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# Cross Border Migration and HIV Vulnerability in South Asian Countries

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## Abstract

The present study aims to explore two prominent international mobility routes between Bangladesh-India and Nepal-India with a holistic approach capturing the range of HIV-related vulnerabilities faced by the key mobile populations at the origin, transit, and the destination. The study also aims to look at the gradual perpetuation of these vulnerabilities at the place of origin from the destination and finally present issues and challenges for making the cross border migration safe within the concept of continuum of care from a macro perspective. The basic data used for the study have been taken from the issues and concerns emerged during EMPHASIS (Enhancing Mobile Populations' Access to HIV & AIDS Services, Information and Support) Mid Term Review, 2012. It has been collected using a combination of qualitative and quantitative research methods along with field observations. Findings reveal that, the vulnerabilities associated with the Bangladeshi and Nepali migrants are slightly different in occurrence but as a whole, they both are at high risk of acquiring HIV.

**Keywords:** Bangladesh-India, Nepal-India; Cross border migration; HIV vulnerability; Undocumented migration

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## Introduction

## Background

Xenophobia, discrimination, sexual and/or labour exploitation, lack of or even absence of socio-legal protection and often lack of access to health care and social services in receiving countries, enhance migrants' vulnerability, which is compounded by linguistic and cultural barriers (UNAIDS, 2000). Mobility, especially in the context of those who are moving in search of employment due to lack of opportunities at the source, leads to high degrees of vulnerability to various social, economic and health problems [1]. Movement from conservative rural settings to the bright lights of open and liberal urban avenues often results into a stage of transformation for these migrants. Metropolitan cities provide a mix of traditional and modern values, norms, and practices regarding sexuality and sexual behaviour. Living away from family translates into the relaxation of restrictive social norms and sexual segregation for these men providing exposure to some young people to liberal sexual culture, offers varied avenues for sexual experiences through its vast sex industry, and provides anonymity that greatly enhances the opportunity for sexual liaisons [2]. In addition, opportunity structures of metropolitan cities, where youth are having easy access to erotic literature influences their articulation of their sexuality and enhanced indulgence with different type of sexual partners in continuously expanding sexual networks. Workplace vulnerability increases migrant's HIV vulnerability. Moving away from the social controls of family and community, migrants become exposed to a mixed-gender environment at workplaces and therefore sometimes initiate sex earlier or have more casual encounters than might otherwise be the case [3]. With domestic and international travel becoming easier and more common, the increase in population mobility is necessitating discussion on several public health issues, with significant focus on the relationship between mobility and HIV/AIDS. However, migrants are more often seen as a threat to public health than as a vulnerable population, and little has been done by local governments to ascertain their special needs, especially in terms of reducing HIV vulnerability. The migrants' vulnerability to acquire HIV/AIDS is often increased during transit and while living at destinations, especially when there is separation from families and partners. Mobile populations have

been identified as a 'bridge' between high HIV prevalence areas in India and low HIV prevalence areas in Nepal and Bangladesh. Further, all the well-established routes of migration are to the high HIV concentrated epidemic zones in India, most of which are the metro cities in the country [4].

With this backdrop, present research aims to study two prominent international mobility routes between Bangladesh-India and Nepal-India with a holistic approach capturing the range of HIV-related vulnerabilities that the key mobile populations may face at the origin, at transit, and at the destination. The study also aims to look at the gradual perpetuation of these vulnerabilities at the place of origin from the destination and finally present issues and challenges for making the cross border migration safe within the concept of continuum of care from a macro perspective.

## Data and Methodology

The basic data used for the study have been taken from the issues and concerns emerged during EMPHASIS (Enhancing Mobile Populations' Access to HIV and AIDS Services, Information and Support) Mid Term Review, 2012 which was a cross country intervention in South Asia. The mid-term review focuses on the progress made so far in achieving the project's goals and objectives by analyzing its relevance, effectiveness, and efficiency. EMPHASIS has been implementing comprehensive programs and services at the source for reducing the impact population's vulnerability, to HIV/AIDS, by raising awareness of HIV/AIDS, capacity building, improving the use of health care services by developing a range of support structures, and creating an enabling environment for behaviour change.

