The Status of Care, Support, and Social Reintegration of Trafficked Persons in Nepal, as of December 2005

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I. INTRODUCTION

Nepal is a small country that has been severely impacted by the trafficking of its girls and women for prostitution in other countries. While the exact numbers are unknown, perhaps thousands of Nepalese girls and women are trafficked to India and other countries each year.[1] Currently as many as 25,000 trafficked Nepalese are prostitutes in India.[2] While considerable measures have been taken to curtail the activities of traffickers and to rescue trafficking victims from the brothels of India, the number of trafficked persons returned to Nepal remained limited as of the end of 2005.[3] As prevention and withdrawal activities increase in effectiveness, there is a need to develop appropriate strategies and practices to provide for the care and support of trafficking victims, and to assist their reintegration into Nepalese society. This Article reviews the

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1. ASMITA, *National Perspective*, http://www.asmita.org.np/Trafficking/national_perspective.htm (last visited Mar. 31, 2006) [hereinafter ASMITA *Perspective*].

2. *Id.*

3. *Id.*

present status of care, support, and reintegration activities for trafficking survivors in Nepal, and discusses the future of these activities in light of recently developed tools and practices.

II. CARE AND SUPPORT

At present, approximately seven Nepalese nongovernmental organizations (NGOs) provide residential care for survivors of trafficking.[4] Residential care facilities are variously termed facilities, shelters, and transit homes, although NGOs and donor partners in Nepal are unclear that these terms designate different care purposes.[5] All presently in operation are basically medium to long-term residential facilities.

Most persons affected by trafficking in Nepal's care facilities are either rescued persons or girls who have been judged at risk of being trafficked.[6] Others are persons who have been intercepted during the trafficking process at the Nepal-India border.[7] At this time, no facilities have residents who have been withdrawn or have exited by other means. This includes, notably, those who have been evicted from brothels for being HIV positive or have returned to Nepal following escape or release from their slavery. Nor have there been any attempts to create greater access for these persons. However, Karuna Bhawan, a residential care facility for persons living with HIV/AIDS (PLWHA), has had some HIV positive voluntary returnees in its care over the years.[8]

Unfortunately, many Nepalese have been institutionalized, in the name of prevention or rehabilitation, without adequate justification. Many adults who have been rescued from the brothels in India have been placed in institutions against their will and are kept institutionalized by force and physical restrictions such as barred windows, guards, and fences. A disturbing number of girls in Nepal are placed in residential care because they are presumed to be at risk of being trafficked, despite the lack of legally valid evidence of such a risk. Standard at-risk

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4. SAHARA GROUP & BEYOND TRAFFICKING: A JOINT INITIATIVE IN THE MILLENIUM AGAINST TRAFFICKING IN GIRLS & WOMEN (JIT), BEST PRACTICES ON REHABILITATION AND REINTEGRATION OF TRAFFICKED WOMEN AND GIRLS (2004), *available at* http://childtrafficking.com/Content/Library/ (then follow "Reintegration" hyperlink; then follow "Nepal" hyperlink; then follow "Click here to download the document" hyperlink under "SAHARA Group" paragraph) (last visited Mar. 18, 2006) [hereinafter BEST PRACTICES].

5. *See* ASMITA *Perspective*, *supra* note 1.

6. *See* Maiti Nepal, *Transit Home*, http://www.maitinepal.org/tranhome.htm (last visited Mar. 31, 2006).

7. *Id.*

8. BEST PRACTICES, *supra* note 4, at 24-25.

indicators have not been developed and legal criteria for separating children from their families have not been clarified. In most cases, families have not been professionally assessed regarding the potential risk to their child or their willingness or capacity to care for the child. Moreover, the antitrafficking agenda to protect at-risk persons by placing them in care facilities is contrary to the accepted knowledge that institutionalization is not conducive to the proper development and well-being of children.[9]

Standard case management (CM) procedures are not conducted for trafficked persons in any of the caregiving institutions in Nepal.[10] These procedures include intake assessment, case planning, case conferences by a multidisciplinary team, and periodic case review for placement or termination of care. What little training has been conducted for some organizations has been inadequate, consisting of little more than providing CM forms and orienting staff on CM procedures.[11] Case management training conducted by social workers, restructuring of staff time to accommodate CM procedures, and on-site mentoring to establish CM processes have not been provided.[12]

