Poverty, Migration, and HIV/AIDS in Dadeldhura District (Nepal)

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Approval sheet

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This report is prepared as partial fulfilment of the requirement of the degree of Master in Public Health (MPH) from Tribhuvan University, Nepal. This thesis has been accepted and recommended for final approval.

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Dr. Giorgi Pkhakadze, 2002

Summary

This study attempt to establish a link between migrant labour and Human Immunodeficiency Virus / Sexually Transmitted Infection (HIV/STI), and, more important between HIV/STI and worsening socio-economic situations of migrant labourers affected. The study focused on five Village Development Committees (VDCs) and one municipality in Dadeldhura district (Far-Western Development Region). The methodology of the present research was cross-sectional, including literature review, a field survey with a detailed questionnaire for 303 respondents (141 migrants, 162 non-migrants) aged between 18 and 49 year old. Participatory sessions for additional qualitative data included 7 focus group discussions with 114 participants. Three case studies, and examination of 118 participants' urogenital specimens for Gram Negative Diplo Cocci test to identify Neisseria gonorrhoeae were also conducted. Blood testing was made for 303 participants for those that agree to take the Venereal Diseases Research Laboratory (VDRL) Rapid Plasma Reagan (RPR) tests to identify Syphilis, the Hepatitis B surface antigen (HBsAg) tests to identify Hepatitis B Virus (HBV), and HIV1 and HIV2 tests to identify HIV. Ethical and technical aspects were discussed with the Nepal Health Research Council, which approved the research. The total duration of the study was 5 months and 25 days (167 days), including 26 days in the field.

Internal and international migration is an important component of the socio-economic situation in Dadeldhura district. Almost every family has a migrating member. Poverty is the main underlying factor for sampled workers to migrate. Migration to India especially in Delhi, Punjab, and Mumbai is the only solution for the majority of them to survive the lack of food and the lack of jobs. There is no main difference in the socio-economic situation between migrant and non-migrant households, apart from land related criteria. The benefits from migration for the household are very low and consist mainly in a reduced number of household's members to be fed on the household income at the place of origin. This study shows that syphilis and HBV infections are still more common than HIV infections and that there is still a low prevalence of HIV infection among the population of Dadeldhura district. However, the non recognition of condom use as a proper way to protect oneself against Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) puts the population at risk of a greater epidemic.

It is recommended that the National Center of AIDS and STD Control (NCASC) be moved from the Ministry of Health to depend directly from the Prime Minister's Office or from the National Planning Commission. Attention should be given to collect reliable information as a basis for a comprehensive mapping exercise of the HIV/AIDS epidemic in Nepal. His Majesty's Government of Nepal (HMG/N) should ensure that the benefits of Poverty Reduction Strategy Paper (PRSP) and of poverty reduction activities under the 10th plan reaches out to places of origin of migrants, like Dadeldhura district. Bilateral agreements should be linked to a registration system at the district level, whereby each Nepalese migrating for work purposes abroad would be acknowledged by HMG/N and by the destination country as a *bona fide* beneficiary for the rights and benefits included in this agreement. The availability of a testing kit in each VDC should be taken as a priority by the World Health Organization / United Nations Joint Programme on HIV/AIDS (WHO/UNAIDS). There is a need for prevention programs targeted to adults, especially the 19-35 years. Awareness raising projects should have a light structure, build on existing Community Based Organizations (CBOs), and should mainstream the HIV/AIDS awareness message within their regular meetings. Radios are also very popular in the district. Already existing awareness messages on radios should be encouraged. As such, an investment in the improvement of prevention counselling and treatment programs is efficient. Each dollar invested now on the issue will save more lives than if invested in five years time.

Abbreviations

AHRTAG	Appropriate Health Resources and Technologies Action Group
AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control Deficiency Syndrome
AJPH	American Journal of Public Health
ANC	Antenatal Care
APROSC	Agricultural Projects Services Center
CETS	Center for economic and technical studies
CBS	Central Bureau of Statistics
CBO	Community Based Organisation
CDC	Center for Disease Control and Prevention
CIS	Commonwealth of Independent States
CIOMS	Council for International Organizations of Medical Sciences
CSW	Client of Sex Workers
DACC	District AIDS Coordination Committee
DDC	District Development Committee
DFID	Department for International Development
DHO	District Health Office
DOH	Department of Health
DoHS	Department of Health Services
ERB	Ethical Review Board
EU	European Union
FAO	Food and Agriculture Organization
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussion
FHI	Family Health International
FHHs	Female Headed Households
FP	Family Planning
FSW	Female Sex Worker
FWDR	Far-Western Development Region
GEM	Gender Empowerment Measure
GNP	Gross National Product

GTZ	Deutsche Gesellschaft fur Technische Zusammenarbeit (German Technical Cooperation)
HBsAg	Hepatitis B surface antigen
HBV	Hepatitis B Virus
HDI	Human Development Indicator
HH	Head of Household
HIV	Human Immunodeficiency Virus
HMG/N	His Majesty's Government of Nepal
HPI	Human Poverty Index
NACO	National AIDS Control Organization (India)
NCASC	National Center for AIDS and STD Control
NGO	Non-Governmental Organization
NHRC	Nepal Health Research Council
NORAD	Norwegian Agency for Cooperation and
NPHL	National Public Health Laboratory
NRs	Nepalese Rupees
PHC	Primary Health Care
PHCC	Primary Health Care Center
PI	Poverty Indicator
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategy Paper
MOH	Ministry of Health
MPH	Master of Public Health
RECPHEC	Resource Center for Primary Health Care
RPR	Rapid Plasma Reagan
RTI	Reproductive Tract Infection
IDP	Internal Displaced Person
IDU	Injecting Drug User
IDRC	International Development Research Centre
ILO	International Labour Organization
IOMS	International Organization of Medical Science
IOM	International Organization for Migration
IoM	Institute of Medicine
IPEC	International Programme on the Elimination of Child Labour

SAARC	South Asian Association for Regional Cooperation
SACEP	South Asia Co-operative Environment Programme
SACTS	STD/AIDS Counseling and Training Services
SASHI	Situational Analysis of Sexual Health in India
SHP	Sub Health Post
SHPO	Sub Health Post Officer
SLC	School Leaving Certificate
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SW	Sex Worker
TANESA	Tanzania-Netherlands Support Program on AIDS
TBA	Traditional Birth Attendant
TU	Tribhuvan University
MoPE	Ministry of Population and Environment
MD	Medical Doctor
MIMAP	Monitoring Micro Impact of Macro Policies
MWDR	Mid-Western Development Region
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nation Development Programme
UNEP	United Nations Environmental Programme
UNESCO	United Nations Education Science and Culture Organization
UNFPA	United Nations Fund for Population Activity
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nation International Children Educational Fund
UNPOP	United Nations Department of Economic and Social Affairs – Population Division
UoH	University of Heidelberg
USAID	United State Agency for International Development
VDC	Village Development Committee
VDRL	Venereal Diseases Research Laboratory
WB	World Bank
WHO	World Health Organization

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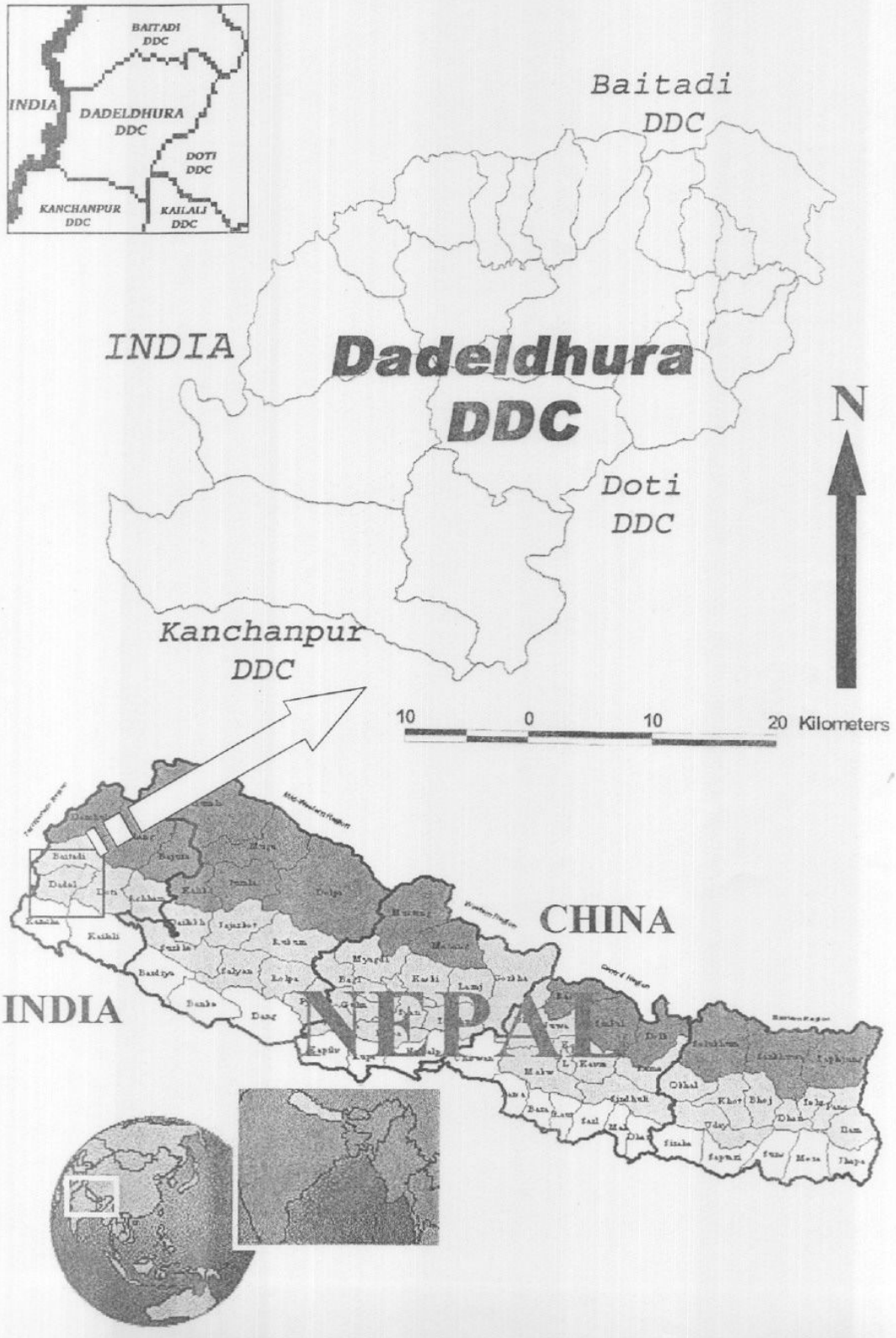
Map 1. Map of Dadeldhura District



Chapter One

Introduction

1.1 Background of the study and statement of the problem

1.1.1 Origin and rationale of the study

The study is part of the assignments given within the Master of Public Health (MPH) program of Tribhuvan University, Institute of Medicine, Department of Community Medicine and Family Health. It also takes place in the context of an increasing awareness at the policy level of the potential dangers of Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) to the socio-economic development of Nepal. The study brings first hand information that will hopefully be of help for policy makers and for organizations having to make strategic choices in projects targeting HIV/AIDS in Nepal.

1.1.2 Statement of the problem: link between HIV/AIDS, STIs and Migrant Labour

Both internal and external migration is very high in Nepal. Migration to India, both on a seasonal and long term basis, is especially high in the Far-Western Development Region (FWDR) of the country. Many of the migrants returning home from India are reported HIV positive, and some have died of AIDS.[1] Several international agencies that have projects in FWDR point in their reports to the migration to India as being the single main factor for the spread of HIV/AIDS and Sexually Transmitted Infections (STIs) in that region. However, actions taken so far are not commensurable with the size of the potential problem.

Most vulnerable to HIV/AIDS since the start of the epidemic in the 1980's are developing countries, where 95percent of the affected population is concentrated. Also since the 1980's globalisation has also had an important impact in all aspects of human life. Migration is on the rise. From an epidemiological perspective, preventive programs, in the new world order, have become difficult without proper coordination and linkages between countries. Infections do not know borders, but often preventive programs do; and in the case of labour migration, a

close cooperation is needed between sending and receiving countries to ensure the follow-up of those at risk and their families. Lack of resources also adds to the problem, as means are sometimes so scarce that even an estimate of the size of the problem is not possible. In Nepal, the official figure of cumulative total 2131 persons infected with HIV/AIDS (NCASC 31/12/2001), is underestimated, according to UNAIDS that puts the figure to up to 40,000 infected people (UNAIDS/ 2000).

High prevalence of poverty in the FWDR (the least developed region in Nepal according to the Human Development Report, UNDP, 2001), open borders between Nepal and India (following the 1950 agreement between the two countries) and a faster economic growth in India in need of cheap labour force, have contributed to an important labour migration from FWDR to India. So have other factors like the common cultural and linguistic background and the fact that the FWDR is better linked to India by roads than to other parts of Nepal itself.

In spite of the fact that empiric evidence shows a link between HIV/STI and migrant labour in Nepal, insufficient scientific information is available to sustain this claim in Nepal.

1.2 Background Research questions

- If poverty is certainly the main underlying factor for workers to migrate, what are other social and cultural elements that may act as a trigger and/or prevent migration?
- What are the perception-based elements that motivate the sexual behaviour of migrant workers? What are the factors that make the transmission of the HIV/AIDS/STIs possible?
- When migrant workers are back home, what are socio-cultural elements that prevent / encourage the spread of the virus to other household members?
- What are the direct consequences of HIV/AIDS on the livelihoods of the families?
- Considering the HIV/AIDS related risks involved in migrating, does it still constitute a safe alternative in the context of scarcity of resources in which these families live? Are there any other alternative livelihoods to be encouraged?

1.3 Research hypothesis and objective

1.3.1 Hypothesis:

- The socio-economic status of migrant workers' households is lower than of those who do not migrate,
- Households with HIV/AIDS will be in a lower economic status than those not affected,
- The incidence of HIV/AIDS and STIs will be higher among migrant workers.

1.3.2 General objective:

To understand the complex relationships between the socio economic situation of inhabitants of Dadeldhura district, migration, and HIV/AIDS/STIs.

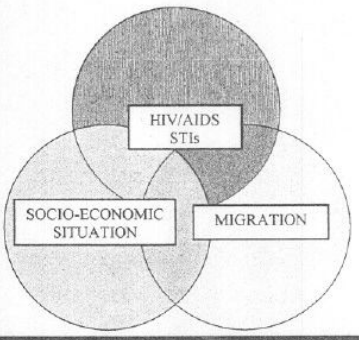


Figure 1 Study's objective: relationship between HIV/AIDS/STIs, socio-economic situation & migration

1.3.3 Specific objectives:

1. To analyze socio-economic factors that lay behind the migration of Nepalese workers from Dadeldhura district to India.
2. To study the behavioral patterns that makes the migrant worker vulnerable to HIV/AIDS and STIs.
3. To study the impact of migration on the socio-economic situation in Dadeldhura district.
4. To study the incidence of HIV/STIs among migrant workers.

5. To study the impact of HIV/STIs on the socio-economic situation of migrant households.
6. To develop recommendations for future policy and activities.

1.4 List of variables

1.4.1 Independent variables

- Age
- Religion
- Marital status
- Occupation
- Literacy
- Main activity
- Migration status
- Duration of migration
- Destination of migration
- Food
- Water and Sanitation
- Shelter
- Land
- Assets
- Education
- Health
- Control over resources and services at the community and household level
- Migratory labour
- Nature of job
- Category of employer
- Location of the work place
- Work hours/days
- Wage received
- Employer's category
- Place currently working

- Reason to leave employer
- Benefits from the contract
- Accident at the work place
- Expenses at the place of migration
- Savings
- Remitances
- Working conditions
- Use of remitance sent home
- Debt repayment
- Occupation arranged at the work place
- Return time in Nepal
- Migration's inputs for the household
- Family support from Nepal based income source
- Sexual contact during migration
- Condom recognition
- Purpose of condom use
- Practice, awareness, and attitude regarding condom use
- Practice, awareness, and attitude on HIV/AIDS

1.4.2 Dependent variables HIV/STIs prevalence

- Sexual behaviour
- Migration
- Poverty

1.5 Operational definitions

Migrant: A migrant worker is a person who had been more than three months outside his/her DDC in his/her adult years (18-49 years) in the last 10 years before the time of the study.

Migration: The process of moving from one region or country to another.

Internal migration: The process of moving from one region to another region of Nepal.

STI: Infections transmited from one person to another though sexual contacts.

STD: Sexually transmitted (or transmissible) diseases, formerly called venereal diseases, are usually contracted during sexual intercourse with an infected partner. The principal disorders commonly transmitted in this manner include syphilis, gonorrhea, genital herpes, nongonococcal urethritis, chancroid, and HIV.

AIDS: Disease of the immune system caused by infection with the retrovirus HIV, which destroys certain white blood cells and is transmitted through blood or bodily secretions such as semen.

HIV: Either of two strains of a retrovirus, HIV-1 or HIV-2, that destroys the immune system's helper T cells, the loss of which causes AIDS. Fully formed human immunodeficiency virus is also called AIDS.

HIV positive: Characteristic of a person infected by the HIV virus

HIV negative: Characteristic of a person not infected by the HIV virus.

Household: People living together in a single home and sharing the same kitchen.

Religion: Beliefs and opinions concerning the existence, nature, and worship of a deity or deities, and his/her divine involvement in the universe and the human life.

Caste: Any of the four main hereditary classes (varnas) Brahmin, Chetrhi, Baishya, and Shudra into which Hindu society is divided and that dictate the social position and status of people according to their professions.

Mother tongue: The first language somebody learns as a child at home (Doteli for most of Dadeldhura inhabitants).

Residence of spouse during migration: Place where the spouses live when the migrants are away.

Occupation: Income earning activity

Farming season: April-May for non-irrigated land and in addition August–September and November-December for irrigated land.

Age in completed years: Completed living years at the time of the study.

Relation to head: Reslationship to the head of household.

Marital status: Describe the status who may have / had / or have not entered a legally recognized relationship, established by a civil or religious ceremony, to live together as sexual and domestic partners.

Iliterate: Any person who says s/he can not read abd write in any language

Literate: Any person who says s/he can read and write in any language

Education level: Academic level describing the knowledge or abilities gained through going to school, university, or other study programme.

Current enrolment: Current status of the person (not) going to school /university.

Main activities: Activities in which the respondent spends most of his time

Duration of migration: Time during which the respondent was absent from home (for at least three months in the last ten years).

Destination of migration: Place where the respondent was settled during the time of migration.

Important festival: Main Hindu and local festival (Ugratara festival).

Luxury Food: Food that the households could not afford on an everyday basis.

Enough to eat: Situation where the respondent did not feel hungry.

Staple stock: Food (rice) that forms the basis of the diet of the people.

Sources of drinking water: Places where respondents usually take their drinking water.

Toilet facilities: Places where the respondents urinate / defecate.

Ownership status: Legal right of the respondents over objects, places.

Type of land: Irrigation status of the land.

Selected assets: Property owned by the household.

Educational institution: Established organisation delivering education programmes.

Health facility: Generic term for all types of places where health services are provided.

Health post: A place where trained staff has medical responsibility.

Medical support: Medical Diagnosis, prescription and counselling.

Financial mean: Financial capacity to cover the costs of a specific service, product.

Necessary medicaments: Medicaments prescribed after diagnosis.

Gender: The social category based on the sex of a person, or of a whole category of people.

Decision making involvement: The extend to which a person is involved in the decision making of a group (e.g. a household).

Unemployed: People not in paid employment.

Nature of Job: Term and payment basis (e.g.: daily, weekly ...).

Location of work place: Whether the job is located in an urban /rural environment.

Wage: Sum of money paid to a worker in exchange for services.

Arrears of salary: Amount of salary paid with delay.

Employer: Person, business, or organization that hires and pays one or more workers

Work contract: Written or oral agreement between an employer and a labourer stipulating conditions for the exchange of labour services against wage.

Benefits: Non wage contributions of the employer to the labourer.

Accident: An accident, causing serious injury, which is job-related and has happened on a work site.

Medical expenses: Expenses linked to medical costs.

Living expenditure: Expenditures needed to sustain the life of the household members, not including expenses linked to unexpected events (e.g.: serious illness..)

Saving: Unspent amount of money kept for future expenses or investments.

Non-local: Foreigner.

Adverse working conditions: Working conditions that do not favour the quality of the production and the welfare of the labourer.

Remittance: Savings sent home.

Positive output: Positive amount of something produced.

Place of migration: Destination of the migrant for settlement for more than three months away from home.

Sexual intercourse: An act carried out for reproduction or pleasure involving penetration, especially one in which a man inserts his erect penis into a woman's vagina.

STI case: Any respondent who give history of having at least one and/or more of the folloving sign and symptoms:

- Ulceration in or around the genitals organs.
- Pus discharge from uretra/vagina
- Smelly discharge from genital organs

Unsafe sex: Sexual intercourse taking place without the necessary precautions (condom).

Dezsability: Permanent lack of function (physical, mental, sensory) that results from impairment

Organizations: Organizations are formal and/or informal groups people working together outside the family home to achieve specific objectives.

Community: People. their families and the organizations that influence their daily lives. This community in its large sense.

Development: The ongoing process of increasing/enhanching individual freedoms and sharing in a more equitable distribution of the world's resourses.

Chapter two

Review of literature

2.1 Global trends

2.1.1 Global and regional trends of HIV/AIDS and STIs

2.1.1.1 Global situation

At the end of 2001, United Nations Joint Programme on HIV/AIDS (UNAIDS) estimated that more than 40 million people globally lived with HIV/AIDS. More than 5 million people were infected with HIV in 2001 alone. An estimated 21.8 million people have died from AIDS since the pandemic started, among which three millions in 2001[2].

The AIDS pandemic in the 21st century continues to have its greatest impact in the developing world with 95 percent of the affected population living in developing countries. UNAIDS expects that the pandemic will continue to grow in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus[2]. In four out of seven Sub-Saharan countries, the population living with HIV/AIDS has crossed 20% and 25%[3]. Most of the HIV/AIDS deaths occurred among young adults, who would normally be in their peak productive and reproductive years, adding an additional cost to the epidemic[4].

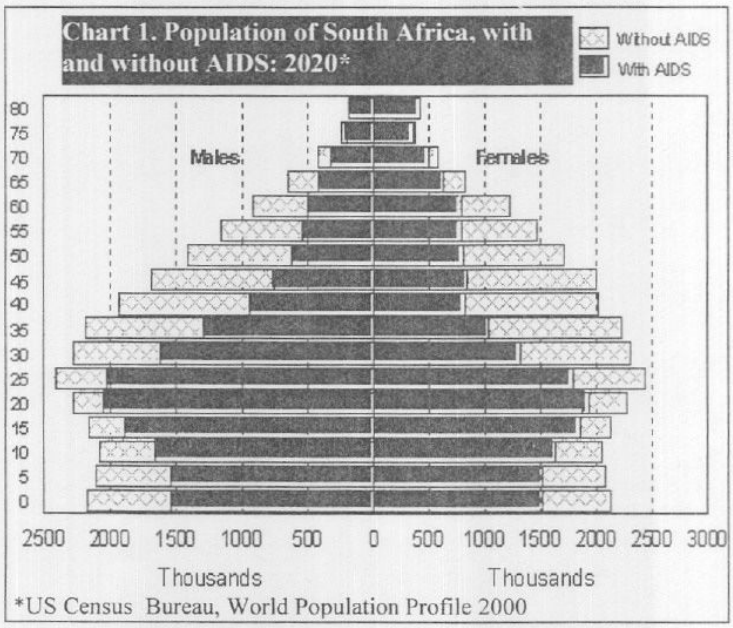
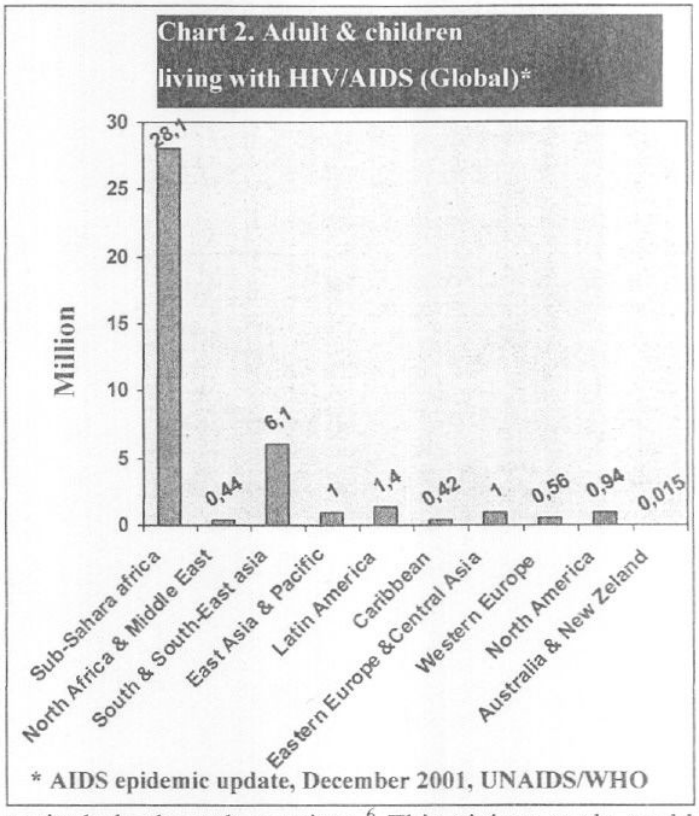


Chart 1. Population of South Africa, with and without AIDS: 2020*

*US Census Bureau, World Population Profile 2000

The impact of AIDS mortality is expected to produce population pyramids so far unseen, as the "population chimney" shown

in Chart 1, particularly in those countries with projected negative population growth, Botswana, South Africa and Zimbabwe.[5] The implications of this new population structure can not be ascertained with full clarity.



One of the consequences may be that by 2020, between the ages of 15 and 44, the overrepresentation of men in each of the 5-year-age cohorts would push them to seek partners in younger age cohorts. This factor may turn increase HIV infection rates among younger women. Current evidence indicates that older men are infecting younger women, who then go on to infect their partners, particularly through marriage.[6] This vicious cycle could result in even higher HIV infection levels.

Another consequence would of course be the extreme burden of social costs that would bring the countries' social systems to the verge of collapse, while the economy would suffer from lower productivity. Based on an analysis of population data from Botswana, Cameroon, Ethiopia, Cote D'Ivoire, Haiti, Kenya, Malawi, Mozambique, Namibia, Nigeria, South Africa, Tanzania, Thailand, Uganda and Zimbabwe, the ILO said there would be about 24 million fewer workers in these 15 countries by the year 2020 as a result of the AIDS epidemic.[7]

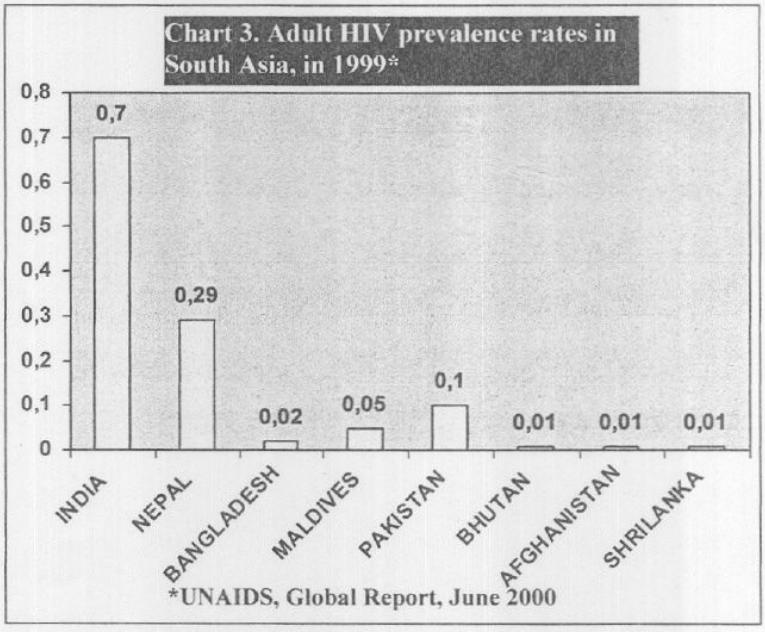
It is now clear that there is a strong correlation between the spread of conventional STIs and HIV transmission. Both ulcerative and non-ulcerative STIs increase the risk of sexual transmission of HIV. STIs continue to be a major and growing public health problem in many parts of the world, especially in developing countries with an estimated annual incidence of 330 million cases of curable STIs. Scientific evidence suggests that 80 percent of HIV infections are spread by sexual route. For example, in Sub-Sahara Africa 70 percent of the HIV infection is found in STI patients and, likewise, 15 to 30 percent of STI patients in

Thailand were found to be HIV positive.[8] Informed and responsible sexual behaviours can therefore play a major role in limiting the risk, while the lack of awareness and irresponsible sexual practices greatly contribute to the epidemic.

More generally, STIs and HIV/AIDS interact at various levels: first, there is a strong correlation between Sexually Transmitted Diseases (STD) and the risk of acquisition and transmission of HIV; second, STD may influence the progress of immunodeficiency in HIV positive individuals; third, HIV may change the natural history of the STI in a patient as the infectivity may be increased or prolonged, and the response to the treatment may be impaired. At present the four most common curable STIs in the world which can be cured easily by adequate antibiotics are Syphilis (12 million cases worldwide), Gonorrhoea (67million cases), Clamydia infections (89 millions cases) and Trichomoniasis (170 million cases)[8].

2.1.1.2 Situation in South Asia

The first case of HIV in South East Asia was identified in India in 1986. By the year 2001, all the countries in the region have reported cases of HIV infections. South Asia has one of the fastest growing AIDS epidemics in the world. In 2001, official figures recorded 6.1 millions adults and children living with HIV/AIDS and 800,000 new infections in South and South East Asia in by the end of 2001.[2] India has seen its infected population double between 1994-98 from 1.8 million to 3.9 million. However, infection rates remain low in most countries of the region, except in a number of states in India and among certain groups at risk, such as commercial sex workers, injecting drug users and migrant workers in Nepal and India.



2.1.2 Global and regional trends of labour migration

The definition of a migrant worker under the United Nations (UN) Convention of the Protection of the Rights of All Migrant Workers and their Families (1990), in "a person who is to be engaged, is engaged, in a remunerated activity in a State of which he or she is not a national". It should be noted that this definition does not have any legal force as the Convention has not yet been ratified by the 20 countries required to be legally binding.

Other UN documents, including reports of technical agencies quote alternative definitions of migrants, for instance individuals "whose decision to migrate is taken freely, for reasons of personal convenience" and "without intervention of an external compelling factor". This definition excludes groups like Refugees (as described in the UN 1951 Convention on Refugees) and Internally Displaced Persons (IDPs) (as described in the 1998 UN Guiding Principles on IDPs).[9]

In practice, each country uses its own regulatory definitions to categorize foreigners.[10] This lack of commonly agreed classifications makes difficult an assessment of migratory trends at the global level as statistics are bound to be impacted by overlapping or contradictory definitions.

As a result, global figures are uncertain. While The International Labour Organization (ILO) estimated in 1999 that over 90 millions people (migrant workers and their families) are currently residing, legally or illegally, in a country other than their own[11], the UN High Commissioner for Human Rights (UNHCHR) and the Special Reporter on the Human Rights of Migrants gave in December 2000 the more precise figure of 97 Millions, and at the same time the International Organization for Migration (IOM) gave an estimate of 150 millions migrants.[12]

However the three organizations agree on the facts that migrants are vulnerable to many kinds of exploitation ranging from smuggling, mistreatment, killings, and generally are exposed to benefit from working conditions below the standards enforced for nationals. To put in the words of ILO Director General, Juan Somavia, "Migrants are all too often relegated to the

dirty, difficult and dangerous jobs in wealthier economies where discrimination and ill treatments are rife".[12]

Those organizations also recognize the fact that migrant workers contribute with an estimated 73 Billions US Dollars as remittances to their national economies, the second largest flow of international transactions after oil related ones, very often higher than the level of international assistance allocated to a particular country. Nepal is a come in mind.

In a context of wide international inequalities, where the poorest one fifth of the world population, the majority of whom live in South Asia and sub-Saharan Africa, struggle for survival with less than a two percent share of the world Gross National Product (GNP), while the richest one fifth enjoy more then 82 percent of it,[13] migrant labour is first and foremost motivated by poverty and constitutes an essential source of income for many nations. Since World War II the largest voluntary migrations have involved groups from developing countries moving to industrialized countries. Some 13 millions migrants became permanent residents of Western Europe between 1960 and 1990, and more than 10 millions permanent immigrants were admitted legally to the United States in that same period, with illegal immigration adding several millions more.[14]

With economic globalisation, movements of goods and persons have become easier within blocs (South Asian Association for Regional Cooperation (SAARC), European Union (EU), Commonwealth of Independent States (CIS) etc.) and expanding national economies in search of cheap labour force have welcomed an increasing number of migrant workers.

At the regional level, South, South-East & East Asia, ILO estimates that between 5 and 7 millions people are foreign residents[11]. This represents around 7 percent of the world migrant population. SAARC declarations and conventions have provided a basis for increased economic cooperation in the region and have made easier the movement of persons between SAARC countries.[15]

ILO Convention # 97 on Migration for Employment (Revised) 1949, and Convention # 143 on Migrant Workers (Supplementary Provisions) 1975, provide the basis for countries to fight illegal migration and impart equal treatment for migrant workers and nationals in terms of

wages, benefits and rights. No country of South Asia has ratified these conventions and there is no regional framework regulating migration.

2.2 Country and district situation

2.2.1 Human Development of Nepal

Nepal lies in the central Himalayas, between India and China. According to the latest census of 2001, the total population of Nepal is 23.3 million, among which 47.3 percent are between 15 and 49 years of age. 88 percent live in rural areas, which is the highest proportion in South Asia. ILO reports that 39.7 percent of the population is economically active.[2]

The average household size is 5.6.[16] The annual population growth is 2.5 percent, which is the second highest in the SAARC countries[16]. In 1999, United Nations Department of Economic and Social Affairs – Population Division (UNPOP) reported a Crude Birth Rate of 34 per thousand which is 10 points higher than India (24.6)[16] and a Crude Death Rate of 33.8 per thousands which is one of the highest in the region after Bhutan (36.9) and Maldives (34.5).16 The Fertility Rate of 4.4 is the second highest after Pakistan (5.0) among SAARC countries.[16] Life Expectancy at Birth is the lowest in the region with only 58 years. The Infant Mortality rate of 77 per thousand, is the second highest after Pakistan (91) among SAARC countries.[16]

The income per capita is US$ 210, twice as low as the Indian one (US$ 440) and the lowest in South Asia.[16] 42 percent of Nepalese population live below the poverty line. 20 percent of them are extremely poor. According to United Nation Development Program (UNDP) Human Development report 2001 Nepal has a low Human Development Index (HDI) of 0.466, currently ranked as 129 out of 162 countries.[13] One of the parameter that has an important negative bearing on the HDI is the low level of adult literacy (50.7%).[17] Female literacy is even lower with 14 percent, the lowest in the SAARC region.[18]

Among eco-development regions, the Far-Western Mountains have the lowest HDI (0.286) and the Mid-Western Mountains rank slightly higher with an HDI of 0.322. In the Hills the

lowest HDI is in Far-Western Development Region (FWDR) (0.393). In general, urban areas show a better picture (HDI=0.616) than rural areas (HDI=0.466).[17]

Poverty is the main problem in the country, with an overall Human Poverty Index (HPI) of 39.2. (23.9 in urban areas, and 41.4 in rural areas). Close to 9 million Nepali citizens can currently be classified as income-poor.[17]

Nepal's Gender Empowerment Measure (GEM), 0.385, reveals an important gender gap. The GEM, however, is not correlated with the Gender Development Index (GDI), 0.605 in urban areas and 0.426 in rural areas. The Mid Western Mountains have the lowest GEM of 0.273 followed by FWDR Hills (0.278).[17]

The Department of Health Services reported in 1999/2000 the existence of 76 Hospitals (one Hospital per 300,000 persons), 745 Health Posts (one per 31,000 persons), 3185 Sub Health Posts (one per 7300 persons), and 45,555 Female Community Health Volunteers.[19] UNDP Human Development Report 2000 indicates that Nepal has the highest percentage of population with no access to health services among SAARC countries (90 percent). By comparison, the figure for Bangladesh is 26%, and 25% for India and for the Maldives.[13]

The low level and unequal distribution of assets and income impacts on the lack of opportunities and access to education, health, and nutrition.[20]

2.2.3 Labour Migration within Nepal

Nepal doesn't have a legal definition of migration, and the ones given by the national censuses vary with the years. In the 1952/54 census, migrants are defined as being absent from home for more than six months. The 1961 census defined migrants residing in the place of enumeration for more than six months. The 1971 census did not mention the duration of residence at the place of enumeration. The 1981 census defines life-time migrants as enumerated in a place different from the place of birth and did not include the period of absence from home and destination.[21] In 2001, the census defined migrants as a "person absent from the household and living in other country more than 6 months".[22]

Indebtedness, assetlessness, landlessness and general poverty motivate agricultural labourers from the mountain and hill regions of the north to move to the Terai in the South. Increased household size and a stagnant economy of subsistence also push some of the households' members to migrate. The table below is a clear illustration of this pattern.

