

Evaluation of Enhancing Mobile Populations' Access to HIV and AIDS Services, information and Support (EMPHASIS)



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Abbreviations

Antiretroviral	ARV
Antiretroviral Therapy	ART
Behavioural Change Communication	BCC
Bharatiya Gramothan Seva Vikas Sansthan	BGSVS
Bengali/ Bangla Speaking Population	BSP
Community Based Organization	CBO
Community Support Group	CSG
Community Support System Mode	CMSS
Delhi and the National Capital Region	Delhi-NCR
Delhi State AIDS Control Society	DSACS
Drop in Centers	DIC
Focus Group Discussions	FGDs
Gender Based Violence	GBV
Government of Bangladesh	GoB
Implementing Partner	IP
Information, Education and Communication	IEC
Integrating Counseling and Testing Centers	ICTC
International AIDS Congress in Asia and the Pacific	ICAAP
International Labour Organization	ILO
International Non-Governmental Organization	INGO
International Organization for Migration	IOM
International Transport Federation	ITI
Joint United Nations Programme on HIV and AIDS	UNAIDS
Knowledge, Attitudes, Practices and Behaviour	KAPB
Monitoring and Evaluation	M&E
Mumbai State AIDS Control Society	MSACS
National AIDS and STI Program	NASP
National AIDS Control Organization (Nepal)	NCASC
Nepal Environmental and Education Development Society	NEEDS
Nepalese Migrant Population	NMP
Outreach Worker	ORW
People Living with HIV and AIDS	PLHIV/PLWHA
Seema Suraksha Bal	SSB
Self Help Group	SHG
Sexually Transmitted Infection	STI
South Asian Association for Regional Cooperation	SAARC
Trade Union	TU
Training of Trainers	ToT
United Nations Development Programme	UNDP
United Nations General Assembly Special Session	UNGASS
Village Development Committee	VDC
Voluntary Counseling and Testing	VCT

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It has taken us a while to come to grips with the complexity of the EMPHASIS project, with its regional as well as country dimensions in India, Nepal and Bangladesh. In helping us do so, the evaluation team would like to acknowledge all the support received from colleagues at CARE India, CARE Nepal, CARE Bangladesh and each of their partner organizations, especially during our visits to each country. Thanks go particularly to all the Partnership Coordinators/Project Manager/M&E Managers who led the making of arrangements in each of the locales we visited. Most of all though we would like to acknowledge the support and keen interest in the evaluation shown by the Regional Secretariat of EMPHASIS, especially Prabodh Devkota and Mirza M Sultana. Without Manbira's continued nurturing encouragement and continued supply and putting together of relevant documentation, this evaluation would undoubtedly have been considerably less effective, so our especial thanks are due to her.

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Executive Summary

EMPHASIS is a 5 year project funded by Big Lottery Fund, UK, which was initiated in August 2009 and is due to conclude in July 2014. It has been implemented in Nepal, India and Bangladesh to address both HIV and AIDS vulnerability and safe mobility issues of cross border migrant populations. Its overall goal has been to contribute to reduction of vulnerability of mobile populations (particularly women) to HIV infection across selected cross border regions within India, Bangladesh and Nepal. There has however, appropriately, been an increased focus on safe mobility issues within the last two years of the project.

The three main outcomes of the project focus on:

- The development of an effective and integrated cross border model of HIV prevention, care, treatment and support to benefit mobile populations and their families and target groups at source, transit and destination locations who are vulnerable to acquiring and spreading HIV and AIDS.
- Building the capacity of partner organizations (including regional authorities, government agencies, border police, customs officials, research institutions, NGO, Community Based Organizations [CBO] and key stakeholders) to deliver improved and integrated services to mobile populations vulnerable to HIV.
- Increasing recognition of the vulnerabilities of mobile populations and demonstration of ways to address them in source and destination communities that will inform policies and produce evidence based advocacy messages with which to lobby government stakeholders.

The aim of this evaluation is to assess the project according to its three outcomes areas and to assess the effectiveness and relevance of different interventions. One week visits to India, Nepal and Bangladesh were conducted at the end of January/ early February 2014 by a team of three people, during which interviews and focus group discussion were conducted, and a Lickert Scale tool administered. These visits were then supplemented by some additional meetings in Bangladesh in April, following the production of the first draft report. An endline study was conducted in parallel to the evaluation, and its conclusions are also drawn upon in this report.

Findings

Overall, EMPHASIS has impressed us an innovative, experimental project setting out to pilot a complex set of interwoven interventions involving multiple actors and partners in a range of source, transit and destination settings in India, Nepal and Bangladesh. In the last two years, especially, this work has shown extremely encouraging signs of coming together as a coherent model demonstrating real differences in the lives of participant migrant groups and their families. Nevertheless, there remain challenges to the completion of this work, particularly with regard to its longer term continuity. This would include finding ways to put Bangladeshi migrants to India more firmly on inter-governmental agendas.

With respect to the endline survey, the indicators, taken collectively, show two main findings. One, that migrant populations reached by the project now know more about HIV and AIDS and how it is transmitted and can be prevented, than they did at the outset of the project, and have imparted this to contemporaries in the control localities at the end of the project. Second, and the most significant change, is the ability of these migrants to discuss issues related to HIV (and safe mobility) with their spouses. The project has made it feasible for women to undertake dialogue and negotiation within the household with their husbands, where it was not before.

For the evaluation, its summary conclusions regard the three outcome areas are as follows.

Outcome 1. Over its five year life span, EMPHASIS has shown that it is possible to develop a cross border model that addresses the most critical issues requirements related to the prevention and treatment of HIV and AIDS. This includes forms of care and support to patients. At high population density locales, for instance, in Mumbai, or the border crossing between India and Bangladesh, mobile or temporary VCT centres that can treat also for other STIs, have shown to be particularly effective means of identifying patients requiring further treatment.

In lower density locations, particularly in source communities, outreach approaches, including the use of peer educators (Nepal), and community support groups (Bangladesh), who can refer people to health centres for a wider range of health related issues, have shown potential as more cost-effective approaches.

The innovation of the EMPHASIS approach, using the continuum of mobility across source, transit and destination sites, has been the most compelling unique feature of the model. There have been two especial gains from this approach. The first is that it has allowed a reinforcement of messages at different points – and there are significant numbers of people, as shown by the endline survey – who have been reached by EMPHASIS at source and destination. And the second point is that it has facilitated multi-institutional approaches and the negotiation of cross border arrangements, especially between India and Nepal, building on the provisions of the Indo-Nepal Peace and Friendship Treaty.

Outcome 2. The capacity building approach adopted by CARE, given the shortness of the overall time frames, has been comprehensive. EMPHASIS India has carried out over 35 different types of training, the majority by local NGO implementing partners of the various types of local actors with whom the project has been working. This training has focused on improving attitudes as much as it has on specific skills and information.

Overall, the training has had three types of effects. The first has been to increase the level of health sector service provision, particularly related to HIV and AIDS, available to migrants and their families, at both source and destination locations. Second, has been the consciousness of most who come into contact with migrants, and have responsibilities for them, that they are humans with rights, and deserve to be treated fairly and justly. This particular applies to actors at the transit locations, where typically migrants have suffered various forms of mistreatment and exploitation.

With regard to these service improvements, the most pertinent question now is whether these improved service levels will continue? Whereas those institutional actors who have their own resources, like the Nepal Border Police, have said they will, and those individual actors who will maintain contact with migrants, like the various transport worker and hotelier peer educators at the transit points, have also said they will continue to provide support to migrants in need, without the continued existence of the drop in centres, and prompts of the local implementing partners, it remains to be seen how much this will actually be the case.

Outcome 3. This outcome focused on advocacy, in particular related to safe mobility issues. The first concluding point to note is that the safe mobility component grew in importance during the course of the project, and particularly within the last two years. This is important given that a migration project that does not focus on safe mobility is not dealing with the primary issues affecting migrants. By ramping up the focus on safe mobility, EMPHASIS made itself more relevant to the day to day issues of migrants, and by doing this established an entry point that also increased their receptivity to information and services around HIV and AIDS prevention and treatment.

Second, this base in action has improved the effectiveness of the advocacy and awareness raising work being conducted at different levels. This is because the advocacy has been based on information being generated directly from migrants and has then contributed to direct action. This helped focus the minds of relevant institutional actors at different levels on finding solutions – whether it be with respect to cross border ART referral, cross-border financial institutional agreements to facilitate the sending of remittances through banks, or on raising the awareness of national and regional actors within the UN and South Asian governments on the health and mobility issues affecting migrants and how they could be addressed.

As a consequence of its basis in action, EMPHASIS has been effective in the regional forums it has held in the last 18 months. Institutional actors have attended because of their interest in learning from EMPHASIS' experience, and the ability of EMPHASIS staff to engage on migration issues and make recommendations from practice. These have included meetings specifically organized by the project including i) a Regional PLHIV and Migration Consultation that brought together civil society and government partners with members of PLHIV networks on the issues of migration, ii) a further Regional Consultation on Migration and Development, organized to share learning at the regional level with a range of UN agencies, UNAIDS, UNDP, IOM, ILO, UN women, academic institutions, government representatives, networks, and researchers, and iii) a regional media consultation held in April 2014 to discuss migrant vulnerabilities, particularly with respect to women, and how the media might improve its coverage of these issues.

With its relevance proved, many of these agencies perceive CARE as an agency that has now established its credentials to represent on migrant issues within South Asia, particularly those issues pertaining to internal migration across borders within the region. But this creates an expectation that CARE will continue to play an advocacy role with regards to these issues – and therefore some dismay that it may not.

Women's empowerment focus

In the latter part of the project especially, EMPHASIS increased its attention to women's empowerment issues, particularly with the spread of the spouse groups in Nepal, and the growing effectiveness of the initiative to encourage the opening of bank accounts, including by women, and for remittances to be transferred safely this way. This focus has brought growing benefit to women, and to the achievement of the project's objectives. With their growing confidence and capabilities, women have been engaging more with their husbands/partners and reinforcing messages and practices around safe sex, HIV prevention and treatment, and safe mobility, as concluded too in the endline survey. This creation of a conversation between women and men, including when women speak to their husbands by phone, is reported by both genders as having an important effect on men especially heeding advice and changing practices.

Recommendations

The recommendations made in the report are of two types. There are some generic programmatic recommendations that relate to any actor who may choose to build on and further the type of migration continuum work that EMPHASIS has initiated. But second, since there also remains unfinished business, CARE itself continues to have responsibilities for work it has initiated, and it is with this that the second set of recommendations is concerned. In this summary, some of the key recommendations are shown. The full list is contained in the concluding section of the report.

Programmatic

1. The overall goal of EMPHASIS was to contribute to the reduction of vulnerability of mobile populations (particularly women) to HIV infection at source, destination and transit sites within India, Bangladesh and Nepal. *To achieve a specific goal such as this with migrant populations, it is essential for any future programming that it is contained within a broader approach focused on the overall safe mobility, rights and empowerment of these populations.*
2. The encouragement and capacity building of service providers to improve the provision of specific health or mobility related services has mostly paid attention to sustainability issues, but in several instances the question of whether the services will persist remains. Many of the directly HIV and AIDS related activities have been institutionalised within government or private sector facilities. *A few critical service activities, listed in the full set of recommendations, remain however, and attention should be paid to how these activities might be sustained.*
3. The role of local implementing partners (IPs), and through them support of community based peer educators and groups (whether self help groups, spouse or support groups), has been critical to the initiation of all local activities in the project. Thus, the continuation of many of these activities is in jeopardy, since the IPs depend on the project funding, and the outreach workers, supporting the peer educators, are on the local NGO payrolls. Peer educators themselves, particularly when they are, for instance, transport workers or hoteliers, who will carry on performing their jobs, have stated

their willingness to continue to conduct IEC activities. However, it will be difficult for them to undertake this for long with no backup support, one to provide IEC materials, and two to provide technical or official support if required. Thus it is important for institutional means to be found to continue the support after the end of the project, and this would be a recommendation for future projects too. For instance, in Nepal, low levels of support to IPs might continue through mechanisms like the VDCs, or through small project funding, to allow a few outreach workers to continue to work with peer educators. *To find more sustainable forms of institutional support to peer educators, is however an important recommendation, not only for the continuation of EMPHASIS's current activities, but for the future spread of the model it has been piloting.*

4. *The benefits to women, men and their families of this additional focus on women's empowerment is clear and should automatically be a part of any future project focusing on issues affecting mobile populations.*
5. Over the past two years, EMPHASIS has raised its regional and national level advocacy work, with the regional team working with national counterparts and partners to organize several regional briefing and advisory meetings and consultations. A total of 30 MOUs with a range of organisations have now been established. *Using these MOUs as a basis, EMPHASIS should seek to encourage public and private institutional actors as fully as possible to commit resources to ensuring the sustainability of services that have been initiated or improved during the life span of the project. Advocacy with government agencies at all levels, reminding them of their responsibilities towards mobile populations should also continue, particularly regarding the health and security of migrants and their families.*

Procedural

This final set of recommendations builds on the concern of many of those interviewed that CARE does not 'abandon' this groundbreaking work that it has started. The below are all seen as measures that are feasible.

6. *It is vital that CARE in South Asia assumes collective responsibility for ensuring that EMPHASIS as a program with vital sets of relationships and activities that have only just started to mature, is not left simply to disappear.* This is important to ensure that the considerable potential now inherent in EMPHASIS is not wasted.
7. There is in addition, the potential to do harm if relationships are dropped where they are at this point in time, especially in some of the more sensitive or complex areas. *The real risks of this happening must be calculated before the ending of the current funding, and mitigation measures put in place.*
8. One achievement of EMPHASIS internal to CARE is that it has raised the profile and importance of programming that has a focus on migration internal to each country, and within the region. *A further recommendation would be that the three country offices continue to have a joint conversation on the subject, preferably facilitated by an ongoing regional secretariat, if there is the funding to continue to support this.*

9. The regional advocacy work that has been undertaken in the last year by EMPHASIS has played a huge role in drawing attention and respect to the ground breaking, piloting role that EMPHASIS has been playing. *Having gained a seat at the table, as it were, it would be a wasted opportunity of being able to influence a range of country and (sub-)regional debates around migration, if CARE were not to keep it. Ongoing means of doing this should be sought. In particular, EMPHASIS staff should engage with UNAIDS and other UN agencies to gain their support for continuing to support the effective mobility continuum initiatives begun by the project.*
10. The work that has just begun on re-interpreting the conditions of the 1950 Indo-Nepal Peace and Friendship Treaty could potentially have hugely beneficial implications for the rights of ALL Nepali migrants in India. *Especially since CARE has been encouraged by senior administrators within the Indian Government to continue this work, because of the extent of its potential impact, this work should continue to be pursued.*
11. *EMPHASIS has been an immense learning experience. If this experience is not to be lost, CARE will need to adopt a programmatic approach to its continuity that encompasses both the countries and the sub-region – a point made by at least two non-CARE interviewees. Any continuity of activities will otherwise be piecemeal, and lose the coherence that has so painfully (and expensively) been achieved over an immensely challenging five years.*

Not all these points may be achievable in the remaining life span of the project, but what is critical is that ‘interregional dialogue’ continues around how to maintain and evolve some of these relationships and strategies, and that opportunities for further funding continue to be sought.

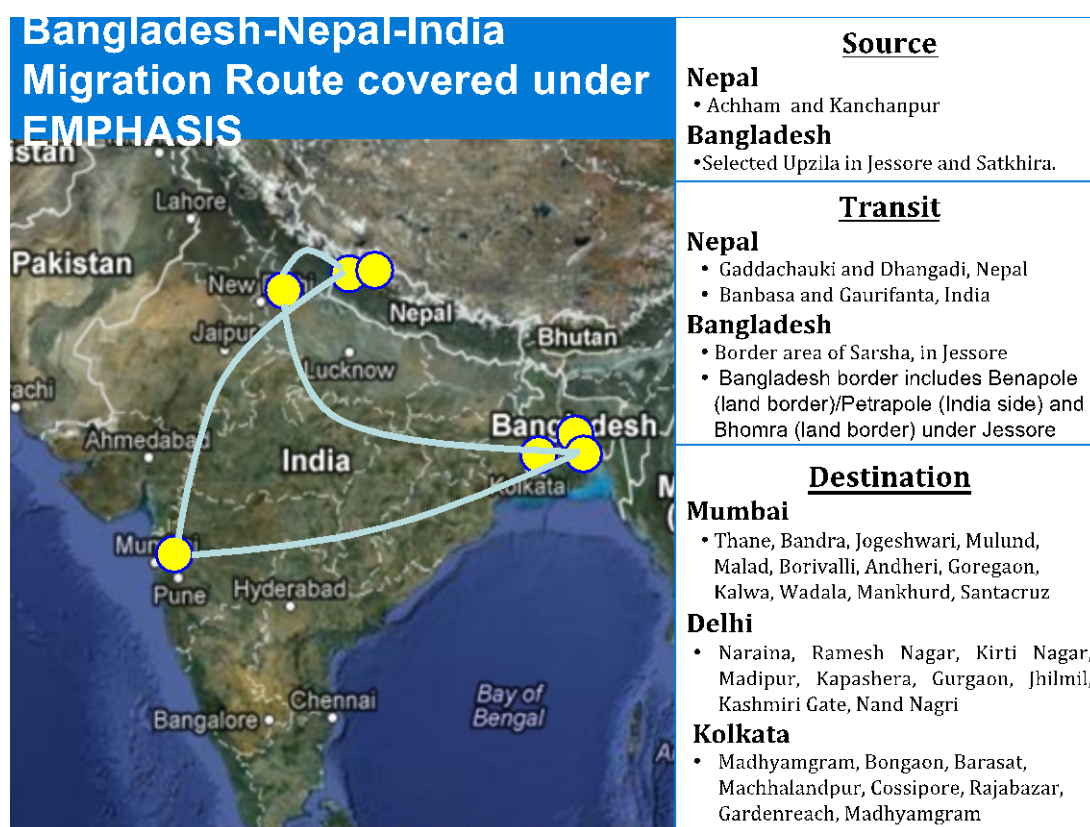
1. Introduction

The EMPHASIS project is a 5 year initiative funded by Big Lottery Fund, UK, which was initiated in August 2009 and is due to conclude in July 2014. It has been implemented in Nepal, India and Bangladesh to address both HIV and AIDS vulnerability and safe mobility issues of cross border migrant populations, who are moving between Nepal and Bangladesh to India and return.

EMPHASIS is a complex project, dealing with difficult issues that affect the vulnerability of migrants moving between countries within the South Asia sub-region. To deal with them effectively, many of these issues require protocols agreed between the governments of the respective countries, and thus also require advocacy at inter-governmental levels. As a result of these complexities, the pilot geographic locations that EMPHASIS has focused upon have been of restricted size. Initiatives, as shown in the figure below, have focused upon the *source* districts of Jessore and Satkhira in Bangladesh, and Accham and Kanchanpur in Nepal. In India, areas within Delhi, Kolkata and Mumbai have been operated within as *destination* sites. Finally, EMPHASIS has also worked within a set of *transit* areas, namely, Bhomra and Benalpole (Bangladesh) / Petrapole (India) and Bhomra (Bangladesh) as a transit site between India and Bangladesh, and then Bhansar (Nepal) / Gourifanta (India) and Gaddachauki (Nepal)/Banbasa (India) as two transit points between India and Nepal. Of these two, the latter is the larger crossing point.

Fig 1.1: Migration Routes focused on by EMPHASIS¹

¹ 'Enhancing Mobile Populations' Access to HIV & AIDS Services, Information, and Support (EMPHASIS): A cross country project funded by BIG Lottery Fund UK', presentation by CARE India, February 2014.



It is fair to say that the EMPHASIS project has been challenging to implement. There were a great many teething problems within the first three years and subsequent challenges still to be addressed, as reported in the Mid-Term Review, conducted in mid-2012.² From the point of view of the final evaluation, what became apparent quickly to the review team was that the management structure and senior staffing of EMPHASIS have undergone a substantial transition within the last two years, with a largely new management and professional team being installed at regional and country levels. This team has made huge strides in turning around the complex project, generating strategy linkages and cohesion, and building institutional relationships and staff and partner confidence, all of which had been less clear at the time of the mid-term review

This report documents the changes that have taken place over the course of the project, but with a specific emphasis on some of the more significant shifts undertaken in the last 18 months. The unique role of EMPHASIS in being the first project to attempt to deal with these complex, cross-border issues dealing with HIV and AIDS and the safe mobility of migrants, is taken into account.

1.1 Objective of Evaluation

The overall objectives for the evaluation are listed below, followed by the overall project goal and outcome areas, which we are expected to assess.

² Prof. S. K. Singh, Ms Nidhi Sharma, Ms Arpita Das, Ms Pallavi Verma and Mr.V.V. Pandey, 2012, Enhancing Mobile Populations' Access to HIV&AIDS Services, Information and Support (EMPHASIS): Mid-Term Review Report.

- Assess the project according to its 3 identified outcomes areas.
- Assess effectiveness and relevance of different interventions.

Overall portfolio goal

To contribute to reduction of vulnerability of mobile populations (particularly women) to HIV infection across selected cross border regions within India, Bangladesh and Nepal.

To achieve the overall goal, there are three portfolio outcomes:

Outcome 1:

By the end of the grant, an effective and integrated cross border model of HIV prevention, care, treatment and support will be developed working with and impacting on a cohort of at least 141,000 direct beneficiaries consisting of mobile populations and their families and target groups at source, transit and destination locations who are vulnerable to acquiring and spreading HIV and AIDS.

Outcome 2:

By the end of the grant, the capacity of at least 30 partner organizations (including regional authorities, government agencies, border police, customs officials, research institutions, NGO, Community Based Organizations [CBO] and key stakeholders) engaged in the project portfolio will be significantly enhanced by 25-30% from the baseline data in order to deliver improved and integrated services to mobile populations vulnerable to HIV.

Outcome 3:

By the end of the grant, there will be increased recognition of vulnerabilities of mobile populations and demonstration of ways to address them in source and destination communities that will inform policies in the area. This will be done by raising awareness of the issue of HIV and AIDs and mobility within the regional policy environment by producing robust evidence based advocacy messages with which to lobby government stakeholders.

Research Questions: Evaluation

Finally, in addition, a more specific set of research questions were also provided to us. These related to the three outcome areas, as well as the overall effectiveness of the project's management.

- To assess whether the strategy of targeting migrants at source, transit and destination has been effective means of addressing migrant vulnerabilities to HIV.
- To what extent have EMPHASIS referral strategies successfully increased access and usage of health services (esp. HIV/STI-related)?
- To what extent do migrant populations targeted by the project perceive the EMPHASIS activities as relevant to their needs?
- To what extent have EMPHASIS-led advocacy initiatives been acknowledged (and/or taken up) by national/ regional level stakeholders and policy makers?
- To what extent was the EMPHASIS intervention able to create a supportive community environment for the impact population?

- To what extent has the EMPHASIS strategy of working directly with migrants, sensitizing stakeholders (community, service provider, private partners) been successful in addressing migrants vulnerabilities?
- To what extent have migrant vulnerabilities been reduced?
- To what extent the capacity building activities with service providers led to improved access and quality services for impact population?
- To what extent has EMPHASIS contributed to the empowerment of migrant women/spouses left at home through its project activities?
- To what extent have the interventions promoted safe mobility and safe remittance?
- To what extent have the range of partnership approaches contributed to the success of the program?

2. Evaluation Methodology and Process

The overall methodology for this evaluation has included both a quantitative endline survey, and a largely qualitative evaluation, being run in parallel. Ideally the endline survey should have taken place ahead of the evaluation study, but owing to time constraints the two processes happened alongside each other.

