Specification of Policy for the Barriers to Care and Treatment of Nepali Migrants Living with HIV/AIDS in India

Sunil Sarode
International Institute for Population Sciences
Pragati Ubale (madhavidattatrayadf@gmail.com)
International Institute for Population Sciences
Asha Banu Soletti
Tata Institute of Social Sciences

Research Article

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Abstract

Nepal is one of the friendly nations of India in the Indian subcontinent. There are no severe international conflicts between India and Nepal. Moreover, cultural commonality is also essential in sustaining friendly relations between two countries. Therefore, the migration from Nepal to India is well established and unobjectionable phenomenon. There are no restrictions and basic requirements for Nepali migrants to come to India. Nepali migrants are coming to India without their families; hence there are high chances of being involved in sex avenues due to loneliness and their reproductive age group. Thus, they are at high risk and get infected with HIV. Later on, they transfer HIV to the general population in Nepal after their return. It is imperative to control such consequences. Therefore, it is necessary to provide preventive and health care services to Nepali Migrants. Therefore, it is crucial to study the existing policies for people living with HIV/AIDS concerning health care treatment. It is equally important to study the challenges for Nepali migrants to access health care treatment due to the existing policy. There is also a need to focus on the recommendations to develop the future policy to deal with the challenges of Nepali migrants to access the health care treatment without any hindrances.

In this study, the qualitative and quantitative approach was adopted to collect the data from the Nepali migrants living with HIV/AIDS. Overall 50 Nepali migrants living with HIV/AIDS were interviewed and 4 Focussed Group Discussions were conducted to elicit the in-depth knowledge on the issues of Nepali migrants living with HIV/AIDS. Apart from that, the three Key Informant Interviews of health care providers were also done to understand their perspective regarding issues of Nepali migrants living with HIV/AIDS.

Background

The phenomenon of migration has played a very important role in spreading HIV/AIDS. This study aims to understand the socio-economic conditions of Nepali migrants staying with HIV/AIDS and explores the barriers that exists in the access of care and treatment for these migrants. This paper is majorly focused on the existing policies and recommendations of the policies for barriers in the care and treatment of Nepali migrants who are living with HIV/AIDS in India.

Overview of the profile of Nepali migrations and migrants in India:

Migration from Nepal to India has a long history. Nepalese were recruited into the British army. Moreover, they were also used to visit to the kingdom of emperor Ranjit Singh at Lahore for trade and commerce (Gurung, 2006). India's proximity, open border, shorter distance, cultural affinity, easy convertible currency, affordable traveling options make integration and assimilation easy for Nepali migrants. Hence, India is a preferred destination for Nepali migrants.

[Note: For more information on the socio-economic and health care conditions of Nepali migrants living with HIV/AIDS in Mumbai. please refer to the paper (http://www.irjmsh.com/abstractview/10894)

For more information on Assessment of Healthcare Utilisation among Nepali Migrants Living with HIV/AIDS in Mumbai, India. please refer to the paper (https://iasp.ac.in/uploads/journal/49_1006.pdf)]

In modern days migration between Nepal and India has been guided by the Peace and Friendship Treaty signed between India and Nepal in 1950, allowing people of both countries to cross the border and find employment without any restrictions freely. This treaty is one of the significant factors for the Nepali population migrating to India.

In the present scenario, Nepali's are migrating to India searching for employment. The economy of Nepal mainly depends upon agriculture; therefore, the crisis of unemployment is likely too high in Nepal. Predominantly, Nepali migrants who come to India, especially to Mumbai, are primarily from the rural part of Nepal (Gurung, 2008). According to 2010 estimates, approximately one million Nepalese are working in India, primarily as unskilled permanent or seasonal laborers (Government of Nepal, 2010). This clearly shows migration from Nepal to India is economic migration. The 1991 census of India shows that 6.6% of Nepali migrants are in India out of the total migrant population. It has been increased to 9.4% in the 2001 census and according to the 2011 census, it has risen to around 14.3%. According to the Integrated Bio-Behavior Survey (IBBS, 2006), the people from western districts of Nepal are migrating to Delhi, i.e., 42.2% and 39.4% are going to Maharashtra. From the mid-far western zone, 43.3% migrated to Maharashtra, 16.4% to Uttaranchal and 15.6% have migrated to Gujarat".

