CHAPTER-ONE
INTRODUCTION

1.1 Background of the Study

Peer education typically involves training imparted by a member of a given group to effect change among the rest of the members of the same group. Peer education is often used to effect changes in knowledge, attitudes, beliefs and behavior at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in policies programs. Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS (Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome) pandemic (United Nation Programme on HIV/AIDS 2009).

An Aids is the acronym used for the medically define acquired immunodeficiency syndrome

Aids, means acquired immunodeficiency syndrome. Acquired means, the virus is non hereditary transmitted .Immunodeficiency means the virus weakens the immune system resulting in greater susceptibility to various opportunistic infections and syndrome is a collection of common symptoms or signs (usually opportunistic infections) which are fairly typical in infected persons.

AIDS is caused by a group of related viruses referred to as HIV (Human Immunodeficiency viruses)

Nepal is facing rapid increase in HIV/AIDS prevalence among high risk groups. According to NCASC (Nepal Center for AIDS and STD Control, 2010) the first HIV infection was detected in 1988.Since then HIV /AIDS epidemic has evolved from low to concentrate among High Risk Groups i.e. Injecting drug users, Female sex workers, Men who have sex with men, Labor migrants.

Peer education has been used extensively in different settings for the reduction of risk-taking behavior related to drug abuse and HIV/AIDS. The basic premise in using peer group members as peer educators' revolves around the belief that young people learn about drug use and sex from their peers. The corollary that these peers can influence social norms in their respective peer group is tested in this intervention model (UNAIDS 2009).

Peer education and support program mapping consultancy Federated States of Micronesia: Country Reports 2009, defines Peer education as, "the teaching and sharing of health information, values and behaviors by the member of similar age or status group."

It further says, Peer education therefore is an education program run by, and for, members of the same peers group; and peer is someone from the same group in which the group member identify with each other because of certain features they have in common.

Peer education has been used in many areas of public health including nutrition, education, family planning, and substance use and violence prevention. However, HIV/AIDS peer education stands out owing to the number of examples of its use in the recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and impact of peer education

in the area of HIV/AIDS prevention, care and support have also increased (UNAIDS 1999).

According to UNAIDS, worldwide peer education is one of the most widely used strategy to address the HIV/AIDS pandemic.

Peer education is effective in promoting the adoption of preventive behavior with regard to HIV/AIDS. Peer education is a widely used component of HIV prevention programmes across population groups and geographical areas, peer education is seldom implemented alone. Rather, it is often part of a larger; more comprehensive approach to HIV prevention that includes condom distribution, STI (Sexually Transmitted Infection) management, counseling, drama, or advocacy (UNAIDS 2009).

Peer education activities include: direct one-on-one education, group based education, Education sessions (e.g. in schools), telephone information service staffed by peers, advocacy on behalf of the target population, advocacy for peer education, condom and resource distribution, theatre/role play education and media production, knowledge and skill Training for peer educators, training for trainers (UNAIDS 2010).

Migration and population mobility has always been a major economic activity in Nepal and is likely to remain major sources of income for the foreseeable future. Migration is one of the structural factors associated with HIV infections. Migrant populations are at higher risk of contracting HIV because of their situation in particular poverty, exploitation, and separation from families and partners that put them at risk. Migrant populations are often working individuals, subject to poor and unstable living and working conditions. Such conditions usually

mean that they have limited access to reliable and culturally appropriate information on HIV/AIDS and health services.

According to United Nation 2010, the definition of migrant labor is broad, including any people working outside of their home country .The term can also be used to describe someone who migrates within a country any people working outside of their home country. The term can also be used to describe someone who migrates within a country, possibly their own, in order to pursue work such as seasonal work.

Over the years, the dimension of migration has changed both in quality and quantity; these same groups of migrant workers who are believed to be bread winner of their families are being seen as the vectors of HIV/AIDS. However, examining the factors in migration will show that the migrant workers are not the problem rather the realities in it is that migration process itself creates problems makes them more vulnerable to HIV/AIDS (Situation Analysis of HIV/AIDS in Nepal may 2001).

Dr KK Rai, 2010 Director of National Centre for AIDS and STD Control (NCASC) said the government has identified migrant workers as the ‘Most at Risk Population (MARP) of HIV/AIDS(The Himalayan Times 2010, Dec. 16).

According to National Center for AIDS and STI Control 2010, the total estimated HIV/AIDS population 41 percent are migrant worker returning from India and 21.5 percent are spouses of these migrants in rural areas, where as 5 percent of HIV/AIDS infected from urban areas.

The number is alarming, if the Most at Risk Population (MARP) of HIV/AIDS are not prevented they would cause the dangerous disease AIDS to spread among the societies.

The present political situation in Nepal has encouraged the outflow of migrants, many youth migrate towards major Indian cities. They remain out of country for a long period of time only visiting during major festivals. The HIV/AIDS prevention and care activity has targeted migrants and youth due to their increased vulnerability in engaging in high risk activities which are peer pressure, solitude and other underlying factors. The overall goal of HIV/AIDS prevention programme is “To prevent HIV infection in labor migrants and young people in Nepal and provide care and support to the affected people (UNAIDS 2010)".

The programme is implemented in many districts of Nepal, like Jhapa, Morang, Illam, Sunsari, Kailali and looking forward to expand its program in other district with high migration pattern, especially to India. The strategies to prevent HIV/AIDS and STI transmission executed by the programme are Advocacy; Behavior Change Communication (BCC); Peer Education; Establishment of Information Counseling Centers; Establishment of Youth Friendly Service Centre and Establishment of STI and VCT (Voluntary Counseling Testing) centre (UNDP, 2006).

In Nepal, the numbers of those travelling to other countries has significantly increased. Many of them are returning with the infection and the impact is widely visible with the spouses and the children who are being infected.

Most of the treatment and education program conducted in any country faces with various achievement hurdles .Numerous cultural, political, and economic barriers make it difficult for programs that promote condom use, structured treatment therapy, and education on sex and health to be both well received and successful in country. From a cultural perspective in many parts of Asia, there is a stigma attached to

HIV and AIDS. Several misconstrued beliefs exist regarding what AIDS is and how one becomes infected, leading to the negative connotation associated with the syndrome. Furthermore, an overall fear is associated with the disease and the people who have it. As a result, these individuals are often shunned and rejected.

To address the issue Nepal government has been implementing HIV/AIDS prevention program in co-ordination with multilateral and bilateral organization, International organization GFATM in many district. Jhapa district is also one of them, where Knight Chess Club (KCC) a NGO, is located in Mechinagar- 10, Kakarvitta Jhapa district. The club has been running comprehensive HIV prevention program i.e. Peer education among labor migration and their families. The migrant focused program is also funded by GFATM to minimize HIV transmission among the seasonal labor migrant. The major objective of the comprehensive HIV/AIDS prevention program amongst the migrant and the family is to provide information through establishment of Information and counseling center ,one and one educator contact educator through outreach worker and peer educators and provide the VCT/STI services the risk community to know their status in confidential way. Overall the program is aiming to reduce risk behaviors in individual and communities and HIV/STI prevention message using variety of communication channel.

Thus, this study is conducted to indentify the effectiveness of peer education program conducted by Knight Chess Club in Jhapa district.

1.2 Statement of the Problem

Rapidly spreading sexually transmitted diseases (STDs) and HIV/AIDS among migrant labors and their families become critical and

alarming problems in many developing countries. In other words STDS and HIV/AIDS are emerging as a major social and health problems in developed as well as developing countries (United Nations, 2000).

This study has also focus on the misconception about the people regarding AIDS and discuss about the stigma associated with and attitudes towards HIV/AIDS. So it is very important to aware the people about HIV/AIDS among the labor migrants for the prevention of AIDS.

With the emergence of the Human Immune Deficiency virus and AIDS, the awareness of STDs became great important and necessary too (Northridge, 1999).

It's true as said by the Northridge, that the awareness of STDs is great important and necessary but with the implementation of the awareness program it is equally important to see how much the program is effective.

The situation of HIV pandemic and its transmission are much more complicated in many developing countries. Unprotected sexual intercourse whether heterosexual or homosexual with multiple partners and intravenous drug use is major cause of the transmission of STDs including HIV infections.

One of the greatest challenges for Nepal’s HIV prevention program is reducing transmission between migrants, who are often clients of sex workers, and their spouses and partners.

Peer education is also one of the HIV prevention program. Peer education programmes are effective in modifying knowledge, attitudes, communication, and risk behaviors related to HIV/AIDS/STI and/or reducing the incidence of HIV/STI (UNAIDS 1999).

