

Baseline Family Planning Survey Including Rapid Assessment of HIV, Sexually Transmitted Infections and FP Situation among Migrant Couples

Bara, Kapilbastu, Nawalparasi and Palpa Districts

Factsheet: Findings from Qualitative Study

Brief Description of the Study

This baseline Family Planning (FP) Survey including Rapid Assessment of HIV, Sexually Transmitted Infections (STIs) and FP situation among male labor migrants (MLMs) and wives of male labor migrants (WoMLMs) was conducted in Bara, Kapilbastu, Nawalparasi and Palpa districts using a mix method approach. This study covered a total of 690 MLMs and 1,028 WoMLMs for individual interviews. Similarly, for the qualitative information, focus groups discussions (FGD) with MLMs (n=8) and WoMLMs (n=8) and key information interviews (KII) with both health (n=13) and non-health (n=17) professionals from the four study districts were conducted. This factsheet only presents findings from the qualitative study. The qualitative study mainly explored the programmatic needs on FP, STIs, and HIV in the study districts. All interviews and FGD sessions were conducted during August-October 2012.

Methods

Participants for the focus group discussions were selected purposively and identified during the individual interview. For key informant interview, district and local level health stakeholders from both health and non-health sectors were included. The focus group discussions and key informant guidelines were developed in Nepali by Saath-Saath Project¹ and pretested by the research partner agency New ERA. Same sex researchers conducted the FGDs and KIIs and consent was taken from all participants prior to the FGD and interviews. All the interviews and FGDs were transcribed and analyzed based on the themes. 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.

Key Findings

Background characteristics of the participants:

Among the KII participants, 13 officials were from health sector and 17 from non-health sector. Almost 56 percent of the MLMs and 58 percent of WoMLMs who participated in the FGD were between the ages of 21-30 years. Only five percent (3/59) MLMs and 16 percent (10/62) WoMLMs were illiterate. Most FGD participants were from rural areas (86% MLMs and 100% WoMLMs) and more than one third (34% MLMs and 39% WoMLMs) belonged to Brahmin/Chhetri ethnic group. Also, more than 50 percent of the MLMs were returnees from Gulf countries.

External migration to work is increasing, gulf countries are popular destinations:

Key informants in all four study districts reported that almost 30-50 percent of the total male population have migrated abroad for work. Most FGD participants reported the total number of MLMs ranged anywhere from 10,000 to 40,000 in these districts. Unemployment was a frequently reported reason for migration. Gulf countries and Malaysia are popular destinations for work for these migrant workers and the pattern is similar across all the four study districts. India is also a popular destination for migrant workers wherein Mumbai, Delhi, Bihar and Punjab states were reported major migration destinations from the study districts. There was a consensus among participants that economic status of the migrant workers plays a vital role in choosing the destination country for work. Most participants in this study revealed that average stay abroad is longer for migrant workers going to countries other than India. Also migrant workers working in India generally return home during festive and/or harvesting/planting seasons.

"...since past few years, migration to work abroad has increased remarkably. Men generally go for labor work as they lack skills for other better jobs"
(FGD, migrants, Palpa)

Communication and home visit practices:

Study participants stated that MLMs generally informed their wives before returning home, usually within a week or two prior to arrival. Migrant workers who go abroad (other than India) on visa are aware about dates when they need to return home due to the visa expiry dates thus their holidays (home return) are generally pre-determined. Communications about returning home are usually done through telecommunication, mostly mobile phones. For example, key informants in Palpa district informed that most of the female counterparts in the district have now better communication access to talk to their husbands abroad because of the availability of mobile phones and extensive installation of telephone towers in the districts.

¹ Project funded by United States Agency for International Development (USAID)

Findings from Qualitative Study

Interestingly, some migrants during FGD session also shared that some migrant workers going to India even like to come home without any prior notice as a surprise visit to check on their wives "behavior" in their absence.

Husbands' migration provides better opportunity for families, some wives even engage in extramarital relationships:

Participants shared that many WoMLMs in hilly areas from districts such as Palpa and northern hilly part of Nawalparasi generally relocate to urban/semi-urban areas with their children for better education opportunities, health services and modern conveniences after their husbands migrate for work. This indicates that women in these communities have now become the primary decision makers regarding how and where to spend the money. However, WoMLMs in Terai districts such as Bara, Kapilbastu and southern Nawalparasi were mostly confined to household activities such as raising children, maintaining their homes and cooking. The key informants from these areas had a notion that there is a strong stigma attached with Terai-origin women moving alone or with children to urban areas and that they do not have access to their husband's earnings and are strapped for cash. Most KII and female FGDs participants also argued that people in general do not approve of sexual relationship outside marriage. Some participants mentioned that it is not a good practice to engage with multiple partners or in risky sexual practices while abroad, however, few argued that since it is a patriarchal society, having multiple partners is okay. Likewise, participants from Palpa and Nawalparasi also hinted that WoMLMs engage in extra marital affairs and some even eloped with other men during their husband's absence. However, most participants from Terai districts believed that extramarital affairs among WoMLMs after their husband's departure as very rare.

