

Vulnerabilities of movement: cross-border mobility between India, Nepal and Bangladesh

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Mobility is not a new phenomenon in South Asia, and national, regional and international mobility is on the rise. Over the last few decades the demand for labour from India's growing economy, in particular, has pulled people from neighbouring countries: Bangladesh, Nepal, Pakistan and Sri Lanka. The rise of HIV in the region is also not a new phenomenon: current HIV trends reveal that South Asia is home to 2 to 3.5 million of the estimated 33.3 million people living with HIV (PLHIV) worldwide (UNDP, 2010) and the sheer numbers of PLHIV in the region make HIV a major public health concern.

Countries in the region are characterised as having epidemics that are concentrated amongst specific most-at-risk-groups (MARPS), including sex workers, injecting drug users, men who have sex with men and, increasingly, migrants. Although mobility itself is not considered a vulnerability factor for HIV infection, the unsafe conditions under which many people migrate expose them to risks of infection. Vulnerability to HIV in source communities can also be heightened if these are not well targeted for HIV and AIDS prevention activities and when the HIV and AIDS-related vulnerabilities of returning migrants have not been addressed in destination communities. Such barriers increase migrants' vulnerability to HIV infection and reduce their ability to protect themselves from HIV (IOM, 2002).

Relatively little is known about the magnitude, causes and consequences of migration in South Asia or the social and behavioural mechanisms underlying

the relationship between migration and HIV-related vulnerabilities. To fill this gap and develop appropriate responses, a regional operation research programme was established with interventions and research at source, transit and destination locations. Led by CARE UK, Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) is a five-year project working with local partners and CARE country offices in India, Nepal and Bangladesh to carry out research and interventions. ODI is providing technical oversight to the research component.

Baseline research, using both quantitative and qualitative methods, was conducted between November 2010 and March 2011 to understand what drives mobility, access to services for migrants at source and destination, and the risks and vulnerabilities associated with migration and HIV and AIDS. Given the interest in exploring vulnerabilities related to migration and HIV along a continuum from source, through transit to destination, this Background Note presents findings from Nepali and Bangladeshi migrants as they move through this continuum.

Nepali migrant workers were interviewed in two cities in India, Delhi (388) and Mumbai (196), as well as returnee migrants, the spouse of a migrant and an adult relative of the migrant in two districts at source, Kanchanpur (298) and Achham (252). Bangladeshi migrants were interviewed in two cities in India, Mumbai (384) and Kolkata (384), and, mirroring the case of Nepal, three groups of respondents in two districts at source, Jessore (260) and Satkhira (290).

These locations were selected based on pre-existing evidence, including mapping done by the EMPHASIS project, of where Nepali and Bangladeshi migrants are concentrated in India and where they tend to come from in terms of the source countries. For fur-

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ther details see the EMPHASIS baseline route reports (Wagle et al., 2011; Sultana et al., 2011).

The questionnaire was complemented by in-depth interviews, focus group discussions, and key informant interviews at source, transit and destination in all three countries.

This paper explores who these migrants are, their migration patterns and their related vulnerabilities, particularly in relation to HIV. It concludes by providing some tentative recommendations both from policy and programmatic responses.

Background

Crossing borders has been central to the lives of many Nepalese and Bangladeshis as they move to and fro between their countries and India in hope of better opportunities for themselves and their families. As a result of a bilateral friendship treaty signed between India and Nepal in 1950, citizens of both countries can travel and work freely across the border and are regarded as native citizens (Bhattarai, 2007). According to recent estimates, there are approximately one million Nepalese working in India (GoN, 2004), mostly as unskilled permanent or seasonal labourers. For Bangladeshis, however, official migration to India is fraught with problems (See Samuels and Wagle, 2011) and most migrants to India are unauthorised. Although exact figures are unknown (the Indian 2001 census for instance mentions there were approximately 3 million Bangladeshi migrants in India, representing 60% of total migrants), people from India and Bangladesh regularly cross the porous borders through many unofficial transit points. These migrants generally find work in the informal sector, often as domestic workers, construction labourers, rickshaw pullers and rag pickers (Naujoks, 2009).

While remittances from migrants are critical for the survival of families in source communities, those who move abroad and those who stay may face numerous vulnerabilities. The migrant moving to a new environment may face language barriers, risky and dangerous work and housing conditions, violence and harassment, and may be unable or unwilling to access health and social services because of government restrictions and discriminatory attitudes and behaviours of staff. They may also face loneliness and depression. All of these vulnerabilities are heightened if a migrant is illegal or unauthorised. Those left at home may face loneliness and exclusion: women migrants and their families in Bangladesh are often excluded from social events, and they may also engage in risky behaviours for livelihood or survival purposes. Working in combination, all of these factors increase the risk of HIV infection.

The HIV prevalence rate in India is approximately 0.34%, rising to 3.61% amongst MARPS, and there are presently around 2.5 million PLHIV in India (NACO, 2009). In Bangladesh, with an estimated 12,000 PLHIV, the HIV prevalence is below 0.1% in the gen-

eral population but rises to 0.7% among MARPS (GoB, 2010; World Bank and UNAIDS, 2009). Similarly in Nepal, where there are 70,000 PLHIV, adult prevalence is approximately 0.5%, with estimates showing that the highest proportion of these are seasonal migrant workers (41%) followed by injecting drugs users (34.7%), clients of sex worker (16%) and partners of HIV positive men (21%) (GoN, 2010).

Who migrates, and who stays home?

Gender, age, marital status and education

Ninety-nine per cent of Nepali migrants at source and 58% at destination were male. Their average age in India was 27 and 31 in Nepal, though these averages were influenced by respondent inclusion criteria, i.e. respondents had to be between the ages of 15 and 49. Thirty-one per cent of the Nepali migrants in India and 48% in Nepal had never attended school. Sixty seven per cent of migrants in India were married, with more migrants being married in Delhi than in Mumbai (73% versus 54%).

