Health Vulnerabilities of Migrants from Nepal

Baseline Assessment

IOM, Nepal
August 2015

International Organization for Migration (IOM)
Nepal

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CBS	Central Bureau of Statistics
DIC	Drop-in-Centre
FGD	Focus Group Discussion
FHI	Family Health International
HERD	Health Research and Social Development Forum
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
INGO	International Non-Government Organization
ILO	International Labour Organization
IOM	International Organization for Migration
KII	Key Informant Interview
MDG	Millennium Development Goals
NGO	Non-Governmental Organization
NPR	Nepalese Rupee
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
ToT	Training of Trainers
UAE	United Arab Emirates
UN	United Nations
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VDC	Village Development Committee
WHA	World Health Assembly
WHO	World Health Organization

EXECUTIVE SUMMARY

Aims: This study aimed to understand the health vulnerabilities of departing and returnee migrants in Nepal in order to inform policy and programme development regarding the health of migrants in South Asia. It was conducted as part of the IOM project, *'Strengthening Government's Capacity of Selected South Asian Countries to address the Health of Migrants through a Multi-sectoral Approach'* that was implemented in Bangladesh, Nepal and Pakistan from 2013 to 2015.

Methodology: The study population consisted of departing (those preparing to leave the country of origin) and returnee migrants (those residing in the country of origin for no longer than twelve months following a period of migration aboard for work) and their spouses in Nepal. The study employed a mixed-methods approach. For quantitative data collection, interviews were conducted using a structured questionnaire, while qualitative data was collected through Key Informant Interviews (KII) with relevant government, international organization and community-based organizations and Focus Group Discussions (FGD) with returnee migrants and their spouses. A multi-stage cluster sampling technique was used for the quantitative sampling. Qualitative participants were recruited through snowball and network recruitment. Research tools were pre-tested and translations of the tools into Nepali language were validated. Informed consent was sought from all the study respondents and participants before incorporating them under this study.

Results: This study interviewed 411 Nepali migrants for the quantitative study, consisting of 201 departing and 210 returnee migrants, 386 male and 25 female. On average interviewees were 29.5 years old, married, with a mean family income of 31,500 NPR (315 USD) per month and a family size of one or two people. Approximately 80 per cent of migrants had completed or reached secondary education. Most migrants interviewed worked in agricultural sector (35%), followed by industry/ manufacturing (28%), and private services (17%). The Middle East was the intended destination region among 95 per cent of departing migrants, the most frequently mentioned countries of destination were Saudi Arabia, the United Arab Emirates, Qatar, and Malaysia. Majority of respondent migrants (81%) were sexually active in the past twelve months. Sexual partners were predominantly spouses, with 70 per cent of all respondents having had sex with their husband or wife in the past year followed by a girlfriend/boyfriend (11%), friend (6%), and sex worker (3%). Departing migrants more frequently reported sex with a spouse or a steady partner (girlfriend/boyfriend). In contrast, the most frequent sex partners among returnees who had sex abroad were sex workers and friends, while sex with a spouse was least frequently reported. Condom use within migrant populations was particularly low with spouses; condoms were used regularly by nine per cent of respondents, and never used by 65 per cent of respondents. Reported condom use was significantly higher with other partners, most notably with sex workers, with condoms always used by 83 per cent of those migrants who self-identified as clients of sex workers. Preventing pregnancy was the main reason for condom use with a spouse, or a girlfriend or boyfriend, while preventing STIs and HIV was the primary reason for using a condom with sex workers and casual acquaintances. It was found that 40 per cent of male and 69 per cent of female returnee migrants experienced forced sex while abroad.

A wide range of health care services were available in the community, predominantly general medical check-ups (91% of respondents) and medical treatment (87%). Both preventive and curative health-care services were mostly provided by community government centres, with private facilities mentioned by about a half of respondents for both men and women. In term of accessibility, 76 per cent of respondents felt that they could use public health facilities any time,

and 82 per cent noted that they could obtain health-care services for free. About 60 per cent of respondents were satisfied or very satisfied, while 18 per cent were unsatisfied with health facilities in the community. About fifteen per cent of respondents expressed difficulties accessing health-care services in Nepal, citing long distances (52%), lack of skilled doctors (27%), and unaffordable costs (14%) as the primary problems. Finding from qualitative study supported that in addition to limited coverage of health services in Nepal in more remote or mountainous areas, further limiting access to health-care is stigma and discrimination towards migrants, particularly those who return ill from abroad. These negative experiences appear to extend to family members, and can manifest in the form of harassment or even refusal of care. While in destination countries, more than a half of returnee migrants reported HIV/STI testing and primary health care were available. Access to curative services was high, particularly provision of medicines and diagnostic testing. Private and government providers were mentioned by more than 70 per cent of returnee migrants as the primary providers of these services. Thirty-three per cent of respondents found health care abroad unaffordable. Those working in the primary sector (Agriculture and Industry) received the least amount of health coverage from their employers and were most likely to pay out-of-pocket. Only six per cent paid for health-care costs using insurance despite the fact that 51 per cent of migrants had health coverage abroad. About one-fourth of returnee migrants had faced difficulties accessing health-care services in destination countries, most often due to language barriers, discrimination as a result of migration status, and unaffordable costs.

On average, 67 per cent of all migrants surveyed had completed a mandatory health examination prior to departure; 93 per cent of returnees and 40 per cent of departing migrants. Private providers were the most popular venues for the mandatory health examination, followed by employers/agencies (31%) and NGOs (17%). About 70 per cent of migrants reported that health providers asked for consent prior to conducting a medical test during the mandatory health examination. Only 32 per cent of migrants were provided with a health examination that adhered to all three protocols, that is, explaining the test, acquisition of consent and sharing of results. Almost 90 per cent of migrants sought health-care when last ill in the country of destination and country of origin. More than 80 per cent of migrants seeking health-care abroad were able to claim some form of assistance, mostly through employers/agencies (51%) or friends/relatives (29%). Private facility and public health provider were the most popular places where migrants sought treatment. The vast majority (>90%) cited perceived insusceptibility as the reason for not seeking a post-arrival medical check-up, only 26 per cent (55 respondents) actually undertook one. The majority of migrants perceived themselves to not be at risk of Tuberculosis, HIV, or Hepatitis C. Notably, no female respondents believed themselves to be at risk of either disease. Twelve per cent of respondents underwent a health orientation or training, health orientations most often discussed general medical check-ups, with particular attention to sexually transmitted infections and health problems associated with the working environment.

Television, radio, educational institutions, and health facilities were important sources of health information among all respondents. Health information in general appeared less accessible to women compared to men, particularly those media requiring literacy, such as newspapers and billboards. About 65 per cent of migrants received health-related communication material from health providers in Nepal, and 91 per cent of them found the contents understandable or easily understandable. While abroad, 43 per cent of returnees had received health communication materials. Two-third of migrants who did receive health communication materials while abroad found the contents understandable or easily understandable, which may be partly attributable to language.

The qualitative results found that several migrants described legal restrictions to emergency health-care, which then cause delays to essential medical services that can ultimately prove fatal. Undocumented migrants face increased barriers accessing health-care, as they are unable to access health insurance and are fearful of being caught if presenting at a health facility. They are also more likely to be unaware of their benefits and rights as stated in their contracts. It was suggested that the government should pay more attention to the health of migrants in Nepal considering Nepal's economic reliance on migrants. Key informants noted that a policy and legal framework is required to form a basis for improved diplomatic efforts. The failure of the government to establish 'migration management' policy prevents officials from confidently standing firm against exploitation faced by migrants.

Recommendations: The major recommendations from the study include the need for the government to ratify global migration related conventions, to incorporate health as an essential and 'non-negotiable' component in bilateral agreements, and to develop a regulatory mechanism to effectively monitor the activities of recruitment agencies and medical testing facilities to make migration process more 'migrant-friendly' than 'state-friendly'. Television and radio should be harnessed for effective health communications. More pressure should be applied to employers and agencies to ensure they provide or finance fair, equitable, comprehensive, and acceptable health services, prior to departure and pre-departure health orientations, as well as access to comprehensive health-care in the country of destination.

CHAPTER ONE

INTRODUCTION

1.1 Project background

This study among Nepalese migrants is under the IOM project *"Strengthening Government's Capacity of Selected South Asian Countries to Address the Health of Migrants through a Multi-sectoral Approach"*. It is implemented in Bangladesh, Nepal and Pakistan". The three objectives of the project were to:

1. Conduct an in-depth assessment among the three South Asian countries to assess health vulnerabilities of migrants, including their access to health and other social services, a mapping of governments' responses to address these vulnerabilities, and to come up with recommendations for action;
2. Support a regional consultation involving the three primary target countries and countries that implemented a similar project before, such as Sri Lanka and Thailand to discuss best practices and agree on success factors to develop a migration health agenda at national level for the target countries;
3. Support the Ministries of Health of Bangladesh and Nepal, and the Ministry of Human Resource Development of Pakistan to develop strategic action plans to address the health of migrants using a multi-sectoral approach.

The project responds to the recommendations from the Regional Dialogue on the Health Challenges for Asian Migrant Workers (July, 2010), the Dhaka Declaration (April, 2011) and the World Health Assembly (WHA) Resolution 61.17 (May, 2008) and assists key migration affected countries in South Asia to implement global and regional commitments and comprehensively address multi-faceted migration related health challenges.

Nepal is predominantly a migrant sending country. From 2013 to 2014 a total of approximately 521,878 labour permits were issued, largely to Malaysia, Saudi Arabia, Qatar and the United Arab Emirates and Kuwait (Department of Foreign Employment Nepal, 2014). In addition, a high number of undocumented migrants travel to India. This is facilitated by the provision of free movement under the Indo-Nepal Treaty of Peace and Friendship of 1950 (Asia-Pacific RCM Thematic Group on International Migration including Human Trafficking (APRCMT), 2012). The health impacts and social consequences resulting from outbound migration flows are substantial and not well explored. Given the likelihood that migration trends will continue to increase in Nepal, improved knowledge of the migration and health related challenges that Nepal faces is needed in order for the key government ministries to understand the importance of supporting migrants, in order to reduce health disparities and ensure better health outcomes for all categories of migrants.

In many South Asian countries, governments have not kept pace with the growing challenges of migration related health concerns, whether it is inbound, internal or outbound migration. The adoption of the WHA Resolution 61.17 on the "Health of Migrants" in 2008 calls upon Member States to develop and promote migrant sensitive health policies and practices. It calls upon the WHO and other relevant organizations, such as IOM, to encourage inter-regional and international cooperation and promote the exchange of information and dialogue among Member States, with particular attention to strengthening health systems (WHA, 2008).

Since 2008, there have been a number of high-level regional meetings and commitments in South and South East Asia to operationalize and implement the WHA Resolution In July 2010, the Regional Dialogue on the Health Challenges for Asian Labour Migrants was held in Bangkok, bringing

together government representatives from thirteen Member States[1] from departments of Labour, Foreign Affairs and Health. During this dialogue delegates discussed and agreed upon a number of recommendations to tackle the health of Asian labour migrants at national, bilateral and regional level. In April 2011, at the Colombo Process[2] 'Fourth Ministerial Consultation for Asian Labour Sending Countries in Dhaka, the Dhaka Declaration was adopted. It included the recommendation to "promote the implementation of migrant-inclusive health policies to ensure equitable access to health-care and services as well as occupational safety and health for migrant workers" (Dhaka Declaration, 2013).

This report presents and discusses the findings of the data collected on the health vulnerabilities of departing and returnee migrants and the health policy regarding migrants in Nepal have been collected and analysed.

1.2 Purpose of study

The overall aim of this study was to contribute to the general understanding of the health vulnerabilities of departing and returnee migrants in Nepal to inform the development of evidence, policies, services and programmes that respond to migration related health challenges.

1.2.1 Specific objectives

Specifically, the objectives of the study were to:

a. Assess the migration related health vulnerabilities of departing and returnee migrants in Nepal;

b. Determine the availability and accessibility of health services, quality of health services, and barriers to accessing health services among migrants in their country of origin and destination; and

c. Provide recommendations to the government and other stakeholders to support policy development on health aspects of migration and programme development.

1.3 Research methodology

1.3.1 Study design

The study employed a mixed-methods approach, employing both quantitative research through questionnaire-aided interviews, and qualitative data collection using semi-structured Key Informant Interviews (KII) and Focus Group Discussions (FGD). Based on the findings of the literature review, both qualitative and quantitative methods of data collection were developed to conduct this study. The methodology framework was designed by a Regional Researcher, and national research teams in Nepal adapted the study protocols to suit the country contexts and settings. This study was carried out among departing and returnee migrants in several districts in Nepal.

[1] *Attending Member States were Bangladesh, Cambodia, China, India, Indonesia, Lao People's Democratic Republic, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand and Viet Nam.*

[2] *The Colombo Process is a an informal and non-binding, regional consultative process of the following Member States: Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand and Viet Nam. The Colombo Process is dedicated to discussing issues of migration.*

1.3.2 Study area

The districts of Jhapa, Nawalparasi, Kathmandu and Pyuthan were selected for this study based on the following criteria:

a. Maximum absentee population and maximum proportion of absentee households - as per the figures available through Central Bureau of Statistics, Nepal

b. Representation of Eastern (Jhapa), Central (Kathmandu), Western (Nawalparasi) and Mid-Western (Pyuthan) development regions

c. High border mobility for cross border migration – (Jhapa and Pyuthan), or

d. The highest number of and most facilities for departing migrants (Kathmandu)

1.3.3 Sampling scheme

A multi-stage cluster sampling technique was used. A total of 28 clusters were selected; fourteen clusters each for departing and returnee migrants respectively.

Household sampling was used for returnee migrants. Clusters were based on wards, which is the smallest administrative unit in Nepal. Clusters of returnee migrants were selected using ward-level data on absentee households from the Central Bureau of Statistics. Aided by key informants and social mapping in the field, enumerators identified central points within each cluster with a high probability of encountering returnee migrants. To randomly select each household, a bottle was spun from the central point to select the starting household. Using the right hand rule, subsequent houses were then identified.

Recruitment agencies/health examination facilities were regarded as single clusters for departing migrants. Selection of appropriate clusters was carried out with reference to a list of recruitment agencies and health examination facilities available from the website of Department of Foreign Employment. From the list, fourteen clusters were selected using the Probability Proportionate to Size (PPS) method. The data collectors visited each facility for a period of four hours (10.00 am -02.00 pm) each day for a week, and respondents were randomly selected from available respondents. If departing migrants were not available in a certain cluster, snowball sampling was used to draw more respondents from health examination facilities. All eligible candidates were screened prior to interview.

1.3.4 Participant selection and eligibility criteria

Quantitative research

A total of 411 respondents were interviewed for the quantitative data collection, consisting of 201 departing and 210 returnee migrants. The following eligibility criteria applied:

- Departing migrants had to be in or have completed the process of signing a contract, applying for a visa, and/or undergoing a pre-departure health examination. Those who planned to migrate but had not yet made definitive moves to do so were excluded.
- Returnee migrants had to have returned to Nepal following a period of migration and resided in Nepal for no longer than twelve months.

Qualitative research

Seven FGDs were held with departing, returnee, and cross-border migrants, divided into male and female groups. Available FGD participants were randomly selected from the clusters selected for quantitative data during the data collection period, with the support of local key informants. The table below shows the detailed group composition and number of participants.

Table 1: Composition and numbers of Focus Group Discussion participants

Group composition of FGD	Number of participants
Departing migrants: male	6
Departing migrants: female	7
Cross border migrants: male	6
Cross border migrants: female	6
Returnee migrants: male	7
Returnee migrants: female	8
Spouse of migrants	9
Total number of participants	**49**

Thirteen (KIIs were conducted, with relevant stakeholders from government, private, academic and NGO representatives related to migration and health for the qualitative data collection. Some participants for KII were selected via the IOM network; remaining participants were recruited through snowball sampling via the initial key informants. The positions/professions of the thirteen key informants are listed below:

1. NGO official advocating migrant rights
2. National Programme Officer of an INGO working with migrants' issues;
3. Programme Officer and Chief Technical Adviser of a global organization dealing with labour issues;
4. Chief of Mission/Director of a major INGO dealing with migrants' issues;
5. Member of Foreign Employment Promotion Board;
6. Programme Coordinator of HIV/AIDS in a bilateral organization;
7. Pre-Departure Training Official in a recruitment agency;
8. Chairperson of a major NGO working with women migrants;
9. Executive Secretary of a Foundation serving Tibetan refugees;
10. Official working in HIV sector in an INGO
11. Chairperson of a refugee rights network;
12. Director at a recruitment and pre-departure orientation centre for female labour migrants
13. Social and Reproductive Health Specialist at an INGO dealing with cross border migrants' issues in India and Nepal

1.3.5 Research tool development

Design, pre-testing and training

Research tools consisted of the quantitative questionnaire and the FGD and KII guidelines. The research tools were developed by the Regional Researcher, based in Dhaka, Bangladesh, in consultation with the IOM teams in the Regional Office for Asia and the Pacific in Bangkok, and in the Country Office in Nepal. National and Field researchers, the Health Research and Social Development Forum (HERD), were selected for conducting the research in Nepal. The HERD team completed the forward translation into Nepali. Pre-testing of the questionnaire was conducted to assess its validity and to determine the appropriateness of the translation and database design. Pre-testing was conducted in several households (of returnee migrants) and recruitment centres (for departing migrants) in Lalitpur district.

A three-day training session for field researchers was conducted during 4 and 6 September 2013 at the meeting hall of HERD prior to the data collection period. A total of sixteen field researchers were trained. Field researchers were selected from a pool of about 200 field researchers who have frequently participated in other studies conducted by HERD. The training was conducted by HERD's Core Study Team which included Executive Director, Senior Qualitative Research Officer, Data Analyst, Research Officers Operations Manager and Senior Administration and Finance Officer. The training included both theoretical and practical sessions, as well as detailed discussions on each question in the questionnaire. Mock interviews and FGD sessions were also held during the training.

1.3.6 Data collection

The quantitative survey and FGDs were conducted by four teams of field researchers, one for each study district. Data collection for the questionnaire interviews and FGDs took place from in September 2013. Within this time period, the duration of quantitative data collection differed by study district. A minimum of three and a maximum of five interviews were completed per field researcher during a field day.

KIIs were conducted by the core research team of HERD, in September and October 2013. Field based supervisory visits were conducted by the core HERD research team, and daily monitoring was carried out by the monitoring desk at HERD via telephone.

1.3.7 Data management and analysis

Quantitative data

Questionnaires were checked through immediately following interviews and at the end of the field day of data collection to ascertain if all questions had been asked. If missing information was discovered, field researchers revisited the households. Field supervisors coded the questionnaires, and at least five per cent of the coding was checked and validated by the data manager. Open-ended responses were coded into numeric codes, code categories were made mutually exclusive and defined precisely. Coded data were entered into a data entry programme, which was designed to check for consistency and non-eligible or outlying data. Data was then transferred into SPSS, cleaned, labelled, and checked for internal consistency. Data analysis consisted of basic cross tabulations to create frequency tables and graphs. Differences between male and female, returnee and departing migrants, age groups, and professions were presented where appropriate. In some cases, statistical methods, including Chi-square tests and logistic regression, were used for bivariate and multivariate analysis.

Qualitative data

For qualitative data, recordings of FGDs were transcribed into the Nepali language by the field researchers and then translated into English by experienced translators. The quality of the translation was checked thoroughly by the field supervisor as well as the core research team of HERD. Recordings of KIIs were transcribed and translated by the core research team members. The translated transcripts were then coded manually and using Atlas.ti software, which were then compiled into themes as per the guidelines developed by the Regional Researcher and IOM.

1.3.8 Ethical considerations

Ethical approval was sought from the Nepal Health Research Council (NHRC) to carry out this research. Letters requesting approval were also submitted to the study district health offices, recruiting centres and health examination facilities. Informed consent was obtained from all study participants before incorporating them into the study via an informed consent form used with all data collection tools. The consent form briefly described the study, requested voluntary participation, and assured participants of confidentiality. The study team also followed UNAIDS guidelines for generating data on HIV/AIDS and other infectious diseases (UNAIDS, 1997).

1.3.9 Study limitations

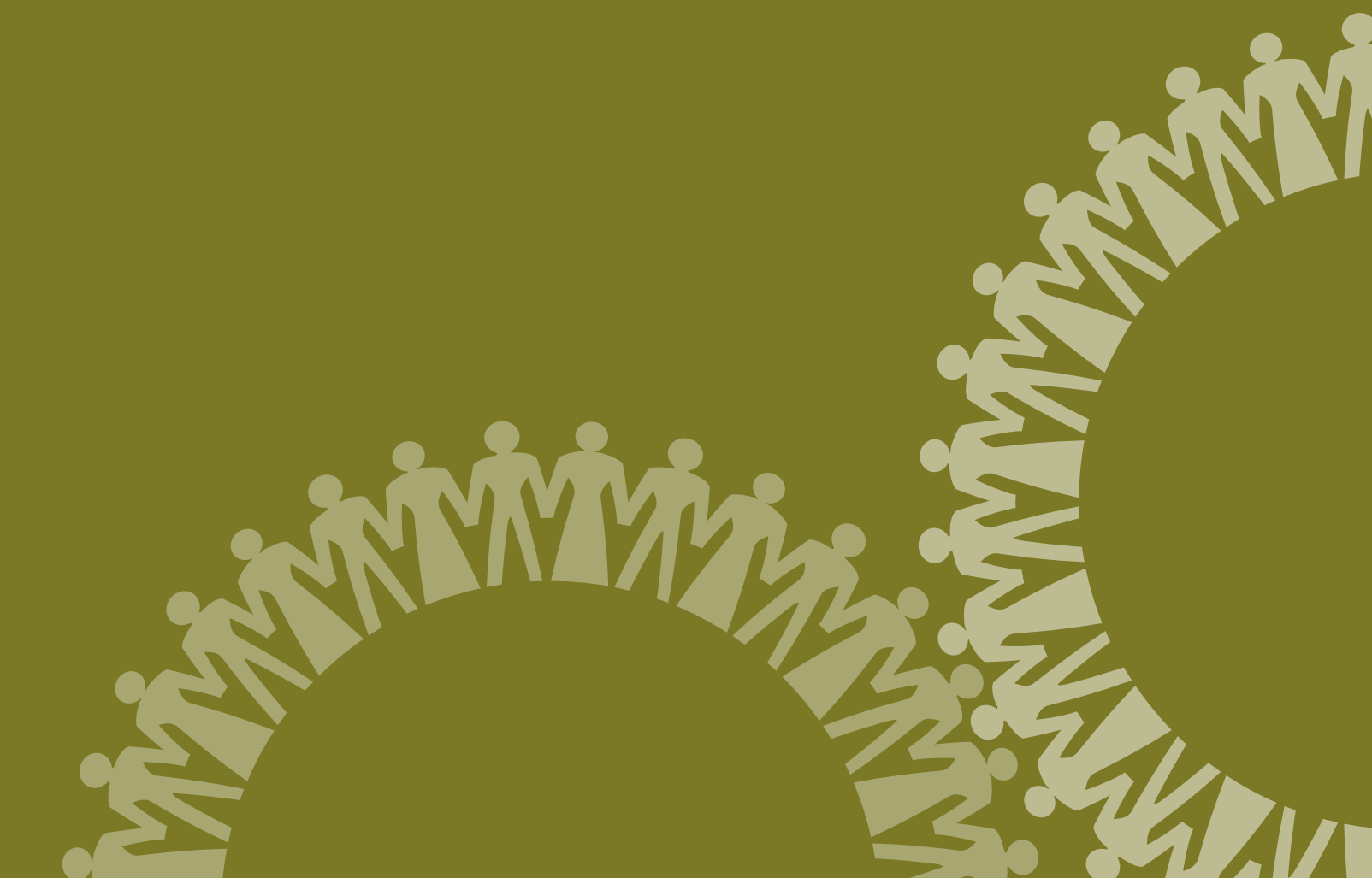
Data collection took place over two weeks in September and October 2013. There were various obstacles that prevented access to departing migrants, including the pre-festival period in Nepal, which limited the recruitment of the desired number of respondents. It was also very difficult to find female migrants, and the findings are thus not necessarily representative of the female migration experience. Furthermore, this study does not capture the experiences of undocumented migrants from Nepal while living abroad and those intend to go abroad for the purpose other than employment.

Although the majority of migrants return to Nepal, those who have returned may be less representative of current migrant experiences abroad, and may have faced overall more difficulties than those who managed to stay longer.

There is risk of response bias, particularly with regard to sensitive topics such as sexual behaviour. The lack of discussion and probing in the quantitative survey poses a limitation, and indicators concerning the health knowledge of respondents, for example, may be underestimated.

CHAPTER TWO

LITERATURE REVIEW



2.1 Labour migration in Nepal

Migration has been a feature of Nepal's social landscape since the early 19th Century. Motivating factors have included poverty, unemployment, long-term internal conflict, rapid population growth and associated food shortages, as well as encouragement from the government to emigrate because of the country's rising levels of unemployment (Bhattarai, 2005). Migration has been referred to as "the de facto core of Nepal's development strategy" (Adhikari & Hobley, 2012); remittances play a large role in the country's economy, constituting 25 per cent of GDP in 2014 (World Bank, 2014b)), recruitment fees and migration associated costs have also been found to generate revenue in the country of origin (ILO, 1995).

From 2013 to 2014 a total of 521,878 labour permits were issued, largely to Malaysia, Saudi Arabia, Qatar and the United Arab Emirates and Kuwait (Department of Foreign Employment Nepal, 2014). In addition, a high number of undocumented migrants travel to India. This is facilitated by the provision of free movement under the Indo-Nepal Treaty of Peace and Friendship of 1950 (Asia-Pacific RCM Thematic Group on International Migration including Human Trafficking (APRCMT), 2012). Of the total number of Nepali migrants, between 3.4 per cent and ten per cent are estimated to be women, many of whom are trafficked through irregular channels (APRCMTG, 2012). It is estimated that 5,000-15,000 Nepali women are victims of human trafficking each year, primarily to India and the Middle East. Overall, the estimated number of absent Nepali abroad is about two million (CBS Nepal, 2011), although the true figure is likely to be higher.

Disseminating information about migration in Nepal is challenging due to its mountainous and landlocked geography, and is thus mostly confined to urban centres. In areas where community education on safe migration practices is low, brokers who facilitate the migration process are in high demand. Their practices are often exploitative, and migrants may be forced to pay high fees and work in abusive and unsafe environments (Department of Foreign Employment Nepal, 2014). A 2011 Amnesty International study among 120 Nepali migrant workers showed that 98 reported disputes over salary; while many others reported being misled about the type of work they were hired for. A Migrant Resource Centre [3] was established in Kathmandu in 2010 through a cooperation between the Government of Nepal and IOM, to provide migrants with counselling and safety information, either face-to-face, via email or telephone (IOM, 2012a). However, the dissemination of migration information beyond the major urban centres needs to be intensified, to reach more potential migrants in remote areas of the country.

2.2 Health system in Nepal

According to records from the World Bank (2014a), Nepal allocated 5.5 per cent of GDP to health and health programming in 2012. Political and economic instability has hindered the development of Nepal's health system. Despite commitment to expanding access to primary health care (PHC) following the National Health Care Policy of 1991, health infrastructure remains particularly limited in rural areas, and a shortage of health professionals, difficult geographic terrain and low levels of literacy and health education pose great obstacles. Physicians are concentrated in urban areas, and only 65 per cent of the rural population live within one hour of a PHC facility; ten per cent live within one hour of a hospital.

Nepal's Second Long Term Health Plan (2007-2017) looks to address disparities in the health-care system, by improving Maternal, Neonatal and Child Health (MNCH) and expand coverage to rural, marginalized and underprivileged populations. Focus on human resource and infrastructural development, and tackling public health issues through effective surveillance, health promotion and community involvement, will be important to achieving this vision.

[3] *The Migrant Resource Centre in Kathmandu is located at the Foreign Employment Promotion Board. It serves as an autonomous body within the Ministry of Labour and Transportation Management for information, welfare and promotional activities related to migration.*

2.3 Health vulnerabilities of Nepali migrant populations

Current lack of sound health system infrastructure illustrates the country's limited capacity to handle migrant populations and places migrant populations at a particular disadvantage, especially if they are seeking mandatory health examination prior to departure or returnee health services for illnesses incurred during a period of migration.

Key health vulnerabilities of migrants include HIV, Tuberculosis (TB), MNCH and mental health issues (Rijal, 2013). The HIV prevalence among the adult population in Nepal is 0.5 per cent (USAID, 2010). The HIV epidemic in Nepal, however, is concentrated among key populations and of all HIV positive cases in Nepal (n= 43,239; aged 15-49), 27 percent are among male labour migrants. Remaining infections were concentrated primarily among men who have sex with men (MSM) who do not sell and or buy sex (14.4%), male sex workers (MSW), transgender (TG) and clients (7.2%) and clients of female sex workers (FSW) (4.4%) (National Centre for AIDS and STD Control Nepal, 2012). Internal and international migration, gender inequalities, and poor education and knowledge of risk factors, are likely to have contributed to the HIV epidemic in Nepal. Women are thought to constitute 28 per cent of infections and are particularly vulnerable due to social forces which limit their negotiating power with respect to safe sex and access to health information (NCASC Nepal, 2012).

