Borderland Crisis- A Study of the socio economic conditions of women around the border regions of India

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ABSTRACT:

The present state system in South Asia, in particular the state system of the sub-continent, is a result largely of the partitions in the eastern and western parts of the erstwhile united India, giving birth to three states – India, Pakistan, and Bangladesh. The borders dividing these countries are markers of past bitter history, current separate, distinct, and independent existence, and the sign of the territorial integrity of these states. The bitterness of the past, the lack of mutual confidence at present, the security concerns of all these states, at the same time the existence of thousand and one linkages make the South Asian borders unique. They are the lines of hatred, disunity, informal connections and voluminous informal trade, securitised and militarized lines, heavy para-military presence, communal discord, humanitarian crisis, human rights abuses, and enormous suspicion, yet informal cooperation.

Borders become the site where this contest over inclusion and exclusion is played out. They demarcate the inside from the outside, sovereignty from anarchy and. the singular from pluralistic space. They construct what Nira Yuval-Davis has termed "the space of agency, the mode of participation in which we act as citizens in the multilayered polities to which we belong." Hence borders are not merely lines. They are zones that situate the gray areas where the jurisdiction of one state ends and the other begins. They are the common ground of two or more states that share them and also interpret its meanings in very different ways to its citizens in their national narratives, history writing and collective spatialized memories. Security concerns overwhelm all other equally legitimate concerns and values. Military security dominates over human security in the border region. In the case of South Asia, these borders, or more precisely borderlands, are also peopled by groups that have linkages to both sides of the borders. Yet in their efforts to emphasize the national identity, state sovereignty demands a severance of those linkages that "encourages difference" leading to a conscious exclusion of the recalcitrant from privileges. As a result of this, States often forget that borders are not only lines to be guarded, they are also lines of humanitarian management, because borders are not lines but borderlands – that is to say these are areas where people live, pursue economic activities, and lead civilian lives attuned to the realities of the borders. Human security in the borderlands would mean first security of the civilian population along the borderlines.

This project concerns itself with women living in these borderlands that Edward Said calls "the perilous territory of not-belonging," and discusses how they negotiate their differences with a state, albeit democratic, which denies space to difference based on either ethnicity or gender. Women living in the borders are the subject of this project not merely because they belong to these perilous territories or the borders but also form them. According to Yuval-Davis the universalistic nature of citizenship that emanates from traditional liberal and social democratic

discourses is extremely deceptive as it conceals the exclusion of women from national identities of citizenship. Thus the ideological constructions of the state are weighted against women who remain in the borders of democracy. Yet in moments of conflict at times they assume centrality. This is because in areas of civil conflict men withdraw from civic life for compulsions of war and self-defense. In such a situation the public sphere retreats into the private and women form the civil societies. They assume roles that are completely new to them and confront and negotiate with the massive power of the state machinery in their everyday lives. Further, as transmitters of cultural value women construct differences that shape the future of the nation and the border.

But in fact most of our traditional efforts to make geopolitical regions more secure are nothing but attempts to privilege a masculine definition of security that result in only feminine insecurities. Yet in addressing questions of security the insecurities of women always remain in the back of beyond. The political class talks about ISI, insurgency, terrorism, and never talks about how trafficking or its linkages with statelessness and HIV/AIDS. Little does it realize that the threat posed by AIDS is much more than the one posed by "terrorism". And, herein lies the fallacy in most policy decisions. When AIDS becomes an epidemic migrant prostitutes are punished without any recognition that they are as much a victim of the system. It is the system that needs to be restructured with gender just vision.

Keywords

Cross-border ties, Social ties, Internal migration, India, Reproductive health, Health, Family planning, Institutional delivery

INTRODUCTION:

Borderlands are conflict-prone landscapes rife with tensions, and the international borders of Rajasthan remarkably exhibit the geopolitical impact of the Redcliff line due to the Indo-Pak border as one of the most strategically militarised borders, having four borderland districts of Ganganagar, Bikaner, Jaisalmer and Barmer. The borderland of Rajasthan has the largest geographical area with 342,239 sq. km and contributes 10.41 % of the complete scope of India.