Table 1. Internal Migrants by Census Region, 1981-1991[16]

Census region	1981[23]		1991[24]		Change 1981-1991	
	No	%	No	%	No	%
Mountain	53,628	5.2	39,751	2.8	-13,877	-25.9
Hill	211,927	20.4	267,116	18.8	+55,189	+26.0
Terai	773,307	74.4	1,111,339	78.4	+338,032	+43.7
Total	***1,038,862***	***100.0***	***1,418,206***	***100.0***	***+379,344***	***+36.5***

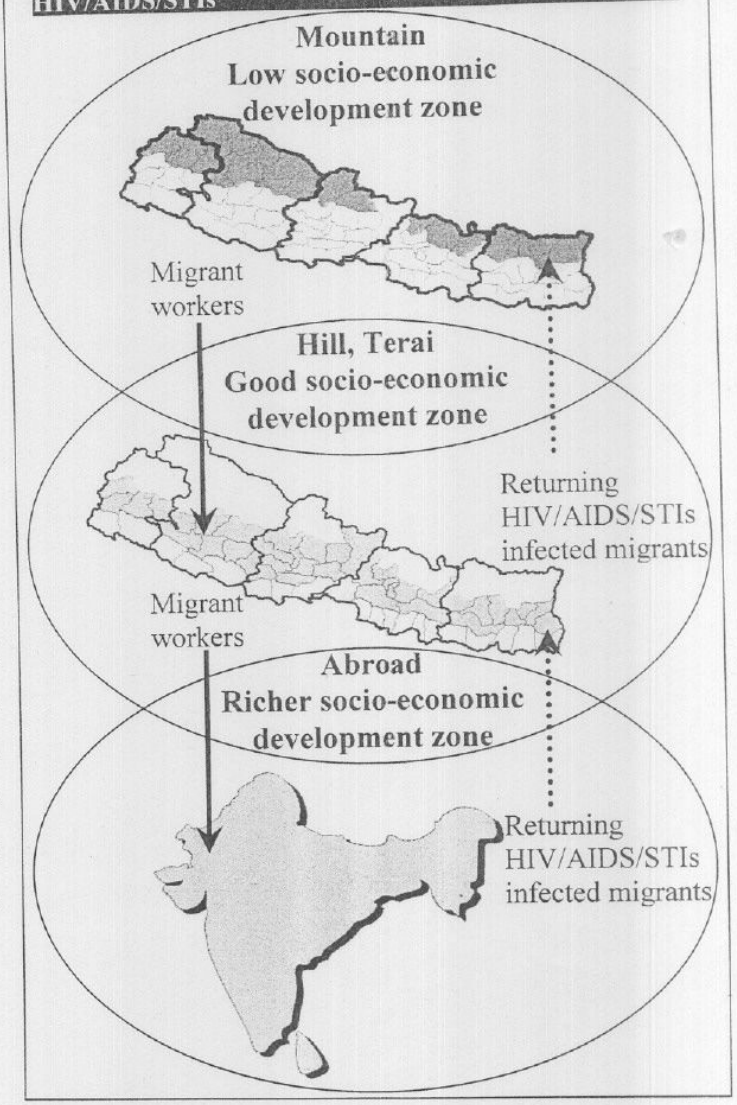
Internal migration had increased between the 1981 census and the 1991 one. While the migrants in the mountains decreased significantly, migrants in the hills increased by 26 percent and those in the Terai by 44 percent between the two censuses. In 1997, figures showed that more than 25.2 percent of population in Nepal are internal migrants (inter-Village Development Committee (VDC) movement). By ecological zones, the Terai has the highest proportion of migrants (31.7%), followed by the hills (19.7%), and the mountains (17.9%). The highest percentage of internal migrants can be found in FWDR (28.8%).[21] This confirms empiric observation that the hills may be "a first stop" for populations coming from the mountains to join the general migration to the Terai. However, recent statistics give a higher HPI for the terai (40.2) than for the hills (37.2). It indicates that the poorest population already left the hills, and that we may reach a stage in the coming years where the migration trend to the Terai will stagnate.[17]

A 1996 survey estimated that as high as 41% of the urban population consisted of internal migrants. Among them 45% were farmers prior to migration, while 19.6% were students and 15% were service holders.[25] In all cases, migration to cities, especially from the hill areas of the country in search of a job opportunity, is the main cause of the rapid growth of the urban population.

2.2.4 Migration to India and other countries[16/21/26/27/28/29/30]

Nepal has not yet signed any labour agreement with all the nineteen countries, which the Nepalese government has officially recognized as open destination for Nepalese to work abroad.[31] However, the Ministry of Labour recognized that remittances from Nepali working abroad (mainly in South East Asia) were equivalent to 850 millions US Dollars in 2001[32], far above the level of aid brought to the country.

Chart 4. Links between: poverty, migration, and HIV/AIDS/STIs



11% of Nepalese migrate to other countries with an even highest prevalence from the hill regions (14%).[21]Like in other migrant labour situations, the migratory movement from Nepal to India is based on a lack of opportunities for unskilled labourers in pockets of the sending country (Nepal) and a need for additional labourers in India. However, this arrangement is not generally grounded on the needed skills unavailable in India that Nepalese would bring in, but on the fact that unskilled labourers from Nepal are ready to accept working conditions Indians would refuse.

Movements of persons between Nepal and India are deeply rooted in the historical and cultural background of the two countries with for instance many Hindu places of pilgrimage on both sides of the border. Similar culture, religion, language, geography are other factors which have made it easy to cross the border. The opening of the 1,065 kilometres long border following the 1950 agreement between India and Nepal had an important impact on the Nepalese economy, especially in the 21 districts bordering India which sometimes have developed stronger commercial ties with their Indian counterparts than with other Nepalese districts. In some, Indian currency is preferred to the Nepalese Rupee.

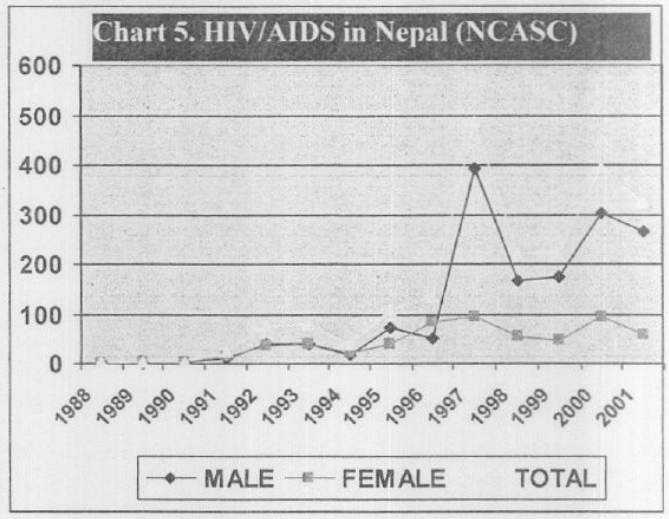
It has to be noted that the protection of labourers' rights are not part of the 1950 agreement, even if article VI and VII may be interpreted as granting ipso facto to Nepalese citizens the same rights than Indian nationals on Indian soil. Issues of labour protection are not detailed in the treaty.

Table 2. Change in Absentees Abroad by Destination, 1981-1991[16]

Destination	1981[33]		1991[34]		Change 1981-1991	
	Number	%	Number	%	Number	%
India	375,196	93.1	587,243	89.2	212,047	56.5
Other Asia	9,319	2.3	25,001	3.8	15,682	168.3
Other/Unstated	18,462	4.6	46,046	7.0	27,584	149.4
Total	***402,977***	***100.0***	***658,290***	***100.0***	***255,313***	***63.4***

India has been the major destination for Nepalese external migrant labourers. 375,196 Nepalese migrated to India in 1981 while by comparison Central Bureau of Statistics (CBS) reported 116,755 Indian citizens in Nepal in the 1981 census. In the 1991 census, it appears that Nepalese migrants diversified their destination with a lower proportion living in India, but the raw figure of Nepalese migrating to India was still on the increase. Other Asian countries of destination included Bangladesh, Pakistan, Sri Lanka, and Thailand. In all circumstances, more than half a million Nepalese people and their relatives are directly exposed to risks of contamination because of their migration.

2.2.5 HIV/AIDS and STIs in Nepal



There is little current information available on HIV/STIs prevalence in Nepal. In 1988, the first four cases of HIV were reported by the National Center for AIDS and STD Control (NCASC) (3 males, 1 female).[35] HIV testing among antenatal clinic attendees was conducted at eight sentinel surveillance sites, including Kathmandu, in 1991 and 1992. At that time, no evidence of HIV infection was found among the antenatal clinic attendees tested. At the end of 2000, UNAIDS estimated the number of adults and children living with HIV/AIDS to be 40,000 (seroprevalence 0.29 percent) while 2,500 died of AIDS during the same year. This is the second highest prevalence among SAARC countries after India (seroprevalence 0.7 percent).[36] Nepal has entered a stage of "concentrated epidemic" were sex workers (SW), clients of sex workers (CSW) and injecting drug user (IDU) are the main risk groups.[37]

The latest reported figure of the NCASC is more conservative with 1,535 male and 596 female persons (cumulative total 2,131 persons) infected with HIV/AIDS (seroprevalence 0.02 percent). Also, according to NCASC in December 2001, 540 persons were infected, and 149 died. Transmission of HIV in Nepal occurs mainly through heterosexual intercourse (81.5 percent among infected persons). Among the 2,131 reported cases, 420 (19.71) were SWs, and 1,316 (61.76) Clients of infected SWs (CSW), while IDU accounted only for 11.3 percent of the sample with 240 cases.[35]

This important discrepancy between the figures of UNAIDS and the NCASC can be explained by the lack of availability of HIV tests and the lack of strict reporting procedures from each hospital to NCASC. Like in any developing country, most HIV infections and cases of AIDS go unreported. Current methods of HIV/STIs diagnosis are also often available or to expensive for the rural population of a country like Nepal. Patients must travel a long distance to receive health care and, even if they come back, the period of infectivity is prolonged by this delay in therapy. Nepal health institutions have also too few laboratory facilities.

Table 3. STD Prevalence in Nepal among different population groups (UoH)

Population groups	ANC Clients		FP attendees	STI symptomatic patients		IDUs
Sample Size	n=1802	n=2030	n=300	Male n=199	Female n=268	Male n=560
Study done by	UoH	UoH	UoH	UoH	UoH	NCASC
Year	1996	1999	1999	1997	1997	1999
Neisseria gonorrhoea	-	-	1.7%	13.6%	1.9%	-
Syphilis (TPHA+RPR positive)	1.3%	1.8%	1.0%	9.5%	7.9%	10.7%

Population groups	Terai Seroprevalence		Kathmandu FSWs	Pokhara SWs	Sentinel surveillance (HSS) among STI patients		
	Truckers	FSWs					
Sample Size	N=400	n=410	n=300	n=250	n=1767	n=1821	n=1666
Study done by	FHI, New Era, SACTS	FHI, New Era, SACTS	FHI, SACTS	UoH, SEDA	NCASC, FHI, UoH	NCASC, FHI, UoH	NCASC, FHI, UoH
Year	1999	1999	2000	2000	1998	1999	2000
Neisseria gonorrhoea	2.5%	9.0%	-	0.8%	-	-	-
Syphilis (TPHA+RPR positive)	5.3%	18.8%	19.0%	3.8%	1.8%	2.0%	2.0%

There is no nationwide record system of STIs in Nepal. The Annual Report 1999/2000 of the Department of Health Services indicates a composite prevalence of Reproductive Tract Infection (RTI) /STD/HIV of 0.11%.[19] The University of Heidelberg (UoH) STI/HIV Project based on specific Non-Governmental Organizations (NGO) and academic studies compiled a table describing the prevalence of STIs in several categories of the population.

The mobility of the population, the absence of awareness of means of protection, high prevalence of sexually transmitted diseases, and sharing of drug injecting equipment are additional factors that make Nepal especially vulnerable to the epidemic.

At the onset of the epidemic, several organizations did small scale studies in different parts of Nepal. They found difficulties in carrying out laboratory investigations, and most studies relied on the analysis of self-reported STIs cases. A recent prevalence study conducted by the NCASC/UoH STD/HIV Project to identify Syphilis and HIV prevalence among 1,802 pregnant women in urban centers of Nepal revealed that 4.7 percent of the women had had a previous Syphilis infection, and 1.3 percent suffered from acute Syphilis. The HIV infection rate was 0.2 percent. A third of the sampled women had at least one symptomatic STD[38].

2.3 Socio-economic situation of Dadeldhura district

Dadeldhura district is situated in FWDR with its headquarters in Khalanga. Geographically it occupies 1,538 Sq. km, bordered on the east by Doti and Kailali District, on the west by Baitadi district and Uttaranchal (India), on the north by Baitadi district and on the south by Kanchanpur district. It is a hilly district with altitudes varying between 457 meters and 2,439 meters.[16] 20 VDCs and one municipality account for 19,648 households with a total population of 128,070.[39]

Dadeldhura ranks 59th out of Nepal's 75 districts on development related indicators. The per capita income of NRs. 5,881 is 30% times lower than the national average of NRs. 7,673. Average life expectancy at birth is 47, lower than the national average of 55 years. The Population Growth Rate of 1.91 percent lower than National average 2.43.[16]

In Dadeldhura, the food deficit is equivalent to 5.2% of the total edible (food stock), compare to 3.6% at national level.[40] However, discussions with development practitioners in the field reveals that for a majority of households in northern and eastern VDCs of the district can meet their food requirements for only three months in a year.

At the district level estimates of incidence of poverty by Poverty Indicator (PI) Per capita income are 51.8%, per capita consumption expenditure 59.7% and per capita food expenditure 63.1%.[41] The average household size is 6.52,[39] higher than the national (5.6)[40] and the regional average (5.9).[16] This higher size of the households is not accompanied by a higher dependency ration: 49% of the population is economically active as compared to the national average of 35.43%. Among the economically active, 91% are farmers, more than the national average of 81%.[42]

The adult literacy ratio is 37.85%, similar to the national figure of 36.72% and higher than the neighbouring Doti district (29.13%).[40] The child illiteracy rate in the district is 42.8% significally higher than at all hill districts level (30.4%). Reflecting the same reality, the child labour rate (from 10 to 14 year old) is 41.6% higher than the all-hill proportion of 31%.[41]

The low sex ratio of 931 women for a thousand men,[16] especially compared to the 1005 women for a thousand men at country level, reflects the gender inequality in access to care and services, and possibly the neglect of the girl child for socio-economic reasons (dowry practices, property rights).[16] Other statistics confirm the difficult situation of women in the district. Only one out of seven women is literate compared to one out of three males.[41] Female Headed Households (FHH)(14.73%), are more numerous than the national level (13.18%), FHH are also concentrated among landless labourers as the incidence of Female Headed Farm Households in the district (5.85%) is lower than the national level of 13.18%.[43] Only 5.35% of females in the district have professional jobs as compared to 15.06% at an all-country level.[40] Gender issues are strongly linked to poverty in the district.

In terms of health facilities, there are two hospitals, one run by His Majesty's Government of Nepal (HMG/N) "District Hospital", and one by an NGO "TEAM Hospital" with laboratory facilities. Also available are 9 health posts (almost twice as much per capita than the national average), 15 sub health posts, 97 Primary Health Center (PHC) Outreach Clinics, 225 Traditional Birth Attendants (TBA), one Primary Health Care Center (PHCC) shared by the 20 VDCs and one municipality. 444 Female Community Health Volunteers (FCHV) are registered in the district.[19] Equipment and manpower is lucking in almost all facilities, except in "TEAM" hospital where all the needed staff is available. Only one medical doctor is available in HMG/N's hospital, while at least 2 are needed. This doctor is also the District Health Officer. The hospital has not a single nurse. No Health Assistants are available in Health Post (9 needed) 4 Auxiliary Nurse Midwifes share the burden of the work in these Health Posts while 5 additional are badly needed. Because of their work burden these health workers are usually not available for the majority of patients (FGD).

However, a scattered population and difficulties of access results in the FWDR having the highest share of households reporting less than adequate health care among regions of Nepal: 75%, as compared to a national level of 59%.[19]

2.3.1 Migrant workers and HIV/STIs in Dadeldhura district

Official data from Dadeldhura District Development Committee (DDC) report 6.87% of households are emigrants and 2.74% of households are immigrants'.[39] However, Focus Group Discussions held in the context of the present research, indicate that the proportion of emigrants may be significantly higher, with at least one migrating person per family.

At present, few data are available on the relationship between HIV/AIDS and migration in the district. Since this is the first study on migration and HIV/STIs in Dadeldhura District, data on neighbouring districts like Doti, Achham, and Kailali, that have similar geographical and economic backgrounds will serve as a basis for comparison.

Several international and national organizations since the middle of the 1990's have studied HIV/AIDS, STIs, and migration issue in FDWR. Since 1997, a UNDP project on "Participatory Planning & Management of HIV/AIDS" is actively working in Doti district. In its 1999 report, it states that 41 percent of households had one or more of their members migrating, of which 94% to India.[44] STI cases in FWDR and Mid-Western Development Region (MWDR) are higher than in other parts of the country with for instance Mahendranagar (Kanchanpur district, FWDR), and Nepalganj, (Banke district, MWDR) with respectively 4.8% and 8.5%. 14 and 25 times higher than 1999 country-wide figures (Nationwide STI data are non-specific. Data combines any case of STI/RTI and HIV and not specific data of STI or types of STIs. According to the Annual Report of HMIS total 0.34% cases of RTI/STI/HIV was reported in 1998-1999).

Preliminary result of a recent study in Doti district gives an estimate as high as 10 percent of migrant workers (n=100) in Doti district infected with HIV/AIDS, for a sample tested as part of the study.[45]

Chapter three

Methodology

3.1 Methodology

The methodology of the present research was cross-sectoral, including literature review, a field survey with a detailed questionnaire for 303 respondents (141 migrants, 162 non-migrants) aged between 18 and 49 years, participatory sessions for additional qualitative data including 7 focus group discussion with in total 114 participants, three case studies, examination of 118 participant's urogenital specimens to identify *Neisseria gonorrhoeae*, and blood testing of 303 participants for those that agree to take the Venereal Diseases Research Laboratory *(VDRL)* Rapid Plasma Reagan *(RPR)* tests to identify *Syphilis*, the Hepatitis B surface antigen *(HBsAg)* tests to identify *HBV*, and *HIV1 and HIV2 tests*. Ethical and technical aspects were discussed with the Nepal Health Research Council, which approved the research. The total duration of the study was 5 months and 25 days (167 days), including 26 days in the field.

3.2 Literature Review

Secondary sources include international publications, documents and figures from HMG/N and related institutions, and reports from international and national NGOs. Reviewed literature was selected base on supervisors and external expert's advice, and on the availability of documents in Kathmandu and on internet. The list of sources is annexed.

3.3 Survey & questionnaires

3.3.1 Sampling

3.3.1.1 Defining the Sample

There is neither an international nor a national definition of migrants. The respondents of the study were 303 persons (111 female and 193 male) chosen at random among which 162 persons (93 female and 69 male) never migrated outside the district and 141 persons (18 female and 123 male) had been more than three months last 10 years outside their district.

Random selection was based on a simple random sampling method. Respondents were selected based on information collected in DDC and VDC level to identify migrant and non migrant households. Each household was given a different number based on its migration status.

Respondents were from Amargadi Municipality, and from five VDCs chosen after the first field visit (see chapter below). Respondents were welcomed in a free health camp that took place in 7 places with the following procedure which is took between 1 and 3 hours, depending on the condition (sickness) of the participants:

- Registration and provision of oral and written information on the study
- Signature of the Subject Consent Form with oral explanation of the all its chapters
- Counselling on HIV/AIDS and STIs
- Physical examination with treatment if necessary
- Blood test
- Interview with questionnaire

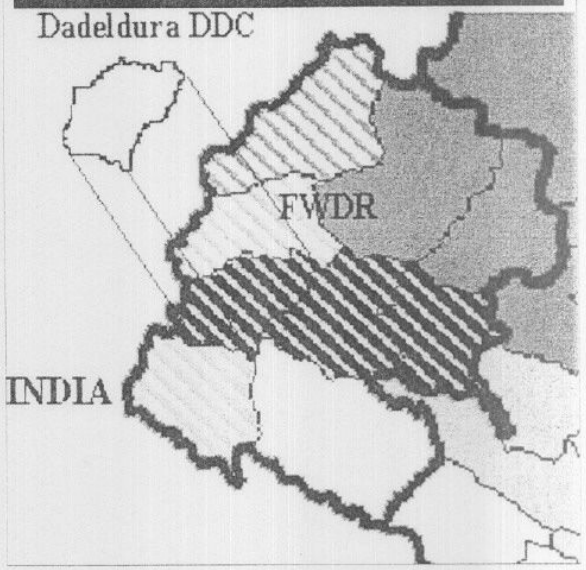
A total of 600 participants were invited to contribute to the study process, among which 406 were registered. Only 303 agreed to participate in the program (including blood test, physical examination, and questionnaire). 110 respondents who did not fit the study criteria (mainly because of the age limit) were also examined. They are not included in the registration and participants list. To sum up, 516 persons participated in one way or another in the study process.

3.3.1.2 Sampling Area: District

It was decided to focus the present study on a district where migration and HIV/AIDS/STIs were still unexplored but that nonetheless presented similar geographic and socio-economic characteristics than districts previously researched (Achham, Doti and Kailali):

1. Located in FWDR that include Achham, Doti, Baitadi, Darchula, Bajhang, Bajura, Dadeldhura, Kanchanpur, Kailali,
2. Part of the hills like Achham, Doti, Baitadi, Dadeldhura,
3. With a common border with India like Darchula, Baitadi, Dadeldhura, Kanchanpur, and Kailali,
4. Bordering a district where migration and HIV/AIDS was previously studied, including Doti, Kailali, and Achham,

Map 2. Far-Western Development Region

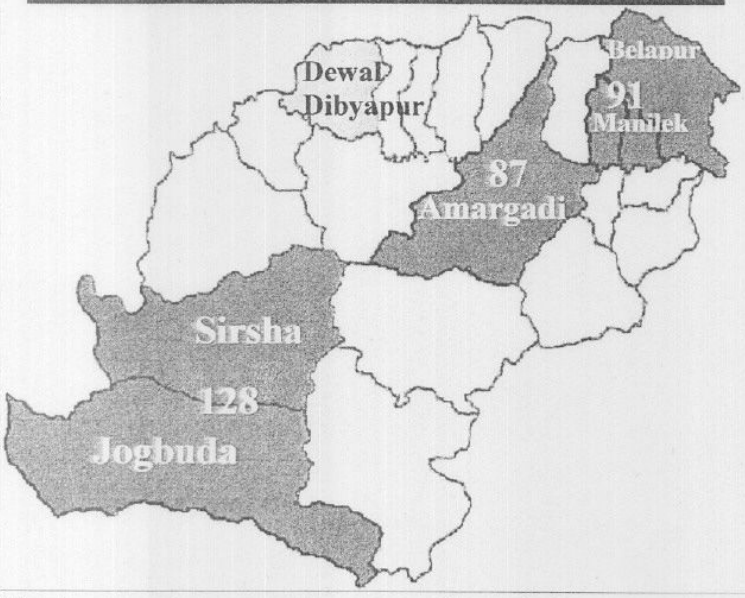


5. With a high level incidence of Female Headed Households (FHHs) (FHHs can be taken as a good indication of male labour migration). In FWDR, Achham has the highest percentage with 21.74 percent of FHHs, followed by Doti with 20.70 percent. Dadeldhura district has 14.49 percent of FHHs.[43]

Dadeldhura district is a hilly district situated in FWDR. It has a western border with India, and other borders with two already studied districts, Kailali and Doti districts, and a higher than usual proportion of FHHs.

The choice of the VDCs was made after the first field visit, based on STI/HIV prevalence data from DHO, "TEAM" hospital, but also according to discussions held with the DDC chairman, the DHO head, and local and international organizations working in the district. (See attachment: First field visit).

Map 3. Sample size by VDCs. Dadeldhura DDC



6 VDCs and one municipality were identified as a result of these discussions: Nawadurga, Belapur, Manilek, Dewal Dibyapur, Jogbuda, Sirsha, and Amargadi Municipality. Criteria for selection were: Female Head of Household, high prevalence of STI/HIV, the district wide distribution of the VDCs (South, North, East, and West).

Table 4. VDC Selection Table

	VDC	Total HHs	Total Population[39]	VDCs recommended by Organizations (1=recommended, 0=not recommended)										Total
No	Name			GTZ/WFP	DHO	DDC	VDC representatives	UNICEF	NGO – "Rural Women Development and Unity Center"	NGO – "Rural Energy Development Program"	Another NGOs	Community motivators from VDCs	HIV/AIDS cases by VDC (data TEAM Hospital)	

1	Ajayameru	5534	8977	0	0	1	0	0	0	0	0	1	0	*2*
2	Alital	1427	8730	0	0	0	1	0	0	0	0	1	1	*3*
3	Ashigram	537	3386	0	0	0	0	0	0	0	0	0	0	*0*
4	Bagarkot	470	3266	0	0	0	1	0	0	0	0	0	0	*1*
5	Belapur	1227	8163	1	0	1	1	0	0	1	0	1	1	*6*
6	Bhadrapur	593	3310	0	0	0	0	0	0	0	0	0	0	*0*
7	Bhageswar	597	3677	0	0	0	1	0	0	0	0	1	0	*2*
8	Chinpur	457	2826	0	0	0	1	0	0	0	0	0	0	*1*
9	Dewal Dibyapur	1060	7060	1	1	0	1	1	0	0	1	0	0	*5*
10	Ganeshpur	753	5277	0	0	0	1	0	0	0	0	1	0	*2*
11	Gankhet	730	5370	1	0	1	0	0	0	0	0	0	0	*2*
12	Jogbuda	2130	14393	1	1	0	0	1	1	0	1	0	1	*6*
13	Kailmandau	760	4477	0	0	0	1	0	0	0	0	0	1	*2*
14	Koteli	803	4620	1	0	0	1	0	0	0	0	1	0	*3*
15	Manilek	807	4940	1	0	0	1	0	0	0	0	1	0	*3*
16	Mashtamandu	587	3300	0	0	0	0	0	0	0	0	0	0	*0*
17	Nawadurga	557	3190	1	1	0	1	1	0	0	1	1	1	*7*
18	Rupal	252	1629	0	0	0	0	0	0	0	0	0	0	*0*
19	Samejee	540	3957	0	1	0	0	0	0	0	0	0	0	*1*
20	Sirsha	1473	9933	0	0	0	0	0	0	0	0	0	0	*0*
21	Amargadi Municipality	2590	17230	1	1	1	0	0	1	0	1	0	0	*5*
	Total	***19247***	***124268***	***8***	***5***	***4***	***10***	***3***	***2***	***1***	***4***	***8***	***5***	

One selected VDC. Dewal Dibyapur was exchanged with another one in course of the study because the primary health center of Jogbuda in which the free health camp took place also covered Sirsha VDC. In the context of the state of emergency, it was also recommended to avoid going to Dewal Dibyapur.

3.3.1.3 Sample size

The sample size was 303 respondents, among them, 141 respondents' migrant workers, and 162 non-migrant worker respondents, were chosen according to a simple random sampling method.

3.3.2 Questionnaire design

The questionnaire focuses on three general aspects including the socio-economic situation, HIV/AIDS/STIs, and Migration. A draft was prepared and submitted with the research proposal to Nepal Health Research Council (NHRC). After having incorporated recommendations from NHRC, the questionnaire was tested during the first field visit to Dadeldhura district (See attachment: First Field Visit). Other external advisers were informally consulted for the finalization of the questionnaire, including representatives from the National Labour Academy (NLA), UNAIDS and the International Labour Organization.

3.3.3 Supervision of the survey

The author supervised the survey, during 2 field visits for a total of 26 days. The survey took place between 22 November and 14 December 2001, at a time when migrant workers are usually at home to celebrate a local festival, "Ugratara Festival", happening on the 30 November in 2001. The overall supervision of the research was ensured by Dr. Bimala Shrestha, Professor and Chairperson and Dr. Anand B. Joshi Associate Professor of the Department of Community Medicine and Family Health at Tribhuvan University.

3.4 Group Based Participatory methods (Focus Group Discussions)

The male members of the households were bound to constitute the most important proportion of the respondents (in the sample 1.6 times more than women). Focus Group Discussions (FGDs) with women allowed the research to ensure that the views of the women from the community are also reflected in the findings.

Seven FGDs were organized with a maximum of 30 participants each. In each FGD, the group was divided in 3 or 4 sub groups of 7-9 participants. The mean number of participants / FGD was 27, apart from one FGD for which specific data on number of participants was not recorded. FGDs lasted on average 50 minutes, including 30 minutes of discussion with sub-groups, and 20 minutes in plenary session.

Four FGDs were organized with women selected among Female Community Health Volunteers. One FGD took place with wives of migrant workers. Two other FGDs included a 12 male teachers group, and one mix (female + male participants). An interpreter assisted the author for the facilitation of these sessions that focused on HIV/AIDS/STIs, socio-economic situation (poverty), and migration. Through these sessions the author also selected some women for in depth individual interviews to better understand ideas and views that could not be expressed in a group situation because of taboos.

3.5 Case study

3 case studies were recorded to provide typical examples to the study.

3.6 Clinical examination and laboratory testing

The purpose of the clinical examination part of the research was to find out the incidence of STIs, including HIV/AIDS. This was accomplished according to the National STD Case Management Guidelines prepared by NCASC. It consisted of an external inspection of the genital area and of the skin status, as well as an assessment of the general physical and medical status. Any possible anomaly was recorded. Blood tests and urogenital specimens provided additional information about STIs.

3.6.1 Clinical examination

The examination was conducted in Health Posts, in a comfortable lighted environment. In the examination room only the participant, the Medical Doctor (MD) (i.e. the author) and the translator were allowed. This privacy permitted in depth discussions to take place, together with the medical observation of the participant. During the physical examination period, the participant was alone with the Doctor without the translator. The clinical examination included syndromic diagnosis, etiological diagnosis and clinical diagnosis. At the end of the examination, each participant was provided with counselling (by MD) to enable him/her to understand how to cope with problems associated with his health status and how to reduce the risks of infection. In case of identified STIs based on syndromic diagnosis, prescription and medicine were provided (see attached list of medicine used in the Free Health Camp). Condoms were also made available.

3.6.2 Laboratory testing

After the clinical examination, the MD took 118 smears from the participants' urethra for the needed identification of culture for *Neisseria gonorrhoea*. Each participant also donated 5 ml of blood for the Venereal Diseases Research Laboratory *(VDRL)* and Rapid Plasma Reagan *(RPR)* tests to identify *Syphilis*, the Hepatitis B surface antigen *(HBsAg)* tests to identify *HBV*, and the *HIV1* and the *HIV2* tests to identify *HIV*. The Blood were collected by professional lab technician from Dadeldhura. Every evening the collected blood samples were taken to the district ("TEAM") hospital laboratory to be centrifuged and around 2.5 – 3 ml of serum/participant was kept in the laboratory's fridge. When the study was completed in the field, all specimens were gathered in a fridge box and flown to the National Public Health laboratory in Kathmandu.

The questionnaire was filled up after the clinical examination and the blood/urethra test. The questionnaires have the same identification number as the medical examination test in order to preserve the anonymity of the respondents.

3.7 Field test of the methodology

A field visit prior to the start of the survey allowed the author to check the practicality and the relevance of the study's methodologies.

During this 3 days field visit the researcher met with district authorities (DDO vice-chairman, DHO), NGOs (German Technical Cooperation (GTZ), "Rural Empowerment Development Center", "Rural Empowerment Forum", "Rural Empowerment Forum", "TEAM" Hospital, Dadeldhura Red Cross Society, and "Rural Women Development an Unity Center"), UNDP supported projects ("Partnership for District Development Program", "Rural Energy Development Program"), UNICEF (District field officer).

The visit allowed the researcher to present the study objectives, and the methodology of the project, to collect latest data of districts and VDCs on STI, HIV/AIDS, poverty, migration, and education. Interviewers were also identified during the visit and the health camp was prepared. The meeting with the District Health Officer (DHO) and with "TEAM" Hospital staff allowed the author to organize the practicalities of blood and urospecimen collection and management (lab-assistants, centrifuge, fridge, ice box, etc.). The meeting with the DHO allowed the author to meet with all Sub Health Post Officer (SHPO) in Dadeldhura District and to identify facilities of Sub Health Post (SHP) for physical examination. NGOs contacts allowed the questionnaire to be field tested on five cases, and the meeting with the Community Motivators of GTZ gave the author the opportunity to check the format for Focus Group Discussions.

3.8 Study team

The study team included:

1. A Researcher/Doctor for the medical examination (1 person),
2. Interviewers for data collection (4 persons),
3. A medical assistant for the collection, the storage management and the transport of blood specimens to Kathmandu (2 persons),
4. A translator from Nepali to English/ Research assistant (1 person),
5. An assistant for data entry (1 person).

Selection of the study team was started during first field visit. In October 2001 the Researcher/Doctor was certified as Foreign National Medical Practitioner (Registration No. 1437) by Nepal Medical Council. The Researcher/Doctor was responsible for physical examination of the respondents and collection serum specimens. The 4 interviewers had previous experience in HIV/AIDS programs in the region. The lab technician had 10 year work experience in the district "TEAM" hospital as laboratory had. The translator/assistant had a bachelor degree of English literature and is in a Master of Sociology programme in Tribhuvan University. Data entry was done with professional statistician from the Institute of Medicine.

The study team followed a two days orientation session organised by the researcher.

3.9 Ethical considerations

The research followed ethical guidelines of the Nepal Health Research Council (NHRC) and the Council for International Organizations of Medical Sciences (CIOMS) based on the Helsinki Declaration. After the concurrence of Institute of Medicine (IoM) on the proposal was secured, the proposal and consent forms with draft questionnaire were submitted to the NHRC. Technical Review Committee and the Ethical Review Board members evaluated research proposal according to ethics, scientific merit, and the adequacy of the consent form. Based on recommendation of the Technical Review Committee and the Ethical Review Board

NHRC approved research proposals. After reception of the official authorization from NHRC (#486), the study started.

The fields of this study (HIV/AIDS and Labour Migration) are sensitive ones and may be the subject of academic and political differences. The author carefully checked the results of the research and did not indulge into extrapolative analysis.