Whereas unskilled migrants, who occupy a low-socio-economic demographic from their source country occupy an even lower socio-economic position in the destination country owing to their 'outsider status. Such migrants do not have the power to negotiate with their circumstances and suffer silently" (Kontunen, Rijks & Nenette, 2014).

The link between Migration and HIV:

Population migration is frequently identified as a key driver of the HIV epidemic (Deane et al., 2010; Farah Seedat, 2011; Mukherjee & Danje, 2006; Ross et al., 2018). Especially when mobility is international (Family Health International/Nepal, 2002) and seasonal or long-term (International Coalition on AIDS & Development, 2004). The process of migration itself needs to be understood. Migration often disintegrates the family unit. In the event of male migration, the male member gets separated from his spouse. The male migrant is usually in reproductive age and is sexually active by choice and travels without a spouse or his regular partner. This combined with poor living conditions, working conditions and witnessing risky sexual behavior (RSB) of fellow male migrant members, predisposes migrants to seek sexual activity, often with commercial sex workers (CSW) (Mukherjee & Danje, 2006; Halli et al., 2007; Singh et al., 2006; Vemuri & Battacharya, 2004). On their return home, workers who have contracted HIV bring back the disease home. Hence, the National AIDS Control Organisation (NACO) referred to migrants as bridge groups that transmit Sexually Transmitted Infections (STIs). Given such transnational consequences, travel medicine must consider the health and well-being of migrant workers (Simkhada et al., 2017).

Nepali Migrants Living with HIV/AIDS in India.

There has been a growing flow of labor into India in the recent past, particularly from Bangladesh, Nepal, Pakistan, and Sri Lanka. Interestingly, in these same regions, the rise of HIV has turned into an epidemic and a major public health concern. According to UNDP (2010), it has been estimated that 2 to 3.5 million people are living with HIV AIDS in South Asia alone. Nepalese migrate to Mumbai, leaving their families behind in Nepal. Staying single and away from the family, they often come in contact with commercial sex workers or women co-workers and get affected with STIs and HIV. Due to stigma and poor wealth, proper treatment is often not sought and this infection is passed to the family members. Returning migrants from Mumbai to Nepal is one of the highest risk groups estimated who can transfer HIV to their spouses through unprotected sex. It has been rectified by Thapa and Sharma (2013) that an unintended side effect of labor migration is the transmission of communicable diseases. In fact, in some parts of Nepal, HIV is known as Mumbai disease (Karki & Shreshtra, 2006).

The National Center for AIDS and STD Control (NCASC) report 2007 estimated a total HIV prevalence of 0.49 percent among the adult population in Nepal, which corresponds to almost 70,000 people living with HIV in the country (NCASC Nepal, 2007). The report also revealed that the high level of infections of HIV found among Nepali labor migrants to India. It has been claimed in the report that out of all HIV infections, Nepali labor migrants returned from India are 42 percent with HIV infection.

One more survey, the Integrated Bio-Behavioral Survey, was conducted in 2006 in eleven districts of the far Western and mid far Western zone of Nepal. This survey was also conducted on labor migrants and the rate of HIV prevalence. The survey results indicate that mostly the migrants move primarily to Mumbai and Delhi in India for work purposes. The majority of the migrants who were participated in the study have stayed in India for more than two years. According to this study, the prevalence rate of HIV was significantly higher with a 5 percent significance level in mid far Western zone among those returned migrants who were more than 25 years of age and they were returned from India involved in sexual contact with sex workers and they were mainly returned from Maharashtra. It is relatively higher than their other counterpart. As far as the statistical results are concerned, it has appeared that the migrants who were participated in this survey among them the rate of HIV prevalence are higher who were aged more than 24 years compared to below 25 years age group that is 4.6 percent and 0.6 percent respectively. In addition to this, this study also has an exciting finding that the HIV prevalence rate is very high among those who ever visited sex workers in India. It is lowest among those who did not have such sexual exposure. If we highlight the percentage level of HIV prevalence, then it is 8.2 percent among those who had sexual contact with sex workers in India and 0.2 percent among those who were not from the same group that is who was not returned from India".