The educational status of these districts has a substantial impact on the measures of health equity as the literacy rate differs across these four regions (Ganganagar is 69.64 %, Bikaner is 65.13 %, Jaisalmer is 57.22 %, and Barmer is 56 %). Health equity identifies distinctions in health care across structural parameters1 with economic status.2 While Jaisalmer is the largest district by area (38,401 sq. km), it is the smallest by population.

Women in border areas, where everyday negotiations are already challenging, possess less power to exercise their agency and are less equipped for the problematic state of affairs. Unequal power relations pose a threat to the existing functioning of the health system, making marginalised women's health conditions quite apparent.3,4 Abundant studies state this gap produces low self-esteem in women, and negative stress is persuaded by refusal to accept one's potential to do something for their health, leading towards discouragement of women, especially in borderland areas. These concealed insight privilege men and act as negative

reinforcements toward women.5 Gender-blind sexism is influenced by Silva's6 colour-blind racism, which assisted in assessing the racially based discrimination observed in American society but does not align with overt racism.

Total fertility rate (TFR) in Assam, Rajasthan and Uttar Pradesh is visibly higher, falling roughly between replacement level fertility of 2.3 and 2.7. TFR levels correlate with poverty, gender inequality and a high maternal death rate. Women in borderland areas need help availing health services due to low literacy levels, economic status and less awareness. Gender proactively furthers the health inequities in conflicting areas.7 Health inequities focus on the fluctuating nature of government interventions across distinct geographical locations.8 The most vulnerable part of this population remains women and children who are deprived even of access to the most basic sustenance needs, justifying the need for the present study to explore the objectives.

The objectives are to examine the role of communication education and practice by healthcare professionals in advancing the effective delivery of healthcare services at service points (Community Health Centers (CHCs), Primary Health Centers [PHCs] and Sub-Centers (Scs)). It also aims to analyse the challenges faced by healthcare workers, especially for vulnerable, viz. women populations, and to comprehend the gap between policy and praxis of access from the perspective of marginalised domains.

ANALYSIS OF THE STUDY:

Recent literature suggests the importance of cross-border ties on health and well-being (Acevedo-Garcia, Sanchez-Vaznaugh, Viruell-Fuentes, & Almeida, 2012), and that there is growing recognition that migrants are affected by both cultures at the destination and ties to sending communities (Olwig, 2006). Cross-border ties have been defined as the process of maintaining relationships across borders through various means (Mouw, Chavez, Edelblute, & Verdery, 2014). The impact of cross-border ties and health is mixed, suggesting that it may have both protective and adverse health effects for migrants (Torres, 2013). It can provide a type of social protection across borders that may have an effect on the health behaviors of migrants (Faist, Bilecen, Barglowski, & Sienkiewicz, 2015), including how healthcare services are accessed, where migrants seek health-related advice, and how they obtain medication (Heyman et al., 2009, Menjivar, 2006, Wang and Kwak, 2015). One study of Korean immigrants to Canada found that migrants often return to their hometowns for health examinations, import their medications, and seek advice from people back home by phone or online platforms (Wang & Kwak, 2015). Therefore, ties to hometowns take on many forms with potentially wide-ranging consequences and effects.

Cross-border ties have been conceptualized primarily from the sociological literature in the context of international migration, with the concept of "border" pertaining to a nation-state boundary (Waldinger, 2015, Waldinger, 2013); however, there have been recent calls to better understand how international migration concepts, including cross-border ties, can translate to within-country migration streams (Ellis, 2012, King and Skeldon, 2010). In India, for example, rural-to-urban migrants frequently visited and sent remittances to their hometowns, with