Nepal has a large TB burden, with an incidence rate of 163 per 100,000 (WHO, 2012). Multi-drug resistant TB (MDR-TB), extensively drug-resistant TB (XDR-TB), and TB/HIV co-infection represent growing concerns and challenges for TB control in Nepal (Banstola, 2010). Migrants are particularly vulnerable to TB due to their lower socio-economic status and poor working and living conditions. Their mobility also makes access to diagnosis and treatment, and compliance to DOTS, difficult (IOM-WHO, 2014). According to a study conducted in Kathmandu, inbound[4] migrants have little knowledge of where to find TB services in the city, while those who did struggled with compliance (Kirwan, Baral & Newell, 2009). The social stigma associated with TB, as well as gender inequality (delayed diagnosis and treatment for women), create further barriers to TB control in Nepal (WHO, 2002).

Pregnancy and reproductive freedom of migrant women can be restricted by conditions set by the receiving country. Pregnant women can be denied migration all together due to their pregnant state. Many women are forced to undergo mandatory pregnancy tests before being issued documentation and may be further subjected to regular pregnancy tests by their employer in the destination country. Women who become pregnant during a period of migration may be dismissed from their work (ILO, 2014). In a study of pregnant women who migrated to England it was found that these women engaged in poor health behaviours such as smoking and alcohol use compared to their counterparts in their country of origin (Perreira, 2008). Furthermore, a study of pregnant Mexican migrant women showed poorer perinatal outcomes compared to their counterparts that remained in Mexico. Babies born to migrant women were 37-64 per cent more likely to have a preterm or low birth weight baby (Hessol and Fuentes-Afflick, 2012). Migration status, especially undocumented migrant status, can increase the number of unintended pregnancies, increase the prevalence of untreated sexually transmitted infections such as Chlamydia and Syphilis, delay or prevent access to prenatal care and family planning services, and increase exposure to violence during pregnancy (Wolff et al., 2008a; 2008b).

Global commitment to mental health problems is not yet priority and as a result it remains underfunded. In 2006, less than one per cent of total global health expenditure was spent on mental health (WHO, 2006). There is also limited research into the mental health of migrants and trafficked persons, particularly women. In a study on Nepali persons displaced due to the armed conflict which ended in 1996, 80.7 per cent were found to suffer from anxiety, 80.3 per cent from depression, and 53.4 per cent exhibited symptoms of post-traumatic stress disorder (PTSD) (Thapa & Hauff, 2012). A small Nepal-based study also found one third of trafficked women and girls to exhibit symptoms of PTSD, and almost all to suffer from symptoms of anxiety and depression (Tsutsumi & Poudyal, 2008).

Furthermore, Nepali migrants are vulnerable to effects of occupational hazards and injury; sexual violence and abuse by employers; poor living and working conditions; psychosomatic effects of stress; poor wages (poverty).

[4] *Inbound migrant is defined as the person migrates into a country and includes categories such as migrant workers.*

2.4 Policy and migration health in Nepal

Nepal has ratified various human rights conventions and International Labour Organization conventions related to migrants, such as the International Covenant on Economic, Social and Cultural Rights (1966), International Covenant on Civil and Political Rights (1966), Convention on the Elimination of Racial Discrimination, Discrimination Against Women (1979), Convention on the Rights of the Child (1989), Right to Organize and Collective Bargaining Convention (1979), Forced Labour Convention (1930), Minimum Age Convention (1973), Worst Forms of Child Labour Convention (1999), Equal Remuneration Convention (1951), Discrimination (Employment and Remuneration) Convention (1958), Weekly Rest (Industry) Convention (1921), Minimum Wage Fixing Convention (1970), Tripartite Consultation (ILS) Convention (1976) and Indigenous and Tribal Peoples Convention (1989).

However, Nepal has not ratified two major conventions related to migration: Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and UN Protocol to Prevent, Suppress and Punish Trafficking in Persons. Furthermore, Nepal has also not ratified two ILO conventions specific to migration: Migration for Employment Convention (Revised), 1949 and Migrant Workers (Supplementary Provisions), 1975.

Some national policies and legislation related to migrants are: Foreign Employment Act 2007, Labour Migration Policy 2006 and The Human Trafficking (Control) Act 2008. However, there is no official health policy for migrant workers from Nepal and, despite their major role in sending remittances to the country there is no allocation of the health-care budget for migrant workers and/or their families.

The mandatory pre-departure orientation training (PDOT), introduced in 2004, is an essential component of worker protection and coordinated exclusively by recruitment agencies. The programme covers foreign employment law of Nepal; the geography, culture, lifestyle and the economic, social and political context of the destination country; language of the destination country; labour, immigration laws and traffic rules of the destination country; HIV/AIDS and other communicable diseases and sexual and reproductive health; occupational safety and health; easy and safe travel; conduct, treatment and security of workers; and simple and safe repatriation of earnings made abroad. The fee for this training is the equivalent of ten USD and is reimbursable for women (IOM, 2012a).

For circumstances where a health examination is required before commencing with work, migrants are often not provided comprehensive information regarding tests and procedures and nor are they informed as to their test results. Respondents from a study that looked at mandatory testing in Indonesia indicated that facilities for health examinations were uncomfortable and there was no consideration for female migrants made, such as only one toilet provided (Elanvito, 2007).

Furthermore, there are no policies or guidelines for the reintegration of Nepali migrants, including those deemed unfit and deported by their receiving country.

This presents one of the largest hurdles for the Government of Nepal to protect and promote the rights of its migrants as the lack of leverage and authority that Nepal has in the international community to stand up or demand for the protection of Nepali migrants remains weak without having ratified major conventions related to migration.

Considering the obstacles and challenges that Nepal faces in addressing the health of migrants the overall aim of this country study is to contribute to the general understanding of the health vulnerabilities of departing and returnee migrants in Nepal to inform the development of migration health-inclusive policies, services and programmes.

Specific objectives include; to assess the unique migration related health vulnerabilities of departing and returnee migrants in Nepal; to determine the availability and accessibility of health services, the quality of health services, and barriers to accessing health services among Nepali migrants in Nepal and their country of destination; and to provide recommendations to the Government of Nepal and other stakeholders to support policy development on health aspects of migration and programme development.

CHAPTER THREE

STUDY FINDINGS

3.1 Quantitative results

3.1.1 Characteristics of study population

Demographic profile. The sample consisted of 411 Nepali migrants interviewed for the quantitative study, consisting of 201 departing and 210 returnee migrants. A significantly larger number of men (n=386) than women (n=25) were sampled. On average interviewees were 29.5 years old, married, with a mean family income of 31,500 NPR (315 USD) per month and a family size of 1 or 2 people. Returnee migrants were on average 32 years of age, and more likely to be married ($p<0.001$; Appendix 1.1).

Approximately 80 per cent of migrants had completed or reached secondary education. Among those with primary education or less, literacy was poor, although comparatively better among returnees ($p=0.062$; Appendix 1.1).

As shown in Figure 1, most migrants interviewed worked in Agricultural sector (35%), followed by Industry/Manufacturing (28%), Private Services (17%) and Public Services (9%) (Appendix 1.2). The four most common jobs were agricultural worker (34%), labourers worker (18%), domestic worker (8%), and technician (7%).

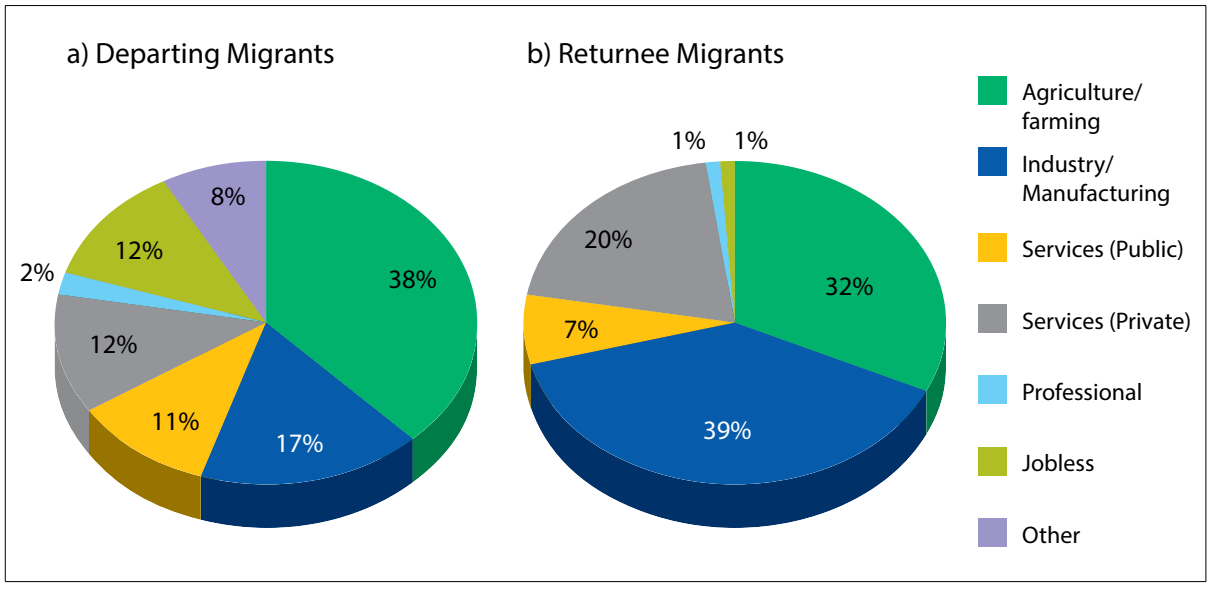


Figure 1: Type of employment among a) departing and b) returnee migrants

Migration profile. The Middle East was the intended destination region among 95 per cent of departing migrants, and the most recent country of work among 70 per cent of returning migrants. As shown in Figure 2, the most frequently mentioned countries of destination were Saudi Arabia, the United Arab Emirates, Qatar, and Malaysia (Appendix 1.3).

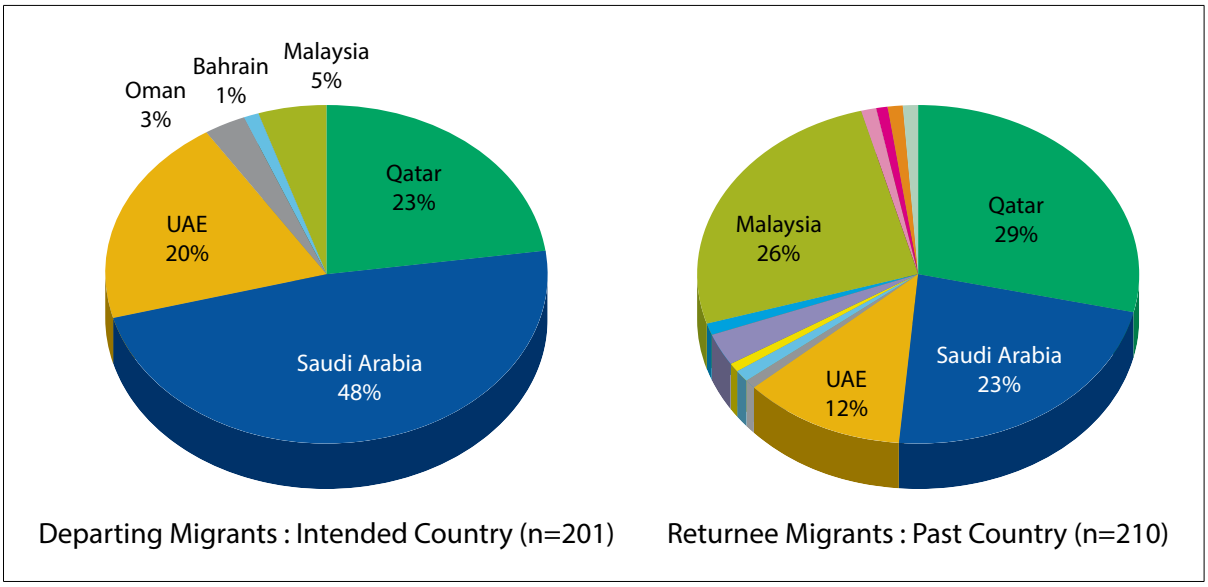


Figure 2: Intended/ past country of work for departing and returnee migrants

In line with eligibility criteria, all returnee migrants had returned within the previous year, and approximately 60 per cent had returned home within the previous six months. Returnees had worked abroad a median of two times and a maximum of eight. In total, 69 per cent of returnees sampled indicated that they plan to go abroad again; women, however, were 20 per cent less likely than men to share this intention. As shown in Table 2, end of contract and annual leave were the most common reasons for return (36% and 19%, respectively for returnees), followed by personal reasons (16%), no benefits/salary (13%) and health problems (9%).

Table 2: Reasons for returning to country of origin according to returnee migrants

	Total (n=210)		Men (n=196)		Women (n=14)	
	%	n	%	n	%	n
End of contract	35.7%	75	33.5%	65	62.5%	10
Coming for annual leave	19.0%	40	19.6%	38	12.5%	2
Personal reasons	15.7%	33	16.0%	31	12.5%	2
No benefits/salary	12.9%	27	13.4%	26	6.3%	1
Health problems	9.0%	19	9.3%	18	6.3%	1
Pushed back (deported)	4.3%	9	4.6%	9	0.0%	0
Uncomfortable working environment	2.9%	6	3.1%	6	0.0%	0
Early termination of contract	1.9%	4	2.1%	4	0.0%	0
Working on jobs outside of contract	1.0%	2	1.0%	2	0.0%	0
Imprisoned	1.0%	2	1.0%	2	0.0%	0
Political unrest	0.5%	1	0.0%	0	6.3%	1
Was living illegally	0.5%	1	0.5%	1	0.0%	0
Company collapsed	0.5%	1	0.5%	1	0.0%	0
Did not get the intended job	0.5%	1	0.5%	1	0.0%	0

*Total exceeds 100% due to multiple responses chosen

Burdens experienced during the migration process for men and women are depicted in 48. The most prominent burdens were financial arrangements (40% of all migrants), bribes to authorities, and inadequate provision of information pertaining to employment. Health check-ups were among the several other problems mentioned (full list in Appendix 1.6). Returnee migrants reported more burdens overall compared to departing migrants, including higher levels of discrimination and abuses as well as corruption. See Figure 3 for full details.

Figure 3: Top 5 burdens faced by migrants during the migration process, by migrant group and sex

For both departing and returnee migrants, personal contacts (relatives and friends) and recruitment agencies were the main sources of assistance), however this order was reversed among returning migrants and women. See Figure 4 for full details.

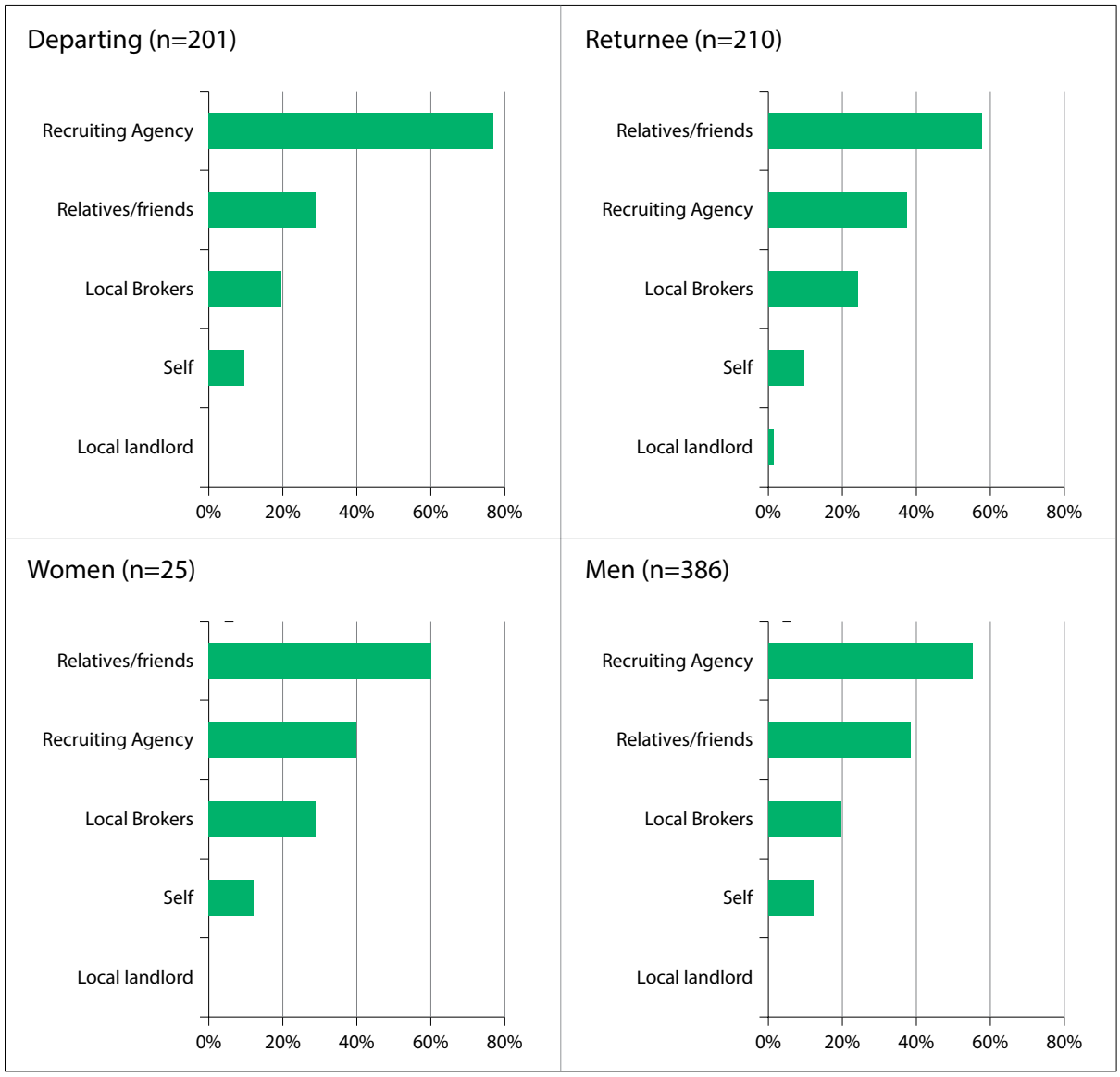


Figure 4: Sources of assistance during the migration process by migrant group and sex

3.1.2 Health risks and vulnerabilities

Health profile and health-care seeking behaviours. More returnee migrants had been ill in the last six months compared to departing migrants (Appendix 1.8). This is partly attributable to the higher percentage of labourers; the employment group with the highest percentage of migrants with a history of illness (described in detail below). 80 per cent of migrants stated that they had fallen ill in their destination country, compared to 70 per cent falling sick in their country of origin.

Among those returnees with a history of illness abroad, minor health problems (82%) and occupational hazards (13%) were the leading causes. Reflecting this, the primary medical services sought abroad were medical treatments and check-ups, followed by laboratory tests and X-Rays.

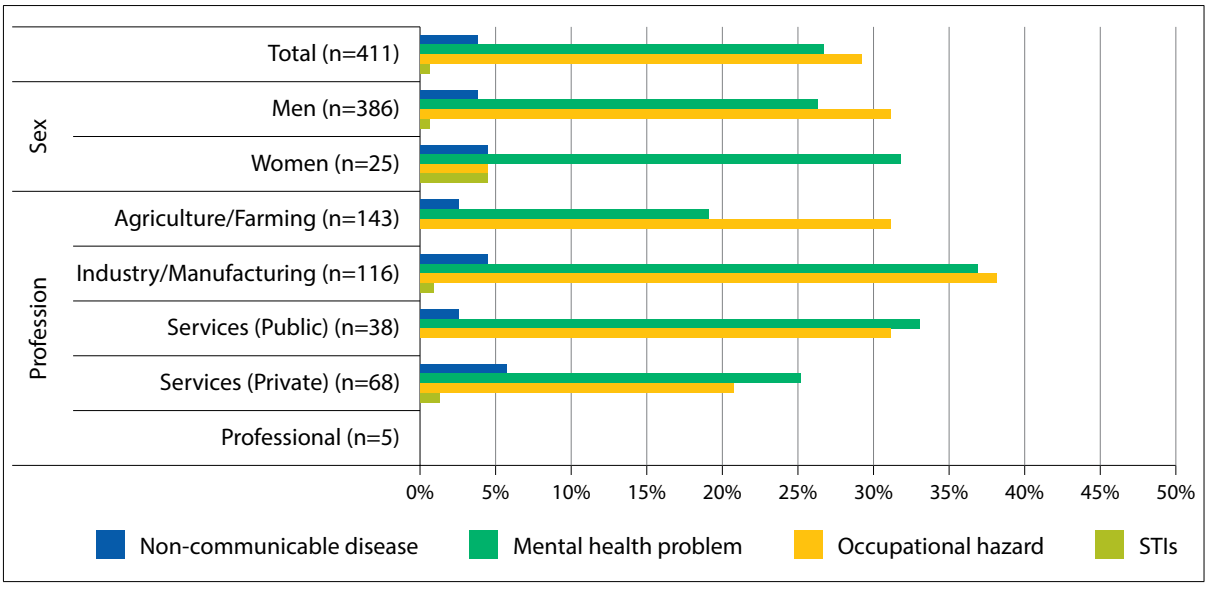


Figure 5: Migrants reporting illness, by sex and area of work (n=411)

Occupational hazards and mental health problems were frequent occurrences experienced by 29 per cent and 27 per cent of all migrants respectively, and were particularly prominent among those working in Agriculture, Industry/Manufacturing and Public Services (Figure 5). Occupational hazards occurred most often among men and were experienced by only four per cent (n=1) of women. Mental health problems were the most frequent health problem among women. Reports of non-communicable diseases and sexually transmitted infections were low in all groups.

Health-care seeking was common for those with non-communicable diseases and notably lower for mental health problems; 86 per cent and 44 per cent sought health-care for these conditions respectively (Figure 6).

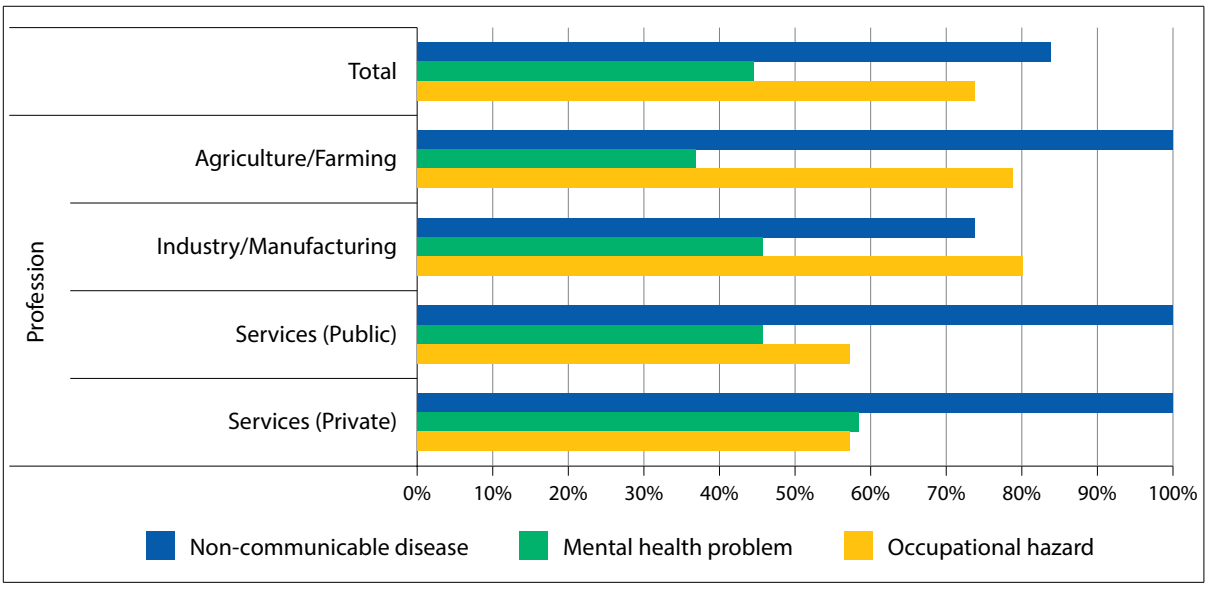


Figure 6: Migrants who sought health-care in destination countries by disease type and area of work (n=151)

In destination countries, those that did seek treatment or advice for these conditions predominantly consulted friends/relatives and formal health facilities. Other sources mentioned by a small minority (each under 4%) included traditional healers, shops, worker's organizations, and companies/employers (Figure 7).

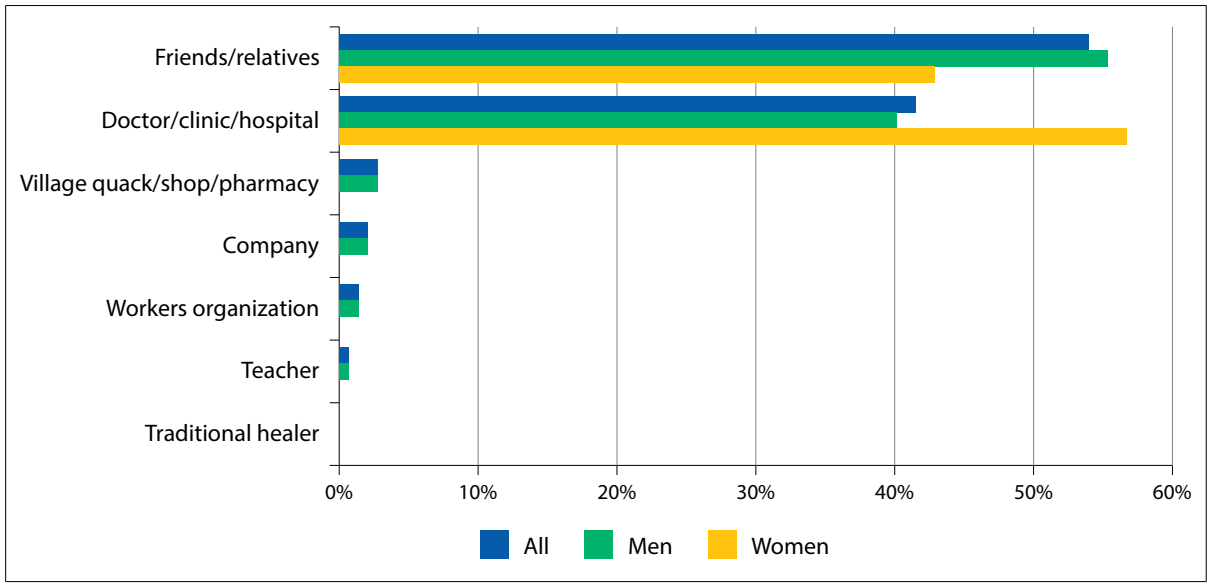


Figure 7: Source of advice or treatment among those who sought health-care in destination countries for non-communicable disease, mental health problem, or occupational hazards

Sexual behaviour among all migrants. Almost 90 per cent of respondents had ever had sex (89% of men and 72% of women), and 81 per cent had had sex in the past twelve months (83% of men and 52% of women). Sexual partners were predominantly spouses, with 70 per cent of all respondents having had sex with their husband or wife in the past year. This was followed by a girlfriend/boyfriend (11%), friend (6%), and sex worker (3%). Only men reported having commercial or casual sex (Figure 8; Appendix 1.10).

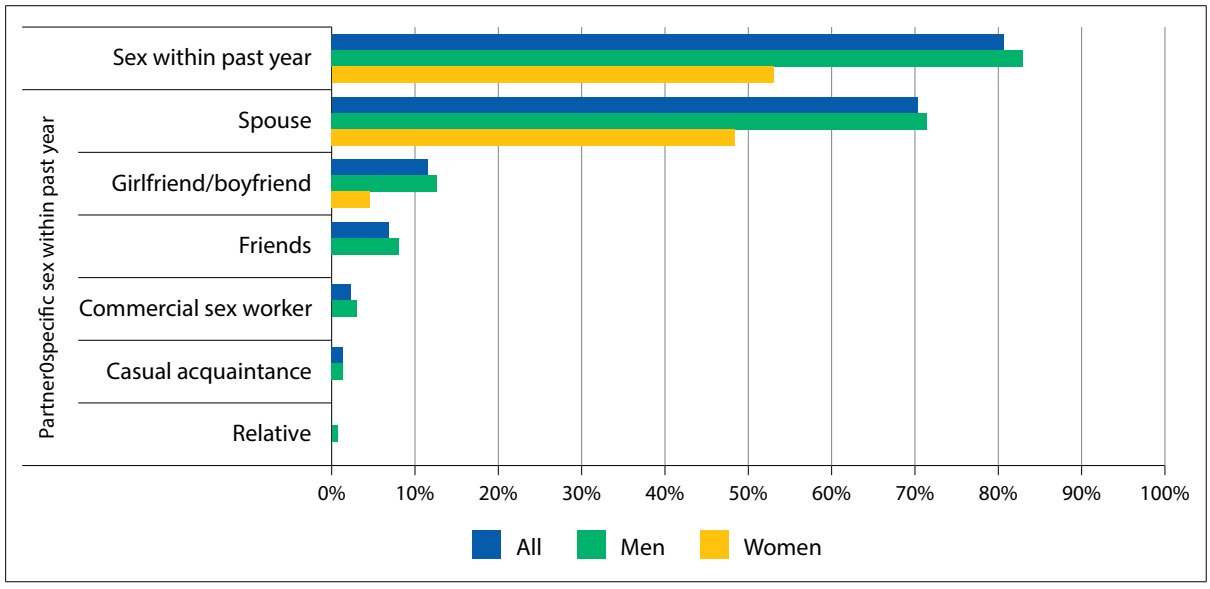


Figure 8: Sex partners reported for all departing and returnee migrants within past yearl (n=411)

Approximately 75 per cent of departing migrants had had sex in the past year, while fourteen per cent of returnee migrants had. Departing migrants reported a median of one partner in the past year, with a maximum of six. Returnees reported a median of two partners, with a maximum of 35. Male respondents reported higher numbers of partners compared to their female counterparts. Female respondents in both migrant groups had a range of zero to one for number of sexual partners in the past year.

