



Vulnerability to HIV and AIDS:
*A social Research on Cross Border Mobile Population from
Bangladesh to India*



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Authors

Dr. Tahmina Sultana, CARE Bangladesh
Anupam Das, CARE India
Mirza Manbira Sultana, CARE Bangladesh
Dr. Fiona Samuels
Dr. Miguel Nino Zarazua



Reviewers

George Kurian, CARE India
Mehrul Islam, CARE Bangladesh
Orianne Boyer, Senior Project Director EMPHASIS
Abu Taher, Team Leader, EMPHASIS Bangladesh
Darinji Sherpa, Team Leader, EMPHASIS Nepal
Nabesh Bohidar, Team Leader, EMPHASIS India

Edited by

Nadia Shadravan

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For more information, or to comment on this document, e-mail: info@bd.care.org; info@np.care.org

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
BDT	Bangladeshi Taka
BDR	Bangladesh Rifles
BGB	Border Guard Bangladesh
BSF	Border Security Force
CBMP	Cross Border Mobile Population
CIUK	CARE International UK
CSW	Sex worker
DK	Don't Know
EMPHASIS	Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support
FGD	Focus Group Discussion
GD	Group Discussion
FP	Family Planning
GFATM Malaria	Global Fund to Fight Against AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
IDUs	Intravenous drug users
IDI	In Depth Interview
KII	Key Informant Interview
MOHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
MSW	Male Sex worker
NASP	National AIDS and STD Program
NGOs	Non Government Organizations
PLHIV	People living with HIV & AIDS
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Workers
UHC	Upazilla Health Complex
UNAIDS	Joint United Nations Programme on HIV & AIDS
VCT	Voluntary Counseling and Testing
VCTC	Voluntary Counseling and Testing Center
WHO	World Health Organization

Executive Summary

There are a growing number of people migrating between Bangladesh, Nepal and India. Mobility has long been linked with heightened vulnerability to HIV & AIDS. While overall HIV prevalence is low in Bangladesh and Nepal, there is a growing concern that vulnerable mobile populations are forming a bridge between high prevalence areas of India and low prevalence areas in Bangladesh and Nepal. Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) is a regional program being implemented by CARE Bangladesh, CARE India and CARE Nepal and led by CARE International UK (CIUK) to reduce AIDS related vulnerabilities among mobile populations crossing the borders of Bangladesh and Nepal into India. This 5-year (August 2009 – July 2014) program, is funded by the Big Lottery Fund (BIG) of United Kingdom.

Baseline Research on cross border migration was initiated to understand the drivers of mobility, access to services for migrants at source and destination, and to understand the risk and vulnerabilities associated with migration and HIV and AIDS. The study was conducted using quantitative methods and a separate qualitative study was conducted to enhance and complement the quantitative data.

Seasonal unemployment, limited opportunities in the agriculture sector and lack of alternative livelihood options are the primary drivers behind illegal migration for people residing in the project districts. The social structure is based on patriarchal gender norms and values where women's mobility is restricted and unaccompanied movement outside the home is perceived as shameful. Undocumented migration as a livelihood strategy for women in this context is driven by extreme poverty and is often a strategy for survival. There is no treaty or policy that allows Bangladeshis to migrate to India for livelihood opportunities. As a result, undocumented migration is often the only option for people traveling to unknown destinations in search of employment. For safety, migrants in Bangladesh choose to use middleman or brokers to navigate their travel across the border. Middlemen or brokers assist with a monetary contract and assure safe reach to destination, and/or the promise of a job upon arrival. The contract between the migrant and the broker may be established but there are often hidden deals and bribes between brokers and border patrol that leave women particularly vulnerable to exploitation. Circular migrants aspire to migrate and live at destination for 2-5 years with occasional visits back home. They aim to earn a good amount of money to allow for the purchase of land, a house and a more comfortable life upon their return. Male and female migrants mostly work as skilled and unskilled laborers at different factories, companies, or at private residences. The jobs at destination are usually organized by brokers or local influential Bangladeshi's in Mumbai and other destination sites. Migrants, with the support of long-time Bangladeshi residents at destination, are sometimes able to secure an ID card, which allows them access to many government provided services including healthcare. Migrants who are not able to secure ID cards rarely attempt to access services for fear of imprisonment. Most Bangladeshi migrants generally migrate alone leaving behind their families and spouses. Many male migrants cope with their loneliness by going to bars and purchasing commercial sex. This tendency of risky behavior increases their vulnerability to HIV and AIDS as prevalence rates are much higher in many of the destination sites in India than in their home districts.

The qualitative study reveals many dimensions of the heightened vulnerability that women who migrate face. For safe passage across the border many women reported sexual harassment, exploitation and forced involvement in the sex trade. Additionally, there is a widely held belief within source communities that women who migrate must be doing so to engage in sex work. As a result, many women who return to their homes after working in India experience stigma and social exclusion. This research showed that overall knowledge of HIV at project sites was low and knowledge levels were higher among educated people. There were many misconceptions among migrants regarding spread of HIV. Service availability and utilization was low across the boarder. Cross border migrants preferred to use village doctors/ private providers for general health services and used government services for Family planning. Migrants cited the behavior of health providers, proximity to their residence and the cost of treatment as the major factors influencing their choice of provider. At destination, the choice of provider largely depended upon whether the migrant had legal documentation.

The research study highlights economic vulnerabilities as the primary driver of migration from Bangladesh to Mumbai (India) or Kolkata (India). The journey across the border can be a dangerous one and many migrants face harassment, violence, stigma and discrimination and remain at risk of HIV infection. Furthermore illegal status at destination coupled with the trials and isolation of entering a new place makes this group of people incredibly vulnerable. Despite these dangers and difficulties many people still choose to migrate because of the economic gain.

1.1 Background

Growing cross-border movement has increased the vulnerability of migrants to HIV & AIDS. The estimates published in 2009 by UNICEF¹ shows an adult (age 15-49 years) HIV prevalence rate of 0.3%, 0.1% & 0.4% in India, Bangladesh and Nepal respectively. While overall HIV prevalence is low in Bangladesh compared to India and Nepal, there is a growing concern that mobile populations are forming a bridge between high prevalence areas of India and Nepal back to Bangladesh. India has a higher prevalence rate of HIV with pockets of much higher prevalence in urban areas. The six states where the HIV prevalence is higher are Manipur, Nagaland, Andhra Pradesh, Karnataka, Maharashtra & Tamilnadu with Manipur having the highest prevalence among all. Unless the issues of HIV and AIDS and mobility are tackled, the HIV & AIDS prevalence in the region will increase. With this concern in mind, CARE initiated a regional program to create a sustainable and cohesive impact on AIDS related vulnerabilities associated with cross border mobility.

Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) is a multi-country project implemented by CARE in Bangladesh, India and Nepal to reduce the vulnerabilities to HIV & AIDS among mobile populations crossing the borders of Bangladesh and Nepal into India. This 5-year (August 2009 – July 2014) program is funded by the Big Lottery Fund (BIG). The program pilots a cross-border intervention to increase access to prevention and treatment services; strengthen capacity of civil society organizations and government institutions to address the needs of mobile populations and influence the creation of an enabling environment for safer mobility and reduced vulnerability to HIV through generating relevant and accurate data and information. The Overseas Development Institute, UK (ODI) is the technical partner agency for the research component of this project.

The initial period (Year-1) of the Program has been designated as the Knowledge Building Phase. This Phase includes activities such as reviewing available verifiable data to help identify knowledge gaps regarding key mobile populations and their specific vulnerabilities. Based on the evidence gathered during this phase, focused interventions will be designed to reduce vulnerabilities to HIV & AIDS.

Some of the specific exercises planned during the knowledge-building phase are: mapping of the mobile populations, a rapid community needs assessment and a stakeholder analysis. The rationale behind carrying out these exercises is identifying the locations of the mobile populations, their estimates; understanding the micro-level dynamics, vulnerability to HIV and the unmet needs of this population. The output of the mapping exercise has been considered to serve as the basis for planning the baseline study. The baseline study has two components, quantitative and qualitative, which were carried out simultaneously.

Studies demonstrated linkages between increased vulnerability during mobility and the spread of HIV. Migrants can function as bridge groups and can carry the virus from high prevalent to low prevalent areas. Migrants can become vulnerable to contracting HIV during transit and after they arrive at their destinations (Skeldon, 2000). This study explored the factors that enhance vulnerability to HIV and AIDS. Other potential risk factors for migrants include separation from families and partners, and separation from the socio-cultural norms that guide behaviors in society (ibid). Most individuals among the mobile population are not aware of their personal risk for HIV infection because they are not residents anywhere long enough to receive targeted behavior change communication messages and essential prevention education. In recent months, most of the National AIDS Control Programs have started to pay more attention to mobile populations. The issue of international migration has been given more importance in the NACP IV strategies, which are currently being developed in India. As multiple factors affect HIV vulnerability, multi-sectoral approaches are required to bring together the key actors from source, transit, and destination communities to minimize the incidence of HIV & AIDS among mobile groups.

At a glance, this report is focused on the mobility context and its relation to HIV and AIDS. The study tried to explore and discuss context and experiences throughout the mobility continuum including sexual behavior, HIV knowledge, stigma and discrimination, violence, service availability and access. It also tried to unearth the multitude of factors that increase vulnerability among migrants and their families.

¹ http://www.unicef.org/infobycountry/nepal_nepal_statistics.html#76

Presentation of the report

In line with the objectives, the baseline survey addresses the following thematic areas:

- Context of Mobility
 - Societal Structure, Pull and Push Factors
 - Mobility Experience including Future goals, wishes, perspectives, hopes, dreams
 - Work and Employment Experience
 - Stigma and discrimination and experience of Violence
- HIV and STI Knowledge
- Sexual Behavior and condom Use
- Service provision and access
- Conclusion

1.2 Research context

The overall research goal was to gather information to help design interventions and to measure progress/changes in behaviors over the implementation period. The baseline quantitative survey was carried out by Nielsen India, Nepal and Bangladesh in the respective countries in 2010-11, using a methodology consistent across the three countries. Various mechanisms were set forth in the pre-survey workshops attended by the EMPHASIS officials and the CARE country offices (Bangladesh, India and Nepal), CARE USA, and ODI to make the process as participatory as possible. The regional research manager and ODI also ensured that dialogue, the sharing of tools and other learning experiences occurred across CARE country offices.

The ultimate objective of the study is to identify and analyze the major vulnerabilities that influence HIV/STI transmission and risk followed by testing a model intervention for addressing those vulnerabilities.

A quantitative and qualitative research design was designed to reach the objectives of the study. The respondents selected for the study were part of our Impact population (spouses, returnees/circular migrants) and other key stakeholders such as community leaders, health providers, sex workers, brokers, police and law enforcement. Through In-Depth Interviews, Focused Group Discussions, Key Informant Interviews and Case studies, data was collected from source, transit and destination sites.

The following are issues mentioned in existing literature that need to be explored further through this study:

- Undocumented status of mobile population
- Exploitation and violence in border or transit areas
- Political sensitivity of illegal migration
- High-risk behavior in destination communities
- Women especially vulnerable to exploitation
- Lack of access to health care
- Spouses and families highly exposed to risk of HIV & STIs
- Discrimination and stigma
- Lack of data to inform interventions

1.2.1 Research objectives

Overall Objectives of the Baseline Research

- To understand the volume, patterns (who, when, where, how, how-often, for how long, etc), and drivers of mobility for the purpose of work (disaggregated by age, sex, caste, occupation.)
- To understand access to service provision (health care, legal services, social services, police/border guards) for different migrant groups along the continuum (disaggregated by age, sex, caste, occupation.)
- To document and measure the main vulnerabilities that contribute to HIV/STI risk (violence, exploitation and risk behaviours) among impact populations (disaggregated by age, sex, caste, occupation.)

** A separate qualitative study was undertaken to complement and triangulate the quantitative study.

1.2.2 Research questions

The research questions are:

- What are the main vulnerabilities that influence HIV/STI risk among impact populations?
- What factors determine levels of vulnerability? (E.g. how people travel (alone or in groups), whether they have connection in destination / transit areas, etc.)
- What are the unique vulnerabilities faced by different kinds of people (men, women, children, older, younger) along the mobility continuum, and what are the sources of these vulnerabilities?
- How do people cope and survive / adjust to vulnerabilities / difficulties?

1.3 Brief Review of Literature

1.3.1 HIV & AIDS situation in South Asia

HIV prevalence rates in South Asia² are relatively low but the absolute figures of PLHIVs is higher when compared to other countries and contexts. According to UNAIDS and World Bank estimates, of the 33.4 million adults and children living with HIV and AIDS (PLHIV) worldwide, an estimated 10 percent (about 2 to 3.5 million people) live in South Asia.^{3, 4} Given its large population, the South Asia region is second only to sub-Saharan Africa in terms of the number of people infected with HIV. In South Asia, as in the rest of Asia, the HIV epidemic is concentrated among highly vulnerable groups engaging in risky behavior, notably injecting drug users (IDU) and their partners, men who have sex with men (MSM), and sex workers and their clients.⁵

South Asia is characterized by relatively rapid economic growth, and low HIV prevalence at less than 1 percent. However, a diverse range of structural factors make each country in the region vulnerable to the spread of HIV, including stigma and cultural impediments to sexual discussion; high rates of sexually transmitted infections (STIs); limited condom use; a large, structured sex-work industry; low social status of women; trafficking of women into commercial sex; porous country borders; poverty, inequality, and illiteracy; and high levels of mobility, including widespread rural-urban, interstate, and cross border migration.⁶

India alone accounts for 2.4 million people living with HIV, approximately 93 percent of those infected in South Asia. The estimated adult HIV prevalence in India was 0.31 percent (0.25% – 0.39%) in 2009. The adult prevalence was 0.25 percent among women and 0.36 percent among men in 2009. Among the states, Manipur has shown the highest estimated adult HIV prevalence of 1.40 percent, followed by Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Besides these states, Goa, Chandigarh, Gujarat, Punjab and Tamil Nadu have shown estimated adult HIV prevalence greater than national prevalence (0.31%), while Delhi, Orissa, West Bengal, Chhattisgarh & Pondicherry have shown estimated adult HIV prevalence of 0.28-0.30 percent. All other states/UTs have lower levels of HIV.⁷

Box: Routes identified by Government of Bangladesh that are used for Trafficking Children and Women, 2004

Route 1:

from Dhaka to Barisal by Launch and from there to Jessore and Satkhira

Route 2:

from Barisal to Benapole and other border areas via Jessore

Route 3:

from Gabtoli, Dhaka to Jessore and Satkhira via Aricha.

Route 4:

from Gabtoli, Dhaka to Chapai Nawabgunjand other border areas via Nagarbari

Route 5:

from Gabtoli, Dhaka to Darshana by bus and from there to different border areas

Route 6:

from Gabtoli, Dhaka to Dinajpur and Lalmonirhat by bus and from there to other border areas

² Countries considered under "South Asia" are – Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka.

³ UNAIDS, "AIDS Epidemic Update", 2009

⁴ Markus Haacker and Mariam Claeson, (eds.), *HIV and AIDS in South Asia – an Economic Development Risk*, World Bank, 2009.

⁵ *Redefining AIDS in Asia: Crafting an Effective Response*, Oxford University Press, 2008

⁶ *Ibid*, World Bank, 2009.

⁷ National AIDS Control Organisation (NACO), Ministry of Health and Family Welfare, Press release, December 1, 2010

Bangladesh is facing a growing epidemic, particularly among injecting drug users, but HIV rates remain relatively low among sex workers, providing an opportunity to avert a heterosexual epidemic.⁸ The first HIV & AIDS case in Bangladesh was reported in 1989. Since 1994, HIV infection levels have increased, although the problem is still relatively in small scale, with around 12,000 adults – 0.2% of the total population – infected.⁹

1.3.2 Mobility in South Asia

Economic imbalances, extreme poverty, population growth, environmental degradation, social networks, long and porous international borders, global and regional employment opportunities, and trade and migration policies all continue to contribute to the increasing magnitude and varied forms of internal and international migration in the region.¹⁰

In the following discussion of migration patterns, nations are designated as source, transit, or destination countries. Within the region, India and Pakistan are considered to be all three. Nepal, Bangladesh, and Sri Lanka are primarily source countries, while the Maldives and Bhutan are mostly destination countries. Mobility patterns show that people from Bangladesh come to India uni-directionally, while there is bidirectional movement between India and Nepal¹¹. Over the last twenty years, there has been an increase in growth in irregular migration. India and Pakistan are frequently used as transit countries for undocumented migrants from Bangladesh and Nepal en route to the Middle East and South-East Asia. Given the informal nature of undocumented migration, no definitive data source of irregular or undocumented migrant workers is available.¹²

Most migrant recruitment in source countries of South Asia is licensed and regulated by source country governments. However, given the number of recruiters involved, governments face a major challenge in regulating recruitment agents and halting the operations of unregistered individual agents (dalals), middlemen, or sub-agents who engage in fraudulent practices. Unregistered agents are pervasive in areas affected by poverty, economic disparities, conflict, and other factors that cause people to migrate. Growing insecurity at home, lack of economic opportunities, and the prosperity stories of recruiting agents and returnee migrants encourage large migration flows from Nepal and Bangladesh to India.¹³

The feminization of migration is a major trend in South Asia, with increasing numbers of women going abroad to work in foreign labour markets, to marry, and to accompany their families. Women migrate through regular and irregular channels, mostly through the latter and face social inequality both in host countries and in their home states. Their employment is largely confined to low skilled, unrecognized, care-centered jobs in the service sector, such as domestic work or entertainment, where vulnerability to verbal, physical, and sexual abuse is high given the isolated nature of their work environment.¹⁴

The women migrating under irregular conditions are at an even greater risk.¹⁵ Bangladesh and Nepal are the major centers of origin countries, while India and Pakistan are two major destinations or transit countries to other regions, particularly the Middle East.¹⁶ Reportedly, In Bangladesh trafficking of children and women is rampant both within the country as well as outside the country. Women and children (both girls and boys) from rural areas are trafficked to urban centers for commercial sexual exploitation and forced labor. Street children living in Dhaka are among the prime targets for organized child-traffickers. Boys are mostly taken to the Persian Gulf, particularly the United Arab Emirates. The girls end up in brothels in India (mostly in Kolkata or Mumbai), Pakistan, and in Middle-Eastern or South Asian countries. The main trafficking route is Dhaka-Mumbai-Karachi-Dubai.¹⁷ Jessore and Satkhira are the areas in the South of the country through which trafficked people are moved to India. The easiest and the best known route to India is through Benapole border crossing in Jessore. Trafficked persons constantly flow in to Kolkata; some to serve in the

⁸ *HIV & AIDS and mobility in South Asia Regional HIV, Health and Development Programme for Asia and the Pacific UNDP Asia-Pacific Regional Centre, 2010*

⁹ *HIV & AIDS in Asia : <http://www.avert.org/aids-asia.htm>*

¹⁰ *Ibid UNDP*

¹¹ *Ibid UNDP*

¹² *Ibid UNDP*

¹³ *Ibid UNDP*

¹⁴ *Ibid UNDP*

¹⁵ *Ibid UNDP*

¹⁶ Masud Ali, A. K. M., "Treading along a Treacherous Trail: Research on Trafficking in Persons in South Asia," in *Data and Research on Human Trafficking: A Global Survey*, IOM, 2005.

¹⁷ "When Victims Become Accused," *Times of India*, October 13, 2003 in *HIV & AIDS and mobility in South Asia Regional HIV, Health and Development Programme for Asia and the Pacific UNDP Asia-Pacific Regional Centre, 2010*

city's flourishing sex trade, while a large number is trafficked to other parts of India¹⁸. Some of the most popular routes are identified in (Figure 1) by the Government of Bangladesh.¹⁹

Official statistics on the yearly flow of workers migrating through formal mechanism from Bangladesh do exist, but there is no record on the migrants moving out through informal channels, the number of permanent returnees, and the number of individuals who have gone abroad. The number of male undocumented migrants from Jessore to India is estimated at 1593 and female migrants from Jessore to India is 3314. Number of male and female migrants from Satkhira is 897 and 807. In Jessore district, the number of female migrants surpasses the number of male migrants³⁰.

