singh, Modicare Foundation in New Delhi].

b. Creating an enabling environment for gender equality and women's empowerment.

Women's empowerment and working through women's solidarity groups was a core programme strategy. The project showed that working with women's solidarity groups at source and destination and ensuring women have access to accurate HIV and health-related information and to referral and support services is key to reducing their vulnerability to HIV and STIs. It also showed that encouraging communication between spouses reduces women's vulnerability to HIV and leads to more equitable family relationships. Building on the understanding that migration is gendered and that women's contributions to migration can be overlooked, the project took care to develop supporting mechanisms that would enable women to engage in project activities. In Bangladesh, Community Support Groups were formed in parallel to the women's groups to create an environment for the women's groups to engage in discussions about HIV and migration. At destination in India, mixed groups and men's groups formed to bring women and men into collaborative conversations.

c. Fostering community ownership.

Two premises underpinned the project's approach to working with migrants; first, focusing on migrant-identified issues (that is, issues that were important to them) and engaging migrants in delivery and follow up would foster ownership and lead to more sustainable results. Second, strength-based approaches to capacity development also retain and develop ownership. Hence, peer educators were recruited from amongst mobile populations and also from amongst various stakeholders along the mobility continuum. The community-led Management Committees ensured the project service centres remained in tune with community concerns.

d. Aligning programme strategies with national and regional priorities.

In order to operationalize the cross-border ART referral mechanism for mobile populations (as described above), the project needed to enlist support from the AIDS authorities in both Nepal and India. In Nepal, EMPHASIS facilitated a joint meeting with the National Centre for AIDS and STD Control (NCASC) and the Seti VCT/ART Centre in Dhangadhi, Kailali district. While the meeting focussed on HIV+ migration issues, the EMPHASIS team was careful to also ask how the project might support NCASC in achieving broader programme objectives related to HIV and STDs. As a result, it was agreed that the project would help strengthen ART service delivery and could move ahead to develop the cross-border ART referral mechanisms. Lobbying activities with State and National AIDS Control Organisations in India focused on how activating an ART referral mechanism was aligned with the government's commitment to not restrict travel based on an individual's HIV status; and to make ART services available irrespective of nationality.[1]

e. Managing and disseminating knowledge and learning.

EMPHASIS set out to build a knowledge base about migrant populations and their families and to promote wider recognition of the vulnerabilities faced by mobile populations. The project drew on internal and external expertise to carry out various research studies and to develop policy briefs, which were published on the EMPHASIS knowledge hub at: http://www.care-emphasis.org.

Each of the parts in this EMPHASIS Learning Series describes in detail different facets of the EMPHASIS cross-border programme model. Each part is written as a stand-alone document, and the parts can be read in any order.

There are five sections as follows:

Part 1. Project Overview

The project overview part begins by describing the project background and the context in which the project was operating. It then describes the project's governance and management structures; provides profiles of the migrant populations; and describes the project's theory of change (project outcomes, pathways and enabling strategies) and its approach to capacity development and results-based management.

Part 2. Reducing HIV Vulnerability

How the project addressed HIV-related vulnerabilities and promoted access to HIV and health-related services through: (a) operationalizing an ART cross-border referral mechanism between Nepal and India; (b) strengthening VCT Services in both Bangladesh and Nepal (migration-oriented counselling, data management and rational use of anti-retroviral therapies); (c) increasing uptake of services amongst male and female migrant populations; (d) ensuring HIV+ migrants and their families have access to HIV-related services and community-based care; and (e) addressing stigma and discrimination.

[1] From: Global database on HIV-specific travel and residence restrictions (at: http://www.hivrestrictions.org/Default.aspx?pageId=142)

Part 3. Migrating Safely (safe mobility, security and dignity)

How the project supported safe travel and reduced levels of violence and harassment at source, transit and destination; and promoted safe remittances through access to bank and financial services.

Part 4. Women's Empowerment

How the project worked with community-led women's groups to provide creative spaces for women: (a) to express themselves as agents of change; (b) to contribute to action around HIV, safe migration and safe remittances; (c) to address stigma and discrimination, support HIV+ women and promote inclusion; and (d) to challenge traditional notions of women's roles, hierarchy and gender.

Part 5. Advocacy and Influence

The EMPHASIS advocacy strategy in action – how the project worked across regional, national and community levels: (a) to influence wider political acceptance of cross border mobility; promote safety and dignity, (b) to reduce violence and stigmatisation; and (c) to promote migrants' rights and entitlements to decent work and services.

Working across the mobility continuum

Illustrations drawn by Satyam Tiwari and Sonu Bohara (EMPHASIS peer educators)

Project overview

Summary

EMPHASIS (Enhancing Mobile Population's Access to HIV and AIDS Services Information and Support) was a 5-year, multi-country project (beginning in August 2009). The project was designed to address cross border mobility-related vulnerabilities, using an HIV lens and a specific gender focus. The project clearly demonstrated that working on HIV and migration opens up pathways to addressing a range of other vulnerabilities that more broadly relate to migration and development, including safety and dignity, workers' rights, violence against women, access to financial services, and stigma and discrimination.

The Overview provides in turn a description of the context in which the project was operating, a summary of the management and governance structure, and profiles of the Nepali and Bengali-speaking migrant populations. It then outlines different program components, including the project's theory of change (the project outcomes and the pathways that are the focus of this Learning Series), and the project's approach to capacity development and results-based management. It closes with a snapshot of the results achieved.

Key messages

EMPHASIS demonstrated that it is possible to facilitate chains of partnership and bring about collaboration across mobility corridors. Cross border synergies are key to:

- Facilitating access to HIV-related services (including cross-border ART referrals) for migrant populations.
- Bringing about positive changes in health behaviours and uptake of counselling and testing and services.
- Reducing the incidence of harassment and violence across the mobility continuum.
- Supporting spouse groups at source and migrants at destination to open up bank accounts (and thus to secure safe remittances).
- Bringing about these changes in ways that empower women and allow them to contribute to action related to safe migration, HIV and health and inclusion of people living with HIV (PWHIV).
- Advocating for wider political acceptance of cross-border migration.

1.1 The context

1.1.1 Migration and development

In 2013 South Asians were the largest group of international migrants living outside of their region. Nearly 40% migrated to the oil-producing Gulf countries. Others migrated to locations in East Asia and Malaysia. Still more migrated within the region itself. As a consequence migration is making significant contributions through remittances to national economies. In 2012 India was one of the top recipients globally with officially recorded remittances of $70 billion (World Bank 2013). Across the region, remittances in 2012 increased by 12.5% over 2011 (an estimated $109 billion). Remittances have become an important and more sustainable source of income than Development Assistance and Foreign Direct Investment and other private flows combined. In Bangladesh and Nepal, remittances are larger than national foreign-exchange reserves. In Nepal, remittances are equivalent to more than 24% of Gross Domestic Product.

Indian cities have historically been popular work destinations for a large proportion of Nepalese migrants, especially those from the far western development regions. In one study more than 80% of the informants from the far western region of Nepal (Wagle 2011) reported that migration was a major source of income for the family; 94% reported migrating to India, either seasonally or long-term. India has also become a corridor for undocumented migrants from Nepal to move to the Gulf and other locations. By crossing over into India and then contracting a recruitment broker, Nepalese citizens are able to bypass Nepal's migration authorities. It is estimated that 60-70 Nepali woman are reaching the Gulf in this way each day, assisted by human trafficking networks (Pandey 2013). That is, India is both a destination country for Nepalese migrants and a staging location for Nepalese migrants going to 'third' countries.

Movement across the border is facilitated by the Peace and Friendship Treaty signed in 1950 between India and Nepal that allows citizens of both countries to travel and work freely across the border and to be treated the same as native citizens – except for voting rights. Article 7 of the treaty states that the Governments of India and Nepal agree to grant, on a reciprocal basis, to the nationals of one country in the territories of the other the same privileges in the matter of residence, ownership of property, participation in trade and commerce, movement and other privileges of a similar nature. But there is no clarity on what other privileges of a similar nature means and no agreement that this should translate, for example, into access to health services. In fact Nepalese migrants can access health services but only those that are part of the government's scheme to provide health services to India's poor, where no identity proof is required. Despite the Treaty, there continues to be harassment on both sides of the shared border. There are also poor living conditions, verbal abuse and exploitation at destination. Access to formal financial services, to send home remittances, is also restricted.

The situation for Bangladeshi migrants is complex. First, there is no treaty or policy that allows Bangladeshis to migrate to India for work. Second, large portions of the shared border are fenced on both sides and tightly regulated. Still, for decades, India has received a constant inflow of unauthorized and unacknowledged migrants from Bangladesh (Sultana et al. 2011). These migrants generally find work as cheap labour in the informal sector, often as domestic helpers, construction labourers, rickshaw pullers and rag pickers (Sikder 2008; Blanchet 2006). Migrants in Bangladesh navigate their travel across the border with the aid of brokers. The brokers assure safe arrival at destination, and/or the promise of a job upon arrival. But while a contract between the migrant and the broker may be established, the journey across the border can be dangerous; hidden deals and bribes between brokers and border patrol leave women particularly vulnerable to exploitation (Sultana et al. 2011).

Following on, two factors are holding back informed planning and the implementation of comprehensive migration policies across national boundaries. The first is lack of reliable data and systematic research about migration in South Asia. The second is lack of acknowledgement of the extent of migration. Comprehensive migration policies and planning are a vital condition towards protection of South Asia's migrant workers and their rights to travel safely and with dignity, to decent work and to health care services.

Discussions about migrants' rights are often overshadowed by the sensitivities around the topic of migration, such as, individual versus national security, or concerns that migrants will burden already over-extended health systems (Khadria 2014:2-3). But being healthy and staying well is prerequisite for migrants to work, to be productive and to contribute to positive development outcomes at source and destination. Given the contributions that South Asian migrants are making to national economies at source and destination, it is essential then that programmes address the needs and rights of migrant workers at source and destination and ensure that migrants and their families are both informed and empowered and aware of their rights and entitlements at destination.

1.1.2 Migration and gender

Historically in South Asia migration has largely been perceived as a masculine domain, and women's contributions to migration and development have gone largely unnoticed. But as Blanchet (2008) notes,

we need to unpack gendered representations of migration. Too often the work that women do is not recorded, as they are described as the spouse, or because their work is domestic (that is, "women's work"). An increasing number of South Asian women are today migrating in search of better livelihood opportunities to support their families. In so doing, they are becoming economic actors (rather than dependent spouses) and financially independent (UN Women 2013). Indeed, South Asia has emerged as the most important source of migrant labour in general and of female migrants in particular to the Gulf. Lack of economic resources and social capital, forced migration and trafficking of women and girls are examples of different levels of constraints that impinge on migrant women (UNDP 2009). It is crucial then that gender-responsive policies and programmes are in place, which reduce the vulnerabilities women migrants face and make migration an experience of dignity for women. Both sending and receiving countries have a role to play in ensuring the positive aspects of migration and in promoting safe migration of women.

1.1.3 Migration and HIV

Migration, in and by itself, is not a risk factor for HIV infection. But the experience of migration involves crossing physical, cultural and emotional boundaries, and the conditions in which migrant workers find themselves may predispose them to HIV and other health risks. Vulnerability to HIV is often at its highest when people live and work in conditions of poverty, powerlessness and social instability. Separation from family and spousal relationships and language barriers can create a sense of isolation and loneliness. The absence of familiar social boundaries and freedom from the norms that regulate behaviours at home may provide migrants with opportunities to explore their sexuality and to engage in high-risk behaviours. Vulnerability is also fuelled by stigma and discrimination; the low social status of women and the trafficking of women and girls; high rates of sexually transmitted infections that go largely untreated coupled with limited condom use; the availability of sex workers and cultural barriers that inhibit open talk about sex and sexuality (and which thus contribute to misinformation and misunderstanding).

Migrants may be unaware of or misinformed about HIV and may continue to remain so even after testing HIV positive. One reason for this is the general absence of treatment and support services across South Asia for HIV and STIs (sexually transmitted infections), coupled with a sense of shame associated with talking about sexual matters with health officials. One consequence of this is that migrants do not seek out early diagnosis. Others may be reluctant to access health services at destination, fearful that they might be reported to authorities and sent home. Even when migrants have access to health and other support services, they generally choose to avoid them due to fear of deportation, discrimination by care providers or linguistic, cultural and gender barriers. Inadequate access to health services adds to the vulnerabilities migrants face (UNDP 2004), and more effort is needed to encourage migrants to take up services that do exist. Balancing the economic benefits of migration with health and wellbeing of migrants should be a critical concern across migration corridors.

This contextual analysis provides a backdrop to the EMPHASIS project. The project's response rests on the following premises: firstly, migration is an integral part of development, and its consequences are influenced both by economic forces and also by the broader structures in which they are embedded (de Haas 2010). Secondly, migrants' contributions to development depend upon the realisation of their capabilities and rights (Sen 1999), and their ability to make choice and to move freely and in dignity. Thirdly, many migrants are able to move, live and work in safety and dignity, but others are compelled to move via irregular migration channels as a result of poverty, environmental degradation and human rights violations, and their choices are constrained.

Thus, in addition to promoting HIV awareness, prevention and care, the EMPHASIS project placed considerable emphasis on:

- Enhancing migrants' capabilities through the provision of pre-departure and post-arrival information and assistance;
- Improving their access to HIV and related health services at source and destination;

- Improving migrants' integration in destination areas;
- Empowering women and ensuring their contributions (both as stay-at-home spouses and as economic actors); and
- Lobbying at the political level for an increased recognition of the vulnerabilities faced by mobile populations.

1.2 The EMPHASIS project

1.2.1 Background and project management structure

The overall goal of the EMPHASIS project was to reduce vulnerability of mobile populations (particularly women) to HIV infection across selected cross border regions within India, Bangladesh and Nepal. The project design included a specific action-learning agenda that set out to ask: "What approaches can reduce the vulnerability to HIV of cross-border mobile populations and their families?" The project operated across four dimensions: (a) testing a cross-border model for HIV prevention, care and support; (b) building a knowledge base about migrant populations and their families and their vulnerability to HIV and AIDS; (c) enhancing the capacity of partners within the programme portfolio; and, (d) supporting increased and wider recognition of the vulnerabilities faced by cross border migrants.

EMPHASIS was funded by the Big Lottery Fund, U.K (£5 million over five years) and implemented through respective CARE Country Offices working with partner NGOs in India, Nepal and Bangladesh. A Regional Secretariat in Kathmandu provided overall coordination. Governance was provided through two structures: a Steering Committee comprised of the CARE Country Office Programme Directors, the CARE Asia Regional Management Unit and the Senior Regional Project Director; and a Regional Advisory Group made up of practitioners and researchers from national and regional agencies from all three countries to provide technical advice and quality assurance inputs.

At source the project was implemented in Achham and Kanchanpur districts in the Far Western Development Region of Nepal and in Jessore and Satkhira districts in Southwest Bangladesh. On the borders, the EMPHASIS project was implemented in two transit locations on both sides of India-Nepal border (in Kanchanpur, Uttarakahand and Uttar Pradesh). It was implemented on one transit location, on both sides of the Indo-Bangladesh border (West Bengal and Jessore). The destination sites in India were in three major urban industrial zones in Delhi-NCR, Kolkata (including adjoining districts of North and South 24 Parganas). Based on the recommendations in the baseline studies (Sultana et al. 2011; Wagle et al. 2011) Mumbai/Thane and adjoining areas were added to the programme portfolio in early 2011 (with funding from CARE International UK).

CARE led on the original project design, with inputs from each CARE Country Office in Bangladesh, India and Nepal and from CARE International (UK). Local partners were selected for project implementation (Table 1). CARE's role was to identify, recruit and support the implementing partners; provide capacity building inputs as needed; provide oversight for program quality (monitoring, evaluation and learning); facilitate cross border synergies and manage donor and public-private sector relations; to manage the knowledge and research agendas; and, to generate evidence for advocacy and influence. Women Power Connect in New Delhi was the strategic advocacy partner for the project. ODI (the Overseas Development Institute) provided support for policy research.

Table 1: Implementing partners

Source	Transit	Destination
Nepal NEEDS (Nepal Environment and Education Development Society), Kanchanpur Gangotri Rural Development Forum (GARDEF), Achham Bangladesh Rights Jessore, Satkhira Ad-din Welfare Centre Jessore	Nepal NEEDS, Kanchanpur India BGSVS (Bhartiya Grampthan Seva Vikas Sansthan), Uttar Pradesh Bangladesh Rights Jessore, Satkhira Ad-din Welfare Centre, Jessore	India Modicare Foundation, New Friends Colony, New Delhi Anchal Charitable Trust, Naveen Shahdra, New Delhi Action Research Centre, Mumbai Bhoruka Public Welfare Trust, Kolkata, West Bengal

A full list of the names of the CARE project teams and implementing partner teams can be found in Annex 1.

1.2.2 Mobile populations

At source in Bangladesh and Nepal, the term migrant (or mobile population) refers to returnee migrants or circular migrants (those that have temporarily returned), spouses of migrants and any adult family member (aged 20 and over) with a family migrant history. At destination in India, migrant refers to male and female migrants who may or may not be living with spouses and/or children. Table 2 compares the profiles of Nepali and Bengali-speaking migrant populations. The profiles are drawn from two baseline studies: Nepali migrant populations in Nepal and India (Wagle et al. 2011); and Bengali-speaking migrant populations in Bangladesh and India (Sultana et al. 2011). The first point to note is that in Bangladesh and the Western Regions of Nepal, poverty and lack of alternative livelihood opportunities were key drivers of migration. The baseline studies revealed that families at source were receiving from around US$220 to US$330 per annum in remittances and that for 86% of the households surveyed, there was no secondary source of income. That is they were surviving on less than US$1.00 per day.

Table 2: Migrant profiles at source and destination

Bangladeshi migrant populations (Sultana et al. 2011)	Nepalese migrant populations (Wagle et al. 2011)
Socio-demographics Undocumented migration was a choice driven by extreme poverty and lack of livelihood options. Generally men were able to cross safely but not women. Unaccompanied movement of women away from the home was perceived as shameful and female migrants faced stigma and discrimination upon their return. Approximately 50% of all HIV cases in country was a migrant. At destination around 60% were Hindu and 40% were Muslim. A higher proportion of the women (nearly 70%) than men (54%) identified as Hindu. All Bangladeshi migrants at destination spoke Bengali. Around one-third were comfortable speaking Hindi as well. The average age was 31 years (34 years for females), with more than 60% aged between 18-33. The mean age at the time of their first migration was 25 years for men and 27 years for women. Over 75% of the female migrant population had married before the age of 18. Nearly 70% of male migrants married between 18-24 years. Approximately 60% at source had attended school but only half of those had completed primary school. At destination, 36% had never attended school; more than 50% had completed middle school. Migrants tended to visit home once or twice a year, during festival periods or for family-related events.	People in low economic brackets migrated because they had limited access to productive employment; some feared the unstable political landscape. Major pull factors were the ease of gaining employment and higher wages. Joining spouses in India and other personal ties were also reported by some of the female migrants in India. Approximately 45% of all HIV cases in Nepal occurred among seasonal migrants to India. The majority of the migrants (99%) were male. The majority of female migrants in India came with their spouses and children. Most migrants were 18-33 years. 98% were Hindu and comfortable speaking Hindi; and more than 40% belonged to the Chhetri caste. Most had migrated for the first time between the ages of 16 to 20 years. Nearly 60% of men migrated with peers. Most migrants were currently married (65% at destination and 75% at source). 33% of migrants at destination and 48% at source had never attended school. In Nepal, the average educational level was class 3; in India more than half had studied up to class 3. Migrants visited Nepal at least once a year, mostly during festivals or planting and harvesting season.

Crossing over (safe mobility) Costs ranged between US$15.00 to US$50.00 at destination and around US$40.00 at source. Money was mostly paid to the broker whose fees varied according to the financial capacity of the migrant and the security she/he could provide. Broker contracts comprised 3 parts: (1) The fee negotiated between the migrant and the broker. (2) The fee negotiated between the broker and power holders (e.g. border officials). (An additional unspoken expectation occurred when the broker promised a border official sex with a female migrant of his choice.) (3) The fee negotiated between the broker in Bangladesh and a broker in India who arranged employment. Approximately 80% of migrants used savings to cover costs. 20% borrowed money from family and friends or from a moneylender. Failure to repay loans on time brought harassment to the migrant's family. Female migrants did not always pay the broker in advance, but paid after arrival from their earnings, an arrangement that kept them under the broker's control.	The overall cost of migration was between US$30.00 to $US40.00, mainly for transportation and food. The source of money for migration for most was either savings or loans from friends/relatives. Almost all respondents migrated to India directly spending little time in transit. The preferred first destination as reported by returnee migrants was Mumbai, followed by Delhi. Some reported having to pay government officials at the border. The return journey was more complicated as migrants would often carry money or valuable goods, and safe passage had to be negotiated through bribery. Money for the journey was drawn from savings or borrowed from family and friends. In some instances money was also taken from a moneylender.
Work and living conditions Approximately 40% of the Bangladeshi men at destination worked as casual labourers; others worked as 'brickees', petty traders, vendors or rickshaw pullers. 46% of the women were stay-at-home housewives; around 25% got work as domestic servants. Others got work as housemaids and office cleaners and in factories. Employment at destination was most commonly arranged either by a broker or by relatives residing in destination. On average migrants reported earning around US$5 – US$6.50 per day. While a few migrants received bonus pay during Durga Puza festival, most migrants did not receive any benefits (including medical support, overtime, or paid time off). Pay was deducted if they missed work due to illness or leave. Female returnees said it was not unusual to work overtime with no extra pay. Bengali-speaking migrants in India were often found living on disputed land or squatting illegally (and hence fearful of displacement) and with poor health, hygiene and sanitation.	Most of the male migrants in India were employed as restaurant/bar workers (56%), watchmen (21.4%) or factory workers (12.6%). The female migrants were mainly domestic servants (49.8%), housewives (18%) or factory workers (12%). 94% of the mobile population in India reported getting work throughout the year, getting paid in cash (99%) and on a monthly basis (84%). 75% were working for an individual; only 10% were employed by private companies. Very few were employed by the government or were daily labourers. The tendency to change jobs frequently was very high and most often driven by more competitive salaries and relationships with other migrants. 70% in India were dwelling in non-slum areas and generally sharing a room. At destination, there were toilet facilities (generally shared). The availability and utilization of municipal services, including water and sanitation and waste disposal, was fairly good but largely dependent on the relationship with the landlord.
Savings and remittances At source, migrant families reported saving some money at different points during the year. Migrant families were comparatively "better off" than their neighbours. Most migrants sent money home via friends or family making home visits, or through a broker in an emergency situation (though this incurred higher fees). Loans were taken out from family and friends and also money lenders.	At source, 90% of households were receiving remittances from a migrant family member. Less than 1/3 of source households saved money (nearly 60% at destination). Most migrants sent money home through friends or during their visits home. Only 4% had bank accounts in India. More than 80% of the households in Nepal and 10% in India had active loans. At source and destination, loans were primarily taken from friends and relatives.
General concerns Both male and female migrants tried to hide their ethnic identity at work to avoid police harassment. Female migrants experienced more exploitation than males. Overall knowledge of HIV was low with many misconceptions regarding spread of HIV. Service availability and utilization was low across the border. Cross border migrants preferred to use village doctors/ private providers for general health services and used government services for Family planning. Migrants cited the behaviour of health providers, proximity	Migrants at destination experienced loneliness, lack of money and poor living conditions. They also experienced verbal abuse by employers or landlords, threats of imprisonment and difficulties in finding suitable places to rent. They tended to keep to themselves and did not interact much with Indians even in the workplace. Overall awareness of HIV and AIDS was high among migrants in India (88%) as well as in Nepal (85%-99%). Some misconceptions still existed regarding the spread of HIV.

to their residence and the cost of treatment as the major factors influencing their choice of provider. At destination, the choice of provider largely depended upon whether the migrant had legal documentation. STIs were generally going untreated and impacting women's health. There was little space for women to speak about such matters (even to each other). Condoms were seen as a planning tool and men were not using condoms in casual sex. Health seeking behaviours were influenced by the attitudes of health providers, proximity to services and treatment and travel costs. At destination, uptake of health services was largely depended upon whether the migrant had legal documentation. The stigma and discrimination towards PWHIV was found high among mobile populations in both India and Bangladesh and a factor that inhibited people coming forward for testing.	While only 30% of the mobile population in India had heard about STIs, the proportion was much higher (51%) among circular and returnee migrants in Nepal. Only about 19% of spouses at source had heard about STIs. There was little or no inter-spousal communications related to these concerns. Awareness of condoms in Nepal was high among male migrants at source and destination; use of condoms in casual sex and spousal relations was low or non-existent. Health seeking behaviours were influenced by proximity to services and treatment (a challenge for those living in remote areas at source). At destination, uptake of health services was determined by awareness of services and by service provider attitudes. Stigma and discrimination towards PWHIV was found to be higher among mobile populations in India than in Nepal though there was also stigma at source against those suspected of being HIV+.

Source: EMPHASIS baseline studies

Specific markers were developed to distinguish Bengali-speaking migrants in India. These included, for example, dialect and accent; men wearing loongi (sarongs) rather than trousers; those working for lower than minimum wages; those with poor health, hygiene and sanitation; those constantly harassed and interrogated by police for the flimsiest reasons; and those living on disputed land or squatting illegally (and hence fearful of displacement). The fact that Bengali-speaking migrants were often found living on disputed land created problems for the project, in that they could be driven off at any time. In Mumbai, for example this required the project to shift project locations on several occasions and to develop responses, such as the mobile drop-in centres.

"Do No Harm" principles (Collaborative for Development Action 2000; DIFID 2010) were key in selection of all implementation strategies. This was critical when working with undocumented migrants and when addressing issues of harassment and discrimination.

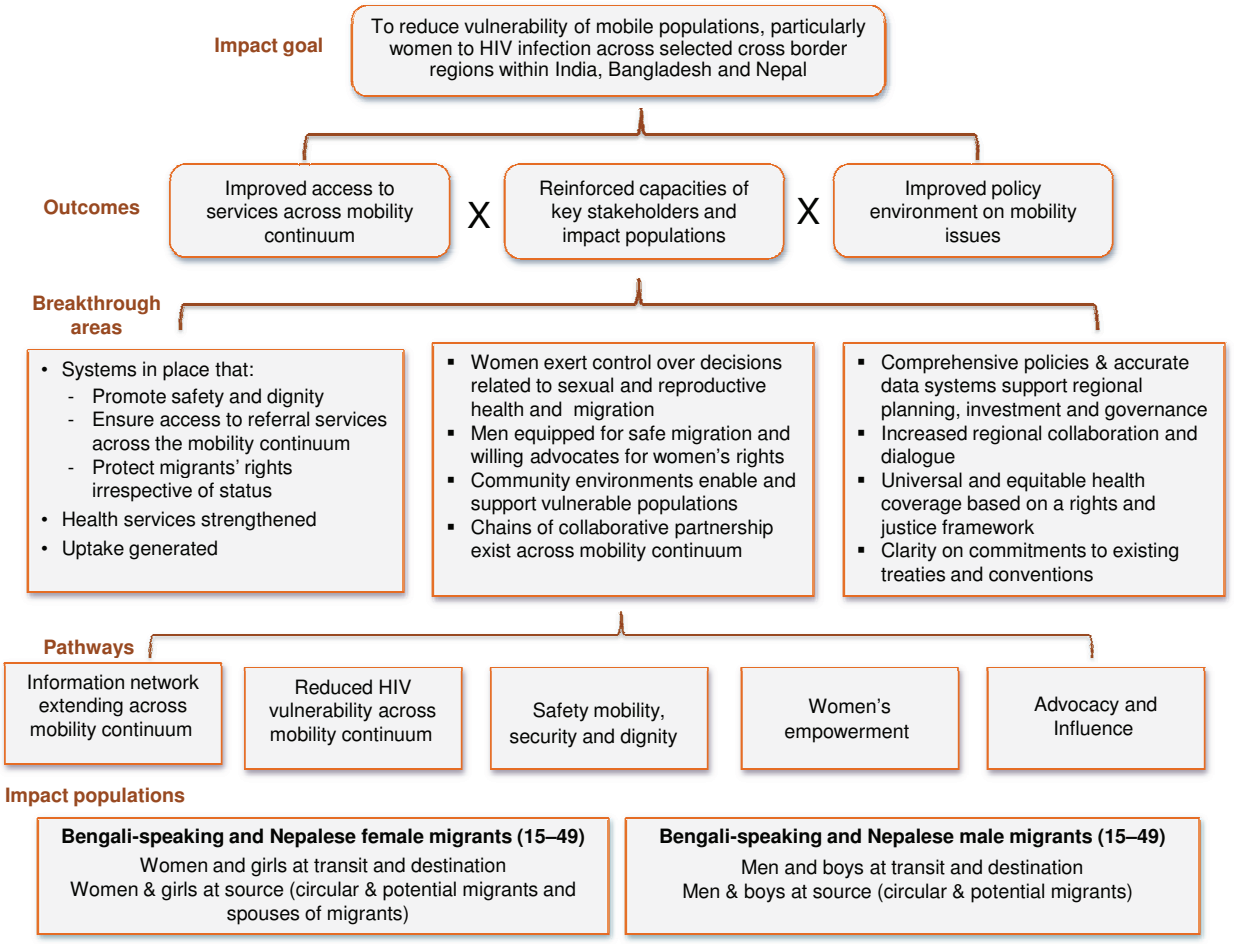
1.2.3 Theory of change

The EMPHASIS theory of change (Fig. 1) included three outcome areas: improved access to services across the mobility continuum; reinforced capacities of key stakeholders and impact populations across the mobility continuum; and an improved policy environment on mobility issues. The dynamic and interconnected nature of change and the catalytic role played by empowered women has been a learning.

The impact populations were defined as:

- Bengali-speaking and Nepalese female migrants (aged 15–49), including women and girls in transit and at destination and women and girls at source (circular/returnee and potential migrants and spouses of migrants).
- Bengali-speaking and Nepalese male migrants (aged 15–49), including men and boys in transit and at destination and men and boys at source (circular/returnee and potential migrants).

Fig. 1. Theory of change



Five critical pathways and five enabling strategies were defined as important precursors to achieving these outcomes and made up the EMPHASIS programme model (Table 3).

Table 3: The EMPHASIS programme model

Pathways:	Enabling strategies:
a. Information network extending across the mobility continuum • Safe travel sites (static and mobile) that provide access to information; counselling and referrals • Outreach worker / peer educator network and community-led solidarity groups (mainly women's groups) • Community-led management committees b. Reducing HIV vulnerability across the continuum of mobility • Facilitating access to cross-border ART referrals and related HIV and health services (health-service strengthening, public and private sector partnerships) • Supporting HIV+ migrants to access treatment and care and livelihood support • Addressing stigma and discrimination through strategies that promote inclusion c. Promoting safe migration (safe mobility, security and dignity) • Addressing violence and harassment across the mobility continuum and decent work at destination • Facilitating safe remittances (and fostering a culture of saving)	a. Establishing collaborative and interdependent programme linkages across the mobility continuum b. Creating an enabling environment for gender equality and women's empowerment c. Fostering community ownership (focusing on migrant-identified issues and engaging migrants in delivery and follow up) d. Aligning programme strategies with national and regional priorities e. Managing and disseminating knowledge and learning

d. Women's empowerment • Implementing specific strategies to address gender inequalities faced by women migrants and women left behind • Providing spaces for women to express themselves as agents of change; to gain control over decision making related to migration and health and how remittances are used; and to transform social norms e. Advocacy and influence • Research to inform evidence-based advocacy & policy dialogues across multiple levels (national, regional and local, including community-led advocacy • Engagement of media and other enablers	

1.2.4 Capacity development

> Capacity refers to the overall ability of a system to perform and sustain itself (its resilience to change)… At an individual, community and organisational level, capacity is about the potential and strength that all people have to create their own future. This potential… can be enhanced through learning opportunities, as well as through identifying and addressing blocks in the operating environment that stand in the way of learning and growth (ECDPM 2008).

Capacity is an essential element in the theory of change with outcome two referring to reinforced capacities of key stakeholders and impact populations across the continuum of mobility. Capacity is defined as an outcome. Capacity development refers to the contributions made through systems and processes to bring about capacity (acquisition of new skills and the confidence to act, durable behaviour change, institutional strength and so on) (Baser et al., 2008; ECDPM 2006; ECDPM 2008).

EMPHASIS' approach to capacity development built on global best practice that highlights the benefits of using strength-based methods (Hammond 2010) that:

- Retain and develop ownership; and which are explicitly adapted to local contexts, culture, languages and local resources.
- Focus on the relationships, structures, patterns of power and authority and resources (Baser et al. 2008: 74-75).

Some examples of training and capacity building activities were:

- Establishing the information network – setting up the service centres (static and mobile) at strategic locations across the mobility continuum; recruiting and training project outreach worker and peer educators, establishing and providing training to women's groups; developing, piloting and disseminating standardised, yet context-specific, educational and behavioural change materials.
- Providing migrant communities with training sessions: (a) to build awareness of migration, HIV and health, safe mobility, safe remittance and savings, and stigma and discrimination; and (b) to promote positive changes in health seeking behaviours; and to promote uptake of HIV and health-related services.
- Capacity needs assessments of service providers, security forces and civil society organisations that informed subsequent sensitisation activities related to migrants' rights and training sessions.
- Training to service providers on STI treatment, infection prevention, universal precautions and migrant-focused VCT services (sensitising service providers to specific needs of migrant populations).
- Operationalizing mobile clinic services to provide STI treatments for migrants.
- Building understanding and capacity of outreach workers and peer educators to make referrals.

- Activating women's groups and community-based organisations to address stigma and discrimination within their communities; providing women with skills and opportunities to contribute to action around HIV, safe migration and safe remittances and violence against women.
- Developing formats to monitor and address harassment, violence and rights abuses along mobility corridors; strengthening capacity to analyse quantitative data and qualitative change stories.

The project end-line study (conducted early in year five) showed an increase of over 25% over the baseline in knowledge and attitude of stakeholders across the mobility continuum.

Figure 2 shows the numbers of people trained across the continuum of mobility. Figure 3 shows the range of stakeholders that participated in (sometimes multiple) sensitisation and training activities organised by the project.