Condom use among all migrants. Condom use within migrant populations was particularly low with spouses; condoms were used regularly by nine per cent of respondents, and never used by 65 per cent of respondents. More women than men stated that they never used a condom with their spouse (Figure 9).

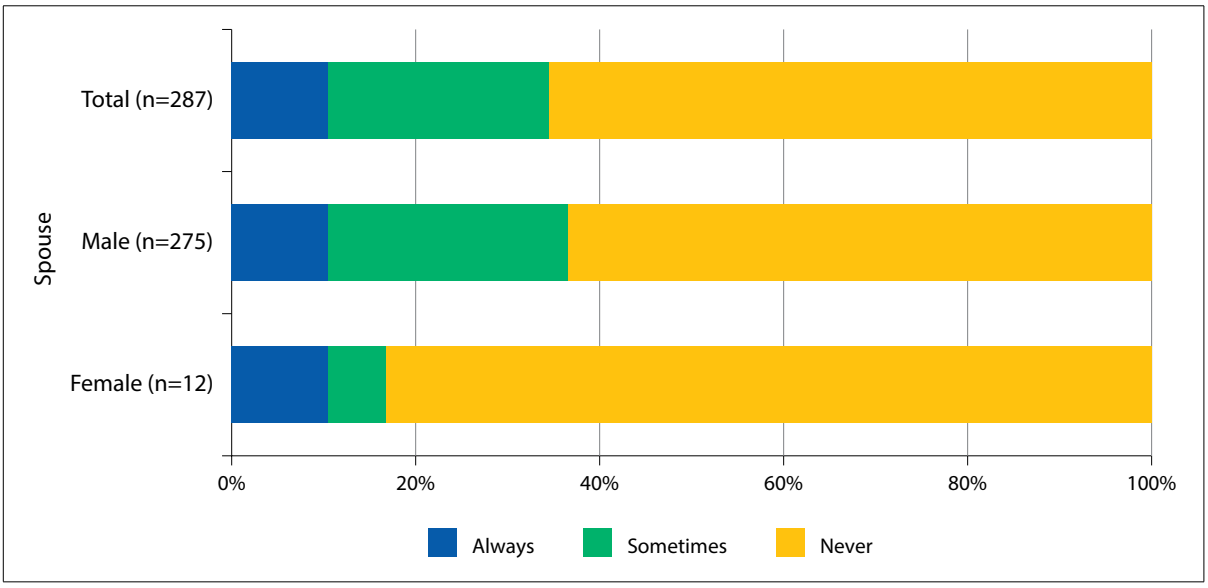


Figure 9: Frequency of condom use with spouse, by sex among all migrants that had sex in the past 6 months

Reported condom use was significantly higher with other partners, most notably with sex workers, with condoms always used by 83 per cent of those migrants who self-identified as clients of sex workers (Figure 10).

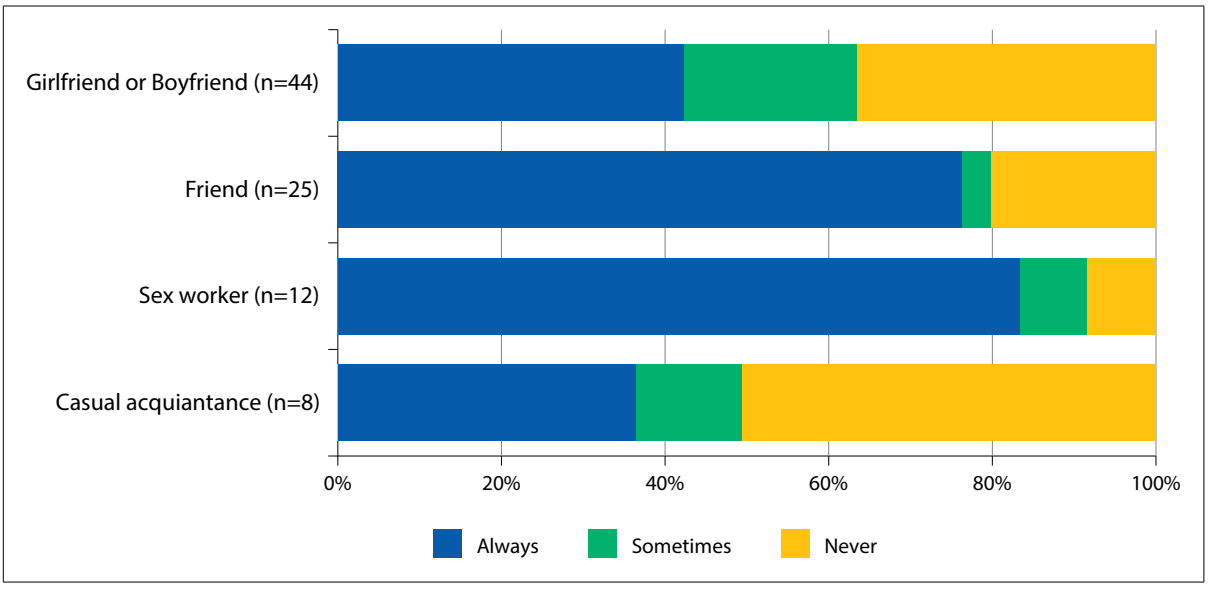


Figure 10: Frequency of condom use with partner other than spouse among all migrants that had sex in the past 6 months [5]

Reasons for using condoms differed depending on the type of sexual partner. Preventing pregnancy was the main reason for condom use with a spouse, or a girlfriend or boyfriend, while preventing STIs and HIV was the primary reason for using a condom with sex workers and casual acquaintances (Figure 11).

[5] *Not disaggregated by sex due to low responses among women*

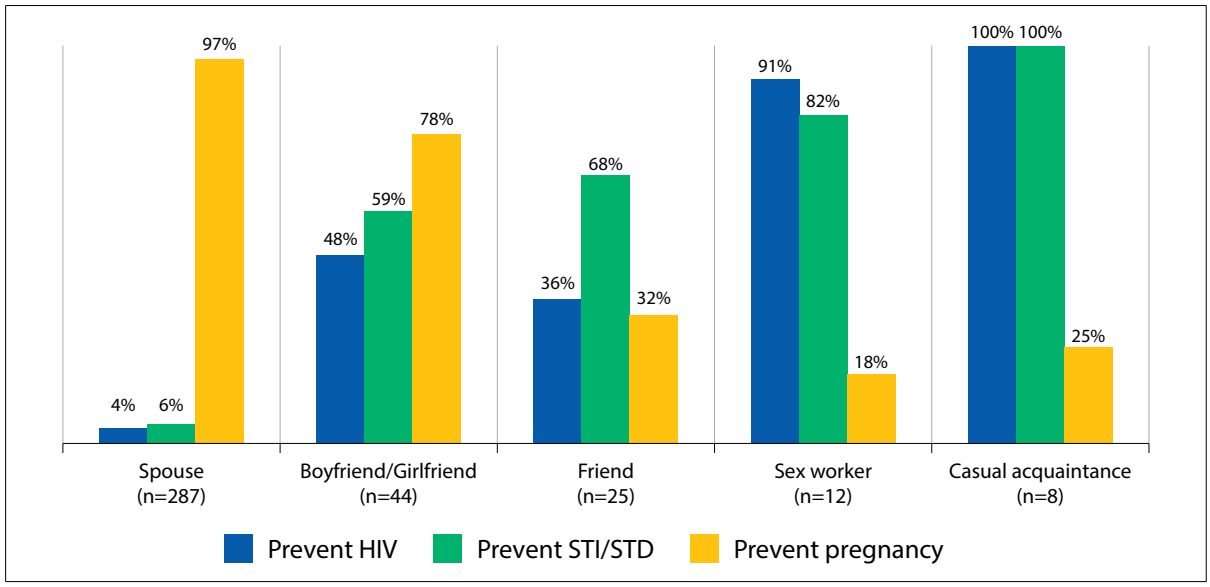


Figure 11: Reasons for condom use by partner type, among those who had sex in the past 6 months

The three primary reasons for not using a condom were trust in one's partner, use of other contraceptive methods, or feeling that condoms were not necessary (Figure 12). Other reasons given for not using condoms included intention to conceive, reduced sexual satisfaction, and partner preference. Female respondents were more likely than male respondents to report that they did not use condoms due to partner preference. Difficulties accessing condoms, due to cost or inaccessible health facilities that provide condoms, were also mentioned, however, less frequently.

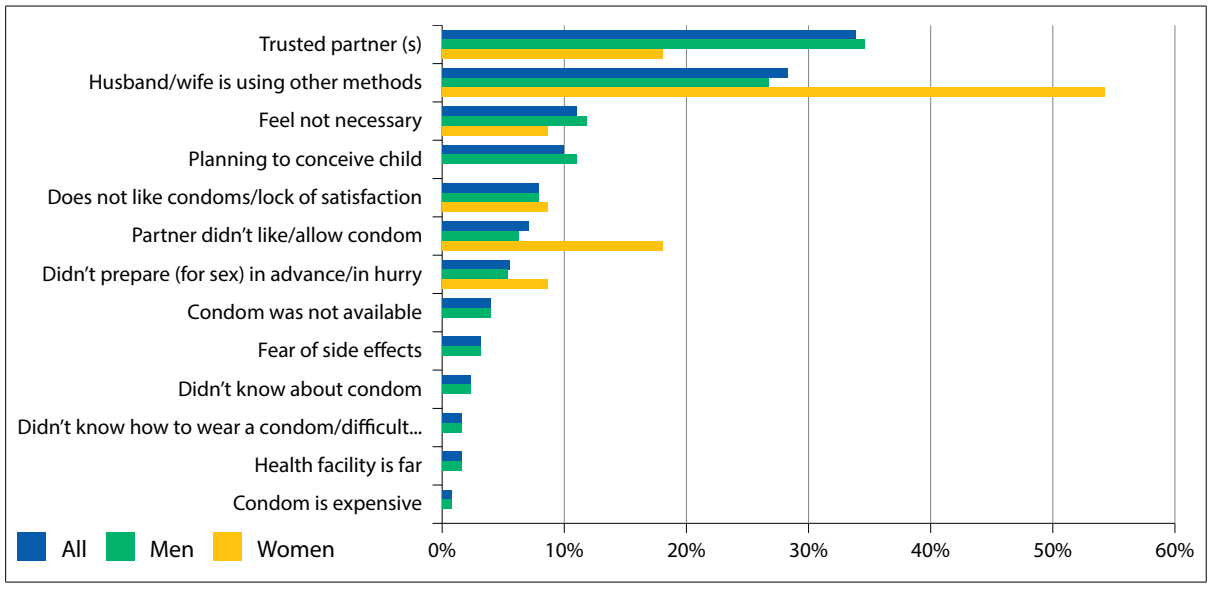


Figure 12: Reasons for not using a condom by sex, among those who had sex in the past 6 months

Sexual behaviour in country of destination. Partner type differed for departing and returnee migrants. As can be expected, departing migrants more frequently reported sex with a spouse or a steady partner (girlfriend/boyfriend). Two percent reported having had sex with a sex worker. In contrast, the most frequent sex partners among returnees who had sex abroad were sex workers and friends, while sex with a spouse was least frequently reported. Furthermore, although sexual activity in the country of origin was higher compared to in the country of destination, the percentage of migrants who had sex with a sex worker was higher during a period spent abroad (7% versus 2%).

Sexual violence in country of destination. As shown in Figure 13, 40 per cent of male and 69 per cent of female returnee migrants experienced forced sex while abroad. Knowledge of peers who were sexually abused while abroad is lower, averaging two per cent, although higher among women, at 12.5 per cent. The four individuals that knew of peers who had been sexually abused reported friends or employers as the primary perpetrators.

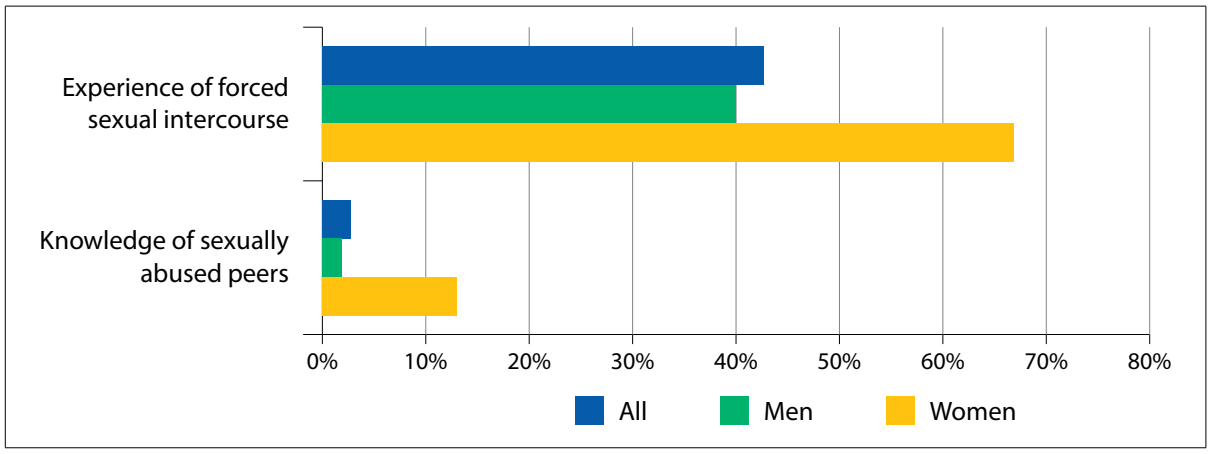


Figure 13: Respondents who experienced forced sex and respondents who knew of sexually abused peers, by sex

Substance abuse. As detailed in Table 3, about 40 per cent of all migrants had used drugs in the past 12 months, with greater reported drug use among men (38%) compared to women (16%; Chi2 P= 0.03), and among returnee migrants (52%) compared to departing migrants (20%, Chi2 P=0.000). There was no discernible trend among different professions, but there were some evidence to suggest that drug use was higher among those with self-reported history of mental illness while abroad.

Table 3: Respondents who had used drugs in the last 12 months, by sex, migrant category and work area (n=411)

	Total	%	n	Chi2 P value (unadjusted)
Sex				
Men	386	37.6%	145	P = 0.030
Women	25	16.0%	4	
Migrant category				
Departing	201	19.0%	40	P < 0.000
Returnee	210	51.9%	109	
Work area				
Agriculture/Farming	143	39.2%	56	n/a
Industry/Manufacturing	116	36.2%	42	
Services (Public)	38	36.8%	14	
Services (Private)	68	35.3%	24	
Professional	5	40.0%	2	
Other	24	25.0%	6	
Agriculture/Farming	17	29.4%	5	

*Totals may not add to 100% due to multiple choices allowed

Among those who had used drugs in the past twelve months**,** alcohol was the most popular (93%), followed by *ganja* (cannabis) (11%). No respondent reported injecting drugs in the past twelve months when unprompted, however when asked specifically, two individuals reported that they had. Women only reported consuming alcohol.

3.1.3 Knowledge of health risks and prevention including HIV/AIDS

General health knowledge. Approximately 90 per cent of all respondents believed that there were diseases that could be transmitted from themselves to partners and other family members (Appendix 1.28). Among them, 80 per cent mentioned HIV/AIDS as an example, followed by STIs (39%) and Tuberculosis (36%). Other diseases were mentioned sparingly, such as Influenza (4%), Malaria (2%) and Hepatitis C (1%) (Appendix 1.28).

HIV/AIDS knowledge. Although around 95 per cent of migrants had heard of HIV/AIDS (Appendix 1.28), knowledge of HIV transmission routes was limited (Figure 14). While almost 90 per cent of respondents recognized the risk of sexual intercourse without a condom, just less than 60 per cent mentioned sharing infected needles or unsafe blood transfusions, and fewer than ten per cent mentioned mother-to-child transmission of any kind.

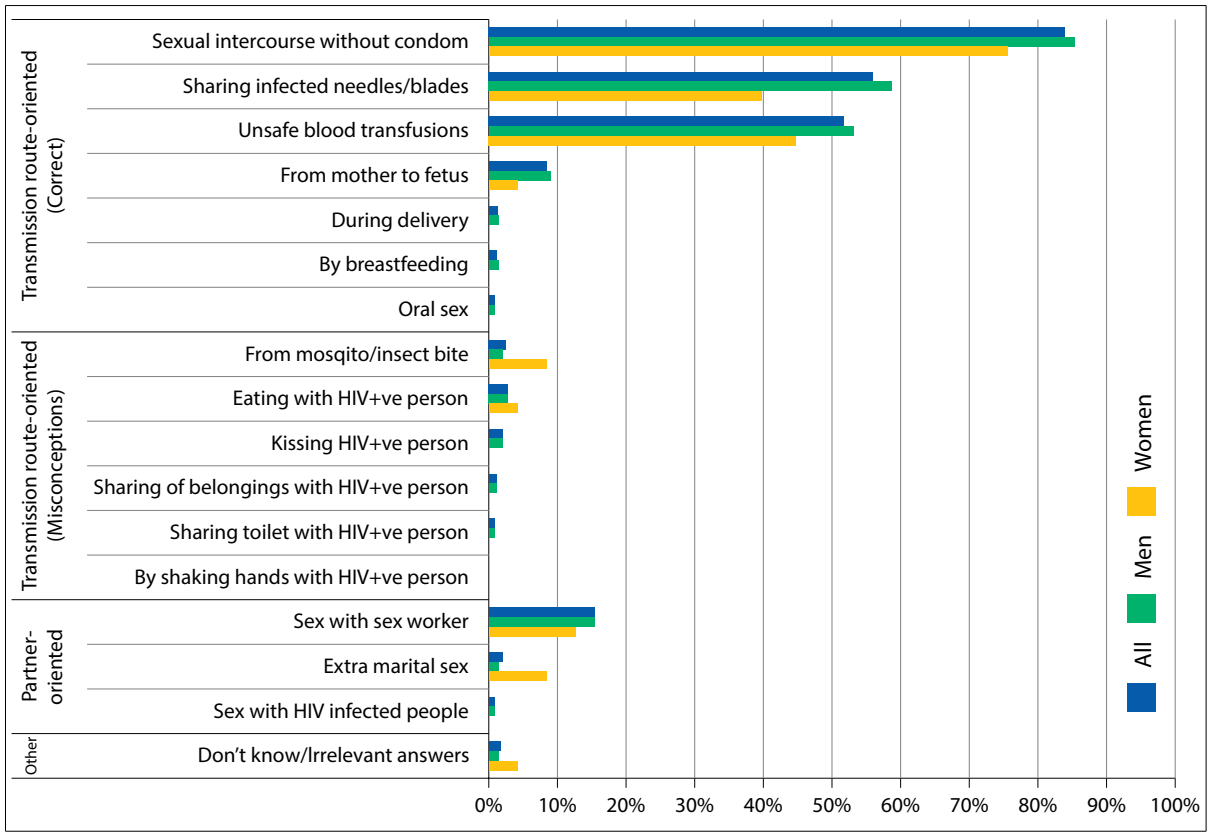


Figure 14: HIV transmission routes identified by migrants, as % of all, male, and female respondents that identified each route

Misconceptions of routes of transmission were not common; provided by less than five per cent of all respondents. Beliefs that HIV can be spread by mosquito bites, by eating with an HIV positive person, and by kissing an HIV positive person, were mentioned. Knowledge of correct transmission routes was lower and misconceptions higher among women. There was a notable focus on the choice of partner, with fifteen per cent of migrants expressing the belief that sex with a sex worker leads to HIV infection.

Perceived risk of infectious diseases

The majority of migrants perceived themselves to not be at risk of Tuberculosis, HIV, or Hepatitis C (Figure 15-c). Notably, no woman included in the sample believed herself to be at risk of either disease. Almost a quarter of migrants did not know whether they were at risk of Hepatitis C, suggesting low understanding of the disease. In the study, 48 per cent, 32 per cent, and sixteen per cent of all migrants had ever been tested for Tuberculosis, HIV, or Hepatitis C respectively, however again nearly a quarter did not know if they had been tested for Hepatitis C (Figure 16c). About 80 per cent of migrants knew of a place to be tested for infectious diseases.

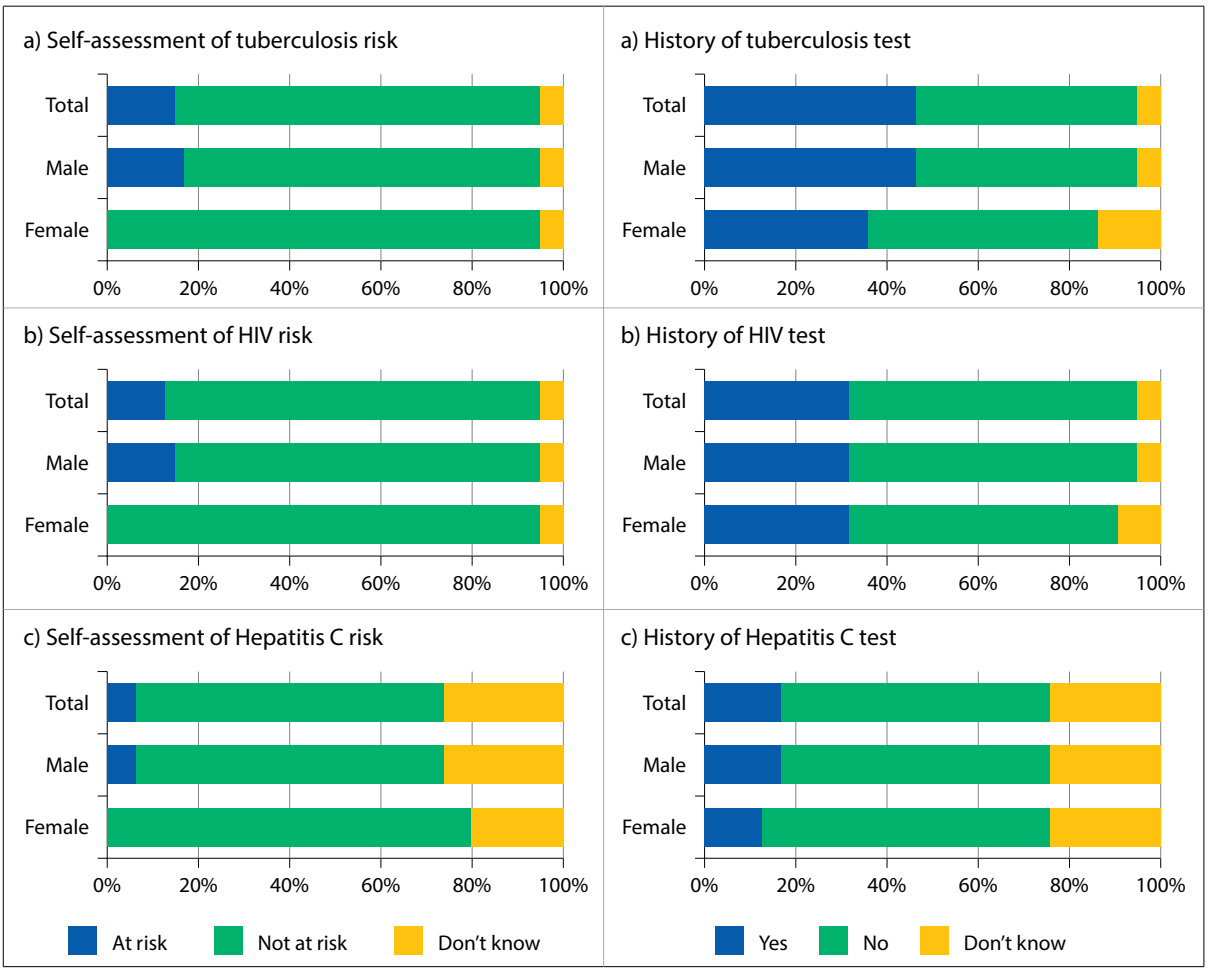


Figure 15a-c: Perceived risk of Tuberculosis, HIV and Hepatitis C among all migrants, by sex (n=411, nm=386, nw=25)

Figure 16a-c: History of Tuberculosis, HIV and Hepatitis C test among all migrants, by sex (n=411, nm=386, nw=25)

Pre-departure health orientation

The study revealed that 12.4 per cent of respondents underwent a health orientation or training, although this percentage was higher among those with professional employment and lowest among those working in private services, including domestic workers and the unemployed (Figure 17). Training was most frequently provided by employers/agencies (76.5%) (Appendix 1.34).

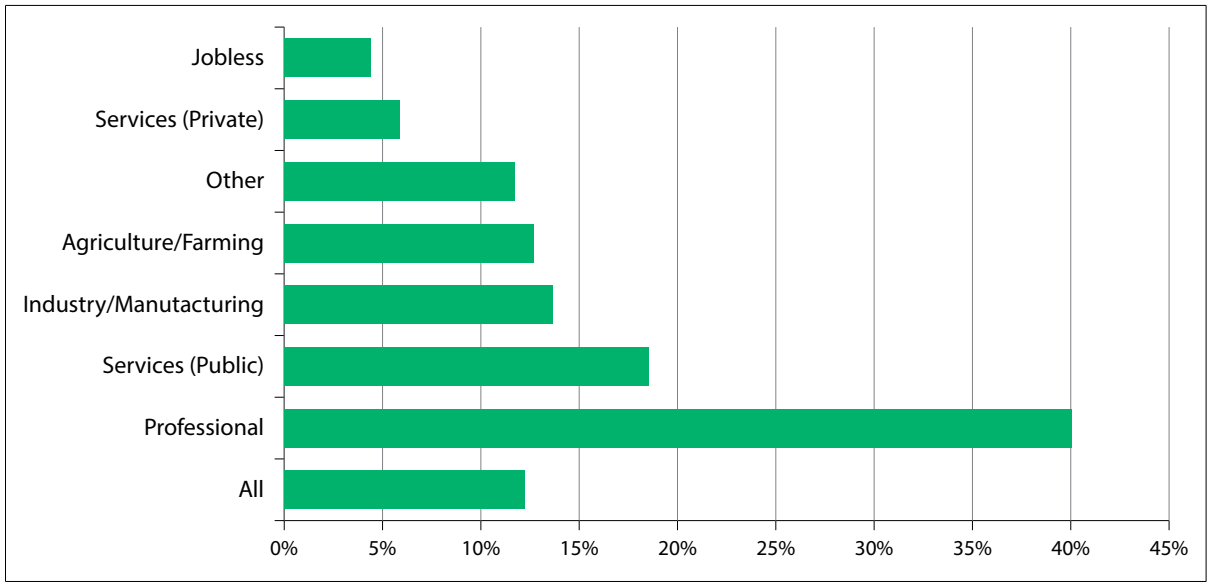


Figure 17: Respondents who had a pre-departure health orientation, by employment type

Health orientations most often discussed general medical check-ups, with particular attention to sexually transmitted infections and health problems associated with the working environment. Fewer orientations discussed Tuberculosis and non-communicable issues, such as physical and sexual violence or mental health (Table 4).

Table 4: Health topics discussed during health orientations, as % of all, male and female migrants who underwent a health orientation

	Total		Men		Women	
	%	n	%	n	%	n
General health check-up	92.2%	47	11.7%	45	8.0%	2
STI and HIV/AIDS	80.0%	41	9.6%	37	8.0%	2
Professional health problems	73.3%	37	9.6%	37	0.0%	0
Immigrants' rights	73.3%	37	8.5%	33	4.0%	1
Tuberculosis	56.7%	29	6.7%	26	8.0%	2
Physical violence	46.7%	24	6.2%	24	8.0%	2
Sexual violence	46.7%	24	6.5%	25	4.0%	1
Mental health	46.7%	24	6.2%	24	0.0%	0

*Total does not add to 100% due to multiple choices allowed

In addition, 45 per cent of migrants who underwent a pre-departure health orientation felt they needed more information; 22 per cent wanted to receive more health education, and eighteen per cent wanted to know more about their employment and working conditions (Appendix 1.33).