1.3.3 Migration and HIV & AIDS

Large proportions of people living with HIV in South Asia were infected while working abroad, indicating that there is a large gap in the HIV response that needs to be addressed. The National AIDS and STD Programme Report (2006), Bangladesh, reported that approximately 67% of identified HIV-positive cases in the country are returnee migrant workers and their spouses. In India, the National AIDS Control Programme Phase III (NACPIII) focuses on three most-at-risk population groups (female sex workers, IDU, and MSM) and one bridge population i.e. migrants. Prior to 2005 sentinel surveys did not include migrants as a vulnerable population, so data related to migrants was limited. From 2005 onward sentinel surveys have started collecting data on migrants (focusing on high-risk migrants/single male migrants), and the overall number of sentinel sites for migrants have been increased.²⁰

How does migration and mobility influence the spread of HIV? International migration patterns where millions of people leave their country in search of better employment opportunities has received attention from the United Nations which noted migration between countries and HIV as two critical social issues that the world is confronted with today.²¹ Migrants may be predisposed to riskier sexual behavior than others in their new social settings owing to personal traits established before migration. The act of voluntary movement — often over long distances, between radically different socio-cultural environments, and with uncertain consequences and support networks at destination — defines migrants, to a greater or lesser degree, as innovators or “risk-takers.” Econometric studies of migrant behavior routinely attribute outcomes different from those affecting non-migrants to migrants’ as “unobservable” risk-taking tendencies or characteristics (Moreno 1994; Rosenzweig and Wolpin 1988). Heightened risk-taking behavior conceivably applies to other aspects of migrants’ lives, including their sexual conduct early in life and in post-migration settings. If so, then migrants might be more likely than non-migrants to engage in unprotected sex with multiple partners at areas of destination, regardless of their gender or the presence of a regular sexual partner (such as a spouse).²²

1.1.4 HIV Situation and Vulnerability in Bangladesh

HIV prevalence in Bangladesh remains less than 0.1% in the general population but epidemiologists agree that it is evolving rapidly. According to the latest BSS (GFATM, BSS, 2007) of Bangladesh, the HIV prevalence among female sex workers, MSW and Hijras (transgenders) was 0.3%. Although HIV prevalence was below 1% among female sex workers, in Hilli (a small boarder town in the northwest part of Bangladesh), the prevalence was as high as 2.7% among casual sex workers all of whom had crossed the border into India to sell sex. Since the detection of the first HIV case in Bangladesh in 1989, UNAIDS/WHO has estimated that 12,000 people in Bangladesh were living with HIV (estimate range: 7,700 to 19,000) (UNAIDS/ WHO/ UNICEF, 2008) in 2007.

Bangladesh still regards HIV and AIDS as a looming threat as the country maintains an increasing rate of needle sharing among intravenous drug users (IDUs), poor knowledge of HIV & AIDS and STIs, high rates of STDs, risky behavior among adolescents, unsafe blood transfusions, and a large number of migrant laborers

¹⁸ *Mapping of missing, kidnapped or Trafficked children and women: Bangladesh Perspective, International Organisation for Migration, Dhaka in The Counter Trafficking Framework Report, Ministry of Women and Children Affairs, 2004*

¹⁹ *Government of Bangladesh CPCCT Project Document in The Counter Trafficking Framework Report, Ministry of Women and Children Affairs, 2004*

²⁰ *HIV & AIDS and mobility in South Asia Regional HIV, Health and Development Programme for Asia and the Pacific UNDP Asia-Pacific Regional Centre, 2010*

²¹ *Interagency Coalition of AIDS and Development, (2004), International Migration and HIV & AIDS*

³⁰ *Documenting the Undocumented: Female Migrant Workers from Bangladesh (2005),Therese Blanchet,Abdur Razzaque,Hannan Biswas*

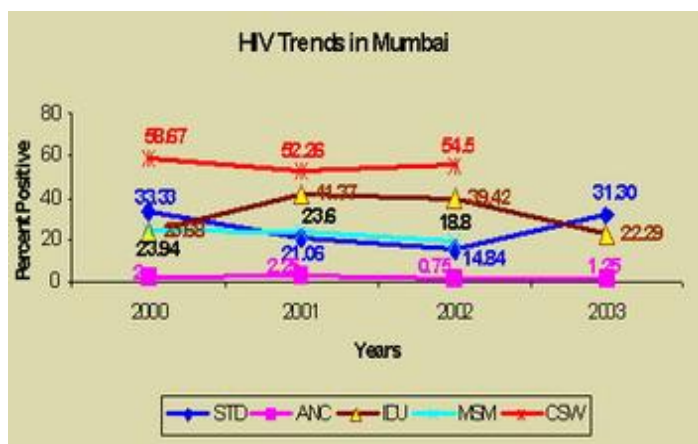
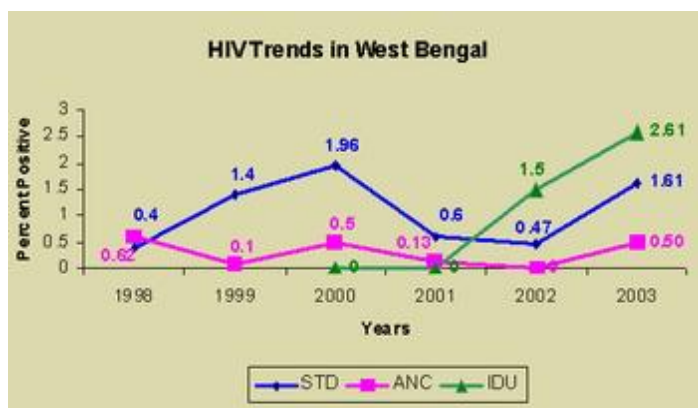
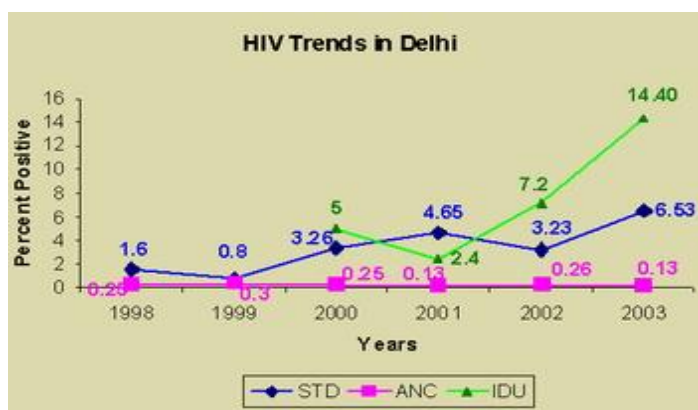
²² *Migration, Sexual Behavior, and HIV Diffusion in Kenya, Martin Brockerhoff Ann Biddlecom 1998*

and transport workers. This coupled with inadequate access to health care s, high rates of illiteracy and poverty causes great concern.

Risky drug injecting practices have increased HIV infection levels to double from 1.7% in 2000-2001 to 4% in 2002-2003 (UNAIDS and WHO, 2005) and the 8th round of serological surveillance survey data (GFATM, BSS, 2007) showed that in central Bangladesh, IDUs had the highest prevalence of HIV (7%). For the first time, HIV has been identified in cities outside of central Bangladesh

An estimated 2.2 to 3.9 million Bangladeshi nationals are considered to be at higher risk of acquiring HIV, including drug users, female sex workers and their clients, men who have sex with men (MSM), and internal and cross border migrants (World Bank and UNAIDS, 2009).

Figure 1.3.5.1 Trends and Estimates of HIV Infections ²³ in Delhi, West Bengal and Mumbai



Moreover, passive case reporting²⁴ suggests that Bangladesh nationals returning from regions of high HIV prevalence, whether victims of cross-border trafficking or migrants returning from jobs overseas, may also be at higher risk (GFATM, BSS, 2007).

For decades, India had been receiving a constant flow of unauthorized migrants from Bangladesh. According to a survey conducted by the Indian Statistical Institute in 2002-2003, most had economic reasons for migrating, such as poverty and lack of employment opportunities, in addition to political instability. These migrants generally found work as cheap labourers in the informal sector, often as domestic helpers, construction workers, rickshaw pullers, and rag pickers.

1.3.5 HIV Situation and Vulnerability in India

New, more accurate estimates of HIV indicate that approximately 2.5 million (2 million–3.1 million) people in India were living with HIV in 2006, with a national adult HIV prevalence rate of 0.3%. Although the proportion of people living with HIV is lower than previously estimated, India's epidemic continues to affect large numbers of people. Prevalence trends in India vary greatly between states and regions. Even in the four southern states (Andhra Pradesh, Karnataka, Maharashtra and Tamil Nadu) where the majority of people living with HIV are residing, HIV prevalence varies and the epidemic tends to be concentrated in certain districts (NACO, 2005; World Bank, 2005). Adult HIV prevalence in six states included in the recent national population-based survey (NFHS-3, 2007) varied from 0.07% in Uttar Pradesh, to 0.34% in Tamil Nadu, 0.62% in Maharashtra, 0.69% in Karnataka, 0.97% in Andhra Pradesh, and 1.13% in Manipur.

Prevalence in all other states was 0.13%. An earlier analysis of sentinel surveillance data also showed that

²³ HIV Epidemic in India ; Delhi, West Bengal & Mumbai (1998-2003), report published by UNAIDS

²⁴ Passive case reporting are the cases being reported and/or confirmed at or by any health facilities (in contrast to active case-finding methods where cases are actively looked for). The passive case detection involves reporting from institutions, like PHCs, dispensaries, district hospitals etc. However, such cases represent those patients who seek treatment from the government institutions and have access to them (CDC, 2008).

HIV prevalence in southern states overall was about five times higher than in northern states in 2000–2004 (Kumar R et al., 2006). However, pockets of high HIV prevalence (mainly among population groups at high risk of exposure to HIV) have also been identified in states where overall prevalence is generally low.

Data from the expanded 2006 sentinel surveillance show stable or declining prevalence among pregnant women in Tamil Nadu, Maharashtra, Karnataka, and Andhra Pradesh, but high HIV prevalence among sex workers, and rising HIV prevalence among injecting drug users and men who have sex with men in a few states. Outside of the north-east of the country, where the use of contaminated drug injecting equipment is a key risk factor, HIV appears to be spreading mainly as a result of unprotected sex between sex workers and their clients, and their respective sex partners (Kumar et al., 2005). Prevention programmes focusing on sex workers show some success and HIV prevalence is on the decline among sex workers in areas that have been the focus of targeted prevention efforts, especially in Tamil Nadu and other southern states. However, prevention efforts are often complicated by the varied nature of commercial sex. (Char, Piller & Shirke, 2003).

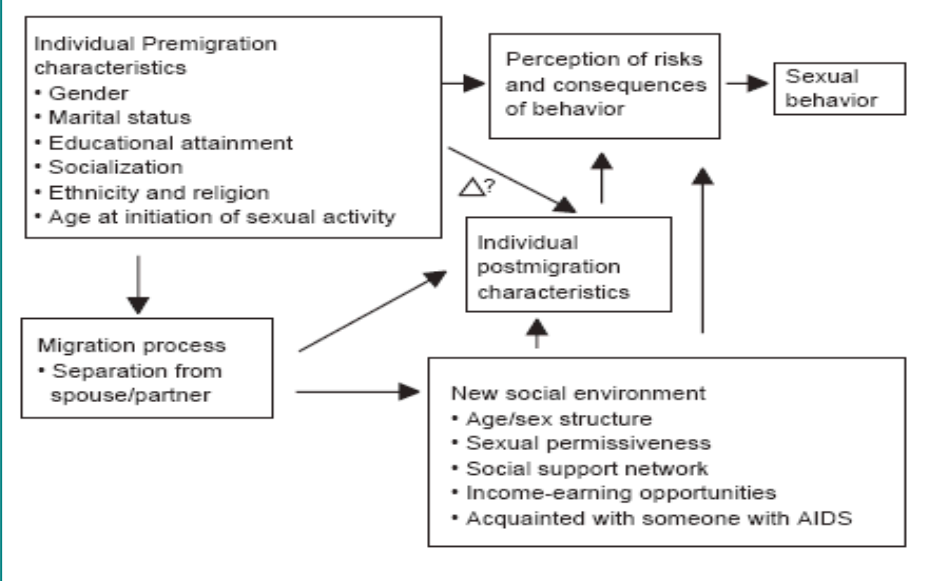
More men are HIV positive than women. Nationally, the prevalence rate for adult females is 0.29 percent, while for males it is 0.43 percent. This means that for every 100 people living with HIV and AIDS (PLHAs), 61 are men and 39 women. Prevalence is also highest in the 15-49 age group (88.7 percent of all infections).

While adult HIV prevalence among the general population is 0.36 percent, high-risk groups, inevitably, show higher numbers. Among Injecting Drug Users (IDUs), it is as high as 8.71 percent, while it is 5.69 percent and 5.38 percent among Men who have Sex with Men (MSM) and Female Sex Workers (FSWs), respectively.

1.3.6 Influence of migration on sexual behavior

Migration is a historic phenomenon that involves crossing physical borders as well as also cultural and emotional borders.²⁵ Vulnerability to HIV is often at its highest when people live and work in conditions of poverty, powerlessness and social instability. Separation from family, spouses, familiar surroundings, coupled with isolation and loneliness in an alien environment creates a sense of anonymity and an absence of social responsibility thereby providing these individuals with more

Figure 1.3.6.1: Conceptual model of the influence of migration on sexual behavior
(Adapted from Martin Brockerhoff Ann Biddlecom 1998)



sexual freedom. Such migrants thus become susceptible to practicing high-risk sexual behaviors (multiple sex partners, sex with sex workers) and, in effect, are more vulnerable to HIV.

²⁵ Interagency Coalition of AIDS and Development, (2004), *International Migration and HIV & AIDS*

2.1 Study Design:

This research employed a cross-sectional design involving both qualitative and quantitative methods carried out simultaneously in two countries along the mobility routes from Bangladesh to India. The study locations were purposively selected based on pre-identified source districts, transit areas and destination cities in which the project is operational. The fieldwork was conducted during the period of November 2010 through to March 2011. The methodology for this study was finalized in discussion with research consultants the Nielsen Company, CARE EMPHASIS team from Bangladesh, India and Nepal, and ODI.

The quantitative study was carried out by Nielsen India and Bangladesh, using a methodology consistent across the countries in order to ensure uniformity of the issues addressed to the extent possible. A qualitative study was also conducted and carried out by the CARE EMPHASIS team to complement and triangulate the quantitative findings. The qualitative study tried to explore deeper insights on specific issues at source, transit and destination.

2.2 Study Methods (Quantitative):

For the quantitative survey the sample size covered in each of the two countries was based on the number of mobile people mapped out by the respective CARE country teams in the areas identified for the EMPHASIS program.

Mapping was carried out to gather information before the study commenced. The purpose was to map sites within each district where migrants either worked or resided, estimate the number of migrants, the types of occupations they were engaged in, their places of origin and the existence of HIV or any other health programs available. To obtain this information, discussions were held with officials of various districts including NGO functionaries, police officials, and leaders of associations. In addition, at each identified site, interviews were conducted with individuals knowledgeable about male migrant workers such as labour union leaders, local association leaders, contractors and security men. This information was used as a base for both the qualitative and quantitative study sample selection.

The sample size for the quantitative survey was calculated using the following statistical formula:

$$n = \frac{p(1-p) \times Z^2}{e^2} \times Deff$$

Where, n is the required sample size; p is the estimated value of the parameter; e is the permissible margin of error; the z statistic is set at 196 which corresponds to the 95% confidence level, and deff refers to the Design Effect.

The study defined the estimated value of the parameter p at 50%, with e set at 5%, and the design effect at 1.2. That resulted in an estimated sample size of 456. Considering 20% as causality, the calculated sample size was 547, which was rounded up to 550. In the end, a sample of 550 respondents was collected in Bangladesh, 260 from Jessore district and 290 from Satkhira district, whereas in India, a sample of 551 Bangladeshi migrants were interviewed, 384 from Kolkata and 167 from Mumbai.

The target population covered by the survey in the two countries were defined as follows: In India, mobile Bangladeshi population (men & women) and in Bangladesh, circular or returnee mobile people (men & women, those who had been to India), spouses of the mobile people, and any adult member in a household with at least one mobile person (see table below).

BANGLADESH	INDIA
<ul style="list-style-type: none"> ● People from Bangladesh who cross into India for the purposes of work. ● Minimum stay is 3 months, maximum stay is 10 years. ● Age group 15-49 ● Men – living at destination without spouse ● Women – living at destination with or without family 	<ul style="list-style-type: none"> ● People from Bangladesh or Nepal who cross into India for the purposes of work (this criteria was relaxed to a condition that women who come along with their husbands who has migrated for work can also covered as impact i.e. mobile population) ● Minimum stay is 3 months; maximum stay is 10 years for Nepali Population and 20 years for Bangladeshi Population. ● Age group 15-49 ● Men – living at destination without spouse (for Bangladeshi men this criteria was relaxed in view of reported difficulty in achieving the sample size, to a condition that sampled men may or not be living with the spouse. ● Women – living at destination with or without family

The survey followed a two-stage procedure. First, a selection of sub-locations within the districts were selected and mapped out by CARE Country offices. CARE country offices carried out an exhaustive mapping of the sub-locations (villages in Bangladesh) identified to have the target population for intervention in the EMPHASIS program. In the case of India, the allocation of the sample by cities was done in a way that Mumbai got 30 percent of the sample and 70 percent of the sample was allocated to Kolkata. The districts served as the universe from where the sample of sub-locations was drawn. The sub-locations/villages, which served as the Primary Sampling Units (PSU), were selected through random sampling procedures.

Second, at the PSU level, a house listing exercise was concentrated in pockets of mobile groups. Such pockets were considered as clusters in the sampling frame from where a sample of households was drawn on a random basis. Households were identified as the impact population if they had at least one member who has migrated to India for the purpose of work. Three categories of respondents were considered for the survey: 1) circular/returnee migrant, 2) spouses of the migrant, and 3) Potential Migrants. Only one eligible person was covered from the identified household. In households with more than one eligible category, preference was given to circular/returnee migrants.

In Bangladesh, the sample was covered from two districts bordering India which were identified as EMPHASIS program districts given the number of migrants residing there. The approximate population size of Bangladeshi migrants in India was considered as the basis for sample allocation between Kolkata and Mumbai. In both countries the survey enumerators had problems identifying respondents. It appears that a group of eligible respondents refused to participate in the survey due to their 'illegal' migratory status. As a result, additional villages had to be covered in each district to compensate for the sample shortfall. The additional villages were identified from the mapping exercise conducted by CARE. However, since the number of eligible respondents in many PSUs was insufficient to cover the required sample, CARE was forced to utilize snowball sampling techniques. As a result, a percentage of the sample population was achieved through non-random processes. This suggests that selection bias problems could be present in the sample and appropriate econometric methods would be required for analysis. In the table below the study locations and the sample coverage in each country are described in more detail.

BANGLADESH	INDIA
Study Site (Districts/cities covered)	
Jessore district (29 villages from sub-districts - Chaugacha, Jhikargacha, Sadar, Sursha)	Cities and Sub Locations covered
Satkhira district (26 villages from Sub-districts - Debhata, Sadar, Kolaroa).	For Bangladeshi Mobile Population Kolkata: 37 Mumbai: 44
Sample Coverage	
Jessore: 260 Satkhira: 290	For Bangladeshi Mobile Population Delhi: 384, Mumbai: 167

1.3 Study Methods (Qualitative):

The method of qualitative study was finalized through a consultative workshop with EMPHASIS staff facilitated by CARE-IUK and ODI. Explorative and qualitative methods framed this research design. The data collection methods included IDI (In-Depth Interview), KII (Key Informant Interview), FGD (Focus Group Discussion), Case Studies, and Spot (Transit Point) observations. In-Depth Interviews were designed to explore vulnerability among the cross border mobile population (CBMP). Data was collected from 154 respondents who were all part of the Impact Population (IP), which was comprised of returnee/circular migrants who cross borders without documentation, the spouses of CBMP, brokers who assist in border crossing, community leaders, potential migrants, members of the local elected body, law enforcement personnel, transport workers and PLHIV. A purposive sample selection method was utilized to choose the respondents. Twenty-five IDIs, 16 KII, 7 FGD, 5 Case studies and 2 transit point observations were conducted in districts where EMPHASIS is operational.