Seventy-nine per cent of Bangladeshi mobile respondents both at destination and source were men. Ages at source and destination were similar: 31 versus 30. At source destinations, 38% had never attended school, while at destination locations that figure was around 36%. In terms of marital status, 56% of the respondents at source and 75% of respondents at destination were married.

Household size and living conditions

Forty-two per cent of the Nepali migrant households at source consisted of one to three members. Those at destination had larger source households: half had four to six dependents. Most families at source consisted of multi-generational households (children, with parents and grandparents) and 54% lived in semi-*pucca* houses (houses with cement floors or walls). There were variations by districts: in Kanchanpur 60% lived in *kutchha* houses (houses built completely of mud/bamboo) compared to 10% in Achham where 90% of households lived in semi-*pucca* houses. An overwhelming majority – 96% – of respondents owned their homestead. Overall, 56% of respondents reported that their households had electricity, and availability of electricity was significantly better in Kanchanpur (76%) than in Achham (39%).

At destination, most Nepali male migrants (64%) lived with relatives/friends, and approximately 80% shared a room with more than two people – the mean number of people sharing a room was nearly four. Seventy per cent of respondents in India reported living in non-slum areas, with a higher proportion in Delhi (74%) than in Mumbai (58%). Seventy two per cent of migrants in India rented their house. Most have electricity in their homes (94%) and 80% used common toilets, though these were in poor condition and had limited water supply. The availability and

Box 1: Discrimination faced by Nepalese from landlords

'We are discriminated in that we have no water supply or toilet/sanitation facilities and if the landlords feel that we are using too much electricity, the line is disconnected.' Married male, staying without spouse in Delhi.

'I have changed my room 8-10 times because of ill treatment by the land lord, unreasonable rent, lack of basic amenities (water, electricity, cleanliness), and distance from my workplace.' Married male, staying without spouse in Delhi.

'... the landlord takes Rs.600 from Indians whereas we have to pay Rs.1000 for the same room. The landlord's language was familiar with the people from U.P. and Bihar. Our language is very different from theirs – that is why they discriminate against us. We have come from another country therefore we have to be fearful. Sometimes we feel that we should go back to our village but then we remember that our family depends on us.' Single male, Delhi.

use of municipal services including sanitation, water and waste disposal was fairly good but dependent on relationships with landlords. The qualitative survey revealed reports of discrimination towards Nepali migrants from their landlords (Box 1).

Amongst Bangladeshis at source, most (68%) lived in kutchha houses and 89% of households reported owning the homestead where they lived. Forty-three per cent of respondents at source reported having access to electricity in their homes.

Similar to the Nepalese, approximately 86% of Bangladeshi respondents shared a room with more than two people, with the mean number of people sharing a room at four. But, in comparison to the Nepalese, 55% of respondents lived in slum areas (mainly women in recognised and men in unrecognised slums) and the remaining 45% in non-slum areas. Most respondents who did not live in a slum lived in Kolkata (64%) while 100% of those living in slums lived in Mumbai. Three-quarters of respondents at destination lived in kutchha houses, with approximately 80% of them owning their houses and more people in Kolkata owning than in Mumbai (87% versus 62%). Those who owned their houses owned the house structure but not necessarily the land on which the house was built. Respondents who had been in India for longer were more likely to own a house. This was a notable difference from the Nepalese who were mostly renting at destination. Some 78% of respondents had access to electricity and half had common toilet facilities.

Migration reasons, patterns and conditions**Why migrate?**

Employment opportunities and higher wages were the driving forces to migrate from Nepal to India. Joining spouses in India and other family ties were also cited by

some female respondents in India. Migration was also spoken of as a rite of passage – it was almost expected that someone will migrate: in some households at source, every male member of the family had done so.

Over 80% of respondents in India and 90% of migrant households in Nepal perceived migration to India as beneficial for the family, resulting in remittance flows for families at source destinations (89% in Nepal and 75% in India). Other common benefits cited were better educational opportunities for children (47% in Nepal and 17% in India), better household food availability (35% in Nepal and 3% in India) and ability to afford health services (29% Nepal and 11% India).

Similarly for Bangladeshis, the main pull factors for migration were economic opportunities in India. At destination locations, the lack of employment and business opportunities at home (about 50%), financial difficulties (nearly 60%), better wages (43%), and joining family members were reported as the main push factors. Similarly, Bangladeshis at source state lack of business/employment opportunities (87%) as the major push for migration, as well as debts that must be paid off (24%) (see also Box 2 overleaf).

Patterns of migration

Most Nepalese respondents migrated for the first time between the ages of 16 to 20 years. More than 57% of men migrated with their peers; in contrast, most women migrating to India came with their spouse and children. Almost all respondents migrated to India directly, spending little or no time in transit. The preferred first destination as reported by returnee migrants was Mumbai (46%). Almost all (98%) of the mobile respondents in Nepal and India reported to have travelled by road from source to transit locations. From transit to destination the major modes of transportation were motor vehicles (67% in Nepal and 85% in India) and trains (62% in Nepal and 37% in India).

The average age of Bangladeshi respondents at the time of their first migration was 25 for men and 27 for women, slightly older than for the Nepalese. The average amount of time since their first migration was 4.8 years for men and 7.1 years for women. The largest proportion of respondents had migrated to Mumbai (43%). While most Nepalese migrants moved on their own or with peers, migration amongst Bangladeshis is arranged largely by migrant brokers (76.4%) (Box 3 overleaf).

In another slight contrast to the Nepalese, most Bangladeshis (54%) stay in transit for one to three days, in general because of a need to cross the border at a certain time when it is easier to cross and not get caught. Their travel time to reach their destination is mostly one to three days (56.3%). Migrants travel mostly by road and by train.

