

**Baseline Family Planning Survey  
Including Rapid Assessment of HIV, Sexually  
Transmitted Infections and FP Situation among  
Migrant Couples in Bara, Kapilbastu, Nawalparasi and  
Palpa Districts**

**Volume I  
A Qualitative Report**

**April 2013**

Published by:

***Saath-Saath Project***

GPO 8033

Baluwatar, Kathmandu-4,

Nepal

Research partner:



**New ERA**

P.O. Box 722

RudramatiMarga, KaloPul

Kathmandu, Nepal

© FHI 360 Nepal/Saath-Saath Project

FHI 360 Nepal

USAID Cooperative Agreement # AID-367-A-11-00005

USAID/Nepal Country Assistance Objective Intermediate

Result 1 & 4

The views expressed in this publication do not necessarily  
reflect the views of the United States Agency for International Development  
or FHI 360

## ACKNOWLEDGEMENTS

The New ERA study team is grateful to Saath Saath Project (SSP) for entrusting it with the task of undertaking this important study. We would like to gratefully acknowledge Dr. Krishna Kumar Rai, Director of National Centre for AIDS and STD Control (NCASC), Dr. Senendra Raj Upreti, Director of Family Health Division (FHD), Mr. Satish Raj Pandey, Chief of Party-SSP, Nepal for their valuable guidance. We are indebted to Dr. Bhanu Bhakta Niraula, Deputy Chief of Party-SSP, Dr. Pramod Raj Regmi, Senior Surveillance and Research Specialist- SSP, Dr. Sampurna Kakchupati, Surveillance and Research Specialist-SSP for their technical inputs and guidance throughout the study.

The study team likes to specially extend gratitude to Ms. Tsering Pema Lama, Former Surveillance and Research Specialist-SSP for her inputs during the initial phase of the study. We also acknowledge technical inputs received from Dr. Rajendra Gurung, Senior Technical Specialist, Jhpiego, Ms. Shanta M. Gurung, Program Coordinator, HIV and AIDS, USAID and Ms. Stephanie Suhowatsky, Program Manager, Jhpiego.

Furthermore, the study team would like to thank SSP Implementing Agencies, Indreni Samaj Kendra (ISK) - Palpa, Sahavagi- Nawalparasi, NAMUNA- Kapilbastu, Lumbini Plus - Nawalparasi, and GWP- Bara for providing necessary assistance and guidance to the study team members.

Special thanks go to the survey respondents, who were critical to the successful completion of the survey. The survey was made possible through the support we received from the district and VDC based health/non-health professionals and other stakeholders. We would like to extend our sincere gratitude to all of them for the kind support they have extended to us.

The effort put up by each and every member of the field team, coders and data analysts have all contributed to the final shape of this report. We sincerely acknowledge their contribution.

~ New ERA Study Team

## TABLE OF CONTENTS

<b>ACKNOWLEDGEMENTS .....</b>	<b>i</b>
<b>TABLE OF CONTENTS .....</b>	<b>ii</b>
<b>LIST OF TABLES .....</b>	<b>iv</b>
<b>ABBREVIATIONS .....</b>	<b>v</b>
<b>EXECUTIVE SUMMARY .....</b>	<b>vi</b>
<b>1.0 INTRODUCTION.....</b>	<b>1</b>
1.1 Background and Context.....	1
1.2 Objectives of Qualitative Study .....	12
<b>2.0 STUDY DESIGN AND METHODOLOGY .....</b>	<b>13</b>
2.1 Implementation of the Study.....	13
2.2 Study Design.....	13
2.3 Research Ethics.....	14
2.4 Sample.....	15
2.5 Survey Tools/Instruments .....	15
2.6 Survey Personnel .....	15
2.7 Pre-testing of the Instruments .....	15
2.8 Recruitment and Training of Study Teams .....	16
2.9 Data Collection Method.....	16
2.10 Data Management and Analysis.....	16
2.11 Organization of the Report.....	17
<b>CHAPTER 3.0: BACKGROUND CHARACTERISTICS OF PARTICIPANTS.....</b>	<b>18</b>
3.1 Key Informant Interview Participants.....	18
3.2 Characteristics of the FGD Participants.....	18
<b>CHAPTER 4.0: MALE MIGRATION AND ITS IMPLICATIONS ON THEIR FEMALE COUNTERPARTS .....</b>	<b>20</b>
4.1 Migration Pattern among Male Migrants.....	20
4.2 Communication between Migrant Husband and Wife at Home .....	21
<b>CHAPTER 5.0: HEALTH SITUATION AMONG MLMS AND THEIR FEMALE COUNTERPARTS .....</b>	<b>22</b>
5.1 Health Issues among MLMs .....	22
5.2 Treatment upon Return .....	22
5.3 Sexual and Reproductive Health (SRH) Problems and Treatment Practices among Female Counterparts.....	23

<b>CHAPTER 6.0: FP SITUATION AMONGMIGRANT COUPLES.....</b>	<b>24</b>
6.1 Use of Modern FP Methods .....	24
6.2 Differences in FP Use between Migrant and Non-migrant Couples.....	24
6.3 FP Preparedness Before or When Male Migrants Return Home .....	26
6.5 Sources of FP Services.....	26
6.7 High Priority FP Service Related Needs.....	26
6.8 Unwanted Pregnancy among Migrant Couples.....	27
6.9 Acceptance of Long-term FP Methods .....	27
6.10 Problems Faced by Migrant Couples in Accessing FP Services.....	28
6.11 Key Changes Suggested in Service Providing Modality .....	28
6.12 FP Programs Implementation and Suggestions for Further Promotion .....	29
<b>CHAPTER 7.0: HIV AND STI SITUATION AMONG MIGRANT COUPLES .....</b>	<b>36</b>
7.1 Knowledge of HIV/STI and Sources of Information.....	36
7.2 Current Situation of HIV and STI.....	37
7.3 Perception on Most at Risk Population.....	37
7.4 Prevention and Treatment .....	38
7.5 HIV and STI Services Available in the Community.....	39
7.6 Barriers to Access HIV and STI Services and Challenges Faced by Service Providers.....	40
7.7 Suggestions on Improving HIV/STI Services.....	41
<b>CHAPTER 8.0: CONCLUSION/RECOMMENDATION.....</b>	<b>42</b>
<b>REFERENCES.....</b>	<b>46</b>
<b>ANNEXES.....</b>	<b>49</b>

## LIST OF TABLES

Table 3.1: Profile of Key Informants .....	18
Table 3.2: Profile of the FGD Participants .....	18
Table 4.1: Migration Destination of the FGD Participants .....	19

## ABBREVIATIONS

CBS	Central Bureau of Statistics
CPR	Contraceptive Prevalence Rate
CREHPA	Center for Research on Environment Health and Population Activities
DACC	District AIDS Coordination Committee
DIC	Drop-in-Center
FGD	Focus Group Discussion
FHD	Family Health Division
FHI	Family Health International
FP	Family Planning
FPAN	Family Planning Association of Nepal
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
I/NGO	International Non-governmental Organization
IBBS	Integrated Biological and Behavioral Surveillance Survey
ILO	International Labor Organization
IOM	International Organization for Migration
IUD	Intrauterine Device
KI	Key Informants
KII	Key Informant Interview
MoHP	Ministry of Health and Population
MSI	Marie Stopes International
NCASC	National Center for AIDS and STD Control
NDHS	Nepal Demographic Health Survey
NCPR	Nepal Country Progress Report
NFHP	Nepal Family Health Program
NGO	Non-government Organization
NHRC	Nepal Health Research Council
OE	Outreach Educators
PE	Peer Educators
PHSC	Protection of Human Subject Committee
PPS	Probability Proportionate to Size
PSI	Population Services International
SCDC	Shrijana Community Development Center
SSP	Saath Saath Project
STI	Sexually Transmitted Infection
UNAIDS	United Nations Program on HIV and AIDS
VDC	Village Development Committee
HTC	HIV Testing and Counseling
WB	World Bank
WHO	World Health Organization

## **EXECUTIVE SUMMARY**

Under the financial support of the US Agency for International Development (USAID) funded, Saath-Saath Project (SSP), this baseline survey was carried out by New ERA during August 22 to October 16, 2012. Ethical approval for this study was obtained from Nepal Health Research Council (NHRC) and the Protection of Human Subjects Committee (PHSC), FHI 360's ethical review board.

The study assess the Human Immuno-deficiency Virus (HIV), Sexually Transmitted Infections (STIs) and Family Planning (FP) situation and measure the Contraceptive Prevalence Rate (CPR) among male labor migrants (MLMs) and wives of male labor migrants (WoMLMs) in four migrant districts SSP is working. The study also aimed to assess their key behavioral and knowledge indicators on HIV, STIs and FP situation and to examine the needs on related services for this community and to identify gaps and priority areas for intervention. The survey was undertaken in three phases: 1) Literature review, 2) Operational mapping and size estimation of MLMs and WoMLMs and 3) Interviews and implementation of research activities in the study districts.

Two representative surveys were conducted, one each among MLMs and WoMLMs in the four study districts: Bara, Kapilbastu, Nawalparasi and Palpa using structured questionnaires. The rapid ethnographic assessment included 16 Focus Group Discussion (FGD) sessions (8 among MLMs and another 8 among the WoMLMs) in the four study districts. In addition to these, seven to eight Key Informant Interviews (KIIs) were carried out with both health and non-health professionals in each district. For the household survey, a two stage cluster sampling method was followed to select 1,034 WoMLMs and 690 MLMs from 47 and 30 clusters respectively selected on the basis of probability proportionate to size (PPS) method. The findings from the survey have been presented in three volumes based on findings from quantitative survey among MLMs, WoMLMs and rapid ethnographic assessment respectively. This report is the first volume of the assessment and presents findings from qualitative study conducted among MLMs, WoMLMs and the key informants with health and non-health professional.

### **Key Findings**

#### **Background Characteristics**

A total of 30 officials from four study districts participated for the KIIs. Thirteen officials were from health sector and 17 from non-health sector. Among these key informants, 13 were health professionals like officials from District AIDS Coordination Committee (DACC) (20%), doctor/nurses (13%) and NGO working on health sectors (10%). Likewise, the key informants from non-health background represented Village Development Committee (VDC) Secretaries and officials from Non-government organizations (NGOs) working with migrant workers (17% each), Local Development Officer (LDOs) /Program Officer- District Development Committee (DDC), (13%) and Women Development Officer (WDO) (10%). Likewise, almost 56 percent of the MLMs and 58 percent of wives of MLMs who participated in the FGD were between the ages of 21 and 30 years. More than 50 percent of the male participants had primary and above level of education and education up to Bachelors

level, while, 39 percent of the wives of MLMs had primary and above level of educational attainments.

### **Migration Pattern among MLMs**

FGD results show that more than 50 percent of the MLMs were returnees from Gulf countries, such as Dubai, Qatar, Saudi Arab, etc. Migrating to India for work was also high as reported by the males (31%) and their female counterparts (34%). Participants' reported number of migrant males ranged anywhere from 10,000 to 40,000 in four different study districts. Key informants in all four districts reported that almost 30 to 50 percent of the total males of the districts have migrated abroad for work. It was found from the FGD sessions and KIIs that the countries of destination for work were similar across all the four districts. Their destinations were mainly Gulf countries, India and Malaysia. Popular cities to work at in India were Mumbai, Delhi, Bihar and Punjab. Migrant workers on average stayed at least two to five years maximum (depending upon the type of contract) in Gulf countries, Malaysia and Korea. However, those who worked in India stayed six months at maximum.

### **Impact of Migration upon Female Counterparts**

Key informants indicated that many WoMLMs in hilly areas and communities from districts such as Palpa and northern hilly part of Nawalparasi move to urban/semi-urban with their children for better education opportunities, health services and modern conveniences after their husbands leave. While those in Terai districts such as Bara, Kapilbastu and southern Nawalparasi, wives of migrant workers were mostly confined to rural setting and limited within traditional household chores of raising children; maintain their homes, cooking, animal husbandry and vegetable gardening. Most of them do not migrate to urban setting after their husbands leave like the women in hilly regions do. According to the key informants, in Terai districts such as Bara, Kapilbastu and Nawalparasi rumors and incidents of extra marital affairs among wives after the departure of their husbands are very few. Whereas in Palpa and hilly areas of Nawalparasi district there were many cases of extra marital affairs and some even eloping with other men in absence of their husbands.

### **Use of Modern FP Methods**

Although the FGD participants reported that contraception has increased than it used to be in the past, it was found that FP methods were now used mainly for child limiting and birth spacing. It was reported by the key informants that non-migrant couples use long lasting clinical methods such injectables and Norplant while migrant couples mostly use non-clinical method such as condoms. As for frequency, non-migrants use FP methods more than migrant couples. MLMs during FGD discussion reported that both husband and wife discuss about their available options and then decide. Focus group discussions with MLMs and their female counterparts reveal that there are usually no exact plans between the couples before coming home. While some men use FP methods such as condoms, some do not use any FP methods.

### **FP Service Related Challenges**

Interviews with key informants from health sector revealed there is a need for detailed and extensive knowledge of FP methods among migrant couples. Individuals are aware about different kinds of methods but do not have detailed information on them. In Bara, Kapilbastu and Nawalparasi districts, health workers reported that in many Muslim communities, there

were issues with access as it is against their religious and cultural norm to use FP methods. In Palpa, geographical barriers were identified as a major challenge in access to FP services. In hilly remote areas all FP methods are not always available as it is challenging to reach such areas. From the perspectives of wives of MLMs, their major challenge was their husbands not agreeing to use.

### **FP Program Related Suggestions**

It was suggested by the key informants that increase in awareness and supply of FP services is important in order to increase accessibility and utilization. It was suggested that migrant couples need more information on FP methods and encourage them to stay protected. Male FGD participants also added that people are aware about FP but they do not have adequate information about it. Other suggestions included recruitment of more health workers from the both the government and NGO, more FP clinics, more budget, increase coverage of programs and also develop programs to empower women and encourage them to make important decisions on their own.

### **Knowledge and Attitude towards HIV/STI**

Most of the participants in both FGD sessions with male as well as female mentioned that they have heard about HIV and AIDS and STIs. However, discussions revealed that individuals lacked comprehensive knowledge about HIV and AIDS and its mode of transmission. It was stated that by some respondents that HIV and STI could be caused due to „lack of cleanliness’. They further explained that people in community hold negative attitude and discriminate towards people with infection. Key informants stated that „migration to India’ is one of the primary factors responsible for the „increasing trend’ in HIV prevalence. Some of the Health workers further stated that many men do not report their families with their infection situation and often times even the person with infection is unaware of it.

### **Prevention and Treatment**

Despite the exposure towards HIV and STI intervention programs, key informants stated that only some are adequately informed about preventive methods. The key informants further added that almost none of the male migrants get tested after returning home either because they are confident of being disease free or due to lack of awareness, societal fear of labeling and lack of awareness about testing facilities. Women do not get tested or treated as most women cannot make their own decision and even if aware about the need to get tested, they are hesitant about expressing it to the husbands for fear of being questioned/accused of infidelity and creating tension in the family. Data gathered from FGD sessions showed that there were no specific organizations providing services to either to the MLMs or the wives of MLMs. According to the respondents, district hospitals provide such services but such services are not targeted towards any specific groups of people. However, few had heard about organizations such as Nepal Red Cross Society, Lions Club, Maiti Nepal and local NGOs that provide HIV/STI related programs and services. According to the key informants, individuals visit variety of places for diagnosis and treatment such as government health organization, district hospitals, and private clinics, NGOs such as KIDS, some also traveled to Kathmandu and India. It was found that people in border areas in districts such as Bara and Kapilbastu also visit India for treatment.

### **HIV/STI Service Related Challenges**

Key informants and FGD participants alike reported that major barriers towards accessing HIV and STI related services were fear of societal labeling, lack of organizations working specifically for migrant population, lack of awareness to get tested, lack of testing centers, geographical barriers because services have not been able to reach some hard to reach areas, inadequate human resources and budget. Key informants report that HIV infection is strongly tied with stigma, negativity, bad character and social outcast because the disease ushers in utter shame in the family and the community stigmatizes the family of the infected individual as well. Therefore, individuals suspicious of infection go without testing.

### **HIV/STI Program Related Suggestions**

Key informants suggested for an increase in coverage of programmatic events, activities and HTC centers in rural areas and areas with high concentration of migrant population and introduction of mobile clinics to conduct tests and counseling. Similar to KI suggestions, wives of MLMs explained the need for targeted programs with an atmosphere for open dialogue and interactions. It was also suggested by health and non-health professionals that government needs to be proactive in raising awareness and programs need to be at the grass root level and in-coordination with local organization and political leaders, increase the number of trained health workers and frontline workers and regular monitoring of the programs.

### **Key Program Implications and Recommendations:**

- Many migrants return home without considering any special occasions. Hence, program should closely monitor the migration destinations of the pocket community and reach migrants during their arrival. However, migrants going to India generally return during festival seasons, thus awareness raising activities should also be conducted during such special seasons.
- Most study participants are aware about FP and HIV services that are available to them, however, comprehensive knowledge about the FP and HIV is absent. Therefore, awareness programs should be designed to be more effective.
- Government health facilities were frequently reported convenient places to obtain free or cheap FP services. Free FP services through these sites should be continued and promoted.
- The existing health service providers are not enough to cover migrant community. Quantity (increase in number of frontline workers) and quality (maintaining confidentiality in treatment and services) of health service providers should be improved with training or refresher training programs on health services.
- FP use is especially low among migrant couples, thus SBC activities focusing the importance and the need for FP preparedness once the husband returns and as well as awareness program on dual protection needs to be promoted targeting migrant couples.

- Awareness raising activities (e.g. Drama, Counseling, Documentary) on FP and HIV and AIDS are mainly conducted in urban areas such as district headquarters, such activities and availability of FP and HIV services should be promoted at places that can be conveniently accessed by the community people. Events/services should be available at VDC level, PHCC, HP, SHP and community people should be made aware of the existence of such facilities. These activities should also aim focusing migrant couples.
- Society and culture remains as one of the major barriers in many communities towards successful program implementation. Strategic Behavior and Communication (SBC) programs preferably led by a native speaker of the language could be a step towards awareness.

# 1.0 INTRODUCTION

## 1.1 Background and Context

The National Center for AIDS and STD Control (NCASC) reports that the *Human Immunodeficiency Virus* (HIV) among male migrants and their female counterparts has emerged as one of the major health concerns in Nepal. Seasonal labor migration is a common trend especially in the Western parts of Nepal (Poudel et. al., 2004; Vaidya and Wu 2011). It is estimated that almost half of the population in the Far-Western and Mid-Western Nepal migrate seasonally every year in search of work (Furber et. al., 2002; Poudel et. al., 2004). It is often argued that existing poverty, limited employment opportunities, deteriorating agriculture productivity and armed conflict are some reasons behind international labor migration in Nepal (Thieme and Wyss, 2005). There is a general argument that individual moving between countries can gain opportunities for greater equality, freedom and career achievement that would have been available at home. One can argue that health is improved if people from poor countries migrate to rich countries but there is also an issue of increased vulnerability to communicable disease, particularly HIV. Previous studies (e.g. George et. al., 1997; Gupta and Singh 2002; Lagarde et. al., 2003) conducted in different geographical settings also reported higher HIV prevalence among migrants compared with non-migrants.

Multiple factors remain responsible for increasing infection rate among the migrant population and their female counterparts. The International Organization for Migration (IOM) report on studies of migrants globally, suggests loneliness as one of the major underlying factors for migrant males to involve in high risk sexual activities. It further reports that freedom from established social norms, separation from family ties and sense of anonymity during migration among male members are responsible agents for getting involved in high risk behaviors. According to the IOM report, transmission is even more widespread in the transit areas along the borders, where large numbers of people move between the countries, pay-checks are easily cashed, drinks purchased and female sex workers (FSW) are readily available and affordable (IOM, 2011). It is also widely accepted that migrants, due to poverty and unemployment, are vulnerable to such high-risk behavior and are more likely to become infected.