Table 2.3.1. Distribution of respondents in each data collection method by type of respondent and sex:

Method used	No.	Types of respondent	Male	Female	Total
Interview					
In-depth interview (IDI) with Impact Population	25	Spouse	05	05	10
		Returnee	04	03	07
		Potential	02	04	06
		Circular	02		02
Total	25		13	12	25
Key In-format Interview (KII)	16	Sex Workers		02	02
		Community leaders	03	01	05
		Brokers	03		03
		Police	03		03
		Transporters	02		02
		Health workers		02	02
Total	16		11	05	16
Focus Group Discussion (FGD)					
Problem tree and Service access wheel²⁶	04	Returnee/circular	13		13
		Spouse		16	16
		Spouse	14		14
Before and Now	02	Spouse		09	09
		Returnee	07		07
Bodies of Control	01	Returnee		09	09
General Discussion		Sex worker		31	31
Total	07		34	74	108
Case Study					
Case Study (CS)	04	Returnee, PLHIV, Broker	02	03	05
	04		02	03	05
Others					
Spot observation	02	All			
Literature review	04	Previous study, paper cutting			
Total no of respondents			60	94	154

Table 2.3.2 Distribution of respondents by number of respondents and place:

Respondents	District	Thana	Union	Villages
77 (FGD-3, GD-1, IDI-12, KII-7)	Jessore	Sharsha	Dihi, Putkahali, Chowgasa, Benapole, Goga	Purundapur, Kushkhali, Tengrali, Salkona, Balunda, Shamtabazar, Bosotpur, Ramchandrapur, Gatipara, Shikarpur, Patbari
77 (FGD-4, IDI-13, KII-9)	Satkhira		Boikary, Bansdah, Bhomra, Chandanpur, Debhata and Ghona	Basantapur, Chanduria, Sonabaria, Kaondanga, Kathonda, Goalpara, Chowbari and Boikary

²⁶ Service access wheel: FGD tool used to assess impact population's access to different services available in the locality

Table 2.3.3. Distribution of respondents in each data collection method by type of respondent and sex at destination and transit in India

Categories at Destination in India	Respondents covered
In-depth interviews	
Men living alone	4
Men living with family	4
Women alone/with family	4
Total	12
Key Informant Interviews	
Police	1
Employer	1
Indian migrants/ local pop migrants	1
Health providers (pub, private, pharmacies)	1
PLHIV	1
Community leaders	1
(Migrant orgs/solidarity groups)	1
Total	7
Case studies	
PLHIV	1
Other interesting cases	1
Total	2
Group discussions	
Men	3
Women	3
Male Youth	2
Total	8
Categories at Transit in India	
Key Informant Interviews	
Police	2
Sex workers / bar girls	2
Transporters	2
Community leaders	2
Total	8
Total number of respondents in India	37
Actual size needed	

The respondents of IDI, FGD and the case study were the impact population of the project. Respondents of IDI, FGD and the case study were selected based on the following criteria:

- Returnees/circular migrants who stayed in India for a minimum 3 months to a maximum of 10 years
- Potential migrants who decided to go to India
- Age group 15-49 years
- Man whose spouse lives in India.
- Woman who's spouse lives in India
- Sex workers who have returned from India.
- PLHIV who have returned from India.

The selection criteria was determined at the beginning of the EMPHASIS programme. To meet the criteria of the IDI respondent a purposive sampling method was followed.

KII were conducted with stakeholders (brokers, community leaders, law enforcement personnel, and health workers) to learn about the perception of and knowledge on HIV & mobility in the community. These stakeholders were chosen based on their connections to the vulnerabilities that exist as a result of mobility between Bangladesh and India. Additionally KIIs shed light on other issues such as women's mobility, perceptions on migration, and access to health and legal services.

From the quantitative report developed by AC - Nielsen and qualitative study report developed by CARE EMPHASIS team, information was further analyzed according to the themes below:

Themes of analysis	
<ul style="list-style-type: none"> - Family status and living arrangements - mobility plan, history & experience of migration - home link - awareness of rights - work and employment experience - Service provision and access (incl. health seeking behavior) - health access - knowledge and perception about HIV & AIDS 	<ul style="list-style-type: none"> - benefits and challenges of migration linkages with different networks - future aspiration - Women's vulnerability - Key problems faced by mobile population - Cause/consequences of problem - Kinds of services available - Key barriers to access services - Impact of migration.

1.4 Ethical Considerations

The ethical considerations were primarily concerned with having formal, written consent from each respondent. The statement of written consent was read aloud by the interviewer before the interview, case studies, and focus group discussions. The names of respondents were not documented if not desired by the respondent. The interviewer did not mention respondents' names during any post-data collection meeting with the research team members.

1.5 Limitations

During its course of planning and implementation the study faced several limitations; primary among them was study area coverage, methodological issues, and operational/country specific limitations.

Study Area Coverage

The baseline research was designed to be carried out in areas decided by CARE. This sample universe was comprised of specific areas identified by EMPHASIS in the source countries (two districts in Bangladesh where maximum mobile people were identified) and in the destination country (cities to which maximum Bangladeshi mobile people were reportedly migrating to). Because of the purposive sample methods used, the baseline sample is not representative of the entire mobile population of source and destination countries.

Methodological

As mentioned earlier, since very little was known about the location of the mobile populations at source and destination, EMPHASIS had to carry out a detailed mapping exercise. The output of the mapping exercise was exhaustive and provided information on the size of the sub-locations/villages in terms of estimated mobile populations therein. The baseline used this mapping data as the basis of selection of the locations for survey. Within the selected locations, in order to identify the mobile (impact) population, during the baseline survey house-to-house listings were carried out. Due to issues related to stigma (in Bangladesh) and fear of revealing identity as migrants (in source as well as destination country), there were problems with regard to self-identifying as migrants. As a result, it was difficult for researchers to find Bangladeshi migrants willing to participate in the quantitative study. To resolve this problem the definition of impact population was relaxed and a marker question was used to identify BD respondents at destination.

Operational

The operational limitations associated with this study were primarily due to stringent definitions that were used in identifying survey respondents in source and destination. Due to an inability to find households meeting such criteria, the research teams had to extend field work to several sub-locations which took more time and program resources than what was originally anticipated.

This chapter provides a socio-demographic profile of the impact population covered during the baseline survey and the vulnerability research, including their living arrangements and legal status.

Chapter -3 Description of the respondents & sites

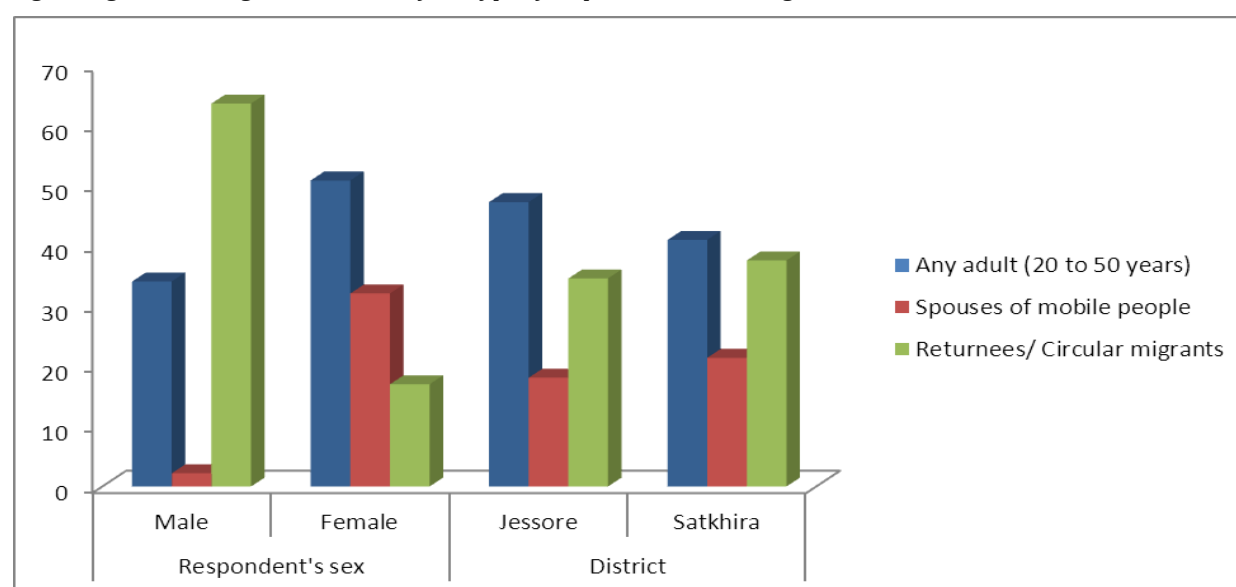
The samples on Bangladeshi Mobile Population selected for the survey at source and at destination were as follows:

Bangladesh (Source)	India (Destination)
Jessore: 260	Kolkata: 384
Satkhira: 290	Mumbai: 167

3.1 Socio-Demographic information of the study population

In Bangladesh three different categories of respondents were interviewed, returnees or circular migrants (36%) (Referred to as a mobile person henceforth), spouses of mobile people (20%) (Referred to as spouse henceforth) and any adult family members (aged 20 to 50 years) from the family of a mobile person (44%) (Referred to as adult henceforth).

Figure 3.g.1 Percentage distribution of the type of respondents according to their sex and location at source



In India respondents were both male and female migrants from Bangladesh who were either living with or without a spouse; (preference was given to those migrants who were laborers). According to the data (including the returnees/circular migrants), 79% of the mobile respondents were male and 21% were female. It was found that the proportion of females was significantly higher in Jessore (31%) than in Satkhira (13%).

Sex and Age profile of the mobile population

The survey only covered those members within impact population who were between the ages of 15-49 years and matched other eligibility criteria.

Table 3.1.1 Percentage distribution of the respondents according to the sex and age of the mobile person at source in Bangladesh

Age of the mobile persons (in years)	Mobile person's sex [^]		District ‡		Total
	Male	Female	Jessore	Satkhira	
<20	13.6	7.7	10.0	14.5	12.4
21-30	52.0 [^]	38.5	50.0	48.3	49.1
31-40	19.9	34.2 [^]	23.1	22.8	22.9
41+	14.5	19.7	16.9	14.5	15.7
Mean age (in yrs.)	29.8	34.0	31.2	30.2	30.7

* P<0.005 for respondent category; [^] P<0.005 for mobile persons' sex; ‡ P<0.005 for district

According to the information from the respondents at source in Bangladesh, the average age of migrant was 31 years. Among females however, the average age was 34 years which was higher than male migrants. A

higher proportion of the respondents (90%) were Muslims, while 10% of the respondents were Hindu. There were significantly more Hindu respondents in Satkhira (16%) than in Jessore (4%).

Table 3.1.2 Age of Respondents at Destination in India (Percent)

Age (Years)	BD		Total
	Male*	Female*	
<18	6.9	3.6	4.9
18-33	59.0	64.1	62.1
34-49	34.1	32.3	33.0
Mean age	30	30	30
SD	10	9	9
Total Respondents	217	334	551

* Chi-square (non-sig) by gender - BD- 0.163

Table 3.1.4 indicates that the mean age of Bangladeshi respondents was 30 years old. Sixty-two percent, the majority, were between the ages of 18-33. Only five percent of respondents were under the age of 18.

Education profile

Sixty-two percent of respondents had attended school. Slightly more than half of those who had attended school had completed a primary level of education (up to class 5). Thirty one percent had attended between class 6-8 and only 17% had attended school beyond class 9.

Table 3.1.3 Percentage distribution of the respondents according to the level of education of the mobile persons at source in Bangladesh

Education of mobile person at source	Mobile person's sex ^		District ‡		Total
	Male	Female	Jessore	Satkhira	
Highest Class Attended					
Class 1- 5	51	60	47.4	56.2	52.2
Class 6-8	32.2	22.2	34.2	28.1	30.9
Class 9-12	16.8	17.8	17.4	15.6	16.9
N	292	45	152	185	337

At destination in India, 36% of respondents had never attended school and another 54 % had completed up to the 8th standard. Only 10% had studied beyond the 8th standard. Differences in findings by gender were not significant. A cross analysis of education profile by city/place of destination and source districts showed significant differences with respect to educational levels. In Mumbai, respondents had higher levels of education than in Kolkata.

Religious profile

Among Bangladeshis overall, 62 percent were Hindu and 37 percent were Muslim. Also a higher proportion of women (67%) than men (54%) reported belonging to the Hindu religion while a higher proportion of men (45%) than women (33%) reported to be Muslim.

While examining religion data by destination, it was found that in Kolkata respondents were predominantly Hindu (87%) and in Mumbai BD respondents were predominantly Muslim (94%). The cross analysis with duration of stay illustrated a statistically significant association between longer duration of stay (10 years or more) and a reporting religious affiliation with Hinduism (94%).

Age at Marriage

The study shows that over three-fourths of female respondents, much higher than men, got married before the age of 18. Over two-thirds of male respondents were married between the ages of 18-24. The mean age at marriage did not differ significantly when disaggregated by source district, place, and duration of stay in India.

Marital and Pregnancy status of the mobile population

Overall, 56% of the respondents at source in Bangladesh were married and living with a spouse at the time of survey. Among the returnees, 77% were married and living with spouse at the time of survey. 23 percent of the respondents were never married, which was significantly higher among males (28%) than females (4%). At the time of the survey, 2.4% of female respondents at source in Bangladesh were pregnant. Overall, three-fourths of respondents residing in India were currently married with a higher proportion of married women than men.

Table3.1.4 Percentage distribution of the respondents according to their own marital status at source and destination

Marital status of the mobile person at source			
	Male	Female	Total
Never married	28.4 [^]	4.3	23.3
Married, But do not live with spouse	13.9	23.9	16
Married, Living with spouse	55.9	53.8 [^]	55.5
Widowed/divorced/ Separated/deserted	1.8	17.9 [^]	5.3
N	433	117	550
Marital status of mobile person at destination			
	Male	Female	Total
Currently married	63.1	82.9	75.1
Never married	33.6	10.2	19.4
Others	3.3	6.9	5.5
N	217	334	551

Current status of Pregnancy at source and destination

The study reveals that 2.4 % of mobile population at source are currently pregnant . Only 7% percent of female respondents at destination reported being pregnant at the time of survey. Since the percentages were small (less than 10%) the cross tabulation did not give very interesting insights.

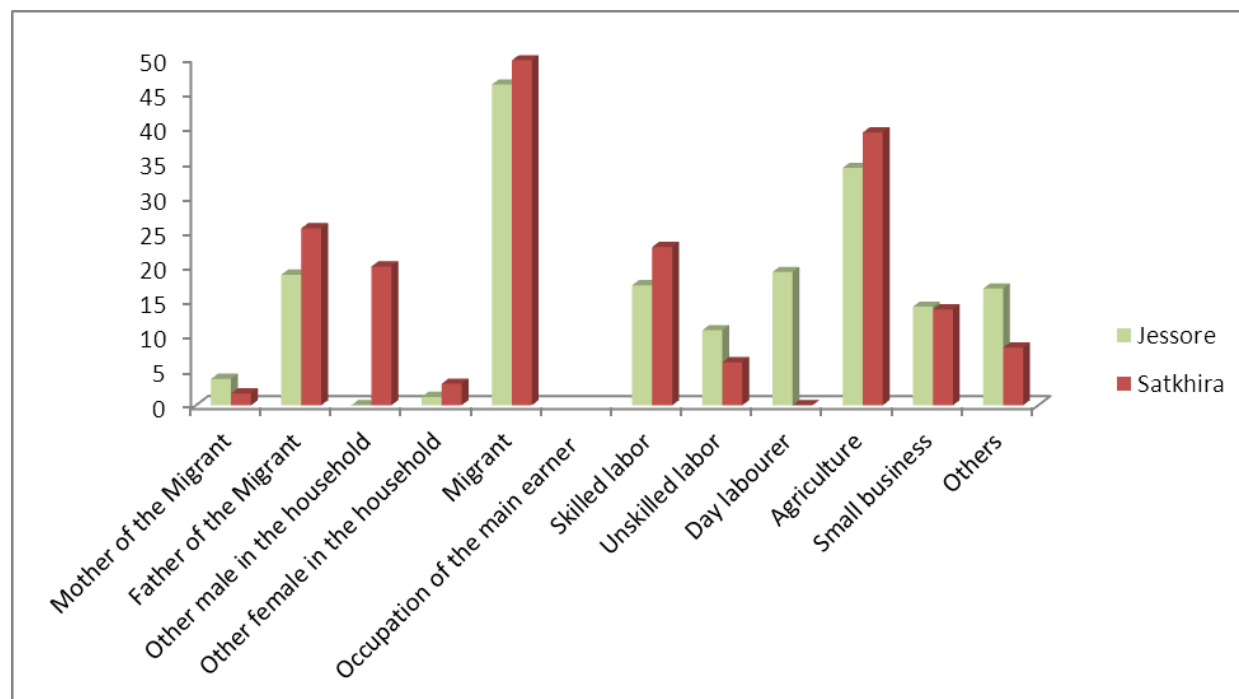
Language

The study shows that almost all BDs (both men and women) at destination were comfortable speaking Bengali. Around one-third were comfortable speaking Hindi as well.

3.2 Livelihoods and economic characteristics

Person as main earner and type of occupation

Figure 3.g.2 Percentage distribution of the respondents according to the person as main earner of their households based on the source district



At source, in 37% of the households the occupation of the main earner was agriculture, followed by day laborer (23%), skilled labor (20%), small business owner (14%) and unskilled labor²⁷ (8%). Further, in around half of the households (48%), the respondents themselves were the main earners for their households, followed by other males within the household (25%), father of the mobile person (22%), and mother of the mobile person (3%).

Table 3.2.1 Percentage distribution of the respondents according to the type of occupation of the main earners of their households at source

Occupation of the main earner	District		Avg. HH size	Total
	Jessore	Satkhira		
Skilled labor	17.3	22.8	4.3	20.2
Unskilled labor	10.8	6.2	4.1	8.4
Day laborer	19.2	26.6†	4.1	23.1
Agriculture	34.2	39.3	4.5	36.9
Small business	14.2	13.8	4.6	14
Others	16.8	8.3	4.18	12.5
N	260	290		550

Bangladeshi men at destination in India were most often casual labourers (42%); worked as mason/mistri (13%); were petty traders (12%), vendors (10%), or Rickshaw Pullers (7%). Nearly half of the women were housewives (46%) and about 23% worked as domestic servants. A few were also found working as casual labourers (9%), petty traders (4%) and tailors (4%).

²⁷ Unskilled labourer is one who does not have any special skill or any technical training on any skill. Day labourer is one in which the labourer is hired and paid one day at a time with no guarantee for work in future.

Table 3.2.2 Percentage distribution of the respondents by Occupation of Bangladeshi Mobile Population at Destination

Occupation at Destination	BD		
	Male	Female	Total
Rag picker	1.4	2.1	1.8
Rikshaw/van puller	6.5	-	2.5
Casual laborer	42.4	9.3	22.3
Auto/taxi driver	1.8	-	0.7
House/domestic servants	-	23.4	14.2

Household Income

The average monthly income of the households was BDT. 5802. Household income was higher in *Jessore* (BDT.6574) than in *Satkhira* (BDT. 5110). Average annual income of the respondents was BDT. 69621.

When the average income was examined according to the type of occupation, it was found that average annual income was higher for households where the main earner was engaged in a small business (BDT. 85915). Further, households with main earners who were unskilled laborers had an average annual income of BDT. 77922 and households with agriculture as the occupation of main earner had an average annual income of BDT. 72277.

Table 3.2.3 Percentage distribution of the respondents according to the total annual income of their households at source

Total annual income of the household (BDT)	Mobile person's sex		District		Total
	Male	Female	<i>Jessore</i>	<i>Satkhira</i>	
12001 -30000	7.4	7.7	6.5	8.3	7.5
30001 -50000	34.4	40.2	27.3	43.1	35.6
50001 -70000	17.6	17.1	17.3	17.6	17.5
70001 -100000	24.2	19.7	28.1	19	23.3
100001 -150000	11.5	8.5	11.9	10	10.9
150001 -200000	3	5.1	5.4	1.7	3.5
200000+	1.8	1.7	3.5	0.3	1.8
Avg. income (BDT)	69951	68400	78886	61315	69621
N	433	117	260	290	550

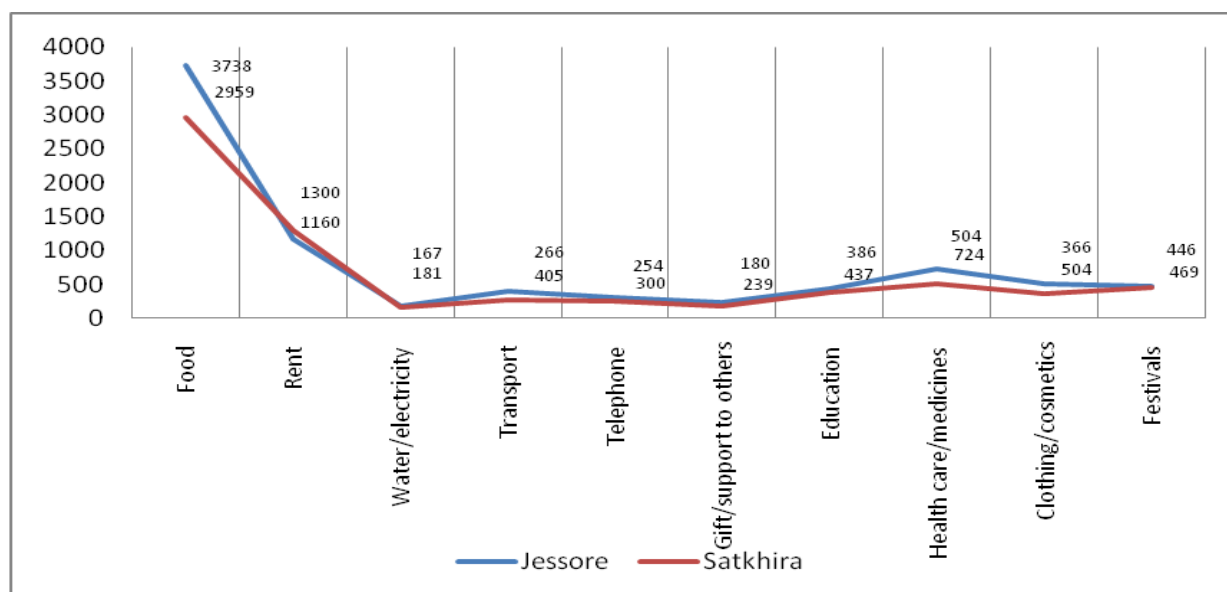
The average monthly and annual income of respondents' households according to the occupation of the main earner shows that earners involved in small business are in a better financial position than unskilled, skilled and agricultural laborers. Interestingly, the data shows that skilled laborers earn less than unskilled laborers with an average annual income of BDT 65805 and BDT 77922 respectively.