Links with home

Thirty-eight per cent of Nepalese respondents living in Nepal, and 60% of those in India, reported going

Box 2: Migration experiences

Reasons for migration:

'I was a teacher in Nepal but I left the job because I used to get Rs.300. In Delhi I get Rs.4000-5000. I have come here for work because there is lack of employment opportunities in Nepal. I know many Nepalese people were doing very well in India therefore I also came here. I came with my brother-in-law (sister's husband).' Nepali male with spouse in Delhi.

'I was 18 years when I first went to India with my friends. I was fascinated by the new clothes and sun glasses worn by the returnee migrants. I thought it is not worth studying so I went to India.' 32-year-old returnee in Kancharpur, Nepal.

Experiences of travel:

'Generally they ask for bills for the items we carry and their interrogations become more serious if we travel with a woman. They ask "Who is she?", "whom do you know in India and where does he stay?". Sometimes, they ask for an identity card. They harass us more if we talk to them in a rigid manner but they let us go easily if we give them money secretly.' Nepali male staying with spouse, Delhi.

'I understand the concern of people who take money or goods from us to give to our families back home – they will be harassed at the border and they will be asked for bills for each item.' Nepali male in Delhi.

The migrants in India also mentioned that rickshaw and cart drivers on the border try to cheat them. 'They fix one amount in the bus stop and ask for more money after reaching the destination.' Nepali women at destination.

'While returning I have got caught by the border security force who searched for money and took away the Rs.20,000 that I was carrying. I came home empty handed.' Returnee male, Bangladesh.

'I am afraid for those who go to India to bring back cows. Those who try to pass cows across the border from India side to Bangladesh often end up being shot – the Law Enforcers don't hesitate to shoot them.' Returnee male, Bangladesh.

Box 3: The broker experience in Bangladesh

Middlemen or brokers assist migrants in crossing borders. Their fee varies according to the financial capacity of the clients and the range of security provided to the client, which is dictated by the broker and other contacts (local and influential) on the basis of payment. Contracts often consist of three distinct parts. The first part is negotiated between the client (the migrant worker) and the broker. The second is negotiated between the broker power-holders (border officials, etc.) to allow the migrant to cross the border. Respondents explain that this sometimes comes with additional or unspoken expectations, whereby the broker has promised border officials sex with a female migrant of his choice. The third part is negotiated between multiple brokers (one in India, one in Bangladesh) to arrange employment at destination. This is the process through which many young girls migrate to Mumbai.

back home at least once a year. Most men reported going home for festivals or planting and harvesting seasons. Qualitative data amongst Bangladeshis showed that circular migrants tend to visit home every six months or at least once a year. They usually stay for several months and then return to destination. In the quantitative study 35% of respondents at source reported that they visit home once a year, while 83.6% of those at destination reported having visited less than once a year. The purpose for visiting mentioned most frequently was 'to see family members' (74%) followed by 'to see friends/relatives' (22%), and some returned 'for personal work' (17%).

Problems faced

Very few respondents in the quantitative survey mentioned facing problems while crossing the border from Nepal into India. Of those who did (9% of migrants living in India and 16% of returnee migrants in Nepal), these problems included physical, verbal and sexual abuse by border police. The return journey was often more complicated as migrants would regularly carry money or other goods. Safe passage through the border was often negotiated through bribery. During in-depth interviews almost all respondents reported harassment while crossing the border and most frequently when they returned to Nepal. Demands for bribes by Indian customs and border patrol were the major problem faced by respondents (Box 2).

Similar to the Nepalese, only 8% of Bangladeshis in the quantitative survey reported problems while crossing the border, mostly related to middlemen deceiving them, taking more money than agreed and verbal abuse from policemen at the border. Qualitative information again revealed another dimension of the problem: women often reported harassment by brokers and sexual harassment by border security forces. Harassment also occurred when returning from India, with money often stolen or confiscated, and migrants being caught by the police, facing verbal harassment, and often being sent to jail and having to pay a fine of around 200-3,000 taka.

The irregular migratory status of many female workers, therefore, which stems from restricted migratory agreements between India and Bangladesh, put these women at high risk of sexual harassment, trafficking and sexual exploitation, and ultimately of becoming transmission channels for the spread of HIV in the region.

The migration-HIV connection points are important institutional challenges that undermine the effectiveness of HIV preventive policies. In particular, testimonies of corruption and coercion between migratory agents, police and criminal organisations underscore the importance of adopting holistic approaches to tackle human trafficking, sexual exploitation and HIV.

Survival at destination and source

Employment and work patterns

In Nepal, 83% of the respondents reported that the migrant was the main source of income for the family (most families included extended family with their children and parents living in the same household). According to a female spouse in Achham with four children: ‘We can’t light fire until he goes to Mumbai and earns money, so he has to go to keep the family alive’.

Most male Nepali migrants in India were employed as restaurant/bar workers (55.8%), watchmen (21.4%) or factory workers (12.6%). The female migrants were mainly house servants (49.8%), housewives (18.1%) or factory workers (11.9%).

Ninety-four per cent of the Nepalese migrants in India reported getting work throughout the year, getting paid in cash (99%) and on a monthly basis (84%). Three-quarters were working for an individual and nearly 10% were employed by private companies. The tendency to change jobs frequently was very high and was often driven by more competitive salaries and relationships with other migrants.

In addition, 12% of the survey respondents mentioned that they had secondary occupations or their spouse was also earning, as the money from the main occupation was insufficient. One male with his spouse in Delhi said: ‘I am a night watchman at Shalimar Garden society area, my salary is INR.3,000 per month. This is not enough to live in Delhi therefore my wife also works as a maid.’

