

10-9-2008

Reproductive Health Services: An Entry Point to Reach Labor Migrants and Their Wives for Providing HIV and STI Services in Nepal

Laxmi Bilas Acharya

Follow this and additional works at: https://digitalrepository.unm.edu/nsc_research

Recommended Citation

Acharya, Laxmi Bilas. "Reproductive Health Services: An Entry Point to Reach Labor Migrants and Their Wives for Providing HIV and STI Services in Nepal." (2008). https://digitalrepository.unm.edu/nsc_research/22

This Article is brought to you for free and open access by the Nepal Study Center at UNM Digital Repository. It has been accepted for inclusion in Himalayan Research Papers Archive by an authorized administrator of UNM Digital Repository. For more information, please contact disc@unm.edu.

Reproductive Health Services: An Entry Point to Reach Labor Migrants and Their Wives for Providing HIV and STI Services in Nepal

Laxmi Bilas Acharya, PhD¹

Background:

In 2007 National Centre for AIDS and STD Control (NCASC) estimated about 65,000 HIV infections among adults in Nepal. Out of them about two in five infections were from labor migrants, particularly those, who go to India for labor type of work. NCASC also has estimated that 1,140,000 to 1,710,000 adult Nepali males migrated abroad in 2007. In the Far Western hill districts of Nepal almost 80 percent adult male from about 80 to 90 percent households migrate to India for labor type of work (NCASC, 2008). Poor socio-economic condition in these districts is the major push factor for such high level of migration in the Far West. Long history of poor socio-economic conditions in the Mid and Far West Region of Nepal has fueled for a kind of sustained culture of short term labor type of migration of adult male in these regions. These are short term migrations and they comeback home in about six months to one year intervals.

Objective:

The main objective of this paper is to discuss and recommend program options to reach and provide HIV and STI services to male migrant laborers and their spouses.

Program Issues:

From all districts of Nepal, mostly economically active, adult males migrate abroad. Integrated biological and behavioral surveillance surveys (IBBS) conducted for NCASC by New ERA and SACTS with technical assistance from Family Health International Nepal show that about 17 to 27 percent of migrants to India from western to far western hills of Nepal practice unsafe sex with female sex workers when they are abroad (FHI, New ERA and SACTS, 2006). If they come back home with sexually transmitted infections (STIs) and/or HIV infections, their spouses also are directly exposed to the risk of infection.

Most of the time migrants are not found in their place of origin because they are back to home only for a short period of time. Because of this it is difficult to reach such migrants through the conventional health programs currently being delivered in Nepal. In this context FHI/Nepal and FHI/India are jointly conducting Reaching Across Border Project targeted to Nepali Migrants and their spouses who normally migrate to Indian cities like Delhi and Mumbai and their spouses at the place of destination in the far West Nepal.

Moreover, HIV and STI programs are not like other general health services providing programs. Because of the stigma and discrimination associated with HIV and STIs,

¹ *Team Leader, Surveillance Research Monitoring and Evaluation Unit, Family Health International, Kathmandu, Nepal. Email: lacharya@fhi.org.np*

Views expressed in this article are the personal views of Dr. Laxmi Bilas Acharya and should not be understood as FHI's Institutional Views.

For discussion in the Third Himalayan Policy Research Conference at Madison, USA

people should be offered services in a confidential way. In the first place, it is very difficult to screen out the individuals who are at risk of HIV and STIs. Principally, those who have multiple sex partners are at risk but people do not want to disclose their sexual behavior easily without properly understanding the risks and benefits associated with such disclosure. People always tradeoff between advantages and disadvantages associated with their decision on the basis of the information they have acquired on the issue.

Because of this reaching to migrants and their wives who are in the risk of HIV and STI for providing treatments may not be successful through the general health services providing approaches.

Discussion and Conclusion:

Knowledge on HIV and AIDS among general population and migrants

In general, knowledge of HIV and AIDS among the general population in Nepal is relatively high and is increasing over time. However, percentage of men and women who have comprehensive knowledge² of HIV and AIDS is much lower. In 2006 only about 20 percent women and about 34 percent men had comprehensive knowledge of HIV/AIDS in Nepal (Table 1). General as well as comprehensive knowledge of HIV/AIDS among men and women is relatively higher among those who were away from home (seasonal migrants) compared to those who have not traveled out of home. Comprehensive knowledge on HIV/AIDS is key factor for initiating or motivating people for changing their sexual behavior and health service seeking behavior.