It was further revealed that monthly per capita income was BDT. 1340. However, when per capita income was compared between source sites of *Jessore* and *Satkhira* it was found that per capita income of *Jessore* (BDT. 1460) was higher than that of *Satkhira* (BDT.1224). Differences in monthly per capita income also existed between people of household's with male mobile persons (BDT. 1371) and people of households with female mobile persons (BDT. 1233).

Monthly Expenditure portfolio

Of the total monthly expenditure by households, 45% was spent on food items, followed by rent (16%), healthcare (8%), education (6%), clothing (6%) and festivals (6%). Households from *Jessore* had higher expenditures on average (BDT 1329) than households in *Satkhira*.

Figure 3.g.3 Expenditure pattern of the households based on source district



Saving and Debts at Source

Overall, 41% of households reported saving some money during the previous months of the survey. However, comparisons between Jessore and Satkhira indicated that 44% of the households of Satkhira saved money during the previous one month while 37% of the households of Jessore reported the same. Further, the proportion of households who saved money was higher among households who had a male mobile person than households with a female mobile person.

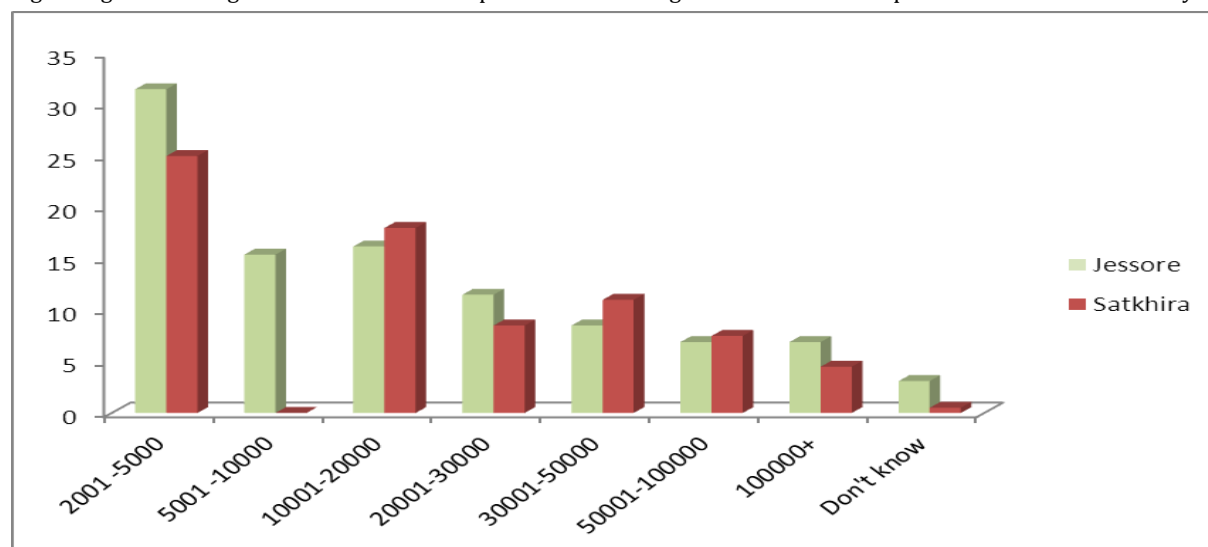
Table 3.2.3 Percentage distribution of the respondents according to their savings at source

Savings in the previous month	Mobile person's sex		District		Total
	Male	Female	Jessore	Satkhira	
Amount of savings in the previous month of survey (BDT)					
up to 200	39.2	44.2	26.8	50.3	40.2
200-500	24.4	23.3	30.9	18.9	24.1
501-2000	22.1	21	27.8	17.3	21.9
2001 +	13.3	7	11.3	12.6	12.1
Don't know	1.1	4.7	3.1	0.8	1.8
Avg. Amount (BDT)	1276.2	863.1	1459.5	1005	1199.2
N	179	41	94	126	220

The average amount of savings during the last one month of the survey was BDT. 1199. Households with male mobile persons saved more (BDT. 1276) than households with female mobile persons (BDT. 863). When compared between *Jessore* and *Satkhira* it was found that though higher proportion of households in *Satkhira* saved money, the average amount saved was higher for *Jessore* (BDT 1460) than *Satkhira* (BDT. 1005).

Among the respondents, 81% reported to have debts during the time of the survey and the average amount of debt was BDT 31098. Comparing between households with male and female household members revealed that on average, households with male mobile persons had more loans. It was also found that households of *Jessore* had more loans than the households of *Satkhira* during the time of the survey.

Figure 3.g.4 Percentage distribution of the respondents according to their debts in the previous month of the survey



Saving and Investments at destination

At destination, around 41% of BDs said they save money and keep it with them. About 23 % reported investing in chit funds/society and 15.5 % said they use banks and committees. Savings did not differ significantly by the different categories of occupation and levels of education. Respondents who saved money and had a bank account showed significantly different wealth index/quintiles. Respondents who were saving money were reportedly sending cash back home (Cash-59%, neither cash nor kind- 38%).

Table 3.2.5 Status of Savings and Investments

Savings and Investments	BD		
	Male	Female	Total
Savings			
Save money	38.6	43.6	40.9
Do not save money	54.8	56.4	55.5
No response	6.7	-	3.6
Total Respondents (excluding housewives / unemployed)	210	181	391
Money saved in India in;			
Bank	21.0	16.5	18.8
Committee	13.6	17.7	15.6
Chit fund/Society	29.6	18.5	23.1
With self	33.3	39.2	36.3
Other	1.2	10.1	5.7
Base: Who save money	81	79	760
Bank Account			
Have bank account in India	15.7	12.7	14.3
Not have bank account in India	81.9	87.3	84.4
No response	2.4	-	1.3
Total Respondents (excluding housewives/unemployed)	210	181	391

* Chi-square (sig) by gender - BD- 0.002 (sig), 0.068 (non-sig), 0.072 (non-sig)

3.3 Living conditions

Living Alone or With Spouse and/or Children

The survey initiated with the intent of only researching men who were staying without spouses at destination but due to sampling issues, this criterion was later abandoned. Overall 70% of respondents reported to be staying with their spouse at destination. Being a multiple response question, 63% also reported staying with children, followed by 31% who stayed with their relatives/ friends/ colleagues/ fellow migrants. Very few stayed alone. More women than men stayed with their spouses or children. More men than women stayed either alone or with their relatives/ friends/ colleagues/ fellow migrants. The findings varied by destination. More respondents stayed with family members in Kolkata (68-76%) than in Mumbai (51-56%). Analysis by age indicated that older people were staying with a spouse or children (<18 years-0-4%, 18-33 years – 56-68%, 34-49 years – 84-85%). The qualitative study revealed that among the twelve

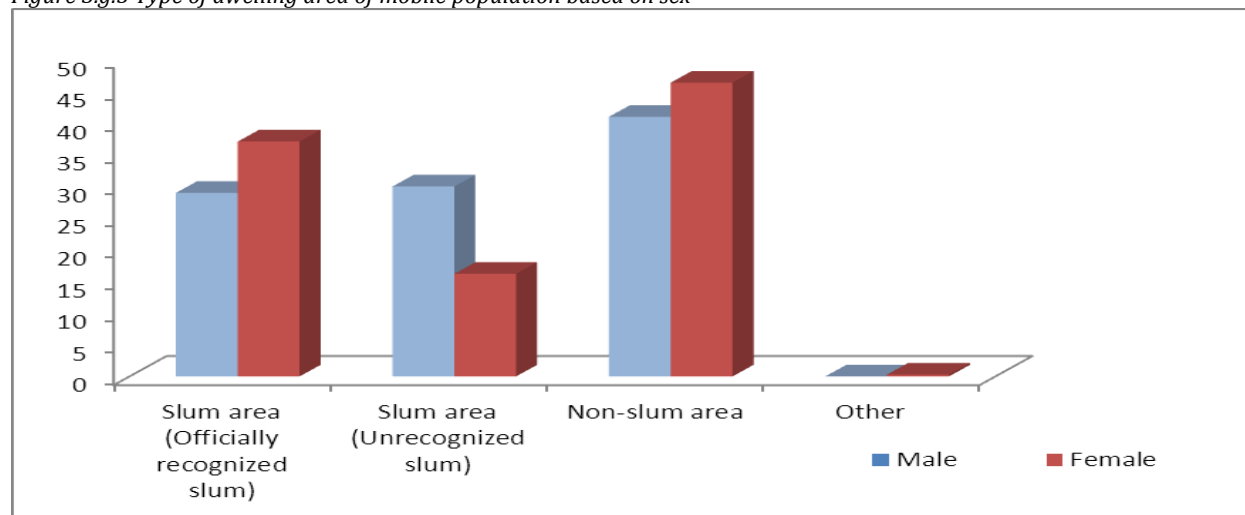
interviews conducted all were staying in a rented home. They are not forced to pay rent on time if prior information is given to the property owner about any financial constraints. Out of the eight male members, four have been staying in destination with their family. The other four male respondents were staying alone. Out of four male respondents who were staying alone, one is married & the rest are single. All of the female respondents were married, and two reside with their husbands and children. One respondent was abandoned by her husband and stays alone with her children. The other woman is a widow & stays alone in the Rajabazar Khaldhaar area.

Room Sharing

The mean number of people respondents shared a room with was 4.0, with a slightly higher mean number in among men than women. Around 86% of respondents shared their room with more than two people.

Type of Dwelling Area

Figure 3.g.5 Type of dwelling area of mobile population based on sex



About 55 % of respondents were dwelling in slum areas (mainly women in recognized and men in unrecognized slums) and the remaining 45 % resided in non-slum areas. There were significant differences between destinations when it came to the type of dwelling. The majority of respondents who did not live in a slum were residing in Kolkata (64%) whereas 100% of respondents living in slums were residing in Mumbai.

Type of House

Three-fourths of respondents at destination lived in Kuncha houses. Kuncha houses were more common in Kolkata (78%) than Mumbai (71%). This variable did not vary significantly when analyzed by age, occupation or duration of stay.

House ownership

Sixty-eight percent of the respondents at source reported that the type of their home is a “Kutcha”, followed by “Semi pucca” (24%), and “Pucca” (8%). During the survey, 89% of the households reported to own the homestead where they were living. This percentage was higher among the respondents of Satkhira (95%) than Jessore (82%). Among the households who had female migrants, 15% did not own their homestead. On the other hand, among household with male migrants, 10% reported that they did not own the homestead at the time of the survey. The majority of respondents (82%) reported owning some cattle or poultry.

Household materials/possessions

Ownership of a radio or television is a measure of access to mass media; telephone or mobile phone ownership measures access to efficient communication; and bicycle and motorcycle ownership is a measure of access to means of transportation. In general, ownership of these items has a strong bearing on households’ access to information and health (BDHS, 2004). Televisions were possessed by 29% of the households that were surveyed. Radios were possessed by 10% of the total households surveyed. Mobile phones in households were considerable, with 63% of households possessing a mobile phone. Of the total households, 48% possessed a bicycle. Three percent of the households surveyed possessed a motorcycle.

Asset ownership at destination

As high as 80 % of respondents at destination owned houses (Table 2.3.7). It is important to note that although a large proportion of respondents reported living in slums in Kutcha houses, these slums are either officially recognized or unrecognized old settlements. This essentially means that although they may not

have a title or deed, they own the structure of their homes and do not pay any rent. Reportedly higher proportion of respondents in Kolkata (87%) owned (BD respondents at destination who live in the slums own the structure of the house) houses than those living in Mumbai (62%). Data varied by occupation and the proportion of those occupation categories who owned houses included casual labourers (77%), masons (84%) and house servants (64%). Additionally, those who owned houses reported a higher duration of stay in India (<1 year- 57%, 1-5 years - 48%, 6-10 years - 77% and >10 years - 93%). Age had no bearing on this variable.

Monthly Rent

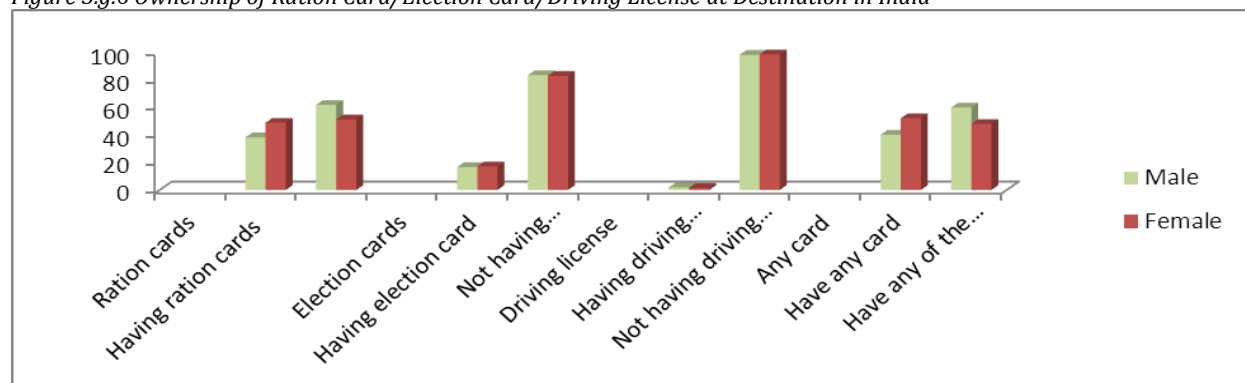
The mean rent at source was Rs. 993. More than half of the respondents (52%) paid a monthly rental fee greater than Rs.500 and the rest paid up to 2000. The mean rental fee was higher for women than men, probably because more men share rooms. The mean rental fee in Mumbai (INR 1074.2) was significantly higher than the rent paid in Kolkata (INR 376). Also rent varied by occupation but not by duration of stay, age or source district.

Availability of Electricity and Toilet Facility

Forty-three percent of the respondents at source reported having access to electricity in their homes. At destination, 78% reported access to electricity, but electricity was not available to 22% of the households. Half of the respondents had common toilet facilities and slightly less than half had individual HH toilets/personal toilets. Two-thirds of those surveyed had flush toilets whereas one-third did not. Access to electricity and toilet facilities in Mumbai (electricity 97%- toilet facilities 98%) was significantly better than in Kolkata (electricity-70% & toilet facilities-95%).

Ownership of Ration Card/Election Card/Driving License at Destination in India

Figure 3.g.6 Ownership of Ration Card/Election Card/Driving License at Destination in India



Nearly half of the respondents (47%) reported to have one or more of the recognized identity cards (Table 2.3.10). The proportion of BD women (52%) possessing any of these cards was higher than BD men (40%). Reportedly higher proportion of respondents in Kolkata had ration cards (Kolkata -51%, Mumbai-30%) and election cards (Kolkata - 19%, Mumbai-12%) when compared to Mumbai. Similarly, a higher proportion of older respondents owned ration cards (<18 years -22%, 18-33 years- 41%, 34-49 years- 54%) or election cards (<18 years - 0%, 18-33 years- 15%, 34-49 years- 23%). The possession of election cards and driving licenses varied by occupation. Possession of ration cards also varied by duration of stay with those who held ration cards reporting living in India for a longer period of time (< 1year-14%, 1-5 years-26%, 6-10 years -35%, >10 years- 61%) (Annex- Chapter 3- Table 3.18.1.0- 3.18.1.2).

Summary

The study population consists of male and female migrants from Jessore and Satkhira in Bangladesh and Mumbai and Kolkata in India. The mean age of the study population was 30, the level of education of half were reached primary education and 55.5% of the study population at source and 75.1% at destination were married. The primary occupation of the main earner at source was agriculture, day laborer as well as skilled and unskilled laborer. At destination the most common occupations were casual laborers and rickshaw pullers. The mean incomes at source were BDT. 5802. At source 74% of the respondent had experience with taking out loan. At destination 55% of the study population were living in slums and most of them were living in kancha (non-brick build) houses. At source, 43% of the study population reported to have electricity. At destination 78% reported having electricity in their homes.

4.1 Societal Structure, Gender Norms Pull and Push Factors

Poor economic conditions and socio-cultural dynamics that contribute to poverty are the driving forces behind undocumented migration to India in the border districts of Jessore and Satkhira. Livelihood options in these two districts are primarily agriculture, shrimp cultivation and daily labour. Employment in the cultivation sector is seasonal and only exists for 5-6 months.

Focus group discussion and interviews reveal that the shrimp cultivation sector is controlled by local influential people who often exploit farmers by inundating crop fields with salty water for shrimp cultivation. This often results in the salination of nearby fields destroying fertility of the soil and causing farmers to sell their land to the shrimp business owners. These dynamics constrain the agricultural sector resulting in a lack of diversity in livelihood options. Lack of diversified livelihood options combined with seasonal unemployment, low income and high debt makes undocumented migration necessary for survival.

In the project districts, the qualitative study revealed that most women are subjected to patriarchal gender norms and their mobility is restricted. In addition, mobility of women outside the household is perceived as shameful and taints the honor of the entire household. In this context, women who choose to migrate do so as a survival strategy and are often in search for more money to pay off debts.

Quantitative study revealed The belief that 'in home a man should have final words' regarding any decision was possessed by 69% of the respondents .Of the respondents, 70% had perception that 'men need sex more than women do'. Further, among the total respondents, 27% had perceived that 'a man can hit his wife if she will not have sex with him'. This perception was more pronounced by females (31%) than their male counterparts (22%).

Box 1: Beauty (fake name) was divorced by her first husband with one children, and left her second husband with her second child and came back to live with her father. After coming back to father she started cloth business to support her family. She took loan from multiple sources and was unable to repay back the enormous amount. At some point she was unable to bear the harassment from loan institutions and decided to migrate to Mumbai, India to earn a better livelihood and repay her loan

Bangladeshis at destination cite lack of employment/ business opportunities (50%) and financial difficulties (60%) as the major push factors for migration. Additionally, respondents mention better wages (43%), ease of getting jobs (67%) and joining family as major factors that draw them to migrate. Similarly, Bangladeshi's at source state lack of business/employment opportunities (87%) as the major factor influencing migration. Another major push factor stated by source population are debts, which need to be paid off (24%) which is significantly higher in Satkhira district (33%) than in Jessore (27%). Source respondent's stated higher wages (91%) and ease of getting employment (77%) are the major pull factors at destination.

Table 4.1.1a): Percentage distribution of the respondents according to their reasons for migration (push factors factors)

Push Factors	Source			Destination		
	Male	Female	Total	Male	Female	Total
Lack of business/ employment opportunities in the home country/town	87.5	82.9	86.5	61.4	43.9	50.1
Overall livelihood related situation	45	60.7	48.4	34.3	44.3	40.8
Repayment of debt	24.7	22.2	24.2	38.0	9.8	19.7
Friends/ middlemen advised	3.2	0.9	2.7	3.6	5.9	5.1
Was angry with family	1.2	0.9	1.1	-	-	-
Got married with someone in India	--	--	--	--	3.9	2.5
Education related concerns	--	--	--	--	1.6	1.1
health related concerns	--	--	--	--	3.0	1.9
Total	433	117	550	166	305	471

Table 4.1.1b): Percentage distribution of the respondents according to their reasons for migration (pulls factors)

Pull Factors	Source			Destination		
	Male	Female	Total	Male	Female	Total
Get higher wages in destination country /place	91.5	88.9	90.9	54.8	35.7	42.5
Ease of gaining employment in destination	77.4	76.1	77.1	77.7	61.3	67.1
Better opportunities for running one's own business in destination country/place	4.8	3.4	4.5	7.2	8.2	7.9
Geographical proximity of destination country/place	4.2	1.7	3.6	0.6	1.3	1.1
Access to good education facilities in destination country/place	--	--	--	-	3.3	2.1
Join my spouse residing in the destination country	--	--	--	0.6	7.2	4.9
Access to good health care/medical treatment in destination country/place	--	--	--	0.6	5.2	3.6
Personal ties in destination country/place	5.1	1.7	4.4	3.0	13.4	9.8
Other pull factors	--	--	--	6.0	8.9	7.9
Total	433	117	550	166	305	471

Perceptions that it would be easier to get employment at destination were more common among respondents from Satkhira (87%) than respondents from Jessore (66%). Other pull factors reported by the respondents included better opportunities for running their own business (5%), geographical proximity (4%) and personal ties at destination (4%).