Bangladeshi men at destination in India were most often casual labourers (42%); of these, 13% worked as masons or mechanics, 12% as petty traders, 10% as vendors, and 7% as rickshaw pullers. Nearly half of the women were housewives (46%) and about 23% worked as domestic servants. A few were also working as casual labourers (9%), petty traders (4%) and tailors (4%). Employment was arranged most commonly by a broker or relatives already living at the destination.

Remittances

At source, 90% of the respondents reported receiving some cash from the migrant, but at destination only 49% reported sending money back home – with a clear difference between female (15%) and male (67%) responses. Migrants with more dependents at home were more likely to send remittances (94% of those with six to ten dependents send money home).

The quantitative data reveals that the average amount sent back home is INR.2,149 per year (India data) compared to INR.13,423 received per year (Nepal data). Forty-five per cent of households in Achham and 24% in Kanchanpur received money more than twice a year. Money is sent through a friend or a relative (86% from destination data), or delivered by the migrant themselves (66% from the Nepal data) or via the *hundi* – an informal system of money transfer (44%, Nepal data). Less than 10% of respondents said they used banks or financial

institutions. The qualitative findings also reveal that small fees are often paid when sending money.

Approximately 17% of Bangladeshis at destination reported sending money back home, with the mean amount sent back home by men (INR. 19,676 per annum) significantly higher than that sent by women (INR. 14,372 per annum). Remittances were usually sent home through brokers who collected a fee each time money was sent. The baseline study reveals that 48% of family members receive remittances in cash and 7.5% receive both cash and kind. Sixty-three per cent reported sending cash through others and 17% reported carrying the cash personally. About 11% of the respondents claimed that *hundi* is the main method they used to send cash to their families.

Remittances have emerged in Bangladesh as a key driver of economic growth, with flows now representing 10.3% of national income, and exceeding various types of foreign exchange inflows, particularly official development assistance and net earnings from exports (World Bank, 2009). But, unlike most international experiences where electronic payment systems dominate the market for remittances, we find a different picture. Brokers are still key channels to send cash from India to Bangladesh and Nepal.

Qualitative evidence also show increasing vulnerabilities arising from handling cash when crossing country borders as one respondent reported: ‘The law enforcer and brokers check us. If they find taka they take it. We put taka in the sole of our shoes, in a belt and bunch it in our hair. Sometimes we send taka home through brokers before we return, but brokers take commission for that.’

Transfers in cash are likely to boost corruption and criminal activities in border areas. But important questions remain unanswered: if the associated vulnerabilities arising from remittances in cash are severe, particularly for female migrants, why do migrant workers not use safe forms of money transfers such as electronic payments? Is it due to accessibility problems or informational constraints? What are the implications for policy design? These are all questions for which further research would be necessary.

Discrimination at work and awareness of rights

Relatively little discrimination within the workplace was perceived. In the quantitative study it emerged that whilst 24% of Nepalese migrants in India saw Indian workers as receiving work-related benefits (i.e. membership of trade unions and provident funds), only 15% of respondents reported receiving them. Similarly, in the qualitative study, interactions at work were mostly with fellow Nepalese and they had relatively few experiences with Indians. One respondent – a married male in Delhi – was working with Indians but did not tell them about his citizenship, as doing so might result in discrimination: ‘In my work place the Indian migrants want to dominate us by calling us by names like Bahadur or Gorkha which I do not like’.

Such terms – literally meaning strong – are used to refer to the Nepalese in India, especially those who work as security guards, and is linked to the history of Nepalese men joining the Indian army.

The 1950 Indo-Nepalese Friendship Treaty ensures Nepalese citizens the right to travel, carry trade and seek employment, as well as access education and health services in India. It also allows for the purchase of land and property in India. In reality, however, ID or election cards or ration cards are vital to access services. The quantitative survey shows that only 7% of migrants were aware of their rights in India. Those who were, mentioned rights related to access to public places, equality in employment and freedom of speech. Only 8% had any identity cards. Similarly, only two of the 32 respondents from the qualitative survey were aware of the treaty, but they were unable to state clearly what the treaty assures Nepalese populations in India.

Many said that bribes are a common method for obtaining ID cards. One respondent said: ‘I paid Rs.600 to make ID card, it could be made at a cheaper rate but I had no proof of my residence I had to pay the cost. I am in the process of opening bank account for which I am in touch with some local agents.’

A similar story is found on workplace rights, with only 19.4% of those who were employed by government, private companies or as daily wage earners being aware of their entitlements. Awareness was higher among Mumbai respondents (33%) than those in Delhi (13%), and the availability of these entitlements was reported to be higher among factory workers (69%) than restaurant workers (23%), watchmen (27%) and domestic servants (15%).

In the same way, only 3% of Bangladeshi respondents were aware of any rights or entitlements including trade union membership, provident funds, accident compensation and health facilities. Again, little overt discrimination, violence or abuse in the workplace was mentioned by Bangladeshis in India, but again this emerged from the qualitative study, particularly with reference to women who, often through brokers, end up being victims of trafficking.

Brokers often exploit women by promising to help them cross the border and secure a job without payment; this often results in the women being sold to brothels or agents at a high price (INR. 20,000-30,000). Once sold, the girls are forced to work until the fee paid for them is recovered. As one woman recounted: ‘... One of my neighbour’s uncle took me to Mumbai giving me the hope of a good job. But he sold me there for 30,000 taka. I stayed there for five months and was compelled to be involved in the sex trade. There I was living under one pimp. She used to take all my earned money and give me a very small amount.’

Stigma at source in Bangladesh

Patriarchal gender norms dominated the surveyed districts in Bangladesh: women’s mobility is

restricted and leaving the home is not usually permitted unless the woman is accompanied or unless it is an emergency. Decision-making power resides with male members of the household. Major decisions in the family, such as household expenditures, income, mobility and enrolment of children in school are decided by the husband, or in his absence, the father-in-law or another male member of the family. In this context, females who migrate for livelihood purposes are subjected to stigma and discrimination upon their return. It is a widely held belief that most women who migrate work in the sex trade.