"The IBBS 2008, which was conducted among the wives of migrant laborers. It was conducted in the four districts of far western Nepal. The survey result indicated that the prevalence rate of HIV among wives of migrant laborers was estimated to be 3.3 percent. It corroborates that HIV is transmitted from migrants to the general population through their wives.

Other studies on Nepali migrants to India and HIV/AIDS (Family Health International, Nepal, 2002) concluded that the prevalence of HIV is high among the Nepali migrants to Mumbai. Further, it has also been pointed out in this study the transmission of HIV is transferred to them from sex with sex workers in Mumbai. The result of the study also indicated that the level of STIs and HIV transmission from infected to non-infected partners was extremely high among the international migrants; non-infected partners are mainly their wives. Migrants who return from India who were HIV infected were not using condoms with their wives. Some of the previous studies show that the wives of the migrants do not expect to use condoms because historically and culturally, wives respect their husbands in the Nepali community. Due to their respect, they even don't believe their husbands might have such extramarital affairs. Thus, HIV spreads to the general population. It has also been observed that the indulgence with sex workers is high as the mobility is escalated because it is five times higher among migrants than non-migrants. The extent of participation in sex with sex workers and the rate of STD and HIV prevalence was great only among international migrants and HIV infection was found only among those who visited Mumbai.

The effects of male migration impact women, children and family health and well-being. There exists a link between male mobility and HIV in women and children (Awasthi et al., 2015). Though women are aware of HIV/AIDS, the patriarchal structure of the society will also prevent them from refusing sex to their husbands, thus increasing the chance of HIV contraction from their spouse (Aryal et al., 2016).

A recent qualitative study conducted by Adhikary et al. (2020) found that "migration to India continues to be livelihood strategy for Nepali male workers, especially unskilled migrants. The researchers concluded that most migrants had difficulty accessing healthcare services in India and low wages, lack of documentation, identity card, the now ubiquitous Aadhar, biometrics, lack of insurance, apathy of employers and discrimination in Indian healthcare facilities were some of the reasons that acted as barriers to healthcare and low healthcare utilization. The authors conclude that institutional ties between the two governments have to be strengthened and more migrant support organizations with support for health care and employer accountability must be enhanced (Adhikary et al., 2020).

Recently, in 2018, the World Health Organization published a report on the health of refugees and migrants for the South East Asian (SEA) region. For instance, In Mumbai, India, 22.9% of women and girls who were trafficked are HIV positive and HIV prevalence is 38% among sex-trafficked women and girls returning from India to Nepal. The report also acknowledges the knowledge gaps pertaining to Antiretroviral Therapy (ART) and how one can benefit from the treatment. The questions of social exclusion, stigma, and discrimination that serve as barriers to accessing health care and the difficulties of undocumented migrants in accessing treatment are also addressed. The travesty is that despite protective legislation and global international laws that call for a rights-based approach, these barriers continue to exist (WHO SEA Report, 2018).

Nepali migrants with HIV/AIDS are facing several challenges with regard to healthcare and treatment. Such as absence of family support, loneliness, unhygienic residences affecting immunity of the patients, stigma from the co-migrants, missing ART. Some other studies are also consistent with this (Samuels et al., 2011; Samuels, 2013).

Present Study:

The present study was conducted to understand the socio-economic and living conditions, level of utilization of care and treatment services, factors influencing the utilization of care and finally to explore the state response to address the issue of barriers to care and treatment for Nepali migrants living with HIV/AIDS in India. The current paper focuses on state response for the barriers in care and treatment of Nepali migrants living with HIV/AIDS in India. Here, state response means the policy of the government concerning the accessibility of healthcare services for Nepali migrants.

Methods

For this study, we collected primary data from Mumbai city. Researchers adopted a mixed-method approach to fulfill the objectives of this study. Interviews were conducted by taking oral consents from the respondents and the researcher maintained the confidentiality of the respondents and their responses. The Key Informant Interviews (KII) of Nepali migrants working for or working with Nepali Migrants living with HIV/AIDS were conducted. We also interviewed healthcare providers such as medical officers in the ART center at the government hospitals where Nepali people living with HIV/AIDS are the beneficiaries.