3.1.4 Accessibility and perceived quality of health services and health seeking behavior

Health-care seeking behaviour

Health-care seeking behaviour was similar for both returnee and departing migrants: 90 per cent and 87 per cent of respondents sought health-care when last ill in the country of destination and country of origin respectively (Appendix 1.26 and 1.27). However, this percentage was lower among

female returnees (75%). More than 80 per cent of migrants seeking health-care abroad were able to claim some form of assistance, mostly through employers/agencies (51%) or friends/relatives (29%) (Appendix 1.27).

The majority of migrants who sought treatment in Nepal did so at a private facility (47%), followed by a public health provider (40%). Women were likely to go to private providers, and more inclined towards local resources such as shops/pharmacies and home remedies. See Figure 18 for full details.

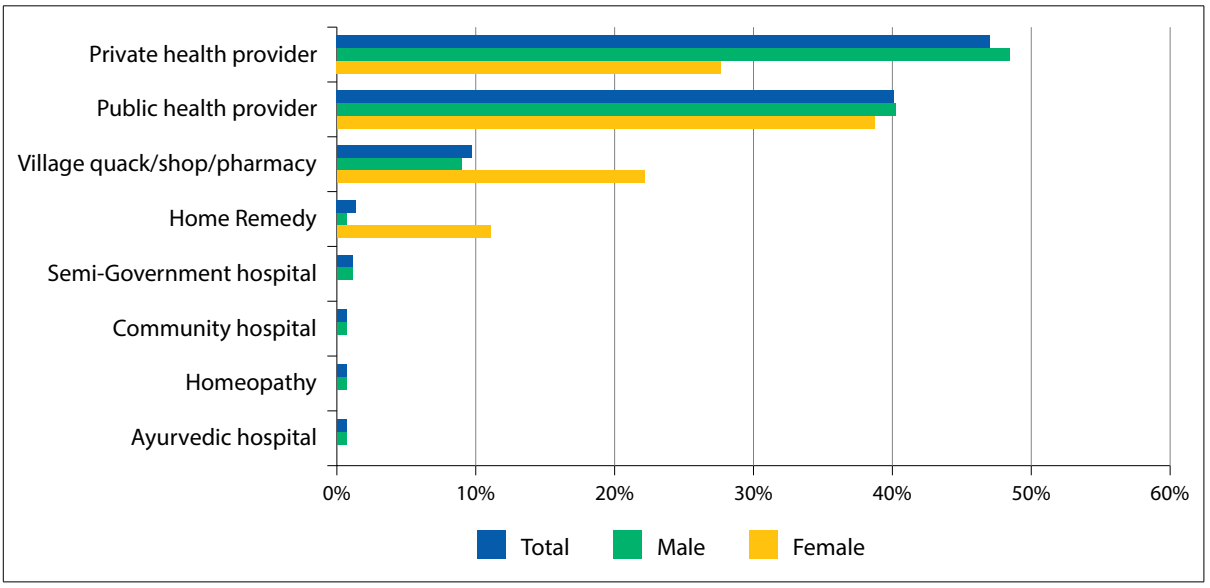


Figure 18: Source of advice/ treatment among all migrants at last illness in Nepal

Post-arrival medical check-up. 65 per cent of returnees stated that they believed a post-arrival medical check-up was necessary following return to Nepal, however, only 26 per cent (55 respondents) actually undertook one. While this was partly attributable to some migrants receiving health assessments in destination countries prior to return (8%), the vast majority (>90%) cited perceived insusceptibility as the reason for not seeking a post-arrival medical check-up (Table 5). Of those that did have a post-arrival medical check-up, 73 per cent did so within 1 month of return, most often choosing to present at a private centre (72%) or government facility (22%) (Appendix 1.27).

Table 5: Reasons for not having a post-arrival medical check-up among returnee migrants, as % of all, male and female respondents who specified each reason

	Total (n=155)		Men (n=141)		Women (n=14)	
	%	n	%	n	%	n
Perceived insusceptibility	94%	145	94%	132	93%	13
Did check-up in working country/ abroad	8%	13	9%	12	7%	1
Inconvenient time	4%	6	4%	6	0%	0
Unaffordable costs	1%	2	1%	1	7%	1
Travelling difficulty	1%	1	1%	1	0%	0
No medical facilities nearby	1%	1	0%	0	7%	1

*Total does not add to 100% due to multiple choices allowed

Like pre-departure mandatory health examination, a general medical check-up was the most cited type of procedure, followed by blood tests, X-ray, a HIV test, urine tests, and TB tests. See Table 6 for full details.

Table 6: Types of post-arrival medical check-up procedures experienced, as % of all, male, and female migrants who underwent each procedure

	Total (n=55)		Men (n=53)		Women (n=2)	
	%	n	%	n	%	n
General health check-up	61.8%	34	60.4%	32	100.0%	2
Blood test	32.7%	18	34.0%	18	0.0%	0
X-ray/video X-ray	20.0%	11	20.8%	11	0.0%	0
HIV test	20.0%	11	20.8%	11	0.0%	0
Urine test	10.9%	6	11.3%	6	0.0%	0
TB test	10.9%	6	11.3%	6	0.0%	0
STI test	9.1%	5	9.4%	5	0.0%	0
Blood pressure	5.5%	3	5.7%	3	0.0%	0
Stool test	0.0%	0	0.0%	0	0.0%	0
Eye check-up	0.0%	0	0.0%	0	0.0%	0
Ears/nose/throat	0.0%	0	0.0%	0	0.0%	0
Other	9.1%	5	9.4%	5	0.0%	0

*Total does not add to 100% due to multiple choices allowed

Health-care accessibility in Nepal

Availability and accessibility of health services. A wide range of health-care services were available in the community, predominantly general medical check-ups (91% of respondents) and medical treatment (87%), followed by maternity care (36%) and laboratory testing (34%). See Table 7 for full details.

Table 7: Health-care services available in the community, as % of all, male, and female migrants who identified each service

	Total (n=411)		Men (n=386)		Women (n=25)	
	%	n	%	n	%	n
Medical check-up	90.5%	372	89.9%	347	100.0%	25
Medical treatment	86.9%	357	87.1%	336	84.0%	21
Maternity care/ ANC	36.0%	148	35.5%	137	44.0%	11
Laboratory tests, blood tests	34.1%	140	34.0%	131	36.0%	9
X-Ray	24.1%	99	24.9%	96	12.0%	3
Optical care	18.7%	77	18.9%	73	16.0%	4
Dental care	17.0%	70	17.4%	67	12.0%	3
Physiotherapy	8.0%	33	8.3%	32	4.0%	1
Others	5.7%	23	5.9%	23	0.0%	0
Mental health or psychological treatment	3.9%	16	4.2%	16	0.0%	0
MRI/CT scan	3.9%	16	4.1%	16	0.0%	0

	Total (n=411)		Men (n=386)		Women (n=25)	
	%	n	%	n	%	n
Infant health	1.2%	5	1.3%	5	0.0%	0
Family planning	1.0%	4	1.0%	4	0.0%	0
Surgery	0.7%	3	0.8%	3	0.0%	0
Ear Nose Throat	0.5%	2	0.5%	2	0.0%	0
Ambulance	0.5%	2	0.5%	2	0.0%	0
Family planning	0.2%	1	0.3%	1	0.0%	0
Don't know	1.0%	4	1.0%	4	0.0%	0

*Total does not add to 100% due to multiple choices allowed

As outlined in Tables 8 and 9, when questioned specifically about the availability of preventive health-care services in their communities, the majority of all migrants mentioned family planning (82%), maternal and child health (76%), primary health care (75%), health education (64%), and HIV/ STI testing (29%). These services were mostly provided by community government centres, with private facilities mentioned by less than half of respondents.

Table 8: Preventive health-care services available in the community, as % of all, male, and female migrants who identified each preventive health-care service

	Total (n=411)		Men (n=386)		Women (n=25)	
	%	n	%	n	%	n
Family planning	81.8%	336	82.9%	320	64.0%	16
Maternal and Child health	75.7%	311	76.7%	296	60.0%	15
Primary health care	75.4%	310	76.4%	295	60.0%	15
Health Education	64.0%	263	64.0%	247	64.0%	16
HIV/ STI testing	39.2%	161	40.4%	156	20.0%	5

*Total does not add to 100% due to multiple choices allowed

Table 9: Providers of preventive health-care services in the community, as % of all, male and female migrants who identified each provider

	Total (n=376)		Men (n=356)		Women (n=20)	
	%	n	%	n	%	n
Govt. Centres at community level	80.9%	304	80.3%	286	90.0%	18
Private	43.6%	164	43.9%	156	40.0%	8
Govt. centres at district level	18.4%	69	18.8%	67	10.0%	2
NGO	16.5%	62	16.3%	58	20.0%	4
Govt. centres at Ilaka level	11.2%	42	11.6%	41	5.0%	1
Local institution/associations	0.3%	1	0.3%	1	0.0%	0
Don't know	0.3%	1	0.3%	1	0.0%	0

*Total does not add to 100% due to multiple choices allowed

Regarding curative health services, maternal health, diagnostics, HIV/AIDS and STI management, surgery, and medication were mentioned (Table 10). Service providers were roughly similar to providers of preventive services, with community government centres the most popular, followed by private providers for both men and women (Table 11).

Table 10: Curative health-care services available in the community, as % of all, male, and female migrants who identified each service

	Total (n=411)		Men (n=386)		Women (n=25)	
	%	n	%	n	%	n
Medicine	97.6%	401	97.4%	376	100.0%	25
Maternal health	79.3%	326	80.6%	311	60.0%	15
Diagnosis	69.8%	287	70.7%	273	56.0%	14
HIV/AIDS and STI management	35.5%	146	36.8%	142	16.0%	4
Surgery	32.1%	132	32.6%	126	24.0%	6

*Total does not add to 100% due to multiple choices allowed

Table 11: Providers of curative health-care services in the community, presented by % of all, male and female migrants who identified each provider

	Total (n=402)		Men (n=377)		Women (n=25)	
	%	n	%	n	%	n
Govt. Centres at community level	78.6%	316	78.5%	296	80.0%	20
Private	50.5%	203	50.1%	189	56.0%	14
Govt. centres at district level	21.9%	88	23.1%	87	4.0%	1
NGO	12.7%	51	13.0%	49	8.0%	2
Govt. centres at sub-district level	11.9%	48	11.7%	44	16.0%	4

*Total does not add to 100% due to multiple choices allowed

In the study, 76 per cent of respondents felt that they could use public health facilities any time, and 82 per cent noted that they could obtain health-care services for free. About 60 per cent of respondents were satisfied or very satisfied, while eighteen per cent were unsatisfied with health facilities in the community (Appendix 1.19).

Affordability and health-care financing. Only eighteen per cent of respondents expressed that health-care in Nepal was unaffordable, an additional 47 per cent stated that health-care was affordable yet difficult, while eight per cent perceived health-care in Nepal as easily affordable (Figure 19). Women appeared to find health-care slightly more affordable than men.

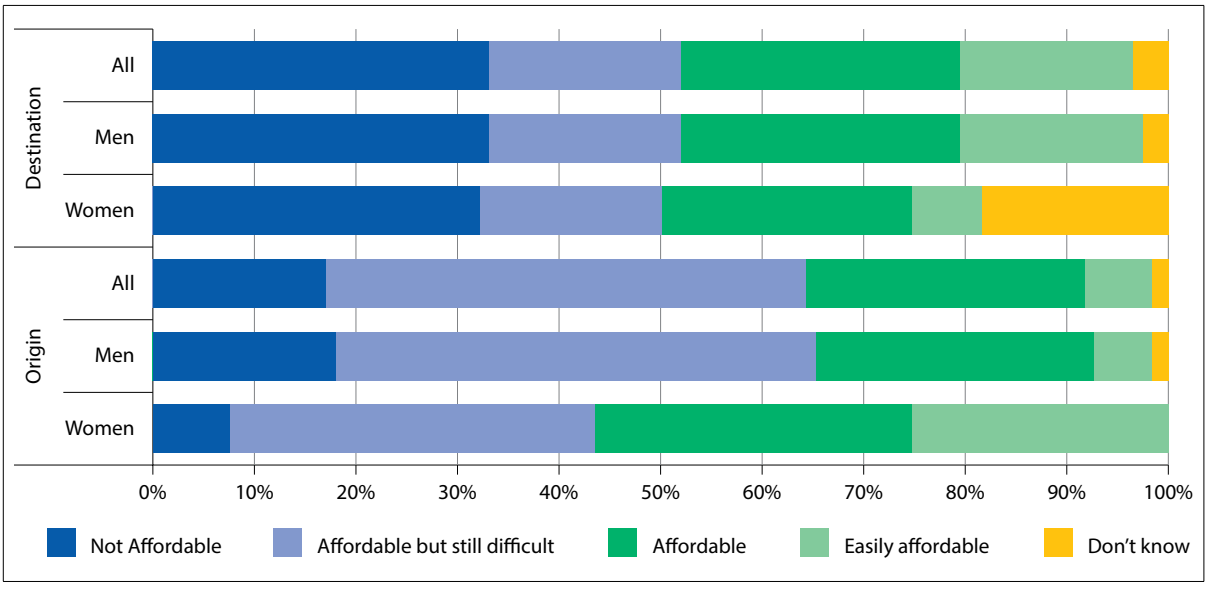


Figure 19: Perceived affordability of health-care services in Nepal and abroad, by all, male, and female migrants

Experience accessing health-care. About fifteen per cent of respondents expressed experiencing difficulties accessing health-care services in Nepal (Appendix 1.20). The most prominent barriers were long distances (52%), lack of skilled doctors (27%), and unaffordable costs (14%) as the primary problems. See Figure 20 for full details.

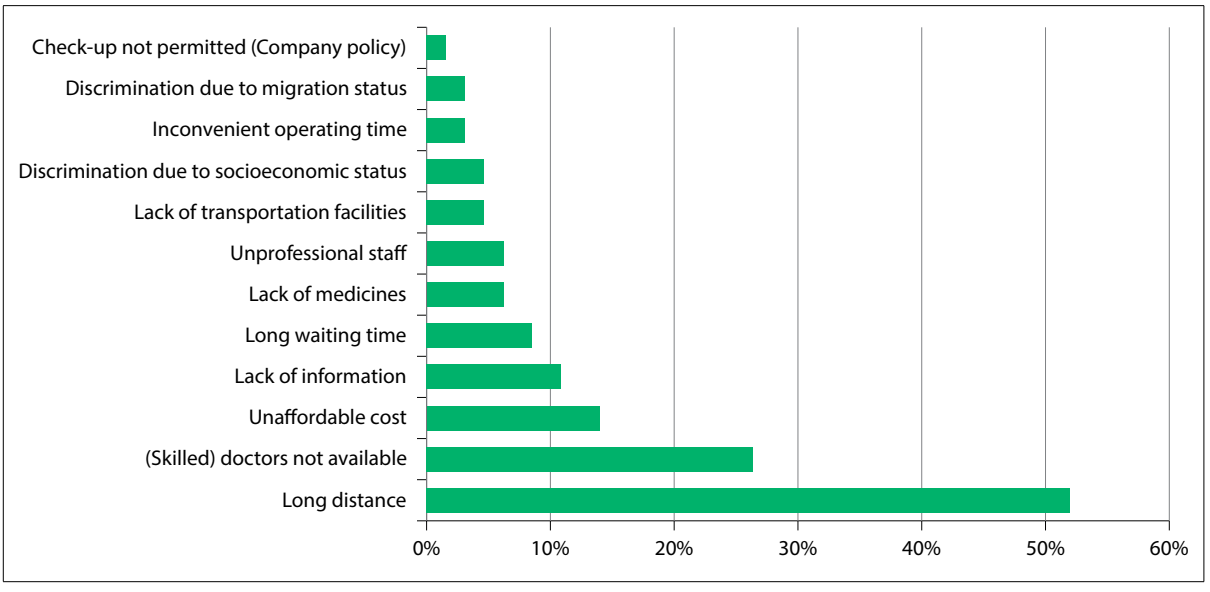


Figure 20: Reported barriers in accessing health-care services (% of all migrants who sought treatment; n=56)

Health-care accessibility in country of destination

Availability and accessibility of health services. HIV/STI testing was the most often reported preventive service abroad by returnee migrants (65%), followed by primary health care, family planning, health education, and maternal and child health. Private institutions were the primary providers of these services, although government organizations were also utilized. NGOs and clinics run by working companies were not frequently mentioned. For full details see Tables 12 and 13.

Table 12: Preventive health-care services available in the destination country, as % of all, male and female returnees who identified the service

	Total (n=210)		Men (n=194)		Women (n=16)	
	%	n	%	n	%	n
HIV/STI testing	65.2%	137	68.6%	133	25.0%	4
Primary health care	63.3%	133	64.9%	126	43.8%	7
Family planning	40.0%	84	42.3%	82	12.5%	2
Health education	39.0%	82	41.2%	80	12.5%	2
Maternal and child health	35.2%	74	35.1%	68	37.5%	6

*Total does not add to 100% due to multiple choices allowed

Table 13: Providers of preventive health-care services in the destination country, as % of all, male and female returnees that identified each provider

	Total (n=165)		Men (n=155)		Women (n=10)	
	%	n	%	n	%	n
Private institution	75.8%	125	75.5%	117	80.0%	8
Government organization	72.7%	120	71.6%	111	90.0%	9
Non-government organization	14.5%	24	14.2%	22	20.0%	2
Clinic run by working company	0.6%	1	0.6%	1	0.0%	0

*Total does not add to 100% due to multiple choices allowed

Access to curative services was high, particularly provision of medicines and diagnostic testing (Table 14). Again, private organizations and government organizations were the primary providers of these services (Table 15).

Table 14: Curative health-care services available in the destination country, as % of all, male and female returnees who identified the service

	Total (n=210)		Men (n=194)		Women (n=16)	
	%	n	%	n	%	n
Medicine	98.1%	206	98.5%	191	93.8%	15
Diagnosis	96.7%	203	97.4%	189	87.5%	14
Surgery	86.7%	182	86.6%	168	87.5%	14
STI management	69.5%	146	73.7%	143	18.8%	3
HIV/AIDS management	43.3%	91	43.3%	84	43.8%	7

*Total does not add to 100% due to multiple choices allowed

Table 15: Providers of curative health-care services in the destination country, as % of all, male and female returnees who identified each provider

	Total (n=207)		Men (n=192)		Women (n=15)	
	%	n	%	n	%	n
Private organization	81.2%	168	81.8%	157	73.3%	11
Government organization	74.4%	154	72.9%	140	93.3%	14
Non-government organization	13.0%	27	13.0%	25	13.3%	2
Clinic run by working company	1.0%	2	1.0%	2	0.0%	0

*Total does not add to 100% due to multiple choices allowed

Affordability and health-care financing. While a large portion of respondents (46%) had their treatment fully paid for by their employer, a third of those seeking health-care reported that the health services were self-paid. Those working in the primary sector (Agriculture and Industry) received the least amount of health coverage from their employers and were most likely to pay out-of-pocket. See Table 16 for full details.

Table 16: Financers of health-care services in country of destination, by sex and work area

	Total	Fully paid by employer		Partially paid by employers		Self-paid		Insurance	
		%	n	%	n	%	n	%	n
Total	151	46.4%	70	16.9%	24	32.5%	49	5.6%	8
Sex									
Men	142	43.0%	61	15.9%	24	34.5%	49	5.3%	8
Women	9	100.0%	9	0.0%	0	0.0%	0	0.0%	0
Profession									
Agriculture/Farming	53	35.9%	19	20.8%	11	41.5%	22	1.9%	1
Industry/Manufacturing	55	49.1%	27	12.7%	7	32.7%	18	5.5%	3
Services (Public)	8	62.5%	5	25.0%	2	0.0%	0	12.5%	1
Services (Private)	32	50.0%	16	12.5%	4	28.1%	9	9.4%	3
Professional	1	100.0%	1	0.0%	0	0.0%	0	0.0%	0
Other	2	100.0%	2	0.0%	0	0.0%	0	0.0%	0

*Totals may not add to 100% due to multiple choices allowed

Only six per cent paid for health-care costs using insurance despite the fact that 51 per cent of migrants had health coverage abroad (Appendix 1.22). This averaged percentage hides an important gender discrepancy: only six per cent of women received health coverage while working abroad, compared to 54 per cent of men. Notably, nineteen per cent of women did not know if they had health insurance, and those with insurance were more likely to find health-care affordable (p=0.003) (Table 16; Appendix 1.22). Logistic regression suggests that there was no correlation between perceived affordability and history of health-care seeking behaviour while abroad.

Table 16: Logistic regression analysis: relationship between affordability and health-care seeking behaviour and health insurance coverage in destination countries

Variable	OR	P value	CI
Did you seek health-care (0=No, 1=Yes)	1.329	0.242	0.825-2.140
Do you have health insurance? (0=No, 1=Yes)	0.066	0.003**	0.509-0.867

An overwhelming majority (82%) of returnees had heard of places where migrants can access care and treatment abroad, primarily at government centres (81%) and private organizations (80%). NGOs (7.6%) and clinics run by employers (1.7%) were also mentioned (Appendix 1.21). 72 per cent stated that they could use public health services in their destination countries.

Experience accessing health-care. About one-fourth (23.3 %) of migrants abroad had faced difficulties accessing health-care services, most often due to language barriers, discrimination as a result of migration status, unaffordable costs, and lack of information regarding the health system (Figure 21; Appendix 1.22).

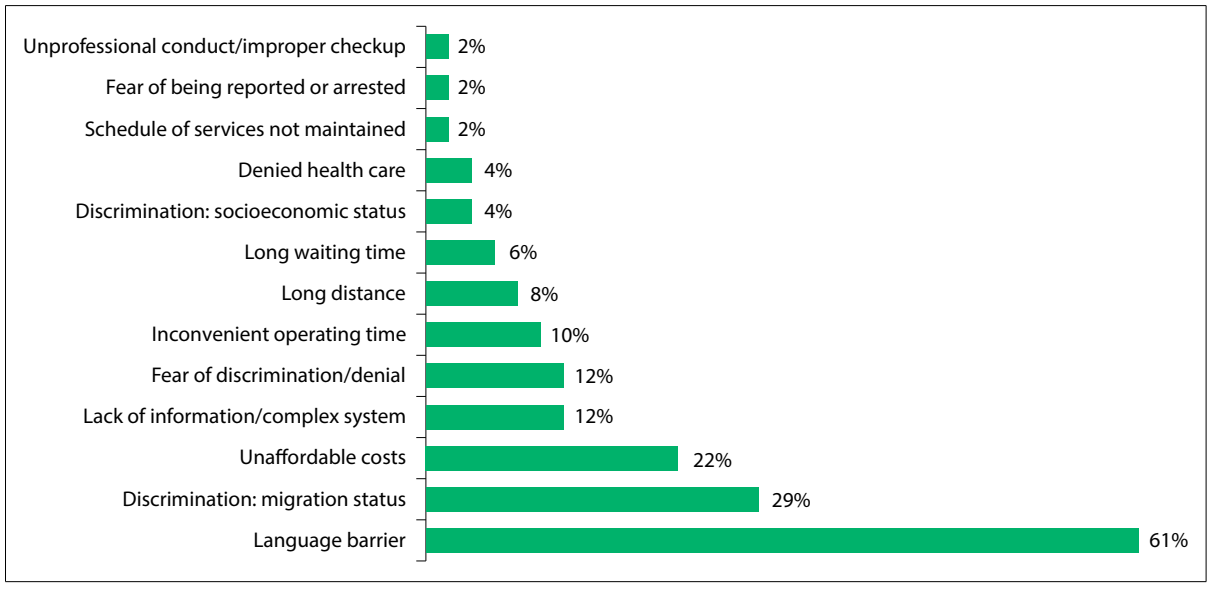


Figure 21: Reported difficulties faced by migrants accessing health-care abroad (n=49)

The majority (69%) of returnees were either satisfied or very satisfied with health-care services abroad, while eleven per cent were unsatisfied (Appendix 1.21).

Mandatory health examination prior to departure

On average, 67 per cent of all migrants surveyed had completed a mandatory health examination prior to departure; 93 per cent of returnees and 40 per cent of departing migrants. However, all departing migrants who had not yet had a health assessment expressed that they intended to (Appendix 1.23).

Private providers were the most popular venues for the mandatory health examination (33% of respondents with mandatory health assessment history), followed by employers/agencies (31%) and NGOs (17%) (Appendix 1.24). A minority (4%) of assessments were outsourced to agencies in India, with these migrants continuing on to work in a number of different countries, including Saudi Arabia, the United Arab Emirates, Kuwait, and South Africa.

As shown in Table 18, the majority of these visits (58%) involved a general check-up, with X-Rays, blood tests, urine tests, HIV tests, and TB tests also frequently cited. These tests are however not mutually exclusive in part due to non-specific terms and lack further explanation. Some X-Rays for instance may constitute a TB-test.

Table 18: Types of mandatory health assessment procedures, as % of all, male, and female migrants who underwent each procedure

	Total (n=276)		Men (257)		Women (n=19)	
	%	n	%	n	%	n
General health check-up	57.6%	159	57.2%	147	63.2%	12
X-ray/video X-ray	57.6%	159	57.6%	148	57.9%	11
Blood test	55.4%	153	56.4%	145	42.1%	8
Urine test	40.9%	113	40.5%	104	47.4%	9
HIV test	38.0%	105	38.9%	100	26.3%	5
TB test	20.3%	56	19.8%	51	26.3%	5
STI test	9.8%	27	9.7%	25	10.5%	2
Stool test	7.2%	20	5.4%	14	31.6%	6
Eye check-up	7.2%	20	7.0%	18	10.5%	2
Ears/nose/throat	2.2%	6	1.2%	3	15.8%	3
Blood pressure	1.8%	5	1.9%	5	0.0%	0
Other	4.0%	11	4.3%	11	0.0%	0

*Total does not add to 100% due to multiple choices allowed

About 70 per cent of migrants reported that health providers asked for consent prior to conducting a medical test during the mandatory health examination. Only 45 per cent reported that the provider explained the test, and 64 per cent were made aware of their results. As an aggregate measure, only 32 per cent of migrants were provided with a health examination that adhered to all three protocols, that is, explaining the test, acquisition of consent and sharing of results (Figure 22).

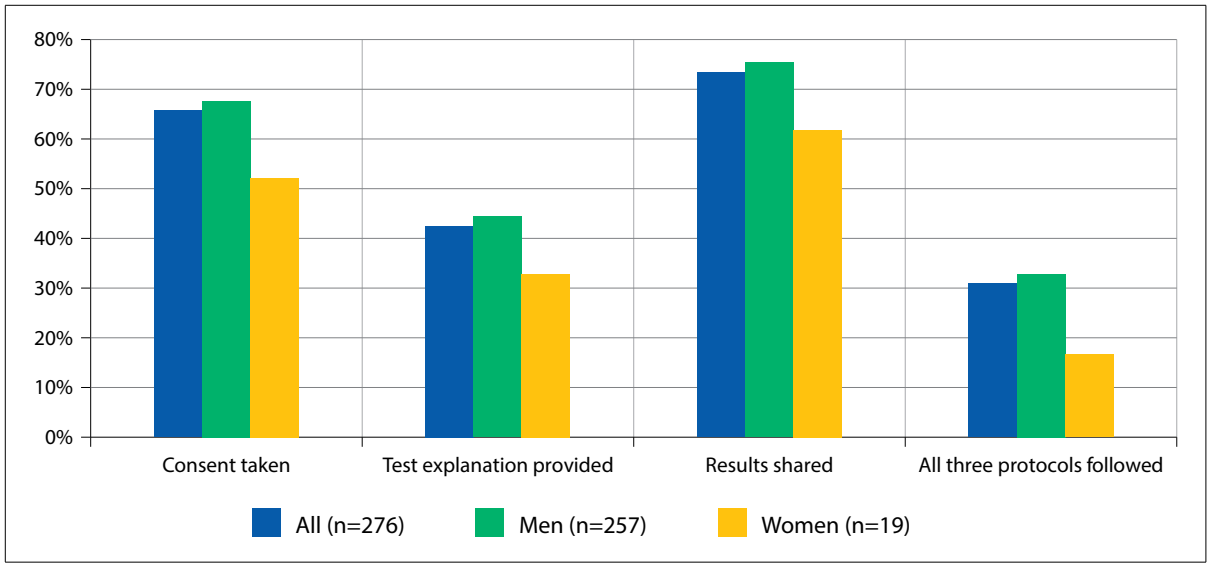


Figure 22: Respondents who underwent a mandatory health examination prior to departure; gave consent, were given an explanation of the test and/ or provided test results, presented by sex

In comparing health providers, there was little variation in terms of adherence to all three protocols. Employers and agencies performed better than government facilities and private agencies in terms of all protocols being followed (Table 19). The sample size of each group, however, is too small for a conclusive comparison.

Female migrants reported a notably worse experience compared to their male counterparts, with 47 per cent of women reporting not being asked for consent compared to 33 per cent of men. Sex differences in terms of test explanation and results sharing were not significant.

