A Qualitative study comparing the effects and outcomes of HIV-related interventions for Nepalese migrants – at source, transit and destination

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Acronyms

HIV	Human Immuno Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
VDC	Village Development Community
DIC	Drop in center
PE	Peer educator
VCT	Voluntary HIV counselling and testing center
STI	Sexually transmitted infections
FCHV	Female community health volunteer
SBI	State Bank of India
OI	Opportunistic infections

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Executive Summary

The qualitative study, commissioned by Care Nepal, sought to explore the effects and outcomes of the EMPHASIS project, launched four years ago to reduce HIV and AIDS vulnerability among cross border migrants; and to influence national and regional policies relating to safe mobility through evidence generated regionally. The project, working along a continuum of source, transit, and destination areas, provides HIV prevention and treatment services to migrants and their families. Additionally, the project partners with local stakeholders to ensure safe passage of migrants on transit besides providing other support services. The study was, thus, designed to assess the influence of the project in addressing HIV vulnerabilities, and at the same to enquire into whether inter country passage has been made safer for migrants. The study aimed to answer the following research questions: a) How has the EMPHASIS intervention impacted HIV vulnerabilities among Nepali migrants, b) What are the qualitative differences between HIV related attitudes and behaviours between migrants reached at destination and their spouses reached at source and those not reached either at source or destination, c) What are the qualitative differences between HIV related attitudes and behaviors between spouses who have been reached by the project and those who have not been reached by the project, d)) What are the benefits and barriers of support services provided to migrants for safe mobility and empowerment.

The study was conducted among 60 migrants and family members, and 5 key informants in four locations- two at the destination site of Delhi and two at the source site of Nepal. In depth interviews by trained researchers were conducted with the help of semi structured interview guides.

The average age of male respondents was 36 years while it was 30 years for female respondents. Educational level was higher among males, the average being 8.6 years of education while it was 2.5 years for females. Fifty six (93%) of the total respondents were married and half of them had 3 children or more. Male migrants were employed as watchmen, cooks, factory workers, computer operator, while spouses of male migrants in Delhi were engaged in household work or worked as salesgirls and domestic help. Spouses and other family members in Nepal were mostly engaged in agricultural and household work .

Knowledge of HIV and AIDS was generally high among all the respondents (92%) except for those who were out of reach of the project area in Nepal and hence, not receiving services and among those who infrequently used available services at the drop in center in Delhi. Dissemination of HIV information at transit routes was less visible as not many respondents reported this. However, there were misperceptions among a few respondents about transmission of HIV through mosquito bites, sharp implements, and different blood groups conferring different transmissibility. Almost all respondents expressed lack of stigma toward PLHIV except for a few which included a woman out of reach of the project area in Nepal and two respondents who rarely used HIV services in Delhi.

The majority of respondents in Delhi reported visiting the drop in centers which were the source of information dissemination on HIV and AIDS, STI and safe mobility, run by partner NGOs, while the majority in Nepal reported having been visited by peer educators and outreach workers for the dissemination of the same. Dissemination of HIV information at transit routes was less visible as not many respondents reported this. Regarding HIV testing, the majority (23 out of 30) of the respondents in Delhi- migrants and spouses of migrants- reported testing for HIV and all the respondents felt that HIV testing was necessary. In Nepal, 12 out of the 26 spouses had tested for HIV while 14 spouses had not tested. The main reason for not testing in Delhi was the belief that it was not necessary since they (respondents) did not engage in sex outside marriage. In Nepal, the main reason for not testing were distance of testing centers, belief that it was not necessary and fear of presumed blood loss. Regarding ART, the three HIV positive respondents spoke of the support they received from the project in accessing ART in the form of travel money and child care.

As regards changes in attitude, knowledge and behaviour, the majority of respondents(~94%) reported changes in their perception of HIV upon receipt of information from the project- changes in thinking of HIV and AIDS as “dangerous” and “dirty” and perceiving PLHIV as immoral people. Women reported less embarrassment in talking about HIV and AIDS. Regarding behaviour change, out of the 53 respondents for whom this question applied, 28 (52.8%) reported there was a change while 19 (35.8%) reported no changes in behaviour. Among men, changes in the patterns of alcohol use, visiting sex workers and using condoms were reported. Among women, changes were reported in using condoms with husbands and in discussing about HIV with their husbands, friends and family members. These changes were facilitated by spousal communication which was more common when both husband and wife received services – husband at destination and wife at source or both at destination- than when neither or only one received services. Linked to this is the finding that the project has created an enabling environment for the women who feel capacitated to communicate with their husbands because of information and motivation by peer educators. Furthermore, talking to one’s peers is another factor that is related to behaviour change.

With regard to other support services, the majority of respondents reported changes at transit routes, in terms of uniform rates of transporters (rickshawala and tangawala) and less harassment from the police while crossing the border. Additionally, remittances through banks were reported by almost half of the sample. The other half reported not doing so primarily due to the difficulties in procuring identity proof to open a bank account in India, and also due to the fact that there was a lack of nearby banks in the VDCs in Nepal.

The project has, therefore, influenced the utilization of HIV prevention and treatment services by making them more accessible while at the same time, influencing the attitudes and behaviours of the impact population. When both husband and wife receive services, it is suggested that it leads to communication between them about HIV and AIDS and adoption of safe behaviours. However, the study also points to the need to increase coverage of most Nepali migrants in destination and spouses at source districts, make HIV testing services more accessible in source districts, focus on removing misperception in HIV information, and facilitate remittances. Among recommendations, the findings suggest the introduction of couple counselling on husbands’ visits, encouragement of spousal communication and peer communication, and expansion of HIV information services at transit routes.

1. Introduction

Rapid economic growth in the south Asian region is witnessing increased migration as a consequence. Evidence suggests that migration occurs due to economic imbalances, extreme poverty, population growth, environmental degradation, porous international borders, employment opportunities and migration policies among others.[1] Despite the economic gains accrued from migrants, the latter remains at a vulnerable state physically, socially and economically both in the home and host countries. While home countries rather encourage migration, they provide very little protection to the migrants in the destinations. Similarly, in destination countries, the migrant often lives without any awareness or recourse to basic human rights. Migration is thus a complex phenomenon having inextricable links with key policy areas including public health and human rights. While conditions of migration lead to HIV vulnerability, access to health services is often limited as the migrant faces discrimination and has no protection to legal and social rights.
Cross border migration between India and Nepal is one of the factors affecting HIV incidence and prevalence in the region. While Nepal acts as a source country from where migrants originate, India is commonly the destination for these migrants. India has the highest number of people (2.9 million) in the Asian region, living with HIV infection, and Maharashtra, with 0.55% prevalence accounting for a large number of those infections, is a state to which many Nepalese migrate. It is, therefore, not surprising that in Nepal today we see 27% of the total 50,200 HIV infections accounted for by migrants [2].

The EMPHASIS (Enhancing Mobile Population's Access to Information, Services and Support) project, implemented in Nepal, India and Bangladesh, has been set up by Care to address HIV/AIDS vulnerability of cross border mobile populations. The project provides HIV and AIDS related prevention messages and referral services throughout the continuum of mobility, i.e. at source, transit and destination. Alongside, the project seeks to strengthen capacity of civil society, government institutions and policy makers to address the needs of mobile populations and create an enabling environment for safe mobility. The referral service was designed to refer clients (migrants and their families) for HIV and AIDS health service, to establish health centers in the locality, and also to refer returnee migrants from source to transit and destination in the EMPHASIS working area. Along with HIV prevention, safe mobility is another mandate of the project, which is seen to facilitate the overall goal of access to and uptake of HIV services.
Currently, the project works in two source districts in Nepal – Achham and Kanchanpur, and two transit routes- Gaddachouki/Banbasa, and Dhangarhi/Gaurifanta. In India,ie, the destination area, the project works in Delhi, Mumbai and Kolkata. In Bangladesh, the project works in the two source districts of Jessore and Satkhira, and the transit route of Benapole/Petrapole. Alongside interventions, the EMPHASIS project has also conducted several studies related to aspects of migration (Anthropological study to understand the socio-economic and political dynamics of undocumented Bangladeshi population; Study among short-term Bangladeshi sailors who travel to ports in West Bengal, India) and those related to HIV vulnerability and HIV infection (Baseline study to understand vulnerabilities of migrant populations and facilitate assessment of gaps in existing policies and service provisions; PLHIV study to assess barrier to access services for cross border mobile PLHIV at source and destination; School children study in Nepal to understand other mobile population's vulnerability to HIV and AIDS).

1.1 HIV & AIDS and Migration in Nepal

An estimated 50,200 (0.3% of the total population) people are living with HIV and AIDS in Nepal in 2012 2. While the rate of new HIV infections has decreased in the last 5 years among key population groups due to targeted interventions, they are seen to be rising among low risk populations mainly through the conduit of bridging populations, namely, male migrants and clients of female sex workers. Although the course of the epidemic initially saw HIV being primarily transmitted through injecting drug use and female sex work, it also saw a rise in the proportion of infections among male migrants, so much so that in 2008, this category of population bore the highest burden of HIV infection (41%) while their wives or partners bore nearly a quarter (21%) of the burden. 3 This was an effect of large scale migration to India, particularly to the state of Maharashtra, where many migrants engaged in risky sexual behaviours due to, amongst other things, peer pressure, work stress and homesickness. Earlier community based studies carried out in districts in the far western region showed higher rates of HIV infection among returnee migrants from Mumbai compared to migrants working in other parts of India and those working in Nepal 4, 5, 6. The same studies also identified sex with sex workers and inconsistent condom use as distinct risk factors for HIV. In fact, recent evidence shows 20% of migrants reporting risky sexual behaviors3.

Recent baseline data from the EMPHASIS project report ease in gaining employment and higher wages as the main factors for migrating among males and joining spouses among females7. Besides, many girls and women are trafficked for sex work, domestic servitude, and forced labour. Indeed, as many as 5000 to 7000 women and girls between the ages of 10 and 20 are trafficked into brothels in cities in India8. The open border agreement between India and Nepal has facilitated large scale migrations as well as trafficking. While the bilateral treaty agreement grants equal rights- except voting rights- to migrants, they are not aware of these rights and live under threats of imprisonment, and face discrimination in India. The baseline data indicates that only 7% of the migrants interviewed were aware of these rights, while only 8% possessed any identity card7.