Table 1: Percentage of adult men and women who had knowledge of HIV/AIDS.

Population	1996	2001	2006
All men (15-49) who had heard of HIV/AIDS	Na	72	92
Men who had not traveled out of home	Na	Na	88
Men who were away from home for less than 6 months	Na	Na	93
Men who were away from home for more than 6 months	Na	Na	97
All women (15-49) who had heard of HIV/AIDS	27	50	73
Women who had not traveled out of home	Na	Na	68
Women who were away from home for less than 6 months	Na	Na	74
Men who were away from home for more than 6 months	Na	Na	84
All men (15-49) who had comprehensive knowledge of HIV/AIDS	Na	Na	34
Men who had not traveled out of home	Na	Na	33
Men who were away from home for less than 6 months	Na	Na	37
Men who were away from home for more than 6 months	Na	Na	37
All women (15-49) who had comprehensive knowledge of HIV/AIDS	Na	Na	20
Women who had not traveled out of home	Na	Na	17
Women who were away from home for less than 6 months	Na	Na	21
Men who were away from home for more than 6 months	Na	Na	28

Source: MOHP, New ERA and Macro International Inc., 2007

² Comprehensive knowledge means knowing that consistent use of condom during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention.

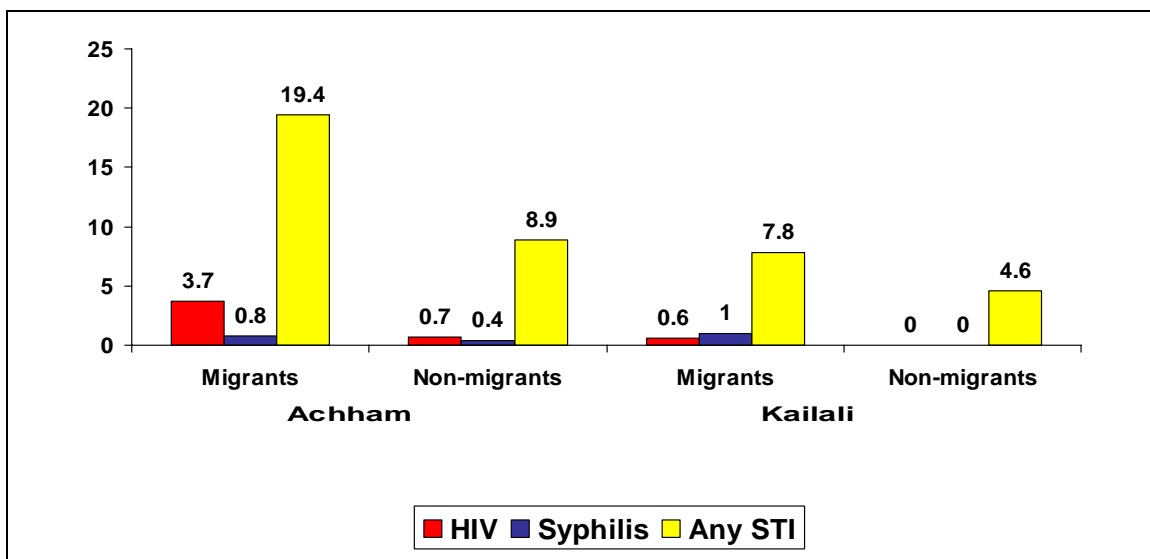
Migrants and their spouses are in the higher risk of HIV and STI

Comparatively male and female who have gone out of home or have migrated to other places for short period of time (referred as migrants in this paper) have better knowledge on HIV/AIDS. But contrary to this they are exposed to higher risk of HIV and STIs.