According to the Integrated Biological and Behavioral Surveillance Survey (IBBS) carried out in 2008 in 11 districts in Western and Mid to Far Western regions among MLMs who go to India as labor migrants, HIV prevalence among male migrants was 1.4 percent (NCASC & ASHA, 2008a). Similarly, another IBBS study conducted with the WoMLMs from Achham, Doti, Kailali and Kanchanpur districts, HIV prevalence among the wives of male migrants was 0.8 percent (NCASC & ASHA, 2010a). IBBS study conducted among male labor migrant workers from Kailali, Kanchanpur, Doti, Achham, Surkhet and Banke districts in 2010 indicates minimal consistent use of condoms and other sources of protection (18%) between husband and wives during sexual intercourse, while consistent use of condom during sexual encounter with female partner and FSW were 10.5% (NCASC & ASHA, 2010b). The United Nations Program on HIV and AIDS (UNAIDS) reports indicate that increasing mobility of the people could result in spread of HIV infection both to those who migrate and

the members of community that receive the migrant (UNAIDS, 2003). These findings suggest that wives of male labor migrant workers and babies born to them are in risk of HIV transmission.

SSP has identified all these conditions as some of the major factors responsible for deteriorating the public health and contributing to the high rate of HIV infection among certain population. The mere supply of clinical drugs and hardware support is not enough to improve the quality of preventive efforts. In order to establish the necessary steps there was a need to understand local context behind the exogamous sexual behaviors among male migrants and their female counterparts. In order to prevent the transmission of the disease and to improve the quality of health services, SSP, through financial and technical support from USAID has been managing HIV prevention, care, and support and treatment projects in Nepal since October 2011. For the continuation of these efforts and to expand the programs, particularly to provide integrated package of services on FP and HIV services targeted to migrants and their spouses, the present survey was conducted in four study districts: Kapilbastu, Nawalparasi, Bara and Palpa. In the absence of authentic data, it was difficult to ascertain as to what extent the HIV, STIs and FP situation exists among this high-risk group. Therefore the main objective of the proposed survey is to provide necessary baseline information on the knowledge, attitude and behavior of the target population on FP and HIV, help identify gaps for better targeting of the services. Progress of the intervention in reaching out to the target population will be monitored, assessed and evaluated against the backdrop of current status as the SSP moves towards its completion of the envisaged activities.

This section of the report presents findings from the literature review which started from the beginning stages of the study and was an ongoing process throughout the field work period. Desk based review of available documents and reports on HIV, STIs and FP situation of migrant couples were researched through navigation of online relevant scientific databases and journals. Furthermore, relevant documents from national and international I/NGOs, Government and ministry publications, district and region level documents, various national surveys and census report were gathered and extensively reviewed.

### ***Labor Migration***

The total number of international migrants has increased exponentially over the last 10 years from an estimated 150 million in 2000 to 215.8 million in 2010, with international migrants accounting for a total of 3.2 percent of the global population in 2010 (World Bank, 2012). It shows that international migrant workers make up a significant portion of the global workforce and are becoming permanent fixtures on the global labor market today.

South-East Asia is emerging as one of the leading migration hub in the global labor market with workers migrating within and outside the region seeking economic opportunity and prosperity. The IOM recently reported that an estimated \$325 billion in remittances were sent by migrants to developing countries in 2010 (IOM, 2011). Officially recorded remittance flows to developing countries are estimated to have reached \$372 billion in 2011, and are expected to grow at seven to eight percent rate annually to reach \$467 billion by (World Bank, 2012). Remittances makeup more than 10 percent of Gross Domestic Production (GDP) in nearly 40 countries and remittances sent by overseas workers have been credited

with directly reducing levels of poverty and keeping the economy afloat in countries like Nepal, Bangladesh, and Philippines which has a high influx of out-migrants and in keeping the economy afloat. The World Bank (WB) book on Migration and Remittance reports that Nepal received remittance of 1.2 billion in 2005, 3 billion in 2009, and 3.5 billion in 2010 (World Bank, 2012). In many developing nations with low economic growth, labor migration has been credited with channeling surplus labor to be productive, thus mitigating the problem of unemployment and reducing potential for social inequality and instability in the home country.

### ***Migration in Nepal***

According to the recent Central Bureau of Statistics (CBS) census report, 7.3 percent of the total populations are absentee population in Nepal. There are almost two million (19, 21,494) absentee populations in Nepal which comprises 87.7 percent male and 12.3 percent female (CBS, 2012). Whereas, previous census carried out in 2001 showed absentee population of 732,189 of which 89 percent were male and 11 percent female (CBS, 2001). With an emigration rate of four percent the Ministry of labor and transportation estimates around two million people having migrated for work abroad (UNAIDS, 2012).

A substantial proportion of the adolescent and adult male population in Nepal seeks seasonal, and sometimes permanent work in several states in neighboring India with which it shares an open-porous border and socio-cultural ties that dates back to centuries. Census data of Nepal also show that out of total migrated aboard, most people had regularly immigrated to India: 79 percent in 1952/54, 93 percent in 1981, 89 percent in 1991; 77 percent in 2001 (Sharma, 2011). The most recent Nepal Demographic Health Survey (NDHS) also reported that the most popular out-of-country destination for Nepalese migrants is India, to which 20 percent of all male migrants and eight percent of all female migrants move to India (MOHP & New ERA, 2011). However, these figures may be underreported. Previously, Thieme and colleagues (2005) argued that an estimated one to three million Nepalese in India, two to five times higher than official statistics show (Thieme et. al., 2005).

Destinations in India and the point of origin in Nepal are not random; besides proximity and ease of transportation, network of middlemen and workers themselves pave the way for friends and others in their community to join in the migration process thereby creating a chain. For example, a study conducted in Delhi found large majority of Nepali migrant factory workers in Delhi to be from the districts of Palpa, Syangja, Gulmi, Kapilbastu, Nawalparasi, and Gorkha (Western region) while the watchmen were mostly from Bajura, Bajhang and Achham in Far Western Nepal and some from Kanchanpur and Kailali districts as well. The trend was found such that those from Bajura work as watchmen in Delhi, while from Achham and Bajhang work in Mumbai and Bangalore respectively (Bhattarai, 2007).

Another study conducted in Kandebash, Baglung reported that 97.4 percent of the total migrants from the district had gone to India to work, of which 31 percent chose it of easy availability of work even for unskilled workers, 22 percent as easy access/open border, 25 percent cited the security and safety of network of friends and countrymen and while six percent were recruited for the British and Indian army (Gautam, 2006).

### ***Migration in the Study Districts***

According to the 2011 census report, the absentee populations in the four study districts were three percent in Bara, 31 percent in Palpa, 19 percent in Nawalparasi and nine percent in Kapilbastu (CBS, 2012). While the NDHS 2011 sub-region data on male migration show that in Bara (Central Terai) 17 percent males, 14.5 percent males in Palpa (Western hill) and 25.9 percent of males in Nawalparasi and Kapilbastu (both Western Terai) have migrated to India for work (MOHP & New ERA, 2011). A more recent 2012 study conducted by Nepal Family Health Program (NFHP-II) and Center for research on Environment Health and Population Activities (CREHPA) in Makar and Tribeni VDCs of Nawalparasi found migration to Middle Eastern countries are now high in Nawalparasi. The pattern is such that while those around the border areas mostly work in India, those from other areas go to the Gulf countries for work (NFHP II & CREHPA, 2012).

### ***HIV and AIDS***

By the end of 2010, an estimated 34 million people were living with HIV globally, while 2.7 million were found to be newly infected. An estimated 2 to 3.5 million people in Asia live with HIV making it the second highest region with HIV infected population after sub-Saharan Africa (UNAIDS, 2012).

Female sex workers (FSW), men who have sex with men (MSM), person who inject drug (IDU), MLMs and clients of female sex workers alone accounted for 58 percent of total HIV infection Nepal, while low risk population accounted for the remaining 42 percent infection rate in 2011. The prevalence of HIV infection was estimated to be the highest among the most productive and sexually active segment of population aged 25–49 years (NCASC, 2012). Over 80 percent of the HIV infections are transmitted through heterosexual transmission. UNAIDS earlier estimated that the highest HIV prevalence rate was found to be in central region and concentrated especially in urban areas and districts with high density of labor migration (UNAIDS, 2003).

### ***Characteristics of HIV and AIDS among Labor Migrants in Nepal***

Migration in itself is not the cause for increased risk of HIV infection however; studies do indicate that migration specifically for work purpose and HIV risk are linked. The IOM cites four primary ways in which migration among workers and the spread of HIV and AIDS are linked. It states that mobility creates conditions encouraging and enabling workers to engage in risky behaviors especially among sexually active young men separated from wives and partners over extended durations. It creates condition where people find themselves isolated and alienated in a new and unfamiliar environment making it difficult to access health facilities. Further, conditions for sexual networking is generated, drawing migrants into urban areas and labor migrants are especially vulnerable to HIV and AIDS because as marginalized, overlooked population, they have been neglected and excluded by policies and laws (IOM, 2011).

Migrants with uncertain legal status and those working in the informal economy are particularly vulnerable to HIV. Since they have little or no legal rights or health insurance,

they are unable to access health and legal services due to reluctance to draw attention from immigration officials and risk of being deported. The link between migration and HIV and AIDS can be attested by the high rate of HIV prevalence found along highway roads, border areas, and major transit points of motility. For example, the highest incidence of HIV and AIDS in Southern Africa is found mainly in countries like South Africa and Botswana which boasts of high cross-border migration created by favorable migratory conditions. A recent report on the studies among migrant farm workers on the South Africa/Mozambique border found that stressful, high-risk work induced a feeling of hopelessness that outweighed the risk of acquiring HIV (IOM 2011). Similarly, migrant workers in China where oscillating migration is common have also indicated that loneliness and peer influence are major motives for engaging with FSWs (Wang et. al., 2007) while Mexican migrant workers in the United States reportedly sought solace and comfort in social spaces such as bar or dance clubs and churches in an effort to mitigate the loneliness, and sense of alienation brought about by migration (Munoz-Laboy et. al., 2009).

Studies conducted among migrant and non-migrant population verify that sexual contact increases with growing mobility of the respondents. For example, a study conducted among Migrants and Non-migrant males in Achham district in Far Western Nepal; it was found that only five percent of the non-migrant males, 14 percent of the internal migrants and 27 percent of the international migrants had sex with FSWs (New ERA, 2002).

Given migrants' contact with FSWs and unsafe sex,, HIV infection it usually high Similarly, the most recent National estimates of HIV infection document that that majority of HIV cases estimated are from labor migrants (27%) and increasing numbers of HIV are occurring among their wives (a combined 27% of HIV cases in low-risk women in rural and urban areas) in 2011. Of all the adults estimated to be living with HIV, a major proportion of HIV infections have consistently been among migrant workers travelling to India for work (NCASC, 2012)

Reportedly, there is a culture among Mumbai migrants visiting brothels; either openly with friends or discreetly. In a study by Poudel and colleagues (2004), they found that several migrants from Far Western had a belief that „Maybe no migrants return home without having sex in Mumbai' and the majority of those who had visited female sex workers reported peer pressure as a motivation for doing so. In their study, many Mumbai returnees claimed that they and their colleagues visited the brothels in Mumbai, and had sex with a new partner at every visit (Poudel et. al., 2004).

The 2008 IBBS survey carried out among male labor migrant from Kailali, Kanchanpur, Doti, Achham, Surkhet and Banke further substantiates the claim; 17 percent in 2006 and 10 percent in 2008 in west and 27 percent in 2006 and 22 percent in 2008 in the Far-West region reported having sex with FSW in India (NCASC & ASHA, 2008a).

Conclusions can be drawn that several factors play a crucial role in influencing the migrants to practice high-risk sexual behaviors. While in India, these include peer norms and pressures, cheaper sex, lack of family restraint, drinking alcohol, and low perceived vulnerability to HIV/STIs as well as a feeling of anonymity and substantial deficits and gaps in their knowledge of HIV/STIs. Drinking and visiting brothels were found to be almost

synonymous in the migrant-lingo. Consequently, when they had sex with commercial sex worker they were drunk leading to impaired awareness of safety and condom use. In the report of Poudel and colleagues, it was further testified by migrants who had never visited brothels that being drunk and intoxicated was a major factor for migrant workers to lose inhibitions and caution, enabling them to visit brothels (Poudel et. al., 2004).

### ***Knowledge and Awareness of STI/HIV and AIDS***

The 2011 NDHS result shows that knowledge and awareness of HIV and AIDS is higher among younger and educated population. While AIDS awareness is universal among men and women with a school leaving certificate, around 70 percent of women with no education are aware of AIDS (MOHP & New ERA, 2011). The majority of HIV and AIDS prevention programs targeting general population advocate the use of condom during sexual intercourse and being in a monogamous relationship with one partner. The 2011 NDHS result shows that while these methods of prevention has been successful in reaching the general population, only 21 percent of women and 30 percent of men have comprehensive knowledge regarding AIDS and that accurate and comprehensive knowledge regarding HIV and AIDS transmission remains inadequate (MOHP & New ERA, 2011).

Regarding knowledge about modes of HIV transmission, half of the men and women of the national survey (NDHS) are aware of the fact that HIV can be transmitted through breast feeding while 35 percent of women and 44 percent of men know that the risk of HIV transmission from mother to child can be reduced if the mother takes special antiretroviral 1 drugs during pregnancy (MOHP & New ERA, 2011). Significantly, there seems to be a common consensus among both men and women in the 2011 NDHS that a wife is justified in asking her husband to use a condom if her husband has STI while the majority of women and men felt it is justified if a women declines to have sex with her husband with questionable sexual history (MOHP & New ERA, 2011).

Transmission of HIVs from migrant males to host females is more widespread in areas where female illiteracy is high. The 2011 population census showed high illiteracy rate (41 to 70%) among women of the above four program districts (CBS, 2012). Around 57 to 85 percent of the women in these area believed that HIV can be prevented by limiting sexual intercourse to one uninfected partner (MOHP & New ERA, 2011). These women, because of their limited exposure to the health awareness program have limited capacity to insist their husbands for a medical check-up after their return from abroad. As a result, the transmissions from husbands to wives and from mothers to children have formed a serious vicious circle in the transmission routes.

Overall, condom use was found to be more prolific among urban men with multiple partners (34%) than among rural men (25%). Only two percent of men aged 15–49 years reported paying for sex in last 12 months prior to survey, out of which two percent were single, unmarried men while men with divorced, separated and widowed status were the highest users of paid sex (10%). Similarly, it was found that single, urban, educated, and wealthy men are more likely than their counterparts to engage in paid sex (MOHP & New ERA, 2011).

### ***Knowledge of HIV and AIDS among Migrants***

Studies conducted in Far Western (Doti district) in 2000 and 2001 among migrant workers indicated substantial and serious deficits regarding the knowledge of HIV/STI; many of the migrant men stating that HIV was a disease of FSWs and thereby implying that they were invulnerable to infection despite their own risky sexual practices (Poudel et. al., 2003). Similarly, almost all the study participants displayed negligent attitude to STI (referred to as „*Bombay Rog*’ for any kind of STI) repeatedly stating that any person can become infected with STI and catching it was not a serious problem as it can be easily cured. „In this area, having *bhiringi* (local name for syphilis) is not a shame at all for men. Many people had such a disease for a long period.’ men in the study stated (Poudel et. al., 2003). „Having syphilis is normal for a real man (*marda*), other would have scabies’ they claimed, thereby revealing how migrant men’s perception of masculinity is associated with flagrant display of sexuality and casual disregard for safety (Poudel et. al., 2004).

Similarly, the 2008 IBBS survey conducted in Western regions (includes Mid to Far Western districts) of Nepal found that only 41 percent in the Western and 36 percent of the migrant men in the Mid-Far Western region understood HIV and AIDS as one form of STI revealing gaps in HIV knowledge and awareness. While those who reported experiencing any form of STIs were low, significantly only about half of them had sought treatment and even then mainly from private clinics due to the tendency to hide (NCASC & ASHA, 2008a).

In the 2008 IBBS study, virtually all respondents in Far-west and Western region indicated being aware of HIV and AIDS with radio being the main disseminator of the HIV and AIDS related information followed closely by community network. Nearly half of the respondents in W

Western region were aware that use of condom and avoiding unsafe sex is the key to prevent HIV and AIDS transmission. However, gaps regarding HIV and AIDS indicator still remains. Only about half of migrant workers in both the regions knew all the three common method of preventing HIV and AIDS infection: Abstinence from sex, being in a monogamous relationship with one partner, and consistent use of condom. Overall, less than 20 percent of the migrant men in the survey had full comprehensive knowledge about HIV and AIDS indicator and prevention (NCASC & ASHA, 2008a).

### ***HIV Testing***

With regards to HIV testing, NDHS 2011 reported only five percent of women and 14 percent of men having tested for HIV infection while the vast majorities i.e. 95 percent of women and 86 percent of men have never been tested for HIV. Sexually active population who had been tested for HIV in the past 12 months increased with age, education, and wealth; HIV testing was nearly twice the number among single men than their married counterparts and more prevalent in urban sectors than in rural areas with similar results in women (MOHP & New ERA, 2011).

According to the IBBS study on 2008 among MLMs, only eight percent in Western and 12 percent in Mid to Far Western region had undergone HIV test, the majority of those who had been tested doing so for employment requirements (NCASC & ASHA, 2008a). Migrants

going to Gulf countries are subject to mandatory HIV test before leaving the country and also while in the destination country as per the terms of employment and if found to be infected will be deported immediately. With trend increasing towards Gulf States migrations, the number of migrants being tested for HIV is also on the rise though involuntarily as may be the case.

### ***STIs Situation***

Evidence suggests that that people infected with STIs are at least two to five times more likely to be infected with HIV than uninfected people if they are exposed to HIV virus through sexual contact (WHO, UNAIDS & UNICEF, 2011, New ERA, 2002). Previous study carried out in Nepal also supported these findings. For example, among the international migrant pool in Achham, 19 percent had at least one form of STI, while 15 percent were found to be HIV infected, and HIV infection rate was low (one percent) among those who did not have any STI, substantiating that HIV infection was significantly associated with STIs (New ERA, 2002).

Thirteen percent of women and three percent of men reported experiencing STI symptoms during 2011 NDHS survey out of which only 44 percent of the women and 54 percent of the men sought medical help indicating that large number of STI cases in Nepal remains unreported due to stigmatization associated with STI (MOHP & New ERA, 2011).

### ***Wives of Migrants***

The total number of people living with HIV for 2011 is estimated at 50,200 with an overall national HIV prevalence of 0.3 per cent. The national estimation report also shows that females account for approximately 27.3% of the total infections, followed by MLMs, remaining males, other MSMs, Male Sex Workers, Transgender and their Clients (MTCs), clients of FSWs, PWIDs and FSWs with 27.0%, 14.0%, 7.2%, 4.4%, 2.2% and 1.5% respectively (NCASC, 2012). What creates a particular urgency in this situation among women is the fact that when a woman gets infected with HIV, it also increases likelihood of transmitting HIV to her future children, thereby threatening the health and safety of a new generation as well.

In many societies and culture, women are particularly vulnerable to HIV infection due to patriarchal cultural norms. Women become infected with HIV through their husbands and partners as women are placed in an untenable position where it is virtually impossible to negotiate safe sex and thus protect themselves in fear of violence, and negative social repercussions.

The IBBS survey conducted in 2008 among wives of migrants' detected HIV prevalence of three percent in Far Western districts (Achham, Doti, Kailali and Kanchanpur) in 2008 with varying figures in the four study areas: five percent in Achham, three percent in Doti, three percent in Kailali, and one percent in Kanchanpur. From the studies so far conducted, conclusions can be drawn that HIV prevalence is significantly associated with their marital status: 40 percent were widows of HIV positive men and two percent of those infected were currently married women and most of the positive women's husbands worked in India in the

past as migrant laborer and served as source of disease to their wives (NCASC & ASHA, 2008b).