Data from the baseline report also shows that although awareness of HIV was high among the migrants awareness of STI was comparatively low (88% as compared to 30%). However, there remained misconceptions about HIV transmission routes and awareness of HIV counselling and testing was reported to be low. Moreover, 13% reported having sex with non regular partners in India out of which half had unprotected sex.7 The returnee migrants did better in all HIV/AIDs indicators than the migrants based in India, suggesting, therefore, that prevention strategies were successful in Nepal in targeting the said population.

1.2 HIV & AIDS and migration in India

India is both a country of origin and destination for migrant workers. Additionally, there is huge internal migration within the country. According to the Indian census of 2001, about 307 million persons have been reported as migrants by place of birth. Out of them about 259 million (84.2%), migrated from one part of the state to another, i.e., from one village or town to another village or town. 42 million (2%) were from outside the country. Migrants from Nepal are the third largest group of foreign nationals in India. Citizens of both countries travel and work freely across the border under the bilateral friendship treaty signed in 1950. The treaty, made to establish a close strategic relationship between the two neighbours, allows free movement of goods and people between the two countries and collaboration on matters of defence. Thus, the treaty allows nationals of both the countries to move across the border without passport and visa, live and work in either country and own property and do trade in either country. The majority work in the private sector and are engaged in low paying manual jobs in manufacturing, construction, agriculture and hotel industry. Internal disturbances in Nepal also led to a huge surge in migration to India. The rise of Maoist insurgency in Nepal in 1996 which resulted in government oppression created an environment of violence and severe human rights abuses perpetrated by both the sides, to escape which there was large scale migration to India. Although there are no clear figures, it is estimated that hundreds of thousands of civilians migrated to India during this time. In fact, according to the 2001 census of Nepal, about 584,000 persons were born in India out of which only 100,000 were registered as Indian citizens.

India has an estimated 2.3 million HIV infected people and is characterized by an epidemic which is concentrated in high risk groups such as injecting drug users, female sex workers, men having sex with men and truckers 9. Heterosexual transmission through unprotected sex is the main mode of HIV transmission in India, which is also the main mode of transmission among truckers and migrants. It is interesting to note that states that have a high HIV prevalence also have high proportions of migrants. Maharashtra is one such state which has around 500,000 Nepalese migrants, according to the 2001 census of India, and one can hypothesize that many of these migrants here have acquired HIV infection through multipartner sex and paid sex.

Delhi, with a population of 17.2 million and 51,800 people living with HIV, is considered a low prevalence state. The Delhi State AIDs Society, however, has deemed it a highly vulnerable state as it has a large presence of truckers and migrants. In fact, it is estimated that 200,000 to 300,000 people a year settle in Delhi permanently from other states in India as well as from outside India as migrants. These people come in search of employment and education opportunities and become permanent residents of Delhi. While there are no figures for HIV infection among migrants in Delhi, it can be assumed that, due to the presence of FSW and the fact that majority of infections are through heterosexual transmission, migrants are highly vulnerable.

1.3 Migration and HIV vulnerability

Circumstances surrounding the migrants in the host country contribute to their vulnerability in acquiring sexually transmitted infections including HIV. It is well known that living and working in conditions of poverty and powerlessness in distant places where social and cultural bonds are loosened, exacerbate vulnerability to risk taking and thence to HIV.

Although the pathways through which migration leads to HIV transmission are not well understood, there may well be multiple factors operating simultaneously to increase HIV risk among migrants. A systematic review of studies among migrants indicated that HIV risk determinants cut across several levels- policy, socio-cultural, sexual practice and mental health.10 Studies have pointed out that prolonged periods of living and working in a host country elevated HIV risk among some migrants 11,12. In fact, this was found among Nepalese migrants as well- those who stayed in Mumbai for more than five years had substantially higher chances of getting infected than those who stayed for shorter durations4,5,6. The longer they stayed away, the more chances there were of having paid sex with sex workers. Furthermore, limited legal status which in turn influences access to public health care made it difficult for migrants in some countries to use HIV prevention13 Indeed, lack of HIV testing has been identified as a risk factor among migrants 14,15. In terms of cultural beliefs and norms, it has been found that migration sometimes frees one of traditional norms around family and fidelity while reinforcing norms around masculinity 16,17., so that the migrant feels free to have multipartner sex and sex with sex workers.

Also, since men migrate to earn money, multi partnering was sometimes perceived as a symbol of economic success rather than social irresponsibility or immorality 10. However, there is also evidence to the contrary- conservative social norms are found to survive longer among migrants that prohibit paid sex which then acts as a protective factor against HIV vulnerability18. Having wives with them is another protective factor against HIV risks as found among internal Indian migrants in Mumbai19. By and large, studies have shown that when migrants travel alone to another country, living far from their families, it is the language barrier, low social support, stress and loneliness, and depression that create conditions of vulnerability which lead to sexual risk taking10. Among Mexican migrants in New York, the majority reported missing their families and lifestyle back home and while their levels of loneliness increased, condom use with girl friends decreased 20.

Thus, migration influences behaviors from a combination of social, geopolitical, cultural, and economic factors. Although the systematic review of studies showed that in multivariate analyses, sexual risk taking, health behavior and mental health issues gained primacy over policy and sociocultural determinants, the writers pointed out the inter relatedness among many of these

determinants concluding that addressing the policy and social environment were just as important as addressing individual behavioral determinants.

2. Methodology

The EMPHASIS (Enhancing Mobile Population's Access to Information, Services and Support) project has completed four years of operation, providing HIV prevention and referral services, as well as support services for safe mobility to migrants from Nepal. The project now aims to assess how the intervention design has been able to address HIV-related vulnerability of direct beneficiaries. As such, a study of impact populations who have been reached at source and at destination was developed to provide the project with an understanding of the effect of the services provided and the extent of the achievement of the overall aim of the project, i.e to reduce HIV vulnerability of impact population. Since the project also focuses attention on safe mobility and empowerment of women migrants and spouses of migrants (factors that influence HIV related behaviors), another aim was to explore the effects of these services.
Therefore, the study aimed to answer the following research questions,

1. How has the EMPHASIS intervention impacted HIV vulnerabilities among migrants?
2. What are the qualitative differences between HIV related attitudes and behaviors between migrants reached at destination and their spouses reached at source and those not reached either at source or destination?
3. What are the qualitative differences between HIV related attitudes and behaviors between spouses who have been reached by the project and those who have not been reached by the project?
4. What are the benefits and barriers of support services provided to migrants for safe mobility and empowerment?

2.1 Study Design

The study was a qualitative investigation using in depth interviews with migrants, families of migrants and key informants. The latter include stakeholders and service providers. Four sites were selected for data collection- Gurgaon in the national capital region (NCR) and Narayana in south west Delhi as a destination site in India, and Achham and Kanchanpur as source sites in Nepal. Data were collected over a period of two weeks by three interviewers- one female and two male.

The comparative study was initially planned to conduct for both Bangladeshi's and Nepalese Impact population. Bangladeshi migrants in India conceal their identity because of their undocumented status. Also, there is political sensitivity about Bangladeshi migrants in India. These accounts were considered while designing the field activity in India and decision was taken not to list Bangladeshi's in the first contact form (line listing) at destination. This linkage was one of the most important aspects of the comparative study which was not possible for Bangladeshi impact population. Therefore, later the study was designed only for Nepalese migrants.

2.2 Recruitment and Sampling

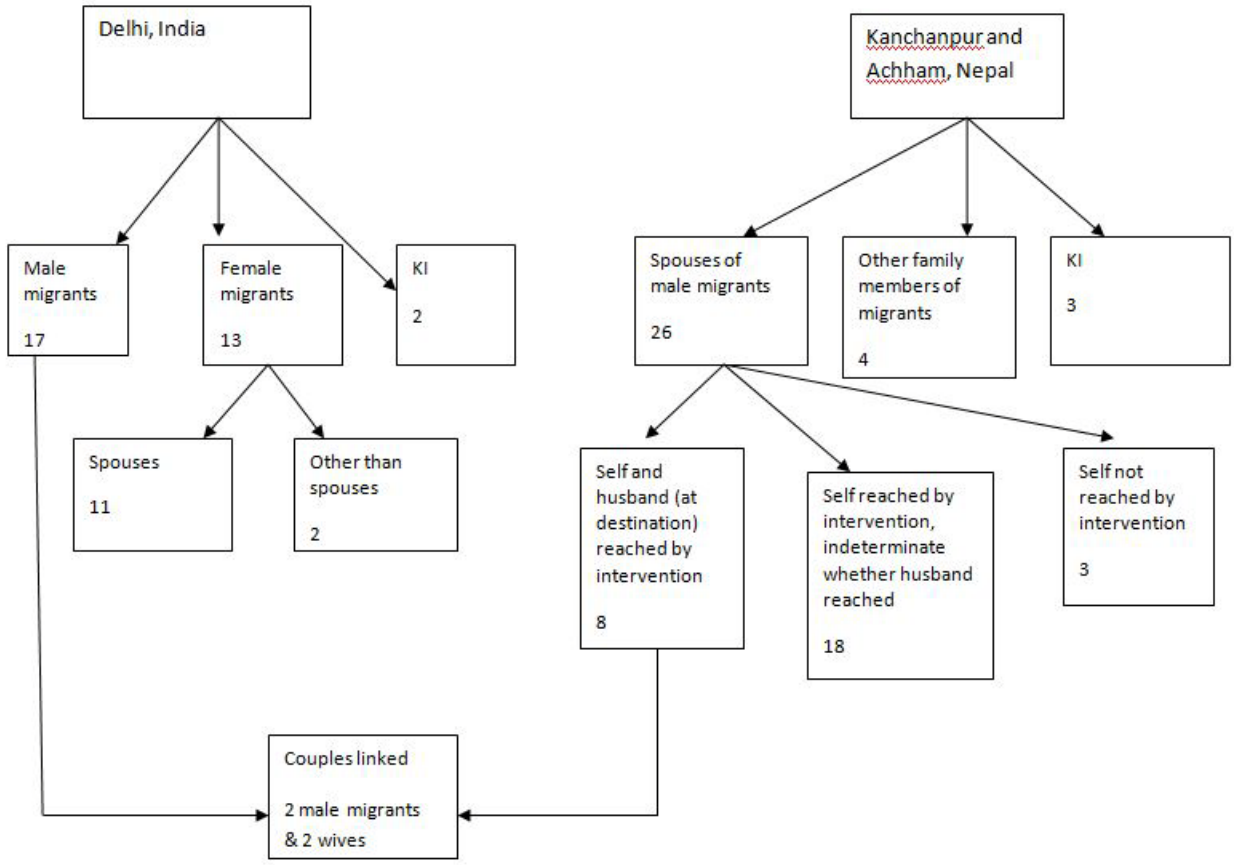
Study participants were selected on the basis of purposive sampling. Information lists of migrants compiled by CARE were used to identify and recruit participants. These lists - validated and non-validated - were previously drawn up to identify key population (i.e., migrants) and their families, for the purpose of targeting interventions. The validated list contained information of migrants traced at destination and themselves or their families who were traced in the source villages. The non-validated list contained information of migrants reached only at destination and whose families or themselves were not reached at source.

