

Population mobility and HIV and AIDS: review of laws, policies and treaties between Bangladesh, Nepal and India

By Fiona Samuels and Sanju Wagle

People move for many reasons, and factors that drive mobility often stem from unequal distribution of resources, climatic instability, conflict and political unrest. Movements have often been conceptualised as being driven by push or pull factors or a combination of the two. Many are pushed out of a country or a region by political instability, violence and natural disasters, and pulled towards other regions and countries with stronger economies and better opportunities.

Mobility is not a new phenomenon in South Asia and national, regional and international mobility continues to grow. In particular, the demand from India's growing economy has pulled populations from Bangladesh, Nepal, Pakistan and Sri Lanka. Cultural affinities between these countries also allow easier cross-border mobility.

Various surveys and studies (e.g. Barbora et al., 2008; Theime, 2006) reveal that migrants are disadvantaged relative to the native population in terms of employment, education and health. While their contributions are often key to the survival of families and communities back home, those who move and those who remain face many vulnerabilities. For the person who moves, language barriers may limit their choices and reduce their capacity to negotiate a better livelihood and distance from family often leads them to seek alternative support, which may lead to risky behaviours. At a programmatic and social level, gov-

ernment policies and programmes and cultural factors uphold discrimination and hinder migrants' access to services. Their legal status adds to their vulnerabilities as laws and policies may prevent them from accessing health and social services.

Those left at home may face loneliness and exclusion and also may engage in risky behaviours for livelihood/survival purposes.

While mobility itself is not considered a vulnerability factor for HIV infection, the unsafe conditions under which people migrate exposes them to a greater risk 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 returning migrants find their home communities ill-prepared to deal with potential HIV and AIDS-related needs and vulnerabilities (IOM, 2002).

In response, CARE UK, in collaboration with CARE offices in India, Nepal and Bangladesh, has established a regional operation research programme, which aims to reduce vulnerability to HIV and AIDS amongst migrants moving between Bangladesh and India and between Nepal and India. EMPHASIS (Enhancing Mobile Population's Access to HIV & AIDS Services, Information and Support) works through local and international partners to provide interventions and carry out research at source, transit and destination sites.

As a background to the programme and in recogni-

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This operations research is being funded by the Big Lottery Fund (UK) and implemented by CARE UK. ODI is providing oversight for the research component.



LOTTERY FUNDED

Box 1

HIV in Bangladesh – HIV prevalence is considered very low at below 0.1% in the general population; however, amongst Most At Risk Populations (MARPs) it rises to 0.7% and was as high as 2.7% among casual sex workers in Hili, a small border town in northwest Bangladesh (Government of Bangladesh, 2010; World Bank and UNAIDS, 2009). There are an estimated 12,000 people living with HIV (PLHIV) in Bangladesh (UNAIDS, 2008), many of them migrant workers. According to the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), 47 of 259 cases of people living with HIV during the period 2002-2004 were identified during the migration process. In 2004, data from the National AIDS/Sexually Transmitted Disease (STD) programme of the Ministry of Health and Family Welfare (MoHFW) showed that 57 of 102 newly reported HIV cases were among returning migrants. The National AIDS/STD programme report of 2006 stated that approximately 67% of identified HIV positive cases in the country were returnee migrant workers and their spouses.

HIV in Nepal – HIV and AIDS has become a major public health concern in Nepal (Ministry of Health and Population (MoHP), 2005, cited by Wasti et al., 2009) and Nepal has shifted from having a ‘low HIV prevalence’ to being a country with a ‘concentrated epidemic’ (Government of Nepal, 2010). In 2010, the country’s HIV prevalence rate was 0.49% and 70,000 people were living with HIV and AIDS (CIA, 2010). According to the National Centre for AIDS and STD Control (NCASC), there are 16,138 HIV positive people in Nepal. The UNGASS 2010 report shows that labour migrants account for the biggest single proportion of those infected (41%). According to the 2008 Integrated Bio-Behavioural Studies (IBBS) about 1% of migrants returning from Mumbai, India, to the Mid and Far western districts were HIV positive. Poor surveillance systems and inadequate access to quality voluntary counseling and testing (VCT) services means that these figures are probably underestimates (Wasti et al., 2003).