Fig. 2. Numbers of people trained across the continuum of mobility

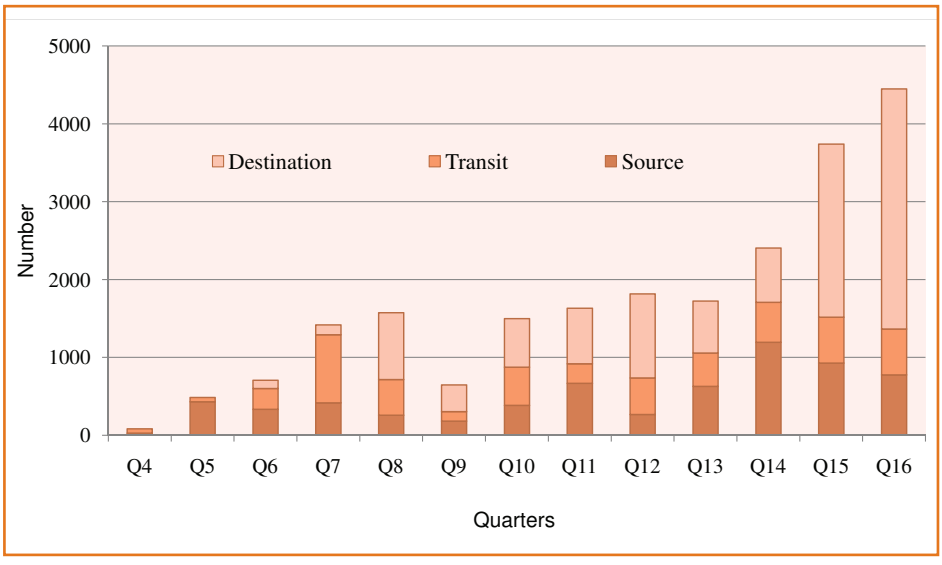
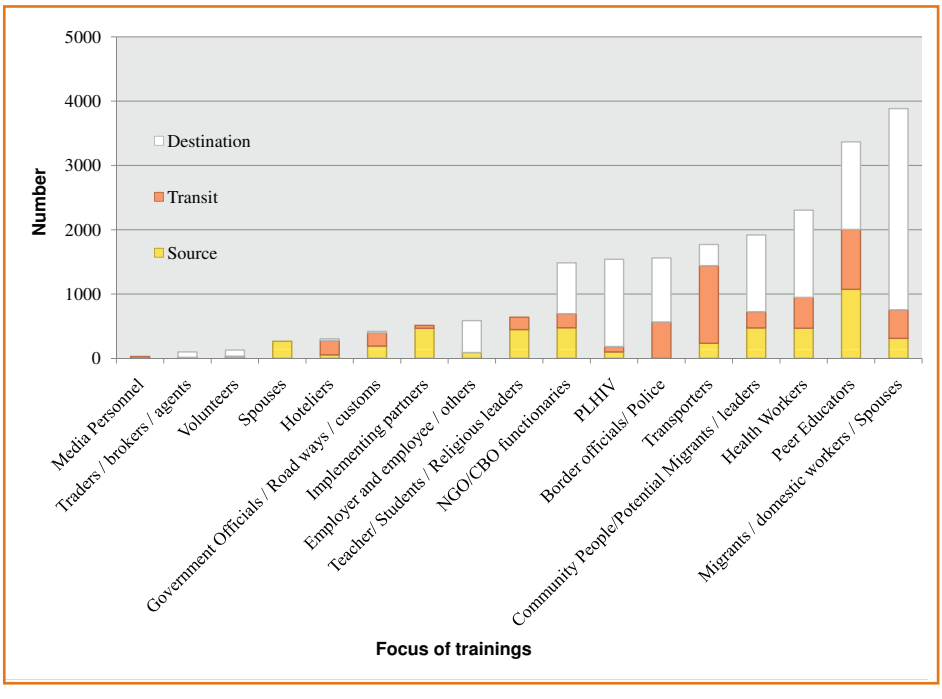


Fig. 3. Numbers and types of stakeholder trained/retrained by the project



Capacity development planning

A strategy of the project was to work with implementing partners and nongovernment and community-based organisations (NGOs/CBOs). Table 4a shows the capacity building plan developed for strengthening capacity of the NGOs/CBOs to implement robust programming and advocacy.

Table 4a: Capacity building plan for NGOs and CBOs

Agenda	Issues identified	Strategies / focus areas	Expected outputs
Governance	Organisational policies were in place but not regularly updated Little or no public sharing of finance and audit data	Review and update of policies Coaching to introduce social audit tools and encourage public sharing of audits	Improved sharing and dissemination techniques Improved transparency and delegation of accountability
Financial management	Financial Management system in place but reporting needed improvement	Training on financial management and reporting techniques	Regular reporting mechanism and sharing of financial matters within the organisation
Planning, Monitoring & Evaluation	Organisations lacked explicit, long term strategies M&E systems in place but not well; utilised it for decision making	Workshops to develop mission and vision and long-term strategy CB on how to optimally use the organisations M&E system	Mission and vision statements informing long term strategy planning Dynamic M&E system in place and informing strategic decision making
Technical capacity	NGOs were aware of HIV/AIDS but not updated on current literature and approaches related to migration	CB on stigma, discrimination and vulnerability related to HIV	Addressing stigma and discrimination, availability of services and gender issues
Attitudes & norms	Organisations had not received formal training on gender	Training on gender and gender equitable norms and implications for programming	Identifying and addressing gender and mobility issues
Networking and advocacy	No formal training to develop networking and advocacy skills	Skills training on advocacy and networking	Networking and advocacy skills in place for managing programs
Rights & duties	No formal training on Human Rights Little or no awareness on the entitlements of mobile populations	Training on human rights with special reference to mobile population	1950 Indo-Nepal treaty – areas for clarification plus implications for programing and advocacy identified

The project also identified and worked with existing service providers – rather than creating parallel structures to meet the needs of the migrant populations. Table 4b show the capacity building plans developed for strengthening their capacity of to deliver migrant-focused services.

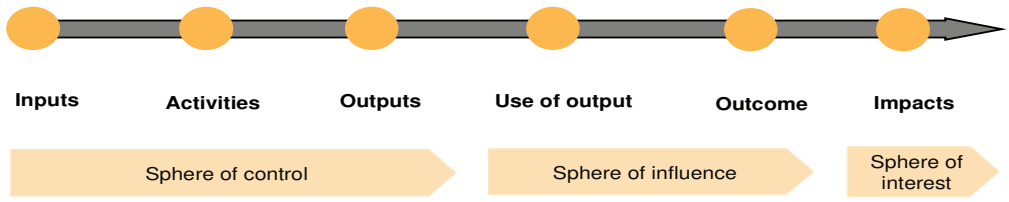
Table 4b: Capacity building plan for existing service providers

Agenda	Issues identified	Strategies / focus areas	Expected outputs
Technical capacity	General lack of awareness of HIV and gender issues; lack of understanding of migration and vulnerability	Basics of HIV and issues related to stigma and discrimination and vulnerability	Reduced Stigma and Discrimination Services are responsive to gender and vulnerability issues
Attitudes & norms	Little or no awareness of gender equitable norms and misconceptions about HIV.	Gender and gender equitable norms along with myths and misconceptions	Shifts in mindset and behaviours in relation to gender and mobility
Rights & duties	No formal training on Human Rights Lack of awareness on the entitlements of mobile population	Gender and gender equitable norms along with myths and misconceptions	Shifts in mindset and behaviours in relation to gender and mobility

1.2.5 Measuring results

Capacity development interventions must also work across multiple levels and make explicit how short-term activities (e.g. stand alone training sessions) contribute to long-term learning outcomes and how these, in turn, link to organisational and systems changes. This is critical if we are to demonstrate results.

In developing these Learning Series documents we drew on a results chain approach to assess the effectiveness of the project interventions.



The results chain incorporates 'use of output' that allows us to ask, whether or not various orientation and training sessions have been applied into practice. As such it eliminates a 'big jump' between output and outcome that is generally based on assumptions and attribution. The results chain also distinguishes sphere of control from sphere of influence and sphere of interest.

Table 5 provides an illustrative example to show how working across multiple levels (women's groups, border police and security officials and media) contributed to changes in health seeking behaviours and safe migration.

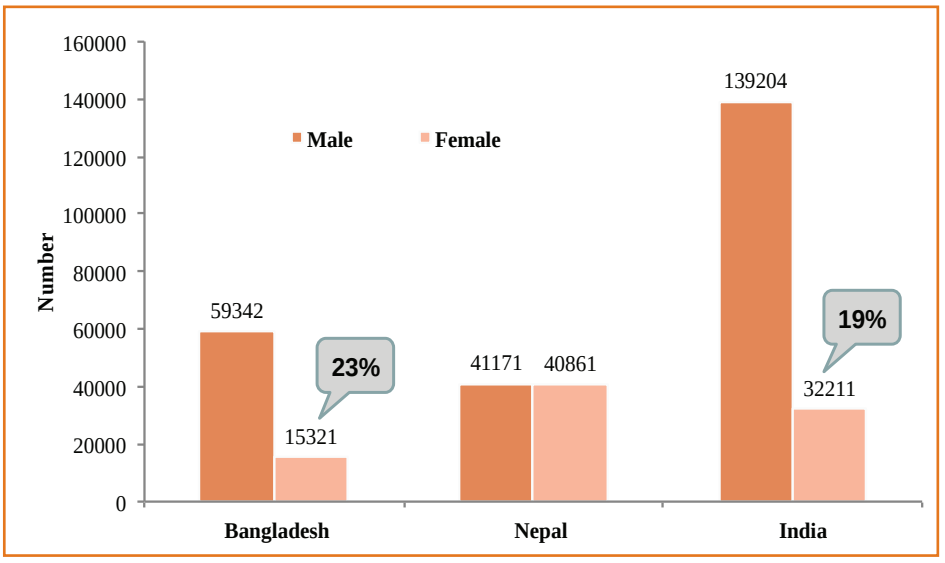
Table 5: Working with women's groups to bring about positive changes in health seeking behaviour and to promote safe migration

Inputs	Activities	Outputs	How outputs were used	Outcomes	Impact
• Design and contextualise orientation / IEC materials • Prepare peer educators for working with women's groups	• Form spouse groups in villages with high family migration history • Conduct orientation and training sessions e.g. HIV/STIs, safe mobility, financial literacy and managing remittances	• Spouse groups formed at source • Increased awareness of HIV & STIs, safe mobility and safe remittances, bank accounts opened etc. • Savings groups formed	• Spouses receive remittance via bank accounts • Inter-spousal talk about safe migration and HIV • Women coming forward for STI treatment • Increased number of women and men going for VCCT	• Women have control over remittances and making decisions about how money is utilised • Increased number of women able to exert control over their sexual and reproductive health • Increased number of migrants accessing and maintaining ART treatments	Reduced vulnerability to HIV
• Project staff develop reporting formats to build evidence of harassment	• Project staff monitor and record cases of violence and harassment at transit	• Reliable data generated about number and types of harassment at border crossings	• Findings shared in cross-border meetings with border security, transport officials, media etc.	• Decrease in cases of violence and harassment at transit	Reduced vulnerability to harassment and violence
Sphere of control			Sphere of influence		Sphere of interest

1.3 Achievements

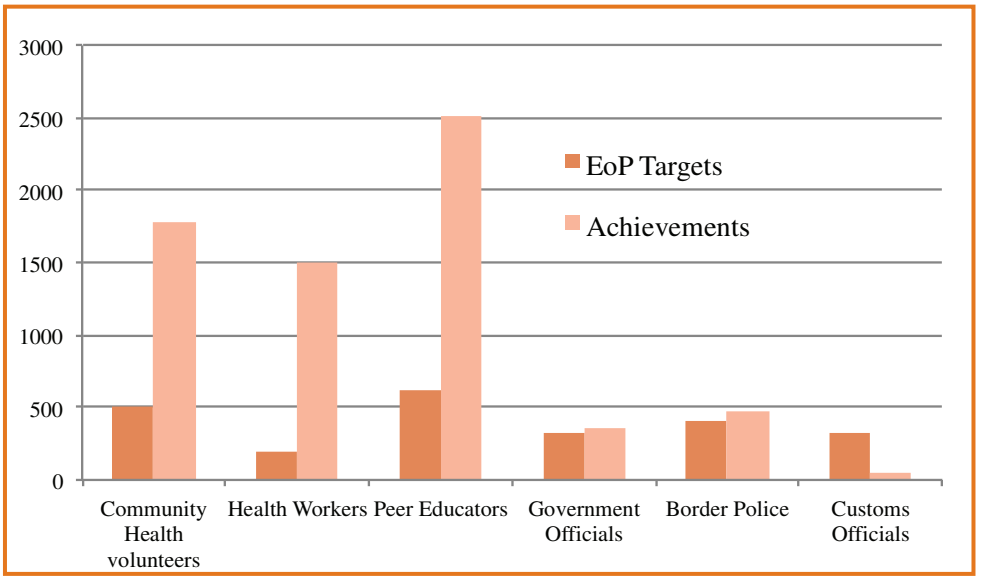
Figure 4 compares the numbers of individuals reached at source and destination (second quarter, year 5). In Bangladesh, the project reached out to more men (around 75%) than women (25%), because of the focus on male truckers at the Indo-Bangladesh border. Truckers are recognised at risk of infection from HIV and other sexually transmitted disease and a potential bridge to their wives and to Indian and Bangladeshi sex workers (Azim 2013). In Nepal, the project reached equal numbers of men and women (50%), which reflects the large numbers of men who migrate from the Far Western Region of Nepal (Wagle et al. 2011). There were also higher numbers of Nepalese and Bengali-speaking male migrants at destination.

Fig. 4. Impact populations (individuals) cumulatively reached by country and gender



By year five, the project had reached out to about 340,000 individuals across all three countries – including migrants and their families plus a wide range of stakeholders across the mobility continuum. The project had also exceeded all end-of-project targets (Fig. 5).

Fig. 5. Progress against end-of-project targets



But the story of EMPHASIS is not only about what the project set out to do in terms of project targets, but also about how it catalysed change in ways that were not initially envisaged in the design phase. By year three the project was addressing a wider range of issues, including migrating safely and workers' rights; and various forms of violence (violence against women and harassment); safe remittances (and access to financial services); children's access to education; and stigma and discrimination. At the time of implementation, EMPHASIS was the only project in South Asia working with migrants across these mobility corridors. As such the project has contributed significant new insights to the domain of migration and development, that will be of interest not only within South Asia, but also more globally.

In particular, the project demonstrated that it is possible:

a. To facilitate cross border programme linkages along migration corridors.

   EMPHASIS built up chains of partnership to establish program linkages that extended across the mobility continuum (from source to transit to destination and back to source) and brought about collaboration amongst an array of stakeholders. These cross border synergies were key to reducing the vulnerabilities of migrants and their spouses to HIV and AIDS and to promoting safe mobility (Samuels 2014; Sarin 2014). The project:

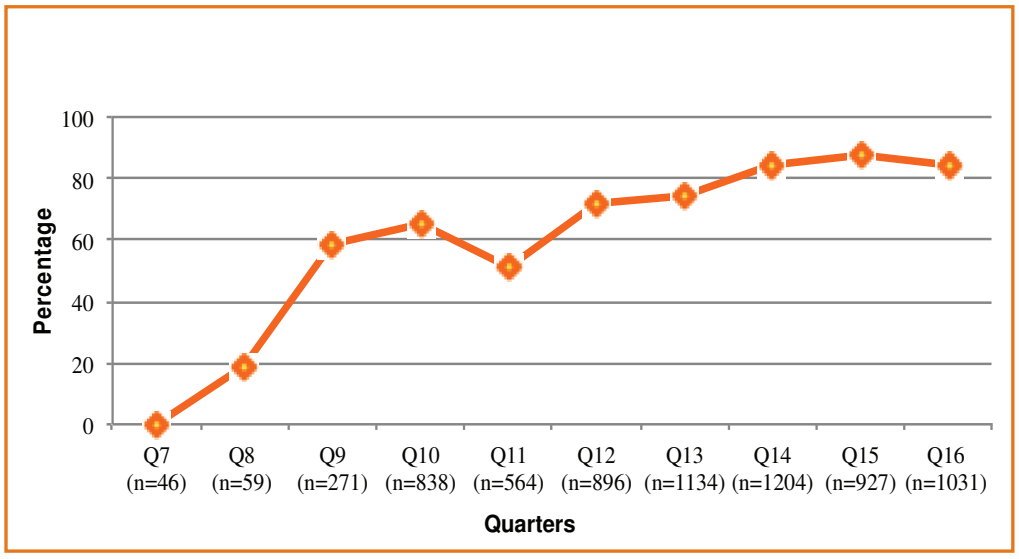
   - Worked closely with local to national-level government authorities in all three countries, especially with guidance from National AIDS authorities, to streamline and align its implementation strategies with national priorities and to support information sharing and face-to-face exchanges amongst high-level government officials.
   - Engaged with UN agencies, the International Organization for Migration (IOM), development partners, civil society organisations and migrant networks and research institutions to expand the dialogue about migration and development.
   - Engaged with a range of stakeholders across the mobility continuum, including public and private sector health service providers; local nongovernment and community-based organisations; hoteliers and food stall owners; transport unions, bus drivers and rickshaw pullers; money transfer agencies and banks; and border security and police officers to address issues related to safe migration, safe remittances and referral to services.
   - Established an information network comprising 700+ outreach workers, peer educators and volunteers as well as drop-in centres and community-resource centres and information desks in order to reach out to migrants and their spouses with HIV-related information and messages about available referral services and safe mobility.

b. To facilitate access to HIV-related services (including ART referrals) for cross border migrants.

   The project facilitated cross-border ART linkages for Nepalese migrants going to and returning from India. It also supported the government of Bangladesh to establish two district-level "best practice" VCT clinics and supported the government of Nepal to strengthen district-level VCT/ART case management. In both cases the services provided are oriented to the needs of pre-departure and returning migrants.

   The project facilitated referrals to counselling and testing services, reproductive health services for women, nutrition services for people living with HIV (PWHIV), trafficking and legal services for returning migrants that had been sexually or physically abused and to organisations providing support to intravenous drug users, men attracted to men, and female sex workers. At the same time, the project encouraged behaviour change that led to increased uptake of HIV and migration services by migrant populations. Figure 6 shows "referral success" across locations (where referral success is an indicator of uptake of services by migrant populations).

Fig. 6. Access to services and referrals



Results:

- More than 20,000 migrants and their families (48% female) were referred for VCT and STI services.
- 59% of those referred followed through and accessed services.
- The percentage of those that accessed services rose from 20% in year two to over 80% in year five.

A key learning from the project is this: non-government organisations, like CARE, are able to work in border spaces and to bridge geographic boundaries in ways which national governments and UN agencies may find challenging. The value added is captured in these comments from one of the implementing partners:

> The approach of integrating HIV prevention and care and establishing a continuum of services from source to transit to destination has created an enabling environment for non government organizations to expand their services beyond borders... the level of partnership has been lifted up and created opportunities for working with community-level stakeholders like transport unions, hoteliers, private hospitals and banks... [this] also provided a platform to address issues of safe mobility [Bipn Thapa, GaRDeF, Achham, Nepal].

c. To promote safety and dignity and reduce the incidence of harassment and violence across the mobility continuum.

An information network that included 37 service centres (drop-in centres, community resource centres and helpdesks) was located at strategic locations across the mobility continuum. These service centres provided a space for migrants and their families to come together to seek out information and to ask questions about particular concerns. Project outreach workers and peer educators (recruited from amongst migrant communities and stakeholders from along mobility corridors) staffed the service centres. Community-led groups – mainly women's groups at source and destination – ensured that migrants and their families received and shared consistent information related to migration and health and safety. A referral network was rooted in the outreach network and in the mobilisation of existing service providers. Standardised, yet multi-lingual and context-specific, social and behavioural change communication materials (SBCC) were disseminated across the network and also included pre-departure information. Community-led Management Committees helped to create an enabling environment and a gateway into communities.

Each year there was a steady annual increase in the number of migrant populations accessing the EMPHASIS service centres, and over time, they proved to be a robust strategy for reaching out to cross-border migrants.

An innovation of the project was to work with both public and private sector actors to provide mobile drop-in services to reach out to communities that were unable to access the EMPHASIS centres because of work pressures. These mobile services have been complemented by outreach activities.

Uptake of the EMPHASIS drop-in centre approach by others

- JEEViKA, a Rural Livelihoods Project under the umbrella of the Bihar Rural Livelihoods Promotion Society, aims to enhance the social and economic empowerment of the rural poor in Bihar. The project includes a focus on the livelihood security and wellbeing of migrants. A team from JEEViKA, following a field visit to an EMPHASIS drop-in Centre and assessing its value-added, made a decision to adopt Drop-in facilities into its own work.

Table 6 shows the number of contacts made through outreach activities (those made via static and mobile drop-in centres and those made by outreach workers visiting migrants in their communities).

Table 6: Outreach activity contacts

Individuals Reached and Number of Contacts	Male	Female	Other	Total
Total number of individuals reached	268471	76829	9	345309
Total number of contacts (individual & Group interactions)	693208	299667	179	993054

The EMPHASIS approach to safe mobility is described in Learning Series, part 3. In summary, the EMPHASIS intervention strategies for promoting safe mobility included:

- Extending the information network across the mobility continuum to provide migrants and their families with advice and information on HIV and safe migration and their rights.
- Co-opting as allies, rickshaw-pullers, police/border police, private transporters, hoteliers and others that contribute to violence and harassment.
- Activating accountability mechanisms.
- Supporting spouse groups at source and migrants at destination to open bank accounts to secure safe remittances.

d. To bring about these changes in ways, which empower women.

The project worked with existing and helped to facilitate the formation of new community-based groups. These included women's solidarity groups at source and destination, PWHIV support groups and other community-based groups. They helped provide information and supported access to referrals and community home-based care. They facilitated income generation through vocational training and livelihood support.

The EMPHASIS approach to women's empowerment is described in part 4 of the Learning Series. In summary, 55 women's groups were evolved in Bangladesh, India and Nepal made up of migrants, spouses of migrants, returnee migrants and HIV+ women. These provided creative platforms for women's leadership in South Asia and opened up conversations about HIV and STIs, safe migration, safe remittances and violence against women. In so doing the women encouraged positive health seeking behaviour change amongst women and men and addressed discrimination and exclusion and challenged accepted norms about what women can and should talk about.

A key learning has been that interventions at source and destination increase communication between spouses, which can reduce women's vulnerability to HIV and lead to more equitable conjugal relationships.

e. To advocate for wider political acceptance of cross-border migration.

Beginning in year three, advocacy (grounded in field experience and research studies commissioned by the project) became a powerful programming tool to gain wider political acceptance of cross-border mobility within the region and, following on, to gain support for addressing the vulnerabilities migrants populations experience across the mobility continuum; for promoting safety and dignity (by reducing violence and stigmatisation); for promoting migrants' rights and entitlements (and thus access to services); and for recognising women as agents of change and economic actors.

Among others, the project facilitated national and regional dialogues on migration and development and safety and dignity; and discussed migrant issues, health insurance and identity cards with Indian and Bangladeshi Parliamentarians.

The next section in the Learning Series – Reducing HIV vulnerability – looks at how the project addressed HIV-related vulnerabilities and promoted access to services for migrants; developed a cross-border ART referral mechanism between Nepal and India; strengthened health services at source in Bangladesh and Nepal; and supported HIV+ migrants (HIV-related services and community-based care).

Reducing HIV vulnerability

Summary

Within the broader frameworks of migration, the health and wellbeing of labour migrants is a major concern. The International Organisation for Migration (IOM 2012), building on the World Health Organisation's goal of achieving universal health coverage (WHO 2012) and a rights and justice framework, has suggested that public health interventions and other multi-sectoral actions should address the underlying issues of health, with specific reference to those related to migrants, regardless of legal status. But discussions about migrants' rights are often overshadowed by the sensitivities around the topic of migration, for example, statehood and national security or concerns that migrants will burden already over-extended health systems. Such viewpoints lead to marginalisation and exclusion of migrants.

The experience of migration involves crossing physical, cultural and emotional boundaries, and the conditions in which migrant workers find themselves (including isolation and poor working conditions) make them vulnerable to HIV and other health risks (UNAIDS 2008). Peer pressure and freedom from the familiar social norms that regulate behaviours at home may also provide migrants with opportunities to explore their sexuality and to engage in behaviours that create risk of HIV. Addressing the vulnerability of migrants to HIV requires that we adopt strategies that bring about changes in awareness, which are then translated into positive changes in behaviours and uptake of health services. It also requires that we address circumstantial constraints, such as safety and dignity, stigma and discrimination, isolation and exclusion, the low social status of women, or gendered notions of masculinity that fuel sexual risk.

This part of the Learning Series begins by providing a snapshot of the HIV epidemic in Bangladesh, India and Nepal where the EMPHASIS project operated. It then looks at the project's response and results achieved, describing first interventions to strengthen VCT (voluntary counselling and testing) services in district-level government health settings in Bangladesh. Next there is a description of how the project worked with public sector service providers in Nepal and India to develop a model for cross-border ART (antiretroviral therapy) referrals. Examples are also given of linkages established with public and private sector service providers to arrange health camps and mobile VCT services, and with civil society actors to expand the range of services available to mobile populations. Reference is made to parallel efforts to create uptake among migrant communities. The next section looks at specific concerns related to HIV vulnerability and people living with HIV. The final section summarises the lessons learned.

Key messages

- Creating cross border synergies and operating at source, transit and destination is key to reducing the vulnerabilities of migrants and their spouses to HIV and AIDS.
- It is possible to establish cross-border ART referrals for HIV+ migrants so that they can maintain ART medication without disruption.
- Community-led processes that build inclusive and cohesive communities can reduce stigma and discrimination among migrant populations at both source and destination.
- Organisations like CARE, with a multiple country presence, are able to broker cross-border programme linkages to facilitate a continuum of services for migrant populations from source to transit to destination.

They left me to be alone

I am Hasina. I am 26 years old. I have 2 brothers and 1 sister. Our father died when I was young, so we had to depend on our brothers to support the family. I went to school for only 3 years. In 1997 my family arranged for me to marry an agricultural labourer. My husband's family wanted a dowry of Taka 40,000 (US$500.00). My parents could give only US$60, so my husband and his family made life miserable for me. They scolded me about the money, saying we had cheated them. They beat me. [Finally] it was settled in the village court that I should return back to my family's home.

In 2000, my brother-in-law, who worked as broker, convinced me to go with him to India. He said I could get a job as a domestic worker. But he lied, and sold me into a brothel. I worked in the brothel for a year and saved some money. I then visited my family in Bangladesh for two months, before returning to India to again work as a sex worker. I did this for four years. By then I had a good relationship with one of my clients, Ali, who was also from Bangladesh. I got married again. Ali worked as a hawker, selling kids wear and fruit. At around that time I became ill, and one of my friends at the brothel helped me get to the hospital. It was then that I found out I was HIV positive. Ali also tested HIV positive. Three months later we decided to come back to Bangladesh.

We have been back now for six years. We live nearby an EMPHASIS Community Resource Centre. Several times, an EMPHASIS outreach worker and a woman from the Self Help Group approached us and said, "As returnee migrants you should go to for a check up". But we were taking our time and trying to avoid them. We thought that if we went for a check-up and other people found out we were HIV positive then they would say hurtful things about migrants from India. We didn't want to disclose our HIV status. Perhaps if we hadn't been so afraid to talk to others and to seek medical help, things might have been different. But then one day my husband got very ill and, finally, we had no choice. So, I took him to the hospital. The doctor referred him to the VCT Centre, and he tested as HIV+. As his wife, I was also tested and showed up as HIV+. Things moved fast then… my husband died only a month later in August. I went back home, and things started to go downhill. People in the community learned about my husband's death. They started to gossip in front of me, saying, "This disease is caused from sexual activity… not from being chaste". They also threatened me, "When the police come to hear about your disease, they'll come and take you away and shoot you".

After my husband's death, the villagers were unwilling to talk to me… I was alone.

But one day some women from the Self Help Group approached me. The group comforted me, and they talked to different community members about HIV and AIDS. They also approached the Union Parsihad chairman and committee members to enlist their support. As the villagers became more aware of HIV and their misconceptions, they began to open up and now people are talking to me – I feel more accepted [Hasina, Bengali-speaking, returnee migrant woman].

2.1 The context

The governments of Bangladesh, India and Nepal have adopted the WHO (2012) ART guidelines. All three countries are in agreement that services at ART centres will be open to all HIV patients, and will not discriminate against any person who asks for services.[2] Access to ART is free of cost in all three countries. However there are major challenges in accessing these services. In source countries, penetration of HIV testing centres and ART services is low. Further, in the destination a migrant needs to produce a proof of residence (something that is extremely difficult for cross border migrants). Further, the attitudes and behaviours of personnel within the centres discourage people from coming forward, and not all VCT/ART centres are receptive to migrants.

HIV prevalence rates in South Asia are relatively low but the absolute figures of people living with HIV (PWHIV) are higher when compared to other countries and contexts. Table 1 summarises HIV prevalence data for Bangladesh, India and Nepal. Overall HIV prevalence in Bangladesh is as low as 0.1%. But the rate of new infections increased by more than 25% between 2001 and 2011 (UNAIDS 2012), leading some to describe the HIV epidemic as latent rather than low, with potential risk of spread of HIV from currently-identified most at risk populations to housewives and entertainment workers (Azim 2012).

[2] Global database on HIV-specific travel and residence restrictions (at: http://www.hivrestrictions.org/Default.aspx?pageId=142)

Experts also fear that widespread discrimination towards people who test positive for HIV may leave infections unreported. Various studies have identified migrant workers, injecting drug users, sex workers and men who are attracted to men as most vulnerable to HIV infections (IRRIN 2013). Contradictory and incomplete data point to a need for more nuanced research and analysis of HIV prevalence amongst different sub-populations in Bangladesh.

Table 1: HIV and AIDS estimates at source and destination

	Bangladesh (Population 160 million)	India (Population 1,237 million)	Nepal (Population 27 million)
Number of people living with HIV	8,000 [3,100 - 82,000]	2,100,000 [1,700,000 - 2,600,000]	49,000 [39,000 - 65,000]
Adults aged 15 to 49 prevalence rate	<0.1% [<0.1% - <0.1%]	0.3% [0.2% - 0.3%]	0.3% [0.2% - 0.4%]
Adults aged 15 and up living with HIV	7,600 [3,000 - 80,000]	1,900,000 [1,600,000 - 2,400,000]	45,000 [36,000 - 60,000]
Women aged 15 and up living with HIV	2,700 [1,000 - 28,000]	750,000 [610,000 - 940,000]	14,000 [12,000 - 19,000]
Deaths due to AIDS	<500 [<200 - 2,300]	140,000 [100,000 - 170,000]	4,100 [3,100 - 5,600]

Source: UNAIDS http://www.unaids.org/en/regionscountries/countries/ (2012)

In Nepal, the HIV epidemic is concentrated within certain at risk populations, with a prevalence of 0.3%. Highest prevalence is seen among the 20-39 years age group. Labour migrants contribute nearly a third of the total estimated number of HIV+ cases. Almost half of those who have tested HIV positive have a migrant work history (Suvedi 2013). Prevalence is relatively high amongst men who have sex with men (14%) and higher amongst females (27%). Within this group of 27%, 1% occurs amongst female sex workers and 26% amongst low risk women. That is, HIV invertical fection is becoming feminised in Nepal, shifting from "most-at-risk" women to "low-risk" married women, exposed to HIV by the sexual (and injecting drug) practices of their husbands (Fileo-Borrommeo 2014).

As in Bangladesh and Nepal, the Indian epidemic is concentrated within vulnerable populations at high risk for HIV and is also higher in certain States. While all the high prevalence States show a clear declining trend in adult HIV prevalence, several of the most at risk groups have high and still rising HIV prevalence rates. The bulk of HIV infections in India occur during unprotected heterosexual intercourse. Consequently, and as the epidemic has matured, women account for a growing proportion of people living with HIV, especially in rural areas. Several factors put India in danger of experiencing rapid spread of HIV if effective prevention and control measures are not scaled up throughout the country. These factors include: unsafe sex and low condom use; men who are sexually attracted to men (relatively little is known about the role of sex between men in the Indian HIV epidemic); the low status of women; injecting drug use; migration and mobility; and widespread stigma (World Bank 2012).

Across all three countries, an absence of reliable data and systematic research are barriers to planning for and implementation of comprehensive migration policies that operate across national and regional boundaries, even thought this is a vital first step towards effective protection of South Asia's migrant workers. In general there has been a focus on generating data for monitoring purposes; more reliable and nuanced data could inform decision-making and allow for tailored responses. Stigma and discrimination against people living with HIV and those considered to be at risk persist and undermine efforts to increase the coverage of effective interventions. This includes harassment by police, "unfriendly" health care providers, and exclusion by family and community.

2.2 Response and results achieved

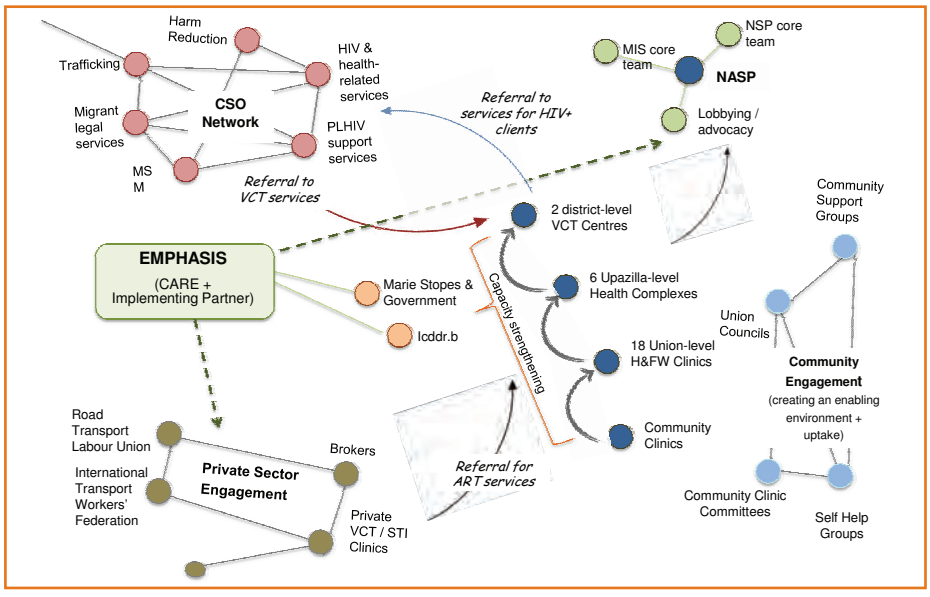
2.2.1 Establishing VCT Services in government health settings in Bangladesh

Voluntary HIV counselling and testing is widely recognised as a critical entry point to ensuring and sustaining treatment and care for people with HIV and essential for the prevention of vertical HIV transmission (WHO 2010). In Bangladesh, Jessore and Satkhira are important transit points for labour migrants moving to and from India. Previously there was one VCT facility operated by Family Health International (FHI) and two private clinics in Jessore and Satkhira, but no government VCT services. This "gap" provided an entry point for CARE project staff to engage in discussions with local and national authorities. Following on, district health authorities made a request for EMPHASIS to support establishing one VCT centre in the Satkhira Medical College and another in the Jessore Government Hospital. The proposal was to build on and extend the infrastructure available in the two government facilities and to use these two sites to develop VCT Centres that could be replicated elsewhere. EMPHASIS had already established a place at the table with NASP (National AIDS/STD Programme), through contributions to two working groups (the National Monitoring and Evaluation Working Group and the Working Group to develop a Migration and HIV National Strategic Plan of Action), and approval for setting up the two Centres was readily granted by the Directorate General of Health Services in the Ministry of Health and Family Welfare.