The help of implementing NGO partners and CARE officials was taken to sample from the lists- 15 participants were selected from the validated and 15 participants were selected from the non-validated lists. During the selection process it was found that many of the migrants identified in the

lists have moved away to other places. It was also found that many family members from the non-validated lists were receiving service at either source or destination. It is perhaps due to the passage of time since these lists were compiled that changes may have occurred in access to HIV services. Care was, therefore, taken to represent a wide range of participants across two areas of Delhi, which has the highest number of Nepalese migrants- Gurgaon and Narayana in Delhi. Two key informants in Delhi and three in Nepal were selected to represent the stakeholder perspective.

Since the original objective of the study was to compare married couples, both of whom received HIV prevention services – one at destination and the other at source- with those couples where one partner did not receive the services, we set out to recruit participants accordingly. However, we learned that most of the migrants in Delhi lived with their spouses and it was their sibling or parent who received services in the source village. Therefore, in order to represent a few couples who lived apart in our sample, we purposively selected wives of migrants in the source villages of Kanchanpur and Achham in Nepal. We also selected three spouses who lived outside the project area of operations and hence did not currently receive services. We had two couples who were linked in our dataset- husbands interviewed in Delhi and their respective wives interviewed in Nepal. Other family members included one father, one mother, one daughter and one father in law.

Thus, our final sample looked like this,



2.3 Research instrument

The interviews were conducted with the help of semi-structured interview guides – one was designed for migrants and their families and the second was designed for key informants. Questions were kept broad and open ended with extensive probes to guide interviewers. Questions were

divided into the following domains: HIV knowledge, access and utilization of HIV services, access and utilization of support services; HIV behaviors and changes in behavior; life as a migrant, stigma and discrimination.

2.4 Training and data collection

A two day training workshop was conducted in Delhi. Three interviewers from Nepal were hired for data collection. The interviewers conducted data collection first in Delhi and then traveled back to Nepal for data collection. The training included the following sessions: 1) Introduction of study 2) Orientation to EMPHASIS project 3) Introduction to techniques of qualitative interviewing 4) Briefing on questionnaire guide 5) Briefing on study process- recruitment of study participants, use of recorder and field notes, informed consent form. One entire day was devoted to role plays and practicing conducting indepth interview.

The partner NGOs in Delhi (Modi care Foundation) and in Nepal (Needs and Gangotri) were helpful in contacting the respondents and organizing the data collection process. After the training, interviewers conducted interviews as per the convenience of study participants. Since most of the male migrants were working, it was necessary to conduct interviews in the early mornings and late evenings. Each interview lasted from 45 minutes to one and a half hours, and was conducted in private settings. Each interviewer introduced himself/herself before the interview, talked about the study and read out the consent form. The consent forms were signed by the study participants and a copy was handed to each of them, while copies of the original consent form were handed over to the lead consultant. None of the field notes or interview scripts included the names of participants – instead they were designated unique ID codes. With the permission of study participants, recorders were used along with writing of notes. These notes were later transcribed with the help of the recorder by the interviewers.

2.5 Data management and analysis

Interviews were conducted in Nepali. These were later transcribed and sent to a translator. The translator translated the interviews from Nepali into English and sent them on to the lead consultant. The translated interviews were then stored in Atlas TI for coding and analyzing. Open coding system was utilized initially to code responses. The codes, at this stage, more or less, corresponded to the categories of questions. Later, some codes were merged to represent a unifying larger theme. Comparisons were made to arrive at similarities and differences within the same code 21 and to find out the different experiences and meanings that an event/perception has for different respondents. We also made use of comparisons across categories of respondents to again find out their varied experiences. For purposes of analysis and to answer our research questions, we made three levels of comparisons: (1) services received at destination by migrants and spouses and services received at source by spouses and other family members of migrants (2) Husband and wife both receiving services versus only one receiving the service (3) Spouses reached by service versus those not reached by service.

2.6 Limitations

The study has a number of limitations. Social acceptability bias may have hindered the quality of responses to questions on sexual behavior. It was observed among many men that although they talked about their friends' behaviors, they were reticent about themselves. In terms of recruitment, we could not make use of the validated versus non validated lists as we learned that many changes have occurred since the making of these lists- in short, what was categorized as non validated (meaning the principal migrant being reached by the project but not his family or vice versa) was no longer so as many family members as well as migrants from the so called non validated lists were in reality being reached by the intervention. We, however, delved deep into the interview scripts to identify respondents whose spouses have either been reached by the intervention or not. Also, we

purposively selected respondents in Nepal to categorize those who were reached by services and those who were not. In Delhi, the time provided for data collection was short and the interviewers had to conduct interviews late at night or in the early morning, in order to cover male migrants who went out to work, and this may have compromised the quality and depth of the interviews. Having male researchers interview women is another limitation as the latter were embarrassed to speak openly about condom use. However, it did not take away from the richness of the interviews as women, in general, were willing to talk about HIV, their husbands' behaviors and their own.

3. Findings

3.1 Demographic profile

A total of 60 migrants and family members were interviewed. The ages of the male respondents ranged from 19 to 58 years while the average age was 36 years. Among females, the age ranged

between 16 to 51 years with the average age being 30 years. While most female migrants were either housewives or worked in shops as sales girls and as domestic helps, the men were engaged in diverse occupations – e.g. watchmen, mechanics, salesmen, computer operator, factory worker etc. All of the female family members, except one student, who participated in the study in Nepal were engaged in agriculture and household work, while the male family members were engaged in agricultural work. The key informants who were interviewed in Delhi included two stakeholders who worked in private companies and who were actively involved in the drop- in center for Nepalese migrants run by the partner NGOs of Care. In Nepal, the key informants included an outreach worker of the EMPHASIS project in Kanchanpur, a facilitator of the EMPHASIS project in Achham, and the District AIDS Coordination Committee (DACC) coordinator of Achham district.

The majority of the migrants belonged to Kanchanpur district, while two came from Achham, two from Baitadi, and one each from Dailekh and Syanja districts. Three of the spouses interviewed in Nepal were HIV infected while none reported HIV infection in the sample in Delhi. The average years of education of male respondents was 8.6 years –12 years of education being the highest and 0 years of education being the lowest. Among female respondents, the average years of education was much lower at 2.7 years, with a range from 0 to 11 years of education. Seven female spouses and one male migrant reported having had no education at all. The majority of respondents was married except one female migrant who was separated, one female migrant who was unmarried, one female family member who was unmarried and one family member who was a widow. Almost half the respondents had 3 or more children. In Delhi, the majority of the female respondents and almost half of the male respondents were found to be living together with their spouses. In Nepal, all the spouses who participated in the study had their husbands living away in India.

An overwhelming majority of respondents reported migrating to India due to poverty, lack of jobs in Nepal, and devastation caused by floods. Three of the respondents reported running away from home due to conflict with their family, while one respondent reported being born and brought up in India. Except for five, all the respondents in Delhi reported sending money back to Nepal, those living with their spouses sent money to their parents.

3.2 Thematic findings

Findings were delineated on the basis of domains covered in the questionnaire. This chapter provides findings for 1) Access to and utilization of HIV and AIDS services, 2) Knowledge, attitude and behaviour and changes in these three aspects 3) access to and utilization of support services, 4) benefits and barriers to services provided by EMPHASIS.

3.2.1 Access to and utilization of HIV prevention and treatment services

Description of HIV prevention and treatment services of EMPHASIS

The EMPHASIS project, partnering with local community based organizations, government institutions and NGOs, provides HIV prevention services at source, destination and transit. In Nepal, it works in two districts- Kanchanpur and Achham, and in India, it works in three states- Delhi, Mumbai and Kolkata. The project has also focussed on a few more strategic areas for the transit based interventions and HIV and AIDS related referral services in Dhangadhi, Kailali. At transit, it provides HIV information services on two transit routes through distribution of information leaflets. At source and destination, HIV awareness and information is provided through peer educators and outreach workers who make door to door visits of the targeted population. Drop- in- centers (DIC) located in the intervention sites also provide information services.

In Delhi, there are five DICs located in four areas of Delhi which has a large presence of Nepali migrants. As an innovation mobile DICs are being conducted to reach out to hard to reach migrants. Alongside, HIV prevention and treatment services such as HIV testing services, STI diagnosis and treatment, and ART provision are provided through active referrals. In Delhi, referrals are made to the government district and city hospitals, while ART is provided through referrals at designated government hospitals.

In Nepal, three drop –in- centers are located in Accham- two in Kanchanpur and one in Kailali. Among these DICs, two are located on the border area of Gaddachauki/Banbasa and Bhansar/Gaurifanta. In Achham, the EMPHASIS project staff mainly refer migrant workers and their spouses for VCT service. They primarily refer to VCT centres of NGOs, GOs and the District Hospital. In Kanchanpur, PLHIV are referred to District Hospital for CD4 count, ART and OI services, while referrals for HIV testing are made to the VCT centre of the NGO, NNSWA and to Zonal Hospitals. The cross border referrals are done through the Mahakali Zonal Hospital in Kanchanpur, Seti Zonal Hospital in Dhangadhi, Kailali and Nyaya Health and District Hospital in Achham In Nepal, travel costs to access ART are borne by the project. Community Support Groups comprising PLHIV and other community volunteers to increase the HIV/AIDS information, increase service access, referrals, provide counselling, social support, peer support and other social support to the PLHIV, migrants and their families at community levels are also introduced.

This section describes respondents' access to HIV and AIDS services provided by the project- HIV testing services, drop-in center services, peer outreach, ART services, STI referrals. It also describes the extent of utilization of services and barriers to utilization. Comparison between service access at source and destination, as well as comparison between the use of services by different categories of people are also included. The findings reveal that while the majority of migrants and family members have reported receiving information on HIV and STI through the partner NGOs at source and destination areas, access to services such as HIV VCT, STI diagnosis and treatment, and referrals were varied- being easily accessible in Delhi while distance of facilities hindered accessibility in Nepal. The majority of migrants were not aware of HIV services provided at transit although a few (5 respondents) reported receiving information leaflets containing advice about not consuming alcohol and practicing safe sex.