HIV in India – HIV prevalence rates are reported to be approximately 0.34%, with an estimated 2.5 million PLHIV (NACO, 2009). An extensive prevention and treatment programme initiated by the Government has targeted high-risk populations such as female sex workers, men having sex with men, and transgender and intravenous drug users including bridge populations such as truckers and internal migrants – cross border populations are absent from this targeting. Since 2005 the Government has provided free antiretrovirals (ARVs), reaching more than 282,500 people by November 2009 (NACO, 2009). Although services are free, many PLHIV in remote areas cannot afford the cost of travel to reach treatment centres; the Government has responded by subsidising rail travel for PLHIV by 50% (UNDP, 2010).

tion of the importance of legal and policy contexts that could ease the vulnerabilities of migrants, EMPHASIS commissioned a review of policies, treaties and conventions around migration, labour, health and HIV and AIDS in the three countries. Such laws and policies will determine the types of services available for mobile people. This, in turn, can determine their vulnerability to HIV and AIDS.

This Background Note provides a summary of key findings. A short overview of the HIV situation in each country is followed by a review of the individual country legal frameworks and an outline of regional initiatives around migration and HIV. The Background Note concludes by discussing priorities and processes that could safeguard the health and rights of migrants and their families.

HIV and AIDS scenarios

South Asia is home to 2 to 3.5 million of the world’s estimated 33.3 million people living with HIV and AIDS (UNDP, 2010). While HIV prevalence is low among the general population in Bangladesh, Nepal, Pakistan and Sri Lanka, it is significantly higher among key populations, such as injecting drug users (IDUs), male and female sex workers (FSW) and their clients, men who have sex with men (MSM), and the wives of male migrants (Box 1).

Bangladesh

Bangladesh is almost totally surrounded by India. A large portion of Bangladesh’s foreign currency earnings comes from remittances – 4% of the country’s GDP, according to the International Organization for Migration (IOM, 2006). Cross-border movements have been a feature since the country’s formation in 1971. Those from better-off families with some degree of education and skills migrate legally to developed nations, while the poor and marginalised often enter India without any valid documentation. Unable to secure a legal permit to work in India, they often cross the border unofficially by paying *dalals* (agents) or brokers for a quick and safe passage. The Border Security Force allows Bangladeshis to cross the border illegally in exchange for money or, in some cases, sex (Datta et al, 2008; Sikder, 2008).

While the exact figures are unknown, people from both India and Bangladesh cross the porous borders regularly through many unofficial transit points – a process eased by the ethno-cultural similarity of the population on both sides of the border. This poses a major challenge to both nations in efforts to control illegal cross-border mobility.

Migration laws and policies

The Ministry of Expatriate Welfare and Overseas Employment is entrusted with protecting the rights

and interests of Bangladeshi migrants in host countries, ensuring the welfare of remittance senders, facilitating overseas employment for prospective Bangladeshi migrants and increasing the capabilities and skills of the labour force. However, these services only cater for documented migrants. A number of legal frameworks are now in place to govern mobility.

The Emigration Ordinance 1982 is the key regulatory instrument on migration, allowing people with valid travel documents to emigrate. Such documents consist of a letter of appointment or work permit from a foreign employer or an employment or emigration visa from a foreign government. Under the Ordinance, the Government is authorised to grant licenses to individuals and companies wanting to recruit emigrants for overseas employment. Undocumented migrants can face up to one year of imprisonment and a fine.

The Ordinance has two major limitations. First, it does not protect migrant workers' rights in destination countries. Second, under Section 24, migrant workers are liable to imprisonment if they return home without completing their employment tenure. Unskilled and semi-skilled women are not allowed to migrate alone; they can only migrate with a male partner. The ban, however, has loopholes that are sometimes exploited.

Some women continue to be trafficked, but protective laws on trafficking treat most illegal women migrants arrested in India – whether trafficked or not – as if they were trafficked victims (Sikder, 2008). Treating non-trafficked female Bangladeshi migrants in this way exacerbates the stigma and discrimination they face (Box 2).

The Government has ratified the International Labour Organization instrument, the Migration for Employment Convention of 1949 and the Migrant Workers Supplementary Convention of 1975. However, it has signed but not ratified the 1990 UN International Convention on Protection of Rights of All Migrant Workers and Members of their Families. This convention ensures full applicability of human rights legislation on female migrants. Overall, ratification of instruments on migration is mainly applicable to legal migrants. As a result, unskilled female mobile workers are still labelled as trafficked victims.