approximately 75% and 67% of participants, respectively, participating in these activities (Banerjee, 1981). Therefore, social ties to hometowns and remittance sending is also relevant for internal migrants, yet there is little known about how these activities may influence health. In fact, the majority of migrants globally move within national borders. According to a report from the United Nations, 740 million of the world's migrants were internal while 214 million crossed international borders (UNDP, 2009). Cross-border ties in the context of internal migration are especially of interest in India, where nearly 30% (309 million) of the nation's population is made up of internal migrants (Faetanini & Tankha, 2013). Researchers encouraging integration of international and internal migration concepts and approaches suggest that migration is a process that should not be confined to national borders (King & Skeldon, 2010). In the internal migration context, therefore, cross-border ties may refer to social ties with hometowns that cross geographic boundaries such as block-levels, villages or sub-districts, districts, and states in India. The objective of this study is to understand how cross-border social ties influence internal migrant behaviors with respect to two reproductive health outcomes.

Cross-border social ties and the influence on internal migration: the role of social ties to hometowns and utilization of reproductive health services

Theories on how social ties may influence health suggest two potential mechanisms: social support and social influence, including peer pressure and social norms (Berkman, Glass, Brissette, & Seeman, 2000). It is known that social ties, social norms, and social support are important determinants of sexual behaviors and reproductive decision-making. According to social norms theory, perceptions of peer behaviors have an effect on the individual's own behavior (Maxwell, 2002; Unger & Molina, 1998). Adolescents are more likely to initiate sex if their friends have had sex (Sieving, Eisenberg, Pettingell, & Skay, 2006), or even if they perceive that their friends have initiated sex (Kinsman et al., 1998, Whitaker and Miller, 2000). This relationship is also true of online social networks with peers (Young & Jordan, 2013). Social support, including emotional (i.e., care and support), informational (i.e., advice), and instrumental support (i.e., money, aid) is protective of adolescent risk behaviors (Ennett et al., 1999, Mazzaferro et al., 2006, McNeely and Falci, 2004). One critical gap in the social ties literature is the lack of attention on the ties that migrants continue to maintain in their hometowns, referred to in this paper as cross-border social ties. Social support and social norms potentially mediate the social ties to hometowns and health outcomes.

First, there is evidence that while social networks in destination communities provide instrumental support, cross-border social ties in hometown communities are often critical in offering emotional support and maintaining a sense of belonging (Viruell-Fuentes & Schulz, 2009). A study in New York found that Caribbean migrants who traveled back to sending communities reported higher levels of social support, while other studies find that perceived social support may reduce adverse physical and psychological health outcomes (Kawachi and Berkman, 2001, Murphy and Mahalingam, 2004). While studies have identified a possible benefit of cross-border social ties on migrant health overall, there remains a limited literature on how such ties might benefit specific health outcomes that are most relevant to women

including sexual, reproductive, and maternal health outcomes. The few studies that exist are mixed in terms of how social ties to hometown may impact migrant women during and after pregnancy. For example, one study found that Pakistani women in the United States experienced difficulties during pregnancy and birth due to their lack of kin support in destination communities. Some women reported maintaining transnational ties with family in Pakistan which resulted in emotional support and guidance during pregnancy and postpartum (Qureshi & Pacquiao, 2013). On the other hand, a study of migrant women and mammogram service uptake in Denmark found that women felt too busy working to provide financial assistance for family in sending communities and consequently did not seek preventative services for themselves (Kessing, Norredam, Kvernrod, Mygind, & Kristiansen, 2013). This led to greater morbidity among migrant women with strong cross-border ties. In India, extended family, friends, and neighbors play a significant part in care during and after childbirth (Choudry, 1997a). Therefore, cross-border social ties could be particularly important for reproductive decision-making.

Second, social ties to family and peers in hometowns may serve as an alternative source of influence for sexual attitudes and norms. Leading researchers suggest that cross-border social ties and communication between migrants and sending communities can lead to sharing of ideas and information (Faist, Fauser, & Reisenauer, 2013), ultimately shaping attitudes and behaviors of migrants.

Past studies have found that migrants are influenced by exposure to hometown and destination sexual ideologies, and this results in transformations of sexual identities and behaviors after migration (Carrillo, 2004). More research is needed, however, on how social support and social norms from hometowns may influence reproductive health among migrant women.