4.2 Mobility Experience

History of Migration

According to our quantitative data, migration is most common among youth. The mean age of respondents at the time of their first migration is 25 years for men and 27 years for women. The average amount of time since their first migration is 4.8 years for men and 7.1 years for women. The duration of time since the first migration varies between Jessore (6.5years) and Satkhira (4.3 years)

Table 4.2.1: Stay and travel time, Purpose of Stay and the person who arranged travel.

Stay Time	Destination		
	Male	Female	Total
< 1 day	10	53.8	41.7
1- 3 days	80	44.2	54.2
Don't remember/DK	10	1.9	4.2
Travel Time			
< 1 day	-	47.1	33.8
1- 3 days	75	49	56.3
More than 3 days	15	2	5.6
Don't remember/DK	10	2	4.2
The person who helped for arranging travel			
Arranged own travel	35.0	5.8	13.9
Middlemen/Broker/Agent	60.0	82.7	76.4
Bangladeshi Government	5.0	-	1.4
Indian Government	5.0	3.8	4.2
Personal acquaintances/Friends	-	3.8	2.8
Family members	5.0	5.8	5.6
Others	-	3.8	2.8
Base: Those who stayed in between	20	52	72

The quantitative study revealed that the majority of respondents migrate to Mumbai (43 %) and Kolkata (18%). Similarly, all those involved in the qualitative study either went or returned from Mumbai or were willing to go to Mumbai. Information from both qualitative and quantitative data indicated that migration is most commonly arranged by brokers (76.4%) or family members (5.6%) and most respondents leave their

spouses and immediate family behind. Only one person at source in the qualitative study reported crossing the border alone by swimming across the river at dawn. The majority of respondents reported staying in transit for 1-3 days (54.2%) or less than a day (41.7%) mostly because of a need to cross the border at a certain time when it is easier to cross and not get caught (86.1%). The travel time to reach their destination is stated mostly as 1-3 days (56.3%) and in some cases less than a day (33.8%).

The cost of undocumented migration usually falls within to the range of 1000-3000 Indian rupees (77.9% at destination) and more than 3000 taka (52% at source) which is mostly used to pay the middleman (51.8 % source and 85.8% destination respondent) and other related travel costs (85.5% at source and 75.4% destination respondent).

Table 4.2.2: Expenditure Made for Entering India, Items of Expenditure and Source of Money.

Amount	Source (Taka)			Destination (INR)		
	Male	Female	Total	Male	Female	Total
Up to 1000	38.9	12.7	31.7	38.6	46.2	43.5
1001- 3000	40.3	34.5	38.7	38.6	32.1	34.4
> 3000	20.9	52.6	29.6	22.9	21.7	22.0
Mean	2426.9	4051.8	2876	2291.2	2162.2	2207.7
SD	--	--	--	2211	2327.9	2285.8
Total Respondents	144	55	199	166	3.5	471

The qualitative study revealed that using middleman or brokers to assist in crossing the borders resulted in a range of experiences for migrants. The broker's fee varied according to the financial capacity of the clients and the range of security that was provided to the client, which is dictated by the broker and other contacts (local influential) on the basis of payment. Also respondents explained that contracts often consisted of three distinct parts. The first part is negotiated between the Client (the migrant worker) and the Broker. The second part is negotiated between the Broker power holders (border officials etc) to allow the migrant to cross the border. Respondents explained that sometimes this comes with additional or unspoken expectations in which the Broker has promised border officials sex with a female migrant of his choice. The third part is negotiated between multiple brokers (one in India, one in Bangladesh) for arranging employment at the destination. This is the process through which many young girls migrate to Mumbai.

Figure: 4.g.1 Expenditure areas during travel

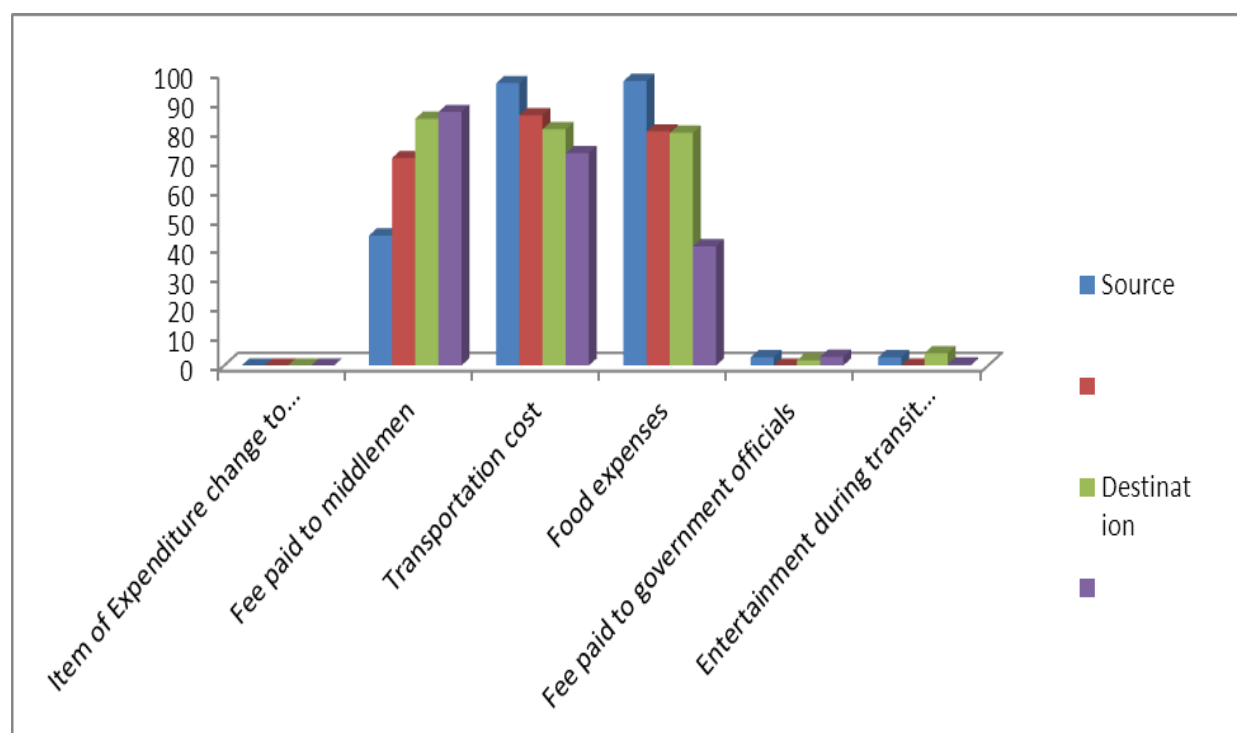
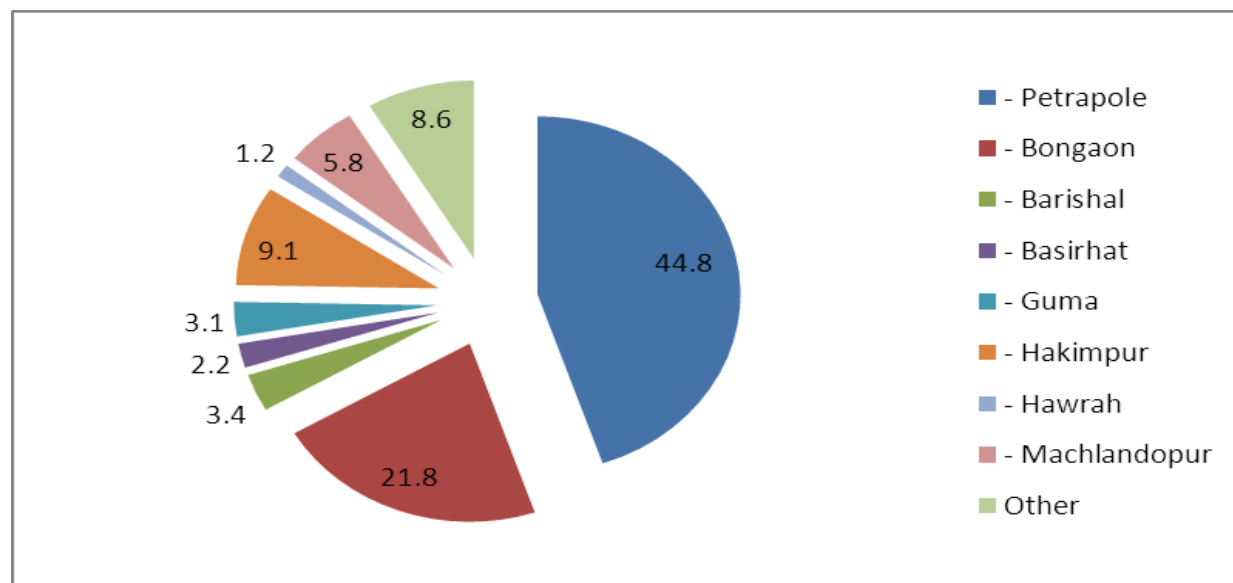


Figure: 4.g.2 Routes reported by mobile population at destination



Most of the travel costs are paid from savings at the country of origin (78.4% source and 80.7% destination) some migrants borrow from family and friends (11.5% source and 13.5% destination) and others take loans from financial institutions (2.5% source). Many female spouses and potential female migrants arrange to pay for travel costs by borrowing money from micro-credit institutions. Once they reach destination and secure more resources they pay instalments toward their loans. Failure to send remittances from destination often brings harassment for the migrant's family. Also in some instances female migrants did not have to pay a broker in advance, but were required to re-pay the broker after their arrival at destination.

Travel Routes

Bangladeshis crossing the border into India travel through a number of border areas between the two countries. According to the respondents at destination, the majority of migrants crossed the border through Petrapole (44.8%), Bongaon (21.8%) and Barishal. Most of the respondents in source and destination reported traveling directly to destination without any stops along the way (76.8% at source and 77.5% at destination). Most of the respondents who did make stops during the journey were women.

Respondents at source (87.4%) and destination (86.6%) most commonly traveled by road. Some respondents at source reported traveling by train (79.4%). Majority of respondents at destination reported traveling by road (71.8%) or train (72.0%) from transit to destination.

Future Plans for Mobility

Circular migrants usually have plans for future migration especially if the migration did not fulfill all of their aspirations or financial goals. Most migrants have positive economic outcomes from their experience, which often inspires others to consider migrating as well. In the quantitative study 14.3% of respondents were interested in migrating within the year and 10.7% wanted to migrate with 2 years,

The qualitative findings showed that no one planned on staying in India permanently. Most of the respondents planned on working in India for 3-5 years to earn a certain amount of money at which point they planned on returning home to secure a future and provide opportunities for their families. The most commonly cited aspirations among those interviewed were purchasing land, saving money for future security, educating their children, buying a good house, arranging a good marriage for their

Box 2: One returnee male said about his future dream: *"I will buy six Pickups, at least buy 8-10 bigha land and will make a brick house. My children will be well educated. Now I am economically fine and passing better life. Earlier I could not bear my family expenses but now manage my family very well."*

One Returnee female who went to India to earn money to provide a dowry for her marriage stated: *"What will be my future plan? If I want a house at Gulshan in Dhaka, is that possible? I want only a husband. I have a lot of dreams. I will have a husband, I will love him, will assist him to wear shirt, will cook good food for him, I will have children, they will love me. But as I am not beautiful, nobody likes me. You know that there is a turmeric tree beside my house. Sometimes I think that I will suicide on that tree. I hold my harmful thoughts after thinking that what will happen in the next life."*

daughter, having land from which one could harvest crops, starting a small business, and purchasing a motor vehicle to start a business. Some respondents recounted frustration and despair because much of their savings were either stolen or confiscated by border patrol or police.

Connection to home

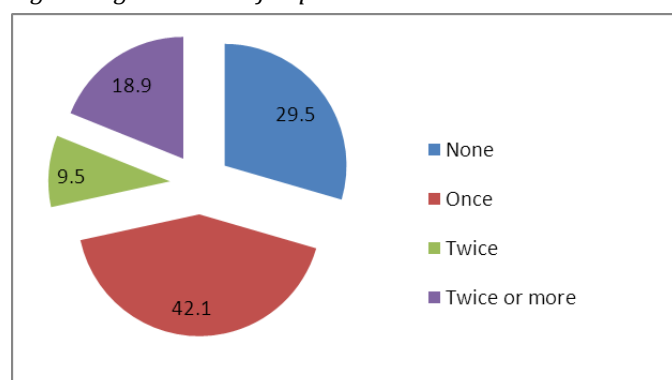
The qualitative data showed that circular migrants tend to visit home every 6 months or at least once a year. They usually stay for several months and then return to destination. During their stay in India, most migrants communicate with their family with cell-phones using an Indian sim card. They make visits back home mostly to visit family and friends.

Table 4.2.3: Percentage distribution of the respondents according to the frequency of home visits by the mobile persons

Back Home Visits	Source			Destination		
	Male	Female	Total	Male	Female	Total
<once a year	16.6	25.5 [^]	18.7	80	86.5	83.6
Once a year	34.7	34.3	34.6	20	8.1	13.4
Twice a year	11.6	6.9	10.4	-	-	-
Thrice a year	2.8	3.9	3.1	-	5.4	3.0
More than thrice a year	2.8	1.0	2.4	-	-	-
Returned forever after one year	23.4	14.7	21.3	-	-	-
Never	2.8	1.0	2.4	-	-	-
Once in three years	2.2	2.9	2.4	-	-	-
N	320	102	422	30	37	67

Thirty-five percent of respondents at source reported that they visit home once a year, while 83.6% of those at destination reported having visited less than once a year. This was the case irrespective of the sex. Further, at source more than one-fifth of the respondents (21%) reported that the mobile person had returned forever after one year. Nineteen percent of the respondents reported less than one visit a year.

Figure: 4.g.3 Number of trips



According to the respondents, the most frequently mentioned purpose for visiting home was to see family members' (74%) followed by "to see friends/relatives" (22%), and some returned "for personal work" (17%). Forty one percent (41%) of the respondents at destination said they made one visit in the last year and thirty percent (30%) visited their home twice in last twelve months.

4.3 Work Employment Experience - Including Remittance

Employment at destination was most commonly arranged either by a broker or relatives residing in destination. Over two-thirds of baseline respondents in destination were working for an individual.

Table 4.3.1: Type of Employer

Type of Employer	Destination		
	Male	Female	Total
Self-employed	30.5	16.6	24.0
Working for/employed by an individual	55.7	82.3	68.0
Employed by government	-	-	-
Employed by private/ limited company	0.5	-	0.3
Daily wage earners	12.9	1.1	7.4
Employed by resident /market committee	0.5	-	0.3
Total Respondents (excluding housewives/unemployed)	210	181	391

* Chi-square (sig) by gender - BD- 0.000 (sig)

More migrants reported being self employed earning daily wages in Kolkata (29% and 12% respectively) than in Mumbai (14% and 0% respectively). Mumbai had a higher proportion of Bangladeshis who were employed by individuals (86%) than in Kolkata (58%).

The qualitative provided detailed insight on experiences at destination regarding employment. Because the definition of impact population at destination was broadened for the qualitative study, there are significant differences around this data point between quantitative and qualitative findings.

In the qualitative study returnee male migrants at source stated working as construction workers, factory

workers, brick field workers, shop-keepers and coolies at destination. Female migrants reported working as housemaids, factory workers (steel factory), and office cleaners. Both male and female migrants reported to hide their ethnic identity at the workplace to avoid police harassment. Female migrants reported experiencing more exploitation than males at destination.. In the case study and IDI, female migrants reported getting sold to pimps by brokers and being forced into the sex trade. These women do not earn any money until their work pays off the amount the Pimp bought her for. Some female migrants reported migrating with the promise of better work and were compelled to engage in the sex trade because the wages were higher than any other form of unskilled labour. Others got involved in sex work knowingly through their peers, roommates or

Box 3: Qualitative data shows that one of the respondent works as a rag picker, collects plastic from dustbin, and distributes it to the factories, which buys them. As a part of his work sometimes, he has to make visits to Bardhaman, which takes 5 to 6 hours. In going out for work, he earns more money at an average of Rs 200- 250 per day. He has also disclosed that he is not very happy to pursue this work and would leave it as soon as he gets a better job. He has informed that he works on a no work no pay basis and earns Rs 100 to 150 daily. He has also informed that even he has to face health problem since he works in an unhygienic environment. He has informed that many other Bangladeshis also works like him. There is neither a system for bonus nor a system for any other aid apart from the wages. He has informed that he is not forced or compelled to do his work but has to work for extra hours during emergencv etc.

relatives who have the same profession.

On average migrants reported earning around 300-400 Rs per day. They usually get paid on a monthly basis. Some migrants receive bonus pay during Durga puza,. Most migrants do not receive any benefits such as treatment facilities, overtime, or paid time off. Female returnees said that sometimes they had to work overtime with no added benefit. Their Pay is deducted if they miss a day of work due to illness or leave.

Table 4.3.2: Awareness of Entitlements at Workplace

Entitlements	Destination		
	Male	Female	Total
Awareness of Entitlements			
Aware of Entitlements	3.4	-	3.2
Not aware of Entitlements	96.6	100	96.8
Base: Who were employed by government/ private company/ committee or daily wage earners	29	2	31
Type of Entitlements			
On duty accident compensation	100 (1)	-	100 (1)
Provision of bonus	-	-	-
Provision of health facility	-	-	-
Base: Who were aware of entitlements (Q.314b=1)	1	-	1

* Chi-square (sig) by gender - BD- 0.790 (non-sig)

Only 3 percent of respondents were aware of any rights or entitlements including trade union membership, bonus, provident fund, accident compensation and health facilities. Other entitlements such as "overtime pay" was usually provided to casual laborers (50%).

Remittances were usually sent home through brokers who collected a fee each time money was sent. The baseline study reveals that 48% of family members receive remittances in cash and 7.5% families receive

both cash and kind. Most families (66%) receive up to 20000 BDT...Sixty-three percent reported sending cash through others and 17% reported to carry the cash personally.

Table 4.3.3: Percentage distribution of the respondents according to the type of support provided to family in Bangladesh

Type of support to the family	Source		
	Male	Female	Total
Cash	50.1	43.6	48.7
Both Cash and kind	6.2	12.0 [†]	7.5
Kind	1.2	0.9	1.1
Neither cash nor kind	42.5	43.6	42.7
N	433	117	550
Amount of cash sent			
Up to 20000	63.9	73.8	66.0
20001-40000	19.3	16.9	18.8
40001-60000	8.6	7.7	8.4
60001-80000	5.7 [^]	0	4.5
Average Amount	23539	17231	22224
N	243	64	307

* P<0.005 for respondent category

† P<0.005 for respondents sex

[^] P<0.005 for mobile persons' sex

‡ P<0.005 for district

About 11% of the respondents claimed that 'hundi' (illegal way of giving cash to someone in destination and someone linked to that person would give same amount of cash to the family back home) is the primary method they used to provide cash support to their families.

4.4 Stigma, Discrimination and Experience of Violence

Major findings of this section are from the qualitative study as there were not many quantitative findings on this point. The quantitative findings in this regard are less representative of the actual situation as in destination it was hard to find undocumented Bangladeshi migrants as they tend to hide their identity, to resolve the problem the definition of impact population was relaxed and the time frame for their stay at destination was increased up to 20 years. As a result people who are legally settled in India might also be included the sample.

The social context in the project districts subscribe to patriarchal gender norms, values and culture like most places in Bangladesh. Women's mobility is extremely restricted and leaving the home is not usually permitted unless the woman is accompanied or unless it is an emergency. Decision-making power resides with male members of the household. Major decisions in the family such as household expenditures, income, mobility, and enrolment of children in school are decided by the husband, or in his absence, the father-in-law or other male members of the family. In this context, females who migrate for livelihood are subjected to extreme stigma and discrimination upon their return. It is a widely held belief that most women who migrate work within the sex trade. Migration experiences among women are very different from the experiences recounted by men. Women often reported harassment by brokers as well as sexual harassment by border security forces. FGDs, case studies and IDIs reveal that brokers sometimes collect information on potential female migrants through local transporters and youngsters and lure them to migrate by promising them highly paid jobs at destination. Many girls are victims of trafficking. Brokers often exploit poor women by promising to help them cross the border and secure a job without payment. As a result they end up selling them to brothels or to agents at a high price (20000-30000 rupees.). Once sold, the girls are forced to work until the fee paid for them is recovered.