Drop- in- Center services

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

This respondent in Delhi talks about how she spends time in the DIC,

> In leisure time I visit the DIC. My relatives also go there. Sometimes sir and madam ((Project Coordinator and peer educator, DIC) come here and give information on HIV…Our children can also visit where they learn dancing and singing. We get opportunity to meet other Nepali friends. We get different types of information, meet all the Nepalis and it is very easy to utilize our free time by coming here.(female migrant, 25 years, Delhi).

This woman talks about the services received at the DIC which is representative of the majority of the respondents in the Delhi sample

> NC (DIC) is like home for those Nepalis who have migrated here because it supports them in every kind of problem. They have peer educators who provide knowledge of HIV and condoms. They send us for blood test (HIV test) to the Government hospital. Sometimes they take us along with them. I feel good in getting these services.(female migrant, 35 years, Delhi).

However, the DIC, perhaps having a limited geographical area within which it operates, do not cover most migrants in the city. This stakeholder, while also talking about the support services provided by the DIC, elucidates this fact ,

> There is good relationship between DIC and the Nepalese who go there frequently. They get information on HIV, STI, bank account and safe travel which makes their lives easy. But many of the Nepalese don't access the DIC. It would be better if they had been included in the DIC.... not all of them visit here. They don't know about HIV services. It is very difficult for the staff to search for them..(company worker, 34 years, Delhi).

In Nepal, only two respondents who lived in and around the DIC accessed it while the majority of the female spouses reported either not knowing about the DIC or not visiting it due to distance. This woman in Nepal, when asked about whether she visited the DIC, says

> You asked me whether I visited DIC or not but I haven't gone there. I don't know about this because it is not in our VDC. I heard from my husband that there is DIC in Delhi. He says that the services provided there are better than here in Nepal. He says that he often visits there.(housewife, 29 years, Achham, Nepal).

However, despite the low reportage of visits to the DIC in Nepal among our sample, this woman who accesses it has positive experience of the DIC,

> Among the services provided by EMPHASIS, DIC services is the best where many people are made aware of HIV transmission and it's prevention. The migrants are able to know about safe migration information and the services available in India also. Many of them are protected being cheated and their money stolen. Nowadays they are so clever that they send money through money transfer where their family can easily get it. They have also changed their habit of drinking alcohol while travelling. This is all because of the awareness given to them.(housewife, 40 years, Achham, Nepal).

Peer education and Outreach services

In Kanchanpur and Achham in Nepal, except for the three women who were not receiving services as they were sampled from out of the project area, most respondents reported being visited at least once by outreach workers of the EMPHASIS project. Only one respondent in Nepal reported an outreach visit before the lifetime of the project i.e, ten years back. Outreach services were the main source of information for the spouses of migrants who otherwise would not go out seeking services as they reported being too busy working in their land and households. Living in a traditional set up with strict mores on moving outside the household, although not obviously cited, could be gleaned from the statements of some of the women in Nepal. The situation is different in Delhi where the spouses had more time, and possibly had more freedom in moving about because they were not living in a traditional set up and therefore could easily access services. In Delhi, 27 of the 30 respondents reported being informed about the DIC by outreach workers who visited them at their homes or in the case of three male respondents, called them on their phones. Outreach workers in Delhi and Nepal were reported to distribute condoms besides giving information about HIV and STIs. The respondents in both Delhi and Nepal also expressed satisfaction about the services they

received and talked positively about their interactions with peer educators and outreach workers. In the absence of drop in centers or health posts in close proximity to villages in Nepal, mobile camps appear to serve the purpose of diagnosis and treatment of STIs as well as testing for HIV, as reflected in the narratives of three respondents. However, two of the narratives related to a different project operating some years back. In our sample, only one woman reported attending a recent mobile camp, while three women reported receiving STI treatment after being referred to a health center.

About one third of the women reported attending spouse groups in which information on HIV, STI, safe mobility was disseminated.

This woman talks positively about the outreach services provided by the project,

> I feel good because they (outreach workers)come to our home and provide us information regarding HIV. We don't get time to go to their services center. We have lots of work in the house. The staff are very friendly and well behaved. The information they have given is very important to me. There is clarity in what they say. It is a big thing to make us understand because we are illiterate. We don't understand easily. They provide us condoms and also suggest to us to go to health post for any kind of problems. (Housewife, 28 years, Kanchanpur, Nepal).

In contrast, women who were not reached by EMPHASIS lacked information about health services, specifically HIV prevention services, and how to access these services as revealed by this woman who has this to say when asked about whether she and her husband accessed any HIV services, referring to the

> I don't know about these services. Where and how do we get it? I know only that if we have some health problems then we have to go to the hospital which is in Mahendranagar because there is no facility in the health post. My husband comes home every year….To be aware about HIV is good for us but I don't know whether my husband also knows about it. He has never talked to me about it. (Housewife, 35 years, Kanchanpur, Nepal).

Peer educators in Nepal were found to form an important link between the spouse and her husband as they also visited the husband whenever he was back in the village. In some instances, the help of outreach worker were sought in explaining to the husband and in convincing him of adopting safe behaviors such as condom use, as narrated in the following quote. The respondent talked about how her husband did not send her money and had once engaged in an extra marital affair. She later went on to report that she communicated about HIV, STI and condom use to her husband with the help of a peer educator, and also reported that she used condoms with her husband.

> When I returned home after that training (women's group) then I tried to share with my husband all that I learned. He scolded me on hearing this. He told me that the women are getting spoilt because of the training and mobile phones. He threatened me that he wouldn't let me participate in such training. When I tried to convince him I couldn't. Then I called an outreach worker named B. She told my husband everything, then he agreed to listen to her. He felt that it is a good thing to adopt safe behaviors in his life.(housewife, 27 years, Kanchanpur, Nepal)

HIV counseling and testing services

As regards HIV testing, the majority (23 out of 30) of the respondents in Delhi reported testing for HIV and all the respondents felt that HIV testing was necessary. Among those who had not tested

were those who felt that there was no need since they had no sexual risk behaviors, i.e., they did not engage in sex outside of marriage or did not visit sex workers. One female migrant reported being afraid of the test because of presumed blood loss, as well as of the "tension" that may arise if one tested positive. Another female migrant who rarely visited the DIC reported not knowing where to go for the test. In Nepal though, the reverse was true with more numbers of women (14 out of the 26 female spouses) responding that they had not tested although they reported being referred by peer educators. The main reason for not testing was the distance of testing centers.

These two spouses from Nepal talk about the difficulties in accessing HIV testing services,

> No I haven't tested (for HIV). But I would like to test for it. I couldn't do it before because we have to go far from here. There is no facility in the community. It would be better to know whether we have HIV or not.(housewife, 39 years, Kanchanpur, Nepal)

This spouse in Nepal, talks about the distance of testing centres in Nepal but also expresses her willingness to test in India when she visits it next

> I don't know where I have to go for the test because it is not in my community and if we go to Sanfe then I have to spend my whole day going there spending my own money. I am going to India tomorrow and will ask my husband about it. If he has tested and wants to take me I will go with him to Indian hospital.(housewife, 37 years, Achham, Nepal).

Regarding HIV testing, we also found that when female spouses received services at source and their husbands received services at destination, or both received services at one place, such as in Delhi, they made better choices about using HIV testing services as compared to those couples in which either partner or both partners may not be receiving services. In Delhi, where both husband and wife received services, it is interesting that more than half (6 out of 11 spouses) of the female spouses reported taking their husbands and family members for testing.

This woman who is out of reach of project services, albeit expressing willingness to test for HIV, is not enabled to go for the test or motivate her husband to test, perhaps because she lacks information and support from peer educators to do so,

> Neither my husband nor I ever talk about it. It is good to test to know about HIV status. My husband told me that there is nothing to him. I feel that we must test HIV because who knows about it. My husband is away from me. I just believe him but I don't know what he does there.(housewife, 36 years, Kanchanpur,Nepal)

In contrast, this woman who is reached by services at source as is her husband at destination, and is also motivated by peer educators, reports that due to the information they received, they could make positive changes such as testing for HIV.

> In the past I used to think that my husband went to earn money in India. I didn't know where he worked. I was always worried about it. Now I feel happy that my husband is also conscious about his life and our future. We have opened our account in the bank which is in Khatima. We always use condoms while sex. When I told my husband to go for HIV test he didn't agree but I forced him to do his HIV test…… When peer educator and outreach workers come to my house then I feel good. When they hear my husband is coming home then they come to visit him and give him knowledge. My husband also got this information in India he says.(housewife, 26 years, Kanchanpur, Nepal).

Similarly, this male migrant whose wife lives with him and receives services from the DIC talks about HIV testing

> There are lots of benefits of HIV testing because we are able to know our health status, whether we are infected or not. After testing it I was so happy knowing my status. I had taken my wife also for the testing. … At first I didn't know about HIV and AIDS but I went to DIC and got extra information. When I returned home I talked to my wife about it (male migrant, 27 years, Delhi).

In contrast, those male migrants (4) in Delhi whose wives in the villages have not received services from the project clearly lack the opportunity to discuss about HIV and AIDS with their wives, and consequently do not feel the necessity to test or use condoms with their wives, as reflected in this quote,

> I haven't used condoms with my wife because she does not have HIV and STI. I didn't get HIV testing because I don't have any symptoms……I don't talk about HIV (to his wife) because there is no problem in my family regarding this. The behavior of my wife is good. I know that we can't predict anything about the future but now we are safe (male migrant, 35 years, Delhi).

Antiretroviral therapy and support services

The three HIV infected respondents in our sample reported how they have received support from the project in accessing ART, and the changes that have occurred in the community's attitude toward PLHIV due to increased information and awareness. The husbands of the three women, also HIV infected, live in India and are reported to be availing ART in their destination sites. All three reported previously negative experiences of being HIV positive as they had to face stigma and discrimination from their communities. However, they reported that the situation has improved now.

This HIV positive respondent talks about the reduction of stigma and increase of support in the the community due to increased knowledge, and describes the support services provided by EMPHASIS.

> After EMPHASIS project was launched here it is very easy to access services. To reduce stigma in the community it plays a vital role. Nowadays we don't face any problem regarding stigma. If we need any help from the community then they (community members) get ready to support us. EMPHASIS provides us travelling cost to go to Mahendranagar for treatment. ……I got 2 goats from EMPHASIS as a support and nutrition like rice, pulses and oil. I feel my family got relief from this.(housewife, 36 years, Kanchanpur, Nepal).