The evaluation team included three consultants, one of whom focused on India and Bangladesh, and the second, Nepal and the regional component of the work. A third consultant focused more on the gender aspects, and being the only Bengali/Bangla/ Hindi and Nepali speaker in the team, undertook more of the focus group discussions (FGDs).

The evaluation of the substantive program interventions had two main areas of focus.

- i) A critical, appreciative enquiry methodology was used to identify and evaluate project achievements and successes, the programmatic challenges that have been faced, and the extent to which they have been addressed, and in what direction participants would take intervention activities next, if they were able to do so. In identifying project achievements, this component has also sought to analyse the evidence base that has been gathered, and how well an account can be told. Qualitative methods were used for this work, particularly the use of FGDs and in-depth interviews with diverse stakeholders, with a view to being able to triangulate the accounts and perspectives that we were receiving.
- ii) The second area of examination was the effectiveness of particularly the service delivery component of the project, in terms of the appropriateness, quality and effectiveness of the services provided. The effects of other interventions such as safe mobility and safe remittances and advocacy initiatives were also examined. This part of the study used a Likert scaling to examine the views of different stakeholders involved in interventions as users or providers.

Assessing the empowerment of migrant women was also accomplished through gender-segregated FGDs and inclusion of migrant women as a respondent group.

The **organizational and managerial performance** component of the evaluation study, will also be intended to focus on the lessons learned and adaptive challenges identified during the implementation of EMPHASIS with three CARE country offices and multiple partners and stakeholders involved across three countries. This will include the nature and effectiveness of partner and stakeholder relations across the countries, and hence broadly, what has been effective in the overall operation of the program. It will allow the question of the cost-effectiveness of components of EMPHASIS to be commented upon, and the surfacing of key lessons that can be used to guide any future interventions in this arena in South Asia and beyond. For this component the views of staff, partners and a regional UN stakeholder were sought through a series of meetings, focus groups and interviews.

The **Lickert Scale** tool complemented the qualitative data collected in the form of individual interviews and Focus Group Discussions. On completion of interviews and FGDs, those participating were then asked to complete one of four Lickert Scale tools, depending on which actor group they represented. The four tools used were for:

- 1) Impact Populations, which included male and female migrants, spouses, and truckers among others;
- 2) Target groups that included people living with HIV/AIDS (PLHIV) Self Help Groups, Community Support Groups, labour leaders and employers;
- 3) Service Providers including those providing sexually transmitted infection (STI) services, HIV Counseling and Testing, Antiretroviral (ARVs) and other AIDS-related services at both private and government health facilities, and some transport workers;
- 4) Implementing Partners including Peer Educators/Outreach Workers/Drop in Centre (DIC) counselors, NGOs and CBOs as well as CARE EMPHASIS staff.

For each tool, respondents were asked to state to what degree they agreed or disagreed to the statements on a scale of one to five. Five representing 'agree very much', four 'agree', three 'neither agree nor disagree', two 'disagree', and one 'disagree very much'.

Process

The evaluation process has had four overall stages to it.

- 1) An inception stage, during which relevant documentation for the evaluation was gathered, read and used in finalizing the design of the evaluation exercise. This included a review of the Mid Term report. During this stage, discussion also took place with key EMPHASIS staff across the three countries, to reach agreement on the evaluation design and implementation process, and informed by the relevant expertise (HIV and AIDS, gender, migration).
- 2) An operational stage, during which the evaluation team assembled in Delhi, and then conducted country visits in India, Bangladesh and Nepal, as well as interviewed members of the regional team, to incorporate also the regional dimension of the project.
- 3) An analytical stage during which all information was assembled, analysed and synthesized.
- 4) A two stage reporting process, whereby a final report was produced after receiving feedback from the regional project management team, as well as other relevant stakeholders.

3. Endline Survey Findings

Key indicators from the endline survey³ are listed in the two tables below. These tables compare EMPHASIS population with the 2011 baseline and a 2014 control population.⁴

The progress of key project indicators in the below tables are measured using three methods: 1) t-tests measuring the statistical difference of means between the relevant populations, 2) propensity score matching to measuring the average treatment effect (ATE) of EMPHASIS programing, and 3) propensity score matching to measure the average treatment effect on the treated (ATT) of EMPHASIS programing.⁵ The results of the end-line activity clearly demonstrate the success and impact of the CARE EMPHASIS project. The key project and outcome indicators offer strong evidence that CARE's EMPHASIS program has had a positive and significant impact on each of the four key impact populations: India Nepali Migrant Populations (NMP and India Bengali Speaking Populations (NSP) individuals within India and Nepali and Bengali households in the source countries.

Based on the endline findings provided in the below two tables, and those found in the EMPHASIS endline report, CARE EMPHASIS has achieved an effective and integrated cross border model of HIV prevention, care, treatment and support. The endline data repeatedly demonstrate this accomplishment. CARE EMPHASIS Impact population respondents consistently cite; lower risk behaviors; increased knowledge of HIV and AIDS; better health seeking behaviors; and they regularly cite CARE EMPHASIS or its associated EMPHASIS workers, village health workers, or peer educators as the source of this information.

The indicators, taken collectively, show two main findings. One, that migrant populations that have been reached by the project now know more about HIV and AIDS and how it is transmitted and can be prevented, than they did at the outset of the project, and imparted to contemporaries in the control localities at the end of the project. Secondly, and the most significant change, is in their ability to discuss issues related to HIV (and safe mobility) with their spouses. The project has made it feasible for women to undertake dialogue and negotiation within the household with their husbands, where it was not before. Some reference to further endline findings will take place in later sections, but these two main conclusions that are relevant to the evaluation provide a context to our own analysis.

³ Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

⁴ See Endline Survey Report for the methodology used in selecting the control localities.

⁵ A theoretical overview of the propensity score matching methods used can be found in section 2.5 and appendix H. of "Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014."

CARE EMPHASIS key indicators (Nepali Migrant Population (NMP) source and destination)

Indicator	Point Estimates			Difference in means (unmatched)		Difference in means Treatment Effect (ATE)		Regression Treatment Effect (ATT)	
	BL (2011)	EL (CTRL)	EL (IP)	Difference to BL	Difference to CTRL	Difference to BL	Difference to CTRL	BL - EL Treatment	CTRL - EL Treatment
India (NMP)									
Percentage of respondents who can identify at least two major modes of transmission of HIV	75.9	90.0	96.4	20.5***	6.4***	19.7***	20.1***	20.7***	21.0***
Sample size	506	229	96						
Percentage of respondents who reject at least 2 major misconceptions about HIV transmission	88.1	97.8	99.6	11.4***	1.7**	12.2***	19.3***	12.7***	20.1***
Sample size (Respondents aware of HIV and AIDS)	506	229	445						
Percentage of respondents who can discuss HIV with their spouse and partners	24.3	26.0	49.5	25.2***	23.4***	25.4***	35.4***	20***	36.2***
Sample size	383	123	281						
Percentage of respondents reporting having used a condom with non-regular partner on the last occasion of having sex	83.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sample size	61	7	25						
Percentage of migrants currently in India who are provided accident compensation from their employer	4.3	1.2	8.7	4.3***	7.5***	1.5	7.1***	1.7	7.9***
Sample size	530	417	473						
Percentage of migrants currently in India who are provided health care benefits from their employer	6.8	0.7	5.9	-0.9	5.2***	-3.9**	5.4***	-4.1**	5.5***
Sample size	530	417	473						
Percentage of migrants currently in India who receive same type of overtime pay as their Indian counterparts?	65.7	23.7	50.1	-15.6***	26.4***	-23.6***	13.2***	-22.7***	10.0***
Sample size	530	417	473						
Nepal									
Percentage of respondents who can identify at least two major modes of transmission of HIV	91.4	83.3	95.4	4.0**	12.1***	13.9***	14.5***	13.7***	18.2***
Sample size	406	420	435						
Percentage of respondents who reject at least 2 major misconceptions about HIV transmission	90.1	95.7	97.9	7.8***	2.2*	16***	3.3	15.7***	3.4
Sample size	406	420	435						
Percentage of respondents who can discuss HIV with their spouse and partners	49.2	26.8	84.6	35.4***	57.8***	25.7***	66.9***	23.6***	69.8***
Sample size ^t	392	41	52						
Percentage of respondents reporting having used a condom with non-regular partner on the last occasion of having sex	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sample size	4	14	17						

Statistically significant at the 10% (*), 5%(**) or 1%(***) levels

^tThe end-line survey did not ask questions around spousal issues if the respondent stated they had never been in a sexual relationship. In Nepal, upon completion of fieldwork, it was discovered there was a misunderstanding on the definition of "sexual relationship."

N/A – Not available due to small sample size

CARE EMPHASIS key indicators (Bengali Speaking Population (BSP) source and destination)

Indicator	Point Estimates			Difference in means (unmatched)		Difference in means Treatment Effect (ATE)		Regression Treatment Effect (ATT)	
	BL (2011)	EL (CTRL)	EL (IP)	Difference to BL	Difference to CTRL	Difference to BL	Difference to CTRL	BL - EL Treatment	CTRL - EL Treatment
India (BSP)									
Percentage of respondents who can identify at least two major modes of transmission of HIV	62.5	90.3	98.4	35.8***	8.0***	33.5***	35.7***	29.1***	35.5***
Sample size	379	217	368						
Percentage of respondents who reject at least 2 major misconceptions about HIV transmission	35.9	97.7	99.2	63.3***	1.5	57.6***	34.7***	55.4***	35.6***
Sample size	379	217	368						
Percentage of respondents who can discuss HIV with their spouse and partners	22.6	8.3	48.1	25.5***	39.8***	26.2***	39.6***	21.7***	41.1***
Sample size	301	133	258						
Percentage of respondents reporting having used a condom with non-regular partner on the last occasion of having sex	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Sample size	3	11	3						
Percentage of migrants currently in India who are provided accident compensation from their employer	0.3	1.2	10.0	9.7***	8.8***	6.6***	7.2***	9.8***	9.1***
Sample size	324	426	411						
Percentage of migrants currently in India who are provided health care benefits from their employer	0.3	0.9	1.2	0.9	0.3	0.9	0.2	1.8	1.0
Sample size	324	426	411						
Percentage of migrants currently in India who receive same type of overtime pay as their Indian counterparts	66.0	21.8	27.5	-38.6***	5.7*	-35.5***	3.7	-35.2***	4.9
Sample size	324	426	411						
Bangladesh									
Percentage of respondents who can identify at least two major modes of transmission of HIV	66.2	44.7	86.6	20.4***	41.9***	31.0***	51.4***	29.5***	49.8***
Sample size	293	311	438						
Percentage of respondents who reject at least 2 major misconceptions about HIV transmission	46.8	65.3	89.5	42.7***	24.2***	48.8***	41.7***	45.6***	40.5***
Sample size	293	311	438						
Percentage of respondents who can discuss HIV with their spouse and partners	28.6	21.5	58.6	30.0***	37.1***	28.8***	38.3***	29.8***	38.5***
Sample size	273	191	246						
Percentage of respondents reporting having used a condom with non-regular partner on the last occasion of having sex	N/A	30.6	63.2	N/A	32.6***	N/A	2.0	N/A	2.3
Sample size	3	36	45						

Statistically significant at the 10% (*) , 5%(**) or 1%(***) levels

N/A – Not available due to small sample size

4. Evaluation Survey Findings

South Asia Internal Migration Context

Box 1: To Have or Have Not Rights - Bangladeshi and Nepalese Migrants in India

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).

*Samuels et al, 2011*⁶

One of the major complexities of EMPHASIS is that the stories of Nepalese and Bangladeshi migrants in India are completely different; one group of people have legal, if not always acknowledged rights, the other does not. And within EMPHASIS overall, each of the country stories is very different from the other two. As the single destination country, the receiving context in India is obviously very different from the sending contexts of Nepal and Bangladesh. But even as source countries, there is very little similarity in the situation between Nepal and Bangladesh because of the sharp political and legal distinctions. Until now, the Bangladeshi government does not even officially recognize that there are undocumented Bangladesh migrants in India, who have crossed the border without passports and visas. Accordingly, this means that not only are Bangladeshi migrants forced to cross the border with India clandestinely, but once within India they are afforded no legal rights or protection, unless they can secure an Indian registered identity.

In contradistinction, the movement of migrants between Nepal and India is governed by the 1950 Indo-Nepal Peace and Friendship Treaty. By the terms of this treaty, residents of both countries enjoy full reciprocal rights in the other country, except the right to vote. Thus even though there are issues with the lack of recognition of these reciprocal rights, the situation

⁶ Fiona Samuels, Miguel Niño-Zarazúa, Sanju Wagle, Tahmina Sultana and Mirza Manbira Sultana, 2011, 'Vulnerabilities of Movement: Cross border mobility between India, Nepal and Bangladesh', ODI Background Note.

of Nepali migrants in India bears little resemblance to that of Bangladeshi migrants, who, for a start, have no incentive even to acknowledge where they come from.

Accordingly in this analysis, we shall deal with the situation of each group of migrants separately. To being with attention will be paid to the regional dimension of the EMPHASIS program, since this provides a setting to understand the different country accounts. This will then be followed by an analysis of the work with Nepalese migrants and their families, first within Nepal itself, then in India. Finally, the work of EMPHASIS with Bangladeshi migrants will be discussed with respect to first the source locations, and then the destination locations in India.

Following these individual sections, we shall then summarize, in so far as that is feasible, the evaluation findings across the set of research questions and outcome areas.

4.1 Regional Secretariat

The EMPHASIS model for interventions for reaching migrant workers travelling between Bangladesh and Nepal and workplaces in India was designed to be an ‘experimental learning platform’, with the objective of exploring the issues related to targeting this mobile population. Migrant issues were examined from a regional perspective for the first time and approaches were tested in source, transit and destination settings. The objective of exploring these issues was accomplished and there is now data and knowledge on practices that are promising and those that are less so.

Overall, the EMPHASIS project structure consists of three country teams, each operating through a set of local partners, and a regional secretariat. The role that the regional secretariat plays in EMPHASIS is critical to the overall direction, coordination and coherence of the project. Its members are based across the three countries, and this physical distribution in itself helps to connect the work. But more critically, there has been an almost total shift in the composition of the regional team since July 2012, which has resulted in an overhaul of the project’s strategy and relationships. These changes have sharply improved the project’s performance in the last phase of its operation, and are documented below.

The Refocusing of EMPHASIS following the Mid-Term Review

EMPHASIS has been an experimental project, seeking to test new approaches and learn through trial and error. However, when the Mid-Term Review for EMPHASIS was conducted in mid-2012, the team noted some difficulties EMPHASIS was facing in conducting this experimentation. The following were the main recommendations made by the review team in September 2012 for the regional component of the project, but they can in fact be read as a set of overarching recommendations representing their views and being made then for the revising of the project’s strategy.

- Strengthen the strategic management information unit at Regional Secretariat with a centralized data system having the potential to track country wise progress and analyze the process with an element of immediate corrective measures.

- Constitute a regional working group of EMPHASIS consisting of all the three country team leaders, and monitoring and evaluation (M&E) officers, so that any program and service at source, transit and destination can have a better synergy and effective positioning of services.
- Strengthen cross border referrals and continuum of services by integration with private sector service providers, NGOs working with a similar mandate and PLHIV groups working across the border for policy harmonization among the country teams.
- Position EMPHASIS programs and services from a project mode to a program mode fitting into the national framework of program implementation in each member country, which may also ensure sustainability and develop an effective exit plan.
- Strengthen the participation of Local Government in EMPHASIS programs and services to ensure cross border referrals and continuum of services.
- Mobilize UN agencies working in member countries to develop strong linkages with local governments and human rights activists to advocate for the rights and entitlements of migrants, especially focusing at risk reduction of STI/HIV and availing care, treatment and support services at destinations.
- Rope in activists across the three countries, especially legal support groups and rights based activists to develop a knowledge network, which in turn may be helpful in enhancing strong advocacy for the continuum of services at host countries without discriminating by region, religion and ethnicity.⁷

In July 2012, before the Mid-Term Review Report was produced in September, a new overall regional project director for EMPHASIS was hired. When he joined EMPHASIS, he realized that ‘people were reluctant to talk about EMPHASIS because it wasn’t doing what it was supposed to be doing... The documents said we were doing hundreds of activities but there was no clear overall focus’.⁸ There was a need ‘to consolidate the[se activities], reflect back and to re-organize them. For a pilot project like EMPHASIS it was a natural process of learning and adjusting with new ideas to strengthen its interventions. To achieve these new insights the background work of EMPHASIS on the ground, provided ground for further analysis.’⁹ Shortly after, an internal meeting was held in Kathmandu to consolidate EMPHASIS’ work. Existing activities were reorganized and clustered into three areas for clarity:

- women’s empowerment
- access to services (Antiretroviral therapy [ART] referrals, gender based violence [GBV] referrals etc)
- safety and mobility continuum.¹⁰

⁷ Prof. S. K. Singh, Ms Nidhi Sharma, Ms Arpita Das, Ms Pallavi Verma and Mr.V.V. Pandey, 2012, Enhancing Mobile Populations’ Access to HIV&AIDS Services, Information and Support (EMPHASIS): Mid-Term Review Report.

⁸ It should be noted that other senior country office staff also described EMPHASIS as being ‘behind’, lacking clarity (including of roles), and suffering project leadership issues, before the change in management occurred.

⁹ Additional comment by Prabodh Devkota, Senior Regional Project Director, 13 June 2014.

¹⁰ Interview with Prabodh Devkota, Senior Regional Project Director, Kathmandu, 23 January 2014.

The project director also noted that within the team there was a lack of confidence. ‘As the only sub-regional project in South Asia, we were slow (afraid?) in developing the linkages with external stakeholders, especially governments, and projecting ourselves within CARE.’ The reorganization and clearer focus thus helped the rebuilding of confidence. The turnaround in many respects was completed 8 months later when the Regional Advisory Group, which included external stakeholders like UNAIDS, met and approved the revised strategy. This was in early 2013, so that by the time of the evaluation, many of the changes that EMPHASIS has undergone were only a year old.

This context is important since several of the more laudatory initiatives in EMPHASIS have been initiated (especially in Nepal), or become much sharper, in this period since the reorganization. For instance, the spouse groups are key to the women’s empowerment strategy in the source districts and only started in Nepal in early 2013, building on some of Bangladesh’s early experience. The much greater focus on safe mobility, building on some early successes at the transit points, is also a response of the reorganization, including measures like the negotiations with banks to enable migrants and their wives to open bank accounts in Nepal into which money can be remitted from Nepalese migrants in India.

It is important to note that the variety of changes that have taken place since July 2012 include other key personnel changes too. Nearly all members of the regional team came into their positions post the Mid-Term Review, as did the Team Leader in Nepal. With the refocusing of strategy, good progress has been made in addressing the MTR recommendations outlined above. Stronger relations with all three CARE country offices have also been developed, as acknowledged by representatives from them, and clearer decision making combined with greater delegation to the country teams, has aided the more rapid advancement of the strategy. Operating within the remit of the priorities in the refocused strategy, the country teams have been able to be more innovative, but also been required to coordinate and communicate with the technical members of the regional secretariat. This has helped improve the overall coherence of EMPHASIS as well as advance the establishment of broader institutional relationships and linkages. It has also helped ensure that whatever its future beyond the end of its current funding, EMPHASIS will influence the future programmatic activities in all three CARE country offices. Within Nepal, CARE is set to increase its focus on migration issues, and views the work on safe mobility and migrant’s access to services as important starting points for future programming.¹¹ In India too, EMPHASIS has established relationships at the national level that the country office will continue to use.¹²

The regional dimensions of EMPHASIS have been advanced, with the participation of regional secretariat and country team members, along with partners, participating in regional fora, such as the International AIDS Congress in Asia and the Pacific (ICAAP) in 2011 and 2013, and the International Aids Conference in 2012, to engage and influence wider audience including policy makers.¹³

¹¹ CARE Nepal Program Strategy Meeting, April 2014 (facilitated by the evaluation team leader).

¹² Interview with Alka Pathak and Rashmi Singh, CARE India MMT members.

¹³ Information in this paragraph is drawn from the interview with Tahseen Alam, Regional Advocacy Manager, 21 January 2014.

Team members have also met with the AIDS control agencies in each of the three countries - National AIDS Control Organisation (NACO) in India, National Centre for AIDS and STD Control (NCASC) in Nepal, and National AIDS and STD Program (NASP) in Bangladesh. Both the National AIDS Centers Directors in Nepal and Bangladesh have written about the significance of EMPHASIS within broader national frameworks.

Many of EMPHASIS' policy advocacy initiatives have also been informed by its series of policy briefs and research built on its work at community level and with institutions. This evidence based advocacy has enhanced EMPHASIS' reputation and ability to influence regional policy discussions. The following table set out in an advocacy brief describes the projects overall advocacy agenda.

Table 1: Global and regional migration issues shaping the EMPHASIS advocacy agenda¹⁴

<p>Key global migration-related advocacy issues:</p> <ul style="list-style-type: none"> • Positioning migration an integral part of development • Ensuring comprehensive programming and governance mechanisms and funding. • Promoting wider recognition of the existence of cross border mobility and the contributions migrants make to national economies • Ensuring safety and dignity, including stopping violence and harassment of migrants and discrimination at the work place and at health centres • Ensuring wider recognition of HIV vulnerability • Ensuring access to ART for all migrants across the continuum of mobility • Ensuring access to money transfer and banking services • Ensuring social security for migrant families 	<p>EMPHASIS focus areas:</p> <ul style="list-style-type: none"> • Safety and dignity of migrants at source, transit and destination: <ul style="list-style-type: none"> - Domestic violence against women within families - Violence and harassment in transit and at the borders - Violence in the workplace and decent work • Access to facilities and services (universal access to ART / health services; access to education services and adequate housing) • Banking and remittance services for Nepali migrant workers • Lack of identity proofs 	<p>Operating modalities</p> <ul style="list-style-type: none"> • Community-led • Evidence-based to inform internal reflection and program adjustment and to inform external policy dialogues • Jointly planned to influence national / bi-lateral government dialogues plus international agencies and local organisation action • Engaging media as enablers in support of wider influence.
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This regional role that EMPHASIS has begun to play more effectively is challenging in that normally it is a role that UN organisations play that have much more unfettered access to senior government officials and ministers in different countries. In this sense for EMPHASIS to have played a role at all in prodding UNAIDS and IOM on HIV and AIDS and safe mobility issues related to internal migration within South Asia, is an achievement in recognition of the role EMPHASIS has nurtured since the start of the project, but which has come to greater fruition in this final stage. The project has also had recent success in meeting with a Parliamentary group in India (a minister and two MPs) and receiving a receptive audience when talking about vulnerabilities of labour migrants including human rights violations, as well as with the Nepalese Director General of Labour, who promised to take up issues experienced by Nepalese migrants in India in bilateral meetings with the Government of India. Of possible significance too, is the work that EMPHASIS has begun with commissioning a lawyer to reinterpret the 1950 Indo-Nepal Peace and Friendship Treaty for the contemporary period. If the project is able to have this work part of bilateral discussions between Nepal and India, it would be an achievement indeed.

There have been other regional level initiatives too. A Regional PLHIV and Migration Consultation organized by EMPHASIS brought together civil society and government

¹⁴ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

partners with members of PLHIV networks on the issues of migration, one aim being to establish a network to facilitate access to cross-border ART for migrants.¹⁵ Similarly, a further Regional Consultation on Migration and Development was a milestone for EMPHASIS to share its learning at the regional levels with likeminded agencies. The participation from a wide range of UN agencies, UNAIDS, UNDP, IOM, ILO, UN women, academic institutions, government representatives, networks, and researchers demonstrated the significant interest of agencies in having a regional platform to discuss migration issues across the South Asia region. These events have also helped CARE through EMPHASIS to establish a profile as an experienced partner on the issues of migration and development.