This highlights the importance of giving particular attention to the vulnerabilities faced by women, and the dynamic and contextual nature of the relationship between social norms, religion and behaviours associated with HIV-risks when designing policy interventions. The findings indicate that approaches also need to focus on social norms and better information about risks, to deal with gendered vulnerabilities at both source and destination locations.

HIV and sexual behaviour

The quantitative study found that 88% of the respondents in India as well as 85% to 99% of the spouses and returnee or circular migrants in Nepal have heard of HIV and AIDS. Returnee and circular migrants were better informed on modes of transmission than the spouses and migrants at destination. Surprisingly, the spouses back home in Nepal were more aware than the migrants interviewed in India. Nevertheless, misconceptions persist and are higher among spouses than among migrants in India and returnee migrants in Nepal. The most common misconceptions were the belief that people could contract HIV ‘from mosquito bites’, ‘kissing/hugging an infected person’ and ‘sharing a meal with someone who is infected’.

A very high proportion of mobile people in India as well as in Nepal had heard of or seen a condom. Ninety-six per cent of migrants in India were aware of condoms. In Nepal, while a very high proportion of returnee or circular migrants reported awareness of condoms (99%), only 83% of spouses reported such awareness.

Around 79% to 99% of migrants in India and in Nepal reported having sexual intercourse. The mean age at first sexual encounter was around 18 years for migrants in India, being slightly lower for women than men (18.03 years versus 19.14). The mean age for the circular migrants and returnees and spouses in Nepal, however, was very low – 15 years for a returnee male migrant and 14 years for a female spouse. Eighty-seven per cent of the respondents in India who had had sexual intercourse in the last 12 months had regular partners. Of these, very few used condoms consistently with their regular partners.

Sixty-one respondents in India (out of 463) had commercial or non-regular partners. Of these, around half (31) had been using condoms consistently. Of

the 61 Nepalese migrants who pursued such relationships, 48 were male, 37 were between the ages of 21-30 years, 44 had attended school and all had heard of HIV and AIDS. On modes of transmission, more than half knew about unprotected sex with multiple partners (32), while knowledge of other modes such as sex with sex workers (17), infected blood (27) and vertical transmission was less common. In Nepal, only four of the circular migrants/returnees reported having non-regular partners, with one reporting to have used condoms. None of the spouses reported non-regular partners.

As with the Nepalese, almost all Bangladeshis at source (96%) had heard of HIV and AIDS. At destination, awareness was still high but lower than at source: 82% of respondents reported that they had heard of HIV and AIDS, with men being more aware than women (89% versus 78%). In terms of HIV transmission, most respondents at source reported 'unprotected sex with multiple partners' (66%) as a mode of transmission of HIV. A similar proportion mentioned 'needle sharing' (38%) and unprotected sex with someone living with HIV/AIDS (38%).

While 27% knew that sex with commercial sex workers can put you at risk of HIV transmission, only 11% mentioned unprotected sex with commercial sex workers as a mode of transmission for HIV. Unprotected sex with multiple partners was reported by 59.3% of respondents at destination as a mode of transmission. Other modes of transmission reported were having sex with sex workers and unprotected sex with someone who has HIV or AIDS (47% each).

As in Nepal, misconceptions persisted. At source, for example, 4% of respondents believed that HIV could be transmitted through sharing clothes or dishes with PLHIV. Two per cent thought that not staying neat and clean could cause HIV and 1% believed HIV could be transmitted through mosquitoes. Among respondents in India, a notable proportion believed a person could contract HIV by kissing or hugging an HIV-infected person (40%), or through mosquito bites (40%), and 38% believed they could contract HIV through sharing a meal with an infected person. About three in every ten respondents felt they could contract HIV and AIDS by sharing utensils, clothes or toilets. These percentages were higher among women than men.

Most Bangladeshi respondents at source (96%) and destination (89%) had either seen or heard about condoms. At source, 93% of respondents were sexually active at the time of the survey. The average age of their first sexual encounter was 18.5 years – 15.9 years for women and 21.6 years for male respondents. At destination, 82% of respondents were sexually active.

At source, 81% of the 287 respondents reported having a sexual relationship in the previous 12 months, the majority (96%) with their regular sexual partners (spouse or live-in partner). At destination, a large proportion (83%) of male respondents had sexual inter-

course in the last 12 months; about 96% reported that their spouse was their regular partner and, amongst these, 67% did not use condoms in their last sexual intercourse with their regular partners. Only 3% of men reported any sexual relationships with commercial and non-regular partners in the last 12 months.

Findings from the qualitative study portray a slightly different picture with men at source sometimes having more than one partner, as a female spouse at source says: 'My husband likes to have new women frequently as sex partner. Being a woman and housewife I have nothing to do to stop him.'

Societal and cultural norms can determine condom use. Peer-group information and shared perceptions are also found to be critical for safe sex practices (Logan et al., 2002). This is important given that the societal norms that characterise the surveyed populations in India and Bangladesh play crucial roles in determining sexual behaviour. Religion, although not directly discussed, seems to be important here. The study finds that a higher proportion of Mumbai Bangladeshi respondents (51%) used condoms than their counterparts in Kolkata (19%). The importance of the findings relates to the fact that 87% of those surveyed in Kolkata embraced Hinduism whereas 94% of the respondents in Mumbai followed Islam. This seems to reveal indirect associations between condom use and religion. The low percentage of condom use may also indicate unobserved socio-cultural factors that constrain HIV-preventive measures, particularly in contexts of patriarchal polygamist societies.