Most Nepalese facilities lack the appropriate professional staff required for the proper care of survivors of trafficking, abuse, or domestic violence. While some facilities have adequately trained counselors, poor training of the managerial staff in the integration of counseling into the general caregiving process hinders the effectiveness of these counselors.[13] Many facilities in Nepal have personnel whom they inappropriately term counselors, including persons who have been given short orientations on counseling theory, but who have no clinical practice and are not qualified to conduct in-depth work with victims of sexual violence. In some cases, retraumatization of survivors by inadequately trained caregivers has been reported.[14]

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9. *See generally* Andrew Dunn et al., Int'l Save the Children Alliance, *A Last Resort: The Growing Concern About Children in Residential Care* (2003), *available at* http://www.scslat.org/pdf/19e.zip; UNICEF Innocenti Research Ctr., *Children in Institutions: The Beginning of the End?* (2003), *available at* http://www.unicef-icdc.org/cgi-bin/unicef/Lunga.sql?ProductID=349; Jan Williamson, *A Family for a Lifetime*, at 5-9, 58-60 (2004), *available at* http://www.synergyaids.com/documents/AFamilyForALifetimeVersion_1March04.pdf.

10. BEST PRACTICES, *supra* note 4, at 23.

11. *See id.*

12. *See id.*

13. *See id.*

14. *Compare id. with* U.N. INTER AGENCY PROJECT ON COMBATING TRAFFICKING IN WOMEN AND CHILDREN IN THE SUB-MEKONG REGION, TRAINING MANUAL FOR COMBATING TRAFFICKING IN WOMEN AND CHILDREN 22 (2001), *available at* http://www.un.or.th/trafficking Project/trafficking_manual.pdf [hereinafter U.N. TRAINING MANUAL].

Social workers and parasocial workers, who perform the vital functions of community/family assessment, case management, and reintegration outreach, are not present in any Nepalese caregiving facilities (although senior staff in some NGOs have had social work training).[15] This is primarily due to the lack of knowledge among donor partners about the role of social workers and parasocial workers, and the consequent absence in donor agendas of integrating social work activities into the care and support process. To address this gap, in 2005, the United Nations Children's Fund (UNICEF) Country Office Nepal commissioned a national social work capacity assessment by specialists from the University of the Philippines and is engaged in developing a Masters of Social Work programme and a parasocial work training programme in Nepal.[16]

Despite certain advances, both participation in and general provision of internationally promulgated human rights to residents are lacking in all facilities.[17] Many of the trafficked returnees are not accepted by their community or their family members and friends.[18] Moreover, those coming from difficult brothel situations can present substantial discipline problems that staff do not have the necessary skills to remedy. Positive discipline procedures are lacking, sometimes resulting in physical abuse of the residents by staff.[19]

Of additional concern has been the fact that many PLWHA were physically segregated from other residents in caregiving facilities for trafficked persons.[20] In 1996, more than 100 rescued persons, approximately half of whom were HIV positive, were brought from India and placed in six facilities in Nepal.[21] This influx led to significant discrimination of PLWHA in caregiving facilities.[22] Today, this has changed. With few exceptions, PLWHA, unless they are seriously ill, are well integrated with nonpositive persons in care. Maiti Nepal—at whose

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15. *See* BEST PRACTICES, *supra* note 4, at 23.

16. Interview with Noriko Izumi, Project Officer from the Education and Child Protection Section of UNICEF, in UNICEF Country Office Nepal (Dec. 2005).

17. *See* BEST PRACTICES, *supra* note 4, at 46-47.

18. *Id.*

19. *See, e.g.*, 1 JOHN FREDERICK, ILO-INT'L PROGRAMME ON THE ELIMINATION OF CHILD LABOUR, CREATING A HEALING ENVIRONMENT: PSYCHOSOCIAL REHABILITATION AND OCCUPATIONAL INTEGRATION OF CHILD SURVIVORS OF TRAFFICKING AND OTHER WORST FORMS OF CHILD LABOUR 40-44 (2002), *available at* http://www.ilo.org/public/english/standards/ipec/publ/download/healing1_trafic02_en.pdf.

