

Seasonal Labour Migration to India of Men as a Factor Influencing their Wives Susceptibility to HIV

**A case study of Women and Children Office's women group in
Sishawanijahada Village Development Committee, Morang District, Nepal**



**A Research project submitted to
Van Hall Larenstein University of Applied Sciences in
Partial Fulfilment of the Requirements for the
Degree of Master in Management of Development,
Specialization “Rural Development of HIV/AIDS”**

**By
Durga Baral Bhandari
September 2012**

Dedication

This thesis is dedicated to the women of Sishawanijahada VDC of Nepal who are socially, culturally and economically backward.

Acknowledgement

Firstly, I would like to thank Netherlands Government for providing me the scholarship to pursue my study at Van Hall Larenstein University of Applied Sciences. Secondly, my sincere thanks go to my supervisor Dr. Marcel Put. His supervision, critique and novel ideas have been truly inspiring in shaping this work from the beginning until the end.

I would like to convey my special gratitude to my course coordinator Koos Kigma who not only continuously encouraged me for my study but supported me during loneliness in the absence of my family members. My sincere thanks go to all my teachers, staff of the University and colleagues who made my life easier during the stay in Wageningen.

I would not remain thanking my beloved friends Goma Sigdel, Sheeva Bhattarai and Menila Kharel who continuously supported throughout my study and made my stay in the Netherlands homely.

I would also like to thank Ministry of Women, Children and Social Welfare, Nepal who provided me the opportunity to undertake this masters study. I am deeply indebted to the women of Sishawanijahada VDC and staff of WCO, Morang for their cooperation during my field work in Nepal.

Last but not the least; I would like to thank my beloved husband Mr. Kishor Kumar Baral for his great patience, love and encouragement. This study would not be possible without the prayers and support of my parents and parents-in-law. My thanks go to my sons Nistuk and Nikhil for their patience during my absence.

Table of Contents

Acknowledgement.....	ii
Table of Contents.....	iii
List of tables.....	v
List of figures	vi
ACRONYMS	vii
Abstract.....	viii
CHAPTER ONE: INTRODUCTION	1
1.1 Background of the study	1
1.2 Problemstatement.....	1
1.3 Objective of the study	2
1.4 Main Research Question.....	2
1.4.1 Subquestions	2
CHAPTER TWO: LITERATURE REVIEW.....	3
2.1 Migration.....	3
2.2 Cause of migration	4
2.3 Migration and susceptibility to HIV	5
2.4 Migrant people and risky sexual behaviour	7
2.5 Male migration and susceptibility to HIV on women	8
2.6 Knowledge about HIV/AIDS.....	8
2.7 Socio-cultural norms and HIV/AIDS	9
2.8 Conclusion.....	9
CHAPTER THREE: METHODOLOGY	10
3.1 Study area	10
3.1.1 VDC selection criteria.....	11
3.1.2 Women and Children Office (WCO)	11
3.2 Research design.....	11
3.3 Selection of sample size	12
3.4 Data collection	12
3.5 Data analysis	12
3.6 Strength and limitations of the study	12
3.7 Ethical considerations.....	13
3.8 Conceptual framework of the study.....	13

CHAPTER FOUR: FINDINGS.....	14
4.1 Characteristics of respondents	14
4.2 Knowledge on HIV/AIDS.....	15
4.2.1 Heard about HIV/AIDS	15
4.4.2 Knowledge on mode of HIV transmission	15
4.4.3 Misconception about the mode of transmission on HIV/AIDS.....	16
4.4.4 Knowledge on HIV prevention methods	17
4.4.5 Knowledge of STDs and chronical illness.....	17
4.5 Risky behaviour of male	19
4.5.1 Use of alcohol	19
4.5.2 Use of male condom	19
4.6 Socio-cultural norms regarding sexual matter	20
4.7 Status of HIV Testing.....	21
CHAPTER FIVE: DISCUSSION.....	22
5.1 Knowledge of HIV/AIDS and STDs	22
5.2 Risky behaviour of male	23
5.2.1 Use of alcohol	23
5.2.2 Use of condom.....	24
5.3 Socio-cultural norms and values regarding sexual matters	25
CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS	27
6.1 Conclusion.....	27
6.2 Recommendations.....	28
References	30
ANNEXES.....	34
ANNEX I Checklists for respondents.....	34
ANNEXII Checklist for key informants	35

List of tables

Table 1 General characteristics of respondents.....	14
Table 2 Knowledge of respondents on HIV/AIDS	15
Table 3 Knowledge of respondents on mode of transmission	16
Table 4 Misconception of respondents about mode of transmission	16
Table 5 Knowledge of respondents on prevention methods of HIV/AIDS.....	17
Table 6 Knowledge of respondents about chronical illness and STDs.....	18
Table 7 Practice of using condoms	20

List of figures

Figure 1 Types of migration	3
Figure 2 Factors affecting migration	5
Figure 3 Mobility affecting susceptibility to HIV	6
Figure 4 Map of Nepal showing the study site	10
Figure 5 Conceptual framework of the study	13

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CBS	Central Bureau of Statistics
DDC	District Development Committee
DHS	Demographic Health Survey
FHI	Family Health International
FM	Frequency Modulation
GDP	Gross Domestic Product
HIV	Human Immune Deficiency Virus
ILO	International Labour Organization
INGO	International Non-Government Organization
IOM	International Organisation for Migration
IDU	Intravenous Drug User
IUD	Intrauterine Devices
MOF	Ministry of Finance
MSM	Men Who Have Sex With Man
MTCT	Mother-to-Child Transmission
NCASC	National Centre for AIDS and STD Control
NGOs	Non-Government Organizations
NRs	Nepalese Rupees
PLWHA	People Living With HIV/AIDS
RH	Reproductive Health
STDs	Sexually Transmitted Diseases
T.B.	Tuberculosis
TISS	Tata Institute of Social Sciences
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VACC	Village AIDS Coordination Committee
VDC	Village Development Committee
WCO	Women and Children Office
WUR	Wageningen University and Research Centre

Abstract

HIV/AIDS is a serious issue in Nepal especially among people who migrate to India as a seasonal labourer in search of a job. The objective of the research was to make recommendations for the reduction of susceptibility to HIV of the WCO's women's group of Sishawanijahada VDC, Nepal. The main research question was to explore the influence of seasonal labour migration to India on male risky behaviour and susceptibility to HIV of their wives.

A desk study and field study of 30 females (15 each in category of seasonal labour migrants and non-migrants males) using a checklist through interviews was carried out for the purpose of the research. The respondents were members of the WCO group, Morang. Information was also generated from interview of three key informants.

The alcohol drinking behaviour in seasonal labour migrants and non-migrants was almost similar. 87% of the seasonal labour migrant males and 80% of non-migrant males never used a condom while having sex with their wives which shows a slight difference between the two categories. 93% of all the respondents said that sex was under the control of their husband and they had to agree for sexual intercourse whenever their husbands wanted. The study also showed that 60% of the wives of seasonal labour migrant males said that they didn't know about the reason of using male condoms while the percentage was slightly lower (53%) in wives of non-migrant males. 27% of the respondents belonging to non-migrant males did not know about symptoms of STDs whereas the proportion was bit higher (40%) in respondents of seasonal labour migrant males. Proportion of the wives of seasonal labour migrant males (40%) who heard about HIV/AIDS was slightly lower than of wives of non-migrant males (67%). The percentage of respondents of non-migrant males was 13% higher than those in wives of seasonal labour migrant males who knew that sexual intercourse with an infected person or multiple sex partners are modes of transmission of the HIV virus. The knowledge on use of condoms for HIV prevention was twice as higher in wives of non-migrants compared to that of seasonal labour migrants. The knowledge was higher in non-migrant groups because of participation in RH trainings and there were more educated females in the group. The knowledge on HIV/AIDS among respondents in the current study is lower than that found in other literatures. The difference may be due to the less literate respondents and the strict culture in the community related to sexual matters. Additionally programs and trainings on HIV and AIDS is very limited in this community. 3 females of seasonal labour migrants and 1 from non-migrant males had the symptoms of STDs but the presence of disease was not confirmed.

Based on the results of the study, it can be concluded that the susceptibility to HIV differs slightly between females of seasonal labour migrant males to India and non-migrants. Seasonal labour migration to India seems not the major factor contributing to women susceptibility to HIV but a number of integrated factors like education level, less awareness about HIV, male behaviour on practising using condoms and strict socio-cultural norms of the society regarding sexuality played an important role.

In order to reduce the susceptibility of females to HIV, it is recommended that awareness program on HIV/AIDS should be launched with joint coordination of various NGOs, INGOs and WCO. The target group of the programs should be males and females (including unmarried ones) of VDC especially focussing on females of seasonal labour migrants groups as their knowledge is less on HIV/AIDS. The awareness on prevention of HIV program should focus on relation between STDs and HIV/AIDS, method of male condom use and importance of HIV tests of the couples belonging to seasonal labour migrant males household. Easy and unlimited access of condoms to the females should be provided by mobilizing Female Community Health Volunteers. Regular reproductive health camps should be organized in the VDC with free treatment facilities by the health post. Programs to reduce alcohol use in males should be implemented by women cooperatives which exist in the village.

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

HIV/ AIDS is primarily a sexually transmitted disease. The epidemic of HIV/AIDS would affect not only the health of individuals but also the welfare and well-being of households, communities, and, in the end, entire societies. The number of HIV positive people is increasing across the world. According to Joint United Nations Program on HIV & AIDS; 33.4 million people are living with HIV & AIDS worldwide and 2 to 3.5 million people living with HIV are in South Asia(UNAIDS, 2009).In Nepal, there are 16,138 reported cases of HIV as of July 2010 with a prevalence of 0.49% National Centre for AIDS and STD Control(NCASC, 2010a). Among them, the source states there are 36% of female reported as living with HIV/AIDS in Nepal. The report further states, 44% of clients of sex worker got infection from 5 % of female sex worker and 27 % of house wives got infection from their spouse.

Migration of population is one of the drivers of HIV/AIDS. Some literatures show that migrated populations are involved in unsafe sexual practice because of their work and living environment. At times, their practices may include commercial or transactional sex, alcohol and sexual violence (Sikder and Uddin, 2008). In Nepal, the migration of citizen is increasing rapidly within country and outside the country especially in India in search of job due to its open border. The migrated population in Nepal was 1.92 million in 2011 whereas in 2001 it was 0.762 million (CBS, 2011). There were an estimated 967,000 to 151,133 seasonal labour migrants in Nepal (NCASC, 2006). Migration may influence individual's risk behaviour, susceptibility to HIV, and there is a negative impact of HIV and AIDS on the individual or community. Since some of the migrant male workers tend to buy sex when they are away from home, they may be at risk of infection during the migration period (Mercer et al., 2007). Seasonal labour migrants constitute 40 % of total estimated people living with HIV in Nepal (NCASC, 2010a). Trend of HIV infection has been increasing in house wives of migrant community each year. The report also revealed that 56 % of women and 31 % of male infected by HIV fall under the age of 20-49 years and at the same time women are getting infection at earlier age than the male community.

According to NCASC (2012), heterosexual contact is the major mode of infection in Nepal which comprises 80% of all the infections. The major risk group consists of men who have sex with man (MSM) and female sex workers. Male labour migrants to India who visit female sex workers and clients of female sex workers in Nepal are at high risk. Furthermore, the risk is aggravated by poverty, low educational status, gender inequality and rooted traditional culture. People of rural areas have high percentage (85%) of migrant population than in urban areas for the employment purpose (CBS, 2011). This situation may increase the susceptibility of rural women to HIV because migrant males are supposed to be carrier of HIV infection when they return back to their home. In general, Nepalese women are traditionally supposed to be passive, obedient and self-sacrificing in sexual relationship with their husbands. They cannot talk about sexual matters nor can negotiate for safe sex, thus further increasing their susceptibility.

1.2 Problemstatement

In Nepal, the prevalence rate of HIV is low but the study area may be at high risk because it has open border with India where 2.5 million are living with HIV and AIDS out of 3.5 million in South Asia (UNDP, 2010a). According to recent estimates, there are approximately one million Nepalese working in India mostly as unskilled permanent or seasonal labour migrants(Wagle et al., 2011). Sishawanijahada Village Development Committee (VDC) is among one of the villages in Nepal which lies at the border of India from where an estimated around 68% of the male population have migrated to India and other countries in search of job. It is one of the

backward VDC in Morang district of Nepal with literacy rate of 31% which is almost twice as low as the national average (61%) (VDC, 2005). This VDC has majority of the population belonging to Madhesi Janajati and Dalit (low caste) who are still discriminated and isolated from the mainstream of state service. Men leave the village as seasonal migrants to India, other countries and even urban areas within country in search of job. The women of this VDC may be susceptible to HIV because of majority of their husbands migrate to India as a seasonal labour and non-adoption of safe sex practices. The society also has traditional and silent culture regarding sexual matters which further increase the risk of HIV infection. Wives of seasonal labour migrants are also susceptible to HIV infection if their husbands bring the disease back with them(UNDP, 2010b). Women and Children Office (WCO) has worked with women of this VDC but it has not given attention to the issues regarding the susceptibility to HIV on women in their working areas. Additionally, it has limited knowledge about the influence of seasonal labour migration on susceptibility to HIV. Therefore, this study is intended to provide recommendations on reducing the susceptibility to HIV among wives in seasonal labour migrants male and non-migrants households.