This woman from Achham, when asked about any difficulties in procuring ART, says that it has become much more accessible as more centres have opened up, and the process has been smoothened with the help of NGOs

> In the beginning there were challenges because I had to go to other districts for ART. I didn't get time to go and it (health center or hospital) was far away… But nowadays we have two hospitals in Achham to provide ARV. So I take from N health hospital. (International NGO affiliated to Nepal government)… It is very easy as we can get it any time we visit the hospital. Sometimes W Nepal (another local NGO in Achham) provides us medicine when we cannot visit the hospital. We

> send our ART cards to W and they send us the medicines.(housewife, 30 years, Achham, Nepal)

In accessing ART, the HIV positive respondents reported that the project supported them with travel money. However, one of them describes the difficulties in visiting distant health centers for ART and narrates a slightly different experience from the others

> It takes 2 days to reach the district hospital. We have to cross a river. When the river is in flood then we are unable to get ARVs. We are compelled to leave our small children in the home when going to get ARV (they generally do not carry small children with them as they have to traverse long distances on foot). Sometimes we have to leave them with other villagers. We have no food some days. We have to have ART with water only. We borrow from other villagers in order to get food. When my husband sends money then it will be enough to return the loan. (housewife, 30 years, Kanchanpur, Nepal).

In summary, HIV and AIDS information is widely reached through drop in centers in Delhi and outreach services in Nepal. It is perhaps due to the remoteness of certain villages in Nepal that makes it challenging for the inhabitants to access DICs or health centers. The use of HIV testing services tends to be lower in Nepal as HIV testing centers are far from the residences of the target population. Furthermore, couples who have been reached by services are better able to communicate with each other and use preventive services such as HIV testing. ART access is being made easier by providing support to the PLHIV in terms of travel costs and child care.

3.2.2 Knowledge, attitude and behaviour

This section describes the extent of knowledge of HIV and AIDS, and changes reported by respondents in knowledge, attitude and behaviours as a result of the EMPHASIS project. The question was posed specifically in reference to the EMPHASIS project i.e., the interventions implemented by the partner NGOs, and hence, although the respondents have had previous exposure to HIV & AIDS information and prevention services through other programmes, in this section, they specifically described the changes brought about by the current interventions. Furthermore, the section will also delve into factors that have influenced behaviour change.

Knowledge of HIV and AIDS

A principal component of the EMPHASIS project is dissemination of HIV and AIDS related information through a variety of channels- outreach and drop- in- center, and through a variety of medium- information booklets, brochures, posters, discussions, and lectures. Drop in centers in Delhi and Nepal form the hub of knowledge dissemination. One to one group Interaction, group meeting, focus Group discussion and other folk media activities are organised to create awareness among migrants on HIV & AIDS, safe mobility & other related issues. In addition to these, in Nepal there are two Subhayatra Migrant Information Desk in strategic locations such as busparks and two community resource centres, one in each source districts. This section describes the extent of HIV & AIDS knowledge among the sample, as well as what kinds of misperceptions exist and among whom.

Overall almost 92% of the respondents had adequate knowledge of HIV/AIDS: its transmission and prevention. While almost 39% of the respondents reported hearing of HIV and AIDS exclusively from the EMPHASIS projects, 41% cited both the latter and other sources from which they heard of HIV/ AIDS, while 4.5% reported exclusively other sources. Other sources included NGOs in Nepal, school, radio, hospital and information leaflets. Some respondents also reported that whereas previously they did not have sufficient information, after being provided information by peer educators of the EMPHASIS project, they now do not perceive HIV as a dangerous disease as they have complete information on its transmission and prevention. There was complete knowledge of transmission and prevention especially where services have reached the population of respondents although a few

had misperceptions about transmission through mosquito bites and the use of any sharp implements. Where services have not reached or where respondents have not accessed the available services, there was lack of knowledge or inadequate knowledge. Also, in Nepal, women who reported being visited very infrequently by peer educators had low knowledge and misconceptions about HIV. We did not see any difference between gender or age groups regarding HIV knowledge.

This woman migrant who accesses DIC services has this to say

> I know about HIV very well. I am close with NC (DIC in Gurgaon). This can infect everyone. It's a normal disease. It is transmitted through mother to child, sharp instruments and unsafe sex. To prevent it we must not keep sexual relationship with others. Shouldn't use sharp things used by others and the mother must give birth in the hospital.(female migrant, tailor, 35 years, Delhi)

This woman who has not been reached by existing EMPHASIS services at source says

> I heard it is a kind of disease. I heard through radio. I don't know much about this disease. There is no time to think about it because we don't get free time from working. I have never gone outside my house. That's why we can't get other information of it. (housewife, 35 years, kanchanpur, Nepal)

Misperceptions of HIV & AIDS were seen in a few responses. Primarily, respondents who reported rarely using the existing services of the EMPHASIS project had misperceptions related to the transmission of HIV, as shown here in the following quotes of two of the respondents

> Once this disease infects people our blood stops circulating in our body. When mosquito bites us then we suffer from fever which leads to HIV..... I visit DIC only sometimes but my wife visits there regularly. What can I do going there? Only literate people can visit there not people like me because I am illiterate. (male migrant, laborer, 40 years, Delhi).

> I heard about HIV from DIC. It transmits through blood contacts, keeping unsafe sex, mosquito bites etc. I don’t have enough time to visit DIC regularly. If this disease infects human beings then they will die. They cannot recover from it. It is very dangerous disease. (female migrant, 18 years, Delhi).

However, this respondent who reports visiting the DIC quite regularly also has misperception regarding transmission through blood. Although there is no conclusive evidence to support this, it is perhaps due to the nature of the information message where the focus, on contact or transmission through blood, is such that it is likely to result in different interpretations.

> It(HIV) transmits only with the same blood groups and cannot transmit with different blood groups. It also transmits through sexual contacts, same blood group and syringes. To prevent it we must keep sexual relationship with different blood group persons. Test the blood and use condoms during sex.(male migrant, mechanic, 19 years, Delhi).

Three respondents in Nepal who reported being visited infrequently by peer educators also expressed misperceptions about HIV and had incomplete knowledge of its transmission and prevention, as revealed in this quote by a woman who reported being visited only once by a peer educator and attending a women’s meeting one year back

> HIV is a transferrable disease. People will die after getting this disease. I am afraid of this disease. It's like scabies. I have to be conscious of this disease because I don't want to die before time. It transmits through mosquito bites, keeping sexual contact with others except husband. And taking blood of others. We must use condoms if we have sex outside marriage. Shouldn't take contaminated blood and syringes. I got some other information of it but I forgot what that was.(housewife, 24 years, Achham, Nepal)

Despite there being perceptions of HIV as a dangerous disease or an Indian disease or a disease carried by migrants in the minds of a few, changes in perception reported by the majority have almost always been facilitated by staff of the EMPHASIS project

> I don't think that it's dangerous disease. It was called life killer disease previously. I used to be afraid of it. Now days I don't feel like this. To prevent it we must keep safe sex using condoms and not use sharp instruments used by others. I got all those information from the peer educators who visited me and made me clear on the issue.(housewife, 23 years, kanchanpur, Nepal).

In sum, knowledge of HIV is high among the respondents except among those who have no access to services, have low utilization of services because of lack of time, and those who are infrequently visited by peer educators. Misperceptions remain through the process of filtering of messages.

Changes in knowledge and attitude

The majority of respondents (~94%) reported changes in their perception of HIV upon receipt of information from EMPHASIS. Changes were reported in the original perception of PLHIV as immoral to somebody deserving compassion. Similarly, while HIV used to be perceived as a 'dangerous' disease, it is now seen as a 'normal' disease, and people expressed feelings of less shame in talking about it. Respondents also reported gaining knowledge of how to protect themselves. Respondents who were not reached by the project did not report any new learning as they had not received HIV services. Interestingly, female respondents pointed out how they were more comfortable in talking about HIV and AIDS as their initial embarrassment has decreased after receiving information. This is perhaps due to their greater interaction with peer educators who talked to them in a friendly, open and frank manner. Male respondents, on the other hand, did not report any such change as they may have never felt shame to talk about HIV to begin with. It was also seen that due to gaining knowledge of other modes of transmission of HIV, and not just sexual transmission, respondents felt it was no longer a "dirty" disease. It was also interesting to note that the female respondents adopted over protective practices such as not using sharp implements, and not allowing husbands to shave outside. Overall, however, they reported positive changes in practices such as asking for disposable needles and syringes when they visited health clinics.

The quote below represents the change in perception,

> In the beginning I used to be afraid of it… but now days I feel it's normal. People can live longer, if they take care of it.(male migrant, 20 years, Delhi)

Because they learned about the different modes of transmission besides knowledge about unsafe sex, it helped some to change their attitude toward infected people

> I used to hear that it transmits through sexual contacts only. Then I hated the people who were infected because I thought they got this from prostitution. But when I learned about the modes of transmission

> then I changed my thinking about them.(housewife, 29 years, Achham, Nepal)

Women report feeling less shame in talking about HIV after receiving information, as this quote represents

> I used to feel shy listening about HIV and AIDS. But after participating in this project I don't feel like that anymore since I now have all the information about it. I removed all shame from my mind. Nowadays I can talk openly about HIV and STIs to my family and friends. They also appreciate me. I feel proud about that.(housewife, 27 years, Kanchanpur, Nepal).

Changes in behaviors

When asked about whether there were any changes in their behaviour as a result of the HIV intervention, 28 out of the 53 (52.8%) respondents to whom this question was applicable replied in the affirmative, while 19 respondents (35.8%) denied having had any change in behaviour. The remaining proportion included the 4 family members and the 3 women who resided outside the project area. Among those who reported changing their behaviours, 10 were male and 18 female respondents. Among men, changes in behaviour related to alcohol use, visiting sex workers and condom use. Among women, changes were reported in using condoms with husbands and in discussing about HIV with their husbands, friends and family members. It is interesting to note that while some male respondents felt there was no need to change as they had never "indulged" in risky activities, some of the female spouses reported feeling suspicious about their husbands' behaviors.

This man gives reasons about why he has not changed his behavior

> I think I don't have to change because I have never gone to such places which spoil my life. I don't even drink alcohol.(male migrant, 19 years, Delhi).