Bangladesh Passport Order 1973: under Clause 11(c) it states that a person who 'fails to produce for inspection his passport or travel document (whether issued under this Order or not) when called upon to do so by the prescribed authority ... shall be punishable with imprisonment for a term which may extend to six months, or with fine which may extend to Taka two thousand or with both'. If migrants are caught in India, they are imprisoned again under India's Acts; when adults are caught with children, they are separated

Box 2: Trafficking of Nepali and Bangladeshi girls

There is growing demand for young Bangladeshi and Nepali girls for sex work and increasing numbers of females are being trafficked to major red light districts in India. Peer educators implementing HIV and AIDS interventions rarely visit them, due to language barriers and the strict control of the brothel keepers. As a result, young girls are isolated from other women by brothel keepers, fearing prosecution and lacking knowledge about HIV and AIDS, associated illnesses, and safer sex. They are sometimes coerced into performing their first act of sexual intercourse with a pimp, local goon or thug, or the sexual partner of the brothel keeper (evidence from field work in Pune City).

Box 3: A cross-border migrant arrested in India

In West Bengal, Bangladeshis caught without a valid passport and visa documents are arrested under the Passport's Act of 1967 or under Section 14 of the Foreigners Act of 1946. Siraj (not his real name) is a prime example. In 2008, he and his children (Khalid and Jamil aged 13 and 11 years) travelled from Bangladesh to India along Jessore Road to the Petrapole border crossing on the India side. He wanted to escape poverty and work in India. When they crossed the border illegally, they were arrested by the Indian Border Security Force. They were handed over to the West Bengal Police and Siraj was taken to Alipore Jail, Kolkata, while the children were taken to the Kolkata Observation Home. Siraj was not interviewed by the authorities for 15 days, and he was unsure about his fate. When he asked the jail authorities about his deportation, he was told that Bangladeshis have to spend at least a year in prison for entering India illegally. Two years have passed and Siraj is still in jail, while his children have been repatriated (evidence from field work in Kolkata).

and the children are kept in safe custody or shelter/observation homes while the adults are jailed (UNDP, 2004) (Box 3).

National HIV and AIDS policies and programmes

The Government formed the National AIDS Committee (NAC) in 1985. Headed by the President as chief patron and chaired by the Minister of Health and Family Welfare, the NAC formulates major policies and strategies, supervises programme implementation and mobilises resources. A NAC Technical Committee of experts provides technical advice to the NAC and National AIDS and Sexually Transmitted Disease (STD) Programme (NASP). The NASP is a wing of the Directorate General of Health Service established in 1998 under the Ministry of Health and Family Welfare (MoHFW), which coordinates with all stakeholders and development partners working on HIV and AIDS.

National HIV and AIDS Policy: Bangladesh's 1997 National HIV and AIDS Policy, supported by a National

Strategic Action Plan (1997-2002), was the first comprehensive document of its kind in the region. It emphasised four cross-cutting priority issues: human rights, gender, behaviour and information, and education and communication. It endorsed the Universal Declaration of Human Rights as a standard for policy-making and action on HIV and AIDS and STDs in Bangladesh. It addressed important components on migration but was weak on issues of cross-border mobility into India.

The 2nd NSP (2004-2010) emerged from a participatory process in May 2005 involving government, civil society and UN agencies. It identifies five priority areas, including support and services for priority groups, prevention of HIV and AIDS-related vulnerability, and minimisation of the impact of the HIV epidemic. It also addresses open borders, labour migration, the sex industry, the link between vulnerable groups and bridge populations, as well as gaps in healthcare delivery, low levels of HIV awareness, gender inequality and poverty as factors in the spread of HIV infection in Bangladesh. The revised National HIV and AIDS Policy strategy emphasises the external migrant labour workforce as a vulnerable segment of the population and identified this group as being at greatest risk.

Bangladesh developed its first Antiretroviral Therapy (ART) treatment guidelines in 2006, with PLHIV able to buy subsidised antiretroviral drugs from specified pharmacies. Unfortunately, most HIV diagnostic facilities are provided by NGOs based in Dhaka and most rural and cross-border migrants miss out on ART, HIV testing and other associated care and support services. If they seek private care, the cost is often beyond their means.