In each location the government's contribution included the laboratory facilities and lab personnel and a counselling room that would allow for confidentiality and privacy. EMPHASIS provided support to upgrade the lab facilities and funding for testing kits and other necessary equipment; renovated the counselling room in each location; and then recruited and trained a counsellor. Standard operating procedures were introduced for managing and consolidating patient records, ethics and confidentiality and other important considerations.

The project recognised that it would need to do more if the services offered by the Centres were to be utilised and sustained. Given the widespread discrimination in Bangladesh towards people who test positive for HIV noted above, the first concern was to promote uptake. Through its community engagement activities with women self help groups and community support groups, the project raised awareness of HIV and migration issues and encouraged women and men to come forward for counselling and testing. For women this included awareness of STIs as well as HIV. Parallel activities occurred with truckers regularly transporting goods across the border (described below).

Fig. 1. Health Service Strengthening in Bangladesh



The second concern was to strengthen capacity across the whole system (Fig. 1). Working in collaboration with the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr.b), Marie Stopes and government staff, EMPHASIS supported training in syndromic management of STIs for Upazilla Health Complex health staff, Union Health and Family Welfare clinic staff, and Community Clinic staff. At the same time, training was provided to private sector clinics operating in the two districts. Linkages were also strengthened with civil society organisations providing migrant-focused services (for example, trafficking and legal services or those working with men having sex with men, injecting drug users, hijra (third gender) and transgender groups to ensure individuals diagnosed with HIV would receive community care and to further encourage uptake of the VCT services.

Results:

Enhanced VCT service access for both migrant and non-migrant populations living in Jessore and Satkhira.

- Standard operating procedures for VCT clinical services introduced into the two district-level hospitals.
- 93 health service providers (government and nongovernment) received training in Jessore and Satkhira districts on Syndromic Management of STIs, HIV and Voluntary Counselling and Testing, HIV and AIDS care and the rational use of ART and sensitisation on migration issues.

Since opening in May 2012, the clinics have generated data about HIV prevalence. Table 2 shows data generated across four different locations in Jessore and Satkhira. Sample sizes are small, and so no definitive conclusions can be drawn. But it is noted that the two EMPHASIS-supported clinics register a prevalence rate of 1.16%, and that all those that tested HIV+ had a migrant family history. The Family Planning International (FHI) clinic in Jessore indicated a prevalence rate of 0.47% with three times as many women testing positive than men. This clinic is located in an area where there are many truckers, and it could be that the truckers are a bridge to the women and/or a link to entertainment work. The Family Planning Association clinic records show a prevalence of 0.47% and the private clinic records zero cases. Obviously the data cannot be assumed to be nationally representative. Nevertheless these anomalies warrant more detailed investigation. For example, are male migrants a bridge to female spouses? What is known about how male-male sex behaviours are impacting on the population? What about other mobile sub-populations?

Table 2: HIV data reported from clinics in Jessore and Satkhira districts, Bangladesh

VCT Service Centre	Total case load	Tested HIV+
EMPHASIS supported (May '12 – Jan '14)		
Jessore district hospital	1,180 (859 / 321)	17 (8 / 9)
Satkhira district hospital	728 (382 / 346)	15 (3 / 12)
Prevalence	1591	32 = 1.16% (includes 1 girl & 3 boys)
FPAB affiliate of IPPF (since Oct. 2003)		
Family Planning Association of Bangladesh, Jessore	879 (522 / 357)	8 (5 / 2 + 1 child) = 0.91%
FHI supported (since 2006)		
Madhumita Shurakha SMC, Jessore	4,600 (95% / 5%)	21 (5 / 16) = 0.47%
Private clinic (since Feb. 2011)		
Nalta VCT Centre, Satkhira	656	0
National HIV data: Estimated HIV+ = 8,000 (var. 3,000 – 82,000 / 36%) = <0.1%		

The multiple linkages and results in this capacity development initiative are summarised in Table 3.

Table 3: Building capacity across the whole system

Partner relation	EMPHASIS's role	Results achieved
Capacity building of Community Clinics Ad-din (27) & Rights Jessore (25)	**52 community clinics** Training provided on migration and HIV and AIDS, condom use and STI / VCT referral services for staff	Community Health Care Provider now doing condom demonstrations & distribution, distributing IEC/BCC materials and making STI and VCT referrals.
Capacity building of Union Health & Family Welfare Centres Ad-din (8) and Rights Jessore (10).	**18 UH&FWCs** Marie Stopes and government personnel training on STI syndromic management; SOPs introduced (supply management, treatment guidelines, reporting format, registers and referral slips); STI medicine provided (lobbying with government to take over supply).	UHFWC doing condom demos and distribution; providing STI syndromic diagnosis and treatment; and making referrals to STI and VCT services,
Capacity building of Upazilla Health Complexes Ad-din (3) Rights Jessore (3)	**6 Upazilla-level Health Complexes** Training facilitated on STI syndromic management (as above) for doctors at and introduced SOPs.	Health Complexes providing STI syndromic treatment and referral for STI and VCT.
Establishing VCT Clinics at the Jessore and Satkhira District Hospitals	**2 District-level VCT Centres** VCT centres set up, one in each district hospital; training facilitated on STI syndromic management for doctors; iccdr.b trained government staff on VCT SOPs and quality assurance.	Referrals are being made from outside hospitals for both STI treatment and for HIV VCT; HIV+ patients are being referred for care and support to 2 PWHIV organizations; District Civil Surgeon lobbying with Secretary of Health for resources to sustain services.
Collaboration with private VCT service providers	Training facilitated on VCT services for three service providers	VCT services are being provided to truckers and preliminary monitoring shows SOPs are being adopted e.g. FPAB now provides pre- and post-test counselling.
Collaboration with private STI service providers	Training facilitated on STI syndromic management and VCT best practice for five services providers plus discussions on joint communications and advocacy; joint quarterly meetings to promote learning related to referrals and quality assurance issues; IEC/BCC materials exchanges.	Referral linkages established and operating; potential for joint lobbying established; agreement by private service providers to offer reduced fees to mobile population clients.
Linking up with PWHIV organisations	MOUs established with Mukta Akash Bangladesh and Geon Health Foundation organisations for provision of care and support services for HIV positive clients.	Organisations are providing HIV-related care and support services for migrants identified through VCT clinics.

2.2.2 Working with truckers in Bangladesh

I've been working as a trucker's helper for 9 years. I started when I was 9-years old. I've used drugs and alcohol and engaged in unprotected commercial sex in both Jessore and Khulna (one of the oldest river ports in Bangladesh). I continued this even after my marriage. But through the encouragement from the project, I went in for counselling and testing. I was negative, and have started to use condoms when I have sex [Poran, trucker's helper, Benapole].

Everyday truckers (truck drivers and their helpers) from both Bangladesh and India transport goods across the Indo-Bangladesh border. The truckers are continually on the move and spend long periods away from their families. At Benapole – the most commonly used border transit point when traveling between Kolkata and Dhaka – as many as 600 trucks cross over each day. When they arrive at truck terminals in Bangladesh, they need to wait for permission from Customs before they can unload. This

can involve anything from 3 to 10 days. During these wait periods the truckers hang out, talk together, drink alcohol and engage in sex (that can include male–male sexual behaviours with each other). A study conducted by EMPHASIS (CARE Bangladesh 2006) reported that 33% of the truckers had paid for commercial sex workers within the previous six months, and that 8% of the Indian truckers and 17% of Bangladesh truck drivers had also experienced male-male sex during the same period (usually with their helpers). These sexual experiences took place in parking lots, truck stops, or in the cabin of the truck. Condoms were rarely used during anal sex. These behaviours are rooted in the truckers' notions of being men "on the road", as well as in the broader social and economic landscape. Truckers are thus at risk of infection from HIV and other sexually transmitted disease and a potential bridge to their wives and to Indian and Bangladeshi entertainment workers.

The EMPHASIS project partners began by facilitating sensitisation meetings with transport/lorry union officials in Jessore and Satkhira. The meetings focused on HIV and STI prevention strategies and safe mobility, with a particular focus on vulnerability and risk factors affecting truckers. Information was also included about how to access VCT services and related health referral information. Second, and in parallel, there were meetings with border officials and local authorities to ensure the project would be able to access the truckers and to ensure that these officials would become more aware of their role as duty holders in promoting safe mobility.

These sensitisation workshops were then echoed with the truckers themselves. Out of these meetings, and building on recommendations from the truckers, the project established a Drop-in-Centre with embedded clinical services at Benapole. EMPHASIS outreach workers located in the centre became the contact points for the truckers and provided 1-1 and group health education sessions (HIV and STI prevention and care) and condom promotion and distribution.

Life skill sessions were also an important entry point to reaching out to both Indian and Bangladeshi truckers, especially for those men who had received little education. These sessions included discussions about the social dimensions of HIV, resisting peer pressure, negotiating safe sex (significant given the power dimensions between helpers and drivers) and coping with stress. In all, life skill sessions were also offered to nearly 1,800 Indian and Bangladeshi truckers.

Results:

- By year five (second quarter) the project had reached out to 36,492 truckers, including 20,618 Bangladeshis and 15,874 Indians.
- Life skill sessions were offered to 1,795 Indian (36%) and Bangladeshi (64%) truckers.
- The interventions led to an increase in self-reported shifts in attitudes towards using condoms in casual sex encounters.

I used to inject drugs and regularly visited sex workers. I was infected with STIs and my health was run down. Once a boy from my village was injured and his father was desperately looking for a donor with O-negative blood. A group of people came to me to donate blood. I was worried about doing it, because I'd had unsafe sex with multiple partners and had an STI. But I couldn't tell them, so finally I went ahead. A few days later I met with one of the EMPHASIS outreach workers in a life skills session. He talked about HIV and STIs, safe migration and condom use. So I went to the testing centre and had an HIV test. The test result was negative. I have developed a good relationship with the outreach worker and often visit the Drop-in Centre. I've stopped visiting brothels and sex workers. I want to lead a happy and long life [Hasan, trucker, Benapole].

2.2.3 Facilitating cross-border ART referrals between India and Nepal

I've been working in India for 20 years. I first started feeling ill while I was in India. So I went back Nepal. But then I was working in the fields and I felt dizzy and I lost weight. The doctor told me to go for a test. I started to feel guilty. I just wasn't ready to go. So I asked my wife to come with me… When I found out I was positive, my world came crashing down – there was darkness… Our family and neighbours asked us what was wrong. I didn't know how to answer… A friend connected me to the EMPHASIS team, and I went to the hospital to get ART. Then I had to come back to India to work to support the family. When my medication ran out I had to go back to Nepal. That meant taking time off work and losing

money. Or I could ask someone else who was going back to get the medication from my wife… I didn't really want to do that, as then I have to explain why. I don't want people asking a lot of questions. Sometimes the medicines ran out and there was a gap before I could start again. I know that's not good but what can I do? Now we can access medicines here in India. I don't have to rely on getting medicine brought in by others from Nepal. It feels more secure and I don't have to talk about my HIV status to others [Sameer, HIV+ male migrant, Mumbai].

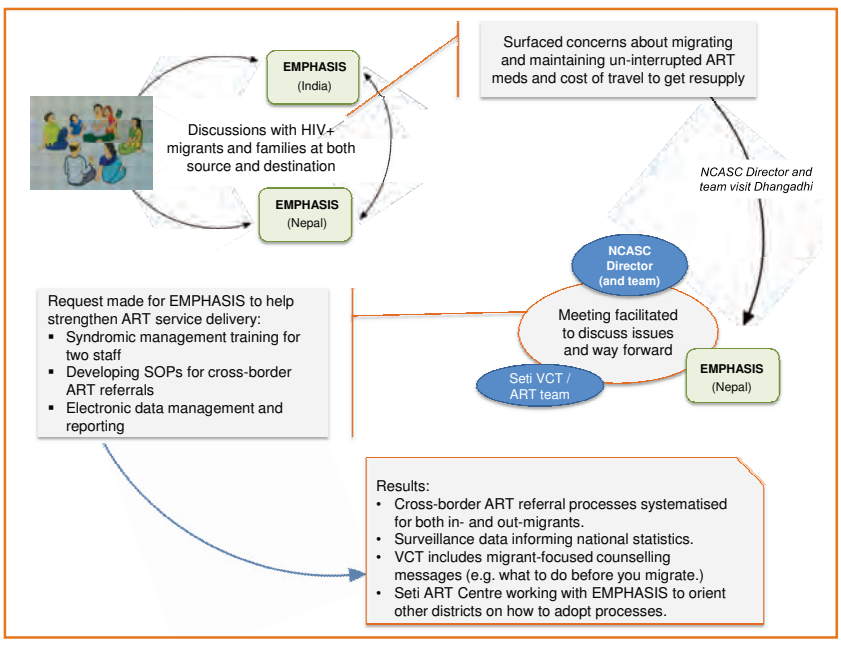
Nepalese migrants who are HIV+ and working in India can access ART services either through private clinics or through government public health services. Private clinics are expensive and thus beyond the reach of most migrants. Article 7 of the 1950 the Indo-Nepal Friendship Treaty states that: "The Governments of India and Nepal agree to grant, on reciprocal basis, to the nationals of one country in the territories of the other the same privileges in the matter of residence, ownership of property, participation in trade and commerce, movement and other privileges of a similar nature."[3] But there is no clarity about what "similar nature" means and whether or not this extends to government services and schemes. Even when a Nepalese HIV+ migrant had a transfer certificate issued back in Nepal, not all public health service staff was willing to accept the certificate. In any case, the migrant was required to again test for HIV and CD4 levels, another inhibiting factor. Some Nepalese, diagnosed while in India, came home and started on ARV medication in Nepal, and then again returned to India for work This meant they needed to return home every two months to follow up and to renew their prescriptions. But not everyone could take time off work. When they could, they lost wages and had to cover the travel costs. Some tried asking friends who were returning to Nepal to bring back their medication. This sometimes meant having to reveal their HIV status. It also meant that their medication was often interrupted.

Discussions with migrant populations in Mumbai and Delhi surfaced concerns about migrating for work and maintaining uninterrupted access to ART treatments. This prompted the project teams in Delhi and Mumbai to work with the ART centres towards developing an alternative to testing again in India and of getting acceptance of transfer certificates from ART centres in Nepal. The project team in India then got in touch with the project team in Nepal, to explore options and to formulate an advocacy response.

Working with the public sector in Nepal

In Nepal, the project began by enlisting support for setting up cross-border referral processes in both Nepal and India. In Nepal this involved parallel discussions with the National Centre for AIDS and STD Control (NCASC) and with the Seti VCT/ ART Centre in Dhangadhi, Kailali district. Following on the NCASC Director and his team made a visit to Dhangadhi and EMPHASIS facilitated a joint meeting with the Seti ART team. While the meeting focussed on the issues raised by HIV+ migrant populations, the EMPHASIS team was careful to also ask how the project might support the NCASC in achieving broader objectives related to HIV and STIs.

Fig. 2. Cross border referrals in Nepal



[3] See, for example: Indian Treaty Series: Treaty of Peace and Friendship between the Government of India and the Government of Nepal [1950] INTSer 12, at: http://www.commonlii.org/in/other/treaties/INTSer/1950/12.html

Out of this meeting, it was agreed that the project would help strengthen ART service delivery and should work with the India project team to develop standard operating procedures for cross-border ART referrals. A formal MOU (memorandum of understanding) outlined the expected results and clarified roles and accountabilities. EMPHASIS in Nepal then worked with the Seti Centre to develop a referral card and necessary documentation (client VCT Report and Transfer-out Card; client ART Report; and contact name and address of recommended ART Centres in India). A requirement from the health authorities in Nepal is that Nepalese planning to migrate to India or any other country inform their ART centre in Nepal at least one month prior to departure, so the referral form can be prepared in time.

Significant results:

a. Cross-border ART referral processes have been systematised for both in- and out-migrants at both source and destination.

b. Accurate and timely surveillance data is now informing national statistics.

c. The Seti Centre included migrant-focused counselling messages into its VCT services, e.g. if you are HIV+, here's what you need to do before you migrate.

The Seti ART Centre also worked with EMPHASIS to orient other districts on how to adopt processes, and the scheme was subsequently taken up by the Bayalpata Hospital in Achham (which, at the time, had a caseload of 1,298 HIV+ men and women, of whom 191 were receiving ARV medication). Prior to July 2013, the Bayalpata Hospital only gave out HIV medications on Thursdays and Fridays. But this was not convenient for many HIV+ patients, some of who had to travel long distances from adjoining districts) to get to the hospital. Others had travelled back from India to renew their prescriptions and needed to return to their places of work. EMPHASIS and the Seti ART Counsellor lobbied with the ART Centre at Bayalpata Hospital to give out ARV medication daily. Two EMPHASIS project team members supported the counsellor to manage the extra workload, helped out with record keeping and talked to patients about the importance of maintaining medication regimes.

Across the border into India

Working in close consultation with district, state and national-level AIDS Control Organisations in Delhi (Delhi State AIDS Control society), Mumbai (Mumbai District AIDS Control Society), and Kolkata (West Bengal State AIDS Control Society), the India project teams assisted in the development of the cross-border referral processes and procedures. They also met with staff in hospitals nearby project sites in Delhi, Kolkata and Mumbai to sensitise the staff to the needs of the migrant populations and to encourage their support. This meant that both Nepalese and Indian health authorities accepted the referral procedures and there was buy in for moving ahead. A critical breakthrough occurred when the EMPHASIS project managed to convince the ART centres to accept a guarantee from the EMPHASIS implementing partners in lieu of address proofs.

The India project teams also strengthened linkages to PHLIV Networks in India so that HIV+ migrants would be able to access support groups, nutrition services and other services available through civil society actors. And the project began to socialise these new opportunities through its Drop-in-Centres, women's groups and network of outreach workers and peer educators to encourage HIV+ migrants at destination to take up the services. Parallel work with mobile ICTC (Integrated Counselling and Testing Centres) (see below) in Mumbai, Kolkata and Delhi were instrumental in identifying HIV+ Bengali-speaking and Nepalese migrants and linking them into services.

The Nepal and India teams also shared VCT referral documentation via email to help facilitate linking migrants to cross-border VCT and referral services. For example, project staff in Nepal worked with HIV+ pre-departure migrants, giving them information about the VCT/ART Centres closest to their intended destination in India and also contact information for an EMPHASIS staff member at the nearest project facility (either a project office location or a Drop-in Centre). This meant the staff person at destination was notified in advance of the arrival of an HIV+ migrant and could prepare the way.

Aarnod first went to India to work in 1988. He was diagnosed HIV+ in 2007 after experiencing continuous fever and weakness. He went back to Nepal and got tests done with the help of a NGO working on HIV. Through the project he was able to get free counselling and testing and treatment and some money to cover food and travel costs. After 3 years, he felt better and so he went back to India for work. But every two months he needed to go to Nepal for his follow up and to get a resupply of ARV medication. This meant time off work and loss of income.

Ranjit, one of the EMPHASIS outreach workers in Delhi, approached Aarnod to tell him about how he could get ART medication in Delhi. At first, Aarnod was suspicious and avoided the contact. But after 3 months Aarnod came forward and asked for help. The EMPHASIS team in Delhi (with help from the CARE India country team) then got in touch with the EMPHASIS partner working at source. Ranjit was told to scan and email Aarnod's medical records. The partner NGO in Nepal then arranged and emailed back the completed referral documents. Aarnod was then able to access free ARV medication from the GTB Hospital in Delhi. For only $1.25 / month he can access a medication to boost his CD-4 count.

It was also possible to support referrals for Bengali-speaking HIV+ returnee migrants that were returning home.

Hasan (aged 52) and his wife, Lata (38), had two children and had been living in India for nearly 7 years before. The family was very poor, and Hasan was barely able to provide for the family's needs. An EMPHASIS outreach worker from the Action Research Centre talked to the family about their vulnerability to HIV and encouraged them to get tested. They agreed, and he accompanied them to a VCT Clinic in a government hospital. Both Hasan and Lata tested positive. She began ART immediately, as her CD-4 count was low. Her husband was told he did not need to start treatment. The wife began attending monthly PWHIV meetings organised by the EMPHASIS project. Her husband did not because of his work hours. So, the project team made follow-up visits to the home. Noting the family's poverty, the project team became concerned that they were under-nourished. So the EMPHASIS team approached a local trust that was able to provide supplementary nutrition support to the family.

Given their poverty and the constant police harassment, the couple decided to move back to Bangladesh in early 2013. The NGO provided the couple with referral letters and contact information for the Ad-din Welfare Centre (the EMPHASIS implementing partner in Jessore) and told to make contact on arrival. A message was sent to Ad-din to expect the couple. On arrival an Ad-din outreach worker accompanied the couple to the VCT centre at Jessore district hospital. The VCT counsellor recommended they repeat the HIV test. This they did. Following on the counsellor referred them both to Mukta Akash Bangladesh – a PWHIV organization working in partnership with EMPHASIS – for further care and support. Through the linkages facilitated by EMPHASIS, the couple has been able to receive HIV-related support free of charge.

Once the referral mechanism got started, the project teams began follow up, to monitor whether or not migrants were able to access services, what was the nature of care and support they were receiving, and if they were adhering to their ARV regimes.

Table 4: Cross border ART linked

	Total	NMP	BSP
PWHIV linked for ART across borders	78	75	3
Self referred (those who heard about and took advantage of available services)	20 (29.4%)	20 (31 %)	0

Table 4 shows the number of successful cross-border ART referrals that were facilitated through the project and also the number of individuals who self-referred, after hearing from others about how to secure cross-border ARV medication. More broadly, EMPHASIS incorporated this work into on-going advocacy and dialogues at national and regional-level forums to make public "what's possible" and also to initiate discussions about how to scale up these successes.

These results are a confirmation of three project outcomes:

#1 Willingness of stakeholders (service providers, authorities, PWHIV networks) to sustain a cross-border model and an indication that migrants will take up health services if they are confident of being well received.

#2 Reinforced capacities of key stakeholders and impact populations across the mobility continuum.

#3 Successfully lobbying a range of actors to bring about change.

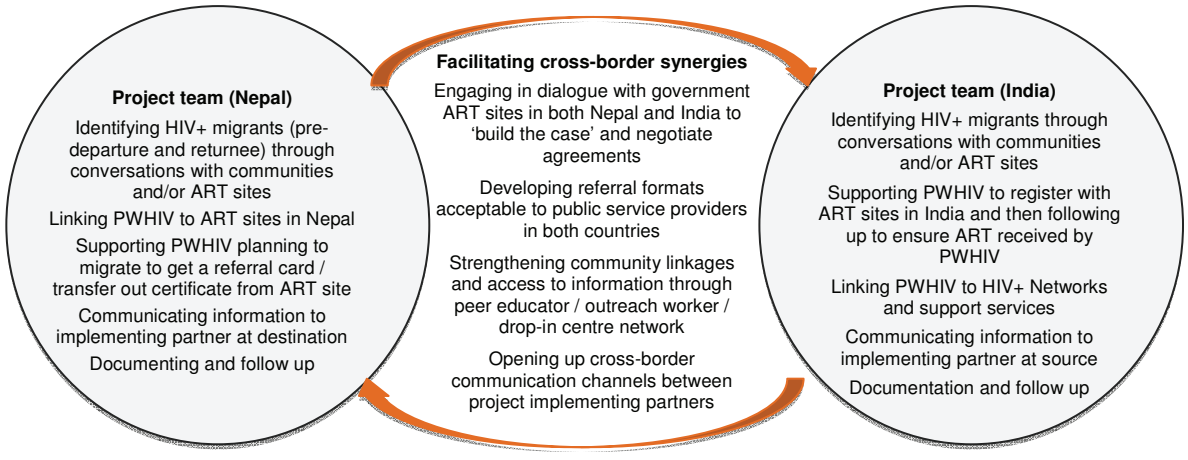
Replicating the approach

Below is a summary of the processes required at source and destination to replicate the cross-border ART model elsewhere. The EMPHASIS cross-border referral pilot facilitated migrants' access to ART medication in India, without migrants having to repeat the HIV/CD-4 testing process. The system involved establishing linkages between implementing partners (local NGOs) in Nepal (Achham and Kanchanpur) and India (Delhi and Mumbai) and coordination with ART sites in Mumbai and Delhi in India and Kanchanpur and Achham in Nepal.

At source:

The implementing partners in Achham and Kanchanpur interfaced between the migrants and the ART sites in Nepal to make sure each HIV+ migrant would get a transfer certificate prior to departure. They also worked with government ART staff in Nepal to include information about transfer certificates into VCT counselling sessions. (This meant potential migrants would be adequately informed about arranging a transfer certificate if they decided to migrate at a later date.) The implementing partner also provided HIV+ migrants with information about service sites in India and contact details for the nearest EMPHASIS project team and forwarded the details to the team, so they would be ready to help, if needed.

Fig. 3. Facilitating cross-border synergies



At destination:

On receiving a referral through the Nepal team, the implementing partner in India acted as the sponsor for each PWHIV, verifying the identify and address with the ART Centre in India. This then allowed the Indian authorities to waive the proof of residence requirement and to accept a guarantee provided by a project implementing-partner. They also did the same for HIV+ migrants identified at destination.

Apart from cross-border referrals, HIV+ migrants were identified through outreach and social and behavioural change (SBCC) activities that increased knowledge and awareness and encouraged uptake. When migrants "put up their hands" to get tested, outreach worker staff offered to accompany individuals and groups to the counselling and testing centres. This helped overcome hesitation and to allay their concerns. Project teams also worked with the testing centres, sensitising them to the work of the project and the needs of migrant populations. Another strategy was to utilise mobile testing vans to reach out to migrants who were reluctant to come forward or who could not get off work during the day (below). These strategies proved successful and 149 people were identified as HIV+ in this way and were registered for pre-ART consultation. Those requiring ART were then provided with medicines.

Results:

- A total of 78 PWHIV migrants were successfully linked through cross-border referral to government ART sites in Delhi and Mumbai.

  Note: The cross-border referral mechanism has reduced the likelihood of double counting of HIV cases at the regional level. That is cross border migrants diagnosed as HIV+ at destination and travelling without transfer certificates were counted twice at the regional level when tested again at destination.

- A further 149 migrants at India, 330 in Nepal and 32 in Bangladesh migrants were found to be HIV based on referrals to testing centres, and were also enrolled for services from government centres.

Key success factors in making this work were:

a. Advocacy – engaging in dialogue with government ART sites in both Nepal and India to 'build the case' and negotiate agreements.

b. Developing referral formats that were acceptable to public service providers in both countries and sensitising public service providers to the needs of migrant populations.

c. Providing migrants with information about the service linkages via the outreach workers and peer educators and drop-in centre network (described in Learning Series, part 3, Migrating safely).

d. Opening up cross-border communication channels between project implementing partners at source and destination.

2.2.4 Mobile solutions for mobile populations

Health camps and mobile ICTC services

The project, in collaboration with government service providers, organised health camps and mobile ICTC services to reach out to populations that might not want to come forward to government hospitals or clinics, or who were unable to get time off from work during the day. Where there were no readily accessible government services, the project linked private practice doctors and other service providers into the mobile health camps. The ICTC camps organised by the EMPHASIS India country teams in Mumbai and Delhi were instrumental in identifying HIV+ Bengali-speaking and Nepalese migrants and linking them into services. They also provided primary care services and families and reproductive health services for women (Behera et al. 2013).

- In Mumbai, for example, a total of 238 Bengali-speaking migrants attended 9 ICTC camps; 8 (equal to 3.4%) were found HIV positive and referred to hospitals.

  Research findings (Sarin 2013) found that there was an increase in awareness and uptake of HIV testing amongst the impact populations, but that utilisation of services was influenced by contextual social mores and physical factors such as distance to facilities. Therefore, while destination sites in Delhi saw a high rate of HIV testing among the impact groups, uptake rates were lower in Nepal due to distance of testing facilities, restrictions on mobility that women face because of their workload and the conditions imposed by living in joint families and also lack of money to cover transport and food costs while away from home. The response in Nepal was to organise mobile HIV Testing and Counselling and STI Camps for people who had not accessed district-level services. The mobile camps provided testing and counselling services (so that clients would understand what a positive or negative result meant), provided treatments for STIs and where necessary, made referrals. The mobile camps were set up in coordination with the National Centre for AIDS and STD Control (NCASC) and with district-level HIV and STI service providers, who then offered their personnel and expertise. EMPHASIS provided logistics and financial resources needed to mobilise the district-level services.

- During the period November 2011 to April 2013, there were 13 mobile camp days conducted in 12 Village Development Committees.
- A total of 1,101 people (867 women) were able to access testing and counselling services: 863 individuals received on-site treatment for STIs; 5 cases were identified as HIV+ and referred for follow up.

2.2.5 Expanding uptake

As shown in Figure 3 (above), the project also facilitated linkages to civil society organisations that provide parallel services that can be accessed by migrant populations. The purpose was: (a) to expand the range of available services (such as, nutrition services for people living with HIV, pre- and post-natal health services; anti-trafficking, groups supporting non-violence and so on); and (b) to draw on existing services so that migrants could continue to access these services after the project had closed.

Standardised, multi-lingual and context-specific SBCC materials were disseminated across the mobility continuum to create demand and update of available among migrant populations. These IEC materials were disseminated via an information network comprising project outreach workers and peer educators; safe travel sites (project drop-in centres, community resource centres and help desks located strategically along the mobility continuum); and women's solidarity groups (described in Learning Series, part 3). The materials included pre-departure information; information about HIV/STIs and available referral services and how to access these at source and destination; and behaviour change training materials.

2.3 Support to PWHIV – promoting social inclusion and wellbeing

> I don't tell anyone. If I tell them they'll want to ask questions… there are misconceptions everywhere. People still think you can get infected from shaking hands. At least we know the facts and don't have to worry about that. But others just don't know. So I don't tell anyone about my status. If I tell them, and then they reject me, I'll feel disappointed. If someone asks why I am taking medicines, I just say that it's a 2-year course for malaria [Rohit, Nepalese man in HIV+ support group, Mumbai].

> I live and work as a housekeeper in Kolkata. Both my daughter and I are HIV+. The NGOs working in our neighbourhood are always telling me to go and get my medication. But I don't go. It takes all day, and the train journey to the hospital and back leaves me feeling stressed and tired. I have to take off one full day from work, and my boss cuts my wage by Rupees 50. This is a lot of money for me. I am the only earner in my family… I face stigma and discrimination within the community because people know about my HIV status. I have kept my daughter's status secret, as I fear she might be thrown out of school [Susmita, Bengali-speaking widow with a 12 year old daughter].

People sometimes express surprise at why those who are HIV+ (or those who suspect they might be) do not come forward for testing and/or treatment. It is important to remember though that the fear of stigma and discrimination is a powerful and troubling emotion. Stigma and discrimination against people living with HIV and AIDS and those considered to be at high risk remain entrenched. Being diagnosed with HIV opens up complex emotions and responses. For this reason, the EMPHASIS project stressed the need for working in ways that would promote inclusion and dignity. In Mumbai, for example, the project established a HIV+ support group for Nepalese migrants. For Sameer, the group brought comfort and quiet to his life, as he explained, "a place where I can be with other men who are also HIV+, I get some peace. I can speak out".

Sadia, a young Bengali-speaking woman described the complex responses she experienced when her husband and then her baby died of HIV-related complications and how the gentle persistence of the

outreach worker (you can live life like everyone else) helped her move forward. As peer educator for the women's group in her community, Sadia's social status improved considerably. She developed new confidence and hope, making it possible for her to hold her head up again.

> When I was diagnosed, my husband blamed me. Later my baby died, and I lost hope. My life was changed when I lost my child. I may have accessed treatment after that, but it was less to keep myself alive than to make some sense of all that tragedy. Sometimes I took my medicine, sometimes not.
>
> [When I met the outreach worker] I was very unhappy. The first time we met, I told her: Go away, I don't have time to talk to you. She said: Just give me two minutes. [Laughing] I snapped back: I don't even have two minutes. She talked to me about why it was important to be regular. She said I could be healthy and live life like everyone else… Now I am taking my medication and I do feel well. I have a job as a domestic worker. I also do my peer educator activities. The role has given me courage and hope. I've shifted now. If I'm on the train and see a woman looking distressed I'll speak to her. I'm giving back now.
>
> This EMPHASIS project has changed our community. The area was uninhabitable earlier, especially for young girls and women… frequent sexual abuse and dirty remarks followed us everywhere. Since the sensitisation workshops, awareness has been raised. We have grown into a habitable and decent society. I want to study further now, and help the young girls. I consider it a great achievement to be able to influence even one life [Sadia, female peer educator in a Bengali-speaking community in Mumbai].

Community support groups operated in the same way at source in both Bangladesh and Nepal. The purpose of these groups was to provide a caring environment to PWHIV and their families and to ensure they could lead their lives with dignity. The groups brought together women (and their children) who were HIV+ with other women who were not, all of whom shared a migrant history. While the EMPHASIS outreach workers were instrumental in getting community support groups started, their role was largely facilitative. The intention was that community members lead and take key decisions that affected their lives. It was the community, for example, that nominated the peer educator from within the group and decided on issues that were most important to them.

> Some of the women who are living with HIV in the Far Western Region of Nepal are widows who lost their husband to HIV-related illnesses. They struggle to sustain their livelihoods, bringing up children alone. They fear stigma and discrimination both from their extended families and the broader community, and they may lack social, spiritual and economic support.
>
> Pabni is HIV+ and a widow. She lives with her young daughter and aging mother-in-law (who also needs looking after) in a village in Achham. Pawan is not always able to cope, especially at those times when she feels ill. She gets her support from the Shanti (Peace) Community Support Group. When Pawan fell ill, group members got her to the hospital and stayed by her side for four days. Other group members took care of her house, child and mother in law. Pawan remembers vividly that her husband never admitted his HIV status and how she herself became infected through ignorance: Those memories of embarrassment have now been erased [Pawan, a widow and member of Shanti support group].