With respect to the media, EMPHASIS worked with the Indo-Nepal Journalist Forum to facilitate a cross-border discussion with 30 journalists on issues of safe mobility. Media stories have also been produced in all three countries. An advocacy task force in Nepal has sought to make government more accountable in finding missing people, and in India, children of migrants from both Nepal and Bangladesh were assisted into education, though the small number of 276, means that the importance of this lies mainly in the precedence established. EMPHASIS also organized a regional media consultation (22 April 2014) and brought together journalists and media experts from across the region to discuss on migrants' vulnerabilities with a specific focus on women migrants, the challenges of covering migration and ways to mainstream migration in media coverage.

Altogether 30 MOUs have been established with a range of different institutions, governmental, media, private sector and civil society, all with the intent of further the potential sustainability of initiatives beyond the end of the project.¹⁶

Thus within the last 18 months, significant activity has been conducted at the regional level, which it is important to acknowledge. Yet, to conclude this section, what happens to the work on the Indo-Nepal Peace and Friendship Treaty, as well as other areas where CARE could leverage what has been achieved particularly in the last 18 months, will still depend much on whether any resources can be secured to continue some of these advocacy related activities beyond mid-2014.

4.2 Nepalese Migrants: Source and Indo-Nepal Transit Locations

This section deals with the work of EMPHASIS with Nepalese migrants and their families, first by looking at their experience in source communities in Nepal, and at transit locations between India and Nepal, and then finally at the project's work with them in destination communities in India. As has already been noted, the story of EMPHASIS in Nepal and the transit locations with India has significant differences to that dealing with the experience of Bangladesh migrants in Bangladesh and India that follows. There is a far greater enabling environment as regards undertaking policy measures to improve the situations of Nepalese migrants and their families, and much greater cooperation and responsiveness between

¹⁵ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

¹⁶ Graeme Storer, 2014, Advocacy and Influence, EMPHASIS Learning Series #4.

different offices and ministries within both the Nepal and Indian governments. The account in this section under the different outcome headings illustrates this.

Outcome 1: Integrated, cross-border model of HIV and AIDS prevention

When looked at from the Nepali side of the border, this model has focused on three main components:

- i) Building the awareness of migrants (at transit points), and particularly migrant spouses in source communities, on HIV and AIDS, and the measures required to prevent its spread and ensure treatment, if required. This includes voluntary counseling and testing (VCT) referral and access to treatments services for STIs.
- ii) Addressing stigma and access to services issues for PLWHA in source communities.
- iii) Establishing a cross-border referral system for ART between Nepal and India.

With regard to the first and second components, the project's strategy has involved working with different types of community groups – community support groups, whose members are PLWHA; spouse groups of the wives of migrant workers; and district migrant networks, being the three main mechanisms. All three groups, and particularly the Sachetana Nari Women's Support Group met with in Kanchanpur, that has some 200 HIV-positive members, has done much to address stigma, and improve the awareness and access to services of their members. The Sachetana Nari group was formed in 2008, and since 2010 has been receiving capacity building support through EMPHASIS' local implementing partner. One outcome is that the group is now able to undertake home based care activities amongst its own members. The leadership have also been able to secure funds from the village development community (VDC) to cover members' travel costs if they have to travel outside the district (ie to Kathmandu) to receive specialized treatment services. Further support from the project has helped some members establish their own IGAs. Over 150 of the group's 200 members are currently receiving ARTs from the treatment centre at Seti zonal hospital in Dhanghadi.

Within the spouse groups, wives now urge their migrant husbands on return to undergo VCT and to adopt safe sex practices. Peer educators, supported by the Nepal Environmental and Education Development Society (NEEDS), the Implementing Partner (IP) in Kanchanpur, which is both a source district and the site of one of the two transit points covered by EMPHASIS, are also involved in referring community members for various (particularly STI ,VCT) kinds of treatment services, both HIV and non-HIV related. As noted in the table above, a group of four PEs had collectively referred 25 community members in December 2013.¹⁷

As far as institutional change and policy effect is concerned, by far the biggest achievement of EMPHASIS has been the initiation of a cross border ART referral system, requirement discussion and agreements within the Ministries of Health of both India and Nepal. The numbers of referrals made under this agreement are increasing – between the ART Centre at the Seti Zonal Hospital in Dhangadhi, the main treatment centre in the Far West, with a case

¹⁷ FGD with Peer Educators, Krishnapur VDC, Wednesday 29 January 2014.

load of over 2500 HIV positive patients, and Bayalpata Hospital in Accham District, 100 referrals have been made to at least 6 different urban centres within India.¹⁸ This is a hugely significant breakthrough through the work of both the India and Nepal project teams in enabling migrant workers requiring ART to maintain treatment and thus their chances of survival.

A further part of the model regarding HIV and AIDS prevention has been the establishment of a series of Drop-in Centres (DICs), especially at transit sites. These centres often act as triage points, with Peer Educators and officials not directly associated with the project, referring people there if they need more information and support. The DICs in the transit areas experience high volumes of migrants (see footnote below), and the role they play will be one that will be missed when at the end of the project they are likely to close due to lack of further funding. A potential indicator of satisfaction related to the DICs is the number of repeat visitors to them, especially as 'repeat' often means that the returning migrant is using his/her positive experience from a previous crossing to introduce other migrants to the services and information provided by the drop in centres. The busiest drop in centre at Banbasa, on the Indian side of the border, has had more than 530 repeat visits; at the less busy Gaurifanta crossing, there have been 250 migrants revisiting.¹⁹

The endline indicators for Outcome 1, below, shows considerable success, with more than half of migrants reporting successfully accessing HIV related health services in both countries. For Nepal itself, some doubt was expressed about the validity of the indicator information. However, the indicators themselves throw comparatively little light on the components of the strategy that have been outlined. Primarily, any survey that includes both HIV-positive and non-HIV positive respondents, is unlikely to reveal much about increased access to services of those living with AIDS. Secondly, 68.7 percent of Nepal survey respondents were not migrants themselves, but either spouses or family members.²⁰ Thus in general, the work related to this outcome area appears to have been relatively successful, even if the scale has been limited. The table below reports that a higher, and statistically significant, percentage of EMPHASIS population respondents feel that confidential HIV/AIDS testing is available compared to control respondents. This, coupled with the cross-border ART referral agreements, paves the way for future Nepali HIV positive migrants travelling to India being in a position potentially to benefit.

Table 2: Outcome 1 Endline Indicators

Percentage of respondents believing a confidential HIV/AIDS test is available – disaggregated by gender and by population ²¹					
	Stratum		Regression Treatment Effect (ATT)	Number of observations	
	EL - CTRL	EL - IP	CTRL - EL	EL (CTRL)	EL (IP)

¹⁸ Figures supplied by the project, up to the end of March 2014.

¹⁹ It would be useful to express this figure as a % of overall migrants visiting the centre. From the EMPHASIS Annual Report to 2 August 13, it can be estimated that 88,000 people visited Drop-in Centres in Nepal and at the transit points in 2012-13 (38.5% of a total of 228,700 people who have used these centres since their formation). It is not clear the numbers passing through the two DICs for which these return migrant figures were mentioned.

²⁰ Table 10, Bruce Ravesloot and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

²¹ Table 71: Bruce Ravesloot and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

	(2014)	(2014)	Treatment		
Nepal	26.0	49.9	24.5***	420	435
Female Respondent	16.1	43.0	28.9***	323	344
Male Respondent	58.8	75.8	13.7*	97	91
Statistically significant at the 10% (*), 5%(**) or 1%(***) levels					

Percentage of impact population reporting access to HIV related services – disaggregated by gender and by population ²²		
	Stratum	Number of observations
	EL - IP (2014)	EL (IP)
Nepal	54.5	475
Female Respondent	53.9	371
Male Respondent	56.7	104

Outcome 2: Capacity built of partner and target organizations

In Nepal, the institutional strategy elaborated by EMPHASIS has been both intricate and effective. The project has both worked to strengthen specific organizations, especially the Implementing Partners and those delivering services, but more far-reaching is the networking and linkage strategy that has also been undertaken at the same time – what EMPHASIS has called, the ‘chain of partnership throughout the continuum of mobility’.²³

Altogether in a project note on capacity building, it is stated that the strategy has incorporated the following elements:²⁴

- The building of service provider’s capacities regarding HIV-related services such as STI, VCT and treatment, care and support.
- Capacity building of the two implementing partners in respect of such as gender, management, governance, advocacy, M&E and knowledge management.
- In order to create an enabling environment for the project, communities have been sensitized on HIV and AIDS and safe mobility.
- In order to achieve the desired safe mobility outcome, a range of official and transport related stakeholders at border and transit sites have been sensitized on HIV and AIDS and safe mobility.
- Learning sites have been established to test models, document the ongoing process, achievements and challenges.

The categories of groups covered by the capacity building training and orientation in Nepal are:

Sub-grantees, NGOs and CBOs. This has included ‘Peer Educators training including training of trainers (ToT) and refresher training... trainings, orientation and workshops carried out under safe migration, research and documentation, governance and team building, capability building of key stakeholders, annual review workshops, regional and national level

²² Table 70: Bruce Raveslout and Lloyd Owen Banwart, ‘CARE EMPHASIS Endline Survey Report’, May 2014.

²³ ‘On the Move’, EMPHASIS Newsletter, Vol 6, January 2013.

²⁴ The information below comes from the note, ‘Capacity Building, Outcome 2’, EMPHASIS project, 2014.

of workshops which facilitated smooth operation of program activities. The cumulative numbers for this capacity building of implementing partners accounted for 1414.²⁵

Service providers. Training has covered i) STI and HIV related services, ‘including safe mobility and HIV, cross border ART linkage, stigma and discrimination, legal access and addressing gender based violence and advocacy. In total 707 service providers trained from health sectors, legal service providers, VDC and community level stakeholders.’

In one specific instance in Nepal, two extra staff have been seconded to the ART Centre at Seti Zonal Hospital in Dhangadhi to cover a critical human resource gap. This centre had 2,368 cases on record at the time of the evaluation visit. These staff – bringing the total to four – has allowed the centre to bring their records up to date and to track ‘lost’ cases, which have been reduced from over 100 to 55.

PLHIV Network. In conjunction with local partners EMPHASIS has supported training for income generation orientation, interaction sessions between PLHIV and non-PLHIV, care giver training to PLHIV and stigma and discrimination orientation to PLHIV women. PLHIV groups were supported to identify advocacy issues for higher level. Income generation support such as goat rearing, tailoring, sewing helped PLHIV livelihoods. The previously mentioned Sachetana Nari Women’s Support Group has been one of the major recipients of these different forms of support. In total, 115 PLHIVs were supported through various capacity building activities.

Actor groups at Transit. This training served to enhance capacities to facilitate safe mobility and reduce exposure of families to HIV and AIDS. Groups trained in transit locations have included: hoteliers, Seema Suraksha Bal (SSB) on the Indian side, custom officials, transport workers, trade union representatives, Indian and Nepal Government officials and journalists. ‘Two events of Indo Nepal Government Officials meeting and two events of Indo Nepal Journalists meeting have been facilitated in Bhansar-Gaurifanta transit and Gaddachowki-Banbasa transit in Kailali and Kanchanpur districts respectively. In total 1568 transit stakeholders are engaged in safe mobility issues.’

CBOs/ SHGs/ solidarity group. EMPHASIS has formed 21 community support groups (CSGs), 2 advocacy task forces, 2 migrant networks, and 20 spouse groups. Their capacity development has included various trainings, orientations and workshops, participation in regional and national level meetings to raise advocacy issues, and further meetings and interaction at community level facilitated by these groups and networks. ‘So far, 1657 members from different spouse groups, migrants network, advocacy task forces, community support group's members including communities have been engaged in the capacity development process’, in Nepal source and transit sites.

Table 3: Cumulative figure for total people trained by type at source and transit²⁶

People trained (cumulative) by type	Source	Transit
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²⁵ Project note on ‘Capacity Building, Outcome 2’, CARE Nepal, April 2014. Specific information quoted below is also drawn from this note and includes the Nepal transit areas.

²⁶ Project note on ‘Capacity Building, Outcome 2’, April 2014.

Health Workers	326	0
Volunteers	1739	0
Peer Educators	1478	0
Government Officials / Road ways / customs	276	20
Border officials/ Police		253
Transporters	360	638
Hoteliers	120	251
Spouses	1217	0
Traders / brokers / agents	0	0
Implementing partners	196	0
NGO/CBO functionaries	440	133
Employer and employee / others	0	0
PLHIV	100	0
Community People/Potential Migrants / leaders	373	248
Teacher/ Students / Religious leaders	447	0
Media Personnel	0	25
Migrants / domestic workers / Spouses	46	
Other stakeholders	110	
Total	7228	1568

During the evaluation meetings themselves, it was clear that the capacity building work has taken place in multi-faceted ways, which in a comparatively short evaluation are relatively hard to understand – and therefore almost certainly incompletely so. For example, in trying to address the issue of rickshaw and tanga pullers often being accused of exploiting migrants they transport across the Indian-Nepalese border, EMPHASIS has sought to unionise them. The Nepalese rickshaw pullers have become part of the Federation of Trade Unions (along with the hoteliers), and their Indian counterparts have become unionized too (see Box below). One of the advantages of this, as a Nepalese hotelier Peer Educator said, is that it is then easier for them to work with bus companies and bus transport workers, since they are also FTU members. In this way, and by working with the Nepalese border police, and with local VDCs, as well as the Implementing Partner, EMPHASIS has sought to establish and build the capacity of a network that can continue to facilitate the safe passage of migrants and provide support to those that require it, beyond the end of the project.

In seeking too, to build the capacity of the Implementing Partners (IPs), and groups like the Community Support Groups, the EMPHASIS staff are also seeking to build the capacity and ability of organisations to continue to provide support around HIV and safe mobility issues, in the longer term. Sachetana Nari, the CSG met with in Kanchanpur, has now secured VDC funding support to help with the transport subsidies it provides to members to access HIV/AIDS services, which will help with its future sustainability. For the IPs, GaRDeF has received help in developing a strategic plan, and both have received capacity building support. NEEDS already has more diverse funding, but for both IPs, specific activities they are supporting now like the drop in centres, they are unlikely to be able to continue to do so once the funding ends.

In Nepal, a focus on developing partnerships with official institutions will support the sustainability of some of the activities. The Nepal border police officer that runs the Citizen Help Desk at the Gaurifanta crossing point stated that this desk would continue to provide information and support to migrants following the project (though likely without the same level of IEC materials).

Indian Transit Areas

Although most of the information above refers to the capacity building activities on the Nepalese side of the border, very similar activities have also been carried out on the Indian side. On the Indian side, as noted by the rickshaw puller, much of the capacity building has focused on engaging with transport workers to take more responsibility for the services they provide, and there is a strong focus on safe mobility issues.

Box 2: Indian Rickshaw Puller, Banbasa

For the last 40 years he has been staying here. His father was a government employer, so he is educated to Standard 10. He is very poor and has 4 children. All are studying. The only way for his livelihood is rickshaw pulling. In 2010 the IP partner came to this area. He saw that the project staff had established this office and the DIC. So he interacted with one of the ORWs and said that he would like to work with the project so became involved as a PE. He showed his interest in working; the advantage for him is that he can speak Nepali, so he was given a chance... The issue that was raised at that time was the exploitation of Nepalese migrants by overcharging, and how the returning migrants were poisoned and looted at the transit points. At some point they also focused on women's and girls issues. Some of the concerns were on Nepalese child labour. So I liked these issues that were discussed in the training by BGSVS and I got a certificate to work as a social worker by the District Management. Earlier the situation of Nepali migrants here was terrible, they were harassed by everyone – rickshaw and tanga pullers and officials. BGSVS pointed out that the migrants were harassed, women were trafficked, and child labour. Now the situation has changed. Now the Nepali migrants sit in our rickshaws and the rickshaw pullers have a fixed rate, and each rickshaw a number to stop harassment. They have formed a union and have formed some rules. They cannot take a rickshaw whilst drunk. They are charged for fighting. So if anyone informs the union that someone is driving a rickshaw drunk, the informer receives a Rs500 payment.

With Indian authorities, some institutions have been more supportive than others – the border police (SSB), immigration authorities and Forest Department being more helpful than the Customs department. As the EMPHASIS Partnership Coordinator on the Indian side was open in admitting, the project has received less enthusiastic support from Indian border officialdom than it has on the Nepalese side. And this is scarcely surprising given the vulnerability of migrants returning to Nepal with goods and cash.

There has however been extensive capacity building work on the Indian side – by December 2013, over 96,000 men had been in contact with outreach workers and peer educators at

the Indian transit points (including Bangladesh).²⁷ The full set of capacity building training provided in transit locations in India is listed below.

²⁷ Project spreadsheet on 'Beneficiary Categories and Targets for the Project', March 2014.

Table 4: Types of Capacity Building at Transit Locations in India²⁸

Transit sites - Nepal border		
Title	Duration	Audience
TOT of Outreach Worker (ORW)/PE/Counsellor on HIV, STI, communication skills and counselling	2 days	Outreach workers, Peer educators, counsellors
TOT of peer educators on outreach and service provision	3 days	Peer educators
Capacity building of peer educators	1 or 2 days	Peer educators
Sensitization of Seema Suraksha Bal (SSB) Jawans on migration and HIV	1 day	SSB jawans
Capacity building of health service providers on STI management & referrals	1 day	Health service providers - MBBS doctors
Capacity building of members of Rickshaw union (Community Based Organization) on vocational skills, DIC management, organizational management and team building	2 days	CBO members
Sensitization of Transporters (Roadways department) on safe mobility and HIV	1 day	Transporters - govt roadways drivers and conductors
Training of CBO/NGO members on issue related to PLHIV especially denial, stigma and discrimination	2 days	CBO members, transporters
Sensitization of Hoteliers on safe mobility and trafficking	1 day	Hoteliers
Sensitization of Local Police on safe mobility and trafficking	1 day	Police officials
Meeting with Border Security Force to sensitize them on HIV and Mobility	1 day	BSF officials
Training of NGO partners on Advocacy and Legal Issues	1 day	Partner staff and peer educators

Overall, this is also a strategy that the outcome indicators below reveal little about, though on being able to access HIV related services and having a supportive environment in this regard, the responses do have a high level of positivity.

Table 5: Outcome 2 Endline Indicators

Percentage of impact population reporting access to HIV related services – disaggregated by gender and by population ²⁹		
	Stratum	Number of observations
	EL - IP (2014)	EL (IP)
India (NMP)	83.6	477
Female Respondent	71.0	100
Male Respondent	87.0	377

²⁸ Taken from the excel file on 'Training and workshops_India', EMPHASIS project, 2014.

²⁹ Table 71: Bruce Ravesloot and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

Percentage of respondents reporting a supportive migration environment – disaggregated by gender and by population. ³⁰					
	Stratum		Regression Treatment Effect (ATT)	Number of observations	
	EL - CTRL (2014)	EL - IP (2014)	CTRL - EL Treatment	EL (CTRL)	EL (IP)
Nepal	3.1	8.4	3.1	448	466
Female Respondent	2.9	8.9	3.7	348	370
Male Respondent	4.0	6.3	0.5	100	96
India (NMP)	2.9	3.2	1.9	417	473
Female Respondent	1.4	2.0	-2.0	209	100
Male Respondent	4.3	3.5	2.5**	208	373
Statistically significant at the 10% (*), 5%(**) or 1%(***) levels					

Indicator 2.3 on safe mobility in contrast has a low response. This is likely a reflection of the much broader encompass of safe mobility, the fact that it involves an outward and a return journey, with a range of factors affecting them, and that potential measures to address these issues remain limited in their scope. The issue is discussed in more detail below; there are no additional indicators for outcome 3.

Outcome 3: Addressing of safe mobility issues, including through evidence based advocacy initiatives

The overall advocacy strategy for EMPHASIS has been summarized as having the following core elements to it:

- Address the vulnerabilities migrant populations experience across the mobility continuum;
- Promote safety and dignity by reducing violence and stigmatisation;
- Promote migrants' rights and entitlements and access to services (covered largely under outcomes 1 and 2);
- Recognise women as agents of change (economic actors, rather than dependent spouses).³¹

In this outcome three section, since the focus by EMPHASIS on the safe mobility of migrants, as well as on HIV/AIDS protection and treatment aspects, has been accentuated in the latter stages of the project, we will also look at the strategy itself, in addition to the advocacy element that is emphasized in the original outcome statement. The relationship between the two lies in the fact that critical safe mobility issues identified require an organized response, and to achieve this requires in turn an advocacy initiative.

Altogether, to address (a), the vulnerabilities that migrant populations experience across the mobility continuum, the safe mobility strategy has included the following components:

- 21 spouse groups in source VDCs, who have received information on safe sex and safe mobility. Large numbers of the women have opened bank accounts, so that their husbands can remit money to them, without having to bring large bundles of

³⁰ Table 72: Bruce Ravesloot and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

³¹ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

cash across the border. This has required significant advocacy work over time with financial institutions in both India and Nepal.

- ii) Organisation of implementing Partner PEs and ORWs, including through the unionization of transport worker groups, and advocacy with different actor groups in the transit locations, on both sides of the border.
- iii) 6 Drop-in Centres in Nepal, and 2 in India in the transit areas (covered in outcome 1).
- iv) Establishment by the Nepal border police of two Citizen Help Desks.

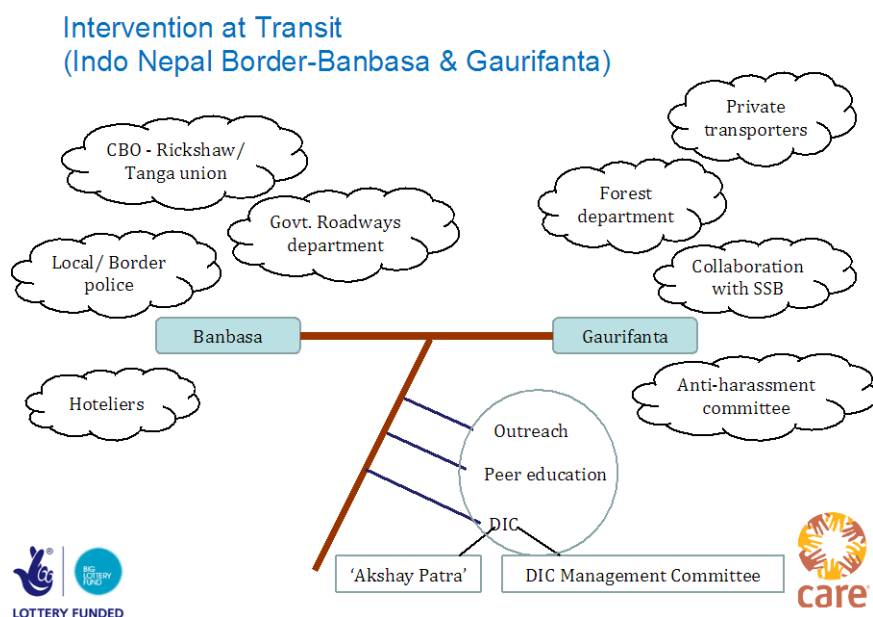
In the two source districts in Nepal, Accham and Kanchanpur, perhaps the single most important methodological shift in the last 18 months has been the addition of spouse groups, drawing upon the approach already used in Bangladesh. These groups, of which there is one per VDC, 21 in all, have provided the wives of migrants an opportunity to organize and start to take a range of collective and individual actions. The groups play a significant role as far as EMPHASIS' achievements with regards women's empowerment are concerned. This covers advocacy area (d), the promotion of women as change agents, as well as (a), the safe mobility continuum. For instance, NEEDS, the IP in Kanchanpur claims that of 556 women spouses in the 11 groups they have formed, over 500 now have bank accounts. This is one of the successes of the project, negotiating both with Nepalese banks to provide migrants with banking services, and with Indian banks, particularly ICICI, to allow Nepalese migrants to remit money through them.³²

Further on advocacy area (a), discussions with banks have included a regional advocacy forum with public and private money transfer agencies to talk about the need to facilitate safe remittances, and to establish the case for making banking services more migrant friendly. A teaming arrangement between the International Monetary Express and the United Bank of India and the Global Bank has been in place since early 2012, and has extended the reach of money transfer services.³³

³² Discussions were held with Ministry of Home Affair, Government of India on issuing advisory to Reserve Bank of India to facilitate opening of bank accounts for Nepalese migrants in India, (Source Manbira Mirza Sultana, 13 June 2013).