In view of the facts as mentioned above, a number of related questions could be raised relating the Effectiveness of Peer education. The questions would be:

- How do people perceive about AIDS?
- How can people identify components and principles that influence HIV/AIDS peer education program quality and effectiveness among the migrant population and spouses?
- Is the peer education program are different for males and female and how much effective is the program?

1.3 Objective of the Study

The overall objective of the study was to find out the effectiveness of peer education on comprehensive HIV/AIDS preventive program among migrant population (labor) and their spouses. The specific objectives of the study were,

- To describe the knowledge, attitude of labor migrants and their spouses towards HIV/ AIDS.
- To examine peer education program and its effectiveness.

1.4 Significance of the Study

Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic, despite its popularity, there has been little documentation and analysis of the operational issues facing peer education (UNAIDS 2010).

Awareness is always the essential component in prevention of the diseases but one of the 'KAB 'study (the gap between the knowledge, attitude, behavior is known as KAB) targeting people under the poverty line concluded that although people have increased access to

AIDS information, their attitudes have not changed significantly and even those who have changed their attitudes haven't changed their behavior (Roy 1998).

Here peer education is one of the prevention program of HIV/AIDS. It helps to create awareness and helps to modify people's knowledge, attitude and belief .This type of peer education has been given to the labor migrants and their spouses in Jhapa but its effectiveness has not been seen yet so far. So, through my entire study the main objective will be to see how mush effective is the peer education program.

So, this study helps to examine the effectiveness of the peer education program given to the migrant labor and spouses and know about the 'KAB GAP'. The gap between the knowledge, behavior is known as KAB gap. Further, this study is also fruitful in policy making and program related to HIV/AIDS prevention in Nepal as this study aims to provide the basic information about peer education.

1.5 Organization of the Study

The chapter one introduces the study with background, objective, research question and its relevance. The chapter two provides some information about the existing literature on the same topic and it tries to view how this study in Jhapa resembles some ideas already expressed by some authors and at the same time, how it differs from them. The chapter three is about the research methods. This part of the study focuses on my own experiences in the field as a researcher as well as some of the limitations I encounter there. Chapter four deals with knowledge, attitude and perception on HIV/AIDS. The chapter five deals with peer education and the migrant labor and the advantages of peer education, the role and

significance of peer educators, prevention program and challenges faced by Knight Chess Club. Chapter six explains the summary of the whole study and includes conclusions and recommendations.

CHAPTER TWO
REVIEW OF THE LITERATURE

This chapter deals with the review of available literature on sexually transmitted diseases, HIV/AIDS, its prevention program.

2.1 AIDS IN Nepal

HIV/AIDS has become a prominent problem in the tiny South Asian-country of Nepal. Experts has stated that the number of AIDS cases has increased fifteen-folder over a three –year period (1990-93) and the numbers were expected to reach 100,000 cases by the year 2000(Suvedi,Baker and Thapa 1994).Although the numeric impact of HIV/AIDS has not been as dramatic as anticipated, it is expected that AIDS will grow at an alarming rate over the next few years. One author proclaims AIDS as a "coming crisis" for Nepal (Seddon 1995).

According to Maskey (1998), the reporting of AIDS in Nepal is very low. We see due to the AIDS people die in Nepal. The death may be due to the lack of education about AIDS or Unavailability of HIV testing. In some places we find that though there is the facility of HIV testing, counseling treatment etc. people die of AIDS as they have the fear of social stigma currently attached to HIV positive person in Nepal. This is the various reasons why people die and why the awareness programmes related to HIV AIDS fails (Maskey 1998).

Here, Maskey in his study has said that the people die due to AIDS knowingly and unknowingly.We sees that in some places people are aware and there are many awareness programmes related to STD but still

the death occurs. So my research tries to find out why such awareness programmes could not be effective to these people.

It is now clear that there is a strong co-relation between the spread of other sexually transmitted diseases (STDs) and HIV transmission, both ulcerative and non-ulcerative. STDs increases the risk of sexual transmission of HIV. According to the National STD case Management Guidelines (Ministry of health 1997), there are few reliable data on STD prevalence in Nepal small number studies have been carried out in various parts of the country. Further regarding the prevalence of STDs in Nepal, Ministry of Health (1997:1) has commented that 'anecdotal evidence suggest that STDs are common and review of gynecology department records show that diagnosis often associated with complications of STD are frequent."It is clear that the prevalence of STDs in Nepal increase the risk for the spread of HIV/AIDS.

According to NCASC 1999, there is the widespread of HIV/AIDS in Nepal but due to the inadequate close observation mechanism and poor data keeping it has been under estimated. Comparatively, the HIV has increased, especially among sex workers, injecting drug users and migrant labors. As a result today Nepal faces a concentrated epidemic of HIV/AIDS. There is an absolute need develop specifically –targeted intervention program for these groups. The mobile population –largely disregarded in the National HIV/AIDS prevention and control program- has clearly emerged as a new group vulnerable to HIV infection. The risk imposed by the mobile population to housewives and their off spring, born and unborn, as well as many other, may further expand and generalize the epidemic. A lack of adequate and effective control program that specifically addresses the mobile population will only accelerate this process.

INGOs (International non –governmental organizations) have contributed greatly to the dominant cultural model of HIV/AIDS in Nepal. There are currently nearly 100 NGOs working in the area of AIDS education and prevention in Nepal. The education and prevention models employed by these organizations are drawn from the National Center for AIDS and STD Control, an organization charged with coordinating all AIDS education and prevention throughout the country and the education and prevention models promoted by the National Center are mainly borrowed from the west (Beine2000). Therefore, the strategies employed and materials distributed focus primarily on the issues these western, organizations (based on the findings of Western KAP/KAB studies) have recommended. Western models dominate the AIDS discourse in Nepal. The result is an emphasis on awareness building that portrays AIDS (even using Western illness schemata) as a highly communicable and fatal diseases associated most directly with prostitution and drug use.

The first case of AIDS was identified in Nepal in July 1998 (Suvedi 1998:53).Since then; the numbers have grown slowly but steadily. HIV infection continues to spread because of high levels of high risk behaviors: such as, low or no condom use, particularly where there is paid for or transactional sex; multiple partner relations, and shared needles during drug use. In Nepal, mobile populations are particularly vulnerable to HIV. There are a significant number of highly mobile people within the country and in border regions especially India. A large number of young Nepalese girls are forcefully recruited and trafficked to brothels in Indian cities. Similarly, many Nepalese males work in India as seasonal workers in homes, factories, and other places. Children are also affected by HIV; the media reports that there is an increase in school

drop-out rates and the numbers of orphans and vulnerable children (OVC) (Nepal Red Cross Society HIV Programme (2008-2009).

The National Center for AIDS and STD Control (NCASC) reports HIV infections to be more common in the Far Western region of the country, where migrant labor is more common, and in urban areas. In addition, nearly 50 percent of HIV infections in Nepal occur in highway districts. As a major identifiable client group of FSWs, truckers are another high-risk population. Increases in condom use among truckers are promising, though, with 93 percent reporting use of a condom at last sexual encounter (UNGASS, 2010).

Peer education has been effective for the mobile population in the prevention of the program as said by the UNAIDS, in spread of HIV/AIDS .But during the research what is found that though the education is effective, the numbers of HIV/AIDS is growing instead of declining. Here, I try to find out what is the reason behind it, so this study tries to find out what is the reason behind the increase of the diseases.

2.1.1 Transmission Mechanism

Cox and Subedi conducted a research survey in 1994 among Nepalese sex workers comparing some of their findings with those of other Asian countries. While relative to neighboring countries the AIDS pandemic has been relatively effect to Nepal, but there is a tremendous potential for rapid spread of infection. Trafficking of Nepalese women and girls to serve the sex industry in India combined with migrant make engagement with commercial sex workers. Both in India and Nepal are primary routes through which the virus threatens to take hold in the general population. High rates of illiteracy taboos regarding the open

discussion of sex and limited health, infrastructure are common notes as factors, which facilitate the spread of infection (Cox and Subedi 1994:1).

HIV/AIDS entered in Nepal through the prostitutes either women or girls who were involved in prostitution in Mumbai and other cities of India. They are generally supposed to come back to home, which helps AIDS to spread in Nepal. Premarital and extra marital sex is not common in Nepal and the high prevalence of STDs in general population further helps HIV transmission in the country (Acharya 1994).

HIV transmission in India and Nepal are common in HIV/AIDS problems. The open boarder, mobile population between Nepal and India disappointed commercial sex workers women from brothel are thought as fuels of the epidemic in both countries. The main routes of HIV/AIDS are in equal state when we compare south Asia countries (UNFPA, 2000).