20. Gauri Pradhan, *Ideas for Action: Repatriation of Nepali Girls*, CHILD WORKERS IN ASIA, http://www.cwa.tnet.co.th/Publications/Newsletters/vol12_1-2/v12_1-2_nepal.html (last visited Mar. 31, 2006).

21. *Id.*

22. *Id.*

large facility approximately fifty percent of trafficking survivors are PLWHA—is a model for the successful integration of PLWHA among its residents.[23] Similarly, several years ago, rescued trafficked persons were either forced or convinced to be tested for HIV, which only added to their stigmatization. Today, access to voluntary counselling and testing is provided to trafficked persons at all facilities.

A. Minimum Standards of Care and Support

As of yet, no Nepalese facilities operate under internationally acceptable minimum standards of care, although a movement towards quality of care is currently gaining momentum. Conceptual clarification activities on care and support for trafficked persons and children in labour situations were conducted during a set of international workshops in 2002, supported by the International Labour Organization's (ILO), International Programme for the Elimination of Child Labour (IPEC).[24] Basic standards and guidelines for care had been drafted, the blueprints of which were synthesized from numerous legally binding standards and guidelines from Ireland, the United Kingdom, and other countries.[25]

In 2003, the Central Child Welfare Board (CCWB), under the Nepal's Ministry of Women, Children, and Social Welfare, teamed with several NGO stakeholders to draft an inadequate minimum standards document. In 2003, a collaborative project among the CCWB, ILO-IPEC, and UNICEF was mobilized to develop comprehensive national minimum standards of care for children in need of special protection.[26] This ambitious project was a participatory activity involving central and local stakeholders, including children and line caregivers, and was intended to develop both regulatory and operational standards and guidelines on all aspects of care and support. The project was constrained due to funding delays and lapsed in 2005. At present, an abbreviated version of the project is being revived.

In early 2005, the South Asia Regional Initiative/Equity Support Program (Sari/Equity), a regional programme under the United States Agency for International Development (USAID), developed a draft set of

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23. John Frederick & Rachana Subedi, Asia Found., Assessment of Reintegration Practices: Maiti Nepal Central Facility, Kathmandu, Nepal (2005) (internal document, on file with author).

24. *See generally* 1-2 FREDERICK, *supra* note 19. Volume 2 is available at http://www.ilo.org/public/English/standards/ipec/publ/download/healing2_trafic_02_en.pdf.

25. *See* 2 *id.*

26. John Frederick, ILO-IPEC, The Development of Comprehensive Minimum Standards for the Care of Children in Need of Special Protection in Nepal (2003) (internal document, on file with author).

regional minimum standards of care.[27] Because the document was not developed through extensive stakeholder collaboration in South Asia and did not utilize professional expertise on technical issues, there are significant gaps, including a lack of clear guidelines for case management, child protection, medical care, and HIV/AIDS response.[28] In the fall of 2005, the ILO-IPEC Trafficking in Children in South and South-East Asia (TICSA) Programme duplicated the activity by developing another set of regional guidelines for caregiving.[29] This activity attempted to create a document that was user-friendly and legally specific regarding standards of care. As with the Sari/Equity standards, these were not developed through extensive stakeholder collaboration and did not utilize professional expertise regarding technical issues. This recent activity also bears the constraint that the regional TICSA countries include Indonesia (in Southeast Asia, not South Asia), Nepal, Sri Lanka, and Bangladesh, but not India, which has not signed ILO Convention #182, an effort to eliminate the worst forms of child labour.[30] Consequently, the TICSA guidelines cannot appropriately be called regional for South Asia. However, while there are inconsistencies and an unnecessary duplication of effort, both activities are a welcome start in the process of promoting quality of care in institutions in South Asia.