Systematic reviews have identified various spheres of life where cross-border ties may make an impact; including familial, socio-cultural, economic, and political experiences and ideals (Faist et al., 2015). In the internal migration context, past studies suggest that the sexual attitudes and norms of hometowns may influence reproductive decision-making (Sudhinaraset, Mmari, Go, & Blum, 2012). Cross-border social ties to hometowns may include physically returning to one's sending community and remitting money. Contemporary migrants maintain such ties to their sending communities through various forms of communication including making phone calls and online communication (Faist et al., 2015, Torres, 2013). Researchers argue that these indicators may not impact a migrant to the same degree across his or her whole life but may differ by time since migration (Amelina and Faist, 2012, Faist et al., 2015). Furthermore, migrants cannot be simply labeled as having cross-border ties or not. Instead, these ties have been identified as existing on a continuum, where migrants vary in the degree to which they are connected to their sending communities and how these ties impact them (Amelina & Faist, 2012). How social ties to hometowns influence family planning and institutional deliveries have not been explored.

Current sexual, reproductive, and maternal health of internal migrant women in India

Sexual and reproductive health behaviors, particularly family planning use and institutional deliveries, are an area of concern for migrant women who generally lack access to contraception, sexually-transmitted disease information, and related health education and treatment services (Usher, 2005). Past studies have found disparities in reproductive health practices among migrants and non-migrants. For example, a study in Delhi based in an urban hospital that primarily served internal migrants found that only 52% of migrant women were using some form of contraception (Kumar et al., 2011). This percentage was found to be more comparable to rural levels of contraception use (48%) than of the non-migrant, urban population (81%) suggesting a low contraception use trend among migrant women (Kumar et al., 2011, Takkar et al., 2005). Potential mechanisms for these differences include the lower educational attainment of migrant women, adherence to traditional health practices, and challenges with accessing services and health information associated with the migrant experience (Borhade, 2011, Kumar et al., 2011, Stephenson and Matthews, 2004).

Furthermore, studies have reported lower levels of maternal healthcare utilization by internal migrants compared to non-migrants, putting migrants at risk for worse maternal health outcomes (Shaokang, Zhenwei, & Blas, 2002). Stephenson and Matthews suggest migrant women are less likely to use maternal healthcare services if they lack social networks and found that only 20% of migrant women have an institutional delivery as opposed to 60% of non-migrants in the same urban setting (Stephenson & Matthews, 2004). Studies have found that the urban poor are subject to higher rates of birth abnormalities and delivery complications, including the proportion of low weight births (27% vs. 18% among non-slum women), although data differentiating between migrant and non-migrant slum women are lacking (Borhade, 2011, Kapadia-Kundu and Kanitkar, 2002). Adverse maternal health outcomes are further complicated by the phenomenon of pregnant migrant women returning to their sending communities to deliver or opting for slum-home births that use untrained midwives despite the availability of delivery services in the urban centers they are living in (Borhade, 2011, Choudry, 1997b).

Programs and policies exist in India to protect the health of migrants although they have their limitations. Government supported Anganwadis are childcare centers that provide maternal health services for India's poor women and children. State-facilitated Jeevan Madhur Yojana programs provide micro health insurance coverage where government systems and migrants split premium costs to cover basic healthcare needs (Borhade, 2011). Despite available programs, migrant women may have trouble accessing services due to restrictions in the mobility of programs and gaps in outreach (Borhade, 2011). Studies have shown migrant women to be less knowledgeable about how to access services, how to obtain health insurance, and what services are available to them. Additionally, they may receive lower quality care due to language barriers, isolation, and stigma related to their migration status (Borhade, 2011, Derose et al., 2007).

Societal complications are coupled with the fact that most migrant women face health challenges without the familial ties and social support of their sending communities (Borhade, 2011, p. 216). Studies have suggested the loss of protective socio-cultural factors may contribute to the deterioration of health status for migrants (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000). The existing health trends of India's migrant women are a result of the environmental and interpersonal conditions that these women inevitably face. India's urban slums are heavily populated by migrants who experience hazardous sanitary conditions and societal isolation resulting in poorer health outcomes overall (Borhade, 2011, Mahajan and Sharma, 2014, Yadav et al., 2011). Cross-border ties of migrants to their sending communities may affect protective socio-cultural factors to some degree and exploring this aspect of the migrant experience may be critical to better understand the reproductive and maternal health outcomes of India's internal migrant women.