Table 19: Respondents who underwent tests that adhered to the three protocols of explaining the test, obtaining consent and result sharing, by of health provider type

	Total	Not followed*		Full protocol followed	
		%	n	%	n
Provincial government facility	3	33.3%	1	0.0%	0
Agency in India	11	27.3%	3	18.2%	2
District government facility	6	16.7%	1	33.3%	2
Private providers	92	9.8%	9	31.5%	29
NGO	46	8.7%	4	34.8%	16
Central government facility	31	6.5%	2	32.3%	10
Employer/Agency	86	5.8%	5	33.7%	29
Semi-government agency	1	0.0%	0	0.0%	0
Total	276	9.1%	25	31.9%	88

*None of the three protocols were adhered to

Almost all (98%) health assessments incurred costs for migrants, and 92 per cent of these were paid for out-of-pocket (Appendix 1.25). Disaggregation of this data by sex and health provider shows that more private providers and agencies in destination countries provided free services compared to government agencies and semi-government agencies (Figure 23).

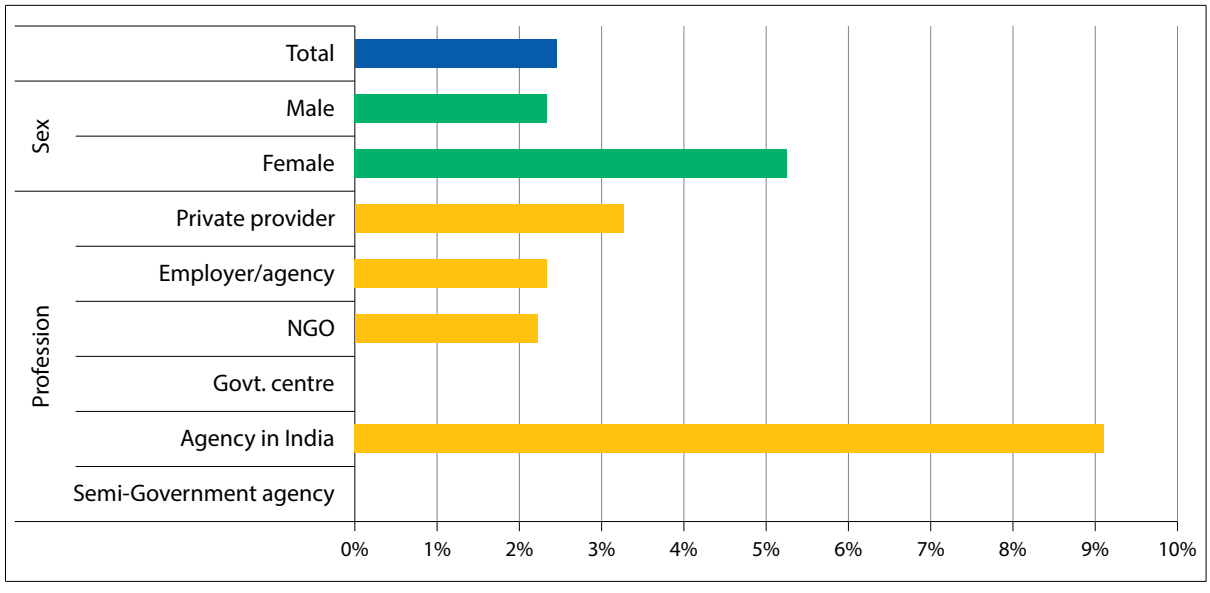


Figure 23: Respondents whose pre-departure health examination was free of charge, by sex and health providers

Access to health information and communication

Available methods of information dissemination and uptake. Television proved to be the most accessible form of media with 90 per cent of respondents accessing television, 66 per cent of whom viewed every day. Radio was also popular, listened to by 83 per cent of migrants. Media requiring literacy were less accessed: the newspaper was read by 75 per cent of respondents, eighteen per cent every day, and the internet accessed by only half of respondents. See Figure 24 for full details.

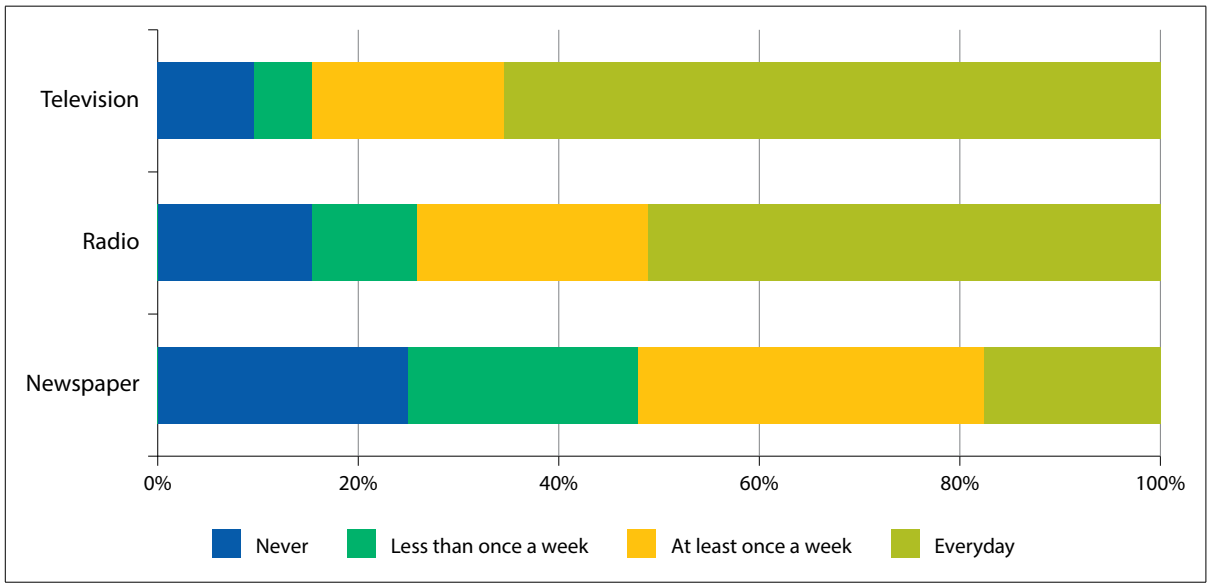


Figure 24: Frequency of access to various forms of media among all respondents (n=411)

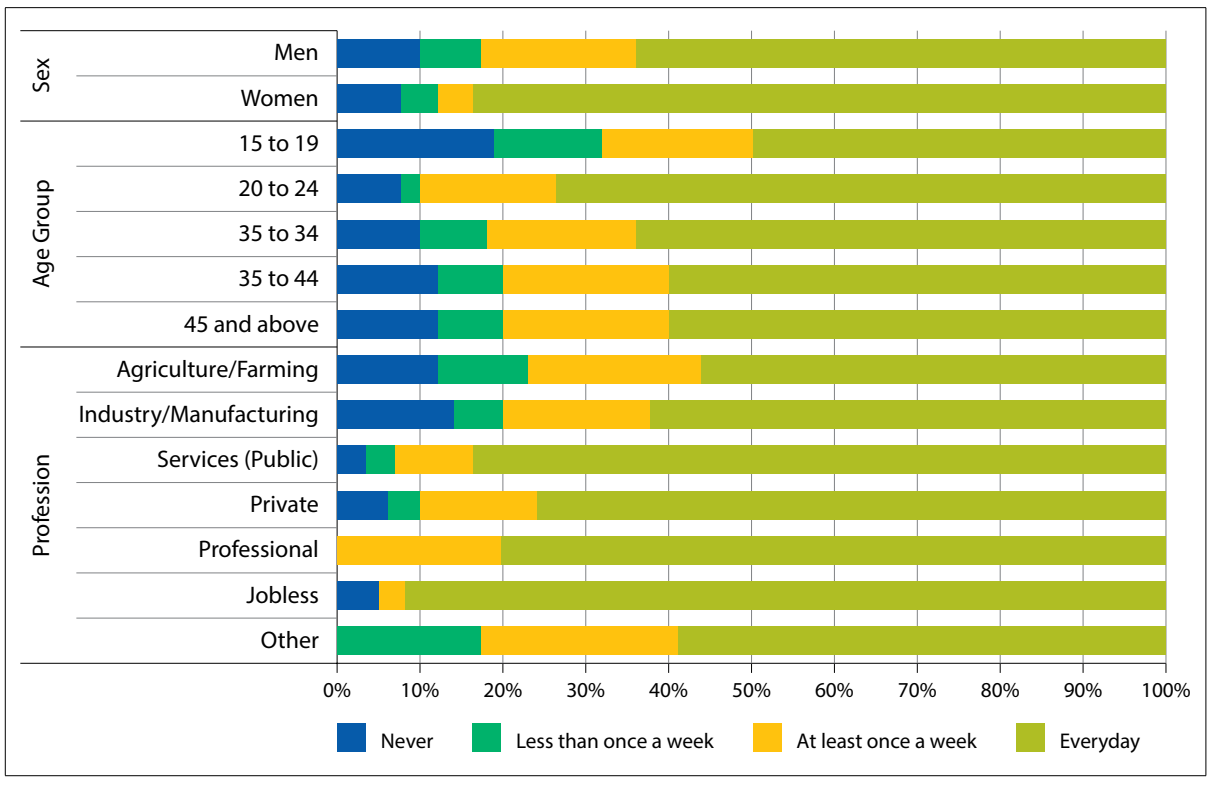


Figure 25: Frequency of access to various forms of media among all respondents by sex, age group, and work area

As shown in Figure 25, 24 year olds were the most receptive age group to all forms of media, while the oldest (45 and above) and youngest (15 to 19) groups were the least. Television watching was found to be particularly high among those working in services (public and private), such as domestic workers, and although access to television was slightly lower among those working in the primary sector compared to other employment groups, it still proved more popular than the radio, newspaper, and internet (Annex 1.29 and 1.30). The gender imbalance was particularly prominent for newspaper reading, with 44 per cent of women never reading the newspaper compared to 23 per cent of men (Appendix 1.29).

Source of health information. Television, radio, educational institutions, and health facilities were important sources of health information among all respondents. Other popular sources included newspapers, community events, outreach, and NGO workers. Religious or community leaders were the least mentioned, particularly among returnees. Health information in general appeared less accessible to women compared to men, particularly those media requiring literacy, such as newspapers and billboards (Table 20). About 65 per cent of migrants received health-related communication material from health providers in Nepal, and 91 per cent of them found the contents understandable or easily understandable (Appendix 1.32). The two individuals (0.8%) who did not understand the contents had less than primary education and poor literacy.

Table 20: Sources of health information, by migrant group and sex

	Total (n=411)		Men (n=386)		Women (n=25)		Departing (n=201)		Returnee (n=210)	
	%	n	%	n	%	n	%	n	%	n
Television	94.9%	390	95.6%	369	84.0%	21	95.0%	191	94.8%	199
Radio	92.7%	381	93.0%	359	88.0%	22	94.5%	190	91.0%	191
Educational Institutions/Peer	90.8%	373	91.2%	352	84.0%	21	94.0%	189	87.6%	184
Treatment Centres/Doctors	87.6%	360	87.8%	339	84.0%	21	90.5%	182	84.8%	178
Newspaper	84.4%	347	86.0%	332	60.0%	15	87.6%	176	81.4%	171
Billboard/Signboard /Poster	79.3%	326	80.8%	312	56.0%	14	88.6%	178	70.5%	148
Outreach counselling	78.6%	323	79.3%	306	68.0%	17	89.1%	179	68.6%	144
Community events	78.6%	323	78.8%	304	76.0%	19	87.6%	176	70.0%	147
NGO/health workers	75.9%	312	76.2%	294	72.0%	18	81.6%	164	70.5%	148
Religious/Community Leader	28.5%	117	28.7%	111	24.0%	6	39.8%	80	17.6%	37

*Total does not add to 100% due to multiple choices allowed

These patterns were reinforced when migrants were asked of their preferred forms of media for health communication: 95 per cent preferred television, while radio and health facilities were also strongly preferred (Table 21).

Table 21: Specified appropriate media for health information, by migrant group and sex

	Total (n=411)		Men (n=386)		Women (n=25)		Departing (n=201)		Returnee (n=210)	
	%	n	%	n	%	n	%	n	%	n
Television	96.8%	398	97.1%	375	92.0%	23	98.0%	197	95.7%	201
Radio	94.6%	389	95.1%	367	88.0%	22	97.5%	196	91.9%	193
Treatment Centres/Doctors	93.7%	385	93.5%	361	96.0%	24	98.5%	198	89.0%	187

	Total (n=411)		Men (n=386)		Women (n=25)		Departing (n=201)		Returnee (n=210)	
	%	n	%	n	%	n	%	n	%	n
Educational Institutions/Peer	93.2%	383	93.3%	360	92.0%	23	98.0%	197	88.6%	186
Newspaper	92.2%	379	93.3%	360	76.0%	19	96.5%	194	88.1%	185
Community events	91.0%	374	90.4%	349	100.0%	25	96.5%	194	85.7%	180
Outreach counselling	87.6%	360	87.8%	339	84.0%	21	95.0%	191	80.5%	169
NGO/health workers	87.6%	360	88.1%	340	80.0%	20	93.0%	187	82.4%	173
Billboard/Signboard /Poster	85.6%	352	86.3%	333	76.0%	19	94.5%	190	77.1%	162
Religious/Community Leader	43.1%	177	43.0%	166	44.0%	11	55.2%	111	31.4%	66

*Total does not add to 100% due to multiple choices allowed

Health topics of particular interest included HIV/AIDS, non-communicable diseases, Tuberculosis, STIs, and other communicable diseases (Appendix 1.32). Women expressed interest in learning more about health services and health providers, and migrants appeared to gain interest in HIV/AIDS after having travelled abroad. See Figure 26 for full details.

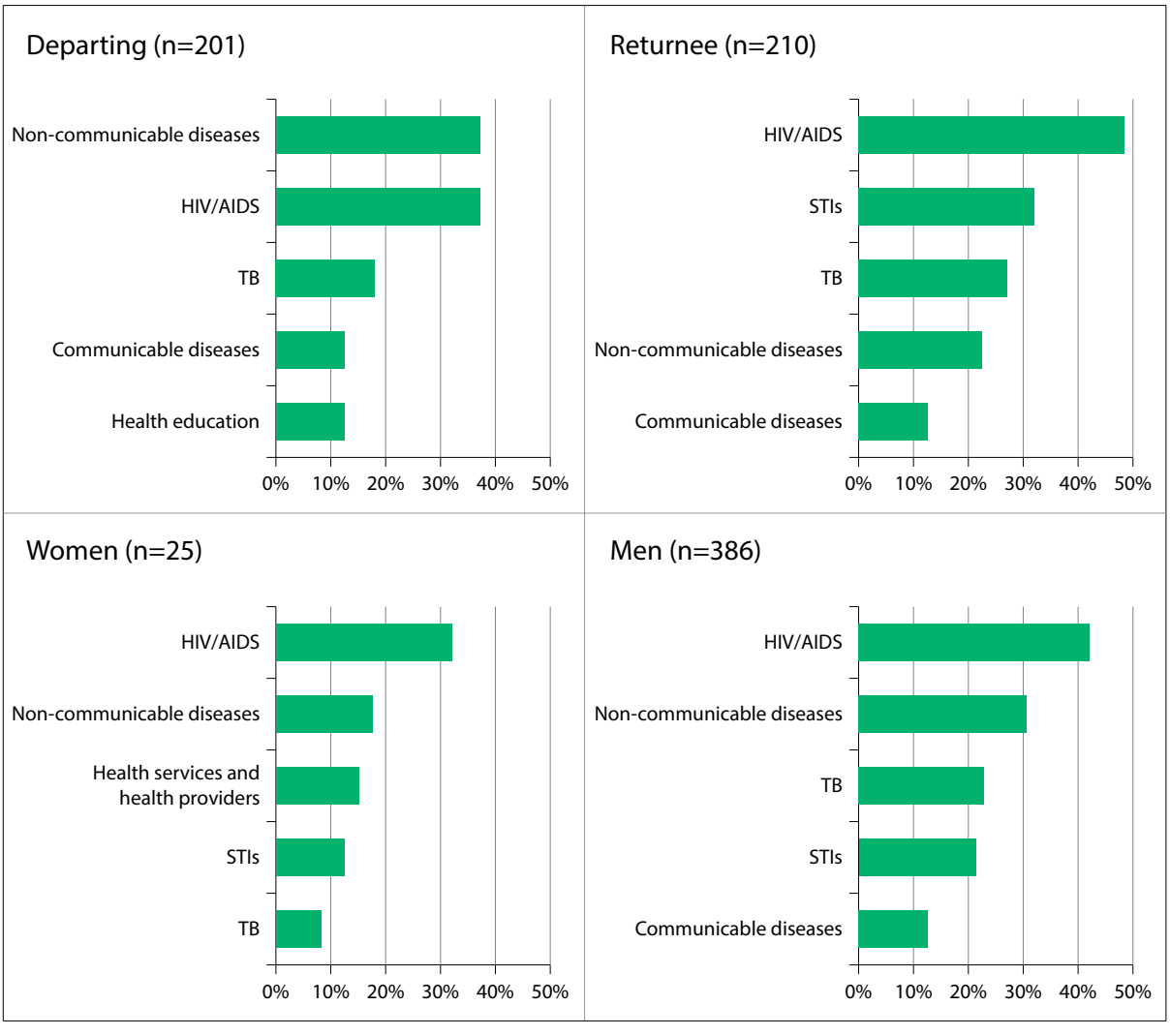


Figure 26: Five most popular topics of interest that migrants would like to receive more information about, disaggregated by migrant group and sex

While abroad, 43 per cent of returnees had received health communication materials. However, 25 per cent of women were uncertain of whether or not they had. 69 per cent of migrants who did receive health communication materials while abroad found the contents understandable or easily understandable, which may be partly attributable to language: 62 per cent reported that the health communications were not produced in their own language (Appendix 1.33).

Sources of HIV/AIDS Information. Irrespective of their place of origin or country of destination, the majority (66%) of migrants mentioned television as their primary source of information on HIV/AIDS. Other important sources included the radio, peer educators and NGO workers, billboards or posters, and magazines. Health workers were mentioned sparingly. Reflecting the gender-balance of access to media communications, newspapers and the internet were more prominent sources for men than for women. See Figure 27 below.

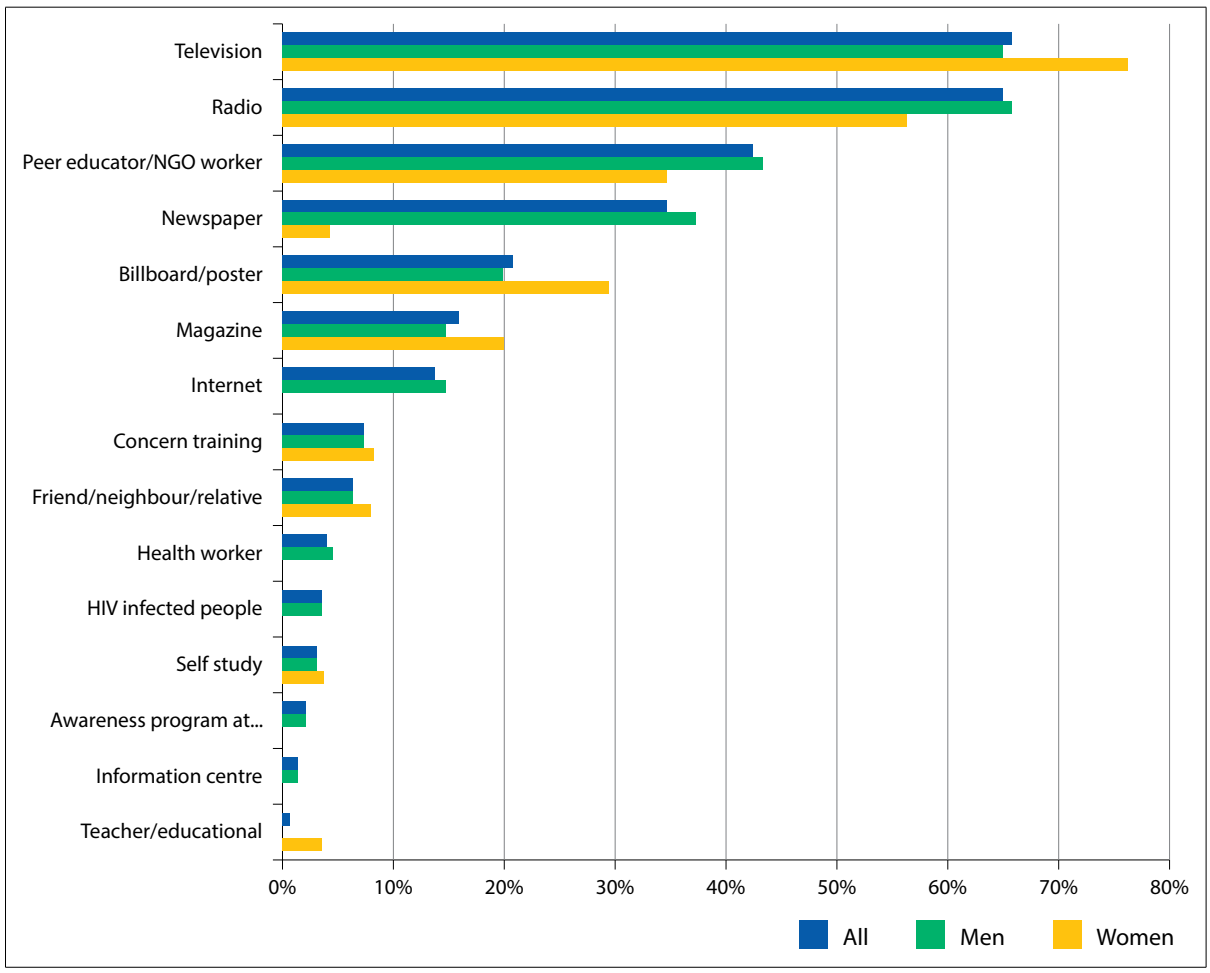


Figure 27: Main sources of information on HIV/AIDS, as % of all, male, and female respondents

3.2 Qualitative results

3.2.1 Health risks faced by migrants

Participants described a range of health vulnerabilities faced by migrants in destination countries. Occupational hazards are common due to the risks associated with unprotected "3 D jobs", namely those jobs that are dirty, dangerous, and difficult. A key informant working as a member of the Foreign Employment Promotion Board elaborated that migrant workers often suffer broken limbs, or become afflicted with lung or kidney diseases, as a result of the working environment.

An officer working with cross-border migrants shared that many Nepali migrants work as watchmen, yet are forced to look for extra jobs due to the low pay. The extended working hours from multiple jobs render migrants vulnerable to health problems. Both key informants and FGD participants also pointed out the risks associated with extreme temperature adjustments, which can lead to serious illness and even death:

> "We have to work in 55-57 degrees and workers get ill due to such conditions."
>
> *FGD participant, Returnee male migrant*
>
> "At such times, firstly the worker gets ill, secondly there is continuous exhaustion due to high temperature, there is loss of appetite and the person starts to lose weight."
>
> *FGD participant, Returnee male migrant*

Despite this, some key informants stated that migrant workers are not aware of the risks or standard precautions due to a lack of information and assistance from employers or agencies.

FGD participants also mentioned the risk of sexually transmitted infections, and that migrants stationed in Malaysia are at greater risks of contracting STIs compared to those who go to Gulf nations stating that the society in Malaysia is more "open."

Anxiety and stress while abroad were also commonly cited by key informants, as well as departing and returnee migrants. They attributed this to financial difficulties such as repaying loans, concerns about the family's well-being, and problems integrating while abroad. One key informant cited anxiety due to working in confined environments, while male migrants complained of family and social disintegration.

> "There are different experiences and you are made to do different work. Thus it is obvious that there are different tensions. There are also issues of debt, your children being ill and family tensions. Another thing is that when you have to work differently beyond your capacity or work more than allocated that in addition to less wages, it is obvious that people have both physical and mental tensions. You cannot take this normally."
>
> *FGD participant, Departing male migrant*
>
> "There are mental problems because the loan taken with "sahu" [moneylender] keeps on increasing [due to interest]...they take the loan at the rate of Rs. 4-5 per 100(per month)."
>
> *FGD participant, Returnee migrant*
>
> "There is a lot of stress in unknown and new places. There is also a bit of language problem...at first we do not know how to eat, how to sleep, how to do our work, how to speak with people. We get scared about all that over there."
>
> *FGD participant, Departing female migrant*
>
> "We can see that tensions have increased due to their wives. Some run away, some waste all the hard earned money, some have boyfriends. When they know about this, they have mental stress in the people."
>
> *FGD participant, Returnee male migrant*

Anxiety was also rooted in the stigma, mistreatment, and exploitation faced by migrants. Female migrants in particular had been discouraged to work abroad, and returnee females shared that they had experienced name calling in the bus park and airport in Nepal. In more serious cases, FGD respondents spoke of witnessing abuse and violence in the workplace, including sexual violence and rape, however did not indicate having experienced such problems themselves. Cross-border male migrants shared their experiences of exploitation by authorities who demanded bribes in order for the migrants to cross the border.

Key informants explained that society considers female migrants to be involved in "wrong deeds," and FGD participants shared the general public's view that "*returnees bring diseases*". As described earlier, these negative perceptions are exacerbated if a migrant actually does return with an infection, such as HIV. These experiences of stigma, abuse, and discrimination can result in serious psychosocial problems.

Respondents made clear that there exists a vicious cycle of difficult and exploitative working environments, as well as economic losses. Migrants are forced into harsh working and living environments as a result of economic struggles, which then lead to health problems which either incur further costs or worsen due to the inability to access effective care.

3.2.2 Health-care seeking behaviour

Most key informants shared that migrant workers do not pay much attention to their health and do not seek care unless issues are serious. Migrants are furthermore deterred by the risk of deportation if identified as ill; excessive health-care costs, particularly if not or only partially covered by health insurance; and they often choose to prioritize other personal matters.

> "While talking to Nepali ambassador at the United Arab Emirates, he told me that our migrants make so little money that they have to make a choice whether to spend money on their own health or to send the money back to their families so that they would have better living."
>
> *Key Informant, Chief of INGO working with migrants*

As medical check-up is not compulsory for returnee migrants, few seek health-care upon return to Nepal unless they are unwell.

3.2.3 Pre-departure orientation

The Government of Nepal has made it mandatory for migrants to attend a two-day pre-departure orientation programme. According to the key informants, these orientations are typically scheduled two days before departure, and are run by 93 accredited organizations. Female migrant workers are required to have a total of 21 days of training, during which time they are oriented about safety and using household appliances.

As explained by the key informant from the Foreign Employment Promotion Board, the standard orientations are intended to facilitate the move abroad by providing information on the immigration process and the destination country, such as culture, language, religion, and traditions. He noted, however, that these topics are not adequately covered in practice.

Health is a minor component of these orientations. An orientation officer reported that one and a half hours are allocated for a health session during his orientations, in which workers are told about health risks abroad and are provided information related to Hepatitis B and HIV. The content of the health sessions has a particular focus on sexual health and HIV:

> "...we provided support to Foreign Employment Promotion Board to develop pre-departure orientation manual where there was a major section on HIV/AIDS and health related information."
>
> *Key informant, Programme Officer from an international organization*

In fact while key informants acknowledged that migrants are a risk population for HIV, they expressed concerns of over-exposure to HIV information at the expense of other important health issues:

> "It is a pity and a matter of concern that most of the health related programmes for the migrants have been HIV focussed and almost nothing else."
>
> *Key Informant, Programme co-ordinator at a bilateral agency*

There is also evidence that orientation providers are often not genuinely invested in teaching migrants. A member of the Foreign Employment Promotion Board shared that there is no monitoring mechanism to ensure good quality orientations in terms of adequate physical and human resources. Alternatively, the process is treated as a 'formality'. Key informants mentioned that there is weak regulation of certificates and falsified certificates can often be bought.

> "…all the migrant workers do not take pre-departure orientation training. They rather prefer buying the fake medical certificates."
>
> *Key Informant, POURAKHI officer*

Exacerbating this, there is low demand for comprehensive orientations among migrants themselves, particularly among those who have lower levels of education and those going abroad for the first time;

> "Some of the educated ones seem to be attentive and interested in taking the orientation classes otherwise those going under 'labour' category do not seem to be much interested in taking such classes. Only when they have gained the first-hand experience, they are eager to learn more on the precautions they need to take while going for the second time."
>
> *Key informant interview, Training officer*

It is thus apparent that pre-departure health orientations are not effective in preparing migrants for their move abroad; they often lack in information and are not taken seriously by orientation providers or first-time departing migrants. A pre-departure health orientation training officer expressed that the orientation should be provided earlier on in the migration process, to enable more informed decision making with regard to migration, and to promote the learning process.