1.3 Objective of the study

The overall objective of this study is to contribute towards the reduction of susceptibility to HIV of the WCO's women groups of Sishawanijahada VDC, Morang Nepal by making recommendations based upon the analysis of the study.

1.4 Main Research Question

To what extent does seasonal labour migration to India influence male risky behaviour and have effect on HIV/AIDS of their wives in Sishawanijahada VDC?

1.4.1 Subquestions

- I. What is the understanding of women in Sishawanijahada VDC about STDs and HIV/AIDS?
- II. What is the difference in risky behaviour between seasonal labour migrant malesto India and non-migrants males in Sishawanijahada VDC?
- III. How the traditions and socio-culture norms about sexuality contribute to women susceptibility to HIV from their husbands in Sishawanijahada VDC?

CHAPTER TWO: LITERATURE REVIEW

This chapter presents concepts of mobility and migration, causes of migration, relation between migration and HIV/AIDS, risky behaviour of males, relation between seasonal labour migration of male and susceptibility among their wives, socio-cultural norms of the society regarding sexual matter and the knowledge of HIV/AIDS. Relevant literatures are reviewed and discussed.

2.1 Migration

Population migration is considered as burning issue in the twenty one century across the world. The movements of people are described by different approach. Migration is the movement of people from one place to another. This movement cannot be assumed by single factor. A number of factors are the prime cause of migration. NCASC (2012)report explains that migration is the physical movement from place of origin to place of destination and the movement of people have intention of setting permanently, semi permanently and temporarily whereas the report on the other hand says that mobility is concerned with the movement of people from place of origin, travel substantial and have intention to return back in place of origin. Migration is related with movement and the forms of movement can be explained in different ways. The UNDP study has categorized migration into three groups.

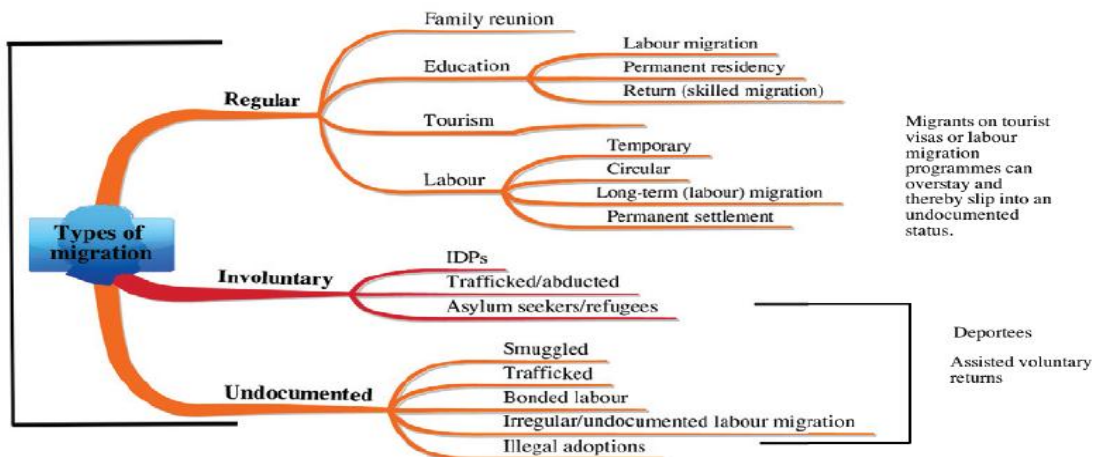


Figure 1Types of migration(UNDP, 2010b)

The labour movements are described into four forms i.e. temporary, circular, long term migration and permanent settlement.

Sharma and Sharma(2011)have defined seasonal migrants as the ones who left their place of residence at least once in a year for less than six months. Migrants are people who either move from their place of birth to another area or frequently change their residence. Migration may be seasonal, temporary, semi-permanent, or permanent depending on the duration and reasons for migration within a defined geographical area. Migration brings significant demographic dynamics to a society and carries socioeconomic implications for both the origin and destination place. Culture and customs, opportunities for education and employment, and geographic hardships are among the major causes of migration (Sharma and Sharma, 2011).

Migration is defined as a “change of residence” and, for demographic purposes, residence is often defined in terms of “length of stay”, whether actual or intentional. For example, voluntary

migrants from one country to another, foreign migrant labours on contract, irregular or undocumented migrants etc.(Supang, 2000).

Migrants are mobile people who take up residence or who remain for an extended stay in a foreign country (UNAIDS, 2001). UNDP (2010b) report states that migration is such movement which bears permanent migration from one country to another whereas mobility has temporary or seasonal labour migration in nature.

UNAIDS (2001) has defined mobile people as “People who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons”. In broad terms, mobility encompasses migration but is often used to refer to the people who move out of their usual residence for short durations e.g. truck drivers, fisher folk, seasonal workers, tourists, traders and salesmen etc. So, in essence, migration and mobility are various stages of a process and emphasis should be given to the “continuum” of the event rather than legal definitions (Supang, 2000).

Migrations have different forms such as labour migration, including seasonal migration; student migration; forced displacement; etc. Labour migration is generally defined as a cross-border movement for purposes of employment in a foreign country. However, there is no universally accepted definition of labour migration. Classification of labour migration is usually based on the duration of activities, as well as on the distinctions made by receiving countries in their regulatory framework where conditions of admission and stay are established(IOM, 2006).

According to the United Nations Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (1990), a migrant worker is a person who is to be engaged, is engaged, or has been engaged in a remunerated activity in a State of which he or she is not a citizen. A “migrant worker” is defined in the ILO’s Migration for Employment Convention, 1949, (No.97) as a person who migrates from one country to another (or who has migrated from one country to another) with a view to being employed otherwise than on his own account, and includes any person regularly admitted as a migrant for employment (ILO, 2002).

The word seasonal labour migrants are generally used for those people who frequently leave their place of origin within or outside the country for short term.Sharma and Sharma(2011)have defined seasonal migrants as the ones who left their place of residence at least once in a year for less than six months. The current study is concerned with seasonal labour migrant males that temporarily move to India in search of work. As agriculture is the main occupation of the study population, males move to India in search of job during off-seasons of agriculture. The males who moved to India at least one year before the commencement of the study for the purpose of earning and returned home at least twice a year are considered as seasonal labour migrants for the purpose of this study.

2.2 Cause of migration

Migration is the third component of population dynamics, the other two being fertility and mortality. This component affects the size of the whole population. Basically it is concerned with social, economic and political variables (Singh, 2010). It is very difficult to know why some people move and why some do not. Nevertheless there are two factors to answer the question.

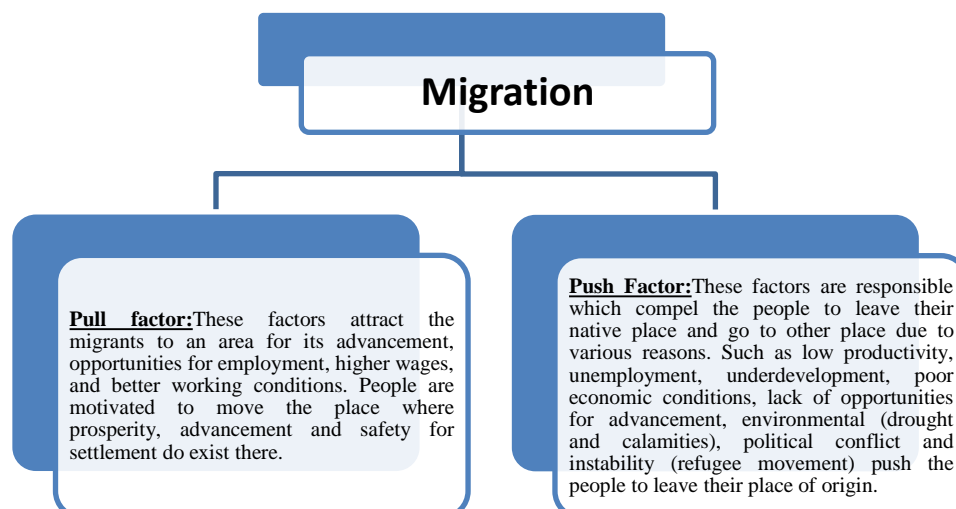


Figure 2 Factors affecting migration(Singh, 2010)

The movement is being occurred across the world normally by above two factors as shown in Figure 2. The study by Niranjana (2008) in India showed that better work opportunities (80 per cent) and subsequently higher income (59 per cent) were the two major pull factors (reasons for moving to the current location) responsible for the movement of respondents to their current place of work. On the other hand, the major push factors (reasons for leaving the place of origin or previous place of work) were low wages (44 per cent), unemployment and debt (29 per cent each), and poverty (23 per cent) at the native place or at the previous place of work.

2.3 Migration and susceptibility to HIV

The chance of an individual becoming infected by HIV is determined by various factors. Biological, social, economic, cultural are the causes of susceptibility. If a person has poor health, he/she will be more susceptible because of weak immune system than person having good health. Likewise, in some society, cultural value and norms are such that there is an inequality between man and woman and females are dominated by males. They suffer from sexual violence making them susceptible to HIV (Holden, 2004). According to Barnett and Whiteside (2006) susceptibility refers to any set of factors determining the rate at which the epidemic is propagated. In this study, susceptibility is meant to any sexual behaviour of the male partner that increases the likelihood of women to be infected with HIV. Susceptibility relates to the chance of an individual becoming infected by HIV. It has two components: (1) the chance of being exposed to the virus, which in turn relates to the risk environment and specific situations of risk that the person confronts and the riskiness of her/his behaviours (both of which may be related); and (2) the chance of being infected with the virus once exposed (Loevinsohn and Gillespie, 2003).

According to Barnett and Whiteside (2006), there are many contributing factors of susceptibility to HIV. The factors may be infrastructure, natural environment, economic and social which have either positive or negative result. The susceptibility may also be influenced by the human character or attitude. Thus, people may be involved in risky behaviour by their differential income, status and social standing. Susceptibility may occur at different level. The mobility/movement of people, civil unrest, or environmental events may make the entire society or country susceptible to HIV. Likewise, the mobile people may be in risky situation and they may make partners susceptible to HIV. The following table shows the relation between migration/mobility and susceptibility to HIV.

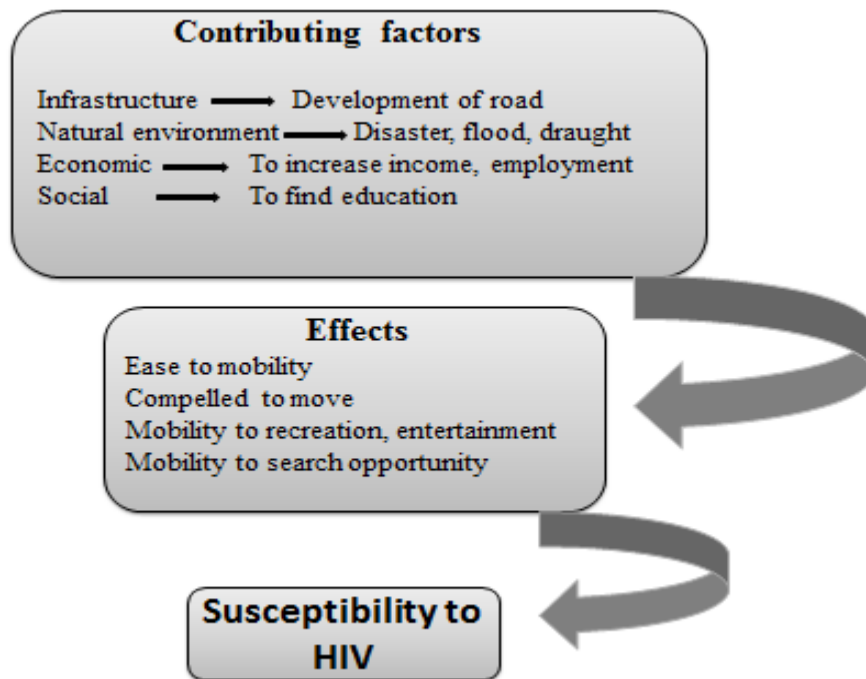


Figure 3 Mobility affecting susceptibility to HIV (Barnett and Whiteside, 2006)

Migration/mobility is associated with HIV transmission to some extent. Numerous studies reveal that there is an ample evidence to point out a close association between increased vulnerability during mobility and spread of HIV(IOM, 2006). A number of studies indicate that migrant labour are working in bad condition and suffer from social exclusion, loneliness and anonymity which increase their vulnerability to HIV/AIDS.