³³ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

Fig 4.1: Actors involved in safe mobility work at Indo-Nepal transit locations³⁴



The diagram here shows all the different actors involved in the safe mobility work in the Indo-Nepal transit locations, and with all the institutional groups listed local level advocacy was undertaken – the transport union, hoteliers, border police (all of these on both sides of the border), forest department and SSB (on the Indian side).

With respect to the rickshaw and tanga³⁵ puller transport workers, they have been unionized in order to reach a common agreement on fares, and non-exploitive transport practices. For instance, each rickshaw has a name plate with the rickshaw puller's name and a number assigned by the rickshaw union as a step to reduce harassment. The chairperson of the All Nepal Trade Union has been attending cross-border meetings in India once every 3 months. The TU will continue to support the interventions by the rickshaw-pullers, even after the project closes down.³⁶

In these zones, the ORWs and PEs of the implementing partners on both sides of the border, are speaking with as many migrants as they can at bus stands, and at the points where rickshaw and tanga pullers pick up migrants. Since members of these transport groups are also PEs, they talk with migrants as well en route, as do those hoteliers who are also PEs. Collectively, they also look to assist migrants who have been robbed, or to intervene in cases of vulnerable young women, of which several instances were discussed.

There is also an overlap between the work undertaken on advocacy area (a), with that undertaken on (b), the addressing of violence and stigmatization. The table below

³⁴ 'Enhancing Mobile Populations' Access to HIV & AIDS Services, Information, and Support (EMPHASIS)', Presentation undertaken by EMPHASIS CARE India team, Delhi, 20 January 2014.

³⁵ A tanga is a horse drawn carriage.

³⁶ Nepalese Men, Rickshaw pullers - Part of Rickshaw Pullers Association, Mahendranagar, Kanchanpur, Nepal Date: 15/2/2014.

summarises the advocacy work undertaken in transit areas aimed at reducing the violence and harassment to which migrants are subjected.³⁷

Table 6: EMPHASIS led initiative to address violence and harassment at transit

<i>Specific initiatives</i>	<i>Enabling processes</i>	<i>Results</i>
<ul style="list-style-type: none"> ▪ Establish Migrant Help Desk ▪ Facilitate cross border meetings with government border security staff ▪ Facilitate Indo-Nepal Journalist meeting ▪ Broadcast public radio programme ▪ Document and report cases of violence and harassment and disseminate these with relevant authorities and through above forums 	<ul style="list-style-type: none"> ▪ EMPHASIS project organised several media events at the border to sensitise district authorities to take accountable action on the issues of violence and harassment ▪ Meetings were held with the senior police officer and his team at the border place to establish a citizen help desk ▪ Joint MOUs were developed between EMPHASIS and Border Police to operate the citizen help desk 	<ul style="list-style-type: none"> ▪ Border police 'manning' the Migrant Help Desk are documenting and acting on reported cases. ▪ The number of cases of violence and harassment decreased from 50 plus per day to only 1-2 cases per day ▪ Journalists are monitoring activities to reinforce accountability and sustainability.

Of these various measures, another outcome of the local advocacy work, and a form of support for safe mobility in the transit areas that will remain after the project's closure, are the Citizen Help Desks run by the Nepal Border police, as discussed in the previous outcome section. These will in particular continue to work with the various local union groups – the transport worker groups and the hoteliers.

Overall, progress has been made with reducing travel risk among Nepali migrant workers. Outcomes of the local advocacy work, and the roles of the outreach workers and peer educators supported by the implementing partners, has resulted in EMPHASIS increasing migrants awareness of the risks, ameliorative strategies, and their rights when travelling.

4.3 Nepalese Migrants at India Destination Locations

India is a country of both origin and destination for migrant workers, the bulk of it, according to the 2001 census, involving some 259 million people, being migrants within the same state. In the same census there were 42 million migrants from outside the country, of which Nepalese migrants were the third largest group.³⁸ A great deal of outmigration from Nepal to India was fuelled by the Maoist insurgency which began in 1996, as people sought to escape the violence. However In the 13 years since the 2001 census, with Nepal's agriculture based rural economy remaining comparatively unproductive, the numbers of Nepalese migrants in India will only have grown.

Implementation of EMPHASIS has probably been the most challenging in India, because of the complexity of trying to work with representative sets of migrants, who are scattered in locales across many parts of the country. Although Nepali migrants are widespread, there are however relative concentrations in Delhi and Mumbai, and thus these two cities served

³⁷ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

³⁸ Enisha Sarin, 2013, 'A qualitative study comparing the effects and outcomes of HIV-related interventions for Nepalese migrants – at source, transit and destination', EMPHASIS, CARE Nepal.

as destination centres covered by EMPHASIS. At the same time, the Indian team also supported an implementing partner in two border transit areas with Nepal, as well as one additional partner in West Bengal covering Bangladeshi migrants.

Thus, in its overall strategy in India, the full set of implementing partners for EMPHASIS in five different locations altogether, are shown in the figure below.

Fig 4.2: EMPHASIS Implementing Partners in India³⁹

Name of the NGO	Operational Location	Area	Field Personnel		No. of DIC/CRC
			ORW	PE	
Bharatiya Gramothan Seva Vikas Sansthan (BGSVS)	Banbasa & Gaurifanta	Nepal Border	8	30	2
Modicare Foundation (MCF)	South Delhi, West Delhi & Gurgaon	Delhi-NCR	4	20	2
Anchal Charitable Trust (ACT)	North Delhi, East Delhi, Ghaziabad, Noida	Delhi-NCR	5	23	3
Bhorukha Public Welfare Trust (BPWT)	Border areas around Petrapole and Kolkata	West Bengal	5	16	1
Action Research Centre (ARC)	Mumbai and adjoining areas	Greater Mumbai-Thane	8	37	1
			30	126	9

For this evaluation, in seeking to cover the work of EMPHASIS and its IPs with Nepalese migrants, visits and meetings were held in both Delhi and Mumbai.

Outcome 1: Integrated, cross-border model of HIV and AIDS prevention

Given the wide set of issues affecting migrants, and seeking to reach a large enough sample of migrants for the numbers affected by HIV, STIs and TB to be meaningful, the challenge for EMPHASIS has been to establish an innovative pilot program that is both manageable but also at a scale that is sufficient to permit the range of experimentation required. In addition the scale has to be sufficient for government officials to recognize the evidence based advocacy issues and information are pertinent.

The core strategies implemented in India, similar to Nepal, include social and behaviour change communication, establishing Drop-in Centres and community resource centres, using the media, and linking with health centres and making referrals to them. A key ingredient for

³⁹ Enhancing Mobile Populations' Access to HIV & AIDS Services, Information, and Support (EMPHASIS)', Presentation undertaken by EMPHASIS CARE India team, Delhi, 20 January 2014.

relative success has been the use of mobile information, education and communication (IEC) facilities.

In Mumbai, the implementing partner for EMPHASIS is the Action Research Centre. Of an estimated 10,000 Nepali migrants in their area of operation, they have undertaken outreach to 9,000, including through the use of a mobile IEC and testing van, with 6,000 formally reached or registered. The implementing partner reported that at first cooperation with Indian health facilities was difficult, but has improved over time, and they have been able to arrange separate times for VCT testing for migrants, to avoid lengthy queuing times. The ICTC counselor himself at the municipally run Ninahai Thakre Maternity Home, noted how EMPHASIS had supported him in his role by the community based group counseling that they organize.⁴⁰ Referrals of Nepalese migrants to the centre also come through the project.

In one FGD held in Mumbai, 12 Nepali men participated, aged between 22 and 44, all with their wives in India. The men mostly work as security guards, their wives as domestic workers, receiving very low pay. Before EMPHASIS they had very low awareness of their rights, especially their rights to health services in India, including maternal health. With the information they have received from EMPHASIS, the majority said they have now had HIV tests, and use condoms more regularly. In her comparative analysis study, Sarin (2013) reported that where both husbands and wives were present, the majority of the wives talked about taking their husbands with them for testing.⁴¹ A small group of Nepali women peer educators in Mumbai, who had reached some 700 migrant women in their area, stated that women participants were now more aware and confident of handling situations, and those women met with in FGDs indeed came across as more open, confident and secure. They reported that their relationships with their husbands had improved, as they could assert themselves better. Their life situations were better too, when they also had access to an income, in addition to their husbands.

In Delhi, discussions were held with a mixed group of Peer Educators working with Modicare, another implementing partner, and Nepali male PEs working with Yuva Association, established through EMPHASIS. The latter were all mainly second generation migrants working in food services as cooks or waiters. They remained in India because of better work opportunities, returning to their home towns in Nepal mainly for festivals. They said more people joined groups after street plays or magic shows, and for youth there was a dance program too. They carried out IEC work, supported by a Modicare HIV mobile test van that comes to the slum. Youths will now much more willingly go for testing; altogether their outreach has covered around 1,200 Nepali migrants.

For women, key topics of interest are pregnancy, testing, and their children's safety. Two subjects they brought up related to their own lives were those of GBV, which they said was often fuelled by alcohol, and that of the risk domestic workers face of abuse by their employers. Modicare outreach workers said that around 200 Nepalese women migrants

⁴⁰ Interview with Rashod Umakant, ICTC Counsellor, Ninahai Thakre Maternity Home, Thane Municipal Corporation, January 2014.

⁴¹ Enisha Sarin, 2013, 'A Qualitative study comparing the effects and outcomes of HIV-related interventions for Nepalese migrants – at source, transit and destination', EMPHASIS, CARE Nepal. FGDs conducted in Nepal also supported this finding.

work as domestic workers in their catchment area. They also raised additional issues that largely go beyond the scope of the project – that of schooling for their children, water services, and broader access to health care (although, as mentioned in the regional section, a limited amount of work has been undertaken on access to schools for the children of migrants).

The two implementing partners in Delhi and Mumbai have also played a role in supporting the setting up of the cross border ART referral from Nepal for migrants. This has involved working with the district and national-level AIDS Control Organisations to establish cross-border referral procedures, and then working with staff in hospitals near project locations to gain their support. By strengthening linkages to PLHIV networks, HIV positive migrants are also able to access support groups, nutrition services and other services available through civil society actors.⁴²

Across the three countries, and different locations, the thirty eight Drop in Centres/ community resource centres serve a variety of roles and functions, sometimes more or less effectively. Some of the more vital in India are the five in Delhi, that have come also to serve as cultural centres for Nepali migrants. This is described well in the text box. In Delhi, the Gender Resource Center, Naraina, has had the backing of EMPHASIS to support women self help groups to establish microfinance activities, and has assisted in the provision of ID cards for women. Over a three year period they have also had 4-5 training sessions, each lasting 3-5 days.

Box 3: Cultural Role of Drop in Centres in India (relevant in outcome 1)

In Delhi, the DIC is not only a service provider but also a cultural center and a place to get together, thus fostering notions of unity and bonding among the Nepali migrants. The DIC provides information about HIV and AIDS, safe mobility, and referral services . Alongside, the DIC in Delhi also holds religious functions and cultural events of the Nepali people. In one particular DIC in Delhi, the interviewers observed dance classes being conducted for children of migrants. Additionally, the respondents' narratives about the DIC reflect the social capital generated by the promotion of these events, which, along with the provision of help and support in times of emergencies, have perhaps facilitated the utilization of services offered there. This is borne out by the evidence that except for three who were infrequent visitors, all the respondents in Delhi have visited the DIC to avail of the services. *Enisha Sarin, 2013*

Altogether, across all the India sets, the following table shows the number and type of referrals undertaken by the project.

⁴² Graeme Storer, 2014, Reducing HIV Vulnerability, Policy Brief #1, EMPHASIS.

Table 7: EMPHASIS in India

Referrals

EMPHASIS in India (Up to Year 5 Quarter 1)			
Number of people referred to various services			
Type of service	Male	Female	Total
ICTC/ PPTCTC	2993	1243	4236
STI	756	916	1672
OI/ART	65	33	96
Nutrition support/ PLHIV network	13	13	26
TB / DOTS	131	44	175
General health	708	573	1281
Govt. Schemes	62	42	104
Legal Support	12	12	24
Others	231	99	330
Total	4976	3013	7989



Outcome 2: Capacity built of partner and target organisations

A relatively full description has already been provided of the capacity building training provided in Nepal at source and Indo-Nepal transit locations. The two tables below show the full range of similar types of training carried out at destination and transit locations in India with implementing partners, service providers, government officials, and different CBO groups (the project was responsible for forming 15 CBOs and SHGs in India). Similar trainings were provided for both Nepalese and Bangladeshi migrants.

Table 8: Types of Capacity Building at Destination Locations in India⁴³

Destination - Mumbai, Delhi and Kolkata		
Title	Duration	Audience
TOT of ORW/PE/Counsellor on HIV, STI, communication skills and counselling	2 or 3 days	Outreach workers, Peer educators, counsellors
Capacity building of peer educators	3 days	Peer educators, volunteers
Capacity building of health service providers on STI management & referrals	1 day	Health service providers - MBBS, MD doctors; Govt frontline workers - Auxilliary Nurse Midwife (ANM), ASHA workers
Capacity building of NGO/CBO members on vocational skills, DIC management, organizational management and team building	1 or 2 days	Local NGO/CBO members/ SHG/ solidarity groups, Members of residence welfare associations
Capacity building of CBO/NGO members on issue related to PLHIV especially Denial, Stigma and discrimination	1 or 2 days	Local NGO/CBO members/ SHG/ solidarity groups, Members of residence welfare associations
Sensitization of domestic workers on rights and entitlement, and issues of violence and harassment	1 day	NMP domestic workers
Sensitization of employees and employers on rights and entitlements of Nepali migrants	1 day	Factory workers, supervisors, factory owners, NMP workers, individual employers/contractors
Sensitization of local Police to sensitize on issues and rights of migrants	1 day	Local police officials
Meeting with police to sensitize them on HIV and mobility.	2 day	Local police officials
Sensitization of transporters on rights and entitlements	1 day	Truckers, transport owners, drivers, conductors, private transporters
Sensitization of transporters on HIV and safe mobility	1 day	Truckers, transport owners, drivers, conductors, private transporters
Sensitization of religious leaders on STI, HIV prevention and condom use	2 day	Maulwi, pandits
Sensitization of brokers, agents for safe mobility and HIV	1 day	Brokers, agents
Capacity building and Orientation of PLHIVs on care and support	1 day	PLHIV network members, Nepali migrants
Training of youth group on life skill education, interpersonal relationship	1 day	Community youth including migrants
Vocational training for women groups	1 day	Women group members
Training of NGO partners on Advocacy and Legal Issues	1 or 2 days	Partner staff and peer educators

⁴³ Taken from the excel file on 'Training and workshops_India', EMPHASIS project, 2014.

The full effect of these capacity building activities has been to draw attention to the issues of Nepalese migrants in India, and particularly to remind Indian service providers that they are entitled to full access to health and other services in India, as per the 1950 Friendship Treaty. Second, by working also with implementing partners and community groups, service providers have valued the all-round support provided by EMPHASIS, especially the range of outreach activities established. These have acted as both an information and a screening device. In Mumbai, the integrating counseling and testing centers (ICTC) counsellor at Ninahai Thakre Maternity Home stated that seven out of ten migrants given referral slips come to the hospital for VCT, suggesting the system is effective.

Box 4: Yuva Youth Association, Delhi

In Delhi, a mixed gender youth group (Yuva Youth Group, Naraina), with members between 18 and 28 years, said that through support, they had been able to undertake the following set of activities:

- Learnt how to strengthen youth group and organize cultural events
- Spread information in the community on hygiene and gender based violence
- Provided letters to local authorities to have lights installed in the slum area
- Progress had been made in helping women have babies in hospitals rather than homes
- The implementing NGO helps them obtain identity cards
- People in the community know their rights better and can talk more about problems and can take action with respect to them
- Dealing with issues like identification cards, security and water provides an opening for them to talk also about HIV
- Medicare, the implementing NGO, supervises them and suggests changes in their approach and also comes when there are problems to solve
- Some personally are inspired to be social workers in the future after their volunteer work with project.

Overall numbers reached by the project may remain relatively low, but for EMPHASIS, the value of the activities lies in their demonstration of ways in which migrant health access and other rights can be met in ways that are feasible, and the scale is sufficient to demonstrate this.

Outcome 3: Addressing of safe mobility issues, including through evidence based advocacy initiatives

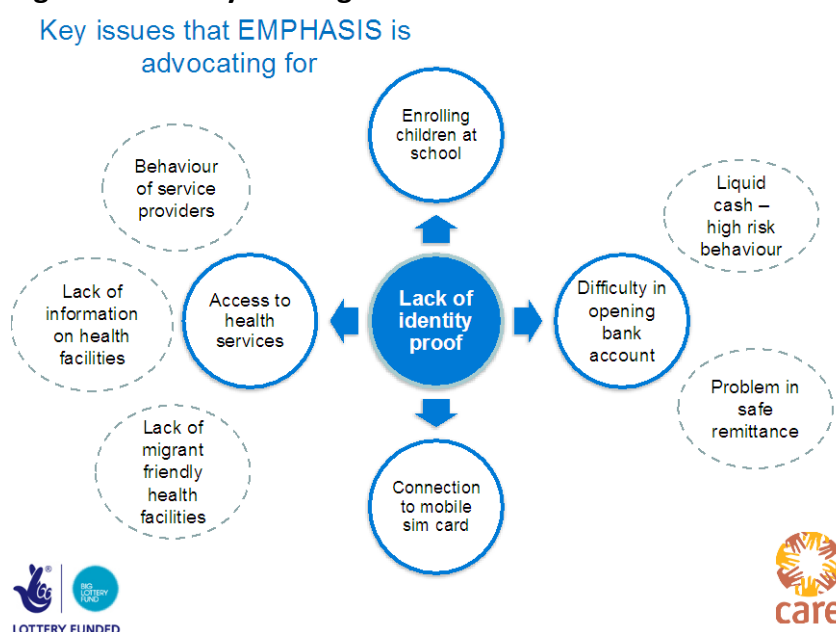
Focus group discussions with Nepali migrants helped show the range of issues they face in their lives, including those of safe mobility. In Thane, Mumbai one discussion was with a group of eleven Nepali single male migrants sharing a single room. They mostly work in small hotels, a few as security guards. All had migrated to India for economic reasons, since India has more employment opportunities than Nepal, though one had come for medical treatment but then stayed on to work. Most came with contacts of family or neighbours in Nepal who were migrants. Although they were legal migrants, many had also used the help of intermediaries, who had to be paid. Despite being legal migrants, they did not have any citizen status, and their experience was one of being harassed unnecessarily by the Indian police. Some earned daily wages or weekly salaries, whilst others were paid monthly,

depending on the nature of the work. Their expenditure was mainly on rent, food, and remittance to their families in Nepal. They stated their salaries are lower than local people and that their employers always try to keep them under pressure, and keep them suppressed.

In Delhi, some of the safe mobility issues for migrants whilst in transit that were raised by Modicare included: migrants being cheated by bus companies; touts taking advantage of migrant workers whilst travelling; the need for migrants to be advised to carry small bank notes (since Indian Rs 500 and 1,000 notes cannot be exported into Nepal), and to carry receipts for electronic goods. They also noted that transit issues provides an opening to discuss HIV issues with migrants, who are hesitant at first to discuss such an issue.

Altogether, some of the key issues for which EMPHASIS are advocating in India are shown in the figure. The lack of proof of identity sits at the centre of these issues. For the most part, for Nepali migrants, the issue can be resolved by Indian service centres accepting Nepali identity cards, which they are legally obliged to do. This requires informing service providers of migrant rights and their obligations. However, if migrants lack a formal proof of identity, then they may need to be assisted in gaining an Indian identity card.

Fig 4.3: Advocacy issue agenda in India



One of the major outcomes of this advocacy has been the addressing of the safe remittance issues. Some of the broader discussions held with financial institutions have been described in the Nepal source section, but the Indian team participated in these discussions too. At a city level, the Action Research Centre in Mumbai has worked with 12 migrant women groups to establish savings groups and help them open individual bank accounts since then. Altogether, in Delhi there were in 2012 about 40 people who remitted money from the localities where the project works and in 2013 the number had risen to 300 in Delhi. In Mumbai, where the project works with many more Nepalese migrants, the number of people rose from about 5000 to 7000 in 2013. The amount of

money remitted by these migrants rose from INR 30,600,000 (\$ 510,000) in 2012 to INR 82,000,000 (\$ 1,366,666) in 2013 from all these locations in India.⁴⁴

Another advocacy activity undertaken in India has been to establish MOUs with 4 Nepalese community-based organisations (Nepali Sanskritik Pariwar Bharat, Help Nepali Mission, Pravasi Nepali Sahyog Sansthan and Pravasi Nepali Sangh) for them to continue awareness raising activities after the closure of the project to their large membership bases. These Nepalese associations have also directly taken on lobbying activities. For example, the United Nepali Organisation in Mumbai wrote to the Director General of the Department of Labour, Ministry of Labour Employment, Nepal to lobby for acceptance of Nepali identity cards in India, and simplification of remittance procedures. Similarly, the Delhi State committee of the Migrant Nepalese Association also wrote to the Director General asking him to lobby for action around acceptance of Nepalese identify cards in India, access to bank accounts at destination, and formal employment contracts.⁴⁵

In India, there were several monitoring visits from NACO and State AIDS control societies in several states or cities – Delhi, Mumbai, West Bengal, Uttarakhand and Uttar Pradesh, covering both the destination and transit sites - as well as meetings organized with key officials of NACO and M/DSACS to improve coordination and health systems response .⁴⁶ For instance, following the two day regional consultation on migration in South Asia that EMPHASIS hosted in July 2013, bringing together senior government officials as well as representatives from migrant networks, UN agencies, international and local NGOs and civil society organisations, a follow up meeting was arranged with NACO from India, and NCASC from India. The officials at this s meeting discussed strategic challenges and points of collaboration across the border and how NACO and NCASC might formalize and scale up the cross border ART referral mechanisms developed by EMPHASIS.⁴⁷

4.4 Bangladesh Source and Transit

In the previous section we explored the experience of Nepali migrants and the issues that affect their and their families' lives at source in Nepal, in transit on both sides of the border crossing with India, and at destination sites in Mumbai and Delhi. Compared with Nepalese migrants, the experience of Bangladeshi migrants in India is a much more difficult one. Neither government recognizes the legality of Bangladeshi migrants travelling without passports and visas – and those from poor households migrating in search of work, will not be doing so. Since there is an absence of government level support systems, migrants depend upon networks, usually kin or community based. For a Bangladeshi migrant travelling routes into India and return, migration is costly, since they often have to pay brokers to cross the border, with high risk. Since without documentation it is difficult for Bangladeshi migrants to access services in India, they are also highly vulnerable, including if they contract infectious diseases. This also affects them on return, since again they have not

⁴⁴ Project note on, 'Supporting Safe Remittance for Indo-Nepal Cross-Border Migrants', 2014.

⁴⁵ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

⁴⁶ Comment added by Prabodh Dovkota, Senior Regional Project Director, EMPHASIS.