The Integrated Biological and Behavioral Surveillance Survey (IBBS) among male labor migrants in 2006 showed that about 17-27 percent of the labor migrants had visited sex workers in India (FHI, New ERA and SACTS, 2006). Among the male labor migrants from Far Western districts who had visited sex workers in India HIV prevalence was as high as 8 percent. The study conducted in 2001 among 97 male migrant-returnees and 40 non-migrants from five rural villages in Doti district where migration to Mumbai is common, indicated that migrants visiting sex workers in India suffer relatively high level of STI such as Syphilis (Poudel, Krishna C. et al., 2003). This study shows that migrants have about 2 times higher risk of syphilis infection among migrants compared to non migrants (OR 1.8, CI (0.6 - 4.9)). Similarly, migrants have almost 5 times higher risk of HIV infection (OR= 4.5, CI (0.5 – 36.2)). Although these odd ratios are not statistically significant it clearly indicated that migrants are in greater risk of HIV and STI.

Studies on HIV/STD prevalence and risk factors among migrant and non-migrant males of Achham and Kailali district in Far-Western Nepal also indicated higher risk of STI among the migrants to India (FHI, New ERA and SACTS, 2002a; and 2002b). Fig 1 shows the higher risk of HIV and syphilis among migrants compared to non migrants in Achham and Kailali districts. So far full scale IBBS studies are not conducted to measure STI infection among male migrants and their wives representing the bigger geographical areas where male labor migration to India is common. Similarly, no studies are conducted among labor migrants in other parts of the country.

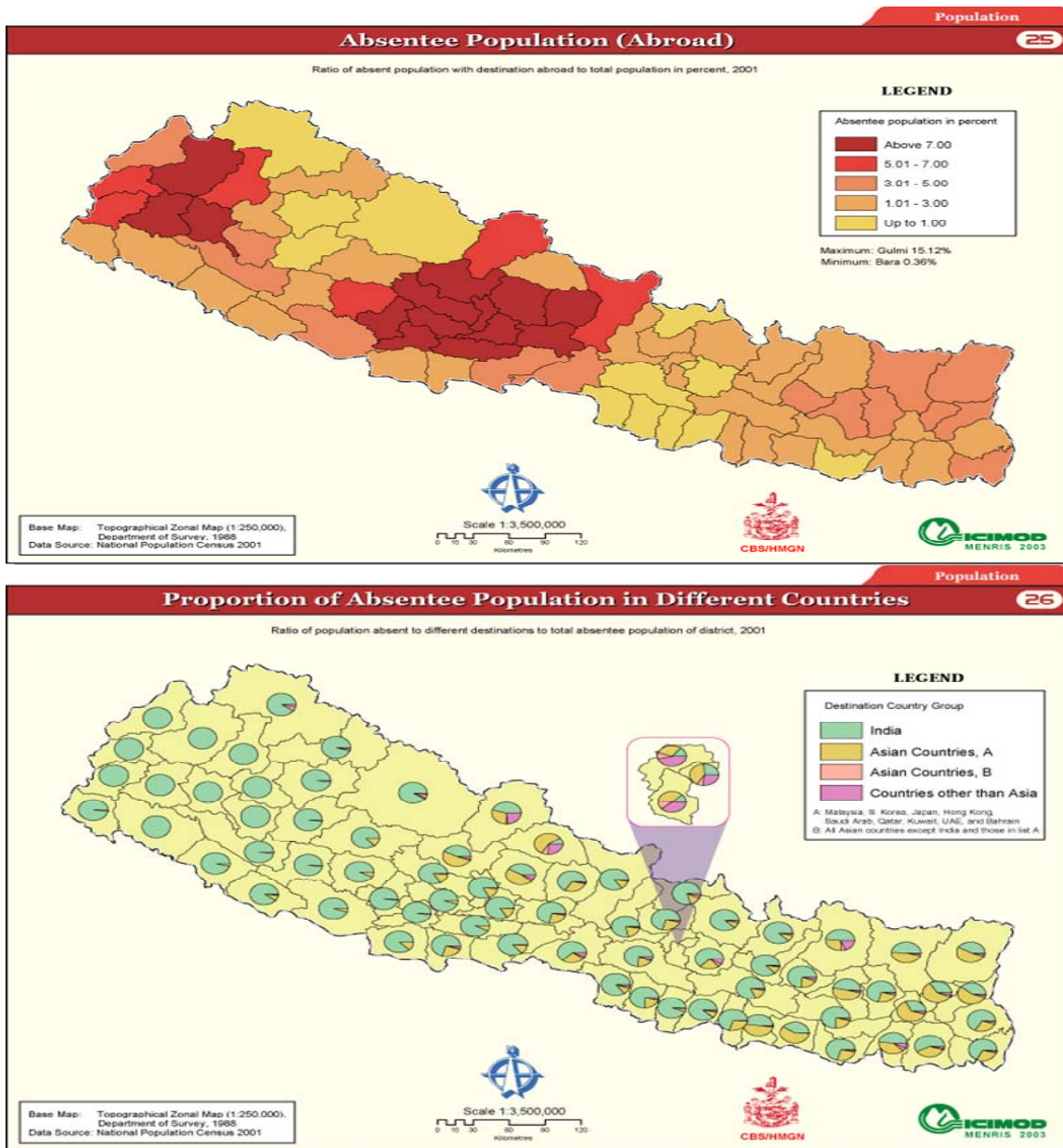
Fig 1: HIV and STI among migrants and non-migrants in Achham and Kailali, 2002