Data have been collected using a combination of qualitative and quantitative research methods along with field observations. In order to get a holistic picture of the challenges at various stages of migration, the study was conducted at 3 stages-2 origin districts each at Nepal and Bangladesh that has data of sending maximum amount of cross border migrants, one transit point each at origin and destination country and three prominent destination cities in India, Delhi, Kolkata and Mumbai which receive maximum number of cross-border migrants. In order to get qualitative insight into the process through which cross border migration enhances HIV vulnerability of the migrants, a set of qualitative interactions was conducted using various scientific techniques like focus group discussions and in-depth interviews with the mobile population and the family members and key-informant interviews at the origin, transit, and destinations. To get a clear picture of vulnerabilities at each stage of movement the interactions were conducted with various stakeholders involved at various stages of move and migrants who actually move. Further, to see the perpetuation of these vulnerabilities back to origin a detailed qualitative dialogue was conducted with left behind women, families of migrants, important stakeholders, self-help groups and networks working for the welfare of left behind families at the origin. To get a macro level picture for assessing the continuum of care across the mobility routes, public health providers and policy makers in all three countries were roped in to get their views on the issues and challenges for making the cross border migration safe and dealing with the challenges at a broader perspective [5]. A total of 276 interviews were conducted in Nepal, Bangladesh, and India. The details of the interviews and their location have been given below **(Table 1).**

The checklists developed for the key informant interviews with key stakeholders were developed by organizing key topics/ issues to be explored. The major domains included-

- Perceptions of HIV vulnerability among mobile population and associated risk factors
- Types of evidence base used in planning of programs and services
- Evidence-based decisions in the planning of programs
- Various components and strategies in service delivery
- Various components and strategies in capacity building efforts
- Various components and strategies in enabling environment and advocacy
- Program strategy to address the recourse of HIV vulnerability
- Strategies to ensure non-generic approach in program implementation
- Government involvement and ownership of program
- Best practices, lessons learnt and their use for program improvement
- Potential to converge into larger Government health programs like NRHM or NUHM in India, NSP 2011-16 in Nepal and NACP 2011-16 in Bangladesh [6].

The checklist/guide developed for Semi structured In-depth Interview of SSH included the domains of-

- Major issues discussed in capacity building program of the project
- Your contribution to the programs and activities of the project
- Suggestion of any additional training program
- Utility and effectiveness of overall programs and activities of the project.
- Least effective and most effective program
- Ways to enhance people's participation

The checklist for FGDs (Out Reach Workers) included domains of-

- Objectives of EMPHASIS program
- Perceived effectiveness of capacity building programs for ORWs
- Mechanism of monitoring and supervision of outreach workers

The checklist for FGDs (Peer Educators) included the domains of-

- Objectives of EMPHASIS program

**Table 1**: IID- Individual level In-depth Interview; KII-Key Informant Interview; SSH- Secondary Stakeholders; ORW- Out-reached Workers; PEs- Peer Educators; PLHIV- People living with HIV; CBO Community Based Organization; SHG-Self-help Grou.

| Location/Type and number of interviews | IID with functionaries | KII with SSH | FGDs | | | | | Interaction with IP | Total interviews |
|---|---|---|---|---|---|---|---|---|---|
| | | | ORWs | PEs | PLHIV | IP | CBOs/ SHGs | | |
| Nepal | 8 | 6 | 3 | 2 | 1 | 1 | 1 | 10 | 32 |
| Bangladesh | 7 | 6 | 2 | 2 | 0 | 2 | 2 | 14 | 45 |
| Transit Nepal | 3 | 2 | 2 | 2 | 0 | 0 | 0 | 22 | 31 |
| Transit India-Nepal | 4 | 6 | 2 | 2 | 0 | 0 | 0 | 18 | 32 |
| Transit India-Bangladesh | 3 | 5 | 2 | 2 | 0 | 0 | 0 | 16 | 28 |
| Transit Bangladesh | 3 | 4 | 1 | 1 | 0 | 0 | 0 | 0 | 9 |
| Delhi | 6 | 4 | 2 | 2 | 0 | 2 | 1 | 12 | 29 |
| Kolkata | 3 | 4 | 2 | 2 | 0 | 2 | 2 | 18 | 33 |
| Mumbai | 4 | 5 | 2 | 2 | 2 | 3 | 4 | 14 | 37 |
| Total | 38 | 42 | 19 | 17 | 3 | 10 | 11 | 134 | 276 |