Most legislation, therefore, addresses formal migration between Bangladesh and other Southeast Asian countries, the Middle East, European nations and the US. Even then national migration policies do not contain laws and regulations to safeguard the interests of migrant workers, especially women. The Emigration Ordinance of 1982 states the need for valid documentation before migration, but does not protect migrant workers' health rights. Similarly, the 385 NGOs working on HIV and AIDS-related issues in Bangladesh are not focusing on cross-border issues. In 2009, for example, Bangladesh received six years of funding from the Global Fund for AIDS, Tuberculosis and Malaria to scale up HIV and AIDS interventions, but cross-border migrants are not covered.

Cultural, linguistic and legal barriers prevent migrants from accessing government healthcare services and increase their vulnerability to HIV infection. Given current mobility patterns and the associated HIV-related vulnerabilities and risks, targeted interventions are needed for migrants. To date, the response of both

Bangladesh and India has been inadequate to deal with the realities along the countries' shared borders.

Nepal

Nepal is sandwiched between India and China and, like Bangladesh, shares much of India's culture, language and religion. Much of its economy is closely integrated with that of India. In recent years, remittances from Nepali migrants have contributed an estimated \$150 million to the national economy, equivalent to almost 25% of GDP, and the true figure could be much higher (Seddon et al., 1998; 2001).

Nepal and India have an 'open-border' policy adopted by both Governments through the 1950 bilateral Peace and Friendship Treaty. Article 7 states that, 'the nationals of either country share the same privileges in the matter of residence, ownership of property, participation in trade and commerce, movement and other privileges of a similar nature in the territories of the other'. Nepalese and Indian people can travel and work across their borders and should be treated like native citizens. Laws and regulations around mobility were not, therefore, included in this review.

Even before the 1950 treaty, Nepalis were being recruited to work in India. The migration trend is growing as a result of political instability, disparities in development across Nepal and poverty. The 2001 census shows that more than 762,000 people – or 3.3% of the total population of just over 23 million – were out of country, with more than 77% of those in India. More recent estimates show between one and three million Nepalis work in India – two to five times more than official statistics suggest (Seddon et al. 2001; Thieme, 2006). The porous border makes it difficult to capture accurate data on cross border movement, but most migrants are men travelling to India to work as unskilled labourers in the informal sector.

National HIV and AIDS policies

The Government of Nepal created the STD and AIDS Control Committee in 1986 and launched the first National AIDS Prevention and Control Programme in 1988. In 1995, the Government formulated its first National HIV and AIDS Policy through consultation with different stakeholders. This one-page document addresses a multi-sectoral programme, decentralisation of programme activities at village and regional level, and discouragement of discrimination on the basis of HIV and AIDS status (Government of Nepal, 1995). A number of note-worthy developments have included: the National Workplace Policy (2006); the National Policy on Drug Control (2006); Nepal Policy Advocacy Panel on HIV and AIDS (2008); the Nepal Leadership Fora on HIV and AIDS (youth, women and

media, 2008); and the HIV and AIDS and Human Rights Forum (2008).

The National AIDS Council (NAC) was formed in 2002 and is chaired by the Prime Minister. Its multi-sector composition aimed to engage different ministries, the private sector and civil society including PLHIV in the response to the HIV epidemic. It was expected to meet at least once a year to review and guide the national response to HIV, but political turmoil and changes in government leadership prevented meetings between 2002 and 2008. The second NAC meeting was organised in August 2009. Today the National Center for AIDS and STD Control (NCASC) and the HIV and AIDS board coordinate Nepal's response to the HIV and AIDS epidemic.

National HIV and AIDS Strategies: following the formulation of the first National HIV and AIDS Policy in 1995, a series of strategies have been developed (1997-2001; 2002-2006; and 2007-2011), each one building on, and learning from, the other. The second National Strategic Plan (NSP), for instance, included detailed activities catering to the needs of various high-risk groups, while the third supported universal access, aiming to reach 80% coverage of prevention, treatment, care and support services to Most at Risk Populations (MARPs) and PLHIV.