The ILO (2002) identifies work situations that cause the worker to be more susceptible to the risk of HIV infection, most of which apply to many migrant/mobile workers: travelling regularly; living away from spouses and partners; working in geographically isolated environments with limited social interaction and health facilities; single-sex working and living arrangements among men; and work that is dominated by men, where women are in a small minority. It shows that migration/mobility is itself not a factor of spread of HIV transmission; it depends upon condition, pattern, process, communities of origin, during transit, at destination and on return of mobility.

Migrant labours not only face physical and social problem but they are also taken as a problem of cultural integrity of a country or to job opportunities for the national population. They must be alert from the xenophobia. Migrant labours face double dealing of discrimination. The first one is the fear of suspicion of HIV and other is the problem of stigmatization (ILO, 2002).

Many studies recognize that impact of migration is related to HIV infection. In Uganda, the highest HIV prevalence was found in people who had moved into a new area during the previous three years. In Bangladesh, approximately 67% of the identified HIV positive cases were returnee migrant worker and their spouses. According to National estimates of 2009, approximately 63,528 adults and children are affected with HIV in Nepal. Labour migrants constitute the largest proportion (40%) of the total HIV infected in the country (NCASC, 2010b).

Migrant labour may be economic force of some receiving countries. But some public health literature indicates that migration is considered as the key drivers of HIV epidemic (Quinn, 1994, Jochelson et al., 2003). Population migration/mobility could be major factors driving the HIV epidemic in a country. Voluntary migration (seasonal worker, truck driver etc.) and forced migration (refugee, displaced person) are both increasing the spread of transmission of HIV but voluntary migration is more critical because the migrant are away from the families and communities and sometimes they infect their spouse when they return their home. However, forced migration occurs along with the family hence, sexual partner seeking behaviour of males may be less thus reducing the chance of HIV infection (UNAIDS, 2001).

2.4 Migrant people and risky sexual behaviour

Risk is determined by individual behaviour and situations and behaviour is directed by person's character, knowledge, education and awareness but situation is influenced by surrounding environment. Research shows that migrant workers engage in risky sexual behaviour because of peer pressure, work stress, and homesickness. While in destination place, the migrants have multiple sex partner, unprotected sex and alcohol which may lead them into risky situation (UNDP, 2010b). A study by Care Nepal (2011) showed that risky behaviour of labour migrants of Nepal were drinking alcohol (29%), drug use (12%) and men having sex with men (11%) while in India. A study conducted in 2006 among Nepali migrants travelling to Indian cities for work found that 27 % of the men engaged in high-risk sexual behaviour while in India (UNDP, 2010b).

Risky behaviour is associated with seasonal labour migrant worker who are at a significantly higher risk of HIV infection than non-migrants. In a study of rural community in Kwa Zulu-Natal of South Africa, people who had recently changed place of residence were three times more likely to be HIV positive than those that had not (Karim et al., 1992). Risky sexual behaviour can lead to a person becoming infected with HIV. It refers to the involvement of individuals in regular alcohol use, risky sexual activity such as choosing of a multiple sexual partner and sex without the use of condom.

Migrants' people are away from their families and communities. They feel difficulty in language and culture in the destination area. Moreover, loneliness and exclusion may be faced by migrant people in the absence of their regular partner. Many research shows that these circumstances lead migrant people in risky sexual behaviour. In a Western Nepal survey, 49% of male and 40% of female who were seasonal labour migrants reported premarital or extramarital sex when they were away from home (Suvedi et al., 1994). Likewise, male migrant returnees of far western Nepal shared their experiences that they fell into the habit of gathering for drinking and then visiting brothels in Mumbai and back home they looked for extramarital affairs with local girl. The unsafe sexual practices and behaviour are the main causes of infection of HIV. A study reports that HIV prevalence among respondents who had ever visited sex workers in India was 8.2% compared to HIV prevalence of 0.8% among those respondents who had not visited a sex worker in India (NCASC, 2010b).

Migration has been associated with higher HIV prevalence in southern Africa as far back as 1989 (Hunt, 1989, Kuma et al., 1991, Jochelson et al., 2003), with one researcher noting that "migration is associated with increased extramarital multi-partner sexual relations through which HIV is spread" (Grundfest, 2003). Therefore, the migrant people who are away from their families for long periods of time might be at higher risk of HIV infection than those who remain at home.

In this study, risky behaviour of males is defined as the sexual behaviour that leads them towards susceptibility to HIV/AIDS. Alcohol use, non-use of condoms and multiple sex partners at the place of origin are taken as indicators of risky behaviour of males.

2.5 Male migration and susceptibility to HIV on women

In Nepal, men are nearly three times more likely to have migrated than women (DHS, 2006). Likewise, Wagle et al. (2011) found that 99% of migrants crossing the border into India were males. Therefore, the spread of HIV transmission is primarily concerned with male migration. Several studies have shown that migration of men have key role in the spread of HIV because they become infected when they are away from family and culture and infect their wives or partners when they return back (Vissers, 2010). Men may have unsafe sexual practices in the destination. Reviewing the literature, it can be said that migration is one of major cause of the many factors of transmission of HIV in families and community. According to a study “Vulnerability to HIV is not just an issue for migrants’ individuals. It involves families and communities” (UNDP, 2010b).

Women have been blamed to infect others and the HIV positive females also suffer from stigma. Naïfs Sadik (2008) said that women suffer from HIV and AIDS itself, and they are also stigmatized due to the infection. Society blame women for infecting their husbands, but in most cases wives acquire infection from their husbands. Sadik added that about one-third of all people living with HIV (PLWH) in China are women, compared with one in ten in 1995 which shows that the pattern is changing with time. Hence, women may be susceptible to HIV due to the migration of men. The situation is more serious in the context of rural women because rural women lack education, knowledge, equality with men and is bounded by rigid culture and religion. In the same way, HIV susceptibility to Nepalese women is the consequence of wide range of biological, economic and socio-cultural factors. Rural Nepalese women have poor access to education and health information, possess limited decision power for marriage and sexual relation, and are economically dependent to their husbands. Additionally, part of culture and religion creates gender inequality. These factors further boost the spread of HIV transmission to women and wives by the returnee migrant. Moreover, women are physiologically more vulnerable to HIV infection than men, particularly, women with sexually transmitted infection. A study states that “Nepal is experiencing a spread of the HIV epidemic from high-risk behaviour groups (sex-workers, migrant workers) to the low risk behaviour population such as housewives” (Wasti, 2007).

2.6 Knowledge about HIV/AIDS

Knowledge about HIV/AIDS plays a key role on decreasing women susceptibility because studies show that knowledge of HIV is associated with safe sexual behaviour. If women have knowledge about transmission, prevention and treatment of HIV, they may be less susceptible. Therefore, the range of knowledge about HIV should cover the methods of transmission and prevention of HIV.

Several studies have explored the level of knowledge of migrants and their spouses regarding HIV/AIDS. A study by Samuels and Wagle (2011) revealed that labour migrants are more informed than their spouse about the infection. The study revealed that 88% of the migrants in India as well as 85% to 99% of their spouses and returnee or circular migrants in Nepal have heard of HIV and AIDS. Returnee and circular migrants were better informed on modes of transmission than the spouses and migrants at destination. The study also reveals that there are misconceptions about HIV in Nepalese society due to the lack of knowledge of HIV. The most common misconceptions were the belief that people could contract HIV ‘from mosquito

bites', 'kissing/hugging an infected person' and 'sharing a meal with someone who is infected'. This misconception in migrants was less than spouse.

2.7 Socio-cultural norms and HIV/AIDS

Nepal is a multicultural and multi-ethnic society with over one hundred ethnic and caste groups (Dahal, 2003). Socio cultural norms have impact on the spread of transmission of HIV/AIDS. In Nepalese society, HIV/AIDS is perceived negatively and is regarded as sin of past behaviour (Broughton, 1999). Sexual matter is a secret issue and not openly discussed. Talking on the issues of sexual matter with family and elders is considered disrespectful and impolite. These types of socio-cultural challenges are responsible to fuel the spread of HIV/AIDS.

Due to the cultural norms and values, women and girls are traditionally lower in social status than men, therefore even if they have knowledge about HIV/AIDS and STDs there is no access to means of protection (Wasti et al., 2009).

Turmen (2003) reported that the risk of HIV infection through unprotected vaginal sex with an infected person is estimated to be 2 to 4 times higher for women than for men. Numerous studies have pointed out that the negotiation for safer sex through condom use is rendered problematic not only by the negative connotations associated with the method, but also by cultural attitudes toward female sexuality. Women who want to practice safer sex may not be able to do so due to fear of being considered immoral and untrusting, and for fear of reprisals in the form of anger and rejection (Gage, 2000).

2.8 Conclusion

Many Nepalese leave their household as seasonal labour or permanent labour migrants to urban centre and other neighbouring countries for the search of employment. Nepal labour survey (2008) stated that the most popular destination place of Nepalese migrants is India, to which 20% of all male migrants relocate. Likewise, NCASC report (2010b) revealed that the estimated seasonal labour migrants in Nepal is 1,511,000. The people of Nepal are migrating to abroad particularly to India in large number due to the socio-economic and political factors. The NCASC report further explained that people owning low productive land, from low economic households and who are directly or indirectly influenced by on-going political conflict are particularly the ones who are likely to migrate. With remittance income (25% of GDP) in the country, the seasonal labour migrants are also bringing some problems related to public health. Separation from families and new social networking of migrants usually lead to unsafe sexual practices and they are at risk of HIV. The migrant males in the destination place earn more money than in the place of origin. As a result, they get involved in risky behaviours to HIV such as alcohol use, non-use of condoms and multiple sex partners, which is further enhanced by loneliness, peer pressure and risky environment UNDP (2010a). Thus, they may acquire infection in the destination place. When they come back home, their sexual behaviour (non-use of condoms) make the females susceptible to the infection. Furthermore, the closed culture of the society and limited knowledge of HIV in females increases the susceptibility.

CHAPTER THREE: METHODOLOGY

This chapter discusses about the research methodology employed in this study. It describes how the desk study and the field study were conducted. It also describes about site selection, method of data analysis and conceptual framework of the study.

3.1 Study area

The study was conducted in Sishawanijahada VDC of Morang district. The district is situated in the eastern part of Nepal and is linked with India in the southern part. Due to open border, people of this district frequently move to India without restriction. According to District Development Committee (DDC) Morang, the movement of people as seasonal labour migrants to India and other countries is increasing. The number of estimated HIV infected in Morang district is 3,500 with a prevalence rate of 0.35% but the reported cases of HIV are 1,027 and number of deaths due to AIDS are 1,055 (DDC, 2011). The VDC lies in the southern part of Morang district and is four kilometres far from the border of India. It has the second largest population among other districts (approximately 1 million). The VDC profile (2005) states that the total population of the VDC is 7,648 comprising 3,639 women. Agriculture is the main occupation in the VDC. There are 70% households who have no food availability for three months. The literacy rate is 31% which is lower than national average (61%). It has been estimated that males around 68% of the households of this VDC move to other countries especially India as seasonal labour migrants (VDC, 2005). Based on the data provided by sub-health post of the VDC, there were three HIV infection cases and 56 cases of STDs infected females in 2011 among 305 females who attended a health camp organized in the village. Majority of the people belong to Madhesi Janajati and Dalit community and follow Hindu religion.