Migrants from Mid and Far Western Region of Nepal are in greater risk of HIV and STI infection

The 2001 census data published by Central Bureau of Statistics, Government of Nepal shows that volume of migrants abroad is relatively higher in the Far- Western Region of Nepal compared to Eastern Region. Besides, larger proportions of migrants from Far Western Nepal go to India (Fig 2 and Fig 3). As indicated by small scale studies discussed above labor type of migrants who go to India and particularly to Maharashtra and Mumbai in India have greater risk of HIV and STI infection.

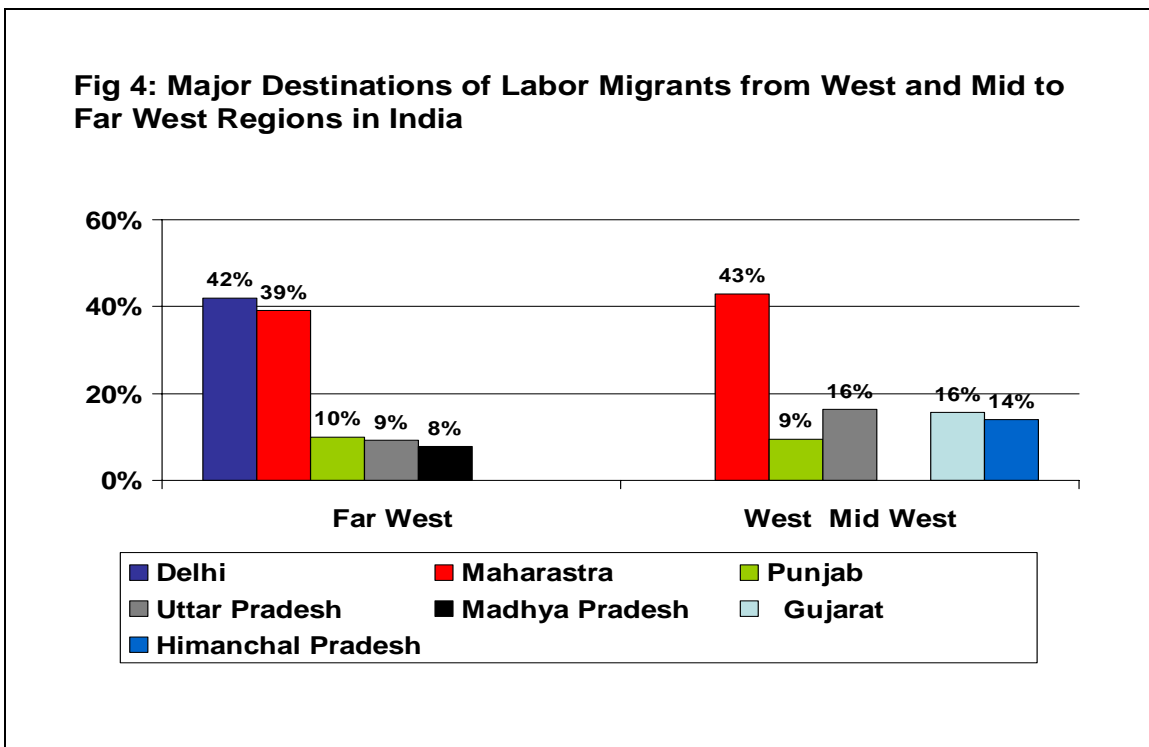
Fig 2 and 3:



For discussion in the Third Himalayan Policy Research Conference at Madison, USA

About 27 percent labor migrants from Far –Western region have reported sex with sex workers while they were in India (FHI, New ERA and SACTS, 2006). When they come back home it is more likely that they will come with HIV and/or STI infections. Because of stigma and discrimination associated with HIV and STI and also due to the lack of volunteering counseling and testing (VCT) and STI testing services in the villages these returnee migrants are less likely to go through the screening for such possible infections. This ultimately increases the risk to their spouses for HIV and STI infection. Such risk is much enhanced due to the fact that when returnee migrants have sexual contacts with their spouses at home consistent condom use is very low (FHI, New ERA and SACTS, 2006).