The study is designed to protect to the maximal extent possible the interest of the participants, and the confidentiality of the data collected.

1. Questionnaire and all documentation did not bear the names of the participants but identification numbers;
2. Interviewers were trained to respect the privacy of the participants;
3. Interviewers did not ask the names of the participants;
4. A day before the interview, all participants were informed about the study and its methodology;
5. Blood testing was done on a voluntary basis;
6. Participants who decided to undertake a blood test, received a complete pre-test counselling;
7. The result of the blood test is shared with the participant with post test counselling by the District Hospital and "TEAM" Hospital based on NCASC regulations. Result received only respondents who voluntarily go and ask result based on there identification number.
8. The final report will be distributed to relevant local authorities and made available to participants.

3.10 Data processing and analysis

3.10.1 Processing

Exit tables for the questionnaire and the medical results underline four categories of participants based on migrant status and HIV/AIDS status. Data from questionnaire and medical examination were inputted under "Epi Info 2000" computer program. To maximize the accuracy of the information, data was entered twice.

3.10.2 Analysis

Results of blood tests were compared with the questionnaire and the clinical examination list, and whenever appropriate their relationships were analysed with Chi square method. Data generated by group based participatory methods provide additional elements for the analysis of the results.

3.11 Limitation of the study

There are five main limitations to the study:

- The sample size is too small for the findings to be scientifically representative of the overall situation in the district, and even less of the situation in the country. However, the elements provided points at some trends to be considered.
- Prior to the study no data had been gathered about migration and HIV/STIs at the district level. Comparison with the past was only possible in participative group methods aimed at gathering qualitative information.

- Because no complete data exist at the country level, no comparison will be possible with situations in other regions of Nepal.
- Because of lack of time and resources, the survey will not review the incidence of HIV/AIDS among family members of migrant workers.
- Because there was no female Medical Doctor in the study only male respondents were checked for the Nisseria Gonorrhoeae test.

Chapter four

Study findings

4.1 Characteristics of households

Table 5. Sampled household average size			
	Migrant	Non-Migrant	*Total*
Sampled population	999	1079	*2078*
Household number	141	162	*303*
Average Household size	7.1	6.7	*6.9*

The average household's size of migrant workers (7.1) is larger than non-migrant's (6.7) by 6%, and larger than the district level (5.7), the FWDR level (5.9), and even than the national average household size (5.6) by more than 25%.[16]

More than half of respondents (59.7%) are between 18 and 24 years old. The proportion of migrant respondents in this younger age category (63.83%) is 14% higher than for non migrant groups. (See table I in Annex 4). Income earning at an early age for migrant allows him/her to become Head of Household (HH) (source FGD).

Chart 6. Age distribution among Migrant Head of Households (%).

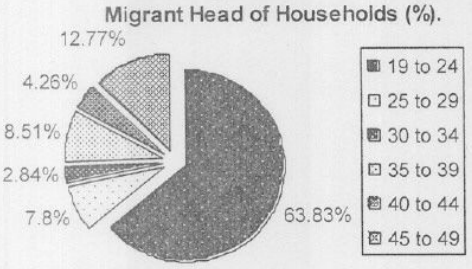
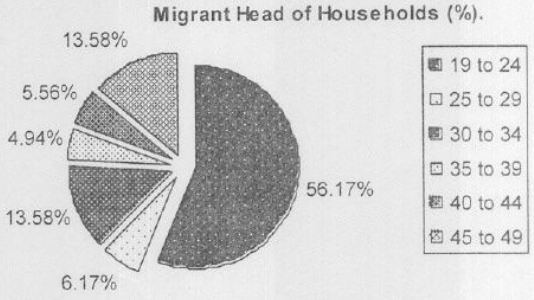
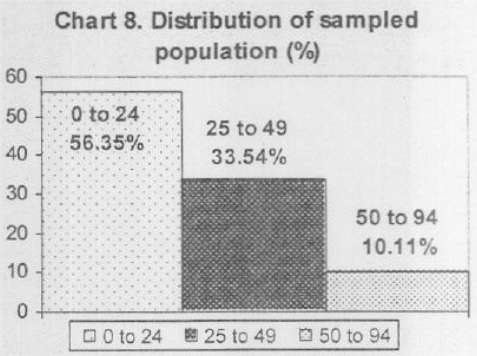


Chart 7. Age distribution among Non-Migrant Head of Households (%).



The sex ratio for the sample population (818) is even lower than for the district level of 931 women for a thousand men and considerably lower than the national level of 1005 women for a thousand men.[16] This record low ratio is illustrative of the extreme gender imbalance

existing among the sampled households in terms of access to health care, and social prejudice against women. Women have much more labour functions than man (including attending to the house chores and agricultural work), but most of them are free labour. In these low level income households, the low sex ratio may be explained by the will to reduce the proportion of non income earners in the house (See table II in Annex 4).



4.2 Socio-economic status of the sampled households

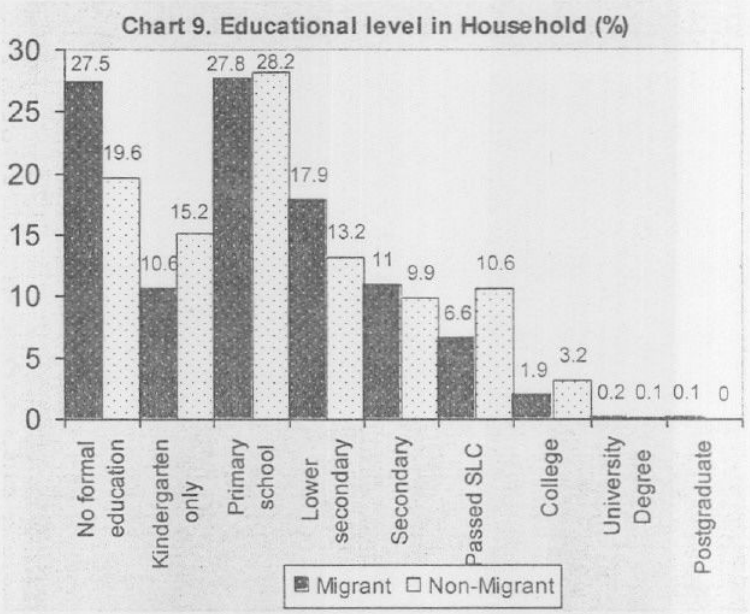
Table 6. Literacy (n (%))

	Migrant			Non-Migrant			*Total*
	Male	Female	Total	Male	Female	Total	
Can read and write with understanding in at least one language	480 (29.67)	321 (19.84)	801 (49.51)	500 (30.90)	317 (19.59)	817 (50.49)	*1618 (100)*
Current enrolment in School	487 (28.95)	365 (21.70)	852 (50.65)	502 (29.85)	328 (19.50)	830 (49.35)	*1614 (100)*

The literacy rate for migrant's households (80%) is slightly higher than for non-migrant households (76%) but significantly higher than the district average (37.85%) and the national average (40%).[16] Interestingly enough, another study found also a literacy rate for the district of 52% higher than the official one provided by CBS.[46] We were also able to cross-check when the respondents were given the Subject Consent Form to sign: the majority of the sample was able to read it and to sign it (oral explanations were provided to others).

The enrolment rate in school is also slightly higher in migrant (79%) households compared to non-migrants (77%) but significantly higher than the district wise enrolment rate of 46% (37% for female, and 56% for male). The district's net primary school enrolment rate is 68% (57% for female, and 78% for male), while the rate decreases in lower secondary school to 15.7%, with the gender gap getting even larger with a net enrolment rate of girls in lower secondary school falling below 10 at 9.6%.[46]

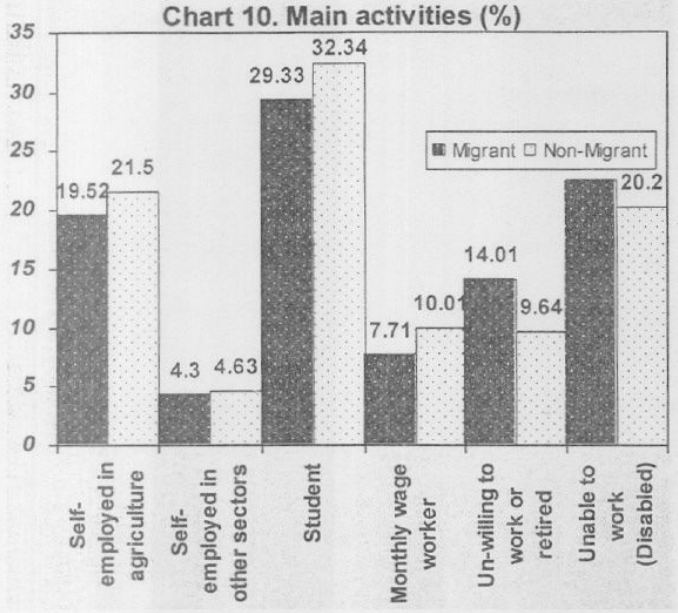
The higher literacy rate and high school enrolment rate may be explained by the fact that hard core poor may not have dared joining the Free Health Camp in which the data were collected. This possible bias will be further confirmed by other findings.



The majority of sampled migrants' household members and non migrants' household members stopped their education before secondary school. Migrant households' have a higher proportion of members who did not go further than the SLC, while non migrant household members are more represented in degrees beyond the SLC. The education level shows that 41.84% and 39.1% of respectively migrant and non migrant household members never attended school, compared to 31.31% for the far west region and to 41% at the country level (See table III in Annex 4).[47]

The very high school enrolment rate of the sample is confirmed here by the high proportion of household members that the respondents define as students (see chart 3.2.2). This is significantly higher than the district level of 21.25%.[25] Empiric evidence shows however that "students", whether below or above 14 years of age, are often expected to contribute to the family by working part-time (See table IV in Annex 4).

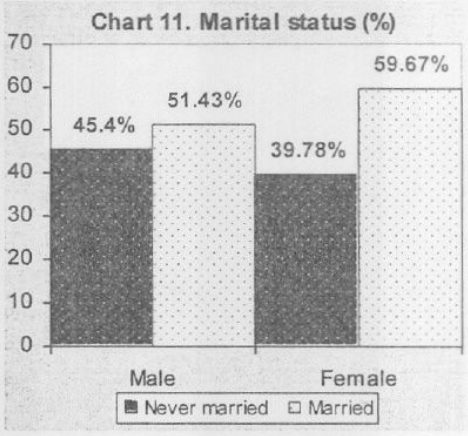
The proportion of household members unable to work is 22.4 among migrants and 20.2 among non-migrant households. It reflects the extensive need of the population for improved health care services. This indicator is significantly higher than the 5 percent estimate of WHO for disabled persons in developing countries, even if this estimate may be biased because of the difficulty to gather accurate data.[48]



Only one fifth of the sampled population is self-employed in agriculture (20.55%), significantly lower than the district wide figure of 45%.[39] This low percentage is not explained by the lack of land of the sample (see further description in 4.1.4 Access to land), but by the fact that only the main occupation of each member is described here. Household members are likely to consider agricultural jobs as an add-up to their main income.

9.5% of migrant households members get an income (either daily, weekly, monthly wage, share dropping, piece rate), while at least 14% are migrating (1 member per family of 7.1). As a result, it appears that a high percentage of migrants do not get the occupation they are looking for abroad and are not in a position to bring back an income home. This fact was actually confirmed in the Focus Group Discussions. 65% of the members of migrant households, and 62% of the members of non migrant households do not have an income generating activity as their main occupation.

No major differences can be identified between migrant and non migrant households' members except the main category of income earning (monthly wage) is 40% higher for non-migrants than for migrants. It underlines the fact that the main reason for household members to migrate is not only to get a remunerated job but also a stable one.



More than half of the sampled population is married, with comparable figures for migrant and

non migrant households. This can be explained by trend of getting married at a young age among the respondents' families (between 18 and 22 according to Focus Group Discussions). The second bigger category is the non-married one, which is coherent with the fact that 44% of the population is below 20. The relatively bigger proportion of male than female widowers (57 times higher) is also consistent with the extremely low female sex ratio of the sample. The low rate of divorces reflects the existing social taboos against this practice (See table V in Annex 4).

4.3 HIV/STIs prevalence in sampled population

Laboratory tests and physical examination revealed that 9.24% of the sample had contracted an STI, including HIV/AIDS. The Department of Health Services Annual Report does not give separate STIs data, and they are combined with figures on Reproductive Tract Infections (RTI), and HIV. In 1999/2000 this combine data indicated a nationwide incidence of 0.11% for RTI/STD/HIV.[19] Without even including all RTIs, the incidence of STD/HIV is much higher among the sample.

NCASC reported a nationwide seroprevalence of 0.02%, with UNAIDS estimate is 0.29%. One out of 303 tested for HIV/AIDS in the sample revealed positive. Although the size of the sample does not allow scientific extrapolation, it would imply a seroprevalence of 0.33.

4.4 Access to resources

The economic vulnerability of the families to migration was defined in terms of poverty: lack of access to and control over resources.

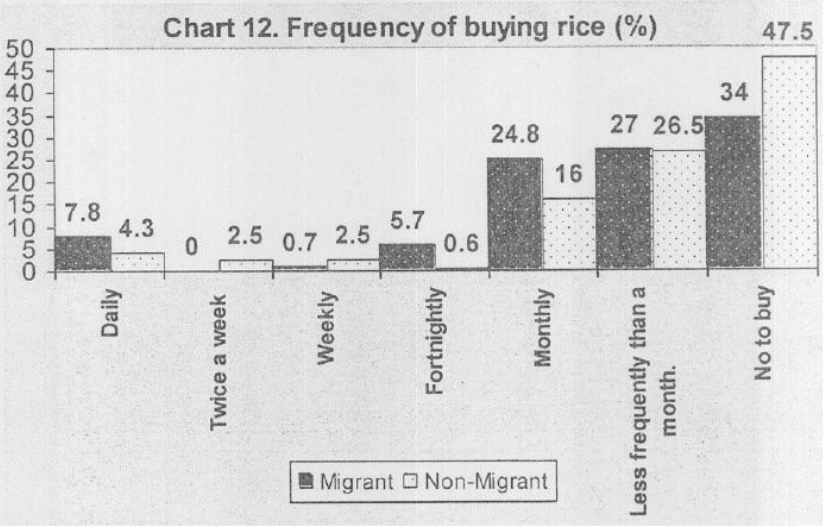
4.4.1 Access to food

Table 7. Food insecurity.

	Migrant	Non-Migrant
Number of days (average) in the last month one meal or less was one meal or less was served	2.1	2.2
Number of days (average) in the last twelve months one meal or less was one meal or less was served	66	69

Both migrant and non-migrant respondents had more than two days in the last month and more than 65 days in the last twelve months during which one meal or less was served. Even if there may be a recalling problem for events past 30 days, these data indicate that the houses are vulnerable to food shortages, that there is little difference between migrant and non-migrant households. FGD also indicated that in December there is no food shortage (2 days with one meal or less food than wished, as compared to more than 5 days as monthly average on the past 12 months). GTZ/WFP Project in Dadeldhura estimates the food shortages to be higher in the district than the present findings at around 3 months per year, for instance, for North-Western VDCs. CBS provided a much more conservative figure of 5% of food deficit in the district in 1997/8.

Rice is the main staple food in the district. The usual meal is composed of rice and lentils with a limited amount of vegetable curry. Around half of non-migrant respondent (47.5%) and only one third migrants (34%) did not buy rice, reflecting their capacity to produce it. The higher proportion of non-migrants, compare to migrant, buying rice hints at their higher capacity to produce it on their



land (See table VI in Annex 4). The low frequency of staple food purchase reveals the capacity of the families to keep stocks, and to cope more easily with unexpected events. The large majority of both migrants and non migrants buy staple food for a month or more, and the average number of weeks of staple food available is 32 for migrants and 39.03 for non migrants.

4.4.2 Access to water and sanitation

Chart 13. Source of drinking water (%)

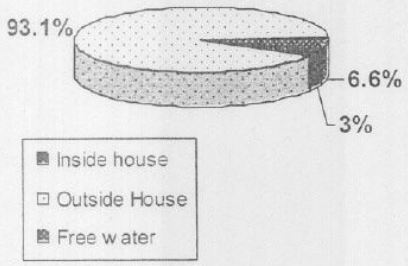
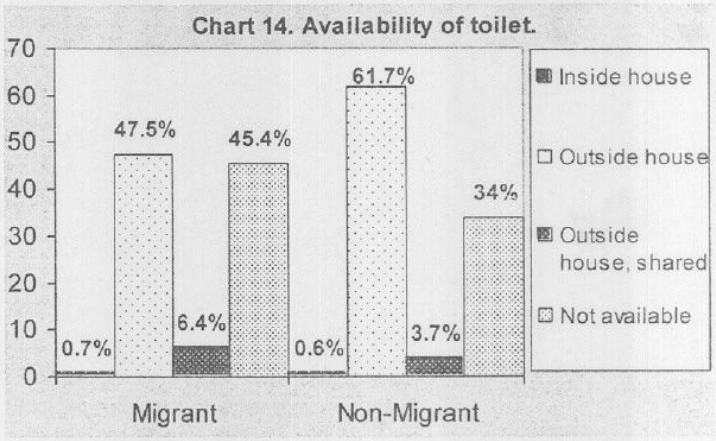


Table 8. Distance from house to source of water (In case the water source is outside the house)

	Migrant	Non-Migrant
Minutes (Average)	9.5	7.6

The large majority of respondents use sources of water outside the house and this indicator discriminate neither between poor and non-poor households nor between migrant and non migrant households. However migrant household members spend 28% more time to fetch water than non-migrant households (See table VII in Annex 4).

Chart 14. Availability of toilet.



Toilets are not available for half of migrant households but only for 34% of non- migrant households. Most of toilets available for families are outside the house (See table VIII in Annex 4).

4.4.3 Access to shelter

Table 9. Ownership status of the house (n(%))			
	Migrant	Non-Migrant	Total
Privately owned	135(95.7)	155(95.7)	290(95.7)
Rented	3(2.1)	4(2.5)	7(2.3)
Given by relative or other to use	2(1.4)	0	2(0.7)
Provided by Government	0	2(1.2)	2(0.7)
Employer's property	0	1(0.6)	1(0.3)
Built on squatter/public land	0	0	0
Other	1(0.7)	0	1(0.3)
Total	***141(100)***	***162(100)***	***303(100)***

Table 10. Type of wall (n(%))			
Walls	Migrant	Non-Migrant	Total
Dry grass	11(7.8)	14(8.6)	25(8.3)
Stone/mud	127(90.1)	142(87.7)	269(88.8)
Concrete	2(1.4)	5(3.1)	7(2.3)
Bricks	1(0.7)	9(5.6)	10(3.3)
Roofs			
Dry grass	22(15.6)	20(12.3)	42(13.9)
Stone	117(83.0)	129(79.6)	246(81.1)
Zinc	1(0.7)	1(0.6)	2(0.7)
Tiles	1(0.7)	9(5.6)	10(3.3)
Total	***141(100)***	***162(100)***	***303(100)***

95.7% of houses of both migrants and non migrant are owned by the occupants themselves.

Most of houses in Dadeldhura have walls made of stone and mud and roofs made of stone (slate). The large majority of the sample population falls in the same category with almost no distinction migrants and non migrants. These standards are therefore coherent with the regional ones (67% of houses in Dadeldhura use stones for roofing material), that are mainly stagnant but in sharp contrast with the urban areas of Nepal where 76.93% of the houses have seen their conditions somewhat improved in the recent years.[25]

4.4.4 Access to land

98 percent of respondents own land, significantly more than the district level average of 77.89%. No differences between migrant and non-migrants can be underlined as far as the proportion of landlords, but the land of migrants is smaller in size and for a somewhat larger

proportion non-irrigated. Both percentages of irrigated land of migrant and non migrant households are lower than the district proportion of 36.5% of irrigated land, and much lower than the Nepal wide proportion of 58.93%. Their land size is also smaller than the national level of 1.09ha.[40]

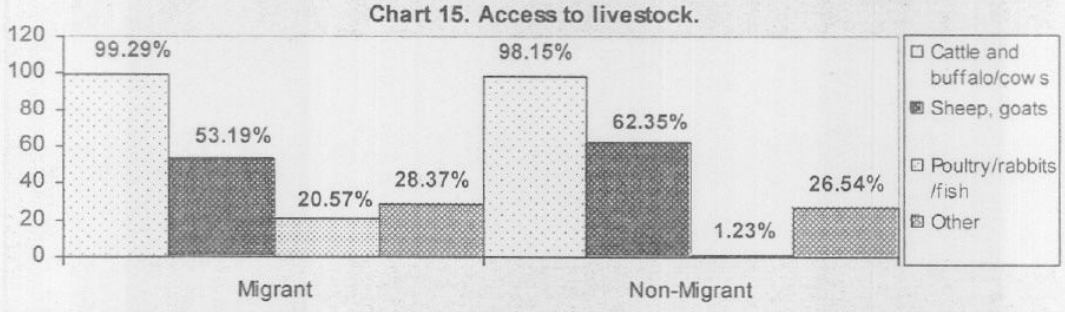
Table 11. Land (n(%))

	Migrant	Non-Migrant	Total
Land owner	138(97.9)	159(98.1)	297(98.0)
No land	3(2.1)	3(1.9)	6(2.0)
Total	***141(100)***	***162(100)***	***303(100)***
Irrigated land	29(21.0)	45(28.3)	74(24.9)
Non–irrigated land	109(79.0)	114(71.7)	223(75.1)
Total	***138(100)***	***159(100)***	***297(100)***
Land size Ropanis (ha)	16.5 (0.825)	17.1 (0.855)	16.9 (0.845)

However, Agricultural Projects Services Center (APROSC) reports that 44.72% of district farms in Dadeldhura have less than 0.5 hectares of land[49]. It seems once again that the sample was not taken from the poorest part of the Dadeldhura society.

The quasi totality of the sample owns cattle. However, the proportion of the migrant households owning sheep and goats is slightly lower than for non migrant households, and higher for poultry and fish. This may be explained by the fact that smaller animals fed in cages do not need a constant attention and are therefore easier to raise for a household already depleted of one of its members. The ownership of household appliances is 10 times higher for

Chart 15. Access to livestock.



the non-migrant houses, but nevertheless remains very low. Jewellery (mainly traditional golden ornaments) is owned by 80% of the households indiscriminately, as a usual way to

invest savings that can be sold, in case of an unexpected event. Migrant families own somewhat less transport means than non migrant households (See table IX in Annex 4).

4.4.5 Access to education

Table 12. Utilization of educational institutions (n(%))

Educational institutions used by households	Migrant	Non-Migrant	Total
Government school	113(80.14)	147(90.74)	260(85.81)
Private school	5(3.55)	1(0.62)	6(1.98)
Boarding school	23(16.31)	14(8.64)	37(12.21)
Distance from house to school			
30-60 min	128(90.78)	137(84.57)	265(87.46)
1-2 hours	12(8.51)	20(12.35)	32(10.56)
2-4hours	1(0.71)	3(1.85)	4(1.32)
4-6 hours	0	0	0
6-more hours	0	2(1.23)	2(0.66)
Total	***141(100)***	***162(100)***	***303(100)***

All respondents' households have access to education institutions. Non-migrant send their children preferably to Government schools, and so do the migrants for the larger share of the sample. However, migrant households, possibly because of the absence of one parent, have a greater percentage of children in boarding schools, and in private school. School is less than an hour away from home for the great majority of the sample. A majority of the households pay schools for education. All parents pay for their children's education.

Although the enrolment rate is not high (77% and 79% for children from respectively non migrant and migrant households), around 54% of migrant and non-migrant households have at least one child not going to school. This fact suggests that school non-attendance is the fact of one category of children rather than based on a social gap discriminating between

Table 13. Reasons for children not going school (n(%))

	Migrant	Non-Migrant
No trust in the school program	2(2.60)	1(1.14)
Need for the children to work	11(14.29)	23(26.14)
Study cost expensive	3(3.90)	4(4.55)
No school close to the household	9(11.69)	14(15.91)
Other category	52(67.53)	46(52.27)
Total household with children not attending school	***77(100)***	***88(100)***

families. Discussion in focus groups showed that this child category is the girl child of more than ten years of age. However, this discrimination can not be easily explained by the respondents. It explains the high proportion of answers under a vague "other" of table 4.1.12 on reason of children for not attending school.

4.4.6 Access to health services

Table 14. Availability and utilization of health facility (n(%))

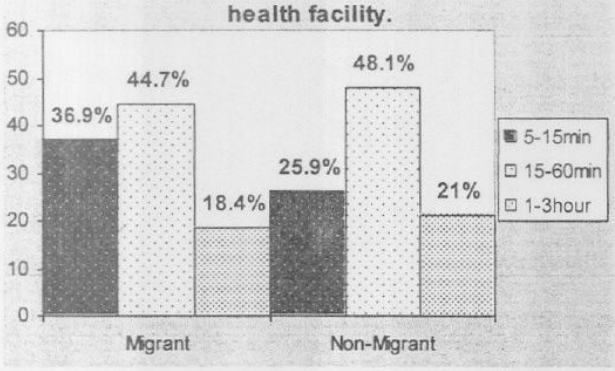
	Migrant			Non-Migrant			Total		
	Used	Available	Total	Used	Available	Total	Used	Available	Total
Traditional healer	7 (4.96)	78 (55.32)	141 (100)	21 (12.96)	49 (30.25)	162 (100)	28 (9.24)	127 (41.91)	303 (100)
Ayurvedic Health Center or an Homeopathic Clinic	5 (3.55)	8 (5.67)	141 (100)	3 (1.85)	12 (7.41)	162 (100)	8 (2.64)	20 (6.60)	303 (100)
Sub Health Post	24 (17.02)	42 (29.79)	141 (100)	18 (11.11)	35 (21.60)	162 (100)	42 (13.86)	77 (25.41)	303 (100)
Health Post	64 (45.39)	64 (45.39)	141 (100)	92 (56.79)	99 (61.11)	162 (100)	156 (51.49)	163 (53.80)	303 (100)
Pharmacy	27 (19.15)	42 (29.79)	141 (100)	18 (11.11)	48 (29.63)	162 (100)	45 (14.85)	90 (29.70)	303 (100)
Private practice	4 (2.84)	28 (19.86)	141 (100)	3 (1.85)	25 (15.43)	162 (100)	7 (2.31)	53 (17.49)	303 (100)
Government Hospital/ TEAM Hospital	34 (24.11)	26 (18.44)	141 (100)	27 (16.67)	27 (16.67)	162 (100)	61 (20.13)	53 (17.49)	303 (100)

Traditional healers are widely available for the sampled population. However, not many patients go to them (9% as compared to 25% at the country wide level[50]). Less than 5% of migrants use traditional Healers' facilities, which is significantly lower than non-migrants (12.96%) probably because migrants have been exposed to different experiences during their migration where their system of beliefs has been challenged.

Sub-Health posts are available to only a quarter of the sample and health posts to a little over half of it. In almost all cases where they are available, health posts are frequented by patients for all sickness, while the proportion is slightly lower for sub health posts. This can be attributed to the lack of qualified manpower, equipment and medicaments in the district sub-health posts. At the national level only 8% of the population considers health services provided by government as "good".[51]

Pharmacies are available to 30% of the patients while only 15% use them, because of the lack of medicaments. Among VDCs studied, only 2 out of 5 pharmacies were actually supplying proper medicines to patients. Even in these pharmacies, some basic medicines like aspirin, calcium, and iron were not available. Private practices are available to a surprisingly high 17% of the sample: however, very few can afford them. Hospitals are more used than available, as persons have to walk hours to get proper diagnosis and medicine. Hospitals came clearly as the first choice of the patients, providing they have the possibility to get there, and the cash to afford the services. As a consequence, the hospital plays also the role of a health post, as the system of reference is not really operational. Specificity worth noticing is that most of the diagnoses are done based on dialogue with the patients, while very limited physical examination takes place.

Chart 16. Distance from house to nearest health facility.



Almost 74% of sampled migrant households and 58% of non migrant households have access to health facility within a 30 minutes distance walk, which compares positively with a 41.33% as a rural Nepal average (See table X in Annex 4).[52]

Table 15. Availability of financial means (n(%))

For diagnosis	Migrant	Non-Migrant	Total
Yes	95(67.38)	124(76.54)	219(72.28)
No	46(32.62)	38(23.46)	84(27.72)
			p=0.0753>0.05
For medicament purchase			
Yes	90(63.83)	113(69.75)	203(67.00)
No	51(36.17)	49(30.25)	100(33.00)
			p=0.2741>0.05
Total	***141(100)***	***162(100)***	***303(100)***

The incapacity of migrant respondents to pay for respectively diagnosis and medicament (33%% and 36%) is significantly higher than for non-migrant respondents (23% and 30%). It indicates the greater helplessness of migrant households in front of unexpected events like accidents or sickness.

4.4.7 Control over resources and services

4.4.7.1 At the community level

Table 16. Election participation and belonging to the trade union (n(%))			
Vote in last local elections	Migrant	Non-Migrant	Total
Yes	121(85.82)	133(82.10)	254(83.83)
			p=0.3808>0.05
Voice of the household heard in the ward discussions			
Yes	118(83.69)	135(83.33)	253(83.50)
			p=0.9339>0.5
Belong to a trade union			
Yes	20(14.18)	16(9.88)	36(11.88)
			p=0.2477>0.05
Total	***141(100)***	***162(100)***	***303(100)***

The sampled respondents have a high participation in the local political life and feel that their concerns are being heard by the ward level structures. A greater proportion of migrant workers are unionised. The rate of participation in election is high, as compared to the 2056 (1999) parliament election where only 59.07% of the district population and 65.79% voted nationwide.

4.4.7.2 At the household level.

Table 17. Gender decision making involvement for migrant HH (See table XI in Annex 4).				
	Daily Income management (n(%))			
	Main decision maker	Consulted	Not consulted	Total
Female HH	4(22,22)	14(77,78)	0	18(100)
Male HH	92(74,80)	29(23,58)	2(1,63)	123(100)
Female member of household	2(11,11)	6(33,33)	10(55,56)	18(100)
Male member of household	8(6,50)	55(44,72)	60(48,78)	123(100)
				p=0.5812>0.05
	Family Planning (n(%))			
	Main decision maker	Consulted	Not consulted	Total
Female HH	5(27,78)	12(66,67)	1(5,56)	18(100)
Male HH	67(54,47)	49(39,84)	7(5,69)	123(100)

Female member of household	0	4(22,22)	14(77,78)	18(100)
Male member of household	8(6,50)	49(39,84)	66(53,66)	123(100)
				p=0.1302>0.05
Education (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	1 (5,56)	14(77,78)	3(16,67)	18(100)
Male HH	84(68,29)	35(28,46)	4(3,25)	123(100)
Female member of household	3(16,67)	5(27,78)	10(55,56)	18(100)
Male member of household	15(12,20)	46(37,40)	62(50,41)	123(100)
				p=0.6945>0.05
Decision to migrate (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	3(16,67)	15(83,33)	0	18(100)
Male HH	90(73,17)	31(25,20)	2(1,63)	123(100)
Female member of household	1(5,56)	7(38,89)	10(55,56)	18(100)
Male member of household	5(4,07)	57(46,34)	61(49,59)	123(100)
				p=0.8249>0.05
Decision to seek medical help in case of sickness (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	3(16,67)	15(83,33)	0	18(100)
Male HH	80(65,04)	42(34,15)	1(0,81)	123(100)
Female member of household	0	8(44,44)	10(55,56)	18(100)
Male member of household	8(6,5)	57(46,34)	58(47,15)	123(100)
				p=0.4934>0.05

Table 18. Gender decision making involvement for non-migrant HH (See table XII in Annex 4).

Daily Income management (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	17(18,28)	74(79,57)	2(2,15)	93(100)
Male HH	36(52,17)	27(39,13)	6(8,70)	69(100)
Female member of household	11(11,83)	29(31,18)	53(56,99)	93(100)
Male member of household	9(13,04)	35(50,72)	25(36,23)	69(100)
				p=0.0245<0.05
Family Planning (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	30(32,26)	60(64,52)	3(3,23)	93(100)
Male HH	25(36,23)	37(53,62)	7(10,14)	69(100)
Female member of household	4(4,30)	29(31,18)	60(64,52)	93(100)

Male member of household	7(10,14)	34(49,28)	28(40,58)	69(100)
				p=0.0086<0.05
Education (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	5(5,38)	70(75,27)	18(19,35)	93(100)
Male HH	31(44,93)	35(50,72)	3(4,35)	69(100)
Female member of household	10(10,75)	34 (36,56)	49(52,69)	93(100)
Male member of household	8(11,59)	37(53,62)	24(34,78)	69(100)
				p=0.0647>0.05
Decision to seek medical help in case of sickness (n(%))				
	Main decision maker	Consulted	Not consulted	Total
Female HH	13(13,98)	79(84,95)	1(1,08)	93(100)
Male HH	28(40,58)	39(56,52)	2(2,90)	69(100)
Female member of household	6(6,45)	37(39,78)	50(53,76)	93(100)
Male member of household	6(8,70)	39(56,52)	24(34,78)	69(100)
				p=0.0562>0.05

Female participation in the decision making process of the household, is consistently lower than the male. It does not appear that there are some specifically female areas of decision making, and Education, Family Planning, Migration and other categories show figures without remarkable discrepancies. The married daughter, the unmarried daughter and the female spouse have the lowest level of participation across the board: marriage does not change the stage of mute obedience for most of them. A male servant in same cases has a higher degree of participation in decision than girls in the house.

Female spouses are not consulted in household decision making in between 55% and 68% of cases for non-migrants and in between 47% and 55% of cases for migrants. By contrast, male spouses in female headed households, are not consulted in between 34 and 40% of cases in non migrant households (male spouses in non-migrant female-headed households are assumed to be ill or disabled), and in between 55% and 78% in migrant households. The lesser extent of consultation in the migrant households may be due to the fact that some of the household do not live together for part of the year, and as a consequence, decisions have to be made in a more unilateral way.

Sons (either married or unmarried) are consulted in around 20% more of the cases than both daughters (married or unmarried). In between 40 and 60% of the cases, parents, brothers,

sisters, are not part of the decision making processes. The role of the brother is however more prominent in the case the male head of a household migrates.

4.5 Situation on migration

A migrant worker is defined as a person who had been (working) more than three months outside their district in their adult years (18-49 years) in the last 10 years before the time of the study. 46.53% of the sample were migrant workers (n=303).

The majority (81.08%) of migrant workers from sampled population are in the 20 to 49 age group. One out of every four migrant (26.01%) stays at the place of migration from 2 to 4 years. Every fifth (19.26%) from 1 to 2 years, and more than 22% stay for more than 6 years. In Doti district, the migrant population appears to stay for a shorter period of time in migration. (77% for up to three years and only 1.6% for more than 5 years).[1] From focus group discussions (FGD), it was learnt that migrants often leave their houses when they are between 16 and 25 years of age, and preferably before getting married (See table XIII in Annex 4). Also in FGDs were noticed by respondents that Migrant's generally go back home once every two years.

Chart 17. Duration of migration.