### ***FP Situation***

According to NDHS 2011, CPR in Nepal was reported at 44 percent over the last 5 years (MOHP & New ERA, 2011). The 2010 mid-term FP, Maternal, Newborn and Child Health Situation Survey in Rural Nepal carried out by NFHP II reports that at least one method of FP is universal among rural women; similarly, 97 percent of currently married women know about female and male sterilization, condoms, contraceptive pills and injectables, while knowledge regarding IUD, Implants and emergency pills are on the rise. The study also found that one in two married rural women was found to be using a method of FP with female sterilization coming as the most popular choice of modern method (NFHP II & New ERA, 2010). Similarly, 44 percent of currently married women (aged 15 to 49) were found to be using modern FP methods, according to the Nepal Maternal Mortality and Morbidity Study, 2008/2009 (FHD, 2010). The 2011 NDHS further reports that 50 percent of married women were using a FP method with 43 percent preferring modern FP method while additional seven percent preferred traditional FP methods (MOHP & New ERA, 2011).

By far, female sterilization is the most popular choice of FP method in Nepal with 15 percent preference followed closely by injectables (nine percent) and male sterilization (eight percent). Female sterilization was found to be more popular choice in Terai (23 percent) than in Hills (seven percent) and Mountain (three percent) while male sterilization and injectables more popular in mountain and hill areas, condom use was nearly three times higher in urban areas than in rural setting (MOHP & New ERA, 2011).

With regards to unmet FP needs the most recent NDHS 2011 reports that there is 27 percent of unmet need for FP among married women; 10 percent for spacing and 17 percent for limiting. The study further states that currently only 65 percent of FP needs of married rural women have been met; a significant increase from 2006 when unmet need for birth spacing was found to be nine percent and 15 percent for limiting purpose (MOHP & New ERA, 2011). Overall, it has been noted that the increasing use of modern FP methods is a significant factor in Nepal's declining fertility rate as well as vital reduction in maternal mortality however, gaps in FP in unmet needs are to be addressed to attain the desired results.

### ***FP among Migrant Couples***

The 2008 IBBS survey conducted among wives of migrants from Far Western region of Nepal also indicates low FP use among the wives of migrants (NCASC & ASHA, 2008b). In the report while 96 percent of the migrant wives heard about condoms and even knew about different condom outlets, only 27 percent of these women had ever used a condom. Whereas among those respondents who had sex with their husbands during their last visit home only six percent reported consistent usage; thus corresponding to reported negligent condom usage among migrant couples (NCASC & ASHA, 2008b). However, IBBS survey among wives of migrants in 2010 indicate a slight change as 97 percent of the migrant wives heard about condoms and 39 percent of these women had ever used a condom and among them 10 percent use condom consistently during their last visit home (NCASC & ASHA, 2010a).

Similarly, the 2011 NDHS reported that 51 percent FP users women discontinued using a method within 12 months of initiation with 26 percent stating that they did not need FP methods as husband was away for the duration (MOHP & New ERA, 2011). Furthermore, use of contraceptive method was only 23 percent among women whose husbands are absent whilst in the case of women whose husbands were living with them, the user rate was high as 62 percent. Another study conducted in 2011 by NFHP-II/CREHPA in six districts: Nawalparasi, Parsa, Doti, Gulmi, Dailekh and Udaypur further illuminate the prevailing practice, attitude and culture regarding FP among migrant couples (NFHP II & CREHPA, 2012). This study indicates that while migrant wives are aware of the different FP methods available, effective and comprehensive knowledge regarding them, especially the protection coverage time against conception provided by the various long-duration methods is extremely low. Significantly, the report notes that wives are informed a month in advance regarding the husband's arrival, unexpected arrival being extremely uncommon, yet despite prior knowledge, it is rare for a wife to be prepared and so acquire or use any contraceptive method prior to their husband's arrival. Consequently, men mostly relied on withdrawal method if they were unable to obtain condom when required (NFHP II & CREHPA, 2012).

Regarding the choice of FP methods, injectables and pills were found to be a popular choice among wives whose husbands visited frequently, while for those whose husbands returned less frequently, condoms and withdrawal methods were used more frequently. However, switching between condoms, withdrawal and pills were found to be a common practice. The NFHP-II/CREHPA study further notes that couples communication regarding matters pertaining to desired number of children, and type of contraceptive to be used for prevention and spacing between births, further communication regarding adoption of long term FP methods seems to be missing. In addition, the study found that although many couples did not desire to further increase their family size, they were not using any methods of FP (NFHP II & CREHPA, 2012).

Cases of reported abortions were noted along with both safe and unsafe attempts that were made to terminate the unwanted fetus in the 2012 NFHP-II/CREHPA report. Some of the women also mentioned taking herbs and unknown medicines in an attempt to abort the fetus while private clinics, pharmacies, and government run hospitals which provide safe abortion services were the preferred choice among those who needed the service (NFHP II & CREHPA, 2012).

Overall the prevalence of condom use among labor migrant couple has been found to be very low in several surveys and studies conducted among migrant labor population. In the 2008 IBBS survey conducted in the Western region of Nepal, consistent condom use with their wives was at 11 percent and 15 percent in the Mid-Far Western region while 74 percent in the Western and 64 percent in the Mid to Far Western region had never used a condom in the past year, many of these respondents citing that they did not think it was necessary or that it didn't enter their head to use a condom as reasons for non-use (NCASC & ASHA, 2008a).

A high proportion of migrant workers in both the regions were supplied with condoms by health posts and health centers, with FCHVs emerging as a major source of free condom among migrant workers in the Mid-Far West region. Furthermore, half of the respondents in

the 2008 IBBS survey stated that it takes them more than 20 minutes to reach a place where they can obtain a condom indicating that making condoms conveniently available needs to be a top priority for FP programs (NCASC & ASHA, 2008a).

CPR for Nawalparasi district was reported at 45 percent in 2008/9 and 41 percent in 2010/11, for Kapilbastu it was 28 percent in 2008/9 and 33 percent in 2010/11, Palpa at 42 percent in 2008/9 and 35 percent in 2010/11 and Bara reported 37 percent in 2008/9 and 45 percent in 2010/11 according to the DoHS Annual report (MOHP 2009, MOHP 2011). However, data of CPR among migrant couples (migrant labor males and their wives) in the study district is unavailable.

The 2012 NFHP II/CREHPA report indicate that FCHVs play a vital role in a migrant couple's decision and choices regarding FP (NFHP II & CREHPA, 2012). Women not only receive information on the various FP methods available but also receive FP related services methods from them. Significantly, both the FCHVs, migrant couples as well as the DHO officials have suggested that FCHVs are the most appropriate medium to disseminate information on FP within the migrant community.

### ***STI/HIV and AIDS Program Coverage among Migrant Couple***

STI/HIV and AIDS program coverage among migrants is far low compared to other most at risk group's coverage programs. According to the Nepal Country Progress Report 2012, migrant workers receive 14 percent, a noticeably less coverage and attention from HIV prevention programs than other high-risk groups in 2010 (NCASC, 2012). Despite increased number of service sites in high migration districts, only eight percent migrants in the Western region and 12 percent in Mid Far Western region were covered, thus highlighting the need to significantly expand and develop better strategies for prevention and outreach programs for Nepali migrants traveling to India for work (NCASC & ASHA, 2008a). This fact has been further substantiated that only two percent of the male migrant in the Western and 15 percent in the Mid-Far Western region had contacted with peer educators (PE) or outreach educators (OE); while less than five percent had visited a STI clinic or Drop-in-Center (DIC) (NCASC & ASHA, 2008a). However, 28 percent migrant wives had been reached by a peer/outreach educator, much higher proportion coverage than amongst the migrant men. Similarly, seven percent of migrant wives had been to HIV and AIDS testing and counseling (HTC) center and 12 percent had further taken HIV test while among the men, eight percent in the Western and 12 percent in the Mid-Far West region had HIV test either voluntarily or because of the employment requirement (NCASC & ASHA, 2010a).

While HIV and AIDS awareness is part of the pre-departure orientation curriculum provided to migrant workers in an effort to stem the infection rate among migrant workers through knowledge and awareness about the virus, undocumented migration to India and abroad however makes the effort to reach and impart knowledge regarding HIV and AIDS awareness extremely challenging and difficult for all concerned.

In conclusion, literature review on migrant workers covered on currently available documents and reports, on HIV, STIs and FP situation of migrant couples available from scientific databases like Medline, reports and books from International organizations like World Health

Organization (WHO), International Labor Organization (ILO), USAID, World Bank as well as those from Ministry of Health and Population (MOHP), National Centre for AIDS and STD Control (NCASC), Family Health Division (FHD), studies conducted by I/NGOs and the world wide web. While data and information about migration, HIV and AIDS and FP were easily available, comprehensive and reliable information/data regarding migrant workers especially in terms of HIV and AIDS and FP in Nepal remains limited even today and indicates the need for further studies and research .

## **1.2 Objectives of Qualitative Study**

Underlying objective of the overall survey is to generate the estimates and identify the gaps, and priority areas to help develop the intervention modality. Outcomes of the study will be integral in formulating program interventions for migrant as well as non-migrant members of the area. The results will also be used as baseline data for monitoring the progress and evaluating these interventions in the future. However, a specific objective of conducting qualitative study is to generate in-depth information behind the quantitative indicators used in the survey. Understanding issues of HIV, STI and FP from the perspectives of the participants acknowledges levels of complexity. Thus, specific objective of conducting FGD sessions and KI interviews were to:

- Obtain general overview of male labor migrants and wives of male labor migrants in study districts, their estimated size and background characteristics
- Obtain views and perceptions of male labor migrants, wives of male labor migrants and personalities working in both health and non-sector regarding the needs on HIV, STI and FP services and as well as identify gaps along with priority areas for intervention and estimate use of contraceptive and key behavioral and knowledge indicators related to HIV, STIs and FP among wives of labor migrants in study districts
- Utilize the findings of FGD sessions and KI interviews to formulate future programs in the target area
- Supplement quantitative data in the baseline survey

## **2.0 STUDY DESIGN AND METHODOLOGY**

### **2.1 Implementation of the Study**

Under the technical support of the USAID funded SSP, the field work of this baseline survey was carried out by New ERA. New ERA was responsible for the overall management of the survey and carried out the fieldwork for data collection using survey tools in coordination with SSP. The survey tools were initially developed in Nepali by SSP team. New ERA conducted pre-testing of the tools, finalized the tools in consultation with SSP team. The information collected has also been analyzed by New ERA and presented in three volumes of the report. The survey was conducted in collaboration with SSP implementing partners working in the study districts.

### **2.2 Study Design**

This study was designed to collect the baseline FP situation including the rapid assessment of HIV and STIs among migrant couples. The study was undertaken in three phases:

- Phase one: Literature review
- Phase two: Operational mapping and estimation of size of study population
- Phase three: Interviews and implementation of research activities in the study districts

In the first stage of this study, available literature around HIV, STIs and FP among migrant couple and on the estimated size of this population were closely reviewed. Relevant electronic resources such as scientific data bases (e.g. Medline), were used to search literatures. Similarly, gray literatures and other relevant documents published by World health Organization (WHO), United Nations Population Fund (UNFPA), United Nations Development Program (UNDP), Department of Health Services (DOHS), USAID, Ministry of Health and Population (MOHP), NCASC, HMIS, I/NGOs on these issues were included in the review. The literature review started from the beginning of the study and continued throughout the field work period.

In the second phase, an operational mapping was conducted when the study team members visited the study sites to map out study areas and estimate the size and distribution of the target population. They also located health service centers/sites, other service centers and programs, social and religious centers, youth clubs, areas having access to HIV and FP services and major exit points of migration. Primary or secondary geographical co-ordinates for GIS mapping of key hotspots in terms of migratory movements, the major transit points, and areas with concentration of migrant labors and service sites for them were also obtained. Information was collected regarding the estimated population size of the study population living in each VDC from all the concerned stakeholders at the district and VDC level; and representatives of local government organizations (GOs) as well as non-government organizations (NGOs) and local people.

The third phase of the study consisted of qualitative as well as quantitative data collection from the randomly selected respondents representing different clusters selected for the survey. The study comprised of both qualitative and quantitative approaches. Both the qualitative and quantitative data were collected simultaneously.

### ***Quantitative Survey***

Two representative surveys were conducted, one each among MLMs and WoMLMs in the four study districts using structured questionnaire. A total of 1028 wives of migrants and 690 MLMs were covered by the survey.

### ***Qualitative Approach***

In addition to quantitative approach, qualitative methods (KII and FGD) were also incorporated during the data collection. Especially in the public health domain using qualitative tools are great in understanding perspectives of individual people because every individual interpret their own meaning and make sense of the world around them. Qualitative methodologies are “always probing contradictions and inconsistencies in the human condition because it is at this level that we begin to understand the dynamics of human behavior” (Ulin et al., 2002, p. 26). Therefore, the current study applied a qualitative approach to explore and identify factors and relationships that may not have been understood through quantitative survey. This assessment used in-depth interviews with key local informants and separate focus group discussions with MLMs and WoMLMs to generate further insights on the current HIV, STI and FP situation, need and priority areas for migrant couples to inform program design and delivery.

## **2.3 Research Ethics**

The study has been conducted in compliance with all human rights and ethical standards required by health researchers conducting studies among human subjects on sensitive issues such as HIV and AIDS. The study protocol was submitted to the Protection of Human Subject Committee (PHSC), FHI 360’s ethical review board and the Nepal Health Research Council (NHRC) for their review and approval. Oral informed consent, which was developed in Nepali, was obtained from all participants prior to the interview/discussions (Annex 2). The oral informed consent was taken in the presence of a witness who signed the consent form. Consent procedure was designed to protect participants’ privacy, allowing for anonymous and voluntary participation. No names and personal identifiers were used for the data collection. During the consent process, it was made clear to participants that they were free to refuse participation and that if they decide to participate; they may stop at any time. They were provided with enough information about the study procedure, confidentiality and study purpose. The interviews and discussion for the survey were conducted by same sex researchers in a private place such as community centers (private room), local school (during off hours), the local SSP implementing agency (private room) or other safe place agreed to by the study participants. Transportation cost and refreshments such as tea and snacks were also provided to the FGD participants.

## 2.4 Sample

The study team conducted eight FGD sessions among the two study populations (four among MLMs<sup>1</sup> and another four among WoMLMs<sup>2</sup>). Altogether, there were 59 male FGD participants and 64 female FGD participants. While seven to eight in-depth interviews from each district were conducted with Key Informants (KI) comprising of both health sector (DACC, DPHO and Health service providers) and non-health sector officials (LDO, IA/IPs and VDC secretariats). The FGD sessions were conducted at the VDC level and in-depth interviews with key informants at the district level. VDCs with highest concentration of male migrants were chosen for the FGD sessions. Each session consisted of around eight participants selected from among those who were the residents of that particular cluster/VDC. These candidates were identified during the household listing and survey. In addition, researchers made sure that participants in the discussion sessions were homogeneous in terms of vocal status and heterogeneous in terms of ethnicity and socio-economic background. Detailed information of the FGD and KI participants is presented in Tables 3.1 and 3.2.

## 2.5 Survey Tools/Instruments

### *FGD and KII*

Two separate checklists were developed to assess information on current HIV, STI and FP situation, need and priority areas for migrant couples to inform program design and delivery. New ERA in consultation with SSP developed an open-ended format to administer the guidelines and recorded the information. Both key informant interview and focus group discussion guidelines were developed in Nepali and same sex trained interviewers conducted these interviews and group discussions.

## 2.6 Survey Personnel

The survey was conducted by a team that was comprised of a Team leader, two Research Officers, one Research Assistant, and 42-member team of field surveyors which included enumerators and interviewers (17 male and 25 female).

## 2.7 Pre-testing of the Instruments

All the study tools were field-tested prior to the field work in non-sample districts of Gorkha and Dhading. These two districts were especially chosen considering their proximities to Kathmandu valley and also because of the presence of a considerable proportion of migrant families in the districts. This helped improve field procedures, schedules and questionnaires, and help familiarize the field enumerators with the instruments. The field test also examined the adequacy

---

<sup>1</sup> **Male Labor Migrants (MLMs):** MLMs included “a returnee male migrant aged 18-49 years, having stayed continuously or with interruption for at least 3 months in India or any other foreign countries as a migrant worker, and returned to Nepal at least once within three years prior to the date of survey”.

<sup>2</sup> **Wives of Male Labor Migrants (WoMLMs):** The WoMLMs included “a currently married women of age 15-49 years whose spouse has spent at least three months in India or any other foreign countries as migrant worker and has returned home at least once within three years prior to the date of survey”.

of the questions, clarity/wording of questions, sequence/flow of questions, and questionnaire administration techniques. In addition to it, observation checklist were created for FGD sessions to see if the moderator, introduce themselves, introduce other team members, ask participants to introduce themselves, address issues of confidentiality, Introduce the topic, ask permission to record, did the moderator talk a lot, encourage others in the group to talk, deal with dominating participants, deal with shy participants, try to understand what the participants were saying, was the moderator judgmental about the topic, did the moderator give participants the idea they gave the wrong/right answers, were open ended questions used, probing questions used.

In light of the experiences gained in the field tests, instruments were modified. The actual fieldwork for data collection was began in August 22, 2012 and ended in October 16, 2012.

## **2.8 Recruitment and Training of Study Teams**

The field teams were selected from among a regular staff pool of New ERA, experienced in conducting similar surveys. A 12 days long training was provided to the study team members to familiarize them with the sampling procedure and the contents of the interview guidelines. Besides, research objectives and the purpose of the research were explained along with the ethical consideration and role and responsibilities of the team members. Additionally, class room lectures, role-play and mock interview exercises also formed an integral part of the training.

## **2.9 Data Collection Method**

Both the interview and FGD guidelines included roles and responsibilities of the FGD moderators and note taking persons. The FGD sessions were tape-recorded with the permission of all participants. The interview and FGD sessions lasted anywhere between one hour to one and half hour. The discussion sessions focused pre-identified topics. The FGD discussion topics and KI interview questions were finalized in consultation with the Saath-Saath Project/ FHI 360 officials before they were implemented in the actual fieldwork. Copies of FGD guideline and KII checklist is presented in Annex 2.

## **2.10 Data Management and Analysis**

Thematic analysis method was used to organize the data and analyze the results. The qualitative data were analyzed according to the “question route” under different “themes”. Verbatim were categorized and supplemented in the report, with or without vignettes, wherever relevant. All of the talks and the textual data that fit under the specific themes and questions were placed with the corresponding pattern. All the FGDs and KIIs were transcribed by data collectors within few days of completion of the discussions and later translated by New ERA core team staffs with fluency in both Nepali and English. It is important that the person who conducts the interviews also does the translation because if the interviewer and the person making the transcripts are the same person, they will be able to draw on additional implicit information (body language, tone of voice etc.) that may help them to choose the appropriate transcription. Therefore, great attention was paid during the entire transcription and translation process because translation-related decisions have a direct impact on the validity of the research and its report. Since the information collected from

FGD participants and KIIs were descriptive in nature and recorded in plain sheets and micro cassettes, they were processed manually. Transcribed data were then translated from Nepali into English onto electronic files by research officers. Translation process also involved listening of recorded interviews during the translation process.

## **2.11 Organization of the Report**

The study report is presented in total of 8 chapters. Chapter two consists of sample, methodologies used to collect data, data management and analysis. The third chapter provides information on profile of the study participants. Fourth chapter is dedicated towards analyzing information of MLMs on their migration pattern, and its impact on their female counterparts. Chapter five moves onto health issues faced by MLMs and the wives, reasons behind such health problems and treatment practices. Next chapter begins to explore into the core subject matter of the study with information on FP situation, service needs and program gaps. Chapter seven analyzes HIV and STI situation, service needs, barriers to access the services, stigma attached with service usage, and program gaps that exist in the study districts. Lastly, chapter eight includes conclusion of the study.

## CHAPTER 3.0: BACKGROUND CHARACTERISTICS OF PARTICIPANTS

### 3.1 Key Informant Interview Participants

A total of 30 officials from four study districts participated for the KIIs. Thirteen officials were from health sector and 17 from non-health sector. Among these key informants, 13 were health professionals like officials from District AIDS Coordination Committee (DACC) (20%), doctor/nurses (13%) and NGO working on health sectors (10%). Likewise, the key informants

Source of Information	Districts				Total	
	Bara	Nawalparasi	Palpa	Kapilbastu	No.	%
<b>Health</b>						
DACC	*	**	*	**	6	20.0
Doctor/Nurse	***		*		4	13.3
NGO		*		**	3	10.0
<b>Non-health</b>						
DDC/LDO	*	*	*	*	4	13.3
WDO	*	*		*	3	10.0
VDC		*	***	*	5	16.7
NGO	**	*	*	*	5	16.7
<b>Total</b>	<b>8</b>	<b>7</b>	<b>7</b>	<b>8</b>	<b>30</b>	<b>100.0</b>

from non-health background represented Village Development Committee (VDC) Secretaries and officials from Non-government organizations (NGOs) working with migrant workers (17% each), Local Development Officer (LDOs) /Program Officer- District Development Committee (DDC), (13%) and Women Development Officer (WDO) (10%). Detailed breakdown of each is presented in Table 3.1.