In addition, risk of infection of HIV and STI among labor migrants increases by the place of destination they choose to migrants. In India places like Maharashtra, Mumbai and Delhi are high risk zones because HIV among the FSWs in these places is much higher compared to other parts of India. Data Presented in Fig 4 shows that a significant proportion of migrants go to Mharastra from West to Far western Nepal. This ultimately increases the risk to wives of migrants for HIV and STI infection.



Current approaches used to provide HIV and STI services to targeted population in Nepal

Nepal is classified as a concentrated HIV epidemic country. That means infections are concentrated to specific high risk groups and infection is very low in general population. Since 2002 HIV prevalence has remained more than five percent among the injecting drug users (IDUs) in four key sites Kathmanu, Pokhara, Eastern Terai and Western to Far

For discussion in the Third Himalayan Policy Research Conference at Madison, USA

Western Terai. But in general population HIV prevalence is estimated to be only about 0.49% (NCASC, 2008).

Besides IDUs other high risk groups identified in Nepal are female sex workers (FSWs) and their clients, and men having sex with men (MSM). Because of the above explained regions male labor migrants, particularly those who visit sex workers, when they are abroad and their wives also are considered in high risk of STI and HIV infection. But the social status of labor migrants and their wives is much different than those of other high-risk groups. This has direct implication on the approaches to be used to reach these population for providing HIV and STI services.

Under the National HIV/AIDS Strategy of the Government of Nepal many governmental and national and international non-governmental organizations are providing prevention and treatment to care services targeted to high risk groups. Prevention programs are heavily backed up by outreach educators and peer educators, static and mobile voluntary counseling and testing services, static mobile and static STI services, integrated health services which include VCT, STI and essential package of care services, community and home based care services and antiretroviral therapy services are some examples. These are targeted programs and because of high level of stigma discrimination associated with risk group, health services are not integrated with the general health service providing programs. To reach the hidden population peer educators and community mobilizers are used to identify and bring them to the static and mobile service providing centers.

Approaches used to reach the risk groups like sex workers, injecting drug users and men having sex men with men are not suitable to the labor migrants and their spouses. This is mainly because of the fact that migrants and their spouses are not directly identified as a group of people who have multiple sex partners. Therefore, people known as migrants in the community do not want to use the services that are targeted to risk groups such as FSWs, clients of FSWs, MSM and IDUs. Because of this a new approach is to be developed and used.

Integration of HIV and STI services with Reproductive Health Services targeted to general women of reproductive age groups

Reproductive health services including ANC services may be the first contact point to the HIV and STI services to the wives of migrants in the districts. Opt-out voluntary HIV and STI screening services can be integrated in the services provided by the local health posts. Introduction of voluntary counseling and testing (VCT) services in the health posts may be another option.

The main philosophy behind the integration of HIV and STI services with the general reproductive health services targeted to general women is that it would not bring the stigma and discrimination associated with people who have multiple sex partners while seeking such services.. All women irrespective of the migration status of their husbands are motivated to use the reproductive health services. Simply adding one screening component to these women on the basis of the migration history of their husbands and

For discussion in the Third Himalayan Policy Research Conference at Madison, USA

asses the risk of HIV and STI on them will empower us to reach a large majority of the spouses of labor migrants.

However this approach has its inbuilt limitations. At present the proportion of women using ANC services is low. The last NDHS of Nepal conducted in 2006 has shown that only about 44 percent of women of age 15-49 used antenatal care (ANC) services provided through local Health Posts. Moreover regional variation on ANC use is high. About 26 percent women from Far- Western development region use ANC services compared to about 51 percent in the Western, 47 percent in Central, 45 percent in Eastern and 44 percent in the Mid-western development regions of Nepal.