In Kolkata, the Community Resource Centre Management Committee facilitated access to community members in Madhyamgram, North 24 Parganas. Similarly the Cossipur Masjid Committee in north Kolkata helped the community access the Bengali-speaking community when the Imam agreed to announce project activities through the public loudspeakers (that were also used for prayers).

The formation of women's groups at destination was also key to promoting inclusion of PWHIV through interventions that facilitated group savings and access to income generating activities, community-based care, access to health and nutrition services. HIV+ women were invited to speak at sensitisation programmes and to highlight challenges they had met and how they had successfully coped with these. This motivated other women to actively engage in reducing stigma and discrimination in their communities.

The project also worked closely with existing PWHIV networks. In general the PWHIV networks have established rapport with governments and donors and are linked into national HIV and AIDS responses to HIV prevention and care. They are thus able to connect PWHIV to civil society organisations, to public and private sector service providers and to the media. The PWHIV networks are also positioned to advocate on behalf of PWHIV at local, national and international levels. Connecting with and connecting across PWHIV networks in Bangladesh, India and Nepal has thus been an integral component to reduce

vulnerability to HIV. Accordingly the project developed MOUs with PWHIV Networks to support HIV+ migrants referred by the project including:

- In Bangladesh, Mukta Akash Bangladesh and GEON Health provided nutrition support, counselling and referral services.
- In Nepal, the National Federation of Women Living with HIV to conduct advocacy initiatives and with Sachetana Nari Samaj (a women-led PWHIV organisation in Kanchanpur) facilitated access to services.
- In India, the North 24 Praganas Network of Positive People in Kolkata, the NPM+ Network in Mumbai, and the Delhi Network of Positive People and the Haryana Network of Positive People in Delhi/NCR also facilitated access to ARV medication and enrolment in government targeted intervention programmes.

Representatives from the networks also contributed in EMPHASIS-led meetings to provide information and inspiration to communities.

In addition to referring HIV+ migrants to PWHIV networks, EMPHASIS organised a regional PWHIV consultation (Sharma 2013) that brought together PWHIV networks and government and civil society actors from Bangladesh, India and Nepal to explore how the project could draw on the strengths of the PWHIV networks in each country to facilitate cross-country linkages, to support access to health and related services for HIV+ migrants and to strengthen cross-border ART linkages.

2.4 Lessons learned

Organisations like CARE, with a multiple country presence, are able to broker cross-border programme linkages, and thus to facilitate a continuum of services for migrant populations from source to transit to destination. In particular the project demonstrated that it is possible to provide HIV-related services for both documented and un-documented cross border migrants throughout the mobility continuum.

Measurable results have been:

a. Facilitating cross-border ART linkage between Nepal and India so that mobile populations can maintain ART regimes when they migrate;

b. Supporting the government of Bangladesh to establish two district-level “best practice” VCT clinics; and

c. Supporting the government of Nepal to strengthen district-level VCT/ART case management.

In both Bangladesh and Nepal the project worked within existing healthcare systems and built linkages to community-led groups and grassroots organisations, rather than create parallel systems for migrants. In India, all the referrals and services were to existing service providers in both government and private settings. This clearly positions organisations such as CARE as facilitators and highlights the importance of evidence-based programming and advocacy.

The project demonstrated that community-led processes that build inclusive and cohesive communities reduce stigma and discrimination among migrant population at both source and destination. Linking HIV+ migrants to PWHIV networks at destination allowed them to access a wide range of government and nongovernment services and also to benefit from counselling and group support.

Working on migration and HIV opens the door to addressing a wider range of issues that more broadly relate to migration and development, not the least being addressing the stigma and discrimination against people living with HIV and those considered to be at risk. EMPHASIS showed that it is possible

to develop community-led processes that build inclusive and cohesive communities to address the stigma and discrimination among migrant population at both source and destination.

Key success factors to reducing HIV vulnerability were the ability to build trust and confidence across multiple levels (from local to national); the political will and commitment shown by relevant government authorities; placing migrant communities and their concerns at the heart of the dialogue; and working in ways that promote their inclusion and dignity.

Migrating safely (safe mobility, security and dignity)

Summary

Migrants' contributions to development depend upon the realisation of their capabilities and rights (Sen 1999), and their ability to make choices and to move freely and in dignity. But not everyone has the opportunity to do so. Constraints to migration operate across multiple levels and include lack of economic resources, limited social capital, forced migration and human trafficking and legal restrictions to migration. Decisions to migrate are often taken at the family level, and individual family members (in particular women) may feel they have no choice. Migrants must weigh the benefits of migration against the potential social, political and physiological costs (UNDP 2009).

Working on migration and HIV opens up pathways for working on various other issues. The project not only focused on reducing migrants' vulnerability to HIV, but also attended to other factors that contribute to migrant vulnerability. One of these was safe mobility and dignity, a key concern for migrants and their families. This part of the Learning Series looks at how EMPHASIS addressed the various issues surrounding mobility, security and dignity. The opening section reviews literature that shaped the project's thinking. The next section describes how EMPHASIS responded in its programme. It begins with a description of how EMPHASIS established an information network across the mobility continuum; the qualities the outreach workers and peer educators brought to their role; the importance of engaging women's groups at source and destination; and how the project promoted safe remittances. This is followed by a description of co-opting strategies to engage those perpetuating harassment and violence and strategies to activate accountability mechanisms. Then there is a description of how cross border synergies can enable safe migration. The document closes with a discussion of lessons learned.

Key messages

- Few projects work with cross-border migrants at both destination and source; this lack of connection has remained a critical gap in cross-border migrant programming.
- It is possible to promote safe mobility and dignity through multifaceted approaches that:
    - Establish an information network (extending from source to transit to destination) made up of static and mobile safe travel sites, outreach workers and peer educators and community-led groups (primarily women's groups).
    - Co-opt as allies, stakeholders that are exploiting and harassing migrant populations.
    - Work with duty bearers to activate accountability mechanisms and to help them locate opportunities to play an active role in addressing safe migration.
    - Engage local media to publicise and name the exploitation that occurs.
- It is also possible to promote safe remittances and provide women at source with greater control over remittances by:
    - Lobbying banks and money transfer services to develop migrant-responsive banking procedures.
    - Working with migrant populations to build their trust in and encourage use of official money channels.
    - Engaging local media to encourage an enabling environment.

Experiences that change who you are

Usha recounted in a factual manner the tale of when she and her two daughters migrated from Bangladesh:

[The guards at the border] separated the slightly better looking ones and their families from the rest of the crowd, and then the harassment began – on any pretext at all. My daughter, Mary, was a young girl, only 15 at the time. My other daughter was a little older… they kept us at the border for three nights before we could finally cross over. That kind of experience changes who you are. It changed all of us! [Usha, Mary's mother]

Alisha (from Nepal) married at the age of twenty. Two years later, she gave birth to a baby girl. Her husband's family was disappointed, wanting a boy child. She got pregnant again and gave birth to two more daughters. Her in-laws started to abuse her. The neighbours gossiped about her. The family and neighbours would not let her attend public functions or ceremonial rituals. She was treated like an outsider, and her opinions were overlooked. The family began hitting her. Things became unbearable: "It was like I had no identity. People stopped recognising me. I didn't have a role in my family". One day Alisha met a woman named Reshma who convinced her she could have a better life in India. Leaving behind her daughters with her mother, she left with Reshma. Bur when she arrived, everything was turned upside down. She learned with a shock that she was to become a sex worker in Bihar. At first she refused. But several men raped her, and she gave in. Later on she found out that her husband's family had sold her to Reshma for around US$100.00. Three months later she was resold to another pimp in Allahabad, this time for US$400.00. All she got for her work was food and shelter; her earnings went to the pimps. She grew close to a customer, Raju. One day she gathered her courage and fled with Raju to Shalimar Gardens (nearby Delhi). She had a baby with him. But then Raju left, and the neighbours started harassing her about her illegitimate child. She returned to sex work to support herself and child. After some months she managed to save some money and decided to visit Nepal. She reached the Banbasa border late evening, alone and vulnerable. The border security asked her for identity papers. Since she had previously migrated illegally, she had no papers. The border security officers raped her and took all the money she was carrying to give to her mother. Helpless, she returned to Shalimar Garden.

It was at this moment that the EMPHASIS team intervened. Alisha was initially hesitant to interact with the team. But slowly she began to open up and to participate in the various project activities. With encouragement from the outreach worker, she became a peer educator. Alisha has chosen to continue in sex work. She has also become a strong voice, speaking out about safe sex. She steps forward if she sees other women in distress. She has become a point of strength to other women [Alisha, peer educator]

3.1 The context

Labour migrants are subject to various forms of exploitation and discrimination, including harassment and intimidation from border officials, manipulation and extortion by brokers and substandard living and working conditions. They may also be unable or unwilling to access health services at destination because they are intimidated by bureaucracy and 'unfriendly' service providers or held back by lack of documentation, low self-esteem and language barriers.

Women migrants experience multiple vulnerabilities for several reasons: socio-cultural norms that prescribe restrictive "at home" roles for women limit their mobility and impact on their ability to access knowledge and information about the outside world. Women and girl migrants are vulnerable to the risk of being sold by agencies and of sexual trafficking. They are more likely to face harassment at the borders, duping in the recruitment process; changes to their contracts upon arrival; and violence and sexual abuse (Samuels et al. 2011; Samuels et al. 2013). Women migrants employed in unskilled jobs (as in domestic service, the entertainment sectors or small-scale manufacturing) are usually without legal status or access to health services. Women in domestic service are largely invisible from public purview and thus susceptible to exploitation and/or physical and sexual violence. Migrant domestic workers are at risk of physical and sexual violence by male and female members, including grown-up male children, in the employer's family (Timothy and Sasikumar 2012).

South Asian migrants that fall victim to various forms of violation at destination return back with psychosocial stress and/or physical disabilities (Hettige et al. 2012). Some are deported home. Women

who choose to migrate, rather than stay at home do not always enjoy honourable status. Assumptions are often made that they are engaging in sex work, that they are sexually promiscuous, or that they have been violated in some way. But as more women migrate and take on the formerly masculine role of breadwinner (Gamburd 2000), traditional concepts of the value of "women's work" are significantly altered, which in turn affects hierarchies of class, caste and gender. For women, this complicates their reintegration into the accepted social order. Successful return to home countries for all migrants depends on their economic, social and psychosocial reintegration into the society of origin.

The harsh living and working conditions in which migrant workers find themselves and the stigma and discrimination they can experience may predispose them to HIV and other health risks. Separation from family and language barriers can create isolation and loneliness. The absence of familiar social boundaries and freedom from the norms that regulate behaviours at home may provide migrants with opportunities to explore their sexuality and to engage in high-risk behaviours. Cultural barriers that inhibit open talk about sex and sexuality also fuel vulnerability.

For men, migrating for work in order to provide for the household may be seen as a 'masculine' and/or a rite of passage. Husbands achieve their rightful status as family head. Male youth become men. Notions of masculinity define and determine risk-taking, including sexual risk when away from family and when in groups of other men. Migrant men and boys perform masculinity through 'proving' behaviours – for example through sex and drinking, through staying on the job even when severely sick, or through acts of violence – that increase their vulnerability (Verma 2013).

Indian cities have historically been popular work destinations for a large proportion of Nepalese migrants, especially those from the Far Western Region. India has also become a corridor for undocumented migrants from Nepal to move to the Gulf and other locations. By crossing over into India and then contacting a recruitment broker, Nepalese men and women are able to bypass Nepal's migration authorities. It is estimated that 60-70 Nepali women are reaching the Gulf in this way each day, assisted by human trafficking networks (Pandey 2013). This "under-the-radar" movement can make migrants vulnerable to duping and exploitation.

Movement across the Indo-Nepal border is facilitated by the Treaty of Peace and Friendship signed between India and Nepal that allows for free and reciprocal flow of resources and people between the two countries. Despite the treaty and the ease of flow, there continues to be harassment on both sides of the border and poor living conditions, verbal abuse and exploitation by employers at destination. The situation is exacerbated for undocumented Bengali-speaking migrants who must navigate the border crossing through a series of "contracts" with brokers. But while a contract between the migrant and the broker may be established, the journey across the border can be dangerous; hidden deals and bribes between brokers and border patrol leave women particularly vulnerable to exploitation (Sultana et al. 2011).

It is crucial then that comprehensive policies and programs are in place to make migration an experience of dignity and safety for migrant workers and their families. Such programmes should focus on enhancing migrants' capabilities through the provision of pre-departure and post-arrival information and assistance; encouraging ethical recruitment; improving migrants' integration in destination areas (and reintegration on returning home); and lobbying at political level for migrants' rights. They also increase the capabilities of migrant households by ensuring access to services and support to cope with the social costs of migration (EC-UN (2011). Both sending and receiving countries have a role to play in ensuring the positive aspects of migration and in promoting safe mobility.

3.2 Response and results achieved

Incidences of violence and harassment faced by Nepalese travelling to and from India follow recurring patterns. It's not uncommon for migrants to fall into a deep sleep on a bus after accepting a snack or drink from a "kind" stranger (who is also a fluent Nepalese speaker). When they awake they find their belongings have gone. Such was the case for Prem who had been to Punjab in India for health treatment and was returning home to Doti in Nepal. On the bus travelling to Banbasa (the transit point on the Indian side of the border crossing) a fellow passenger offered Prem something to eat. Prem had heard about doping, so he declined. But the man must have slipped something into his water, as the next thing Prem remembers is waking up lying on the roadside. He lost 10,000 Indian rupees (US$160.00), his shoes and a mobile phone. He told some people he met about what had happened, and they gave him 200 rupees, which he used to buy new shoes. He then walked to the Banbasa border crossing.

To learn more about harassment and violence at the border transit points, the project developed simple reporting systems and collected case stories to monitor and report on the number and types of occurrences. This provided a clearer idea of the extent of the problem. Figure 1 shows that Prem's experience was not an isolated event – theft, threatening behaviours (that required some kind of payment or favour) and physical abuse were most common, followed by sexual and verbal harassment.

Fig. 1. Types and number of violence and harassment-related cases

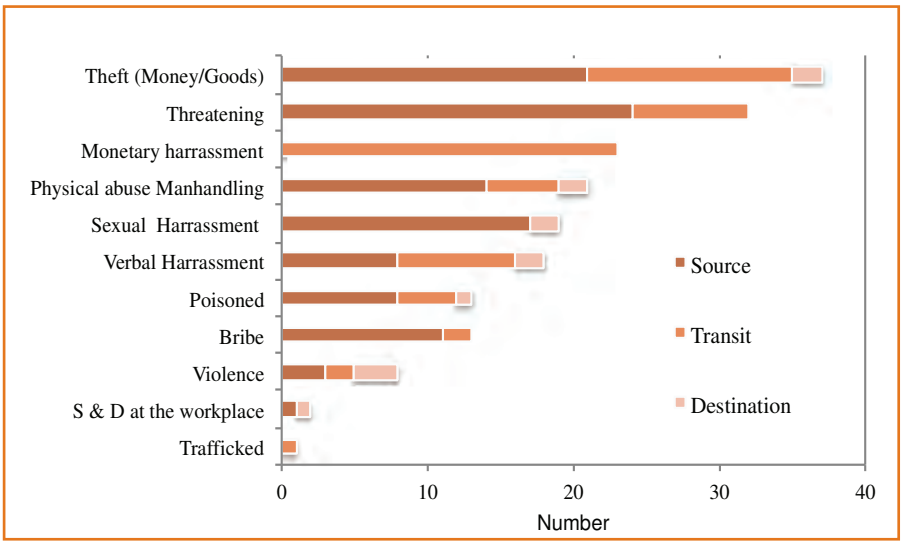
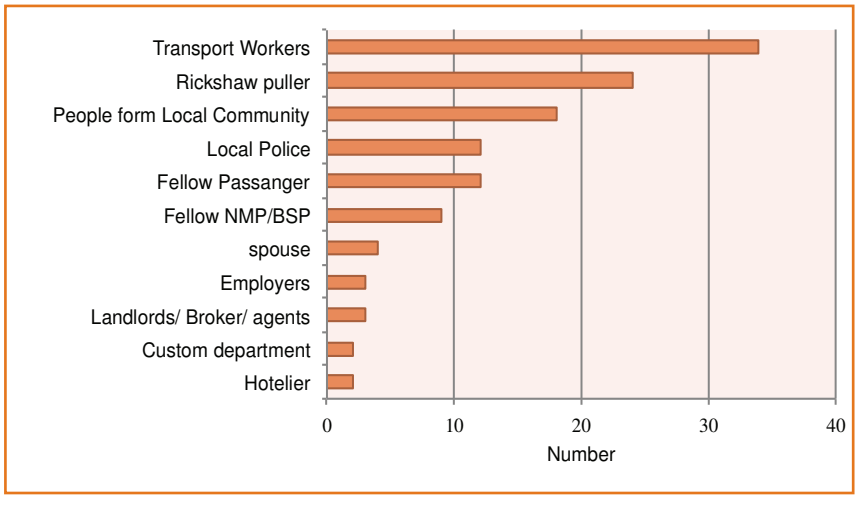


Fig. 2. Who was involved in violence and harassment of impact population?



The data generated also showed that a cast of characters were involved (Fig. 2), most commonly transport workers (at the bus and train stops), rickshaw pullers and "locals". Next were the Indian and Nepalese border police, fellow passengers and other Nepalese and Bengali-speaking persons. It appears that everyone was talking down to the migrants, over-charging in rest stops and restaurants, demanding "service" fees.

The next section will describe how the project:

- Established an information network to ensure migrant populations were more aware of their rights and entitlements, about how to travel safely, and what to do when they experienced harassment and violence.
- Co-opted stakeholders along the mobility continuum in supporting efforts to reduce harassment and violence.
- Activated accountability mechanisms by bringing together migrants and duty bearers.

3.2.1 Establishing an information network

Safe travel sites

EMPHASIS established service centres (Drop-in Centres, Community Resource Centres and Helpdesks) as safe spaces for migrants to meet and discuss their concerns. The centres provided access to multi-lingual and context-specific information and education materials that were standardised across the mobility continuum. These included pre-departure materials about HIV vulnerability and migrating safely; information about HIV and health-related services (and how to access these at source and destination) and information about government policies and legal frameworks. There were also behaviour change training materials, such as the EMPHASIS Pocket Book (summarising relevant source, transit and destination information) and interactive education materials.

Establishing service centres at strategic locations along travel routes with high migrant traffic and at destination nearby high-density migrant populations identified in the baseline survey (Sultana et al. 2011 and Wagle et al. 2011) ensured that migrant populations were able to access consistent and accurate information about HIV and the opportunities and risks of migration. Outreach workers at the centres informed HIV+ migrants about how to access HIV-support services (including antiretroviral medicines). HIV+ migrants returning home were told how to receive care and support on arrival. At source, the information materials were distributed via community-led solidarity groups, nongovernment organisations also working on HIV and migration and through local government offices. The centres also provided counselling services and made referrals to sister NGOs addressing trafficking, violence against women and legal support. Community-led Management Committees ensured the Drop-in Centres and Community Resource Centres remained in tune with community concerns, which promoted ownership and sustainability.

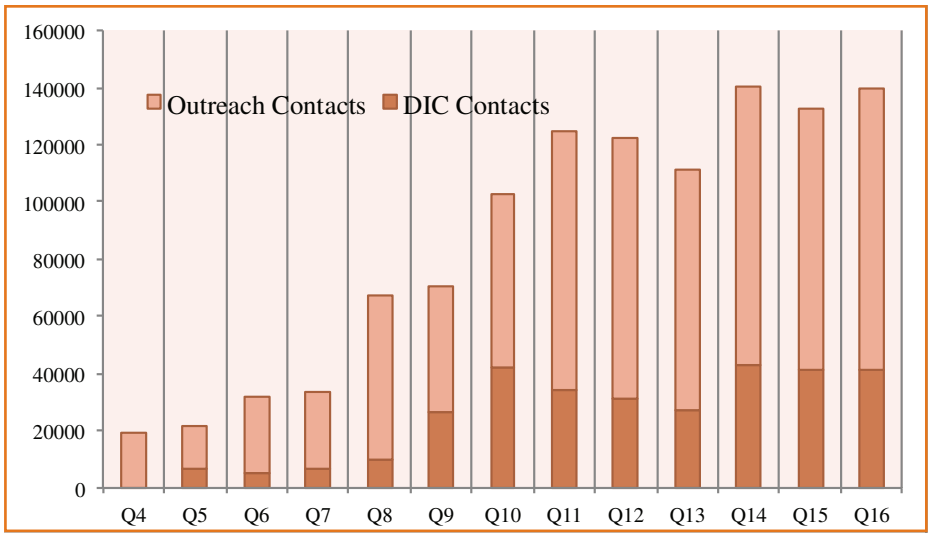
Each year there was a steady annual increase in the number of migrant populations accessing the EMPHASIS service centres (Table 1). Over time, the centres proved to be a robust strategy for reaching out to cross-border migrants.

Table 1: People accessed via drop-in centres (Q2, year 5)

Number of service centres in operation = 37				
	Male	Female	Transgender	Total
Number of Operators / Counsellors / Volunteers	23	18 (55%)	-	41
Number of migrant contacts	357,086	68,442 (14%)	4	425,532

An innovation was to work with public and private sector actors to provide mobile drop-in services, so as to reach out to communities that were unable to access the static centres because of work demands (Fig. 3). The average daily "footfall" at mobile drop-in centres operated in Mumbai and Delhi was four-times higher than at the static drop-in centres (Behera et al. 2013), and were effective in reaching migrants staying in dispersed areas or in non-permanent slums.

Fig. 3. Quarterly trend of contacts made by Outreach team and DICs across the continuum of mobility



The centres also became an axis for migrants to organise community-led events including, for example, World AIDS DAY, International Women's Day as well as religious and cultural festivals and to extend out to a wider community. In this way they helped to breakdown the isolation and loneliness that some migrants experience when away from home and contributed to their social capital.

A second innovation was the emergency fund. The Danpatra Box (Nepal transit) and the Akshaya Patra Fund (India transit) were schemes whereby migrants and others contributed to a fund for migrants who had been looted or harassed in some way and needed money to get back home. These emergency funds continued beyond the project and were managed by community members who make decisions about when funds are released.

Peer educators at work

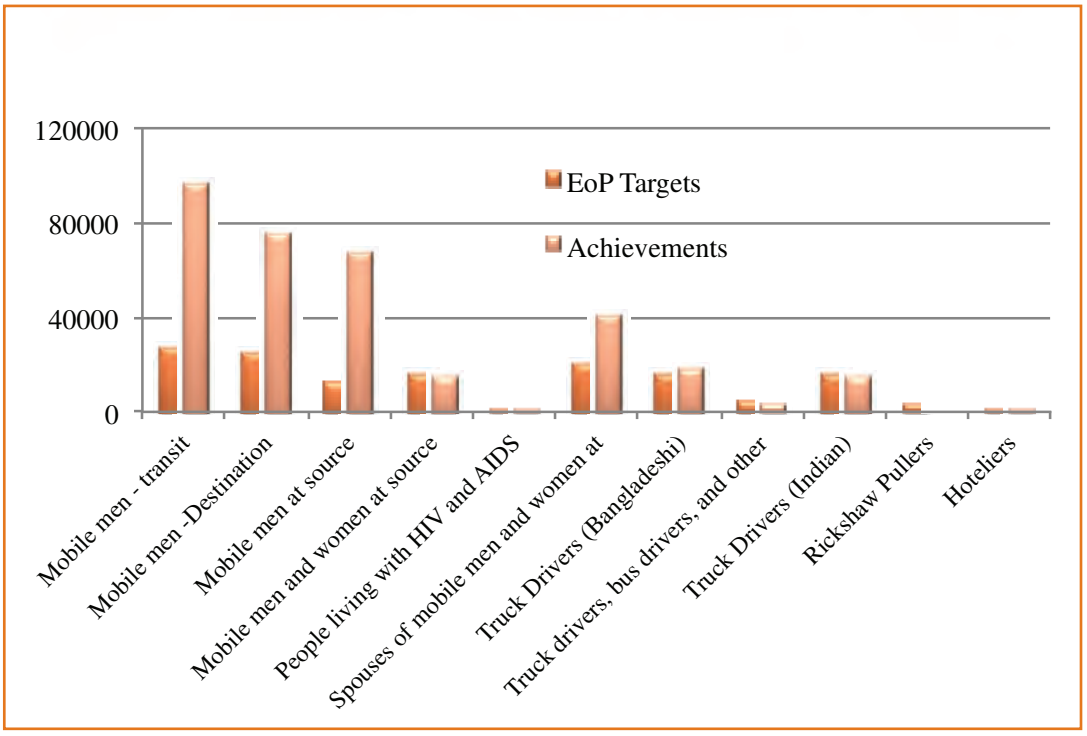
The network of outreach workers and peer educators played an essential role in disseminating information and education materials to mobile populations. The outreach workers were staff of the implementing partners who recruited and trained the peer educators from amongst migrant populations or from stakeholders along the mobility continuum (such as, private sector service providers, transport union officials, rickshaw pullers, hoteliers and local community members). The outreach workers and peer educators became the contact points for the migrant populations. They ensured access to the project's information and education materials and provided linkages to public and private sector service providers, NGO networks and other stakeholders. At destination, peer educators connected with newly arrived migrants, the more seasoned migrants helping the others to settle in and to learn about how to be supported in their new location.

A referral network was rooted in the outreach strategy and in the mobilisation of existing service providers (public and private sector, nongovernment organisations and other stakeholders along the mobility continuum). Supporting migrant-responsive services was a focus of the capacity building initiatives with service providers.

Results:

- In total the project established a network of 700+ outreach workers, peer educators and volunteers that reached out to migrant families and communities, providing information about referral services and safe mobility.
- Through the network, the project reached around 335,000 people in Nepal, India and Bangladesh (by far exceeding end-of-project targets, Fig. 4).

Fig. 4. EMPHASIS progress against end-of-project targets



In interactions with the peer educators and outreach workers across all locations, two themes emerged: the first was a genuine concern for the migrants' wellbeing and a commitment to unconditional giving (we do this because we can help out). Outreach workers and peer educators responded to calls for help from community members at all hours of the day. The second theme that emerged was that the experience of being a peer educator was empowering – it gave meaning to what was otherwise an ordinary life. The following story is illustrative of how a group of young men contributed to safety and security at destination.

EMPHASIS established a Nepali male youth group in an urban slum known as the Rajiv Gandhi Camp, which is situated alongside a railway line in South Delhi. Around 3,500–4,000 people live in the area. The land belongs to the Railways Department. People have been living on the land for 30 plus years. There is a sense of permanence; alleys and pathways are concreted. The one-room 'apartments' are built of brick and stacked one on top of another. The following excerpts are taken from a discussion with seven men from the youth group on a Saturday morning – including a peer educator – in a room rented by one of the members. All of the men had jobs, but had taken time off work to meet us: "Yes we are losing salary today, but we have a responsibility to talk". They began by talking about their motivation for forming a youth group.

When I saw young people smoking drugs and living without hope, I felt hurt. It was like a smoking gun. So a group of us came together and we talked about what we could do. There were lots of problems – drugs, kids not in school, sexual abuse.

And in the community there was no electricity and no clean drinking water [Bishal, aged 22].

Now there are fewer young guys and less old people smoking dope [than before]. More kids are in school, especially adolescent boys who used to just hang around [Prakash, aged 20].

We help boys and girls to enrol in vocational training centres run by the Indian government. When we can, we link them to jobs [Bishal].

I followed my friends in and then stayed. These guys [pointing to the older men in the group] made us aware of the harm we were doing to ourselves. We are now an example to other young people our age. It has motivated us to be better, to be part of the community and to contribute to activities [Sameer, aged 17].

The youth group was also concerned with problems that affected the community more broadly, not just those affecting young people.

Initially someone from the project helped us to write a letter to approach the railway about the problems in this community. We then took the letter to the authorities and explained our situation… The road into the area has since been upgraded. There is electricity connected to each room and there is a water supply… the biggest problem we are dealing with is lack of sanitation… we are struggling with that. Each room has a small area for washing but there are no toilets. We have to cross the railway line and go in the bushes. We've written to the authorities and invited a railway official to look at the situation, but nothing has happened.

The project drew us together; it gave us direction and voice. We were a just a bunch of individuals earlier. We've become a group. Trainings on community management and development have been a boon to the team-we can now take care of things in a much better organised manner. We have had the opportunity of exposure visits, learnt new systems and have gained the power of knowledge and sharing. The Drop-in Centre has become a second home to us, the place where we bring our troubles and resolve our issues [Kiran, group leader and peer educator].

Supporting fellow migrants during times of emergency was a rallying factor for the migrants at destination.

Ramesh, living fell ill and was on the verge of dying. There was no one to take him to the hospital. We first met him at one of the early meetings at the drop-in centre, and we got to know him. One day I was passing his place, so I knocked on his door to say hello. I found him semi-conscious. I called some of my friends and we took him to the hospital. We learned that he was a diabetic and had a serious liver condition. It was really hard to get Ramesh through this period. He needed $80.00 for the treatment at the hospital. We literally went from house to house to collect the money. We were able to do it and slowly, he recovered we got him back home safe and well. . The doctor said that if there had been further delay in getting him to the hospital, he would have died. This opened our eyes. We talked together – if we do not support each other, we might face a similar situation. The first thing that we decided to do after setting up our group was to build up an emergency fund to help out fellow migrants [Rocky, male youth club, Kapashera, Delhi].

A group of women at the Gauri Phanta border crossing also described how the experience of working as peer educators had also changed their lives.

When I was studying in middle school, girls came back to the hostel from the Centre and they talked about what they were doing. I was curious and came along. At first I thought it was sinful. I wasn't confident. But the older women encouraged me. When we started, the railway officials would look down on us. They wanted to know why we were coming to the station every day. I worried about what people thought of me. Now I feel that I have grown up. I used to always look down and would never look anyone in the face when talking. Now I can hold my head high [Madhu, young female India peer educator, Gauri Phanta].

I dreamed I'd get out of the home and have a social presence, even though I come from a very traditional village. Now… I feel proud. I can fulfil my hopes and dreams. I have the confidence to talk out about a range of issues… Another thing, I can continue to do this kind of work, even if the project closes down. I can continue to give 1 or 2 hours a day. When I am old, I won't have to worry about being alone. I won't need to hang around with the other old women [Sneha, older peer educator in Gauri Phanta].

Working with women's group at source and destination

Women left at home while their husbands migrate for work can be at risk of HIV infection, if returning husbands have engaged in risky sexual behaviours while away. The EMPHASIS baseline studies (Sultana et al. 2011; Wagle et al. 2011) indicated that lack of information was a contributor to misconceptions about HIV among migrant families at source. Vulnerability to HIV/STIs was exacerbated by the low social status of women, cultural barriers that inhibit open talk about sex and sexuality, sexually transmitted infections that go largely untreated and limited condom use.

Few projects work with cross-border migrants at both destination and source; this lack of connection has remained a critical gap in cross-border migrant programming (Behera and Bohidar 2013). Thus, the decision to bring community-led groups (female, male and mixed groups) into the information network was key to closing this gap and, in particular, to addressing specific vulnerabilities faced by women. Reaching migrants and their spouses with HIV-related information, referral and support services is key to reducing their vulnerability to HIV and AIDS (Samuels et al. 2014). In Bangladesh, Nepal and India, the women's groups provided a safe space for talking about HIV and migration and HIV-related services. They also encouraged dialogue between the women and their families about the risks associated with HIV and migration. The women were supported in their efforts through literacy and negotiation skills training that helped them develop the confidence to ask questions and to seek answers from their spouses and from local officials. This was also important in promoting safe remittances (below). The women's groups also came together to address issues of community and household-level harassment and violence.

Significant results:

- In Nepal, project data showed that approximately 80% of the women in spouse groups self-reported talking to their husbands about safe mobility and HIV prevention (either during phone calls to their husbands in India or when their husbands returned home on holiday); nearly 70% of these women accessed HIV counselling and testing services.
- In Bangladesh, women self-help groups promoted the dual use of condoms for family planning and STI prevention plus STI and VCT services; women and girls began talking about menstruation and STIs; and a few women self-reported talking to their husbands about STIs and HIV. These are modest steps, but noteworthy given the constraints on women's mobility and sexuality in Bangladesh.
- At source and destination, women's groups organised themselves to monitor and address cases of harassment and violence within migrant communities and in the workplace.
- A programmatic link with the Gender Resource Centre – a Delhi State government initiative – supported women to monitor and address violence against women within their communities and provided counselling when needed.

> I was working as a cleaner in a gym, and the manager sexually harassed me – he offered me money for sex. So I told the other women what had happened, and they said they would stand beside me and support me. We confronted the manager and said he had to stop. He backed down and apologised. I wouldn't have been confident to speak up in the past …and I couldn't have done this alone… since then I've started talking to other women in my community about reproductive health issues, and I know some of these women have become confident to talk to their husbands about family planning [Roshani, female migrant in women's group].
>
> We have linked up with the Gender Resource Centre. A group of women has been nominated to track and record cases of domestic violence. The women will also get in touch with any married woman they know is being beaten by her husband, to see if she needs assistance. When the violence is persistent or when the woman says she wants help, we call on the Centre. The Centre sends a counsellor to work with the family [Nirmala, group member].

In Bangladesh, cases of violence against women were reported through Community Support Groups and traditional village structures. The Community Support Groups – made up of local elected bodies, influential persons, religious leaders and representatives of migrant workers – took on the discrimination and humiliation experienced by migrant families. They supported spouses left behind (who were subject

to sexual and emotional harassment), children treated poorly by teachers (made to sit in the back row or bullied by classmates), and men whose wives had migrated to India and who were shunned at the mosque (because the other men assumed the wives were "up to no good").

The project also established linkages with sister organisations working on preventing trafficking to raise awareness about trafficking issues. This and the linkages with the Gender Resource Centre in Delhi to address violence against women are examples of the project identifying and making referrals to existing services and expertise, rather than trying to set up parallel structures.

Promoting safe remittances

A full description of how the project worked across multiple levels to promote safe remittances can be found in Learning Series, part 5, Advocacy and influence. In summary, migrants tended to use informal channels to send money home, such as a friend from the same village or a 'money-broker'. These channels were not always reliable; migrants lost money to unscrupulous brokers, were harassed at the borders or robbed in transit. One barrier that prevented migrants from using banking or money-transfer services was lack of identify-proof. Another was lack of trust in and non-familiarity with banks. The project's response was threefold: first, EMPHASIS lobbied banks and money transfer services at source and destination to simplify their procedures and requirements. Second, the project worked with migrant populations to encourage them to use official money channels. For example, messages about safe remittances were written into pre-departure and information materials. Forums were also organized with community members at source and destination (both to create demand and to raise awareness of how using formal channels would be a better option than relying on middlemen and unreliable brokers). Third, EMPHASIS worked with local media who published stories of the issues and promoted use of banking services (both to encourage uptake by migrant families and to put pressure on the banks and transfer services).