- Main responsibilities of PEs
- Capacity building of PEs
- Monitoring and supervision of activities
- Barriers in effective functioning of EMPHASIS program in this area (source, transit and destination)

The In-depth interview guide for program Director and Program Coordinator contained-

- Association with EMPHASIS
- Perception about vulnerability among mobile populations in this area (S/T/D) and associated risk factors
- The strategy adopted by the project for the capacity building of staff
- Service provisions in the context of vulnerability factors addressed
- Detail about the project strategies to enhance community mobilization for effective functioning and also to generate support system for the project
- Government involvement and ownership of program
- Best practices, lesson learnt and their use for program improvement [7].

## Findings

Cross border migration from Nepal and Bangladesh have a basic difference of prior being legally permitted and latter being majorly undocumented. Nepal and India have an 'open-border' policy adopted by both Governments through the 1950 bilateral Peace and Friendship Treaty. Nepalese and Indian people can travel and work across their borders and should be treated like native citizens. For Bangladesh-India migration, a number of legal frameworks are now in place to govern mobility allowing people with valid travel documents to emigrate [8,9]. Yet, the vulnerabilities seem equally distressing in terms of health, well-being, and safety of migrants from a humanitarian perspective. It has emerged from the study that the vulnerability of the migrants is different at the place of origin for the two mentioned countries but it is almost same for the migrants at the transit and destination. The movement, with or without family, is always governed by factors that operate at the macro level and shape the micro level conditions.

## Vulnerability at transit

The streams of migration are dominated by a number of gatekeepers who are mostly the stakeholders playing a crucial role in the continuum of movement. The vulnerabilities start from the transit areas where migrants are harassed by BSF jawans, money lenders, rikshaw and tonga pullers and agents/ brokers who are involved in making arrangements for crossing the borders with or without the documents. An alarmingly high incidence of harassment by the Border Security Force (BSF), rickshaw pullers and tonga owners was reported at these transit points. The transit areas even lack an effective mechanism to lessen harassment by the border or local police.

## Vulnerability at destination

Owing to their undocumented status or simply lack of required documentation proofs, cross-border migrants are often denied social entitlements resulting in the lack of access to any social institutions like hospitals, educational institution and even banks. Along with these larger issues of vulnerability, there are many small factors related to their housing and work conditions. Social exclusion, lack of basic amenities and necessities puts these cross-border migrants and their migrating families at a higher level of risks and deteriorates their quality of life. At destination place, the basic need of housing and amenities is not even sufficed for these migrants. There is a complete lack of drinking water facilities and toilet facility in the areas of the dwelling of these migrant populations. This makes their situation worse and their health vulnerable. Moreover, due to the undocumented nature of the Bangla Speaking Population (BSP), the community refuses to come up in open and avail any services making them further deprived of basic needs.

The BSP and the Nepali Migrant's Population (NMP) face dearth of job opportunities at the destination. Most of the NMP takes up the job of watchman and in the transport sector as bus conductors, drivers, truckers etc. The male BSPs, on the other

hand, take up jobs like labourers and butchers, while the female BSPs also become construction site helpers and labourers other than taking up the jobs of rag picking and being housemaids. It has also been reported that a substantial portion of BSP women are engaged in mobile sex work. Most of the BSP women who take up rag picking as job at the destination and they are most vulnerable to sexual harassment by local men who are mainly watchman of the industrial areas where these women go for rag picking and sometimes they are forced to have sexual relation with the men working in those industries.

The living condition and social context in which the population dwells, serves as a platform for risk behaviour. These migrants are mostly unskilled and illiterate and are at a very high risk of work place difficulties. They often face discrimination and harassments at the workplace and are often low paid. Some women migrants also make their livelihood by working as sex workers and since their awareness about HIV/AIDS is low, resulting in the inconsistent use of condoms. There is also a high prevalence of domestic violence reported in these communities, which many times occur under the influence of alcohol. However, this study repeatedly underlines that women are vulnerable at all the places, be it the origin or destination and even if they have migrated with their husbands.