⁴⁷ Graeme Storer, 2014, Advocacy and Influence, Policy Brief #4, EMPHASIS.

been regarded as a population that might need some more focused attention. ‘Not in a complete sense, but to some extent EMPHASIS proved that there are alternatives to save people’s lives. Thus, it is important for stakeholders to think about these alternatives.’⁴⁸

Outcome 1: Integrated, cross-border model of HIV and AIDS prevention

In order to understand the premise of the Bangladesh component of the EMPHASIS work, the key point to understand is that before the project began there was limited, specific HIV-related treatment facility for migrants within health systems in Bangladesh, because of the lack of official acknowledgement of their status and HIV vulnerability. Accordingly, the main intent and achievement of the work in Bangladesh was to ‘demonstrate more sustainable potentials as most of our interventions have been implemented through Government’s existing health system such as VCT, integrating STI/HIV prevention into community clinics, establish and use community support group members as peer educator etc. However, it was not a typical project. It was seen as a learning platform that lasts five years’.⁴⁹

Project coverage. In one setting in Jessore, 5-6 Peer Educators each work within 1-2 villages and reach about 300 people each. Altogether EMPHASIS operates in two unions out of eight in Jessore, a major source zone for migrants. An estimated 23% of the migrants in Jessore have been covered. As the slide below shows, the total coverage is of a significant number of people in the context of piloting work.

Table 9: Area and Population Coverage as of December 2013

Implementing Partners (2)	Right Jessore	Ad-din Welfare Centre
No. of districts (2)	Satkhira District	Jessore District
No. of Upazila (6)	Satkhira sadar, Kolaroa, Debhata (3)	Jhikorgacha, Jessore sadar, Sharsha (3)
No. of union (26)	12 Unions (out of 31)	14 unions (out of 93)
No. Of village (242)	114 villages (493)	128 villages (1434)

By January 2014, the total impact population reached with health education was 82,008 (long term 45,516 and short term 36,492 truckers-Bangladeshi and Indian), with approximately 20 of this population being women. Definitionally, ‘long term’ includes returnee migrant, circular migrant and spouses left at home within the project implementing areas who can be found in the community, whereas truckers and their associates are reaching only once at transit points.⁵⁰

⁴⁸ Comment made by Prabodh Devkota, Senior Regional Project Director, 3 April 2014.

⁴⁹ Dr Jehangir Hussain, Program Director of Health, CARE Bangladesh, Revised interview notes, 15 April 2014.

⁵⁰ Prokriti Nokrek, Technical Coordinator, M & E and Documentation, HIV Program, CARE Bangladesh, email 29 April 2014.

Progress in establishing community level services. The establishment of STI services in Community Health Clinics at the community level, Union Health and Family Welfare Center (UN&FWC) at the union level and a VCT system for HIV testing in Government district hospitals in Jessore and Satkhira was a major accomplishment of the project. This means that the provision of STI services in community clinics has now become part of the government plan. Thus, even though it took a long time to establish the HIV counseling and testing services at the government hospitals, full commitment to the continued support of the services, created where there were none previously, has now been obtained. This is in part because of the relatively high figure of migrants going for VCT who have been found to be HIV positive – 38 people, including twenty three women, out of 2184 tested for HIV at the Jessore and Satkhira government hospital VCT centre (1.7%). EMPHASIS is now advocating for the government to create a counselor position to take over counseling and testing from the EMPHASIS supported staff once the project ends; the arrangement will take time to be finalized within the government.

*Reflecting the quantitative data collected, 72.5% of Bangladeshi Population Participating Impact Population said they had access to health and support services (HIV-related). There was no data from the baseline to compare with. A noteworthy 6.3% percent (IP in Bangladesh) said they had access to health services at both source and destination.*⁵¹

Community support showing potential. A further more significant achievement of the project was in terms of engaging existing Community Based Organizations and creating Community Support Groups (CSG) that included community leaders like business leaders, Imams and teachers. By building the capacity for collaboration of these groups the potential for sustainability is greater and more cost-effective than creating a network of project outreach workers. As explained in the text box below, the Community Support System model (CmSS), is a model that CARE Bangladesh has developed in conjunction with the Government of Bangladesh. It is a model increasingly being rolled out across the country, which seeks to improve both the interaction between community user groups and government health services, as well as the accountability of those service providers. One importance of the model is its potential to ensure better that service providers cater more effectively for the priority needs of the community. Another benefit of the CSGs is that at the end of the project they provide an option to continue the work of the Peer Educators. During 2013, community clinic staff were also trained to provide HIV and STI information and STI treatment, as part of an improved community engagement process. These topics will be

Box 5: Use of the Community Support System Model (CmSS)

One of the great changes in health system of Bangladesh during last 5 years, the GoB created one Community Clinic for average 1000 households or 5 to 6 thousand populations. Using learning from CARE's CmSS model---GoB establishes 03 Community Support Groups under each of Community Clinic catchment areas. GoB provides different capacity building training to the CSG members. EMPHASIS used these existing CSG members to disseminate the HIV messages and act as referral agents. These CSG members and community clinic service providers were found effective to refer the VCT clients and also to disseminate the HIV prevention messages. EMPHASIS uses the CmSS model at the later part of the implementation but it may need some more time to document the effectiveness.

Dr Jahangir Hossain, Program Director of Health, CARE Bangladesh, email 15 April 2014.

⁵¹Table 69: Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

returned to at the end of this section.

*For Bangladesh migrants, the endline survey showed a significant increase in condom use with the last non-regular partner among Bangladeshi Population Participating Impact Population (BSP/PIP) from a 33.3% in the baseline to 64.4% in the endline.*⁵²

Demand for convenient HIV testing growing. On a further encouraging note, 70% of migrant workers working in India participating in a FGD in Bangladesh, said they underwent HIV counseling and testing, and Outreach Workers also notice an increasing demand for testing.

A key issue in returned migrants and their spouses actually going for testing was that of the distance to the two VCT centres, with only 14% of 3,878 referrals going for testing in Jessore.⁵³

Including truckers and border complexities. Transport workers are one of the groups who have cross border mobility and whose risk behaviour practices at the transit points makes them vulnerable to HIV and AIDS. Both Bangladeshi and Indian truck drivers cross the border every day, and often have to wait there 3-10 days to get the customs clearance they need to cross. This makes them highly vulnerable to unsafe sex practices. With no current initiative in place, the International Transport Federation (ITF) expressed their interest in conducting a joint initiative with EMPHASIS to address the HIV and AIDS risk vulnerability of transport workers, through intensive awareness and a sustainable health service program. An MOU was signed between CARE, Ad-din and RIGHT Jessore, the two implementing partners, and ITF on 1st December 2011.⁵⁴

Altogether since then truckers have become a significant population reached by EMPHASIS' implementing partners, as shown in the table below.⁵⁵

Table 10: Numbers of Truckers Reached, February 2012 – January 2014

Type of Transport Worker	Ad-din	Right Jessore	Total
Bangladeshi Truckers	13015	7322	20337
Indian Truckers	11568	4587	16155
Total	24583	11909	36492

At the border crossing points there are now 6 outreach workers (4 at Jessore, 2 at Satkhira) providing IEC advice and materials. Although the distance that truck drivers have to go for VCT remains an issue – the site was 40 km away, and in one FGD only 4 of 14 truck drivers and loaders had gone for testing – it is clear that to others the access to advice has been life changing. The account below of Akhil provides one such case.⁵⁶

⁵² Table 31: Bruce Ravesloot and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

⁵³ Rehena Khattun, Monitoring and Evaluation Officer of Ad-din Welfare Centre in Jessore, February 2014.

⁵⁴ 'Annual report on Collaboration among CARE EMPHASIS project and Bangladesh Transport Association and International Transport Federation', February 2012 – July 2013, CARE EMPHASIS.

⁵⁵ Ibid

⁵⁶ Ibid.

Box 6: Akhil's Story

According to him, "I became an undisciplined person by injecting drugs and visiting sex worker on a regular basis. I was infected with STI and suffered from illness. Once a boy from my village (son of an influential person in his village) was injured and at that time that influential person was badly looking for a donor who has O negative blood. A group of people came to me to ask for blood donation. I was worried about blood transfer, because I had unsafe sex with multiple partners in the brothel and was suffering from STI. Finally I donated blood to this boy. Few days later one of the ORW of EMPHASIS project conducted life skill session with me and delivered information about HIV, STI, safe migration and condom use. I have visited VCT center for HIV testing and the test result was negative. Now, I have developed a good contact with EMPHASIS outreach worker. I often visit Drop in Center and gaining knowledge about safe mobility and HIV. I also stopped visiting brothel and sex worker after getting information. I want to lead a happy life for the rest of my life".

Drop-In and Community Resource Centres. The strategy to develop Drop-In Centres (DICs) in Bangladesh was adjusted. In the source communities, there was limited demand, due to both location and the limited scope of the centres, and they have since been turned into Community Resource Centres, that have still been playing a role. Beyond the end of the project, the functions of the CSGs are likely to overtake the role of the CRCs, which will be discontinued.

However, at the border transit point, where truckers may be forced to wait for several days, the two DICs have been more effective. At one crossing point, set up in a driver's union office, over 2,200 mainly Bangladeshi drivers visited the centre in a 15 months reporting period to May 2013. A part time STI clinic operating out of the centre also attracted truckers, since this service they could access on site.

Reaching women. In the Jessore and Satkhira sites, nine spouse groups were formed with 15-20 members per group. With the relatively low prevalence of HIV in source communities, the women were often more interested in non-health issues like family violence and dowry. 'Non health issues like early marriage, trafficking and economic problems were of greatest interest among women'.⁵⁷ Some of the groups created savings schemes.

With other issues as potential entry points, the spouse groups did deal with HIV awareness and protection issues too, and all the women in the SHG interviewed in Bangladesh had gone for HIV counseling and testing. They also inspired their husbands to go and test their blood. 'Our wives are now more open now and talk more freely', a Bangladesh male migrant said in a FGD. A truck driver added that he got a 'big lecture on fidelity' after his wife attended a group session in Jessore.

*Reflecting the progress in improved couple communication found in the qualitative data, Bangla Speaking Women who can "discuss HIV with spouse" more than doubled from 22.6% to 48.1% from the baseline to the endline.*⁵⁸

⁵⁷ Rights Jessore Outreach Worker in FGD, February 2014.

⁵⁸ Table 2: Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

Behaviour Change Communication (BCC) increasing awareness. The EMPHASIS BCC strategy involves a combination of interpersonal communication, distribution of printed materials and events like street theatre. The network of Outreach Workers, Peer Educators and partners like youth groups and CBOs conduct interpersonal communication on a one on one basis and in small groups often using flip charts to stimulate discussion. ‘

*Knowledge of two modes of transmission rose to a large degree among Bangladeshi people from 66.2% in the baseline to 86.6% in the endline. There was a similarly large increase in the ‘rejection of misconceptions’ which rose from 46.8% in the baseline to 89.5% in the endline.*⁵⁹ *Events like dramas set the stage for interpersonal communication.* Street dramas, magic and puppet shows had been seen in almost all settings visited by more than half of Impact populations participating in Focus Group Discussions. It was noted in a FGD that, ‘the dramas had a huge impact and increased the support for Peer Educators’.⁶⁰

Using a broader health model. Finally, in this section, a return is made to an issue that arose a few times in the evaluation discussions. There was agreement amongst many stakeholders that the EMPHASIS model in Bangladesh had been expensive at source sites – not the transit points - because of its singular focus on HIV and AIDS. If CSGs focus on a broader range of health issues, following the CmSS model, which CARE has used elsewhere in Bangladesh.

One comment made by an experienced HIV and AIDS researcher in Bangladesh sums this up: ‘We need to steer away from HIV a little bit, in order to bring HIV into the picture... It needs to be put into a broader picture.’⁶¹ CARE’s Health Program Director also concurred with her view, when it was sent to him in an email, ‘Regarding Tasnim Azim's comment... I am in agreement with her comments... For any future program, I would strongly recommend to use CmSS model for developing community based referral and health including HIV message dissemination mechanism, rather [than] creating vertical outreach workers and peer educators as it may not be sustainable’.⁶²

This is a more cost effective approach, and thus is an appropriate lesson to be learned. Nevertheless, in its capacity of establishing collaborative relations with the Ministry of Health and with NASP, getting the two VCT centres established, and temporary clinics for STI diagnosis for truckers, and simply for putting the health needs of Bangladeshi migrant workers on the agenda, EMPHASIS has achieved some vital results in this outcome area.

Outcome 2: Capacity built of partner and target organisations

The approach of EMPHASIS in Bangladesh to capacity building has been quite different from the model used in Nepal, with a much stronger focus on health systems strengthening, and much less of a focus on safe mobility issues. This is illustrated in both the figure and table below. The first diagram illustrates the more recent focus on starting from the base, with a focus on establishing community support groups (CSGs), and then linking them to both governmental and non-governmental health systems providers. As discussed above, the

⁵⁹ Table 2: Bruce Ravesloot and Lloyd Owen Banwart, ‘CARE EMPHASIS Endline Survey Report’, May 2014.

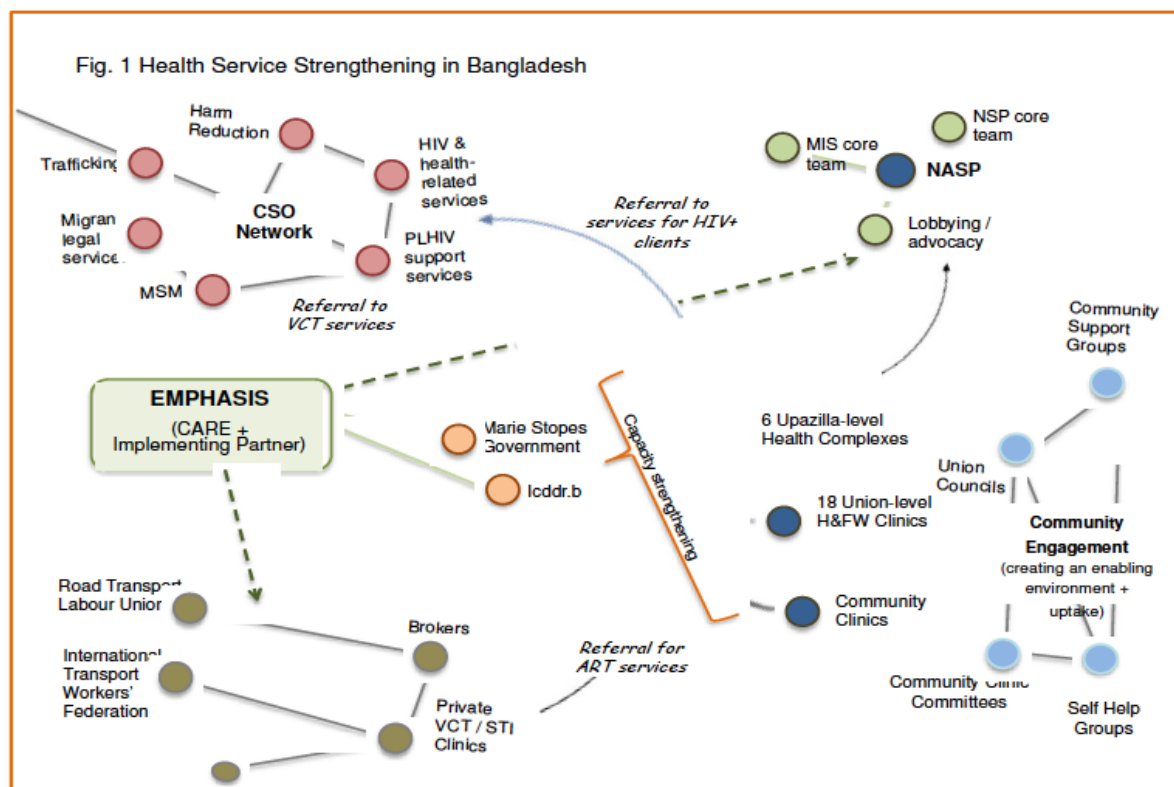
⁶⁰ FGD with Peer Educators, Basantapur, Jessore February 2014.

⁶¹ Tasnim Azim, Director Centre for HIV and AIDS (icddr,b), Bangladesh, 13 April 2014.

⁶² Dr Jahangir Hossain, Program Director of Health, CARE Bangladesh, email 15 April 2014.

focus has been on VCT and STI detection and management, and with a more effective system and interface between community groups and health services set up, for the CSGs this focus now needs to be broadened to incorporate a wider range of health issues. Overall, our evaluation concurred that the help provided through EMPHASIS to develop both management and technical skills was well appreciated. ‘Our technical assistance through our coordinators increased the quality of services’.⁶³

Fig 4.4: EMPHASIS’ Approach towards Health Systems Strengthening in Bangladesh⁶⁴



The table below shows the depth of the health systems strengthening capacity building. A lot of this work undertaken was basic ground work, largely hidden. It is fair to ask about the cost-effectiveness of this work, an issue already discussed to some extent in Outcome 1, with the conclusion that the capacity strengthening undertaken, particularly of community based institutions, pays off much more once there is a broader health focus.

However, there is also a second way of looking at this. The work undertaken on developing and strengthening VCT services and STI syndrome management is also paying off in terms of many more STIs being identified and treated successfully. And with respect to HIV and AIDS, the government now has a much better sense of the fact that HIV positive levels are higher amongst migrant workers travelling to India than they are amongst other categories of the population, and thus this group – and especially truckers – needs to be added to the at risk demographic categories, and paid more attention. The levels of health systems strengthening that have taken place in this regard have been relatively expensive for a project like EMPHASIS to achieve – but if this strengthening had taken place entirely within

⁶³ ibid

⁶⁴ Graeme Storer, 2014, ‘Reducing HIV Vulnerability’, EMPHASIS Learning Series #1.

the framework of a government health systems strengthening program, it would have been considered effective and relatively cheap at the price.

Thus there are different metrics that can be used for reviewing this work, and as long as CARE is to continue to carry out policy and institutional strengthening work, based on the relationships it has established, and leverage the CSG capacity building at community level more effectively, then it can be argued, that as a learning initiative, the investment has been worthwhile.

Table 11: HIV and STI capacity and systems strengthening in Bangladesh⁶⁵

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

There remain some questions about the sustainability of the new VCT and related health systems activities established in government. Part of this is budgetary, and the time it takes a government bureaucracy to go through a budgeting cycle, in order to confirm (or not), whether it can afford to take on the funding of activities initially supported through external funding. All indications, as for instance confirmed by NASP,⁶⁶ is that the government are buying into the achievements that have been made, and will seek ways to continue the services.

⁶⁵ Graeme Storer, 2014, 'Reducing HIV Vulnerability', EMPHASIS Learning Series #1.

⁶⁶ Dr Husain Sarwar Khan, Line Director, Bangladesh National AIDS and STI Program (NASP), Interview 13 April 2014.

Outcome 3: Addressing of safe mobility issues, including through evidence based advocacy initiatives

In Bangladesh, even though estimated remittances were equivalent to 14% of GDP in 2012 (second only to earnings from the garment sector,⁶⁷ the challenges of Indo-Bangladesh relations means that the portion of these remittances being returned from India still do not attract official recognition. This has minimized EMPHASIS' ability to tackle safe mobility issues beyond those related to HIV and AIDS vulnerability. Even for an area like remittances, Bangladesh migrants are forced to use from amongst a number of informal measures, as the text box below shows.

Box 7: Remittance Mechanisms for Bangladeshi Migrants

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

Graeme Storer, 2014, Advocacy and Influence, EMPHASIS Learning Series #4

Crossing the border itself presents many challenges, and it has not been possible for EMPHASIS to make nearly as much progress with issues as it has been India and Nepal. Points raised by CARE's Health Program Director on this are as follows:

- EMPHASIS has met with Bangladesh border agencies at national level but with limited success
- Illegal activities around border crossing benefits both sides
- Border issues like bribes are sensitive issues not dealt with and with no concrete progress
- More political dialogue with the government side is needed to change laws.⁶⁸

Accordingly, much of EMPHASIS work sought to draw attention to the challenges faced by migrants through the safer vehicle of focusing on their vulnerability to HIV and AIDS. At the local level, EMPHASIS and its implementing partners proved to be effective in engaging community leaders and union level political leaders to gain policy support for establishing HIV related services and creating a supportive environment. This local level advocacy also resulted in a reduction of stigma towards People Living with HIV and AIDS.

At the national level, the EMPHASIS team was invited to contribute to a national strategic planning meeting to incorporate migration into Bangladesh's 7th National Strategic

⁶⁷ Graeme Storer, 2014, 'Advocacy and Influence', EMPHASIS Learning Series #4.

⁶⁸ Dr Jahangir Hossain, Program Director of Health, CARE Bangladesh, email 15 April 2014.

Development Plan. This invitation in itself ‘was extended as recognition of EMPHASIS’ contributions in the field of migration and development and acknowledgement of the advocacy issues that had been raised by EMPHASIS’.⁶⁹ Credit was also extended to EMPHASIS by several UN agencies – UNGASS, UNAIDS, UNDP and IOM – for their efforts to raise the profile of internal migrants in the region and the vulnerabilities they face. In Bangladesh, for example, the new NASP Director lauded the achievement of EMPHASIS in helping the establishment of two government VCT centres in Jessore and Satkhira, and had just attended a round table discussion on migration, acknowledging that much more work needed to be done to address the health related issues of migrants and their families.⁷⁰

Nevertheless, in many respects this is a dialogue that is really only just beginning, and on that score EMPHASIS’ main contribution has been to nudge the issue to the table. The Director for the Centre for HIV and AIDS noted that the project was the first implementing study to try and address migrant issues with respect to HIV and AIDS. ‘And we always suspected it that it would be very hard to deal with people who are illegal. What you can do is try and work with them when they come home and are not stigmatized. What [EMPHASIS] have shown is that you can do this, but the numbers they have reached are quite small (of the potential reach)... [though] they are just at the point of being able to leverage their work more broadly. EMP has made contacts now with a whole group of people. They really shouldn’t lose their network.’⁷¹

4.5 Bengalis at India Destination

If it has been a testing time for EMPHASIS to make headway on migrant issues in Bangladesh, in India it has been yet more challenging, as the box below makes clear.

Box 8: Policy Context for Bangladeshi Migrants in India

There is no treaty or policy that allows Bangladeshis to migrate to India for livelihood opportunities, and large portions of the shared border are fenced on both sides and tightly regulated. As a result, undocumented migration is often the only option for people traveling to unknown destinations in search of work (Sultana et al. 2011). Still, for decades, India has received a constant inflow of unacknowledged migrants from Bangladesh. These migrants generally find work as cheap labour in the informal sector, often as domestic helpers, day labourers, rickshaw pullers and rag pickers (Sikder 2008; Blanchet 2006). Migrants in Bangladesh travel across the border with the aid of a network of brokers that spans across both sides of the border. The brokers claim to assure safe arrival at destination; some promise a job upon arrival. But while a contract between the migrant and the broker may be established, the journey across the border can be dangerous. There are often hidden deals and bribes between brokers and border patrol personnel that leave women particularly vulnerable to exploitation (Sultana et al. 2011). Because of the large number of undocumented migrants, at times a controversial shoot-on-sight policy has been enforced by the Indian border patrols (Rao, 2011). Bangladeshi migrants are able to “assimilate” into West Bengal because of shared historical and socio-linguistic ties, though for the majority, their illegal status means they live in constant fear of getting challenged by authorities. Graeme Storer, 2014, *Advocacy and Influence*, EMPHASIS Learning Series #4.

⁶⁹ Graeme Storer, 2014, ‘Advocacy and Influence’, EMPHASIS Learning Series #4.

⁷⁰ Interview with Dr Husain Sarwar Khan, Line Director, NASP, Bangladesh, 13 April 2014.