We approached 100 respondents by using purposive and snowball sampling. Out of 100, 50 respondents were interviewed for a quantitative survey and 50 participated in Focussed Group Discussions (FGDs). This data was analyzed using SPSS software, and frequency and cross-tabulation emerging from this analysis have been interpreted to suggest the findings. For Focus Group Discussion and KIIs, the dialogue was considered the basis of analysis and the responses received were linked to answering research questions and objectives using Thematic Analysis.

Results

The following diagram shows the influencing factors and barriers in getting treatment for people living with HIV/AIDS (PLHA), which we found in this study.

Discussion

Efforts from Nepal for Nepali Migrants living with HIV/AIDS in India:

Nepal's local efforts to curb transmission create policies and interventions for healthcare have been summarized in the Country Progress Report published by the Ministry of Health, Government of Nepal. The report contributes to the global monitoring of HIV and also provides a status update on the ten commitments made towards HIV prevention and monitoring. These indicators are essential in monitoring the diseases and their implications for cross-border transmission. These commitments are reducing and eliminating infection in children, women and other vulnerable groups, eliminating discriminations against women living with HIV/AIDS, creating knowledge and awareness, increasing HIV health care services led by community and expenditure on health, working for the rights and justice for PLHA, Universal health coverage.

Why there should be a policy in India for Nepali Migrants Living with HIV/AIDS:

HIV prevention initiatives are the need of the hour (Murray, 2019). The positive side of migration in India is that they are an important part of the workforce and can aid the destination country's economic and social development. It isn't easy to bring an end, but such policy could attempt to work on the prevention ground both in India and Nepal. When the HIV and AIDS-related vulnerabilities of migrants have not been addressed, there is also a big risk of spread in the general population in both origin and destination places (Vaidya & Wu, 2011). Thus, leading to an urgency in policy and programmatic intervention at both place of origin (Nepal) and place of destination (India).

Policy recommendation for Nepali Migrants:

In a study conducted by Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) and Overseas Development Institute (ODI) (2011), it was found that "migration was an important survival strategy for low-income groups from low-income countries. However, once the HIV diagnosis happened, there was a further downward shift in the quality of life owing to many factors. Hence the policies and programs must be developed at origin and destination. An important aspect of international treaties and various provisions under their ambit is recognizing the right to health as a right irrespective of nationality or residentially. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) recognized the "right to the highest attainable standard of physical and mental health."

At the World Health Assembly in May, WHO (2008) argued that four strategies were necessary to address the vulnerabilities and healthcare needs of migrants.

1. "Advocacy and policy development, a crucial factor to ensure migrants have equitable access to health services."
2. "A need to assess trends in migrants' health by improving country health information systems, which can help identify and fill gaps in service delivery."
3. "It is essential to train policy-makers and health stakeholders on migrant health issues,"
4. "To improve service delivery to reinforce migrant-friendly public-health services and establish minimum healthcare standards for all vulnerable migrant groups (World Health Organization, 2008)".

There are numerous barriers to health care for Nepali immigrants to India. Many human rights and health rights advocates have studied for policy change to increase access to health care for undocumented immigrants, providing novel insurance options, expanding safety net services, training providers to better care for immigrant populations, and educating undocumented immigrants on navigating the system.

State response concerning healthcare treatment of Nepali migrants living with HIV/AIDS:

State response is primarily referred to as the policy which may affect the care and treatment for Nepali migrants. The policy-making is not only the function of the state but implementation too. As far as the barriers to care and treatment for Nepali migrants living with HIV/AIDS are concerned, it is associated with the health policy for those living with HIV/AIDS. The task of implementation of the policy is assigned to healthcare agencies or health care personnel. There is no specific policy for migrants living with HIV/AIDS in India and sometimes, policy in the destination itself becomes a problem for migrants. Policy for local populations applies to migrants living with HIV/AIDS. Few facilities are provided for the migrants; for instance, the arrangement of ART centers close to the border. Since India is a significant recipient of cross-border migrants, such a policy benefits migrants from neighboring countries.