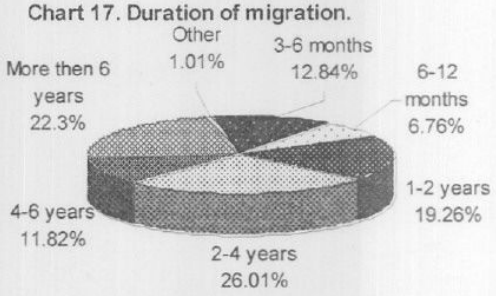
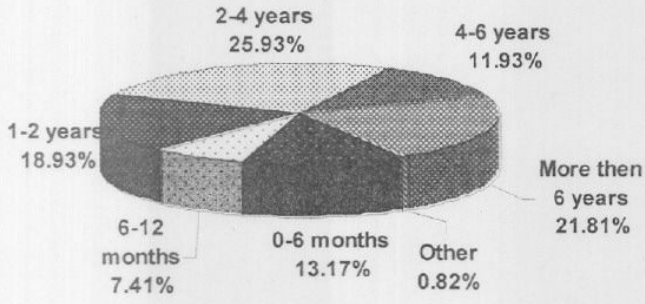


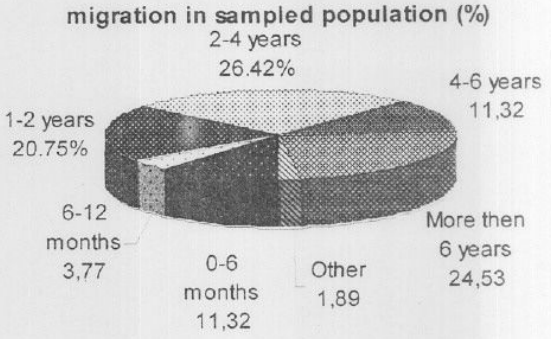
Chart 18. Duration of male migration in sampled population.



Female respondents represent only 21% of the migrant population but they tend to stay longer in the place of migration. In Focus Group Discussions, the majority of respondents underlined the fact that female migrant often migrate with their husbands, and that in cases where the entire family migrate, the duration of migration is usually longer. They save money on transport related costs, and household related costs at the place of migration,

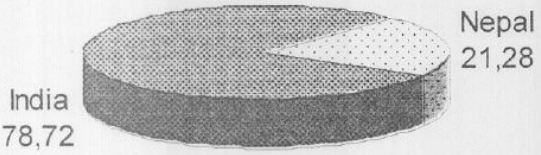
as the wife will take care of household chores. This particularity must also have an important bearing on the sexual behaviour of the migrant worker, and may function as a protective mean against STD/HIV infections (See table XIV in Annex 4).

Chart 19. Duration of female migration in sampled population (%)



The respondents migrate to a variety of places: there is no district wide selection of one destination but it appeared in the focus group discussions that the contacts taken at VDC or Ward level are important in the identification of the destination for the migrant. Whether to secure a job, accommodation at the time of arrival, or to provide a secure environment, migrants tend to move because of previous contacts established by other members of their community at the place of destination (See table XV in Annex 4).

Chart 20. Migration by countries (%)

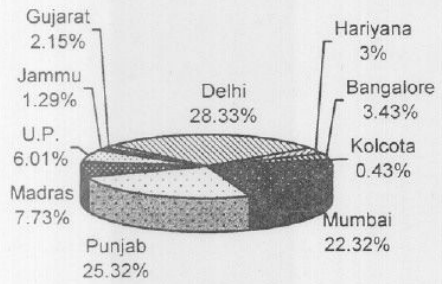


Internal migration is not significant, but provides apparently a first step towards international migration.[1] The only international destination for the sample is India (78.72%), and the migrants concentrate in the cities (62% of migrants to India). In Nepal, the hills are the main destination (36.51%), followed by the Kathmandu valley (28.67%), and the Terai (17.46%). Only 12.7% migrate in neighbouring districts of FWDR. In neighbouring Doti district, 33% of the migrants go to Mumbai and 25% go to Punjab, 16.3% go to Madras and only 2% to

Table 19. Internal migration: Destinations

Where	Number (%)
Hills	23(36.51)
Terai	11(17.46)
Kathmandu valley	18(28.57)
Mountain Nepal	
FWDR	8(12.70)
MWDR	1(1.59)
CDR	1(1.59)
EDR	1(1.59)
Total	***63(100)***

Chart 21. Migrants to India: Destinations.



Delhi.[1] 60.5% of the migrants of the FWDR go to work in Uttar Pradesh.

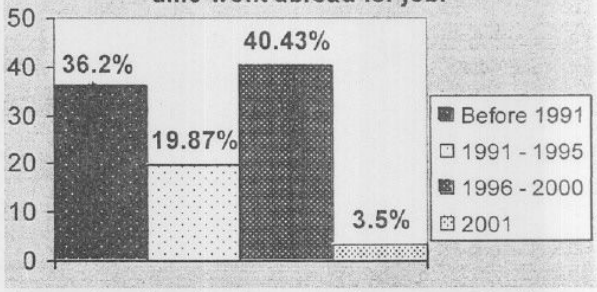
Table 20. Ethnicity among migrant workers

Caste	District data[39]	Number (%)
Brahmin	19.87%	13 (9.22)
Chhetri	50.48%	88 (62.42)
Vaishya	6.48%	11 (7.8)
Shudra	22.46%	28 (19.86)
Others	0.71%	1 (0.7)
Total		***141 (100)***

The majority of sampled migrant workers in Dadeldhura are Chhetri (62.42%), which is consistent with data from Doti district (56.7%).[1] Chhetri and Vaishya tend to migrate more than Brahmin (their proportion within the sampled migrant population is higher than their proportion at the place of origin), while Brahmin and Shudra tend to stay in Dadeldhura (their proportion among the migrant sample is lower than their proportion in Dadeldhura).

More than one third of migrant workers went for their first time abroad before 1991. While the years 1991-1995 saw an important decrease in the caseload of new migrant labourers, a sharp increase happened in the years 1996-2000 (See table XVI in Annex 4).

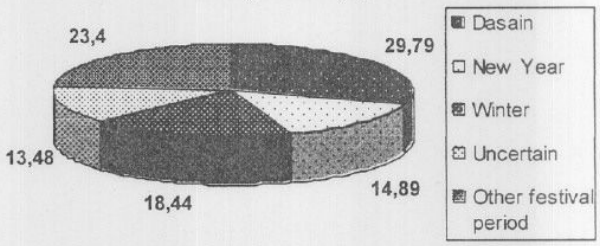
Chart 22. Year when respondents first time went abroad for job.



One of the main reasons of the increasing migration in the past five years is the road constriction (1997).

The most common time for migrants to come home during the year is Dasain / Tihaar festival (29.79%) and Ugratara local festival (23.4%). As a comparison, the most popular time to come back to home from place of migration in Doti district is Dasain festival 41.9% and New Year/ Bisau Jathra, local festival with 17.7%.[1] (See table XVII in Annex 4).

Chart 23. Return time from place of migration (%)



4.5.1 Work conditions

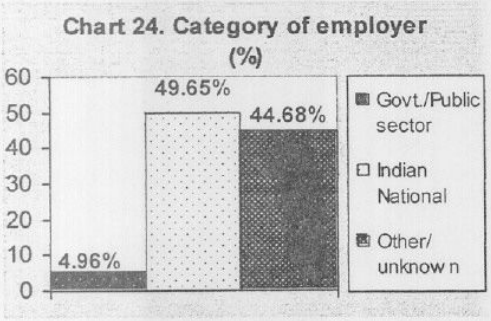
Table 21. Job arrangement at the place of migration (n(%))	
	No (%)
Arranged beforehand by a middleman who got paid for it;	1(0.71)
Arranged by family members, friends;	75(53.19)
Left without having a job assured.	65(46.1)
Total	***141(100)***

More than half of the sample got their jobs arranged beforehand on a free basis, by friends or family members. Once again, it underlines the importance of personal networks for getting a job in a place of migration. However, a significant proportion of the sample also left without having a job assured (46.1%). More than half respondents were unemployed for less than 5 days before getting a first job. 31% who did not respond are very likely to form the caseload of those that did not get a job. According to FGD, it is increasingly difficult to get a job for migrant workers in India.

Table 22. Time of unemployment in before getting first job.	
Days	No (%)
1-5	85(60.28)
5-10	9(6.38)
10-15	1(0.71)
15-20	1(0.71)
20-30	1(0.71)
No response	44(31.21)
Total	***141(100)***

Table 23. Nature of job	
Job	No (%)
Regular long term employment with monthly wage	64(45.4)
Regular employment with daily/piece wage	12(8.5)
Daily wage casual worker	3(2.1)
Piece wage casual worker	2(1.4)
Self employed	53(37.6)
Other	7(5.0)
Total	***141(100)***

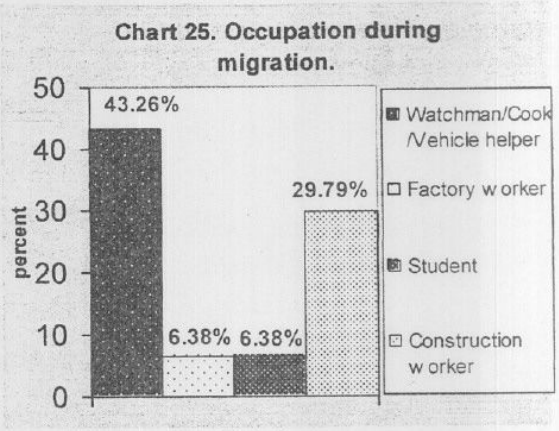
Around half (45.4%) of respondents have regular long term employment with monthly wage. 37% declare themselves as self-employed. However, looking at the categories of jobs, they are likely to be casual labourers, selling their work for a short period of time. They do not perceive the services they offer as being covered by an employment contract, as they are likely to be excluded from benefits and labour rights.



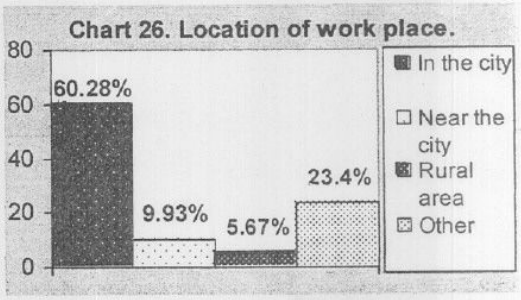
Half (49.65%) of migrant workers work for Indian nationals. Almost half of the sample can not identify its employer, either because the employer changes from day to day or because they work in a system of contracts that implies the existence of middlemen working for "unknown" employers.

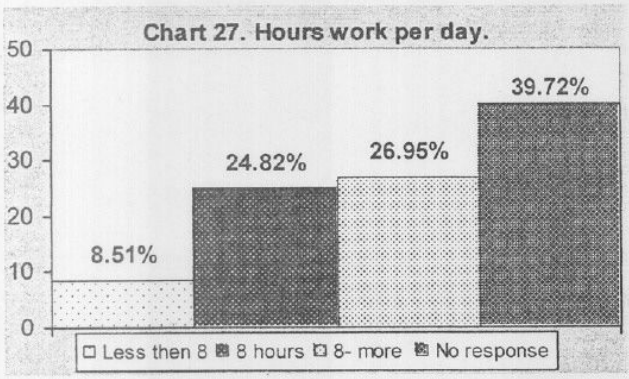
(See table XVIII in Annex 4).

The proportion of watchmen / cooks / vehicle helpers (43.26%) is inferior to the one in Doti (84.2%).[1] However the proportion of watchmen / cooks / drivers / vehicle helpers (46.8%) is consistent with the country level of migrants working in the service sector (47.4%). At the country level 4% are students, against 6.4% in the sample.[21] The 10.64% of no response corresponds to the part that did not get any job or has been undertaking multiple or undefined jobs. Sex workers are also not likely to disclose their professions as an important taboo is linked to it. FGD discussions allowed the researcher to witness a paradoxical attitude of families towards sex workers, whereby the remittances from the sex worker would be accepted but she would not be allowed to enter the house. (See table XIX in Annex 4).

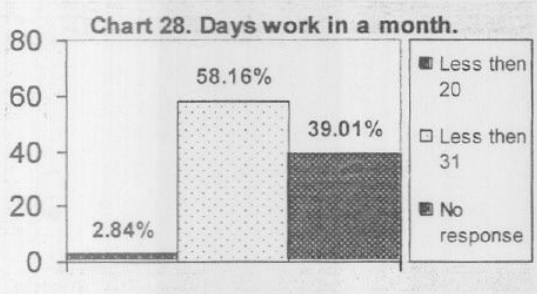


More than half (60.28%) of respondents work in the cities, a similar share than the total of 57.5% for main listed cities and Kathmandu valley identified before as place of migration, suggesting that only a small portion of the sample live and work in small cities. This proportion of urban migrants is significantly higher than the proportion from FWDR (36%), with subsequently a smaller share migrating to rural areas (5.67% against 17.7% at FWDR level) (See table XX in Annex 4).[21]





Around 40% of the sample did not respond to the question regarding working hours and very likely have such unstable working conditions that they are not able to define an average. Almost a fourth of the sample work more than 10 hours per day. Around 9% of the sample works part-time (See table XXI in Annex 4).



Again, an important proportion of the sample work too irregular to be able to provide a precise number of days worked per month. A very limited number (2.8%) has fixed part time arrangements. The majority of the sample (58%) has less than the legal number of days of rest per month (See table XXII in Annex 4).

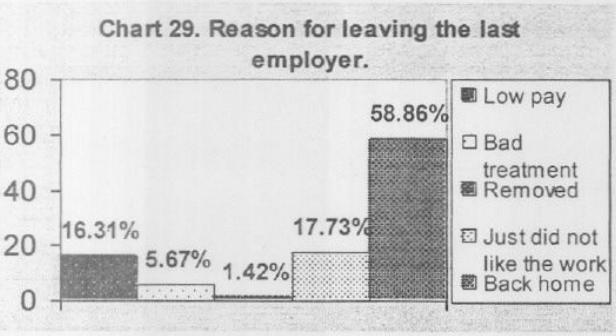
Only five respondents had problems with salary arrears. This situation is certainly the result of the labour vulnerability of the sample. As the majority works on a daily /piece basis, there is no salary arrears.

However this vulnerability contradicts the fact that half has not changed its employer since they started to work as a migrant and almost 90% has had less than four employers. We witness therefore a situation of labour where long term contracts are linked to flexibility in the way the work is paid and ordered, possibly a version of attached labour contracts whereby the designated employer has a priority on the work delivered by the workers, but would pay them only when there is actually work to do.

Table 24. Place currently working (n(%))		
	n=69	n=141
Don't know/ don't say	6(8.69)	4.25%
Second	26(18.44)	18.43%
Third	14(20.29)	9.93%
More	23(33.33)	16.31%
Total	***69(100)***	***141(100%)***

There was confusion on the scope of the question (table 5.2.11), while some thought it mean change of job, others thought it meant the holidays leave they were enjoying in their place of origin. This confusion may however be a sign of job uncertainty: holidays leave is similar to permanent leave as one is not sure to get back his/her occupation when

Table 25. Changed the employer first joined	
	n (%)
No	72(51.06)
Yes	69(48.94)
Total	***141(100)***



going back to the place of migration. It is also interesting to note that the main reason for labourers to leave (definitely) their employers is from their own decision (either because of unacceptable working conditions, low pay or bad treatment) (See table XXIII in Annex 4).

Almost one out of five respondents has been facing adverse working conditions because of the fact that they are migrants.

Table 26. Discrimination to which the migrant is subjected

Adverse working conditions	n(%)
None	114(80.85)
Harassment from employer	16(11.35)
Harassment from fellow worker	1(0.71)
Low pay than other fellow worker	6(4.26)
Other	4(2.84)
Total	***141(100)***

Table 27. Benefits are mentioned in the contract

Benefits	n(%)
Wage rate	5(3.55)
Job progression	4(2.83)
Accommodation	5(3.55)
Food	5(3.55)
Medical care	2(1.42)
Paid holidays	0
Others	3(2.12)
Total benefit	***24(17.02)***
No specification	***117(82.98)***
Total	***141(100)***

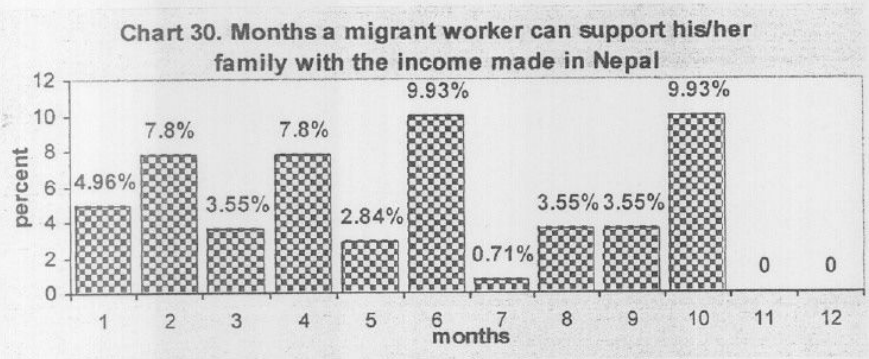
No respondent had a written labour contract. This lack of labour contract can not be attributed to their illiteracy level (very low), but to a expressed wish of the employer to keep the arrangement out of the scope of legal labour dispositions, as an additional mean to maintain the flexibility already observed with other tables. For the great majority of the respondents the basic terms of their agreement are not decided before the work is accomplished, and must therefore be the subject of negotiations after its completion. No one has paid holidays. However, in more than 90% cases, promises of specified benefits are respected.

Table 28. Accident at the work place and financial support for medical costs

Accident	Total n(%)	Yourself n(%)	Employer n(%)	Other n(%)
Yes	18(12.77)	15(83.33)	1(5.56)	2(11.11)
Total	***141(100)***	***18(100)***	***18(100)***	***18(100)***

In a manner coherent with other indications provided in the research on the existing labour relationships between migrant labourers and employers, most of the latter deny any responsibility for covering medical costs related to accidents happening at the workplace. In the great majority of cases, the costs are supported by the labourer him/herself.

4.5.2 Benefit from migration



Nearly half of the migrant workers do not get any income from Nepal and rely entirely on their income made during the time of migration. The need to cater for basic consumption needs is at the basis of the decision to migrate (See table XIV in Annex 4).

Table 29. Positive out puts from migration (n(%)		
	For the family	For the spouse
Yes	53(37.59)	55(39)
No	88(62.41)	86(61)
Total	***141(100)***	***141(100)***

A great majority of respondents do not see a positive output for migration neither for the family as a whole nor for the spouse. FGD with wives of migrants and teenager girls staying in Dadeldhura revealed that this lack of perceived positive impact comes from an unbalance between the economic benefits the migration brings home (although with a low level of remittances as the later tables will show), and the perceived social disadvantage of being exposed to other culture and losing the sense of one's own traditions. The migrant coming back from a big city to Dadeldhura for a short period of time every year must feel estranged to his/her own roots.

Table 30. Income, expenses, savings and remittances in the month preceding the coming back of the migrant (n(%))

NRs.	Income	Living expenses	Savings	Remittances
0	-	-	66(46.81)	124(87.94)
100-300	15(10.64)	22(15.6)	21(14.89)	7(4.96)
300-500	7(4.96)	17(12.06)	15(10.64)	3(2.13)
500-1000	13(9.22)	37(26.24)	26(18.44)	4(2.84)
1000-2000	35(24.82)	18(12.76)	8(5.67)	2(1.42)
2000-more	1(0.71)	3(2.13)	5(3,55)	1(0.71)
Don't know	70(49.65)	44(31.21)	-	-
Total	***141(100)***	***141(100)***	***141(100)***	***141(100)***

Although elements related to income and expenditures are often very difficult to capture and findings must be treated with great caution, some indications of global trends can be found by comparing the income, the living expenses, the savings and the remittances of the last

month of work at the place of migration. The main bias that may exist in this exercise is the high proportion of non response. Only by assuming that it is actually the same part of the sample (between 31% and 46%) that is not answering the questions, can we attempt an analysis.

More than 25% of the sample gets fewer wages than the minimum wage (equivalent to 64.8 NRs/day in India and 60 NRs/day in Nepal). For an important part of the sample, living expenses are higher than income and they must rely on consumption credit. The saving curve is coherent with the curves of both income and expenses.

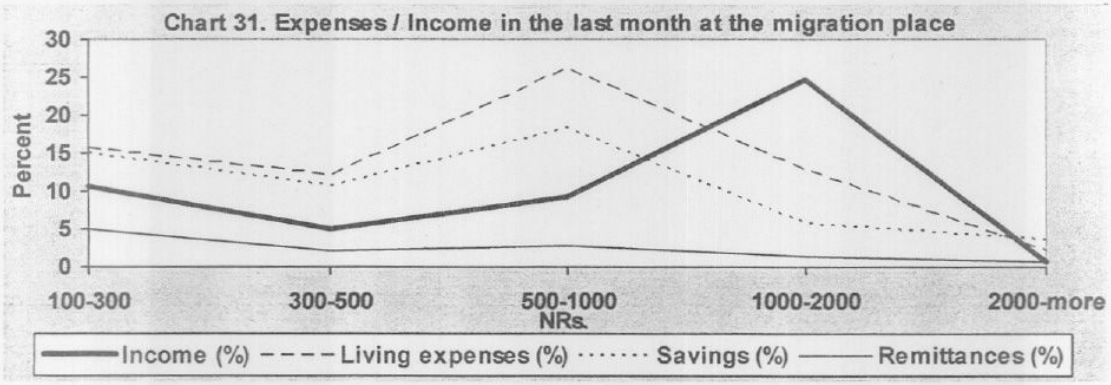


Table 31. Remittance services	
	n(%)
Labourer	40(28.37)
Bank	2(1.42)
Friends & relatives	38(26.95)
Co-worker	0
NGO/MFI	1(0.71)
No remittances	60(42.55)
Total	*141(100)*

Only a small percentage of the sample (12.06%) is able to send back home some limited remittances. This may be due to the fact that some families travel together, and that there is a little capacity to send back home remittances. The main benefit of the migration would not be in terms of outputs for the family, but of the number of persons not to be fed from the land at the place of origin.

Table 32. Expenses and remittances during last *coming back*	
NRs.	Spent on transport/ Brought goods worth/ Bought cash etc. n(%)
100-300	10(7.09)
300-500	3(2.13)
500-1000	3(2.13)
1000-2000	3(2.13)
2000-3000	10(7.09)
3000-more	32(22.69)
Don't know	80(56.74)
Total	*141(100)*

Some remittances are also carried back home

annually. The large majority of the sample, however, can not recall the amount spent during the last trip either for personal expenses or for remittances. Most of the sample does not use formal systems to carry home their remittances. For the majority, they are carried either by the labourer him/herself, or friends and relatives.

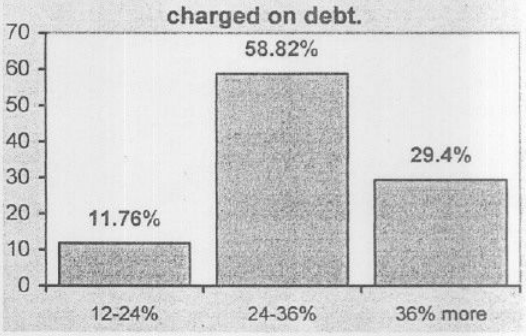
Table 33. Major use of remittance sent home

	n(%)
Consumption	47(33.33)
Buy land	0
Build house	0
Pay debt	31(21.99)
Education	2(1.42)
Health	0
Marriage	1(0.71)
Other	60(42.55)
Total	***141(100)***

The majority of remittances sent home are used for consumption purposes, and/or to repay debts. This importance of debt repayment confirms our earlier assumption of the heavy reliance of the households on consumption credits to cope with living expenses.

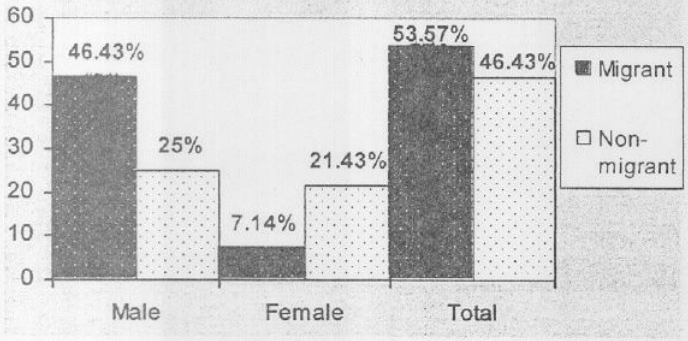
Most of the rates of interests paid by migrant workers reflect the informal source of the credit. By comparison, Grameen Bikas Bank proposes loans with 19% interest rates per annum (declining balance) (See table XXV in Annex 4).

Chart 32. Interest rate per year charged on debt.



4.6 Situation on HIV/AIDS

Chart 33. Distribution HIV/STIs by gender.



Among respondents who agreed to be tested on HIV/STIs (303) 9.24% were identified as positive. Differences between migrant and non-migrant are not significant except for syphilis. Differences appear greater when data are disaggregated by gender. Migrant males are almost two (1.86) times

more infected than non-migrant male. but migrant female are three times less infected than non-migrant female. There was one single case of HIV positive (migrant) (See table XXVI in Annex 4).

Table 34. Infections profile among migrant workers (n(%))			
Infection	n=141	%	95% Confidence Interval
HBV prevalence	2	1.4	0.2 – 5.0%
HIV prevalence	1	0.7	0 – 3.9%
Syphilis prevalence	12	8.5	4.5 – 14.4%
Infections profile among non migrant workers (n(%))			
Infection	n=162	%	95% Confidence Interval
HBV prevalence	3	1.9	0.4 – 5.3%
HIV prevalence	0	0	0 – 2.3%
Syphilis prevalence	12	7.4	3.9 – 12.6%

It appears that a total 32 respondents are infected with HIV/STIs/HBV (10.89% from total sample size) and one respondent is infected with Syphilis and Hepatitis B virus (0.33% from total sample size). Twice as many migrant respondents (3.96%) are infected with syphilis as compared to non migrant respondents (1.98%).

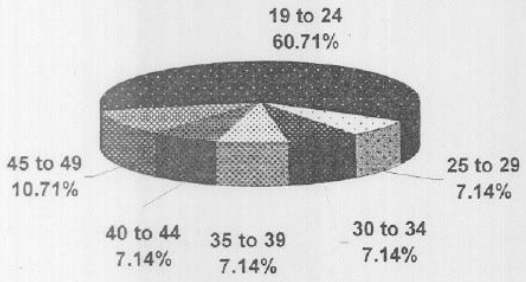
The STI/HIV positive rates in migrant and non migrant workers are identical and do not show a statistically significant difference.

Table 35. Disease profile prevalence among sampled population (n=303(%))					
Disease	Migrant		Non-migrant		***Total***
	Male	Female	Male	Female	
HBV	2(0.66)	0	0	3(0.99)	*5 (1.65)*
HIV	1(0.33)	0	0	0	*1(0.33)*
Syphilis	12(3.96)	2(0.66)	6(1.98)	6(1.98)	*26(8.58)*
Gonorrhoea	0	-	1(0.33)	-	*1(0.33)*
Total	*14(4.62)*	*2(0.66)*	*7(2.31)*	*9(2.97)*	*32(10.56)*
	16(5.28)		*16(5.28)*		*303(100)*

The prevalence of syphilis in the sample population is 8.58 percent, significantly higher than national figures 0.11% (for a composite index of RTI/STI/HIV).[19] HBV prevalence among respondents is 0.2 – 5.3% significantly higher than the national figure of 0.09% (in a composite index including Jaundice & Infectious Hepatitis).[19] There are no major differences between migrant and non migrant respondents for HBV infection. Because of the lack of female Medical Doctor in the study only male respondents were checked for Nisseria Gonorrhoeae test. Only one (0.33%) non migrant male was infected. No respondent before the study knew, that they had been infected with any of those infections.

Because of their exposure to the infections during their migration time, migrants are more HIV/STIs positive than non-migrant respondents. It shows that the epidemic of Syphilis and the HIV pandemic are only at their starting point in Dadeldhura. However, in the absence of proper protection, and preventive actions, it is likely to spread with 1/an increase of positive cases among migrants, and 2/an increase among the non migrant population.

Chart 34. HIV/STIs by age groups (%)



The most affected age group is the young between 19 and 24 years old. It underscores the need of preventive programs targeted to this category (See table XXVII in Annex 4).

4.6.1 Sexual behaviour

Table 36. Frequency of sexual relationship past month (n(%))

Number of times in sex	Migrant HH			Non-Migrant HH			Total
	Male	Female	Total	Male	Female	Total	
1	3(12.50)	0	3(10.71)	0	1(12.50)	1(6.25)	4(9.09)
2	8(33.33)	1(25.00)	9(32.14)	3(37.50)	4(50.00)	7(43.75)	16(36.36)
3	5(20.83)	0	5(17.86)	1(12.50)	1(12.50)	2(12.50)	7(15.91)
4	4(16.67)	1(25.00)	5(17.86)	1(12.50)	0	1(6.25)	6(13.64)
5	2(8.33)	0	2(7.14)	1(12.50)	0	1(6.25)	3(6.82)

10	0	0	0	1(12.50)	0	1(6.25)	1(2.27)
12	0	1(25.00)	1(3.57)	0	1(12.50)	1(6.25)	2(4.55)
14	0	1(25.00)	1(3.57)	0	1(12.50)	1(6.25)	2(4.55)
15	1(4.17)	0	1(3.57)	0	0	0	1(2.27)
20	0	0	0	1(12.50)	0	1(6.25)	1(2.27)
25	1(4.17)	0	1(3.57)	0	0	0	1(2.27)
Total	***24(100)***	***4(100)***	***28(100)***	***8(100)***	***8(100)***	***16(100)***	***44(100)***

Frequency of sexual relationship in past month is very sensitive question to answer as it relates to the very private life of the respondents. However, almost 20% of the migrants and 10% of the non migrant respondents answered the question. The majority of those who answered had two sexual intercourses last month, with a mean of 1.12 for migrants and 1.76 for non-migrant respondents. This reported low sexual activity may act as a delaying factor in the spread HIV.

Table 37. Sexual contact during migration

	Male	Female	Total
Yes	26(21.14)	4(22.22)	30(21.28)
No	97(78.86)	14(77.78)	111(78.72)
Total	***123(100)***	***18(100)***	***141(100)***
			p=1.0000>0.05

This very low percentage of both female and male who had a sexual intercourse during the time of migration can be explained by the taboo attached to answering such questions, by the low interest observed in the sample for sex contacts and by the wide use of abstinence / masturbation for fulfilling sex needs. Among the sample, the mean number of sexual intercourses is 4.26 for an average period of migration of 11 months. From the table below, we can see that most of the migrants are reunited with their spouses during major festivals, when they come home. Campaigns of prevention on HIV/AIDS and STIs should concentrate on these periods where the families who stayed behind are at risk of getting infected.

Table 38. Frequency respondent meet his/her spouse in year period

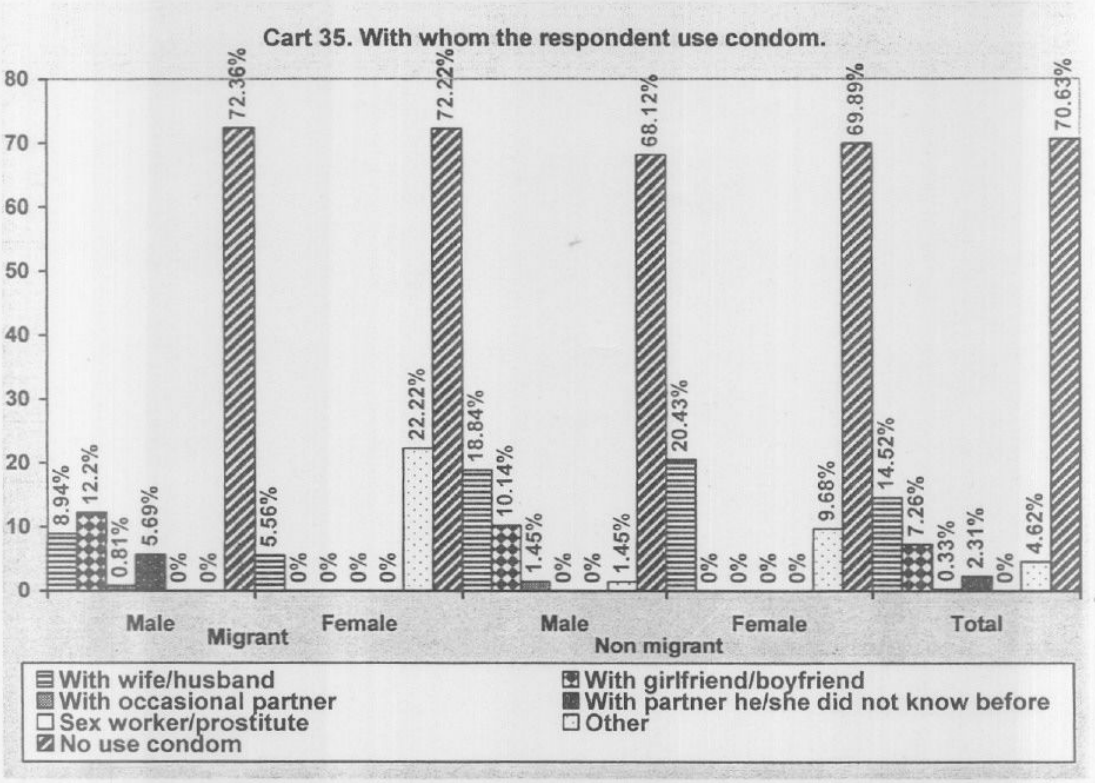
	Migrant		
	Male	Female	Total
Only during major festivals	26(21.14)	4(22.22)	30(21.28)
In intervals of 1-3 months	7(5.69)	0	7(4.96)
During farming season	10(8.13)	1(5.56)	11 (7.80)
Other	45(36.59)	6(33.33)	51(36.17)
No answer	35(28.46)	7(38.89)	42(29.79)
Total	***123(100)***	***18(100)***	***141(100)***
			p=0.0765>0.05

Table 39. Sexual contact when spouse is absent from the house (n(%))							
	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
With girlfriend/boyfriend	15 (12.20)	0	15 (10.64)	7 (10.14)	0	7 (4.32)	22 (7.26)
With occasional partner	1 (0.81)	0	1 (0.71)	1 (1.45)	0	1 (0.62)	2 (0.66)
With partner he/she did not know before	7 (5.69)	0	7 (4.96)	0	0	0	7 (2.31)
SW/prostitute	0	0	0	0	0	0	0
Other	11 (8.94)	5 (27.78)	16 (11.35)	14 (20.29)	28 (30.11)	42 (25.92)	58 (19.14)
							p=0<0.05
Don't have sex	89 (72.36)	13 (72.22)	102 (72.34)	47 (68.12)	65 (69.89)	112 (69.14)	214 (70.63)
							p=0.5413>0.05
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***300 (100)***

27.66% of male migrant workers and 31.88% of male non migrant workers declare having sexual contacts with other partners than their wives (when the partner is absent). Women enjoy extra marital affairs in the same proportions. Among defined categories of partners, long term partners (abid not permanent) are the norm. From informal discussions it seemed that the category of other refers (for man) to sex workers that are, accepted by the village (for men), and to occasional partners.

Table 40. How respondent protect them self from getting HIV/AIDS (n(%))							
	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
Don't know	16 (13.01)	6 (33.33)	22 (15.60)	1 (1.45)	27 (29.03)	38 (23.46)	60 (19.80)
Avoiding sex	11 (8.94)	1 (5.56)	12 (8.51)	4 (5.80)	5 (5.38)	9 (5.56)	21 (6.93)
Avoiding sex with multiple partners	77 (62.60)	8 (44.44)	85 (60.28)	39 (56.52)	57 (61.29)	96 (59.26)	181 (59.74)
Avoiding prostitute	16 (13.01)	3 (16.67)	19 (13.48)	13 (18.84)	4 (4.30)	17 (10.49)	36 (11.88)
Using condom	3 (2.44)	0	3 (2.13)	12 (17.39)	0	2 (1.23)	5 (1.65)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0.3745>0.05

Avoiding multiple sex partners is the favourite protective strategy for both migrant and non migrant respondents. before avoiding prostitute. Condom use is considered by only a minority of the sample. One out of five respondents does not know how to protect him/herself.