⁷¹ Tasnim Azim, Director Centre for HIV and AIDS (icddr,b), Bangladesh, 13 April 2014.

One of the first challenges for the project in India was simply to identify Bangladeshi migrant populations. Few migrants would acknowledge they were openly from Bangladesh – and therefore undocumented in the country. Many try and obtain Indian national identity cards (through brokers), and if successful in doing this have no incentive at all for revealing their migrant status. Thus, in general, the project sought to work essentially with Bangla speaking population groups in West Bengal, Delhi and Mumbai. Once relationships had been established, outreach workers could often learn more fully about the status of individuals, but the main point was that the project was often not working with formally identified migrant groups, but those that were likely to be, but would certainly be cautious in discussing their undocumented status and would much rather be seen as being Bengali than Bangladeshi.

Outcome 1: Integrated, cross-border model of HIV and AIDS prevention

For the above reasons, it was more difficult to identify and reach Bangladeshi migrant workers in India, than it was Nepalese migrants. There are very few existing Bangladeshi community based organizations while there are many that are active and thriving on the Nepalese community side. ‘They are not interested in meeting in groups or forming CBOs,’ stated the project coordinator of the implementing partner, Action Research Centre in Mumbai. CARE Bangladesh’s Health Director also pointed out:

- There is tension between India and Bangladesh migrants
- There are more expectations for making progress with Nepalese migrants in India, whose rights are legally recognized
- Bangladeshis in India are hard to find and you cannot do the same work with them as with Nepalis.
- It is a challenge getting services with dignity for Bangladeshis in India.⁷²

As noted in the Learning Series documentation, EMPHASIS, ‘in collaboration with government service providers, organised health camps and mobile VCT services to reach out to populations that might not want to come forward to government hospitals or clinics, or who were unable to get time off from work during the day. Where there were no readily accessible government services, the project linked private practice doctors and other service providers into the mobile health camps.’⁷³ These ICTC camps in Mumbai, Kolkata and Delhi helped identify HIV+ Bengali-speaking and Nepalese migrants and to link them to services. They also provided primary care services and families and reproductive health services for women (Behera et al. 2013). In Mumbai, for example, a total of 238 Bengali-speaking migrants attended 9 mobile ICTC camps, established in conjunction with the state AIDS control society (MSACS); 8 (equal to 3.4%) were found HIV positive and referred to hospitals.⁷⁴

‘We now know more about HIV, TB, condoms and risk from sex with sex workers’, a Bangladeshi migrant to India said in a FGD. ‘They were not aware of HIV before’, a Peer Educator relates. ‘They are now more aware and now talk openly’.⁷⁵

⁷² Dr Jahangir Hossain, Program Director of Health, CARE Bangladesh, email 15 April 2014.

⁷³ Graeme Storer, 2014, ‘Reducing HIV Vulnerability’, EMPHASIS Learning Series #1.

⁷⁴ Ibid.

⁷⁵ FDG with 9 Peer Educators supervised by Modicare in Delhi, January 2014.

In this context, the role of the implementing partner outreach workers was important, requiring sensitivity. In the Learning Series documentation, Sadia, a young Bengali-speaking woman in Mumbai, describes the complex responses she experienced when her husband and then her baby died of HIV-related complications and how the gentle persistence of the outreach worker – ‘you can live life like everyone else’ - helped her move forward. As peer educator for the women’s group in her community, Sadia’s social status has improved considerably, and she has now developed new hope and confidence.⁷⁶

Box 9: Sadia’s Story

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

Sadia, female peer educator in a Bengali speaking community in Mumbai

Focus Groups with Bangladeshi Migrants. The FGDs with Bangladeshi male migrants, both in India and in Satkhira, Bangladesh, provided a picture of their lives in India. In Mumbai, a discussion was held with 5 Bangladeshi men ranging in age from 22 to 45,⁷⁷ all from the border area of Bangladesh and who stated they had been in India for at least 10 years. Their occupations included being tailors in factories, construction labourers and brick layers. All stated they are paid below the market rate paid to Indians for 8 hours labour 6 days work a week. Half were married to women working in garment factories and the other half to women back in Bangladesh.

Their contact with the project was through an outreach worker of the Action Research Centre, who came to the community clinic and gave talks, held meetings for discussions and distributed leaflets and booklets in English and Bangla, from which they had learned and remembered how HIV was contracted. They were provided guidance on using condoms and all had seen a magic show two months ago in an open space in the neighborhood, attended by 1,500 people, which covered the importance of being careful and safe sex.

Changes they discussed that had taken place as a result of the project were that:

⁷⁶ Graeme Storer, 2014, ‘Reducing HIV Vulnerability’, EMPHASIS Learning Series #1.

⁷⁷ FGD with Bangladeshi migrant worker men in Bangalipura Wadala, Mumbai, January 2014.

- They talk about different relationships
- They know more about HIV, TB, condoms and risk from sex
- They are aware of precautions to take, like not sharing needles and HIV testing
- Women now go to health facilities for births while most had babies at home before.
- Women also talk more openly and freely now.

In another FGD with 21 Bangladeshi migrants, aged between 18 and 38 years, who had returned home to Satkhira, it was clear that most intended to return to jobs they had in India, so that, despite the difficulties, their pattern was one of circular migration.⁷⁸ As a group they highlighted the traumas involved in crossing the border. It was best not to cross at the river as a land crossing is easier. If you are arrested crossing illegally, you can spend seven months in prison, and even if you pay a broker to cross it does not always work. In India, a third had been arrested by the police because they were from Bangladesh. Outside officialdom, they had not experienced few problems in India, though on occasion they can be beaten if revealed to be Bangladeshi.

Altogether they said that EMPHASIS had helped them with health and other issues, including help with passport and legal papers, and that they had more trouble sending money home before. They had received some useful information on travelling and safe mobility.

There was a discussion amongst the evaluation team on the project's decision not to target female sex workers from Bangladesh, since they are a vulnerable group and four of the 17 people testing HIV positive at the Jessore VCT centre were female sex workers. However, in India there is a large NACO program focused on sex workers, and as the EMPHASIS team states, working with sex workers requires very specialist interventions. In terms of cost-effectiveness, working with the truckers at the border crossing points between India and Bangladesh can be argued to have yielded greater returns, since the numbers of truckers reached – some 36,500 by January 2014 – is high for a comparatively inexpensive intervention. VCT access at facilities in India and Bangladesh was of course open to women migrants whether spouses or sex workers, and the results of the testing in Jessore show that women were using the service.

A significantly high percentage, 84.8%, of Bangla Speaking Population Participating Impact Population (BSP/PIP) believe confidential HIV/AIDS testing is available to them. There was no data from the baseline to compare with, while 69.1 percent of the control population felt confidential HIV/AIDS testing is available.⁷⁹ A significant 40.3% percent (BSP-India) said they had access to health services at both source and destination.⁸⁰

In terms of additional benefits to women, women also reported from FGDs increasing condom use also for family planning (ie dual protection) purposes, and in India, there was a statement in one FGD that, 'Women now go to health facilities for births while most babies were born at home before'.⁸¹

Outcome 2: Capacity built of partner and target organisations

⁷⁸ FGD with Bangladeshi migrant men, Basantapur (East Para) Devhata, Satkhira, Bangladesh, February 2014.

⁷⁹ Table 44: Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

⁸⁰ Table 69: Bruce Raveslout and Lloyd Owen Banwart, 'CARE EMPHASIS Endline Survey Report', May 2014.

⁸¹ A Bangla speaking woman migrant in India said in a FGD in Kolkata, January 2104.

Information on the capacity building activities of EMPHASIS in India and its achievements was provided in the section on Nepali migrants in India. Now that key lessons have been learned, and the work has just reached the stage where it can be leveraged more broadly, one note on it was by the project coordinator for Bhoruka Public Welfare Trust in Kolkata: 'CBOs and NGOs want interventions to continue as they are just beginning to have success; it took such a long time to get going'.⁸²

Outcome 3: Addressing of safe mobility issues, including through evidence based advocacy initiatives

'Large numbers of Bengali-speaking migrants are living and working in conditions of poverty, and social instability that predispose them to HIV, tuberculosis and other health risks. The sensitive political environment with respect to Bangladeshi migrants and the absence of high-level dialogue makes it extremely difficult to highlight issues and concerns of Bangladeshi populations.'⁸³

Given the constraints faced by the project in interacting with Bangladeshi migrants in India, EMPHASIS itself has tried to understand their situation further, in part by undertaking an anthropological study of Bangladeshi migrants in India.⁸⁴ There is broad agreement that there needs to be more political dialogue at a senior level between the governments of Bangladesh and India to change laws and create a more supportive migration environment and reduce HIV risk. The absence of a legal treaty between Bangladesh and India similar to the one between Nepal and India is a major obstacle clearly leads to the disrespect of the rights of Bangladeshi migrants, to which under international law they should be entitled.

Broaching this kind of sensitive political issue, is however more a job for the UN than an international non-governmental organization (INGO), one reason UN agencies were respectful of the work EMPHASIS was undertaking. It was thus also an especial – and even to regional staff, a surprising – success when working with Women Power Connect, they were able to facilitate a consultation with Indian federal parliamentarians in Delhi on Vulnerabilities of Labour Migrants – Challenges and Way Forward in December 2013. The one-day consultation discussed vulnerabilities faced by migrants, the challenges around accessing migrant rights, gaps in laws and policy frameworks and potential schemes for migrant workers (such as ID cards and health insurance schemes). A second meeting was facilitated with parliamentarians in Bangladesh.⁸⁵

Safe mobility issues. Although there was not a large focus on this component with the Bangladeshi migrants, there was a reporting by migrants for them becoming more self-confidence through being more aware of their rights, as well as increasing their awareness of their vulnerability to HIV. 'There has been a positive change in attitude and they are more

⁸² Supata De, Project Coordinator for Bhoruka Public Welfare Trust, Kolkata, January 2014.

⁸³ Graeme Storer, 2014, 'Advocacy and Influence', EMPHASIS Learning Series #4.

⁸⁴ Arijita Pal, Shweta Damle, Dipika Banerjee, 2012, Bangladeshi Migrants in Mumbai: Cases from Wadala and Kalwa, CARE EMPHASIS.

⁸⁵ Tahseen Alam, Regional Advocacy Manager, 21 January 2014, and Graeme Storer, 2014, 'Advocacy and Influence', EMPHASIS Learning Series #4.

aware of prevention'.⁸⁶ In particular, there was mention of receiving support in resolving money transfer problems and not losing cash whilst they were travelling across the border, and with receiving help from outreach workers with passports and legal papers.⁸⁷

The strategy of dealing with common challenges faced by migrants like money transfer, border harassment, identification papers and use of health facilities, created a level of confidence between the project and the impact populations. 'Before they felt like aliens now they feel cared for'.⁸⁸ 'Now they feel more comfortable they can handle situations. All had misconceptions and fears before. Now that fear is gone.' That confidence also opened the door for dealing with the more difficult and sensitive issues like HIV, STIs and sexual risk behavior. 'No one listened in the beginning as they didn't want to hear about HIV'.⁸⁹ Overall those migrants who had contact with project activities had a positive reaction and found it relevant to their needs. 'It was a useful project that brought about important changes'.⁹⁰

Bangladesh Conclusion

Despite the limitations of EMPHASIS regards reach, it was encouraging to note that one third of male migrant workers participating in FGDs in Bangladesh had contact with project activities in India in different Indian cities. Thus, even though there are many more Bangladeshi migrants who need support, in terms of establishing a clearer issue agenda, EMPHASIS has helped to achieve this. The broader question for CARE is what it does now, especially given that seeking to persuade the Bangladesh government to pay greater attention to the situation of their citizens migrating to India, is something that will require working largely through allies, such as regional UN organisations, and networks, and require diplomatic skills. Whilst CARE's expertise may lie more at the practical level of developing a clearer understanding of the issues and means of supporting migrants, it will need the diplomatic allies who can support policy issues at a national level, on a step by step basis. For CARE to continue any of this work further, will require new funding beyond the end of the EMPHASIS project. There might be challenges for securing this, especially for as fraught an environment as faced by Bangladeshi migrants in India. If the work does not continue, however, it would be a loss of a considerable understanding of critical rights issues that affect several million people. For a start, there is not even a close approximate figure for how many Bangladeshi migrants there are in India. A 2001 census put the figure at 3.1 million, an 'official' figure endorsed in a UN Department of Economic and Social Affairs (DESA) report released in September 2013 – and immediately rejected by the Government of Bangladesh. The Government of Bangladesh (GoB) still claims there has been no migration to India, except during the independence conflict in 1971, when 10 million people left, and all returned.⁹¹ The Government of India itself recognizes as legal citizens all Bangladeshi's who resided in India before Independence from Pakistan in 1971. Since then the figures are guesstimates. The 3.1 million figure rejected by the Bangladesh Government is the low figure, other estimates made range from between 15-20 million people.⁹²

⁸⁶ Outreach Worker in Kolkata, Bhoruka Public Welfare Trust, January 2014.

⁸⁷ FGD with Bangladeshi migrant men, Basantapur (East Para) Devhata, Satkhira, Bangladesh, February 2014.

⁸⁸ Outreach Worker working for Modicare, Delhi, FGD, January 2014.

⁸⁹ FGD with Peer Educators working with Rights Jessore, February 2014.

⁹⁰ Male migrant worker participating in a FGD in Basantapur, Satkhira, Bangladesh, February 2014.

⁹¹ Financial Express, Dhaka, Sunday September 15, 2013.

⁹² http://en.wikipedia.org/wiki/Bangladeshis_in_India

It is a very significant human rights issue that CARE through EMPHASIS has at least managed to throw a little light, even if still rather dimly.

5. Research Questions Summary

This section of the evaluation report seeks to reconcile the distinct accounts of EMPHASIS with regard to its separate Bangladeshi and Nepalese streams of institutional relationships and interventions. In addition to the three outcome areas the evaluation team was asked to report on a series of research question that cover all the outcome areas but ask for additional information and detail as well. This summary considers these questions.

Research Questions

- *To assess whether the strategy of targeting migrants at source, transit and destination has been effective means of addressing migrant vulnerabilities to HIV.*

The strategy of targeting migrants at source, transit and destination increases the chances of the different HIV issues affecting a mobile population at each point being identified, and then mechanisms being established to address these. In the case particularly of cross-border ART referral, this has involved complex, institutional linkages being established in both India and Nepal, through the national Ministries of Health. This has allowed an agreed inter-country protocol to be established, whereby Nepali migrants already on ARTs in Nepal can now be referred to appropriate health institutions in India, to continue to receive treatment. Although these protocols were initially established with health care institutions in Delhi and Mumbai, already the ART Centre at Seti Zonal Hospital in Dhangadhi, Nepal, has made referrals to health institutions in Bangalore, Chennai, Punjab and Gujarat as well. A small number of referrals have also been made back from India, with a total of 100 being made so far in both directions.

On the destination side, the story is more complicated, since it is harder to reach significant groups of migrants, especially with respect to undocumented Bangladeshi migrants in India. Nevertheless, Nepalese migrants, who have often formed associations, have been reached, and in FGDs in Bangladesh itself, a third of returning migrants said they had also been involved in EMPHASIS activities in India. What has undoubtedly been the case is that understanding of the context of migrants situations in India has been much better understood, and some approaches, such as the use of mobile ICTC units to reach migrant populations, as well as appropriate policy issues, can now be put on the table, as a result of the experimental work undertaken.

At the transit points, the numbers of people reached have been high, since all migrants passing through the selected border crossings can potentially benefit from the safe sex messages and contraceptives being provided by Peer Educators and the Drop-in Centres. At the crossing points between India and Bangladesh, over 37,080 truckers have been reached, with a mobile STI clinic at one crossing point proving of particular value.

In the two source districts in Nepal, the numbers of male migrants seeking VCT services and accepting safe sex practices, largely through the intervention of their wives, has increased, whilst in Bangladesh, through the support of EMPHASIS, two government hospitals have established VCT hospitals in centres near the India border that are significant sources of migrants. The late adoption of community support groups (CSGs) in Bangladesh, rather than the original outreach worker and peer educator model, has also made the approach to reaching migrants families more likely to be sustained after the ending of the project, particularly if wider health issues are incorporated within the purview of the groups.

Altogether, the unique strategy of EMPHASIS in targeting migrants in all three locations has yielded a range of valuable practical and policy related lessons on how to reduce vulnerabilities to HIV and other STIs.

- *To what extent have EMPHASIS referral strategies successfully increased access and usage of health services (esp. HIV/STI-related)?*

Awareness raising activities linked to referral mechanisms adopted by EMPHASIS, including using peer educators and outreach workers, as well as specific crowd drawing mechanisms like street plays or magic shows, and in some locations drop in centres, has increased the numbers of people going for VCT counselling. The percentage of people referred actually going to testing centres has been highest where the centres are close to where people live – in Kanchanpur, Nepal, and at sites in India, and rates have been lower, though still significant, where distances are greater, as in Bangladesh.

The diagnosis and treatment of Sexually Transmitted Infections at community level health facilities has met with success, especially at transit points in Bangladesh, where temporary clinics based in the Drop in Centres have provided services for truckers. In Bangladesh, advocacy by EMPHASIS was responsible for the main VCT services being developed. In addition, the promotion of HIV testing including escorting impact population members to established testing facilities and arrangements to conduct mobile testing in migrant communities and their workplaces, has increased impact populations undergoing testing in destination and source communities. Mobile clinics have played an effective role in India, where greater numbers have gone for testing.

Links and coordination between migrant PLHIV and services in India and their country of origin have increased the chances of use of services, including CD4 count tests and access to Antiretrovirals, and remaining compliant. Reference has already been made to the success in establishing an agreed system for cross border ART referrals.

As noted earlier too, Lickert Scale scores for referral were also high in both India and Nepal, falling only in Bangladesh, because of the travel distance issue.

- *To what extent do migrant populations targeted by the project perceive the EMPHASIS activities as relevant to their needs?*

Migrant populations spoken to during the evaluation found EMPHASIS activities relevant to their needs especially those relevant to their daily challenges including obtaining identification papers, sending money back to source communities, gaining access to public health services in India, and reducing harassment travelling and crossing borders.

Activities on non-health issues usually provided an entry point to engagement with migrants, and opened the door to an examination of vulnerabilities to HIV infection and the taking of actions to prevent it. This includes increased condom use, better couple communication, STI diagnosis and treatment and Voluntary HIV Counselling and Testing.

In the Lickert Scale scoring, migrants in India and Bangladesh has an average score of 4.2 for relevance, and in Nepal, 4.6.

- *To what extent have EMPHASIS-led advocacy initiatives been acknowledged (and/ or taken up) by national/ regional level stakeholders and policy makers?*

Advocacy efforts at the local (including city) and community level have met with significant success with the engagement of local officials and the creation of Community Support Groups and coordination with local government services. This has been the case in all three countries, and at all forms of locations, destination, transit, and source. New forms of institutional arrangements with local institutional stakeholders have been most successfully pursued and embraced in Nepal, where government institutions (local hospitals, border police), local VDC authorities, and the private sector (banks, transport companies), have all been supportive and enacted either policy changes, or provided forms of support and funding. There was also some success in addressing cross border issues between Nepal and India. The establishment of the ART cross border referral system, involving discussions with both Ministries of Health has already been discussed. Advocacy with banks both in Nepal and India (especially ICICI), also resulted in agreements about the ability of Nepali migrants to remit money to Nepali bank accounts through ICICI branches in India. Additionally in India, a number of MOUs have been signed with community based organisations.

In India, one further major success achieved was the agreement of a group of parliamentarians to meet with CARE's regional team and to discuss the issue of Bangladeshi migrants in India sympathetically.

In contrast, it was not possible to engage in direct advocacy around migrant issues with such national level policy stakeholders in Bangladesh, where the government still officially denies the existence of Bangladeshi migrants in India. But where EMPHASIS was successful in its advocacy in Bangladesh was with the Ministry of Health and the National AIDS and STIP Programme (NASP) around the provision of VCT services to areas where there were significant numbers of households with migrant members..

Broadly, EMPHASIS has been able to increase the visibility to local and national stakeholders of the vulnerability of migrant populations to both safe mobility and HIV issues. With respect to regional stakeholders, the regional UNAIDS office (in Bangladesh), has acknowledge the role EMPHASIS has been playing in drawing attention to the rights

issues of internal migrants within South Asia, issues which the UNAIDS Country Director in Bangladesh acknowledged that the UN should be doing more to address.⁹³ In addition CARE EMPHASIS has achieved registration with the secretariat of the South Asian Association for Regional Cooperation (SAARC), based in Kathmandu, which improves their chances of an application to SAARC for further funding.

- *To what extent was the EMPHASIS intervention able to create a supportive community environment for the impact population.*

In the intervention zones, EMPHASIS and its local partners have engaged stakeholders at all levels and brought them on board through meetings, trainings and support in setting up a range of community support groups for both HIV and safe mobility issues. These groups usually seemed both motivated and effective, and although limited in number, they seemed strongly likely to sustain themselves after the end of the project, which if they do suggests their value as a future model. For example in Nepal, 21 spouse groups have been established in the last 12-18 months in specific villages, and their memberships have increased to include 30-70 women in each village whose husbands are migrants. These groups have started to tackle a range of issues that go beyond those of migration. Similarly, spouse groups were created earlier on in Bangladesh too.

Other groups that have been effective are community support groups dealing more directly with HIV and AIDS issues. They have helped contribute to reducing stigma related to PLWHA by increasing their confidence and reducing misinformation in migrant source and destination communities about the virus, and have improved access to medical services for PLWHA. In transit areas, there was also evidence that Peer Educators and Outreach Workers have also been able to tackle such stigma.

- *To what extent has the EMPHASIS strategy of working directly with migrants, sensitizing stakeholders (community, service provider, private partners) been successful in addressing migrants' vulnerabilities?*

In the intervention areas the EMPHASIS strategy of engaging stakeholders has resulted in reduced vulnerabilities and increased confidence at all levels across the safe mobility continuum from source to destination and return. The effectiveness of the strategies used have been in their multi-actor nature, with CARE and local partners working with a range of government, NGO, community and private sector actors, to generate new forms of collaboration in addressing the vulnerabilities of migrants and their families. In Nepal and the Indo-Nepal transit areas, for instance, there was a common interest in and commitment expressed to the work that was revealed in the various caselets that people provided of how they had become involved in the work, instances of support they had provided to people, what they were proudest of achieving and what motivated them, and the sense that there was a unified network of support.

In the accounts by transport worker peer educators on the Indian side of the border, one particular type of vulnerability they focused upon that has not been mentioned previously, was that of adolescent girls making the journey, if they did not appear to be

⁹³ Interview with Leo Kenny, UNAIDS Country Director, Bangladesh, 7 May 2014.

accompanied by appropriate relatives. Several stories were told on this topic. In two, young girls travelling alone (one was only 12), were brought to the office of the IP partner, and then with the support of the police taken back across the border to the Nepal police, to be returned home. In another case where it appeared a young woman was being trafficked into sex work by an older woman who was accompanying her, the peer educator phoned the brother of the girl, who eventually after two weeks came and fetched her. In other instances, the rickshaw pullers said they will transport women for free if they feel they are vulnerable or being harassed.⁹⁴

This topic received an extremely high Lickert Scale rating by migrant populations in every country – 4.5 in India, 4.4 in Bangladesh, and 4.7 in Nepal.

- *To what extent have migrant vulnerabilities been reduced?*

Migrants and their families across all three countries rated themselves as being much less vulnerable to HIV risks as a result of two main factors:

- i) Their increased knowledge, both of how the disease is transmitted and can be prevented, and of their rights, and
- ii) Their improved access to services.