### 3.2 Characteristics of the FGD Participants

Table 3.2 shows that almost 56 percent of the MLMs who participated in the FGD were between the ages of 21 and 30 years. More than 50 percent of the participants had primary and above level (up to grade 10) of education and a quarter of them had completed SLC and above level education. Male participants mainly belonged to the ethnic group of Brahmin/Chhetri (34%) and of Terai origin (31%), while a few belonged to the Dalit (9%), Janajati (19%) and Muslim (9%) ethnic groups. Almost 86 percent of the male FGD participants resided in rural areas. Similarly, almost 58 percent of wives of MLMs were aged between 21 and 30 years and 39 percent of them had primary and above level (up to grade 10) of educational attainments. Most of the female FGD participants belonged to the ethnic group of Brahmin/Chhetri (39%) then of Terai origin (24%), Janajati (21%) and Dalit (16%). All the female FGD participants (100%) were from rural areas. Rural areas here is to be interpreted as areas outside of the cities and towns, primarily VDCs and urban as areas with higher population densities and with some elements of urbanization such as district headquarters and major cities.

Characteristics	MLMs		WoMLMs	
	Number	%	Number	%
<b>District</b>				
Bara	13	22.0	16	25.8
Palpa	14	23.7	17	27.4
Kapilbastu	16	27.1	15	24.2
Nawalparasi	16	27.1	14	22.6
<b>Age</b>				
<20	5	8.5	5	8.1
21-30	33	55.9	36	58.1
31-40	17	28.8	19	30.6
41+	4	6.8	2	3.2
<b>Education</b>				
Illiterate	3	5.1	10	16.1
Primary 5	11	18.6	17	27.4
Primary to Grade 10	30	50.8	24	38.7
SLC and above	15	25.4	11	17.7
<b>Ethnicity</b>				
Dalit	5	8.5	10	16.1
Janajati	11	18.6	13	21.0
Chhetri/Brahmin	20	33.9	24	38.7
Muslim	5	8.5		0.0
Terai Origin	18	30.5	15	24.2
<b>Residence</b>				
Rural	51	86.4	62	100.0
Urban	8	13.6		0.0
<b>Total</b>	<b>59</b>	<b>100.0</b>	<b>62</b>	<b>100.0</b>

The FGD results showed that more than 50 percent of the FGD participants were returnees from Gulf countries, such as Dubai, Qatar, Saudi Arab, etc. (Table 3.3). Over 52 percent of the wives of MLMs also reported that the migration destinations of their husbands were Gulf countries. Migrating to India for work was also high as reported by the males (31%) and their female counterparts (34%).

Characteristics	MLMs		Wives of MLMs	
	N	%	N	%
Country of Migration				
Malaysia	10	16.9	9	14.5
India	18	30.5	21	33.9
Gulf Countries	30	50.8	32	51.6
Europe/America	1	1.7	-	0.0
Africa	-	-	1	1.6
<b>Total</b>	<b>59</b>	<b>100.0</b>	<b>62</b>	<b>100.0</b>

## CHAPTER 4.0: MALE MIGRATION AND ITS IMPLICATIONS ON THEIR FEMALE COUNTERPARTS

### 4.1 Migration Pattern among Male Migrants

Almost all the FGD and KII participants agreed that external migration for work is on a steady rise. Participants' reported number of migrant males ranged anywhere from 10,000 to 40,000 in four different study districts, and amongst these migrating men, almost 50 percent were unmarried. Key informants in all four districts reported that almost 30 to 50 percent of the total males of the districts have migrated abroad for work and its number continues to rise. This clearly suggests high number of males migrating abroad for work. It was also reported that the trend for migration for work is on a sharp rise. Unemployment was a frequently reported theme across all the interviews as a definite cause for increasing trend of migration. The FGD participants also explained lack of job opportunities in own country for the unemployed and educated youth in addition to desire to work abroad as the underlying cause for migration.

*"Men are educated but they cannot find jobs and also because of the geographical terrain, agriculture is not sufficient to sustain livelihood. They have to buy food for which they need cash"*

– **Health Worker, Palpa.**

*"The number of MLMs has increased because there are no job opportunities in Nepal and unemployed individuals can earn good money by working abroad."*

– **Male FGD Participant, Bara.**

It was revealed during the interviews and FGD sessions that the countries of destination for work were similar across all the four districts. Their destinations were mainly Gulf countries, India and Malaysia. However, financial conditions did play a role. For example, most study participants argued that men who could afford prefer to work in the Gulf countries, Malaysia and also Korea, while those could not bear to afford the initial costs such as visa, passport, and airfare migrate to India. The key informants also reported that it was easier to find works in India, did not have to worry about visa and passports as it was right across the border, have network of friends and similar socio-cultural background which made India a favorable place to work for. Popular cities to work at in India were Mumbai, Delhi, Bihar and Punjab.

*"Many people go to India because of the close cultural/social ties with India and the jobs are easily available even for the unskilled/uneducated. Plus, there is low cost of getting there. "*

– **Non Health Professional, Kapilbastu.**

*"India is in close proximity with open border system, no work permit is required. It is especially easy to go to UP because Sunauli border is nearby".*

– **Non Health Professional, Palpa.**

Discussions with migrants and their wives revealed that migrant workers on average stayed at least two to five years maximum (depending upon the type of contract) in Gulf countries, Malaysia and Korea. However, those who worked in India stayed six months at maximum. Their average length of stay at home also depended upon the country of destination. Those working in Gulf, Malaysia and Korea stayed home for two to three years while those in India the duration is unsure, depending upon types of works in which they are involved and farming situation of the families. It was also reported that most unmarried men do not return

home for vacation, they usually tend to return home after the termination of contract. The overall findings from FGDs and key informant interviews indicate that generally migrants in India returned home during the festival/holiday and agricultural seasons and depart to migrating destinations when work at home is finished. On the contrary, those migrating to gulf countries, Malaysia and Korea did not have any specific schedule of departure and return.

#### 4.2 Communication between Migrant Husband and Wife at Home

Qualitative findings revealed that most migrant males informed their wives before returning home, anywhere between one to two weeks before their arrivals. Migrants who go abroad on visa had the expiry date and aware about dates when they need to return home because their holidays are already pre-determined and therefore always inform their family and spouse. Such communications are usually done through telecommunication. However, there were some migrant males who liked to come without any prior notice. This usually happened among those who go to India for work. The FGD participants in this context mentioned that some of their friends tried to make a surprise home visit so that they were able to learn about their wives' behavior in their absence.

*“Most of them inform their spouse or other family members. However, there are some who like to make a surprise visits so that they can learn about their wives' behavior in their absence.”*

**– Male FGD Participant, Palpa.**

Key informants in Palpa reported that most of the female counterparts in the district have now better communication facility with their husbands abroad because of the availability of mobile phones and extensive installation of telephone towers in the districts. These facilities have also helped accessing remittance money from their husbands directly. As a result, key informants indicated that many WoMLM in hilly areas and communities from districts such as Palpa and northern hilly part of Nawalparasi move to urban/semi-urban with their children for better education opportunities, health services and modern conveniences after their husbands leave. This indicates that the women in the area have become the primary decision makers in how to spend the money. Key informant interviews indicated that moving in the urban areas provides WoMLM a wider exposure of the urban world. They get their own benefits of health, education and for their children. Many also engaged in novel entrepreneurships such as running shops, small businesses such as beauty parlors, tailors, making bead necklaces or hold daily wage jobs and so forth. Interestingly, study participants also argued that the modern communications facilities (e.g. mobile phones) have also provided many opportunities for them to engage in extramarital affairs, for example:

*“...major reasons for such extra marital affairs are mainly because of the advanced communication system, like cell-phones and the provision of emergency contraceptive pills. Cell phones allow women to correspond with other men in secrecy and easily arrange meetings without others learning about it. The use of emergency contraceptive pills which is easily available now in the community, permit women to prevent any accidental pregnancies as a result of such affairs”.*

The key informants mentioned that there are only few wives who are not involved in economic activities after migrating to urban/semi-urban areas and are limited to household

chores caretaking of their children and entirely dependent upon husband's earnings from abroad.

However, this study also found that the spouse migration has not brought so much of changes in the life of women in Terai region. The discussions with the key informants indicate that in Terai districts such as Bara, Kapilbastu and southern Nawalparasi, WoMLMs were mostly confined to rural setting and limited within traditional household chores of raising children; maintain their homes, cooking, animal husbandry and vegetable gardening. Most key informants from Terai region argued that most wives in these districts have very little engagement in other external income generating activities after the husbands leave thus do not migrate to urban setting after their husbands leave like the women in hilly regions do. The key informants also had notions that there is a strong stigma attached with Terai-origin women moving alone or with children to urban areas.

Key informants further add that migrant couples in Terai areas have less communication with each other than the couples from hilly region and communities. They do not have access to their husband's earnings from abroad and thus have very limited access to cash. These reasons prevent them from becoming the primary decision makers of their own lives or that of their children. Furthermore, socio-cultural backdrops, such as *Purdah* system (in *Purdah* system women put scarf on their heads in presence of other men) also limit them within their household. Culmination of these situations prohibits women of movement at their own will. They are hesitant to come forwards and share their feelings with the outsiders. In general, this study found that wives of migrant workers in Terai-origin communities are comparatively less privileged than the wives of migrant workers in hills.

*In Terai districts such as Bara, Kapilbastu and Nawalparasi rumors and incidents of extra marital affairs among wives after the departure of their husbands are very few. Whereas in Palpa and Nawalparasi district the participants in FGD and key informants reported many cases of extra marital affairs and some even eloping with other men in absence of their husbands. It was further pointed out by them that the socio-cultural system of the hill-origin people and in hilly areas makes women more empowered and relatively give more freedom in decision making process than the women in Terai areas. While wives in hilly area districts do not require any special approvals for their activities, women of Terai-origin communities still in traditional system and under the obligation of household heads and need consent to make decisions.*

## CHAPTER 5.0: HEALTH SITUATION AMONG MLMS AND THEIR FEMALE COUNTERPARTS

### 5.1 Health Issues among MLMs

Key informants and FGD sessions inform that MLMs have high chances of getting HIV and AIDS, STIs, tuberculosis, malaria, respiratory diseases, jaundice, malnutrition and other various health problems due to sudden changes in the weather condition including heat-wave, physical injuries due to work hazards and unsafe sexual behavior. The destination countries for migrants played a significant role towards the health issues faced by the migrants. For example, FGD among migrants revealed that individuals who migrate to India had greater threats of HIV and AIDS and STIs mainly due to the exposure to female sex workers in the city areas and unsafe sexual intercourse. They explained that female sex workers visit the migrant men during pay day at Malaysia, suggesting even the males who migrate to Malaysia are also at risk. While those in Gulf countries the extent of indiscriminate sexual contacts and contraction of sexually transmitted diseases were reported to be very low. The participants mainly complained about respiratory ailments and physical injuries among migrants working in Gulf countries. According to the respondents, anonymity in abroad, lack of awareness, information and health neglect are the culprits behind such health problems.

### 5.2 Treatment upon Return

Migrant workers when in need for medical care reported to have visited variety of health service centers. In-depth interviews with both health and non-health personnel stated that these people generally visit district hospitals, private clinics, health posts, sub-health posts. Few also argued that some migrants male even go to India to seek such services. It was usually the case that individuals sought services at hospitals and public health posts with minor illnesses as it is cheaper. However, if the problems are more complicated and related to sexual transmitted infection then they generally prefer confidential services and seek medical help at private clinics or across the border, especially for individuals who live near the border areas. Many FGD participants from Bara and Kapilbastu reported going to India for medical care in cities such as Gorakhpur and Raxaul.

*“...people prefer government services and prefer getting treatment from health posts; they only go to big hospitals and private sector if needed.” (Health Worker, Palpa)*

Treatment Practices: Key informant interview with health workers in the study districts reported that migrant workers prefer private clinics for privacy reasons and public sector services for low cost services; however which service point they chose depends upon the nature of the illnesses. For example, upon their arrival at their native place and if in need of medical assistance, migrants choose to get treatment from government health facilities as the costs are relatively minimal. However, if migrants are in doubt of HIV and STIs, they prefer private clinics and hospitals

*“...they try to hide to their illness due to fear of stigmatization from the community but some go to private sector as they provide confidentiality.” (Health Worker, Bara)*

in India. In some cases, fear of stigmatization from the society holds back migrants to seek services related to reproductive health issues, HIV and STIs.

Lack of confidential services was reported as the number one cause for hesitancy towards seeking such health services at their native place. It was a common for migrants to seek medical help only if they have to, as minor illnesses goes unnoticed. Similar responses were found throughout the interviews with respondents from health as well as non-health sectors in all the study districts.

### **5.3 Sexual and Reproductive Health (SRH) Problems and Treatment Practices among Female Counterparts**

The FGD participants expressed that many women including the wives of migrant workers of the study districts were suffering from various types of SRH problems such as menstrual disorder, excessive bleeding, swelling, genital discharge and pain in lower abdomen, uterine prolapse, unwanted pregnancies. Some even named HIV/STIs as common problem among migrants' wives. Most FGD and interview participants agreed that they generally seek treatment in local health posts, hospitals for common illnesses and go to private health clinics for serious problems. They further hinted that the reason for visiting private clinics is to ensure confidentiality. Few participants revealed that some women in this community also travel across the border (India) for services as they believe that services available in India are better and confidential.

*“...some women go to India for treatment because the service in India has been much publicized and they offer confidentiality.” (Health Worker, Kapilbastu)*

*“...they go to places like Bhaisa Lotan, Tudibari and Gorakhpur as they trust the doctors there more and the services are better and confidential.” (Health Worker, Nawalparasi)*

## CHAPTER 6.0: FP SITUATION AMONG MIGRANT COUPLES

### 6.1 Use of Modern FP Methods

The findings from discussion among the participants suggest that current FP use situation in study districts continues to rise. In addition to prevent unwanted conception and avoid sexually transmitted infection, health workers in the districts reported that use of family planning methods has increased. Participants unanimously accepted that the influence of education and public awareness programs in the community have played key role increasing FP use. However, FGD among MLMs revealed mixed reviews about use of FP methods. Individuals in general had the knowledge about FP methods but rationale behind the use varied. Although the respondents reported that use of FP has increased than it used to be in the past, it was found that FP methods were now used mainly for child limiting and birth spacing. The interview participants agreed that those who do not want children use FP and those who wish for more children don't use it. The FGD participants mentioned that FP use for safe sex or to prevent from being infected with the diseases was very rare among the migrant couples.

*"...those who need it, use it, those who wish for more children don't use it." (Male FGD Participant, Kapilbastu)*

*"...the current FP use situation in this district among the MLMs is high; it is especially used for limiting and spacing births." (Male FGD Participant, Nawalparasi)*

### 6.2 Differences in FP Use between Migrant and Non-migrant Couples

KII informants as well as FGD participants suggested that Condom, Copper T, Injectables, Pills, Intrauterine Device (IUD) and Depo-Provera are some of the FP methods among used by the migrant couples. Interviews with health experts had mixed opinions when inquired about any differences that may exist between migrant and the non-migrant couples. While some health workers believed there are no such differences. On the other hand, few interviewees shared that differences exist such as the type of methods used and frequency of usage. They argued that generally non-migrant couples use long lasting FP methods such injectables and Norplant while migrant couples mostly use non-clinical method such as condoms. As for frequency, non-migrants use FP methods more than migrant couples. As husbands and wives live separately, FP use is less frequent among migrant couples than non-migrants.

*"...no single person makes the decision, after discussion between the couple they make a mutual decision on what contraception is to be used." (Male FGD Participant, Kapilbastu)*

*"...both husband and wife discuss and then decide. The women are more assertive about it as they are the ones who have to bear the burden of children. Men take the initiative as women don't leave the house and can't think about going outside to get it." (Male FGD Participant, Bara)*

FGD among MLMs revealed that both husband and wife discuss about their available options and then decide. They suggested that women are more assertive about it as they are

the ones who have to bear the burden of children. As for the collection of condoms and oral pills from the market, men take the initiative in most cases.

### 6.3 FP Preparedness Before or When Male Migrants Return Home

Focus group discussions with MLMs and their female counterparts reveal that there are usually no exact plans between the couples before coming home regarding the use of FP method. While some men use FP methods such as condoms, some do not use any FP methods and state that FP use depends on the couple needs. The study participants also discussed about preparedness about FP. In some cases it was reported that women themselves visit health posts or get counseling and discuss about their available options which ranged from pills, injectable, Depo-Provera and condoms. However, few wives also explained that first the husband comes and then the decision to use FP is discussed. Some women during the FGD stated that husbands refuse to use condoms after return as condoms limit sexual satisfaction and are bothersome to use.

*“...they don’t have any such plans before coming home. It depends upon the person. If they are educated or are in doubt they use FP methods and conduct check up.” (Male FGD Participant, Palpa)*

*“...depends on the couple’s needs; contraceptive is only used when the husband and wife live together; some are already sterilized so they do not need any additional contraceptives”. (Male FGD Participant, Kapilbastu)*

### 6.5 Sources of FP Services

Most wives of the MLMs during FGD sessions shared that if they need any FP related services they generally visit health posts, sub health posts, turn to FCHV, pharmacy, local women’s organization, Marie Stopes International (MSI), Family Planning Association of Nepal (FPAN), Population Services International (PSI) and local NGOs. It was also reported that sometimes health camps are organized where women can easily access FP methods. However, they claimed that there are no specific organizations providing FP services exclusively to the migrant population so they share same resources as the general population. While discussing about attitude of health workers, almost all the respondents had positive replies about their service providers. Key informants added that most couples prefer to seek services from private sector; however, they accepted that many couples still visit government services because they are cheap and free. Some health experts had also experienced that women visited private clinics and organization if the husband is away. Couples do not usually travel to India to seek FP services except for those residing in the border areas. In general, it was found that people went to variety of places for services including both government and private health centers.

*“...they go to all sorts of places such as private health services, FP division, medical clinics and government run service centers. But for assurance of confidentiality they prefer private services.” (Health Worker, Nawalparasi)*

### 6.7 High Priority FP Service Related Needs

Interviews with key informants from health sector revealed that there is a need for comprehensive knowledge of FP methods among migrant couples. Most health workers interviewed stated

*“...people need elaborative and extensive knowledge regarding FP services and correct FP method usage. They should also have regular health checkups and services that match the need and desire of people.” (Health Worker, Bara)*

that community people including migrants/wives are aware about different kinds of FP methods but do not have detailed information on them. They suggested that people should not just be informed about various kinds of FP products but also on correct use of the method. In addition to it, they also indicated that regular health checkup service should be provided and promoted and let people have the information on the right kind of FP methods that matches their need and desire.

## 6.8 Unwanted Pregnancy among Migrant Couples

Most wives of the FGD had a notion that if a woman gets pregnant in her husband's absence, then the situation gets controversial. Husband, the family and society become critical and ostracize. It becomes an extremely disputed issue and the women can end up being thrown out of the house and left alone to cope. Pregnancies resulting in absence of husbands do not leave women much choice other than abortion. They further added that despite it is now legal; abortions are not commended in community and some to the extent that they find it negative and unacceptable. Husbands also disapprove of it unless it is a jointly made decision. Confidentiality and secrecy are thus essential for women if they decide to

*"...wives getting pregnant in her husband's absence can be very controversial. People in the community will question the paternity and counting the day the husband left to determine who the father is and the pregnant woman can even be thrown out of the house and the village itself". (Female FGD Participant, Nawalparasi)*

undergo abortion. Generally, most women in the study preferred such services from private clinics and organizations such Marie Stopes International.