3.2.4 Migrant focused services in Nepal

Government-initiated, migrant-specific health services are lacking in Nepal, save for health examination prior to departure required by destination countries. All key informants expressed that the health of migrants is a neglected issue, as reflected in the following quotes:

> "All the investments related to HIV have come from external sources. There are no focused [government] programmes on migrants."
>
> *Key Informant, Programme coordinator of a bilateral agency*

Similarly,

> "There is no specific consciousness, programmes or sensitivity associated with the migrant workers' rights on the part of the government."
>
> *Key informant, human rights activist and chair of a rights network*

The lack of national policy on migrant health is linked in part to the fact that there is apathy towards health in general in Nepal, with economic and legal concerns taking precedence:

> "The focus on fraudulent cases, cheating by agents, trafficked cases, salary issues, false contracts, have overshadowed the health issues...it is a side-lined issue given the fact that there are reports of 3 Nepali migrant workers dying every day."
>
> *Key informant, official from international organization working with migration*

One key informant expressed his opinion that the government's disregard of health is irresponsible considering Nepal's economic reliance on migrants:

> "While sending the migrant workers, the government is eager to glamourise the migrant workers for their contribution in remittance, but in terms of health issues, the government is not sensitive at all."
>
> *Key Informant, Chairperson of an NGO working for female returnee migrants*

There are however migrant-specific health services delivered through NGOs. The key informants from international and national NGOs discussed a range of activities, including shelter homes and counselling for migrant workers. A key informant working with cross-border migrants in the Far-Western Region shared his experience of organizing mobile camps related to STIs and HIV, and disseminating information through drop-in centres and help desks established through the 'migration trail'[6] for departing migrants. These help desks provide information on required documents, tips on exchanging currency, places to go for work, and contact details of Nepali authorities (embassies, welfare groups, social service organizations, etc.), among others. Another key informant shared that they conducted migrant-specific sexual health programmes in four districts, where they mainly engaged with spouses of migrants, as well as migrant workers during the festival period. Activities included providing counselling and referrals related to family planning, as well as HIV and STIs. Another informant working in an organization for returnee migrants indicated that they provide medical and legal support, psychosocial counselling, and maternity support as required by returnees.

[6] *The participant used the term migration trail and explained that the migrant workers move from their village to the district headquarter and then to Dhangadi or Kanchanpur.*

Despite this, responses from the FGDs suggest that the reach of these activities is limited. Both departing and returnee migrants stated that they were not aware of any health related activities targeting migrants apart from mandatory health examination. The majority of migrants thus are unable to benefit from health services that address migration related vulnerabilities.

3.2.5 Accessibility and perceived quality of health-care in the country of origin and destination

The FGDs and KIIs indicated that there is limited coverage of health services in Nepal, particularly in more remote or mountainous areas. Some participants, particularly from areas within the Terai region like the Sarlahi district, shared that they have access to nearby health facilities and general health services like child vaccination, antenatal check-ups, iron tablets, and family planning. Others expressed difficulties accessing government facilities due to long distances and unavailability of transportation. Participants from the mountainous Rasuwa district reported that they have to walk for nearly two hours to reach a health facility. Distances are increased if major treatment is required; almost all FGD participants mentioned that they receive general services and treatment for minor illness in the nearby facilities but have to go to cities or towns for major illnesses or more complex procedures, such as surgery.

Private facilities appeared to be both more accessible and of higher quality than public facilities, with a wider range of services. Participants expressed preference for private facilities due to shorter waiting times and improved accessibility:

> "The health post is very far and even if we manage to get there, it is always crowded. If we don't go, it might complicate things; so we have to go to private clinic because the treatment is immediate."
>
> *FGD participant, cross border male migrant, Pyuthan*

A key informant working in a bilateral organization maintained that the private sector is 'booming' but is limited to urban areas. Another key informant from an international organization working with labour issues reasoned that the improved quality of services is due to improved remuneration among service providers, an opinion which was shared by returnee migrants.

Comparatively, key informants commented that Nepal's health services are generally inadequate and of poor quality. An NGO officer who advocates migrant workers' rights maintained that much needs to be improved in terms of availability of facilities and resources, such as medicines.

Respondents indicated that psychosocial services are limited, with only some NGOs providing psychosocial counselling. One key informant shared his view that health protection and promotion should be extended to include mental health issues.

Further limiting access to health-care is stigma and discrimination towards migrants, particularly those who return ill from abroad. These negative experiences appear to extend to family members, and can manifest in the form of harassment or even refusal of care.

"People who have HIV are seen a bit differently."

FGD participant

"There are problems related to poverty and then husbands not being at home for the migrants' spouses. When the spouses go to the health services to get family planning services or if the spouse suffers from HIV, they are being harassed."

Key informant working with cross-border migration

Both the FGD participants (departing and returnee) and key informants expressed their concern regarding the affordability of services, particularly for illnesses that require many tests and advanced treatment. Participants reported that it is not uncommon to take out loans to treat or manage serious diseases. This in part stems from weak regulation of the private sector:

"In the urban areas, there is no regulation of the private sector in terms of the fees they charge and the quality of services they provide. The concept of health insurance has just started but then again there is another concept of free health or universal health coming up. There is no consensus at the policy level as to which would be beneficial and there has been no proper discussion on this either."

Key informant, bilateral organization

Health-care facilities abroad were generally described to be good or adequate. Female cross-border migrants were particularly satisfied with the treatment facilities in India, where many migrants obtain medical check-ups due to the relative ease and lower costs of finding foreign employment through Indian agencies compared to Nepal. Indeed all of the participants of one focus group discussion of female returnees had travelled through Mumbai to obtain work abroad, and respondents expressed the opinion that facilities, particularly private facilities, were superior to those available in Nepal. However in other countries, migrants faced a synergetic combination of financial and legal difficulties accessing them. The *Kafala system* in the Gulf countries for instance involves a sponsorship system that binds an employee to their specific employer, who can then regulate their residency and employment. The *Kafala system* allows employers, for example, to bar domestic workers from moving outside of their homes.

"If we find any services, then they are very good but in most of the companies, it is very hard to get the services."

FGD participant, Returnee male migrant

Accessibility and affordability of health-care abroad was determined by access to health insurance. Key informants shared that it is the responsibility of the employing organization to provide health insurance to their migrant workers, by issuing health cards that entitle migrants to medical treatment as well as periodic medical check-ups. However, only a few departing migrants were aware that employees had this responsibility, and experiences varied among returnee migrants.

Several returnee migrants described positive experiences accessing health-care through their employers while abroad:

"In good companies, once you scratch cards, then you do not need to pay any fees. You can immediately get treatment and once you show your card, they don't charge you any fees."

FGD participant, Returnee male migrant

"Good companies give a variety of facilities. In companies producing milk, labourers have to work in minus 15 degrees condition. The company regularly checks the health condition in their every step while working. When the company is good, it is safer....and even the workers are happy and eager to work."

FGD participant, Returnee male migrant

"We had to tell them that we are sick and they would take us. They bore the expenses. We don't have to spend a single paisa."

FGD participant, Returnee female migrant

"My leg had fractured and they themselves took me to the hospital. My salary was not deducted and I did not have to spend money. It was impractical for them to take care of me themselves but they hired another person as a caretaker who would help me go to the toilet, change clothes, take a bath, etc."

FGD participant, Returnee female migrant

Some migrants also discussed various insurance arrangements with their employers, such as coinsurance; companies covered 80 per cent of costs and the remainder was deducted from workers' salaries or deductibles whereby:

"It is not totally free of cost....if our expenses exceed this [the amount paid by company], we have to pay it all on our own accord."

FGD participant, Returnee male migrant

Other returnee migrants noted the difficulties associated with accessing insurance, particularly due to reliance on employer initiative. While insurance mechanisms may exist, they cannot be put to use or activated unless employers 'reach out' to the insurers. A key informant who is a member of the Foreign Employment Promotion Board (FEPB) stated that he was not aware of a single case where the employment company had given full compensation to migrant workers.

"Company is supposed to fight for that amount with the insurance company."

FGD participant, Returnee male migrant

"If anyone loses a finger, then the person is supposed to get certain amount. The insurance company does that but the main thing is who will reach to that insurance company to receive that amount?"

FGD participant, Returnee male migrant

Failure to provide financial support or compensation for illness is exacerbated when a worker is deported. In such cases, the key informant from the FEPB noted that it becomes extremely difficult to co-ordinate with the employing companies via the diplomatic channel to make them liable for providing compensation.

Other migrants reported absolute negligent and unethical treatment of migrants when ill:

> "There are many such companies which do not even say where to go. They do not even provide any transportation facility....even if we suffer from any health problems like cough, we cannot go anywhere and we just have to sleep in our room."
>
> *FGD participant, Returnee male migrant*

> "If any worker gets sick and stays in the camp, then the boss comes and notes his name; then reports about him saying he is being lazy and not coming for work."
>
> *FGD participant, Returnee male migrant*

Similarly, few male FGD respondents and no female FGD respondents were aware of the provision of health insurance by recruitment agencies, mandated by the Foreign Employment Act of 2007, although a few returnee migrants discussed being issued a health card to access public services.

Where migrants did not receive health-care coverage or health cards by employers, private health-care was often the only available option. This was noted to be the case in India, where Nepali migrants are not eligible to receive a Ration Card, which is distributed to Indian citizens in poor households and entitles holders to subsidized commodity prices and access to health insurance. Turning to private facilities, however, incurs deterrent out-of-pocket payments.

> "There are good facilities provided in the government health facilities too but since we do not have the ration card, we cannot use those services and we are compelled to use the private clinics which are much more expensive. For common earners like us, it is very expensive and we cannot afford that...we have to work without treating any health problems that we have."
>
> *FGD participant, Cross-border male migrant*

3.2.6 Barriers to accessing health-care services

Several migrants described legal restrictions to emergency health-care, which then cause delays to essential medical services that can ultimately prove fatal. In several instances, the completion of certain police procedures was required before the injured individual could the touched. In these cases, FGD respondents shared their feelings of helplessness, forced to watch their friends in pain and unable to help:

> "One cannot take his friend to the hospital even if he had a serious accident such as leg cut in front of him….. Police need to come and investigate first."
>
> *FGD participant, Returnee male migrant*

Several FGD respondents spoke of difficulties logistically accessing health-care facilities while abroad. While close health-care services may exist, health-care coverage by employers is typically restricted to more remote hospitals that are designated by employing companies due to lower costs. This leads to increased travel time and financial difficulties accessing hospital services.

> "We have to travel outside the company paying 30-50 for bus fare and go to the company hospital even for common problems like common cold and cough. Due to this, for taking any medicine worth only 10, we have to spend extra 50."
>
> *FGD participant, Returnee male migrant*

The need to travel to a company hospital can be particularly problematic during emergency cases, where the more remote and unfamiliar location delays access to needed medical attention.

> "Taking time out to search for them [drivers] takes so long that the patient reaches very difficult stage."
>
> *FGD participant, Returnee male migrant*

> "The person cannot be taken to other than company designated hospital though that place is nearer. Taking help of ambulance is expensive and even looking at severity those ambulances may take the patient to a good hospital which costs more, so, company does not authorize to use that…. If there is a heavy bleeding, person dies because of these rules and restrictions."
>
> *FGD participant, Returnee male migrant*

Key informants explained that undocumented migrants face increased barriers accessing health-care, as they are unable to access health insurance and are fearful of being caught if presenting at a health facility.

> "They fear that if they go to health services, the authorities might ask for passport, visa and other official documents and if they don't receive those, they would be put in prison and would be deported."
>
> *Key Informant, Programme Officer of a UN agency working with labour issues*

Undocumented migrants are also more likely to be unaware of their benefits and rights as stated in their contracts.

Language barriers pose a particular problem for migrants, as they both limit knowledge of and access to appropriate health-care facilities, and further obstruct effective consultations with health-care staff. One FGD participant jokingly noted that migrants, unable to express themselves to the doctors, continuously receive the same medication, whatever the ailment:

> "*Laughs* When we have fever and pain, we have to say 'tahawan', when we have headache, again we have to say tahawan. It's the same for all. We do not know anything else, then our medicine is also the same."
>
> *FGD participant, Returnee male migrant*

The inability to access appropriate health-care or medication can only lead to further deterioration of health, potentially leading to deportation.

> "With international doctors, we Nepali have to face language difficulties..., they cannot make the doctors understand about their health problems...the worker continues to suffer from the problems and comes back. He takes one pain killer named Panadol and comes back [to work]. Then the same disease continues to degrade his health. Company does send him to places for required treatment but the representative of the company who goes with the patient does not speak up about him. When the representative does this, there is no other option for the patient except being dragged down by his illness. After this, the company also becomes forced to send him back home."
>
> *FGD participant, Returnee male migrant*

FGD respondents discussed their general understanding or their own personal experiences of discriminatory treatment at health-care facilities. Some FGD respondents felt that they were discriminated against due to being Nepali, to the extent that Nepali migrants may not even be afforded treatment.

Inability to speak local languages appears to be a major determinant of discrimination. Male cross-border migrants shared that they were treated better if they could speak the local languages, such as Madrashi in South India or Gujrati in Gujrat. Some noted that they experienced no discrimination when speaking Hindi in Hindi-speaking areas of India.

The issue of deportation came up frequently in the qualitative discussions and interviews. As already described, it is often unwarranted medical fitness certificates or the inability to access effective health-care to prevent deteriorating health that leads to serious illnesses and deportation. A key informant reported that the cost of a sick employee can be considered too great an economic loss for employers:

> "...They are sent back to the countries of origin as the medical cost for keeping those workers in the destination countries becomes very high."
>
> *Key informant, Foreign Employment Promotion Board*

Returnees also shared stories of when their illnesses were reported as 'laziness', ultimately resulting in dismissal and having to return home:

> "If one cannot go to work, then the boss asks the in-charge about why he did not come to work. The in-charge tells the head office and the boss that he did not come due to laziness. He does not tell about his illness."
>
> *FGD participant, Returnee male migrant*

Deportation has serious consequences for migrants. They experience financial losses due to the dismissal and subsequent loss of salary, the costs associated with returning to the country or origin, and the longer-term opportunity costs due to prolonged illness and reduced economic productivity. Migrants also face the stigma associated with returning to the country of origin. These problems are extended to their family; key informants explained that deportation can result in the reduced economic status of the household and worsened education opportunities for their children. As related by an FHI 360 [7] official, as a result of deportation, 'In general, they would have a ruined status'.

[7] *FHI 360 (formerly Family Health International) is a non-profit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions.*

Key informants explained that the government can provide financial compensation if workers are deported within 2 months of departure. This, however, is not common knowledge among migrant workers; the subject of government compensation was not brought up during the discussion with migrant workers.

The key informant interviews elucidated that the Government of Nepal has also established a welfare fund for migrant workers and their families to provide compensation if they return injured or ill, or die while abroad. Every documented departing migrant contributes 1,000 NPR to this fund. A key informant who works as a member of the Foreign Employment Promotion Board (FEPB) shared that there is a technical board at the FEPB that determines the gravity of medical illness per case and the appropriate amount of compensation. However, again, none of these provisions were mentioned during the Focus Group Discussions.

3.2.7 Mandatory health examination prior to departure

As explained by key informants, the Government of Nepal has mandated that migrants require a health examination prior to departure and a certificate deeming them medically fit to be eligible for work abroad. FGD participants were familiar with mandatory health examination, and most expressed having had one prior to departure. Blood tests, urine tests, and X-rays were commonly cited components of the examination.

The quality of the tests performed by medical facilities was questioned by both key informants and FGD participants, particularly returnee male migrants. FGD participants expressed mistrust in the health examination services in Nepal, perceiving doctors as negligent and the laboratories as "infected" and unreliable.

Fake or unwarranted medical certificates are also frequently issued, leading to the deportation of migrants found to be medically unfit by the destination countries[8]. Key informants explained that deportation leads to mental stress and anxiety, and migrants are often subjected to further economic losses and harassment. Inaccurate health examinations or falsified certificates can also result in migrants becoming seriously ill while abroad. As described by a migrant in a FGD:

> "...For instance, even if you are unfit, there is a provision that your bio-data is sent claiming that you are fit. Due to this, there are situations that labourers are sometimes found dead due to some illness in destination countries within a very limited time period."
>
> *FGD participant, Departing male migrant*

3.2.8 Sources of health information and knowledge

Officials spoke of the dissemination of many printed materials. ILO and UN WOMEN supported the FEPB to publish a Pre-Departure Orientation Manual in 2009, which includes a health section and is currently being updated to include more county-specific information. Key Informants also mentioned the development of an Information Guide for Domestic Workers for Lebanon. POURAKHI shared their radio programme and IEC materials on awareness of safe migrants, which according to a representative key informant, are issued "in the form of posters, pamphlets, booklets, handbooks. We disseminate them at all levels and it even reaches the community level."

[8] *At the time of this study (September-October 2013), there were newspaper reports of migrant workers being returned from Malaysia on account of fake medical certificates. (http://www.himrights.org/download/14_186468721.pdf; http://www.nepalresearch.com/economy/employment.html).*

Non-printed resources included 'edutainment' materials such as ludo games and wheel games, used by FHI 360. Radio was a further means of health communication, and other key informants relayed that POURAKHI, IOM, and USAID had broadcasted radio programmes covering migration and health topics. These programmes are aired on Radio Nepal and up to 23 other FM stations. Migrant hotspots were identified as key locations for information dissemination by key informants. There included, bus parks, airports and border check points. An official at CARE Nepal also identified Drop-In-Centres (DICs) at border check-points. Health providers were additionally used; departing male migrants of Kathmandu recalled seeing signboards and banners regarding communicable diseases and sanitation and hygiene in health facilities.

The officer at FEPB shared that health related information is disseminated via social mobilizers, who are the secretaries of village development committees (VDC), who are paid a small amount as an incentive for this work. Finally, the radio programme broadcasted by POURAKHI had wide scope, aired on Radio Nepal and 23 other FM channels, while IOM reached its target audience through coordination with the Ujjyalo 90 Network.

Most of the interviewees working in NGOs/INGOs claimed that they have been successful in reaching out to their targeted audiences. ILO officials claimed that their materials, particularly the Information Guide for Domestic Workers, have been much appreciated by migrants and there is demand for more copies. Similarly, FHI 360 official claimed that due to a participatory approach while developing the IEC materials, migrants find it 'user-friendly'.

However, FGD participants expressed a contrasting opinion. They noted that undocumented Nepali migrants are not easily reached through these means given their lower likelihood of passing through typical migrant hotspots. Departing migrants also viewed that IEC/BCC materials are not 'interesting' enough to catch attention. As explained by one migrant:

> "Most people watch TV series, especially English series, but they don't watch health related programmes. For example there is a Nepali programme called 'Thorai Bhaye Pugi Sari', but nobody watches it, they watch Hindi series instead."
>
> *FGD Participant, Departing migrant*

Indeed, all FGD participants indicated low knowledge of general health issues and possible problems in destination countries. HIV/AIDS was the exception; most FGD participants expressed knowledge of HIV/AIDS, and most of them knew about transmission routes.To improve health communications, spouses of migrants in Jhapa expressed a preference for television and radio rather than billboards and posters, stating that:

> "When it is a poster we have to go there and look at it. Whereas in case of TVs and radios we can listen to or watch them even while we are working. That is much better."
>
> *FGD participant, female spouse of migrant*

3.2.9 Higher-level and multi-sectoral coordination

Respondents expressed the need for the Nepali government to increase their diplomatic pressure on receiving countries. The presence of Nepali embassies appears to be rather unimposing; returnee migrants expressed disappointment with the Nepali embassy abroad, stating that they did nothing to provide assistance. Similar perceptions were expressed regarding the labour attaches that exist in some embassies abroad. One of the key informants shared:

"The officials of the destination countries very much know that the Nepali embassy officials also care less about Nepali migrant workers and there is no one to raise the voice of Nepali migrant workers."

Key informant, Chairperson of NGO working for female returnee migrants

"Our Nepali migrants have been the victims of international politics and failed diplomacy."

Key informant, Chairperson of NGO working for female returnee migrants

Key informants noted that a policy and legal framework is required to form a basis for improved diplomatic efforts. One noted that the failure of the government to establish 'migration management' policy prevents officials from confidently standing firm against exploitation faced by migrants.

Supplementing this, some informants stressed the necessity of an inter-sectoral approach and strengthened coordination among relevant ministries. A key informant working for POURAKHI suggested that the government should coordinate with the agencies to promote improved provision of information on safe migration and health insurance.

"there are various aspects associated with migrants such as remittance, skill development, entrepreneurship development, increment in jobs, etc. all these aspects are closely associated with the health of migrants. Therefore, health of migrants should be the major concern of all the stakeholders."

Key Informant, FHI 360 official

Ultimately, however, it appears that the government must improve its own commitment to protecting migrant workers. The POURAKHI official noted that the government needs to dedicate more efforts to prevent occupational risks and promote the safety of migrants, as all external policy efforts must first begin in the country of origin.

Nepal has a long history of dynamic migration and has declared migration "the de facto core of Nepal's development strategy" (Adhikari & Hobley, 2012). Migrants are motivated to move by factors including poverty, unemployment, long-term internal conflict, rapid population growth and associated food shortages, as well as encouragement from the government to emigrate because of the country's rising levels of unemployment (Bhattarai, 2005). Remittances play a major large role in the country's economy, constituting 25 per cent of GDP in 2014 (World Bank, 2014b). Nepali migrants face concerning health risks in countries of destination and may leave Nepal with insufficient health profiles to avoid these risks as a result of limited health infrastructure in remote and rural areas. The following discusses the key findings of the study to provide a more comprehensive understanding of the health and other challenges Nepali migrants face throughout the migration process.

CHAPTER FOUR

DISCUSSION OF FINDINGS

4.1 Migration profile

The majority of study respondents were male, had a mean age of 29.5 years, were married, and had an average income of 31,500 NPR (315 USD) per month and a family size of one or two people. Returnee migrants were on average 32 years of age, and more likely to be married compared to departing migrants. Approximately 80 per cent of migrants had completed or reached secondary education.

More than half of respondents faced difficulties during the migration process; most difficulties were related to financial arrangements. Importantly, there appears to have been an increase in the quantity and severity of difficulties encountered. More returning migrants reported problems than departing migrants, and the nature of problems shifted from administrative difficulties at home to more serious issues, such as corruption, discrimination and abuse while abroad.

These difficulties, however, were not significant enough to deter migrants from traveling abroad for work; the primary reasons for return were having completed work contract or taking leave, and the majority of returnees indicated that they intended to migrate again.

These findings suggest that migrants have reduced support and bargaining power while abroad, with increased vulnerabilities and risk of exploitation.

4.2 Health risks and vulnerabilities

Migrants recruited in this study were generally healthy. Serious diseases were rare, as was returning to the country of origin for health reasons. Minor illnesses, such as head colds were commonly cited. This reflects the 'healthy worker' effect[9]. Migrants are often a young, able, and healthy population, particularly when compared to the population at large.

Despite this, migrant workers face elevated vulnerabilities compared to their non-migrant counterparts of the same age. The findings complement the large body of literature on the deplorable working and living conditions experienced by migrants that lead to degraded health. Occupational hazards are a particular risk, experienced by 1 in 10 migrants during their most recent trip abroad. They are, to a large extent, often rooted in large proportion of labourers, exposed to '3D'[10] working environments, long working hours, and the consequential risk of workplace accidents.

Risk of contracting a sexually transmitted infection also appears to be elevated among migrants when abroad. Returnee migrants reported having more concurrent relationships and transactional sex compared to departing migrants. While direct comparison between sexual activity in the country of origin and destination is difficult due to differences in time periods, higher risk behaviour is well documented among male migrants abroad, where living and economic circumstances, as well as distance from the regular sex partner motivate soliciting commercial sex. It was a positive observation that condom use at last sex was reported highest with casual and commercial partners, and overall use increased while abroad to as much as 93 per cent. However, condom use is frequently overestimated.

Promoting condom use will prove difficult in this population. Only a small minority had poor information or poor access to condoms, and dislike of condoms or perceiving them unnecessary proved to be more important barriers to use. For some migrants, this may be because condoms are legitimately unnecessary for many, including those in monogamous relationships and/ or who are seeking pregnancy. However, data suggests that migrants should be encouraged to recognize risks and the need for protection, particularly among those engaging in high-risk sexual behaviour. Women should also be empowered to demand condoms; women's bargaining power appears to be limited, as more women than men cited partner preference as a determinant of condom use.

[9] *HWE is a phenomenon initially observed in studies of occupational diseases: Workers usually exhibit lower overall death rates than the general population because the severely ill and chronically disabled are ordinarily excluded from employment (Last, 1995)*

[10] *"3D jobs" is a neologism for work that is "dirty, dangerous and demanding (or degrading)". Countries with a high economic status typically hire migrants as a labour source for such work as it is unattractive to the local population. 3D jobs can include janitorial or domestic work, construction, farm work, and jobs in the entertainment sector (often a euphemism for sex work). (Wolffers et al. 2003)*

Past and current use of injecting drug use was low; approximately two per cent of all migrants. This limits risk of HIV infection through parenteral means among migrants, however, the HIV risk for those that do inject drugs cannot be unknown due to the lack of information on sharing of needles. Alcohol consumption, associated with lower condom use and higher occurrence of accidents, was moderate, although significantly higher among returnee migrants. This suggests an increased reliance on drugs and alcohol while abroad, found to be associated with elevated mental health problems. Other health risks associated with consuming alcohol are unknown, as the data does not discern the patterns and level of consumption.

Mental health problems are also common among migrants as a result of the demands of unfamiliar and difficult living and working environments. Migrants encounter anxiety and stress rooted in financial, familial, language, and legal barriers or difficulties, including deportation. In more extreme cases, migrants' psychosocial health is threatened due to experiences of discrimination, abuse, and violence. Women were found to be particularly at risk, with more than two-thirds of female returnee migrants having experienced forced sex while abroad. Considering this and the significantly lower proportion of respondents who knew of peers having been sexually abused, it is probable that such issues are not widely discussed or that forced sexual intercourse is not explicitly recognized as sexual abuse. Furthermore, recognition of mental health issues appeared to be disproportionately low, suggesting a need for improved awareness of mental or psychosocial health and the validity of seeking assistance. Extending beyond health-care, political initiatives such as Nepal's new Operation De Pogo[11] scheme, if effectively implemented, may limit the exploitation and abuse faced by Nepali migrants, and reduce or avoid psychosocial distresses experienced during the migration process.

In spite of the aforementioned health risks, migrants perceived themselves to have low susceptibility; most chose to forego post-arrival medical check-ups and perceived themselves as not at risk of Tuberculosis, HIV and Hepatitis C. It is not possible to directly cross-reference these perceptions with actual risk, however, it is probable that perceived susceptibility is underestimated due to limited knowledge of disease transmission, and perhaps influenced by a general ambivalent attitude which is often observed in young, working-age populations. There exist several studies that indicate that migrant workers do have an increased risk of those listed diseases due to the living and working environments already described in this paper.

4.3 Health-care seeking behaviour

Migrants exhibited limited concern for their health or drive to seek health-care. This can be contributed to a mixture of high health-care costs, perceived poor quality of health services, fear of legal or economic repercussions while abroad, such as dismissal and deportation, as well as perceived insusceptibility to disease. As already discussed, while migrants do belong to a generally healthy demographic, their working and living conditions while abroad present heightened health vulnerabilities warranting increased precaution.

The data indicated gender differences in health-care seeking, with a higher percentage of men seeking health-care at private health providers, particularly among returnees. The reason for women's lower level of health-care seeking and preference of public health facilities is not clearly understood from the available data, however the qualitative findings suggests that it may be linked to fears of discrimination. Although more women found health care affordable at home, finances do not appear to be an important determinant; there was no statistically significant difference between the incomes of men and women, and no correlation between income and history of health-care seeking. Public facilities may offer more female-friendly services, however this cannot be determined using the collected data.

[11] *Operation De Pogo is a scheme devised by the Government of Nepal to protect Nepali migrants from corruptive practices implemented by recruitment agencies. The scheme was developed as an effort to eliminate exploitation of the large Nepali migrant workforce. (Pattisson, 2014)*

4.4 Health-care accessibility and perceived quality in the country of origin and destination

According to the National Health Policy 1991, every Village Development Committee should have a sub health post[12] to impart promotional, preventive and curative health services. However, data indicates that there are variable and often limited services, with participants from the mountainous Rasuwa district having to walk almost two hours to reach a health facility for basic care. Specialist services, such as dental and optical care seem to be entirely limited to urban areas, and services that cater specifically to migrants or to the health conditions they commonly experience, such as mental health illness and psychosocial problems, are not provided, save for some services offered by small-scale NGO activities. The women in this study were disproportionately affected by these factors, with lower reported access to services compared to men.

The quality of public facilities is hampered by inadequately skilled doctors, low adherence to standards of practice, and long waiting hours due in part to inadequate resources, poor planning, and poor guideline implementation. Private providers were deemed of better quality but were again limited to urban areas and identified as exceedingly expensive.

Indeed despite the adoption of universal health coverage and the fact that a large majority (82%) of Nepali migrants stated they had access to free health-care services in Nepal, health-care affordability remained difficult in practice. This supports the findings of other studies that have found that while total out-of-pocket payment has decreased in recent years, the distribution of financial protection and access to health-care has not significantly improved (Adhikary, 2013). The low affordability may be linked to the opportunity and transportation costs of visiting inaccessible clinics, but may also be rooted in a large and unregulated private health-care market.