No use condom p=0.5413>0.05; use condom p=0.0001<0.005

The number of those who do not use condoms match precisely for each category of male/ female, migrant and non migrant respondents the proportion of those who do not have sex outside their marriage. It means that the community is *in principle* well protected against STIs and in particular HIV. However, the rate of STIs among the sample compared to available national statistics (see earlier) comes as a denial of this description, as does the fact that only 2.13 percent of migrants and 1.23 percent non migrants consider the use of condom as a protection against HIV/AIDS. The only explanation being that practice vary widely from answers given, because 1) the respondents more subjected to social taboos do not report extra marital affairs and do not practice safe sex, 2) although it is known among those who have extra marital affairs that condom use is important it is not yet practiced widely (See table XXVIII in Annex 4).

Table 41. Talk with friends and family about HIV/AIDS (n(%))							
	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
No	37 (30.08)	11 (61.11)	45 (31.91)	21 (30.43)	40 (43.01)	61 (37.65)	106 (34.98)
Yes	85 (69.11)	7 (38.89)	95 (67.38)	48 (69.57)	53 (56.99)	101 (62.35)	196 (64.69)
Other	1 (0.81)	0	1 (0.71)	4 (5.80)	0	4 (2.47)	5 (1.65)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0.3546>0.05

Almost two third (64.69%) of respondents talk with friends and family about HIV/AIDS, with no major differences between migrant and non migrant groups. HIV/AIDS is however more a subject of male than female discussions.

4.6.2 Awareness

Table 42. Can recognize condom (n(%))						
	Migrant			Non-Migrant		
	Male	Female	Total	Male	Female	Total
Recognized	61(49.59)	6(33.33)	67(47.52)	37(53.62)	57(61.29)	94(58.02)
Not recognized	62(50.41)	12(66.67)	74(52.48)	32(46.38)	36(38.71)	68(41.98)
Total	***123(100)***	***18(100)***	***141(100)***	***69(100)***	***93(100)***	***162(100)***
						p=0.0675>0.05

The percentages of respondents recognizing a condom are extremely low, compared for instance with 91% of boys between 12 and 18 in the Dang district (inner Terai, Western Development Region) who know what a condom is and 87.5% who know where to find one.[20] In the same study the ratio for girls were respectively 90% and 100%. More male migrant workers can recognize a condom compared to female migrant worker while the situation is opposite among non-migrants with more female recognizing a condom as compared to male.

Table 43. Purpose for using condoms (n(%))

	Migrant							Non-migrant						
	Male		Female		Total			Male		Female		Total		
	Spontaneously	On probing	Spontaneously	On probing	Spontaneously	On probing	*Total*	Spontaneously	On probing	Spontaneously	On probing	Spontaneously	On probing	*Total*
Does not know	20(13.89)	0	4(2.78)	0	24(16.67)	0	***144(100)***	6(3.68)	0	16(9.82)	0	22(13.50)	0	***163(100)***
Avoid pregnancy	100(69.44)	119(82.64)	13(9.03)	15(10.42)	113(78.47)	134(93.06)	***144(100)***	49(30.06)	66(40.49)	59(36.20)	83(50.92)	108(66.26)	149(91.41)	***163(100)***
Intercourse during menstruation*	0	15(10.42)	0	1(0.69)	0	16(11.11)	***144(100)***	0	10(6.13)	0	9(5.52)	0	19(11.66)	***163(100)***
Protection against the STIs	43(29.86)	118(81.94)	3(2.08)	15(10.42)	46(31.94)	133(92.36)	***144(100)***	23(14.11)	67(41.10)	17(10.43)	81(49.69)	40(24.54)	93(57.06)	***163(100)***
Protection against HIV/AIDS	52(36.11)	122(84.72)	5(3.47)	15(10.42)	57(39.58)	137(95.14)	***144(100)***	37(22.70)	67(41.10)	31(19.02)	84(51.53)	68(41.72)	151(92.64)	***163(100)***
Other	1(0.69)	0	0	0	1(0.69)	0	***144(100)***	1(0.61)	1(0.61)	0	1(0.61)	1(0.61)	2(1.23)	***163(100)***

*According to Hindu tradition women do not haw sex during menstruation period (source FGD and private conversation with respondents).

Migrants have consistently a better rate of spontaneous identification of the use of a condom as a way to avoid pregnancy, to protect against STIs, and to protect against HIV than non migrants. However, among migrants, female respondents have consistently a lower rate of spontaneous identification of the same. 43% of non migrants, after probing, do not identify condom use as a safe way to avoid STIs. Female non migrants have often a better rate of

spontaneous identification than male. A residual percentage does not identify any condom use, even on probing.

Table 44. Know some one with HIV/AIDS/STIs, existing in Nepal, and existing in place of migration (n(%))

Believe that HIV/AIDS exist in Nepal	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
No	24 (19.51)	8 (44.44)	32 (22.70)	6 (8.70)	14 (15.05)	20 (12.35)	52 (17.16)
Yes	84 (68.29)	5 (27.78)	89 (63.12)	53 (76.81)	59 (63.44)	112 (69.14)	201 (66.34)
Don't know	13 (10.57)	5 (27.78)	18 (12.77)	10 (14.49)	19 (20.43)	29 (17.90)	47 (15.51)
Other	2 (1.63)	0	2 (1.42)	0	1 (1.08)	1 (0.62)	3 (0.99)
							p=0.0756>0.05
Know someone with STI (incl. HIV/AIDS)							
Co-worker during migration	5 (4.07)	0	5 (3.55)	-	-	-	5 (1.65)
Persons from place of origin	4 (3.25)	1 (5.56)	5 (3.55)	4 (5.80)	7 (7.53)	11 (6.79)	16 (5.28)
Other	21 (17.07)	1 (5.56)	22 (15.60)	18 (26.09)	10 (10.75)	28 (17.28)	50 (16.50)
No	93 (75.61)	16 (88.89)	109 (77.30)	47 (68.12)	76 (81.72)	123 (75.93)	232 (76.57)
							p=0.0603>0.05
HIV/AIDS in place of migration							
No	93 (75.61)	11 (61.11)	104 (73.76)	-	-	-	-
Yes	17 (13.82)	2 (11.11)	19 (13.48)	-	-	-	-
Don't know	13 (10.57)	5 (27.78)	18 (12.77)	-	-	-	-
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***

Two thirds (66.34%) of respondents agree that HIV/AIDS exist in Nepal but less than a fourth of them has met with someone who was HIV positive. Fewer migrants believe that HIV/AIDS exist in Nepal, while more female respondents claim not to know. Almost 45% female

migrants believe that HIV/AIDS does not exist in Nepal. Almost one fourth of the migrants do not think that HIV/AIDS exist in the place of migration.

Table 45. Known and alleged sources of HIV/AIDS (Total of positive answers)

	Migrant		Non Migrant	
	Spontaneously	On probing	Spontaneously	On probing
Right answers	225 (98.6%)	679 (85.7%)	234 (96.2%)	733 (86.2%)
Wrong answers	3 (0.4%)	113 (14.3%)	9 (3.8%)	117 (13.8%)

The categories of questions included sexual intercourse including with wife, with multiple partners or prostitutes, use of non sterile syringe and of old razor blade at the barber shop, shaking hand, eating from the same plate and sharing the same bathroom than an HIV positive person, blood transmission, mosquito bite, mother to child during pregnancy. The proportion of right answers is more important when the question was answered spontaneously. Wrongly founded prejudices regarding the communality with HIV positive patients are reflected in the answers on probing. There is no difference in the quality of the understanding of the causes of HIV transmission between migrants and non migrants.

4.6.3 Attitude

Table 46. Do you think that you yourself are in danger of getting HIV/AIDS (n(%))

	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
No	88 (71.54)	16 (88.89)	104 (73.76)	61 (88.41)	70 (75.27)	131 (80.86)	235 (77.56)
Yes	35 (28.46)	1 (5.56)	36 (25.53)	8 (11.59)	13 (13.98)	21 (12.96)	57 (18.81)
Don't know	0	1 (5.56)	1 (0.71)	0	10 (10.75)	10 (6.17)	11 (3.63)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0.0015<0.005

Only out of five of the respondents, including one out of four for migrant respondents see themselves as in danger of getting HIV/AIDS. More than twice male migrants consider themselves at risk, as compared to male non migrants.

Table 47. Reaction to condom use (n(%))

	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
Les sexual satisfaction	10 (8.13)	0	10 (7.09)	6 (8.70)	3 (3.23)	9 (5.56)	19 (6.27)
Difficult to use	3 (2.44)	0	3 (2.13)	1 (1.45)	2 (2.15)	3 (1.85)	6 (1.98)
No problem	61 (49.59)	9 (50.00)	70 (49.65)	18 (26.09)	19 (20.43)	37 (22.84)	107 (35.31)
Other	2 (1.63)	0	2 (1.42)	4 (5.80)	2 (2.15)	6 (3.70)	8 (2.64)
No answer	47 (38.21)	9 (50.00)	56 (39.72)	40 (57.97)	67 (72.04)	107 (66.05)	163 (53.80)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0<0.05

The great majority of the respondents either expressed no problem for the use of the condom, or did not provide answer. Around 10% of both migrants and non migrant found that condoms were difficult to use, provided less sexual satisfaction or had other undisclosed reasons for disliking it. In the FGD and during physical examination, female migrant did not (dare to) provide details about their disliking of condoms, hinting at a stronger taboo than for non-migrant female respondents.

Table 48. What respondent think about man who are using condom (n(%))

	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
Positive attitude	62 (50.41)	7 (38.89)	69 (48.94)	33 (47.83)	21 (22.58)	54 (33.33)	123 (40.59)
Negative attitude	3 (2.44)	1 (5.56)	4 (2.84)	1 (1.45)	5 (5.38)	6 (3.70)	10 (3.30)
Does not know/does not care	21 (17.07)	3 (16.67)	24 (17.02)	5 (7.25)	10 (10.75)	15 (9.26)	39 (12.87)
No answer	37 (30.08)	7 (38.89)	44 (31.21)	30 (43.48)	57 (38.71)	87 (53.70)	131 (43.23)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0.0007<0.05

Expressed negative attitudes are very few, while positive attitudes balance with the absence of answer and indifference. Female respondents have consistently a less positive attitude towards a man using condoms than men themselves. Migrants have a more positive attitude towards using condoms than non-migrants.

Table 49. What respondent thinks of woman, if she asks for a condom before sexual intercourse (n(%)).

	Migrant	Non-Migrant	Total
Positive attitude	68(55.28)	47(68.12)	115(59.90)
Negative attitude	6(4.88)	0	6(3.13)
Does not know/does not care	22(17.89)	16(23.19)	38(19.79)
No answer	27 (21.95)	6 (8.70)	33 (17.19)
Total	***123(100)***	***69(100)***	***192 (100)***
			p=0.021<0.05

More than 40% of the respondents do not have a positive attitude towards a woman who asks to use a condom before a sexual intercourse. The use of condom is likely to be linked in the mentalities to the existence of multiple partners. While the private life of a male partner is not questionable, the request for a condom from a female partner, can stigmatise her as having socially unacceptable behaviour.

Table 50. Capacity to recognize (n(%))

A man with AIDS	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
No	121 (98.37)	17 (94.44)	138 (97.87)	64 (92.75)	84 (90.32)	148 (91.36)	286 (94.39)
Yes	1 (0.81)	1 (5.56)	2 (1.42)	5 (7.25)	9 (9.68)	14 (8.64)	16 (5.28)
Don't know	1 (0.81)	0	1 (0.71)	0	0	0	2 (0.66)
							p=0.0115<0.05
A woman with AIDS							
No	104 (84.55)	6 (33.33)	110 (78.01)	56 (81.16)	68 (73.12)	124 (76.54)	234 (77.23)
Yes	19 (15.45)	9 (50.00)	28 (19.86)	10 (14.49)	16 (17.20)	26 (16.05)	54 (17.82)
Don't know	0	3 (16.67)	3 (2.13)	3 (4.35)	9 (9.68)	12 (7.41)	15 (4.95)

							p=0.0872<0.05
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***

The great majority of the sample thinks that it is not possible to recognize a man with AIDS, while a lesser majority think the same for a woman. This idea that a woman could show AIDS signs (while a man could not) illustrate once again the gender discrimination in the community where a girl would be more easily stigmatise for alleged signs of HIV/AIDS than a man. This internalised discrimination would even come in a greater proportion from women themselves, with up to 50% of female migrants thinking they can spot a girl with AIDS, while only 6% think they can do the same for a man.

Table 51. The extent to which someone from the respondent's family would continue to interact/would marry a person if someone from that person's family was known to have HIV/AIDS (n(%))

Continue to interact	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
No	60 (48.78)	9 (50.00)	69 (48.94)	25 (36.23)	35 (37.63)	60 (37.04)	129 (42.57)
Yes	61 (49.59)	7 (38.89)	68 (48.23)	38 (55.07)	48 (51.61)	86 (53.09)	154 (50.83)
Don't know	2 (1.63)	2 (11.11)	4 (2.84)	6 (8.70)	10 (10.75)	16 (9.88)	20 (6.60)
							p=0.0141<0.05
Marry							
No	83 (67.48)	14 (77.78)	97 (68.79)	38 (55.07)	69 (74.19)	107 (66.05)	204 (67.33)
Yes	23 (18.70)	0	23 (16.31)	14 (20.29)	14 (15.05)	28 (17.28)	51 (16.83)
Don't know	3 (2.44)	3 (16.67)	6 (4.26)	6 (8.70)	5 (5.38)	11 (6.79)	17 (5.61)
Only with HIV -test result	14 (11.38)	1 (5.56)	15 (10.64)	11 (15.94)	4 (4.30)	15 (9.26)	30 (9.90)
Other	0	0	0	0	1 (1.08)	1 (0.62)	1 (0.33)
							p=0.7348>0.05
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***

HIV/AIDS prejudices also extend to the family of the alleged HIV positive person. Almost half of the respondents would stop interacting with a person if someone from that person's family was known to have HIV/AIDS. More than two thirds (67.33%) of the respondents will

refuse to marry a healthy person if someone else from his/her family is known to be HIV positive. Female migrants appear once again to be the more conservative with 50% "stopping interaction" and 78% "refusing to marry". This table illustrates the social cost of having HIV/AIDS, not only for the infected person but for the entire family, likely to lose the social support they need more than ever.

Table 52. Declared reaction of the respondent in case a member of the family becomes HIV positive (n(%))

	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
Care for the person, give support	105 (85.37)	13 (72.22)	118 (83.69)	56 (81.16)	72 (77.42)	128 (79.01)	246 (81.19)
Expel from family	5 (4.07)	1 (5.56)	6 (4.26)	0	5 (5.38)	5 (3.09)	11 (3.63)
Don't know	7 (5.69)	1 (5.56)	8 (5.67)	9 (13.04)	10 (10.75)	19 (11.73)	27 (8.91)
Other	6 (4.88)	3 (16.67)	9 (6.38)	4 (5.80)	6 (6.45)	10 (6.17)	19 (6.27)
Total	***123 (100)***	***18 (100)***	***141 (100)***	***69 (100)***	***93 (100)***	***162 (100)***	***303 (100)***
							p=0.3089>0.05

Support systems for the sick person seem to be well functioning within the family where the majority of respondents (81.19%) plan to give care and support to the family member who will feel ill. Expulsion from the family is considered an option for 3.6% of the respondents with the higher percentage for female migrants. No major differences can be noted between migrants and non migrants.

Chapter five

Discussion

Among the sample, the average household size 6.9 is higher than the national (5.9), among of the household size at migrant household is even higher than non migrant household.

Majority of respondents are from 18 to 24 years old. Migrant respondents are younger than non migrants.

Education related indicators rear much better for the sample than at district and national level. It may indicate that poor and very poor were not reached with the free health camp.

The preparation of the sample relying primarily on self employment in agriculture is much lower than the district average. Migration does not always prove to be a successful alternative for extra stable income. 9.24 percent of the sample had contacted an STI (including a single case of HIV positive). This percentage is much higher than recorded national average.

The sample show good records in terms of food security compared to the district averages, a high level of school enrolment and of literacy compared to district and region averages. It is highly possible that the methodology used (a free health camp opened to all) did not succeed in reaching out to the hard core poor.

Land related indicators show that the sample is situated in a lower national category in terms of land size and quality (irrigated), but on a higher side compared to district characteristics.

The size and the quality of the land discriminates also migrants and non migrants, and show that migrants benefit from lesser access to agricultural production at home than non-migrants.

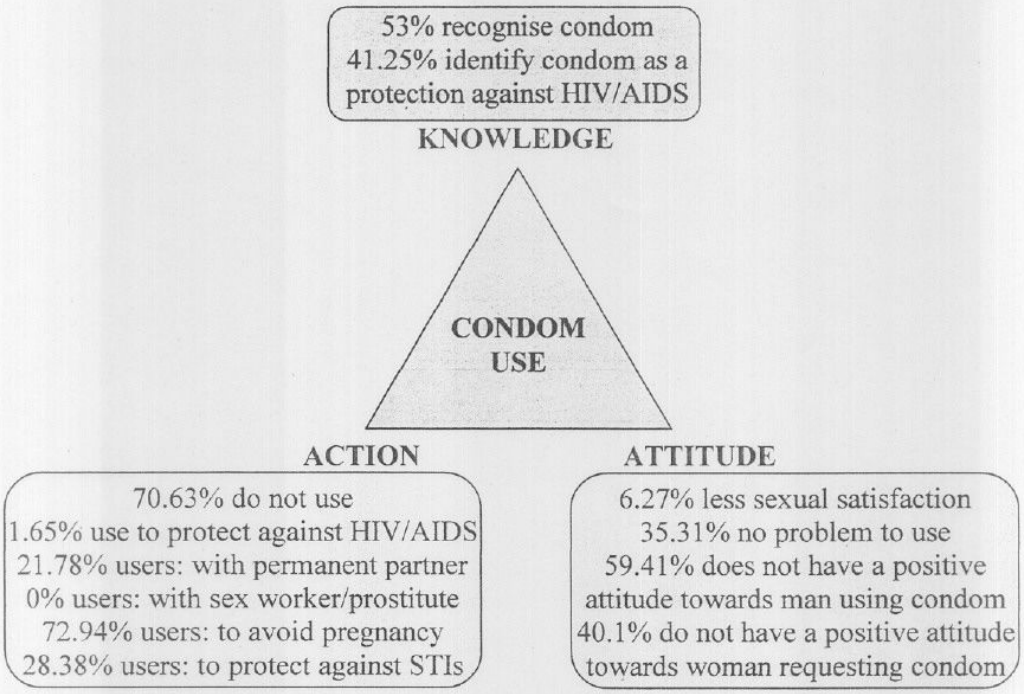
The lack of adequate health care is a pressing problem for the entire sample with 20% of the population incapable of working because of sickness / disabilities. Migrants have also lesser access to health care because of their greater incapacity to pay, but are less amenable to traditional healing practices than non-migrants.

Control over resources show a favourable position of both migrant and non migrant households, but within the households a clear gender based hierarchy in terms of control over resources and decisions pertinent to the entire household.

The main outcome the migrant's household gets out of migration can be counted in negative terms: one less member to be fed on income at the place of origin. The level of remittances is extremely low for the sample. This benefit, however is earned through great efforts, as the typical migrant would work under a type of attached labour arrangement, where benefits are low (no health costs coverage in case of accidents), and uncertain.

Of 303 samples tested one was HIV positive (0.33%), 5 had Hepatitis B (1.65%) and 26 had syphilis (8.58%). One male migrant worker was co infected with HBV and syphilis. The risk group is typically composed of individuals between 19 and 24 years old (twice as much infected by Syphilis than non-migrant). Although Syphilis can be easily treated, the mode of transmission is the same than for HIV/AIDS. Other factors expose the sample to a high risk: the non-recognition of condom use as a proper way to avoid infection, and the erroneous belief that they are not at risk. The main protective factors are the low level of sex activity and the preference for long term partners rather than sex workers / occasional partners. However, these factors are not sufficient to protect the sample from HIV/AIDS infection when they migrate to places where the prevalence is high.

Figure 2. Knowledge, action and attitude on condom use



Chapter six

Conclusion and recommendations

6.1 Conclusion

Internal and international migration is an important component of socio-economic situation in the Dadeldhura district. Almost every family has minimum one migrant worker. Poverty is the main underlying factor for sampled workers to migrate. Migration to India especially in Delhi, Punjab, and Mumbai is the only solution for the majority of them to survive the lack of food and income generating activities. Migration doubled in the last five years (compared to the previous five (1995-2001) years). One explanation may also be related to the construction of roads in the district in the last five years. This trend is expected to continue. There is no main difference in the socio-economic situation between migrant and non-migrant households, apart from land related criteria. The direct consequence is that non-migrant households are likely to start migrating, should their low income be impacted negatively by an unsuspected event (sickness, drought...).

This study shows that syphilis and HBV infections are still more common than HIV infections and that there is still a low prevalence of HIV infection in population of Dadeldhura district. However, the non recognition of condom use as a proper way to protect oneself against HIV/AIDS puts the population at risk of a greater epidemic. The benefits from migration for the household are very low and consist mainly in a reduced number of household members to be fed on the household income at the place of origin. Should the epidemic of HIV/AIDS start in a greater proportion, this fragile equilibrium would be directly threatened as the sick migrants would rely on the already insufficient income of the household. This situation would put many families below survival level.

6.2. Recommendations

6.2.1 Policy recommendations

Although attention and resources are concentrated at present on solving the current emergency, the start of the HIV/AIDS epidemic in Nepal should not be overlooked as it may well prove more deadly in the long term, if not given the proper attention.

At present, the Strategic Plan for HIV and AIDS in Nepal competes on the agenda of health post workers with numerous other National Plans. However, if given proper attention, the above mentioned Strategy may avert a major health disaster, as international experience has shown that prevention programs need to be started early to be effective.

For this reason, it is recommended that the NCASC be moved from the Ministry of Health to depend directly from the Prime Minister's Office or from the National Planning Commission. This higher status would ensure a better coordination between medical and non-medical partners and would signal the importance HMG/N places into its existence.

Health institutions do not share information on HIV/AIDS and STD prevalence in their areas of responsibility and as a consequence it is impossible for the NCASC to build up a global picture of HIV/AIDS and STDs in the country that fully reflects the reality. Once the NCASC would have been given the place it deserves within HMG/N, attention should be given to collect reliable information as a basis for a comprehensive mapping exercise of the HIV/AIDS epidemic in Nepal.

HIV/AIDS spreads because of migratory movements; migration has its roots in poverty. HMG/N should ensure that the benefits the PRSP and of poverty reduction activities under the 10th plan reaches out to places of origin of migrants, like Dadeldhura district.

Neither bilateral nor regional agreements exist to protect the rights of Nepalese migrants at their place of migration. HMG/N should put special efforts to reach agreements with countries where most of Nepalese migrants go (India), and not prioritise countries where the greatest share of remittance comes from (South East Asia and Middle East).

These bilateral agreements should be linked to a registration system at the district level, whereby each Nepalese migrating for work purposes abroad would be acknowledged by HMG/N and by the ratifying country as a *bona fide* beneficiary for the rights and benefits included in this agreement. An additional advantage of this registration would be to monitor the STD/HIV status of the population at greater risk of infection.

The main problem facing health system in Dadeldhura is the lack of proper manpower. A system of financial and non-financial incentives and result oriented management should be worked out (or improved) to motivate dedicated medical staff to take posts in remote areas. The shifting of medical staff around the country should be part of a general long term plan reflecting the needs of the health system and the aspirations of the medical staff. Care should be brought to ensure that staff remain in a post long enough to get a sense of ownership of their post and achieve tangible results.

Some of the major problems facing vulnerable populations in Nepal are the little availability of HIV tests and the delays between the tests and the results (due to the distance between the person's place and the testing place). This time between the test and the result delivery allows for further contamination of the person's spouse and sex partners. The availability of a testing kit in each VDC should be taken as a priority by WHO/UNAIDS.

6.2.2 Recommendations to International organizations and international NGOs

The HIV/AIDS pandemic is in still in Nepal at its concentrated stage, as it affects mainly targeted and identifiable populations. As such, an investment in the improvement of prevention counselling and treatment programs is efficient. Each dollar invested now on the issue will save more lives than if it is invested in five years time.

Special attention should be put to develop a field base awareness of the extent of the problem and create interventions that are not Kathmandu based but owned by the field level institutions. Impositions of plans, programs, one shot activities on the already fragile field structure would prove totally unsustainable. Previous multilateral projects on HIV/AIDS have had little else impact in Dadeldhura than leaving some computers behind.

6.2.3 Recommendations to national NGOs

Awareness raising projects on HIV/AIDS have so far primarily focused in Dadeldhura on school going children. However it appears that awareness messages regarding sexual behaviour and protection means are not shared with the adults. There is a need for prevention programs targeted to adults, especially the 19-35 years. Awareness raising projects should have a light structure, build on existing Community Based Organizations (CBOs), and mainstream the HIV/AIDS awareness message within their regular meetings. To this end, training of trainers should be organized for motivators of these groups focusing on clear, crucial and easily deliverable key messages and on process to facilitate a change of attitude of the groups' members. Radios are also very popular in the district. Already existing awareness messages on radios should be encouraged.

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Appendix

Appendix 1. Work schedule

Time available from 1 September to 25 February 2001 (5 month 25 days)

No.	Activity	Time period by days	Time period by date					
			Sep.	Oct.	Nov.	Dec.	Jan.	Feb.
1	Literature review	122	1-30	1-31	1-30	1-31		
2	Proposal writing	11	25-30	1-5				
3	Questionnaire preparation	20		8-28				
4	Group discussion format	20		8-28				
5	Logistic for field work	11		29-	8			
6	First field visit/testing	4			10-14			
7	Preparation for second field visit	7			15-21			
8	Second field visit	23			22	14		
9	Found data collectors	6			10-14 22-24			
10	Training for interviews	1			24			
11	Field data collection	19			25-	13		
12	Blood sample collection	19			25-	13		
13	Collected information/data translation	6				14-20		
14	Data entry	15				15-30		
15	Exit table	6				20-26		
16	Fill in table, polishing	10				27-	5	
17	Laboratory result analyzing	5					5-10	
18	Analyze 1st draft	5					11-15	
19	Comments	10					16-25	
20	2nd draft	8					26-	3
21	Edition of 2nd draft	12						4-15
22	Report	-						15

Appendix 2. First field visit

Date: **From 10/11/2001 to 14/11/2001**
Place: **Kathmandu – Nepalganj – Dadeldhura – Nepalganj - Kathmandu**

Research team:

Researcher/Doctor – Dr. George Pkhakadze
Assistant/translator – Mr. Rajan Kumar Bhattarai (NCASC)

Field visit objectives:

1. Meeting with officials (the DDC chairman, the DHO, local and international organizations).
2. Checking of the questionnaire with at least 5 respondents.
3. Checking the format for FGD with FWHV (one group) or community motivators.
4. Ensuring the logistic for blood collection (fridge, transport, food, accommodation, etc.).
5. General medical examination facility (availability health post, equipment, etc.).
6. Collecting all available data and report regarding study.
7. Choose the VDC (based on available data and meetings with local Government bodies, NGOs, INGOs, UN agencies).

Work plan

No	Date	Activity	Location / Place	Total time duration	Comments
1	11/Nov.	Departure from Kathmandu to Nepalganj	Kathmandu Airport	From 12:00 to 13:00	Flight delay
2	11/Nov.	Departure from Nepalganj Airport to Konalpur	Nepalganj	From 13:00 to 14:00	By bus
3	11/Nov.	Departure from Kohalpur to Attaria	Nepalganj/Konapur	From 13:30 to 19:00	By jeep
4	11/Nov.	Departure from Attaria to Dadeldhura	Attaria	From 19:30 to 23:30	By jeep
5	11/Nov.	Accomodatio in Doho lodge	Dadeldhura	23:50	
6	11/Nov.	Contact by telephone to DHO, DDC, GTZ, several NGOs and contact persons in Dadeldhura	Dadeldhura	From 8:00 to 9:00	DDC like and another NGOs start working from 10:00. I contact only with some NGOs and DHO.
7	11/Nov.	Accommodation in GTZ guesthouse	Dadeldhura	9:30-9:50	Nice guesthouse, clean, with hot water facility and nice cook
8	11/Nov.	Meeting with Mr. Pashupati Nath Jha – District Program Advisor GTZ Food for Work Program	Dadeldhura	From 10:00 to 10:20	Collect information about program, present district situation and available data. Present study project.
9	11/Nov.	Meeting with Mr.	Dadeldhura	From 10:20	Collect information

		Mahesh Khadka - UNDP support programme "Rural Energy Development Program"		to 12:40	about program, present district situation and available data. Present study project
10	11/Nov.	Meeting with Mr. Bishnu Bhatta – "Rural Empowerment Development Center"	Dadeldhura	From 10:40 to 12:50	Collect information about program, present district situation and available data. Present study project
11	11/Nov.	Meeting with Dr. Lok Raj Paneru - DHO	Dadeldhura	From 11:10 to 12:40	Gave letter from NCASC. Collect information about present district situation and available data. Present study project. Discuss about future VDCs were possible to do study. Logistic related blood collection and fridge, facility for physical examination, and etc. Planing meeting with SHPO.
12	11/Nov.	TEAM Hospital	Dadeldhura	From 13:30 to 14:00	Collect information about present district situation and available data (HIV/AIDS and STIs cases). Present study project
13	11/Nov.	Meting with Mr. Bhod Raj Bhatta - DDC vice-chairman	Dadeldhura	From 14:10 to 14:25	Chairman was absent (official visit to China). Collect information about present district situation and available data. Present study project
14	11/Nov.	Meting with two NGO members in DDC office. Mr. Gog Raj Joshi – "Rural Empowerment Forum", Mr. Mr. Paban Karki – "Partnership for District Development Program" (Program support by UNDP), and 5 members from both NGOs.	Dadeldhura	From 14:25 to 14:45	Collect information about programme, present district situation and available data. Present study project
15	11/Nov.	GTZ office Focus Group Discussion with Community Motivators	Dadeldhura	From 15:30 to 16:30	See attachment No. 00

16	12/Nov.	Meeting with Mr. Pashupati Nath Jha – District Programme Advisor GTZ Food for Work Programme	Dadeldhura	From 9:30 to 10:20	Specify VDCs by poverty indicators etc. Final recommendation about VDCs. Recommendation for the study project.
17	12/Nov.	Meting in DDC office with executives.	Dadeldhura	From 10:25 to 10:40	Find transport facility, road facility (regarding VDCs), logistic aspects, collecting data, etc. Collect report
18	12/Nov.	Meting with two NGO members "Rural Empowerment Forum" and "Partnership for District Development Program". Checking questionnaire.	Dadeldhura	From 10:40 to 13:40	Brief orientation of questionnaire (English version) for 5 NGO members. Convince 5 volunteers to check questionnaire.
19	12/Nov.	TEAM Hospital	Dadeldhura	From 13:40 to 14:10	Collect HIV/AIDS & STIs data. Also found laboratory facility (centrifuge machine, fridge, etc.)
20	12/Nov.	Meeting with Dr. Lok Raj Paneru - DHO	Dadeldhura	From 14:20 to 15:20	Finalise collected information about VDCs. Making brief plan of action. Arrange meeting for 24/11/2001 with District all SHPO in-charge. Finalise logistic aspects.
21	12/Nov.	Meting with Mr. Habhajit Karmacharya – "Rural Women Development an Unity Centre "	Dadeldhura	From 15:20 to 15:45	Collect information about programme, present district situation and available data. Present study project. Decide to organise together FGD with Women activists in Amargadi Municipality approximately 28/11/2001
22	12/Nov.	Meting with Mr. Gopal Thapa Magar – District Field Officer/UNICEF	Dadeldhura	From 15: 55 to 16:25	Collect information about programme, present district situation and available data. Present study project. Decide organise two FGD one in Dandaban

					second in Dewaldibyapur.
23	12/Nov.	Meting with Mr. Khem Raj Joshi - Dadeldhura Red Cross Society	Dadeldhura	From 16:30 to 16:50	Collect information about programme, present district situation and available data. Present study project.
24	12/Nov.	Meting with 4 VDCs representatives in GTZ office	Dadeldhura	From 16:50 to 17:30	Interviewers recruitment. Explain study objectives and questionnaire module.
25	13/Nov.	TEAM Hospital	Dadeldhura	From 9:00 to 10:00	Collecting data (data recording and management in the hospital very bad to found one information it is necessary to visit hospital sever times. Local staff are very friendly and co-operative, international staff "very busy")
26	13/Nov.	Departure from Dadeldhura to Konalpur	Dadeldhura	From 11:00 to 21:00	By local bus.
27	13/Nov.	From Kohalpur to Nepalganj hotel	Nepalganj	22:00	By jeep.
28	14/Nov.	Departure from Nepalganj Airport to Kathmandu	Nepalganj / Kathmandu	12:00	By air.

Outcome:

During 3 days field visit research team met: District authorities (DDO vice-chairman, DHO), NGOs ("Rural Empowerment Development Centre", "Rural Empowerment Forum", "Rural Empowerment Forum", TEAM Hospital, Dadeldhura Red Cross Society, and "Rural Women Development an Unity Centre "), UNDP supported programs ("Partnership for District Development Program", "Rural Energy Development Program"), UNICEF district field officer, International Organization (GTZ).

In the meeting time with organizations, researcher presented, study objectives, methodology and durration of the project. Also were done discussions about study/selected VDCs. Researcher tried to collect latest data of district/VDCs (STI, HIV/AIDS, poverty, migration, education, etc.).

Meeting with local NGOs gave possibility to find interviewers for the study. Also organize Focus Group Discussion in different VDCs and mobilize communities for the study by informing people before Health Camp starts.

Meeting with DHO and TEAM Hospital staff made clear picture of blood and uro specimen collection and management (lab-assistants, centrifuge, fridge, ice box, etc.).

Meeting with DHO made possible to organize meeting with all SHPO in Dadeldhura District. Also identify facility of SHP for physical examination.

Meeting with NGOs gave possibility to check 5 questionnaires.

Meeting with Community Motivators from GTZ office gave opportunity to check the format for Focus Group Discussion.

Logistic aspect was regulated with GTZ office and DHO. Accommodation of research team in Amargari Municipality was arranged in GTZ guesthouse, in Dewaldibyapur SHP guesthouse, in Jogbudha, DHO recommend local guesthouse.

Transportation in the District was arranged with TEAM Hospital driver (See attachment: Contracts).

VDCs were selected based on collected information from organizations, STIs data (from DHO), HIV/AIDS data (from TEAM Hospital) and geographical location (see table below). Based table was identified 4 VDCs: Nawadurga, Belapur, Dewaldibyapur, Jogbuda, and Amargadi Municipality.

Appendix 3. Medicine and equipment used in Free Health Camp

Medicine, medical and lab equipment used in the Health Camp for physical examination and blood/uro-genital testing.