National HIV and AIDS Action Plan (NAP): the NAPs of 2006-2008 and 2008-2011 aimed to operationalise the National HIV and AIDS Strategies. The second NAP recommends providing prevention, care and support programmes for those most at risk before they leave the country, and on their return and/or reintegration into their communities. This includes migrants who move to higher HIV prevalence states in India, such as Maharashtra and Mumbai. To reach these populations, the plan has considered mapping the location of migrant workers, estimating the size of the high risk population, assessing behaviours and helping to design targeted interventions. A parallel programme for spouses of most-at-risk migrants has also been proposed.

The 2011-2016 National HIV and AIDS Strategy is under discussion and the protection of Nepali migrants in India and on their return is a priority. There is also awareness of the risk imposed by migrants to their spouses, children and others and general agreement that an adequate and effective control programme that addresses migrants specifically will help reduce the epidemic.

India

As the region's economic power house, and with its porous borders, India was estimated to host approximately 330,000 migrants in 2004 (Benoit, 2006). In the 2001 census, about 5.1 million people were reported as

migrants, listing a previous residence across the border. In India, 96.9% of these migrants are from neighbouring countries including Bangladesh, Pakistan and Nepal.

Migration laws and policies

While there are many labour laws and policies that cater for internal migrants, most benefit only those working in the formal sectors and are poorly enforced. Few workers are aware of them, especially Nepalis who, despite the 1950 Act giving them specific entitlements, are unaware of their existence and often view themselves as living in India illegally. Undocumented migrants from Bangladesh, obviously, have no access to the benefits associated with these laws and policies.

The key Indian law relevant to migrants is the Foreigners Act of 1946, which deals with the entry, stay and exit of foreigners in the country, with the exception of Nepalis. Amongst other things, this act gives the Government the power to: 1) order controls over foreigners, 2) restrict their movement, activity and residence, and require their proof of identity and regular appearance before the police; and 3) deport them.

With the large influx of Bangladeshis in the state of Assam, the Government created the Illegal Migration Determination by Tribunals Act on 12 December 1983, applicable only to Assam. This allowed legal citizenship for those who had settled in Assam before 25 March 1971. However, there were issues about providing citizenship and the Supreme Court ruled the Act unconstitutional in 2005, stating that it contravened Article 355 of the Constitution. Today, the Foreigners Act of 1946 is the only law that deals with cross-border migrants, particularly Bangladeshis in India.

Therefore, despite numerous labour protection acts and policies, none of them address vulnerabilities faced by foreign migrants. Most of India's legal instruments address employees in the formal sector, which accounts for only 7% of all workers in India, leaving the remaining 93% without social benefits.

Health laws, legislation and policies

Soon after the first AIDS case was detected in 1986, the Government established the National AIDS Committee within the Ministry of Health and Family Welfare. In 1992, the first National AIDS Control Programme (NACP), implemented for seven years (1992-1999), focused on monitoring HIV infection rates among risk populations in selected urban areas. In the second phase – 1999 to 2006 – India expanded the programme at state level, focusing on targeted interventions for high-risk groups and preventive interventions among the general population. A National Council on AIDS was formed during this phase, consisting of 31 ministries and chaired by the Prime Minister. The objective was to mainstream HIV and AIDS in all minis-

Box 4: HIV and AIDS and the right to work

With the ratification of the UN International Convention on the Protection of Rights of All Migrant Workers and Members of their Families, most countries pursue a policy of mandatory check-up for HIV and AIDS prior to departure. If HIV is detected, the destination countries deport the migrant worker immediately to their home country. In Bangladesh, for example, the Bureau of Manpower, Employment and Training (BMET) agrees to the destination country's policy of mandatory HIV tests prior to departure. Only those testing negative receive BMET clearance for departure. Such policies raise serious questions about human rights violations and the right to work.

tries and departments by treating it as a development challenge, not solely a public health issue.

NACP Phase III (2006-2011) scaled up targeted interventions dramatically, aiming to halt and reverse the epidemic by integrating programmes for prevention, care, support and treatment. At the end of 2008, targeted interventions covered almost 932,000 of those most at risk, or 52% of the target groups (49% of FSWs, 65% of IDUs and 66% of MSM). The NACP does not have any clause or section mentioning HIV and migrants specifically, whether documented migrants or undocumented.