The development of available and accessible, migrant-friendly, government-funded health services would help promote migrant health, but would require a cultural shift towards prioritizing health amidst competing economic and legal interests.

The picture of health-care accessibility abroad is complex and is dependent on the destination country. Health service quality appears to be satisfactory, particularly when sought in India, accessing these services, however, has proved difficult. The percentage of migrants that had faced difficulties accessing health-care services increased from 14 per cent of migrants at home to 23 per cent of returning migrants abroad.

Barriers to access to health-care services in the country of destination were typical of those reported by migrants who struggled with integration: language barriers, discrimination due to migration status, unaffordable costs, and lack of information. Access appeared to be a particular problem in the Middle East where legal constellations, such as the Kafala system, curtail the rights of migrants to seek health-care. Comparatively, cross-border migrants in India are in better condition with respect to better health insurance coverage by employers and less discrimination. The Kafala system has been under considerable pressure in recent years, with Qatar recently opting to abolish the sponsorship system. While this may be a step in the right direction, the real impact is yet to be determined, and the responsibilities of brokers and individual agencies in formulating working contracts with health coverage clauses must not be forgotten.

It is clear that HIV/AIDS is a priority disease within the health-care service, particularly in destination countries, as it is frequently cited as a specific diagnostic or treatment service and is prominently featured in most communication channels and health communications. Importance should be placed on HIV but not at the expense of other important health concerns that need to be addressed.

Health-care affordability in the country of destination is more disparate compared to in Nepal, with increased dependency on formal financing schemes and employer coverage, and a reduced ability

[12] *The National Health Policy 1991 talks of establishment of sub-health posts in all VDCs with one village health worker, one maternal and child health worker and one auxiliary health worker under basic primary health services.*

to rely on informal networks. Employers thus play a key role in ensuring access to health-care, and it is concerning that this responsibility has often been neglected with voided or altered contractual clauses. Again, herein lies the important role of the recruitment agencies and the government's regulatory body to ensure that departing migrants enter the destination countries with a written commitment of the employer to fulfill their obligations for migrants' health.

Labourers in the primary sector benefited least from employer coverage of health costs while abroad. Although health insurance appears limited for all migrants, this was particularly so among women. It is unclear if this is due to restricted insurance policies or poor awareness among migrants regarding access to and use of insurance, indicated by the fact that only a minority of those covered actually used insurance to cover health-care costs. However the fact that 20 per cent of women did not know if they were insured in the country of destination suggests a need for increased education regarding insurance coverage and rights to health in the country of destination. Only with adequate knowledge about health insurance can migrant workers optimize the financial support guaranteed by employers or the state.

4.5 Mandatory health examination prior to departure

Almost all surveyed migrants had or were going to undergo the mandatory health examination prior to departure. Tests included in the health examinations clearly have a range of shortcomings, including poor adherence to standard ethical procedures such as informed consent and results sharing, lack of standardization, as well as negligent staff and unequipped facilities. Issuance of falsified medical certificates is associated with deportation and the development of serious medical conditions while abroad, both of which can result in economic losses, social problems, and the further degradation of physical or psychosocial health. These procedures require improved standardization and regulation, including the application of ethical guidelines, and there is a need for increased accountability among certifying bodies to deter unwarranted claims of medical fitness.

4.6 Health knowledge and sources of health information

It is positive that the majority of migrants independently recognized HIV/AIDS to be an infectious disease transmissible between themselves and their partners or other family members. This is particularly important as male labour migrants constitute one of the biggest risk groups for HIV transmission in Nepal. Knowledge of other significant diseases including Tuberculosis, Hepatitis, and respiratory infections, however, paled in comparison.

Additionally, while awareness of HIV/AIDS was high, there was lower knowledge of specific transmission details, including parenteral transmission and mother-to-child transmission. In fact there was no mention of anal sex or male-male sex, although this is likely to reflect social stigma or cultural barriers rather than poor knowledge. It is notable that 'sexual relationship with a sex worker' was one of the most frequent HIV risks mentioned by respondents.

Stigma and perceived inferiority of sex workers have been associated with a lowered ability of sex workers to demand condom use. It is difficult to make such conclusions without further investigation into migrants' attitudes towards sex workers, however it is essential to consider sex worker empowerment when discussing condom use among migrant populations.

Television and community radios were the most important health communication channels identified as major information resources, including for health topics such as HIV/AIDS. These channels were explicitly preferred by respondents for information dissemination, they had a high uptake in general, and proved particularly appropriate for key groups such as primary sector labourers, women, those with poor literacy, and undocumented migrants. It was noted that

optimizing the entertainment value would improve their effectiveness; migrants stressed the poor effectiveness of printed materials. It appears that the majority of health information is imparted verbally; 90 per cent of migrants cited health facilities as a source of health information in Nepal, but just under two thirds of migrants had received health related communication materials from health providers. Despite this, there appears to be a disproportionate focus on print materials for distribution to migrants.

In the country of destination the availability of effective health information was clearly more restricted, with only a minority of respondents being provided a pre-departure health orientation and less than half receiving health communication materials. Many of these materials were not published in a language understandable by respondents. Coverage of important health topics was moderate during health orientations. The main focus appeared to be mandatory health examinations, presumably those associated with work/ visa regulations. There was a clear preference for more health information, with most migrants expressing interest in specific diseases. The fact that migrants specifically wished to know more about HIV/AIDS in spite of established high awareness indicates need for more comprehensive, post-basics information. Furthermore, almost half of those who attended a health orientation expressed a desire for more information, largely related to health and working conditions.

It is important to improve at least the effectiveness and appropriateness of health education provided by health providers and pre-departure orientations. Given the high level of contact between migrants and agencies or employers, the pre-departure orientation is an ideal opportunity to provide essential living, working, and health information through participatory and interactive means.

4.7 Gender issues

Men are at higher risk of occupational hazards and infectious diseases than women, as indicated by the male-dominated labour market and more frequent risk behaviour such as unprotected sex with sex workers and drug use. However, women appear to have worse psychosocial health, indicated by more mental health problems possibly linked to issues such as increased sexual violence and discrimination experienced in the country of destination.

Women also frequently displayed poorer health knowledge and awareness of health-care availability, including relatively poor knowledge of infectious diseases, health insurance, and migrant-friendly health services. Indeed women displayed lower willingness to migrate again for work, which may be linked to carrying a disproportionate burden of problems during the migration process.

The following recommendations have been made following the *World Health Assembly Resolution on the Health of Migrants Global Operational Framework*. Improvements to migrant health can be achieved through both health infrastructure developments within in Nepal, as well as improved employer or agency support and social integration while abroad. The definition of migrant health needs to be universally recognized to include not only infectious diseases but also chronic conditions and mental health concerns.

These improvements can only be attained through bilateral and national multi-sectoral commitments both in Nepal and in destination countries. Migrants should be active players in the improvement of their own health and in the services they use. They should be equipped with the necessary information to be aware of their health and to effectively utilize and pay for services.

The following recommendations have been made in accordance with the *World Health Assembly Resolution 61.17 on the Health of Migrants Global Operational Framework*. The framework consists of four primary action points, namely monitoring migrant health; policy-legal frameworks; migrant sensitive health systems; and partnerships, networks and multi-country frameworks.

CHAPTER FIVE

RECOMMENDATIONS

5.1 Monitoring migrant health

Health research of migrants concentrates predominantly on newly arrived migrants and is communicable disease focused. However, given the increases in migration flows, the duration of stay and diversity of migrant populations there is great need for expanding migrant health monitoring efforts. Research of migrant health should include social and economic risk factors, as well as health throughout the migration process and long term effects of migration beyond first generation migrants. The following are specific recommendations on monitoring migrant health.

a. Further research on both inbound and outbound migrants in Nepal should be undertaken to understand their health-care facilities, accessibility, finance, sexual risk behaviours and vulnerabilities to STIs/HIV;

b. More research is required to understand women's experience of migration, given the male-dominated sample in this study and the general shortage of studies targeting female migrants;

c. More comprehensive research of the sexual behaviours of migrants throughout the migration process would be useful to understanding their risks of STIs/HIV;

d. Research should be undertaken to consider destination country-specific migrant experiences to enable custom interventions;

e. More research should examine the health status of cross-border and irregular migrants, who are not frequently covered in current literature;

    i. Research should be done in the study countries to identify key indicators that are acceptable and useable across the region; and to identify the techniques of promoting the inclusion of migration variables in existing censuses, national statistics, targeted health surveys and routine health information systems, as well as in statistics from sectors such as housing, education, labour and migration.

5.2 Policy and legal frameworks

Policy and legal frameworks that fail to take into account the health needs of migrants negatively impact migrants' right to health and inevitably their overall wellbeing. Policy should be aimed at improving the health of migrants and must consider the interdisciplinary nature of the topic. Countries and communities involved in the migration cycle must harmonize their efforts, support and maintain policy that complies with international standard to ensure that the rights of migrants are upheld. The following are specific recommendations on policy and legal frameworks.

a. The Government of Nepal should ratify the major migration related conventions: Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and UN Protocol to Prevent, Suppress and Punish Trafficking in Persons. Furthermore, Nepal has also not ratified two ILO conventions specific to migration: Migration for Employment Convention (Revised), 1949 and Migrant Workers (Supplementary Provisions), 1975. Ratification of these conventions will show Nepal's commitment to the international community about protecting the rights of migrants.

b. Health issue of migrants should be an essential and 'non-negotiable' component when Nepal establishes bilateral labour agreements and MOUs with any labour receiving country.

c. The Government of Nepal should create effective health related foreign policies, especially at the diplomatic level so that all high level diplomats show concern and take necessary action if any Nepali citizen faces any problem related to his/her life and health risks.

d. Involvement of a third-party overseeing authority or development of stricter regulations should be applied to minimize contract alteration and ensure agencies or employers adhere to their contractual commitments.

e. The Government of Nepal should take into consideration the problems faced by undocumented migrants and form comprehensive policies to include them under the umbrella of protection and promotion. This can be done by including migration issue as an agenda for South Asian Association for Regional Cooperation (SAARC) processes.

5.3 Migrant sensitive health systems

Health systems have been challenged to provide services inclusive of migrants throughout the migration process. In addressing the health needs of migrants, the public health approach should ensure that the health rights of migrants are upheld; disparities in access and health status should be avoided; excess mortality and morbidity should be reduced; and the negative impact of the migration process should be minimized. The aim of migrant sensitive health systems is to incorporate the needs of migrants so as to facilitate their access to health services in the countries of origin, transit and destination. The following are specific recommendations on migrant sensitive health systems.

a. Agencies and employers should take on increased responsibility for the wellbeing of migrants they process, particularly with regard to health-care coverage and providing information on the living and working environment.

b. The Government of Nepal should continue to invest in improved health infrastructure and health provider capacity, particularly in rural areas. This should cover training and dissemination of guidelines to ensure implementation of SOPs such as informed consent, sharing of test results, and post-test counselling, as well as equitable and ethical treatment of migrants.

c. Integration of migrant health into the health-care system and recognition of migrants as a particular group with their own health risks and needs should be promoted through capacity building sessions as well as regular staff meetings with both medical and migration staff to encourage exchange of knowledge and best practices.

d. The Government of Nepal should take further steps to monitor and regulate the activities of local brokers, recruitment agencies, and health examination facilities. This should include standardizing pre-departure orientations and health examinations, ethical compliance, and policies related to health insurance coverage.

e. Use of popular media, particularly television channels and radio stations, should be optimised to disseminate health messages targeting migrants both in the country of origin and destination. Emphasis should be placed on providing applicable information to female populations, both those intending to migrate, as well as those who remain behind to care for dependents of migrants.

f. Health provider expertise should be utilized for improved health education. Improved health materials should be developed, using effective content and language.

i. Using the aforementioned means, migrants should be provided comprehensive and practical information on;

ii. Specific health issues, including relevant communicable diseases such as HIV, TB, and Hepatitis; non-communicable diseases; occupational hazards; mental health problems, including those related to sexual violence; as well as the validity of seeking health-care for these conditions;

iii. Availability of health-care and health insurance, as well as relevant terms and conditions;

iv. The non-negotiable importance of condom use.

g. Employers and agencies should ensure that migrants have access to pre-departure orientations which feature health information. Content should be standardised and should encompass general medical check-ups, immigrant rights and access to health-care and health-care financing in the destination country, as well as specific diseases and conditions related to their work, including comprehensive information on HIV/AIDS, Tuberculosis, mental health, and sexual violence. In countries where periodic medical exams are carried out for labour migrants, exams should be enhanced to include health information dissemination to address knowledge gaps using a language recipients understand and in a culturally appropriate manner.

5.4 Partnerships, networks and multi country frameworks

Sound management of migration requires collaboration and cooperation at the global, regional, inter-regional and national levels, as well as with sectors and institutions involved in the migration process. Specifically alliances with and engagement of civil society organisations and the private sector are integral to ensure migrants health rights are upheld and that they have sustained access to health services in countries of origin, transit and destination. The following are specific recommendations on partnerships, networks and multi-country frameworks.

a. Interactions should take place in the form of discussions, meetings and conferences with representations from government, private agencies, NGOs/INGOs and migrants to come up with a comprehensive policy and implementation mechanism relating to addressing the health vulnerabilities of migrants.

b. The Government of Nepal should take initiatives of inter-ministerial coordination between stakeholder agencies, especially Ministry of Foreign Affairs, Ministry of Labour and Employment and Ministry of Health to facilitate the foreign employment process. The National Human Rights Commission and the National Women Commission should also be included in this national level broader coordination to strengthen monitoring mechanism of health rights of migrants.

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ANNEXES

Annex 1: Bivariate and multivariate tables

Appendix 1.1: T-test/logistic regression comparing demographic features of departing and returnee migrants

	Total % (n) or Mean (SD; range)	Departing % (n) or Mean (SD; range)	Returnee % (n) or Mean (SD; range)	OR/ T-test difference (CI)	P
Gender(n=411)					
Men	94% (386)	95% (192)	92% (194)	0.6 (0.2. 1.3)	0.183
Women	6% (25)	4% (9)	8% (16)		
Age(n=411)	29.5 (17-53)	27.1 (6.6; 17-48)	31.7 (6.7; 18-53)	4.5 (5.8. 3.2)	<0.001***
Marital Status					
Never married Married Widowed/Divorced/ Separated	27% (110) 73% (299) <1% (2)	41% (82) 59% (119) 0% (0)	13% (28) 86% (180) 1% (2)	0.2 (0.1. 0.4) +	<0.001***
History of formal education (n=411)	93% (381)	94%(188)	92%(193)	1.2 (0.6. 2.7)	0.527
Highest level of education(n=411) No formal education Below Primary Primary Secondary College/University	 7% (30) 6% (23) 14% (58) 55% (226) 18% (74)	 6% (13) 5% (11) 14% (28) 52% (106) 21% (43)	 8% (17) 6% (12) 14% (30) 57% (120) 15% (31)	 1.1 (0.9.1.3)	 0.237
Literacy among those with Primary education or less (Ease of letter writing)(n=111)					
Easily With Difficulty Not at all Don't know	47% (52) 39% (43) 14% (15) 1% (1)	37% (19) 46% (24) 15% (8) 2% (1)	56% (33) 32% (19) 12% (7) 0% (0)	1 (-) 2.2 (1.0. 5.0) 2.0 (0.6. 6.3) +	- 0.062 0.247
Employment Agriculture/farming Agriculture worker Industry/Manufacturing Labour worker Technician Services (Public) Services (Private) Domestic worker Professional Jobless Other	 35% (143) 34% (139) 28% (116) 18% (73) 7% (30) 9% (38) 17% (68) 8% (31) 1% (5) 6% (24) 4% (17)	 38% (76) 37% (75) 17% (34) 8% (16) 6% (13) 11% (23) 12% (25) 4% (8) 2% (4) 12% (24) 7% (15)	 32% (67) 30% (64) 39% (82) 27% (57) 8% (17) 7% (15) 20% (43) 11% (23) <1% (1) 0% (0) 1% (2)	1 (-) 0.4 (0.2. 0.6) 1.4 (0.7. 2.8) 0.5 (0.2. 0.9) 3.5 (0.4. 32.3) + +	- <0.001*** 0.418 0.027* 0.265
Average income(n=407)	31.596 (800-150.000)	24.143 (1000-150.000)	20.785 (800 -150.000)	4077 (-624. 8779)	0.089

	Total % (n) or Mean (SD; range)	Departing % (n) or Mean (SD; range)	Returnee % (n) or Mean (SD; range)	OR/ T-test difference (CI)	P
No. of earning members in the family(n=411) 3 or less 4 to 7 8 to 11 12 or more	 10% (43) 71% (292) 16% (65) 3% (11)	 11%(22) 67% (134) 16% (65) 3% (11)	 10% (21) 75% (158) 12% (26) 2% (5)	 LR: 1.2 (0.9. 1.7)	0.219
Total number of family members					
1 2-3 4-6	44% (182) 47% (193) 8% (36)	39% (79) 51% (103) 9% (19)	49% (103) 43% (90) 8% (17)	LR: 1.3 (1.0. 1.8)	0.078
Total		**201**	**210**		

* <.05 p-value

** <.01 p-value

*** <.001 p-value

+ Excluded 'Do not know'/'Other'/or groups with too low n for analysis

Appendix 1.2: Job categorization and recoding

Primary	Secondary	Tertiary		Professional	Other	
1. Agriculture/ farming	2. Industry - unskilled	3. Services (Public) - includes desk job and management	4. Services (Private)	5. Professional (medical. academic)	6. Jobless	7. Not classified
4. Farmer/ agricultural worker	1. Labour	22. Beautician	2. Domestic work	15. Teacher	6. Unemployed	30. Foreign job
10. Poultry farm/ fresh house	3. Construction worker	7. Contractor	9. Security guard	21. Veterinary	16. Student	
	13. Painting in plastic company	8. Business	11. Care taker			
	12. Mechanical worker	20. Salesman	18. Driver			
	17. Bar painter	23. Operator	25. Cook			
	5. Technician	26. Coordinator in travel agency	28. Private job holder			
	24. Carpenter	29. Government job holder				
	19. Sewing					

Appendix 1.3: Past and intended mobility patterns, by departing and returnee migrants

Region and country	Departing (Intended Country)		Returnee (Past Country)	
	%	n	%	n
Middle East	95%	191	70%	148
Qatar	23%	47	29%	61
Saudi Arabia	48%	96	23%	48
United Arab Emirates	20%	40	12%	25
Oman	3%	7	<1%	1
Bahrain	<1%	1	1%	3
Iraq	0	0	1%	3
Kuwait	0	0	3%	6
Lebanon	0	0	<1%	1
South East Asia	5%	10	26%	55
Malaysia	5%	10	26%	55
South Asia	0	0	1%	3
Afghanistan	0	0	1%	3
East Asia	0	0	<1%	1
Japan	0	0	<1%	1
Europe	0	0	<1%	2
Denmark	0	0	<1%	1
Russia	0	0	<1%	1
Africa	0	0	<1%	1
South Africa	0	0	<1%	1
Total		**201**		**210**

Appendix 1.4: Past and intended time abroad, by departing and returnee migrants

	Departing (Intended Country)		Returnee (Past Country)	
	%	n	%	n
1 year or less	0%	0	<1%	1
Between 1 and 3 years	73%	147	57%	119
Between 3 and 5 years	24%	49	30%	62
Between 5 and 10 years	2%	5	13%	27
10 years and above	0%	0	<1%	1
Total		**201**		**210**

Appendix 1.5: Past mobility patterns among returnee migrants

	All returning		Men		Women	
	%	n	%	n	%	n
When did you return home?						
Less than 3 months	37%	78	36%	69	56%	9
3 to 6 months	22%	47	24%	46	6%	1
6 to 12 months	34%	72	36%	70	13%	2
12 or more months	6%	13	5%	9	25%	4
How many times have you been abroad for work?						
1	43.8%	92	43.3%	84	50.0%	8
2	39.5%	83	40.2%	78	31.3%	5
3	9.5%	20	9.8%	19	6.3%	1
4 to 5	4.8%	10	4.6%	9	6.3%	1
6 and above	2.4%	5	2.1%	4	6.3%	1
Median	2 (1 – 8)		2 (1 – 8)		1.5 (1 – 7)	
Do you plan to go again?						
Yes	68.6%	144	70.1%	136	50.0%	8
No	31.4%	66	29.9%	58	50.0%	8
Total		**201**		**194**		**16**

[1] Total exceeds 100% due to multiple responses chosen

Appendix 1.6: Migration burdens and assistance

	Total		**Departing**		**Returnee**		**Men**		**Women**	
	%	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
Financial arrangements	40.4%	166	31.8%	64	48.6%	102	55.6%	159	28.0%	7
No burden	37.7%	155	46.8%	94	29.0%	61	49.7%	142	52.0%	13
Bribes to the authorities	5.4%	22	1.5%	3	9.0%	19	7.0%	20	8.0%	2
Work information not provided	5.6%	23	4.5%	9	6.7%	14	4.9%	14	36.0%	9
Discrimination/Abuses	4.1%	17	2.5%	5	5.7%	12	5.2%	15	8.0%	2
Need to come to Kathmandu for processing	3.2%	13	2.0%	4	4.3%	9	4.5%	13	0.0%	0
Difficult/lengthy process obtaining visa	5.6%	23	7.0%	14	4.3%	9	8.0%	23	0.0%	0
Health check-up	3.6%	15	3.0%	6	4.3%	9	4.9%	14	4.0%	1
No transparency/government help	2.2%	9	1.0%	2	3.3%	7	3.1%	9	0.0%	0
Proxy manpower	1.2%	5	0.0%	0	2.4%	5	1.7%	5	0.0%	0
Did not get work and salary as per the agreement	1.0%	4	0.0%	0	1.9%	4	1.4%	4	0.0%	0
Others	4.6%	19	2.5%	5	6.7%	14	6.3%	18	4.0%	1
Total		**411**		**201**		**210**		**386**		**25**

Appendix 1.7: History of illness in last 6 months

	All		Men		Women	
	%	n	%	n	%	n
Have you fallen ill in the last six months?						
Yes	23.6%	97	23.1%	89	32.0%	8
No	76.4%	314	77.0%	297	68.0%	17
Total		411		386		25
From whom did you seek advice/treatment?						
Advice not sought	53.5%	220	53.9%	208	48.0%	12
Private health provider	29.2%	120	28.5%	110	40.0%	10
Public health provider	12.7%	52	13.2%	51	4.0%	1
Friends/relatives	3.2%	13	3.1%	12	4.0%	1
Village quack/shop/pharmacy	2.4%	10	2.3%	9	4.0%	1
Semi government hospital	0.5%	2	0.5%	2	0.0%	0
Homeopathy	0.2%	1	0.3%	1	0.0%	0
Health camp	0.2%	1	0.3%	1	0.0%	0

Appendix 1.8: Determinants of history of illness in the last 6 months (multivariate logistic regression analysis)

Independent variable	Odds ratio	z	2sided P value	95% CI
Sex (Male = 0. Female = 1)	1.48	0.87	0.386	0.61-3.56
Age	0.99	-0.72	0.473	0.95-1.02
Category worker* (Returnee = 0. Departing =1)	0.57	-2.24	0.025	0.34-0.93
Return	1.10	2.39	0.017	1.02-1.19
Income*	0.99	-0.40	0.693	1.00-1.00

*Controlled for sex and age

Appendix 1.9: History of illness in last 6 months

	Total		Men		Women	
	%	n	%	n	%	n
Did you suffer from an illness in your destination country?						
Yes	79.5%	167	79.9%	155	75.0%	12
No	20.5%	43	20.1%	39	25.0%	4
Did you seek health-care when you last felt sick in your destination country?						
Yes	90.4%	151	91.6	142	75.0%	9
No	9.6%	16	8.4%	13	25.0%	3
Total		**210**		**194**		**16**

	Total		Men		Women	
	%	n	%	n	%	n
What type of illness did you suffer from? [1]						
Minor health problems	81.5%	123	81.7%	116	77.8%	7
Occupational hazards	12.6%	19	12.7%	18	11.1%	1
Typhoid	3.3%	5	3.5%	5	0.0%	0
Respiratory problems/disease	2.6%	4	2.8%	4	0.0%	0
Renal stone	2.6%	4	2.8%	4	0.0%	0
Vein related problem	2.6%	4	2.8%	4	0.0%	0
Hypertension	2.0%	3	2.1%	3	0.0%	0
TB	2.0%	3	2.1%	3	0.0%	0
Heart disease/diabetes	2.0%	3	2.1%	3	0.0%	0
Sexual and Reproductive Health	1.3%	2	0.0%	0	22.2%	2
Bone/joint problem	1.3%	2	1.4%	2	0.0%	0
Mental illness	0.7%	1	0.7%	1	0.0%	0
Total		**151**		**142**		**9**

[1] Total exceeds 100% due to multiple responses chosen

Appendix 1.10: Risk sexual behaviour among all migrants

	Total		Men		Women	
	% / median	N / range	% / median	N / range	% / median	N / range
Have you ever had sex?						
Yes	87.8%	361	88.9%	343	72.0%	18
No	12.2%	50	11.1%	43	28.0%	7
Have you had sex in the past year?						
Yes	80.8%	332	82.6%	319	52.0%	13
No	19.2%	79	17.4%	67	48.0%	12
Number of partners in the past six months	1	0-15	1	0-15	1	0-1
Types of partners had sex with						
Spouse	69.8%	287	71.2%	275	48.0%	12
Girlfriend/boyfriend	10.7%	44	11.1%	43	4.0%	1
Commercial sex worker	2.9%	12	3.1%	12	0.0%	0
Casual acquaintance	1.9%	8	2.1%	8	0.0%	0
Friends	6.1%	25	6.5%	25	0.0%	0
Relative	0.2%	1	0.3%	1	0.0%	0
Total		**411**		**386**		**25**

Appendix 1.11: Condom use with spouse (among those who reported sex with spouse in past year)

	Total		Men		Women	
	%	n	%	n	%	n
How often do you use a condom when you have sex with your spouse?						
Always	9.1%	26	9.1%	25	8.3%	1
Sometimes	26.1%	75	26.9%	74	8.3%	1
Never	64.8%	186	64.0%	176	83.3%	10
Did you use a condom at last intercourse with your spouse?						
Yes	18.1%	52	18.2%	50	16.7%	2
No	81.9%	235	81.8%	225	83.3%	10
Total		287		275		12
Why did you use a condom? (among those who Always or Sometimes use a condom)						
Prevent pregnancy	97.0%	98	97.0%	96	100.0%	2
Prevent STI/STD	5.9%	6	6.1%	6	0%	0
Prevent HIV	4.0%	4	4.0%	4	0%	0
Total		**101**		**99**		**2**

Appendix 1.12: Condom use with girlfriend/boyfriend (among those who reported sex with girlfriend/boyfriend in past year)

	Total		Men		Women	
	%	n	%	n	%	n
How often do you use a condom when you have sex with your girlfriend/boyfriend?						
Always	40.9%	18	39.5%	17	100.0%	1
Sometimes	20.5%	9	20.9%	9	0%	0
Never	38.6%	17	39.5%	17	0%	0
Did you use a condom at last intercourse with your girlfriend/boyfriend?						
Yes	54.5%	24	53.5%	23	100.0%	1
No	45.5%	20	46.5%	20	0	0
Total		44		43		1
Why did you use a condom with your girlfriend/boyfriend? (among those who always or sometimes use a condom)						
Prevent pregnancy	77.8%	21	80.8%	21	0%	0
Prevent STI/STD	59.3%	16	61.5%	15	100.0%	1
Prevent HIV	48.1%	13	50.0%	13	0%	0
Total		**27**		**26**		**1**

Appendix 1.13: Condom use with friend (among those who reported sex with friend in past year)

	Total		Men		Women	
	%	n	%	n	%	n
How often do you use a condom when you have sex with a friend?						
Always	76.0%	19	76.0%	19	-	-
Sometimes	4.0%	1	4.0%	1	-	-
Never	20.0%	5	20.0%	5	-	-
Did you use a condom at last intercourse with a friend?						
Yes	76.0%	19	76.0%	19	-	-
No	24.0%	6	24.0%	6	-	-
Total		25		25		0
Why did you use a condom with your friend?						
Prevent pregnancy	32.0%	8	32.0%	8	-	-
Prevent STI/STD	68.0%	17	68.0%	17	-	-
Prevent HIV	36.0%	9	36.0%	9	-	-
Total		**25**		**25**		**0**

Appendix 1.14: Condom use with sex worker (among those who reported sex with sex worker in past year)

	Total		Men		Women	
	%	n	%	n	%	n
How often do you use a condom when you have sex with a sex worker?						
Always	83.3%	10	83.3%	10	-	-
Sometimes	8.3%	1	8.3%	1	-	-
Never	8.3%	1	8.3%	1	-	-
Did you use a condom at last intercourse with a sex worker?						
Yes	83.3%	10	83.3%	10	-	-
No	16.7%	2	16.7%	2	-	-
Total		12		12		0
Why did you use a condom with a sex worker? (among those who Always or Sometimes use a condom)						
Prevent pregnancy	18.2%	2	32.0%	8	-	-
Prevent STI/STD	81.8%	9	68.0%	17	-	-
Prevent HIV	90.9%	10	36.0%	9	-	-
Total		**11**		**11**		**0**