"...generally, we spend our time with household work and caring our children"
(FGD, wives of migrants, Bara)

Migrant workers are at risk from communicable and non-communicable diseases while abroad:

Study participants believed that MLMs are at higher risk from various diseases such as tuberculosis, malaria, respiratory diseases, jaundice, malnutrition and other various health problems due to sudden changes in the weather condition including heat-wave and work-related physical injuries and hazards. They are also at risk of HIV due to their unsafe sexual behavior while aboard. Conditions of destination countries chosen for work played a significant role towards the health issues faced by these migrant workers. For example, most migrant workers during the FGDs sessions revealed that individuals who migrate to India have greater threats of HIV and AIDS and STIs mainly from opportunities to engage in unsafe sexual relations with female sex workers (FSWs) in the city areas. Some migrant workers further explained that FSWs visit these men on pay day in Malaysia, suggesting even MLMs migrating to Malaysia are at risk. For Gulf countries, the extent of indiscriminate sexual contacts and contraction of sexually transmitted diseases were reported to be very low.

Use of modern FP methods is increasing but migrants and their wives still lack comprehensive information on FP methods:

Participants agreed that use of FP methods in the districts have increased. KII believed that long lasting methods (e.g. injectables and Norplant) are popular among non-migrant couples while migrant couples mostly use non-clinical method such as condoms. FGD participants also mentioned that FP

"...we do not use FP methods. We do not have information either but we know about condom. Only better educated people use condoms and injectables. Some men use condom abroad"
(FGD migrants, Bara)

use for safe sex or to prevent from being infected with diseases was very rare among the migrant couples. Although many migrant workers during FGD discussion reported that both husband and wife sometimes discuss about the available options for FP, but preparation for using FP between the couples before coming home is very rare. It was found that most of the male and female participants possessed basic knowledge around FP methods. They however lack detailed information (e.g. availability, its uses) about FP methods. Key informants also acknowledged the need of detailed and extensive knowledge of FP methods for migrant couples and suggested that increase in awareness and provision of FP services is important in order to increase accessibility and utilization of services. Other suggestions included were recruitment of more health workers for both the government and NGO facilities, more FP clinics, more budget and increased coverage of programs. Key informant also believed that implementation of programs which empower women may also help them to facilitate decision making on FP use.

Most awareness raising programs are urban centered; cultural and geographical barriers remain challenges accessing FP and HIV information and services:

Participants highlighted that there are no HIV, STIs and AIDS-related service centers at the Village Development Committee (VDC)-level and stressed the need to establish such centers. Both FGD and KII participants accepted that generally FP and HIV-related awareness raising events are organized in urban areas such as district headquarters or major market areas. Health

Findings from Qualitative Study

workers from Bara, Kapilbastu and Nawalparasi districts expressed that in Muslim communities there are issues with access as it is against their religious and cultural norms to use FP methods. In Palpa, geographical barriers were identified as a major challenge to improve access to FP services. In hilly remote areas, all FP methods are not always available as it is challenging to maintain regular supplies to such areas.

Treatment practices upon arrival is low, migrants generally prefer private services providers for confidential services:

The study found that migrant workers generally visit district hospitals, private clinics, health posts, sub-health posts but it is common for migrants to seek medical help only if they have to, as minor illnesses goes unnoticed. Participants also argued that some migrant workers even go to India to seek health services. Generally, they visit hospitals and public health posts with minor illnesses as it is cheaper. However, if the problems are more complicated and related to STIs, they prefer confidential services and seek treatment at private clinics or travel abroad, especially for individuals who live near the border areas. Many FGD participants from Bara and Kapilbastu districts reported going to India for medical treatment and care in cities such as Gorakhpur and Raxaul. Both male and female FGD participants frequently reported that lack of confidential services was the main cause for hesitancy towards seeking such health services at their native place.