No	Name	Quantity
1	VITACURE (Multivitamin Capsules)	1000 tab.
2	PORPHYROCIN –500mg. (Erythromycin)	300 tab.
3	PARACETAMOL – 500mg.	1000 tab.
4	Co-trimoxazole – 480mg.	1000 tab.
5	FERROUS SULPHATE TABLETS I. P. – 200mg (equivalent to approx. 60 mg. Ferrous Iron)	2000 tab.
6	AMOXYCICLLIN – 500mg.	1000 tab.
7	DOXYCYCLINE – 100mg.	1000 tab.
8	ASPIRIN – 300mg.	500 tab.
9	FORTIPLEX (Vitamin B-Complex Capsules with C and Zinc)	1000 tab.
10	HAEMATINIC CAPSULES-500mg	500 tab.
11	IMODOUM – 2mg.	100 tab.
12	STREPSILS	100 tab.
13	ZOXAN (Ciprofloxacin Hydrochloride Tablets IP)– 500mg.	300 tab.
14	B-Complex tablets – 500mg.	1000 tab.
15	ULFAM-40 (Famotadine tablets USP) – 40mg.	280 tab.
16	Calcium lactate BP – 300mg. (calcium-39mg)	1000 tab.
17	Folic Acid Tablets IP (F-VIT)-5mg.	1000 tab.
18	PROTOGYL FORTE (Metronidazole tablets BP) – 400mg.	400 tab.
19	Siozole (Omeprazde Capsules IP) – 20mg.	100 tab.
20	Fam-O 20 (Famotidine USP) – 20mg.	500 tab.
21	Albendazol – 400mg.	100 tab.
22	Con-Zellin (alcohol swabs)	700 pieces
23	Medical hand Plast (4 different size)	8 pieces
24	Disposable syringe – 5ml.	500 pieces
25	Disposable syringe – 2ml.	200 pieces
26	Hypodermic needles, thin-walled (0.60x25mm.)	1000 pieces
27	Brand Evacuated Blood Collection Tubes (Tube size 125x16mm.)	900 pieces
28	Blood tube box	5 pieces
29	Examination Gloves	2000 pieces
30	Micro Slides (size: 75mm. Long x25mm.wide. Thickness: 1.35mm.)	500 pieces
31	Micro Slides Box	20 pieces
32	Condoms	2000 pieces
33	Ice boxes with ice substitute (one for 31 tube second for 500 tube)	2 pieces
34	Extra ice substitute (for ice boxes)	5 pieces
35	Bags (for Doctor, for lab-assistant, and doctors assistant)	3 pieces
36	Scissors	1 piece
37	Cotton	1 kg.
38	Spirit	1000 ml.
39	Stethoscope	2 piece
40	Mechanical centrifuge	1 piece
41	Turn quite	1 piece

Appendix 4. Tables

Table I. Age and gender distribution of sampled Head of Household (n=303) (n(%))

Age group	Migrant			Non-migrant			Total
	Male	Female	Total	Male	Female	Total	
19 to 24	77(62.60)	13(72.22)	90(63.83)	34(49.28)	57(61.29)	91(56.17)	181(59.74)
25 to 29	10(8.13)	1(5.56)	11(7.80)	2(2.90)	8(8.60)	10(6.17)	21(6.93)
30 to 34	3(2.44)	1(5.56)	4(2.84)	11(15.94)	11(11.83)	22(13.58)	26(8.58)
35 to 39	11(8.94)	1(5.56)	12(8.51)	5(7.25)	3(3.23)	8(4.94)	20(6.60)
40 to 44	6(4.88)	0	6(4.26)	2(2.90)	7(7.53)	9(5.56)	15(4.95)
45 to 49	16(13.01)	2(11.11)	18(12.77)	15(21.74)	7(7.53)	22(13.58)	40(13.20)
Total	***123(100)***	***18(100)***	***141(100)***	***69(100)***	***93(100)***	***162(100)***	***303(100)***

Table II. Distribution of age in sampled population (%))

Age group	Gender		Total
	Female	Male	
0 to 4	76(3.66)	98(4.72)	174(8.37)
5 to 9	97(4.67)	155(7.46)	252(12.13)
10 to 14	101(4.86)	144(6.93)	245(11.79)
15 to 19	104(5.00)	135(6.50)	239(11.50)
20 to 24	129(6.21)	132(6.35)	261(12.56)
25 to 29	89(4.28)	86(4.14)	175(8.42)
30 to 34	88(4.23)	68(3.27)	156(7.51)
35 to 39	64(3.08)	70(3.37)	134(6.45)
40 to 44	56(2.69)	64(3.08)	120(5.77)
45 to 49	52(2.50)	60(2.89)	112(5.39)
50 to 54	21(1.01)	48(2.31)	69(3.32)
55 to 59	13(0.63)	20(0.96)	33(1.59)
60 to 64	27(1.30)	28(1.35)	55(2.65)
65 to 69	6(0.29)	12(0.58)	18(0.87)
70 to 74	8(0.38)	12(0.58)	20(0.96)
75 to 79	5(0.24)	7(0.34)	12(0.58)
80 to 84	0	2(0.10)	2(0.10)
90 to 94	1(0.05)	0	1(0.05)
Total	***937 (45.09)***	***1141 (54.91)***	***2078(100)***

Table III. Educational level (n (%))

	Migrant	Non-Migrant	Total
No education	198 (19.82)	262 (24.28)	460 (22.14)
Non-formal education	220 (27.5)	160 (19.6)	380 (23.5)
Kindergarten only	85 (10.6)	124 (15.2)	209 (12.9)
Primary school	223 (27.8)	230 (28.2)	453 (28.0)
Lower secondary	114 (17.9)	108 (13.2)	222 (13.7)
Secondary	88 (11.0)	81 (9.9)	169 (10.4)
Passed SLC	53 (6.6)	87 (10.6)	140 (8.7)
College	15 (1.9)	26 (3.2)	41 (2.5)
University Degree	2 (0.2)	1 (0.1)	3 (0.2)
Postgraduate	1 (0.1)	0	1 (0.1)
Total	***999(100)***	***1079(100)***	***2078(100)***
			p=0.0002<0.05

Table IV. Main activities (n (%))

	Migrant	Non-Migrant	Total
Self-employed in agriculture	195(19.52)	232(21.50)	427(20.55)
Self-employed in other sectors	43(4.30)	50(4.63)	93(4.48)
Student	293(29.33)	349(32.34)	642(30.90)
Daily wage worker	13(1.30)	5(0.46)	18(0.87)
Weekly wage worker	2(0.20)	0	2(0.10)
Monthly wage worker	77 (7.71)	108(10.01)	185(8.90)
Piece rate worker, sharecropper	3 (0.30)	1(0.09)	4(0.19)
Un-employed, looking/available for job	0	3(0.28)	3(0.14)
Un-willing to work or retired	140(14.01)	104(9.64)	244(11.74)
Unable to work (Sick or Disabled);	224(22.42)	218(20.20)	442(21.27)
Domestic work	7(0.70)	7(0.65)	14(0.67)
Total	***999(100)***	***1079(100)***	***2078(100)***
			p=0.0021<0.05

Table V. Marital status in sampled population (n (%))

Marital status	Male	Female	Total
Never married	859(45.40)	72(39.78)	931(44.80)
Married	973(51.43)	108(59.67)	1081(52.02)
Widow/widower	57(3.01)	1(0.55)	58(2.79)
Divorced	3(0.16)	0	3(0.14)
Total	***1892(100)***	***181(100)***	***2078(100)***

Table VI. Frequency of buying rice (n(%))

	Migrant	Non-Migrant	Total
Daily	11(7.8)	7(4.3)	18(5.9)
Twice a week	0	4(2.5)	4(1.3)
Weekly	1(0.7)	4(2.5)	5(1.7)
Fortnightly	8(5.7)	1(0.6)	9(3.0)
Monthly	35(24.8)	26(16.0)	61(20.1)
Less frequently than a month.	38(27.0)	43(26.5)	81(26.7)
			p=0.0029<0.05
No to buy	48(34.0)	77(47.5)	125(41.3)
			p=0.0173<0.05
Total	***141(100)***	***162(100)***	***303(100)***

Table VII. Source of drinking water (n(%))

	Migrant	Non-Migrant	Total
Tap/pipe inside house	4(2.8)	5(3.1)	9(3.0)
Tap/pipe outside house	105(74.5)	129(79.6)	234(77.2)
Tube well	1(0.7)	0	1(0.3)
Manual well	22(15.6)	16(9.9)	38(12.5)
Hand pump	1(0.7)	0	1(0.3)
Ponds, rain water, dam/Spring	0	2(1.2)	2(0.7)
River/stream	8(5.7)	10(6.2)	18(5.9)
Total	***141(100)***	***162(100)***	***303(100)***
			p=0.3886>0.05

Table VIII. Availability of toilet (n(%))

	Migrant	Non-Migrant	Total	
Inside house	1(0.7)	1(0.6)	2(0.7)	
Outside house	67(47.5)	100(61.7)	167(55.1)	
Outside house, shared	9(6.4)	6(3.7)	15(5.0)	*p=0.3181> 0.05*
Not available	64(45.4)	55(34.0)	119(39.3)	*p=0.0001< 0.05*
Total	***141(100)***	***162(100)***	***303(100)***	

Table IX. Access to Assets (n(%))

	Migrant	Non-Migrant	Total	
Livestock				
Cattle and buffalo/cows	140(99.29)	159(98.15)	299(98.68)	*P=0.6261> 0.05*
Sheep, goats	75(53.19)	101(62.35)	176(58.09)	*P=0.0698> 0.05*
Poultry/rabbits/fish	29(20.57)	2(1.23)	31(10.23)	*P=0< 0.05*
Horses and donkeys	1(0.71)	1(0.62)	2(0.66)	
Other	40(28.37)	43(26.54)	83(27.39)	*P=0.7222> 0.05*
Transportation				
Motorcycles	1(0.71)	0	1(0.33)	
Bicycles	9(6.38)	8(4.94)	17(5.61)	*P=0.5857> 0.05*
Tractors/other vehicles	0	4(2.47)	4(1.32)	
Carts (Bull, Donkey)	13(9.22)	25(15.43)	38(12.54)	*P=0.2115> 0.05*
Other				
Radios	85(60.28)	108(66.67)	193(63.70)	*P=0.2491> 0.05*
Televisions	2(1.42)	8(4.94)	10(3.30)	*P=0.2491> 0.05*
Video cassette recorders	0	1(0.62)	1(0.33)	*P=0.112> 0.05*
Refrigerators/ freezers	0	1(0.62)	1(0.33)	
Electric or gas cookers	0	5(3.09)	5(1.65)	
Sewing/knitting machines	4(2.84)	5(3.09)	9(2.97)	
Water / treadle pump	0	2(1.23)	2(0.66)	
Fans / coolers	2(1.42)	4(2.47)	6(1.98)	
Ornaments	113 (80.14)	131(80.86)	244(80.53)	*P=0.8742> 0.05*
Others	1(0.71)	1(0.62)	2(0.66)	
Total	141(100)	162 (100)	303(100)	

Table X. Distance from house to nearest health facility (n(%))

	Migrant	Non-Migrant	Total
5-15min	52(36.9)	42(25.9)	94(31.0)
15-30min	52(36.9)	52(32.1)	104(34.3)
30-60min	11(7.8)	26(16.0)	37(12.2)
1-3hour	26(18.4)	34(21.0)	60(19.8)
3-6hour	0	4(2.5)	4(4.3)
2-more days	0	4(2.5)	4(1.3)
Total	141(100)	162(100)	303(100)
			p=0.0111<0.05

Table XI. Gender decision making involvement for migrant HH

	Daily Income Management						Family Planning						Education						Decision to Migrate						Decision to seek medical help in case of sickness						Total	
	Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted			
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	N	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
HH male	25	20.33	96	78.05	2	1.63	34	27.64	86	69.92	3	2.44	16	13.01	91	73.98	16	13.01	25	20.33	96	78.05	2	1.63	17	13.82	103	83.74	3	2.44	123	100
HH female	16	88.89	1	5.56	1	5.56	11	61.11	6	33.33	1	5.56	14	77.78	3	16.67	1	5.56	17	94.44	0	0.00	1	5.56	15	83.33	2	11.11	1	5.56	18	100
Spouse female	8	6.50	55	44.72	68	55.28	8	6.50	49	39.84	66	53.66	15	12.20	46	37.40	62	50.41	5	4.07	57	46.34	61	49.59	8	6.50	57	46.34	58	47.15	123	100
Spouse male	2	11.11	6	33.33	10	55.56	0	0.00	4	22.22	14	77.78	3	16.67	5	27.78	10	55.56	1	5.56	7	38.89	10	55.56	0	0.00	8	44.44	10	55.56	18	100
Unmarried son	12	9.84	34	27.87	76	62.30	12	9.84	31	25.41	79	64.75	17	13.93	32	26.23	73	59.84	7	5.74	39	31.97	76	62.30	8	6.56	41	33.61	73	59.84	122	100
Unmarried daughter	1	5.56	2	11.11	15	83.33	1	5.56	1	5.56	16	88.89	1	5.56	3	16.67	14	77.78	1	5.56	1	5.56	16	88.89	1	5.56	1	5.56	16	88.89	18	100
Married son	12	9.76	48	39.02	63	51.22	12	9.76	43	34.96	68	55.28	14	11.38	41	33.33	62	50.41	8	6.50	54	43.90	61	49.59	7	5.69	55	44.72	61	49.59	123	100
Married daughter	1	5.56	4	22.22	13	72.22	1	5.56	4	22.22	13	72.22	1	5.56	4	22.22	13	72.22	1	5.56	4	22.22	13	72.22	1	5.56	4	22.22	13	72.22	18	100
Father	10	9.71	50	48.54	43	41.75	12	11.65	42	40.78	49	47.57	11	10.68	47	45.63	45	43.69	9	8.74	50	48.54	44	42.72	9	8.74	51	49.51	43	41.75	103	100
Mother	0	0.00	3	37.50	5	62.50	0	0.00	3	37.50	5	62.50	1	12.50	2	25.00	5	62.50	0	0.00	3	37.50	5	62.50	0	0.00	3	37.50	5	62.50	8	100
Brother	9	11.69	41	53.25	27	35.06	9	11.69	39	50.65	29	37.66	9	11.69	39	50.65	29	37.66	6	7.79	43	55.84	28	36.36	5	6.49	45	58.44	27	35.06	77	100
Sister	0	0.00	0	0.00	3	100	0	0.00	0	0.00	3	100	0	0.00	0	0.00	3	100	0	0.00	0	0.00	3	100	0	0.00	0	0.00	3	100	3	100
Male relative	5	8.62	30	51.72	23	39.66	6	10.34	28	48.28	24	41.38	3	5.17	34	58.62	21	36.21	3	5.17	32	55.17	23	39.66	2	3.45	34	58.62	22	37.93	58	100
Female relative	0	0.00	0	0.00	1	100	0	0.00	0	0.00	1	100	0	0.00	0	0.00	1	100	0	0.00	0	0.00	1	100	0	0.00	0	0.00	1	100	1	100
Male servant	3	6.67	22	48.89	20	44.44	4	8.89	24	53.33	17	37.78	4	8.89	23	51.11	18	40.00	2	4.44	26	57.78	17	37.78	3	6.67	25	55.56	17	37.78	45	100
Female servant	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Male no relative	1	5.56	11	61.11	6	33.33	3	16.67	11	61.11	4	22.22	1	5.56	11	61.11	6	33.33	1	5.56	12	66.67	5	27.78	1	5.56	12	66.67	5	27.78	18	100
Female no relative	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Table XII. Gender decision making involvement for non-migrant HH

	Daily Income Management						Family Planning						Education						Decision to seek medical help in case of sickness						Total	
	Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted		Main decision maker		Consulted		Not consulted			
	n	%	n	%	n	%	n	%	n	%	n	%	N	%	n	%	n	%	n	%	n	%	n	%	n	%
HH male	30	44.12	37	54.41	1	1.47	27	39.71	39	57.35	2	2.94	19	27.94	43	63.24	6	8.82	22	32.35	45	66.18	1	1.47	68	100
HH female	78	83.87	13	13.98	2	2.15	45	48.39	46	49.46	2	2.15	59	63.44	29	31.18	5	5.38	63	67.74	28	30.11	2	2.15	93	100
Spouse male	9	13.04	35	50.72	25	36.23	7	10.14	34	49.28	28	40.58	8	11.59	37	53.62	24	34.78	6	8.7	39	56.52	24	34.78	69	100
Spouse female	11	12.5	29	32.95	53	60.23	4	4.55	29	32.95	60	68.18	10	11.36	34	38.64	49	55.68	6	6.82	32	36.36	50	56.82	88	100
Unmarried son	9	13.04	34	49.28	26	37.68	8	11.59	33	47.83	28	40.58	7	10.14	38	55.07	24	34.78	5	7.25	39	56.52	25	36.23	69	100
Unmarried daughter	2	2.15	32	34.41	54	58.06	4	4.3	25	26.88	64	68.82	4	4.3	35	37.63	54	58.06	3	3.23	36	38.71	54	58.06	93	100
Married son	7	10.14	36	52.17	26	37.68	5	7.25	36	52.17	28	40.58	6	8.7	37	53.62	26	37.68	3	4.35	37	53.62	29	42.03	69	100
Married daughter	7	7.53	29	31.18	57	61.29	7	7.53	27	29.03	59	63.44	10	10.75	33	35.48	50	53.76	6	6.45	33	35.48	54	58.06	93	100
Father	5	9.8	21	41.18	25	49.02	4	7.84	19	37.25	28	54.9	3	5.88	22	43.14	26	50.98	3	5.88	21	41.18	27	52.94	51	100
Mother	5	7.58	22	33.33	39	59.09	7	10.61	20	30.3	39	59.09	3	4.55	24	36.36	39	59.09	3	4.55	26	39.39	37	56.06	66	100
Brother	4	10	18	45	18	45	2	5	17	42.5	21	52.5	2	5	18	45	20	50	3	7.5	18	45	19	47.5	40	100
Sister	3	7.14	19	45.24	20	47.62	5	11.9	18	42.86	19	45.24	5	11.9	18	42.86	19	45.24	5	11.9	19	45.24	18	42.86	42	100
Male relative	3	10	17	56.67	10	33.33	2	6.67	16	53.33	12	40	1	3.33	17	56.67	12	40	3	10	16	53.33	11	36.67	30	100
Female relative	1	4.35	12	52.17	10	43.48	4	17.39	7	30.43	12	52.17	1	4.35	12	52.17	10	43.48	1	4.35	11	47.83	11	47.83	23	100
Male servant	1	6.25	10	62.5	5	31.25	1	6.25	8	50	7	43.75	0	0	12	75	14	87.5	0	0	9	56.25	7	43.75	16	100
Female servant	0	0	5	45.45	6	54.55	3	27.27	3	27.27	5	45.45	1	9.09	6	54.55	4	36.36	3	27.27	3	27.27	5	45.45	11	100
Male no relative	0	0	4	50	4	50	0	0	2	25	6	75	1	12.5	4	50	3	37.5	0	0	4	50	4	50	8	100
Female no relative	1	16.67	3	50	2	33.33	1	16.67	2	33.33	3	50	0	0	4	66.67	2	33.33	0	0	4	66.67	2	33.33	6	100

Table XIII. Duration of migration and age group distribution in sampled population level (n(%))

Age group	3-6 months	6-12 months	1-2 years	2-4 years	4-6 years	More than 6 years	Other	Total
5 to 9	0	0	0	0	0	1(1.52)	0	1(0.34)
15 to 19	7(18.42)	1(5.00)	6(10.53)	7(9.09)	1(2.86)	1(1.52)	0	23(7.77)
20 to 24	10(26.32)	1(5.00)	6(10.53)	16(20.78)	10(28.57)	5(7.58)	0	48(16.22)
25 to 29	7(18.42)	2(10.00)	8(14.04)	12(15.58)	9(25.71)	11(16.67)	0	49(16.55)
30 to 34	2(5.26)	6(30.00)	9(15.79)	12(15.58)	8(22.86)	14(21.21)	0	51(17.23)
35 to 39	2(5.26)	6(30.00)	7(12.28)	12(15.58)	1(2.86)	12(18.18)	0	40(13.51)
40 to 44	5(13.16)	0	6(10.53)	6(7.79)	4(11.43)	10(15.15)	1(33.33)	32(10.81)
45 to 49	1(2.63)	2(10.00)	7(12.28)	5(6.49)	0	5(7.58)	0	20(6.76)
50 to 54	3(7.89)	1(5.00)	3(5.26)	4(5.19)	2(5.71)	5(7.58)	0	18(6.08)
55 to 59	1(2.63)	0	3(5.26)	2(2.60)	0	1(1.52)	1(33.33)	8(2.70)
60 to 64	0	1(5.00)	1(1.75)	1(1.30)	0	0	0	3(1.01)
65 to 69	0	0	0	0	0	0	1(33.33)	1(0.34)
70 to 74	0	0	0	0	0	1(1.52)	0	1(0.34)
75 to 79	0	0	1(1.75)	0	0	0	0	1(0.34)
Total duration	***38(12.84)***	***20(6.76)***	***57(19.26)***	***77(26.01)***	***35(11.82)***	***66(22.30)***	***3(1.01)***	***296(100)***
Grand Total	***38(100)***	***20(100)***	***57(100)***	***77(100)***	***35(100)***	***66(100)***	***3(100)***	***296(100)***

Table XIV. Duration of migration by gender in sampled population (n(%))

	0-6 months	6-12 months	1-2 years	2-4 years	4-6 years	More then 6 years	Other	***Total***
Male	32(13.17)	18(7.41)	46(18.93)	63(25.93)	29(11.93)	53(21.81)	2(0.82)	***243(100)***
Female	6(11.32)	2(3.77)	11(20.75)	14(26.42)	6(11.32)	13(24.53)	1(1.89)	***53(100)***

Table XV. Destination of migration in sampled population (n(%))

Where	By country	Total
Nepal	Number (%)	Number (%)
Hills	23(36.51)	23(7.77)
Terai	11(17.46)	11(3.72)
Kathmandu valley	18(28.57)	18(6.08)
Mountain Nepal		
FWDR	8(12.70)	8(2.70)
MWDR	1(1.59)	1(0.34)
CDR	1(1.59)	1(0.34)
EDR	1(1.59)	1(0.34)
Total	***63(100)***	
Urban India		
Mumbai	52(22.32)	52(17.57)
Madras	18(7.73)	18(6.08)
Delhi	66(28.33)	66(22.30)
Hariyana	7(3.00)	7(2.36)
Bangalore	8(3.43)	8(2.70)

Kolcota	1(0.43)	1(0.34)
Total Urban India	152 (65.24)	
Rural India		
Punjab	59(25.32)	59(19.93)
Jammu	3(1.29)	3(1.01)
Gujarat	5(2.15)	5(1.69)
U.P. (except Delhi)	14(6.01)	14(4.73)
Total Rural India	81(34.76)	
Total India	***233(100)***	
Total		***296(100)***

Table XVI. Year of first migration

Year	n(%)
Before 1991	51(36.2)
1991	4(2.8)
1992	8(4.7)
1993	2(1.4)
1994	5(3.5)
1995	9(6.4)
1996	11(7.5)
1997	13(9.2)
1998	14(9.9)
1999	6(4.3)
2000	13(9.2)
2001	5(3.5)
Total	***141(100)***

Table XVII. Year period for return home

Months	n(%)
Dasain/Tihaar	42(29.79)
New Year	21(14.89)
Winter	26(18.44)
Uncertain	19(13.48)
Other local festival	33(23.4)
Total	***141(100)***

Table XVIII. Category of employer

Employer	n(%)
Govt./Public sector	7(4.96)
Foreign establishment	1(0.71)
Indian National	70(49.65)
Other	3(2.13)
Unknown	60(42.55)
Total	***141(100)***

Table XIX. Occupation in the migration time

Occupation	n(%)
Watchman	42(29.79)
Cook	8(5.67)
Driver	5(3.55)
Vehicle helper	11(7.80)
Factory worker	9(6.38)
Agriculture worker	0
Student	9(6.38)
Construction worker	42(29.79)
Other	0
No response	15(10.64)
Total	***141(100)***

Table XX. Location of work place

Location	n(%)
In the city	85(60.28)
Near the city	14(9.93)
Rural area	8(5.67)
Isolated place	1(0.71)
Other	33(23.40)
Total	***141(100)***

Table XXI. Hours work per day

Hours	n	(%)
1	1	0.71
4	2	1.42
5	2	1.42
6	4	2.84
7	3	2.13
8	35	24.82
Total	***47***	***33.33***
9	1	0.71
10	3	2.13
12	26	18.44
14	1	0.71
18	1	0.71
24	6	4.26
No response	56	39.72
Total	***141***	***100***

Table XXII. Days work in a month

Days	n(%)
1-5	1(0.71)
5-10	0
10-15	2(1.42)
15-20	1(0.71)
20-31	82(58.16)
No response	55(39.01)
Total	***141(100)***

Table XXIII. Reason for leaving the last employer

	n(%)
Low pay	23(16.31)
Bad treatment	8(5.67)
Removed	2(1.42)
Unacceptable work conditions	25(17.73)
Back home on holidays but not live the job	83(58.86)
Total	***141(100)***

Table XXIV. Months per year can migrant worker support family with the income get or the food produced in Nepal

Months	n(%)
0	64(45.39)
1	7(4.96)
2	11(7.8)
3	5(3.55)
4	11(7.8)
5	4(2.84)
6	14(9.93)
7	1(0.71)
8	5(3.55)
9	5(3.55)
10	14(9.93)
11	0
12	0
Total	***141(100)***

Table XXV. Interest rate per year charged on debt

	n(%)
12-24	4(11.76)
24-36	20(58.82)
36-48	2(5.88)
48-60	2(5.88)
60-72	0
72-84	1(2.94)
84-108	1(2.94)
Above 108	4(11.76)
Total	***34(100)***

Table XXVI. Distribution HIV/STIs by gender and migration status (n(%))

	Migrant			Non-migrant			***Total***
	Male	Female	Total	Male	Female	Total	
HIV/STIs positive	13 (46.43)	2(7.14)	15(53.57)	7 (25.00)	6(21.43)	13(46.43)	***28(100)***
							p=0.4333>0.05

Table XXVII. HIV/STIs positive by age group (n(%))

Age group	HIV/STIs positive		
	Male	Female	Total
19 to 24	11(55.00)	6(75.00)	17(60.71)
25 to 29	1(5.00)	1(12.50)	2(7.14)
30 to 34	2(10.00)	0	2(7.14)
35 to 39	2(10.00)	0	2(7.14)
40 to 44	2(10.00)	0	2(7.14)
45 to 49	2(10.00)	1(12.50)	3(10.71)
Total	***20(100)***	***8(100)***	***28(100)***
			p=0.66>0.05

Table XXVIII. With whom the respondent use condom (n(%))

	Migrant			Non-Migrant			Total
	Male	Female	Total	Male	Female	Total	
With wife/husband	11(8.94)	1(5.56)	12(8.51)	13(18.84)	19 (20.43)	32 (19.75)	44 (14.52)
With girlfriend/boyfriend	15(12.20)	0	15(10.64)	7(10.14)	0	7(4.32)	22 (7.26)
With occasional partner	1(0.81)	0	1(0.71)	1(1.45)	0	1(0.62)	1(0.33)
With partner he/she did not know before	7(5.69)	0	7(4.96)	0	0	0	7(2.31)
Sex worker/prostitute	0	0	0	0	0	0	0
Other	0	4(22.22)	4(2.84)	1(1.45)	9(9.68)	10 (6.17)	14 (4.62)
No use condom	89(72.36)	13(72.22)	102 (72.34)	47(68.12)	65 (69.89)	112 (69.14)	214 (70.63)
Total	***123(100)***	***18(100)***	***141(100)***	***69(100)***	***93(100)***	***162 (100)***	***303 (100)***

Appendix 5. प्रश्नावली Questionnaire (Nepali version)

प्रश्नावली

१. अन्तर्वाता लिनेको नाम : हस्ताक्षर : संकेत :

२. सुपरिवेक्षकले परिक्षण गरेको मिति (महिना/ दिन वर्ष) _____/_____/_____

स्थल परिक्षण	हो	होइन	परिक्षणको नाम	
रुजु	हो	होइन	रुजुगर्नेको नाम	
कैफियत	लागत		बाहेक	
कारण				

३. सुपरिवेक्षकको हस्ताक्षर

(A) *व्यक्तिगत विवरण*

क. सं.	प्रश्नहरु	संकेत	
A1.	मिति (महिना/दिन/वर्ष ____/____/_____		
A2.	गा. वि. स.को संकेत :		
A3.	अन्तर्वार्ता दिनेको संकेत :		
A4.	धर्म १. हिन्दु, २. बौद्ध, ३. मुस्लिम, ४. क्रिस्चियन, ५. अन्य		
A5.	जात : १. ब्राम्हण, २. क्षेत्री, ३. बैश्य, ४. शुद्र, ५. अन्य		
A6.	जन्म स्थान (जिल्ला)		
A7.	मातृ भाषा : १. नेपाली, २. डोटेली, ३. अन्य		
A8.	अन्य वाट आएका कामदारको पति/पत्निको बसाई १. घरमा, २. कामदार सगै, ३. अन्य		
A9.	पति / पत्निसंग कति समयमा भेट हुन्छ ? १. मुख्य चाड पर्वमा मात्र २. १-३ महिना सम्ममा, ३. खेती गर्ने समयमा, ४. अन्य		
A10.	कामदारको पति/पत्निले काम गर्छ । (घरमा हर्न समामान्य काम लगायत) ०. गर्दैन, १. गर्छ		

(B) पारिवारीक ढाँचा

क्र. सं.	क घरमुली संगको सम्बन्ध	ख लिङ्ग	वर्ष (पुरा भएको)	ग वैवाहिक अवस्था	पाँच वर्ष भन्दा माथिको सबै व्यक्ति			१० वा सो भन्दा वढी वर्षको सबै व्यक्ति			
					घ साक्षरता	ङ शिक्षा	च वर्तमान पेशा	छ मुख्य गतिविधि	ज कामको लागि घर छोडेको तीन महिना भयो	झ घर छाडेको अवधि	ञ गएको स्थान
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											

क. १. घरमुली, २. पति/ पत्नि, ३. छोरा/छोरी (अविवाहित), ४. छोरा/छोरी (विवाहित), ५. बुवा/आमा, ६. दाजु भाई/दिदीबैनी, ७. अन्य नाता, ८, नोकर, ९. नाता छैन

ख. १. पूरुष, महिला

ग. १. अविवाहित, २. विवाहित, ३. विदुर/विधुवा, ४. पारपाचुके गरेको

घ. १. कुनै पनि भाषामा पढ्न/लेख्न जानेको छ ? ०. छैन १. छ

ङ. १. औपचारिक शिक्षा छैन, २. पूर्व प्राथमिक शिक्षा, ३. प्राथमिक शिक्षा, ४. निम्न माध्यमिक शिक्षा, ५. माध्यमिक शिक्षा, ६. एस. एल. सी. मात्र, ७.स्नातक, ८. स्नाकोत्तर

च. १. ०. छैन, १. छ

छ. १. कृषिमा आफ्नै काम, २. अन्य क्षेत्रमा आफ्नै काम, ३. विद्यार्थी, ४. दैनिक ज्यालादारी ५. साप्ताहिक ज्यालादारी, ६. मासिक ज्यालादारी, ७. अधिया/ठेक्का गर्ने कामदार ८. वेरोजगार/रोजगारको खोजीगर्दै, ९. कामगर्न अनिच्छुक, १०. कामगर्न असक्षम, ११. घरायसी काम, १२. अन्य

ज. ०. छैन, १. छ

झ. १. ०-६ महिना, १. ६ - १२ महिना, ३. १२ वर्ष, ४. २ - ४ वर्ष, ५. ४-७ वर्ष, ६. ६ वर्ष भन्दा माथि ७. अन्य

ञ. यदि नेपालमा भए १. पहाड, २. तराई, ३. काठमाण्डौं, ४. सुदुर पश्चिमाञ्चल, ५. मध्यपश्चिमाञ्चल ६. पश्चिमाञ्चल, ७. मध्यमाञ्चल, ८. पूर्वाञ्चल ९. भारत, यदि भारत भए प्रान्त उल्लेख गर्ने, १०. अन्य सार्क राष्ट्र - देशको नाम लेख्ने, ११. अन्य देश - देशको नाम लेख

(C) आर्थिक तथा सामाजिक तथ्याङ्क
ऋण तथा स्रोत विवरण

खानाको विवरण

No.	प्रश्न	संकेत
C1.1.	के त्यहाँ कुनै महत्वपूर्ण चाड थियो र अथवा के गत सात दिनमा घरमा कुनै पाहुना थिए । ०= थियो १ = थिएन	
C1.2.	यदि ग १.१ को उत्तर नकारात्मक भए, गत सात दिनमा कति दिन घरमा कस्ता खानाहरु प्रमुख खानाको रुपमा खाइयो ।	खाएको दिनहरु
	आरामदायी खाना / खानाको नाम उल्लेख गर्ने	
C1. 1.	आरामदायी खाना१ मासु	
C1. 2.	आरामदायी खाना२ खिर	
C1. 3.	आरामदायी खाना३ अण्डा	

No.	प्रश्न	संकेत
C1.4.	गत ३० दिनमा कति दिन तपाइले प्रयाप्त खाना खानु भएन ? (दिनहरुको संख्या)	
C1.5.	गत १२ महिनामा तपाइको घरमा कति महिना कमसे कम एक दिन पनि नखाई बस्नु भो । महिनाको संख्या)	
C1.6.	चामल कतिपटक किन्नु हुन्छ ।	
1.	दैनिक	
2.	हप्तामा २ पटक	
3.	साप्ताहिक	
4.	पाक्षिक	
5.	मासिक	
6.	एक महिनामा एक पटक भन्दा कम	
C1.7.	तपाईको हालको खाद्यभण्डारले कति समम पुग्छ ? (हप्तामा)	

पानी तथा सफाइको विवरण

No.	प्रश्नहरु	संकेत
C1.8.	खानेपानीका स्रोतहरु : १. घर भित्र धारो तथा पाईप २. घर बाहिर धारो तथा पाईप ३. ट्यूबेल ४. इनार ५. हयाण्ड पाइप ६. पोखरी, परेको पानी, नहरको पानी ७. वर्षाको पानी ८. नदी/खोलाको पानी ९. अन्य	
C1.9.	पानीको स्रोत बाहिर भएको खण्डमा, स्रोत समम पुरन कति समय लाग्छ ।	मिनेटमा
C1.10	पाइखाना सुविधा १. घर भित्र, २. घर बाहिर ३. घर बाहिर साझा ४. छैन, ५. अन्य	

बासस्थानको अवस्था

No.	प्रश्न	संकेत
C1.11	घरको स्वामित्वको तथ्याङ्क १. खुल्ला सार्वजनिक जग्गामा बनाइएको २. एकल स्वामित्वमा रहेको ३. नातेदार तथा अरु कसैले प्रदान गरेको ४. सरकार द्वारा प्रदान ५. भाडामा, ६ मालिकको सम्पत्ति ७. अन्य	
C1.12	भित्ताको प्रकार १. खडाइको, २. ढुङ्गा/माटो ३. ढुङ्गा बालुवाको ४. इट्टाको	
C1.13	छानाको प्रकार १. खरको छाना, २. ढुङ्गा, ३. जस्ता, ४. टायलको	

भूमीको विवरण

No.	प्रश्न	संकेत
C1.14	के तपाईको जमिन छ ? ०= छैन (प्रश्न ग १. १८ मा जानुस) १= छ	
C1.15	कस्तो प्रकारको जमिन हो ? १. सिंचित, २. असिंचित ३. खेतिपातीको लागि होइन (एक भन्दा बढी उत्तरहरु सम्भव छ ।	
C1.16	जमिनको क्षेत्रफल रोपनीमा उल्लेख गर्ने ।	

सम्पत्ति विवरण

No.	प्रश्न	संकेत
C1.17	घरको स्वामित्वमा रहेको सम्पत्तिको संख्या (एक भन्दा बढी स्वीकार्य हुने छ)	
	सम्पत्तिको प्रकार	
वस्तुभाउ		
C1.17.1	गाई भैंसी	
C1.17.2	भेडा, बाख्रा	
C1.17.3	पंक्षि, खरायो, माछा	
C1.17.4	ढोडा तथा गद्या	
C1.17.5	अन्य	
यातायात साधन		
C1.17.6	मोटरसाइकल	
C1.17.7	साइकल	
C1.17.8	ट्रयाक्टर तथा अन्य गाडीहरु	
C1.17.9	गाडा (साँढे, गद्या)	
अन्य		
C1.17.10	रेडियो	
C1.17.11	टेलीभिजन	
C1.17.12	भिडियो क्यासेट रेकर्डर	
C1.17.13	रेफ्रिजिरेटर/फ्रिजर	
C1.17.14	कुकर विद्युतिय/ग्यास	
C1.17.15	सिउने तथा बुन्ने मेसिन	
C1.17.16	पानी पम्प तथा ट्रेडल मेसिन	
C1.17.17	पंखा तथा कुलर	
C1.17.18	गरगहना	
C1.17.19	लुगाधुने मेसिन	
C1.17.20	अन्य	