Significant results:

- Financial inclusion – over 700 families at source and destination opened up bank accounts for the first time. As more and more women opened up accounts and talked to others about how they were receiving money through the banks, other women follow their lead.

  In Achham and Kanchanpur districts of Nepal 50% of 494 women surveyed in 2013 had opened up accounts; all 45 women belonging to the spouse group in Ridikot in Achham had opened up accounts.

- Greater control over resources – being the signatory on a bank account meant that wives were able to regularly receive remittances and could make decisions about how the remittances sent by family members were used.

- A culture of saving – in both Delhi and Mumbai there was a significant increase in the number of people remitting money and in the amounts being sent via formal channels. Being able to build up savings is a precursor to ensuring household resilience.

Note that for the undocumented Bangladeshi migrants, access to banking services was not an option. The most common informal channel for remittances was for relatives and neighbours from the same village to carry back money on return visits to Bangladesh. Brokers were also used, but this was subject to delays and high fees. The preferred option is the hundi system, which operates in a similar fashion to regular money transfer services. No actual exchange of cash occurs across the border, but instead the arrangement is transmitted via mobile phone.

3.2.2 Co-opting strategies

A challenge for the project was to enlist as allies the support of those stakeholders that were exploiting and harassing migrants. This section describes how the implementing partners patiently worked with stakeholders at transit to bring them around to supporting the project's efforts to reduce harassment and violence.

Rickshaw Pullers Association

I always charged the Nepalese extra. I'd speak impatiently and sometimes use abusive language. I've changed now… and I am trying to talk to other rickshaw pullers [rickshaw puller at Banbasa].

Banbasa is full of rickshaw pullers and hoteliers, who are generally the first points of contact for migrants. The rickshaw and tanga pullers would grab hold of the migrants, as they got off buses and trains at the border-crossings, charging high rates for even the shortest distances. Without asking they pulled down luggage from the buses and loaded it onto their rickshaws and tangas and then forced the owners into their vehicles. The hoteliers offered shelter and a smile and then over-charged.

Bhartiya Gramin Seva Vikas Sansthan (BGSVS) was the implementing partner operating on the Indian side of the border. The project staff began talking to the Rickshaw and Tonga Pullers' Association to develop rapport. It was a tough task. The members felt no need to change their behaviour, seeing the Nepalese migrants as easy game. They resented any efforts to curb their activities. But the project team persisted, sharing case stories and pictures. They introduced them to migrants living near the transit area. They asked union members how they would feel if their brothers or sisters were robbed and physically abused. It took a full year before the union members came around. But finally, they agreed to help out. Some were drawn into the role of peer educators, taking part in training led by the outreach workers and then talking with their Nepalese passengers about STIs/HIV, condom use and where to go for help when needed. The Union president personally engaged in promoting the usage of condoms. The Union set fixed rates for travelling along the mobility routes (such as, across the border or from border to bus and train) and posted these on boards and walls around the transit areas. The Union also agreed to monitor its own members – this proved to be the most effective change-maker, deterring possible offenders. Unique code numbers were allotted to each vehicle, which made it possible to identify individual rickshaw and tanga drivers, and made it easier for migrants to lodge concrete complaints.

Table 2 summarises the results achieved through working with the Rickshaw Pullers' Association at the Banbasa Indo-Nepal transit in Uttarakhand.

Table 2: Enlisting the Rickshaw Association at Banbasa (Indo-Nepal) transit

Stakeholder / Purpose	EMPHASIS's role	Results
The Uttranchal Rickshaw Association (Chalak Kalyan Samiti); 360 members Purpose a. To develop solidarity with the rickshaw pullers b. To enlist their support in addressing violence and harassment	a. Facilitated monthly meetings to: • Discuss the rights and entitlements of rickshaw pullers and migrants • Sensitise Association members on safe mobility, violence and harassment and HIV b. Facilitated cross-border Indo-Nepal Friendship meetings c. Strengthened documentation and reporting capacity of Rickshaw Association Management	a. Standard fares were fixed and Association members monitored compliance b. 12 Rickshaw Pullers enlisted as Peer Educators c. Active participation in project activities such as Folk Media and Infotainment. d. Increased co-ordination with Police Department Anti- Trafficking Cell.

Working with hoteliers[4]

Migrants traveling from the Far Western Region of Nepal to the border sites can journey for two or more days, starting out with a long walk from the village to a bus stop. Along the way, they rest at small restaurants or guesthouses. Once they arrive at the border, they are intent on getting across as quickly as possible. Project staff recognised that the rest stops and bus stations provided an opportunity to prepare migrants with pre-departure information about safe migration and HIV.

GaRDeF, the local implementing partner in Achham district, approached hoteliers to gauge their interest in helping out. The first reactions were suspicious; the hoteliers were worried their business

[4] The term hotelier refers to people who own or operate simple guesthouses where migrants stop off to eat and rest or stay overnight.

interests would be affected, or that the police would question them about what they were doing. From the Emphasis Drop-in Centre at Sanfe (a transit hub in Achham district where migrants converge from several neighbouring districts) GaRDeF was able to convince a group of female hoteliers to go on an exposure visit to transit sites at Banbasa and Gauri Phanta. There they learned from returning migrants, border officials and NEEDS staff (the implementing partner at the border) about the level and kinds of harassment and violence. They also engaged in broader discussions about migration and HIV.

This core group then co-hosted two one-day workshops with staff from twenty-two hotels in Jaygard and Chaukhutte and the peer educators from the drop-in-centres in Sanfe, Chaukhutte and Jaygard. During the workshops, the hoteliers described their interactions with migrants. GaRDeF provided an orientation to the drop-in centres established at transit points. The hoteliers then discussed how they could coordinate with the drop-in-centres and contribute to safe mobility and reinforce HIV-related health messages. Following on, each hotelier developed posters to display in their hotels. Other practical actions were placing brochures around the mirrors, placing safe mobility messages on water jugs and mugs on the tables where migrants take their meals, and distributing brochures and condoms to travellers.

Sarita described what she got back:

> Migrants used to tell me stories about how they had been robbed or harassed while migrating to India. I was sympathetic but nothing more. I was surprised when I realised someone like me could give more support and information about HIV and safe mobility ...and by how much the migrants appreciated this. It has given me new direction... I can do something for our migrants who really need support [Sarita, hotelier, Chaukhutte].

And any fears the hoteliers had that engaging with the project would have a negative impact on business proved unfounded:

> A teacher from Bajhang in Nepal went to India to get money from a family member working there. On the way, he stopped overnight at a hotel. Dev told him that if he opened a bank account, he could be sure that the money would be received safely, and he wouldn't have to make the return trip. Next morning he went on his way. He got the money, but on the way back he was robbed – a bitter taste – but he is now telling other migrants to stay at the same hotel. This is a win for Dev. His customers trust him and they are telling others to stay at his hotel. He has been issued with an identity card from the project so the local police let him quietly get on with his work [Dev, hotelier, Gaddachowki].

The context at the closed Indo-Bangladesh border is very different. Migrants in Bangladesh must navigate their travel across the unofficial transit points with the aid of brokers. Generally men are able to cross safely but not women. Broker contracts comprise three parts: the first is the fee negotiated between the migrant and the broker. The second is the fee negotiated between the broker and power holders, such as border officials. (An additional unspoken expectation occurs when the broker promises a border official he can have sex with a female migrant of his choice.) The third is the fee negotiated between the broker in Bangladesh and a broker in India who arranges employment.

Brokers work in teams under a leader, the ghat malik (or owner of the ghat, from where migrants are ferried across the waterway). The brokers' networks extend from bus departure points inland from the border to destination points in India. It took three years before the project was able to establish four broker groups and conduct sensitisation activities: "We now believe you are here to help, not to get us." This allowed the outreach workers to meet with migrants at bus stations. These broker groups also reported talking to migrants about EMPHASIS' services at source and destination. It is not clear if this groundwork could be expanded to positively influence attitudes about harassment and violence from

brokers during transit. Aware of the power and influential relations associated with the brokers' network, CARE and the implementing partners viewed these relationships with caution.

3.2.3 Activating accountability mechanisms

The Achham District Migrant Network

In some cases, migrants leave for India and "disappear". They don't come back, and their families don't know where they are or how to trace them. When talking with returnee migrants about their stories, the issue of "men missing" surfaced. This started EMPHASIS project staff thinking: given our commitment to promoting safety and dignity and protecting migrants' rights, how can we respond? The starting point was to bring together a group of returnee migrants to clarify the issues and to gauge their interest in working together in some way. There was no hesitation from the returnees:

> The plight of these families compelled us to start searching for the missing. I used to work in India. I suffered a lot. We came together and shared our experiences. We found we had all suffered in some way ...and we knew some had lost their lives. We decided we had to search for the missing. With this in mind we formed the Migrant Network. [Since then] we have travelled to many Village Development Committees and Wards. We found out that 21 people had gone missing. Another had been killed. Relief to the families of those killed and a search for the missing... those are our demands of the government [Mithu, Migrant Network member].

The Migrant Network met with the Chief District Officer (CDO), District Administration Office at Achham, to talk about what they wanted to do and why and to enlist his support. At first the CDO was suspicious but then he agreed to a joint public announcement of the initiative on radio early in 2013. The Network members then travelled around to 14 different district-level village councils and met with migrant families. They identified the missing and worked with the families to compile the documentation needed to lodge a complaint (identity papers, photos and a formal letter of application). The final documentation was submitted to the CDO, who collated all the papers and forwarded them onto the Home Ministry. They also collected stories that were printed in the local press.

Since its formation, the Achham District Migrant Network has become a platform:

- To provide migrants' families with information about how to lodge official reports of those that have gone missing, those injured in work-related accidents or violently abused, and those that have died.
- To lobby the district authorities to initiate searches to trace missing migrants or to claim compensation.
- To engage local media and human right organisations to lobby for ensuring justice and redress.
- To ensure potential migrants are better prepared when making decisions about where and how to migrate for work.

Significant results:

- The Migrant Network was able to activate an accountability mechanism; the District and National-level authorities became aware of the extent of the problem and fulfilled their duty in reporting missing migrants.
- The Migrant Network encouraged potential migrants to register with the local authorities before leaving their homes, in case something happens to them. (In this way the network contributed to promoting safer migration).

Migrant helpdesks

Sometimes change occurs because a series of events come together and help break down barriers. This was the case with Mr Narad Dhami, the Sub-Inspector, in charge of the Bhansar transit site in Dhangadhi. Narad was concerned about the levels of violence and harassment migrants experienced while crossing the border. But he was uncertain how to take on the various "forces" at play. At one

point in his career, he had been part of a UN peacekeeping mission in Sudan and had participated in human rights training. He thus brought a perspective the project was looking for. But it was the chain of events that unfolded when a reporter was crossing the border that added impetus to his drive.

> A journalist was crossing over from India and he had to pay 1,000 Rupees (US16.50) to the Indian border police. When he told me this, I wrote up a report. Then I took the report across to the other side and said: We are neighbours. We don't need to do this. The report got passed up to a senior Indian Border Security Force official. At the same time, the story got aired on BBC and on the radio and newspapers. There was a lot of noise, and the whole Indian Border Security Force team got replaced. It made the issue of harassment and exploitation public.
>
> With EMPHASIS we decided to set up the Citizens' Help Desk, around the bend from the Indian border, so that people could make complaints as soon as they cross into Nepal. We are keeping accurate records of all harassment cases and information about missing persons. If we accurately record this information at transit, then police have something they can act on. The reports I prepare go to the district office and then get passed on to the Home Ministry. It's simple, but is a mechanism to hold everyone accountable.
>
> We have started having monthly cross-border meetings with our Indian counterparts – one month they come here, and the next we go there. This means that everyone is working together. I also set up a small desk near to the Indian side where I have stationed a couple of Nepali border police… before there was always a no-mans' land and we could not see each other around the bend in the road. Now we monitor each other. The next step is to get this going at a national level… there are so many transit sites and this can be set up at all sites.
>
> These people crossing the border are my younger brothers, my older brothers… they work hard and make some money while in India. Their money should be safe… people should be able to travel safely, and they should be able to report any problems they meet. It's a human right …people should have a life with dignity… if that's not happening, then why are we here… the NGOs or the Administration?
>
> There used to be 50–60 cases per day. We've got this down to only 1-2 cases. Previously, migrants would always prepare a small amount of money to pay bribes when crossing. Now they're asking: What's going on? The border police aren't asking us anymore [Narad Dhami, Sub-district Inspector, Nepal Border Police].

The project continued to facilitate cross border exchanges with the border officials. It also set up quarterly cross-border meetings with other stakeholders (project staff and peer educators from both sides, hoteliers, rickshaw pullers, transport unions and so on). These Indo-Nepal Friendship Meetings were publicised by the media, something that helped to give legitimacy to the approach and also raised "the accountability stakes".

The project also helped to set up a migrant information desk in the District Administration Office in Kanchanpur. All migrants who apply for a passport and are planning to migrate for foreign employment are now given an orientation on safe mobility and HIV through the information desk.

Migrant Information Desks were also established in Kanchanpur and Dhangadhi bus parks in collaboration with the Far West Bus Association in Dhangadhi and the Trade Union in Kanchanpur and 'manned' by peer educators from the community.

3.3 Cross-border synergies enable safe migration

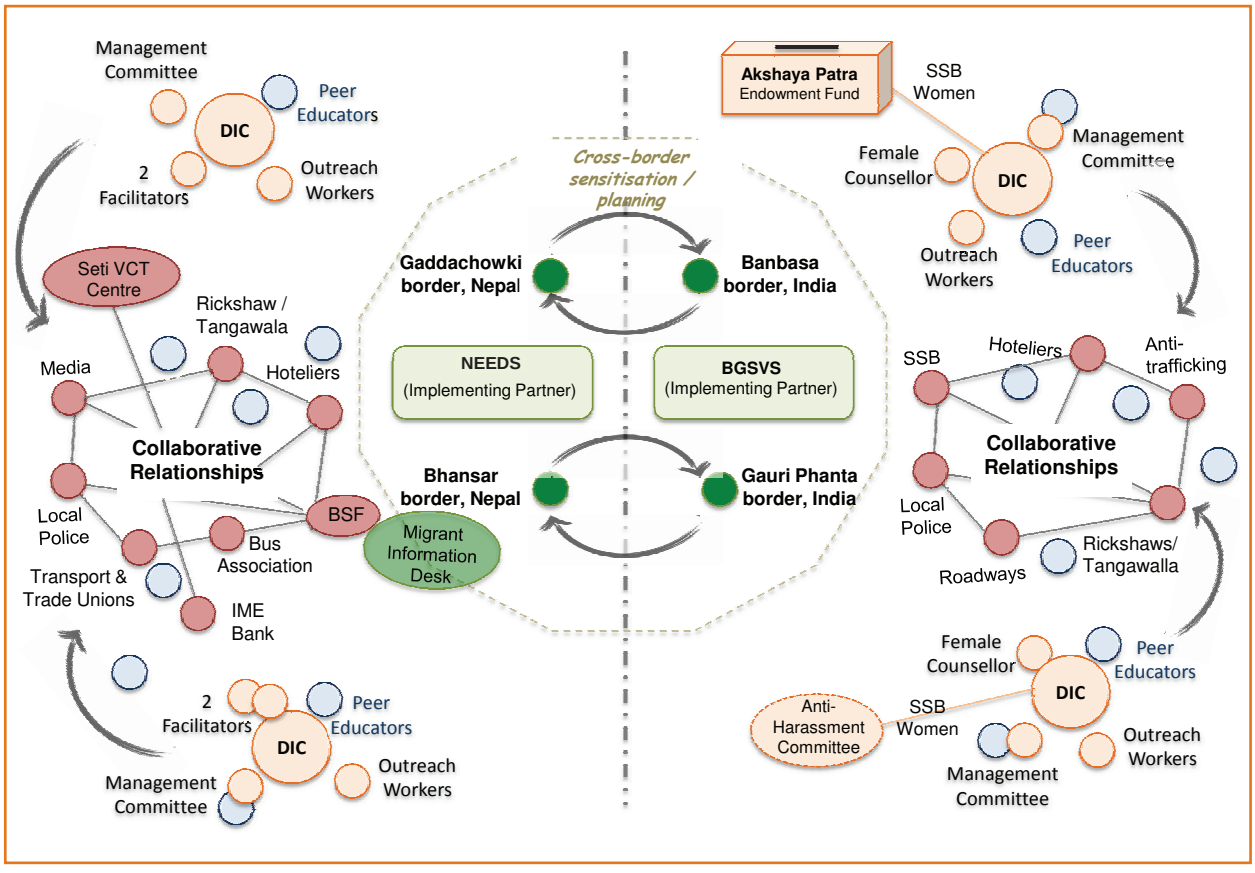
The above examples demonstrated how the project enlisted the support of a range of stakeholders (many of whom had previously been in exploitive relations with the migrants) and facilitated cross border programme linkages, to promote safety and dignity. A key success factor in the process was the ability of the outreach workers to persuade the stakeholders by simultaneously appealing to their business sense and compassion.

> I focused on being human …I also brought in the team leader to talk to them. He spoke about what this might mean for them from a business perspective. If there is more looting, the migrants may choose another corridor or choose not to stay at their hotels. [Bhuwan, Outreach Worker, NEEDS team, Kanchanpur]
>
> We also showed them short video clips of victims, and used these to appeal to their compassion. I asked them: Have you every helped out a migrant in anyway?" They described giving food to someone who had been robbed and had no money,

things like that. So then I said: "What you are doing is just bit by bit. No one knows about it. If we get organised and work together we would have a bigger impact, and more people would hear about it. This would bring your good contributions to the fore, which would help you get more business [Prakash, Program Coordinator, NEEDS team, Kanchanpur].

Figure 5 maps the partner and programme linkages that were established at the Indo-Nepal border, and which contributed to safe migration. The implementing partner, NEEDS, managed two border crossings and staffed the drop-in-centres at Bhansar and Gaddachowki. On the Indian side of the border, BGSVS managed the crossings at Banbasa and Gauri Phanta. On both sides of the border, linkages were established with civil society organisations that were able to respond to trafficking and legal issues. Peer educators were embedded in the bus and rail stations, and relationships were established with rickshaw pullers, bus drivers, transport unions and hoteliers.

Fig. 5. Program linkages at the Indo-Nepal border transit sites



The outreach workers and peer educators interacted with migrants when they got on trains, when they got on and off buses, and when they arrived in a cart. They included hoteliers who gave out advice, brochures and condoms and rickshaw pullers who talked to their passengers about HIV and safe migration, as they pedalled from the transit point to the bus stop. The relationship established with the Sub-Inspector in charge of the Bhansar transit in Nepal led to setting up a help desk on the bridge at the border that was able to immediately respond to complaints from migrants and a spirit of cooperation between border officials on both sides of the border.

After this scheme was set in place, the number of reported cases of harassment at the Bhansar/Gauri Phanta crossing dropped dramatically from 50–60 cases per day to only 1–2 cases per day. Migrants expressed surprise that they were no longer being asked for "facilitation" fees.

An important enabler was the cross-planning visits – project staff from both sides of the border regularly engaged in reflection and problem solving meetings. The border police (Nepal Prahari in

Nepal and SSB in India) continue to meet together quarterly to discuss issues related to migration and security, under the banner of Indo-Nepal Friendship Meetings. Cross visits also engaged the media, rickshaw drivers and transport officials and more. These meetings helped to foster a sense of working together. These are reflections from a meeting that brought together border officials, the media and EMPHASIS project staff.

> The more we share our problem and ideas with friends the closer we come. I think media on both sides can play an important role in creating an atmosphere of friendship and trust. I am always willing to be part of this initiative for fostering friendship and greater ties between people of both countries. [Journalist]
>
> There can be no compromise on the security issue. But we are equally aware that people on both sides must feel safe while moving across the border. I am ready to provide any help you require from our side [Indian border security policeman].

Cross-border planning of this kind was not possible at the Indo-Bangladesh border. Instead project teams communicated by phone and WEBEX or Skype. Actual face-to-face meetings on "no-mans land" were restricted to two to three interactions per year, especially on World AIDS Day, and certain festivals.

3.4 Lessons learned

Several factors contributed to the success of the efforts to promote safe mobility and dignity. The first was the information network that extended from source to transit to destination. The information network included static and mobile service centres and outreach workers, peer educators and community-led groups (primarily women's groups) that shared consistent educational information about safe mobility. A referral mechanism was rooted in the outreach worker/peer educator network. The project demonstrated that linking migrants and their spouses through the information network across the mobility continuum is not only key to reducing their vulnerability to HIV and AIDS, but also to promoting safe mobility.

The second was the focus on building linkages with and co-opting stakeholders from across the mobility continuum. At the start of the project, many of the stakeholders were actively engaged in exploitive and abusive relations with the migrants, taking advantage of the fact that most migrants were unaware of their rights and entitlements and how to claim them. The project was able to draw in the stakeholder's by appealing to their good sense – here's how helping would benefit your interests – and compassion: what if your brothers and sisters were treated in this way? In parallel the project also engaged the media to publicise and name the kinds of exploitation that were occurring.

The third was the focus on working with duty bearers to activate accountability mechanisms and to help them locate opportunities to play an active and productive role in addressing safe migration.

The fourth was the project's response to promoting safe remittances: (a) lobbying banks and money transfer services to develop migrant-responsive procedures; (b) working with migrant populations to build trust and encourage the use of official money channels; and (c) engaging local media to encourage uptake by migrant families and accountability by the banks and transfer services. The end result has been twofold: an increase in safe remittances via banking services; and greater control for women at source over how remittances are used.

An innovation of the project was establishing emergency funds through local donations to support migrants during transit. Migrants and local stakeholders contributed to the funds, and a local committee managed them. This promoted ownership and sustainability.

Two enabling factors were:

- First, the project's ability to bring project staff and stakeholders into cross-border planning sessions at the Indo-Nepal border, in the spirit of: how can we work together? This was not possible at

the Indo-Bangladesh border, and so the project teams instead emphasised safe mobility through women's groups and community groups at source in Bangladesh, while also facilitating access to services for Bengali-speaking migrants at destination.

- Second, CARE's ability to draw on its regional presence to work in the inter-border spaces and its willingness to tackle entrenched power relations.

A key learning has been the importance of carrying out a careful analysis of the potential risks of taking on powerful influences. This is critical when money changes hands and when reaching out to undocumented migrants. At the same time, project teams need to critically challenge themselves by asking: are we taking a safe path, and thus complicit in maintaining the status quo? Can we do more and also ensure no harm to the migrants themselves.

Women's empowerment

Summary

Historically in South Asia migration has been perceived as a masculine domain, and women's contributions to migration and development have gone largely unnoticed. But gendered representations of migration need to be unpacked; what is missing is precise data on the influences of women throughout the migration cycle (Blanchet et al. 2008). In reality, an increasing number of South Asian women are today migrating in search of better livelihood opportunities to support their families. They are becoming economic actors rather than dependent spouses as before, with migration offering women a choice to work and become financially independent. In so doing, they are transforming power relations within the family, especially when the woman migrant worker has been instrumental in lifting the family out of poverty" (UN Women 2013). South Asia has emerged as the most important source of migrant labour in general and of female migrants in particular to the Gulf. In the contexts where EMPHASIS operates – Bangladesh, India and Nepal – neglect of women's health needs, violence against women, trafficking and other violations of their human rights persist. For these reasons empowerment of women migrants and also women that are left behind when their husbands and sons migrate was central to the success of the EMPHASIS agenda.

This part of the Learning Series – Women's empowerment – begins with a review of the literature relevant to women and migration, looking in turn at how gender inequalities impact on health and security; violence against women; the impacts of migration on women left at home; and how more women are expressing themselves as economic agents through migration and challenging traditional gender hierarchies. The next section provides an overview of CARE's women's empowerment framework – agency, relations and structure. Then there is a description of the project's responses, starting with the women's solidarity groups at source and destination, and how the groups opened up the space for women to talk about migration and HIV and to contribute to action around safe migration and safe remittances. This is followed by a description of how the women's groups addressed stigma and discrimination and supported women who are HIV+. Next there is a discussion of how women at source and destination promoted inclusion and community. The following section refers back to CARE's women's empowerment framework to discuss where EMPHASIS did well in each of the three framework domains and where there are opportunities for work that are more gender transformative. This informs the final section on lessons learned.

Key messages

- Working with women's solidarity groups at source and destination is key to ensure women have access to timely HIV-related information and to referral and support services is key to reducing their vulnerability to HIV and STIs.
- Encouraging communication between spouses reduces women's vulnerability to HIV and leads to more equitable family relationships.
- Solidarity groups provide a platform for women to play a role in promoting safe mobility and safe remittances, to reduce violence against women, to reduce stigma and discrimination, and to challenge expectations about women's roles and their place alongside men.
- Outreach programmes via static and mobile service centres can help isolated migrants and their families to strengthen their social capital.

When I started sending money… their attitudes changed

I am Sheuli and I am 27 years old. I have two younger sisters and one younger brother. My father died when we were young. We were very poor, and my mother could not afford to pay for our schooling. So I had to leave school when I was in class three (aged 9). When I turned 14, my mother arranged my marriage to Korban, a van driver. We lived together for 3 years. We tried to have a baby. But I never conceived. My husband blamed me, saying: This is your problem. There is nothing wrong with me. My in-laws also blamed me. My mother-in-law would say: You are baza (infertile). We don't get any profit from giving free food for you, so why should we provide food for you?

Over time my relationship with my husband and his family members deteriorated. My husband and in-laws threatened divorce and started to treat me badly. I had to put up with both verbal and physical abuse. Finally my husband divorced me, and I returned back to my own family. My family and the in-laws live in the same area, so the divorce had wider consequences. My mother wanted to arrange marriages for my two younger sisters. Perhaps my sisters would also be 'unworthy' wives. Now my mother and sisters were unhappy with me. It was too much. One day I was talking to a woman from a neighbouring village. She said there were many work opportunities in India where people could earn big money and change their lives. So I decided to move to India. I contacted a broker, who said he would take me across the border if I paid him US$50,00. I saved the money by stitching quilts.

I left for India in 2005 without asking consent from my mother. I was sure she wouldn't let me go. The broker took me to the ghat malik[5]. That night the broker raped me and threatened me: If you tell anyone about what happened, I won't help you cross the border. So I kept quiet. The next day the broker took me across the river to the India side of the border. We stayed overnight. Then he took me to Mumbai and sold me into a brothel. The broker made a deal that I would have to pay him US$600 in the first 3 months. After the 3 months was over, I continued working and made good money. I used to dance in the bar and did sex work. In the beginning it was difficult. I had to go with many clients each day. Gradually I learned to deal with the situation and to enjoy my life. Three months later I made a call to my mother and sisters, but they didn't want to talk to me. But then when I started sending money home each month, their attitudes changed.

In 2008 I came back to Bangladesh with my friends. We were able to cross over without asking for help from the brokers. In the 3 years I had been in India, I had saved around Taka 8 lakhs (US$10,000). With this money I built a house, one made with brick walls and a corrugated iron roof. I also brought some land for agriculture. And I arranged for my younger sisters' marriages, which made me happy and free from their blame. When I returned home with all this money, many guys asked me to marry them. In 2011 I decided to get married and chose one handsome guy. (He is the son of a broker.) I gave him a wedding present of Taka 2 lakhs (US$ 2,500) and a motorbike. I gave birth to a baby boy within a year of our marriage [Sheuli, returnee migrant, Bangladesh].

4.1 The context

4.1.1 Gender inequalities, health and security

Gender inequality damages the health of millions of girls and women across the globe. Taking action to address women's rights to health is one of the most direct and potent ways to reduce health inequities overall and ensure effective use of health resources (Commission on Social Determinants of Health 2008)[6]. Gender inequality in health is socially governed and therefore actionable. Sex and society interact to determine who is well or ill, who is treated or not, who is exposed or vulnerable, whose behaviour is risk-prone or risk-averse, and whose health needs are acknowledged or dismissed. Gender also intersects with economic inequality, racial or ethnic hierarchy and caste domination. Gender relations of power are among the most influential of the social determinants of health (Sen, Östlin and George 2007). We also know that the poor are worse off in terms of both health access and health outcomes than those who are not poor. But we know less about how the intersection of migration and poverty with gender, caste or social position affects health outcomes.

[5] There are several unofficial transit points, where undocumented migrants cross the border. The ghat is a series of steps leading down to the bank of river. The brokers work in teams under a leader, the ghat malik (owner of the ghat).

[6] The social determinants of health inequities are linked to social and economic disadvantage through, for example, the unequal distribution of income, wealth, employment, education, housing and power.

Women migrants that are employed in unskilled jobs within domestic service, in the entertainment sector or in small-scale manufacturing are vulnerable to health problems that can be attributed to long working hours, sometimes-degrading work conditions and poor living conditions. They are also largely invisible from public purview and thus susceptible to exploitation and/or physical and sexual violence by male and female members, including grown-up male children, in the employer's family (Timothy and Sasikumar 2012).

With the help of a broker, 39-year old Hasina migrated to Mumbai in October 2012. The broker also found her a job as domestic worker. She was expected to do all household chores and take care of the family's children. She stayed in the job for a year and a half. Things seemed to be going well, until the day her employer's 22-year old son came home from university. During his stay the son kept asking Hasina for sex. She refused him several times. One day when all family members were out the son repeatedly raped her. Afterwards he threatened her about keeping her mouth shut. Another day the son and some of his friends offered Hasina money for sex. When Hasina refused, they threatened her and said: "You are Bangladeshi and you are staying here illegally. We will inform the police about you". Hasina was afraid and pleaded with them not to. Then they forced themselves on her. She was gang raped. Hasina passed out. When she came to, there was nobody in the house. She gathered up her things and left with US$60.00.

Officially, more than 80,000 Nepali women are engaged in work in 65 countries (excluding India) and sending home about 11 billion Nepali Rupees per year as remittances. This accounts for nearly 11% of the total remittances entering the country. Unofficially, over 140,000 Nepalese women are working in Gulf countries and reached their destinations through informal and second country channels. There is somewhere between 30,000 and 40,000 undocumented women migrating from Nepal into India each year (Nepal Institute of Development Studies 2011). Only one third of the Nepalese working in Gulf countries are provided with insurance for health services by their employer. Lack of leave for illness, cost and fear of losing their jobs are barriers to accessing health care services (Joshi et al. 2011).

Even though migrants are making significant contributions to economic growth and social welfare in source countries and to the labour economies of destination countries, they continue to be subject to exploitation and discrimination; lack of access to secure banking and financial services that are essential for sending remittances back home; and substandard living and working conditions. South Asian women migrants are especially vulnerable for several reasons: first, socio-cultural norms that exert control over women's sexuality plus early marriage can prevent women from working outside the home (or from leaving the home without a male relative). Women who choose to break away from these norms are often subject to moral criticism and gossip. Such controls impact on women's ability to access knowledge and information about the outside world, and many women who seek to migrate for work can be easily misled and exploited. Women and girl migrants are vulnerable to the risk of being sold by agencies and of sexual trafficking. They are more likely to face harassment at the borders; duping in the recruitment process; changes to or violation of their contracts upon arrival; and violence and sexual abuse at destination (Samuels et al. 2011).

4.1.2 Violence against women

Physical and sexual violence within marriage and intimate partner relations occurs across all regions and cultures and is influenced by complex and mutually reinforcing factors (WHO 2002, 2005). Risk factors include women's autonomy, early and arranged marriages, lack of information on sexual matters and unequal power relations. Alcohol consumption by men plays a significant precipitating role in physical and sexual violence (and is too often used as an excusing factor after the event). Patriarchal family structures and cultural, social and religious patterns all enforce women's lower status in family and society and may act as a catalyst for sexual violence (Pradhananga and Shrestha 2010).

Table 1: Violence against Women in Bangladesh, India and Nepal

Bangladesh	India	Nepal
From 1 January 2001 to 28 February 2007, there were 5,816 reported cases of rape against women and children. Among these numbers, 636 women were killed after being raped, and 69 committed suicide. During this period 1,024 women were subjected to acid violence and 1,884 women fell victim to dowry related violence (Odhikar, 2007). 60% of women face violence in the country. 57.5% of the women in the provinces of Bangladesh have suffered from either or both sexual and physical violence. 70% of the abuse happens at home. More than half of the women in the country marry before age 15 (the highest rate of early marriage in Asia and among the highest worldwide). There are many incidents of acid attacks due to dowry disputes, leading often to blindness, disfigurement and death.	In 2009 there were 89,546 reported cases of cruelty by husband and relatives; 21,397 cases of rape; 11,009 cases of sexual harassment and 5,650 cases of dowry harassment (National Crime Records Bureau, India, 2009). One-third of women in the age group 15-49 have experienced physical violence and about one in 10 have experienced sexual violence. 35% of women experience physical or sexual violence. Nearly two in five (37 per cent) married women have experienced some form of physical or sexual violence by their husband. The prevalence of physical or sexual violence ranges from 6% in Himachal Pradesh to 59% in Bihar. 16% of never married women have experienced violence since they were 15 years of age, generally by a parent, a sibling, or a teacher.	5,000 to 7,000 girls are trafficked from Nepal to India and other neighbouring countries every year, primarily for prostitution. 200,000 Nepali girls and women are currently working in the sex industry in India. 39% of all rape victims are young women and under the age of 19. Another 39 per cent are between 20 and 29 years. All are at high risk of sexually transmitted infections, particularly HIV, and other sexual and reproductive disorders (World Bank, 2012).

Sources: We can end all violence against women campaign, at: http://www.wecanendvaw.org

UNW, Focus area; Violence Against Women, at: http://www.unwomensouthasia.org/focus-areas/violence-against-women-2/

About 50% of Nepal's female sex workers have previously worked in Mumbai, and an estimated 100,000 Nepalese women continue to work there. An estimated 50% of Nepalese sex workers in Mumbai brothels are HIV positive. A similar profile exists for Bangladeshi female sex workers (a population group that is highly marginalised), and socio-cultural and linguistic constraints hinder their ability to negotiate sexual safety with clients (World Bank 2012). Undocumented women migrants and those crossing "closed borders" have a higher risk of experiencing violence and harassment than those that are documented and migrating through open and official channels.