Comprehensive knowledge on HIV and AIDS is poor, many still hold negative attitude towards HIV and AIDS:

It was found that both MLMs and WoMLMs are aware about the name of HIV and AIDS and STIs. Radio, television, female community health volunteers (FCHVs), health institutions, community networks are some of the sources of information regarding HIV and AIDS and STI. Interestingly, AIDS was more commonly heard than HIV in the study area. However, discussions with the male and female participants further revealed that migrant couples lack comprehensive knowledge about HIV and AIDS. Surprisingly, some respondents even shared the cause of HIV and STI as due to 'lack of cleanliness', highlighting their poor knowledge on HIV and AIDS. Most study participants also shared that community people including those from educated background still held negative outlook towards people living with HIV (PLHIV) and stigmatized and discriminated them. Key informants stated that 'migration to India' is one of the primary factors responsible for the increased HIV cases in the community. Some of the Health workers further stated that many men in the community do not report their status to their family and at times even the person himself/herself may not be unaware of his/her HIV status.

Migrants rarely get tested for HIV due to lack of awareness and societal fear:

Migrants and most KII were convinced that HIV and STIs are on a steady rise in the study districts. They stated that almost none of the male migrant workers get tested after returning home as they are confident of being disease free or don't get tested due to lack of awareness regarding HIV and available services and societal fear of being stigmatized. WoMLMs do not get

"...sometimes husbands come without informing us thus we cannot do anything...we cannot say our husbands to get tested as they feel bad if we request them to go for a test", (FGD wives of migrants, Nawalparasi)

tested as they cannot make their own decision and even if they are aware about the need to get tested, they are hesitant about expressing it to their husbands for fear of being questioned/accused of infidelity and causing internal disputes.

No specialized services for migrant workers, they even visit India for HIV and STI services:

FGD participants argued that there are no organizations providing services specifically to migrant couples while a few named Nepal Red Cross Society, Lions Club, Maiti Nepal and other local NGOs as those providing HIV and STIs-related programs and services. According to the key informants, individuals visit variety of places for diagnosis and

"...they prefer private service centers and sometimes go to India for checkup. They believe them most" (key Informant, Bara)

treatment such as district hospitals, private clinics and NGOs such as KIDS while some other also travel to Kathmandu and to India. It was found that people residing in areas close to the Indian border such as Bara and Kapilbastu visit India for treatment. Key informants and FGD participants reported that major barriers towards accessing HIV and STIs-related services were fear of being stigmatized and discriminated by the community, lack of organizations working specifically for migrant population, lack of awareness to get tested, lack of testing centers, geographical barriers, inadequate human resources and budget. They further added that HIV infection is strongly tied with stigma, bad character and possible social outcast because HIV brings shame to the whole family and the community even stigmatizes the family of the PLHIV. Therefore, even individuals who are suspect of infection go without testing.

Findings from Qualitative Study

Key Program Implications and Recommendations

- There does not seem to be a specific pattern of returning home.. Migrant workers going to India generally return during festival seasons, thus awareness raising activities should also be conducted during such special seasons. Given this, migrant programs need to be operational at all times to serve the need of potential migrants and returnees.
- Most study participants are aware about FP and HIV services that are available to them, however, comprehensive knowledge about the FP and HIV is low. Therefore, awareness programs should be designed to be more effective.
- 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.
- The existing health service providers are not enough to cover specific needs of 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 migrant health services.
- Society and culture remains as one of the major barriers in the promotion of FP and HIV services. Awareness raising activities (e.g. Drama, Counseling, Documentary) on FP and HIV and AIDS are mainly conducted in urban areas (e.g. district headquarters, major market areas), such activities and availability of FP and HIV services should be promoted at places that can be conveniently assessed by migrant workers and other community people.

“...awareness raisings on FP and HIV through street drama, radio, trainings would be best approach for migrants couples” (Key Informant, Kapilbastu)

The survey was conducted through technical and financial support of United States Agency for International Development (USAID)-Funded Saath-Saath Project under USAID Cooperative Agreement # AID-367-A-11-00005 to FHI 360. USAID/Nepal Country Assistance Objective Intermediate Result 1 & 4

National Centre for AIDS and STD Control and Family Health Division were principle investigators in the survey. All field work and data compilation was carried out with support from New ERA.

The views expressed in this publication do not necessarily reflect the views of USAID or FHI 360.

For more information and the full report, please contact

Saath-Saath Project

GPO 8033

Baluwatar, Kathmandu-4, Nepal

Phone: +977-1-4437173, Email: fhinepal@fhi360.org