शैक्षिक विवरण

No.	प्रश्न	संकेत	
C1.18.	के तपाइको गा. वि. स. मा कुनै शिक्षण संस्था छन् ? ०=छैन (प्रश्न ग १ २४ मा जानुहोस्)		
C1.19.	कस्तो किसिमको शिक्षण संस्था क्रियासिल छन् ? १.सरकारी विद्यालय २.निजी विद्यालय ३. बोर्डिङ्ग स्कूल ४.अन्य		
C1.20.	घरबाट पाठसाला जान कति समय लाग्छ ? १. ३० मिनट, २. १-२ घण्टा ३. २-३ घण्टा ४. ४-६ घण्टा ५. ६ घण्टा भन्दा बढी		
C1.21.	के शिक्षाको लागि पैसा तिर्नु भयो ? ०= तिरिन (प्रश्न २४ मा जानोस) १= तिरें		
C1.22.	यदि तपाइको घरका बालबच्चा स्कूल जाँदैनन् भने किन ? १. विद्यालालयीय शिक्षा प्रति अविश्वास , २. घरमा काम गराउन पर्ने भएकोले ३.अध्ययन शुल्क महङ्गो भएकोले ४. स्कूल टाढा भएकोले ५. अन्य		

स्वास्थ्य विवरण

No.	प्रश्न	संकेत		
C1.23	तपाइको गा. वि. स. मा. कस्तो किसिमको स्वास्थ्य सेवा उपलब्ध छ ? ० = छैन, १= छ			
C1.23.1	परम्परागत उपचार			
C1.23.2	आयुर्वेदिक औषधी			
C1.23.3	उपस्वास्थ्य चौकी			
C1.23.4	स्वास्थ्य चौकी			
C1.23.5	घरायसी औषधी			
C1.23.6	रासायनीक औषधि			
C1.23.7	वयक्तिगत अनुभव			
C1.23.8	अन्य			
C1.23.9	सरकारी अस्पताल			
C1.23.10	टिम अस्पताल			

No.	प्रश्न	संकेत	
C1.24	सबभन्दा नजिकको स्वास्थ्य चौकि घरबाट कति टाढा छ ? १. १५ मिनट २.१५-३० मिनट ३.३०- ६० मिनट ४. १-३ घण्टा ५. ३-६ घण्टा ६. ६-१२ घण्टा ७.१२-२४ घण्टा ८.१-२ दिन ९. दुई भन्दा बढी दिनहरु		
C1.25	तपाईको परिवारमा कोहि बिरामी हुँदा के तपाइको आर्थिक अवस्था सक्षम थियो ? डाक्टरलाई देखाउन) ०=थिएन, १ = थियो		
C1.26	जब तपाईको घरमा कोहि विरामी हुँदा के तपाईसंग औषधिहरु किन्ने पैसा थियो ? ०=थिएन, १=थियो		
C1.27	गत समयमा तपाइएको परिवारमा विरामी पर्दा कस्ता किसिमको औषधि सुविधा उपयोग गर्नु भयो । १. घरायसी औषधी २. आर्युवेदिक स्वास्थ्य केन्द्र ३. उपस्वास्थ्य केन्द्र ४. स्वास्थ्यकेन्द्र ५. औषधि पसल ६. व्यक्तिगत अनुभव ७. अन्य		
C1.28	तपाइले किन उक्त सुविधा उपयोग गर्नुभयो ? १. उक्त सेवामा विस्वास भएर, २. सस्तो सेवा भएर ३. नजिक भएर ४. परम्परा, ५. अन्य		

ऋद्दा साधन तथा सेवामा नियन्त्रण

समुदायीक स्तरमा

No.	प्रश्न	संकेत	
C2.1.	तपाईको घरमा भएको १८ वर्ष भन्दा माथिका व्यक्तिले गत गा. वि. स. वा जि. वि. स. को चुनावमा भाग लिए । ० = लिएन, १ = लिए		
C2.2.	वार्ड स्तरको कुनै पनि छलफलमा तपाइको परिवारको कुरा सुनिन्छ । मानिन्छ ? ० = सुनिन्न १ = सुनिन्छ ।		
C2.3	तपाइ व्यापार संगठनमा हुनु हुन्छ ? ० = छैन, १ = छ		

घर व्यवहारमा

C2.4	कार्य विभाजनमा लैङ्गिक विभेद				
Ser. No	परिवार सदस्यको सहभागिता (१० वा सो भन्दा बढी उमेर) निर्णयमा (क)				
	दैनिक आय व्यवस्थापन	परिवार नियोजन	शिक्षा	बसाई पर्ने निर्णय	विरामि भएको बेलामा उपचार खोजी
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
(क) १ = मुख्य निर्णायक २ = राय दिनेवाला, ३ = नपुछिनेवाला					

(D) वाह्य कामदार

No.	प्रश्न	संकेत	
D1.	तपाई कहिले कामको लागि समुन्द्र पार जानु भयो ?	साल	
D2.	पहिलो काममा लाग्नु भन्दा अघि कति समय वेरोजगार हुनुहुन्थ्यो ?	महिना	दिन

No.	प्रश्न	संकेत	
D3.	कामको प्रकृति : १. लामो समयको लागि नियमित रुपमा मासिक तलव पाउने गरि । २. नियमित र दैनिक ज्याला पाउने गरि । ३. कहिले काहि दैनिक ज्याला पाउने गरि । ४. ठेक्का ५. आफ्नै काम ६. अन्य		
D4.	तपाईको मालिक कुन दर्जामा पर्छन् ? १. सरकारी सार्वजनिक क्षेत्र । २. विदेशी संस्था । ३. भारतीय नागरिक । ४. अन्य ।		
D5.	तपाईले शुरुमा के काम गर्नु भयो ? १. वाच मेन २. भान्से ३. ड्राईभर ४. खलाँसी ५ फ्याक्ट्री कामदार ६. किसान ७. विद्यार्थी ८. निर्माण कामदार ९. अन्य		
D 6.	काम गरेको स्थान : १. शहरमा २. शहर नजिकै ३. दुर्गम क्षेत्रमा ४. विकट स्थान ५. अन्य		

D 7.	प्रति दिन कति घण्टा काम गर्नुहुन्छ ?	घण्टा	दिन
D 8.	एक महिनामा कति दिन काम गर्नुहुन्छ ?	दिन	
D 9.	एक महिनाको मजदुरी कति हुन्छ ?	रुपैयाँमा	
D10.	गत वाह्र महिनामा बुझेका ज्याला	रु	महिना
D11.	के तपाईले काम गरेको पैसा लिन वाकि छ ? छ भने कति महिनाको छ ?	महिना	

No.	प्रश्न	संकेत	
D12.	के तपाईले पहिलो मालिकलाई छोड्नु भयो ? ० = छैन, १ = छोडें		
D13.	अहिले तपाई कतिऔं ठाउँमा काम गर्दै हुनुहुन्छ ? १ = पहिलो २ = दोस्रो ३ = तेस्रो ४ = धेरै		
D14.	अघिल्लो साहु (मालिक) लाई किन छोड्नु भयो ? १ = थोरै पैसा २ = नराम्रो व्यवहार ३ = निकालिएको ४ = काम मन परेन		
D15.	अहिले गर्दै गरेको कामको लागि कुनै सहमति पत्रमा हस्ताक्षर गर्नु भएको छ ? ० = छ, १ = छैन		
D16.	उक्त सहमति पत्रमा तपाईलाई फाइदा हुने के कुरा उल्लेख गरिएको छ ? १ = ज्यालादार २ = कामको दर्जा ३ = बसाई ४ = खाना ५ = औषधी उपचार ६ = विदाहरु ७ = अन्य		
D17..	के तपाइले सहमतिभए अनुसार सुविधाहरु पाउनु भयोत ? ० = पाइन, १ = पाएं		
D 18.	काम गरेको ठाउँमा कुनै दुर्घटनामा पर्नु भा छ ? ० = छैन, १ = छ		
D 19.	यदि छ भने उपचार खर्च कस्ले बेहोर्‍यो ? १ = आफै, २ = मालिक ३ = अरु		
D 20.	तपाइको कार्यस्थलमा जिविकोपार्जन गर्न लाग्ने मासिक खर्च कति हो ?	रु.	
D 21.	तपाईको मासिक बचत कति हुन्छ ।	रु.	
D 22.	प्रतिमहिना कति पैसा घर पठाउनु हुन्छ ?	रु.	
D 23.	यो पाली यहाँ आएर कति खर्च/ किन मेल गर्नु भयो ?	रु	
1.	यातायातमा		
2.	सामान किनेको		
3.	नगद ल्याएको		
D 24.	स्थानिय कामदार नभएको कारण झेल्नु परेको प्रतिकुल परिस्थितिहरु ? ० = ठीकै छ १ = मालिकले शोषण गर्छन २ = सहकर्मीले ,, ,, ३ = सकर्मीलाई भन्दा कम पैसा ४ = अन्य	सुहाउँदो परिस्थिति	
D 25.	तपाइले पठाएको पैसाको प्रमुख उपयोगिता के हो ? १ = उपभोग २ = जमिन किन्नु ३ = घर बनाउनु ४ = ऋण तिर्नु, ५ = शिक्षा ६ = स्वास्थ्य, ७ = विवाह	खेस्रा प्रतिशत	

D 26.	यदि ऋणीतनु हुन्छ भने उक्त ऋणमा कति प्रतिशत ब्याज तिनु पर्छ ?	५	
D 27.	कति जना नेपालीहरुलाई काम खोज्न मद्दत गर्न भएको छ यदी तपाई भारतिय वा पाकिस्तानी हुनुहुन्छ भने ?		
D 28.	तपाईले कमाएको पैसा तथा उब्जाएको अनाजले तपाइको परिवारलाई कति महिनालाई धान्छ ?	महिना	

No.	प्रश्न	संकेत	
D 29.	कहिले फर्कनु भयो ? १ = दशैं, २ = नयाँ वर्ष ३ = जाडो याममा ४ = अनिश्चित ५ = अन्य पर्वमा		
D 31.	यदि तपाइले नेपालको सीमा पार गर्नु भएको भए, त्यो कहाँ हो ?	ठाउँ	
D 32.	के यस अस्थाइ बसाईले तपाइको परिवारमा कुनै सकारात्मक परिणाम ल्याएको छ ? ० = छैन, १ = छ, २ = अन्य		
D 33.	के यस बसाईले तपाइको लोग्ने/स्वास्नीमा कुनै सकारात्मक परिणाम देखिएको छ ? ० = छैन, १ = छ, २ = अन्य		
D 34.	कसरी यो काम पाउनु भयो ? १ = दलाली द्वारा २ = परिवार सदस्या तथा साथी भाई द्वारा, ३ = आफै		
D 35.	यदि दलालीले लगाएको भए तपाइले पेश्की वा उधारो लिएर दिनु भयो ? ० = होइन, १ = हो		
D 36.	यदि दलालले मिलाइदिएको भए तपाइलाई आफु यो काममा ठगिएको जस्तो लाग्छ ? ० = लाग्दैन, १ = लाग्छ		
D 37.	कमाएको पैसा कसरी घर पठाउनु हुन्छ ? १ = आफै, २ = बैंक द्वारा ३ = साथी तथा नातेदार द्वारा ४ = सहकर्मी द्वारा ५ = ल न इारःाँक्षद्वारा ६ = पठाउँदिन ७ = अन्य, उल्लेख गर्ने		

९७० शारीरिक सम्पर्क, कण्डम प्रयोग गर्ने तरिका र एच. आइ. भि. एड्स प्रति धारणा

No.	प्रश्न	संकेत	
E1.	के तपाई (कामदार) काम गर्न घर छोडी आएपछि योन सम्पर्क गर्नु भयो ? ० = छैन (क्र. स. ड ४ मा जानुस) १ = छ, २. अझसम्म यौनसम्बन्ध नै राखेको छैन ।		
E2.	कति पटक		
E3.	को संग ? १ = पत्नी, २ = केटी साथी, ३ = प्राय गर्ने गरेको साथी, ४ = चिनेको छैन, ५ = कोठीवाली (बेश्या) ६ = अन्य		
E4.	मानिसहरु कहिले कन्डम प्रयोग गर्छन ? ० = हरेक पटक, १ = परिक्षणकोलागि		

N	E5.	कुन उद्देश्यको लागि मानिसहरु कन्डम प्रयोग गर्छन ?	उल्लेख गर्ने	
			तुरुन्तै	परिक्षण पश्चात
			० = होइन, १ = हो	
	E 5. 1	थाहा छैन ।		
	E 5. 2	अपरिचित मानिस वा वेश्याबृती गर्ने संग		
	E 5. 3	गर्भ रहन नदिन		
	E 5. 4	महिनावारी भएको बेलामा		
	E 5. 5	एस. टी. आई बाट बचावको लागि		
	E 5. 6	एच. आई. भि/एड्स बाट बचावको लागि		
	E 5. 7	अन्य		

No.	प्रश्न	संकेत	
E6.	के तपाइले कहिले कन्डम प्रयोग गर्नु भएको छ ? ० = छैन (क्र. स. ड. १२ मा जानुस), १ = छ		
E7.	कहिले कहिले ? १ = सधैं, २ = अक्सर गरेर, ३ = कहिले काहीं, ४ = कहिले पनि होइन, ५ = अन्य		
E8.	को संग ? १ = पत्नी, २ = केटी साथी, ३ = अक्सर साथी ४ = अपरिचित महिला ५ = बेस्या, ६ = अन्य		
E9.	कन्डोम लगाई संभोग गर्दा कस्तो महसुस गर्नु भयो ? १ = कम आनन्द, २ = प्रयोग गर्न साग्रो ३ = ठीकै छ, ४ = अन्य		
E10.	कन्डोम लगाउनेहरु प्रति तपाइको धारणा कस्तो छ ? १ = लगाउनु राम्रो हो । २ = लगाउनु राम्रो होइन । ३ = मतलब छैन । थाहा छैन ।		
E11.	यदि महिलाले कन्डोम लगाउनलाई भनि भने तपाइलाई कस्तो लाग्छ ? १ = राम्रो हो, २ = राम्रो होइन ३ = मतलब छैन । थाहा छैन ।		
E12.	के नेपालमा एच. आई. भी / एड्स लागेको पाइएको छ ? ० = छैन, १ = छ, २ = थाहा छैन ३ = अन्य		
E13.	के तपाईले काम गर्ने ठाउँमा एच. आइ.		

	भी./एड्स पाइएको छ ? ० = छैन, १ = छ, २ = थाहा छैन, ३ = अन्य		
E14.	साथीहरु संग र परिवारमा तपाई एच. आई. भी एड्स सम्बन्धि कुरा गनु हुन्छ ? ० = गर्दिन, १ = गर्छु, २ = अन्य		
E15.	के तपाईले यौन सम्बन्धबाट सर्ने रोग संभवत एड्स लागनेको मानिस चिन्नु भएको छ ? १ = संगै काम गर्ने साथी २ = घर भएको स्थानको मानिस, ३ = अन्य		
E16.	के एच. आई. भी./एड्स लागेको मानिस चिन्न सकिन्छ ? ० = सकिदैन, १ = सकिन्छ २ = थाहा छैन ।		
E17.	के एच. आई. भी./एच. टी. आई लागेको आइमाइलाई चिन्न सकिन्छ ? ० = सकिदैन, १ = सकिन्छ, ३ = थाहाछैन		
E18.	के तपाई आफैलाई एच. आई. भी./एड्सको डर लागिरहेको छ ? ० = छैन, १ = छ २ = थाहा छैन, ३ = अन्य ।		
E19.	तपाईले आफूलाई एच. आई. भी. / एड्सबाट बच्न के गर्नु हुन्छ ?. १ = थाहा छैन २ = संभोग नगर्ने ३ = धेरै जनासंग सम्भोग नगर्ने ४ = कन्डम लगाउन् ५ = पेशागत वेश्या संग यौन सम्बन्ध नराख्ने ६ = अन्य		

E20.	कसरी एउटा मान्छेलाई एड्स/एच. आई. भी. लाग्छ ? ० = आफै, १ = अरुबाछ सर्छ ।	उल्लेख गर्ने तुरुन्तै	परिक्षण पश्चात ० = होइन १ = हो ।
E20.1	पत्तिलाई समेत यौन सम्बन्ध राख्दा		
E20. 2	एकभन्दा बढी / वेश्साहरुसंग यौन सम्बन्ध राख्दा		
E20. 3	एड्स लागेको मानिससंग हातमिलाउँदा		
E20. 4	स्टेरिलाईज गरेको सिरिन्ज प्रयोग नगरेमा		
E20. 5	सैलुनमा पाँत्ति छुराको प्रयोधग गर्दा		
E20. 6	एउटै थालमा खाँदा		
E20. 7	एड्स लागेको व्यक्तिको रगत अरुलाई दिएमा		
E20. 8	लामखुट्टेको टोकाइबाट		
E20. 9	एउटै चर्पी प्रयोग गर्दा		
E20. 10	बच्चा जन्मदा आमाबाट छोरा/छोरीमा सर्ने		
E20. 11	अन्य		

No.	प्रश्न	संकेत	
E21.	यदि एउटी केटी स्वस्थ्य छ तर उन्को परिवारको अन्य कसैलाई एच. आई. भी / एड्स छ भने तपाई उनी संग विहे गर्नु हुन्छ ? ० = गर्दिन, १ = गर्छु, २ = थाहा छैन, ३ = एच. आई. भी. रहित परिक्षणबाट ४ = अन्य		
E22.	कुने परिवारमा एच. आई. भी. / एड्स छ भने पत्ता लागेको तपाईको त्यस परिवारसंगको सम्बन्ध यथावत रहन्छ ? ० = रहदैन, १ = रहन्छ, २ = थाहा छैन ।		
E23.	यदि तपाइको आफ्नै परिवारको कसैलाई एच. आई. भी./एड्स लागेको थाहा पाइएमा के गर्नु हुन्छ ? १ = उस्को राम्रो हेरचाह २ = घरबाट निकाल्नु, ३ = थाहा छैन ४ = अन्य		

९० सहयोगको लागि धन्यबाद दिने !

सहभागिलाई कुनै प्रश्न छ कि भनि सोध्ने ।

सहभागिको
जिज्ञासा:.....
.....
.....
.....
.....
.....
अन्तर्वार्ताको बारेमा
टिप्पणी:.....
.....
.....
.....
.....

No.	प्रश्न	संकेत	
F1	शारीरिक परीक्षण		
F2	रगत परीक्षण तथा युरो जेनिटल स्पेशिमेन		
F3	युरो जेनिटल परीक्षणको सुचित धारणा		

Appendix 6. Questionaire (English version)

The Socio-economic Impact of HIV/ AIDS, STIs on the Communities of Migrant Workers in Dadeldhura District (Nepal)

QUESTIONNAIRE

1. Interviewer's name: signature: code:

2. Date checked by supervisor (mm/dd/yyyy): _____/_____/_____

Spot Check	Yes	No	Checked By	
Back Check	Yes	No	Back Check By	
Remarks	Include		Exclude	Redo
Reasons				

3. Supervisor's signature:

A. ***Personal Data***

No.	Question	Code	
A1.	Date (mm/dd/yyyy): _____/_____/_____		
A2.	VDC Code:		
A3.	Respondent Code:		
A4.	Religion: 1=Hindu; 2=Buddhist; 3=Muslim; 4=Christian; 5=Others		
A5.	Caste: 1=Brahmin; 2=Chetrhi; 3=Baishya, 4=Shudra; 5=Other.		
A6.	District of birth:		
A7.	Mother tongue: 1= Nepali; 2= Doteli; 3=Other.		
A8.	Residence of spouse during migration: 1=stay at home; 2=migrate with respondent; 3=other		
A9.	How often does s/he meet his/her spouse: 1=only during major festivals; 2=in intervals of 1-3 months; 3=during farming season; 4=other.		
A10.	Is the respondent's spouse working (in addition to usual domestic chores at home): 0=no 1= yes;;		

B. Household structure

Serial No.	A Relation to Head	B Sex	Age (In Completed Years)	C Marital Status	ALL PERSONS 5YEARS AND ABOVE			ALL PERSONS 10 YEARS AND ABOVE			
					D Literacy	E Education level	F Current Enrolment	G Main Activities	H Has left the house for more than three months for labour in the past year	I Duration of migration	J Destination of migration
1											
2											
3											
4											
5											
6											
7											
8											

A. 1=Head; 2=Spouse; 3=Son/daughter (unmarried); 4=Son/daughter (married); 5=Father/mother; 6=Brother/sister; 7=Other relative; 8=Servant; 9=Non relative.

B. 1=Male; 2=Female.

C. 1=Never married; 2=Married; 3=Widow/Widower; 4=Divorced.

D. Can read and write with understanding in any language? 0=No; 1=Yes.

E. 1=No formal education; 2=Kindergarten only; 3=Primary school; 4=Lower secondary; 5=Secondary; 6=Passed SLC; 7=College; 8=University Degree; 9=Postgraduate.

F. 0=No; 1=Yes.

G. 1=Self-employed in agriculture; 2= Self-employed in other sectors; 3=Student; 4=Daily wage worker; 5=Weekly wage worker; 6=Monthly wage worker; 7=Piece rate worker, sharecropper; 8=Un-employed, looking/available for job; 9=Un-willing to work or retired; 10=Unable to work (Disabled); 11=Domestic work; 12=other.

H. 0=No; 1=Yes.

I 1=0-6 months; 2=6-12 months; 3=1-2 years; 4=2-4 years; 5=4-6 years; 6=More then 6 years; 7=other:

J. If in Nepal: 1=Hills; 2=Terai; 3=Kathmandu valley; 4=FWDR; 5=MWDR; 6=WDR; 7=CDR; 8=EDR; 9=India-if in India, write the state or the city; 10=Other SAARC countries-write the country; 11=other countries-write the country.

C. Socio-economic status

C1 ACCESS TO RESSOURCES

(Access to Food)

No.	Question	Code	
C1.1	Was there an important festival, and / or did the household receive some guests in the past seven days? 0=no; 1=yes.		
C1.2	If no on C1.1, during the last seven days, for how many days were the following foods served in main meal eaten by the household?	No. of days served	
C1.2.1	Luxury Food 1	Meat		
C1.2.2	Luxury Food 2	Rice Pudding		
C1.2.3	Luxury Food 3	Egg		

No.	Question	Code	
C1.4	During the last 30 days, for how many days did your household not have enough to eat every day? (Number of days)		
C1.5	During the last 12 months, for how many months did your household have at least one day without enough to eat? (Number of month)		
C1.6	How often do you buy rice? 1=Daily; 2=Twice a week; 3=Weekly; 4=Fortnightly; 5=Monthly; 6=Less frequently than a month.		
C1.7	The staple stock you have at present would last for how long? (Number of weeks)		

(Access to water and Sanitation)

No.	Question	Code	
C1.8	Sources of drinking water: 1=tap/pipe inside house; 2=tap/pipe outside house; 3=tube well; 4=manual well; 5=hand pump; 6=ponds, rain water, dam; 7=spring; 8=river/stream; 9=other.		
C1.9	In case the water source is outside the house, how long does it take to reach there?	Minutes	
No.	Question	Code	
C1.10	Toilet facilities available: 1=inside house; 2=outside house; 3=outside house, shared; 4=not available; 5=other.		

(Access to Shelter)

No.	Question	Code	
C1.11	Ownership status of the house: 1=built on squatter/public land; 2=privately owned; 3=given by relative or other to use; 4=provided by Government; 5=rented; 6= employer's property; 7= other.		
C1.12	Type of wall: 1=dry grass; 2=stone/mud; 3=concrete; 4=bricks.		
C1.13	Type of roof: 1=dry grass; 2=stone; 3=zinc; 4=tiles.		

(Access to Land)

No.	Question	Code	
C1.14	Do you have land? 0=No (Skip to Q. No. C1.17); 1=Yes.		
C1.15	What is the type of land? 1= irrigated; 2=non –irrigated; 3=not for agriculture (More than one answers are acceptable)		
C1.16	Area of land in Ropanis:		

(Access to Assets)

No.	Question	Code	
C1.17	Number of selected assets owned by the household: (More than one answers are acceptable)		
0=No; 1=Yes			
	Asset Type		
Livestock			
C1.17.1	Cattle and buffalo/cows		
C1.17.2	Sheep, goats		
C1.17.3	Poultry/rabbits/fish		
C1.17.4	Horses and donkeys		
C1.17.5	Other		
Transportation			
C1.17.6	Motorcycles		
C1.17.7	Bicycles		
C1.17.8	Tractors/other vehicles		
C1.17.9	Carts (Bull, Donkey)		
Other			
C1.17.10	Radios		
C1.17.11	Televisions		
C1.17.12	Video cassette recorders		
C1.17.13	Refrigerators/ freezers		
C1.17.14	Electric or gas cookers		
C1.17.15	Sewing/knitting machines		
C1.17.16	Water / treadle pump		
C1.17.17	Fans / coolers		
C1.17.18	Jewelry		
C1.17.19	Washing machines		
C1.17.20	Others		

(Access to Education)

No.	Question	Code	
C1.18.	In your VDC you have any educational institution. 0=No (Skip to Q. No. C1.24); 1=Yes		
No.	Question	Code	
C1.19.	What kind educational institutions utilize you household to get education? 1=government school; 2=private school; 3=boarding school; 4=other.		
C1.20.	How far from your house school? 1=30-60 min; 2=1-2 hours; 3=2-4hours; 4=4-6 hours; 5=6-more hours.		
C1.21.	Did you pay money for education? 0=No (Skip to Q. No. C1.23); 1=Yes.		
C1.22.	If children from you household don't go to school reason is: 1=no trust the school program; 2=you need your children to work at home; 3=study cost expensive; 4=no school close to the household; 5=Other.		

(Access to Health)

No.	Question	Code	
C1.23	What kind Health facility available in your VDC:		
0=No; 1=Yes			
C1.23.1	Traditional healer;		
C1.23.2	Ayurvedic Health Center or an Homeopathic Clinic;		
C1.23.3	Sub Health Post;		
C1.23.4	Health Post;		
C1.23.5	Pharmacy;		
C1.23.7	Private practice;		
C1.23.8	TEEM Hospital;		
C1.23.9	Government Hospital;		
C1.23.10	Other.		
No.	Question	Code	
C1.24	Haw far from you house nearest health post? 1=5-15min; 2=15-30min; 3=30-60min; 4=1-3hour; 5=3-6hour; 6=6-12hour; 7=12-24 hour; 8=1-2day; 9=2-more days.		
C1.25	When last time someone from your family needed medical support, did you have the financial means to consult a medical person? 0=No; 1=Yes.		
C1.26	When last time someone from your family was sick, did you have the financial means to buy the necessary medicaments? 0=No; 1=Yes.		

C1.27	When last time someone from your family was sick what king medical facility / assistance you utilise? 1=Traditional healer; 2=Ayurvedic Health Centre or an Homeopathic Clinic; 3=Sub Health Post; 4=Health Post; 5=Pharmacy; 6=Private practice; 7=Other.		
C1.28	Why do you visit this institution / facility? 1=Trust this institution / facility; 2=Reasonable price; 3=Near for household; 4=Tradition to use this kind facility; 5=Other.		

C2. CONTROL OVER RESOURCES AND SERVICES

(At the community level)

No.	Question	Code	
C2.1.	Did persons above eighteen years of age in your household vote in the last elections of the ward or VDC or DDC chairman? 0=No; 1=Yes.		
C2.2	In the ward discussions do you feel that the voice of your household is being heard? 0=No; 1=Yes.		
C2.3	Do you belong to a trade union? 0=No; 1=Yes.		

(At the household level)

C2.4.	Gender decision making involvement;				
Serial No.	Involvement of Household Member (10 years & above) In Decisions Making (A)				
	Daily Income manage-ment	Family Planning	Edu cation	Decision to migrate	Decision to seek medical help in case of sickness
1					
2					
3					
4					
5					
6					
7					
8					

A. 1=Main decision maker; 2=Consulted; 3=Not consulted.

D. Migratory labour

No.	Question	Code		
D.1	When did you first went to abroad for Job?	Year		
D.2	How long you were unemployed before getting into the first job?	Month	Day	

No.	Question	Code	
D.3	Nature of Job: 1=Regular long term employment with monthly wage; 2=Regular employment with daily/piece wage; 3=Daily wage casual worker; 4=Piece wage casual worker; 5=Self employed; 6=Other.		
D.4	What is the category of your employer? 1=Govt./Public sector; 2=Foreign establishment; 3=Indian National; 4=Other.		
D.5	Your occupation in the migration time: 1=Watchman; 2=Cook; 3=Driver; 4=Vehicle helper; 5=Factory worker; 6=Agriculture worker 7=Student; 8=Construction worker; 9=Other.		
D.6	Location of work place: 1=In the city; 2=Near the city; 3=Rural area; 4=Isolated place; 5=Other.		
D.7	How many hours you work per day?	Hours	
D.8	How many days you work in a month?	Days	
D.9	What is the wage received: (calculate for month)	NRs.	
D.10	Total wage received for	NRs.	

	last 12 month:		
D.11	Do you have to get any arrears of salary from the present employer? How many months?	Months	
D.12	Have you changed the employer you first joined? 0=No; 1=Yes.		
D.13	Which place you are currently working? 1=First; 2=Second; 3=Third; 4=More.		
D.14	Why did you leave the last employer? 1=Low pay; 2=Bad treatment; 3=Removed; 4=Just did not like the work		
D.15	Did you sign any work contract (present job) 0=No; 1=Yes.		
D.16	Which benefits are mentioned in the contract?	0=No; 1=Yes.	
	1. Wage rate		
	2. Category of job		
	3. Accommodation		
	4. Food		
	5. Medical care		
	6. Paid holidays		
	7. Others		
D.17	Did you receive the wage and non-wage benefit as per the contract? 0=No; 1=Yes		
D.18	Have you met any accident in work place? 0=No; 1=Yes		
D.19	If yes, who spent for medical expenses? 1=Yourself; 2=Employer; 3=Other.		
D.20	What is you total expenses on food and other living expenditure in migration place (Rs. per month)?	NRs.	
D.21	What is your saving per month? (Rs. per month)?	NRs.	
D.22	How much money you send home per month?	NRs.	

D.23	This time when you came, how much you spent/ brought?		
	1. Spent on transport etc.		
	2. Brought goods worth		
	3. Bought cash		
D.24	Because you are non-local (Example: Indian, Pakistani, etc.) worker what adverse working conditions do you think you have been facing?	The appropriate	
	0=No problem		
	1=Harassment from employer;		
	2=Harassment from fellow worker;		
	3=Low pay than other fellow worker;		
	4=Other.		
D.25	What is the major use of the remittance you sent?	**Rough in %**	
	1. Consumption		
	2. Buy land		
	3. Build house		
	4. Pay debt		
	5. Education		
	6. Health		
	7. Marriage		
D.26	If pay debt - what is the interest rate per year charged on debt?	%	
D.27	How many fellow Nepali you have helped directly or indirectly to find job in place of migration (Example: Indian, Pakistani, etc.)?		
D.28	For haw many months per year can you support your family with the income you get or the food you produced in Nepal?	**Month**	
D.29	Then did you returne? 1=Dasain; 2=New Year; 3=Winter; 4=Uncertain; 5=Other festival period:		
D.31	If you crossed the Nepalese border, where was that?	Place	
No.	Question	Code	
D.32	Did migration bring a positive output to your household? 0=No; 1=Yes; 2=Other.		

D.33	Did migration bring a positive output to your spouse? 0=No; 1=Yes; 2=Other.		
D.34	Was your job at the place of migration: 1=arranged beforehand by a middleman who got paid for it; 2=arranged by family members, friends; 3= left without having a job assured.		
D.35	If your job was arranged by a middleman, did you take a credit / a salary advance from him / her? 0=No; Yes=1.		
D.36	If a middleman arranged your job, do you consider that you have been deceived regarding the nature of the job? 0=No; Yes=1.		
D.37	How do you send home the money, earned during migration? 1=By yourself; 2=Thought bank; 3=Throught friends & relatives; 4=Through co-worker; 5=Throught NGO/MFI; 6=I don't sending money home; 7=Oter, specify		

E. *Sexual behavior, condom use, perception on HIV/AIDS.*

No.	Question	Code	
E.1	Did respondent have sexual contacts during migration period: 0=No (Skip to Q. No. E4.); 1=yes; 2=never had sex yet (Skip to Q. No. E4.).		
E.2	How many times:		
E.3	With whom? 1=wife; 2=girlfriend; 3=occasional partner; 4=girl he didn't know before; 5=sex worker/prostitute;6=other		
E.4	Can the respondent recognize a condom? 0=No; 1=Yes.		

E.5	For which	Mentioned	
		Spontaneously	on probing
		0=No; 1=Yes.	
E.5.1	Does not know		
E.5.2	With unknown girls and prostitutes		
E.5.3	Avoid pregnancy		
E.5.4	Intercourse during menstruation		
E.5.5	Protection against the STIs		
E.5.6	Protection against HIV/AIDS		
E.5.7	Other		

No.	Question	Code	
E6.	Have respondent ever use condom: 0=No (Skip to Q. No. E12.); 1=Yes		
E7.	How often: 1=always; 2=frequently; 3=sometimes; 4=never; 5=don't know		
E8.	With whom? 1=wife; 2=girlfriend; 3=occasional partner; 4=girl he didn't know before; 5=sex worker/prostitute; 6=other.		
No.	Question	Code	
E9.	How respondent feel about using condoms during sexual intercourse: 1=less sexual satisfaction; 2=difficult to use; 3=no problem; 4=other.		
E10.	What respondent think about men who are using condoms: 1=positive attitude; 2=negative attitude; 3=does not know/does not care.		
E11.	What respondent think of women, if she asks for a condom before a sexual intercourse: 1=positive attitude; 2=negative attitude; 3=does not know/does not care.		
E12.	Does HIV/AIDS exist in Nepal: 0=No; 1=Yes; 2=Don't know; 3=other.		
E13.	Does HIV/AIDS exist in your place of migration: 0=No; 1=Yes;		

	2=Don't know; 3=Other.		
E14.	Do you talk with friends and family about HIV/AIDS: 0=No; 1=Yes; 2=Other.		
E15.	Respondent know some one who caught an STI, possibly HIV/AIDS: 1=Co-worker during migration; 2=Persons from place of origin; 3=Other.		
E16.	Is it possible to recognize a man with HIV/AIDS: 0=No; 1=Yes; 2=Does not know.		
E17.	Is it possible to recognize a girl with HIV/STIs: 0=No; 1=Yes; 2=Does not know.		

No.	Question	Code	
E.18.	Do you think that you yourself are in danger of getting HIV/AIDS: 0=No; 1=Yes; 2=Don't know; 3=Other.		
E19.	How do you protect yourself from getting HIV/AIDS: 1=Don't know; 2=Avoiding sex, 3=Avoiding sex with multiple partners; 4=Avoiding prostitutes; 5=Using condoms; 6=Other.		

E.20.	How can a person get HIV/AIDS:	Mentioned	
		Spontaneously	on probing
		0=No; 1=Yes.	
E.20.1	Sexual intercourse including wife		
E.20.2	sex with multiple partners /prostitute		
E.20.3	Shaking hands with HIV/AIDS affected person		
E.20.4	Non sterile syringes		
E.20.5	Razor blades at barber shop		
E.20.6	Eating from the same plate with HIV/AIDS affected person		
E.20.7	Blood transfusion		
E.20.8	Mosquito bite		
E.20.9	Sharing the same bathroom with HIV/AIDS affected person		
E.20.10	From mother to child during pregnancy		
E.20.11	Other specify:		

No.	Question	Code	
E21.	If a girl is healthy, but someone else from her family is known to be HIV(+) or to have AIDS would you marry her: 0=No; 1=yes; 2=don't; 3=only with a negative HIV test result; 4=other.		
E.22.	Would you continue to interact with a family if you know that one of its member has HIV/AIDS? 0=No; 1=Yes; 2=Don't know;		
E.23.	What would you do if someone from your own family was found to be HIV (+): 1=care for the person, give support; 2=expel from family; 3=don't know; 4=other.		