The “cultural approach” stresses the sociocultural factors linked to HIV/AIDS: the specific features of the epidemic must be understood on the basis of local cultures, beliefs, myths and traditions, ways of life and so on. These cultural factors can be obstacles to open discussion and information about HIV/AIDS and to effective prevention. Nonetheless, each culture has an immense pool of appropriate responses to combating the disease – as long as culture is seen as an infinitely rich, diverse, multifarious and changing resource. In addition to promoting research, methodological tools and pilot projects, the project aims to create opportunities for theoretical reflection on HIV/AIDS themes and a platform for dialogue to improve. As of the end of 2004 women accounted for nearly 50% of all people living with HIV worldwide, and the UNAIDS report stresses the way in which women’s increased risk is a reflection of gender inequalities. In most societies, the rules governing

sexual relationships differ for women and for men, with men holding most of the power. This means that for many women, including married women, their male partners' sexual behavior is the most important risk factor.

2.1.2 Migrant Labors Vulnerable to HIV/AIDS

Dixit (1996) has studied AIDS using the political economy approach and found poverty as the main cause of AIDS but my research is based on people's perception ,knowledge ,attitude so I consider poverty is not only the cause of AIDS. Migration has also been a factor identified as contributing to the spread of HIV/AIDS in Nepal. As mention previously; it is believed that many migrant laborers are bringing the HIV home with them when they return Nepal. It is estimated that there are up to 2000,000 Nepalese women involved in sex trade in India (UNAIDS 2010).There are also many Nepali men working abroad. In 1981, it was reported that over one-half millions Nepalese were working away from home and that the majority of these migrants were from the mid-hills region (Seddon 1995).

Nepali men in search of work migrate in large numbers of India and further abroad where they subsequently obtain the service of HIV infected commercial sex workers, and when they return home they transmit the virus to their unsuspecting wives, who subsequently pass the virus to their unborn children (Poudel 1994).

So, it is very essential to aware the labor migrant and their spouses about HIV/AIDS. There has been various program of prevention of HIV/AIDS, among them Peer Education is one of them.

Recent arguments and discussions has been that there are married women (house wives) who engage in extra marital affairs especially in communities where husband are absent having migrated to another city or country for a long period of time. The lack of sexual intimacy between husband and wife because of them being separated causes instabilities in their sexual relation as well as financial status, leading housewives to, seek sexual pleasure from someone else and/or, to have sex with multiple partners as economic supplement to their needs. Sex with multiple partners and often, lack of access to information and condom affect their abilities to protect themselves from HIV infection (NCASC 1999).

According to NCASC 2000, in dominant Nepali culture married women are not supposed to engage in extramarital sexual affairs so they are believed not to be at high risk of HIV/AIDS. Here, we see the gap in perception and realities on this issue.

Aryal (2000), has pointed out trafficking of young girls for prostitution outside the country, seasonal migration of youth in search of job, low level of awareness of HIV/AIDS, growing urbanization, low coverage of mass media on AIDS prevention, poor health infrasture, stigmatization of HIV infected people and lack of sex education in school level as some of the factors that are considered for rapid transmission of HIV inside the country.

As people migrate, the rules of sex culture changes (Herdt 1997). However, adequate studies are lacking in Nepal to ascertain the sexual behavior of mobile population. It can only be grossly said that cut off from their families and social support system, a mobile person may engage in unprotected casual or commercial sex rendering themselves to STDs and HIV infection. A study aimed at understanding the sexual

behavior of nonresident men in Nepal (Puri et al 1998) states that 28% of the men had casual sex with non-regular partner and only one third of them used condoms(NCASC 2001).

Seasonal migration to India from Far-Western Nepal, organizers say, has been wide spread over the past several decades. Migration from Bajhang and Doti districts is common: at least one member among 40% to 90% of households migrates to India. A baseline study conducted in 2008, by CARE in Bajhang revealed that 5% of married women had heard of HIV/AIDS; 3% of them knew that HIV transmission could be prevented and 1% was aware that appropriate condom use could protect them from contracting HIV. It also found that only 2 migrants out of 32 uses condoms; reasons cited for failure to use were 'maja audiena' (unpleasurable sex) and unnecessary complications. When they have STD symptoms, many migrant workers not visit health clinics for treatment due to lack of medicines or absent health workers. Anecdotal reports indicate low levels of awareness about HIV/AIDS and low levels of safer sex practices among migrants (HIV/AIDS/STDS Prevention Care and Support Program).

Migration and mobility of individuals could influence the concentration and geographical spread of the disease in the future. As most recent data indicate, a significant proportion of new infections occur among married women whose husbands are infected with HIV. Studies have found that migrant men are a major source contributing to the spread of HIV to rural areas where the volume of mail out-migration for employment is high (Vemuri 2004; UNAIDS 2006).

The above study has said that there is the low levels of awareness about HIV/AIDS and low levels of safer sex practices among migrants in

far- western Nepal. Similarly, my study is helpful to analyze the awareness program in eastern Nepal.

One of the study (Subedi et al 1993) states that 49 % of male and 40 % of female migrants had either premarital or extramarital sexual relationship during seasonal migration. About 70 % of these migrants had no knowledge on HIV/AIDS and about 83% had no knowledge on condom use. Obviously this puts migrant workers at a greater risk of HIV transmission. A large percentage of these men who indulge in sexual intercourse with non-regular partners did not perceive themselves at a risk of contracting HIV/AIDS (NCASC 2001).

According to 2008, Integrated Bio-Behavioral Studies (IBBS) data from Mid to Far Western district samples, about 1 percent of the migrants returning from Mumbai, India, were found to be HIV positive. Migrants who visit FSWs (female sex workers) and/or go to the Maharashtra state of India appear to be at highest risk of HIV infection.

According to Nepal's 2010 United Nation General Assembly Session (UNGASS) Report, labor migrants make up almost 40 percent of the total estimated HIV Infection in the country followed by the wives and partners of the infected with HIV(26 percent).One of the greatest challenge foe Nepal's HIV prevention program is reducing transmission between migrants, who are often clients of sex workers, and their spouses and partners

A number of epidemiological studies have pointed to a link between population mobility and the spread of HIV, a link that should not be surprising. At the risk of stating the obvious, it is in the bodies of human beings that human immunodeficiency virus is carried from one place to another, as people move between different zones of HIV

prevalence. Thus, at the beginning of the epidemic – and in countries or regions with adequate epidemiological monitoring – the first cases of HIV can sometimes be traced to individuals or groups passing through, such as truck drivers, people displaced by conflict, military personnel, or returning migrant workers. This stage is now passed, however: HIV is now present in every country of the world. At later stages in the epidemic, when HIV is already established in a particular area, migrants, refugees, internally displaced people and individuals in transit for professional or other reasons often find themselves in situations where they are at increased risk of becoming infected, thus, in turn, potentially carrying HIV to yet other places in transit, or back to their communities of origin.

The resulting co-mingling of the two mobile, sexually active, high-risk populations explains high prevalence of HIV and STI rates in truck drivers and the subsequent spread of the disease through the African continent. In addition to having sex with FSW, most truck drivers have regular girlfriends or wives at home who are likely to become infected with HIV by their husbands and boyfriends, and continue spreading the virus in their local communities (Hudson, 1996).

So the need of Peer education or the awareness program is very essential in order to prevent from HIV/AIDS.

2.2 Peer Educations and Prevention Program

Peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy. The English term ‘peer’ refers to “one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status”. The term ‘education’ refers to the “development”,

"training", or "persuasion" of a given person or thing, or the "knowledge" resulting from the educational process (Merriam Webster's Dictionary, 1985).

Peer education is thought to facilitate empowerment through the stimulation of a dialogically-rather than didactically achieved awareness about conditions of impoverishment and about the possibilities of changing and improving these. Peer educators programs are intended to facilitate the altering of group identities, which will allow in turn for the challenging of traditional norms, particularly those which underpin patriarchal and violent approaches to sexual practices (Horizons 1999)

Peer education appears to be a strategy of choice in intervention campaigns targeting truck drivers. Most stop-over towns are located in remote areas and are beyond the reach of mass media (except radio.) In addition, truck drivers are in daily contact with other high-risk populations concentrated in fairly small areas, which should make peer education outreach programs easier to plan. What distinguishes peer education efforts targeting truckers from many others is their involvement of peer educators from other populations interacting with truckers on a daily basis, such as sex workers, bar maids, garage workers, hotel workers, retired drivers and fuel station attendants (Blaire, 1997, AIDS Analysis Africa, 1995).

Truck drivers know these individuals, they share the same background and know the community, and therefore are more likely to be trusted and accepted. Gysels (2001) also suggested that middlemen, who are increasingly important in buying goods and procuring sex for truck drivers at truck stops, can serve as "opinion leader" group providing condoms and information on STD/HIV, and possibly referrals to

treatment and testing centers. The fact that most of these groups are found in the same relatively small area is an opportunity to plan integrated peer education campaigns where the same message can be repeated from a variety of sources for more credibility and impact.