This woman, however, feels differently

> Sometimes I suspect my husband because he is so far away from me and I never know what he does there. Nobody knows,he might be indulging in sexual activities but I am afraid of asking. In his next visit I will talk to him openly.(housewife, 28 years, Kanchanpur, Nepal)

Six out of the ten male migrants who reported changing their behaviour, mentioned quitting alcohol as it leads to visiting sex workers, or only drinking at home, not going out with friends and using condoms whenever necessary

> I used to drink alcohol, and get involved in sexual activities without using condoms. But nowadays if somebody asks me to go out for sex then I tell them that if I have condoms then only I go otherwise I don't go.(male migrant, 27 years, Delhi)

The above response is substantiated by this key informant when he shares

> It (the project) has brought about a lot of changes in their lives. They are very careful about their life after getting information about

> HIV. Most of the teenagers are aware of it. Some of them have stopped the habit of drinking alcohol. They visit the DIC when they are not working. They changed their lifestyle after visiting NC (DIC)(Company worker, 34 years, Delhi).

Condom Use

Out of the complete 43 records of condom use, 27 (60%) respondents reported not using condoms, primarily with spouses, while 14 respondents (39%) reported condom use. Two respondents said they used condoms irregularly with their spouses. Male migrants living with their wives reported that they rarely used condoms as they 1) believed in their partners' fidelity 2)their partners had adopted family planning methods, such as IUD and contraceptive injections, and so they felt there was no need to use condoms 3) condoms were not necessary to use with married partners. Thus, condoms were mainly perceived as a family planning device within the marital space. It was only in the context of sexual contacts outside of marriage that condoms were perceived as protection against diseases. There was also a perception that condoms were used only in case of diseases and infections. Furthermore, women who reported not needing to use condoms talked about their trust in their husbands and their adoption of family planning methods. The three HIV infected women reported using condoms with their husbands as they had learned of viral load and knew that there was more transmission of the virus in case of sexual contact without condoms. Spouses who have been reached by the project reported that due to the encouragement of the project staff, they had been able to talk to their husbands in motivating them to use condoms and in some cases, had taken the help of peer workers to convince their husbands. In fact, spousal communication was seen to be a major influence in adopting condom use.

This man talks about why he does not feel the need to use condoms with his wife,

> I never use condoms because my wife got permanent family planning (sterilization method). I have two children - that's enough and I never have sex with other women.(male migrant, 37 years, Delhi)

This woman in Nepal talks about how the project has influenced her behavior, especially with regard to condom use,

> I didn't know about HIV. But now I am able to share with my husband whatever I learnt about HIV. I told him about the usage of condoms. ….I use condoms when my husband returns back home. (housewife, 23 years, kanchanpur, Nepal)

A definite pattern was seen among male migrants receiving services who tested for HIV, discussed about HIV with their friends and also advised their friends, to adopt condom use, as this unmarried man discloses

> Yes I use condoms when I need. I get it from the civil (Public Hospital. …I have tested for HIV many times. It benefits to know one's HIV status. We get a confirmation report which removes our tension. I have talked to my friends about condoms when they go out.(male migrant, 20 years, Delhi).

Changes in gender relationship

Although our questionnaire did not focus specifically on women's empowerment or gender relationship, the narratives of the female respondents, in describing their thoughts about their migrant husbands, their perception about the risks of HIV, their efforts at influencing their husbands' behaviour and adopting safe behaviours with the latter, underpin the changes that the intervention has brought to the relationship of the married couples. Spousal communication was seen to be initiated largely by the women, and was often related to making conscious changes in behaviors.

Spousal communication, in some cases, was also given a fillip through the intervention of peer educators. For instance, some women reported that their husbands refused to talk with them or scolded them when they brought up the subject of HIV and safer sexual behaviours, but in the end gave in as they heard more about it through peer educators. Furthermore, formation of spouse groups and attendance in the same has resulted in an increase in skills and knowledge related to safe sexual behaviours, safe mobility and safe remittance.

This spouse in Nepal describes the changes both she and her husband have made in their behaviors and how the project, in providing services to both, has helped in facilitating these changes,

> He (husband) got the information in the same project in Delhi. We have changed our behaviors. We don't use needle and syringes used by others. I am successful in using condoms during sex. X project was the biggest influence in making these changes. Previously my husband used to drink alcohol wherever he liked. He didn't listen to me. But because of the project he knows everything about HIV and is careful of it. Nowadays he has changed his habit of drinking alcohol. If he wants to drink then he drinks in his room. We share about HIV on the phone. If we want to have sex then sometimes I visit India and he also comes here taking leave or during holidays…..Yes we use condoms every time we have sex because we don't want to have baby. ..In the beginning he didn't agree to use condoms but when he knew all about it then he changed his mind. Nowadays he agrees with whatever I tell him. I am using condoms for 2 years since I got the training of how to use them.(housewife, 27 years, Achham, Nepal).

However, not all women report positive changes after discussing with their husbands, as this woman narrates,

> I shared with my husband whatever I learnt about HIV. We haven't used condoms during sex because my husband doesn't allow me. I told him about the use of condoms. It was very difficult to convince him, he scolded me. He blamed me that I might have brought HIV from other men. Once I got some discharge from my vagina, I thought it was an STI problem and told him to go for the treatment but he fought with me. Then I talked to my mother-in-law about it and she convinced him, so he calmed down. I wish that somebody could convince my husband because he never listens to me. I myself have gone to test my blood (for HIV)(housewife, 23 years, Kanchanpur, Nepal)

However, by and large, women have reported positive changes in their ability to talk with their husbands and have a more equitable relationship.

Spousal communication as a factor influencing behaviour change

It was seen that in general, when both husband and wife received services, it led to better communication and adoption of safe behaviors such as condom use, as compared to those when only one partner received services or those who were out of reach of the project area. Since it is almost always the woman who initiates discussion with her husband, when she does not receive services and is consequently not well informed or empowered enough, there is a lack of communication between the couple. When the woman receives services at source but her husband at destination does not, even then it was seen that the couple did not have discussions or adopted safe behaviours as perhaps the husbands, having had no exposure to interventions, had little sympathy for whatever discussion the wives started. However, it was also seen that sometimes, with the intervention of peer educators, women felt empowered to discuss about safe behaviours with

their husbands. The quotes below are examples of different situations representing whether both husband and wife received service or not and in consequence, whether they were enabled to communicate with their partners.

This woman, who receives services in Nepal but her husband in Gujrat does not, shares her failed attempts at discussions with her husband

> I tried to discuss about HIV and STI with my husband. But he refused to listen. I am always worried about him……. I always worry about his life thinking about HIV. When I talked to him, he scolded me saying how I could think about that. He says he is safe from HIV because he has never been involved in risk activities. So what could I do(housewife, 36 years,Kanchanpur, Nepal)

In contrast, this woman who receives services from the partner NGO in Nepal and reports that her husband receives services from EMPHASIS in Mumbai has this to say about condom use and HIV testing,

> Yes we are using condoms since 4 years to protect from unwanted pregnancy and HIV/STI. This is the reason for using condoms. We can easily get the condoms through PE. My husband is an understanding person…..I often tease him over the phone saying " If you can't control yourself then don't forget to take condoms with you"…..I visited W VCT centers though it is far because we can have treatment and blood test there. My husband also visits DIC Mumbai. He often says that he has attended meetings and trainings organized by EMPHASIS there.(housewife, 35 years, Achham, Nepal).

This male migrant whose wife receives services in Nepal shares his experience,

> Yes I have told her (wife) about this (*laughs*). I think you must know how much aware about it wives are today; they know more than us. When I go to my house then my wife tells me about HIV, STI and to open account in the bank. There is an organization named N in Kanchanpur. She goes there and learnt many things regarding this.(male migrant, 30 years, Delhi)

Whereas, this woman who does not reside within the project area and hence does not receive services, has a different experience

> My husband comes here every year. With his money I buy food and clothes and take land on lease. To be aware about HIV is good for us but I don't know whether my husband is also able to know about it. He has never talked to me about HIV. I know the behavior of my husband; he is also growing old. We have never used condoms; it not necessary for us because we don't have such types of disease.(housewife, 35 years, Kanchanpur, Nepal)

Similarly, this male migrant whose wife in Nepal does not receive services by the project as she lives in a district different from the intervention area, feels no necessity to discuss about HIV with his wife or use condoms with her,

> Why should I talk about it if there is no PLHIV in my house? But I have told my other friends about it…… with my own wife there is no

need to use condoms because there is no risk. I never use it.(male migrant, 19 years, Delhi).

In summary, respondents have gained an increase in knowledge of HIV which has resulted in many of them changing their earlier perceptions. Alongside, changes in the consumption of alcohol, pattern of consumption (drinking at home and not outside), not having paid sex and using condoms if doing so are some of the changes reported by the male migrants. Couples who have received services are better at communicating and adopting condom use. Men who share HIV information with their friends are also the ones who test for HIV and adopt condom use during paid sex. The project has also created an enabling environment by empowering the female spouses to communicate with their husbands about HIV and safer behaviours. In cases where the women have not received services, there is less spousal communication and less adoption of safer behaviours.

3.2.3 Stigma and Discrimination

The section describes respondents' feelings of stigma toward HIV infected individuals, and feelings and experiences of stigma and discrimination related to being migrants and belonging to migrants' families.

Stigma related to HIV and AIDS

Approximately 97% of the sample reported an absence of feelings of stigma toward HIV infected people, an indicator that HIV/AIDS information was reaching the migrants and their family members in our sample. In fact, two of the three respondents who were outside the project area of EMPHASIS, did not express stigma toward HIV infected people as perhaps they had heard of HIV previously through other sources, though they may not have complete knowledge of its transmissions, and they might have been exposed previously to stigma reduction messages or intervention. Absence of stigma could be a result of the HIV services provided by EMPHASIS as many of the respondents also talked about how their original perceptions of HIV as a "dangerous" disease and a "dirty" disease were altered due to information provided by the peer educators of the project. (A later section deals with this in detail.)

The quote below typifies the attitude of most of the respondents in the sample

HIV infected persons are also like us. Nobody has HIV written in the forehead. We will be able to know only after our test. I would be a friend of HIV infected person. It doesn't transmit by eating together and sleeping together.(male migrant, 35 years, Delhi)

This woman in Nepal who reports being visited by peer educators has this to say about PLHIV

We can make friends with them and we can eat and sit together. If my family member is HIV infected then I would take care of them. I would keep them with me. I wouldn't isolate them because I know the transmission and prevention modes of HIV.(housewife, 22 years, Kanchanpur, Nepal)

However, in areas where HIV interventions have very little reach, there is perhaps hardly any scope of close interaction with peer educators or outreach workers who would otherwise clarify misperceptions about HIV infection and HIV infected people. Therefore, even while we had most of the women who were out of the EMPHASIS project area express lack of stigma, this woman, however, who clearly believes HIV is transmitted through sharing food, says,

I don't know much about HIV infected people but they are also human beings like us. I would never be friends with them and eat with them.