B. Quality of Care Capacity-Building

Although comprehensive, technically sound, and culturally appropriate minimum standards of care may be several years from mature development in Nepal, there is a current movement to develop the capacity of local caregiving organizations, so that they are in accordance with rigorous international minimum standards. The quality of care capacity-building strategy is based on the idea that local caregiving organizations, over several years of carefully planned development and training, have the potential to reach international standards of care. This strategy eschews piecemeal capacity-building activities for a comprehensive, unified approach. Based on the medical services

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27. SOUTH ASIA REGIONAL INITIATIVE/EQUITY SUPPORT PROGRAM [SARI/EQUITY], MINIMUM STANDARDS OF CARE AND SUPPORT FOR THE VICTIMS OF TRAFFICKING AND OTHER FORMS OF VIOLENCE IN SOUTH ASIA (2005), *available at* http://www.sariq.org/downloads/download.asp?file=11_07_22newbook.pdf.

28. *See generally id.*

29. Elaine Pearson, Rights-Based Recovery and Reintegration: Draft Standard Guidelines for Caregivers of Child Survivors of Trafficking in Asia (2005) (draft document, on file with author).

30. ILO, *Ratification Campaign*, http:www.ilo.org/public/english/standards/ipec/ratification/map/index.htm (last visited Mar. 31, 2006).

training model, it applies quality standards not only to eventual care operations but also to the capacity-building process, including assessment, training, mentoring, monitoring, and evaluation. This model disallows capacity-building shortcuts common in donor agendas, such as one-off workshop trainings, omission of clinical practice, low quality training of trainers approaches, and a lack of response to evaluation recommendations.

In 2004, a quality of care capacity-building strategy and three-year plan of action were developed for a consortium of donor partners to Maiti Nepal, including Save the Children United States, Save the Children Norway, ILO-IPEC, and The Asia Foundation.[31] The plan of action included a strategy, time frame, and budget for each of eight aspects of the proposed capacity-building.[32] This did not include a legal response, medical care provisions, or an HIV/AIDS response.[33] The eight subprojects were divided among the donor partners. These included:

1. Organizational system and staff development
2. Case management
3. Protection and participation
4. Psychosocial care
5. Social reintegration
6. Occupational development
7. Physical environment
8. Safe migration[34]

In 2005, Planète Enfants, in collaboration with Doctors of the World USA (DOWUSA), embarked on a comprehensive quality of care capacity-building activity with two local NGOs, ABC Nepal and Saathi, which operate care facilities and transit homes.[35] Following detailed assessments of the current facilities, a three-year phased strategy was developed, with DOWUSA providing capacity-building support for medical assistance and HIV/AIDS treatment, care, and support.[36] During this process, comprehensive guidelines for capacity-building according

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31. John Frederick, Plan of Action for the Capacity-Building of Maiti Nepal (2003) (internal document, on file with author).

32. *Id.*

33. *See id.*

34. *Id.*

35. John Frederick, Strategy, Timeframe and Human Resources for Capacity-Building: ABC Nepal and Saathi Caregiving Facilities (2005) (internal document, on file with author).

36. *Id.*

to minimum standards were developed.[37] Moreover, this strategy will be applied at a regional level. Terre des hommes Foundation, based in Lausanne, Switzerland, has recently initiated a programme to use the quality of care capacity-building strategy in a long-term project to enhance the caregiving capacity of Saanlap in Kolkata, India, which operates several facilities for trafficked and abused girls and women.

III. REINTEGRATION

Due to the absence of operations research, the success rate of reintegration of formerly trafficked persons in Nepal is unknown. Follow-up of supposedly reintegrated persons is almost entirely lacking, and almost all NGOs claim to have lost contact with most of their former residents after reintegration, while at the same time paradoxically claiming a high rate of success.[38] Some organizations, such as Saathi and Maiti Nepal, are realistic about the difficulties of reintegration and report that a high proportion of their residents return to the facilities and/or experience re-victimization at their reintegration destination.[39] Doubts as to the claims of successful reintegration come from local NGOs, primarily working with HIV/AIDS, who see numerous formerly rehabilitated persons among the local prostitutes of Kathmandu Valley and other parts of the country.[40]

As with care and support, conceptual clarity is lacking regarding the activities to be conducted for reintegration and the possible destinations of survivors. However, all caregiving NGOs are putting considerable effort into preparing survivors for reintegration, primarily through skills training.[41] Conceptually, reintegration activities are confused: preparing the survivor for reintegration is usually considered part of rehabilitation activities, and apart from skills training, the goals of self-sufficiency and self-protection upon reintegration are not addressed.[42] Moreover, postreintegration activities, that is care and support after the person leaves the facility, are not carefully considered and few actions are taken in this regard.