Peer education was found to be effective in increasing condom distribution and promoting the use of condoms with paying partners amongst truckers and prostitutes in Malawi as a result of sex workers peer educators (Walden et al, 1999). The peer educators were trained to promote and distribute condoms and to promote safe sex negotiation skills. Interestingly, truck driver peer educators were found to be generally inactive and ineffective effective in holding meetings or in distributing condoms. However, the companies where training had occurred were likelier to encourage and distribute condoms, and to have reduced high-risk sexual behavior. The concerns with regard to peer educator efforts included acceptance of peer educators, non-use of condoms with non-paying partners and randomness of criteria for condom use in both populations.

In practice, peer education has taken on a range of definitions and interpretations concerning who are a peer and what is education (e.g. advocacy, counseling, facilitating discussions, drama, lecturing, distributing materials, making referrals to services, providing support, etc.) (Shoemaker et al., 1998; Flanagan et al., 1996).

Peer educators are effective and credible communicators who have inside knowledge of the intended audience and use appropriate language/terminology as well as non-verbal gestures to allow their peers to feel comfortable when talking about issues of sexuality and HIV/AIDS. Peer education is effective in promoting the adoption of

preventive behavior with regard to HIV/AIDS. Peer education is also a cost-effective intervention strategy because its use of volunteers makes it inexpensive to implement and/or expand (UNAIDS 1999).

According to one UNAIDS publication**,** the most effective HIV/AIDS programs targeting young people: “respond to the diversity of young people and their needs; encourage youth participation in design and implementation; work in a climate of openness that recognizes realities that young people face; focus on young men’s sexual health needs as well as those of young women; focus on the positive aspects of sexual health as well as unwanted pregnancy and STIs; promote greater awareness of sexual and reproductive health rights; and offer improved access to education and health services.” (Adolescent Sexuality, retrieved July 20, 2003, from www.unaids.org).

Peer education typically involves the use of members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person’s knowledge, attitudes, beliefs, or behaviors. However, peer education may also effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies (UNAIDS 2OO9).

Many NGOs like Sahara Nepal, Care Nepal also reported that their institutions had begun to integrate HIV/AIDS peer education activities into broader health and development programs in reproductive health, violence prevention, substance abuse, life skills training, microcredit, and community development. Many informants were interested in learning more about these types of “crossover “experiences that link HIV/AIDS peer education programs with other health and development initiatives.

Red Cross currently operates HIV peer education initiatives in Pohnpei and Kosrae. It targets young people aged 15–24. The main aim of this project is to “increase awareness in HIV/AIDS” (Federated States of Micronesia country Report, 2009).

Here we see that most of the study is carried on only in the awareness of the people but less has been done on looking at how much the program is effective.

Nepal succeeds in decreasing new HIV infections by more than 25%in last one decade (UNAIDS report on the Global AIDS epidemic, 2010)

Report on the Global AIDS Epidemic shows: The AIDS epidemic is beginning to change course as the number of people newly infected with HIV is declining and AIDS-related deaths are decreasing. At least 56 countries have either stabilized or achieved significant declines in rates of new HIV infections.

2.3 Knowledge and Perception on HIV/AIDS and STDS

AIDS has a bio medical reality, yes but it also has reality as a social construction. As Fee and Fox (1992:9) have claimed above, AIDS is a particularly good example of social construction of disease. Further building on in the hypothesis they have contended that AIDS, the syndrome associated with a HIV virus, is more of a social construction than a biomedical reality.(Fox and Fee 1992:10).Various other authors, making this same claim to varying degree ,have also alluded to this social side of AIDS. Schoepf, for instance, commenting on her research in Zaire, has stated that, AIDS may be usefully viewed as socially produced.(1992:260)Farmer(1992:xi) contends that the world pandemic

of AIDS and social response to the disease. And Susan Sontag (1998) has demonstrated how we used familiar metaphors to make meaning of AIDS when it first emerged.

The perception of AIDS is also changing. One major feature of the cultural models is that they are dynamic. Farmer (1994) and Berridge (1992) have both traced the change of the dominant cultural model of AIDS through the years in Haiti and Britain respectively. In the early years, Aids was perceived to be fatal, infectious diseases. The new available therapies describe earlier, however, are modifying the image of AIDS here, as in the rest of developed world, from “acute” to “ chronic”.(Herdt 1992:11).Although numbers of new HIV infections are on the rise of America, the death rate for AIDS related deaths dropped in 1996 for the first time since the advent of the epidemic .The America media now boast that “Aids has been contained” and it touts that the once certain “death sentence” is now a “chronic manageable condition” (Treichler 1992:88)

Religious, socio-cultural practices and other traditions rigidities especially with respect to sex have made talk more difficult in the context of Nepalese society .It is paradox that sex is one of the commonest things in our life, still we talk least about it among and in between the people in our society .It's an issue to be so considered being a very personal and secret matter whenever children ask their parents about sex and sexual organ they either ignore them or scold them or even tell them utter lies (Gurubacharya,1994).

Because of wide spread taboos and wrong impression about sex and sexual organ, or children's and even adults are not ignorant about sex and reproductive health but they have the misconception that they should

not talk about sex and this should be supposed as much as possible (Gurubacharya,1994)

Several studies have found that 10 percent or more of the general adults' population in the central Nepal and boarder area of Terai region of Nepal have fury of STDs infection. The prevalence of STDs is due to lack of awareness about infections, false beliefs about how to protect from STDs, social taboo against sex and low rates of condom use (Subedi, 1999).

Even though fewer people are being infected in Nepal, the number of people with HIV is expected to grow five-fold to 200,000by 2020.At present most infected people are in the 15-49 age group, male migrant worker make up nearly one third of all infected people and 25 percent are women (17-23 February 2012 Nepali Times)

Peer education that’s why is now consider an important strategy in prevention of HIV/AIDS. It is believe, to be one of the best way of educating people through peers ,who are from their same group ,age ,sex about the diseases. Peer education programs targeted at truck drivers and sex workers can be used as a bridge in the spread of positive attitudes regarding condom use and HIV education .A concerted effort is needed to target high-risk population in a non-discriminatory manner and to use their occupation to spread HIV-prevention messages and promote condom use(UNAIDS2010).

CHAPTER-THREE
METHODOLOGY

Selection of area is also important according to the research topic. In this study relevant data were collected mostly with the help of primarily data collection methods. For this study, observation and interview were applied as the chief methods.Quantitative as well as qualitative data were also collected according to the nature of the topic.

3.1 Selection of the Study Area

The physical infrastructure and the trade opportunities lured the people to migrate from different parts of the country and India as well. Kakarvitta, one of the town of Mechinagar, is the main transit route to North east of India, Bhutan and Bangladesh, hundreds of people move in and out through this point daily. The continuous and unmanaged flow of the people itself created social disorder and crime, which added the fuel to burning social problems like; unemployment, drug use, prostitution among youth community.

This research is based on the study of effectiveness of peer education on the migrant labor and the spouses. For the purpose of this study , Mechinagar -10, Kakarvitta ,Jhapa district is chosen. This place is selected as it is a border area and high rate of women trafficking, prostitution drugs abuse, migrated labor are found according to the Knight Chess Club information sheet 2010.

3.2 Nature and Source of the Data

Mostly qualitative data were collected from the field through the uses of various tools and techniques in order to achieve the stated

objectives and to answer the research question. The data was gathered from primary and secondary sources like articles, journals, research papers. The primary data was gathered from the field through the observations, interviews (unstructured) and key informant interviews.

3.3 Universe and Sampling

The Mechinagar -10, Kakarvitta, Jhapa district, is a border area and high rate of women trafficking, prostitution, drugs abuse, migrated labor are found. This area is highly dense with the labor migrant populations. I selected the migrant labor and their spouses and the program coordinator to know about the effectiveness of peer education, perception about HIV/AIDS and to analyze whether peer education program are different for males and females by using snowball sampling. In this research, I focused on objective and tried to find out the answer using the above methods. Here, I did not control for a specific demographic characteristics since I was not interested in one particular group or in comprising the views of two or more groups. I attempted with only partial success, to achieve as much as information through the various kinds of labors (truck drivers, cooleys, workers etc.). Initial contacts were made through references from friends, neighbors and then each person interviewed was asked to recommend one or two migrants labors. Several chains of subjects were developed simultaneously and followed up those chains that widened the demography. The number of conversations and other contacts varied greatly depending on their availability, their breadth of information and willingness to spend many hours with me.