HIV-related stigma and discrimination

Stigma not only makes it more difficult for people trying to come to terms with HIV and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole.

Less than half of the respondents in India (48%) and only 77% of migrants and migrant family members in Nepal said they would remain friends with people who became HIV positive. More than one third of respondents in India and migrants and their families in Nepal agreed that people with HIV should be legally separated from others to protect public health. More than 67% of migrants in Nepal agreed with the statement 'women with HIV should be prevented from having children'. Among migrants in Nepal, 59.6% agreed with the statement 'Men and Women with HIV should not be allowed to get married'.

Findings were mixed, however, with 80% of those residing in India (29% strongly agreed, 50% agreed) and 90% of migrants and their families in Nepal (49% strongly agreed, 38% agreed) agreeing with the statement that 'patients with HIV have the right to the same quality of care as another patient'.

Similar findings emerge amongst Bangladeshis: 61% of respondents at source mentioned that if any

of their friends contracted HIV they would not remain friends with them. Ninety-five per cent of respondents at source agreed with the statement ‘patients with HIV have the right to the same quality of care as any other patient’, falling to only 9.4 % of respondents at destination, where 67% disagreed with the statement.

On the other hand, more than half of the respondents at source (56%) were in favour of keeping people with HIV separated from others to protect public health. At destination, 11% were in favour and 66% were not in favour of keeping people with HIV separated from others to protect public health. At destination, 63% felt that women with HIV should not be prevented from having children and close to 60% felt that people with HIV should be allowed to get married.

The differing perceptions about HIV and AIDS, and peoples’ behaviours and attitudes towards HIV and PLHIV, are likely to be influenced by their exposure to awareness-raising activities and other interventions. Culture, norms, gender and power relationships are also likely to influence attitudes.

Access to health and HIV services

General health access

The quantitative part of the study reveals that a similar proportion of Nepali respondents in India used government (43%) and private health providers (42%). Fifty-two per cent of respondents explained that they had chosen a private service because it was close to their residence and because of the quality of care, even though this often meant higher costs, as the qualitative study revealed. Other respondents from the qualitative study said they do not go to private or government doctors, as they are either ‘expensive’ or they do not have the time and resources to seek treatment. They depend, instead, on chemists (Box 4).

In source communities in Bangladesh, general health, maternal and child health and family planning services are provided by community health clinics under the government health department. For most illnesses, however, most respondents from the qualitative study visited local medicine shop-keepers or village doctors. Most respondents expressed their comfort with receiving services from village doctors with whom they have a good rapport and who offer their medical advice free of charge. At the community clinic, doctors charge money for prescribing medicine and then patients have to visit the pharmacy to buy their drugs. The quantitative survey at source revealed a similar situation, with most respondents using the village doctor (63%), followed by government/municipal hospitals (61%), pharmacy/drugstores (28%), Upazila health complexes (21%), or private doctors/clinics (14%) for general illnesses (multiple responses possible).

According to the quantitative study, Bangladeshis in India preferred private doctors/clinics for general

health care, but government/municipal hospitals for family planning and pregnancy-related services. Returnee respondents in the qualitative study said that they never went to government hospitals when they were in India, as this could lead to the disclosure of their illegal status. Respondents explained that if they had a serious illness they would visit private doctors where there was no such risk. Some returning female migrants said they often returned to Bangladesh for treatment because their employers do not provide any treatment facilities.

HIV testing

The proportion of Nepalese migrants who were aware of HIV testing and counselling services in their area was very low in India (23%) in comparison with responses in Nepal (circular migrants and returnees: 62%, spouses: 34%). Among Nepalese migrants in India there was higher awareness among those in Mumbai (53%) than those in Delhi (6%). Respondents under 18 years of age were not aware of these facilities at all.

There are considerable differences between respondents in Mumbai and Delhi on HIV testing. A far higher percentage of migrants in Mumbai (31%) got tested than those living in Delhi (5%). At source, 16.9% of respondents underwent HIV testing and among those who were tested, 70.5% were from Achham and 29% from Kanchanpur.

A troubling finding shows that 37% of those who received an HIV test in India did not receive any counselling. Of those who did receive some counselling, 6% had been given only minimal information. The qualitative study also emphasises that of those getting tested, only one knew the result of their test. Most respondents did not go back to collect their test results because of the distance to the facility or, in some cases, because of the fear of testing positive.

Amongst Bangladeshis, only 4% of respondents at source knew where they could get tested for HIV. Fifteen respondents at source reported getting tested for HIV; among those who were tested, only 10 knew their test results. At destination 66% respondents

Box 4: Views on health care access and services

‘the staff of the private hospitals were friendlier ... the doctor at the hospital treated us differently because of our language.’ Nepalese female, Mumbai.

‘Services provided by the Employment State Insurance and government hospitals are not up to the mark and also we have to wait in long queues for availing such services’. Single Nepali women in Delhi.

‘Whenever I face sickness I go to the village doctor. Medicines are not available in the hospital. After standing in a long queue the doctor recommends medicines to buy from outside. Besides that trained doctors are not available everywhere. Village doctors are well-behaved. They don’t ask money for advice ...’ Bangladeshi female with spouse at source.

had heard about HIV testing and counselling facilities at government hospitals and 20% had heard that this is available in the area where they lived. Only 2% of respondents had received an HIV test.

As above, country differences could be explained by different amounts of funding and commitment to recognising and dealing with HIV and AIDS, resulting in fewer government and NGO-led interventions, particularly for the case of Bangladesh.

HIV treatment

Among Nepalese respondents in India, 10% were aware of the availability of treatment for those infected with HIV, with higher awareness in Mumbai (28%) than in Delhi (1%). This proportion was higher among the spouses (34%) and among circular migrants and returnees (48%) in Nepal. Similar patterns were seen on awareness of Antiretroviral Therapy (ART) with 8% of respondents in India claiming awareness compared to 33% of returnees and 14% of spouses in Nepal.