In 2009 India established a National HIV and AIDS Policy and the World of Work, with the ratification of ILO Convention No 11 on Discrimination (Employment and Occupation) (Box 4). This led to a policy statement to create a framework for non-discrimination against workers on the basis of their real or perceived HIV status. As a result India expanded its HIV and AIDS policy and programmes in the workplace as a key component of the mainstreaming strategy of the NACP Phase III. Under this policy all enterprises in the public, private, formal and informal sectors are encouraged to establish workplace policies and programmes based on the principles of non-discrimination, gender equity, health work environment, non-screening for the purpose of employment, confidentiality, prevention and care and support.

The policy document does not, however, enforce any agents to ensure worker protection. Instead, it encourages HIV prevention through a multi-sectoral approach. While the policy posits that the issues migrants face must be addressed in collaboration with the State AIDS Control Society (SACS) and enterprises within the informal sector, the policy has not been implemented to date. Even though Nepalese and Indian citizens have equal rights, field visits revealed that Nepali migrants faced problems in accessing HIV and AIDS-related services from the Government because they were unable to provide proof of residence.

Box 5: Rights and principles for migrants

- Safe mobility and migration in accordance with international labour standards/conventions;
- Non-discrimination and protection against abuse and other human rights violations;
- Minimum wage and gender equity;
- Health and equal access to HIV services, welfare, security, and safety;
- Access to information, form associations, access legal aid, exercise their voting rights;
- Counseling facilities for migrant workers; and
- Stay, work, and not be deported on the grounds of HIV status.

Therefore, despite policies and strategies – many of them innovative – the needs of cross-border migrants are not being addressed.

Regional bodies and initiatives

A number of regional initiatives exist that are important when considering issues of cross-border mobility and HIV. The South Asia Association of Regional Cooperation (SAARC), established in 1985, was initially dedicated to economic, technological, social and cultural development, emphasising collective self-reliance. As member states faced common emerging health issues, health became part of SAARC's work. Eight South Asian countries are now members: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

In 2004, SAARC signed a Memorandum of Understanding with UNAIDS to help member states work toward the goals of HIV prevention and appropriate care and support for PLHIV. In the same year, the SAARC Regional Strategy on HIV and AIDS (2006-2010) was formulated, emphasising regional level coordination, collaboration and partnership with organisations and national programmes. Critically, it stresses promotion of regional dialogue on cross-border issues relevant to HIV and AIDS. A meeting and workshop held in 2007 and 2008 in partnership with ILO and UNDP discussed leadership and development challenges to address HIV and AIDS and mobility, defining basic rights and principles for tackling HIV in the context of migration (Box 5).

In addition to SAARC, the Colombo Process, or the *Ministerial Consultation on Overseas Employment and Contractual Labour for Countries of Origin in Asia* was initiated in 2003. The governments of five South Asian countries (Bangladesh, India, Nepal, Pakistan and Sri Lanka) participate in this process alongside six other Asian labour exporting countries. The priorities are 1) protection of, and provision of services to, migrant workers; 2) optimising benefits of organised

labour migration; and 3) capacity-building, data collection, and inter-state cooperation.

After three ministerial meetings in Colombo (2003), Manila (2004), and Bali (2005), the Colombo Process was expanded to include labour-receiving countries in the EU, the Gulf and Asia at the Abu Dhabi Dialogue in January 2008. In April 2011 the 4th ministerial meeting in Dhaka, Bangladesh, adopted the Dhaka declaration. This puts forward 21 recommendations to promote the rights, welfare and dignity of workers and build services and capacity. But once again, it was silent about labour migrants to India.

Such initiatives are examples of positive regional cooperation on issues of migration and trafficking. Regional fora are critical for addressing issues in an integrated manner, including establishing the nexus among mobile populations, trafficking and HIV. However their focus tends to be on labour migration to the Middle East and other developed countries, rather than cross-border mobility from Nepal and Bangladesh to India.

Recommendations

Asian countries have a long way to go to ensure adequate protection of cross-border migrants. Given India's strong economic growth, migration from Bangladesh and Nepal to India is likely to increase. The following identifies ways to create a safer environment for migrants – one in which vulnerability to HIV and AIDS could be reduced.