Sheuli's story (above) is illustrative of the structural barriers that constrain Bangladeshi women and the violence undocumented women migrants face at the border. It also shows how social norms and early marriage limit women's decision making and exert control over their sexuality. Sheuli was "at fault" for not conceiving, and there was little kindness in her first marriage. When she returned home, a divorced girl, she was subject to the ire of her own family for spoiling her sisters' chances of finding husbands. So, she left home without her mother's permission, breaking yet another prohibition, but at the same time, taking control of her life. She paid a price when she crossed the border. We may or may not like that she became a sex worker, but it is noteworthy that she earned respect through the work. As Blanchet et al. (2008:14) note: the wealth gained through migration can allow Bangladeshi women "to strengthen their position and claim citizenship rights they had been denied before." When she started sending money home, her family's attitudes changed. She returned home proud and confident. She chose her husband and is holding her head high.

4.1.3 Migration can both empower and disempower women left behind

Migration can have different and contradictory impacts. Migrant remittances constitute a valuable input to family income, contributing to household resilience during unforeseen events. Remittances may even reduce household level poverty or at least, help families from sliding into further poverty. In

Bangladesh, for example, poverty levels (around 30%) in households with internal migrants were less than the poverty levels (as high as 60%) in non-migrant households (Rahman and Lian, cited in Siddiqui 2012). Migration also has a positive influence for those women who directly receive and manage remittances (and especially when these are transferred to a bank account where a woman is signatory). In the absence of their husbands, women become the de facto head of the household and their decision-making autonomy increases.

In Bangladesh and Nepal, migrants' spouses generally stay behind in the villages with their parents-in-law when the men migrate. They must invest in the patrilineal relations and depend on their social networks. That is, a husband's absence may increase dependency on the husband's family and lead to feelings of isolation and insecurity within the household and the village. In such cases, women's bargaining power does not usually increase. Migration also reduces available village labour and imposes extra responsibilities on women, who become heavily involved in domestic work and care, as well as agricultural work and collecting firewood and water (Siddiqui 2012). When a mother migrates away, these additional burdens usually fall to an older girl child.

4.1.4 Women that choose to migrate

A distinctive feature of the current international migration from South Asia is that almost half the population movement to the Gulf countries consists of women, and more women are being employed as semi-skilled or skilled workers. The primary motivation for women to migrate is to provide a better life for their children or immediate family members, to cover basic household expenses, to pay for schooling for children, to cover health care for family members, to fix the roof after the monsoon and, in some instances, to escape from an abusive relationship. Dislocation from family and familiar rituals can lead to feelings of remorse and loneliness. On returning home women migrants may find their children are estranged or that their husbands and community members greet them with suspicion. Assumptions might be made that they have "been up to no good" (perhaps, engaging in sex work or being sexually promiscuous). This puts them in a more difficult situation in terms of reintegration back into family and society more broadly. Some Nepalese migrant women have been reluctant to talk about their experiences from abroad, because society perceives migrant earnings, particularly from the Gulf countries and India, in a poor light (Adhikari et al. 2006). Others have changed their place of residence in Nepal after returning. For women, this complicates their reintegration back into the accepted social order. But as more women migrate and take on the formerly masculine role of breadwinner (Gamburd 2000), traditional concepts of the value of "the right way of living" and "women's work" are substantially altered. This in turn affects caste hierarchies, class relations, gender roles, and traditional family power relations (UN Women 2013).

Putul's explained how she weighed up the opportunities and risks associated with migration and took on the role of breadwinner in her family:

> I am Putul and I am 34 years old. My husband is a farmer and he works on our small piece of land. We have two sons (aged 18 and 16) and one daughter (aged 12). My elder son had to leave school in class nine, as we didn't have enough money at the time. But the younger son is now in class 10 and preparing for the Secondary School Certificate exam next year. My daughter is studying in class six in a local school. In 2009 we were struggling financially. It felt like we'd been always struggling. It was hard to manage food costs and school costs for the children. My husband is lazy and does as little as possible. He does not provide much for the family. I was from a poor family and used to hard work. So, given the circumstances, I decided to go to India. My brother-in-law helped me to make the arrangements, and so I was able to cross the border …without facing any challenges. It cost me Bangladeshi Taka 2,000 (approximately US$250.00). I went to Mumbai. I struggled a lot in the first year … to find a decent job. But then I found a job in a factory, making cutlery. It paid 10,000 Indian rupees (US$165) per month. I shared a room with four other women working in the factory. I lived as cheaply as possible only spending money on the basics and I saved money. I sent money to my husband every two weeks through a money broker. This meant my family started a more regular life and the children stayed in school. [Putul, Bengali-speaking female migrant]

Putul's story is one of agency. Given her circumstances and a husband that would not pull his weight, Putul made a choice to leave her children and join the large number of undocumented migrants who

look for work across borders. She needed to leave home if she was to break from the cycle of poverty and disappointment she had lived in for so long. She worked hard. She saved money and returned to more solid prospects.

Kavitha was 29 and had two boys, aged 5 and 7. She had come to Mumbai in 2006 as an accompanying spouse. When she joined the project as a peer educator, she was able to learn new skills and grow the confidence that had always been beneath the surface. As with Putul, migration for Kavitha was a positive experience that opened up new possibilities.

I was married at 18. My in-laws were very strict. I wasn't allowed to speak or go out of the house. There were so many restrictions. My husband was studying for a Bachelor's at the time and he wasn't financially independent. So we had to bite our tongues. He was always under pressure. In his final year, he failed one subject and he decided to migrate to Mumbai for work. I was left behind with his family for a year. It was intolerable. Then he came back and said to his parents: I should take Kavitha back with me. She's not doing anything here. She should come with me. They agreed, and I moved with him.

For the first two years, I had no idea of the outside world or of the other Nepalese migrants. I never stepped out and only talked to the women living nearby. Then I met the EMPHASIS outreach worker. She was looking for someone to work as a peer educator, someone who could read and write. My neighbours knew that I had finished high school, so they told her to ask me. When she approached me I said: I don't know anything about HIV, but I do know something about working with women. After attending some training, I started. I began going from door to door. But I didn't start with HIV. I talked to the women and told them that we had to get united and begin to find ways to deal with our own problems. I said: We are all Nepalese and we should work together to address our problems. In this way I began to build rapport.

I went back to the outreach worker and said: We should call a meeting and talk to the women about why we should get united. She agreed. After two initial meetings with the women, Once I had convinced the women about being united, we formed a savings group. We are putting money to cover school fees, food and trips home.

When I talk to women I tell them about my own experience and the problems I had. I am honest about myself. Over time I have learned a lot about the community and their needs and how to refer them to available services. My husband has been very supportive. He told me: You can do anything you want to do. I feel free. Unfortunately not all women feel this way. Their husbands say: You have so much to do at home. I tell them they have so much to offer. My hope is that these women will be able to stand up …and be confident and courageous.

Now when we go home, my mother in-law can see I have changed. She has started asking: When are you going to come back and live here in our village [in Pokhara]. I used to be submissive with her and never spoke back. Now I am stronger and confident and she is more compassionate and kind. I hope my children will also have freedom in their lives.

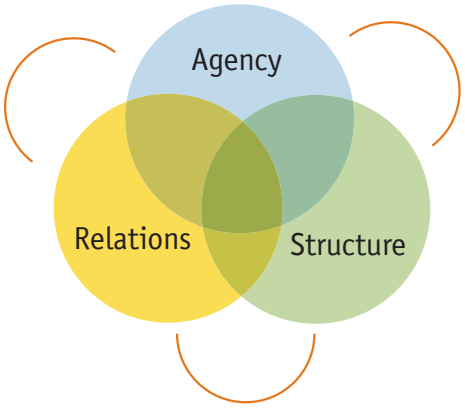
When her husband left for Mumbai, Kavitha was completely under the control of her in-laws. She felt isolated and insecure. But her work as a peer educator with the EMPHASIS project allowed her to open up and create new possibilities for herself and her family. She has been able to draw out the strength of the women in the group that formed in a Nepali hamlet in Goregaon, Mumbai.

Given the different ways that men and women experience migration and that women are made vulnerable at source as well as at transit and destination, the project design set out to address cross border mobility-related vulnerabilities, using a specific focus on women's empowerment strategies.

4.2 CARE's Women's Empowerment Framework

A premise that underpins how CARE approaches women's empowerment is this: where gender inequality exists, it is generally women who are excluded or disadvantaged in relation to decision-making and access to economic and social resources. Therefore, a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and ensuring women have more autonomy in decision making and managing their lives. CARE describes women's empowerment as the sum total of changes needed for a woman to realize her full human rights. It is the interplay of changes in agency, relations and structure.

Fig. 1. CARE's Women's Empowerment Framework



For CARE, women's empowerment is the sum total of changes needed for a woman to realise her full human rights. It is the interplay of changes in:

- Agency – a woman's own aspirations and capabilities. It is linked to such factors as literacy, knowing one's rights, confidence, self-esteem and mobility.
- Structure – the environment that surrounds and conditions her choices (e.g. laws that allow for women to be landowners and the customs and practices support this).
- Relations – the power relations through which she negotiates her path. These also include the way that gender intersects with class and other vulnerabilities.

In the following sections we look at how the EMPHASIS project responded at source, transit and destination to specific issues identified in the contextual analysis, before looking at how the responses "measure up" against the Women's Empowerment Framework.

4.3 Response and results achieved

4.3.1 Women-led solidarity groups

Table 2: Number of women's groups that evolved at source and destination

	Locations	Groups	Number of members
Bangladesh	Jessore Satkhira	3 women's groups 6 women's groups	39 90
Nepal	Accham Kanchanpur	10 spouse groups 11 spouse groups	313 399
India	Delhi West Bengal Mumbai	7 women's groups 13 women's groups 5 women's groups	56 93 123
	Total	55	1,113

Across the region 55 women's solidarity groups (based on the principles of women-centred decision making, self-help and mutual support) provided EMPHASIS with the platform for working with women migrants at source and destination. During the start up period, the project conducted a comprehensive mapping exercise to identify locations for implementation (Sultana et al. 2011; Wagle et al. 2011). One criterion for selection was those communities at source with a relatively high number of households with migrant histories (current and/or previous migration). A second was locations where there were high populations of migrants living and working at destination. A project outreach worker then approached the identified communities to gauge interest. Ruma, a female outreach worker from the Madhyamgram Community Resource Centre in Kolkata, described how she entered a Bengali-speaking community.

I started out by talking to shop keepers and other gatekeepers. I established my presence. Then I talked to the migrants. At first people were suspicious. We were outsiders. But over time we became closer, and they began to speak about their lives and personal experiences. People now recognize me for what I can bring. They seek me out when they are feeling unwell and ask me what they should do… But my entry point was not HIV or EMPHASIS. I asked them: "How are you? What about your work?" I told them: "I have come to talk to you about your family and health issues". In this way I established trust, and they started opening up: My child has not gone to school today… he is not well. My husband beat me. What should I do? I just listened and offered examples from my life. They started to call me sister. After a while I began to talk about HIV and STIs [Ruma, Outreach Worker, West Bengal].

Other outreach workers echoed Ruma's reflections about placing community concerns at the centre:

We have to be open to talking about the issues that are important to the migrants, like safe remittances or birth registration. During information sessions the migrants raise all sorts of questions. By responding to the questions they bring, we show them that we have their interests at heart, and they open up [Tilak Thapa, male Outreach Worker Mumbai].

In all cases, each group selected one woman from within the group as the peer educator. She acted as the liaison between the project and the group and, building on training provided by the project, facilitated meetings and disseminated information about HIV and health and migrating safely (with "shadow" coaching support from project outreach workers). A common theme that emerged in discussions with peer educators – at source, transit and destination – was how the experience had changed their lives:

I moved here with my family 13 years ago. I was 5 at the time. I started school when I turned six, but my parents didn't have a lot of money, so I left in class 9. Oh, I had lots of dreams. But when I got married I just stayed at home. I never went anywhere. I thought, "What's the point? Why bother to think about education". But connecting up with EMPHASIS has changed me. Now I realize that I can learn more. I should learn more. Before I would go outside, but just for daily things. I didn't really interact with people. I thought I would say something wrong or silly. I thought: "I'm just a woman. I can't do much. I don't have anything to give others".

The skills I've gained have made me more confident and have helped me to be interested in other people. …I used to feel people looked down on me. But I've become more confident to talk to others. Now I think: "Yes, I am a woman and I can do many things". The outreach worker asked the community to select one woman to be the peer educator. The other woman said: "Tara can do this". There is more awareness now and the women are taking care of their health, coming forward to get tested. Before the woman wouldn't even talk to each other about STIs. The self-help group and the revolving savings fund brought the women together [Tara, female peer educator, Mumbai].

Women's groups in Bangladesh

In Bangladesh, nine women's solidarity groups were formed in Jessore and Satkhira (two districts in South-western Bangladesh). The purpose of the Self Help Groups was to provide women with opportunities to organise and to address their vulnerability to HIV and reduce stigma, discrimination and violence. The entry point was to ask the women about their concerns. Regular follow up meetings – either at the EMPHASIS Community Resource Centre (so that the women become aware of the services available via the project) or in the community itself – helped the women to stay connected and to gauge how well they were doing. The sessions also included specific training inputs on migration and HIV, sexual and reproductive health, gender equality and diversity, literacy, life skills and managing group savings funds. The outreach workers also encouraged community members to take advantage of STI and VCT clinic services and to raise their voice about cases of violence and harassment against women. Assessment of progress of empowerment indicated that the women left at home had increased their knowledge on HIV and AIDS and were also articulate in their collective efforts to redress stigma and violence associated with women's mobility.

Sonia described how she took on the role of peer educator and how, over time, people opened up to her:

> Sonia married Jashim when she was 15. Jashim went to work in India on building sites. While he was away, Sonia was selected by a women's self-help group as the peer educator to support the EMPHASIS outreach worker.
>
> At first, I was hesitant about talking publicly about condoms and STIs. I didn't feel I had enough knowledge. It wasn't easy, and there were lots of challenges talking to groups… it was hard talking to just one person. Some of the teenage boys used to tease me and call me condom bhabi (condom aunty). And other women didn't want to talk to me about STIs and condoms. That was hurtful, like they weren't accepting me. But slowly their attitudes changed. Now the women who used to laugh at me, are telling me about their STI problems and coming to self-help group meetings. To begin with, the project gave training on HIV and migration and how to do outreach activities. Later there was training on social mobilisation activities and gender equality and diversity.
>
> As I learned more, I grew more confident. Participating in project workshops helped me to practice talking about HIV and migration. I've also grown braver in my personal life. When my husband came back from India I told him to use a condom during sex. At first he got angry. When I talked to him about the benefits of condom use, he calmed down. We both tested our blood at the VCT Centre. We were negative. Nowadays my husband is back home and working as a moto-taxi. We stay near the border, and many people migrate along this route. My husband talks to them about safe mobility. He has also called his friends in India about condom use.
>
> I felt proud when we jointly raised our voices to reduce stigma and discrimination for one PWHIV. When Hasina's husband died, people found out he had died of an AIDS-related condition. Everyone started gossiping about what they had been doing in India, saying she had been a sex worker. They wanted to get her banned from the village. So a group of us women got together and started talking to community members and about their misconceptions. We also asked the Union Parishad chairman and committee members for support. There has been a significant change in the community. Hasina is now part of the Self Help Group, and people are speaking to her. She is learning to read Arabic with other women. She is included in community activities [Sonia, educator].

Table 3 provides a snapshot of the women's groups formed in Bangladesh and the enabling structures that were put in place to support the women.

Table 3: Women's group formed in Bangladesh and enabling structures

Partner relation	Roles	Results achieved
Women's Self Help Groups	9 SHG groups formed Skills and confidence building and group solidarity; access to information about family planning, STIs and HIV and safe migration; discussion of socio-cultural issues e.g. early marriage and expectations of dowry payments; income-generating skills training.	SHG promoted dual use of condoms for family planning and STI prevention plus STI and VCT services; spoke out about violence against women and reported VAW through village structures. Women and girls began talking more openly about menstruation and STIs; some women talked to their husbands about STIs and HIV; and women better able to make informed decisions about migration.
Engaging Community Support Groups as allies	6 CSG groups formed Sensitisation and enrolment; Each CSG defined ways to support the self help groups.	CSGs addressed discrimination and humiliation as experienced by migrant families (spouses and children and men whose wives have migrated); and ensured migrant spouses were included in government programs.
Linkages with Union Councils	14 Union Councils Outreach workers represented EMPHASIS at the Union Standing Committee meetings for Health and Family Planning, and Standing Committee against Violence against Women; Union council members engaged in EMPHASIS committees and local-level advocacy meetings.	Union Councils are opening up space for dialogues about migrants' rights and actively participating in various observation days.

Six Community Support Groups were formed to engage men and gatekeepers (local elected bodies, influential persons, religious leaders and representatives of migrant workers). These groups created an enabling environment for the women's groups to engage in discussions about HIV and migration. The project first held one-on-one sessions with gatekeepers to inform them about EMPHASIS and to gauge

their interest and then facilitated group meetings to familiarise the support groups with HIV, migration and gender issues. The group also discussed how they could address discrimination and humiliation experienced by migrant families, e.g. ensuring that spouses left behind were not subject to sexual and emotional harassment or excluded from food for work programmes or government subsidies (as has been the case in the past). They also supported children treated poorly by teachers (made to sit in the back row) or bullied by classmates; and made sure men whose wives have migrated to India were not shunned when they went to the mosque.

The linkage to the Union Council as an enabling body was important, as the Union Council is the smallest local administrative level of government and can influence development priorities and allocation of resources.

Women's groups in Nepal

In Nepal it was noted that many women left at home were "in the dark" about the mysteries of migration. Recognising these challenges, the EMPHASIS teams in Nepal supported spouse groups in Achham and Kanchanpur. The purpose was to open up a space for women at source to talk about how migration was affecting their lives. The spouse groups played an important role in sharing information on HIV prevention and HIV counselling and testing with their spouses at destination and/or when the men returned home. These conversations were also shared with other women in the community. In so doing the women brought talk about STIs and HIV "out of the kitchen" and into public spaces.

Early on, concerns surfaced about harassment and their husband's safety and difficulties with getting remittances. In talking together the women recognised that they shared similar concerns and that the younger wives could learn from those with longer experiences:

> All the wives experience similar problems but [feel] unable to share these with family. The group provides an opportunity for us women to work collectively and find appropriate solution regarding cross border issues ...and to understand our husbands' migration experience [Bina, wife of migrant, Achham, Nepal].

Experience shows that encouraging inter-spousal talk about sex and HIV is challenging in any HIV project. This is because of multiple factors, including gendered notions that prescribe what women can and should publicly talk about and notions of masculinity. Men can and do react with anger and violence when wives broach discussions about use of condoms and the implications of extra-marital relations. The project's starting point was to engage women's groups in discussions about safe migration and sexual safety. In opening a space for the women's groups to surface their concerns with each other, the women were able to "language and rehearse" how they might raise their concerns with their spouses, framed within the context of safeguarding the family. As women began to bring their concerns to their spouses, they were encouraged to discuss 'what happened' with the group. In this way, they learned together what worked and what did not work. At the same time the project worked with men at destination, exposing them to the issues of safe mobility and sexual risk and asking them to think about how they could contribute to the health and well-being of their wives and children. Following on, the project facilitated mixed group discussions at destination to raise issues of health and wellbeing and gender-based violence. Over time the women became more comfortable and came forward for VCT services and treatment of STIs.

They also spoke with their husbands about strategies for ensuring safe remittances. The women were encouraged to open bank accounts – financial literacy classes helped them to navigate the banks – so they could have greater control over the flow of remittances. Negotiation skills training helped them develop the confidence to ask questions and to seek answers of the bureaucracy.[7] The women were also intent on addressing gender asymmetries. In two communities in Achham, the women took on the issue

[7] Note: Banking services are not available for the largely undocumented Bengali-speaking migrants. However, they do have recourse to what is known as the hundi system. A hundi is an unconditional written order made by one person directing another to pay a certain sum of money to a person named in the order.

of chhaupadi (menstrual quarantine) and subsequently declared their Village Development Committee chhaupadi-free.

Sustained engagement in the spouse group added to the women's sense of solidarity and strength. They extended their knowing to other women, helping others navigate the challenges of being separated from family members who had migrated for work. In so doing the spouse groups were challenging traditional expectations about women's right to information and about what talk is appropriate for women.

Some of the women's groups formed savings groups, and savings' activities were usually (though not always) linked to livelihood support for those living with HIV. In Nepal, Community Support Groups were formed in communities where there were people living with HIV (either widows of migrants or women whose HIV+ husbands were working in India). Suresh, an outreach worker in Kanchanpur described the way the community support group had been able to promote support for a man whose family was living with HIV:

> In one community, there was such fear and misunderstanding about HIV that one man built a fence to block out the neighbour when he found out the man [a returnee migrant] was HIV+. After listening to the community support group, he broke down the wall. The children from the two houses are again playing together. Even the goats from the two houses are getting together …there's been an increase in the number of goats [NEEDS Outreach Worker, Kanchanpur].

Results achieved:

- The project supported 21 spouse groups in Achham and Kanchanpur, made up of 445 women whose husbands or any other family members were working in India.
- 12 women groups and 5 mixed groups in India, encouraged safe remittance across borders.

Within a one-year period in Nepal:

- 87% (385) of the women had initiated discussions with their spouses about condom negotiation and safe mobility.
- 71% (318) had accessed HIV counselling and testing services.
- The women promoted talk about safe mobility with their spouses and with others in the community.
- More than half of all women (245) opened up bank accounts, and 146 (60% of those women with accounts) began to regularly receive remittances via the banks.

Key learning emerging from this work is:

- Combining health-related issues with social issues (those identified by group members) brings about more powerful and multiple effects.

  In helping the women open up bank accounts, the project not only initiated the idea of "savings" but also ensured that women had control over decisions about when and how the money was used. There was less likelihood of violence and robbery in transit.

  Data can be gathered about how much money is being sent home (nearly Nepali Rupees 25 million via these accounts (approximately US$260,000).

- Recognising women as agents of change and providing them with space to talk about sexual and reproductive health and gender inequalities has challenged power relations that dictate what women can talk about and has allowed them to have greater control over decisions that affect their lives.

Table 4 below summarises the range of activities that Nepalese women engaged in to bring about changes within their families, between families and community-wide.

Table 4: Spouse Group activities at source in Nepal

Intra-family level behaviour change	Inter-family behaviour change	Community-level change
HIV prevention and care: • Promoting use of condoms • HIV testing and counselling • Ensuring / insisting husbands go for HIV testing Safe mobility: • Promoting inter-spousal communication about safe mobility • Supporting safe remittance	HIV prevention and care: • Disseminating information to other women living in the community • Supporting / accompanying women living in the community to access HIV-related services Safe mobility: • Dissemination of information to other spouses • Involving husbands in meetings when they return home seasonally or longer-term	Challenging social norms: • Engaging in advocacy on women's rights and in campaigns for social awareness

Women's groups in India

The formation of women's groups was also central to programming at destination. Interventions included awareness raising and discussions about HIV and safe mobility; group savings and financial literacy classes to encourage women and their families to open up bank accounts and to use money transfer agencies; income generating activities; linkages to government health and nutrition services and social welfare schemes; linkages to the National AIDS Control Organisation's targeted interventions programme; and (in collaboration with the state government Gender Resource Centre) strategies for reducing violence against women (Behera and Bohidar 2014). In Delhi, for example, and with the support of the government's Gender Resource Centre, migrant women participated in campaigns to encourage community members to create safe environments for women and girls (the Awaz Uthao campaign) and to encourage families to celebrate the birthdays of girl children (the Chuppi todo age bado campaign).

Over time, the project began to focus on other issues, including lobbying for decent work for domestic workers in New Delhi. Discussions with community members revealed that female Bengali-speaking domestic workers were working in poor conditions and for long hours, for as little as US$30 per month (which is less than minimum rate set by the Government of India). The majority of the women had got their jobs through brokers, who continued to exploit the women, controlling and often delaying their monthly salary, or making deductions if a woman asked for time off to deal with family needs. Abuse and harassment and violence and molestation were also common.

The project facilitated a series of sensitisation meetings with the women that included discussion of rights and entitlements as well as decent work. Following on, joint employer-employee meetings were set up. Initially the employers were unreceptive. But after consistent follow up meetings, the employers agreed to increase the monthly payment to US$40.00 per month. Issues related to providing medical facilities to the workers and insurance remain unsolved. The group persisted though and was able to build on the energy generated in the State elections in 2013, to bring their situation into focus for a wider group of people. After a lot of discussion and persuasion, their pay was again increased to US$65.00 per month and they were granted an 8-hour flexible working day.

Results:

- 74 domestic workers – from both Nepal-migrant and Bengali-speaking communities – were able to negotiate flexible working hours and increased wages with their employers (from US$30 to US$65.00 per month).

While there is still much more to be achieved to ensure all migrants are able to gain decent working conditions, this case study clearly demonstrates that it is possible to advocate for migrant workers' rights at destination. Other areas for attention include focusing on healthy work environments, living wages (that met government standards), regular work hours and health insurance and medical benefits.

Initially the focus at destination was on forming women-only groups, but over time mixed groups and men's groups emerged, with the men actively promoting gender equality and non-violence in families. Table 5 summarises the range of groups formed at destination and the results achieved. It also describes the role EMPHASIS project staff played, which was generally to facilitate group formation, to provide training inputs as needed and then to accompany the group until it was able to self-lead.

Table 5: Types of women's group formed at destination

Types of group and purpose	EMPHASIS role	Results
Delhi / NCR Four female self help group (each with12 members) formed in Rajiv Gandhi Camp, New Delhi Purpose • To promote savings and group loans • To minimise outside money lending process	• Facilitated group formation • Facilitated earlier meetings on HIV & related issues • Facilitated linkages to services • Accompanied group to become self-leading	• Group savings and bank accounts were established and the women stopped taking loans from outside money lenders Women: • Led monthly meetings and celebrated cultural events; • Made joint decisions about how loans were disbursed and used; • Shared information on HIV and health, safe migration etc. with other community members
A female dance group with 8 young women in Kapashera Purpose • To provide a platform for female youth to talk about sexual and reproductive health and migration • To promote self-esteem and community attachment	• Facilitated group formation • Provided training / capacity building • Supported planning and execution	• The young women began earning income through performing at cultural events in their community and in other communities
A women's CBO that included both 24 Nepali and Indian internal migrants Purpose • To promote women's empowerment • To build awareness and uptake of available services • To minimise stigma	• Facilitated formation • Provided follow up and accompanying • Training and capacity building	• Group started saving money • Group led monthly meetings to discuss community issues and take decisions on how to resolve the issues • Group spearheaded campaign to make the community safer for women
West Bengal Rajabazar cultural group (self help group / since December 2011); 11 members / Kolkata Purpose • Group members expressed a desire to form a self-help group	• Facilitated group committee formation • Facilitated meetings • Enhanced their knowledge about project activities.	• Group disseminated information within the community related to HIV and health • Providing support in response to cases of harassment
Women's groups formed in each of the 10 project locations (Bongaon, Chandpara, Machhlandapur, Guma, Bira, Madhyamgram, Barasat, Rajabazar, Cossipur and Gardenreach) Purpose • To provide women with an opportunity to come together to discuss issues and solutions	• Facilitated group committee formation • Facilitated meetings • Enhanced their knowledge about project activities. • Engaging with the group on solution making	• Women no longer dependent on high-interest loans from 'outsiders' • Women supported each other to address domestic violence and harassment • Women generated awareness among the wider community

Mumbai 5 groups / 112 members – two groups opened up bank accounts for the group's savings fund Purpose • To motivate women to become more engaged in migration-related issues • To set up group savings to provide loans to members and non-members	• Facilitated group formation • Vocational training • Supported opening bank account • Linked stakeholders to facilitate ICTC testing and to address domestic violence and alcohol abuse	• Increased knowledge of HIV, STIs and safe mobility • Personal development / confidence developed • Skills gained for micro-business activity resulted in increased income levels

4.3.2 Promoting inclusion and community

How women addressed stigma and discrimination

Reducing stigma associated with HIV was an important strand in the project. In Nepal general awareness raising, coupled with carefully facilitated discussions with community support groups that included women living with HIV, were instrumental in reducing stigma by creating wider acceptance and a more inclusive environment.

> People said my husband died of HIV, so no one should visit my house or touch my children. No one should drink water touched by me… After the group formed, things improved. [Now] the Community Support Group looks after my fields for me and takes care of my livestock when I can't manage. When I go for a check up, the neighbours feed my children [Sunita, mother and widow, HIV+].
>
> She is like my sister-in-law. We have eaten together and slept in the same bed… A few years ago we were told you could contract HIV just by breathing in the smoke from the funeral pyre of an HIV+ person. Now we eat in the same place. We use the same towel. We bathe together at the public tap [Sunita's neighbour].

The metaphors of "eating together", sleeping together" and "using the same towel" were powerful markers of inclusion for those living with HIV. Here's how an HIV+ man in a Bengali-speaking community in Mumbai described how his interaction with an EMPHASIS outreach worker helped him regain his place, and to eat alongside others in the community:

> When I was first diagnosed, I looked sick. People shunned me – my family and other people didn't want to talk to me. The outreach worker said: "Let them be like that. You should focus on yourself… lead your life". That wasn't easy. The EMPHASIS team helped me to get the medication. Then I started to look better, and I put on some weight. I told them: I will not infect you. Today I am infected. Tomorrow it may be you. Should I treat you in the same way? After I started the medicine, people started talking to me again. They shared food with us [Bengali-speaking man who migrated to Mumbai with his wife, both are HIV+].

The women's groups also played a key role in reducing stigma. As described above, the community support groups in Nepal were led by HIV+ women but also included HIV+ women from the same village, the latter providing support as needed (such as keeping an eye on the children when an HIV+ women went for a health check up or accompanying her to hospital if she fell ill). In Delhi/NCR HIV+ women were invited to accompany outreach workers to speak at sensitisation programmes about the challenges they had met and how they had coped with these. These women became a source of inspiration to other women.

Addressing gossip that fuels stigma

Equally important, EMPHASIS' work with women was concerned with stamping out gossip that fuels suspicion and violence against women migrants (and too, spouses of migrants). After escaping from an abusive marriage Alkima decided to migrate to take care of her children. She was treated poorly on her return.

Alkima got married when she was only 14 years. She had 2 sons and 1 daughter. But she was unhappy with her married life. Her husband and in-laws verbally and physically abused her because her family had failed to meet the dowry demand. She tolerated this for a long time. But when the in-laws started mistreating her children, she moved out and went to stay with aunty. In 1999 she left, leaving her children with her aunty. She agreed with the broker that she would pay him back over six months. Alkima got a job as a cook. She worked hard and saved money. In 2003 she came back to Bangladesh and bought some land. A short while after arriving home, some men asked her for sex, saying they thought she must have been a sex worker in India. She refused and told them if they asked again, she would complain to a Union Parishad member. One day when she was alone in the kitchen, 2 men attacked her, covered her mouth with their hands and took her into the field. Four men raped her. They warned her that if she told anyone, they would force her to move from the village. She told no one. She tried to recover from the experience, but eventually decided she would return to India. It was then that she met an EMPHASIS outreach worker who provided her with counselling and support so that she could begin to take care of her emotional and physical wellbeing [Alkima, Bangladeshi woman].

Left-behind wives may also be subjected to harassment and gossip. But as Riya, a Bangladeshi woman explained, the women's group provided her with the confidence to speak up.

My husband was away in India, and some people in the community were taking advantage of his absence. They threw stones on my roof during the night and banged on my door. I went first to my in-laws and then the Union office but they didn't want to help. I thought a prominent community member was responsible and I shared my story in the Self Help Group. The group facilitated a non-confrontational but out-in-the-open discussion without directly accusing the man. This allowed everyone to resolve the problem sensibly, without further confrontation… the harassment stopped [Riya, migrant spouse in Bangladesh].

Women at the destination also faced stigma and gossip, simply because they were non-Indians. Rekha's story exemplifies the kind of harassment they face.

I lived with my two children in Shalimar Garden. If any woman from our community went out in the evening there would be catcalls and lewd remarks. The male youth in the neighbourhood did this regularly. They would shout out: Look, look the Nepalan (Nepalese women) is going out …who are you going to meet? The only option was to look down and try to ignore… to say nothing, even though I felt ashamed. After we organised ourselves into a group, this was one of the first issues we decided to take up. One day we went out together and confronted them. We spoke reasonably, telling them about how we felt when they called out like that. After that, the catcalls stopped. This has made me feel confident about standing up for my dignity [Rekha, Peer Educator, Delhi].

Inclusion and social cohesion

The starting point for membership in any group was an individual's relationship with migration, not who she was or where she came from. At the Kapashera Drop-in Centre in Delhi, we met with 13 women ranging in age from 18 to 40 years. Three peer educators and two outreach educators also joined the discussion. One of the women was from West Bengal, the others from Nepal. Everyone spoke; everyone was listened to. The group members were united around their identity as women living in a migrant community and around their wish to support one another.

We knew from our experience that there was no one to help out when there was any kind of trouble. So we formed a women's group to work together and fix our own small problems… There was one time when a pregnant woman was sick for 7 days, and there was no one to help her. So …we all joined hands to get some money and took her to the hospital where she had a safe delivery. That got me thinking …about how we could help each other and that we could motivate other women and men to unite for collective action and mutual support. Slowly the group has grown… there are now 23 members [Harsina, Nepalese woman].

The women lack knowledge about their rights. They are not economically empowered… they depend on their husbands. Some men have extra marital affairs and beat their wives. The women don't feel they have a voice. The women's group provides a space for them to speak [Nirmala, Nepalese woman, peer educator].

In Delhi, project staff noted that the groups had not always been all including, and that migrants identified strongly with their caste (Kaur et al. 2014). While they did not discriminate openly, the migrants visiting the drop-in-centres at destination were cautious of each other. People of higher caste were not comfortable sitting together in the drop-in centre with people of a lower caste. Some refused biscuits in the tea break, as there were people from a lower caste in the room.

The EMPHASIS project team thus decided to take on caste-based discrimination. First, community meetings were called to discuss caste issues and gain support from amongst local community leaders. A result of this has been that the drop-in centre community-led Management Commitee and other ad hoc committees include representation from all sections of the local migrant community. Follow on, meetings with the wider community openly discussed caste and inclusion. During these meetings, project staff were careful to ensure that all were treated equally and that there were no distinctions about who sat where, who got tea first and so on. The project also ensured that every member of the community, irrespective of his/her caste, was able to participate in all project activities (such as street plays, magic shows, infotainment programs and video shows) as well as to celebrate festivals like Holi, Dusshera, Teej and Diwali together. These steps contributed to fostering a sense of unity among the Nepali migrant community in Delhi.