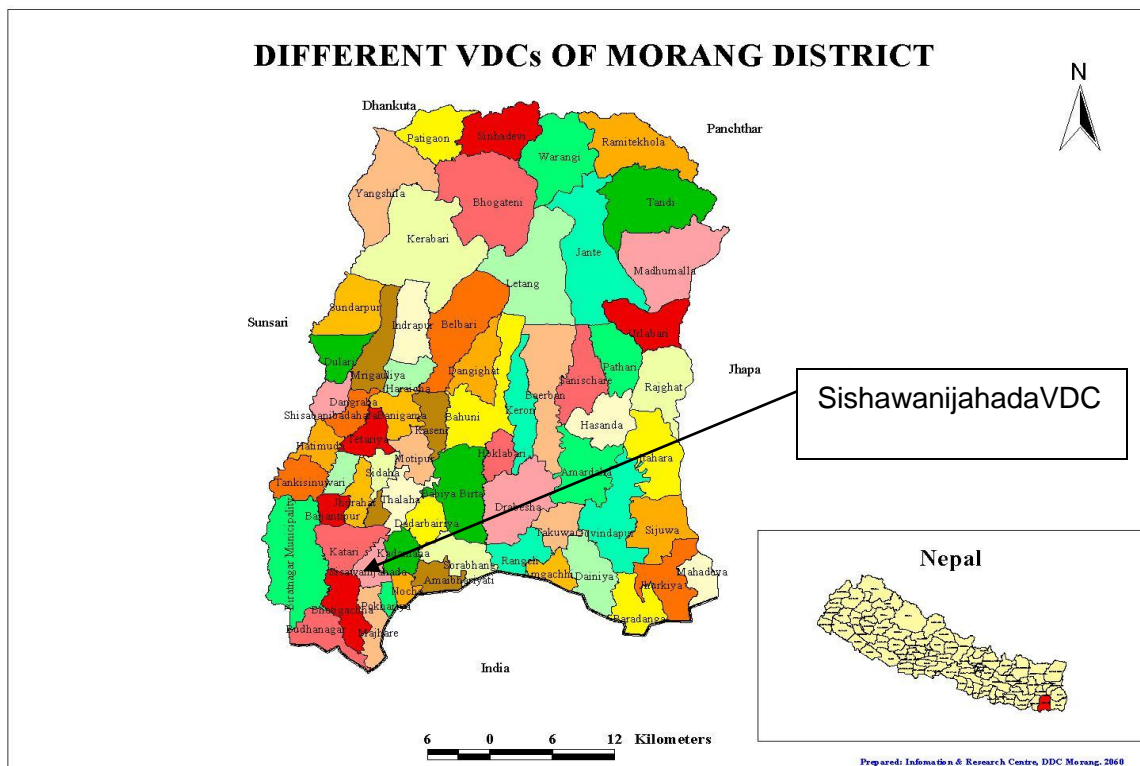


Figure 4 Map of Nepal showing the study site

Source: DDC, Morang

3.1.1 VDC selection criteria

Sishawanijahada VDC was selected for the study based on VDC and DDC profile, reports of WCO, Morang and discussion held with WCO and DDC of Morang district.

The following criteria were used for the VDC selection:

- Proximity to India border
- High volume of seasonal labour migrant males to India
- Low literacy rate of women
- Closed culture regarding sexual matters

3.1.2 Women and Children Office (WCO)

The respondents of the study group are members of WCO, Morang. WCO is an implementing body at the district level under the Ministry of Women, Children and Social Welfare (MOWCSW). It collaborates with district level stakeholders in order to execute gender related interventions. The stakeholders include DDC, VDC, sectoral government line agencies (agriculture, health, education etc.), related Non-governmental Organization (NGOs) and International Non-governmental Organizations (INGOs). There are 20 women groups in the Sishawanijahada VDC under the facilitation of WCO. Each group consist 7-20 members who are economically and socially backward. The WCO works for gender equality of women through their empowerment. To achieve this, WCO has focused on seven priorities: gender equity, reproductive health awareness, economic prosperity, institutionalization, community affiliation, adolescent girl development and men's participation. It provides awareness and capacity building trainings to the group members. However, WCO has organized only Reproductive Health (RH) training. RH training included the HIV/AIDS issue as a one component. Therefore, only few respondents of this study participated in this training. WCO does not have any strategy plan related to HIV/AIDS hence; programs cannot be launched in an intensive way.

3.2 Research design

The study used a qualitative approach making use of primary and secondary sources. It was based on desk study and field study data.

The desk study was conducted to search relevant information from various sources such as books, article and journals, internet searching, and national and international statistics. Data were collected from the publications of DDC, VDC, WCO and NGOs by personal visit to these organizations. Majority of the literature were searched using Wageningen University and Research Centre (WUR) online library.

The field study data were collected from two sources. Firstly, information was collected from the respondents of the study who were the wives of seasonal labour migrants to India as well as wives of non-migrant households. The males who migrated to India at least one year before the commencement of the study as a seasonal labour migrant and returned home at least twice a year were considered as seasonal labour migrants whereas, those who had never moved to India as seasonal labour migrants were considered as non-migrants. Secondly, relevant information was gathered from key informants who were chief of WCO, VDC secretary and chief of sub-health post. The checklist interview questions were used to generate information from the respondents which were mainly unstructured and open-ended questions. Likewise, open-ended questions were also used for the key informants using checklist. The checklists are presented in the Annex I and II.

3.3 Selection of sample size

In this study, 30 respondents were selected for interview using checklist. The respondents were divided equally into two groups' i.e.15 wives of seasonal labour migrant male households and 15 wives of non-migrant male households. This was done to compare the susceptibility to HIV on women between these two types of households. The respondents are the members of WCO's groups. There are 180 women members who are tied up with WCO's groups. Among them, husbands of 65 women had migration to India and other countries while remaining 115 women had non-migrant husbands. Purposive sampling method was used to select the respondents from both the groups.

Three key informants were selected on the basis of their expertise and linkage with women's group in the VDC. The key informants were (i) Village Development Committee (VDC) secretary, who is full time employee of the VDC and is always in touch to the community in terms of planning, implementing and monitoring of VDC programs. He has the authority to formulate and allocate budget in the area of HIV/AIDS. (ii) Member secretary of Village AIDS Coordination Committee (VACC) and chief of the sub-health post, who is the prime coordinator of the committee who is also familiar with women's issue related to STDs and HIV/AIDS (iii) Women Development Officer (chief of WCO), who bears the capability of introducing program and budget for women awareness for the reduction of susceptibility to HIV.

3.4 Data collection

The household field study was carried out from mid-July to mid-August 2012. Before starting the main process of data collection, an introductory meeting was organized by inviting social mobilizer, VDC secretary, health assistant and almost 40 women of WCO's group members to explain the purpose of my research. Three women were selected randomly to perform the pre-test for checklist interview questions. Some questions were reviewed after pre-testing. Field study data was collected from respondents and key informants through household visits.

3.5 Data analysis

The collected data was entered into the excel sheet. Simple statistical tools were used to present the data in different forms such as tables and figures. To analyse knowledge and behaviour a difference was made between women of migrant men and women of non-migrant men. In addition a distinction was made between educational level and women who had and who had not attended training on RH.

3.6 Strength and limitations of the study

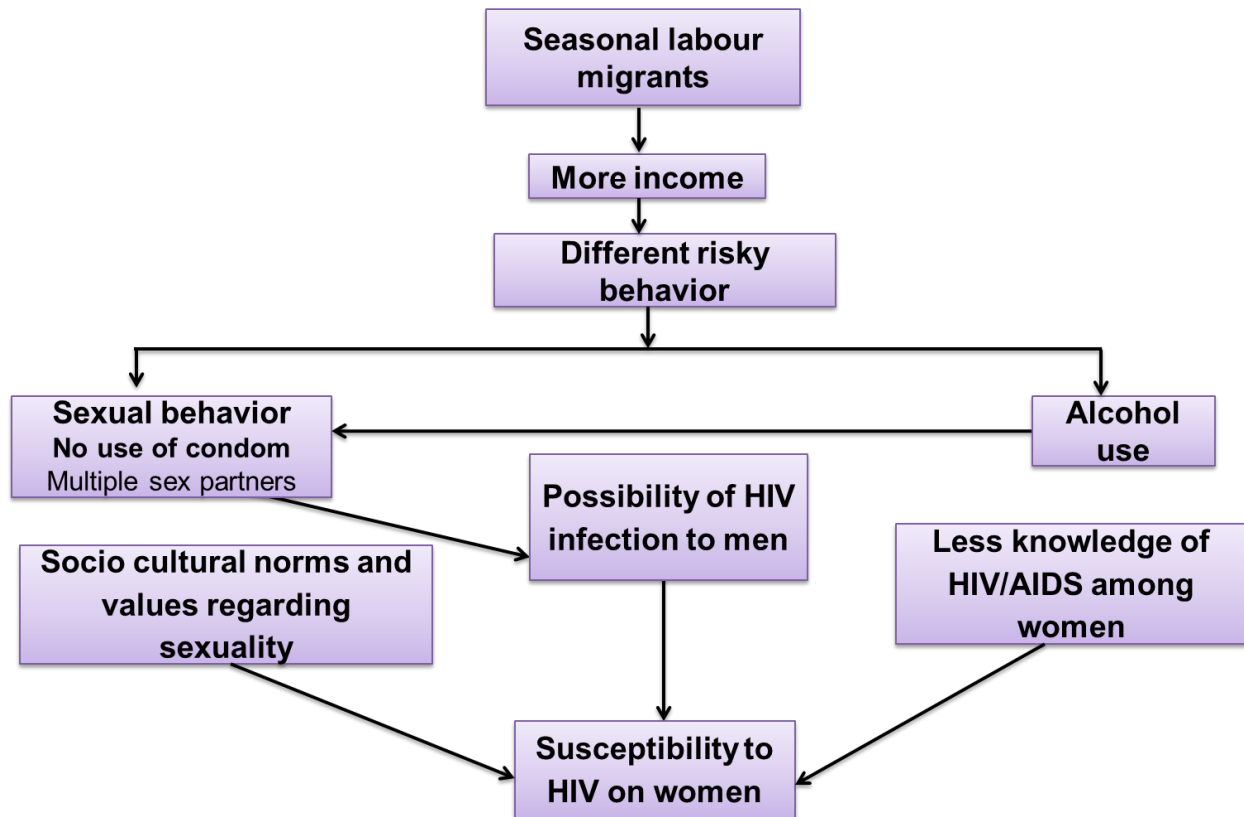
As the interviewer had worked with the women of WCO group since a year, there was familiarity between them which eased the communication. Being a female interviewer, it was easier to extract information related to sexual matters from the respondents. However, information related to the multiple female partners of their husbands could not be extracted either due to privacy reasons or due to unknown real situation. The respondents were unknown about the sexual behaviour of their husbands because of blind faith towards them and unseen sexual activities. Additionally, in Nepalese society it is considered impolite to talk openly on sexual matters which may influence the reliability of information provided by the respondents. Furthermore, males were not interviewed in the study; therefore it was difficult to explore their sexual behaviour. The study could not cover the real situation of the entire VDC as information was collected only from 30 respondents, so the results of the study cannot be generalized for the whole population.

3.7 Ethical considerations

Ethical issue was maintained by asking respondents to participate voluntarily and informal permission for the study was taken from the respondents. All the data were handled with confidentiality and were used for research purpose only.

3.8 Conceptual framework of the study

This study is focused on male seasonal labour migration to India that may increase susceptibility to HIV on their wives. The conceptual framework of the study is shown as follows:



Note: The factor element in bold will be studied in research.

Figure 5 Conceptual framework of the study (based on literature review)

The above framework reveals that seasonal labour migration of male occurs to earn money. When they earn more money in the destination place compared to place of origin, they may be engaged in risky sexual behaviour such as alcoholism, visit to brothels, sex without condom and sex with multiple partners. Thus they may acquire HIV infection. When they return back to their home, their wives may be susceptible to HIV due to their risky sexual behaviour such as non-use of condoms. In Nepalese culture, women cannot talk with their husbands about sexuality and their safety measures. On the other hand, they may not have sufficient knowledge about the transmission of HIV/AIDS and their preventive measures which may further increase their susceptibility to HIV. This is the main conceptual framework of this study. It is uneasy to measure the risky sexual behaviour of males because it is associated with sexual activities that cannot be expressed directly, therefore proxy indicators will be used for example non-use of condoms and alcohol use.

CHAPTER FOUR: FINDINGS

This chapter describes the findings of the research study. It presents the analysis of knowledge of women about HIV/AIDS and STDs, risky sexual behaviour of seasonal labour migrants and non-migrant male partners, and analysis of socio-cultural norms regarding sexual matter. The findings of the study are presented followed by discussions.

4.1 Characteristics of respondents

Information was obtained from 30 female respondents and 3 key informants through interviews using check lists. The respondents surveyed were divided into two categories; category A - wives with male partners who are seasonal labour migrants to India and category B - wives with non-migrant male partners. Each of the category consisted of 15 respondents. Table 1 shows the respondents' age range, education level and participation of training.

Table 1 General characteristics of respondents

	Age group	Educational level				Total
		Illiterate	Informal	Primary school	Secondary school	
Category A	25-35	5	3	1	0	9(60)
	35-45	5	0	0	0	5(33)
	>45	1	0	0	0	1(7)
Total		11(73)	3(20)	1(7)	0	15
RH Training		1	0	1	0	2(13)
Category B	25-35	4	1	3	1	9(60)
	35-45	3	1	0	0	4(27)
	>45	1	1	0	0	2(13)
Total		8 (53)	3 (20)	3 (20)	1(7)	15
RH Training		2	1	2	1	6(40)

* Category A - females with male partners who are seasonal labour migrants

** Category B - females with non-migrant partners

***The number in brackets represents percentage

****Informal education denote the adult literacy class

Majority of the respondents of both categories (60%) were within the age of 25 to 35 years. In category A, overall 73% of the respondents were illiterate whereas illiteracy was lower in category B (53%). The number of females attending primary and secondary education was higher in category B (27%) than category A (7%). Also, the attendance of respondents in training about Reproductive Health (RH) was higher (40%) in category B in comparison to category A (13%). As per information of WCO, RH training had a seven days period in which eight components were included i.e. family planning, adolescent health care, HIV/AIDS and STDs, infertility, safe abortion, neonatal baby care and reproductive health right. Under the content of HIV/AIDS and STDs, the main symptom of STDs, mode of transmission of HIV, prevention methods on HIV were discussed in training. Participation of category A respondents was low because the training was residential and they couldn't stay in WCO's training centre as they have to care their home in the absence of their husbands.