The belief that migrant women might face sexual assault imposes stigma on women who return. Many women who return and their family face social pressure, exclusion and denial. As a result, many women try to conceal their employment. On the other hand, males at destination often solicit sex workers or marry a second wife. Upon their return, they do not face any stigma and are comfortable openly discussing their migration and their extra marital affairs.

Bangladeshi migrants reported harassment of border security upon their return from India. Getting caught by BSF usually results in being sent to jail and having to pay a fine of around 200-3000 taka. Many Mumbai respondents reported getting caught by police and faced verbal harassment. Upon their return, border security often steals or confiscates their cash.

At destination, fear of police harassment and violence was reported. Captured undocumented migrants at destination generally face imprisonment and a large amount of money is required for their bail. The Quantitative study reports 2% of the total respondents facing problems at destination.

"One returnee said, "while returning I have got caught by BSF and the border security force searched for the money and took away 20000 rupee that he was carrying with himself. I came home empty handed."

The type and level of harassment varies by gender. If males are caught at the border, the law enforcers beat them in the camp at first and send them to prison. Sometimes on the Indian side of the border, the law enforcers will actually shoot at the men who try to cross the border.

Female returnees tend to hide their own story of violence but they tell stories about other girls and women who faced sexual abuse and rape.

Box 4: From observation during IDI, it seemed that among some returning female migrants, there was a tendency to hide the truth about their profession. For example, take the story of one returnee 25-year-old female. *"The first time I went to Mumbai when I was only 13 years of age. I went to Mumbai several times, but I used to come back to Bangladesh almost every year to see my younger brother who lives with my grandmother. I use to send money I made to my grandmother to help take care of my grandmother. Once, I was caught by the Mumbai police and forced back to Bangladesh after being in a Mumbai prison for 6 months. However, I returned to Mumbai by going through a broker. Although I used to face many problems crossing the border, I frequently go and come back now, so the Power people at the Border know me very well now.. Now they don't create problem for me, rather they help me. Now In Mumbai I have a very good life. My husband loves me very much, and I don't need to work."*

However, the legitimacy of this story is questioned and it carries the sense that women are not eager to disclose their profession at Mumbai to people. This is another dimension of vulnerability among female migrants in which they are compelled to cope with the social context by hiding information .

Kulsum (fake name) got married at the age of 22 and later found out that she is the second wife for her husband. She has two children, and her husband was not paying for her family. She went to Mumbai with a neighbor to earn a livelihood for her family but was sold to a pimp at a rate of 30000 taka; she was forced to get involved in commercial sex while most of her earning was taken by the pimp leaving a small amount for her. To cope with her status and psychological trauma she used to take drugs there. Later she was repatriated by a rights based organization.

Summary

Undocumented migration is a choice driven by extreme poverty and lack of alternative livelihood options at source. Although goals and aspirations for migrants are similar among both male and females their experiences vary greatly. Most migrants cross the border with the help of a broker or middleman who they pay a fee to ensure they reach their destination. While most men are able to cross safely, women often face harassment and sexual assault by police and border patrol. Many women are deceived by brokers and are sold into the sex trade. Many female migrants, regardless of their occupation at destination, face stigma and discrimination upon their return. Our research reveals that women are subjected to a different level or vulnerability when they migrate than their male counterparts.

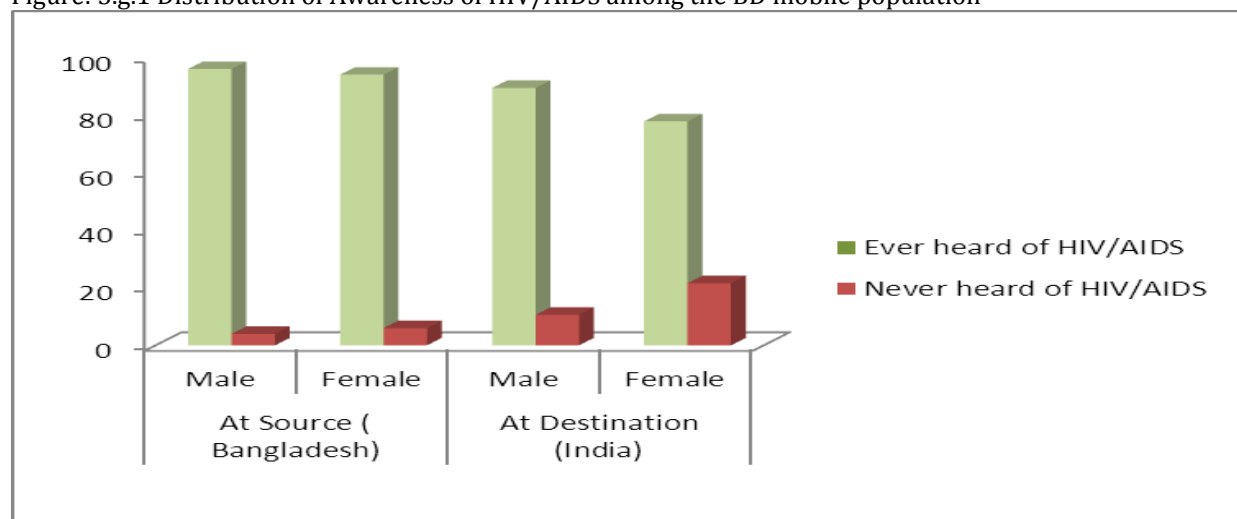
This chapter explores the knowledge, awareness and practices of respondents regarding HIV/ AIDS. The chapter also discusses stigma and discrimination related to HIV & AIDS.

Ever heard of HIV and AIDS?

The baseline survey intended to assess the knowledge and practices of the impact population (mobile persons and their spouses) regarding HIV and AIDS. At source, an overwhelming proportion of the spouses (96%) and the migrants (returnee/circular migrants) reported having heard of HIV and AIDS. A higher proportion of male respondents (96%) had heard of HIV and AIDS than their female counterparts (94%). At Destination, overall awareness of HIV and AIDS was high with 82 % of the respondents reporting that they had heard of HIV and AIDS. The proportion of men aware of the disease was higher (89%) than women (78%). Since overall awareness was high, the cross analysis of this variable by occupation categories, place and duration of stay, frequency of back home visits, living arrangements and dwelling type did not show any significant variations. The awareness of HIV and AIDS was significantly higher in Mumbai (93%) than in Kolkata (78%). Those who had heard of HIV & AIDS had attained higher educational levels.

Knowledge of modes of transmission for HIV

Figure: 5.g.1 Distribution of Awareness of HIV/AIDS among the BD mobile population



The respondents were asked about the possible ways HIV can be transmitted. Among the respondents at source who had heard of HIV and AIDS, the majority reported “unprotected sex with multiple partners” (66%) as a mode of transmission of HIV. A similar proportion of the respondents mentioned ‘needle sharing’ (38%) and unprotected sex with someone living with HIV & AIDS (38%). While 27% knew that sex with Sex workers can put you at risk of HIV transmission and 11% of them mentioned unprotected sex with Sex workers as a mode of transmission for HIV.

Table 5.1.1: Percentage distribution of Spontaneous Awareness of Modes of Transmission of HIV/ AIDS among the BD mobile population and their families at source and destination

Spontaneous Awareness of Modes of HIV transmission	At Source (Bangladesh)			At Destination (India)		
	Male	Female	Total	Male	Female	Total
Unprotected sex with multiple partners	59.4	72.7†	66.2	52.1	64.6	59.3
Unprotected sex with someone having HIV & AIDS	32.9	43.3	38.2	47.9	41.9	44.5
Sex with sex workers	44.8†	9.3	26.6	40.7	51.9	47.1
Used needles	-	-	38	37.6	48.1	43.6
Infected blood	17.5	21.3	19.5	38.7	44.6	42.1
From infected mother to child	2.8	6.0	4.4	11.3	28.8	21.4
Sex without condom with Sex Workers	14.0	8.7	11.3	-	-	-
Casual contact with PLHIV	1.4	1.3	1.4	-	-	-
Don't know	6.3	16.0	11.3	24.2	16.5	19.8
No Response	-	-	-	1.0	1.2	1.1
Base: Who have heard of HIV & AIDS	143	150	293	194	260	454

Unprotected sex with multiple partners was reported by 59.3 % of respondents at destination as a mode of transmission. This mode was reported by a higher proportion of women (65%) than to men (52%). Other modes of transmission reported were, having sex with sex workers and unprotected sex with someone having HIV/ AIDS (47% each).

The awareness did not vary significantly by occupation and living arrangements of respondents at destination. However, there was significant variation by duration and place of stay in India-

More people at source (66.2%) than in destination (59.3) were aware of unprotected sex with multiple partners as a mode of transmission. In response to the question on mode of transmission, more respondents at destination than at source selected unprotected sex with someone who is HIV positive. Overall the knowledge around modes of transmission was found to be higher among respondents at destination than at source.

Knowledge around methods of HIV Prevention

Overall, respondents showed lower levels of knowledge around methods of HIV prevention. When it came to abstinence, only 28% selected this as a method and only 47% selected “using a condom correctly every time they have sex” (47%). The awareness among circular and returnee mobile people and spouses was considerably higher on all the modes of prevention.

In India, occupation, duration of stay and age did not have any impact on this variable. Analysis by cities/place of destination revealed that awareness regarding prevention was better among those living in Kolkata (33%,53%) than those in Mumbai (19%, 43%).

- The proportions varied significantly when analyzed by education. Those with higher levels of education had more knowledge around the modes of prevention.
- Abstaining from sex- 1-5th-26%; 6-8th- 25%; 9-10th-37% ; 11-12th-60%;
- Be faithful - 1-5th-60%; 6-8th- 62%; 9-10th- 69%; 11-12th-60%
- Correct and consistent Condom use - 1-5th-45%, 6-8th -51%, 8-10th- 57%, 11-12-77%

Table 5.1.2: Knowledge about Modes to Prevent HIV & AIDS (Prompted) (Percentage)

Particulars	Bangladesh		
	BD Mobile population in India	Returnees/Circular	Spouse
One can prevent HIV & AIDS by			
By abstaining from sexual intercourse**	28.0	75.1	75.2
By having one uninfected faithful sex partner**	57.3	63.3	56.2
By using a condom correctly every time they have sex**	46.7	78.2	72.4
Total N – those aware of HIV & AIDS	454	188	105

**Z test Significant at 1.96 (Between categories of Bangladeshi mobile people), between Bangladeshi circular/returnees

Interposal Communication

This section explores the extent of communication around HIV and AIDS among sexual partners and spouses.

Discussion With Spouse/ Sexual Partner

At source, among those who discussed HIV with their spouse (n=80), 44% reported to discuss rarely, while 44% reported discussing it sometimes. However, 28% could not remember the last time they discussed HIV & AIDS with their spouse. Another 28% of the respondents reported that they had discussed HIV during the month preceding the survey.

Communication between spouses regarding HIV and AIDS was reported by 26% of the respondents. Spousal communication was reported more frequently by males (30%) than by females (23%).

As many as seven in every ten respondents at destination reported never discussing HIV and AIDS with their sexual partner or spouse. This percentage was relatively higher among men than women. Among those who

had discussed HIV&AIDS, two-thirds had discussed only on rare occasions. Forty-five percent of those who had discussed the disease said they did so more than 3 months ago.

Table 5.1.3: Ever Discussed with Spouse /Sexual Partner about HIV & AIDS, Frequency of Discussion and When Last Discussed (At Destination)

Inter-spousal Communication			
BD mobile people in India (Destination)			
	Male	Female	Total
Ever discussed with pouse/sexual partner	8.2	26.2	18.5
Never discussed	79.9	63.5	70.5
No response	0.5	1.5	1.1
Not applicable	11.3	8.8	9.9
Base: Who have heard of HIV & AIDS	194	260	454
Frequency of discussion with spouse/partner			
Very often	-	4.4	3.6
Sometimes	43.8	23.5	27.4
Rarely	56.3	69.1	66.7
Can't say	-	2.9	2.4
Base: Who ever discussed	16	68	84
When Discussed Last Time			
Up to 1 month ago	6.3	5.9	6
Up to 2 months ago	31.3	7.4	11.9
Up to 3 months ago	12.5	23.5	21.4
> 3 months ago	31.3	48.5	45.2
Don't remember	18.8	14.7	15.5
Base: Who ever discussed	16	68	84

* Chi-square (sig) by gender - BD- 0.000 (sig), 0.330 (non-sig), 0.094 (non-sig)

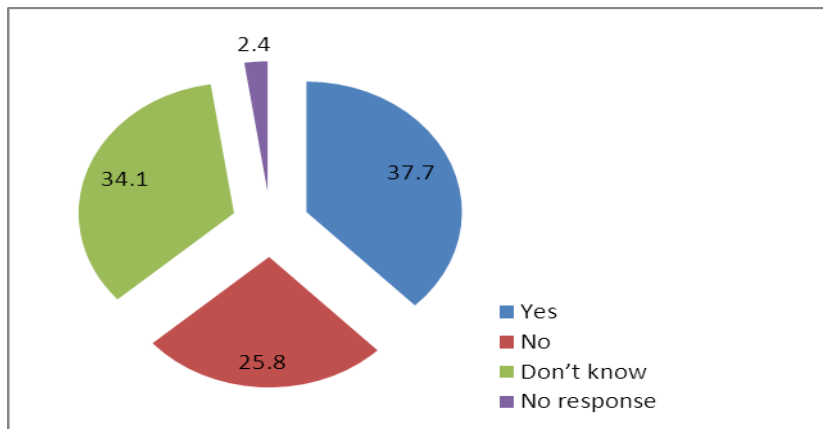
Analysis by city/place of destination showed significant differences within this variable with more respondents in Mumbai reporting having a discussion related to HIV & AIDS (23%) than those in Kolkata (16%). Similarly, when observed by occupation, discussions were reported by house servants (36%), housewives (24%), casual labourer (11%), and Masons (14%). Forty-six percent of those who discussed HIV & AIDS had reported undergoing and HIV & AIDS test; and belonged to a younger age group (18-33 yr- 20%, 33-49 yr-18%) and reported a shorter duration of stay (<1yr-43%, 1-5 year-12%, 6-10 yr-20%, >10 yrs-13%).

Misconceptions around HIV

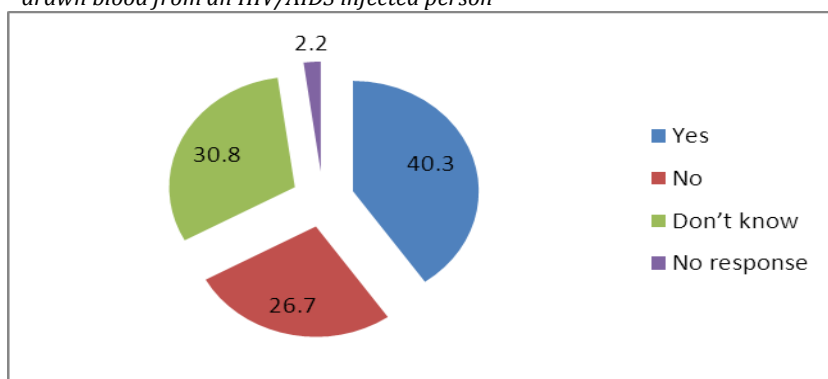
At source, many misconceptions persisted among respondents. For example, 4% of respondents believed that HIV could be transmitted through sharing clothes or dishes with people living with HIV (PLHIV) . Two percent of respondents thought that not staying neat and clean could cause HIV and 1% believed HIV could be transmitted through mosquitoes. Furthermore, 11% of the respondents did not know any specific mode of HIV transmission. Not knowing the ways HIV is transmitted was significantly more common among spouses of migrants (18%) than migrants (7%). Among respondents in India, a notable proportion believed a person could contract HIV by kissing/hugging HIV infected person (40%), or through mosquito bites (40%), and 38% believed they could contract HIV through sharing a meal with an infected person. About three in every ten respondents also felt they could contract HIV/ AIDS by sharing utensils or clothes or sharing toilets. These percentages were higher among women than men. This analysis reflects important gender differences with regard to knowledge on HIV- and other STD-related issues.

Figure:5.g.2 Misconception around HIV/AIDS at destination

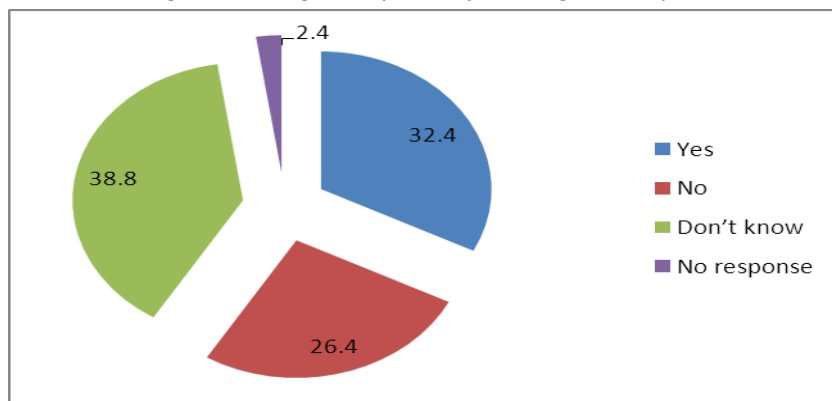
1. Can get HIV/AIDS by sharing a meal with someone who is infected



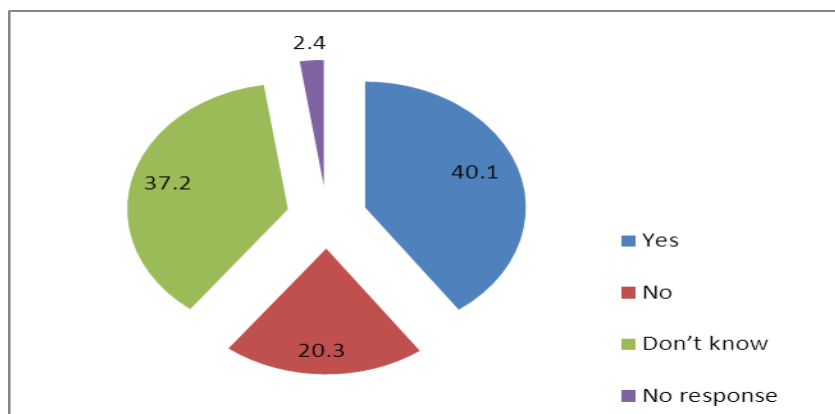
2. Can get HIV/AIDS from a mosquito bite if the mosquito has drawn blood from an HIV/AIDS infected person



3. Whether a person can get HIV/AIDS by sharing utensils/clothes



4. Whether a person can get HIV/AIDS by kissing/hugging HIV infected person



Qualitative findings suggest that misconceptions around HIV are common at source.

Respondents believed that HIV could spread due to being dirty, walking barefoot, going to bars, having sex with women other than one's wife or having sex with a "bad girl". People also thought that HIV & AIDS was a disease from India, especially from Mumbai. Researcher also observed that although some respondents were involved in high risk behaviours, they did not think they were at risk of HIV. Rather, they thought that only other people who engaged sexing such behaviours were at risk. When it came to HIV & AIDS treatment, respondents believed HIV to be fatal with no treatment currently existing. The respondents who did know about HIV and PLHIV said that PLHIV are a burden for their families and society. They said that the family members of PLHIV are not respected by society, and that the community hates them.

Stigma & Discrimination towards HIV and AIDS infected person

Of the respondents, who had ever heard about HIV & AIDS, 61% at source mentioned that if any of their friends contracted HIV they would not remain friends with them. Ninety-five percent of respondents at source gave affirmative responses to the statement "patients with HIV have the right to the same quality of care as any other patient". But at destination only 9.4 % of the respondent agreed that PLHIV have the right to the same quality of care as any other patient and 67% disagreed with the statement. On the other hand, at source more than half of the respondents (56%) were in favor of keeping people with HIV separated from others to protect public health. Furthermore, agreement to the query was

found higher among females (62%) than males (48%). At destination, 11% were in favor and 66% were not in favor of keeping people with HIV separated from others to protect public health.

Box 6 : Stigma to a PLHIV - Case Highlights

Farida (fake name), 27 years of age residing at Benapole became HIV infected as a victim of vulnerability related to cross Border mobility.