Current priority of the reproductive health services in Nepal is to increase its coverage and ultimately reduce the maternal mortality rate in the country. In the changed political context in Nepal, high priorities are given to the public health issues. Increase in the percentage of women utilizing the reproductive health services would be instrumental to empower women and increase their participation in aspects of nation building up to 50 percent.

Integration of HIV and AIDS component on the reproductive services must focus on increasing the use of such services which should be relatively easy since no stigma is associated with reproductive health services targeted to general women.

Another beauty of such integration would be that through attendance by the wives of labor migrants at ANC services, their husbands could also be reached and provided HIV and STI services. Most of the time male migrants are out of home. It is very difficult to reach them through the ongoing programs in the place of origin. Because of this difficulty Family Health International's Nepal and India country offices have launched a Cross-Boarder HIV and AIDS program with technical and financial support from DFID. The main focus of this program is to reach the Nepali migrants in India and provide them HIV and STI services and link them with the services available in their place of origin and continue the care and treatment they are using while they back home even for short period of time.

The concept of accessing labor migrants through their wives is challenging in the sense that women should be encouraged to talk about their husbands' sexual behaviors when they were abroad. There are two limitations: i) how much information about their sexual behavior will be shared to their wives by husbands and ii) how effectively wives can inform/educate their husbands and can refer them to available HIV and STI services. However, it is worth doing because in the recent time many men and women are changing their traditional attitude and thinking on sexual behaviors of men and women, particularly when some behaviors are driven by biological needs and directly related to the health risk of the individuals, their spouses and children.

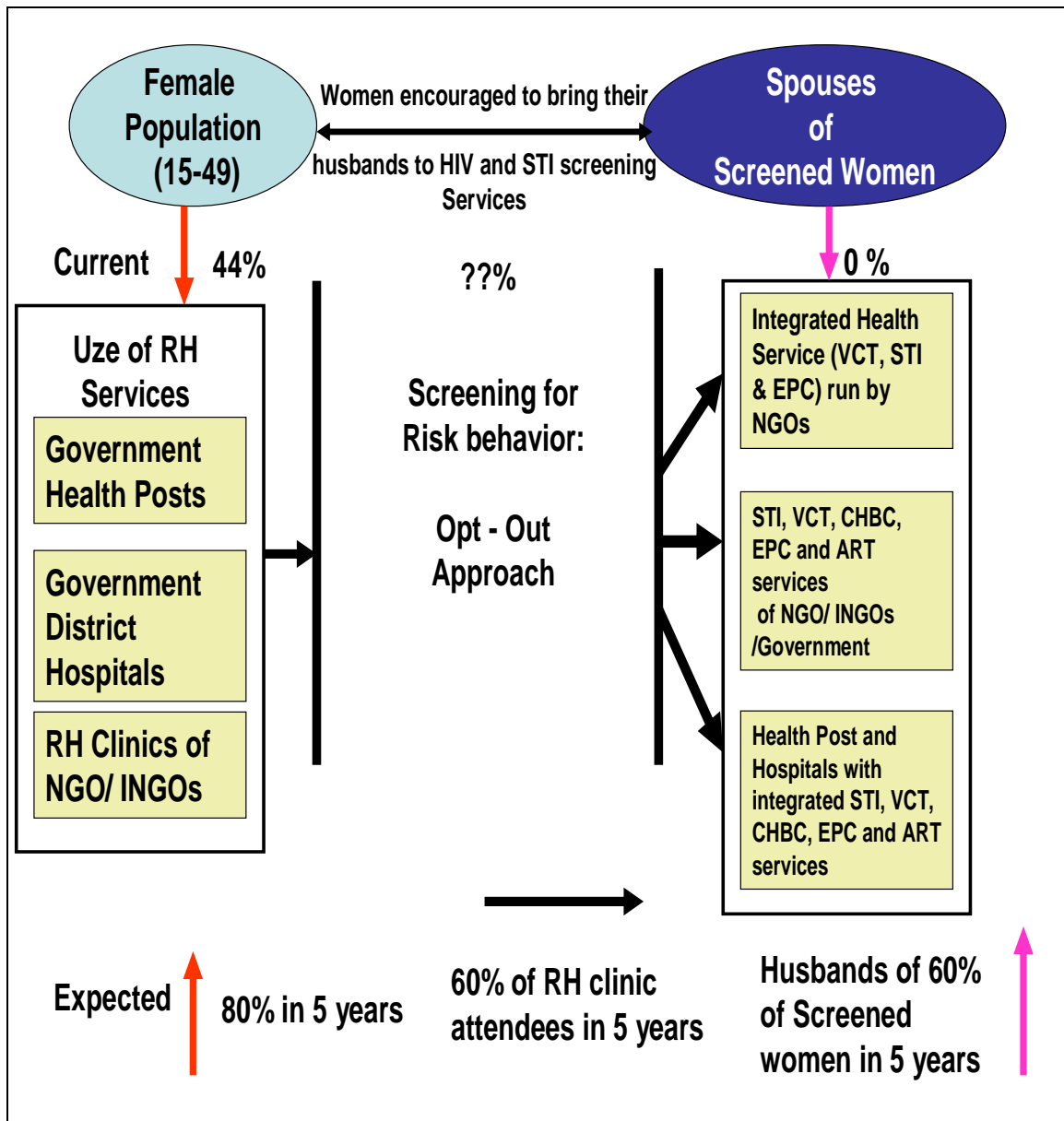
The risk of HIV infection is high among the migrants who originate from the Western to Far - Western regions of Nepal. So as a pilot program, HIV and STI services can be introduced as components of ongoing reproductive health services in the western to far