In Bangladesh, 43% of respondents did not know whether HIV treatment was available. Most respondents had never heard of ART (80%) with a higher lack of awareness among men than women. Knowledge of the availability at destination was lower: only 29% knew that some treatment was available with more men in this case than women being aware of the availability of treatment (though most respondents, 80%, had never heard of ART). Respondents in Kolkata (37%) had higher awareness of treatment services than those in Mumbai (11%).

Challenges and coping mechanisms for migrants at destination

Challenges

Quantitative data indicated that only 10% of respondents in India and 27% of the circular migrants and returnees in Nepal faced problems while in India. Shortage of finances (51%) was the most common problem mentioned by respondents in India. Forty-six per cent of circular migrants and returnees and 39% of migrants in India reported loneliness – most of them men.

A very different picture emerges from the qualitative data, with most migrants in India saying that they face discrimination.

In the quantitative findings, only 6% of migrants in India and 27% of returnees in Nepal mentioned a perceived fear of violence and harassment while in India. Among them, 85% of returnees in Nepal and 30% of migrants in India mentioned that they feared physical harassment while in India. Thirty-one per cent of returnees and 54% of migrants in India expressed fear of imprisonment.

Only 12% of the Nepali migrants in India and 16% of the respondents in Nepal mentioned or perceived that their family members at home faced problems

while they were away. Among those who reported family problems, loneliness (72% migrants in India and 54% of respondents in Nepal) and lack of money (36% migrants in India and 56% of respondents in Nepal) were the most common problems mentioned. Among Bangladeshis, only 6% faced problems in India, with shortage of finances (47%) and police harassment (23%) among the problems reported most frequently. When asked if they felt fear of violence or harassment, 11% said yes.

Even fewer Bangladeshis (2%) than Nepalese saw their families back home as facing problems as a result of their absence. In qualitative findings Bangladeshi migrants reported harassment by border security forces (BSF) upon their return from India. Getting caught by BSF usually resulted in being sent to jail and having to pay a fine of around 200-3,000 taka. Many Mumbai respondents reported getting caught by police and facing verbal harassment. Upon their return, BSF often steal or confiscate their cash. Similarly at destination, fear of police harassment and violence was reported. Captured undocumented migrants at destination generally face imprisonment and a large amount of money is required for their bail. A 25-year-old female returnee in Bangladesh shares how she felt stigmatised both in destination and in source: 'In Mumbai people discriminated against me. They looked at me as if I was a thief. Sometimes I felt that they were whispering about me. After coming back to Bangladesh I felt that people here didn't like me, they hated me. They said that she came from Mumbai; they whispered that I am a sex worker. I feel ashamed.'

Coping and recreation

Data at destination sites indicate that the main activities used to cope with loneliness and for general recreation amongst Nepalese were watching television (39%), listening to the radio (26%), smoking cigarettes and/or *bidis* (20%), chewing *paan/gutka*/tobacco (18%) and watching movies (16%). In Nepal, returnee migrants (48%) and (38%) spouses listened to the radio and 36.2% of both groups reported chatting to friends and relatives. All of these activities were reported at higher levels among men than women in India. In India 29% of men reported drinking alcohol, 12% reported using drugs, 13% had sex with women and 11% reported having sex with men. A negligible proportion of women reported engaging in these activities.

Recent efforts to reduce the spread and the impact of HIV and AIDS have focused on changing high-risk sexual behaviour, especially in environments where risky activities take place; and the information collected by the study provides insights into the environments that are conducive to reducing high-risk sexual behaviour.

Environmental factors, such as alcohol-serving establishments, are strong determinants of alcohol consumption, and alcohol consumption is corre-

lated significantly with risks for sexually transmitted infections (STI), including HIV and AIDS (Fisher et al., 2007; Kalichman et al., 2007).

Survey data provides interesting information about the incidence of alcohol use in the populations studied. One fifth of the male Nepalese migrants in India who drank alcohol in the last month (25 respondents) and 33 circular or returnee migrants in Nepal mentioned that they had sex after consuming alcohol. Data also shows a clear gender divide: men are more prone to drink, with 73% of male returnees and 42% of male migrants in India reporting drinking, which would increase the likelihood of engagement in high risk behaviour among men.

Women's risks are often associated with their male sex partners' drinking behaviour. The report finds that among migrants in Nepal who had sex with their wives while consuming alcohol, nearly 85% did not use a condom. This type of sexual behaviour provides important information for policy design. Environmental conditions can also facilitate safe sexual behaviour but only if knowledge of a source with easy access to HIV-preventive methods such as condoms is widely available (Sambisa and Stokes, 2006).

Another important finding relates to the channels through which high-risk sexual behaviour are addressed. In particular, recent efforts to reduce the spread and impact of HIV and AIDS have focused on raising the awareness and changing HIV-related knowledge, attitudes and behaviours through mass media (Bertrand et al., 2006). However, the existing evidence on mass media effectiveness remains inconclusive, particularly on knowledge of HIV transmission and reduction in high-risk sexual behaviour.

The reported survey data hints at what seems to limit the impact of mass media on HIV: only a small percentage of Bangladeshi respondents (29%) reported having a TV, and only 10% had a radio. This indicates that the ability of organisations to change attitudes and behaviours towards HIV via media campaigns is constrained by asset deprivations among the impact population. Alternative diffusion strategies are required to improve policy reach and impact.

Regarding social networks, only 2% (five males and five females) of Nepalese migrants in India reported being members of social network or groups. In Nepal, 35% of the migrant families were members of social networks – 89% of these networks granted financial support to its members. Other services mentioned were raising awareness, organising cultural functions, and supporting access to HIV and AIDS services.