The results of the study showed that, education level and especially the numbers of RH trainee participants were higher in category B respondents than category A as depicted in

table 1. Education and training enhances the knowledge and information about HIV/AIDS among women which reduce the susceptibility to HIV. Education and training empower women which can protect themselves from sexual violence by their husband and also can negotiate for safe sex with them.

4.2 Knowledge on HIV/AIDS

The knowledge of respondents on different aspects of HIV/AIDS was assessed. It included hearing about HIV, mode of transmission, misconception of HIV/AIDS, prevention methods of HIV infection and STDs symptoms.

4.2.1 Heard about HIV/AIDS

The respondents were asked if they had heard about HIV. The study found that there was only 40% of the category A respondents against 67% category B respondents who heard about HIV/AIDS. Among category A respondents all who heard about HIV/AIDS were educated or attend training or both. Similarly, the category B respondents were able to hear about HIV/AIDS by training and education. In both categories, two of the respondents who heard about HIV/AIDS were illiterate and didn't attend training but they heard about it by their friends. The findings indicate that there were more educated and trained respondents in category B as compared to category A (Table 2). Therefore, the respondents who heard about HIV/AIDS was higher in category B. However, 33% respondents of category B did not hear HIV/AIDS.

Table 2 Knowledge of respondents on HIV/AIDS

Education	Category A			Category B		
	Heard	Not heard	Participation of training	Heard	Not heard	Participation of training
Illiterate	2	9	1	3	5	2
Informal	3	0	0	3	0	1
Primary	1	0	1	3	0	2
Secondary	0	0	0	1	0	1
Total	6(40)	9(60)	2(13)	10 (67)	5(33)	6(40)

*The number in brackets represents percentage

4.4.2 Knowledge on mode of HIV transmission

The study revealed that the overall knowledge of mode of transmission on HIV/AIDS among category A respondents was less in comparison to category B respondents. The percentage of respondents in category B was 13% higher than those in category A who knew that sexual intercourse with infected person and multiple sex partner are modes of transmission of HIV virus. Among category B respondents' one respondent had secondary education and RH training, other two respondents had both primary education and training, other two had only training but no education and last one had informal education and training both. 27% of the category A respondents had knowledge of mode of transmission on HIV through sex with infected person and multiple sex partners. Among them one respondent had primary education and training both, another one had training but illiterate and others two had informal education and training. It seems that illiterate group members were not focused in training program by WCO. Rather educated and active members were focused. It can be seen in the table 2 that only one illiterate in category A and two illiterates in category B had got training respectively. Knowledge on mode of transmission of HIV about Mother to Child Transmission (MTCT) was nil in category A respondents. It seems that MTCT was not focused in the training and they were not able to get the knowledge of MTCT. Based on table 5, the findings are those categories B

respondents' had better education and training as compared to category A. Therefore category B respondents are less susceptible to HIV because of their education and training.

Table 3 Knowledge of respondents on mode of transmission

Mode of transmission	Category A			Category B		
	Yes	No	Don't know	Yes	No	Don't know
Through sex	4 (27)	0	11 (73)	6 (40)	0	9 (60)
Multiple sex partner	4 (27)	0	11 (73)	6 (40)	0	9 (60)
Blood transfusion	3 (20)	0	12 (80)	6 (40)	0	9 (60)
MTCT	0	0	15 (100)	0	6 (40)	9 (60)
Needles among intravenous drug users	2 (13)	0	13 (87)	4 (27)	0	11 (73)

*The number in brackets represents percentage

4.4.3 Misconception about the mode of transmission on HIV/AIDS

Table 4 shows that misconception about the mode of transmission of HIV/AIDS is high in both groups of respondents, although it is relatively lower in category B respondents. Category A respondent didn't have any idea if the infection transmits through kissing whereas 40% believed that it doesn't transmit through kissing in the category B. About mosquito bite, category B respondents had a lower misconception (27%) compared to category A. In category B who reported that mosquito bite couldn't transmit HIV virus by having education and training. The result showed that the misconception about the mode of transmission on HIV/AIDS was higher in illiterate and untrained respondents compared to educated and trained. There was similar number of respondents reported that witchcrafts transmitted HIV virus. The superstition is rooted in this community, therefore both the categories of respondents had same beliefs about witchcraft. In the category A, there were more illiterate and less attended training of RH compared to category B. Although misconception was bit higher in illiterates and less educated, as compared to educated, one of the respondents with primary education and participation in training had misconception on witchcraft in category B. The misconception in educated and trained females is a result of rooted beliefs that exist in the community. It can be seen that misconception about HIV virus prevailed in both category but there was slightly lower misconception in category B than category A

Table 4 Misconception of respondents about mode of transmission

Mode of transmission	Category A			Category B		
	True	False	Don't know	True	False	Don't know
Kissing	0	0	15(100)	0	6(40)	9 (60)
Mosquitoes bite	4 (27)	0	11 (73)	2 (13)	4 (27)	9 (60)
Witchcrafts	3(20)	1(7)	11 (73)	3 (20)	3 (20)	9 (60)

*The number in brackets represents percentage

4.4.4 Knowledge on HIV prevention methods

Most of the respondents in both of the categories expressed that they did not have knowledge about all the preventive measures of HIV/AIDS. However, overall knowledge on HIV prevention methods was slightly higher in respondents with category B compared to respondents of category A. Most of the respondents (40%) who had knowledge about the prevention methods in category A believed that sex with only one partner and avoiding sexual contact with infected person helps to prevent HIV. Among them, who had knowledge about it, three had informal education with training, one had primary education with training and another one had training but illiterate. Additionally, the knowledge on use of condoms for HIV prevention was twice as higher in category B compared to category A. Because category A respondents had low level of education and less attend in training. Similarly, the category B respondents had higher knowledge about condom, because of their education and training. Most of the respondents in both categories did not know about all the prevention methods of HIV who were illiterate and had not attended in training. It can be seen that education and training had key role to prevent susceptibility to HIV. Knowledge on prevention methods was seen better in category B. The reason of low attendance in training among category A respondents was that they had no supporting hands in absence of their husbands. Additionally, the other reason was that WCO couldn't able to focus their group members for participation of RH training to the seasonal labour migrant males wives.

Table 5 Knowledge of respondents on prevention methods of HIV/AIDS

Prevention measures	Category A			Category B		
	Yes	No	Don't know	Yes	No	Don't know
Avoid use of infected needles	2 (13)	6 (40)	7(47)	5(33)	2(13)	8(54)
Sex only with one partner	6 (40)	0	9(60)	11(87)	0	4(27)
Use of condoms	3 (20)	0	12(80)	6(40)	0	9(60)
Avoid sexual contact with infected person	6 (40)	0	9(60)	8(54)	0	7(47)

*The number in brackets represents percentage

4.4.5 Knowledge of STDs and chronic illness

The study investigated the knowledge of respondents on chronic illness and symptoms of STDs (white discharge, itching, pain when urinating). It also explored the number of husbands and wives that suffered from STDs, T.B and prolonged fever as an indication of HIV infection. Additionally, respondents were asked about the relation between STDs and HIV/AIDS. The results of the study are presented in Table 6. According to the study, majority of the both categories of respondents did know about STDs. The percentage of respondents who had knowledge on STDs in category B was 13% higher than those in category A. And the higher knowledge was linked with training and education level and also some of the other respondents in both of the category said that they had also knowledge about STDs because they got the information from the STDs health camp which was organized by sub health post a year before. However, the percentage of respondents having knowledge on TB and prolonged fever was similar in both groups. Both categories of the respondents said that they had knowledge about TB and prolonged fever through the sub health post. According to chief of health post of this VDC there is DOTS (Directly Observed Treatment, Short-course) program. DOTS is a strategy for TB control. It has been launched since 1996 in Nepal, which has been extended to reach all health units up to VDC level. Under this DOTS strategy, awareness, publicity and

treatment are moving together. The awareness about TB is being provided to all the population of the VDC under the DOTS programs especially focused among social networks i.e. women groups, community health volunteers, social mobilizers and community leaders. Thus knowledge in respondents about TB and prolonged fever was high due to mass awareness program implemented by health post.

The respondents were asked about whether they knew about the relation between STDs and HIV/AIDS. Based on the interview, all (100%) category A respondents had no any idea that HIV/AIDS and STDs have relationships (87%) of the category B respondents said that they had no such idea. Only one respondent in category B said that she had knowledge about it when she went to check up her white discharge, uterus prolapsed problem and other one reported that she knew about it through secondary school and RH training. It shows that the RH training didn't focus on relation between STDs and HIV/AIDS. Based on knowledge of STDs and chronic illness among respondents, knowledge on STDs was slightly higher in category B whereas there was little difference between category A and category B about the knowledge of relationship between STDs and HIV/AIDS.

Additionally, the number of respondents suffering from symptoms of STDs in seasonal labour migrant group (3) was higher than that in the non-migrant group (1). In category A, there were three respondents who suffered from white discharge. Among them one was illiterate of above 45 years and remaining two respondents were illiterate between 35-45 years. Additionally, in category B, one respondent (32 years) who had white discharge and uterus prolapsed had informal education and had attended in RH training. According to respondents, one of the category A male had suffered from prolonged fever for two months but he got cured and went back to the destination place.

Table 6 Knowledge of respondents about chronic illness and STDs

Disease category	Category A			Category B		
	Yes	No	Suffered	Yes	No	Suffered
STDs	9 (60)	6(40)	3 (20)	11 (73)	4(27)	1 (7)
T.B.	15 (100)	0	0	15 (100)	0	0
Prolonged fever	15 (100)	0	0	15 (100)	0	0

*The number in brackets represents percentage

Tables 2,3, 5 and 6 show that category B scored better than category A on knowledge heard about HIV/AIDS, mode of transmission, methods of prevention of HIV and knowledge on symptom of STDs. Additionally, category B scored better than category A in the knowledge of STDs but there was limited difference among them. There was no difference in the two categories regarding knowledge on TB and prolonged fever. Likewise, the misconception about mode of transmission was comparatively lower in category B respondents. Without knowledge, women don't know how to safeguard themselves on HIV infection which makes them more susceptible to HIV. If they know about it, they are able to negotiate for safe sex with their husbands. The result showed that respondents who had education and training had better knowledge than those who had not. Between two groups, category A respondents had got less opportunity to participate in the training due to their responsibility in both home and outside, and another reason was that WCO didn't focus them for the training. Therefore, the category B respondents had better educational level and more respondents had training compared to category A which enhance their knowledge about HIV/AIDS.

4.5 Risky behaviour of male

The risky behaviour to HIV/AIDS of category A and category B males were explored. As the males were not directly interviewed, proxy indicators of their risky behaviour were assessed through their wives' interviews. The indicators used were alcohol use and use of condoms by males.

4.5.1 Use of alcohol

The respondents who were interviewed expressed their experiences that the risky behaviour was associated with alcohol use. Regarding alcohol use, respondents of category A males increased from 87% to 100% who said that their husband drank every day after returning back from their destination place as compared to the frequency when they were at home. Similarly, 74% of non-migrant wives reported that their husband took alcoholic drink every day and 13% drank weekly. In both the categories, 13% of the males had alcoholic drink occasionally but none was non-alcoholic. 13% of the respondents said that the volume of alcohol use was increasing after migration compare to when they were at home. In addition, the equal per cent of respondents (13%) of category A also doubted that their husbands may have been involved with multiple sex partners after drinking in the destination place because they were also in doubt when they were at home.

Based on the results, almost all the respondents of both categories expressed that their husbands drank alcohol every day. According to respondents, most of their husbands drank alcohol heavily and physical and sexual violence occurred after their husbands had a drink. Hence, not only seasonal labour migrant males were engaged in drinking alcohol but non-migrant males also drank alcohol heavily. Alcohol consumption may lead to male unsafe sexual behaviour. According to two key informants, there are 10 to 12 female sex workers in the VDC which may increase the chance of HIV infection in males if involved in unsafe sex thus, increasing the susceptibility of their wives. It can be seen that, both of the categories of respondent's husbands drank heavily and also did physical and sexual violence which may lead them to unsafe sexual behaviour. Due to heavy alcohol drinking of their husband both categories of women were susceptible to HIV.