F. THANKING THE RESPONDENT!

Asking whether he would like to add anything or has questions.

Questions of the respondent:.....
.....
.....

Comments on the interview:.....
.....

No.	0=No; 1=Yes.	Code	
F1.	Physical examination		
F2.	Tested blood and uro-genital specimens		
F3.	Informed consent for blood and uro-genital tests		

Appendix 7. Physical Examination

Physical Examination

1. Date (mm/dd/yyyy): ____/ ____/ _____

2. VDC Code: ☐☐☐☐☐☐☐☐☐☐ 3. Respondent Code: ☐☐☐☐☐

4. Household category: ☐ 1= migrant worker, 2=non-migrant workers

5. Age of respondent: ☐☐ Date of birth: (mm/dd/yyyy): ____/ ____/ _____

Present complaints if any/brief history:

.....
.....
.....
.....
.....
.....
.....

Recent use of drugs/permanent medication: Yes ☐ No ☐

Type & reason: .....

.....

Place of treatment/Purchase: .....

.....
.....
.....

RR/Pulse rate RR: ..... Pulse rate: ...../ min

Physical examination

		Yes	No	Comments
1	All findings within normal range.			
2	Lungs			
3	Heart			
4	Reflex status			
5	Eyes & Mouth			
6	Abdomen			
7	Skin			
8	Lymph nodes			
9	Genital Region			

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.....
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Respondents sent for treatment: Yes_____ No_____

Comments on clinical examination:

Respondents particularly shy . .

Refused examination of genital organs. . .

.....
.....
.....
.....

Signature _____

Appendix 8. व्यक्तिगत स्विकृति फाराम Subject's Consent Form (Nepali)

व्यक्तिगत स्विकृति फाराम

एच आइ भि / एड्स र वाह्य कामदार डडेलधुरा जिल्लामा वाहिर वाट आई काम गर्ने कामदारको समुदायको एच आइ भि एड्स तथा एस आइ टि को स्थितिमा आर्थिक तथा सामाजिक प्रभाव

यूरोजेनिटल स्पेसिमेन डाक्टरी परीक्षण निसेरिया, गानोरिया तथा रक्त परीक्षण वाट ख्र्चि ९च्एच०, त्एज्ज गरी सिफिलिज र ज्वक्ब्न गरी ज्वख तथा ज्ख्ख पत्ता लगाउन म सहमत छु ।
यस अनुसन्धान अध्ययनको वारेमा मेरो सहभागिताको सहमति लिन मलाई
निम्न जानकारीहरु पढ्न लगाइएको थियो ।

मलाई उपरोक्त शिर्षक अनुसन्धान प्रोजेक्टमा स्वयमसेवकको रुपमा भाग लिन वोलाइएको हो । उक्त उद्देश्य प्राप्तिमा मैले ख्र्चि तथा त्एज्ज वाट सिफिलिज पत्ता लगाउन रक्त दान गर्नेछु । ज्वक्ब्न परीक्षण गरी ज्वख तथा ज्ख्ख पनि सोहि रगत वाट पत्ता लगाउन सक्ने छ । यस फाराममा हस्ताक्षर गरी म मेरो व्यक्तिगत सहमतको आभास दिन्छु । मलाई यस अध्ययनमा सहभागिताको वारेमा पूर्ण जानकारी छ र मेरो विचार दिन या नदिन स्वतन्त्र छु ।

मनोनयन तरिका
प्रश्नकर्ता यस डडेलधुरा जिल्लामा अन्य क्षेत्रवाट आई काम गर्ने समुदायको यौन रोगको स्थितिमा सामाजिक तथा आर्थिक प्रभावको जटिल सम्वन्धको वारेमा ईच्छुक भएर मलाई यसमा निम्त्याइएको हो । यसमा करिव ४०० सहभागिहरु हुने छन् । जस् मध्य २०० अन्य क्षेत्रवाट आएका र २०० त्यहिका वासिन्दा कामदार हुने छन् ।

विधि
यदी म यस अनुसन्धानमा सहभागी भए भने मैले निम्न उतरदायित्व वहन गर्ने छु ।

- प्रश्नावली भर्ने
- साधारण स्वास्थ्य परीक्षण गराउने
- परिचारिका द्वारा यूरेथ्रा को कल्चर गरी निसेरीया र गोनेरीया परिक्षण गर्ने ।
- ख्र्चि र त्एज्ज परिक्षण गरी क्थउजर्षष्क र ज्वक्ब्न परिक्षण गरी ज्वख र ज्ख्ख पत्तालगाउन ५ मि. लि. रगत प्रदान गर्ने छु । मेरो सहभागिताको समय जम्मा १ घण्टाको हुनेछ ।

जोखिम
मैले दिने केहि जानकारीहर व्यक्तिगत प्रकृतिका हुन सक्ने छन् र म यसै जानकारीको कारण केही हद सम्म सचेत तथा दुःखी हुन सक्ने छु । रगतको नमुना दिदा पनि वेहोस हुने तथा रगत लिएको ठाउँमा इन्फेक्सनको खतरा पनि हुन्छ ।

फाईदा
मैले ख्र्चि, त्एज्ज परीक्षण द्वारा क्थउजर्षष्क, ज्वक्ब्न परीक्षण द्वारा ज्वख, ज्ख्ख क्ब्म्क, ल्भष्ककभचष्ब नयलयचचजभब परीक्षण तथा निशुल्क स्वास्थ्य परीक्षण गराउने छु । यसको साथै निशुल्क कण्डोम पनि दिइने छ ।

सहभागिता लागत र क्षतिपूर्ति
अध्ययनको क्रममा गरिएको यस अनुसन्धानमा कुनै मूल्य तथा मौद्रिक क्षतिपूर्तिको व्यवस्था छैन । र म निशुल्क भाग लिनेछु ।

गोप्यता
मेरो सहभागिता अवधिभर दिइएको कुनै पनि सूचना तथा विचारहरु नितान्त गोप्य रहने छन् । म केवल संकेत नम्वर वाट चिनिने छु र कुनै पनि परिणाम प्रकाशनमा मेरो नाम देखिने छैन । मेरो कुनै प्रश्न भएमा मैले अनुसन्धान कर्ता संग त्यतिखेरै, अनुसन्धानकै वेला तथा अनुसन्धान पछि कुनै पनि वेला सोध्न सक्ने छु । मैले म्चा ज्भयचजष्ब एपजबपबमशभ, लाई पोष्ट वक्स नं. ८९७४ सि पि सि ०२५ ठमेल, काठमाण्डौं नेपाल । ऋबर्षस् एपजबपबमशभ)नभयचनभ२जयक्तबर्षीअक तथा त्भी ल्या ढठठ(ज्ञ(द्दठद्दण्ढट मा सम्पर्क गर्न सक्ने छु ।

सर्वाधिकार
यो फाराममा हस्ताक्षर गरी मेरो सहमति लिनु अघि यस कार्यको विधि, अप्ठ्याराहरु, जोखिमहरु तथा फाईदाहरुको वारेमा मलाई राम्रो संग व्याख्या गरिएको छ । मेरा जिज्ञासा हरु पुरा गरिएका छन् । म कुनै पनि वेला प्रश्न सोध्न सक्ने छु । र यस प्रोजेक्टवाट स्वतन्त्र रुपले वाहिरिन सक्ने छु ताकि मलाइ नराम्रो महशुस र उपचारको क्रममा कुनै नकारात्मक असर नपरोस् । यदी अनुसन्धान कर्ताले मलाई सहभागितावाट हटाउन चाहेमा हटाउनुको कारण उल्लेख गर्नु पर्ने छ । यस अन्ध्ययनको शिलसिलामा विकास भएका नयाँ जानकारीहरुले मेरो सहभागिता प्रतिको चाहनालाई असर पार्ने भएको हुँदा त्यस्तो जानकारी प्राप्त हुना साथ मलाई सूचित गरिने

छ । यस फाराममा हस्ताक्षर गरी मैले मेरा कुनै पनि कानुनी अधिकार दिएको छैन । यस सहमति फारामको एक प्रति मलाई दिइने छ ।

सहभागिको हस्ताक्षरः मितिः

अनुसन्धान कर्ताको प्रतिबद्धताः
मैले उपरोक्त प्रोजेक्टको प्रकृतिको बारेमा सहभागिहरुलाई राम्रो संग बताएको छु । म मेरो स्वविवेक द्वारा यो प्रमाणित गर्छु कि यो फारम हस्ताक्षरगर्ने भाग लिने व्यक्तिले यस प्रोजेक्टको प्रकृति, माग, फाइदा तथा जोखिमको बारेमा राम्रो संग बुझेको छ र उक्त व्यक्तिको हस्ताक्षर कानूनीरुपमा मान्य हुने छ । शिक्षा, भाषा तथा स्वास्थ्य समस्याले यस समझदारीमा कुनै बाधा पारेको छैन ।

प्रस्तोताको हस्तक्षरः मितिः

अनुसन्धान कर्ताको हस्ताक्षरः मितिः

Appendix 9. Subject's Consent Form (English)

Subject's Consent form

Study on
HIV/AIDS and Migrants
The Socio-economic Impact of HIV/ AIDS, STIs on the Communities of Migrant Workers in Dadeldhura District (Nepal)

The clinical examination with urogenital specimens to identify Neisseria gonorrhoeae, and blood testing for those that agree to take the test for VDRL (RPR), TPHA tests to identify *Syphilis, HBSAg* tests to identify *HBV*, and *HIV*.

I'm being asked to read the following material to ensure that I'm informed of the nature of this research study and of how I will participate in it, if I consent to do so. Signing this form will indicate that I have been informed and that I give my consent. I can know the nature and the risks of my participation and can decide to participate or not participate in a free and informed manner.

Purpose
I'm being invited to voluntarily participate in the above-title research project. For the purpose of this project I donate my blood (5ml.) to determine for VDRL (RPR), TPHA tests to identify Syphilis, HBSAg tests to identify HBV, and HIV. I also give possibility to do examination of urogenital specimens to identify Neisseria gonorrhea. I will also have a clinical examination (general checkup) to identify health status and skin examination to identify STIs related diseases. I will answer questions about my health status.

Selection criteria
I'm being invited to participate because the investigator is interested to understand the complex relationship between the socio economic situation of inhabitants of Dadeldhura district, migration, and HIV/AIDS/STIs. Approximately 400 respondents will be enrolled in this study. From them 200 will be respondents coming from households with migrant workers and 200 coming from households non migrant workers.

Procedure
If I agree to participate, I will be asked to consent to the following:

- Complete a questionnaire,
- Have a general examination,
- Allowe nurse will take a culture for *Neisseria gonorrhoea* from the urethra,
- I will also donate 5 ml of blood for VDRL (RPR), tests to identify Syphilis, HBSAg tests to identify HBV, and HIV.

The total time for my participation will be for about one hour.

Risk
Some information that I provide may be personal in nature and I may become somewhat self-conscious or embarrassed with the research having access to the information. There is some risk associated with providing a blood sample including fainting and a bruise or infection at the site of the blood draw.

Benefit
I will receive information about the results of VDRL (RPR), TPHA tests to identify Syphilis, HBSAg tests to identify HBV, HIV/AIDS, Neisseria gonorrhea test and also reseive free clinical examination. I will also receive free condoms.

Participation cost and compensation
There is no participation cost or monetary compensation for my participation in this study. I will participate free of cost.

Confidentiality
Any information obtained during my participation in this study is strictly confidential. I will be identified only by a code number and my name will not appear in any publication of results. Should I have any questions, I can disscuss than with an investigator at any time before, during or after the research project. I can contact Dr. Heorhii Pkhakadze, GPO 8974, CPC 025 Thamel, Kathmandu, Nepal E-mail: pkhakadze_george@hotmail.com, Tel: 977-1-272096.

Authorization
Before giving my consent by signing this form, the methods, inconveniences, risks, and benefits have been explained to me, and my questions have been answered. I may ask questions at any time and I'm free to withdraw from the project at any time without causing bad feeling or affecting my medical care. The investigator may end my participation in this project for reason would be explained. New information developed during the course of this study that may affect my willingness to continue in this research project will be given to me as it become available. I do not give up any of my legal rights by signing this form. A copy of this consent form will be given to me.

Participant's Signature Date .

Investigator's affidavit

I have carefully explained to the participant the nature of the above project. I hereby certify that, to the best of my knowledge, the person who is signing this consent form understands clearly the nature, demands, benefits, and risk involved in his/her participation, and he/she signature is legally valid. A medical problem or language or educational barrier has not precluded this understanding.

Presenters Signature Date .

Investigators Signature Date

Appendix 10. Orientation Session

Orientation Session with Research Team

Date: **25 November** ***Place:*** **GTZ office, Dadeldhura**
Duration: **from 11:00 to 16:45**
Total participants: **11 (eleven)**

Participants list

No	Participants name	Participants address	Selected or not. If yes code	Kind of participation in study project
1	Jeet Raj Bhatta	Dadeldhura District, Amargari Municipality, Roll-5	01	Lab-assistant
2	Birendra Kumar Manral	Dadeldhura District, Ajayamoru, Roll-8	03	Interviewer
3	Ran Bahadur Bohara	Dadeldhura District,	05	Interviewer
4	Yagya Raj Awasthi	Dadeldhura District, Belapur Word-8	02	Interviewer
5	Narendra Bahadur Pal	Dadeldhura District, Dewaldibyapur	No	
6	Bir Bahadur Dhal	Dadeldhura District, Amargari Municipality-8	No	
7	Pusp Raj Joshi	Dadeldhura District, Koteli	04	Interviewer
8	Siddha Raj Pathak	Dadeldhura District, Koteli	No	
9	Shev Bdr Dhant	Dadeldhura District, Amargadhi-8	No	
10	Megha Raj Bhatta	Dadeldhura District, Amargari Municipality	06	Driver (with vehicle)
11	Lal Pokharel	Chitwan District, Bachhauli VDC, Ward-3	07	Research Assistant

Orientation session for interviewers

Objective:

To present questionnaire and prepare interviewers
To present Study "The Socio-economic Impact of HIV/AIDS, STIs on the Communities of Migrant Workers in Dadeldhura District (Nepal)" working plan in Dadeldhura.

Facilitator:

Dr. George Pkhakadze, M.D., MPH Student (IOM, TU).

Participants:

Representatives from non-government organizations and social workers, 10 participants.

Date:

November, "25", 2001

Time:

From 11:00 to 16:45

Selection of participants:

Selection of participants will be try application forms distributed in organizations before 2 weeks on the day of workshop (In first field visit time). Last date of submit application will be one week before on the day of workshop. Finally around 20 (minimum 10 maximum20) participants will be admitted in orientation session.

Evaluation:

Evaluation will be based on application forms follow up by participants before, during and at the end of workshop. Analyze information collecting in the orientation session: discussions, group works, presentation etc...

Workshop outline:

I. Introduction;
II. Overview of orientation session;
III. Introduction of Dr. George Pkhakadze study;
IV. Discussion on HIV/AIDS/STI and migration in Dadeldhura district.

Equipment/technical support: (*name (quantity)*)

Flip charts (3),, markers (3), paper (1 set), ball pan (15), material sets: questionnaire (English (One copy), Nepali (Three copy)), working plan (English), Attendance list (English), Physical Examination (English), Subject's Consent Form (Nepali, English), proposal one copy (15), card holder (15), photo camera (1), lunch (15).

Content:

11:00 – 11:15	Welcome to participants by Dr. George Pkhakadze
11:15 – 11:35	Participants presentation
11:35 – 12:00	Presentation of Dr. George Pkhakadze study "The Socio-economic Impact of HIV/AIDS, STIs on the Communities of Migrant Workers in Dadeldhura District (Nepal)" with methods
12:00 – 12:30	Presentation of questionnaire and introduction to participants. By Dr. Pkhakadze
12:30 – 12:45	Reading questionnaire individually
12:45 – 13:05	Questions about questionnaire
13:05 – 13:25	Lunch
13:25 – 14:00	Divided by groups and testing questionnaire
14:00 – 14:30	Changing partners and continue testing questionnaire
14:30 – 15:00	Discussion about problems in the questionnaire
15:00 – 15:30	Divided by groups and testing questionnaire
15:30 – 15:55	Changing partners and continue testing questionnaire
15:55 – 16:25	Discussion about problems in the questionnaire
16:25 – 16:45	Closing the orientation session. Signature contracts with interviewers.

Appendix 11. Focus Group Discussion (form)

Focus Group Discussion with Female Community Health Volunteers

Date: **6/12/2001** ***Time:*** **12:30 – 13:15** ***Place:*** **Navadurga Sub-Health Post, Dandaban**
Organiser: **Researcher**
Number of participants: **19**
Facilitator: **Dr. George Pkhakadze**
***Translator/assistant*:** **Mr. Lal Prasad Pokharel**

Equipment used in the FGD:
1. Audio recorder (one)
2. Micro Audio cassette (one)
3. Paper (four)
4. Marker (one)
5. Refreshment (20 person)

Statistics

Number		Age	VDC	Husband		
				Migrate	At the time stay at home	Place of migration
	1	22	Nawadurga	Yes	Yes	Bombay
	2	22	Nawadurga	Yes	Yes	Bangalore
	3	30	Nawadurga	Yes	Yes	Pahjab
	4	23	Nawadurga	Yes	Yes	Bombay
	5	23	Nawadurga	Yes	Yes	Panjab
	6	20	Nawadurga	Yes	Yes	Panjab
	7	35	Nawadurga	No	Yes	No
	8	25	Nawadurga	Yes	No	Bombay
	9	25	Nawadurga	Yes	No	Panjab
	10	23	Nawadurga	Yes	Yes	Madras
	11	25	Nawadurga	Yes	No	Madras
	12	23	Nawadurga	Yes	Yes	Bombay
	13	30	Nawadurga	Yes	Yes	Bombay
	14	24	Nawadurga	Yes	Yes	Panjab
	15	40	Nawadurga	No	No	No
	16	25	Nawadurga	Yes	Yes	Panjab
	17	25	Nawadurga	No	No	No
	18	22	Nawadurga	Yes	Yes	Tarai
	19	26	Nawadurga	Yes	Yes	Bombay
Total	***19***	***Mean age 23.58***	***Nawadurga***	***3-No; 16-Yes***	***5-No; 14-Yes***	***18-India; 1-Nepal***

All the participants were informed in advance about the topic of discussion and permission was taken before starting the discussion.

Question No.1

Do you think migration is good?

- Yes, It is good
- Something new can be learned
- Something new can be seen

Question No. 2

Do you feel happy when your husbands go away for job?

- No, definitely not but they have to (from group)

Question No. 3

In terms of economical condition has this migration helped you?

- Yes, it has
- To some extent
- It has helped a lot

Question No. 4

How long do they stay in their workplace?

- Five years
- Six months
- One year
- Two months
- Three years

Question No. 5

How do they send money to their home?

- By other people
- Through friends
- By relatives

Question No. 6

Why do people migrate?

- Because their fathers worked there before
- Their friends work there
- For treatment
- For study
- To visit

Question No. 7

Were your parents migrant workers too?

- Yes, my father (slowly 10 hands were risen)
- Not mother

Question No. 8

Do your parents think its good to migrate?

- They don't but it has become like tradition.

Question No. 9

Regarding the health condition don't you think its dangerous to migrate?

- Yes it is dangerous

- Unlike before less people go these days

Question No. 10

What do you know about HIV/AIDS ?

- It is transmittable disease
- We all have heard about it
- We are not clear about it
- It can be transmitted husband to wife, if they do something (had sex) in India and come home (group laugh)

Question No. 11

Do you know someone living with HIV/AIDS in your society?

- We haven't seen anyone but we have heard about it
- Two men have died because of the disease

Question No. 12

In which VDC is that?

- This Nawadurga VDC

Question No. 13

Do you know which village?

- Dhwand and Swankot

Question No. 14

How did you know they died of AIDS?

- Doctors in hospital said

Question No.15

Which hospital?

- TEAM hospital

Question No.16

What do you know about STDs?

- AIDS is STD
- That is same

Question No. 17

How do you call STD in your local language?

(After long silence)

- Bhringi and heavy laugh

Discussion:

Would you like to say something?

Facilitator gave brief information about HIV/AIDS and distributed published materials from NCASC

Facilitator:

Thank for participation "Dhanebat" and "Namaste"

Participants:

Heartily gratitude was expressed for their participation.

Appendix 12. Free Health Camp Fact sheet

Free Health Camp

Date: **From 26/11/2001 to 12/12/2001**
Place: **Dadeldhura District**

Information about place of study:

Population: 128070 from them women 60579 and men 67491

Household: 19648. Women Head of Household: 2894 (14.73%).

Average size of household: 6.52

Migration status: 1350 (6.87%) out-migrant HH; 538 (2.74%) in-migrant HH.

1. Amargadi Nagarpalika (Municipality) Under Amargadi Municipality were selected 4 places to rolling Free Health Camp;
   - District Hospital (Dadeldhura) – 26/11/2001
   - Sub Health Post (Ugratara) – 27/11/2001
   - Sub Health Post (Sahastraling) - 28/1/2001
   - Sub Health Post (Bhumiraj) – 29/11/2001
2. Belapur VDC (Mimya, Gilla, Timla, villages) – 2/12/2001
3. Health Post Dandaban (Nawadurga VDC) – From 3/12/2001 to 6/12/2001
4. Primary Health Centre (Jogbudha VDC) – From 9/12/2001 to 12/12/2001

Every day routine of Health Camp were depended of the Free Health Camp location.

Total participants in the study:

Agree to participate – **303** individuals (**2078 population**)

Registered but not participate – **100** individuals

Not registered and not participate but done physical examination and collected informal information related to study – **110** individuals

Total **560** participants (except FGD and case studies)

Total were registered 406 participants from them 152 female and 254 male, 148 migrants and 246 non-migrants.

Agree to participate in the program ware 306 for them 117 female and 188 male from them 141 migrant: female 18 and male 123. 162 non-migrants: 69 male and 93 female.
118 male participants did gonorrhoea test. Female participants aren't did gonorrhoea test because study doesn't have facility to do it.

Every day routine of Health Camp		
No.	*Time*	*Activity*
1	*9:00 – 9:30*	Meeting with team in GTZ office, discussion about previous day problem and planning working day.
2	*9:30 – 9:35*	Transportation from GTZ office to TEAM Hospital
3	*9:35 – 9:45*	Collection ice box with fresh ice from TEAM Hospital small briefing with Lab-assistant from TEAM Hospital about problems etc
4	*9:45 – 10:00*	Departure from TEAM Hospital to Free Health Camp place
5	*10:00 – 10:15*	Preparation for Helth Camp, manage all equipment. Brifing with SHP offiser in charge/staff about technical and administrative aspects. Registration of partisipants (continiouse all day)
6	*10:15 – 17:00*	Health Camp
7	*17:00 – 17:10*	Briffing with team, collection questionqires, blood samples. Paceting all equipment. Photo with SHP staff and team.
8	*17:10 – 17:25*	Departure from Health Camp place to TEAM Hospital.
9	*17:25 – 17:30*	Give blood sample to lab-assistant in TEAM Hospital to do centrifuge.
10	*17:30 – 17:35*	Transportation from TEAM Hospital to GTZ office

	Registered		Migrant		Non migrant	
Sex	M	F	M	F	M	F
Total	***254***	***152***	***129***	***19***	***113***	***133***
Grand Total	**406**		**148**		**246**	

	Agree to participate		***Total***	Migrant		***Total***	Non migrant		***Total***
Sex	M	F		M	F		M	F	
Gonorrhea test	118	0	***118***	89	0	***89***	29	0	***29***
Blood test	190	114	***304***	121	19	***140***	69	95	***154***
Questionnaire	189	114	***303***	120	19	***139***	69	95	***154***
Total	***192***	***114***	***306***	***123***	***19***	***142***	***69***	***95***	***154***
Grand Total	**306**			**142**			**164**		

Gonorrhea test participants code: 001; 006; 007; 011; 013;016; 017; 018; 028; 029; 032; 047; 050; 077; 076; 075; 081; 082; 084; 086; 087; 088; 089; 101; 102; 103; 107; 108; 109; 121;124;125; 126; 129; 130; 185; 197; 186; 189; 194; 190; 191; 192; 195; 198; 199; 165; 163; 167; 162; 182; 184; 175; 180; 183; 173; 161; 179; 178; 176; 181; 135; 139; 132; 131; 207; 208; 201; 164; 239; 238; 237; 234; 235; 217; 215; 221; 240; 213; 211; 315; 317; 319;

307; 098; 099; 096; 059; 060; 051; 062; 072; 068; 063; 091; 336; 340; 067; 064; 094; 092; 321; 367; 365; 369; 322; 368; 364; 362; 357; 356; 349; 342; 373; 363; 360.

Respondents code: 001; 002; 003; 004; 005; 006; 007; 008; 009; 010; 030; 031; 032; 033; 034; 035; 036; 037; 038; 039; 040; 041; 042; 043; 044; 045; 046; 047; 048; 049; 050; 023; 025; 077; 016; 017; 080; 078; 079; 021; 075; 076; 011; 014; 013; 012; 015; 018; 020; 024; 019; 022; 026; 029; 028; 027; 110; 122; 127; 104; 105; 123; 107; 121; 130; 124; 108; 125; 129; 106; 109; 129; 103; 102; 101; 088; 089; 086; 087; 084; 082; 081; 090; 083; 085; 070; 141; 145; 198; 195; 189; 186; 197; 185; 196; 199; 194; 192; 191; 190; 200; 193; 187; 188; 165; 163; 167; 162; 182; 184; 175; 180; 183; 173; 161; 179; 168; 178; 177; 176; 170; 181; 174; 171; 169; 172; 166; 140; 208; 164; 237; 134; 132; 131; 201; 240; 239; 238; 135; 133; 207; 202; 139; 136; 206; 210; 205; 204; 203; 137; 138; 209; 218; 235; 234; 213; 221; 217; 240; 215; 214; 236; 223; 225; 226; 227; 231; 228; 220; 230; 233; 219; 216; 222; 232; 224; 229; 212; 320; 316; 313; 314; 312; 311; 310; 309; 308; 303; 305; 304; 302; 301; 100; 097; 211; 318; 315; 317; 319; 307; 098; 099; 306; 096; 066; 119; 116; 111; 333; 052; 341; 339; 338; 334; 337; 330; 058; 054; 056; 053; 112; 069; 065; 073; 117; 115; 114; 331; 335; 120; 118; 132; 059; 060; 051; 062; 072; 068; 063; 091; 336; 340; 055; 071; 067; 064; 061; 074; 113; 057; 094; 093; 092; 329; 095; 354; 142; 344; 148; 144; 343; 350; 355; 353; 347; 358; 366; 270; 324; 326; 325; 346; 345; 352; 328; 371; 359; 372; 143; 149; 321; 367; 365; 323; 369; 322; 368; 364; 362, 357; 356; 349; 342; 146; 150; 147; 373; 160; 348; 361; 363; 360; 159; 327; 351.

Female: 009; 035; 036; 040; 042; 043; 044; 045; 046; 080; 078; 079; 021; 012; 110; 122; 127; 104; 105; 123; 083; 085; 070; 141; 145; 200; 193; 187; 188; 174; 171; 169; 172; 166; 140; 136; 206; 210; 205; 204; 203; 137; 138; 209; 223; 225; 226; 227; 231; 228; 220; 230; 233; 219; 216; 222; 232; 224; 229; 212; 320; 316; 313; 314; 312; 311; 310; 309; 308; 303; 305; 304; 302; 301; 100; 097; 066; 119; 116; 111; 333; 052; 341; 339; 338; 334; 337; 330; 058; 054; 056; 053; 112; 069; 065; 073; 117; 115; 114; 331; 335; 354; 142; 344; 148; 144; 343; 350; 355; 353; 347; 358; 366; 270; 324; 326; 325.

Male: 001; 002; 003; 004; 005; 006; 007; 008; 010; 030; 031; 032; 033; 034; 037; 038; 039; 041; 047; 048; 049; 050; 023; 025; 077; 016; 017; 075; 076; 011; 014; 013; 015; 018; 020; 024; 019; 022; 026; 029; 028; 027; 107; 121; 130; 124; 108; 125; 129; 106; 109; 129; 103; 102; 101; 088; 089; 086; 087; 084; 082; 081; 090; 198; 195; 189; 186; 197; 185; 196; 199; 194; 192; 191; 190;165; 163; 167; 162; 182; 184; 175; 180; 183; 173; 161; 179; 168; 178; 177; 176; 170; 181. 208; 164; 237; 134; 132; 131; 201; 240; 239; 238; 135; 133; 207; 202; 139; 218; 235; 234; 213; 221; 217; 240; 215; 214; 236.; 211; 318; 315; 317; 319; 307; 098; 099; 306; 096; 120; 118; 132; 059; 060; 051; 062; 072; 068; 063; 091; 336; 340; 055; 071; 067; 064; 061; 074; 113; 057; 094; 093; 092; 329; 095; 346; 345; 352; 328; 371; 359; 372; 143; 149; 321; 367; 365; 323; 369; 322; 368; 364; 362, 357; 356; 349; 342; 146; 150; 147; 373; 160; 348; 361; 363; 360; 159; 327; 351.

For participants were provided medicines (See attachment: Medicine and equipment used in Health Camp). Doctor did pre-test counseling of STIs & HIV/AIDS. Published materials from NCASC and condoms, provided by DHO also were distributed.

Research Team:

1. *Doctor/researcher* – **Dr. George Pkhakadze.**
2. *Research assistant/translators* – **Mr. Rajan Kumar Bhattarai, (Code: 009), Mr. Lal Prasad Pokharel (Code: 008).**
3. *Lab-assistants* - **Mr. Jeet Raj Bhatta (Code: 001), Mr. Radam Singh Bhat (Code: 006).**
4. *Interviewers* – **Mr. Yagya Raj Awasthi (Code: 002), Mr. Birendra Kumar Manral (Code: 03), Mr. Pusp Raj Joshi (Code: 004), Mr. Ran Bahadur Bohara (Code: 05).**
5. *Driver* – **Mr. Megha Raj Bhatta (Code: 007).**

Appendix 13. Test results from National Public Health Labolatory

His Majesty's Government
Ministry of Health
DEPARTMENT OF HEALTH SERVICES
NATIONAL PUBLIC HEALTH LABORATORY

Tel: 252421
Fax: 252375

Pachali, Teku
Kathmandu, Nepal

Ref.:

Date: 18/01/2002

Test results of the study: Migrants and HIV/AIDS

Memorandum

Laboratory testing was done for study on "*The Socio-economic Impact of HIV/AIDS, STIs on the Communities of Migrant Workers in Dadeldhura District (FWDR)*" by Dr. Heorhii (Giorgi) Pkhakadze in collaboration with National Centre for AIDS and STD Control & National Labour Academy. The study is part of the assignments given within the MPH program of Tribhuvan University, Institute of Medicine, Department of Community Medicine and Family Health.

On the 14th December 2001, the National Public Health Laboratory received 304 blood samples and 118 glass slide with smear. Tests undertaken and results are detailed below:

HIV-AIDS *HIV1, HIV2 tests* – 1 participant No.: 195.

(0.33% from total sample size)

Syphilis *VDRL (RPR)* tests – 26 participants No.: 123, 365, 359, 082, 084, 045, 040, 116, 354, 357, 367, 369, 005, 001, 227, 307, 143, 159, 171, 231, 237, 147, 055, 095, 199, 146.

(8.55% from total sample size)

Hepatitis B *HBSAg* tests - 5 participants No.: 036, 199, 188, 024, 174.

(1.64% from total sample size)

Neisseria gonorrhoeae *(ICDC) Gram Negative Diplo Cocci test* – Seen 1 participant No.: 360 **(0.33% from total sample size)**

As a conclusion, it appears that a total of 32 participants are infected with HIV/STIs (10.52% from total sample size) and one participant is infected with Syphilis and Hepatitis B No.: 199, (0.33% from total sample size).

Mr. Purushottam Poudyal
Deputy chief, Medical Technologist
NPHL, Teku

Appendix 14. Curriculum Vitae

Dr. Giorgi Pkhakadze

Address: Chawny, G.P.C. Box: 8974 Male
CPC: 025, Thamel, Katmandu Nepal
Tel.: +977 1 272 096.
Email: pkhakadze_george@hotmail.com

Born in 1976, Ukrainian citizenship, driving license: B

WORK EXPERIENCE

1997 – 2000 **United Nations Association of Georgia**
Coordinator of the field-office in Imereti region (1997-2000)

- Provided support to the Regional Department of Education to reach out to 523 primary and secondary schools with projects on Human Rights and Healthy Lifestyle education,
- Supervised a team of 43 volunteers for the above described projects,
- Fund raised from UNICEF, UNFIP, UNDP, UNV, USAID, British Embassy in Georgia, Soros Foundation, for the same,
- Published in local newspapers, and animated radio-programs, on related issues.

1998 – 2000 **Working Group of Humanitarian Assistance (WGHA)**
Assistant Coordinator

- As a volunteer, assisted on an ad-hoc basis in the organization throughout the CIS of regional workshops on psycho-social rehabilitation of displaced persons, emergency preparedness and emergency assistance (between other subjects), as part of the WGHA of the Regional Conference on Refugees and Displaced Persons.

1998 -1999 **Imereti Regional Health Education Center Ministry of Health in Georgia**
Public Health Doctor (part-time)

- Organized and facilitated monthly training-seminars on sanitation for shopkeepers, on health education for schools and universities,

1997 -1998 **Charity Humanitarian Center Abkhazeti**
UNICEF funded project
Doctor and Social Worker

- Prepared and animated a Sunday school for 40 children displaced because of conflict, with a psycho-social rehabilitation focus,

1996 -1997 **Hospital 2, Tbilissi, Georgia**
Surgeon Assistant of Professor Sulkhan Kemoklidze

- Apart from the usual tasks of an Assistant Surgeon, also published an article on Gastritis in the university magazine.

1995 - 1996 **Republic Epidemiological Hospital in Tbilissi, Georgia**

Nurse within the Intensive Care department

- In extreme circumstances (with electricity cuts and lack of basic medicines), attended to the needs of patients in the intensive care department.

1995 – 1996 **Department Mother and Infant Center in Tbilissi, Georgia**
Assistant of Professor la Verulashvili Assistant

- As an intern, assisted Professor Verulashvili in the diagnosis of gynecological diseases.
- With colleagues, published a joint article on endocrinology.

EDUCATIONAL/TRAINING QUALIFICATIONS

October 2001 **Nepal Medical Council**

- Certificate of Foreign National Medical Practitioner. Registration No. 1437

Since April 2001 **Tribhuvan University, Institute of Medicine, Katmandu, Nepal**

- Student, Master of Public Health (MPH) program

1999 **International Foundation for Election System (USA), Tbilissi, Georgia**

- Professional trainer in democratic election management

1995-1999 **United Nation Association of Georgia, Tbilissi, Georgia**

- Trained on Human Rights Education

1991- 1997 **"L&C" University, Faculty of Medicine, Tbilissi, Georgia**

- Graduated as a Medical Doctor by decision of the State Examination Commission on December the 30th, 1997, specialized in General Surgery.

1981-1991 **School 52, L'viv, Ukraine**

- History specialization

SKILLS

Languages

Russian	native speaker
Georgian	native speaker
Ukrainian	good
English	good

Computer

Microsoft office-2000 XP, data analysis through EPI Info 2000