Of all the areas where vulnerabilities across the safe mobility continuum have been improved, probably the most telling is with regard to the provisions that have been made through the project's interventions for safe remittances. Previously migrants were trying to return home with bundles of cash, aggravated by the fact that Indian Rs500 and Rs1,000 notes cannot be brought into Nepal, increasing the size of the bundles the migrants would have to carry. They risked being both robbed en route and fleeced by Indian border police and customs officials. The new arrangements have resulted in banks in Accham, the mountainous of the two source districts, even being prepared to send officials into villages to help with the opening of accounts. For women, this is an important source of empowerment, since previously many had neither access to nor any decision making control over their husbands' migrant earnings. Now, not only are larger sums being remitted, but the wife is part of the decision making process, with many saying that they talked with their husbands by mobile phone about the use of the money.

The empowerment of women by this means, and through their belonging to spouse groups, has also improved their confidence in speaking to and negotiating with their husbands over safe sex practices, and going for VCT counselling.

Two Lickert Scale scores back this. First, for reduced vulnerability to HIV infection, the scores are 4.5 for Bangladesh, 4.4 for India and 4.8 for Nepal, and then for reduced vulnerability with respect to safe mobility, the Lickert Scale scores are 4.4 for India and Bangladesh, and 4.6 for Nepal.

- *To what extent has the capacity building activities with service providers led to improved access and quality services for impact pop?*

⁹⁴ FGD with Peer Educators, India, BGSVS Project Office, 27 January 2014.

The capacity building activities with service providers conducted by EMPHASIS was greatly appreciated by both the NGO and government sectors in all three countries and resulted in both increased skills and access by impact populations. This has been documented across all the countries, and particularly the gains in terms of the numbers of migrants and their families now being able to access health services related to the protection and treatment of HIV and AIDS. In Nepal, as peer educators made clear, once a referral system is established, community members can be referred for other health related needs, and for instance, many were for maternal health related needs. The community support groups in Bangladesh can play a similar role, where a broad range of health needs were identified.

Critical capacity building activities have been conducted with partner NGO areas, and with local transport unions, eg rickshaw pullers, as well as hoteliers, at transit sites. Other support has been provided to the Nepalese border police to help them establish Citizen Advice Centres at the border crossings. These may become more important in the future, if the Drop-in Centres funded by the project are forced to close.

- *To what extent has EMPHASIS contributed to the empowerment of migrant women through its project activities?*

Even though the empowerment of women was not a direct outcome being sought by EMPHASIS, it was made one of the three main priorities of the project when its focus was revised and clarified in late 2012. And there has been an impact on women's empowerment, especially in source communities. These are mainly the spouses of migrants, rather than migrant women themselves. For example, it is these women that have been opening bank accounts for their husbands to remit money safely. In one spouse group we met with, 54 of 68 women members have opened accounts. This has had two effects. First of all, larger amounts of income are being remitted than when the husband was trying to bring back money on his person. And second, women are playing a role in the decision making regarding how the money is used, which they were not previously. Many women reported discussing expenditure with their husbands by mobile phone (presumably so they could not be accused of misusing the money). These spouse groups were also tackling additional issues like that of *chaupadi*, the practice of forcing menstruating women to sleep in animal sheds during their menstruation, including during cold winters in the mountains, often with little food. One of the groups we met with said they had ended this practice in their entire village.

More broadly migrant women and spouses of migrants in the intervention areas have increased their awareness of their vulnerability and gained confidence in communicating more openly and frankly with partners, including about safe sex practices. They report being confident to talk to husbands over the phone about such practices, and being able to ask them to go for VCT services on their return, and to use contraceptives.

These changes in women's lives can collectively be summed up by the value proposition shown in the table below, with which we would concur – the above account talks to much of it.

At the core of the women's empowerment strategy is the organising of women migrants or spouses into groups. This activity has been intensified in the last 18 months, both with the forming of spouse groups in Nepal and the community self-help groups in Bangladesh. By far the largest membership in these groups occurs in the spouse groups formed from early 2013 in Nepal. The current membership is likely to be even higher than the figure listed in the table below, since women in the villages where the groups have been formed, are continuing to join the groups. That this demand is ongoing, in itself illustrates the value the groups are fulfilling. The Lickert Scale scores for women's empowerment, of women themselves, were also high, across all three countries.

Table 12. Number of women's groups that evolved at source and destination⁹⁵

Locations		Groups	Number of members
Bangladesh	Jessore	3 women's groups	39
	Satkira	6 women's groups	90
Nepal		21 spouse groups	712
India	Delhi	9 women's groups	139
	West Bengal	13 women's groups	93
	Mumbai	5 women's groups	123
Total		63	1,196

- *To what extent have the interventions promoted safe mobility and safe remittance?*

Progress has been made in the intervention areas especially when migrant populations have collaborated through community based groups in developing responses to the challenges. This has been backed by migrants becoming more aware of their rights, and both them and their spouses gaining increased confidence on actions they can take to reduce the risks they face whilst travelling between source and destination locations and vice versa.

There is evidence of reduced vulnerabilities among migrant populations in each of the different types of intervention areas, though to varying degrees. In the destination sites, and to an extent in the source communities too, the narrow scope and scale of EMPHASIS, allowed for the development of effective approaches, but not for a critical mass of migrant populations and their families to benefit. In transit areas, however, the interventions established benefit all migrants passing through the borders, and thus the benefits are much more widely experienced. Two major problems experienced by migrants, first the theft of their belongings and money by people feeding them drugged food or drink, has been addressed by the issuing of clearer warnings and advice. In addition, peer educators working with transport companies and local hoteliers, are also providing support for migrants who do happen to be affected. A second problem, that of the systematic charging of illegal duties by Indian customs officials has also been tackled by complaints being made by the Nepal police on their side.

⁹⁵ Graeme Storer, 2014, 'Women's Empowerment, EMPHASIS Learning Series #3

In addition, the establishment of bank protocols between India and Nepal that allow Nepali migrants (or their spouses) to open accounts in Nepal and then use correspondent banks in India to transfer remittances, offers widespread potential to reduce the exposure of migrants to theft on their return journeys home. What is required now is much more advertising of the options here, for instance, through national media, as well as through IEC materials at transit locations.

The learning series documentation identifies four factors that played a role in improving safe mobility:

- i) The information network that was built up from source through transit to destination, focused on the migrant workers themselves and their spouses, but supported by a range of actors who provide that information at different points for health and safe mobility issues;
- ii) The focus on building linkages with and co-opting institutional actors across the mobility continuum, described below as the ‘chain of partnership’ approach;
- iii) Working with duty bearers to activate accountability mechanisms, for instance with regards to health service institutions in all locations, and transport worker unions at the transit locations;
- iv) The project’s interventions to facilitate safe remittance transfer.⁹⁶

Altogether for this topic, the Lickert Scale ratings of migrants was also high – 4.7 for India, 4.4 for Bangladesh, and 4.3 for Nepal, illustrating the progress made.

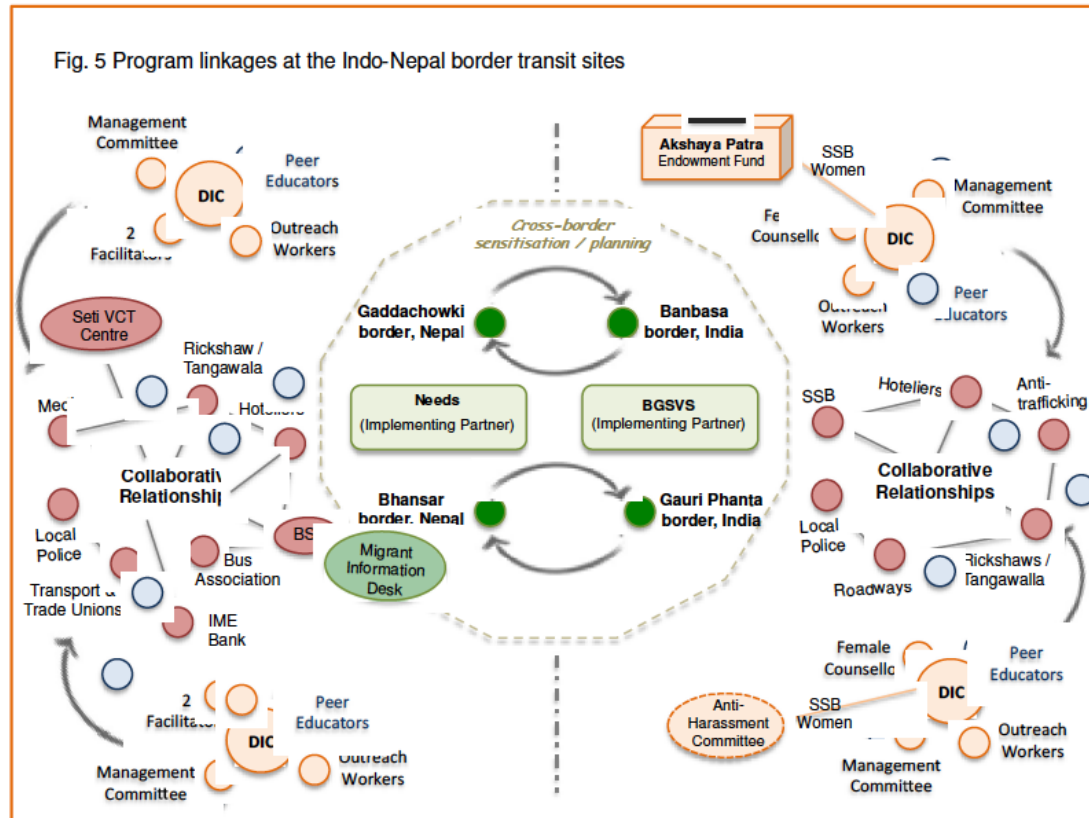
- *To what extent have the range of partnership approaches contributed to the success of the program?*

EMPHASIS has adopted a very broad approach to developing partnerships, and deserve credit for turning around an approach which until the last two years had not been especially coherent. The relationship strategy that has been established is complex, as the diagram below for just the Indo-Nepal transit area shows, with the intent being to develop a networked chain of partners between source and destination. By and large this strategy has been effective.

Naturally, some of the institutional relationships have been harder to establish than others, and their outcomes vary. The relations with implementing partners, whilst crucial to the project – they are shown at the centre of the diagram below – at the same time, are also amongst the most vulnerable to being cut once EMPHASIS ends. This does have critical implications, as the partners do hold many other relationships together, especially through their networks of outreach workers and peer educators. In Nepal, for instance, both IPs professed a commitment to keeping activities going where they could, but they could only do this, if they can maintain at least some of the outreach workers. Facilities like the drop in centres will fall away.

⁹⁶ Graeme Storer, 2014, ‘Migrating Safely’, EMPHASIS Learning Series #2.

Figure 4.5: Institutional Linkages at the Indo-Nepal Border Crossings⁹⁷



There are many positives, however. In Nepal in particular, the partnership strategy has come together exceptionally well over the last two years, and has resulted in a network of interrelationships that has begun to yield broad dividends. It is important to note the stages and time that this has required. First EMPHASIS has had to establish relationships with various government entities and private sector agencies, like banks, on a one to one basis, and on both sides of the border. Then the project has had to reach senior levels in these institutions in India and Nepal to persuade the institutions themselves to establish a dialogue with their counterparts in the other country. This has then subsequently resulted in policy arrangements being made, such as with the cross border ART referrals, which have only just started to be put into practice, but have the potential of being leveraged much further.

In addition, the development of strong local level partnerships with Implementing Partners, service providers, local government and community leaders, has built the confidence of these actors, and contributed to improved relationships between them, as well as more effective service provision, even if many of these successes remain relatively localised.

It will be extremely important that CARE is able to maintain some of these relationships in the future. It is one of the real harms that a project approach can do, by setting up a strategy that involves complex relationships that do require further nurturing, and then largely abandoning it, just when the relationships are starting to come to fruition. This

⁹⁷ Graeme Storer, 2014, 'Migrating Safely', EMPHASIS Learning Series #2.

abandonment can also lead to a breakdown in trust, with specific actors – like the transport workers – feeling that they have made a great effort to change their practices, and then suddenly they are once more left to their own devices.

This applies not just to negotiated cross-border agreements such as the ART referral and the banking exchanges, but also for instance, in recent discussions over the 1950 Indo-Nepal Peace and Friendship Treaty. This Treaty guarantees reciprocal rights for Nepalese and Indian migrants in each other's countries, except the right to vote. However, the provisions of the Treaty have never been interpreted for conditions later than its founding date, so there are a significant number of questions about rights that remain grey areas in the present (such as the rights of Nepali migrants to access various kinds of social service or social protection benefits in India). CARE has discussed this with parliamentarians in India, who advised the EMPHASIS team to pursue this at inter-governmental levels between the two countries, to advocate that a joint inter-governmental group undertakes this reinterpretation. With the closure of the project due in July 2014, the regional EMPHASIS team has decided instead, however, to employ a lawyer to undertake a reinterpretation of the Treaty for the present day. This type of legacy, which has emerged only in the last 12-18 months, could potentially change the relative cost-effectiveness of the project in retrospect, significantly.

In addition, through the learning that has taken place, EMPHASIS has also adjusted some of its approaches in order to make them cost-effective – replacing peer educators in Bangladesh with community self-help groups, being one such measure. EMPHASIS has been an expensive project, but it has been piloting work in some very uncharted waters. Some of the impacts already achieved are not insignificant. Nevertheless, what is extremely important now, is how these gains are leveraged beyond July 2014, and the discussion on cost-effectiveness really depends on this.

6. Conclusions and Recommendations

In this evaluation study we were asked to assess the EMPHASIS according to its three identified outcomes areas, as shown in the basic theory of change diagram below, and to assess the effectiveness and relevance of different interventions. A more general conclusion is followed by specific statements on each outcome area, and then a set of recommendations.

Improved access to services along the mobility route	X	Reinforced capacities of the main stakeholders and impact population	X	Improved policy environment on mobility issues	=	Reduced vulnerabilities to HIV and AIDS
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The complexity of EMPHASIS has been stressed, for good reason. At the time of the Mid-Term Evaluation the project clearly had many weaknesses and lacked an overall coherence. In this sense, it is fortunate that with changes in the project's management there has been a substantial turn around in the project's strategy, relationships and performance.

There has been some refocusing of the project strategy too, with the Senior Regional Director describing the project as now focused on a slightly revised, and importantly broader, set of priorities compared with the original project theory of change above.

- women's empowerment
- access to services (ART referrals, GBV referrals etc)
- safety and mobility continuum

There are two ways this turn around can be reviewed. A more critical perspective would point out the time and resources lost in the first three years and the potential for EMPHASIS to have achieved much more. The last point is certainly true; EMPHASIS could have achieved more, and can still do so, if some ongoing support to key elements of the project are continued. But it is also unrealistic to think that a project as ground breaking and complex as EMPHASIS could have landed on its feet running from the very beginning.

For CARE in South Asia, it is clear that EMPHASIS has required a huge learning curve. Despite jointly participating in the design of the project, there was limited communication between the three host country offices early on in the project's life. The shift in senior management in mid-2012 provided the project with a more experienced leadership 'that has the contacts, has credibility with SARC and governments, and has the ability to negotiate within CARE to mobilize the support needed too'.⁹⁸ Key to the greater outcomes achieved since July 2012,

⁹⁸ Interview with Ayesha Kariapper, CIUK Programme Management Team Leader, Tuesday 11 February 14.

has been the clarification of the main components of the project strategy, and vastly improved internal and external communications with all actors.

There are of course missed opportunities in the fact that it has taken EMPHASIS quite so long to reach this level of clarity. Chief of these is that the new collective leadership have not had the time to evolve the project's strategy and relationships to a level of maturity, where broader levels of ownership and greater leveraging of the more successful components of the project strategy could have been achieved. Consequently, it is clear that the project is really ending at the wrong time. Even a further year's work would have enabled a great deal of consolidation to take place, and the more effective transfer of key activities to other institutions.

Within the last 18 months, the EMPHASIS strategy has evolved more in Nepal than it has in Bangladesh, owing to the political lack of recognition in the latter of the existence of its citizens, undocumented, in India and the issues they face. Given the political turmoil that has also affected Bangladesh within this period it may also be churlish to expect the Bangladesh EMPHASIS team to have done more at an advocacy level, but nevertheless it is clear that without policy change within the Government of Bangladesh, the situation of Bangladeshi migrants in India will remain risky, with clear rights denial. The strategy of EMPHASIS has been to chip away where it can, particularly on health related issues, but to be more broadly effective, a much wider alliance would be needed – and not led by CARE.

This contrasts hugely with the situation of Nepal migrants, both in India and on return to Nepal, where innovations in the strategy in the past eighteen months have borne already some significant policy shifts, especially with regards to the initiation of cross-border ART referral, and the bank agreements brokered in both Nepal and India. The latter has now allowed migrants and their spouses to establish bank accounts in Nepal into which migrants in India can remit money through cooperating banks. This, and the initiative to set up Spouse Groups in source districts in Nepal, has provided a vehicle for women's empowerment in the project that had not existed before. Here, then, it really is of regret that the project has not had more time to expand the scope of this intervention. Other benefits of the source and destination strategies result from the chance to reach migrants and their families twice, at both ends, and the opportunity this offers to reinforce messages and services.

In the transit zones between Nepal and India, and India and Bangladesh, the work of the project has benefited probably the largest numbers of people, because all migrants crossing at these points are potential beneficiaries – it is truckers who are largely benefiting at the Indo-Bangladesh crossing points. At the Indo-Nepal transit point, selecting Peer Educators whose work is with migrants, as rickshaw and tanga pullers, bus conductors, and hoteliers, ensures too that these people will continue to advise and support migrants. However, key transit zone facilities like the drop-in centres, which act as triage points, will much reduce the visibility and thus effectiveness of the transit zone interventions once EMPHASIS closes. The Citizen Help Desks established by the Nepali border police will help, but would need a continue supply of IEC materials really to be effective.

It was noted at the beginning of this conclusion that the project theory of change has been expanded to cover wider aims over the last 18 months, even if with the same Impact

Population. The importance of this is vital, since it has helped improve the cost-effectiveness of the project, and can certainly help improve this further looking ahead. An expanded attention to safe mobility and women's empowerment issues has attracted the interest of greater numbers of people at all three types of locations, and have meant that outreach workers and peer educators are having an enhanced and more diverse impact than they would be if just focusing on HIV and AIDS prevention and treatment activities.

In the next section, a specific concluding summary for each outcome area is set out.

6.1 Conclusions by Outcome

Outcome 1

Over its five year life span, EMPHASIS has shown that it is possible to develop a cross border model that addresses the most critical issues requirements related to the prevention and treatment of HIV and AIDS, a statement backed also by the endline results. This includes forms of care and support to patients. At high population density locales, for instance, in Mumbai, or the border crossing between India and Bangladesh, mobile or temporary VCT centres that can treat also for other STIs, have shown to be particularly effective means of identifying patients requiring further treatment.

In lower density locations, particularly in source communities, outreach approaches, including the use of peer educators (Nepal), and community support groups (Bangladesh), who can refer people to health centres for a wider range of health related issues, including maternal health related issues, is a more cost-effective approach.

The innovation of the EMPHASIS approach, using the continuum of mobility across source, transit and destination sites, has been the most compelling unique feature of the model. There have been two especial gains from this approach. The first is that it has allowed a reinforcement of messages at different points – and there are significant numbers of people, as shown by the endline survey – who have been reached by EMPHASIS at source and destination. And the second point is that it has facilitated multi-institutional approaches and the negotiation of cross border arrangements, especially between India and Nepal, building on the provisions of the Indo-Nepal Peace and Friendship Treaty.

It is perhaps an indicator of the success of the approach trialled by EMPHASIS that several of the non-CARE personnel interviewed fretted over the fact that such an approach, with the promise it was showing, was not guaranteed that it would continue to be pursued beyond the end of the current Big Lottery funding.

Outcome 2

The capacity building approach adopted by CARE, given the shortness of the overall time frames, has been comprehensive. EMPHASIS India has carried out over 35 different types of training, the majority by local NGO implementing partners of the various types of local actors with whom the project has been working. This training has focused on improving attitudes as much as it has on specific skills and information.

Overall, the training consequently has had three types of effects. The first has been to increase the level of health sector service provision, particularly related to HIV and AIDS, available to migrants and their families, at both source and destination locations. Second, has been the consciousness of all who come into contact with migrants, and have responsibilities for them, that they are humans with rights, and deserve to be treated fairly and justly. This particular applies to actors at the transit locations, where typically migrants have suffered various forms of mistreatment and exploitation.

With regard to these service improvements, the most pertinent question now though is, will these improved service levels continue? Whereas those institutional actors who have their own resources, like the Nepal Border Police, have said they will, and those individual actors who will maintain contact with migrants, like the various transport worker and hotelier peer educators at the transit points, have also said they will continue to provide support to migrants in need, without the continued existence of the drop in centres, and prompts of the local implementing partners, it remains to be seen how much this will actually be the case.

Outcome 3

This outcome focused on advocacy, in particular related to safe mobility issues. The first concluding point to note is that the safe mobility component grew in importance during the course of the project, and particularly within the last two years. This was for good reason. A migration project that does not focus on safe mobility is not dealing with the primary issues affecting migrants. Thus by ramping up the focus on safe mobility, EMPHASIS made itself more relevant to the day to day issues of migrants, and by doing this established an entry point that also increased their receptivity to information and services around HIV and AIDS prevention and treatment.

Second, this base in action improved the effectiveness of the advocacy and awareness raising work that was being conducted at different levels, because the advocacy was based on information being generated directly from migrants and was then contributing to direct action. This helped focus the minds of relevant institutional actors at different levels on finding solutions – whether it be with respect to cross border ART referral, cross-border financial institutional agreements to facilitate the sending of remittances through banks, or on raising the awareness of national and regional actors within the UN and South Asian governments on the health and mobility issues affecting migrants and how they could be addressed. It was the experimentation being conducted by EMPHASIS that was different. Institutional actors were largely aware of the issues, but they lacked the information from praxis that allowed the making of much more direct recommendations, as in the above examples.

As a consequence of its basis in action, EMPHASIS has been effective in the regional forums it has held in the last 18 months. Institutional actors have attended because of their interest in learning from EMPHASIS' experience, and the ability of EMPHASIS staff to engage on migration issues and make recommendations from practice. These have included meetings specifically organized by the project including i) a Regional PLHIV and Migration Consultation that brought together civil society and government partners with members of PLHIV networks on the issues of migration, ii) a further Regional Consultation on Migration and

Development, organized to share learning at the regional level with a range of UN agencies, UNAIDS, UNDP, IOM, ILO, UN women, academic institutions, government representatives, networks, and researchers, and iii) a regional media consultation held in April 2014 to discuss migrant vulnerabilities, particularly with respect to women, and how the media might improve its coverage of these issues.

With its relevance proved, the response of many of these agencies has been to ask of CARE, what happens next? They perceive CARE as an agency that has now established its credentials to represent on migrant issues within South Asia, particularly those issues pertaining to internal migration across borders within the region. But this creates an expectation that CARE will continue to play an advocacy role with regards to these issues – and therefore some dismay that it may not.

Women's empowerment focus

In the latter part of the project especially, EMPHASIS increased its attention to women's empowerment issues, particularly with the spread of the spouse groups in Nepal, and the growing effectiveness of the initiative to encourage the opening of bank accounts, including by women, and for remittances to be transferred safely this way. This focus has brought growing benefit to women, and to the achievement of the project's objectives. With their growing confidence and capabilities, women have been engaging more with their husbands/partners and reinforcing messages and practices around safe sex, HIV prevention and treatment, and safe mobility, again a feature also noted from the endline survey. This creation of a conversation between women and men, including when women speak to their husbands by phone, is reported by both genders as having an important effect on men especially heeding advice and changing practices.