> We are also invited to attend many mass events and cultural gatherings, which earlier were mostly attended by the upper caste [Kundan Sunar, 32, Shalimar Garden, Dalit caste].
>
> I used to hesitate to sit with the lower caste people and share food with them… now I realize that being a good human being is more important than belonging to an upper caste and discriminating against people in the name of tradition. The project has done a tremendous job to change people's mindset [Kamal, 35, Shalimar Garden, Brahmin].

While the barriers were not completely removed, caste-based hierarachies did begin to break down. People began hearing out each other's views without judgement. The network of peer educators also became more diverse, made up of Nepalese and Bangladeshis and Indians, old and young, HIV+, sex workers, men who are sexually attracted to men, Buddhist, Muslim and Hindu and so on.

Interestingly, and in contrast, caste-based discrimination was reported as a non-issue among the Nepali migrant community in Mumbai. People from different castes showed no reservations about sitting and drinking tea with each other or about participating in activities. Some Nepalese migrants resisted being asked to identify their caste, as they felt that being away from Nepal, caste-based identities were irrelevant.

> While working with Nepali community in Mumbai, caste issues did not surface. All castes joined in project activities and shared their experience with each other. They took snacks together. They lived together cooked together. In Mumbai mixed-caste groups of Nepali migrants work alongside one another. They live together where they work in hotels, companies, guardhouses and they shared rented rooms [Purna Kumal, Project Coordinator, Mumbai].

At the start of the project, the migrant communities in India were spread out and isolated. People kept to themselves. The drop-in-centres and the women's groups (and also men's groups, youth groups and PWHIV groups) provided a platform for people to connect, and contributed to knitting together more socially cohesive communities. In discussions with a male and female youth group at the Kapashera Drop-in Centre, it became apparent that the group had been an important touchstone for young men and women to create meaning out of their lives as migrants.

> We used to be really scattered. Though we were all migrants living in the same area, we weren't a community. We were divided. We would look at each and think: Oh that person looks Nepalese. But we didn't really know each other… The youth group has given us a platform to come together. We feel less isolated now. We support each other. In the Centre, I feel I'm in my own family. It doesn't matter who you are, where you come from …what class you are. There is a sense of community here, a sense of country [Deepak, young man working part-time and studying for a business degree].

Another feature common across all groups was the pride the members express in what they had been able to achieve. This is exemplified in the following excerpts from a discussion with the Nepalese women's self help group that formed in a Nepali hamlet in Goregoan, Mumbai.

> Significantly the group has been able to open a group bank account… this has made us feel proud… it has given us legitimacy. Our dream now is to get registered… and to mobilise the men and get them to form a men's group. Initially, our husbands were against the idea of a women's group… so the project helped us to organise a meeting with the men and we talked it through, and they agreed. Now they can see the benefits and changes.

We are a family... we feel strengthened... people are intimidated by us. Some men think they can harass women and get away with it. They can't – we will come as a group and confront men like this.

What has made us powerful? Dignity, unity, courage, faith and trust, getting organized and doing things on time. We have learned to work together and to cooperate.

4.3.3 Women's empowerment – did it measure up?

Building on the examples described above, the basis for working with women groups in EMPHASIS, is summarised in the value proposition below:

If we ensure women have access to accurate and timely information about STIs and HIV prevention and condom use and how to access treatment, If we address their concerns about safe mobility and remittances, If we provide opportunities for building skills and self-esteem and financial literacy, And if we ensure solidarity and group strength by providing a space for reflection on challenges and shared solutions,	We can reduce vulnerability to STIs / HIV: • Group members self-report talking about HIV-related issues with husbands who come home seasonally; some women convinced their returnee husbands to seek out testing before re-engaging in sexual intercourse. • Some report talking on the phones about HIV and sexual safety with husbands in India. • Women are accessing VCT Services and coming forward to treat STIs. • Women are speaking out to other migrant spouses (passing the message on) so that more women are better informed. We can increase safe mobility and safe remittances: • Women are opening bank accounts; husbands are sending remittances via the accounts; migrants are carrying smaller amounts of cash when they travel. • Official data are being generated about remittances. We can make shifts in gender norms: • In speaking openly about sex and sexual health, the women are challenging expectations about women's roles and their place alongside men.

The story that emerged from the EMPHASIS project is about how the women's groups provided a platform for relationship (building solidarity and levelling out hierarchies) and agency and in some instances, for challenging power structures that impinge on women's choices. The project ensured that women had access to information about migration and STIs and HIV prevention and where and how to access related health services.

Observable changes were as follows:

- More women openly spoke about and promoted the dual use of condoms for family planning and STI prevention.
- More women accessed integrated counselling and testing services.
- More women came forward and got treated for STIs, instead of hiding in the shame of ignorance.
- Access to information about safe migration meant that more women were better able to make informed decisions about and weigh up the risks and the opportunities of migration.

Supporting wives of migrants to open up bank accounts had multiple effects:

- It was a confidence boost for the women: To open up the bank account we had to learn to read and to write our names. We realised that we can learn things, we can do things and we grew more confident (female spouse from the 'Conscious' group in Ridikot, Achham, Nepal).
- Women were able to receive and withdraw money without relying on a middleman.
- The project was able to record data about remittances received (and to make this available to others).

In opening up talk about STIs and HIV, the project encouraged non-threatening inter-spousal conversations about sex and sexual safety. In Bangladesh women and girls began talking together

about menstruation and STIs in ways that were new. In all sites at source and destination, the project was able to report that women were speaking out about violence against women and reporting cases of violence against women through community and government structures.

> We knew about the domestic violence going on in one family. So we invited the wife and husband to come and talk to us in the Centre. The group heard the perspectives of both the husband and wife, and tried to help them through their problems. Other women now know they can directly approach us and talk [Laxmi, Nepalese woman].

In summary, women were challenging traditional structures that limit what a woman can and should speak about:

> Previously, people were too embarrassed about talking about HIV, especially with elders… now the female peer educators are even talking about HIV and giving condom demonstrations in front of their brother-in-laws and father-in-laws [Kamal Raj Giri, DIC Counsellor, NEEDS team, Kanchanpur].

The Conscious group in Ridikot, when asked what else they wanted the group to take on, replied: Chhaupadi – the practice of quarantining women in huts during their menstrual period[8]. EMPHASIS helped the women to get in touch with the local Village Development Committee. The Committee worked with the women to organise a rally with banners and posters to publicise the issue in Ridikot and followed up with a meeting with key stakeholders. There is still resistance to change amongst older men and women in the community. But the practice has lessened somewhat, and fewer women are being sent to the hut. These are promising beginnings.

Generally across all locations where the project worked, sustained action is needed to overcome the structural barriers that constrain women's agency and to protect women's right to move freely, without coercion. For example, engaging with the violence and sexual exploitation that women experience at border transit points or working with the often hidden and undocumented domestic workers will require deep analysis of the power relations and strategies that engage men as allies (like those that are described in Learning Series, part 3, Migrating safely).

4.4 Lessons learned

This part of the Learning Series has highlighted women's contributions to migration, both their role holding the family together as spouses at home or as spouses at destination, and their role as migrant workers. Engaging with women's solidarity groups and ensuring women have access to timely HIV-related information, referral and support services are key to reducing their vulnerability to HIV and STIs. Encouraging communication between spouses at source and destination reduces women's vulnerability to HIV and leads to more equitable family relationships. This opens up further conversations related to safe mobility and safe remittances; violence against women; and stigma and discrimination. It also challenges expectations about women's roles and their place alongside men. Outreach programmes at drop-in-centres can help isolated migrants and their families to strengthen their social capital.

Projects like EMPHASIS are well positioned to capture both the quantitative aspects and qualitative aspects of women's contributions across the migration cycle and to reflect this into gender-responsive programming. They are also positioned to draw on the relations they establish with migrant women to uncover the "darker side of migration" (as occurs at the borders, when women move into informal and undocumented work and when women face stigma and exclusion when they return home) and to do this in ways that neither harm nor place migrant women at risk.

[8] Nepal's Supreme Court outlawed Chhaupadi – the practice of segregating menstruating women from their houses and men – in 2005. Nevertheless, the practice persists. See, for example, OCHA (2014).

Specific areas where projects like EMPHASIS can contribute through research are increasing awareness of the feminisation of migration; lobbying for comprehensive pre-departure orientations and on-arrival programmes at destination; encouraging ethical recruitment and accountability from brokers; providing access to justice for women migrant workers; safeguarding women's right to decent work; and enlisting law enforcing agencies into treating women migrants – both documented and undocumented – with dignity.

Gender inequality damages the health of millions of girls and women across the globe. But it can also be harmful to men's health despite the many tangible benefits it gives men through resources, power, authority and control. These benefits to men do not come without a cost to their own emotional and psychological health, often translated into risky and unhealthy behaviours (Östlin and George 2007). The determinants of sexual risk for male migrants operate across multiple levels. It is critical to understand where these determinants come from, which risks are unique to migrant men, and to what extent some of the risks are predisposed (Verma 2013). The way that notions of masculinity define and determine the idea of risk taking among men, including sexual risk when away from family and when in groups of other men, has implications for programme design. Migrant men and boys perform masculinity through 'proving' behaviours, for example, through sex and drinking, through staying on the job even when severely sick, or through acts of violence. A better understanding of these nuances would allow projects like EMPHASIS to more actively engage men, and in so doing, to enhance their work with women.

Advocacy and influence

Summary

The CARE EMPHASIS project worked to promote the safety and dignity of Nepali migrants and Bengali-speaking migrants across the continuum of mobility in various ways. This included addressing safe mobility and also securing remittances and access to banking and money transfer services. This part of the Learning Series sets out to address two questions: first, to what extent have EMPHASIS's advocacy initiatives been acknowledged and/or taken up by national and regional stakeholders and policy makers? Second, to what extent were the community-led advocacy initiatives effective in raising the voice of communities and influencing district level decision-making and program management?

The opening case study illustrates a community-led advocacy effort to trace migrants that had gone missing. Next, a description of the policy context in the three countries where EMPHASIS worked (Bangladesh, India and Nepal) highlights the need for bi-lateral and dialogues towards the implementation of regional migration policies that would protect South Asian migrant populations. This leads to a discussion of advocacy and policy issues that are pertinent within the context of migration in South Asia. Following on, there is a summary of the key features of the EMPHASIS advocacy strategy, as informed by field experience and selected research studies. Examples are then given to illustrate the advocacy strategy in action at regional, national and community levels that includes another case study to illustrate how the project advocated for and promoted safe remittances. The final section summarises the lessons learned and points to areas for future programming.

Key messages

Establishing programme synergies across the mobility continuum to engage local, national and regional stakeholders is prerequisite to expanding policy dialogues and to activating accountability mechanisms in sending and receiving countries.

Policy issues

- Low skilled labour migrants have little or no access to minimum wages, time off and social security benefits. They also have limited options to collectively bargain for their rights and entitlements. Strengthening linkages with local community-based organisations and existing trade unions and labour movements that are addressing workers' rights at destination opens the door to addressing migrants' rights at work.
- Inter-country dialogue is needed on the Indo-Nepal Treaty to clarify the rights and entitlements of Nepalese migrants in India and of Indian migrants in Nepal and what this means for programming.
- Large numbers of Bengali-speaking migrants are living and working in conditions of poverty and social instability that predispose them to HIV, tuberculosis and other health risks. The sensitive political environment with respect to Bangladeshi migrants and the absence of high-level dialogue make it extremely difficult to highlight issues and concerns of Bangladeshi populations.
- There is an opportunity for SAARC to play a role in advancing bi-lateral dialogues around these issues and for influencing adoption and implementation of regional migration policies that protect SAARC citizens.
- There is also an opportunity for Nepali community-based social and cultural organisations to lobby the Nepalese and Indian governments to protect migrants' rights.

Searching for those who never came back

Creating a supportive and enabling environment to promote safe mobility and dignity of migrant workers was a central pillar in EMPHASIS's work. Migrants were subject to harassment and even violence at source, in transit and at destination. They lost their property, and were cheated by brokers. In some cases, migrants left for India and didn't come back, and their families didn't know where they were or how to begin to trace them.

One mother in Achham district in Nepal, wept as she told the story of her son:

I see the people coming back from Mumbai. My son is not amongst them. My tears keep flowing. My husband died when I was a young woman, and my son became the only breadwinner of the family. He was responsible for his siblings. But now he is no more. The roof is about to fall off. There is no one to take care of the children… I had the strength to bear my husband's death. But my son's death has shattered me. [Roshani, widow]

When talking with returnee migrants about their stories, the issue of "men missing" surfaced. This prompted the EMPHASIS project staff to think about how to respond, given the project's commitment to promoting safety and dignity and protecting migrants' rights. The starting point was to bring together a group of returnee migrants to clarify the issues and to gauge their interest in working together in some way. There was no hesitation from the returnees about getting involved:

The plight of these families prompted us to start searching for the missing. I used to work in India. I suffered a lot. People like me came together and we shared our experiences. We'd all suffered … and we knew some had died. We decided we had to search for the missing. With this in mind we formed the Migrant Network… we have travelled to many Village Development Committees and Wards. We found 21 people had gone missing. Another had been killed. Relief to the families of those killed and a search for the missing… those are our demands of the government [Mithu, Migrant Network member, Achham].

The Achham Migrant Network met with the Achham District Chief to talk about what they wanted to do and to enlist his support. The Chief District Officer from the Achham District Administration Office and the Network publicly announced the initiative in a kick-off radio broadcast early in 2013. The Network members then travelled around to 14 different Village Development Committees (Councils) and met with migrant families. They identified 21 missing family members and one other that had died. They then worked with the families to compile the documentation needed to lodge complaints (copies of identity papers, photos and a formal letter of application). The stories they collected were printed in the local press. Finally, the Migrant Network submitted the documentation to the Achham District Chief. The District Office collated all the papers and forwarded them onto the Home Office.

Since its formation, the Achham District Migrant Network has provided a platform:

- To compile data that identifies those that are missing, those that have been injured in work-related accidents or violently abused, and those that have died.
- To lobby the district authorities to initiate searches to trace missing migrants or to claim compensation for those migrants who have been injured / abused or lost their lives.
- To engage local media and human right organisations to lobby for ensuring justice and support in tracking the identified cases.

The migrant network contributed to safe migration in several ways: first, in relating their migration experiences with men and women in villages in the district, the migrant network helped to raise awareness about safe migration. This means that potential migrants are better positioned to make informed choices about where and how to migrate for work. Second, the Network was able to activate an accountability mechanism from the duty bearers (in this case, the District and National-level authorities). Third, they encouraged potential migrants to register with the local authorities before leaving, in case something should happen.

Nongovernment organisations working across borders have an important role to play to build an evidence base about the level of violence and harassment experienced by migrants and then lobbying for accountable action from local and national bodies at source and destination. For policy makers there is an important role in advancing bi-lateral dialogues and influencing adoption and implementation of regional migration policies that protect migrant populations across South Asia. This should include lobbying the South Asia Association of Regional Cooperation, UN agencies and regional networks to articulate solutions for regional migration management.

5.1 The policy context

5.1.1 Mobility flow across the region

Indian cities have historically been popular destinations for work for a large proportion of Nepalese migrants, especially those living in the Far Western Region. One study (Wagle et al. 2011) reported that migration was a major source of income for more than 80% of households in the Far Western Region, with 9% reporting migration to India, either seasonally or long-term. An estimated 700,000 to 1.7 million Nepalese migrants are living and working in India. The 1950 Indo-Nepal Treaty of Peace and Friendship envisages a free and reciprocal flow of resources and people between the two countries. In particular, article 7 states that "the Governments of India and Nepal agree to grant, on a reciprocal basis, to the nationals of one country in the territories of the other the same privileges in the matter of residence, ownership of property, participation in trade and commerce, movement and other privileges of a similar nature".

There is lack of agreement about what "other privileges of a similar nature" means, and the discourse related to the Indo-Nepal treaty expresses convergent and divergent views. For some the debate is about national interests and, in particular, national security. Growing out of this position, there have been calls to either close or strictly monitor the border by installing check-posts. The argument is that regulated border crossings would prevent terrorists and third country nationals from misusing the open border to enter into India and Nepal (Thapliyal 2012). It would also help address the harassment and violation of migrants' rights at the borders. Others argue that border management must take into consideration the special relationship between the people of the southern Nepali plains and the people of the neighbouring Indian states of Bihar and Uttar Pradesh: the "traditional ties of roti-beti (bread and daughter) in the region cannot be ignored [and] ...greatly impact Nepal's hill people who also earn their living in different cities of India" (Tammang 2001). Nepal reaps considerable economic benefits from the flow of remittances, and stemming the flow would severely impact household livelihoods and the overall GDP.

Despite the treaty and the ease of flow across the Indian-Nepal border, there continues to be harassment on both sides of the border and poor living conditions, verbal abuse and exploitation by employers at destination. Nepalese migrants living in India should be able to access basic services, including health services provided by the government to serve India's poor. They should also be able to access ART with proof of residence (such as a letter from a landlord). But lacking Indian identity cards – Nepalese identity cards are not recognised – and unsure of their status, many migrants do not try to take up these services. Similarly access to financial services, to send home remittances, is also a challenge for migrants.

India has become a corridor for undocumented migrants from Nepal to move to the Gulf and other 'third-country' locations. By crossing over into India and then contacting a recruitment broker, Nepalese are able to bypass Nepal's migration authorities. While there is need for more reliable data, Nepali women are reaching the Gulf, assisted by human trafficking networks (Pandey 2013).

There is no treaty or policy that allows Bangladeshis to migrate to India for livelihood opportunities, and large portions of the shared border are fenced on both sides and tightly regulated. As a result, undocumented migration is often the only option for people traveling to India in search of work (Sultana et al. 2011). For decades, India has received a constant flow of unacknowledged migrants from Bangladesh. Migrants in Bangladesh travel across the border via a network of brokers that spans across both sides of the border. The brokers claim to assure safe arrival at destination; some promise a job upon arrival. But while a contract between the migrant and the broker may be established, the journey across the border can be dangerous. There are often hidden deals and bribes between brokers and border patrol personnel that leave women particularly vulnerable to exploitation (Sultana et al. 2011). At times, a controversial shoot-on-sight policy has been enforced by Indian border patrols, in an attempt

to curb the flow of migrants (Rao, 2011). Bangladeshi migrants are able to "assimilate" into West Bengal because of shared historical and socio-linguistic ties, though for the majority, their illegal status means they live in constant fear of getting challenged by authorities. Generally, they find work as cheap labour in the informal sector, often as domestic helpers, day labourers, rickshaw pullers and rag pickers (Sikder 2008; Blanchet 2006).

In summary, there is an urgent need for committed bi-lateral and regional dialogues towards the adoption and implementation of regional migration policies that would protect South Asian migrant citizens. A number of treaties and conventions – if ratified and properly implemented – could provide a platform for promoting greater political acceptance of cross border mobility within the region and a vehicle for addressing the vulnerabilities of mobile populations across the migration continuum. Table 1 provides some examples of such treaties and conventions.

5.1.2 Migration and governance

Migration and HIV

The experience of migration involves crossing physical, cultural and emotional boundaries, and the conditions in which migrant workers find themselves may predispose them to HIV and other health risks. Separation from family and spousal relationships and language barriers can create a sense of isolation and loneliness. The absence of familiar social boundaries and freedom from the norms that regulate behaviours at home may provide migrants with opportunities to explore their sexuality and to engage in high-risk behaviours that create vulnerability to HIV. Vulnerability is also fuelled by poverty and powerlessness; stigma and discrimination; the low social status of women and the trafficking of women and girls; cultural barriers and social norms that inhibit open talk about sex and sexuality. In Nepal, India and Bangladesh there is a clear correlation between migration and HIV prevalence (Sultana and Kaur 2013).

Discussions about migrants' rights – such as their right to decent working conditions and to health services – can be overshadowed by concerns related to national security or concerns that migrants will burden already over-extended health systems. Such viewpoints can marginalise migrants. Even when migrants have access to health services, they generally choose to avoid them due to fear of deportation, discrimination by healthcare providers or linguistic, cultural and gender barriers. Balancing the economic benefits of migration with health and wellbeing of migrants should be a critical concern across the migration cycle and in the post-2015 development agenda dialogues (Brolan et al. 2013).

The feminisation of migration

The feminisation of migration is a major trend in South Asia, with increasing numbers of women going abroad to work in foreign labour markets, to marry, and to accompany family members abroad. Women experience gender inequalities in both destination and home countries (Sultana 2011). Yet women's contributions to migration and development and also their experiences and deprivations are not being fully acknowledged. More nuanced and reliable research that captures both the quantitative aspects and qualitative aspects of women's contributions across the migration cycle would provide a boost to gender-responsive programming.

There also needs to be more research that uncovers the "darker side of migration" (as occurs at the borders, when women move into informal and undocumented work and when women return home and face stigma and exclusion). Above all it is crucial that comprehensive policies and programmes are in place to make migration an experience of dignity for women migrant workers. Such programmes need to include both pre-departure orientations and on-arrival integration consultation; encourage ethical recruitment and accountability from brokers; support exploited women migrants in destination countries and facilitate their return home; and help returning female migrants to deal with social criticism, to find new employment and to reintegrate into society.

Brokers and recruitment agencies

Across the region there are large numbers of government-approved recruitment agencies that are facilitating movement of migrant workers to countries in East Asia and the Middle East. But without standard operating procedures and stronger regulation of the 'migration industry', the quality and consistency of the services provided by recruitment agencies is questionable. In any case, migrant workers continue to arrange their migration through unofficial channels and non-approved recruiting agents. They thus migrate outside government systems and are undocumented. As a consequence they are more likely to be deceived during recruitment, to pay higher fees, to be trafficked or face other rights violations. As noted, Bangladeshi undocumented migrants require the help of a broker to cross the Indo-Bangladesh border.

Safe remittances

It is difficult for migrants to open up bank accounts in India. They need to provide a valid Indian identity proof; proof of residence (a letter from a landlord or employer along with a copy of a utility bill}; and a letter of introduction from an existing bank account holder. But landlords and employers are not always willing to provide letters and guarantors can be hard to find (particularly for undocumented migrants). Some migrants turn to brokers to provide forged documents, which can place them at greater risk if the forgery is discovered. It's not surprising then that so many migrants rely on friends and relatives to carry money back home, even those carrying money when travelling are at risk of looting or extortion from border officials or robbery in transit (sometimes from fellow travellers).

Improved access to financial services for migrants would help foster a culture of savings and allow for more productive utilisation of their remittances. Three programme / policy issues emerge from this conclusion: first, there is scope for building linkages with banks and micro-finance and private sector institutions, so as to facilitate remittances, particularly for migrants living in remote, rural areas. Second, in order to promote the use of formal channels for remittances, banking procedures need to be simplified and bank transfers must be efficient and cost less. Third, raising the level of financial literacy amongst migrants as well as of remittance recipients would increase confidence in banking procedures and encourage use of official channels.

Support for returning migrants

In general, returning migration has been under-researched and under-documented. Researchers and policymakers have focused on understanding and analysing decisions for departure, failing to acknowledge that migration is a multidimensional process, which includes emigration, settlement in the host country and the possibility of return. Like departure, return entails a complex decision-making process (ACPOB 2013; Bastia 2011). There are few data on the quantity or quality of human capital returning to origin countries. For example, how do returnee migrants impact on social and economic development back home? What (new) skills do they bring?

South Asian migrants that are victims of various forms of violation at destination return back with psychosocial stress and/or physical disabilities (Hettige et al. 2012). Some are deported home. There are government and nongovernment programs addressing the reintegration of migrants into their communities, but these are not operating together in a coherent manner. There are few reintegration programmes for returnee migrants that are HIV-positive. Successful return depends on economic, social and psychosocial reintegration into the society of origin. Across the region there is a need for more accessible shelters and support services for migrant workers who are victims of violence and abuse but who have limited access to legal redress mechanisms and limited access to information about their rights, and no means to support themselves while in dispute with employers.

Women migrants do not always enjoy honourable status; in some cases, assumptions are made that they are engaging in sex work or that they are being sexually promiscuous. This puts them in a more difficult situation in terms of reintegration back into family and society more broadly. Some Nepalese migrant women have been reluctant to talk about their experiences from abroad, because Nepalese society

perceives migrant earnings, particularly from the Gulf countries and India, in a poor light (Adhikari et al. 2006). Others have changed their place of residence in Nepal after returning. But as more women migrate and take on the formerly masculine role of breadwinner (Gamburd 2000), traditional concepts of the value of "women's work" are significantly altered, which in turn affects caste hierarchies, class relations, gender roles, and family interactions. For women, this complicates their reintegration into the accepted social order.

Reliable data for planning and governance

Migrant remittances make significant contributions to national economies. In 2012 remittances across South Asia reached an estimated US$109 billion (a 12.5% increase over 2011). Remittance flows for 2013 are expected to reach almost US$114 billion (World Bank 2013). India recorded remittances of US$70 billion. In Bangladesh, Nepal, Pakistan and Sri Lanka, remittances were larger than the national foreign exchange reserves. In Bangladesh estimated remittances were equivalent to 14% of gross domestic product in 2012 (second only to earnings from the garment sector). In Nepal, remittances were equivalent to more than 24% of GDP (the highest in the region). Lack of systematic data on remittances (the total value through both formal and informal channels and how they are utilised) and on the numbers of migrants (at destination and returning migrants), disaggregated by such factors as gender, geographic location, migration status, ethnic minority or caste, is hindering the ability of governments in the region to plan and budget across multiple sectors and to develop comprehensive regional migration programmes.

Table 1: Examples of treaties and conventions that could promote effective regional programming

a. The UN Convention on Elimination of All Forms of Discrimination Against Women (CEDAW 1979). • Bangladesh, India and Nepal have all ratified CEDAW, albeit some articles have been exempted. But all countries lack local and district level mechanisms to implement CEDAW, in part because there is lack of a clear definition of discrimination in their constitution and domestic laws, as required by CEDAW. Domestic laws are not always in line with CEDAW provisions related to employment, equality of treatment, violence, and access to justice.
b. The Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (OHCHR 2000). • Only Bangladesh has ratified the MWC.
c. ILO Conventions related to protection of migrants' rights. • ILO Convention #97: Migration for Employment (1949a) • ILO Convention #97L: Migration for Employment (1949b) • ILO Convention #C143: Supplementary Provisions related to Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers (1971) • ILO Convention #C181: Private Employment Agencies (2000) • None of the three countries have ratified these relevant ILO Conventions.
d. National policies related to domestic workers. • India is currently developing a National Policy on Domestic Workers.
e. National policies related to migration for work and regulation of employment agencies • Bangladesh: the (decentralised) Bureau of Manpower, Employment and Training (BMET), under the Ministry of Expatriates' Welfare and Overseas Employment, has overall responsibility for licensing of recruitment agencies, training, and pre-departure orientation. • India: the (decentralised) Protector of Emigrants, under the Ministry of Overseas Indian Affairs, is responsible for granting emigration clearance and protecting and aiding with advice all intending emigrants. • Nepal: the Department of Foreign Employment, under the Ministry of Labour and Employment, issues clearance for work overseas and is responsible for ensuring agencies are providing orientation.
f. National migrant workers' insurance and reintegration schemes. • Bangladesh: Wage Earner's Welfare Fund. • India: National Health Insurance Programme (RSBY) and the Overseas India Insurance Scheme (PBBY). • Nepal (Jones and Basnett 2013): Welfare fund for workers (every migrant contributes NRs. 1,000 to a fund used to support workers encountering problems in destination countries or to cover repatriation in case of death); and

Compulsory insurance of between NRs. 2,000 and 3,000 to provide all migrants with health insurance coverage of NRs. 500,000.

The government also provides labour attachés in countries with over 5,000 Nepali workers (at present in Qatar, Saudi Arabia, Malaysia and the United Arab Emirates); safe houses for women have been set up in some countries.

g. National-level HIV and AIDS policies related to travel and residence restrictions.

From: Global database on HIV-specific travel and residence restrictions (at: http://www.hivrestrictions.org/Default.aspx?pageId=142)

- All countries have agreed that (a) travel will not be restricted based on an individual's HIV status (there are no specific entry regulations for people with HIV and AIDS); and (b) ART services will be made available irrespective of nationality.

5.2 The EMPHASIS advocacy strategy

Within the context of the opportunities and constraints described above, the project looked at advocacy as a powerful process that could lead to wider political acceptance of cross border mobility in the region and, following on, result in support for the implementation of policies and procedures that would:

- Address the vulnerabilities migrant populations experience across the mobility continuum;
- Promote safety and dignity by reducing violence and stigmatisation;
- Promote migrants' rights and entitlements and access to services; and
- Recognise women as agents of change (economic actors, rather than dependent spouses).

Overarching advocacy goal

Stakeholders at regional and country level in India, Nepal and Bangladesh are acknowledging vulnerability towards HIV and discrimination emerging from cross border mobility and are developing/ strengthening policies to address sustainable access to HIV and health services for mobile populations.

Sub-objectives

- Develop understanding among regional and national stakeholders on vulnerabilities associated with cross border mobility, particularly in India, Bangladesh and Nepal using EMPHASIS's research and other evidence.
- Strategically use evidence generated from EMPHASIS to develop advocacy messages and influence EMPHASIS activities and regional/ national policies to address barriers to access services and gaps in services addressing rights of cross-border mobile population at source, transit and destination.
- Develop collaborations/ partnership with SAARC and member governments to pilot referral linkage models on HIV services using EMPHASIS platform, and advocate to influence policies on sustainable services addressing HIV vulnerability across borders.
- Participate in coalitions at national/ regional/ global levels to share collective strength from alliances and networks facilitating conscious understanding and call for action addressing HIV and related vulnerabilities affecting mobile population and rights to access basic services at source, transit and destination.

Consideration of global migration-related advocacy issues and the specific contextual features of the South Asia Region have shaped the EMPHASIS advocacy agenda (Table 2).

Table 2: Global and regional migration-related advocacy issues shaping the EMPHASIS advocacy agenda

Key global migration-related advocacy issues:	EMPHASIS focus areas:	Operating modalities:
• Migration as an integral part of development. • Comprehensive programming and governance mechanisms and funding. • Wider recognition of the existence of cross border mobility and the contributions migrants make to national economies. • Safety and dignity, including stopping violence and harassment and discrimination at the work place and at health centres. • Wider recognition of HIV vulnerability. • Access to ART for all migrants across the continuum of mobility. • Access to money transfer and banking services. • Social security for migrant families.	• Safety and dignity of migrants at source, transit and destination: - Domestic violence against women within families. - Violence and harassment in transit and at the borders. - Violence in the workplace and decent work. • Access to facilities and services (universal access to ART / health services; access to education services and adequate housing) • Banking and remittance services for Nepali migrant workers. • Lack of identity-proofs.	• Community-led. • Evidence-based to inform programme adjustment and policy dialogues. • Jointly planned to influence national / bi-lateral government dialogues plus international agencies and local organisation action. • Engaging media as enablers in support of wider influence.

5.3 Research reports and policy briefs

Working on HIV and migration provided an entry point to a range of other issues – safety and dignity, workers' rights, violence against women, access to financial services, and stigma and discrimination. These issues were generated out of field experience and informed by various research studies and policy briefs. All EMPHASIS reports and policy briefs were published on the EMPHASIS knowledge hub at: http://www.care-emphasis.org.

Examples of EMPHASIS research reports that informed programme / advocacy responses are:

- Two baseline studies (Sultana et al. 2011; Wagle et al. 2011) informed project start up implementation and targeting strategies.
- An anthropological study (EMPHASIS 2013) of Bangladeshi Migrants in India provided perspectives on working with undocumented migrants and assessed the challenges and opportunities for working with this population group.
- A study (Sultana and Kaur 2013) of the experiences of Nepalese and Bangladeshi cross border migrants living with HIV highlighted the significance of mainstreaming PWHIV care and support services in existing government facilities in Bangladesh (rather than creating parallel structures) and the need to lobby the government to resource and take over the services. The study also noted the need to increase livelihood support to PWHIV and their families in Nepal; and the need to work with the governments in India and Nepal to develop transfer protocols that would formalise the cross-border ART referral mechanism. These recommendations were subsequently taken up by the project.
- A school children study (unpublished) explored the migration context of school-aged children who seasonally migrate to India and their potential vulnerability to HIV. The study found that poor economic conditions, "rites' of passage" and poor performances at school were major drivers for migrating to India, but found no conclusive evidence of HIV vulnerability.

- In 2011 the project conducted an assessment of the Drop-in Centres and Community Resource Centres. Following on, a truckers' drop-in centre was established at transit in Benapole in Bangladesh (away from the centre at source, which had not proved effective). In Nepal though it was noted that the drop-in centres had proved successful and that the management committees were mobilising resources locally to sustain the centres. In India, it was found that mobile drop-in centres were more effective for reaching migrant populations, especially in those locations where the migrants were continually moving from one location or living in semi-permanent slums, as in Mumbai. Drop-in centres were effective on the Indo-Nepal border and for migrants living in long-established (permanent) slums in Delhi; Drop-in centres at the Indo-Bangladesh border were not.
- A policy brief (Samuels and Wagle 2011) reviewed laws, policies and treaties between Bangladesh, Nepal and India and subsequently informed advocacy efforts. The brief highlighted the lack of clarity around the 1950 Indo-Nepal Friendship Treaty, in particular, with respect to entitlements.
- A study of the cross-border synergies created by the project (Samuels et al. 2014; Sarin 2014) showed the efficacy of targeting migrants, their spouses and families at source and destination.
- A study of the characteristics, working conditions and HIV-related vulnerabilities of Bangladeshi sailors (Samuels et al. 2013) provided insufficient evidence for including the sailors into the project's impact population.

5.4 Advocacy highlights

This section provides examples of how the advocacy strategy operated across local, national and regional levels.

5.4.1 Working across multiple levels to promote safe remittances

The baseline studies (Sultana, et al. 2-11; Wagle et al. 2011) had shown that migrants tended to use informal channels for sending money home, such as a friend from the same village or a 'money-broker'. But these channels were not always reliable and certainly not regular. Migrants related stories about losing money to unscrupulous brokers, being harassed at the borders, or about waking up to find they had been robbed after accepting a 'friendly' offer of food from a fellow passenger on a bus. One barrier that prevented migrants from using banking services was lack of identify-proof and proof of residence. Another was lack of trust in and non-familiarity with banks and "official" places. For EMPHASIS, the challenge was then twofold: first to lobby banks and private money transfer services to simplify procedures and requirements; second to work with migrant populations to shift their perceptions, so as to encourage them to make use of official channels.