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37. JOHN FREDERICK, GUIDELINES FOR THE OPERATION OF CARE FACILITIES FOR VICTIMS OF TRAFFICKING AND VIOLENCE AGAINST GIRLS AND WOMEN: RATIONALE, BASIC PROCEDURES AND REQUIREMENTS FOR CAPACITY BUILDING (2005) (on file with author).

38. BEST PRACTICES, *supra* note 4, at 23-27.

39. Interview with Bishwo Khadka, Director, Maiti Nepal (Sept.-Oct. 2005); Interview with Pramada Shah, President, Saathi (Sept.-Oct. 2005).

40. *See* sources cited *supra* note 39.

41. BEST PRACTICES, *supra* note 4, at 23-27.

42. For one of the few examples of this, see *id.* at 29.

A. Preparation for Reintegration

Preparation for reintegration is almost entirely focused on providing income-generating skills. Because among donors and local NGOs there is no conceptual distinction between occupational therapy (conducting work activities as a healing measure) and occupational training, many girls and women are taught skills such as cloth painting and doll making that, while of therapeutic value, will not provide sufficient income.[43] Few organizations seek the opinions of survivors regarding what skills they would like to learn and what skills they perceive to be viable for generating income. Some organizations, like Maiti Nepal and Saathi, seek to place survivors in the few existing Nepalese local training institutions.[44] Some, like Maiti Nepal, have developed relationships with the private sector, placing survivors in work-experience situations in hotels and restaurants.[45] While both policies have shown some success, NGOs state that there are insufficient training and work-experience situations available to place the girls and women in their care.[46] On the other hand, the residents are frequently unmotivated to take outside training or to work. In many facilities, the girls and women spend much of their time idle.

At present, the imparting of what are termed life skills is limited to awareness activities on legal rights, gender, HIV/AIDS, health, and nutrition. Meanwhile, valid, essential skills such as assertiveness, communication, social presentation, protection against gender violence, values clarification, decision-making, and problem-solving are not provided, nor is the need recognized by most NGOs or donor partners. In its reintegration capacity-building activity with Maiti Nepal, The Asia Foundation recently addressed this lacuna by developing a comprehensive life skills curriculum that imparts these skills.[47]

As yet, NGOs do not provide intermediate living situations for survivors as a bridge between the institution and society. These would include small group homes, halfway houses, short- or long-term foster family care, or short-term trial stays at the planned destination. However,

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43. *See, e.g.*, *id.* at 39.

44. *See* Frederick & Subedi, *supra* note 23; John Frederick & Rachana Subedi, Planète Enfants, Assessment of Saathi Women's Shelter, Nepalgunj, Banke District (2005) (internal document, on file with author).

45. *See* Frederick & Subedi, *supra* note 23.

46. *See id.*; Frederick & Subedi, *supra* note 44; John Frederick & Rachana Subedi, Planète Enfants, The Assessment of ABC Nepal Central Facility, Kathmandu (2005) (internal document, on file with author).

47. John Frederick, Asia Found., Power Girls: Life Skills for Personal Strength and Social Confidence (2005) (unpublished document, on file with author).

the need is recognized among the NGOs. For instance, ABC Nepal and Maiti Nepal would like to establish small group homes and halfway houses.[48] In the fall of 2004, ILO-IPEC conducted a set of conceptual clarity workshops for intermediate living situation strategies. These workshops focused on reintegration practices, destination environments, and stigma and discrimination concerns.[49] It is hoped these will lead to better preparation for reintegration by NGOs.