*"It gets very controversial. Smart women don't let the community know and immediately abort". (Female FGD Participant, Palpa)*

## 6.9 Acceptance of Long-term FP Methods

Key informants from health sector indicated that if couples are satisfied with the number of children, they are open to using long term FP methods. Despite some acceptance, in most cases it is not much accepted as people question the validity of using long term FP methods if the husband is not around. They think that as husbands are away there is no need of FP methods. Women fear being gossiped about for using FP in their husband's absence and her character comes under scrutiny. So much of the couples did not think long-term FP was needed. Many non-health workers also stated that there is no need of FP services if the husbands are away, unless the wives are having extra-marital affairs. However, they also stated that wives need FP in husband's absence to prevent unwanted pregnancy and practice safe sex with other men.

*"...long term family planning methods are not much acceptable as people question the validity of using long term methods if the husband's not around and so don't need FP. Women fear being gossiped about for using family planning in husband's absence and her character looked at suspiciously as well. So they think long term FP is not needed" (Health Worker, Nawalparasi)*

## 6.10 Problems Faced by Migrant Couples in Accessing FP Services

According to the key informants major barriers in access to FP services are social, cultural and geographical limitations, women unable to make own decision, financial issue and side effects from some of the methods used. In Bara, Kapilbastu and Nawalparasi districts, health workers reported that in many Muslim communities, there were issues with access as it is against their religious and cultural norm to use FP methods. They further added that despite the risk of getting caught some Muslim women use FP discreetly while some Muslim women say it is God's gift so they keep on having babies.

*"...women in Muslim community do not use sterilization because it is against their religion. If women do so, people do not even drink water their hands and when they die, different kinds of rituals are applied to them as they got sterilized".(Health Worker, Kapilbastu)*

In Palpa, geographical barriers were identified as a major challenge in access to FP services. In hilly remote areas all FP methods are not always available as it is challenging to reach such areas. Key informants mentioned that strong prevalence of stigma was found in the community if migrant wives use FP methods while the

*"The husband will question the need for using contraceptives. Some women use it without husband or others knowing about it. If they know the husband is coming then she will use the three month injectable and ask the health workers not to tell anyone about it. Men are not understanding about reproduction problems women face and some won't even let their wives go to health posts, they don't like wives stepping out of the house. So some women pretend to go to cut grass while going to get injected with the injectables". (Female FGD Participant, Kapilbastu)*

husband is away for work as people think she has another sex partner. From the perspectives of WoMLMs, some participants reported that their major challenge is their husbands not agreeing to use contraceptives and this was especially true if the husbands are away.

## 6.11 Key Changes Suggested in Service Providing Modality

Key informants from health sector attest that key changes needed in FP service providing modality to increase accessibility and acceptability was through increase in awareness and supply of FP services. It was suggested that migrant couples need more information on FP methods and encourage them to stay protected. Key informants suggested that intervention would be improved if awareness programs are held during times of holidays or agricultural season when men will be home. According to them, more health workers from the both government and NGO sectors should be trained and mobilized so that they are available whenever people need them. Programs should also be able to empower women and encourage them to make important decisions on their own. Some participants also suggested that Labor Ministry and

*"Programs have to be able to reach the target population and it has to be long duration one". (Health Worker, Palpa)*

*"Labor Ministry and manpower companies should provide orientation on HIV/STI and FP". (Health Worker, Kapilbastu)*

*"There has to be increase in health works, budget for health sector have to be raised so that it's adequate and instruments required has to be supplied".(Health Worker, Nawalparasi)*

manpower companies located in Kathmandu valley as well as in the district headquarters should give out orientation in HIV/STI and FP to migrants and their female counterparts before they leave abroad for work.

## 6.12 FP Programs Implementation and Suggestions for Further Promotion

According to the key informants, many promotional activities were conducted in the four study districts to promote awareness about FP and safe sex measures. Government and non-government organizations alike had conducted activities and events such as street dramas, radio programs, discussion groups, counseling in health centers, trainings at schools, and advertisements on hoarding board and pamphlets, promotion of safe sex, documentary screenings and so forth.

*“Appropriate budget has to be allocated for programs, there should be awareness programs on radios, street dramas and conferences to increase awareness. PHC and sub health post should work to organize public awareness programs”.*  
(Health Worker, Nawalparasi)

However, such programs were not aimed at the migrant population. It was suggested that programs should reach the target group and hard to reach rural areas. There should also be more FP clinics in the communities and more awareness programs and for this more budgets should be allocated. Key informants further share that usually in the hilly areas and remote VDCs with disadvantaged population; people are in need of FP related interventions and services. Health related services and facilities need to be thus expanded from time to time, along with monitoring and evaluation of services by health organization. Informants across all the districts agreed that there should be increase in coverage of the programs. Male FGD participants added that people are aware about FP but they do not have adequate information about it. Therefore, the need to increase quality of services being provided was yet another suggestion.

*“Besides condom, we don't know many things about FP and surrounding health posts are not bothered. FCHV provides health related information directly and are more proactive than health posts in providing services. There is a need for FP services but there are no services and information about FP, what else can we say about suggestions? The doctors are not good and no treatments either”.* (Male FGD Participant,

## CHAPTER 7.0: HIV AND STI SITUATION AMONG MIGRANT COUPLES

### 7.1 Knowledge of HIV/STI and Sources of Information

Most of the participants in both FGD sessions with male as well as female mentioned that they have heard about STIs including HIV and AIDS. There were some male respondents in Kapilbastu who said they knew about AIDS but had not heard about HIV or STI. Many pointed out that HIV is „sexually transmitted disease’. Such statements point towards lack of comprehensive knowledge about HIV and AIDS and its mode of transmission among the migrants and their families. It was stated that by some respondents that HIV and STI could be caused due to „lack of cleanliness’. Some also mentioned that it is only transmitted through sexual routes. Some MLMs further pointed out that they were not familiar with the symptoms of HIV and STI and are „clueless’ about how they are transmitted.

*“...everyone has heard of AIDS but most haven’t heard of STI and HIV. Most of us are clueless about symptoms of STI and how it is transmitted”. (Male FGD Participant, Kapilbastu)*

*“...women don’t know what an STI is and think it is caused by lack of cleanliness. It is also caused by lack of care and carelessness during post-partum period in women which later on creates issues such as uterus prolapsed, white vaginal discharge, back pain etc. It is more common among older generations like mother in laws”.(Female FGD Participant, Bara)*

Radio, television, FCHVs, health institutions, community networks are some of the sources of information regarding HIV/STI to the community as cited by the FGD participants. Some respondents in Kapilbastu also mentioned that they had come to know about HIV/STI through awareness programs and community discussions.

#### *Attitude towards STI and HIV and AID*

The FGD participants agreed that the general attitude of people towards those living with HIV or STI has been gradually changing as their awareness level is growing up. However they added that there are still some people who hold negative attitude and discriminate such people like giving them separate plates to eat and not mixing up with them. The male migrants further added that those who are educated and aware understand everything still they look down at the infected person.

*A woman of 38-40 years was physically marked as a sign of stigmatization and thrown out of the house and community by her husband and mother in law when it became known that she has been infected with HIV. (Non-health Professional, Bara)*

*In my own VDC, a man died of HIV and the family blamed his wife for the husband’s infection and subsequent death and threw her out of the house.(Non health Professional, Kapilbastu)*

*There was a man in the market who gave counseling on STIs. That person was made to leave the town because local did not like his work and had doubts on him. (Health Worker, Bara)*

Further interviews with the key stakeholders also suggest that there are still many people who hold negative perception and discriminate and ostracize HIV/STI infected people. One of the Key informants mentioned

that in practice the community people react negatively towards those infected, even if they say that they don't discriminate publicly.

## 7.2 Current Situation of HIV and STI

When FGD participants were asked to discuss about the current situation of HIV and STI in the district, most replied that they are not aware of the situation in their community and have only heard stories about it because people tend to hide about it if caught by infection. Only few participants knew of people with infection and had interactions. However, most MLMs and both health and non-health workers from each study districts were convinced that HIV and STI is on steady rise. Three of the 13 Health workers mentioned that „migration to India' is the primary factor responsible for the „increasing trend' in HIV prevalence. The key stakeholders belonging to non-health background also agreed that „migration to India' and the „open border' have resulted to free mobility and thus contributed to the increase in HIV vulnerability. They further stated that HIV cases are high in the VDCs in close proximity with Indian border and those that lie in the highway belt. Some health workers further stated that many men do not report their families with their infection situation and often times even the person with infection is unaware of it. There is also negative connotation associated with the infection as community usually discriminated those who are infected and as well as the family. In Kapilbastu some male respondents in FGD session pointed out that there have been 2-4 deaths due to AIDS.

*“...in my own VDC a man died of HIV and the family blamed his wife for the husband's infection and eventual death of husband. They threw her out of the house”. (Non health Professional, Kapilbastu)*

*“...people who migrate to India to work visit sex workers who have high HIV prevalence and thus get infected” (Health Professional, Nawalparasi)*

*“...in Kalaiya, ward 7, a hilly community boy got infected while injecting drugs, BIJAM organization helped out for a while but now he is helpless, awaiting death”. (Non health Professional, Bara)*

This comes as an interesting finding that most of the male FGD participants said they had not met anyone with HIV/STI, on the contrary many women FGD participants said they had met or seen someone who had STI or were HIV positive.

*“Can't tell if someone is infected (HIV positive or has STI) because it is never written on their face nor do they say it publicly”.(Male FGD participant, Kapilbastu)*

## 7.3 Perception on Most at Risk Population

Female FGD participants discussed that that migrant workers are one of the most at risk groups of acquiring HIV and STIs in the study districts. In some of the FGD sessions, the respondents specifically mentioned that those migrants who go to India or Mumbai in India are especially at risk groups. The other at risk groups as pointed out by them included uneducated and unemployed youth, injecting drug users, drivers/transport workers, commercial sex workers and laborers.

*“Men who migrate to Mumbai in India bring the disease with them from abroad”. (Female FGD Participant, Bara)*

*“People who reside along the highway and border areas are more prone to HIV/STI transmission”.(Health Worker, Bara)*

Non-health workers as well as other key stakeholders also mostly perceive MLMs and sex workers as the population who are most at risk followed by drug users, transport workers and also uniformed personnel. Sexual promiscuity and careless sexual encounters of the husbands were identified as the leading behavior that put couples at risk for infectious diseases. Some respondents in Bara and Kapilbastu mentioned that male migrants returning from India are particularly at risk because they do not go for regular checkups and testing. Key informants added that mostly it is carelessness on husband's part that puts wives at risk. Women are also forced to trust their husbands but the husbands do not share their about their risky practice outside the country with their wives thereby put wives at risk.

People in general do not approve of sexual relationship outside marriage. FGD participants mentioned that it is not normal or okay for migrant men to engage in risky sexual practices while away from wife/family. However, few respondents said since it is our patriarchal society, having multiple partners is okay and that men do it regardless. Key informants reported that as a patriarchal society such practices are not regarded as a serious offence. Although few cases of extra-marital affairs and abortions are heard from time to time, key informants explained that among the wives of MLMs such activities are frowned upon, absolutely not approved of and not much common.

#### 7.4 Prevention and Treatment

Key informants stated that more and more people are getting aware of HIV and STI due to various intervention programs as and exposure to health workers, media and educational programs. However they agreed that only some are adequately informed on preventive methods. The key informants further added that almost none of the male migrants get tested after returning home either because they are confident of being disease free or due to lack of awareness with combination of societal fear of labeling. They also do not get immediate testing after returning home due to lack of awareness about testing facilities. Even the educated people aware about HIV/STI feared getting tested because of society's negative perceptions about HIV and AIDS. Also, HIV testing centers are not available everywhere as pointed out by some of the key informants and so it is always not convenient for those who want to take up the test as they have to travel long distance and pay more for testing. Other reasons such as societal fear with combination of lack of awareness were pointed out by many women why people do not get tested as well. Women do not get tested or treated as most women cannot make their own decision and even if aware about the need to get tested, they are hesitant about expressing it to the husbands for fear of being questioned/accused of infidelity and creating tension in the family. According to the key informants this is particularly true about women from Terai belt.

*"...women do not get testing or treatment. When they come to clinic for other physical health issues, STIs are diagnosed. This is because they are not aware about STIs and their signs. If some women do know about their symptoms, they do not seek medical help for fear of embarrassment; hide it from husband, and for fear of community's response".(Health Worker, Kapilbastu)*

*"Only the educated class adopts preventive measures like use of condom with workers". (Health Worker, Bara)*

Health professionals almost unanimously agreed that with the increase in awareness people are using condom to protect themselves from HIV transmission especially when they have sexual relationship with female sex workers. However some key informants further added that „only the educated classes adopt preventive measures like use of condom. FGD sessions with male migrants further revealed that migrant workers are not very cautious about safe sex practices with their wives as they feel safe with them. Those who have been indulged in unsafe sexual practices also secretly take up testing but do not practice safe sex with their wives thus increasing the chances of STI/HIV transmission to them as well.

*“No HIV/STI service for migrant workers exists in the VDC. There has to be an informed person in the VDC who can at least provide direction to those who need HIV/STI services.” (Male FGD Participant, Bara)*

Discussions with the participants, it was revealed that people mostly visit government health facilities whenever any problems are detected. Some also go to private clinics/medical centers and HTCs. One of the health professional further mentioned that some also seek help with organizations that deal with HIV and follow recommendations and suggestions provided to them by the counselor. Female FGD participants in all the districts pointed out that since treatment and care services are not available in the VDC; the local people have to travel to the district headquarters to receive them.

*“There are no services in the VDC or anywhere close by either. For HIV and STI related services people have to travel to Taulihawa, Bhairahawa which are not close”. (Male FGD Participant, Kapilbastu)*

## **7.5 HIV and STI Services Available in the Community**

Information from FGD sessions showed that there were no specific organizations providing services to either to the MLMs or the wives of MLMs. According to the respondents, district hospitals provide such services but such services are not targeted towards any specific groups of people. However, few had heard about organizations such as Nepal Red Cross Society, Lions Club, Maiti Nepal and local NGOs that provide HIV/STI related programs and services. According to the key informants, individuals visit variety of places for diagnosis and treatment such as government health organization, district hospitals, private clinics and NGOs, some also travel to Kathmandu and India. Participants signaled that people in border areas in districts such as Bara and Kapilbastu even visit India for treatment. According to the key informants, some of the active organizations in the four study districts were:

*Bara:* FPAN, Red Cross, Marie Stopes International, Blue Diamond Society (BDS), Bidhyarthi Jagarn Mancha (BIJAM), General Welfare Pratisthan (GWP), Save the Children and District Public Health Office (D(P)HO).

*Kapilbastu:* Marie Stopes International, Government hospitals and health organizations, NAMUNA, Sakriya Sewa Samaj, Samarpan Sahayog, Active Society Service, Sunshine Women’s Sudhar, and KIDS.

*Nawalparasi:* District hospital, FPAN, Marie Stopes International, District Health Office (DHO), Red Cross, Lumbini Plus, Sahabhagi, BDS, Suwarna Samudaik Bikas Manch and Shrijana Community Development Center (SCDC).

*Palpa:* Indreni Samaj Kendra, FPAN, Mission Hospital and Active society service.

The majority of the FGD participants however pointed out that there were no HIV and AIDS/STI service centers in the VDC level and pointed out the urgent need to establish such centers. During FGD sessions MLMs reported the need for a confidential separate service centers targeted towards male migrants. According to them, testing and treatment centers should be extensively run in the communities by qualified health workers with sound knowledge and well-equipped machines. In addition to these services, participants also vouched for public awareness programs, such as street drama, discussion groups, billboard and door to door awareness programs targeted towards the migrant workers and the wives of migrant workers. Key informants across all the study districts shared similar views regarding the service needs for migrant couples. They encouraged for focus on promotion and availability of preventive methods, prompt services, provide information about organizations that work with HIV and STIs, inclusion of more public awareness programs targeted at migrant couples and appropriate counseling services.

*“... there has to be awareness programs for migrant couples to raise massive awareness about the issue, the programs should especially target wives of migrant workers”. (Male FGD participant, Nawalparasi)*

*“Those males who migrate abroad get general check up but it would be good if our wives are also able to access such services”.(Male FGD participant, Bara)*

## **7.6 Barriers to Access HIV and STI Services and Challenges Faced by Service Providers**

According to female FGD sessions and key informants, major barrier to access HIV/STI services for wives of migrants were fear of societal labeling, lack of organizations working specifically for migrant wives and lack of awareness among the wives and as well as the society. They added that if the wife wanted her husband to get tested for HIV or STI then the husband would get annoyed/furious that despite going aboard to earn money for the family he is being questioned. Geographical barriers were yet another challenge because service has not been able to reach in some areas. Social barriers also exist due to which there are massive social blindness and lack of awareness in rural and hard to reach areas. The female FGD participants indicated that one of

*“...they (wives of migrants) don't go to get treatment until it gets serious/life threatening. If service centers were available nearby, everybody could access it easily by pretending to have other health issue, and would not need to take permission from family members to travel long distance”. (Female FGD participant, Bara)*

*“Men are the main obstacles for wives in accessing HIV/STI services, there are men who won't let them use certain services while they use it for themselves”.(Female FGD Participant Bara)*

the main transferring points of the diseases is their husbands. As they indicated, the barrier was the long distance to the HIV testing centers which is located mostly in the district headquarters, and thus innocent wives become victims of the disease.

Some of the wives of migrants opined that they could conveniently talk to FCHVs but it was not always easy for them to meet FCHVs as they are busy working in the field or doing household chores. They also had a notion that FCHVs are themselves shy and embarrassed to discuss topics relating to sexual contacts with them.

Interviews with health professionals and other key stakeholders revealed challenges faced by them in providing HIV and STI services. Deep rooted superstition, lack of awareness, gender dynamics, fear of society and financial constraints were considered by health workers as major challenges while providing such services or intervention programs. Key informants shared that few VDCs are difficult to reach due to geographical inaccessibility, bad roads and lack of transport services. Most health services are centered on flat belts but people tend to hide their illness, thus difficult to reach them. They also mentioned that there is also lack of resources: human resources and budget. Key informants report that HIV infection is strongly tied with stigma, negativity, bad character and social outcast. Even if some families accepted the infected family member the care provided accompanies blame and discrimination. Key informants relate that this is because the disease brings utter shame in the family and the community stigmatizes the family of the infected individual as well. Therefore, individuals suspicious of infection go without testing. Grave association between the infection and the negative social perception makes many men conceal their suspicion.

### **7.7 Suggestions on Improving HIV/STI Services**

Key informants mentioned that there had been programs such as street drama, celebration of condom and AIDs day, blood testing services, educational programs, and conferences organized by district level hospitals, various I/NGOs and DACC in the study districts. These activities were confined only to the district headquarters and market areas. They attest that in addition to such previously held programs there are needs for HIV/STI testing and counseling before people go abroad for work which also needs to be conducted in the rural area where there are high concentration of migrant population. Similar to KI suggestions, wives of MLMs explained the need for targeted programs with an atmosphere for open dialogue and interactions. They argued that programs on awareness should be targeted towards male migrants in an appropriate time so that everyone can attend such events.

It was also suggested by health and non-health professionals that government needs to be proactive in raising awareness amongst community people and that the intervention programs need to be simple to understand, designed in local languages and acceptable in the community. According to them, programs need to be at the grass root level and in-coordination with local organization and political leaders. They further added that there should be more HTC centers especially in areas with high concentration of migrant population and introduction of mobile clinics to conduct tests and counseling.

*“...door to door program targeting migrant wives needs to be held, and there has to be interaction programs including both males and females”.*(Female FGD participant, Palpa)

*“...migrant returnees could be provided with testing services at the access points and given orientation on prevention and awareness before going home”.*(Female FGD participant, Bara)

*“...husbands should be specifically targeted for participation in group discussion and interactions. Such awareness programs should be organized and held periodically especially during leisure periods like off season during farming so all males could attend”.*(Female FGD participant, Kapilbastu)

Health professionals working in the study districts further suggested the need to increase the number of trained health workers and frontline workers, so that the work is more efficient. It was recommended by key informants that there should be increase in coverage and quality of the programs, free treatment services, regular monitoring of the programs and that such program should be targeted towards the migrant population.