It has been derived from key informants that people living with HIV/AIDS are not denied the treatment despite their migrant status. Even respondents also pointed out that they were not denied the treatment. For a good policy or program implementation, it is essential to understand the obstacles from both the migrants and health care personnel side.

National Aids Control Organization (NACO) is the principal state agency responsible for implementing the policy and programs for the people living with HIV/AIDS in India with the help of their state branches.

The patient's adherence to the treatment depends upon the health personnel and waiting time, as pointed out by (Andersen, 1995). HIV/AIDS is a chronic health problem; therefore, it generates a regular need for healthcare services. Hence, it is expected to minimize the problem of obtaining healthcare treatment and establish a healthcare system free from such hindrances in the health care services, which are barriers for Nepali migrants living with HIV/AIDS. Here the focus is on all the aspects of state policy and its implementation, which were pointed out by both respondents and key informants who are the Chief Medical Officers of the public healthcare institutions.

Following is the discussion of some barriers in access to health care treatment and the plausible state response as solutions.

Unavailability of Identity Cards:

According to the rules of NACO, it's mandatory to produce proof of identity to access healthcare and treatment for people living with HIV/AIDS. It is not only essential for Nepali migrants but also mandatory for the host population. The purpose is effective management of health institutions, flawless healthcare treatment and easy follow-up but this becomes a barrier for migrants taking care in India as a majority of the time, they don't have identity proofs. As they are migrants, health care professionals may ask for a passport, but the majority of the Nepali migrant comes to India by train, given the porous status of the border and lower socio-economic status of the migrants. The majority of them are working in the informal sector and living with friends or relatives, due to which they rarely have a working ID or residential proof. In fact, in the context of Nepali Migrants, it has been suggested by the key informants that they can get the transfer certificate along with them from Nepal so that we will come to know the person is PLHA and he is on ART. The policy of mandatory ID proof to start the treatment is narrated by both the respondents and the key informants; therefore, there is no gap between respondents' views and public healthcare officers. Suppose policy affects the treatment and becomes one of the barriers to care and treatments for migrants, especially for the cross-border migrants. In that case, there is a need to modify the policy with some solutions. The key informants have narrated that Non-Governmental Organisations' (NGO) linkage with the hospitals could be one of the solutions to this problem. NGOs can refer the patient to the hospitals or patients can issue a referral letter in the absence of ID proof from NGO, with this letter, patients can access healthcare treatment. In this study, as mentioned by the health care professionals, identity proof is mandatory to start the treatment. Still, even in the absence of identity proof, medicine is not denied to Nepali migrants. There is one more recommendation on the part of respondents that if there is a compulsion of identity proof, then the state should provide identity proof or a residence letter of employer's certificate that states that the person is working at his place. These recommendations should be incorporated in the Indo-Nepal friendship and peace treaty; then, the Nepal embassy can also issue a certificate for Nepali migrants. This would be very helpful because then the embassy collects all the information about the migrants and it would be difficult to miss the ART patients from Nepali migrants. In such a case, the migrants would not leave India without informing the hospital authority. Even if any migrant patient goes to a native without informing the hospital authority, he can continue his medicine in Nepal with the help of an embassy certificate.

Loneliness/ Unavailability of family and company/ absence of caregiver:

Non-governmental organizations (NGOs) can also provide moral support to the patients. HIV patients need moral support and Nepali migrants are predominately single migrants and away from family; therefore, they urgently need moral support due to loneliness. There is a policy by which it is expected by the healthcare institutions that there should be someone to accompany the patient at the time of admission; this is not the rule only for Nepali but for all the patients. Of course, the policy's purpose is right but the person who will accompany the patient will be a migrant again, and the issue of loss of one day salary, stigma and confidentiality could be the problems again. If the patients who do not have anyone to take care of them in case of emergency, there must be the provision of the caregiver or in such a case health institution will take care of the patients. The issue of the provision of the caregiver is so important that all the key informants expect that Nepali migrants must have fixed and permeant jobs so that they should not change the residence and stick to one place.