B. Postreintegration Activities

Postreintegration activities are undeveloped in Nepal. While NGOs have clearly expressed the need for such an attempt to provide follow-up support to survivors after they have left the facilities, they are constrained by a lack of skills, manpower, and funding. Most NGOs do not recognize and/or do not have the capacity to prepare and support survivors who choose not to return to their families and communities, but desire other living situations, such as marriage, independent living, or returning to India.

Providing postreintegration care and support is problematic for trafficking survivors in Nepal for several reasons:

1. Many home/community destinations are in conflict zones and cannot be reached by outreach workers.
2. Many survivors cannot and do not wish to return to their original families and communities. Other reintegration options, including independent living and marriage, are difficult.
3. In Nepal (and South Asia generally), women's reintegration option of independent living (i.e., where a single woman or several women can rent rooms, take employment, and conduct an independent life) is proscribed according to cultural norms that require that women be under the protection of either male family members or husbands. Such women are often accused of being prostitutes and are subject to harassment from the community, as well as potential physical and sexual abuse from community members and police. In such a situation, existing stigma is compounded for trafficking returnees and PLWHA.
4. Most survivors do not wish to be contacted after reintegration because they wish to hide their past, due to stigma and discrimination in the family and community, and thus fear the presence of NGO workers enquiring after their well-being. This poses problems for treatment, care, and support of reintegrated PLWHA.

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48. Frederick & Subedi, *supra* note 23; Frederick & Subedi, *supra* note 46.

49. JOHN FREDERICK, ILO-IPEC, COMPASSIONATE CARE: DIRECTIONS IN COMMUNITY-BASED CARE AND SOCIAL REINTEGRATION FOR NEPAL (2006).

5. Conceptually and politically, NGOs perceive a limited range of reintegration destinations. Many NGOs adhere to a value that trafficking survivors must return to their families and communities, and do not recognize the wishes of survivors for marriage, independent living, or returning to India.

These constraints were examined in depth in conceptual clarity workshops conducted by ILO-IPEC in 2004.[50]

It is only recently that the tools and strategies for postreintegration work that were lacking have surfaced in Nepal. In 2005, the Asia Foundation, in its reintegration capacity-building activity with Maiti Nepal, developed an extensive set of tools and strategies for postreintegration, including comprehensive guidelines for reintegration practice, as well as tools and procedural guidelines for reintegration case management, family assessment, and the provision of social support.[51]

However, human resources and skills are needed to conduct postreintegration care and support. NGOs are severely constrained by the lack of personnel needed to travel in rural Nepal to provide care and support to reintegrated survivors. Some NGOs, like Saathi and ABC Nepal, have mobilized workers from other local NGOs to assist. Unfortunately, there is a pronounced lack of necessary basic social work skills to conduct outreach activities, particularly family interventions. However, as mentioned above, UNICEF is attempting to address this need through the development of a parasocial work training programme.[52]

Successful postreintegration activities have been conducted by one local NGO in Nepal, Nava Jyoti Kendra.[53] This NGO provides a six-month residential empowerment programme for abused and abandoned women, including war victims.[54] After the women return to their communities, Nava Jyoti Kendra outreach workers conduct cyclical visits to them over a six-month period.[55] The reintegration success rate for these women has been very high. Although Nava Jyoti Kendra has cared for trafficking survivors in the past, it has none in residence now.

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50. *See id.*

51. John Frederick, Asia Found., Principles and Guidelines for the Reintegration of Victims of Trafficking and Violence Against Women and Girls (2005) (internal document, on file with author).

52. U.N. Office for the Coordination of Humanitarian Affairs, *Nepal: Focus on Challenges of Rural Education*, http://www.irinnews.org/report.asp?ReportID=46855&SelectRegion=NEPAL (last visited Mar. 31, 2006).

53. BEST PRACTICES, *supra* note 4, at 26-27.

54. *Id.*

55. *Id.*

However, it remains a model of simple, practical, and successful postreintegration work.