*“Only the educated ones use condom, rest are least aware about HIV and STI preventive measures”.* (Health worker, Kapilbastu)

*“The young generation is more aware about preventive measures but the older generation is still clueless, they do not use preventive methods due to carelessness and also because they believe and want to follow the same age-old practices that they have been practicing since many years”.*(Non-Health Professional, Nawalparasi)

*“Those men who indulge in sex abroad has to use condom compulsorily, but most wont use it with their wives as they feel safe with them. Even if they are infected, they keep it a secret and go to discreet places to get tested/treated”.*(Male FGD participant, Bara)

*“For diagnosis and treatment they go to various hospitals and clinics and everything is done in confidential manner. Even the wives are unaware of it”.*(Male FGD Participant, Palpa)

## CHAPTER 8.0: CONCLUSION/RECOMMENDATION

This chapter presents brief discussion on major findings of the baseline survey on FP and HIV/STI situation among wives of migrants in the study districts. The ethnographic assessment used in-depth interviews with key local informants and separate focus group discussions with MLMs and WoMLMs to generate insights on the current HIV, STI and FP situation, need and priority areas for migrant couples to inform program design and delivery. It also sought to explore and identify factors and relationships that may not have been understood through quantitative survey. The assessment has revealed some degree of knowledge gaps and has explained that the migrant couples are hardly reached by ongoing interventions. This section draws the following conclusions based on the main findings of the assessment:

The trend of out migration in the four program districts continues to increase. Most males prefer Gulf countries such as Qatar and Saudi Arabia while men from VDCs that are close to the Indian border prefer India. At the same time, those males who can afford the employment processing cost including visa fees, payment to the recruitment agencies/agents go to other foreign countries than India. This study also revealed that destination countries also plays a major role in health issues male labor migrant experience. While those in Gulf and Malaysia suffer from respiratory diseases, the general perception is that those migrant workers working in India are mostly more at risk of HIV/STI transmission. This is assigned to easy access to sex workers in “Mumbai”.

In general, the use of contraception has increased among migrant couples in the study districts especially for the purposes of child limiting and birth spacing. Use of FP methods like condoms for safe sex or to prevent from STIs is very rare among migrant couples. Not much difference is noticed on the type of FP method used by migrant and non-migrant couple. Although long lasting methods like injectables and Norplant are slightly more common among non-migrant couple than migrant couple who prefer non clinical methods as condoms. The decision on the use of FP method is mostly taken jointly by migrant couple and in many cases the decisions are made after the migrant workers reach home. Government service facilities like health posts, government hospitals, FCHVs are preferred sources of FP services largely because of the availability of free services.

This study found that many women in the study area still cannot access FP services because of the social, cultural and geographical barriers faced by them. The other major challenge is their husbands not agreeing to use FP methods. Additionally, a strong stigma is associated with the use of FP by a married woman whose husband is away. Migrant couples also lack adequate knowledge about the type and availability of FP services. Individuals are aware about different kinds of methods but do not have detailed information on them. They also do not have information about their sources.

Migrant couples are reluctant towards diagnosis and treatment of the STI/HIV. Negative social labeling and stigmatization are the premise for hesitancy. Apart from socio-cultural barriers, geographical terrain cause further barriers towards access of the FP/HIV/STI services. Most of the migrant workers and wives of migrants have heard about HIV/STIs.

Radio, television, FCHVs, health institutions, community networks are some of the sources of information regarding HIV/STIs.

The general attitude towards HIV and those living with HIV or STI have been gradually improving as the general awareness level is growing up. However there are still some people who hold negative attitude and discriminate such people like giving them separate plates to eat and not mixing up with them. Fear of being exposed as being 'at risk', lack of awareness, and absence of easy and confidential testing facilities are some of the reasons why many migrants workers or their spouses do not get HIV test. There are certain organizations providing HIV/STI and FP related services to the people in the study districts. However, there are no specific organizations providing services to either to the MLMs or the wives of MLMs.

### **Key Program Implications and Recommendations:**

- Although there was a notion that migrants return home during harvesting, crop cultivation and festival seasons however this study revealed that migrants return home without considering any special occasions. Hence, program should closely monitor the migration destinations of the pocket community and reach migrants during their arrival. As many study participants also shared that migrants going to India generally return during festival seasons, thus awareness raising activities should also be conducted during such special seasons. It was also frequently argued that migrants working in India (such as Mumbai, Delhi, Bihar and Punjab) are a high risk population. Therefore, such groups should be identified, monitored and encouraged to seek services. Special awareness programs towards these groups should be implemented.
- Although individuals are aware about FP and HIV-related services that are available to them, however comprehensive knowledge about FP and HIV was absent. Awareness programs should be designed to increase their comprehensive knowledge on FP and HIV as well as promotion of existing FP and HIV services available for migrant couples.
- Health posts and other public health services were frequently reported convenient places to obtain free or cheap FP services. Free FP distribution through these sites should be continued and promoted.
- Both health and non-health professional key informant revealed that the existing health service providers are not enough to cover migrant community. Quantity (increase in number of frontline workers) and quality (maintaining confidentiality in treatment and services) of health service providers should be improved with training or refresher training programs on health services.
- FP use is especially low among migrant couples, thus SBC activities particularly on their FP preparedness once the husband returns and dual protection should be designed and promoted.
- There was a belief that that awareness raising activities (e.g. drama, discussions, documentary) are mainly conducted in urban areas such as district headquarters, such

activities and availability of FP and HIV services should be promoted at places that can be conveniently accessed by the community people. Events/services should be available at VDC level, PHCC, HP, SHP and community people should be made aware of the existence of such facilities.

- Society and culture remains as one of the major barriers in many communities for transferring FP and HIV knowledge and program implementation. Strategic Behavior and Communication (SBC) programs preferably led by a native speaker of the language could be a step towards awareness. This may help create comfortable environment in the community to generate FP and HIV service demand.

## REFERENCES

- Bhattarai R. (2007). Open borders, closed citizenships: Nepali labor migrants in Delhi. International migration, multi-local livelihoods and human security: Perspectives from Europe, Asia and Africa. Netherlands: Institute of Social Studies.
- Central Bureau of Statistics (CBS). (2001). National Population and Housing Census 2001. Kathmandu, Nepal: Ministry of Population and Environment and Central Bureau of Statistics.
- Central Bureau of Statistics (CBS). (2012). National Population and Housing Census 2012. Kathmandu, Nepal: Ministry of Population and Environment and Central Bureau of Statistics.
- Family Health Division. (2010). Nepal Maternal Mortality and Morbidity Study 2008/2009. Department of Health Services, Government of Nepal.
- Furber A, Newell and Lubben M. (2002). A systematic review of current knowledge of HIV epidemiology and of sexual behaviour in Nepal. *Tropical Medicine and International Health*, 7(2):140-8.
- Gautam T. (2006). Causes and Impact of Migration: A Sociological Study of Emigration from Kandebash, Baglung, Nepal. *Dhaulagiri Journal of Sociology and Anthropology*, (1):146-63.
- George, S., Jacob, M., John, T. J, et al. (1997). A case-control analysis of risk factors in HIV transmission in South India. *Journal of Acquired Immune Deficiency Syndrome*, 14:290-293
- Gupta K and Singh S.(2002). Social networking, knowledge of HIV/Aids and risk-taking behaviour among migrant workers. International Union for the Scientific Study of Population (IUSSP) Regional Population Conference on Southeast Asia's Population in a Changing Asian Context. Bangkok : Thailand. [Online] Available <http://www.iussp.org/Bangkok2002/S06Gupta.pdf> (10th January, 2012).
- International Organization for Migration (IOM) (2011). World Migration Report 2011: Communicating Effectively about Migration. Geneva, Switzerland: IOM Publications.
- Lagarde E, van der Schim M, Enel, C, et al. (2003). Mobility and the spread of human immunodeficiency virus into rural areas of West Africa. *International Journal of Epidemiology*, 32:744-752.
- Ministry of Health and Population (MOHP) and New ERA (2011). Nepal Demographic and Health Survey 2011. Kathmandu: Ministry of Health and Population
- Ministry of Health and Population (MOHP). (2009). Annual Report: Department of Health Services 2066/67 (2008/2009). Kathmandu, Nepal: Ministry of Health and Population
- Ministry of Health and Population (MOHP). (2011). Annual Report: Department of Health Services 2066/67 (2009/2010). Kathmandu, Nepal: Ministry of Health and Population.

- Munoz-Laboy M, Hirsh J & Quispe-Lazaro A. (2009). Loneliness as a sexual risk factor for male Mexican migrant workers. *American Journal of Public Health*, 99(5):802-10.
- NCASC. (2012). National Estimates of HIV Infections in Nepal 2012. Kathmandu, Nepal: National Center for AIDS and STD Control.
- NCASC and ASHA. (2008a). Integrated Biological and Behavioral Surveillance Survey Among Migrant Laborers in 11 Districts of Western to Mid and Far-Western Regions of Nepal: 2008. Kathmandu, Nepal
- NCASC and ASHA. (2008b). Integrated Biological and Behavioral Surveillance Survey among Wives of Migrant Laborers in Four Districts of Far-Western Regions of Nepal: 2008. Kathmandu, Nepal
- NCASC and ASHA. (2010a). Integrated Biological and Behavioral Surveillance Survey among Wives of Migrant Laborers in Four Districts of Far-Western Regions of Nepal: 2010. Kathmandu, Nepal.
- NCASC and ASHA. (2010b). Integrated Biological and Behavioral Surveillance Survey among Male Labor Migrants in 11 Districts in Western and Mid to Far Western Regions in Nepal: 2010. Kathmandu, Nepal.
- Nepal Family Health Program (NFHP) II & CREHPA. (2012). Family Planning Needs of Migrant Couples in Nepal. Kathmandu, Nepal.
- Nepal Family Health Program (NFHP) II & New ERA. (2010). Family Planning, maternal, Newborn and Child Health Situation in Rural Nepal: A Mid-term Survey for NFHP II. Kathmandu, Nepal.
- New ERA. (2002). HIV/STD Prevalence and Risk Factors among Migrant and Non-Migrant Males of Achham District in Far-Western Nepal. Kathmandu, Nepal: New ERA.
- Poudel K, Jimba M, Okumura J, Joshi A & Wakai S. (2004). Migrant's risky sexual behaviours in India and at home in Far Western Nepal. *Tropical Medicine and International Health*, (8):897-903. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/15303995>
- Poudel K, Sherchand J, Jimba M, Murakami I & Wakai S. (2003). Malaria disease in Far Western Nepal: HIV infection and syphilis among male migrant-returnees and non-migrant. *Tropical Medicine and International Health*, 8 (10):933-9. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/14516305>
- Sharma S. (2011). Lost in enumeration. The Kathmandu Post. Retrieved from <http://www.ekantipur.com/the-kathmandu-post/> (Accessed: September 2012).
- Thieme S and Wyss S. (2005). Migration Pattern and Remittance Transfer in Nepal: A Case Study of Sainik Basti in Western Nepal. *International Migration*, 43(5):60-98.
- Thieme S, Bhattarai R, Gurung G, Kollmair M, Manandhar S & Muller-Boker U. (2005).

Addressing the Needs of Nepalese Migrant Workers in Nepal and in Delhi, India. *Mountain Research and Development*, 25(2):109-14. Retrieved from [http://www.geo.unizh.ch/~suthieme/MRD\\_PAMS.pdf](http://www.geo.unizh.ch/~suthieme/MRD_PAMS.pdf)

Ulin, P, Robinson E, Tolley E, & McNeil E. (2002). *Qualitative Methods: A field guide for applied research in sexual and reproductive health*. Research Triangle Park, NC: Family Health International.

Vaidya N and Wu J. (2011). HIV epidemic in Far-Western Nepal: effect of seasonal labor migration to India. *BMC Public Health*, 11:310.

UNAIDS (2012). Nepal Country Progress Report 2012. Retrieved from [http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce\\_NP\\_Narrative\\_Report.pdf](http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_NP_Narrative_Report.pdf)

UNAIDS. (2003). *The HIV/AIDS/STD Situation and the National Response in Nepal*. Kathmandu, Nepal: National Center for AIDS and STD Control.

Wang B, Li X, Stanton B, Fang X, Lin D & Mao R. (2007). HIV-Related Risk Behaviors and History of Sexually Transmitted Diseases among Male Migrants Who Patronize Commercial Sex in China. *Sexually Transmitted Diseases*, 34 (1):1-8. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1941657/>

World Bank. (2012). *Migration and Remittance Factbook 2011*. Retrieved from <http://go.worldbank.org/QGUCPJTOR0> (Accessed: July 2012).

World Health Organization (WHO), UNAIDS, & United Nations Children's Fund (UNICEF). (2011). *Global HIV/AIDS Response: Epidemic update and health sector progress towards universal Access*. Geneva, Switzerland: World Health Organization.

# **ANNEXES**

## **ANNEX - 1**

### **Study Teams Members**

#### **Core Team Members**

1. Jagat Basnet – Team Leader
2. Pranita Thapa – Senior Research Officer
3. Pragati Shah – Assistant Research Officer
4. Naveen Lama – Research Assistant
5. Sunita Gurung – Research Assistant
6. Rajendra Dangol – Senior Computer Programmer
7. Ramita Shakya – Data Processing Supervisor

#### **Administration Support**

1. Sanu Raja Shakya – Assistant Word Processing Officer
2. Geeta Amatya (Shrestha) – Senior Word Processor
3. Sujan Bhakta Shrestha – Assistant Accounts/Admin Officer
4. Rajendra Kumar Shrestha – Office Assistant

#### **Data Entry/Tabulation/Coding**

1. Ishwori Rijal
2. Resha Pradhan
3. Sujan Pradhananga
4. Sita Poudel
5. Manisha Thapa
6. Deepa Shakya

#### **Field Team Members**

- |                            |                         |                          |
|----------------------------|-------------------------|--------------------------|
| 1. Umesh Shrestha          | 16. Om Kishor Chaudhary | 31. Goma Lama            |
| 2. Buddhi Narayan Shrestha | 17. Nabaraj Tiwari      | 32. Renu Kumari Gupta    |
| 3. Ishwor Rijal            | 18. Kalpana Dhungana    | 33. Ganga Pokhrel        |
| 4. Kashi Nath Devkota      | 19. Bhagawati Sharma    | 34. Gita Gupta           |
| 5. Mahesh Prasad Deo       | 20. Sujanya Limbu       | 35. Manita Koirala       |
| 6. Satya Narayan Sah       | 21. Mamata Khadgi       | 36. Kancy Yadav          |
| 7. Krishna Kumar Shrestha  | 22. Anu Upreti          | 37. Samjhana Dhamy       |
| 8. Bimal Labh              | 23. Sarita Dhungana     | 38. Babita Shah          |
| 9. Ashwinee Kumar Thakur   | 24. Renu Sen            | 39. Kalpana Kumari Singh |
| 10. Jagadish Khatiwada     | 25. Shanta Pokhrel      | 40. Sunita Kumari Gupta  |
| 11. Dadhiram Paudel        | 26. Usha Sedai Upreti   | 41. Bina Sah             |
| 12. Radhey Shyam Chaudhary | 27. Krishna Kharel      | 42. Anu Karn             |

- |                             |                            |
|-----------------------------|----------------------------|
| 13. Santosh Kumar Chaudhary | 28. Rojina Bhaila Shrestha |
| 14. Ravi Kumar Sah          | 29. Indrakala KC           |
| 15. Prabhakar Jaiswal       | 30. Runa Chaudhary         |

## ANNEX - 2: QUESTIONNAIRE

### Saath-Saath Project (SSP)

#### Oral Informed Consent Form for Focus Group Discussions with Male Labour Migrants

##### **Introduction**

Namaste! My name is .....

I am working for (Name of Research Organization) on a USAID funded Saath-Saath Project (SSP) research.

This research is on the HIV, sexually transmitted infections (STI) and FP (FP) situation among migrant couples in Bara, Kapilbastu, Nawalparasi and Palpa districts.

We are asking you to take part in this research study to get your opinion and experience on this topic. We want to be sure that you understand what participation in this research involves before you decide if you want to join the research. Please ask us to explain any information that you may not understand.

##### **Information about the Research and Your Role**

You have been selected to participate in rapid assessment of HIV, STI and FP situation. The objective of this study is to assess the HIV, STI and FP situation among male labor migrant in this district. This will help us assess the needs and identify gaps and priority areas for program intervention.

If you agree to participate in this research study, you will participate in a group discussion today. There will be about 8-10 other MLMs in this discussion. You will be asked to discuss on the following topics based on your opinion, knowledge and experience:

- General overview of MLMs in this district
- The HIV, STI and FP situation in the district in general and among migrant couples
- The need for HIV, STI and FP services in this district and specifically for MLMs
- The gaps and priority areas for programmatic intervention in field of HIV, STI and FP

The discussion will take approximately 1- 1.5 hours.

##### **Confidentiality**

We are conducting this group discussion in a private place to make it difficult for other people to hear what you say. The information you tell us will be used only for the research. There is a risk that other group members will share some of the information you discuss. But, all members will be instructed to keep information confidential. Your name will not appear on any forms related to this research or in any reports. We will protect information about you and your participation to the best of our ability. Only the researchers of this study will have

access to notes and audio recordings from the discussion. All study information or material will be identified only by individual participant code numbers. We will not ask you to put your name or sign on this consent form, but only ask you to agree verbally (with spoken words) in the presence of a third person. We will be responsible and serious about maintaining confidentiality during the entire study process.

### **Possible Risks**

The risk of participating in this study is minimal, if any. Some questions could make you feel uncomfortable or embarrassed. You are free not to answer such questions and also to stop participating in the research at any time you want to do so. Please also know that there is a possibility of a potential breach of confidentiality and social harm despite the precautions that we will be taking to keep your identity and involvement in this study private and confidential.

### **Possible Benefits**

After the group discussion, you will be provided with educational materials on the various FPmethod and safe sex along with HIV and STI prevention materials and condoms. In addition, the information you provide will be very useful to plan HIV and FP services in new migrant districts. We hope that you and your spouse will benefit from the services that will be provided in this district. If you require counseling, testing or any other services related to HIV, STI and FP, we will encourage you to seek such services by referring you to the nearest available service sites.

### **If You Decide Not to Be in the Research**

You are free to decide whether or not to take part in this research. There is no penalty for refusing to take part in this research study and it will not affect the services that you receive from agencies providing HIV prevention and FP services.

### **Payment**

We will provide NRs. 200.00 (around USD 2.75) to cover local transportation costs for coming to the agreed upon focus group discussion site.

### **Digital Recording**

We would like to digitally record the group discussion, so that we remember all the information that participants give us. Afterwards, we will listen to the recording and write down the discussion. The information from this and other group discussions and interviews may be presented at professional meetings or in written articles. We will not mention yours or anyone's name in any presentations or written papers. We will store the digital recordings in a safe place at the FHI 360 Nepal country office for duration of up to three years after which it will be destroyed.

### **Leaving the Research**

You may leave the research at any time. If you do, it will not change the health services you normally receive from the study clinic.

### **If you have a questions about the study**

If you have any questions about the research, call:

**Pramod Regmi**, FHI 360 Nepal, Baluwatar, Kathmandu, Phone: 01-4437173;

**Your Rights as a Participant**

This research has been reviewed and approved by the Protection of Human Subject Committee (PHSC) of FHI 360 and Nepal Health Research Council (NHRC). If you have any questions about how you are being treated by the study or your rights as a participant you may contact:

NHRC, Phone: 01-4254220/4227460; Email: [nhrc@healthnet.org.np](mailto:nhrc@healthnet.org.np);

PHSC, phone number: 1-919-405-1445, e-mail: [phsc@fhi360.org](mailto:phsc@fhi360.org)

**VOLUNTEER AGREEMENT**

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

---

Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

---

Signature of Person Who Obtained Consent \_\_\_\_\_ Date \_\_\_\_\_

**Saath-Saath Project (SSP)**  
**Oral Informed Consent Form for Focus Group Discussions with Wives of Male Labor**  
**Migrants**

**Introduction**

Namaste! My name is .....

I am working for (Name of Research Organization) on a USAID funded Saath-Saath Project (SSP) research.

This research is on the HIV, sexually transmitted infections (STI) and FP(FP) situation among migrant couples in Bara, Kapilbastu, Nawalparasi and Palpa districts.