Address the lack of data: Insufficient data on migrant numbers, demographics and health status is a barrier to meeting their needs and protecting their rights. Lack of data results in laws and policies in these countries that do not reflect the realities on the ground. Documentation of migrants is also hindered by political sensitivity around migration in Bangladesh and India, compelling people to move illegally and to remain beneath the radar of surveys in destination countries. In the case of Nepal, the open border policy makes it difficult to estimate migrant numbers, as migrants have no legal obligation to document their travel to India.

To address this, governments of both receiving and sending countries should map, amongst other things, the mobility and livelihood patterns of migrants, their social and sexual behaviour and their housing conditions. This would facilitate the development of appropriate policy and programmatic interventions at national and regional levels.

Recognise the existence of undocumented labour migrants from Bangladesh to India: The Government of Bangladesh does not acknowledge the existence of migrants to India. This hampers the development of programmes and policies to protect the rights and entitlements of mobile populations. Once migrants

cross into India, they lose the power to negotiate or bargain for basic rights and services. As a first step, the Government of Bangladesh should begin to acknowledge their existence.

Address weak labour laws and policies: Available studies show clearly that the rights of labourers in the informal sector are not well protected – regardless of whether they are internal migrants or from neighbouring countries. While national policies provide access to social services for migrant workers in the formal sector, few migrant workers have access as most (along with 90% of the workforce in India in general) work in the informal sector. There is, therefore, an urgent need for NGOs and others to work with the Indian labour ministry to ensure the rights of the labourers in the informal sector. This could take time, so a more immediate step is to work with major employers of migrant workers in the informal sector to establish appropriate health insurance schemes.

Distinguish between trafficked victims and cross-border migrants: Undocumented Bangladeshis in India face the constant threat of lengthy and uncertain deportation processes. Both the Indian and Bangladeshi Governments see women migrants found in India as trafficked victims because they do not want to acknowledge or deal with illegal migration. This makes the deportation process longer and increases the stigma faced by migrant women labelled as trafficked. Civil society organisations need to sensitise the Bangladesh Deputy High Commission, the District Intelligence Board (India) and the Ministry of External Affairs (India) to coordinate efforts to clarify the reasons for migration and develop an appropriate process to handle undocumented Bangladeshis.

Include migrants in India's health and HIV and AIDS services: India prioritises internal migrants in its HIV and AIDS policies, plans and strategies. Source countries should, therefore, put this issue on the agenda for bilateral and regional dialogue, as rising rates of HIV among migrants and increasing mobility across borders will have an impact on both source and destination countries. Meanwhile, civil society organisations need to highlight the lack of HIV programming for Bangladeshi migrants in source, transit and destination communities and encourage donors to fill this gap.

Raise awareness of migrant rights: Nepalis are legal migrants to India. They can travel and work freely in India and are to be treated as native citizens. However, their own lack of awareness of their rights as migrants in India stops them accessing health and social services. Raising their awareness of their rights should be a priority, as part of pre-departure orientation in their source communities or when working with migrants in India.

Strengthen implementation of regional and national policies: The SAARC Regional Strategy on HIV and AIDS (2006-2010) aims to develop and implement a prevention strategy, develop policies and programmes on treatment and care, and counter stigma and discrimination. To date, however, it lacks alignment with member states' own national HIV and AIDS policy frameworks. SAARC needs to be strengthened to influence policies of its member countries and develop and provide consistent and comprehensive programmes for migrants across these countries.

In short, the development of policies to protect the rights and entitlements of mobile populations is thwarted by inaccurate estimates of their num-

bers, lack of acknowledgement of undocumented Bangladeshi labour migrants in India and lack of awareness among Nepali migrants of their legal rights in India. Governments, NGOs and donors must be encouraged to provide HIV prevention and control programmes for mobile populations in source, transit and destination sites. Similarly, to ensure the needs of mobile populations are met, existing laws and policies in countries of origin and destination must be harmonised and regionalised.

Written by Fiona Samuels, ODI Research Fellow (f.samuels@odi.org.uk) and Sanju Wagle, Regional Research Manager, EMPHASIS, CARE (swagle@co.care.org).

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Useful resource:

For the full report on this study, please see www.carenepal.org/publication.php

Overseas Development Institute, 111 Westminster Bridge Road, London SE1 7JD, Tel: +44 (0)20 7922 0300, Email: publications@odi.org.uk. This and other ODI Background Notes are available from www.odi.org.uk.



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