IV. STIGMA AND DISCRIMINATION OF TRAFFICKED PERSONS

Although there are significant activities to address stigma and discrimination against PLWHA in Nepal, there are almost none that specifically address the stigma of trafficked persons. Primarily, activities to address the stigma and discrimination of trafficking survivors have been subsumed in activities that address the stigma of PLWHA.[56] These two sources of stigma are linked, as many trafficking returnees are HIV positive or are perceived to be HIV positive by family and community.[57] However, having been trafficked or having been a prostitute has its own causes of stigma, which are somewhat different from the stigma that is attached to PLWHA.[58] The returned traffickee is regarded as being a "fallen woman," a "whore," or an "impure person."[59] Families fear that trafficking returnees will shame the family, spoil their daughters, continue to conduct prostitution in the village, and ruin the family's opportunity to arrange good marriages for their other children.[60]

In Nepal, the trafficked persons' organization, Shakti Samuha, directly addresses the stigma of trafficked persons, treating stigma reduction for PLWHA as a separate, although related, issue.[61] Maiti Nepal professes to address stigma reduction in its activities to prepare communities for returnees' reintegration, however, these are linked with strong antitrafficking messages, which instead may possibly increase stigma against returnees.[62] The Women's Rehabilitation Centre (WOREC) conducts the most planned and effective activities to raise awareness and reduce stigma on trafficking and HIV/AIDS.[63] However, in its documentation and its activities, the two are routinely linked, which as mentioned above, can be counterproductive. It thus remains incumbent upon Nepal to develop discrete stigma-reduction activities for

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56. VAISHALI SHARMA MAHENDRA ET AL., COMMUNITY PERCEPTIONS OF TRAFFICKING AND ITS DETERMINANTS IN NEPAL 2 (2001), *available at* http://www.asiafoundation.org/pdf/nepal_traffickingperceptios.pdf.

57. *Id.*

58. *Id.*

59. *Id.* at 43-45.

60. *Id.*

61. *See* Shakti Samuha, *Shakti Samuha in Brief*, http://www.shaktisamuha.org/about/introduction.htm (last visited Mar. 31, 2006).

62. *See* BEST PRACTICES, *supra* note 4, at 24.

63. *See* WOREC, *About Us*, http://www.worecnepal.org/about_worec.html (last visited Mar. 31, 2006).

trafficking by addressing the somewhat different causal factors for stigma and discrimination.

V. MONITORING AND EVALUATION

Generally, antitrafficking activities, including care and support, are neither monitored nor evaluated. A recent study in Nepal examined the planning, strategizing, monitoring, and evaluating activities of twenty-one NGOs directly or indirectly conducting antitrafficking activities.[64] It was found that seventy percent had developed no strategy for programme implementation, eighty-three percent had developed no indicators for monitoring and evaluation, and seventy-two percent did not assess the programme after completion.[65]

This lack reflects upon the donor partners as much as the implementing NGOs. While there have been good generalized analyses of programming, almost no operations research on programme effectiveness has been conducted. At the implementation level, NGO staff is generally untrained in monitoring and evaluation, not funded for sufficient time and effort to conduct monitoring and evaluation, and are not cognizant of the vital importance of the process. Also, as in many development activities, there is a tendency for NGOs to prematurely report success to their donor partner, and for donor partners to then report success to their home offices. This has resulted not only in ineffective programming, but many years of repeated mistakes and reinventing the wheel.

VI. CONCLUSION

It is easy to identify the present misconceptions, mistakes, and lacunae in Nepal's antitrafficking interventions regarding the care, support, and reintegration of trafficking survivors. However, it is notable that many of Nepal's donors, as well as its leading caregiving NGOs, are aware of the challenges to be faced in the coming years. Capacity-building of local organizations toward quality care is a long and arduous process requiring considerable funding, professional expertise, and transparency among both NGOs and donor partners. Notably, at present there is a movement in Nepal to develop psychosocial care systems according to standards and practices used to develop medical care systems, *viz* the quality of care capacity-building concept. This, with the

64. *See* INST. FOR INTEGRATED STUDIES & U.N. DEV. FUND FOR WOMEN, NEPAL FIELD OFFICE, STATUS AND DIMENSIONS OF TRAFFICKING WITHIN NEPALESE CONTEXT 42 (2004).

65. *Id.*

development of national and regional minimum standards, can, in time, lead to NGOs that are able to successfully provide care, support, and reintegration for trafficking victims according to international standards of quality care.