4.5.2 Use of male condom

The respondents were asked about the knowledge of condoms (reason of using condom) and the practice of use of condom to explore their unsafe sexual behaviour while having sex with their husbands. The study showed that 40% of the category A respondents said that they knew about condom. Among 40% respondents who knew about condoms of category A, there were 33% who sometimes used condom. Among the category A respondents, who knew about condoms, one of the respondents who had primary education and got training, two of had formal education and one had attained training but illiterate and others two were illiterate. Likewise the respondent, who sometime used condoms, had primary education and training. It showed that the respondent who had education and training had more knowledge and also had capacity to convince their husband to use condoms. Males of 47% of the category B respondents who knew about condom, 43% used it regularly with their wives, i.e. every time while being involved in sexual intercourse. Among 43% who used condom regularly, all of the three respondents had training. Besides training, one had secondary education and other two had primary education. The equal number of respondents of both categories who used condom regularly and sometimes respectively could negotiate to use condoms with their husbands. Among them, the category A respondents who could negotiate for using condom were educated; one of them had primary education while the other had attained RH training. Similarly in non-migrant group, one female had secondary level education and the other attended primary education besides training so that they could negotiate for using condom.

The result showed that a high percentage (87%) of category A respondents husbands never used condom while having sex with their wives before migration and after returning home. According to respondents they never thought that it was necessary because they believed that condom is a birth control device which was not necessary for them. Among them, almost all were illiterate and didn't participate in RH training. On the other hand, high percentage (80%) of the category B respondents never used condoms while having sex with their wives. They also didn't think that condom use was necessary for their birth control because they used hormonal injections for birth control. Based on the result; there was a slight difference in knowledge about condom and use of practice of condoms between two categories. It seemed that only knowledge and education in females did not play an important role in practising condom use, the attitude of males towards using condoms could be a major factor. Thus there was no more difference in susceptibility to HIV among two categories of respondents based on practice of using condoms.

Table 7 Practice of using condoms

	Category A		Category B	
Don't know condom	9 (60)	60	8	53
Know about condom	6 (40)	40	7	47
Regular use	0 (0)	0	3	43 (3/7)
Sometimes use	2 (33)	33 (2/6)	0	0
Never use	13 (87)	87 (13/15)	12	80 (12/15)
Negotiation with male partner for use	2 (100)	100 (2/2)	2	67 (2/3)

4.6 Socio-cultural norms regarding sexual matter

The study showed that almost all respondents couldn't open the discussion about sex matter with their husband. Due to shyness, they could not talk about use of condom and couldn't disagree to involve in sexual intercourse. Social and traditional cultural norms established that women are not supposed to talk about sexual matters. It totally depends upon what their husband wants. If women discuss about it, it is considered rude. 93% of all the respondents said that the sex was under the control of male and they could not have sex with their husbands according to their desire (less active role) for sexual intercourse. Among 30 respondents, only one female of category B had active role for sexual intercourse and she had attended secondary education and training both. Among both category of respondents, 87% respondents couldn't ask their male partner to use condom. Both seasonal labour migrant and non-migrant household of respondents had the same belief towards sexual matters.

The above finding shows that both the categories of respondents have similar beliefs about sexual matter and both groups faced similar sexual violence with their husbands. Due to silence and strict culture regarding sexual matter, both categories of female couldn't talk about safe sex with their husband while having sex which makes them susceptible to HIV.

One of the category B respondents gave her painful statement regarding sexual matter. She said *"I am 32 years married women and have two kids. My husband is a cart puller. He earns Rs.300 per day but he doesn't support us for food, children's school fee and medicine. He doesn't give me money. I am doing turmeric business for food. In the morning, he goes to his work and returns back in the evening drinking local alcohol and beat me. This is his routine work. He wants to have sexual intercourse with me but I don't like his behaviour. Due to fear of violence I have to be compelled to have sex with him. I have uterus prolapse problem but he*

doesn't understand, he just wants sex at any cost. I have attained reproductive health training and know the importance of condom, but he doesn't like to use it. Actually, he is out of sense and motivated to have forced sex when he is in alcohol. I am also a chair person of women cooperatives. Being a chair person of cooperatives, I have to solve many domestic violence problems within women group but I am not able to solve my own problem".

4.7 Status of HIV Testing

The respondents were asked about the HIV status indirectly. Entire respondents of both the categories never tested their blood for HIV status. Both categories of respondent expressed that they never thought blood testing is necessary. But one of the Category A respondent said that she wanted to test but she didn't know the right place to undergo HIV testing. According to respondents, none of them knew about the HIV status of themselves and their husbands.

CHAPTER FIVE: DISCUSSION

This chapter discusses about the findings of the study and compares the results with findings of other studies as far as possible. It includes the knowledge of HIV/ AIDS and STDs among females and risky unsafe sexual behaviour of their husbands; and socio-cultural norms and values regarding sexual matter in the study area. The relation between these factors and susceptibility of females to HIV belonging to seasonal labour migrant and non-migrant males will be discussed.

5.1 Knowledge of HIV/AIDS and STDs

Findings of the study revealed that majority (60%) of the wives of seasonal labour migrant males and 33% of the wives of non-migrant males have noheard about HIV/AIDS. The result is contrasting to the results of Care international (2011) which reported that awareness of HIV & AIDS was high (85%-99% heard about HIV and AIDS) among spouses and returnees of migrant groups. However, level of knowledge of only non-migrant wives separately was not found. Similarly, Nepal demographic and health survey (2011) has also shown that 86% of women in Nepal have heard about AIDS. In our study, the percentage of females who knew that sexual intercourse with infected person and multiple sex partners are modes of transmission of HIV virus was 13% higher in non-migrant households than seasonal labour migrant households. The study also revealed that there was misconception about mode of transmission of HIV virus among both categories of respondents in this VDC and it seemed slightly higher among wives of male seasonal labour migrant households. About MTCT the seasonal labour migrants wives didn't know that it can be transmitted HIV virus, and also non-migrants wives 40% knowledge about it. The misconception about witchcrafts on both types of respondents on transmission of HIV is due to superstition that prevails in the village. The village has low literacy and the Madhesi Janajati groups are very traditional about witchcrafts.

Knowledge on HIV prevention methods among respondents was also low. Among 15 females of seasonal labour migrant males only 20% respondents told that use of condoms was the preventing method of HIV/AIDS while according to Care international (2011), 83% of the spouses of migrants were aware of condoms in Nepal. Similarly, 6 respondents (40%) of non-migrant males had knowledge that the use of condoms is the preventing method to avoid HIV. In the current study, 40% of the females of seasonal labour migrant males and 87% of the females of non-migrant males had opinion that AIDS can be reduced by sticking to only one partner. However, DHS survey (2011) reported that 79% women had views that the AIDS can be reduced by limiting sex to one partner which is a large study among migrants and non-migrants. The difference between current study and other literature may be the low literate respondents and the strict culture in the community related to sexual matters. Additionally programs and trainings on HIV and AIDS is very limited in this community.

The results may be due to closed socio-cultural norms regarding sexual matter in the Madhesi Dalits and Janajatis where programs focussed on sexual issues are not reachable. During study period, it was found that the respondents had never attended trainings about sexual matters but some of them had attended R.H. training on HIV. The wives of seasonal labour migrant had work burden in absence of their husbands which may be one of the leading causes. Lower literacy of the females belonging to seasonal labour migrant males compared to the females of non-migrant males may be one of the factors. Additionally, females of non-migrant males participate in RH training related to HIV as they are supported by their husbands which may have enhanced their knowledge on HIV. But the little difference between seasonal labour migrant and non-migrant respondents about the knowledge of mode of transmission on HIV and prevention methods of HIV leads to both categories of women susceptible to HIV.

The study showed that 60% of the wives of seasonal labour migrant males and 73% belonging to non-migrant males knew about STDs. Regarding the knowledge of STDs, another study by New Era in Western Nepal revealed that 49% of the wives of migrants cited vaginal discharge as one of the symptoms of STDs followed by 25.5% of those wives who regarded an ulcer around genital area as a symptom of STD. 20% wives of seasonal labour migrant males in this study suffered from white discharge and the problem was comparatively lower (7%) in wives of non-migrant males. White discharge is a symptom of STDs which leads to higher chance of infection to HIV. A study in Western Nepal revealed that 11% of women were diagnosed with one or more untreated STDs (Smith-Estelle and Gruskin, 2003) and a significant association was observed between STD, including HIV and having a husband who migrated to India or within Nepal for work. However, no figures were found for females of migrant males of Nepal in other studies. The seasonal labour migrant males may have contracted the infection at the destination place and transmitted to their wives. During this study, it was found that a seasonal labour migrant male had suffered from prolonged fever for two months when he was at home and was cured before returning back to the destination place. But none of the seasonal labour migrant and non-migrant males were found to have symptoms of STDs, and it cannot be suspected that other males had HIV infection except the one that had prolonged fever.

The findings show that all (100%) the females of male seasonal labour migrant wives had no idea that HIV and STDs have relationships while 13% non-migrant wives said that HIV and STDs have relationship. This difference may be due to the participation of females of non-migrants in RH training and health camps. New Era (2008) reported about understanding of STDs those 4 in 10 respondents (41.4%) in the Western region and 35.6% in the Mid to Far Western region understood HIV/AIDS as one form of STD.

5.2 Risky behaviour of male

Risky behaviour is associated with seasonal labour migrant workers who are at a significantly higher risk of HIV infection. In a rural community study in South Africa by Karim et al. (1992) people who had recently changed place of residence were three times more likely to be HIV positive than those who did not mobile/change the place. The report stated that the migrants were infected with HIV in the destination place. In this study, alcohol use and non-use of condom among males are discussed as risk factors for susceptibility to HIV on their wives.

5.2.1 Use of alcohol

In this study, the percentage of males who drank alcohol everyday increased from 87% to 100% after returning back from their destination place as compared to the frequency when they were at home. It shows slight increase in drinking habit of alcohol after being migrated. According to ILO (2002), the rate of alcohol use among migrants is higher than among non-migrants. Similarly, New Era (2002) has also reported that persons using alcohol were slightly higher in migrants group compared to non-migrants. This result is supported by another study in which it is stated that 73% of male Nepalese migrants to India drink alcohol (Samuels and Wagle, 2011). The use of alcohol may lead to risky sexual behaviour because of the influence on decision making (Simkhada et al., 2009). According to study in Nepal by New Era (2010) and Kalichman (2007) in Sub-Sahara Africa, the use of alcohol leads to a higher chance of risky sexual behaviour. Various studies have shown some association between alcohol use and sexual behaviour. Due to alcohol use, males get engaged into unprotected sex and multiple sex partners thus increase the risk of getting STDs and HIV infection (Kalichman et al., 2007). Kapiga (2003) has shown that females whose husbands consumed alcohol every day were at significantly higher risk of acquiring STD than women who reported that their husbands occasionally, rarely or never consumed alcohol. Alcohol use by males also increases sexual violence to their wives which may increase the susceptibility of women to HIV. But, in this study,

there was very little difference of consumption of alcohol among seasonal labour migrant and non-migrant male and both them did sexual and physical violence to their wives after drinking alcohol heavily. The reason may be that respondents were more dependent with their husband to survive and also the community is male dominated where males show their dominating attitude by drinking alcohol. This leads to susceptibility to HIV of both seasonal labour migrant and non-migrant males' partners.

5.2.2 Use of condom

The study revealed that only 40% and 47% of the wives of seasonal labour migrant and non-migrant males respectively knew about the purpose of using condom. Similar type of study by New Era (2010) in Western Nepal, shows majority of the females of seasonal labour migrant males (97.5%) knew about condoms whereas 2.5% of them had never heard of them. The difference in these studies may be due to socio-cultural differences in these two societies and less awareness programs in the study area about sexual matters and HIV/AIDS.

In the study, 87% of the seasonal labour migrant males (before and after migration) and 80% of the non-migrant males never used condoms while having sex with their wives according to the respondents. This finding is comparable to the study done by New Era (2010) in which 77.4% and 63.5% of the migrants in western and mid to far western region of Nepal respectively never used condoms with their wives. The DHS survey (2011) also stated that condom use among migrants and their wives were low: 5.1% in the western and 7.6 in the mid to far western region of Nepal. High proportion of them (60.9%) had never used condoms. The government of Nepal has distributed condoms free of cost in the health posts. However, UNAIDS (2007) has reported that government supply of condoms is irregular and there is no accessibility of free condom in all the areas which discourages target groups for adopting safer sex practices. The chief of sub-health post who is one of the key informants stated that females feel shy to get condoms and males do not feel easy to use it. Additionally, most of the males and females of the VDC believe that condom is only a contraceptive device; therefore they prefer to use contraceptives for long-term birth control for example hormonal injections and intrauterine devices (IUD). Wasti (2009) has also stated that it is impolite to talk about sexuality in Nepalese society and people might feel embarrassed about buying condoms.