After knowing about HIV status, Farida tried to communicate her husband over phone in Saudi Arab. But He did not response well. Over the period his response became poorer and finally ceased. The interim period became hard for Farida to pass. She came back to home and become completely depended mentally and physically on her parent at source. Her father lived from hand to mouth with his 3 daughters at home (All are back from In law's house). The further pain added to the family when Farida started to get frequent sickness: One disease cured and another disease started- this was the phenomena. This ways the days were passing by. She heard from people that the returnees from India get this type of disease always. One said to her " *You returned from India and now suffering from sickness, you must did illegal sex there, It is perfectly right that you are infected with that bad disease*". She was isolated in the family and society after an unintended disclosure.

Table 5.1.4: Impact Population Attitude towards HIV-Infected People

Impact population's attitude towards HIV-Infected People	Mobile population at Source			Mobile population at Destination		
	Male	Female	Total	Male	Female	Total
1. Would still be friends with him/her even if they find him/her infected with HIV						
Yes	38.7	37.8	38.5	20.1	28.8	25.1
No	61.3	61.3	61.3	57.2	60.4	59
No response	0	0.9	0.2	22.7	10.8	15.9
N	416	111	527	194	260	454
2. People with HIV should be legally separated from others to protect the public health						
Strongly agree	28.6	16.7	26.1	4.1	5.4	4.8
Agree	28.6	33.3	29.6	8.2	4.6	6.2
No opinion	4.3	7.1	4.9	30.4	12.7	20.3
Disagree	28	33.3	29.1	33.5	29.2	31.1
Strongly disagree	10.6	9.5	10.3	23.7	43.1	34.8
Not applicable					5	2.9
N	161	42	203	194	260	454
3. Women with HIV should be prevented from having children						
Strongly agree				4.6	2.7	3.5
Agree				7.2	8.1	7.7
No opinion				32.5	14.6	22.2
Disagree				30.9	24.2	27.1
Strongly disagree				23.7	45.4	36.1
Not applicable				1	5	3.3
N				194	260	454
4. Men and women with HIV should not be allowed to get married						
Strongly agree				4.1	3.1	3.5
Agree				7.2	10.8	9.3
No opinion				37.1	17.7	26
Disagree				28.9	20	23.8
Strongly disagree				22.7	43.5	34.6
Not applicable					5	2.9
Base: Who have heard of HIV & AIDS				194	260	454

At destination, another 63% felt that women with HIV should not be prevented from having children and close to 60 % felt that people with HIV should be allowed to get married. Deeper probing is required to understand these kinds of mixed perceptions among the impact population. Education levels seem to have no affect on their attitudes towards HIV-infected people probably because there is not much variance in education level among the sample.

Knowledge about STIs

The respondents were also assessed on their knowledge around STIs. At Source, 24% of the respondents - with 25% of the male respondents and 24% of the females - reported to have heard about STIs.

Knowledge of STIs was reported higher among migrants (25%) than spouses (23%). When the respondents were further asked if they have suffered from any STIs in previous 12 months, 8% of them responded affirmatively. This was found much higher among the spouses of the mobile persons (10%) than the circular/ returnees (6%).

A total of 23 respondents reported suffering from STIs in the previous 12 months. Many of them reported of doing nothing to treat the infection while others opted for homeopath, home based treatments or traditional healing methods.

In order to assess the incidence of STIs a description of genital discharge and ulcer was read out to all respondents at destination. The description was: "Ever had a thick yellowish/ greenish discharge with foul smell from penis or vagina or had an ulcer or sore in genital area in the past 12 months". Only 3% of respondents reported experiencing the mentioned symptoms.

Summary

Although awareness of HIV & AIDS regarding sexual transmission was good among mobile people, their knowledge around vertical transmission was very low. Awareness of having sex without a condom and unprotected sex with sex workers was especially low among migrants in India and spouses in source communities. Bangladeshi migrants had low knowledge about modes of prevention such as "abstaining from sexual intercourse" and "using a condom correctly every time they have sex". Misconceptions ran high among migrants in India as well as in Bangladesh. This requires immediate attention as misconceptions often lead to stigma and discrimination. There were indications of some kind of awareness generation programmes for circular and returnees in Bangladesh as a considerable proportion of them were aware of 'having sex without condom with sex worker' as one of the modes of HIV transmission, different ways of HIV prevention and had also heard about STIs. High stigma about PLHIV found among migrants at source and destination. Inter-spousal discussion about HIV & AIDS was limited among mobile people; however, it was higher among returnees. Stigma and discrimination was high among all categories. Risky sexual behavior was negligible among all the categories of mobile people. Knowledge about STIs was very low among respondents as only 25% of the respondents at source had ever heard of an STI.

Age at first sexual encounter

At source, 93% of the respondents (n=308) were sexually active at the time of the survey (irrespective of their marital status). The average age of their first sexual encounter was 18.5 years. The average age was 16.1 years for spouses and 19.9 years for migrants. Further, for females the average age of sexual initiation was 15.9 years and 21.6 years for male respondents. Moreover, among the married respondents the average age at first sexual encounter was 18.5 years and 17.6 years for the 5 unmarried respondents.

At destination, 82% of respondents had had sex before. This percentage was higher among women (90%) than men. Of those who had ever had sexual intercourse, 56 % had their first sexual experience before they turned 18 years old. Duration of stay had no bearing on this variable. The results varied significantly when analyzed by education – (1-5th- 81%; 6- 8th – 78%; 9-10th- 78%). The mean age at first sex was significantly higher among those with higher levels of education (1-5th :17.6, 6- 8th: 17.8, 9-10th:19.1).

Sexual relationship in previous 12 months and condom use

At source, out of 287 respondents, 81% reported having a sexual relationship in the previous 12 months. These respondents were further asked if they have any regular sexual partner (spouse or live in partner). In response, 96% of the overall respondents – with 99% of the spouses and 95% of the mobile persons – reported affirmatively. Regular sexual partner was also acknowledged by 97% of the females and 95% of the male respondents. Overall, among those who had sex in the last 12 months, 29% had reported using a condom.

During the last time they had sex, 72% of those with regular partners did not use condoms (N=68). Among those who reported using condoms the last time they had sex reported doing so for several reasons including: to avoid pregnancy, to protect themselves from STI/HIV & AIDS, to protect their partner from STI/HIV & AIDS, and for pleasure.

At destination, a large proportion (83%) of male respondents had sexual intercourse in the last 12 months. This percentage was higher among men than women. Of these, a staggering 68 percent reported that they had never used a condom. This proportion was higher among women than men.

Sex with Regular partner in the last 12 months and condom use

At destination, all the respondents who had sex in the last 12 months were first asked whether they had any regular partners. About 96 % reported that their spouse was their regular partner and this percentage was relatively higher among women than men. Cross analysis in this regard by duration of stay in India, frequency of going back to Bangladesh, and attendance in school showed no significant variation.

Knowledge of condoms and its use

At source, when respondents were asked about condom use, 96% of them said that they had either seen or heard about condoms with 4% of them not knowing about them at all. Knowledge of condoms was consistent among respondents from the two districts and among different categories. The respondents who knew about condoms were further asked about the purpose of using a condom and the sources of getting condoms. The majority of respondents (93%) said condoms were used to avoid pregnancy. The other purposes of condom, as mentioned by the respondents, included controlling HIV & AIDS (50%), sexual pleasure (12%), and prevention of STIs (12%).

At source, the majority of respondents (84%) obtained condoms from general stores followed by “pharmacy” or medical stores (64%), health workers (25%), family planning centers (15%) and clinics or hospitals (13%).The respondents at source were further asked about how comfortable that would feel in getting condoms and 58% of the respondents expressed confidence in getting a condom. A higher proportion of respondents from *Satkhira* (62%) than those from *Jessore* (54%) expressed confidence in obtaining condoms. However, 27% of the respondents were somewhat confident and 12% of them were not at all confident.

At destination most had seen or heard of a condom (89%) and this was similar across men and women. Among respondents who had seen or heard of a condom, 89 % felt that the purpose of a condom is to avoid pregnancy. This was reported more frequently by women (96%) than men (75%). Preventing HIV/ AIDS was also mentioned as a purpose but only by one fifth of the sample. A meager 4 percent of the respondents mentioned STI prevention as one of the purposes.

Condom awareness did not vary by occupation and duration of stay. Awareness of condoms was significantly higher in Mumbai (96%) than Kolkata (85%). Condom awareness was better among higher age groups (<18 yrs- 70%, 18-33 yrs- 94% and 34-49yrs -82%). Education had no impact on this variable.

Condom Use with the Regular Partner during Last Sexual Encounter

Among respondents, more than two-thirds (67%) had not used condoms the last time they had sexual intercourse with their regular partner. No significant variation emerged when this data was analyzed by age, attendance in school, duration of their stay in India and frequency of going back. However, it was found that higher proportion of Mumbai respondents (51%) used condoms than their counterparts in Kolkata (19%).

Condom use during sex

All the respondents who had regular partner were asked how correctly and consistently they used condoms with their regular partners in last three months. Investigators read aloud the following steps involved in correct condom use to respondents before answering the question:

1. Check for the expiry date of the condom
2. Open the pack carefully
3. Condom should be worn only on the erect penis
4. Press the tip of the condom and fix it on the erect penis.
5. Hold the tip of condom and unroll it to full length
6. After the intercourse, hold the bottom of the condom and gently withdraw the penis
7. Remove the condom carefully without spilling the semen
8. Knot the condom and dispose it.

At source, in the past three months, only 7% of the respondents used condoms every time they had sex. Among those who used condoms during sex, 18% reported that they had correctly used condoms over the past three months. Among respondents at destination who had ever used condoms and had a regular partner, only 7 % reported they always used condoms correctly. Close to half revealed that they had not used condoms correctly in the last three months highlighting a strong need for efforts to increase awareness around correct and consistent condom use.

Sex with commercial and non- regular sex partners and condom use

In case of men, only a meager proportion (3%) reported pursuing any sexual relationships with commercial and non-regular partners in last 12 months. This small percentage might be due to selection bias problems and misreporting.

Qualitative data reveals that among the male respondents at source (both husbands of migrants and returning male migrants) that it was common to have more than one wife. Six of the 12 male respondents reported to have first had sex before marriage with a girlfriend, cousins or sex worker. They did not feel discomfort in discussing their extramarital sexual relations. Some husbands of migrant workers were found to have married for a second time after their wives left for India. As one migrant's husband explained, "There is a Brothel in Jessore. There are also brothels in Mumbai where mostly Bangladeshi girls are sex workers. I suspect that my wife is also a sex worker there. Several times I requested her to come back in Bangladesh but she refused me. Hence I decided to marry again."

Group Discussion with Sex workers at Beanapole explored that every sex worker frequently travelled to and from India. They said that they go to India through brokers and are not required to pay money. They usually have sex with border patrol or power-holders to get across the border. They said that they usually negotiate with the client to use condoms. Most of the time they are successful in these negotiations, but sometimes if the client is rich/businessman and offers more money to discard the condom, they will have unprotected sex. Some sex workers said that they know of men who encourage their wives to sell sex in India.

All female respondents (both the wives of migrants and the returning female migrants) said that the first time they had sex was with their husbands after marriage, except for one woman who said that she was a Sex worker in India.

Most of the wives of migrant workers said that they never had sexual relations with someone other than their husbands. Generally, they don't discuss contraceptives or condoms with their husband. Their husbands decide whether they use contraceptives. All female spouses reported using the oral pill for family planning. It is evident that some couples used condoms but this was very infrequent and inconsistent as there were fears and misconceptions about condoms.

One female spouse said: *"My husband likes to have new women frequently as sex partner. Being a woman and housewife I have nothing to do to stop him."*

Another female spouse said: *"I had sex with my husband on our first day of marriage and I got menstruation for the first time in the same day. He brought contraceptive pill for me I took pill for 2 years. Now I don't take anything. I tell my husband to use condom but he does not like it and says that I have no wish to stay with you and no need to use that. He has relation with another woman. I don't know whether they use condom or not. If I ask any question about that, he becomes angry and hurts me."*

Misconceptions found around using condoms are: Condoms are not necessary during sexual intercourse between husband and wife, condoms cause sexual disease, condoms reduce sexual pleasure, and condoms might get lost inside the woman. One male potential migrant said: *"We should not go to brothel. But if people earn more, then they may change their minds. If I ever go to brothel, I will must use condom. Once I used condom with my first wife. After that, I never used it. For family planning my wives take Ovstate, Femicon pill"*.

Ability to put on a male condom

Men who had sexual intercourse in the last 12 months were asked about their own ability to use condoms and frequency of condom breaks that they had experienced. At source, respondents who were sexually active were asked if they or their partners had ever used a condom and 29% of them (n=232) responded positively. Condom use was found higher among the mobile persons (33%) compared to the spouses (22%). The respondents, who had used a condom during sex (respondent or their partners), were further assessed for their ability to use condoms. They were asked to agree or disagree to a few of the sentences on how to put on a condom. In response, 44% of the 68 respondents said that they generally put on male condom with ease and 6% of them have expressed that they can even put on a condom in the dark. However, more than one-third of the respondents agreed that it is difficult for them put on a condom. Such difficulty was acknowledged by higher proportion of returnees/circular migrants (40%) compared to the spouses of mobile persons (22%).

Table 6.1.1: Percentage distribution of the respondents according to their ability to put on male condom (%) at source and destination

Use of Condom	At source		Total	At destination
	Respondent Category*			BD Men
	Spouses	Mobile persons		
Ability to put on male condom				
I find it difficult to put on a male condom	11.1	6.0	7.4	12.6
I find it somewhat difficult to put on a male condom	11.1	34.0	27.9	33.1
I find it generally easy to put on a male condom	50.0	42.0	44.1	50.4
I can put on a male condom even in the dark	0	8.0	5.9	3.9
Never used	5.6	2.0	2.9	
No role	22.2	8.0	11.8	
N	18	50	68	127
Frequency of Condom Breaks				
Very often	-	-	-	5.5
Sometimes	-	-	-	2.4
Rarely	-	-	-	12.6
Never	-	-	-	41.7
No response	-	-	-	37.8
Base: Who had sexual intercourse in the last 12 months				127

* P<0.005 for respondent category ‡ P<0.005 for district-

At destination, about half of the men who had sexual intercourse in the past 12 months said that they generally found it easy to put on a condom. About one-third said they found it somewhat difficult. Only 4 percent reported that they could put a condom on in the dark. A higher proportion of men in Mumbai (56%)

reported finding it difficult to put on a male condom than those in Kolkata (41%). Differences were not significant when this information was analyzed by other variables.

Four in every ten men said they never experienced condom breaks amid sexual intercourse. However, 6 percent reported breakage of condoms very often and 3 percent said it happened to them sometimes. A higher proportion of men in Kolkata (80%) had ever experienced condom breakage during sexual intercourse than those in Mumbai (10%).

Summary

Among migrants, condom use was primarily used to avoid pregnancy and rarely used to prevent HIV or STIs. Knowledge about the purpose of using condoms among all respondents was very low though lower at destination than source. Around one third of respondents experienced difficulty in putting on a condom correctly. Among migrants, it was found that condom use was higher in cases where men lived with their spouses and the chances of using a condom were greater if he/she was aware that condoms could be used to prevent HIV.

Chapter -7

Provision and Access to Services

This chapter discusses the availability and accessibility of various services and health facilities to the impact population. The chapter also explores the levels of confidence and satisfaction expressed with the services used.

Availability of Services

The availability of all services, except local transportation and in some cases water supply, is an issue that needs to be addressed. The reported utilization of these services, except for transportation services, was low, especially when it came to police and legal services. The availability (except police and lawyer services) and the requirements (except transportation services) were significantly higher in Mumbai (A- 78-98%, R- 58-99%) than in Kolkata (A- 36-59%, R- 45-93%). The reported utilization of services (except police and lawyer services) was higher in Kolkata (U- 78-98%) than in Mumbai (45-88%). of the age of respondents did not affect the findings on availability, requirement or utilization of any of the services except that older people tended to report lower availability of municipal services. More of the respondents who reported positively on the availability of services also reported living in India for a longer duration of time.

Table 7.1.1 Availability, Requirement and Utilization of Various Services (Percent)

Specific services	BD		
	Available	Require	Utilize
Police services	44.5	60.6	8.3
Lawyer services	36.5	48.6	4.2
Municipal services - Sanitation	51.0	89.7	45.4
-Water supply	70.6	94.7	64.6
-Waste disposal	49.9	90.4	47.2
Local transportation services	90.2	98.5	87.5
Total Respondents	551	551	551

Base: Respondents who reported the availability of the service

Health facilities

At source, the primary services made available are primary healthcare (including maternal and child health, family planning) and micro credit services available through unions and at the village level. Community leaders informed researchers that legal services are also available, but this was rarely known or discussed among respondents. General health, maternal & child health and family planning services are provided by the Community health clinic under the government health department. Respondents mentioned that services were not consistent in regard to medical supply and logistics. Respondents explained that although the contraceptive pill is always available, condoms and STI medicine are often not. The service providers of Community Health clinics are usually trained in family planning general health but do not have experience in STI Management. Though NASP has developed STI Management guidelines they have not been distributed widely. Because service providers are not trained they often mis-diagnose patients in accordance with older guidelines.

For most illnesses, respondents claimed to visit medicine shop-keepers or village doctors (trained on providing primary health care) who sit at the pharmacy and sell drugs. Most respondents expressed comfort in receiving services from village doctors whom they have a good rapport with and who offer their medical advice free of charge (though they charge for the medicine). At the community clinic, doctors charge money for prescribing medicine and then patients have to visit the pharmacy to purchase their drugs. None of the health workers or respondents (Includes Spouses, Returnee/circular migrants) knew anything about VCT or care & support services for PLHIV.

Returnee male and female respondents said that they never went to Govt hospitals for treatment when residing in India. Because they did not possess a legal ID card, they could not receive health services and were afraid of disclosing their illegal status in India. Respondents explained that if they had a serious illness they would visit private doctors who would not request a national ID card. Respondents claimed that for **Family planning and pregnancy related services, they were not required to show an ID card and so they regularly accessed these services from government facilities.**

Returning female migrants said that sometimes they liked to return to Bangladesh for treatment because their employers do not provide any treatment facilities. Some respondents who were housemaids reported that on occasion their bosses would send them to doctors if their conditions were severe although they tried

to minimize expenses by not continuing to pay for care when symptoms subsided. The returnee female respondents also reported occasionally facing discrimination from health workers after they had returned to Bangladesh.

Information from the Quantitative study at destination shows some diverging results largely due to different types of respondents. The respondents were different. In the quantitative sample, around 50% of those interviewed were living in India for over 10 years and possessed ID cards.

Access to care for general illness, FP services and pregnancy related services

At source, visiting private paramedic/village doctors was the primary preference for treatment by the majority of respondents. For general illnesses respondents used the following health services and facilities: village doctor (63%), followed by government/municipal hospital (61%), pharmacy/drugstore (28%), Upazila health complex (21%), private doctor/clinic (14%).

Table 7.1.2: Sources of Availing Services Related to General Health Care, Family Planning and Pregnancy at source and destination

Sources of Availing Services	At source		Total	At destination		
	Male	Female		Male	Female	Total
For General Health Care Services						
Government/Municipal Hospital	63.8	57.9	60.7	36.4	45.8	42.1
UHC/UHP/UFWC /CHC/rural	32.2	10.1	20.8	-	-	-
NGO or Trust hospital/Clinic	5.4	3.1	4.2	-	-	-
Government dispensary	-	-	-	3.2	3.3	3.3
Private hospital	4.7	6.3	5.5	11.1	7.8	9.1
Private doctor/clinic	13.4	15.1	14.3	7.0	70.4	70.2
Pvt. Paramedic/Village doctor	59.7	66.7	63.3	-	-	-
Traditional healer	3.4	3.1	3.2	-	-	-
Pharmacy/Drug store	23.5	32.1	27.9	11.1	5.7	7.8
Community volunteers /Health worker /Other	4.7	8.2	6.5	0.5	-	0.2
N	149	159	308	-	-	-
For Family Planning Services						
Government/Municipal Hospital	93.9	94.4	94.3	54.4	71.3	64.6
NGO or Trust hospital/Clinic	8.7	8.2	8.4	-	-	-
Government dispensary				12.4	7.8	9.6
Private hospital	6.0	4.4	5.2	13.4	11.4	12.2
Private doctor/clinic	6.7	8.8	7.8	54.8	29.9	39.7
Pharmacy/Drug store	6.0	3.8	4.9	4.6	41.9	27.2
Dai (TBA)	14.8†	3.1	8.8			
Home treatment	4.7	1.3	2.9			
Community volunteers/ Health worker	25.5	39.0†	32.5			
Other				1.4	4.5	3.2
N	149	159	308	-	-	-

* Chi-square (sig) by gender - BD- 0.000 (sig), 0.000 (sig), 0.000 (sig)

At destination, respondents preferred Private doctors/clinic for general health care, but preferred Government/Municipal Hospital for family planning and pregnancy related services. At source, the majority of respondents visited government hospitals for family planning services (57%), followed by community health worker (33%), upazila health complex (UHC) (27%), and finally by private paramedic/village doctor (22%). However, 3% of respondents reported opting for home treatment when it came to pregnancy related services. At destination, more respondents in Kolkata (83%) accessed government provided family planning or pregnancy services compared to those in Mumbai (76%). Also, a higher proportion of younger respondents preferred to use private facilities (<18yrs-66%, 19- 33 yrs- 47, 34-49yrs-40%).