Overall, EMPHASIS remains a mixed and nuanced story, which even as an evaluation team left us in different minds. In summing up, several of the above points are reiterated by Leo Kenny, UNAIDS Country Director for Bangladesh, who is provided the last word.

'Just to summarize, my accolade to CARE is that they have done a very good job in providing services, but it was never sustainable. It has never moved from being a project approach to a program approach. To do so it needs working with UNAIDS and IOM to establish an interregional dialogue in part around country coordinating mechanisms. And the cross border part is difficult. Needs a global fund application to look at regional cross-border mechanism and issues – needs a regional dialogue led by UNAIDS to achieve this, building on country plans.'⁹⁹

6.2 Recommendations

The following recommendations are of two types. First there are some generic recommendations that relate to any actor who may choose to build on and further the type of migration continuum work that EMPHASIS has initiated. But second, since there also

⁹⁹ Interview with Leo Kenny, UNAIDS Country Director Bangladesh, 6 May 2014.

remains unfinished business, CARE itself continues to have responsibilities for work it has initiated, and it is with this that the second set of recommendations is concerned.

Programmatic

12. The overall goal of EMPHASIS was to contribute to the reduction of vulnerability of mobile populations (particularly women) to HIV infection at source, destination and transit sites within India, Bangladesh and Nepal. *To achieve a specific goal such as this with migrant populations, it is essential for any future programming that it is contained within a broader approach focused on the overall safe mobility, rights and empowerment of these populations.*

13. In some instances, the encouragement and capacity building of service providers to improve the provision of specific health or mobility related services has paid attention to sustainability issues, but in several instances the question of whether the services will persist remains. Many of the directly HIV and AIDS related activities have been institutionalised within government or private sector facilities. A few critical activities, however, remain reliant on project support, where government providers lack resources.

- One is the two additional staff seconded to the ART Centre at Seti Zonal Hospital. An application has been made to the hospital to continue to fund these positions, but it may take time before the hospital can add the additional positions. *Since these position are essential to the effective running of the centre, an interim strategy will be needed to keep the staff in place.*
- Another is the *part time STI clinics being run for truckers on the Indo-Bangladesh border out of drop in centres. These have proved of enormous value and also require a continuity strategy.*
- A third innovative activity is the use of mobile ICTC units in Indian cities. These have also reached and received many more people than has been the case when migrants are simply referred to a health centre, that may be some distance away, and have to make the journey themselves. *Particularly in India, the retaining of and further investment in such mobile units should therefore be encouraged.*

14. The role of local implementing partners, and through them support of community based peer educators and groups (whether self help groups, spouse or support groups), has been critical to the initiation of all local activities in the project. Thus, the continuation of many of these activities is in jeopardy, since the IPs depend on the project funding, and the outreach workers, supporting the peer educators, are on the local NGO payrolls. Peer educators themselves, particularly when they are, for instance, transport workers or hoteliers, who will carry on performing their jobs, have stated their willingness to continue to conduct IEC activities. However, it will be difficult for them to undertake this for long with no backup support, one to provide IEC materials, and two to provide technical or official support if required. Thus it is important for institutional means to be found to continue the support after the end of the project, and this would be a recommendation for future projects too. For instance, in Nepal, low

levels of support to IPs might continue through mechanisms like the VDCs, or through small project funding, to allow a few outreach workers to continue to work with peer educators. *To find more sustainable forms of institutional support to peer educators, is however an important recommendation, not only for the continuation of EMPHASIS's current activities, but for the future spread of the model it has been piloting.*

15. The increased emphasis on women's empowerment in the latter stages of the project yielded significant additional benefits. It reinforced messaging around HIV and AIDS prevention and treatment, by providing women with the confidence and mutual support to engage with their husbands. At the same time, additional more specific benefits to women have started to emerge. Women have greater access to and control over money, and have begun to tackle harmful traditional practices. *The benefits to women, men and their families of this additional focus on women's empowerment is clear and should automatically be a part of any future project focusing on issues affecting mobile populations.*
16. Over the past two years, EMPHASIS has ramped up its regional and national level advocacy work, with the regional team working with national counterparts and partners to organize several regional briefing and advisory meetings and consultations. At national level, a total of 30 MOUs with a range of organisations have now been established. *Using these MOUs as a basis, EMPHASIS should also seek to encourage public and private institutional actors as fully as possible to commit resources to ensuring the sustainability of services that have been initiated or improved during the life span of the project. Advocacy with government agencies at all levels, reminding them of their responsibilities towards mobile populations should also continue, particularly regarding the health and security of migrants and their families.*

Procedural

This final set of recommendations builds on the concern of many of those interviewed that CARE does not 'abandon' this groundbreaking work that it has started. The below are all seen as measures that are feasible.

17. *It is vital that CARE in South Asia assumes collective responsibility for ensuring that EMPHASIS as a program with vital sets of relationships and activities that have only just started to mature, is not left simply to disappear.* This is important as a way of accounting for some of the early drift of the project, but more critically now to ensure that the considerable potential now inherent in EMPHASIS is not wasted.
18. There is in addition, the potential to do harm if relationships are dropped where they are at this point in time, especially in some of the more sensitive or complex areas. *The real risks of this happening must be calculated before the ending of the current funding, and mitigation measures put in place.*
19. One achievement of EMPHASIS internal to CARE is that it has raised the profile and importance of programming that has a focus on migration internal to each country, and within the region. In a recent program strategy development exercise, migration is one

theme that CARE Nepal has highlighted it needs to focus upon more. In India, members of the Mission Management Team, stated that this was a potential impact population they would need to consider adding to their program in the future (though in the short term it might be seen as a sub-set of their existing impact populations).

However, these internal discussions are happening independently. *A further recommendation would be that the three country offices continue to have a joint conversation on the subject, preferably facilitated by an ongoing regional secretariat, if there is the funding to continue to support this.*

20. The regional advocacy work that has been undertaken in the last year by EMPHASIS has played a huge role in drawing attention and respect to the ground breaking, piloting role that EMPHASIS has been playing. *Having gained a seat at the table, as it were, it would be a wasted opportunity of being able to influence a range of country and (sub-)regional debates around migration, if CARE were not to keep it. Ongoing means of doing this should be sought. In particular, EMPHASIS staff should engage with UNAIDS and other UN agencies to gain their support for continuing to support the effective mobility continuum initiatives begun by the project.*
21. The work that has just begun on re-interpreting the conditions of the 1950 Indo-Nepal Peace and Friendship Treaty could potentially have hugely beneficial implications for the rights of ALL Nepali migrants in India. *Especially since CARE has been encouraged by senior administrators within the Indian Government to continue this work, because of the extent of its potential impact, this work must be pursued beyond the end of the current funding period.*
22. *EMPHASIS has been an immense learning experience. If this experience is not to be lost, CARE will need to adopt a programmatic approach to its continuity that encompasses both the countries and the sub-region. Any continuity of activities will otherwise be piecemeal, and lose the coherence that has so painfully (and expensively) been achieved over an immensely challenging five years.*

Not all these points may be achievable in the remaining life span of the project, but what is critical is that 'interregional dialogue' continues around how to maintain and evolve some of these relationships and strategies, and that opportunities for further funding continue to be sought.

Annex 1: Impact Population Lickert Scale Results¹⁰⁰

This tool was used with Impact Populations, which included male and female migrants, spouses, and truckers among others (14 statements). For the tool, respondents were asked to state to what degree they agreed or disagreed to the statements on a scale of one to five. Five representing 'agree very much', four 'agree', three 'neither agree nor disagree', two 'disagree', and one 'disagree very much'.

The responses are interesting, and back the analysis above, in that consistently across the three countries, the responses of migrants and spouses in Nepal score highest, followed by respondents in India (who could be Nepalese or Bangladeshi), and then those in Bangladesh. The only score for which there is a lower score by respondents in Nepal is on the last question about safe mobility. This results suggests that migrants in India have been better informed are/ are more confident about safe mobility practices for when they return home, than perhaps migrants and their spouses in Nepal – and the majority of these responses in Nepal are likely to be spouses.

There are a few other scores worth highlighting. First, areas of high scoring are with respect to knowledge, attitude and behavioural changes, reflecting the effectiveness of strategies in this regard. Referrals for VCT also score high, except in Bangladesh, where as already discussed, distances to the two centres established did discourage attendance. Scores around reduced vulnerability to HIV and AIDS also were high, as were those for women's empowerment, which is a strong positive for the project.

The lowest scores were for the exposure of impact population members to EMPHASIS, particularly in Bangladesh, where outreach activities were more challenging, with the greater dispersal of the population and challenges in developing a cost-effective way of reaching them. Following the establishment of the community support groups, this score if repeated in the future may rise.

#	Lickert Scale Question	India	Bdesh	Nepal
1	Knowledge, Attitudes, Practices and Behaviour (KAPB) Changes. As a result of the EMPHASIS project or its partners I am more aware of HIV, have better access to HIV testing and STI treatment and have reduced my risk behaviours with condom use and partner reduction.	4.6	4.7	5.0
2	Referrals. I have been referred to HIV related services like Voluntary Counselling and Testing and Sexually Transmitted Infection services through the EMPHASIS project.	4.5	3.6	4.8
3	Referrals. I now know where to get referrals to HIV related services like Voluntary Counselling and Testing, Sexually Transmitted Infection services.	4.5	4.2	4.7

¹⁰⁰ n figures not currently available.

4	Exposure. I have been exposed to a Peer Educator, Outreach Worker or a Drop In Centre counsellor.	4.1	3.4	4.7
5	Exposure. I have attended a meeting with a Self Help Group, People Living with HIV group, or another EMPHASIS Support Group	4.0	3.9	4.4
6	Exposure. I have had contact with the EMPHASIS in two of the following three levels: in out home countries, in transit to the destination country, in the destination country.	3.8	2.3	4.0
7	Reduced Vulnerability. My increase access to HIV related services like HIV testing, STI services and condoms has reduced my vulnerability to HIV infection.	4.5	4.4	4.8
8	Referral Strategies. I have been inspired to use and have easy access to HIV related services like HIV testing and STI services because of the EMPHASIS project.	4.6	4.6	4.7
9	Relevance to Migrants. EMPHASIS project activities like the Drop In Centres, Peer Education, Outreach, counselling and referrals to HIV related services are relevant and meet my needs.	4.2	4.2	4.6
10	Supportive Environment. I consider that there is currently a community environment that is supportive of HIV services and programming for people like myself	4.0	4.0	4.0
11	Awareness. I am more aware of my vulnerability to HIV and AIDS today as a result of the work of project EMPHASIS including community awareness, access to HIV related service providers and contact with local organizations.	4.5	4.4	4.7
12	Reduced Vulnerability. I feel less vulnerable to HIV infection and problems if infected today as a result of project EMPHASIS.	4.4	4.4	4.6
13	Migrant women empowerment. I feel that I am more confident and able to deal better today with my vulnerability to HIV infection and harassment as a result of my contact with project EMPHASIS.	4.6	4.4	4.8
14	Safe Mobility. I feel more safe travelling, free of harassment and better able to avoid HIV infection now when travelling to and from the destination country as a result of project EMPHASIS.	4.7	4.4	4.3

Annex 2: Summary of Meetings held with Regional Personnel

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
Prabodh Devkota	EMPHASIS Senior Regional Project Director	Joined EMPHASIS in July 2012. Founded project with multiple activities but no focus; a hard working staff but with no confidence. Now, new focus has been achieved and a team built with improved relationships and communications.
Tahseen Alam	Regional Advocacy Manager, EMPHASIS	One year in position. Works with Women Power Connect, an advocacy partner in India, and works with UN and government bodies on migrants rights in the region. Participates in regional fora.
Nabesh Bohidar	Regional Monitoring and Knowledge Manager, EMPHASIS	Set up NING, a social networking platform to allow ORWs and other staff to communicate with each other. Have sought to improve learning and communication between countries to identify what is working and what is not. NING was also a key attempt to democratize the project and allow field staff to have a voice, in so far as technical constraints could be overcome.
Mirza Manbira Sultana	Regional Research Manager, EMPHASIS	Project has established within the last year a range of institutional relationships with regional entities – UNAIDS, IOM, UNDP, SAARC.
Alka Pathak and Rashmi Singh	CARE India Mission Management Team (MMT) members	Project has established a way of operating regionally in CARE. EMPHASIS has been able to establish new ways of working and partnering and has established new relationships at national level that are helpful to us.
Lex Kassenberg	Country Director, CARE Nepal	The change in regional and country management in EMPHASIS in 2012 has galvanized the project. Institutional relationships at regional and country level are much improved and country offices are better involved.
Ayesha Kariapper	Programme Management Team Leader, CARE International in the UK	CIUK has treated the project with special attention because of its ambitious scope, complexity of the cross border implementation approach, and its role as a learning initiative, carrying high reputational risk. Looking back, we have succeeded through demonstrating a lot of accountability in acknowledging and addressing the teething problems, in setting up a high level governance mechanism across the three COs, ARMU and CIUK. The experience has generated valuable learning in implementing such a cross border project, and in adjusting to new ways of working and the skills and competencies

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Annex 3: Nepal Meetings

The table below summarizes highlights from key interviews and FGDs conducted in Nepal and the Indo-Nepal transit areas.

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
Lokesh Shah	Regional HIV and AIDS Program Officer, NCASC	Monitors government and NGO AIDS control services. In Far West region are 8 ART sites, with all making referrals to India, 50-70 in total.
Indira Ojha	Women Development Officer, Accham	She focuses on domestic violence issues; EMPHASIS has helped with media coverage and posters on this and <i>chaupadi</i> . Would like project to cover a broader area.
Mahendra Kunwar	ART Counsellor/ Health Assistant, Bayalpata Hospital, Accham	Hospital has 238 clients on ART, 24 have been referred cross border to Indian ART centres. Concerned about follow up on referrals when EMPHASIS ends.
District Migrant Network	1 member from each of 25 VDCs in Accham	They track and map issues affecting migrants from all VDCs in Accham District, including cases of migrants who have gone missing in India. Have circulated Min of Foreign Affairs; some assistance provided to families whose husband have died.
Sachetana Nari, Women's Support Group, Kanchanpur	Group has 200 HIV +ve members (190 women) from 4 VDCs	Group started in 2008 with 35 members, now have 200. Provide support to members to access ART, CD4 count and other treatment necessary, covering travel costs where needed. Have tackled stigma issues and now much wider acceptance. Recently negotiated ongoing funding from VDC.
ART Centre, Seti Zonal Hospital, Dhangadhi	4 staff members who run the centre, which has 2,000 + registered cases	Largest ART Centre in Far West. Has case load of 2,368 HIV+ patients, 1,306 on ART; 35 referrals made to 6 locations in India. EMPHASIS supports 2 of 4 staff
Mohan Singh Dhami, Nepal Border Policeman	Runs Citizen Help Desk at border established in Sept 13	Project supports with IEC materials. Have registered 200 cases of harassment. Have regular meetings with Indian colleagues and cases are reducing. One migrant had Rs20,000 taken by Indian Border Police – and after official complaint whole Indian team was transferred, and cooperation has improved.
Gangotri Rural Development Forum (GarDeF), Accham	Partner Staff, Board members and ORWs for GarDeF, IP in Accham	EMPHASIS has supported their development of an organisation strategic plan and institutional capacity building. Working with

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
	for 5 years.	spouse groups (there are 10 now), has transformed their village level work.
Nepal Environment and Education Development Society (NEEDS), Kanchanpur	Partner Staff, Board members and ORWs, IP in Kanchanpur since Sept 2012.	In 18 months they have mobilized 180 PEs, and have 556 spouses in 11 groups (1 per VDC), of whom 500 have opened bank accounts. Also work with 11 community support groups, and have MOUs with 12 different institutions.
Bhartiya Gramothan Seva Vikas Sansthan (BGSVS), Banbasa, India	Indian Partner in transit area, Staff and ORWs in meeting.	Main drop-in centre is here. 568 migrants have <u>revisited</u> it by December 2013. Acts as a triage point for migrants who have been robbed/ harassed, and/ or require information or support.
Peer Educators, Banbasa, India	Group of 9 PEs, largely transport workers, working with BGSVS.	Rickshaw pullers have unionized since EMPHASIS started, with tanga pullers now have common agreement on fares. Work to provide migrants info on safe mobility and get involved when they believe migrants need protection. Mentioned several cases of rescuing Nepali adolescent girls crossing the border with non-relatives and contacting relatives to fetch the girl.
Outreach Workers and Counsellors, Gaurifanta, India	Staff of BGSVS working at second transit site and drop in centre	ORWs work mainly with migrants travelling by bus, provide safe mobility/ sex info. Drop-in centre is near bus stand and deals with migrants in need – various cases mentioned. 250 migrants have <u>revisited</u> the centre, by December 2013, bringing others with them.
Drop-in Centre Counsellors, Dhangadhi	5 DIC management committee members	Oct-Dec main festival period is busiest – over 1,000 men in Nov-Dec 2012, 550 in Jan 13. Coordinate with bus companies, and Nepal border police. Meet with and train bus staff, rickshaw pullers, police, hoteliers.
Peer Educators, Krishnapur VDC	2 men and 2 women PEs working with NEEDS.	Provide HIV awareness to community members, support with access to services, opening bank accounts, dealing with domestic violence, registering marriages. Referred 25 people collectively in the last month for VCT, TB, ART and antenatal services.
Hoteliers, Kanchanpur	All Peer Educators at the transit point with India.	Engaged by Federation of Trade Unions to be Peer Educators and support migrants with safe mobility/ sex materials, and to provide material support for cases in need.
Spouse group, Accham	Group of 30 women, all spouses of migrants in India.	Spouse group continues to expand; most members now have bank accounts, and husbands remit money through them. Have control over money for the first time. Council husbands on safe sex practices and

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
		refer for VCT. Have stopped <i>chaupadi</i> practice in village and deal with domestic violence.

*Tanga – a horse drawn carriage.

Annex 4: Bangladesh Meetings

The table below list the key, salient interviews and FGDs and some summary points undertaken with regard to the work undertaken to explore ways in which Bangladeshi migrants and their families might be better supported.

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
Dr Husain Sarwar Khan,	Line Director Bangladesh National AIDS and STD Programme (NASP)	Acknowledged that the GOB had not been able to implement that part of its HIV and STI program on cross border migrants and HIV. Therefore welcomed EMPHASIS support in establishing two VCT centres at government hospitals in Jessore and Satkhira and hoped there would be further NGO support for the 'social aspects' of HIV AIDS.
Anisur Rahman	Deputy Program Manager, Bangladesh National AIDS and STD Programme	Could have done more at central level and had more involvement across the three countries as it is a regional project. Easier access between the countries would reduce the problems. Costly project to start up but some parts can duplicate. STI services in community service centers now part of government plan. More coordination with government would add to cost efficiency.
Md. Abu Taher	Emphasis Team Leader, CARE/Bangladesh	This year intended to inform policy makers but was delayed. Sensitivity of Bangladeshi speaking people a challenge. Don't know numbers in India. BSP need to be protected and information disclosed discreetly. Bangladeshi truckers and sex workers important bridging populations
Zakia Sultana	VCT Counselor, Bedded General Hospital, Jessore	Paid by project. Gets most referrals (1000) from EMPHASIS field staff. 1,347 tested from May 2012 to April 2014 and 22 positives (11 men and 11 women). Almost all positives had contact with India. Women includes 4 female sex workers and 5 left behind spouses and women who went to India with husband. All

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
		referred and accessed services including ARV.
Director	NNP+ North 24 Paraganas Network for People Living with HIV/AIDS	873 registered members, 200 from migrant communities. Exchanged ideas with EMPHASIS on how to open doors to services and get treatment for positive migrants with no papers. Send to hospital with a note referring for free CD4 count test. EMPHASIS provided training of board members in management and how to integrate migrants and get them treatment
5 members	CRC (Community Research Centre) Management Committee	CRC located on quiet street with few passers by. Users include domestic workers, brokers, employees and employers. Management Committee met with community stakeholders including teachers, business leaders, religious leaders. First reaction hesitant needed to explain need for CRC. Doctor provides services for poor.
Brokers all males aged between 16 to 65, an average 30	Brokers arrange passage of illegal workers into India from Bangladesh	Discussed safe mobility and HIV prevention and condom use. Both sides of border problems with border guards. Negotiate with officials on both sides (BDR and BSF) to allow safe passage. Better now than in past as less arbitrary shootings during crossings and rapes reduced.
Bangladeshi men in India	Bangladeshi Migrant Worker Men in Bangalipura Wadala, Mumbai, India	5 Bangladeshi men ranging in age from 22 to 45, average age 33. All from border area of Bangladesh and in India a least 10 years. Occupations include tailors in factories, construction labourer and brick layer. -Talk about relationships with spouses. Know more about HIV, TB, condoms and risk from sex. Women now go to health facilities for births while most had babies at home before.
Transport Workers	FGD with Bangladeshi Male Transport Workers at India- Bangladesh border, Benapole, Jessore, Bangladesh	Range in age from 18 to 43, average age 29. 5 drivers and 9 helpers. Time spent a border loading and unloading. 6/14 married. 5/14 underwent counseling and testing others said they didn't get tested because no time to travel 40 km to hospital for test or felt they are not infected. Mostly obtain free condoms from projects and sex workers but will buy them at shops. Never lacking condoms.
Saima Khan	Strategic Information Advisor, UNAIDS/Bangladesh	Project impact minimal. Highly concentrated with good local implication but difficult to replicate. Not a question of quality of programming but have to look at cost-effectiveness. Need to reach more people.
Peer Educators, Jessore, Bangladesh	10 Peer Educators, aged 17 to 25, working in Basantapur with	Conduct one to one and one to group sessions with those migrating to India or returned and their family members. Cover HIVandAIDS, STI

Name of Group/ Individual	Role of Group/ Individual	Key Points from Discussion
	returning workers and families	and do condom demonstration to male and female groups.
Outreach Workers,	FGD with 6 ORW with Rights Jessore (4 male, 2 female, aged 24 to 48, average age 28)	ORWs selected 14 PE. Work with truck drivers. 3 years average service and none of ORW have quit. Wives of migrants vulnerable to STI (syphilis gonorrhea). Women agree to STI tests but not HIV. Problem is hospital VCT testing location 20km to 60 km away.

Annex 5: Summary of Groups met with in Bangladesh and India

Research was conducted in India in the following locations: Delhi (3 days), Mumbai (3 days), and Calcutta (3 days). It was conducted in Bangladesh in Satkhira (3 days), Jessore (2 days) and Dhaka (1 day).

- 116 Likert surveys administered in the two countries: 68 on Bangladesh and 43 in India. The respondents included the following numbers: L1 Impact populations 42; L2 Target Groups 14; L3 Service Providers 17; and L4 Implementing Partners 43.
- 12 Focus Group Discussions were held with Impact Populations (six in India and six in Bangladesh) with the following groups:

IN INDIA

- Bangla Speaking Men 5
- Nepali Women 8
- Nepali Women 17
- Bangla Speaking Women 9
- Nepali Male Migrants 8
- Bangladeshi Male Migrants ?

IN BANGLADESH

- Male Migrants 8
- Women Left Behind 7
- Male Migrants 23
- Women Left Behind 14
- Male Truck Drivers 14
- Female Migrants 6

- Group discussions were held with the following stakeholders:

IN INDIA

- Peer Educators 10
- NGOs/CARE staff 11
- Youth Volunteers 7
- PLWHA NGO 6
- PLWHA NGO 4
- Peer Educators 3
- Peer Educators 5
- Youth volunteers 8
- PLWHA NGO 3
- Community leaders 7
- Health centre committee members 6

- Outreach Workers 7

IN BANGLADESH

- NGO partners 7
- NGO partners 7
- Peer Educators 10
- Community Support Group 14
- NGO partners 7
- Border brokers 9
- Peer Educators 9
- DIC support group 6
- Outreach Workers 9