We are asking you to take part in this research study to get your opinion and experience on this topic. We want to be sure that you understand what participation in this research involves before you decide if you want to join the research. Please ask us to explain any information that you may not understand.

**Information about the Research and Your Role**

You have been selected to participate in rapid assessment of HIV, STI and FP situation. The objective of this study is to assess the HIV, STI and FP situation among wives of migrant laborers in this district. This will help assess the needs and identify gaps and priority areas for program intervention.

If you agree to participate in this research study, you will participate in a group discussion today. There will be about 8-10 other wives of migrant laborers in this discussion. You will be asked to discuss on the following topics based on your opinion, knowledge and experience:

- General overview of the wives of migrants in this district
- The HIV, STI and FP situation in the district in general and among migrant couples
- The need for HIV, STI and FP services in this district and specifically for wives of migrant laborers
- The gaps and priority areas for programmatic intervention in field of HIV, STI and FP

The discussion will take approximately 1- 1.5 hours.

**Confidentiality**

We are conducting this group discussion in a private place to make it difficult for other people to hear what you say. The information you tell us will be used only for the research. There is a risk that other group members will share some of the information you discuss. But, all members will be instructed to keep information confidential. Your name will not appear on any forms related to this research or any reports. We will protect information about you and your participation to the best of our ability. Only the researchers of this study will have access to notes and audio recordings from the discussion. All study information or material will be identified only by individual participant code numbers. We will not ask you to put

your name or sign on this consent form. But only ask you to agree verbally (with spoken words) in the presence of a third person as a witness. We will be responsible and serious about maintaining confidentiality during the entire study process.

### **Possible Risks**

The risk of participating in this study is minimal, if any. Some questions could make you feel uncomfortable or embarrassed. You are free not to answer such questions and also to stop participating in the research at any time you want to do so. Please also know that there is a possibility of a potential breach of confidentiality and social harm. This is despite the precautions that we will be taking to keep your identity and involvement in this study private and confidential.

### **Possible Benefits**

After the group discussion, you will be provided with educational materials on the various FPmethod and safe sex along with HIV and STI prevention materials and condoms. In addition, the information you provide will be very useful to plan HIV and FP services in new migrant districts. We hope that you and your spouse will benefit from the services that will be provided in this district. If you require counseling, testing or any other services related to HIV, STI and FP, we will encourage you to seek such services by referring you to the nearest available service sites.

### **If You Decide Not to Be in the Research**

You are free to decide whether or not to take part in this research. There is no penalty for refusing to take part in this research study and it will not affect the services that you receive from agencies providing HIV prevention and FP services.

### **Payment**

We will provide NRs. 200.00 (around USD 2.75) to cover local transportation costs for coming to the agreed upon focus group discussion site.

### **Digital Recording**

We would like to digitally record the group discussion, so that we remember all the information that participants give us. Afterwards, we will listen to the recording and write down the discussion. The information from this and other group discussions and interviews may be presented at professional meetings or in written articles. We will not mention yours or anyone's name in any presentations or written papers. We will store the digital recordings in a safe place at the FHI 360 Nepal country office for duration of up to three years after which it will be destroyed.

### **Leaving the Research**

You may leave the research at any time. If you do, it will not change the health services you normally receive.

### **If you have a questions about the study**

If you have any questions about the research, call:

**Pramod Regmi**, FHI 360 Nepal, Baluwatar, Kathmandu, Phone: 01-4437173;



**Saath-Saath Project (SSP)**  
**Written Informed Consent Form for In-depth Interview with Key Informants**

**Introduction**

Namaste! My name is .....

I am working for (Name of Research Organization) on a USAID funded Saath-Saath Project (SSP) research.

This research is on the HIV, sexually transmitted infections (STI) and FP(FP) situation among migrant couples in Bara, Kapilbastu, Nawalparasi and Palpa districts.

We are asking you to take part in this research study to get your opinion and experience on this topic. We want to be sure that you understand what participation in this research involves before you decide if you want to join the research. Please ask us to explain any information that you may not understand.

**Information about the Research and Your Role**

You have been selected to participate in rapid assessment of HIV, STI and FP situation. The objective of this study is to assess the HIV, STI and FP situation among migrant couples in this district. This will help us assess the needs and identify gaps and priority areas for programmatic intervention targeting migrant couples.

If you agree to participate in this research study, we would like to interview you and ask you questions about:

- Your general overview of migrant couples in this district
- The HIV, STI and FP situation in the district in general and among migrant couples
- The need for HIV, STI and FP services in this district and specifically for migrant couples
- The gaps and priority areas for programmatic intervention in field of HIV, STI and FP specifically for migrant couples

This interview will take approximately 1- 1.5 hours.

**Confidentiality**

We are conducting this interview in a private place to make it difficult for other people to hear what you say. The information you tell us will be used only for the research. Only the researchers will have access to documents and audio recordings from the interview. We will be responsible and serious about maintaining confidentiality during the entire study process. You will be asked to sign this informed consent form. But your name will not be connected to what you say in this interview. We assure you that all the information collected during this study will be kept in a secure place.

**Possible Risks**

The risk of participating in this study is minimal, if any. Some questions could make you feel uncomfortable or embarrassed. You are free not to answer such questions and also to stop

participating in the research at any time you want to do so. Please also know that there is a possibility of a potential breach of confidentiality and social harm. This is despite the precautions that we will be taking to keep your identity and involvement in this study private and confidential.

**Possible Benefits**

The information you provide us will be very useful to plan effective interventions on integrated HIV and FP services in the four migrant program districts.

**If You Decide Not to Be in the Research**

You are free to decide whether or not to take part in this research. There is no penalty for refusing to take part in this research study.

**Payment**

We will not pay you for your participation.

**Digital Recording**

We would like to digitally record the interview, so that we remember all the information that you give us. Afterwards, we will listen to the recording and write down the answers. The information from this interview may be presented at professional meetings or in written articles. We will not mention yours or anyone’s name in any presentations or written papers. We will store the digital recordings in a safe place at the FHI 360 Nepal country office for duration of up to three years after which it will be destroyed.

**Leaving the Research**

You may leave the research at any time.

**If you have a questions about the study**

If you have any questions about the research, call:

**Pramod Regmi**, FHI 360 Nepal, Baluwatar, Kathmandu, Phone: 01-4437173.

**Your Rights as a Participant**

This research has been reviewed and approved by the Protection of Human Subject Committee (PHSC) of FHI 360 and Nepal Health Research Council (NHRC). If you have any questions about how you are being treated by the study or your rights as a participant you may contact:

NHRC, Phone: 01-4254220/4227460; Email: [nhrc@healthnet.org.np](mailto:nhrc@healthnet.org.np);

PHSC, phone number: 1-919-405-1445, e-mail: [phsc@fhi360.org](mailto:phsc@fhi360.org)

**VOLUNTEER AGREEMENT**

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

---

Signature of study participant \_\_\_\_\_ Date \_\_\_\_\_

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

---

Signature of Person Who Obtained Consent      Date

## Focus Group Discussions (FGD) Guideline among Male Labor Migrant

Date of interview (dd/mm/yy): \_\_\_\_\_

Name of Interviewer/Moderator: \_\_\_\_\_

Name of Note Taker \_\_\_\_\_

VDC/Municipality \_\_\_\_\_ Village/Tole \_\_\_\_\_ District: \_\_\_\_\_

### Characteristics of the FGD participants

ID	Education (write completed grade)	Age (write completed age)	Ethnicity /caste	VDC/ Municipality	Ward	Country and city of migration
1						Country: City:
2						Country: City:
3						Country: City:
4						Country: City:
5						Country: City:
6						Country: City:
7						Country: City:
8						Country: City:
9						Country: City:
10						Country: City:

Note: Participant must be a Returnee male labor migrant (establish this first)

### 1. Male Labor Migrant General Information

Theme	Main Question	Follow-up Question
<b>Male Labor Migrants General</b>	How many male labor migrant are going abroad for labor work in this ward/ VDC (estimates)?	
	Has the number of MLMs going abroad for work increased, decreased or remained the same over the past five years?	
	What is the common occupation of the male labor migrant laborers while abroad?	
	Do MLMs inform spouse or relatives about their time of return beforehand?	<ul style="list-style-type: none"> <li>• If so, how many days or weeks in advance do they usually give this information? Was there also evidences that delayed return? How many times it happened in your case?</li> <li>• How do they usually give this information? (e.g. Telephone, letters, message sent with friends)</li> </ul>
	Do the spouses of migrants accompany their husband who migrate for work?	<ul style="list-style-type: none"> <li>• If so, how long do the spouses stay abroad?</li> </ul>
What are the major health problems faced by MLMs in this district?	<ul style="list-style-type: none"> <li>• While abroad, what do MLMs do in case they need medical care?</li> <li>• Do MLMs seek health services when they return to Nepal? If so, where do they generally go for such services?</li> </ul>	

### 2. Assess the FP situation in New Migrant Program District

Theme	Main Question	Follow-up Question
<b>FP Situation</b>	What is the current FP use situation in this district among the MLMs who returned home and their wives?	
		<ul style="list-style-type: none"> <li>• How do MLMs prepare or plan for FP measures before or when they return home?</li> <li>• In your opinion, what are the most commonly used modern FP methods among migrant couples?</li> <li>• In your opinion, in adapting FP methods, who decides and how?</li> </ul>

### 3. Assess the need for FP services for MLMs

Theme	Main Question	Follow-up Question
<b>Need for FP Service</b>	Are there organizations providing FP services to the migrant population in this district? If so, which organization? What other service do they provide?	

### 4. Identify gaps and priority areas for intervention to help guide the development of program intervention (FP)

Theme	Main Question	Follow-up Question
<b>Program Gaps for FP Services</b>	What needs to be done to improve the access and quality of FP services among MLMs?	<ul style="list-style-type: none"> <li>• What program intervention will best reach MLMs for FP services?</li> <li>• When would be the best time to provide these services to MLMs?</li> <li>• What programs have been held in this district to promote awareness on safer sex and FP among MLMs?</li> <li>• What could be the best methods to raise awareness about FP among MLMs?</li> </ul>

### 5. Assess the HIV and STI situation in new migrant program district

Theme	Main Question	Follow-up Question
<b>HIV and STIs Situation</b>	Have you all heard about the Sexually Transmitted infections (STI) and HIV?	<ul style="list-style-type: none"> <li>• If so, what is the current HIV and STI situation in this district?</li> <li>• Have you met person (your peer migrant) who had STI?</li> <li>• In your opinion, who are the most at risk groups of acquiring HIV and STIs in this district?</li> <li>• How do people in this district react if they know that a person is infected with HIV and/or STI?</li> <li>• How aware are the people in this community (or district) about HIV and STIs prevention methods?</li> <li>• What are the source of current awareness on HIV and STIs and the preferred methods?</li> <li>• What groups appear to contribute most to the spread of sexually transmitted infections?</li> <li>• What behaviors put MLMs at risk of HIV and STI transmission?</li> <li>• Where do MLMs go for HIV and STI related diagnosis and treatment? Where do they go for treatment if they have STI related symptoms?</li> <li>• What preventive methods do MLMs take? Do migrant laborers use condoms with different sex partners, if they have?</li> </ul>

**6. Assess the need for HIV and STIs services migrants**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>
<b>Need for HIV and STIs Services</b>	What type of HIV and STIs services do you think are needed for MLMs in this district?	<ul style="list-style-type: none"> <li>• Are there organizations providing HIV and STIs services to the migrant population? If so, which organization? What other service do they provide? Is migrant population their main target population?</li> </ul>

**7. Identify gaps and priority areas for intervention to help guide the development of program intervention (HIV and STIs)**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>
<b>Program Gaps for HIV and STIs Services</b>	If current HIV services exist in the district, are MLMs satisfied with the available services? If not, how can it be improved further.	<ul style="list-style-type: none"> <li>• What program intervention will best reach MLMs for HIV services?</li> <li>• When would be the best time to provide these services to MLMs?</li> <li>• What programs have been held in this district to promote awareness on HIV prevention among MLMs?</li> <li>• How can maintenance of privacy and confidentiality be improved?</li> <li>• What can be done to stay protected by MLMs in the first meeting with their wives after they return home?</li> <li>• When you returned home from abroad, in the first meeting with your wife, what measures did you take to stay protected? What would have happened if you did not do so?</li> <li>• Who made the decision to do so? Was it your wife or was it both of you?</li> </ul>
	If current STIs services exist in the district, are MLMs satisfied with the available services? If not, why?	

## Focus Group Discussions (FGD) Guideline among Wives of migrants

Date of interview (dd/mm/yy): \_\_\_\_\_

Name of Moderator: \_\_\_\_\_

Name of Note Taker: \_\_\_\_\_

District: \_\_\_\_\_

VDC/Municipality \_\_\_\_\_ Village/Tole \_\_\_\_\_

### Characteristics of the FGD participants

S.N./ Respondents ID	Education (Write completed grade)	Age (Write completed age)	Ethnicity /caste	VDC/ Municipality	Ward	Country/city of husband's migration
1						Country: City:
2						Country: City:
3						Country: City:
4						Country: City:
5						Country: City:
6						Country: City:
7						Country: City:
8						Country: City:
9						Country: City:
10						Country: City:

Note: Participant must be wives of returnee MLMs. (Please make it certain before beginning)

### 1. General information on wives of migrant workers

Theme	Main Question	Follow-up Question
<b>A. General information about wives of migrants</b>	What is the estimated number of wives of male labor migrant in this VDC?	<ul style="list-style-type: none"> <li>Has the number of MLMs going abroad for work increased, decreased or remained the same over the past five years? Why?</li> </ul>
	What economic activities (e.g. household activities, jobs, daily wage labor, agriculture, own business) are these wives involved in while in Nepal?	<ul style="list-style-type: none"> <li>How do they spend a day in general while they are in Nepal?</li> <li>Are they economically active?</li> </ul>
	Do the spouses of migrants accompany their husband who migrates for work?	<ul style="list-style-type: none"> <li>If so, which country do they go to?</li> <li>How do the spouses get to their husband's destination? With whom do they generally go with ( alone or with other relatives/neighbors) while visiting their</li> </ul>

Theme	Main Question	Follow-up Question
		<p>husband?</p> <ul style="list-style-type: none"> <li>• What do the spouses of migrants do there? What occupation do they take up?</li> </ul>
	<p>What are the major health problems faced by wives of migrants in this VDC/areas?</p>	<ul style="list-style-type: none"> <li>• What do wives of migrants do in case they need medical care? Do they seek health services and if so, where do they generally go for such services?</li> </ul>
<p><b>B. FP Situation</b></p>	<p>What are the current FP services available in your VDC/community?</p>	<ul style="list-style-type: none"> <li>• If the women require FP services where will they go?</li> <li>• How is the behaviors/attitude of the FP service providers?</li> <li>• What are the sources of FP information and services in your VDC/community?</li> </ul>
	<p>What is the current FP use situation among migrant couples in this district?</p>	<ul style="list-style-type: none"> <li>• How do migrants or wives of migrants prepare or plan for FP measures before or when the husband returns home?</li> <li>• When the husband returns, what FP methods do wives of migrants adopt?</li> <li>• In your opinion, what are the most commonly used modern FP methods among migrant couples?</li> <li>• How do people in your community react if the wife of a migrant worker is using FP method while the husband is away? Why?</li> <li>• How much interest does the wife show in knowing if her husband is infected with HIV or STI when he returns home?</li> <li>• If she shows interest in knowing about her husband's situation, what preventive methods does she take?</li> </ul>
<p><b>C. Need for FP service</b></p>	<p>How controversial does it get if the wife of a migrant worker gets pregnant while the husband is absent?</p>	<ul style="list-style-type: none"> <li>• What challenges/difficulties does the migrant couple face in accessing FP services in this V.D.C.?</li> <li>• What kind of difficulties/challenges do the wives of migrant worker face when her husband is advised and suggested to use FP methods?</li> </ul>
<p>D. Program gaps for FP services</p>	<p>What needs to be done to improve the access and quality of FP services among migrant couples?</p>	<ul style="list-style-type: none"> <li>• Are they satisfied with the available services?</li> <li>• Probe: If not, how can it be improved further</li> <li>• What program intervention will best reach returning migrant and their wives for FP services?</li> <li>• When would be the best time to provide these services to returning migrant and their wives?</li> </ul>



Theme	Main Question	Follow-up Question
<b>E. HIV and STIs Situation</b>	Have you all heard about the Sexually Transmitted infections (STI) and HIV?  If so, what is the current HIV and STI situation in this community (or district)?	<ul style="list-style-type: none"> <li>• Have you seen / met people infected with STI and HIV (among your peers/relatives...)?</li> <li>• How do people in this VDC/area react if they know that a person has been infected with HIV and/or STI?</li> <li>• What groups appear to contribute most to the spread of sexually transmitted infections in this community?</li> <li>• How aware are the people in this district about HIV and STIs prevention methods?</li> <li>• How do the women in this V.D.C. get information on HIV and STI?</li> </ul>
	If so, what is the current HIV and STI situation among wives of migrants in this community (or district)?	<ul style="list-style-type: none"> <li>• What behaviors put wives of migrants at risk of HIV and STI transmission?</li> <li>• Where do wives of migrants go for HIV and STI related diagnosis? Where do they go for treatment if they have STI related symptoms?</li> </ul>
<b>F. Need for HIV and STI Services</b>	Are there organizations providing HIV and STIs services to the wives of migrant population?	<ul style="list-style-type: none"> <li>• If so, which organization? What other service do they provide?</li> </ul>
	What are the barriers to accessing and using HIV and STIs services for wives of migrants in this community or district?	
<b>D. Program gaps for HIV and STIs Services</b>	If current HIV services exist in the district, are the wives of migrants able to access this service?	<ul style="list-style-type: none"> <li>• If unable to gain access to these services, why?</li> </ul>
		<ul style="list-style-type: none"> <li>• If current STIs services exist in the district, are wives of migrants accessing the services?</li> <li>• What program intervention will best reach wives of migrants for STIs services?</li> </ul>

## Rapid Ethnographic Guide: Key Informant In-depth Interview (health professionals)

Respondent ID# \_\_\_\_\_

Date of interview (dd/mm/yy): \_\_\_\_\_

Type of Respondent: \_\_\_\_\_

Name of Interviewer: \_\_\_\_\_

VDC: \_\_\_\_\_

District: \_\_\_\_\_

### Instructions to the interviewer:

#### 1. Planning:

- a. Coordination/invitation for the interview on time
- b. Arrive 5-10 minutes before schedule,
- c. Ensure interview site (preferred by the interviewee), is clean and confidential
- d. Pre-test tape recorder
- e. Arrange for refreshments (if necessary),
- f. Arrange for transportation fee for participant (if applicable),
- g. Note book/pen
- h. Consent form copy for participant

Theme	Main Question	Follow-up Question	Probe Question
<b>Male labor Migrants General</b>	what is the estimated number of migration among married and unmarried men in this district?  In this district, which VDC's have the maximum number of male migrants going abroad for labor work?	Is the level of migration very low, low, average (like other places), very high, high?	Can you give me some examples or elaborate further?
	What are the major health problems faced by returnee migrants in this district?	In your opinion, what do MLMs do when they need medical care/assistance for it?  Do they frequently visit health facilities or not? Do they seek health services on time or not?  Are there any health services male migrants will not seek, even if they need them? What are they and why they do not seek them?	From which sector do they most prefer to obtain service from: government, NGO, or private sector and why?  Do they go to India to seek these services? If so, where in India and why so?