In this respect it is important to note that women face specific forms of marginalisation in border areas. This include:

1.   Harassment by the security personnel including sexual abuse and killings.

2.   The border security forces on both sides engage in forcible push-backs – extreme harsh methods of deportation resulting in loss of limbs, lives, money, and dignity.

3.   The daily economic activities of many women such as fisherwomen fishing in river-borders are hampered greatly resulting in sustained distress

4.   Long and undue detention at jails and sub-jails when these women are caught while crossing a border.

5.   Rampant sexual abuses

6.   Undue harassment of immigrant women on the suspicion of either being terrorists or harbouring terrorists.

7.   Harassment of women marked as having loose sexual morals and thereby endangering people through sexually seducing them.

8.   Undue harassment of immigrant women as harbingers of AIDS

9.   Harassment of women living in border enclaves

10. Harassment of women belonging to matri-lineal tribes who are seen as susceptible to entanglement with immigrant men.

11. Women are deprived of ownership of resources such as land.

12. Effects of communalization of women in the borders

Women belonging to both settled, immigrant communities, and those living in the enclaves face many of these marginalisations. Such marginalisations affect women in areas such as

Northeast India, Kashmir, Rajasthan and many other regions as India has over 17 border states. Yet no study till date has been conducted keeping this particular problematic in mind and so such a research work will not just fill a gap in the existing literature on governance but it will also have definite policy implications as well.

n marking International Women's Day today, we have the opportunity to celebrate achievements made towards gender equality and we're obliged to take stock of areas where further progress is still necessary.

Although half of all people on the move globally are women, border management is a field still dominated by men at both the operational and managerial levels. [1] In many countries, the duties of a border guard are considered a man's job; women and people of diverse gender identities and/or expressions may feel discouraged from applying to work at border agencies and men are often favoured for leadership positions. Without diverse views and considerations, border management does not meet the needs of people of all gender groups.

Migration is a gendered process. From the motives for migrating, safety along the way and the use of transnational migration networks, to the opportunities available at destination, gender affects every step of the migration journey. Taking migrants' lived identities as a primary consideration, gender mainstreaming is a strategy that the International Organization for Migration (IOM) uses to assess the gendered implications of all planned actions, including policies, programming, and legislation. IOM is committed to promote gender-sensitive and human rights-based approaches for migration management to ensure gender equality and diversity inclusion in the design, decision-making and implementation of policies and programmes in all spheres, and at all stages of migration governance. IOM aims to contribute to gender equality and reach migrants of all groups to make sure that existing inequality is not perpetuated.

But what does this mean in practice?

Over the last few years, gender mainstreaming has been increasingly applied in Immigration and Border Management (IBM) projects at IOM. In 2021, 65.6% of new IBM projects had a gender component, in contrast to only 9% in 2017. Within this initially limited number of projects, many only featured women as vulnerable migrant groups or cooperated with women's organizations as implementing partners. As gender mainstreaming has become more prevalent, it has also become more comprehensive. For example, many of IOM's new projects develop staff capacities for conducting gender analysis, include gender-responsive budgeting, integrate gender in monitoring and evaluation, support policies to address gender-based discrimination and harassment, and improve gender- and age-disaggregated data collection.

Women's specific needs when crossing borders cannot be marginalized when, globally, on average, migrants are 48% female [2]. This proportion is notably higher, at 52%, [3] in the South-Eastern Europe, Eastern Europe, and Central Asia (SEEECA) region, and IOM is actively working with these countries' border services to better integrate gender perspectives in their everyday work

A comprehensive training course on Gender Mainstreaming in Border Management was conducted through two online sessions last year, with the aim of enhancing the capacity of IOM staff who work in IBM in the SEEECA region and giving them the tools to promote gender mainstreaming in projects and among partners and beneficiaries. Today, IOM would like to highlight the work of some of these colleagues and the feedback that they've received from beneficiaries.