3.4 Methods of Data Collection

Following are the methods used for the data collections**:**

3.4.1 Participant observation

The participant observer collects data by participating in the daily life of those he or she is studying. The approach is close to everyday interaction involving conservation to discover participants, interpretation of situations they are involved in (Baker 1958).

I spent the initial days of my research observing the peer-educators and the labor migrants' interactions at the time of educating them about HIV/AIDS, including the training sessions of voluntary peer educators and the counseling room. This has provided me information on the interaction pattern of peer educators and the labor migrants and also have helped me to know how much interest do they give on sexual education, video shows and condom distribution, their attitudes on prevention programs and complaints about the HIV/AIDS prevention programs. Here, I tried to understand the culture of the migrant labor and their society through their perspective about HIV/AIDS and awareness programmes.

3.4.2 In-depth Interview

The in depth interview was conducted by me with the key informants' i.e. program coordinator of Knight Chess Club, labor migrants 20 in numbers and their spouses, 16 volunteer peer educators and with the member of Knight Chess Club, who are undertaking this program.

One of the tasks of the researcher is to participate in daily activities of the people to get first hand information. In this study, I interviewed with Program coordinator of knight chess club, peer educators, peer volunteers and the labor migrants and their spouses. In this study conversation took place at average 40 minutes to 1 to 2 hours a day and know how people are taking HIV/AIDS and what is Peer education program doing on preventing this vulnerable diseases. To know about the effectiveness of this program I also had formal and informal conversations with the peer educators and the migrants' labor and the spouses.

Participating with the informants with the skilled rapport building behavior allows researcher to talk and ask question to various types of people about what they observe at the field in the context of HIV/AIDS from the interview it was also found that how much effective is the program and how much serious do the people take the awareness program. Interviewing with people for getting information about various knowledge, attitude, perception about the HIV/AIDS .The necessary information was gathered by means of structured and unstructured interview.

3.4.3 Key Informant Interview

A key informant is more than someone who controls a lot of information about a culture i.e. are knowledgeable person (Bernard ,1995).The information of Peer Educations among the labor migrants, the way of giving training to the peer volunteers and selection of peer volunteers, the achievement of the program and its advantages along with disadvantages was collected from the key informants. Here, the key

informants were Program coordinator of knight chess club, peer educators, peer volunteers and the labor migrants and their spouses.

The most important information collected from the key informant was the effectiveness of the program. This method was used to check the validity of data with some knowledgeable persons. Key informants interview was utilized to get in depth information from the study area.

3.5 Data Analysis

Data analysis is a continuous process of reviewing the information, it is collected, classifying it, formulating additional questions, verifying information and drawing conclusions. Analysis is the process of making sense of the collected information. The task of analysis is to bring order out of the chaos of your notes, to pick out the central themes of your study and to carry them across to your written work (Baker, 1999).

The data and information collected through interview were processed manually.The collected information were classified and tabulated as per the objective of the research.

The quantitative data was also used to know the numbers of people infected by HIV virus and to see the process of increasing or decreasing the numbers of infected people as per the demand of the objective of the research.

The study is mainly descriptive and the analysis of the result is described logically.

3.6 Limitation

Conducting research on in any topic that is related to sex is always a great challenge. Every person in our society wants to keep his/her sexual behavior secret .Nobody wants to be exposed and identified in the society due to the social taboo and from fear of being expelled from the family and the society as well.

Findings of the study were based on Knight Chess Club, which conducts peer education program for migrant labor and their spouses in Jhapa district. So the findings may not be applicable in other district or in organizational context.

CHAPTER FOUR
KNOWLEDGE, PERCEPTION AND ATTITUDE TOWARDS HIV/AIDS

During my study on the effectiveness of peer education among the migrant labor and their spouses the knowledge about HIV/AIDS was also explored.

4.1 Migrants' Knowledge and Perception on HIV/AIDS

In Nepalese context according to the UNAIDS (2000), with the improved prospects for longevity (due to the new drugs), many couples with HIV now want to start families, new technologies such as a new method of invitro fertilization that includes " sperm washing " are also reducing the passing of the virus to unborn children.

According to KCC, the perception of AIDS among the HIV positive people is changing. During the counseling period, the program noticed that the people living with HIV/AIDS wants to have children, work and function normally, they further added that before PLHA had hard life due to lack of medicine and stigma but now the medicine are improved and with the awareness of this infection or diseases people discuss it openly.

On the radio program one HIV positive interviews commenting on his improved health said: for ten years we had been waiting for an illness that would be the final one. Now we say, "Let's start living."

The peer education programs have helped the PLHA and non-PLHA group to understand about HIV/AIDS in wider view. Now, the

people like to discuss about the sexual issues openly as they understood more they hide more they will suffer.

The cultural model of HIV/AIDS has changed dramatically. The motif of HIV/AIDS sufferers has gone from dying from AIDs, to living with AIDs.

During my visit to the study area, one of the married women said, “People of this place have very less knowledge of HIV. Whatever they know is through TV or the HIV/AIDS awareness camp which is held once a year at village. But I don't know about these people who run the camp. I am myself very less informed about HIV, so what can I say about others? But I have heard that some NGO distribute pamphlets educating people about AIDS and HIV and heard that they distribute condoms (key informants, 32year old, married woman).

Here, I found that though the peer education program has been implementing in this particular village the women are still unaware about the organization and don't have any education about HIV/AIDS. Why is this happening, why they are not able to access the HIV education directly? I tried to find the answer and came to know that in the migrant society most of the women are uneducated and they don’t want to speak about their sexual matters to others and if someone comes to share their ideas about sex or condoms they just ignore or hide in their house and there is a misconception about AIDS. Some people think AIDS is caused due to bad deeds, ill fate etc.

AIDS is caused due to sex with prostitutes without condom. If a man uses condom while having sex he cannot get infected. This is always advertised on TV and radio. Friends also say the same thing. If you have nirodh you cannot get infected by AIDS. AIDS can be cured if one goes

to doctor immediately."(Key informants, 30yearsold, married male respondents).

"I have heard about AIDS from people and also through radio. But what causes this disease? I am not aware. I do not have much knowledge about it. I do not know whether it is black or white." (Key informants, Maya, married respondents).

"I have heard about HIV/AIDS. What is the difference between these two, I am not aware. None of my acquaintance has died of HIV/AIDS. It happens due to sex with prostitutes. To save oneself from these one should not go to a prostitute and in case one does go he should use condom." (Key informants, Hari, married respondents)

Here, we see that Male migrants perceive that their risk of acquiring HIV infection is low. This is coupled with the fact that, despite migrants' exposure to modern medicine, knowledge about HIV transmission and prevention is exceptionally low. Migrants' lack of knowledge may also be seen from the large extent of inconsistent condom use among men who engage in high-risk sexual encounters. It is therefore essential to scale up existing HIV/AIDS programmes and to introduce new programmes to address the high level of HIV vulnerability among male migrants in Jhapa. That knowledge about HIV is low; it should be a compelling reason to recognize how such a situation can result in faster spread of the epidemic.

4.2 HIV Related Knowledge Attitude and Behavior

The results have shown that the older adolescents had better knowledge than their younger counterparts. This might be due to the fact that the older adolescents are more sexually active and more conversant

with peer groups and other members of the family. It was also found that adolescents living in joint or extended families had better knowledge than the adolescents of nuclear families. Khan opined that age related increased knowledge on STDs/AIDS among the older adolescents might be unrelated to education; their increased knowledge level may be due to experiential factors such as having contracted STD rather than routine sexuality education. This was not identified in this study, but assessing biomedical markers of STDs might be helpful for exploring the fact which need to be further searched. However, Khan found significant association of knowledge on AIDS with level of education of adolescents. In fact, education is the pathway of communication for any message. Increased age with increased level of education give an opportunity to have more reproductive health information, more use of heath care services and support from peer groups. Another aspect of the study was that adolescents having better knowledge on sexually transmitted diseases had better knowledge on AIDS. This creates an opportunity for programme implementation in the control and prevention of STDs and HIV/AIDS simultaneously, not in isolation or haphazardly. **(**Khan MA. 2002.)

4.3 Rejection of Misconceptions about HIV and AIDS

In addition to knowing about effective ways to avoid contracting HIV, it is useful to be able to identify incorrect beliefs about AIDS to eliminate misconceptions. Common misconceptions about AIDS include the idea that HIV-infected people always appear ill and the belief that the virus can be transmitted by sharing food with someone who is infected, or by witchcraft or other supernatural means.