#### 2. Introduce briefly about yourself and study and ask for the interviewees introduction

#### 3. Key informants must be one of the following groups:

- a. District (Public) Health Officer [D(P)HO]
- b. District FP focal person (FP officer/assistant)
- c. District AIDS Coordination Committee (DACC) Coordinator / HIV Focal Person (if applicable)
- d. Reproductive Health Coordination Committee (RHCC) Member/s

- e. Health service providers such as Public Health Nurse (PHN), Female Community Health Volunteers (FCHVs), Auxiliary Nurse Midwife (ANM), other community health volunteers/workers (Maternal Child Health Workers-MCHW and Village Health worker-VHWs), medical officers at district hospital and primary health care centers, private practitioners/pharmacist etc.
  - f. NGO workers providing health services
4. **Obtain Informed consent** – read out the informed consent clearly and slowly in Nepali to the interviewee. Obtain the signed consent from the interviewee before proceeding with the interview.
  5. **Use the guideline to guide the interview process and only ask the sub-questions to probe for further information. The order of the interview for the sub-questions need not be as in the guideline.**
  6. **Start with an ice-breaker and proceed with the interview session**

### 1. Male migrant general information

### 2. Wives of migrant general information

Theme	Main Question	Follow-up Question	Probe Question
<b>Wives of Migrant Laborers General</b>	What is the estimated number or proportion of wives of migrant laborers in this district?	In your knowledge, which VDCs have the highest number of females whose husbands have migrated? Why?	Have the wives of migrants shifted to some other places (city or semi urban area) for jobs or children's education or due to any other reason?
	What economic activities (e.g. household activities, jobs, daily wage labor, agriculture, own business) are these wives involved in while in Nepal?  <i>Note: Ask health professionals working at community level ex: FCHVs, ANM, Community health workers/volunteers etc.</i>	How do they spend a day in general?  Do(es) this/ these activities bring in money or other resources?	
	Do wives of migrants accompany their husbands abroad?  <i>Note: Ask health professionals working at community level ex: FCHVs, ANM, Community health workers/volunteers etc.</i>	If so, around what proportion of wives of migrants do so?  How long do they stay with their husbands abroad?  Do they also work while abroad?	How many out of 100 (percentage)?  How many weeks or months?  What types of work do they do while abroad? Do get paid for their work?
	What are the major health needs of wives of male migrants who are from this district?	What are the various kinds of health problems for which they seek health services?  Where do they generally go for such services?	Can you give me some examples of common health problems they face?  Do they tend to use services at Government, NGO or private facilities? Do they go to India to seek these services? If so, where in India and why so?

### 3. Access the FP situation in new migrant program district

Theme	Main Question	Follow-up Question	Probe Question
<b>FP Situation among Migrant Couples</b>	In general, what is the trend in contraceptive use for this district? Has it increased, decreased or remained the same? Why?	In this district, which are the pockets where CPR is low or stagnant? If yes, what are possible reasons for this?  What efforts have been carried out in this district to increase CPR?	
	What is the current FP use situation among migrant couples in this district?  What difficulties are there in this district while providing FP commodities in a simple manner?	what different is there between migrant couples and non-migrant couples in this district regarding current FP use and why?  In your opinion, what are the most commonly used modern FP methods among migrant couples?  From where do they most prefer seeking FP service: Government, NGO or private facilities?  Do they go to India to seek these services? If so, where in India and why so?  How do people in this community react if the wife of a migrant worker is using FP method while the husband is currently absent?  Which of the FP commodities are always in short supply and which commodities have excess supply this district? Why?  Do male migrants use FP commodities while away on foreign lands? If so, why?  Do wives of male migrants use FP commodities during husband's absent? If so, why?	

#### 4. Access the need for FP Service among migrant couples

Theme	Main Question	Follow-up Question	Probe Question
<b>FP Service Needs for Migrant Couples</b>	What type of FP services is needed for returnee migrant couples in this district?	Are there organizations providing FP services to the migrant population in this district?	If so, which organization? What other service do they provide?
	What type of FP unmet need is present among returnee migrant couples in this district?	What are the high priority needs in terms of FP services for migrant populations?	
	What is the community's reaction if the migrant couple wishes to terminate unwanted pregnancy? Why?	If a pregnancy is unwanted, how common is it for a migrant couple to undergo abortion in this community?  Where do women usually go for abortion service?	
	How acceptable are long-term FP methods such as sterilization, IUD and norplant? Why?	Are there any difference in want of long term FP method among migrant couples or is one method fine for both of them?	
	What has been done to address the FP needs of migrant couples in this district?  What are the problems/challenges faced by migrant population in accessing and using FP services in this district?  Is there stigma attached with FP use?  What are the facilitating/motivating factors for seeking FP services?		Example: what were the target areas? What kinds of activities/services/awarness – raising programmes were provided? Example of possible factors: Social, cultural, economic, geographical barriers etc.  If so, in what ways? Please elaborate.

**5. Identify gaps and program areas for intervention to help guide development of program intervention (FP)**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>	<b>Probe Question</b>
<b>Program Gaps for FP</b>	<p>What key changes made in FP services would make them more accessible and acceptable to migrant couples?</p> <p>What programs have been held in this district to promote awareness on safer sex and family planning?</p> <p>Which VDCs in this district have a high number of male migrant population where there is a scarcity of FP commodities?</p> <p>How can the supply of FP commodities be increased in these areas?</p>	<p>In your opinion, what program intervention will best reach them for FP services?</p>	<p>How can this intervention program be made better? Why? When would be the best time to provide these services?</p> <p>Do you have specific recommendation or idea that would help improve upcoming similar program?</p> <p>Why is there a scarcity in supply of FP commodities?</p>

**6. Access the HIV and AIDS Situation in new migrant program district**

<b>Theme</b>	<b>Main Question</b>	<b>Follow up question</b>	<b>Probe Question</b>
<b>HIV and STIs Situation</b>	<p>What is the current HIV and STI situation in this district?</p>	<p>In your opinion, who are the most at risk groups of acquiring HIV and STIs in this district?</p> <p>How do people in this district react if they know that a person has been infected with HIV and/or an STI ?</p> <p>How aware are the people in this district about HIV and STIs treatment methods?</p> <p>Do the male migrants get tested and treated for HIV and STI infection as soon as they return home?</p> <p>Do wives of male migrants use HIV or STI services?</p>	<p>More, less, or the same?</p> <p>Can you give me some examples of incidents of stigma and discrimination?</p> <p>What methods do they adopt to prevent being infected?</p> <p>If they do get infected, what do they do to get treated?</p> <p>What are some reasons they do/ don't use the testing/treatment services?</p> <p>What are some reasons they do/ don't use the testing/treatment services?</p>

<b>Theme</b>	<b>Main Question</b>	<b>Follow up question</b>	<b>Probe Question</b>
	Do the male migrants inform their families about their HIV infection status?	<p>In your opinion how many of the male migrants report HIV infection in this district?</p> <p>How many returnee male migrants have been found to be HIV positive in this district?</p> <p>Where do they go for HIV testing and treatment?</p> <p>Which VDCs in this district have highest number of HIV positive cases among returnee MLMs?</p>	<p>Lots, few, a little, sporadically, etc?</p> <p>Where do they most prefer to get these services: Government, NGO or private facilities?</p>
	Do the male migrants inform their families if they are diagnosed with other sexually transmitted diseases besides HIV? Do they get treatment?	<p>What are the common STIs reported or diagnosed in your district?</p> <p>Where do they go for screening diagnosis and treatment of STI?</p> <p>Are the drugs for the treatment provided free or do they have to be purchased?</p>	<p>Please provide some examples.</p> <p>Do they tend to go to Government, NGO or private facilities?</p>
	Do the wives of migrants report HIV infection or are diagnosed with HIV infection to their families?	<p>Where do they go for HIV screening, diagnosis and treatment?</p> <p>How many of the wives of migrants report HIV infection in this district?</p> <p>Which VDCs in this district have higher HIV cases among wives of migrants?</p>	Do they tend to go to Government, NGO or private facilities?
	Have the wives of migrants been diagnosed with other sexually transmitted diseases besides HIV?	<p>What are the common STI reported or diagnosed?</p> <p>Where do they go for screening, diagnosis and treatment of STI?</p> <p>How do they manage the drugs prescribed? Are the drugs for the treatment</p>	<p>Do they tend to go to Government, NGO or private facilities?</p> <p>How do health service providers follow up the STI diagnosed cases?</p>

Theme	Main Question	Follow up question	Probe Question
		provided free or do they have to be purchased?	

**7. Access the need for HIV and STI Service among migrant couples**

Theme	Main Question	Follow-up Question	Probe Question
<b>HIV and STI service needs for migrant couples</b>	What is your sense of the need for HIV and STI services among migrant couples?	<p>What are the high priority needs in terms of HIV and STI services for migrant populations?</p> <p>Is the need different for MLMs and their wives in terms of STI services?</p> <p>Is it considered common that husbands engage in risky sexual practices while away from their wife/ family?</p> <p>Do wives engage in activities considered risky for her sexual or reproductive health when her husband is away?</p> <p>Are there organizations providing HIV and STI services to the migrant population?</p>	<p>Why?</p> <p>If so, which organization? What other service do they provide?</p>
	What are the problems/challenges faced in providing HIV and STI services to migrant population?	<p>Are these populations hard to reach for programmatic intervention in this district?</p> <p>Is risk perception prevalent among migrants and their wives in this district?</p> <p>What about stigma and discrimination faced by HIV infected person from the family?</p> <p>How many people are there in this district who suspect they are HIV infected but won't be tested for fear of being stigmatized and discriminated by family and society?</p>	<p>If so, why are they hard to reach?</p> <p>Why does the family show discrimination?</p>

**8. Identify gaps and program areas for intervention to help guide development of program intervention (STI and HIV)**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>	<b>Probe Question</b>
<b>Program gaps for HIV and STI</b>	What key changes made in HIV services would make them more accessible and acceptable to migrant couples?	<p>In your opinion, what program intervention will best reach them for HIV services?</p> <p>What programs have been held in this district to promote awareness on HIV prevention?</p> <p>Which are the high priority geographical and service areas for intervention? Why?</p> <p>How can the services/programmes be improved further?</p>	<p>How can this programme be better implemented? Why? When would be the best time to provide these services?</p> <p>Do you have specific recommendation or idea that would help improve upcoming similar program?</p> <p>Is there any VDC where there is a need for the program but available program have not reached yet?</p> <p>For instance: Appearance of services; Interpersonal communication (provider-client); Services provided in private and confidential manner; Cost of services is acceptable etc.</p>

**Rapid Ethnographic Guide – Key Informant In-depth Interview  
(Non-health professionals)**

**Respondent ID#** \_\_\_\_\_ **Date of interview (dd/mm/yy):** \_\_\_\_\_  
**Type of Respondent:** \_\_\_\_\_ **Name of Interviewer:** \_\_\_\_\_  
**VDC:** \_\_\_\_\_ **District:** \_\_\_\_\_  
**Instructions to the interviewer:**

- 7. Planning:**
  - a. Coordination/invitation for the interview on time
  - b. Arrive 5-10 minutes before schedule,
  - c. Ensure interview site (preferred by the interviewee), is clean and confidential
  - d. Pre-test tape recorder
  - e. Arrange for refreshments (if necessary),
  - f. Arrange for transportation fee for participant (if applicable),
  - g. Note book/pen
  - h. Consent form copy for participant
- 8. Introduce briefly about yourself and study and ask for the interviewees introduction**
- 9. Key informants must be one of the following groups:**
  - a. District Development Committee (Local Development Officer or Program Officer –Social Development.)
  - b. VDC Secretariat (from high migrant population VDC)
  - c. Women development officer / Mothers group
  - d. Safer migration network representative
  - e. NGOs/development workers working with migrant population
- 10. Obtain Informed consent** – read out the informed consent clearly and slowly in Nepali to the interviewee. Obtain the signed consent from the interviewee before proceeding with the interview.
- 11. Use the guideline to guide the interview process and only ask the sub-questions to probe for further information.**
- 12. Start with an ice-breaker (ask the respondent about their job and involvement with the community) and proceed with the interview session**

**1. Male migrant general information**

Theme	Main Question	Follow-up Question	Probe Question
	What is the estimated number of males migrating for work in this district? Is the level of migration very low, low, average (like other places), very high, high?	What percentage of them is unmarried?	
	What is the migration trend in this district? Is the migration increasing, decreasing or the same? Why?	Why do you think these VDCs have the most MLMs? Can you give me some examples or elaborate further?	Why are these destinations popular for males in this district?
	Which VDCs have the most male labor migrant workers?	What are the most popular destinations? If the duration of stay varies by destination, what is the average duration of stay	

Theme	Main Question	Follow-up Question	Probe Question
<b>Male labor Migrants General</b>	<p>Where do they migrate for work? What are the most popular destinations?</p> <p>What is the average duration of stay for migrants abroad?</p> <p>When the MLMs return home, how long do they usually stay at home?</p> <p>Which months do the migrants visit Nepal and leave Nepal?</p> <p>Is there a change in migration destinations? Ex: people who used to go to India now migrate to other countries.</p>	<p>according to the countries of migration?</p> <p>Do they usually visit during a particular time, e.g. festivals, harvesting and cultivating seasons? If so, which time?</p> <p>Why do you think change in migration destination occurred?</p>	
	<p>In your opinion, what are the major health problems of male migrants?</p>	<p>Why and what are the reasons males migrants experience these kinds of health problems?</p> <p>In your opinion, what do MLMs do in case they need medical care?</p> <p>Do you think migrants seek health services when they return to Nepal? If so, where do they generally go for such services?</p> <p>Do they go to India to seek these services? If so, where in India and why so?</p>	

## 2. Wives of migrant general information

Theme	Main Question	Follow-up Question	Probe Question
<b>Wives of Migrant Laborers General</b>	What is the estimated number or proportion of wives of married migrant laborers in this district?	Are most wives of migrants currently living in their home or have shifted to some other places (city or semi urban area) for jobs or children's education or due to any other reason?	
	Do wives of migrants accompany their husbands abroad?	If so, around what percentage of wives of migrants do so?  How long do they stay with their husbands abroad? How many weeks or months? Do they work while abroad? What types of work do they do? Do they get paid for their work?	
	For those who do not accompany their husbands abroad, what economic activities (e.g. household activities, jobs, daily wages, agriculture, own business) are these wives involved in while in Nepal?	How do they spend a day in general?  Do(es) this/ these activities bring money or other resources?	
	Are there cases of extra marital affairs? If so, how common are such cases in this district?		
	What are the major health problems of wives of male migrants who are from this district?	What are the common health problems wives of male migrants experience for which they seek services?  Where do they go for such services?  Do they tend to use services at Government, NGO or private facilities?  Do they go to India to seek these services? If so, where in India and why so?	

### 3. Access the FP situation in new migrant program district

Theme	Main Question	Follow-up Question	Probe Question
<b>FP Situation</b>	<p>When the male migrants return home, what is the level of FP use among the couples?</p> <p>Do wives of male migrants use FP services while their husbands are away? What are some reasons they do/ don't use the services?</p> <p>Do male migrants use FP services while they are abroad? What are some reasons they do/ don't use the services?</p> <p>In this district, which of the FP commodities are easily available and which commodities are not easily available?</p>	<p>What is the level of FP use in the initial period after male migrants return home?</p> <p>In your opinion, what are the most commonly used modern FP methods among migrant couples?</p> <p>Do they tend to go to Government, NGO or private facilities? Do they go to India to seek these services? If so, where in India and why so?</p> <p>How do people in your community react if the wife of a migrant worker is using FP method while the husband is away?</p> <p>Why are some contraceptive commodities not easily available?</p>	

### 4. Access the need for FP Service among migrant couples

Theme	Main Question	Follow-up Question	Probe Question
<b>FP Service Needs for Migrant Couples</b>	<p>What type of FP commodities and services are needed for migrant couples in this district?</p> <p>What is the community's reaction if the migrant couple wishes to terminate unwanted pregnancy?</p>	<p>Are there organizations providing FP services to the migrant population in this district? If so, which organization? What other service do they provide?</p> <p>What are the high priority needs in terms of FP services for migrant populations?</p> <p>What kinds of FP services would be ideal for MLMs and their wives?</p> <p>Would it be better to provide same FP commodities to both husband and wives or provide</p>	

Theme	Main Question	Follow-up Question	Probe Question
		different kinds of FP commodities? Why? Do wives need FP services while their husbands are abroad? Why? Are there any programs or management to provide FP commodities to migrant worker who returned home and their wives?	
	What are the problems/challenges faced by the migrant population in accessing and using FP services in this district?	What factors are associated with FP use? Or. what are the barriers for seeking FP services? Example of possible factors: social, economic, health, education/awareness etc.  Is there stigma attached with FP use? If so, in what way? Please elaborate	

**5. Identify gaps and program areas for intervention to help guide development of program intervention (FP)**

Theme	Main Question	Follow-up Question	Probe Question
<b>Program Gaps for FP</b>	If the migrant couples are not using FP commodities, why do you think they are not using it?  What program gaps are there in terms of FP services for migrant couples?	In your opinion, what program intervention will best reach them for FP services? When would be the best time to provide these services?  What programs have been held in this district to promote awareness on safer sex and family planning? Do you have specific recommendation or idea that helps improve upcoming similar program?  Is there any VDC where the number of male migrants is high but supply of FP services and commodities are low?  How can the services be improved further? For instance: Appearance of	What are the reasons for low supply for FP services and commodities?

Theme	Main Question	Follow-up Question	Probe Question
		<p>services; Interpersonal communication (provider-client); Services provided in private and confidential manner;</p> <p>Cost of services is acceptable;</p> <p>Awareness of any IEC/ BCC campaign to reach migrant couples; operation time;</p> <p>Availability of preferred FP services</p>	

#### 6. Access the HIV and AIDS Situation in new migrant program district

Theme	Main Question	Follow-up Question	Probe Question
<b>HIV and STIs situation</b>	<p>What is the current HIV and STI situation in this district? (Increasing, decreasing or the same)</p>	<p>In your opinion, who are the most at risk groups of acquiring HIV and STIs in this district?</p> <p>How do people in this district react if they know that a person is infected with HIV and/or STI ?</p> <p>Can you give me some examples of incidence of stigma and discrimination?</p> <p>How aware are the people in this district about HIV and STIs treatment methods? What methods do they adopt to prevent being infected? If they do get infected, what do they do to get treated?</p> <p>Do the male migrants get tested and treated for HIV and STI infection as soon as they return home? What are some reasons they do/ don't use the testing/treatment services?</p> <p>Do wives of male migrants use HIV or STI services? What are some reasons they do/ don't use the testing/treatment services?</p>	

**7. Access the need for STI and HIV Service among migrant couples**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>	<b>Probe Question</b>
<b>HIV and STI Service Needs for Migrant Couples</b>	How prevalent is HIV and STIs among migrant couples in this district? What is your sense of the need for HIV and STI services among migrant couples?	What type of HIV and STI services do you think are needed for migrant couples in this district? Can you provide examples? (Ex. prevention, diagnosis, treatment, care and support etc.)  Is it considered common that husbands engage in risky sexual practices while away from their wife/ family? And why?  Do wives engage in activities considered risky for her sexual or reproductive health when her husband is away? What type of risky sexual practices would those be?  Are there organizations providing HIV and STI services to the migrant population? If so, which organization? What other service do they provide?	

**8. Identify gaps and program areas for intervention to help guide development of program intervention (STI and HIV)**

<b>Theme</b>	<b>Main Question</b>	<b>Follow-up Question</b>	<b>Probe Question</b>
	What key changes made in HIV services would make them more accessible and acceptable to migrant couples?	In your opinion, what program intervention will best reach them for HIV services?  What programs have been held in this district to promote awareness on HIV prevention?  Do you have specific recommendation or idea that helps improve upcoming similar program? For instance: Appearance of services; Interpersonal communication (provider-client); Services provided in private and confidential manner; Cost of services is	What are the reasons why these VDCs have higher number of infected individuals but limited or no programs?

<b>Program gaps for HIV, STI</b>		<p>acceptable; Awareness of any IEC/ BCC campaign to reach migrant couples; operation time</p> <p>Is there any VDC where the population of infected individuals are high but without or limited the program but available program? What are the names of those VDCs?</p>	
	<p>What key changes made in STI services would make them more accessible and acceptable to migrant couples?</p> <p>What program gaps are there in terms of STI services for migrant couples?</p>	<p>In your opinion, what program intervention will best reach them for STI services? (Why and how would it be the better program intervention? When would be the best time to provide these services? )</p> <p>What programs have been held in this district to promote awareness on STI prevention? (Do you have specific recommendation or idea that helps improve upcoming similar program?)</p> <p>How can the services be improved further? For instance: Appearance of services; Interpersonal communication (provider-client); Services provided in private and confidential manner; Cost of services is acceptable; Awareness of any IEC/ BCC campaign to reach migrant couples; operation time</p>	