Similar to those for the Nepalese, the main activities at destination to help Bangladeshis cope with loneliness or stress included: watching television (45%); chatting with their friends (40%); smoking cigarettes and bidis (20%); chewing tobacco/pan/gutka (15%); and listening to the radio (14%). All of these were reported to be higher among men than

among women. In addition, 17% of men reported taking alcohol and 1% having sex with male partners. Again, similar to the Nepalese, only 11 (three men and eight women) Bangladeshis were members of a support group or association at destination.

Recommendations

A number of recommendations can be drawn from these baseline findings, picking up on the vulnerabilities that migrants can face that can increase their risk of contracting HIV. Some recommendations are already being taken up by the programme implementers.

Increase access to HIV-related information at source and destination. Although awareness about HIV and AIDS is high, misconceptions about transmission, alongside stigma and discrimination, persist among all populations at all sites. Increasing access to HIV-related information is critical. This could be facilitated through the development of a comprehensive strategy and plan to generate behaviour change among different target audiences, including migrants and their families, health personnel, service providers and border security forces at source and destination to reduce HIV-related stigma and discrimination.

Interventions to reduce stigma and discrimination towards migrants. Stigma and discrimination towards migrants at destination and female return migrants, particularly in Bangladesh, remain major challenges. Several responses include the following:

- *Undertake outreach activities with landlords, employers and neighbours at destination.* Such activities would increase awareness of the rights of migrants, as well as the potentially stressful and lonely situations they face and how this links to health and HIV-related vulnerabilities.
- *Carrying out information sessions with health staff at destination and source.* Such sessions would increase health workers' awareness of the rights of migrants and patients to receive non-discriminatory health services. A complaint system could also be established to hold accountable health staff who withhold services or show discriminatory behaviours.
- *Working with employers.* Employers of businesses that attract migrants (restaurants, bars, factories, security providers) will be included in the programme to ensure non-discriminatory work places. In other cases, migrant solidarity groups can be supported to monitor and document experiences of discrimination and violence sharing their findings in wider forums and for advocacy.
- *Formation of women-led support groups.* In communities in Bangladesh where the families of female migrants are socially excluded, women-led community support groups (networks) will be formed to ensure inclusion of these women and

their families into the community. This, alongside behaviour change communication, will facilitate community acceptance and change attitudes towards female migration.

Interventions, often gender sensitive, to ensure safe mobility for migrants. Given that vulnerabilities related to mobility are different for Bangladeshi and Nepalese migrants because of their different legal statuses, interventions to ensure safe mobility need to be context specific:

- *Increase awareness of rights of migrants to promote informed choice for migration.* Activities with migrants before they move, at transit and at destination should be carried out to increase awareness of their rights at destination, including access to health services. Nepalese migrants in particular need to know about the treaty that allows them equal access to services as fellow Indians. Bangladeshi migrant communities must be made aware of their basic human rights, the risks involved in crossing the border, particularly for women, from whom they can seek help if they face problems, and the services that are available. As brokers and middlemen are critical for migrant Bangladeshis, they should be included in these programmes and used to disseminate messages to migrants.
- *Development and provision of a safe mobility information package.* Such a package could be provided to migrants during outreach at destination, transit and source locations. It should contain information on services available at destination, rights, links to support groups, including support groups and services for women who may have faced harassment at borders, and where and how to obtain identify cards for in India. Because many migrants are illiterate, materials need to be developed in ways that will convey messages successfully.
- *Watchdog groups at borders.* Particularly for the India-Bangladesh border, watchdog groups should be established at major illegal border crossing points to document instances of violence, including sexual violence or coercion, ensuring that such cases get immediate attention and that victims are repatriated home in a proper way without having to face undue delays and added harassment.
- *Sensitisation of border personnel.* In the case of Nepal, border personnel must be made aware of the rights of Nepalese migrants in India; while Bangladeshi border staff must be sensitised on the human rights of illegal migrants and on safe repatriation.
- *Strengthening supervision of BSF on the Nepal/India border.* The project should encourage increased supervision of border security forces by their superiors to reduce the exploitation of migrants.

- *Facilitating remittances.* The findings suggest that less than 5% of migrants in India have bank accounts, so it is important to ensure that they have access to banking facilities to ensure the safety of their earnings and the safe transfer of money back home without the fear of being robbed on their return journey.

Increasing employment and livelihood opportunities at source. To lessen the reliance on remittances in source communities, and mitigate the potential negative effects of not receiving any, efforts should be made to create employment, business and livelihood opportunities in source communities. Linking community members to existing government run vocational skills training as well as credit institutions are a few suggested activities.

Increase support services or recreational spaces for migrants at destination. Few migrants belong to support groups and many seem to isolate themselves. There is some evidence of male migrants, in particular, engaging in risky behaviours such as drinking alcohol and having unprotected sex with sex workers. The provision of more safe spaces and support structures for migrants, such as drop-in-centres, may not only increase community cohesion and solidarity, but it may lessen the likelihood of young men engaging in potentially risky behaviours. Care needs to be taken when developing such safe spaces to avoid fuelling stigma, discrimination and fear still further, particularly amongst Bangladeshi migrants.

A quantitative and qualitative survey is planned for 2013/2014, where we hope to follow up these migrants and their families, allowing us to get deeper and dynamic insight into the social and economic factors that underpin the relationship between migratory decisions and sexual-related risks and vulnerabilities among these populations. It will also allow us to further tease out the differences between the countries, the different forms of vulnerabilities and the different kinds of programme and policy responses at local, national and regional level necessary to tackle the vulnerabilities related to migration and HIV. Additionally, a number of smaller focused studies are currently underway to explore the characteristics and vulnerabilities of particular groups of people including child/adolescent migrants and sailors.

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