The knowledge that people cannot get the AIDS virus by sharing food with a person who has AIDS is lower than knowledge that the AIDS virus cannot be transmitted by supernatural mean. That is, respondents were also asked if they thought that people could get the AIDS virus because of witchcraft or other supernatural means, and the majority of respondents rejected this idea. As with many other indicators of HIV and AIDS knowledge, rejection of misconceptions regarding HIV and AIDS is higher among respondents in urban areas than rural areas. Among both men and women, rejection of misconceptions about HIV and AIDS increases with age. Educational attainment and\ increasing wealth are positively associated with rejection of misconceptions.

4.4 Stigma Associated with and Attitudes Toward HIV and AIDS

Discrimination and stigmatization against persons living with HIV and those around them – one of the dramatic consequences of HIV/AIDS and a major obstacle to prevention and care – are grim realities that we sometimes prefer to ignore. All too often, infected persons are ostracized by their families and communities, evicted from their homes, rejected by their spouses and sometimes suffer physical violence, even murder. Subject to personal and institutional discrimination, they may find themselves denied access to health care, insurance coverage, entry to certain countries and employment. Fear of discrimination and stigma causes people to shun screening tests and prompts those infected with and affected by HIV/AIDS to remain silent and deprive themselves of essential treatment and social care and concern

Knowledge about AIDS can affect people’s opinions and attitudes toward people with AIDS. In order to measure respondents’ attitudes

toward people with AIDS, a number of questions were asked, including questions about willingness to care for a family member who has AIDS, not wanting to keep secret that a family member has AIDS, and willingness to buy vegetables from someone who has AIDS.

HIV/AIDS-related are stigma and discrimination most closely related to sexual stigma. This is because HIV is mainly sexually transmitted and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the "norm."HIV/AIDS-related stigma and discrimination has therefore appropriated and reinforced pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution, and sexual "deviance" (Gagnon and Simon 1973; Plummer 1975; Weeks 1981).

Children with HIV/AIDS or associated with HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV-positive school children or children associated with HIV (Gilborn etal. 2001). Discrimination against HIV-positive children in the USA and Brazil, including exclusion from collective activities or expulsion from school, has led to non-discrimination legislation (Public Media Center 1995; Galvão 2000). However, less concern has been shown for young people who are perceived to be responsible for their HIV infection and who are already stigmatized and discriminated against because they are sexually active, homosexual, or drug users. In the USA, for example, HIV-positive young gay men have been expelled from school and in some cases subjected to violence (Kirp et al. 1989).

This need to rethink, as we need to give them support to lead their life .Knight Chess Club program also seemed to give important to people living with HIV/AIDS, PLHA people are seen working as the peer volunteer and counseling people.

In some contexts, HIV/AIDS-related stigmatized and discriminated has been reinforced by religious leaders and organizations, which have used their power to maintain the status quo rather than to challenge negative attitudes toward marginalized groups and PLHA. For example, at the international symposium Religious Health Organizations Break the Silence on HIV/AIDS, organized by the African Regional Forum of Religious Health Organizations during the 13th International AIDS Conference in July 2000 (Singh 2001), it was noted that religious doctrines, moral and ethical positions regarding sexual behavior, sexism and homophobia, and denial of the realities of HIV/AIDS have helped create the perception that those infected have sinned and deserve their "punishment," increasing the stigma associated with HIV/AIDS.

Certain practices (such as condom use) have never been observed in many of these at-risk communities in the past, and it is extremely difficult to change tradition-based cultures. Strong political figures can have a large effect on individuals' acceptance and knowledge of HIV/AIDS.

In societies with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection (Kegeles et al. 1989). In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Panos 1990;

Warwick et al. 1998). The type of cultural system and where it fits along the continuum of individualism and collectivism will therefore influence the ways in which communities respond to HIV/AIDS and the ways in which Stigma and discrimination are manifested. So the person with HIV may think that he is the one who is ruining his family.

The family is the main source of care and support for PLHA in most developing countries. However, negative family responses are common. Infected individuals often experience stigma and discrimination in the home, and women are often more likely to be badly treated than men or children. Negative community and family responses to women with HIV/AIDS include blame, rejection, and loss of children and home. Since HIV/AIDS-related stigma and discrimination reinforce and interact with pre-existing stigma and discrimination, families may reject PLHA not only because of their HIV status but also because HIV/AIDS is associated with promiscuity, homosexuality, and drug use. In many cases, HIV/AIDS-related stigma and discrimination has been extended to families, neighbors and friends of PLHA. This ‘secondary’ stigmatization and discrimination has played an important role in creating and reinforcing social isolation of those affected by the epidemic, such as the children and partners of PLHA (Bharat and Aggleton 1999).

In individuals, the way in which HIV/AIDS-related stigma and discrimination are manifested depends on family and social support and the degree to which people are able to be open about such issues as their sexuality as well as their serostatus. In contexts where HIV/AIDS is highly stigmatized, fear of HIV/AIDS-related stigma and discrimination may cause individuals to isolate themselves to the extent that they no longer feel part of civil society and are unable to gain access the services and support they need. This has been called internalized stigma. In

extreme cases, this has led to premature death through suicide(Bharat and Aggleton 1999).

Even when laws exist to protect PLHA rights and confidentiality, few individuals are willing to litigate for fear that this will result in disclosure of their identity and HIV status. Given widespread negative community and family responses, many people choose not to know or reveal their serostatus. Even when the family response is positive, fear of stigmatization and discrimination by the community may mean that an individual's serostatus is not revealed outside the home.

Due to the stigma and discrimination the PLHA may generate the feeling of social inequality stigmatization therefore, it not only helps to create difference but also plays a key role in transforming difference based on class, gender, race, ethnicity or sexuality into social inequality.

An understanding of stigmatization and discrimination as political and social processes can also help us to reconsider responses to HIV/AIDS-related stigma and discrimination.

For example, identity theory suggests that those who are stigmatized can take action to resist the forces that discriminate against them (Castells 1997; Hall 1990). Those who are marginalized generate "resistance identities" and use them to build a new identity that redefines their position in society and thus seeks the transformation of overall social structure. This would include resistance through mobilization of movements, at community, national, and international levels, aimed at social change.

I think to respond to the HIV/AIDS related stigma and discrimination, there should be developing programs that aim to achieve

social and community change rather than just individual behavior change, drawing on the experience of community mobilization and social transformation in other areas . Priority should be given to approaches that aim to strengthen capacity for resistance among stigmatized and marginalized groups, since empirical evidence indicates that some of the most effective responses to the HIV/AIDS epidemic have been those where affected communities have mobilized themselves to fight stigma, discrimination, and oppression as said by Daniel and Parker 1993 in their study about sexuality, politics and AIDS in Brazil.

To respond to HIV/AIDS related stigma and discrimination ,the knight chess club has given particular attention to the PLHA ,for example some peer volunteer are the people who are infected with AIDS and with their experiences they share experiences in community and helps them in educating about AIDS.

4.5 Best Person With Whom To Discuss HIV and AIDS

The key informants were asked questions on who they thought would be the best person to discuss HIV- and AIDS-related issues with. Whether a health worker, teacher, pastor, community leader, clan leader, politician, family or other. The results show that an equal proportion of women and men believe that health workers are the best person to discuss HIV and AIDS with. The results show that almost all are more likely to trust health workers to discuss HIV- and AIDS-related issues, which is an indication of a perception that HIV and AIDS are health issues and not socioeconomic or development ones. Only a few women and men (less than 2 percent each) trust other people, such as teachers, pastors, community leaders, clan leaders, politicians, family and others. There is

not much variation in women's or men's background toward health workers as the best people to discuss HIV and AIDS with.

Further, I asked about sharing about sexual issues with life partner, almost everybody said it would be very easy to talk on this issue with their partners as there will be no hesitation and shyness and talk with them freely.

CHAPTER FIVE
PEER EDUCATION AND MIGRANT LABOR

Peer education has been widely advocated as alternative or complementary to interventions presented by adults and is becoming an increasingly popular method for promoting behavioral change in HIV prevention programmes (UNAIDS, 1999).

The HIV infected people is increasing and as said by UNAIDS most of the HIV victims are drug abusers, migrant labor. So it is important to aware migrants' people about HIV/AIDS to prevent them from such vulnerable diseases.

The rationale behind peer education is that peers can be a trusted and credible source of information. They share similar experiences and social norms and are therefore better placed to provide relevant, meaningful, explicit and honest information. Young people are trained to offer information and services on issues of sexual and reproductive health based on the premise that most young people feel more comfortable receiving information from people of the same age group rather than from adults. Peer education increases young people’s access to sexual and reproductive health education – subjects which are often not fully addressed by parents and schools – and reaches vulnerable/ marginalized young people. By means of appropriate training and support, the young people become active players in the educational process rather than passive recipients or messengers.