According to the respondents of the study none of the seasonal labour migrant males and only 3 non-migrant males used condoms while having sexual intercourse with their wives regularly in this study. Results of a study by New Era (2010) show that very high percentages of the migrant males (60.9%) had never used condoms regularly with their wives. Moreover, all the wives of the seasonal labour migrant and non-migrant males in this study revealed that their husbands never tested for HIV in the place of origin. None of the respondents had also tested for HIV status. Sexual intercourse without using condoms increased the susceptibility of the females to acquire HIV. The wives of non-migrant males are also susceptible to HIV as most of the males don't use condoms regularly. According to two key informants, there are 10 to 12 female sex workers in the VDC. Recent data (NCASC, 2010a) shows that around 20% of migrants engage in unprotected sex in India i.e. they never used condoms with female sex workers in the past year and as a result, this group now accounts for 40% of all HIV infections in Nepal with numbers of HIV cases also increasing among wives and partners.

Only 2 females of both the seasonal labour migrant and non-migrant males could negotiate with their males in using condoms. 73% wives of seasonal labour migrant males and 53% wives of the non-migrant males are illiterate in this study which may prevent them from negotiating regarding sexual matters. Also, the closed culture of their society and superior feeling of the males prevent them from talking about sexual matters even with their husband.

The existing situation regarding the use of condom in the VDC revealed that knowledge of the respondents and the behaviour of their husband was also the causal factor for not practicing condom beside their migration as a seasonal labour. The study shows that there was only little difference between wives of seasonal labour migrant and non-migrant males about knowledge and uses of condoms. Most of the literature shows that the high percentage of males who migrated out of the country has never used condoms which are in agreement with the results of this study. Results of a study by New Era (2010) show that very high percentage of the migrant males (60.9%) had never used condoms regularly with their wives. Additionally, non-use of condoms in non-migrants in this study was comparable to seasonal labour migrant. This shows that seasonal labour migration of male is not the sole factor influencing knowledge on condom and practicing use of condom. The cause may be the male attitude towards the condoms.

5.3 Socio-cultural norms and values regarding sexual matters

AIDS is a social, cultural and economic/financial issue, and it is considered disrespectful to talk about these matters in Nepalese society. Sexual behaviour is not openly discussed in Nepal and talking about sex is considered impolite. Parents and elders also do not talk openly about sex with adolescents. The community of the study site consisted of Madhesi Dalits and Janajatis who are very rigid and strict about sexual matter. According to one of the key informant, the chief of WCO, the culture of this society is very traditional in terms of sexual matters. The females are dominated by males and they do not have any decision power related to family matters for instance, property, marriage and child birth. Sexual and domestic violence prevail in the society due to dowry system (system of giving property in terms of cash and kinds by bride's family to the bridegroom's family based on demand during marriage in Madhesi community). The study showed that almost all females in both the seasonal labour migrant and non-migrant groups couldn't open the discussion about sex matter with their male partner. The females have passive role in sexual activities and the females are fully dependent with their husbands to survive. Therefore they cannot negotiate with their husbands for using condoms and cannot disagree to have sex with them. Thus, females of both the seasonal labour migrant and non-migrant groups may be susceptible to HIV.

Moreover, the females of the study site do not have decision power to access health service because they are fully dependent on family members and husband in terms of decision making. On top of that, they do not seek medical help in case of STDs due to shyness. This increases their susceptibility to HIV infection.

Most of the HIV positive people may be unaware about their status and may continue to be engaging in unsafe sexual practices. In our study, none of the seasonal labour migrant males and their wives had ever undergone blood testing for HIV. According to report by New Era (2002) STDs treatment seeking behaviour of the labour migrants was found to be poor. Only 47.5% people in Western region and 31.1% in Mid to far western region of Nepal were aware of the availability of confidential HIV testing facilities in the community. Very small proportion of respondents in both regions (8.1% in Western and 11.7% in Mid to Far Western) had ever undergone HIV testing. In our study, none of the females were suspected to have HIV/AIDS during interview. There is a negative perception of people about HIV/AIDS (UNAIDS, 2004) and the infected ones are stigmatized. Therefore, there is a trend of hiding the true status due to fear of stigmatization from family and society.

From the study, it was observed that women were not open to discuss about sexual matter with their husbands because they were bounded by the prevailing values, norms and rules of culture. Most of the women of this VDC are illiterate who are following traditional values that make them

shy and silence to discuss about the sexual matters. Majority of the respondents said that they cannot talk freely about sexual matter. Seasonal labour migration could be one factor of susceptibility to HIV but current study shows that the socio-cultural norms and values regarding sexual matter also lead to susceptibility to HIV on women.

As mentioned in the discussion part, many literatures have shown that seasonal labour migration of male is a major factor of women susceptible to HIV. According to Grundfest (2003) "migration is associated with increased extramarital multi-partner sexual relations through which HIV is spread". Therefore, the migrant people who are away from their families for long periods of time might be at higher risk of HIV infection than those who remain at home. However, the current study showed that seasonal labour migration of male is not a single reason of women susceptible to HIV. In this study, both categories of males may have been engaged in unsafe sexual risky behaviour and both categories of respondents have low knowledge about HIV/AIDS and higher illiteracy rate. These all factors lead to female susceptibility to HIV.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

According to CBS, Nepal 2011, people of rural areas have high percentage (85%) of migration population than in urban areas for the employment. This situation may increase the susceptibility of rural women to HIV because migrant males are supposed to be carrier of HIV infection when they return back to their home. However findings of the current study proved that seasonal labour migration of male is not a major factor of susceptibility on women to HIV in the study site. From the study, it was seen that, women have low knowledge on HIV/AIDS, STDs and the cultural norm regarding sexuality do not allow them to talk about it openly. So, it does not matter whether the male are migrant or not. On the other hand, women are fully depended with their husband for the livelihood. Due to the less empowerment (illiteracy, poor health, less access to earn money) they cannot ask their husband's risky sexual behaviour to multiple female partner and negotiation for safe sex with their husband as well which may be susceptible to HIV. The conclusions drawn from results are as follows.

The overall knowledge of HIV/AIDS among both categories of females is low. Therefore, they cannot keep themselves safe from the mode of transmission such as infected blood transfusion, sharing infected needles and MTCT. Additionally, the female also don't know about preventive measures of HIV and STDs. Therefore they cannot talk to their husband for safe sex which is one of the major factors of susceptibility to HIV on women. Thus, it can be concluded that, the seasonal labour migration of male is not a major factor of women susceptibility to HIV but low knowledge of HIV/AIDS among women lead them susceptible to HIV.

The females of both groups who had attended primary/secondary education or who had participated in RH trainings is found to be aware about the preventive methods of HIV/AIDS compared to illiterates and RH untrained. The females of both groups who could negotiate for safe sex and use condoms regularly had primary or secondary education. Therefore it seems that education level and awareness of the females is an important factor that determines their susceptibility to HIV.

The risky unsafe sexual behaviour of males related to alcohol consumption is another factor of susceptibility to HIV among women. Respondents noticed that alcohol drinking habit of seasonal labour migrant males increased after returning back home from the destination place. There is a possibility that drinking alcohol lead the males towards unsafe sexual practices thus making them susceptible to HIV. Some of these seasonal labour migrant males also sexually violated their wives after drinking making their wives susceptible. So, as far as concerned to non-mobile, all of them are drunkard. They also involved in physical and sexual violence of their wives after drinking alcohol and may have engaged in unsafe sex which makes them susceptible to HIV. Thus, female susceptibility is not influenced by seasonal labour migrants of male only but the attitude and behaviour of male is the main cause of risky sexual behaviour.

The risky sexual behaviour of males related to no use of condoms is the major reason of HIV infection. Most of the seasonal labour migrant males (87%) and non-migrant males (80%) never used condoms while having sex with their wives which make their wives susceptible to HIV. Although, almost similar number of respondents in seasonal labour migrant and non-migrant categories did not know about condom, there are some non-migrant males who use regularly condoms while this number is nil in seasonal labour migrant males. Based on the result, it can be seen that there is no more difference between seasonal labour migrant and non-migrant males about knowledge and use of condoms. Therefore, it can be said that the wives of non-migrant males are also susceptible to HIV. Thus it can be concluded that seasonal labour

migrants of male is not only the factor which leads to non-use of condom by males while having sex with their wives which make females susceptible to HIV.

Furthermore, rigid socio-cultural norms of the society and passive role of females in sexual matters played a negative role in practising safe sex. Based on the results of the study, there is no more difference between the seasonal labour migrant and non-migrant respondents about negotiation of condom use with their husbands. Thus the susceptibility to HIV is almost similar between wives of seasonal labour migrant males and wives of non-migrant males. Therefore it cannot be said that seasonal labour migration of male is one of the major factors that influence women susceptibility to HIV. Besides, a number of integrated factors like education level, less awareness about HIV, and strict culture of sexuality among both categories of females' further influence the susceptibility to HIV.

The findings showed that non-migrant wives' knowledge of STDs is higher than that in the seasonal labour migrants' wives. Furthermore, there were more females suffering from symptom of STDs (white discharge) in the seasonal labour migrant group than non-migrant. STDs symptoms increase the chance of getting HIV virus. Similarly, none of the respondents and their partners were tested for their HIV status, therefore their HIV status was not known. Thus, it can be concluded that, seasonal labour migration of male is not the major factor but may be one of the indirect influencing factors that lead to women susceptibility to HIV.

The findings showed that both of the seasonal labour migrants' wives and non-migrants wives who attained RH training were mostly educated. It seems that WCO was not able to include their groups' members in the training who were illiterate. Almost all the respondents who didn't have knowledge about HIV/AIDS and STDs couldn't negotiate for safe sex with their husbands, thus couldn't be able to safeguard themselves from sexual and physical violence were illiterate and uneducated. Thus, it can be concluded that less empowerment of women is one of the major reason of susceptibility to HIV.

6.2 Recommendations

Based on the findings of the study, the following recommendations are made to the WCO, Morang to reduce the susceptibility to HIV of wives belonging to both seasonal labour migrant and non-migrant males' households.

- ✓ Though various organisations are working in the village to create awareness on different areas (e.g. sanitation, gender, child right etc.) this study show that wives belonging to both the seasonal labour migrant and non-migrant males have limited knowledge on mode of transmission of HIV virus and prevention methods of HIV. The knowledge is even lower in wives of seasonal labour migrant males which indicate that these groups are not covered by the programs and are more susceptible to HIV. Thus awareness program on prevention of HIV should be implemented with special focus on wives of seasonal labour migrant males and should also include non-migrant males and females. Special attention should be given to empower illiterates and those who haven't attended RH trainings. Joint coordination of related NGOs, INGOs, youth clubs and government organisations (DDC, VDC and DHO) is necessary. The awareness on prevention of HIV program should focus on;
 - Methods of mode of transmission and prevention of HIV
 - Negotiation skills in using condoms with their husbands (life skill training)
 - Methods of proper use of condom
 - Relation between STDs and HIV/AIDS
 - Importance of HIV tests of the couples of seasonal labour migrant and non-migrant households

- ✓ The awareness about prevention of HIV/AIDS can be done by the use of following aids
 - Local FM
 - Placement of holding boards in health posts and public places
 - Wall painting in public places
 - Monthly meeting of women groups by WCO's social mobilizer
- ✓ The result showed that there was very limited knowledge on MTCT among females of non-migrant and none of the seasonal labour migrant's wives knew about it. Therefore, the awareness about mode of transmission especially should focus on MTCT for those wives of both seasonal labour migrants and non-migrants who have breastfeeding and pregnancy. This should be done by the collaboration with related I/NGOs and local bodies.
- ✓ WCO does not have a strategy plan relating to issues of HIV/AIDS. Therefore a plan to address the issues of HIV/AIDS of the females needs to be formulated and HIV prevention programs should be launched.
- ✓ According to one of the key informant of this study, although the government has declared to provide condoms free of cost in health centres, females do not go to the health post to get condoms due to shyness and males also do not go to bring condom due to not interested. On one hand, the availability of free condoms is low and on the other, people don't go there. So it is important to distribute condoms to the females by mobilizing Female Community Health Volunteers because the female health volunteers are more attached with the WCO's groups.
- ✓ Alcohol use among males is one of the factors that caused physical and sexual violence in females thus increasing their susceptibility to HIV. So, it is important to launch programs to reduce alcohol use in males which can be done by the effort of women cooperative which is already existent in the VDC. For instance, in some VDCs of Morang district, female groups have declared their area as alcohol free area. The initiation should be taken by WCO, Morang.
- ✓ This study found out that four respondents of the study had symptoms of STDs. Therefore, regular health camps should be organized by the sub-health post with collaboration with WCO for reproductive health of the females and free treatment facilities should be provided.
- ✓ This study did not include information from the males which could have generated more information about the female susceptibility. Therefore, further research on this issue should also include males. Additionally, similar study should be conducted all over the district to find the real situation and to ensure representation.