For discussion in the Third Himalayan Policy Research Conference at Madison, USA

western districts where the volume of labor type of migration, particularly to high risk areas in India, is high.

A conceptual integration model of Reproductive and HIV/STI services are depicted in Fig 5.

Fig 5. A conceptual model for integration of reproductive health services and HIV/STI services targeted to labor migrants and their wives



Recommendations

This paper presents a health care proposal that has public policy interest. But, the proposal is based on logic or hypothesis that reproductive health services including ANC services provides a veil from social stigma for women to obtain treatment for HIV and STI for themselves or their husbands.

This hypothesis is pretty strong but is not well backed up by research in Nepal. What are the alternative methods of reaching HIV patients particularly among labor migrants, what are the associated costs or what are their possible reaches, and why ANC is the best option? Can be further understood and answered.

It would be better if such research is conducted before a pilot program of integrating HIV services with Reproductive Health Services can be reasonably proposed. Author highly recommends for such research in the near future. The lessons learned from cross – boarder program on HIV and AIDS implemented by Family health International and DFID in Nepal and India would be a milestone for designing such research in Nepal.

References:

CBS, 2003. Population Census of Nepal, Central Bureau of Statistics, Government of Nepl, Kathmandu.

ESIMOD, 2003. Analysis of Abesntee Population in Nepal – powerpoint Presentations. Kathmandu, Nepal.

FHI, New ERA and SACTS, 2002a. HIV/STD Prevalence and Risk Factors among Migrant and Non-Migrant Males of Achham District in Far-Western Nepal. Study report submitted to Family Health International (FHI), Kathmandu Nepal.

FHI, New ERA and SACTS, 2002b. HIV/STD Prevalence and Risk Factors among Migrant and Non-Migrant Males of Kailali District in Far-Western Nepal. Study report submitted to Family Health International (FHI), Kathmandu Nepal.

FHI, New ERA and SACTS, 2006. Integrated Biological and Behavioral Surveillance Survey (IBBS) among Male Labor Migrants in the 11 Mid to Far Western districts of Nepal. Study report submitted to Family Health International (FHI), Kathmandu, Nepal.

Krishna C. Poudel, Junko Okumura, Jeevan B. Sherchand, Masamine Jimba, Izumi Murakami and Susumu Wakai, 2003. Mumbai disease in far western Nepal: HIV infection and syphilis among male migrant-returnees and non-migrants. *Tropical Medicine and International Health* volume 8 No 10 pp 933–939, October 2003.

Ministry of Health and Population (MOHP), New ERA, and Macro International Inc., 2007. Nepal Demographic and Health Survey, 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and Macro International Inc.

NCASC, 2008. National Estimates of HIV Infections in Nepal, 2007. Report Published by Natioanl Centre for AIDS and STD Control (NCASC), Ministry of Health and Population, Kathmandu, Nepal.