Gender-responsive training has been an important component of an ongoing project aiming to improve border security at selected Turkish airports. This project demonstrates how gender issues need to be emphasized in diverse capacity building activities. As one of the main roles of customs officials is to analyse travellers for possible safety risks, using a gender-sensitive lens in passenger control procedures can demonstrate gaps in the risk assessments

performed during customs checks. Furthermore, including gender in training programmes for border security staff can ensure that gender-based discrimination is averted at all levels.

In North Macedonia another project from the IBM portfolio, which includes migrant protection and assistance activities at Temporary Transit Centres for migrants, as well as humanitarian border management capacity building for the national border police, has entered its third phase. By building on a foundation of responsiveness to the needs of migrants in vulnerable positions, the focus of this project has extended beyond introducing gender mainstreaming, to applying it in more consistent and systematic ways.

For example, one workshop conducted with the participation of border police officials on the identification and referral mechanism of migrants in vulnerable situations, including trafficking in human beings, dedicated particular attention to the gender and human rights approach. A human rights law professor and former police academy educator spoke about the nexus between migrant protection, gender, and human rights in a legal context, complemented by her operational experience and concrete examples relevant to border police duties.

As British academic Cynthia Cockburn once observed, "Gender has a curious way of being both simultaneously present and absent in popular perception." (Cockburn 2004)

Women's access to fundamental rights are frequently left out of the political discussions, actions and networks that run through conflict zones. A gendered lens must be used to analyse conflict because of the complicated challenges and cascading repercussions that occur before, during, and after the war and the substantial impact it has on women's lives. The war zone presents a socio-political discourse that is still underdeveloped both in India, as well as internationally.

This should especially be examined in light of the fact that "Civil conflicts have more than doubled over the last two decades, rising from 30 in 2001 to 70 in 2016." These grim numbers serve as a reminder to the never-ending conflicts that have pervaded human history. They prompt us to reconsider how we approach the political and social terrain of conflict zones and to reflect on the challenging path to achieving justice for women.

Sexual violence as a tactic of war

Wartime sexual violence is not just committed by some individuals, but rather it is often deployed as a tool to further political/military gains, to prove a point. This becomes especially challenging in the absence of justice delivery mechanisms and the lack of criminal infrastructure. To that extent, rape has also been normalised as an inevitable outcome of war. In a similar vein, Bharat H Desai and Balraj K Sidhu observed in their 2017 article in EPW, 'Sexual Violence in Conflict Zones: A Challenge for International Law?':

 The struggle to ensure justice for women victims of sexual and gender-based violence (SGBV) is aggravated by pre-existing exclusions and discrimination that typifies women's status in many societies. It, in turn, has a compounding effect in exacerbating gender vulnerability in war-torn societies.

Ann Tickner, who has dedicated her life's work in providing for a feminist theory to be integrated into the realm of international relations, underscores the prevalent biases in the masculinised, realist version of security studies. She has argued that "Adding women's experiences to the subject matter of our investigations is not enough: feminist perspectives must also expose previously hidden gender relations in order to demonstrate how gender inequalities can themselves be a source." (Tickner 1995)

Security Concerns

Everyone's experience of war is different. Structural violence only brings to light the insecurity of individuals trying to survive in conflict zones. Sapna K Sangra in her 2018 EPW Perspective piece titled 'Transcending Ethnic Differences: Feminist Perspectives from Jammu and Kashmir' sheds light on the experiences of middle-aged women in the Kashmir conflicts, for whom, security concerns overshadow even the economic concerns.

As recurrent migrations, persistent living in inhumane conditions under the constant glare of strangers, with no space for privacy, along with the highly militarised borders, have made them vulnerable, especially to sexual threats. Due to the fencing and the presence of the BSF, their space has been curtailed. They do not have open access to their fields and often feel suffocated within the boundaries of their houses.