> If there is HIV infected in my family then I would take them for the treatment, what else.(housewife, 35 years, Kanchanpur, Nepal).

Stigma and discrimination related to migration

Although most of the respondents in Delhi reported that they did not feel stigmatized or discriminated against, some of them (six of the respondents) narrated incidents of being teased because of their poor language skills, being physically threatened by local hoodlums, being admonished by bosses, and being forced to take up jobs on lower salaries. Interestingly, it is the stakeholders who, perhaps because of their involvement in the lives of many Nepalese migrants, narrated widespread discriminations by factory owners, landlords, exploitation by shopkeepers, and stigma in being called "Nepali" or "Bahadur" which has the connotation for watchman in India, thus depicting somebody of a lowly position. The respondents in Delhi lived in the catchment area of the drop-in centers which serve as major sources of support, and had other people from their community living near them. Therefore, not many of them reported feelings of loneliness or alienation and in fact, male migrants reported having Indian friends from their work place in their social networks too. In Nepal, family members did not report feelings and experiences of stigma because of belonging to migrants' family as they said that almost all in their villages were also migrants.

Narrating an incident from his life, this respondents says

> There is risk to our lives. It is very dangerous to walk alone at night. One night the local boys here blocked my way and scolded me very badly. I also felt angry with them but I was alone and came back home without saying anything. We have come to another country, so we have to keep patience.(male migrant, 19 years, Delhi).

This stakeholder from Delhi narrates the following, highlighting one of the many different ways a migrant can be exploited,

> The local people here build houses and give on rent. The house-owner will also have a shop nearby. The Nepalese who are staying in his room are forced to buy the things from his shop at high price. If they don't buy from there then they are asked to leave the room.(stakeholder, 34 years, Delhi)

However, by and large, the respondents do not express feelings of alienation as, reported by this woman, they have learned the language and consequently have adapted to their host country, besides having their own native network of migrants,

> Actually I don't feel loneliness and boredom. Sometimes I visit the DIC with my husband and children. We enjoy there. We meet other Nepali migrants and know about each other and share our experiences about being migrants in another country…In the beginning Indian people used to laugh at us when we spoke Hindi. At that time we couldn't speak well but now days I can speak well. So nowadays nobody laughs at us.(female migrant, 34 years, Delhi).

3.2.4 Access to support services – safe mobility

The section includes findings about other support services provided by EMPHASIS as part of the overall intervention. These relate to safe mobility, remittance, support service for PLHIV and women's empowerment through livelihood programmes.

Description of Safe Mobility intervention

In order to ensure safety of Nepali migrants at transit routes and stop violence and harassment during travel,, the EMPHASIS project works with various stakeholders on the Gaddachouki/ Banbasa and Bhansar/Gaurifanta routes. Several MoUs (memorandum of understanding) signed with various stakeholders including transport workers unions, hotel owners unions, trade unions, media and organizations working on migrants at these transit routes ensure uniform rates charged by transporters and hoteliers so that there is little chance of exploitation and harassment experienced by migrants. Additionally, as women empowerment is one of the key focuses of EMPHASIS, women's group inclusive of migrant spouse, returnee migrant and women migrants are formed at source and destination. These initiatives are evolving as potential platform to enhance women's leadership towards safe mobility at various levels.

Experience at Transit Routes

Out of the 28 migrants in Delhi who responded about the transit routes they used in travelling to and from Nepal, 9 (32%) reported that they used the Banbasa route, 4 (14%) used the Gaurifanta route and 15 (54%) reported using other routes, the most common among which was the Melaghat-Khatima route. One respondent reported that except when she was a child, she has never travelled to Nepal, and another respondent reported that she could not recall the name of the route she travelled as it was a long time ago. The experiences at the transit routes are mixed- majority of those who travelled recently on the Banbasa and Gaurifanta routes pointed to the decrease in harassment by transporters and the police compared to previous times. However, two respondents reported that there were no changes from previous years. Among those using the other routes, a few (3) talked about the same level of harassments that they had faced earlier, while most (13) talked of the improvement in the transit routes in terms of less harassment and exploitation. While most respondents were not aware of any services being provided at transit, the changes they reported from previous years is perhaps an indication that the advocacy and partnerships that the EMPHASIS project has forged with local stakeholders has had an influence on ensuring safe mobility.

Following are the quotes which reflect changes from previous years in terms of harassment

> I use the Banbasa route. 5 years back there were lots of problems that we had to face during travel. We were cheated by Tangawala,(horse drawn cart) rickshaw pullers and police man. But when I went last year to my village I didn't face such types of problems. All was ok. Only the police man checked, which it is their duty to do. Otherwise it's fine.(housewife, 25 years, Delhi)

> I use the Banbasa way to come here and go home. Compared to previous years it is a little bit easy for us to travel. There is uniformity in price between rickshaw pullers and tangawala. The behavior of policemen is normal. To change this, the DIC established near Gadda Chauki has had a hand. It is working for the right of the migrants. It provides information of safe migrantion during travelling. I think everyone has changed due to this project.(male migrant, 29 years, Delhi).

Respondents using other routes have also commented on the changes they have experienced

> I use Jogada Melaghat. In previous days they gave us trouble. They used to ask us whether we have stolen goods.But nowadays they do a little check and leave us alone.(female migrant, 27 years, Delhi)..

Some respondents report receiving services such as information on safe mobility at transit, as revealed by this response

> They gave me a leaflet in the bus where it was written "don't keep 500 and 1000 rupee notes with you! Don't eat the things given by others! And don't drink alcohol while travelling!" I got the information at Dhangadhi Milan Chawk. The providers were the staff from NGO but I don't know who they were.(male migrant, 19 years, Delhi).

3.2.5 Access to support services: Remittance and community support services for PLHIV

Description of support services: Remittance, Community support services for PLHIV, livelihood

The Emphasis project has introduced remittance service to migrants in destination and families at source by providing information about safe remittance. At destination, the project offers help in setting up bank accounts by facilitating the process of procuring identity proofs and by introducing the migrant to a bank. Also, spouse groups have been formed to have bank accounts of their own and they are now receiving earned money in India through banking or money transfers easily in Nepal. These women inform potential and returnee migrants including their own husbands and family members on safe mobility processes and safe sexual behaviour.

In Nepal, livelihood support to PLHIVs is being delivered through formation of Community Support Groups (CSGs). They are the community level self help group formed to engage community to support people living with HIV & AIDS. The support groups are the key community based structure through which EMPHASIS project delivers its support activities especially nutrition, transportation, educ ational and livelihood to infected and affected communities. As a sustainability approach on livelihood support, these CSGs have started to return the livelihood support profit to the respective group which is functioning as a revolving fund to support other PLHIVs of the VDC.

Access to and utilization of remittance and livelihood services

In terms of remittances, out of the 30 migrants in Delhi, 14 (~47%) reported sending money through banks, while 11 (~37%) reported sending it through friends or carrying it themselves. Five respondents reported not sending money as they had their families in Delhi. We have 13 records of remittance among spouses in Nepal, out of which 7 reported that their husbands sent money through the bank while 6 reported receiving money through friends and neighbours. Among those who still send money to their families through friends and relatives , lack of information, lack of time, not having a bank in the village in Nepal, and lack of identity proof has been cited as main reasons for not remitting money through banks. Identity proofs are documents needed by the respective authority or service provider (in this case, banks) that establishes a person's identity that he/she is living and working in India. Identity proof can be derived through ID cards such as ration cards, driving licence etc. Migrants residing in Delhi who remit money reported either being helped by the drop- in- center staff in setting up a bank account or having their bank accounts opened by the companies they work in. The women in Nepal reported getting information about it in meetings conducted by the partner NGOs.

However, even when they have bank accounts, some may prefer sending money through friends as they have to spend a long time in the bank and thus lose their daily wages, as this man explains

> There is an SBI bank at Gurgaon sector 14. I send money through it sometimes. Otherwise, altogether we are 15 Nepalese staying together. Sometimes one of us have to go to our village. So we send with each other. I have an account in SBI bank Nepal. But it's very difficult to send money through bank. It takes long time. We have to lose our daily wages Rs 500 if we try to send through bank because we have to spend whole day there.(male migrant, 30 years, Delhi).

In our sample, we did not find any respondents participating in livelihood trainings, although when asked about it, they expressed a desire to have such a service. However, the three HIV infected respondents did report receiving nutrition, transportation and livelihood support. Family members in Nepal reported attending women's group meetings where HIV information and information on safe mobility was imparted. A family member in Achham reported participating in a revolving loan facility, while a male migrant in Delhi talked about a group they had formed with the help of the drop in center,

> We are formed into a group of 10 members. We kept the name Mahakali Saving Group. We collect Rs 500 per person every month. If there are any problems regarding money then we immediately withdraw that money and send it home. We have planned to open a bank account in Nepal and deposit that amount there.(male migrant, 30 years, Delhi).

In summary, the process of transit has become easier and less troublesome as described by many of the migrants. However, there are migrants who use other routes where there is no intervention. Although many people have been supported by project staff in setting up bank accounts which has made the transfer of money safer, there are still many others who, due to lack of identity cards, have not been able to take up the benefit. We did not see any difference between those receiving services at source and destination regarding safe mobility and remittance. While some of our female respondents have participated in women's groups or spouse groups in Nepal, the HIV infected respondents have reported receiving community support services although the other female respondents have reported not knowing about livelihood programmes or participating in them.

4. Benefits and Barriers of services provided by EMPHASIS

The respondents – both male migrants and spouses- in Delhi listed among the major benefits, HIV and STI information, knowledge of condom use, referrals to government hospitals, help during emergencies from the drop- in- centers, meeting other Nepalese migrants, information about safe mobility and help rendered toward setting up bank accounts and making ration cards. The respondents- spouses and family members- in Nepal mentioned HIV and STI information, knowledge of condom use, STI referrals, referrals for HIV testing and information about safe mobility. Mention was also made of the information services available at their doorstep without having to travel anywhere. The HIV infected respondents mentioned about the travel costs in accessing ART and CD4 tests that were borne by the project as one of the main benefits.