Type of Facility

Six out of ten respondents reported visiting private doctors/ clinics during their last visit. This percentage was similar across men and women. One- fourth of respondents had visited a government or municipal hospital during their last visit and this was reported higher among women than men. Significant discrepancies did not emerge when this was analyzed by duration of stay in India. However, a higher proportion of older respondents chose government hospitals while younger ones chose private hospitals. A

higher proportion of respondents in Kolkata (31%) opted for government facilities while those in Mumbai chose private facilities (12%). More than three-fourths of the respondents, men and women alike, cited the availability of a good doctor as the main reason for choosing a health facility. This was followed by proximity of the facility to their residence (54%). Cost was also a factor among respondents in Mumbai (27%) and Kolkata (15%)

Type of Services

All respondents were asked about the type of services they received from the facility during their last health visit. Among respondents at destination, almost all of them had gone to the health facility for general health care. This percentage was similar across men and women. The average amount paid for transportation to get to the health facility was INR. 70. About 79 percent of them did not pay anything for their transportation. The average cost of drugs that respondents had to pay was INR. 475. This figure was relatively higher among women than men. The mean consultation fee was INR. 72. None of the respondents had any insurance.

Level of Confidence and Satisfaction

Among respondents at destination, 6 out of 10 felt confident and satisfied with the services provided. More men reported this than women. However, only one-fourth felt highly confident and satisfied with the services they received (27%). More respondents in the older age group (<18 yrs-11%, 19-33 yrs- 29%, 34-49yrs-25%) reported being highly confident and satisfied. Also those in Kolkata (28%) were more satisfied than those in Mumbai (23%)

Places where one can receive an HIV test

At source, few respondents knew where one could get tested for HIV (4%). Out of 13 people who could mention a place for HIV testing, eight people reported government hospital and three people recommended a private hospital/ clinic/ diagnostic centre (three persons), other places mentioned were VCT centers. Among respondents, 15 reported getting tested for HIV (12 males and 3 females). Among those who were tested, only 10 people knew their test results. When it was inquired whether treatment for HIV & AIDS was available, 40% (N=308) of the respondents reported positively. Nineteen percent of the respondents did not know whether HIV & AIDS treatment was available

Table 7.1.3. Percentage distribution of the respondents according to their knowledge of whether treatment for HIV is available (%) at source

whether treatment for HIV is available	Respondent Category*		Respondent's sex †		Total
	Spouses	Mobile persons	Male	Female	
Yes	21.1	49.7*	58.4†	22	39.6
No	53.2*	33.7	27.5	52.8†	40.6
Don't know	25.7*	16.1	13.4	25.2†	19.5
N	109	199	149	159	308

At destination, among BD mobile population it was found that 66% respondents heard about HIV Testing and counseling facilities at govt. hospitals and 20% heard that it is available in VCTC and ICTC facilities in the area they stayed.

Table 7.1.4: Awareness of Facilities from Where HIV Testing and Counseling Services are Available at destination

Particulars	BD		Total
	Male	Female	
Awareness of HIV Testing and Counseling Facilities			
Aware of facilities	2.3	3	2.7
Not aware of facilities	94.5	88.3	90.7
No response	3.2	8.7	6.5

HIV testing facilities

Most of respondents had never been tested for HIV & AIDS (93%). Only 2 percent of respondents had ever received an HIV test. Cross analysis with respect to selected variables was not significant. The number of respondents who were tested was too low to analyze further.

Awareness of HIV treatment

Those who had heard about HIV/ AIDS were asked whether they knew about treatment services and Anti-Retroviral Treatment (ART). Forty-three percent of respondents did not know whether HIV treatment was available. Most respondents had never heard of ART (80%).

Table 7.1.5: Awareness about Availability of HIV Treatment and ART at destination

Particulars	BD		Total
	Male	Female	
Awareness about Availability of HIV Treatment			
HIV Treatment available	35.9	24.9	29.2
Not available	19.8	26.6	24
Don't know	41	44.3	43
No response	3.2	4.2	3.8
Base: Who have heard of HIV & AIDS	217	334	551
Awareness of ART (Anti-Retroviral Therapy)			
Heard about ART	2.8	3.9	3.4
Did not hear about ART	83.4	78.4	80.4
No response	13.8	17.7	16.2
Base: Who have heard of HIV & AIDS	217	334	551

* Chi-square (sig) by gender - BD- 0.033 (sig), 0.352 (non-sig)

All the female respondents who were aware of HIV/ AIDS were asked about PPTCT services. Table 7.4.2 shows that the majority of female respondents had not received PPTCT services (97%). Out of 7 women who received PPTCT services, 2 women had also received an HIV test .

Care and Support

Those who had heard of HIV/ AIDS were asked whether they were aware of networks of HIV positive people, NGOs or government organizations that take care of people living with HIV/ AIDS (PLHAs). A meager 1 percent of respondents were aware of some networks or agencies that offer care or support to PLHAs.

Insurance Coverage

At destination, about 95 % of respondents did not have any insurance coverage as presented in Table 7.6.1.

Summary

Service provision at access is an issue that needs attention at both destination and source.. Overall, availability and utilization of most services were significantly higher in Mumbai than in Kolkata. Most respondents preferred visiting village doctor/ private paramedic for general health services and government services for family planning. Preference for health providers for those at source depended largely on the provider's behavior, proximity of provider to residence and the cost of treatment. . At destination, preference for health provider depended on legal status (ID card), proximity of facility and treatment cost. At source only 4% respondents had knowledge of where to get an HIV test. At destination, only (2-3%) were aware of HIV Testing and Counseling Services and had ever been tested. Most of the respondents at source and destination had not heard of ART nor received PPTCT services. Almost all were unaware of any networks or agencies care or support PLHAs. About 95 percent of respondents did not have any insurance coverage at destination.

The report presents the results of a baseline study that aims at improving our understanding AIDS-related vulnerabilities among Bangladeshi migrants. This study contributes to existing literature on migration and HIV and AIDS in three important respects: first, it focuses on a region that has not been sufficiently investigated; second, it aims to identify the drivers of cross-border mobility along the continuum; and third, through having a focus on the continuum and undertaking research and interventions at source, transit and destination, it allows for a more complete and dynamic perspective of the lives of mobile or potentially mobile people. This continuum perspective also provides important insights into the dynamic processes underlying the association between migration and the spread of HIV in the region.

The report provides interesting information from both qualitative and quantitative data conducted in high mobility and high prevalence areas supporting the assumption that mobile people are often exposed to areas where HIV-related risk activities take place. While much of the data from quantitative and qualitative surveys complement and reinforce each other, there are discrepancies. Some of this can be simply do to methodology, though some of these findings are interesting in themselves and require further investigation. For instance, while the qualitative data illustrated challenges and troubles faced at border crossings, this was not reported through the quantitative data. Perhaps, therefore, what people face at borders is merely seen as an everyday kind of problem that has to be lived with and nothing above the ordinary.

Data collection is always a difficult task, and especially when considering that vulnerable groups engaging in risky behavior can be difficult to reach. The report acknowledges difficulties in identifying the impact population during the process of data collection. The fact that only 2% of the migrant workers interviewed in the quantitative survey at the destination locations reported to have faced harassment and/or suffered from other sorts of violence, and that only 3% reported having pursued any sexual relationship with commercial and non-regular partners in last 12 months, do seem to suggest that a group of young migrant workers were either difficult to reach or declined to participate in the survey. Younger migrants may be reluctant to talk simply because they have limited information about their rights and entitlements. Survey data actually points at this direction: only 3% of the Bangladeshi male population (and none of the female respondents!) were aware of their rights and entitlements, including accident compensation and access to health facilities. If these constraints are found to be associated with risky sexual behaviors, then appropriate analytical methods will be required to address the selection bias constraints.

Besides this, selection bias can also tell us something important about both migrants' attitudes and perceptions and knowledge towards social institutions. The report finds that *"among Bangladeshi respondents, a meager one percent was aware of any networks or agencies that take care of people with HIV & AIDS"*. If because of unobserved factors, young male migrants are difficult to reach in destination countries, what operational challenges can this pose for policies aiming at preventing spread of HIV? Again, would it be more effective to focus interventions on locations at source? This is of high relevance for further enquiries into the migration-HIV relationship in the Bangladesh-India context.

The report also draws attention to an issue of major concern, namely human trafficking and sexual exploitation. The irregular migratory status of many female workers, which stems from restricted migratory agreements between India and Bangladesh, put women at high risks of sexual harassment, trafficking and sexual exploitation, and ultimately at risk of contracting HIV. In the report, the migration-HIV connection points at important institutional challenges that continue to undermine the effectiveness of HIV prevention programs. In particular, testimonies of corruption and coercion between migratory agents, police and criminal organizations underscore the importance of adopting holistic approaches to tackling human trafficking, sexual exploitation and HIV & AIDS. The follow-up survey and qualitative studies can provide valuable information to better assess the dynamic processes underpinning this phenomenon.

Remittances are a major income source for households with migrant members, and for the country as a whole. Indeed, remittances have emerged as a key driver of economic growth and represent 10.3% of the national income, exceeding various types of foreign exchange flows including official development assistance and net earnings from exports.²⁸ But unlike most international experiences that show electronic payment systems increasingly dominating the market for remittances, the baseline survey reveals a different picture where brokers are key in sending *cash* across the India-Bangladesh borders. Qualitative evidence also shows increasing vulnerabilities arising from handling cash when crossing country borders: *"The Law enforcer and Brokers check us. If they find taka they take it. We put taka in the sole of our shoes, in a belt and bunch it in our hair. Sometimes we send taka home through brokers before we return, but Brokers take commission for that"*.

²⁸ See World Bank (2009) *Bangladesh Economic Update, Economic Policy and Poverty team. South Asia region, September*

Cash transfers are likely to boost corruption and criminal activities in bordering areas. If such associated vulnerabilities are severe, particularly for female migrants why aren't safer forms of money transfers such as electronic payments used? Is it due to accessibility problems or information constraints? Are these factors associated with sexual harassment and other HIV-related risks? What are the implications for policy design? The follow up study can provide further insights into these questions.

Recent efforts to reduce the spread and impact of HIV and AIDS have focused on raising the awareness and changing HIV-related knowledge, attitudes and behaviours through mass media.²⁹ However, the existing evidence on mass media effectiveness remains inconclusive, particularly with regard to knowledge of HIV transmission and reduction in high-risk sexual behavior. The reported survey data gives hints into what seems to limit the mass media approach: a small percentage of Bangladeshi respondents (29%) reported to have a TV, whereas only 10% had a radio. This indicates that the ability of organisations to change attitudes and behaviours towards HIV via media campaigns remains largely constrained by asset deprivations among the impact population. In response, alternative diffusion strategies would be required to improve policy reach and impact.

Societal and cultural norms can determine condom use. Peer-group information and shared perceptions are also found to be critical for safe sex practices.³⁰ This is important given that societal norms characterizing the impact populations in India and Bangladesh play crucial roles in determining sexual behavior. Religion although not directly discussed, seems to be important here. The report states *"Among the Bangladeshi respondents, more than 67% had not used condom during the last time they had sexual intercourse with their regular partners. No significant variation emerged when this data was analyzed by age, school attendance, and duration of their stay in India. However, it was found that higher proportion of Mumbai Bangladeshi respondents (51%) used condom than their counterparts in Kolkata (19%)."*

The importance of the finding relates to the fact that 87% of the impact population in Kolkata embraced Hinduism whereas 94% of the respondents in Mumbai followed Islam. This seems to reveal hidden associations between condom use and religion. The low percentage of condom use also may indicate that 1) unobserved socio-cultural factors constrain HIV-preventive measures, and 2) condom effectiveness may be limited among migrants living with regular partners, particularly in contexts of patriarchal polygamist societies. Indeed, the report shows that more than 50% of male respondents, both husbands of migrants and returning male migrants at source destinations, had more than one wife.

This highlights the importance of giving particular attention to the vulnerabilities faced by women, and the dynamic and contextual nature of the relationship between social norms, religion and behaviours associated with HIV-risks when designing interventions.. Approaches need to, therefore, focus on social norms, which lead to gendered vulnerabilities at both source and destination; similarly, approaches need to be tailored to the drivers of HIV-related vulnerabilities and HIV-transmission within different population groups at source, destination, and transit.

Another important contribution of the study comes from the income and consumption data. Existing evidence suggests that the poor are hit harder by the physical and social effects of HIV; however, the risks of infection are not necessarily greater for the poor. In fact, evidence of associations between wealth status and HIV is still very limited and inconclusive.³¹ Income and consumption data will allow a deeper examination of the relationship between wealth status and risks of HIV infection and provide more information on this issue.

Learning from the challenges and limitations faced during baseline data collection, recommendations are being prepared for the program design and the second round of quantitative data collection. This second round, while using the same questionnaire, will be more rigorous in the sampling of respondents and will identify stronger methods of recruitment. More complex analytical work will be employed with this set of data to ascertain change over time and make comparisons with the baseline findings. More rigor will also be sought from the qualitative data, ensuring the richness of the findings is reflected in the analysis and final report. Finally greater effort will be made during the final analysis to explore the continuum issue in more depth to provide valuable information for programmers and policy makers working at the nexus of HIV and mobility.

²⁹ Bertrand et al (2006) *Systematic review of the effectiveness of mass communication programs to change HIV & AIDS-related behaviors in developing countries*, *Health Education Research*, 21(4), pp. 567-597

³⁰ For a comprehensive review, see Logan, TK, Cole, J., and Leukefeld, C. (2002) *Women, Sex, and HIV: Social and Contextual Factors*, *Meta-Analysis of Published Interventions, and Implications for Practice and Research*, *Psychological Bulletin*, Vol. 128, No. 6, 851-885

³¹ For a discussion, see Gillespie, S., Kadiyala, S., and Greener, R. (2007) *"Is poverty or wealth driving HIV transmission?"* *AIDS*, 21(7):S5-S16

The key findings of this study illustrate that lack of employment opportunities in Bangladesh, low wages, poverty, growing trends toward migration and the influence of brokers are prominent factors that make migration to India an attractive and at times necessary strategy for survival. Many migrate in search of work with dreams of a bright future characterized by greater income that will secure a good life at home in Bangladesh. To attain these dreams, migrants undertake long and arduous journey where they face a multitude of challenges and harassment from their own communities, brokers, law enforcers, employers in India, and health providers in both Bangladesh and India. Women face the greatest challenges and risk posed by mobility. Although migration can result in more money, it often comes at the cost of self-stigma and social exclusion upon their return. Additionally, rape, sexual violence and little access to services or support systems make women particularly vulnerable to HIV and AIDS. Despite this, both men and women continue to migrate because of the economic gain, which is often vital for their survival and the future of their families.

Picking up on a number of potential vulnerabilities that migrants face which can also increase their risk in relation to contracting HIV, a number of conclusions and recommendations can be drawn from these baseline findings. Most of the recommendations are programmatic with few could potentially be taken up for policy advocacy.

Increase access to HIV and migration-related information at source and destination: Although awareness about HIV and AIDS is high, misconceptions about transmission along with stigma and discrimination persists amongst all populations in all sites. Therefore, increasing access to HIV-related information and migration through a number of means is critical. A comprehensive Social and Behavior Change Communication strategy/plan focusing on behavioral change among different target audiences like general community including the migrant and their families, health professional, service providers, and law enforcers at source and destination to ensure reduction in HIV and migration related stigma and discrimination.

Interventions to Reduce Stigma and discrimination towards Migrants: Stigma and discrimination towards migrants in destination and female migrants in Bangladesh were the key findings of these studies. Therefore several activities to reduce it could include:

Undertake outreach activities with landlord, employers and neighbors in destination: The landlords, employers and neighbors who come into contact with migrant populations must be reached to increase their awareness of the rights of migrants, as well as the potentially stressful and lonely situations they face and how this potentially links to health and HIV-related vulnerabilities.

Carrying out sensitization/orientation sessions with health staff at destination and source : The health workers will be made aware of the rights of migrants and patients to get nonjudgmental services to ensure that migrants and their families' access and receive non-discriminatory services. A complaint system is established to hold accountable those health staff who withhold services or for showing discriminatory behavior towards migrants and migrant families in destination and source (Bangladesh).

Working with the employers of key sector: The employers of the few identified sectors like the restaurants and bars, factories and watchmen suppliers will be engaged in the program to ensure non discriminatory work places. In case of other informal sectors where migrants are noted to work monitoring and documentation of discrimination and violence's through the migrant solidarity groups will be done and later shared in wider forums and used for advocacy.

Formation of Women lead support groups: In communities in Bangladesh where female migrant's families are socially excluded women lead community support groups (networks) will be formed to ensure inclusion of these women and their families into the community. Together with it behaviour change communication will target the community to facilitate the acceptance process and change their mindset towards female migration.

Interventions to Ensure Safe mobility for migrants:

Watchdog groups in Borders: Especially in case of India Bangladesh border where a lot of movements happens outside the official border crossing, watchdog groups should be established at major identified illegal border crossing points to document any instances of violence and ensuring they get immediate attention and the victims get repatriated back home in a proper way without having to face undue delays and added harassment.

Border personnel must be sensitized In case of Bangladesh they must be sensitized on human rights of the illegal migrants and on safe repatriation.

Increase awareness of rights of migrant to promote informed choice for migration: Activities with migrants both before they move, at transit and at destination should be carried out to increase their awareness of their rights in the destination, including access to health services. For the Bangladeshi, the migrant communities without targeting specific families must be made aware of basic human rights, the risk involved in crossing the border (if at source), whom they can seek help from if they face any problems and of services that are available. Along with this since brokers and middlemen are prominent in their movement they should be taken as a major medium to disseminate these messages to the migrants.

Information package: Information package on safe mobility needs to be developed to be provided to the mobile population during outreach both in destination transit and source. It should contain information on services available in destination, their rights, links to support groups etc.

Increasing employment and livelihood opportunities at source: Remittances is main source of income for most migrant's families in Nepal (83%) and 52% of migrant families in Bangladesh receive remittances. If migrant does not send money home the family would possibly starve, so efforts should focus to mitigate the negative consequences of migration. Along with that create employment, business and livelihood opportunities for those who are left at home to diversify their income source and not to rely solely on remittances money. Linking community members to existing government run vocational skills training as well as credit availability are a few suggested activities.

Increase support services or recreational spaces for migrants at destination. Few migrants belong to support groups, many seemed to isolate themselves and there is some evidence of male migrants especially engaging in risky behaviours including drinking alcohol and have unprotected sex with sex workers. The provision of more safe spaces and support structures for migrants (e.g. DICs), may not only increase community cohesion and solidarity, but it may lessen the likelihood of especially young men engaging in potentially risky behaviours. If we want to encourage use of such spaces by Bangladeshi migrants care must be taken not to target such spaces to specific to them, open in location identified as inhabited by Bangladeshi migrants without indicating it is specific to them to safeguard their desire to remain hidden and assimilated.

Women's Groups/ Network formation in destination: The women in destination seemed powerless where they had little to say in the overall decisions relating to migration and they lacked social support. Therefore formation of support group/ network must be facilitated to provide space for them to come together and share their problems and learn life skills.

Anthropological Study among Bangladeshi migrants: Presence of Bangladeshi migrants in India is obvious and well known fact, but during the field activities these populations were found to be hidden in destination. Therefore to have a clear understanding of their networks, social interactions and support systems and be able to work with them it is recommended to carry out an anthropological study to suggest the possible way of engaging and working with these population.

Facilitating Remittances: The findings suggest that less than five percent of the mobile population in India have bank accounts so it is important to ensure that the migrant population have access to banking facilities which ensures safety of their earnings and they can remit money safely back home without the fear of being looted in their return journey.

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CARE Bangladesh
Pragati Insurance Bhaban, 9th Floor
20-21 Kawran Bazar, Dhaka- 1215
Telephone: 9112315, 8114207

CARE India
E-46/12 Okhla Industrial Area,
Phase II, Delhi- 110020
Phone: +91-11-4910-1100

CARE Nepal
P.O Box 1661
Pulchowk, Lalitpur, Nepal
Telephone: 977-1-5536615