The single migrant men stay mostly in group of friends and other acquaintances and thus without anyone taking the role of chaperone ship to give moral checks, their risky behaviour becomes uncontrollable. Due to the absence of any sort of social entitlements and especially without bank accounts, they have liquid cash in their hands, which they mainly spend on activities like alcohol consumption and sex. Alcoholism is very common among these communities and they often visit sex workers resulting in alcohol and sex interface. Unsafe sex under the influence of alcoholism and alternative support becomes one of the main HIV-related vulnerability to the migrants. This increases their STI and HIV vulnerability [10].

Despite all the HIV prevention efforts across the countries, the level of knowledge, awareness, and attitude towards the safe sex among NMP about HIV/AIDS is below satisfactory. The major reason associated with HIV vulnerability among the mobile population is its undocumented nature and fear of being singled out especially in the case of BSP because of which they deny coming under any kind of network. Further, it was reported that dearth of work opportunity at the destination coupled with the propensity to find employment often forces female migrants to take up sex work as a profession and thus making them at high risk of HIV. Men, on the other hand, elevate their vulnerability by indulging in risky behaviours like alcohol, casual and commercial sex under the influence of peer pressure or in order to find an alternative support outside the family. It was reported by the staff at Kolkata that almost half of males living in the BSP's community in Kolkata, visit nearby red light areas. The visits are often made after consumption of alcohol leading to the interface of alcohol and sex. This further increases the risk of perilous and unprotected sex in paid intercourse.

The migrants' feel discriminated and rarely come out with their problems for treatment as they feel secluded from the mainstream population in India and are not welcomed by the native population. This also enhances their vulnerability, as in fear of identification and stigma, discrimination; they do not go for treatment or testing even when their health is engulfed with risky situations. There is also a lack of mechanism to ensure the availability of ART services when the migrants move out of the city of their destination and go to their native place for a long time. This happens mainly in the case of NMP PHLIV, resulting in ART defaulters and loss of follow up. This adds up to the vulnerability of their women at the destination and this is one of the main reasons behind increasing number of HIV cases in Nepal. On the other hand, BSP population fears to come under any institutional mechanism offering services of health checkups, primarily due to fear of identification. Regularising efforts among these migrant communities is a challenge. There also lies challenge for the ORW and PE of ongoing projects to work with the BSP population, which hampers need based services for PLHIV among BSP. Lack of political will for the welfare of the BSP, entering into CBOs and getting key stakeholders on a common platform creates challenges in terms of community mobilisation efforts.

## Vulnerability at origin

The female partners of the migrants, mostly wives or girlfriends at the origin, become vulnerable as the migrants play a role of bridge carrying the virus from destination cities to origin places across the border. This is more found among the Left Behind Women (LBW) in Nepal since most of the NMP population migrate as single male migrants, leaving their families behind. Further, women at the origin reported a very low level of condom use within the wed locks and intimate partnerships due to the societal stigma attached to the condom in their community.

The sighting of cases of husband contracting HIV at the destination and then transmitting it to their wives/women at the origin is not uncommon at the villages of origin. Information was gathered from left behind women at Nepal and Bangladesh that men primarily migrate due to poverty and unemployment and in many cases do not come back and accept their previous life over lucrative jobs and extra marital relations at the destination places. These conditions make the LBW as a soft target for social and physical harassment from family and local people as well as blind response from the local administration. In these conservative societies, without spousal support women face social vulnerability along with the obvious economic hardship, it becomes challenging for them to run a family and are unable to fulfill basic needs and have to cut down on necessities like education, health care, etc. The remittances sent by the male migrants are not regular and most of the times are not sufficient for the LBW to run their family. As their husbands have migrated to India the local administration often does not address any of their problems and they are often deprived of governmental facilities. Societal and familial isolation forbids them to take any step towards the betterment of their lives. It is also been reported that LBW are more vulnerable towards sexual harassment by family members and teasing and taunting by males in the locality is an everyday phenomenon in the life of these women.

Reinforcing our findings and argument about the role of cross border migrants in shaping the HIV epidemic in their native country is the term used as a local name for HIV "Mumbai ki Bimari" ("Disease of Mumbai") commonly used in Ancham district of Nepal. This shows that there is universal awareness of HIV/AIDS among the women in Ancham and this name is marked since almost every village of Ancham district has PLHIV who are mostly migrants returning from Mumbai. Many of the interviewed persons or their friends/acquaintances have lost their spouses to HIV, who used to work in Mumbai and in some cases, the wives also got infected with HIV. Nevertheless, on an optimistic note, in spite of all sorts of vulnerabilities, the LBWs of both Bangladesh and Nepal are well aware of HIV/AIDS and they too impart this knowledge to their husbands when they communicate or talk over the phone.