The project started by systematically mapping available options. In Nepal and India, two private money transfer agencies – Prabhu Money Transfer and International Money Express – offered money transfer services. Between them they had more than 300 outlets in Nepal alone. EMPHASIS then organised a regional advocacy forum with the public and private money transfer agencies to talk about the need to facilitate safe remittances and to establish the case for making banking services more migrant-friendly. The project also met directly with Prabhu Money Transfer, who subsequently agreed to provide money transfer services for the EMPHASIS impact populations without service charge during festivals like Diwali (the Hindu festival of light). Similar linkages were established with the Everest bank and Union Bank, both of which also have cross-border connections.

In parallel, EMPHASIS worked with local media, who began to publicise stories of migrants being looted and how border officials demanded bribes at the border crossings. This raised the profile of the advocacy issue at both local and national levels.

At the same time the project included messages about safe remittances into all pre-departure and related IEC (information, education and communication) materials. Forums were also organised with community members at source and destination (both to create demand and to raise awareness of the benefits of using formal channels over middlemen and unreliable brokers). These included jointly facilitated meetings where EMPHASIS project staff and bank staff from the Malika Bank in Achham and Global and IME bank in Kanchanpur visited migrant communities to raise awareness about financial literacy and safe remittances and to provide information about opening bank accounts. This helped to create trust between the migrant families and the banks (critical in high relationship contexts, like in Nepal).

Another key success factor was the focus on working with women's groups in Nepal and India. With help from the project, women from these groups opened up bank account in their own names for the first time. They asked their spouses to send money directly to their bank accounts or in their name through money transfer agencies. This meant they were no longer dependent on intermediaries (in-laws or neighbours from the community) to gain access to the money sent back.

Additionally, the project engaged Nepali cultural associations and labour unions in India to spread information to migrants not directly reached by the project and to support migrants with the documentation requirements for remittance transfer

Table 3. Supporting safe remittances through solidarity groups

Groups supporting safe remittance	India	Nepal	Total
- Women groups	13	21	34
- Cultural organisations and labour unions	16	21	37
- Mixed (male and female) migrant groups	6	2	8
Total	35	44	79

The success of the women's groups was reported in the local media:

बैंकमा

पैसा पठाउनुस् है

सुरक्षाका लागि सचेत पार्छौं

Significant results:

The project's focus on supporting safe remittances (beginning in 2012) led to the following results:

- Financial inclusion – over 700 families at source and destination opened up bank accounts for the first time. As more and more women opened up accounts and talked to others about how they were receiving money through the banks, other women follow their lead. In Accham and Kanchanpur districts of Nepal 50% of 494 women surveyed in 2013 had opened up accounts; all 45 women belonging to the spouse group in Ridikot in Achham had opened up accounts.
- Greater control over resources – being the signatory on a bank account meant that wives were able to regularly receive remittances and could make decisions about how the remittances sent by family members were used. Equally importantly, the women grew confident about how they could organise and work together:

> To open up the bank account we had to learn to read and to write our names. We realised that we can learn things. We can work together and grow more confident [woman from the "Conscious" spouse group in Accham].
>
> [Because the money is coming to us directly] we are now taking decisions within the household… the women in the group are supporting each other to be confident and to take control [second woman from the same group].

- Developing a culture of saving – in both Delhi and Mumbai there was a significant increase in the number of people remitting money and in the amounts being sent via formal channels. In Delhi, in 2012, only 40 people reported remitting money from the localities where the project worked; by 2013 the number had risen to 300. In Mumbai, the number rose from around 5000 individuals in 2012 to 7000 in 2013. The amount of money remitted from all locations in India rose from US$510,000 (Indian Rupees 30,600,000) in 2012 to US$1,366,666 in 2013. In the locations where the project worked in Nepal nearly US$263,000 (Nepali Rupees 25,130,600) was received via formal channels in 2013.[9]

There is no treaty or policy that allows Bangladeshis to migrate to India for livelihood opportunities, and access to banking services was not an option for Bengali-speaking migrants. A mapping exercise conducted by the project in Jessore district revealed that the most common informal channel for remittances was for relatives and neighbours from the same village to carry back money. Brokers that regularly operate and move across the border were sometimes used (mostly when no one was travelling home and there was a pressing need to send money). But brokers have a reputation for delays and broker fees vary. More recently, Bangladeshi migrants have made use of the hundi system, which operates in a similar fashion to regular money transfer services. The migrant completes an unconditional written order and directs the hundi to pay a certain sum of money to a person named in the order. No actual exchange of cash occurs across the border, but instead the arrangement is transmitted via mobile phone. Widespread use of mobile phones means that transfer is quick and reliable and easily verifiable. This adds a level of trust not seen with brokers.

5.4.2 Regional-level advocacy

Hosting a regional consultation on migration

EMPHASIS hosted a 2-day regional consultation on migration in South Asia (July 2013) that brought together senior government officials as well as representatives from migrant networks, UN agencies, international and local nongovernment organisations and civil society organisations. This consultation was preceded by national-level consultations that were held in Dhaka and Kathmandu and state-level consultations in Kolkata, Mumbai and Delhi. The purpose of the regional consultation was to identify innovations, challenges and opportunities; to prioritise regional advocacy issues; and to locate points of collaboration and collective action to address migration in the South Asia Region. The meeting

[9] The estimates are based on informal discussions with migrants who have remitted money and with two remittance companies (Prabhu Money transfer and International Money Express in India).

proceedings were widely distributed and expanded the dialogue on migration and development within the region.

- A follow up meeting was arranged with high-level government officials of the Indian National AIDS Control Organisation (NACO) and the Nepali National Centre for AIDS and STD Control (NCASC). Representatives from both discussed strategic challenges and points of collaboration across the shared border and how NACO and NCASC might formalise and scale up the ART cross-border referral mechanisms developed by EMPHASIS.
- Following on, a consultation was held with Indian national parliamentarians in Delhi on Vulnerabilities of Labour Migrants – Challenges and Way Forward (December 2013). The one-day consultation discussed vulnerabilities faced by migrants, the challenges around accessing migrant rights, gaps in laws and policy frameworks and potential schemes for migrant workers (such as ID cards and health insurance schemes). While, the parliamentarians acknowledged the human rights of undocumented migrants, they also stressed that: "they are not entitled to enjoy the entitlements due to Indian citizens". A second consultation was facilitated with parliamentarians in Bangladesh. Both consultations highlighted the need to advocate further for increased country to country and regional-level dialogues about how to maximize economic opportunities from migration within the region, while also protecting the rights of South Asian citizens.

Participation in regional consultations

Migration and Women's Health: EMPHASIS was invited to contribute to a 3-day Regional Consultation organised by CARAM Asia (Coordination of Action Research on AIDS and Mobility in Asia) held in Bangladesh in May 2013.

Consultation for the 2013–2014 Implementation of the Joint Action Programme in the Greater Mekong Sub-region: EMPHASIS was invited to participate by the Secretariat for the Joint United Nations Initiative on Migration, Health and HIV in Asia (JUNIMA) and the Asian Development Bank.

The 7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention (30 June–3 July 2013 in Kuala Lumpur, Malaysia): A presentation was made by the Senior Regional Project Director of the EMPHASIS Project, presented on "HIV services for cross border migrants in the context of Nepal, India and Bangladesh: issues and opportunities" in a workshop session on strategies for providing HIV prevention, treatment care and support to cross-border migrants.

The Global Forum on Migration and Development Summit Meeting held in Mauritius in 2012 provided a platform for 160 member states of the UN to address migration issues. The recommendations from the meeting informed the High-level Dialogue on International Migration and Development held in September 2013 in New York that discussed including migration into the post 2015 Millennium Development Goals. EMPHASIS participated actively in the summit and took a lead in organising discussions on migrant protection and legal, social and financial protection of women migrants and their families in a session for the South Asian coalition of migrants.

EMPHASIS was also represented at the Asia-Pacific Regional Meeting for the General Assembly High-level Dialogue on International Migration and Development held in Bangkok in May 2013. The meeting identified a practical set of recommendations for optimising the benefits of migration and managing its adverse impacts, while also protecting the rights of migrants. These recommendations also informed the High-level Dialogue on International Migration and Development in New York.

- These invitations extended to Emphasis indicate that the project had established credibility in the field of migration and where there was uptake of the contributions made by the project.

Regional PWHIV Meeting, Kathmandu

A strategy employed by the project was to link HIV+ migrants (and their families) to existing PWHIV Networks that provide services and support to people living with HIV (via public and private sector and

nongovernment service providers). Importantly, the PWHIV networks have established rapport with and are recognised by governments and donors for their contributions to HIV prevention and care and have access to the media. As a consequence they are able to advocate on behalf of PWHIV local, national and international levels.

A Regional PWHIV Consultation (EMPHASIS 2013) brought together representatives from PWHIV networks and government and civil society actors from Bangladesh, India and Nepal. The consultation explored how to draw on the strengths of PWHIV networks in each country: (a) to facilitate cross-country linkages to health and related services for HIV+ migrants, and (b) to scale up the cross-border ART model developed by EMPHASIS.

- Three agreements emerging from the meeting were, firstly, to sustain the effort and to continue to find ways to jointly plan and organise; secondly, to collate and distribute research and best practice information on migration and HIV, so that the PWHIV Networks can speak with an informed voice; and thirdly, to develop common advocacy positions, such as, on protection of undocumented migrants, safety and dignity, and the status of women migrants.
- In addition, the PWHIV Networks agreed to meet quarterly to identify and problem solve issues related to HIV+ migrants and to develop strategies to realise cross-border support and service linkages.

5.4.3 National-level advocacy

Informing national-level HIV dialogues

The EMPHASIS team in Bangladesh was invited to contribute to a national strategic planning meeting to mainstream migration into Bangladesh's 7th National Strategic Development Plan. This invitation was extended as recognition of EMPHASIS's contributions in the field of migration and development and acknowledgement of the advocacy issues that had been raised by EMPHASIS.

The EMPHASIS team in Bangladesh also contributed to and influenced national-level HIV dialogues with the National AIDS and STD Program (NASP) through participation in two national level working groups: the Management Information System Working Group for National Reporting on HIV and AIDS, and the core team to develop the National Strategic Plan of Action for HIV and Migration.

A key input into these dialogues was the findings from an EMPHASIS study on PWHIV (subsequently published as Sultana and Kaur 2013) that was presented at a meeting of 84 representatives from government, academics, development workers and media personnel (CARE Bangladesh 2006). This meeting also highlighted the importance of expanding government VCT (voluntary counselling and testing) centres as a key HIV prevention strategy in Bangladesh. EMPHASIS had previously lobbied with the Directorate General of Health Services to establish two district-level VCT Centres in Jessore and Satkhira District hospitals (each of which was serving a population of around 1.5 million). A full description can be found in Learning Series, part 2: Reducing HIV vulnerability.

Measurable results include:

- Training provided to 93 service providers (both government and private sector providers) in Jessore and Satkhira on syndromic management of STIs (sexually transmitted infections), HIV and AIDS care, counselling and testing procedures and rational use of ART. This led to:
    - A strengthened / operational referral system (from 52 Community Clinics up to the two District-level Centres and from NGOs/private sector providers to the District Centres).
    - Best practice procedures implemented and data management improved and informing national surveillance data.
    - Increased service access for communities living along the Bangladeshi-India border.

- Government ownership
    - NASP lobbied the government to allocate resources to enhance and sustain VCT service delivery, including counselling services, at these government health facilities beyond the project.
    - The Health Ministry made a commitment to include migrant populations in the national sero-surveillance survey.
    - NASP with the International Organisation for Migration allocated resources from the Health, Nutrition and Population Sector Development Program Fund to address HIV vulnerability amongst overseas migrants.
    - The District Civil Surgeon lobbied the Ministry of Health to budget resources to sustain services beyond the life of the project.

  It is noteworthy that EMPHASIS's work in Bangladesh was subsequently described as best practice by UNGASS Bangladesh (NASP 2012).

In February 2014 (year five of the project) CARE Bangladesh and the Daily Gramer Kagoj newspaper jointly organised a roundtable meeting – Reaching Unreached Populations through a lens of HIV and AIDs, Migration and Development – for government and nongovernment health service providers, nongovernment organisations, implementing partners, PWHIV network organisations, migrants and the press. At the roundtable, CARE EMPHASIS staff described how the project's strategies contributed to reducing HIV vulnerabilities amongst cross border populations.

In Nepal, EMPHASIS was able to work with an existing Seti VCT/ART site in Dhangadhi to support STI syndromic management training of staff, to help develop and systematise cross-border referral procedures (described fully in Learning Series, part 2), and to implement electronic record keeping. As a result of this effort the data generated are now informing national-level aids surveillance and the procedures have been taken up in other districts. In both Bangladesh and Nepal, HIV counselling processes now include information about what to do when migrating and provide linkages to services across the border.

Indo-Nepal Journalist Forum

Engaging with and mobilising the media is an effective strategy for creating an enabling environment. Late in 2013, EMPHASIS worked with the Indo-Nepal Journalist Forum to facilitate a cross-border discussion about safe mobility with 30 journalists from India and Nepal. In the meeting, the journalists and police committed to support any efforts that would reduce harassment and violence against migrants at transit.

5.4.4 Linking local actors with existing service providers

EMPHASIS was able to expand its reach by building on the linkages it had established with both public and private sector service providers and nongovernment organisations so as to build an awareness amongst duty bearers and stakeholders of the need for provision of services for migrants and their families. A number of actors showed commitment to continue services initiated by EMPHASIS after the planned closure of the project. This was key to sustaining the work beyond the project life cycle.

Results:

30 Memoranda of Understanding (MOUs) were signed to formalise these commitments (Table 4).

Some examples are:

- MOUs with PWHIV Networks in Kolkata, Mumbai, Delhi/NCR, Bangladesh and Nepal to facilitate on-going access to services and care for HIV+ migrants.

- MOUs with public sector services providers to support access to VCT/ART services in Nepal and India and to facilitate cross-border ART referrals.
- MOUs with government and nongovernment organisations in Bangladesh to strengthen capacity for STI Syndromic Management and referral services at Upazilla- and community-level clinics.
- An MOU with the State Government's Gender Resource Centre in Delhi, to address domestic violence and help women's groups to self-organise and monitor violence.
- An MOU with the International Transport Federation in Bangladesh and the project implementing partners to establish Drop-in-Centres and to mobilise truckers' participation in programme activities.
- MOUs with the media in Nepal to support advocacy for migrating safely and to promote safe remittances.
- MOUs with 3 Nepalese community-based organisations (Nepali Sanskritik Pariwar Bharat, Help Nepali Mission and Pravasi Nepali Sangh) in India to continue awareness raising activities after the project closure and to extend reach to their large membership base.

Table 4: MOUs established by EMPHASIS

MOU partners	Location	#
Public sector (hospitals, transport departments)	Transit (India) Source (Bangladesh) Source (Nepal	2 3 4
Private sector (trade unions, banks)	Destination (India) Source (Bangladesh) Source (Nepal)	1 2 3
Community-based organisations	Destination (India) Source (Nepal)	6 1
PWHIV Networks	Destination (India) Source (Bangladesh) Source (Nepal)	2 2 2
Media Associations and Radio Channels	Source (Nepal)	2
	Total	30

These Nepalese community-based Organisations / Associations directly took on lobbying activities. For example, the United Nepali Organisation in Mumbai wrote to the Director General of the Department of Labour, Ministry of Labour Employment, Nepal and called on the Director General to lobby for acceptance of Nepali identity cards and simplification of remittance procedures. Similarly, the Delhi State committee of the Migrant Nepalese Association wrote to the Director General asking him to lobby for action around acceptance of Nepalese identify cards, access to bank accounts at destination and formal employment contracts.

Recognising that more than 90% of HIV transmission in India is related to unprotected sexual encounters or sharing of injecting equipment, the Indian government initiated a "targeted intervention programme" (see NACO 2007b: Guidelines for working with truckers and mobile populations). The targeted intervention programme reaches out to networks and individuals who have a higher number of sexual partners or share injecting drug equipment. Services include, for example, condom promotion and distribution, linkages to STI services; distribution of lubricants and syringes, and linkages to tuberculosis voluntary counselling and testing centres. EMPHASIS was able to further extend its reach through referrals to local nongovernment organisations implementing the targeted intervention program.

5.4.5 Local-level and community-led advocacy

Access to education at destination for the children of migrants

EMPHASIS facilitated access to education for children (aged 3-9) of Nepali migrants and Bengali-speaking populations. Strategies included outreach to build awareness amongst migrant populations of available services; sustained dialogue with key stakeholders within the education sector on issues and possible actions; and a "signature" campaign to get migrants' communities to add their voice to the lobby. The project also arranged non-formal education to prepare children for entry into school and help them get through the entry exam. The Anchal Charitable Trust in Delhi, through its mobile learning van, provided classes at the Sonia Camp and Shalimar Gardens Drop-in-Centres in Delhi. In

other communities, parents came together to offer preparatory classes. At the same time the project also engaged local education authorities in dialogue about allowing the children of migrants to enrol in public schools in India (after they had passed the entry exams).

- A total of 276 migrant children (180 boys, 96 girls) were able to enrol in Indian schools at destination (April 2014).

Bangla and Nepali Speaking Migrants' Children Linked to Education in Delhi

EMPHASIS is working with both Bangla and Nepali speaking migrant population in Delhi, India one of the destination sites. Often children from poor migrant families are engaged in rag picking and other similar activities to support their families. EMPHASIS team's constant efforts have been instrumental towards ensuring enrolment of more than 200 children from migrant communities in schools. While working with BSP Migrants it was observed that most of them are in to rag picking and collecting. Instead of going to school, children were engaged in waste collecting to earn money for the survival of the family. The area namely Shalimar Garden and Nayee Seemapuri were identified as the major hub for BSP population.

EMPHASIS took the intiative and encouraged the children to come to DIC for getting basic education. EMPHASIS facilitated one hour class every day. Interesting rhymes, poems, math and moral education were taught during the classes. Apart from this, the Mobile Learning Van (MLV), supported by another project of the partner organization, was mobilized to the Nayee Seemapauri area thrice in a week. The MLV is well equipped with study materials, visual aids, teachers and other necessary items in it which further generated interest among the children. The Mobile van reaches to the children around 11:00 a.m. in their workplace, collect them, makes them sit comfortably, review the previous lessions, and starts new sessions with lot of audio visual materials. Time to time the children were tested for their performance. At the same time, EMPHASIS team started having series of discussions and sensitization at the nearby schools. Initially schools were reluctant to enrol these children but later they agreed. With all the support, almost 40 children qualified in the entrance exams and got enrolled in the formal educational institution.

Similarly during individual interactions and group meetings, EMPHASIS discovered that due to some hindrances couple of Nepali Migrant Population (NMP) were not able to enroll their children in the school. One of the major obstacles was lack of identify proof. EMPHASIS team of Anchal (Local Implementing partner in Delhi) started an initiative to provide non-formal education to the children through the DIC at Shalimar Garden and the DIC at Ganeshpuri. On the other hand, parents were also sensitized. Gradually parents realized the importance of education. They started coming to the DIC to drop their children for their education.

Simultaneously EMPHASIS team started engaging with nearest government and private schools to sensitize these institutions. After a rigorous process and support from stakeholders, around 160 NMP children have been linked to formal education, by December 2013.

The opportunity for nongovernment organisations, like CARE, is to develop case stories that show how migrant children were assimilated into schools in India, so as to encourage local education authorities to take in other migrant children missing out on schooling. Social research would also help uncover the financial and structural barriers that prevent migrant children from entering and staying in school.

Bangladeshi women lobbying for changes in attitudes towards women

In the Bangladeshi context, discrimination and humiliation are common experiences for families of migrants. Spouses left behind when their husbands migrate to work in India, are often subject to sexual and emotional harassment, and seen as "easy prey" for men. Children may be treated poorly by teachers (made to sit in the back row), or bullied by classmates. Men, whose wives have migrated to India, can be shunned when they go to the mosque. The Women Self Help Groups in Bangladesh provided a safe space where women could come together, identify issues that were important to them, and then work collectively to resolve these issues. The Self Help Groups were formed in communities where there were families with a migrant history (someone in the family was currently a migrant or had been a migrant in the past). Self Help Group discussions included HIV and health, safe migration, stigma and discrimination of people who are HIV+ and harassment of migrants and their families. There were also income-generating activities and skills building sessions, so that the women could grow the confidence to raise their voice in the family and in the community and contribute to family-level decision-making. Riya described how her involvement in one women's group helped her to speak out:

My husband was away in India, and some people in the community took advantage of his absence. They threw stones on my roof during the night and banged on my door. I went first to my in-laws and then the local union office, but they didn't want to help. I thought a prominent community member was responsible and I shared my story in the Self Help Group. The group facilitated a non-confrontational but out-in-the-open discussion without directly accusing the man. This allowed everyone to resolve the problem sensibly, without further confrontation… the harassment stopped [Riya, migrant spouse in Bangladesh].

Nepali women fighting against harmful social norms

One woman's groups in Achham district – Prerana (or Inspiration) – had for some time been talking to each other and to others outside the group, about issues related to HIV and migration. In addition, the group also talked about women's rights and their wish to fight against chhaupadi, the practice of segregating menstruating women from their houses and men, forcing them to stay in a small hut (goth) built on the edge of the village. Chhaupadi restricts women's mobility and damages their health, depriving them of proper sanitation and hygiene, a nutritious diet and family support. Nepal's Supreme Court outlawed Chhaupadi in 2005. Nevertheless, the practice persists (OCHA 2014).

EMPHASIS helped the group to get in touch with the Women's Development Network in Achham, which was already working on the Chhaupadi Goth Mukta, a campaign to stamp out this practice from the entire district. Together they organised a rally with banners and posters to publicise the issue in their community and then followed up with a meeting with key stakeholders. The practice has not been completely wiped out but there are fewer women being sent to the hut.

The "Conscious" Women's Group in Ridikot heard about these efforts and wanted to also take part. The women were angry, as a few years earlier a young girl had died while in quarantine. With support from GaRDeF Nepal (the implementing partner), Menaka Bhatt (the peer educator) organised the women to campaign against chhaupadi. The women staged a rally and cultural programme that enlisted support from a larger number of women and men. At the end of the rally, the women made a definitive statement and destroyed all the goth structures in the village. Women are no longer being quarantined.

Women-led advocacy task force in Nepal

HIV prevalence is high in Achham and Kanchanpur districts in Nepal (Suvedi 2013; UNAIDS 2012), and the HIV positive widows in these districts generally struggle to earn a livelihood. They also face stigma and discrimination from within the community and from within their families. In addition, their low socio-economic status and lack of easily accessible facilities are barriers to accessing health services and care when needed.

The EMPHASIS project supported the formation of two Advocacy Task Forces (Fig. 1) to raise awareness of the challenges faced by HIV+ women and to explore ways to address these. Each Task Force was led by a HIV positive widow and included district-level government representatives, local NGOs and community leaders and comprised 30 executive members that reached

Fig. 1. Mobilising Advocacy Task Force in Nepal

out to 500 HIV+ women. The Advocacy Task Forces consistently engaged local leaders, media, local stakeholders and community groups. The project provided training inputs to build awareness of HIV health issues and rights and to engage members and communities in discussions about HIV and stigma and discrimination.

Results achieved:

Resources allocated

- 7 Lakhs Nepali Rupees (approximately US$7,000) were secured from the local administration during the District Planning Assembly and commitments were received from government agencies and political cadres for different care and support services for PWHIVs.
- The Achham Transport Association agreed to reduce fares for PWHIV travelling to access HIV-related services.

Participation and inclusion

- PWHIVs reported tangible signs of reduced stigma and discrimination: "we feel more comfortable" and "are included in community activities" (e.g. now playing a role as peer educators).
- Task Force representatives participated in a 2013 National-level AIDS Conference and presented on the issues faced by HIV infected and affected women and children.
- Task Force representatives were included in the preparation of the District Advocacy Strategy.

The advocacy task forces continue to lobby government departments for the implementation of policies that support the needs of PWHIV and increased coverage of Voluntary Counselling and Testing services, care and support to vulnerable and socially excluded groups, especially HIV+ women and children.

Lobbying for decent work for domestic workers

In Nayee Seemapuri, New Delhi, EMPHASIS worked with female Bengali-speaking domestic workers, after learning that many were working in poor conditions for long hours for as little as Rupees 1,800 (US$30) per month, which is less than minimum labour rate set by the Government of India. The majority had got their jobs through brokers, who exploited the women, controlling and often delaying their monthly salary, or making deductions if a woman asked for time off to deal with emergency family needs. Abuse and harassment and violence and molestation were also common. Here are the voices of three domestic workers:

> I dropped out from school and started working alongside my mother as a domestic helper when I was 11. After marriage, my husband was working in a meat shop as a daily wage labourer. His monthly income was only US$100, which was not enough for our family. I got this job, cleaning by hand the skins of dead chickens, which meant I could add US$30 to our monthly income. I used to work 9-10 hours a day and handed over the skins to the brokers who would then sell them. One day I asked for more money. The owner strictly refused and told me to leave the job [Sabila].
>
> My name is Suresh and I live in Shalimar Garden. I work as a security guard in a residential colony. If I go out to the nearest shop for a minute to buy cooking oil for my family, then the owner expects my wife or daughter should step in and make up for lost time. In fact, I don't get anytime off, even during holidays. We are given a 50 square feet space for all 5 members of my family. It's in the car parking area of the building, which is very clumsy and always muddy [Suresh].
>
> I stayed with my 3 children for almost 3 days on the footpath – no job, nothing to eat, no blanket to cover our heads. This was after losing my job as a domestic maid. When employer learned I was pregnant, I was fired. So, I was not able to pay my room rent on time and the house owner threw me out [Sita].

In group meetings and discussions, the EMPHASIS project staff learned about the circumstances that compel migrants to undertake risky and poorly paid work. Migrant families in this particular community were large, and more than one family member needed to work so the family could make ends meet. The EMPHASIS outreach team set out to motivate women domestic workers to be more aware of healthy work environments. Sensitisation workshops addressed rights and entitlements including government-regulated working hours, minimum wages and allowances). Later EMPHASIS facilitated a meeting

between employers and employees. The meeting proved unsuccessful; the employers were not receptive to allowing flexible working hours and reluctant to increase payment to the workers. But after consistent follow up meetings, the employers agreed to increase the monthly payment to US$30.00, though other issues related to providing medical facilities to the workers and insurance remain unsolved.

The domestic workers united and formed a group and decided to keep pushing for their demands to be met. The outreach workers helped the women to launch a "Signature Campaign" to get even more community members involved. In December 2012, ahead of the Indian government Assembly election, there were rumours that the Municipal Corporation of Delhi was planning to hold meetings in Nayee Seemapuri and other areas of Delhi. The workers group decided to "seize the moment" and to not work until their claims were approved by the employers. Finally, after a lot of discussion and persuasion, their pay was again increased to US$65.00 per month and they were granted an 8-hour flexible working day. Sabila (one of the domestic workers in the group) had this to say: We are happy with the progress. At least now we can send our children to school, give them nutritious food and share more of the financial burden in our families.

- In all 74 domestic workers – from both Nepalese-migrant and Bengali-speaking communities were able to negotiate flexible working hours and increased wages with their employers.

The case study clearly demonstrates that it is possible to advocate for migrant workers' rights at destination. Given that the right to decent work is a struggle even for Indian nationals in India, this was a significant achievement of the project.

Safety and dignity in transit and at destination

Some issues that related to safety and dignity in transit and at destination – and the project's responses – are exemplified in the following two case stories:

My name is Maya and I am 32. I arrived here 12 years ago with my husband. We travelled from the West Bengal side of Nepal. There was a heavy security check. We had to convince the border officials we were coming for work. We experienced a lot of harassment when we first came. We had to pay more rent compared to Indian tenants. We could only rent if we agreed to buy groceries from the landlord. When I first arrived, I worked for a paint company. They paid me $US30.00 (1800 rupees) each month. The Indian staff got $US42.00. When the owner molested me, I left. I next worked in a factory making light bulbs. Again I was paid less than the Indian nationals. I took another job in a factory making vehicle parts. But they weren't women friendly, and I had to work more hours than the men. So, I left [Maya Gurung, project counsellor].

Kulmata's first husband deserted her. Her second husband died of TB and lung cancer. When she came to the attention of the EMPHASIS project peer educator and outreach worker, Kulmata was living in abject poverty. Her daughter, Seema (15), worked as a cleaner in a Mall and provided some financial support. Her second daughter, Aruna was too young to help out. Kulmata became ill with a high fever and persistent cough. Fearing that Kulmata's illness would spread, the neighbours turned against her. They urged the landlord to evict her. They stopped inviting her to visit their homes. She was excluded from community functions. Seema's employer had also started to harass her, because she was young and illiterate and willing to do any jobs to support her family. Kulmata was in a low state, physically and psychologically. The EMPHASIS Drop-in Centre counsellor, Maya Gurung, stepped in and accompanied Kulmata to the hospital, where she was diagnosed with early-stage TB. She followed up to make sure Kulmata was keeping up with her medication and that her health improved.

Project staff met with Seema's employer and, as a result, Seema was treated more fairly at work. They encouraged her to join functional literacy classes at the Drop-in Centre. With the help of the implementing partner, the youngest daughter of Kulmata was admitted into a government school, after the partner provided her identity proof. Today, Kulmata is an active member of the EMPHASIS programme. Every Sunday afternoon she goes out into the community and brings women to the drop-in centre. She also leads discussions about the programme and how it is addressing issues experienced by Nepali migrants coming for work [Kulmata, Nepali widow and peer educator in Delhi].

Transit based interventions at the Indo-Nepal border (summarised in Table 5 below) included creating spaces for bi-lateral meetings between authorities on both sides of the border to address migrant vulnerabilities and to curb incidents of violence and harassment. These interventions were complemented by safe migration messages promoted through Drop-in Centres and Community Resource Centres, via women's groups and their families at source, and migrant support desks both at border transits and at "stops" along the way. (See also Learning Series, part 3: Migrating safely.)

Table 5: EMPHASIS-led initiatives to address violence and harassment at transit

Specific initiatives:	Enabling processes:	Results:
• Establish Migrant Help Desk • Facilitate cross border meetings with government border security staff • Facilitate Indo-Nepal Journalist meeting • Broadcast public radio programme • Document and report cases of violence and harassment and disseminate these with relevant authorities and through above forums	• EMPHASIS project organised several media events at the border to sensitise district authorities to take accountable action on the issues of violence and harassment • Meetings were held with the senior police officer and his team at the border place to establish a citizen help desk • Joint MOUs were developed between EMPHASIS and Border Police to operate the citizen help desk	• Border police 'manning' the Migrant Help Desk are documenting and acting on reported cases. • The number of cases of violence and harassment decreased from 50 plus per day to only 1-2 cases per day. • Journalists are monitoring activities to reinforce accountability and sustainability.

Table 6 summarises local-level advocacy initiatives addressing violence at destination, showing the linkages between issues identified, actions taken and results achieved. (See also Learning Series, part 4: Women's empowerment.)

Table 6: Addressing violence at destination

Types of violence:	Enabling processes:	Results:
• Domestic violence • Harassment and verbal abuse by landlords and/or other persons with power, including police and local gundas (thugs/gangs) • Physical and sexual harassment and abuse of females • Group violence within migrant communities	• Linkages with Gender Resource Centre in Delhi • Legal awareness and sensitisation meetings • Working with CBOs to address individual cases • Public meetings and local-level consultations with women's groups, domestic workers' groups and job-placement agencies • Sensitisation meetings with police and key influential persons	• Migrants are now taking action and seeking ways to resolve violence-related issues within families and within the larger community.

5.5 Lessons learned

Advocacy was a key programme strategy, and the EMPHASIS project advocated on a range of issues, including HIV and related-health services, safety and dignity, workers' rights, violence against women, access to financial services, and stigma and discrimination. Advocacy efforts were supported by case stories generated out of the migrants' lived experiences and research studies and policy briefs commissioned by the project.

A critical success factor in operationalizing the advocacy strategy was the ability to establish chains of partnership across the mobility continuum and to bring about collaboration across multiple levels. The project worked:

- With local to national-level government authorities in all three countries and, in particular with the National AIDS authorities, to support information sharing and face-to-face exchanges amongst high-level government officials.
- With UN agencies, the International Organisation for Migration, development partners, civil society organisations and migrant networks and research institutions to expand the dialogue about migration and development.

- With “on the ground” stakeholders who interact with migrants on a daily basis: public and private sector health service providers, local nongovernment and community-based organisations, hoteliers and food stall owners, transport unions, bus drivers and rickshaw pullers, money transfer agencies and banks, and border security and police officers.

Many migrants are subject to exploitation, e.g. abuse and fraud in the recruitment-process; poor working conditions and low pay; discrimination; psychosocial stress and vulnerability to HIV and work-related health issues. Women migrants are particularly vulnerable to these stresses. But the notion of ‘protecting women’ by restricting their right to mobility and safe work perpetuates patriarchal norms and attitudes. Thus the project also worked to make migration an experience of dignity for women. Both sending and receiving countries need to implement national and regional policies and programmes to allow women to make positive contributions to migration and to move freely and without fear.

A key learning has been that the issues experienced by Nepalese migrants are similar to those experienced by internal migrants in India. In particular, low skilled labour migrants are generally relegated to the margins of society. They have little or no access to minimum wages, holidays or days off from work and social security benefits. They also have few options to unionise or to collectively bargain for their rights and entitlements. This insight opens the door for further strengthening linkages to existing local community-based organisations and trade unions and labour movements at destination that are addressing workers’ rights.

The project has highlighted the need for clarification and inter-country dialogue on the Indo-Nepal Treaty – both what it means for migrant populations and also for development partners and civil society organisations supporting migration and development programming. These dialogues should focus on the rights and entitlements of Nepalese migrants in India and of Indian migrants in Nepal. From a public health perspective, guaranteeing migrants equitable access to health care and health promotion is a sound and practical investment. Being healthy and staying healthy is a prerequisite for migrants to work, to be productive and to contribute to positive development outcomes.

The sensitive political environment with respect to Bangladeshi migrants and the absence of high-level dialogue makes it extremely difficult to highlight issues and concerns of Bangladeshi populations. What has become apparent though is that large numbers of Bengali-speaking migrants are living and working in conditions of poverty, and social instability that predispose them to HIV, tuberculosis and other health risks. Until there is committed dialogue around these issues, migration programming for Bengali-speaking mobile populations needs to continue to work through existing networks and people-to-people contacts.

There is, however, an opportunity for Nepali community-based social and cultural organisations to pick up the work described here and to lobby the Nepalese and Indian governments for action to protect migrants’ rights. There is also an opportunity for SAARC to play a role in advancing bi-lateral dialogues around all of these issues and to influence the adoption and implementation of regional migration policies that protect SAARC citizens.

Annexes

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