In the society of migrant laborers, what I found is that the peer educators selected were mostly the young house wife, the main goal behind this is that the wives can discuss openly sexual practices with their

husbands, then with others as they feel comfortable. I found that commonly the husbands are out in work so at day or free time the wife gather and talk and share their opinions regarding HIV/AIDS.

Though peer educators can be anyone from the same group male, females but Knight Chess Club has targeted the spouses of migrant laborer as most of the males are out for work and they feel that women are the one to see the family and free and get time for the awareness training.

Though in some peer educators there is also male .At the time of conversation I found that though wife is the peer educators but she personally hesitates to say her husband on using the safety device.

This can be analyzed through the saying of Maya a peer volunteer:

"hamilai tha cha tara mero lokney testo chaina, parya kt ko ma jadaina sarai sojo cha tesailay ma uslai paryog gara bhandina"

Meaning, Maya says that she is well educated about HIV/AIDS, but she does not say her husband to use condom as she believes that her husband does not make a sexual affair with other women beside her.

Peer education is sometimes seen as an easy and inexpensive solution to addressing the sexual and reproductive health of a large number of young people. However, successful peer education programmes require intensive planning, coordination, supervision and resources. Moreover, for peer education programmes to work they must motivate the peer educators and make them feel valued members of the organization. This instills a feeling of ownership, which shows in their work and which young educators pass onto their peers.

As said above to promote the Peer Education programmes, they must motivate the peer educators and make them feel valued members of the organization .The Knight Chess Club has also kept the program of awarding the best peer volunteer for motivating them.

Peer education programmes do not take place in a vacuum. They are shaped by, and respond to, prevailing social norms and community contexts. Peer education can take place in any setting where young people feel comfortable. This can include street corners, social clubs, school grounds, churches, bus stations, work places, homes, and farms. Peer Education meetings can also be formal or informal (IPPF, 2007).

Peer education and support involves the training and use of individuals from the target group to educate and support their peers. Peer-led interventions are based on the assumption that behavior is socially influenced and that behavioral norms are developed through interaction. They are also derived from the extensive literature on the value of social support and nonprofessional help in promoting mental health (IPPF, 2007).

By using peers as resources or resources person, information, skills and caring can be extended in an exponential way and the social climate can be enhanced. Peer education and support can be especially effective among adolescents because friends are their main sources of information about sexual practices, and peer influence often motivates their behavior (PATH 2003).

As said by the program coordinator of Knight Chess Club, while giving training they are very careful, as they have to trained the migrant labor spouse or marginalized women who live under the condition of violence and dependency and most of them are under S.L.C.(school

leaving certificate).They try to see from their perspective as training of peer education technical staff is not as simply as ensuring that know about HIV. So if they don't work on that issue then the whole educations process can be distorted.

5.1 Peer Education Process

Peer educators knock the door of many houses according to their field site, built a rapport at first talk about the HIV/AIDS and try to know their opinion on that, discuss about the contraceptive devices and do counseling when required. They also try to persuade people to try to go to health post or come in their office for their queries and convince them that their conversation will be confidential. I found that some of the peer educators in the community have good name and fame as now they are helping the society for the eradication of vulnerable diseases.

One of the Peer educator, who was the wife of migrant labor, said that before she was just a house wife. She was uneducated and thought that her life would be stuck only in the daily house activities but when she took training in KCC about Peer Education, she is now recognized as peer volunteer. In her village everybody knows her by name and if they have some problem regarding STD, they come to her for advice and suggestion and also she is called in programs to deliver speech or giving training regarding HIV/AIDS.

Regarding the recognition of "peer volunteer ", it's true that women are engaged in some type of positive work but here question arises how much serious are the women regarding the education or did they join the work or became peer volunteer for name and to be recognize in the society?

This is the very serious question regarding the preventive program. It's true that females are engaged but most important thing is to see how much education is being flourished in the society regarding the awareness of HIV/AIDS and its prevention.

One of the peer volunteer Sarita says, "*mero shriman lai yesko (HIV/AIDS) ko bare ma tha cha pheri mailey pani training ma sikey ko kura bhanchu,yesma hami satarka chum ra aru lai pani sartarka hunu bhanchum."*

Meaning, that both Sarita and her husband is aware about HIV/AIDS and they are very much careful on this issue and they too educate others about this…

In case of Sarita, I found that she is one of the active peer volunteer who is aware and educating the society about HIV/AIDS prevention program.

Before few years back she adds that the case was different when she used to talk about HIV/AIDS, condoms people use to say her,*" laj lakdaina yesto kura garna*", meaning don't you feel shy to talk about such issue. It was very difficult to convince people.

This was not only her problem but also of peer educators in general. Due to the radio programmes, drama, commercials people have become aware that to discuss about HIV/AIDS is not the matter of shame but instead it helps people to prevent it.

Since lack of awareness is considered to be the primary factor contributing to the spread of disease and education is viewed as the primary weapon to fight the spread of diseases, resultant prevention programs developed from this theoretical paradigm tend to give primacy

to "awareness-building". For instance, one KAB study done in Nepal recently concluded that, "the most effective strategy to reduce the spread of the epidemic in the short term and protect women is to raise the awareness amongst the men"(Smith 1996)

It cannot be denied that increased awareness is an essential component in the fight against HIV/AIDS in Nepal. It is encouraging that several recent studies have reported success in awareness building among certain population .Among certain groups of CSW (commercial sex workers), for instance, it has been detected that "HIV messages have been successfully disseminated and understood by target populations."(New Era 1997: xiii)

It's very true that due to the awareness people now talk about HIV/AIDS and STDs but when we compare to rural and urban areas, in urban people talk more openly, as there is more education facilities compared to the rural areas. I found that the society of the migrant labors can be categorized in two, one where the cooleys (potters, truck drivers, thelawala, rickshaw pullers less who are less educative and where there is male domination. The other was the mixture of both educative and less educative.

There I met with a Cooley's wife who was the peer volunteer saying that as being the peer volunteer she has the knowledge about HIV/AIDS and she also aware the society about it but she says regarding her husband,

"*tha cha tara mero shriman lai kehi bhandina,aafno logney ko biswas nagareko jasto huncha ni,pheri resayo bhanee ghar kasari chalcha……..."*

Meaning, her husband knows everything but he does not share with her and she too is afraid to share with a fear that he might be angry and may not look after the family.

So what I think is that only awareness cannot prevent HIV/AIDS. Though people are aware but sometime being aware also they hesitate to implement in their own life, as seen in above.

PLHA (people living with HIV/AIDS), were not able to work or live normal life as AIDS was consider as a stigma or a kind of curse. But with awareness of this diseases people now believe that it's not a curse nor the results of bad deed but just an infections like malaria, common colds etc. Nowadays, the numbers of people coming for counseling has increased in compare to past days according to the program coordinator of KCC.

5.2 Significance of Peer Education

Adolescents are more likely to discuss openly sexual practices with their peers than with adults, whom they regard as authority figures ,knowledge and experiences can be shared in a language understandable and accessible to young people. Adolescents identify with and can be positive role models for one another. They are also more likely to change their behavior if they observe liked and trusted peers changing their behavior. In peer education, group discussions and debate can contribute to the development of new collective norms of behavior and relationships (Campbell & Mac Phail, 2002).

Young people are recognized as partners in solving problems. Increased youth participation in decision making contributes to their taking ownership of their own health and taking the initiative to address

some of the problems they experience. This contributes to higher levels of empowerment

Peer education and support can improve relationships and the climate in a school . HIV/AIDS-related peer education in school contexts often aims at postponing sexual involvement and promoting condom use. This is done through sharing information about HIV, providing role models that promote healthy behavior, demonstrating negotiation skills and providing individual support.

Young people are at the centre of the global HIV/AIDS epidemic; both regarding new infections and opportunities for halting the transmission of HIV. Therefore the awareness program is necessary. Research results also indicate that many young people are still at risk because of high-risk sexual behavior, despite sound knowledge about sexual health risks. The level of perceived vulnerability in this group was found to be low, and unprotected sex was common. However, there is growing evidence from several countries that where HIV prevalence is decreasing, it is young people who are reversing the trends, since they are the ones who are more likely to adopt new behaviors. It therefore remains important to focus preventive interventions on young people (Manosh and Mahy,2006,cited in IPPF; 2007).

5.3 Peer Education and Knight Chess Club Prevention Program

Knight Chess Club in Jhapa has been conducting the peer education to prevent HIV/AIDS to labor migrant and their spouses by implementing various programmes. The project i.e. peer education ,established two information and counseling centers in Birtamod and

Kakarvitta and One VCT/STI center in Kakarvitta. According to the program coordinator, to make the program fruitful the Peer educators meeting were conducted where they explore their difficulties faced in the field and develop the strategies from the group through brainstorming. Peer educators were trained on the lacking areas like communication skills, counseling, in-depth HIV/STI knowledge.