Appendix 1.15: Condom use with a casual acquaintance (among those who reported sex with casual acquaintance in past year)

	Total		Men		Women	
	%	n	%	n	%	n
How often do you use a condom when you have sex with a casual acquaintance?						
Always	37.5%	3	37.5%	3	-	-
Sometimes	12.5%	1	12.5%	1	-	-
Never	50.0%	4	50.0%	4	-	-
Did you use a condom at last intercourse with a casual acquaintance?						
Yes	37.5%	3	37.5%	3	-	-
No	62.5%	5	62.5%	5	-	-
Total		**8**		**8**		**0**
Why did you use a condom with a casual acquaintance? (among those who Always or Sometimes use a condom)						
Prevent pregnancy	25.0%	1	25.0%	1	-	-
Prevent STI/STD	100.0%	4	100.0%	4	-	-
Prevent HIV	100.0%	4	100.0%	4	-	-
Total		**4**		**4**		**0**

Appendix 1.16: Sexual behaviour among departing migrants (among those who reported sex with casual acquaintance in past year)

	Total		Men		Women	
	%	n	%	n	%	n
Did you have sex in the past year?						
Yes	72.6%	146	74.5%	143	33.3%	3
No	27.4%	55	25.5%	49	66.6%	6
How many partners did you have in the past year?						
None	27.4%	55	25.5%	49	66.6%	6
1 or less per year	62.7%	126	64.1%	123	33.3%	3
2 per year	5.0%	10	5.2%	10	0.0%	0
3 to 10 per year	5.0%	10	5.2%	10	0.0%	0
11 and above per year	0.0%	0	0.0%	0	0.0%	0
Median	1	0-6	1	0-6	1	0-1
Types of partners (as % of all departing)						
Spouse	56.7%	114	58.3%	112	22.2%	2
Girlfriend/boyfriend	15.9%	32	16.1%	31	11.1%	1
Commercial sex worker	1.5%	3	1.6%	3	0.0%	0
Casual acquaintance	1.5%	3	1.6%	3	0.0%	0
Friends	7.0%	14	7.3%	14	0.0%	0
Relative	0.0%	0	0.0%	0	0.0%	0
Total		**201**		**192**		**9**

	Total		Men		Women	
	%	n	%	n	%	n
Types of partners (as % of departing who had had sex in past year)						
Spouse	78.1%	114	78.3%	112	66. 7%	2
Girlfriend/boyfriend	21.9%	32	21.7%	31	33.3%	1
Commercial sex worker	2.1%	3	2.1%	3	0.0%	0
Casual acquaintance	2.1%	3	2.1%	3	0.0%	0
Friends	9.6%	14	9.8%	14	0.0%	0
Relative	0.00%	0	0.0%	0	0.0%	0
Total		**146**		**143**		**3**
Condom use at last sex with specified partners						
Spouse (n=144)	19.3%	22	19.6%	4	0.0%	0
Girlfriend/boyfriend (n=32)	62.5%	20	61.3%	19	100.0%	1
Commercial sex worker (n=3)	66.7%	2	66.7%	2	-	-
Casual acquaintance (n=3)	66.7%	2	66.7%	2	-	-
Friends (n=14)	78.6%	11	78.6%	11	-	-

Appendix 1.17: Sexual behaviour of returnee migrants in country of destination

	Total		Men		Women	
	%	n	%	n	%	n
Did you have sex abroad?						
Yes	13.8%	29	13.9%	27	12.5%	2
No	86.2%	181	86.1%	167	87.5%	14
How many partners did you have while abroad?						
None	86.2%	181	86.1%	167	87.5%	14
1 or less per year	8.6%	18	8.2%	16	12.5%	2
2 per year	2.4%	5	2.6%	5	0.0%	0
3 to 10 per year	1.4%	3	1.5%	3	0.0%	0
11 and above per year	1.4%	3	1.5%	3	0.0%	0
Median	2	0-35	2	0-35	1	0-1
How many partners did you have abroad? (Adjusted: per year)	2.5	0-23	3	0-23	0	0-1
Types of partners had sex with (as % of all departing)						
Spouse	1.0%	2	0.0%	0	12.5%	2
Girlfriend/boyfriend	4.3%	9	4.6%	9	0.0%	0
Commercial sex worker	6.7%	14	7.2%	14	0.0%	0
Casual acquaintance	2.4%	5	2.6%	5	0.0%	0
Friends	5.2%	11	5.7%	11	0.0%	0
Total		**210**		**194**		**16**

	Total		Men		Women	
	%	n	%	n	%	n
Types of partners had sex with (as % of departing who had had sex in past year)						
Spouse	6.90%	2	0.00%	0	100.00%	2
Girlfriend/boyfriend	31.03%	9	11.39%	9	0.00%	0
Commercial sex worker	48.28%	14	17.72%	14	0.00%	0
Casual acquaintance	17.24%	5	6.33%	5	0.00%	0
Friends	37.93%	11	13.92%	11	0.00%	0
Total		**29**		**27**		**2**
Condom usage at last sex with specified partners						
Spouse (n=2)	100.0%	2	-	-	100.0%	2
Girlfriend/boyfriend (n=9)	88.9%	8	88.9%	8	-	-
Commercial sex worker (n=14)	92.9%	13	92.9%	13	-	-
Casual acquaintance (n=5)	100.0%	5	100.0%	5	-	-
Friends (n=11)	81.8%	9	81.8%	9	-	-

Appendix 1.18: Sexual violence in destination country

	Total		Men		Women	
	%	n	%	n	%	n
Have you ever been forced to have sexual intercourse?						
Yes	42.4%	89	40.2%	78	68.8%	11
No	51.0%	107	54.1%	105	12.5%	2
Don't know	6.7%	14	5.7%	11	18.8%	3
Do you know anyone of your peers who has been sexually abused during their work abroad?						
Yes	1.9%	4	1.0%	2	12.5%	2
No	82.9%	174	83.5%	162	75.0%	12
No sexual contact	15.2%	32	15.5%	30	12.5%	2
Total		**210**		**194**		**16**
If yes, by whom?						
Friends	75.0%	3	100.0%	2	50.0%	1
Employers	25.0%	1	0%	0	50.0%	1
Total		**4**		**2**		**2**

Appendix 1.19: Health-care accessibility in country of origin

	Total		Men		Women	
	%	n	%	n	%	n
Have you heard of places with migrant services?						
Yes	14.4%	59	14.8%	57	8.0%	2
No	85.6%	352	85.2%	329	92.0%	12
If yes, where?						
Private centre	42.4%	25	43.9%	25	0	0
NGO	23.7%	14	24.6%	14	0	0
Government centres at district level	22.0%	13	19.3%	11	100%	2
Government centres at community level	8.5%	5	8.8%	5	0	0
Manpower company	1.7%	1	1.8%	1	0	0
Do not remember	1.7%	1	1.8%	1	0	0
Can you and your family use public health facilities anytime?						
Yes	75.5%	310	75.9%	293	68.0%	17
No	24.6%	101	24.1%	93	32.0%	18
Do you get free services from any of these facilities?						
Yes	81.5%	335	81.1%	313	88.0%	22
No	15.1%	62	15.3%	59	12.0%	4
How satisfied are you with the health facilities in your community?						
Very satisfied	5.4%	22	4.7%	18	16.0%	4
Satisfied	51.1%	210	51.6%	199	44.0%	11
Slightly satisfied	22.9%	94	23.3%	90	16.0%	4
Unsatisfied	18.3%	75	18.1%	70	20.0%	5
Don't know	2.4%	10	2.3%	9	4.0%	1
Total		**411**		**386**		**25**

Appendix 1.20: Difficulties accessing health-care in country of origin

	Total		Men		Women	
	%	n	%	n	%	n
Have you ever faced difficulties accessing health-care services?						
Yes	13.6%	56	14.3%	55	4.0%	1
No	62.3%	256	62.2%	240	64.0%	16
Health-care not sought	24.1%	99	23.6%	91	32.0%	8
Total		**411**		**386**		**25**

	Total		Men		Women	
	%	n	%	n	%	n
Have you faced difficulties accessing health-care services?						
Yes	18.0%	56	18.6%	55	5.9%	1
No	82.0%	256	81.4%	240	94.1%	16
Total		**312**		**295**		**17**
What barriers did you face when seeking health-care?						
Long distance	51.8%	29	52.7%	29	0.0%	0
Doctors not available/lack of skilled doctors	26.8%	15	25.5%	14	100.0%	1
Unaffordable cost	14.3%	8	14.5%	8	0.0%	0
Lack of information	10.7%	6	10.9%	6	0.0%	0
Long waiting time	8.9%	5	9.1%	5	0.0%	0
Lack of medicines	7.1%	4	7.3%	4	0.0%	0
Lack of transportation facilities	5.4%	3	5.5%	3	0.0%	0
Discrimination due to socioeconomic status	5.4%	3	5.5%	3	0.0%	0
Inconvenient operating time	3.6%	2	3.6%	2	0.0%	0
Discrimination due to migration status	3.6%	2	3.6%	2	0.0%	0
Company did not allow check-up at company's clinic	1.8%	1	1.8%	1	0.0%	0
Total		**56**		**55**		**1**

Appendix 1.21: Health-care in destination country

	Total		Men		Women	
	%	n	%	n	%	n
Have you heard of places with migrant services?						
Yes	81.9%	172	83.0%	161	68.8%	11
No	18.1%	38	17.0%	33	31.3%	5
Total		**210**		**194**		**16**
If yes, where?						
Government organization	81.4%	140	80.7%	130	90.9%	10
Non-government organization	7.6%	13	8.1%	13	0.0%	0
Private organization	79.7%	137	80.1%	129	72.7%	8
Clinic run by job company	1.7%	3	1.9%	3	0.0%	0
Total		**172**		**161**		**11**
Can you and your family use public health facilities anytime?						
Yes	72.4%	152	71.7%	139	81.3%	13
No	17.6%	37	18.0%	35	12.5%	2
Don't know	10.0%	21	10.3%	29	6.3%	1

	Total		Men		Women	
	%	n	%	n	%	n
How satisfied are you with the health facilities in your community?						
Very satisfied	21.4%	45	20.1%	39	37.5%	6
Satisfied	47.1%	99	47.9%	93	37.5%	6
Slightly unsatisfied	14.3%	30	13.9%	27	18.6%	3
Unsatisfied	10.5%	22	11.3%	22	0	0
Don't know	6.7%	14	6.7%	13	6.3%	1
Total		**210**		**194**		**16**

Appendix 1.22: Difficulties accessing health-care in destination country

	Total		Men		Women	
	%	n	%	n	%	n
While working abroad, did you have health coverage?						
Yes	50.5%	106	54.1%	105	6.3%	1
No	42.4%	89	39.7%	77	75.0%	12
Don't know	7.1%	15	6.2%	12	18.8%	3
Have you faced difficulties accessing health-care services?						
Yes	23.3%	49	24.2%	47	12.5%	2
No	71.9%	151	71.7%	139	75.0%	12
Don't know	4.8%	10	4.1%	8	12.5%	2
Total		**210**		**194**		**16**
What difficulties did you face?						
Lack of information/complex system	12.2%	6	10.6%	5	50.0%	1
Fear of discrimination. of being unwelcome. or denied	12.2%	6	10.6%	5	50.0%	1
Inconvenient operating times	10.2%	5	10.6%	5	0.0%	0
Long distance	8.2%	4	8.5%	4	0.0%	0
Long waiting time	6.1%	3	6.4%	3	0.0%	0
Discrimination due to socioeconomic status	4.1%	2	2.1%	1	50.0%	1
Denied health-care	4.1%	2	4.3%	2	0.0%	0
schedule of services not maintained	2.0%	1	2.1%	1	0.0%	0
Fear of being reported or arrested	2.0%	1	2.1%	1	0.0%	0
Unprofessional conduct /improper check-up	2.0%	1	2.1%	1	0.0%	0
Total		**49**		**47**		**2**

Appendix 1.23: History of mandatory health examination prior to departure

	Total	Men	Women	Departing	Returnee
	% (n)	% (n)	% (n)	% (n)	% (n)
Have you had a health examination prior to departure? (n=411)					
Yes	67.2% (276)	66.6% (257)	76.0% (19)	40.3% (81)	92.9% (195)
No	32.9% (135)	22.4% (129)	24.0% (6)	60% (120)	7.1% (15)
Total	(411)	(386)	(25)	(201)	(210)
Will you have mandatory health examination prior to departure? (departing migrants)					
Yes	100% (120)	100% (114)	100% (6)	100% (120)	n/a
Total	(120)	(114)	(6)	(120)	n/a

Appendix 1.24: Experience of mandatory health examination prior to departure

	Total		Men		Women	
	%	n	%	n	%	n
From where did you get health examination medical tests done?						
Private agency	33.3%	92	33.9%	87	26.3%	5
Employer/agency	31.2%	86	31.5%	81	26.3%	5
NGO	16.7%	46	17.5%	45	5.3%	1
Govt. centre in the capital	11.2%	31	11.7%	30	5.3%	1
Agency in India	4.0%	11	2.0%	5	31.6%	6
Govt. centre at district level	2.1%	6	2.0%	5	5.3%	1
Govt. centre at provincial level	1.1%	3	1.2%	3	0.0%	0
Semi-government agency	0.4%	1	0.4%	1	0.0%	0
What kind of health check-up did you have?						
General health check-up	57.6%	159	57.2%	147	63.2%	12
X-ray/video X-ray	57.6%	159	57.6%	148	57.9%	11
Blood test	55.4%	153	56.4%	145	42.1%	8
Urine test	40.9%	113	40.5%	104	47.4%	9
HIV test	38.0%	105	38.9%	100	26.3%	5
TB test	20.3%	56	19.8%	51	26.3%	5
STI test	9.8%	27	9.7%	25	10.5%	2
Stool test	7.2%	20	5.4%	14	31.6%	6
Eye check-up	7.2%	20	7.0%	18	10.5%	2
Ears/nose/throat	2.2%	6	1.2%	3	15.8%	3
Blood pressure	1.8%	5	1.9%	5	0.0%	0
Other	4.0%	11	4.3%	11	0.0%	0
Total		**276**		**257**		**19**

Appendix 1.25: Mandatory health examination financing

	Total		Men		Women	
	%	n	%	n	%	n
Are these tests free?						
Yes	2.5%	7	2.3%	6	5.3%	1
No	97.5%	269	97.7%	251	94.7%	18
Total		**276**		**257**		**19**
If no, who paid for the treatment?						
Self	92.2%	248	95.2%	239	50.0%	9
Employer/agency	6.7%	18	4.4%	11	38.9%	7
Relatives	0.7%	2	0.4%	1	5.6%	1
Friends	0.4%	1	0		5.6%	1
Total		**269**		**251**		**18**

Appendix 1.26: Health-care seeking in country of origin

	Total		Men		Women	
	%	n	%	n	%	n
Did you seek health-care when last sick in your home country?						
Yes	60.8%*	250	60.7%	233	68.0%	17
No	9.0%	37	9.3%	36	4.0%	1
N/a (never sick)	30.2%	124	30.1%	117	28.0%	7
Total		411		386		25
Who did you consult when you were last sick?						
Private health provider	46.7%	134	48.0%	129	27.8%	5
Public health provider	40.1%	115	40.2%	108	38.9%	7
Village quack/shop/pharmacy	9.8%	28	8.9%	24	22.2%	4
Home Remedy	1.1%	3	0.4%	1	11.1%	2
Semi-government hospital	0.7%	2	0.7%	2	0	0
Community hospital	0.4%	1	0.4%	1	0	0
Homeopathy	0.4%	1	0.4%	1	0	0
Ayurvedic hospital	0.4%	1	0.4%	1	0	0
Total		**287**		**269**		**18**

*87.1% of those with history of illness sought health-care when last sick.

Appendix 1.27: Health-care seeking in destination country among returnee migrants

	Total		Men		Women	
	%	n	%	n	%	n
Did you seek health-care when you last felt sick in your destination country?						
Yes	90.4%	151	91.6	142	75.0%	9
No	9.6%	16	8.4%	13	25.0%	3
Total		210		194		16
What medical services did you seek abroad?						
Medical treatment	82.1%	124	81.7%	116	88.9%	8
Medical check-up	74.2%	112	73.9%	105	77.8%	7
Lab tests. Blood tests	25.2%	38	24.6%	35	33.3%	3
X Ray	21.9%	33	21.8%	31	22.2%	2
Physiotherapy	2.6%	4	2.8%	4	0.0%	0
Surgery	2.0%	3	2.1%	3	0.0%	0
Optical care (e.g. Glasses)	2.0%	3	2.1%	3	0.0%	0
Dental care	1.3%	2	0.7%	1	11.1%	1
Maternity care	0.7%	1	0.0%	0	11.1%	1
MRI	0.7%	1	0.7%	1	0.0%	0
Counselling	0.7%	1	0.7%	1	0.0%	0
Where did you go when sick abroad?						
Private clinic	54.3%	82	54.9%	78	44.4%	4
Government hospital	37.1%	56	35.2%	50	66.7%	6
Shop/pharmacy	4.0%	6	4.2%	6	0.0%	0
Medical unit/clinic	4.0%	6	4.2%	6	0.0%	0
Return home	2.0%	3	2.1%	3	0.0%	0
Semi-government institution	1.3%	2	1.4%	2	0.0%	0
Friends/relatives	0.7%	1	0.7%	1	0.0%	0
Who accompanied you/assisted you to get health-care?						
Employer/agency	51.0%	77	50.1%	72	55.6%	5
Friends/relatives	28.5%	43	28.1%	40	33.3%	3
None	20.5%	31	21.1%	30	11.1%	1
Total		151		142		9

Appendix 1.28: Post-return medical check-ups among returnee migrants

	Total		Men		Women	
	%	n	%	n	%	n
Do you think it is necessary to do a health check-up after return?						
Yes	65.2%	137	67.0%	130	43.8%	7
No	32.4%	68	30.4%	59	56.3%	9
Don't know	2.4%	5	2.6%	5	0	
Did you have a check-up after return?						
Yes	26.1%	55	27.3%	53	12.5%	2
No	73.8%	155	73.7%	141	87.5%	14
Total		**210**		**194**		**16**
When did you get the medical check-up?						
Within a week	40.0%	22	37.7%	20	100.0%	2
Within a month	32.7%	18	34.0%	18	0	0
In 3 months' time	3.6%	2	3.8%	2	0	0
After 3 months	23.6%	13	24.5%	13	0	0
Total		**55**		**53**		**2**
Location of post-return health check-up						
Private centre	71.9%	39	71.7%	38	50.0%	1
Government centre	21.8%	12	20.8%	11	50.0%	1
NGO	3.6%	2	3.8%	2	0	0
Semi-governmental	1.8%	1	1.9%	1	0	0
Other	1.8%	1	1.9%	1	0	0
Total		**55**		**53**		**2**

Appendix 1.29: Knowledge of disease among migrants

	Total		Men		Women	
	%	n	%	n	%	n
Do you think there are some diseases that could be transmitted from the migrants to their partners and other family members?						
Yes	88.6%	186	90.2%	175	68.8%	11
No	8.1%	17	8.3%	16	6.3%	1
Don't know	3.3%	7	1.6%	3	25.0%	4
Total		**411**		**386**		**25**
What kind of diseases do you think can be transmitted from migrants to partner or family members?						
HIV/AIDS	80.1%	149	79.4%	139	90.9%	10
STIs	39.2%	73	40.0%	70	27.3%	3
TB	36.0%	67	36.0%	63	36.4%	4
Flu	4.3%	8	4.6%	8	0.0%	0
Skin diseases	2.7%	5	2.3%	4	9.1%	1
Cold and cough	2.7%	5	2.3%	4	9.1%	1
Allergy	2.2%	4	2.3%	4	0.0%	0
Malaria	1.6%	3	1.7%	3	0.0%	0
Respiratory disease	1.6%	3	1.7%	3	0.0%	0
Hepatitis	1.1%	2	1.1%	2	0.0%	0
Epilepsy	0.5%	1	0.6%	1	0.0%	0
Total		**186**		**175**		**11**
Have you ever heard of HIV?						
Yes	94.2%	387	94.6%	365	88.0%	22
No	5.8%	24	5.4%	21	12.0%	3
Have you ever heard of AIDS?						
Yes	96.1%	395	95.6%	370	100%	25
No	3.4%	14	3.6%	14	0	0
Don't know	0.5%	2	0.5%	2	0	0
Total		**411**		**386**		**25**

Appendix 1.30: Exposure of migrants to basic communications

		N	Number				Percent			
			Never	Less than once a week	At least once a week	Every day	Never	Less than once a week	At least once a week	Every day
Total	Newspaper	411	101	99	138	73	25%	24%	34%	18%
	Radio	411	69	37	97	208	17%	9%	24%	51%
	Television	411	41	27	72	271	10%	7%	18%	66%
Newspaper										
Profession	Other	17	2	4	8	3	12%	24%	47%	18%
	Jobless	24	4	8	7	5	17%	33%	29%	21%
	Professional	5	0	1	1	3	0%	20%	20%	60%
	Private	68	21	12	19	16	31%	18%	28%	24%
	Services (Public)	38	8	4	14	12	21%	11%	37%	32%
	Industry/ Manufacturing	116	31	25	45	15	27%	22%	39%	13%
	Agriculture/ Farming	143	35	45	44	19	24%	31%	31%	13%
Age Group	45 and above	15	6	4	2	3	40%	27%	13%	20%
	35 to 44	75	22	17	24	12	29%	23%	32%	16%
	35 to 34	209	52	57	67	33	25%	27%	32%	16%
	20 to 24	96	16	17	40	23	17%	18%	42%	24%
	15 to 19	16	5	4	5	2	31%	25%	31%	13%
Sex	Women	25	11	4	8	2	44%	16%	32%	8%
	Men	386	90	95	130	71	23%	25%	34%	18%
Radio										
Profession	Other	17	3	1	3	10	18%	6%	18%	59%
	Jobless	24	3	4	6	11	13%	17%	25%	46%
	Professional	5	0	1	1	3	0%	20%	20%	60%
	Private	68	14	4	22	28	21%	6%	32%	41%
	Services (Public)	38	10	2	5	21	26%	5%	13%	55%
	Industry/ Manufacturing	116	28	8	30	50	24%	7%	26%	43%
	Agriculture/ Farming	143	11	17	30	85	8%	12%	21%	59%
Age Group	45 and above	15	2	1	3	9	13%	7%	20%	60%
	35 to 44	75	14	9	20	32	19%	12%	27%	43%
	25 to 34	209	41	15	48	105	20%	7%	23%	50%
	20 to 24	96	9	9	24	54	9%	9%	25%	56%
	15 to 19	16	3	3	2	8	19%	19%	13%	50%
Sex	Women	25	6	1	7	11	24%	4%	28%	44%
	Men	386	63	36	90	197	16%	9%	23%	51%
Television										
Profession	Other	17	0	3	4	10	0%	18%	24%	59%
	Jobless	24	1	0	1	22	4%	0%	4%	92%
	Professional	5	0	0	1	4	0%	0%	20%	80%
	Private	68	4	3	10	51	6%	4%	15%	75%
	Services (Public)	38	1	1	4	32	3%	3%	11%	84%
	Industry/ Manufacturing	116	16	7	21	72	14%	6%	18%	62%
	Agriculture/ Farming	143	19	13	31	80	13%	9%	22%	56%
Age Group	45 and above	15	10	5	15	45	67%	33%	100%	300%
	35 to 44	75	10	5	15	45	13%	7%	20%	60%
	35 to 34	209	20	17	38	134	10%	8%	18%	64%
	20 to 24	96	7	3	15	71	7%	3%	16%	74%
	15 to 19	16	3	2	3	8	19%	13%	19%	50%
Sex	Women	25	2	1	1	21	8%	4%	4%	84%
	Men	386	39	26	71	250	10%	7%	18%	65%

Appendix 1.31: Exposure of migrants to internet

		Yes		No	
		%	n	%	n
Total		50.1%	206	49.9%	205
Profession	Other	64.7%	11	35.3%	6
	Jobless	62.5%	15	37.5%	9
	Professional	100%	5	0%	0
	Private	54.4%	37	45.6%	31
	Services (Public)	68.4%	26	31.6%	12
	Industry/Manufacturing	52.6%	61	47.4%	55
	Agriculture/Farming	35.7%	51	64.3%	92
Age Group	45 and above	26.7%	4	73.3%	11
	35 to 44	38.7%	29	61.3%	46
	25 to 34	47.9%	100	52.2%	109
	20 to 24	70.8%	68	29.2%	28
	15 to 19	31.3%	5	68.8%	11
Sex	Women	40.0%	10	60.0%	15
	Men	50.8%	196	49.2%	190

Appendix 1.32: Distribution of health communication materials from health providers in Nepal

	Total		Men		Women	
	%	n	%	n	%	n
Do you get health-related communication materials from the health providers/facilities?						
Yes	64.9%	267	66.6%	257	40.0%	10
No	24.6%	101	23.3%	90	44.0%	11
Don't know	10.5%	43	10.1%	39	16.0%	4
Total		**411**		**386**		**25**
How easy do you understand the contents of these materials?						
Easily understandable	56.9%	152	56.8%	146	60.0%	6
Understandable	33.7%	90	34.2%	88	20.0%	2
With some difficulties	8.6%	23	8.2%	21	20.0%	2
Don't understand	0.8%	2	0.8%	2	0%	0
Total		**267**		**257**		**10**

Appendix 1.33: Health information requested by migrants (in country of origin)

	Total		Men		Women		Departing		Returning	
	%	n	%	n	%	n	%	n	%	n
HIV/AIDS	43.3%	390	43.3%	167	31.8%	8	36.8%	191	49.5%	199
Non-communicable diseases	29.9%	381	30.6%	118	18.3%	5	37.3%	190	22.9%	191
TB	22.4%	373	23.0%	89	8.5%	2	17.9%	189	26.7%	184
STIs	20.9%	374	20.7%	80	13.5%	3	10.0%	190	31.4%	184
Communicable diseases	13.6%	375	14.0%	54	4.5%	1	12.9%	191	14.3%	184
Health services and health providers	10.9%	376	9.9%	38	15.8%	4	7.5%	192	14.3%	184
No need of information	9.7%	377	9.6%	37	8.5%	2	11.9%	193	7.6%	184
Health education	9.2%	378	9.3%	36	4.5%	1	12.4%	194	6.2%	184
Mental health	4.9%	379	5.0%	19	2.3%	1	4.5%	195	5.2%	184
Health check-up	4.6%	347	4.9%	19	0.0%	0	7.0%	176	2.4%	171
Malaria	3.6%	326	3.3%	13	4.5%	1	3.5%	178	3.8%	148
Don't know	3.4%	323	3.3%	13	4.0%	1	6.0%	179	1.0%	144
Hygiene and sanitation	1.5%	323	1.6%	6	0.0%	0	0.5%	176	2.4%	147
Road Traffic Accident	0.2%	312	0.3%	1	0.0%	0	0.0%	164	0.5%	148
Safety/precaution about work	0.2%	117	0.2%	1	0.0%	0	0.5%	80	0.0%	37
Total		**411**		**386**		**25**		**201**		**210**

Appendix 1.34: Health communications in country of destination

	Total		Men		Women	
	%	n	%	n	%	n
Did you get any health related communications materials while abroad?						
Yes	42.9%	90	42.3%	83	43.8%	7
No	51.9%	109	53.6%	104	31.3%	5
Don't know	5.24%	11	3.6%	7	25.0%	4
Total		**210**		**194**		**16**
Were they produced in your own language?						
Yes	37.8%	34	41.0%	34	0.0%	0
No	62.2%	56	59.0%	49	100.0%	7
How easily do you understand the contents of these materials?						
Easily understandable	33.3%	30	36.1%	30	0%	0
Understandable	35.6%	32	37.4%	31	14.3%	1
With some difficulties	20.0%	18	15.7%	13	71.4%	5
Don't understand	11.1%	10	10.8%	9	14.3%	1
Total		**90**		**83**		**7**

Appendix 1.35: Pre-departure health orientation

	Total		Men		Women	
	%	n	%	n	%	n
Did you go through any health orientation / throughout the process of your migration?						
Yes	12.4%	51	12.7%	49	8.0%	2
No	87.6%	360	87.3%	337	92.0%	23
Total		**411**		**386**		**25**
If yes, who conducted/organized the orientation?						
Employer/Agency	76.5%	39	75.5%	37	100%	2
NGO	13.7%	7	14.3%	7	0%	0
Government Organization	7.8%	4	8.2%	4	0%	0
Private Institute	2.0%	1	2.0%	1	0%	0
What topics would you like to know more about?						
Nothing	54.9%	28	55.1%	27	50.0%	1
Health education	21.6%	11	22.4%	11	0%	0
Work and conditions	17.7%	9	16.3%	8	50.0%	1
Emergency services	2.0%	1	2.0%	1	0%	0
Law of working country	2.0%	1	2.0%	1	0%	0
Other	2.0%	1	2.0%	1	0%	0
Total		**51**		**49**		**2**

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