REFERENCES

- BARNETT, T. & WHITESIDE, A. 2006. *Aids in the twenty first century: Disease and globalisation*, Basingstoke, UK, Palgrave Macmillan.
- BONDURANT, T., FRANKLIN, B. & NEILSENG. 2001. *HIV/STI prevention and care strategies for the far western, mid-western and western regions of Nepal* [Online]. Available: <http://www.fhi.org/NR/rdonlyres/efip5yl5ehrabktvr3x3bfchpb3pe4oksyqzhsi3j2f7lf6yx4mvqn42feqxduqltr6wxcqez6g4j/hivcarestartegies1.pdf> [Accessed 22 nd August 2012].
- BROUGHTON, B. 1999. *Guide to HIV/AIDS and Development*. Australia.
- CARE NEPAL. 2011. *Population mobility, and HIV & AIDS: Review of laws, policies, and treaties among Bangladesh, Nepal and India*. Kathmandu, Nepal.
- CBS 2011. *Priliminary result of census 2011*. Central Bureau of Statistics.
- DAHAL, D. 2003. *Social composition of the population: caste ethnicity and religion in Nepal*, Kathmandu, Nepal, National planning commission, population monograph of Nepal.
- DDC 2011. *Annual progress report*. Morang, Nepal: District Development Commitee.
- DHS. 2006. *Demographic and health survey* [Online]. Kathmadu, Nepal: Population division, Ministry of health and population. Available: <http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf> [Accessed 31 July 2012].
- DHS. 2011. *Demographic and health survey* [Online]. Kathmandu, Nepal: Population division, Ministry of health and population. Available: <http://sgdatabse.unwomen.org/uploads/DHS%20-%202011.pdf> [Accessed 1 August 2011].
- GAGE, A. 2000. *Female empowerment and adolescence: Women's empowerment and demographic processes*, London, Oxford University
- GRUNDFEST, S. B. 2003. *Uganda: Lessons for AIDS control in Africa. Review of African Political Economy*.
- HOLDEN, S. 2004. *Mainstreaming HIV/AIDS in Development and Humannitarian Programmes* [Online]. Oxfam GB.
- HUNT, C. W. 1989. *Migrant labor and sexually transmitted disease: AIDS in Africa*. *Journal of Health and Social Behavior*, 30, 353-373.
- ILO 2002. *The technical workshop on population mobility, migration and HIV/AIDS*. ILO, Geneva.
- IOM 2006. *HIV/AIDS and population mobility: Overview of the IOM global HIV/AIDS programme 2006*. Bangkok, Thailand: International Organization for Migration.
- JOHELSON, K., MOTHIBELI, M. & LEGER, J. 2003. *Risk factors for HIV infection among women in Carletonville, South Africa: Migration, demography, and sexually transmitted diseases*. *International Journal of Sexually Transmitted Diseases and AIDS*, 14 814–817.

KALICHMAN, S., SIMBAYI, L., KAUFMAN, M., CAIN, D. & JOOSTE, S. 2007. Alcohol use and sexual risks for HIV/AIDS in Sub-Saharan Africa: Systematic review of empirical findings. *Prevention Science*, 8, 141-151.

KAPIGA, S. H., SAM, N. E., SHAO, J. F., MASENGA, E. J., RENJIFO, B., KIWELU, I. E., MANONGI, R., FAWZI, W. W. & ESSEX, M. 2003. Herpes Simplex Virus Type 2 Infection among bar and hotel workers in Northern Tanzania: Prevalence and risk factors. *Sexually Transmitted Diseases*, 30, 187-192.

KARIM, A. Q., KARIM, A. S., SINGH, B., SHORT, R. & NGXONGO, S. 1992. *Sero prevalence of HIV infection in rural south Asia* [Online]. South Africa: Medical Research Council. Available: <http://www.ncbi.nlm.nih.gov/pubmed/1492937> [Accessed 19 August 2012].

KUMA, Z., GOUWS, E., WILLIAMS, B. & LUIRE, M. 1991. Human immunodeficiency virus and migrant labor in South Africa. *International Journal of Health Services*, 21 (1), 157-173.

LOEVINSOHN, M. & GILLESPIE, S. R. 2003. *HIV/AIDS, food security and rural livelihoods: Understanding and responding*, IFPRI Washington, DC.

MERCER, A., KHANAM, R., GURLEY, E. & AZIM, T. 2007. Sexual risk behavior of married men and women in Bangladesh associated with husbands' work migration and living apart. *Journal of American Sexually Transmitted Diseases Association*, 34 (5), 265-273.

NCASC. 2006. *National STI review* [Online]. Teku, Kathmandu: STI National Programme. Available: <http://library.elibrary-mohp.gov.np/mohp/collect/mohpcoll/index/assoc/mohp:295/0.dir/doc.pdf> [Accessed 7 August 2012].

NCASC. 2010a. *National estimate of HIV infections of Nepal 2009* [Online]. Kathmandu Nepal: National Centre for AIDS and STD Control. Available: <http://aidsdatahub.org/en/whats-new/307-nepal/594-ncasc-2010-national-estimates-of-hiv-infections-2009-nepal> [Accessed 3 August 2012].

NCASC. 2010b. *National targetted intervention operational guidelines* [Online]. Teku, Kathmandu: National Centre For AIDS and STI Control. Ministry of Health and Population Nepal Available: http://www.ncasc.gov.np/ncasc/Other%20publications/TI/Volume_1_Introductio.pdf [Accessed 5 August 2012].

NCASC. 2012. *National centre for AIDS and STDs control* [Online]. Teku, Kathmandu: Ministry of Health and Population Available: <http://www.ncasc.gov.np/> [Accessed 7 August 2012].

NEW ERA. 2008. *Integrated biological and behavioral surveillance survey among male labor migrants in 11 districts in western and mid to far-western regions of Nepal* [Online]. Kathmandu, Nepal: New Era. Available: <http://ncasc.gov.np/ncasc/Reports/Integrated%20Bio-Behavioral%20Surveys-%20Nepal/Migrants/Far%20West/2008/Male%20labor%20migrants%20Final%20Report%20-%202008.pdf> [Accessed 4 August 2012].

NEW ERA. 2010. *Integrated biological and behavioral surveillance survey among wives of migrants in four districts of far-western Nepal* [Online]. Kathmandu. Available:

<http://aidsdatahub.org/en/nepal-reference-library/item/14629-ibbs-survey-among-wives-of-migrants-in-four-districts-of-far-western-nepal-round-ii-2010-new-era-intrepid-nepal-and-fhi-2010> [Accessed 13 August 2012].

SADIF, N. 2008. *Online news* [Online]. Beijing: Reuters news. [Accessed 2 nd August 2012].

SAGGURTI, N. 2008. New Delhi, India: South and east Asia regional office Available: www.popcouncil.org [Accessed 13 th August 2012].

SAMUELS, F. & WAGLE, S. 2011. Population mobility and HIV and AIDS: review of laws, policies and treaties between Bangladesh, Nepal and India. *ODI Background Notes, June. London: ODI.*

SHARMA, J. & SHARMA, S. 2011. Enumerating migration in Nepal (A review). Kathmandu, Nepal.

SIKDER, M. & UDDIN, J. 2008. Population movement and the threat of HIV/AIDS virus at theBangladesh - India border. *NTS-Asia*

SIMKHADA, P., VAN TEIJLINGEN, E. R., REGMI, P. R. & BHATTA, P. 2009. Sexual health knowledge, sexual relationships and condom use among male trekking guides in Nepal: a qualitative study. *Culture, Health & Sexuality*, 12, 45-58.

SINGH, G. K. 2010. Push and pull factors of migration: A case study of brick klin migrant workers in Panjab. Amritsar, India.

SMITH-ESTELLE, A. & GRUSKIN, S. 2003. Vulnerability to HIV/STIs among rural women from migrant communities in Nepal: A health and human rights framework. *Reproductive Health Matters*, 11, 142-151.

SUPANG, C. 2000. Mobility and HIV/AIDS in the greater Mekong subregion. Bangkok, Thailand.

SUVEDI, B. K., GURUBACHARYA, V. & THAPA, K. 1994. Seasonal migration and its relation to HIV transmission Nepal B HIV across the Indo-Nepal border in western Nepal (abstract). *International Conference on AIDS.*

TU"RMEN, T. 2003. Gender and HIV AIDS. *International Journal of Gynecology and Obstetrics* 82, 411–418.

UNAIDS. 2001. *Population mobility and AIDS, UNAIDS technical update* [Online]. Available: http://data.unaids.org/publications/irc-pub02/jc513-popmob-tu_en.pdf [Accessed 4 August 2012].

UNAIDS. 2004. *Report on the global AIDS epidemics* [Online]. Switzerland: Joint United Nations Programme on HIV/AIDS. Available: http://data.unaids.org/Global-Reports/Bangkok-2004/unaidsbangkokpress/gar2004html/gar2004_00_en.htm [Accessed 1 August 2012].

UNAIDS 2007. UNAIDS's implementing AIDS prevention and care project. Family Health International.

UNAIDS. 2009. *AIDS epidemic update* [Online]. Switzerland: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization. Available: http://data.unaids.org/pub/report/2009/jc1700_epi_update_2009_en.pdf [Accessed 5 August 2012].

UNAIDS. 2011. *UNAIDS terminology guidelines* [Online]. Geneva, Switzerland: UNAIDS. Available: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf [Accessed 6 August 2012].

UNDP. 2010a. *HIV/AIDS and mobility in South Asia: Regional HIV, health and development programme for Asia and the Pacific* [Online]. Bangkok, Thailand.: UNDP Asia Pacific Regional Centre. Available: http://scholar.google.nl/scholar?q=UNAIDS%2C+%E2%80%9CAIDS+Epidemic+Update%E2%80%9D%2C+2011&btnG=&hl=nl&as_sdt=0&as_vis=1 [Accessed 10 August 2012].

UNDP. 2010b. *Mobility and migration: A guidance note for human development report teams* [Online]. New York: Human Development Report Office. Available: http://hdr.undp.org/en/media/NHDR_Migration_GN.pdf [Accessed 7 August 2012].

VDC 2005. Village profile Morang, Nepal: Sishawaijahada VDC.

VISSERS, D. C. J. 2010. *The role of mobility in HIV transmission and control*, Erasmus University Rotterdam.

WAGLE, S., BOHIDAR, N., SAMUELS, F., NINO-ZARAZUA, M. & CHAKRABORTY, S. 2011. Emphasis baseline: Vulnerability to HIV & AIDS: A Social research on cross-border mobile populations from Nepal to India. Kathmandu, Nepal.

WASTI, S. P. 2007. Involvement of HIV positive persons in AIDS prevention activities. *University Medical Journal*, 5, 1-3.

WASTI, S. P., SIMKHADA, P., RANDALL, J. & TEIJLINGEN, E. 2009. Issues and challenges of HIV/AIDS prevention and treatment programme in Nepal. *Global Journal of Health Science*, 1, P62.

ANNEXES

ANNEX I Checklists for respondents

1. General characteristics (age, level of education, participation of training)
2. Behavioural changes (e.g. isolation from family) after coming back from destination place
3. Frequency and amount of drinking alcohol at place of origin and destination place
4. Behaviour towards their wives (e.g. physical and sexual violence) after drinking alcohol before and after coming back from destination place
5. Males' sexual relationship with other women before and after coming back from destination place
6. Doubt of wives with their husband's sexual behaviour in the destination place
7. Knowledge about STDs (Itching, vaginal discharge, wound around genital)
8. Presence of STDs in both males and females for the last one year
9. Presence of STDs in males after coming back from destination place
10. Suffering from prolonged fever in both male and female for the last one year
11. Suffering from prolonged fever in males after coming back from destination place
12. Suffering from T.B in both male and female for the last one year
13. Suffering from T.B in males after coming back from destination place
14. Test of HIV status
15. Knowledge on relation between STDs and HIV/AIDS
16. Knowledge on modes of transmission of HIV
17. Knowledge on prevention methods of HIV/AIDS
18. Misconceptions related to HIV/AIDS
19. Knowledge about condom
20. Use of condom
21. Negotiation with husbands for using condom
22. Openness to talk about sexual matters with husbands

ANNEXII Checklist for key informants

1. Mobility and HIV/AIDS status/situation of the VDC
2. Plan/Programme/Policy regarding HIV/AIDS
3. Change in behaviour of returnee mobile males
4. Sex workers in area
5. Socio-cultural norms regarding sexual matter in the community