Women's bodies are seen as "instruments of war" in such zones, and as the article points out, violence is directed towards women in various forms. Women's physical, mental as well as emotional well-being is at stake; they are often displaced from their land, defrauded, widowed, and left to live as refugees.

Women as peacebuilders

As conflicts and consequent humanitarian crises continue to wreak havoc on communities and impede communities general prosperity and well-being. Women disproportionately bear the brunt of war, yet are given little opportunity to emerge as equal stakeholders in post conflict rebuilding of states. They end up paying the larger price for the destruction; which includes

rising gender-based violence and discrimination as well as a decline in gender-sensitive structures.

Rita Manchanda in her 2005 article 'Women's Agency in Peace Building' observed that there is a lack of attention to the post-conflict experience of "peace" that in turn produces greater impoverishment of women.

Dominant reconstruction models involve downsizing government and privileging private sector as the engine of growth. Women are the first to be laid off in wage employment in the public sector. The feminisation of the informal sector is a phenomenon of post-conflict societies. Moreover, structural adjustment programmes reduce the availability of public resources for food security, health and education.

On similar lines, G Amarjit Sharma in 'Politics of the Informal: Women's Associational Life and Public Space in the Hills of Manipur' explains how women foster positive change in ethnic conflict-afflicted contexts-

Women volunteers went from house to house, collecting rice, pulses, clothes, blankets, and charcoal or firewood for cooking. The volunteers aimed to resettle the displaced and empower them to restart their normal lives by working in cultivation, as vegetable vendors, or daily wage earners.

These examples serve to remind one of how critical it is to increase women's bargaining power in these spaces.

International Law

Uneven international justice delivery mechanisms persistently fall short of providing swift justice for sexual offences in war zones. Mark Skelden in his 2001 EPW Commentary, 'On Asian Wars, Reparations, Reconciliation' narrates how 'The Women's International War Crimes Tribunal on Japan's Military Sexual Slavery' offers a distinct perspective on handling of war zones.

The Tokyo Tribunal presented the salient facts of violence against women in war as a basis for establishing individual criminal culpability and state responsibility to press the Japanese government to issue an unequivocal official apology and provide restitution to the victims for that nation's war with Asia.

Moving beyond binaries

In conflict zones, the home-outside binary, or the private-public is often erased in practice as violence enters people's lives and personal spaces, diluting any distinction between combatants and non-combatants. Samreen Mushtaq in her 2018 article, 'Home as the Frontier Gendered Constructs of Militarised Violence in Kashmir' elucidates why "[w]omen cannot simply be placed between the binaries of "victims of violence" and "agents of peace." Even when seen as survivors, witnesses or frontliners resisting militarised violence in the everyday, the analysis

must not fall prey to romanticising a notion of resistance that invisibilises the violence, despair, and resilience of women's lives in conflicts."

CONCUSION:

By fostering dialogue on the topic of gender mainstreaming within border management, both examples provided IOM the opportunity to hear directly from border officials about the specific issues which affect them.

Border police officials in North Macedonia particularly noted the importance of cultural differences intersecting with gender, which further compound pre-existing vulnerabilities. They expressed their interest in cultural mediation tools and greater knowledge-sharing on cultural differences in order to better asses, and respond, to migrants' needs in a more timely and effective manner.

Similarly, in Turkey, explicitly including gender considerations during trainings gave border staff of all genders a platform to discuss their concerns. For instance, the lack of women's bathrooms at certain border checkpoints for both staff and migrants was an issue that was raised and addressed for the first time.

Through initiatives such as these, IOM is making quantifiable progress in its goal of addressing gender inequality for migrants and professionals working in the field of migration, by being committed to the promotion of gender mainstreaming and learning from beneficiaries at all levels.

The diverse set of perspectives presented here are intended to emphasise the adoption of a contextual approach to problem-solving in conflict zones instead of adopting homogenous strategies that exclude women. Advancing their meaningful political inclusion in war-ridden spheres is critical to both fulfilment of human rights and post-war recovery.

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