NGOs can also help the hospitals to do the follow-up of the patients. Thus, they can continue the patients' attachment with the hospital and help the hospitals prevent missing cases. This is extremely helpful for hospitals because hospitals do not have any machinery for follow-up patients. They don't have field staff, especially in the ART center. This experiment is conducted in some parts of Mumbai, especially in Navi Mumbai and it is very successful in the context of Tuberculosis patients. It will increase the follow-up if we distribute responsibilities among local NGOs and local health care providers like Direct Observation Treatment (DOT) under the Revised National Tuberculosis Control Program same program could be replicated in the context of ART treatment.

This experiment would be helpful for Nepali migrants living with HIV/AIDS in India. Follow-up is an essential component in care and treatment; if the follow-up mechanism is weak, it may adversely affect the patients and the health care system.

Anderson and Numan already emphasize social networking as an essential factor for healthcare utilization, especially in case of emergency. In the context to the Nepali migrants where they are living close to each other or in surrounding localities, there are no more difficulties in follow up in the time of emergency because Nepali migrants have robust social networking, which helps them to pass on the information and to remind each other about the medicine and the timing of the medicine. In case of lack of social networking among Nepali migrants, they have to depend on the NGOs or the staff of the ART centers.

One more issue in the context of Nepali migrants is that they do not have anyone to accompany them to the hospital at the time of admission. It is mandatory to have someone with the patient for admission. Nepali migrants face the problem of the absence of company at the time of admission since their living as a single person. In such a case, NGOs can help them because they can utilize their staff to accompany the patient unless the fund is available. This experiment should become part of the policy.

Shelter home or Nepali Bhavan should be available for Nepali migrants living with HIV/AIDS because some of the Nepali migrants are very helpless; they don't have anyone to take care of them and they are not even supported by their family due to their HIV status some are homeless and their condition is so severe that there is no one to look after them.

Delay in treatment due to patient's load in Hospitals:

The patient's load is also one factor that affects the smooth functioning of the treatment. It depends upon the distribution of the services and the size of the geographical location where the services are distributed. For instance, in the Mumbai suburbs, there are public hospitals in almost every suburb; therefore, there is a manageable load of patients. In contrast, in Navi Mumbai or in towns that occupy a sizeable population due to which the treatment gets delayed and the respondents have to wait for a long time to meet the doctor or to get medicine. Sometimes local patients do not want to take treatment from the hospitals which are in their locality because they are scared that others will come to know about their positive status. Therefore, they prefer to take treatment from another locality. It leads to the crowd of patients due to which the treatment is being delayed. The policy can be formulated based on the Revised National Tuberculosis Control Programme (RNTCP), in which direct observation treatment is practiced. It can be practiced in the context of ART medicine. The medicine can be kept with the NGOs, which are linked with the hospitals or the medicine can be kept with the local healthcare providers in the locality of the patients with their consent. Once upon a time, Tuberculosis was also a stigmatized disease but nowadays it is acceptable and the Tuberculosis patients are not stigmatized the way they were treated earlier. It may also reduce the crowd in the hospitals. It would be positively associated with the adherence because if there is no crowd, then patients do not have to wait for a long and they may not have to lose one-day income.

Problems to adherence to the treatment:

There are challenges of adherence to the treatment; primarily, the patient has to listen to the counselor carefully and put into practice the suggestions given by the counselors. It is a challenge for the hospital authority to monitor whether the patients follow the counseling or not.

In addition to this, it's a mobile and floating population; therefore, they change their residence after some point in time. The same thing happened in the context of Nepali migrants; they changed their residence as they changed their employment. If they move somewhere in Mumbai, then there won't be a problem but sometimes they go out of Mumbai, which affects the adherence. It is the expectation of the healthcare providers that they should inform them so that the healthcare providers can provide transfer letters to the migrants and continue their treatment even if they are out of Mumbai. This is the positive response of the state healthcare providers. In this study, health care professionals reported that there is a staff of ART centers for counseling that inform the patients about the next visit and to continue the treatment regularly they should not have discontinued the treatment the cancellers explain the patients about the adverse impact of the missing the treatment but there is no official follow up mechanism. ART centers do not have community staff to do the patients' regular field-based follow-up. It will be beneficial for the hospitals and patients as well if the whole process of referral and follow up assisted by the NGO and if they do the advocacy by the patients, especially Nepali patients, to guarantee to continue the ART treatment regularly.