## Discussion

There are a number of vulnerabilities that place these groups of migrants at an elevated risk of acquiring HIV. Though the vulnerabilities associated with the Bangladeshi and Nepali migrants are slightly different in occurrence but as a whole, they both are at high risk of acquiring HIV. The migrants often fail to avail healthcare facilities due to fear of identification and lack of social entitlements thus increasing their vulnerability at the destination. The Nepali population is mostly uneducated and mostly unskilled workers, who are at a high risk of work place based difficulties. This results in their either working in very bad conditions or in unemployment. These men stay in groups, mostly with a bunch of friends or acquaintances. There is no one to do a moral check or to teach or control the risky behavior. Hence, these groups often indulge in risky activities. Most of the NMP population migrate as single male migrants, leaving their families behind and are mostly in their prime. There is a lot of peer pressure, leading to deviant behavior. In this entire situation of independent living and peer pressure, alcoholism in this community has increased to a very high level. Almost 70% of NMP men indulge in rampant alcoholism. This further leads to visiting commercial sex avenues and thus results in alcohol and sex interface. It is well established in the literature that sex under the influence of alcohol often results in unsafe sex and also violence and sexual harassment. There is also very low HIV awareness among this group. Similarly, the vulnerabilities of the BSP population also start with the migrant status. The Bangladesh Indian migration is undocumented and thus once identified, a person can be deported back to the home country. This worsens the vulnerabilities of this population as BSP groups are constantly trying to conceal their identities. They do not come out in the open about their problems and requirements, do not take any services and do not give any priority to health. This makes the community a closed one in which generating demand and utilization of services remain the biggest challenge. As reported by NMP, the migration is of mostly single male migrants. They also stay in big groups in not so appropriate living conditions and without the basic facilities. Owing to their undocumented status, there are no social entitlements in any form for this group. They do not have a bank account, which results in their having considerable liquid cash. This is mostly spent on activities like alcohol and sex. A lot of peer pressure to indulge in risk activity and this is supported by the presence of liquid cash with the BSP migrants [11].

An important aspect of this study was to build a macro level picture of vulnerability across the mobility routes and across the international HIV corridors by roping in the public health providers and policy makers of all three countries. Findings suggest to enhance understanding of the factors underpinning HIV related risk and design appropriate policy responses at the regional level such as universal access to HIV testing and treatment. Further, it has emerged from the data collected from PLHIV and groups working with PLHIVs that cross border referral mechanism for HIV positives as well as their spouses with active involvement of PLHIV groups, civil societies and people to people contacts is one of the most critical issues that needs urgent attention. Strengthening the working relationship between partners working across borders by policy harmonization among the countries can be a key strategy to address HIV vulnerability among cross border migrants. Continuum of services is an important aspect, which can be achieved by regionalization of services with larger advocacy efforts, strengthening the linkage between programmes and services. These findings demand concerted efforts for advocacy efforts at regional level with policy harmonisation in terms of improving access and utilisation of improved health care services at place of destination and care and support programmes and services.

### Challenges that needs focus

In both the source countries, the institutionalization of cross border referrals and continuum of services is needed. The Nepal-India situation is relatively better than that of Bangladesh-India, largely due to the issue of undocumented migration. Relatively large numbers of PLHIV do not have access to empowered health and nutrition services which is a matter of urgency. The Bangladesh-India border lacks an effective mechanism to lessen harassment by border or local police and hence it may require larger advocacy efforts to focus on the humanitarian approach of the issue. The lack of mechanism to ensure the availability of ART services when NMP PLHIV move out of the city and go to the native place for long spells, needs to be strengthened since it has often resulted in ART defaulters and loss to follow up. Intensification of advocacy efforts to reduce stigma and strengthen the care, treatment and support program by expanding the project activities is required. Strengthening the network of PLHIV and ART centres at source and destination in order to minimise defaulters in the treatment regimen is also necessary.

## Conflict of Interest

Authors declare no conflict of interest

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