This service provider from Nepal describe the benefits of the EMPHASIS project,

> I think the project has brought great change in their lives. They use condoms while having sex, get to know about safe migration and are protected from being cheated by the police. Every migrant's family opens bank account here and gets the money through the bank. Nowadays they think many times before visiting sex workers. If they go then they always take condoms with them. Because of the HIV related projects, they disclose their HIV status and this number (of people who disclose) is increasing but the new infection is decreasing. (DIC facilitator, 24 years, Achham, Nepal)

Among barriers, while most respondents replied that that there were no barriers, in Delhi, six respondents mentioned their lack of time in not visiting the DIC regularly which led to their not availing of all the services or not being able to attend all the meetings held at the DIC. In Nepal, seven respondents mentioned their lack of time and difficulty in visiting health centers or drop in centers located in distant VDCs.

This woman in Nepal talks about her problem in accessing services,

> We have lots of problems while receiving the services. This VDC is adjoining to India. We have to depend on India for small things. Even we use Indian currency. We don't have a DIC here. We have to go to Mahendranagar for services and for banking transactions which is very far away from here.(housewife, 27 years, Kanchanpur, Nepal).

Stakeholders in Delhi mentioned the scattered groups of Nepali migrants who were out of reach of services of the DIC, while stakeholders in Nepal mentioned the remoteness of some villages and distant service centers, among barriers.

This stakeholder from Nepal talks about the problems in the existing service

> The services like VCT, PMTCT, STI treatment, access of condoms and DIC are available for migrants and their family but all are not accessible to them. Some of them are out of reach because the project has not covered the whole district and due to geographical condition they cannot get the services….these services are not sufficient because it is implemented in 10 VDC only out of 75 VDCs. (DACC coordinator, 37 years, Achham, Nepal).

When asked about what kind of services they needed or what kind of improvement they wanted to see in the services, the responses from both male and female migrants in Delhi included: a) desire to have the existing programme continue, b) increase in coverage so that all Nepali migrants can be reached either in their work places or through DICs, c) mobile camp to conduct HIV testing d) similar programme in GB Road (brothel area where there are Nepali sex workers)and d) information and services on transit for HIV testing In Nepal, the responses included a) desire to have a drop in center or health center in their VDC, b) increase in coverage to other VDCs, c) continuity of project d) help in getting HIV test done. Mention was also made of the need for income generation and livelihood programmes, frequency in visits of outreach workers, contact between husband and peer educators. Two respondents from Achham have talked about the need to be provided with refreshment when they attended meetings in distant places or go for HIV testing to distant centers, while another wished for supplementary services like education and nutrition for their children**.**

This woman talks about the different aspects of the project which can be improved

> There must be DIC at different points so that everyone gets an opportunity to visit one. It would have been better if STI treatment service was available in the DIC. It provides the services of awareness and prevention. For treatment it refers to other organization like the hospital and WACNepal. I see there must be counseling skills for every staff. Not always but sometimes I felt hurried, it's due to my work in the field. They refer us to WAC Nepal VCT centers for blood test. Sometimes I feel that it would be better if we get required services from one organization. WAC Nepal conducts mobile camp every month. So it is closed for many days. During that time many of the clients have to be deprived from the services.(housewife, 27 years, Achham, Nepal).

5. Discussion and Conclusions

The study was undertaken to find the qualitative effects and outcome of the EMPHASIS intervention. Overall, the findings highlight the importance of the project in bringing HIV information to the doorstep of those at risk, and in providing measures for safe mobility and safe remittance, thus influencing the knowledge, behaviors and attitudes in particular, and the lives, in general, of the target population.

The majority of the respondents have received HIV services – migrants at destination and spouses of migrants at source - HIV information, HIV counseling and testing, STI information, referrals for STI treatment, and CD 4 count test and anti- retroviral treatment for HIV infected people. HIV services are perhaps not so visible at transit as not many respondents have mentioned them when asked. Although many of them have received HIV information previously through other sources, respondents talked mostly about the information they received through the drop in centers in Delhi and through women's group meetings and outreach workers in Nepal, run by the EMPHASIS project. However, some of them still had misconceptions about HIV transmission, especially related to mosquito bites and blood group. Spouses of migrants who were out of reach of services provided by EMPHASIS project clearly had inadequate knowledge of HIV. They were also less able to communicate with their husbands about HIV and hence less able to influence their behaviors.

From the little available data that we have, we can point to the importance of both husband and wife receiving information so that they are able to communicate with one another and influence decisions about condoms use and HIV testing. Additionally, women in our study are seen to take the initiative in communicating with their husbands about HIV and to take greater responsibility in persuading their husbands to test for HIV or use condoms. And in this matter, they have been helped by peer educators who visit their homes and talk separately to their husbands when the latter are present. Thus peer educators are fulfilling their role of educating both the spouses as and when they are available.

The nature of the places where services are provided, the type of service centers, and the type of respondents determine their use of services. Female spouses in Delhi, being more mobile, use the DIC frequently as a place to meet other women, while female spouses in Nepal, being less mobile, have limited access to service centers. In Nepal, door to door outreach is the focal point of service, while in Delhi, it is the drop in center. The latter serves not only as a provider of HIV services but also as a cultural center and a place to get together for the migrants. Also, due to greater mobility, migrants and their families in Delhi, at least in our sample, are being able to access a wide range of services such as HIV testing and STI treatment. In Nepal, the distance of service centers is a major barrier to HIV testing, and can be problematic to the access of ART. However, it is must be noted that mobile camps, whenever they are organized, are a great source of STI diagnosis and treatment for many of the spouses in Nepal, while problems in accessing ART and CD 4 tests are being met by the project through provision of travel money and child care.

Our findings also point to the changes that have occurred in the attitudes of the respondents, toward HIV as a disease and toward HIV infected people, as a result of the intervention. Changes have also been reported in the consumption of alcohol, visiting sex workers and using condoms. Although it is difficult to see associations in qualitative research, we found that, generally, men who shared HIV information with their friends, or advised them, tended to also adopt safe behaviors. It echoes findings from another study in Thailand where migrants who were socially integrated and shared information were found to practice preventive behaviors[22] However, although there were reports of condom use for paid sex, it was inconsistently used with spouses. It is interesting to note that some spouses harbored doubts about their husbands' sexual behaviors and desired to adopt

safer sex practices. These women need to be identified and additional support and couple counseling provided to them.

There have been improvements on the process of safe mobility based on our findings. Uniform rates charged by rickshawallas and tangawalas, and the absence of harassment by the police have been reported by the respondents who travelled in recent years. This could be a result of the efforts of several organizations working on the transit routes- work with transport unions, hotel unions, the police force of both the countries- that has brought about a greater awareness of harassment and atrocities happening on the border along with an increased accountability of all the stakeholders to respond to the situation. Many of the migrants, however, do not use the transits that have the intervention, and hence may not get the benefit of safe mobility. Although these routes are reported to be generally safe, there are occasional cases of harassment by the border security police. Interestingly, some of these other routes used by migrants have also shown improvements in terms of less harassment and exploitation. Whether this is due to the diffusion of intervention will be an interesting research topic. The outreach workers, DIC counsellors and peer educators have facilitated the process of remittances by helping migrants to open accounts. Nevertheless, there are still some of them who have not done so due to lack of identity proof.

In summary, the study found that many benefits related to HIV knowledge, preventive behaviors and safe mobility are being conferred on the migrants and their spouses through the project. When both husband and wife receive services, it is better in terms of communication and adoption of safe behaviors. The study, however, also points to the need to increase coverage so that other migrants can be reached in destination and their spouses in source. Additionally, facilities like safe transfer of money need to be expanded and information on having identity proofs such as ration cards need to be provided and the process made easier.

1. Recommendations

1. Replication of the modality of reaching out to all female spouses of migrants in source districts is a need that has come out from the findings. Women who were out of reach of services evinced low knowledge of HIV, lack of communication with husbands, and low use of HIV testing services while there was a positive impact of the intervention on those spouses who were reached.

2. Couple counselling when the husband is in the village, or when both husband and wife live at destination, is another recommendation so that couples can work on their relationships and are enabled to practice safer behaviors. Similarly, it is recommended that there should be identification of women, through outreach, who find it difficult to talk to their husbands about HIV & AIDS, yet express a desire to access HIV testing and adopt preventive behaviors such as condom use, in order that peer educators may conduct couple counselling during the husbands' visits.

3. One of our main findings i.e., when both husband and wife receive services it is better for spousal communication and adoption of safe behaviours leads us to suggest that validated lists and non validated lists be updated and given a new lease in life by the process of identifying husbands at destination and spouses at source and providing services to both. A referral system can be established in those places which do not have the presence of the EMPHASIS intervention so that identified husbands and wives can be provided with the respective HIV prevention services.

4. Information campaigns and materials should focus on removing misperceptions regarding HIV transmission, especially related to mosquito bites and blood groups and on misunderstanding about the lack of necessity of condom use with spouses.

5. Introduction of frequent mobile camps at source districts is recommended to make prevention and treatment services more accessible to spouses of migrants. Our data revealed that distance to health centers was one of the main factors in lack of utilization of HIV testing. Furthermore, STI diagnosis and treatment in mobile camps can be an added boon to those women who suffer from infections but are unable to visit distant health centers.

6. Increase in distribution of HIV & AIDS information at transit routes is another recommendation. Transit routes serve as perfect places to target a large mass of migrants and provide them the necessary information. Many of the migrants also move to areas in India where they are outside the area of interventions and hence may fall out of the purview of HIV prevention. Mechanisms for continuous dissemination of information must be developed so that all migrants passing through the routes are targeted.

7. Expansion of safe mobility strategies to other transit areas is recommended, as our data revealed that there are migrants who travel through routes other than those which have safe mobility interventions.

8. Information on the process of procuring identity proof in India must be provided and the process facilitated by the project in order that remittances through banks can be easily made. The absence of banks in close proximity to where families of migrants live in Nepal needs to be taken into account while developing and improving the process of remittance.

9. Increase in outreach in both destination and source to reach out to the target population who have little time in accessing service centers, and increase in the number and frequency of door to door contacts by peer educators is another recommendation.

5.1 Recommendations from respondents and key informants

1. Expansion in coverage of intervention to other migrants in the destination city.

2. Continuity of current intervention at source and destination

3. Introduction of Income generation and livelihood programmes at source districts.

4. Increase in mobile DIC at destination and mobile camps at source for HIV testing

5. Extension of intervention to other VDCs

6. Establishment of health centers in VDCs in source districts

7. Increased frequency of outreach visits in source districts

8. Introduction of intervention in G.B.Road (brothel area) in Delhi

9. Opening of HIV testing facilities at transit areas

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