Poor Economic Status:

It is also expected to arrange economic support in the form of medical reimbursement or free medicines other than ART for Nepali migrants living with HIV/AIDS. Because Nepali migrants are working in the informal sector; hence they are not earning much. They have to take care of their family in native. Therefore, they have to send remittances. In addition to this, they may not have a regular job sometimes they are unemployed. Thus, Nepali migrants living with HIV/AIDS should get this facility in the form of social security with medical insurance that must be provided for them.

In a qualitative study, it has been observed that if the migrants go back to Nepal for one or two months, if they request the medicines for additional one or two months, then the request is considered and they are given extra medication. Such cooperative responses should be shown on the part of the healthcare personnel.

Subsequently, it is very important for the migrants that when they go to the native place, they have to ensure to take transfer letter along with them to make sure that they do not miss the continuity of their treatment. It is difficult for ART center authority to deal with this challenge but it is not that difficult for NGOs to deal with this challenge because they have regular contact with patients.

Mainly NGOs collaborate with hospitals to benefit their patients; this is not an official collaboration in most cases. It is either a part of goodwill or sometimes NGOs are doing a project on the concerning issues. Though it is benefiting both the NGOs and hospitals but to some extent. If it is an official collaboration, then NGOs get funds for this work. Then it could be mandatory for the NGOs to refer the patients to the hospitals and to work as per the requirements of the hospitals.

The good rapport and linkage between NGOs and public hospitals are very important to deal with the issue of Nepali Migrants with HIV/AIDS. This collaboration of NGOs and Public hospitals would be helpful in the smooth functioning of healthcare treatment for the migrants living with HIV/AIDS. As a part of this collaboration, hospital staff and NGOs can have a monthly meeting in which they can share their grievances and work to settle the grievances.

Earlier Indo-Nepal friendship and peace treaty 1950 was signed between two countries. This treaty recognized migration from both countries but it did not recognize legal protection. It also did not mention anything about health facilities. Of course, at that time, HIV/AIDS was not a severe health issue; therefore, no question arose. Secondly, this policy was withdrawn for the last 20 years due to political conflicts between the two countries. This policy can be modified and the expectations of the Nepali migrants can be added to this policy. The government of India solely cannot provide such facilities but it can be provided with the collaboration of the Government of Nepal. India can provide infrastructure and maintenance but finance can be provided by the Government of Nepal. These expectations cannot be achieved or fulfilled entirely by the state of India because politically, they are not the citizens of India and demographically, India doesn't have the policy to seek immigrants from Neighbouring countries. Some of these facilities are not available for Indian people living with HIV/AIDS but on the humanitarian ground, the state of India can form such a policy in collaboration with the state of Nepal.

Thus, labor migrants are one of the components of transmission of HIV/AIDS in Nepal. Therefore, it would be good for both India and Nepal to work for the healthcare treatment of migrants because Nepali migrants living in Mumbai without their families have sexual relations with the women of the local population. Therefore, if migrants are aware of HIV/AIDS and are given treatment, then it may not transmit or it may lower the level of transmission of HIV/AIDS among the local population and their spouse in Nepal.

Further research, especially in the context of the Nepali migrant population in India, may be useful to frame the policy for the migrant population regarding health issues like HIV/AIDS. There is a need for National Survey on International Migration in India. It includes immigrants and emigrants the way in Nepal they have an integrated Bio-behavioral Survey. These National surveys will provide detailed information about the migrants and their issues in India. It will assist the state in bringing about effective policy for the migrants.

Conclusion

Consistent with previous studies, this study also elicited that migrant people living with HIV/AIDS face difficulties in getting treatment and follow-up in the destination country. There is no specific policy for Nepali migrants with respect to healthcare treatment in India; therefore, the policy for the host population is being applied to the migrants. Migrants are essential for both countries of origin and destination. Thus, the collaboration of both Nepal and Indian governments is suggested to modify the existing policy for Nepali migrants. Partnership in hospitals and NGOs is also recommended as this will ease many problems of migrant PLHA such as unavailability of Identity Cards, loneliness, unavailability of family and company, absence of caregiver, delay in treatment due to patient's load in hospitals, poor economic status. More research projects both in Nepal and India are suggested. This will improve the access and adherence to the treatment among migrant PLHA.

List Of Abbreviations

Human immunodeficiency Virus Infection and Acquired Immune Deficiency Syndrome (HIV/AIDS); People Living with HIV/AIDS (PLHA); Integrated Bio-Behavior Survey (IBBS); National AIDS Control Organisation (NACO); Risky Sexual Behavior (RSB); Commercial Sex Workers (CSW); Sexually Transmitted Infections (STIs); United Nations Development Programme (UNDP); National Center for AIDS and STD Control (NCASC); South East Asian (SEA); Antiretroviral Therapy (ART); World Health Organisation (WHO); Key Informant Interviews (KII); Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) and Overseas Development Institute (ODI); International Covenant on Economic, Social, and Cultural Rights (ICESCR); Non-governmental organizations (NGO); Direct Observation Treatment (DOT; Revised National Tuberculosis Control Programme (RNTCP);

Declarations

Ethics approval and consent to participate: For this research, ethical clearance was taken from the Institutional Review Board of Tata Institute of Social Sciences, Mumbai.

Consent for publication:

Not Applicable

Availability of data and materials:

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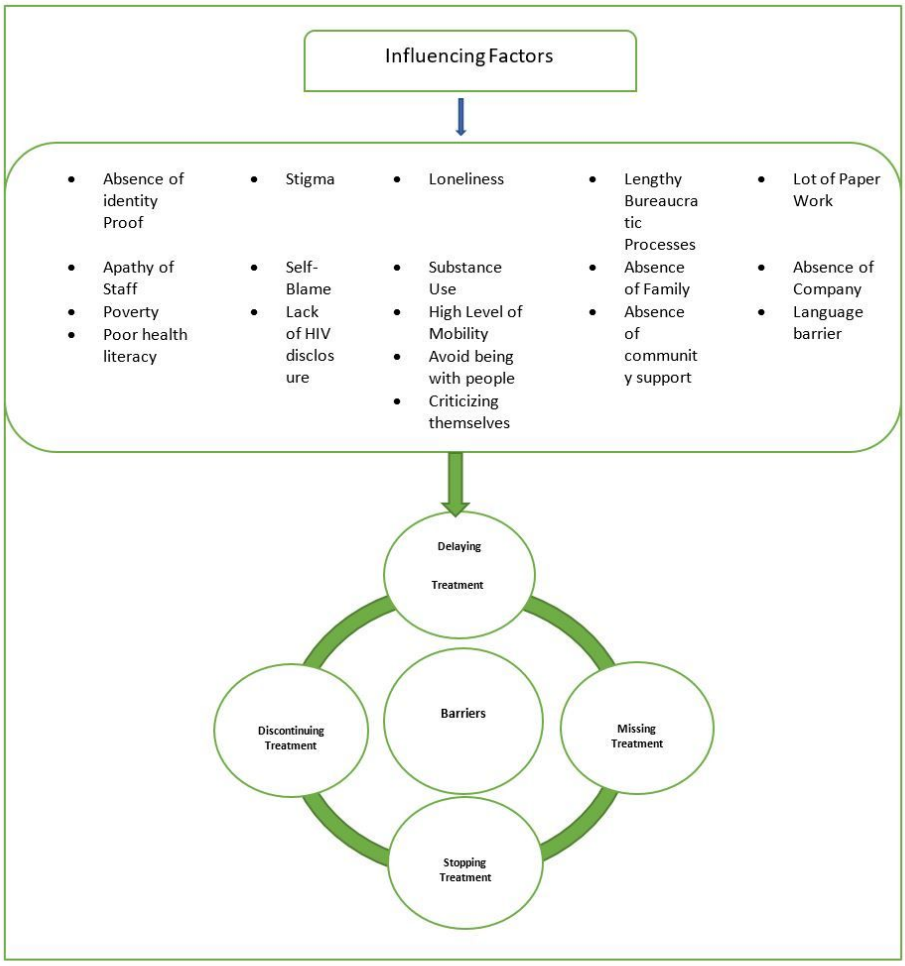
Figures



[Refer: (Sarode et al., 2020) ; (Sarode & Soletti, 2021)]

Figure 1

Legend not included with this version.