KCC is not covering the whole Jhapa district due to the budgetary constrain. It is covering 13 VDCs i.e. Bahundangi, Dhaisan, Santinagar, Duhagadi, Jymirgadi, Chandragadi, Budhabare, Sanishre, Arjundhara, Ghailadubba, Garamani, Charpane Anarmani and two municipality i.e. Mechinagar Muncipality, Bhadrapur Municipality only.

Other activities done to make the programe more effective by Knight Chess Club are

1.Client reach is the one major activities of the comprehensive HIV prevention program. HIV cases have been seen in the migrant labor and their families in Jhapa district where KCC is working. There are HIV message disseminated through various ways but the one and one contact is only the effective intervention strategies.

2.Video show is one of the activities to enter into the community carrying HIV/AIDs and STI message. Video is shown in the community. The video helped to spread HIV message with fun. Compare to the past people's perception towards HIV is changing; still according to them they face challenges and difficulties in the community

As per their saying, video show could give picture of the potential risk that anybody could be encountered. It can motivate people for further in depth knowledge on HIV. It can create demand of HIV education. So it is

carried out. There are not many options of HIV related video. The one which they have been presenting is too long (2 hours) and sometime people could not mange time. So, they prefer to have one and half hour's similar video which would be more productive and effective. As this is funded by GFATM ,so the HIV related video is also given by them which is two long but as said by the program coordinator they are looking forward to shorten it by talking with GFATM.

3. VCT one of the major component of the comprehensive HIV prevention program. KCC has one VCT/STI center in Kakarvitta. They actually counseled 1294 clients and tested to 1206. Among the tested one 32 (22male and 10 female) Positive cases were identified and referred to the respected centre and hospital for further support and treatment.

The different activities conducted to create demand of the VCT like FM program, Video show, ML mobilization, mother groups orientation, student training, IEC distribution including PE and OW mobilization outcome will be seen when risk group people do visit the service site and utilize the facilities. Their VCT /STI site is providing regular service and is so far satisfactory. The collaborative effort of activities creates good clients flow in the VCT. It can be seen from the VCT site service utilization register.

4. STI is also one of the major program activities. In the STI case Management Knight Chess Club Planned to manage 800 cases. In STI case management the flow of clients seemed to be good. The overall input of the different community focusing activities like, Video Show, Orientation, and FM Jingle has helped to spread the message up to the remote areas. The person hears the message and headed to the center for the further support and treatment, the people who came for counseling

replied that they were happy after the STI services .It is taken very positively and they too provide service to the needy people who were suffered from last five years.

In the STI alternative person are available with them which bridge the gap in case of one in leave. But the medicine supplies from NCASC (National Center for AIDS and STD control) don't match as per other demand however the DPHO support is excellent to fill the gap.

5. Condom Distribution is major activities of the program. People still feel uncomfortable to take condom from centers though they need it. The program have been distributing in one and one reach through PE(peer educators), OW(organization workshop) and ICC(International Co-ordination Community) and I found that in every center one condom box is kept in isolation area.

6. Spouses' orientation- Knight Chess Club provides orientation to the staff by teaching them how do they approach to the people at the time of education and what they need to do when they are in field for educating migrant family about HIV/AIDS.

7. F.M broadcast - KCC had FM program for enabling people and message dissemination from Pathivara FM (local FM) throughout the year. Learning from the past experience the original nine event FM program was changed as a *JINGLE* for nine month and continuously broadcast from Pathivar FM Damak twice a day before the main news in the morning and evening. The objective of the program is to spread the VCT/STI message up to the grass root level for demand creation. Compared to the half an hour nine event JINGLE was found more effective and productive. The phone number provided in the JINGLE was

inquired by the clients and services have been received by them. This is the indicator of the effectiveness of the program.

8. Information Education Communication (IEC) distribution is another activity. One good thing in IEC distribution is that it reaches up to the hidden people. The shy nature and hesitant people could carry and read it comfortably in their own time. One IEC could be use for many people. But it could not provide the curiosity of the clients in depth. If any question arises they have to contact with somebody. The IEC (Information, Education, Communication) includes about the awareness program of HIV/AIDS.

9. Safer travel kit bag distribution – FPAN (Family Planning Association of Nepal) introduce a tool kit bag to be distributed to migrant labor. The bag has been distributed through PE, OW and ICC with full record to real migrant only. The migrants are happy for the bag but feedback is not received yet. Bag distribution is a good idea to spread the message of HIV. The migrants kept their daily uses items during their outside stay and see the message repeatedly which help to change their behaviors in the long run.

So far there are some comments they made at their first glance. One comment is the bag is too long and the items kept into the bag are not connected with HIV like key ring, Nail cutter etc. The mirror is too small they commented. Other than they have taken bag very positively.

When I asked to the returnee migrant they said that though the bag given to them reminds about the messages of HIV/AIDS and its awareness but they feel more that the bag represents a handy tool where they can keep their goods like keys comb etc.

10. Monitoring from FPAN- Monitoring visit from FPAN regional coordinator, FPAN central office were made and observed KCC activities. They had given feedback for better performance and KCC team and staff also shared their concerns and issues to the FPAN Project Director during the meeting.

11. Training & Workshop- FPAN is continually working in the capacity building of SR's staff'. FPAN organized M&E training and financial management training was held in Pokahara for M&E associate and program coordinator. Similarly finance officer received financial management training.

FPAN took one staff, Program Coordinator, for exposure visit to Mumbai India from November 6 to 13. During the visit they got chance to observed HIV related activities implemented in Mumbai, India. Two full days were arranged for study visit in different NGOs working with MSM (men having sex with men) and Migrant labor. The exposure visit helped them to generate new activities and ideas which could be implemented in Nepal as well, as said by them.

KCC is doing their best for the prevention of HIV/AIDS among the labor migrants. Though some of the drawbacks could be analyzed from the above study. The infected and affected people are mobilized by KCC in a good percentage which is helping to explore and identify the other risk people.

The best part is that they were able to convince at least one VDC, Bahundangi and allocated NRs 20000/- for the affected and infected family.

Anthropology has played an important role in AIDS prevention research (Singer and Bear, 2007). The social dynamics of AIDS transmission and its social evaluation illustrate why it must be addressed not only as a disease but also as sickness and illness. Cultural perspectives are essential for addressing the spread of HIV infection because, without cure, the only effective response is prevention, which requires changes in people's behavior. Cultural perspectives are necessary for determining

- Factors predisposing high-risk populations
- Risk behaviors in the general population
- Relatively secretive and hidden aspects of high-risk behaviors
- Social responses affecting the perception of AIDS
- Medical, political, and economic policies that affect AIDS research and treatment

Behavioral and community-based efforts are necessary to assist populations in avoiding exposure, based on knowledge regarding the immediate contextual influences on risk behavior. High rates of HIV/AIDS in minority populations in part reflect failures of prevention programs to provide culturally appropriate interventions. What leads people to engage in behaviors that expose them to HIV? When is exposure most likely to occur? The ability to change relevant behaviors is complicated by the primary mode of transmission—sex—that constitutes a tabooed area in all cultures. The need to alter sexual behaviors not ordinarily discussed makes it of utmost importance to understand the social and cultural factors affecting risk-related behaviors. Cultural approaches provide understandings of the context and motivation of high-risk behaviors that must be addressed for effective risk-reduction programs.

Assessments of changes in high-risk behaviors among communities receiving AIDS prevention programs show that education alone is not sufficient to eradicate high-risk behaviors. Cultural approaches are necessary to identify factors that inhibit the adoption of safe-sex techniques and contribute to the continuation of unsafe sexual practices. Because behavior is typically reinforced in social networks and interpersonal contact, knowledge of the norms, beliefs, and influences within a community is essential for understanding how to prevent the spread of HIV.

Anthropologists have also made contributions to the study of AIDS in directing attention to the specific issues involved in various ethnic and cultural groups. Cultural aspects of AIDS prevention programs are illustrated in Singer's (1992) approach to the AIDS epidemic in U.S. ethnic minorities. He shows that anthropologically informed research is necessary for project design, implementation of project structure and content, and evaluation of project effectiveness. Anthropological methods are particularly effective in acquiring in-depth understandings that provide a basis for culturally sensitive approaches. Implementing culturally sensitive approaches also requires community liaison skills, producing partnerships among community and health care organizations by engaging community participation. Culturally sensitive, socially relevant, and locally grounded information needs to be obtained before program development. Ideal methods for obtaining these data include the anthropological methods of participant observation, informal and unstructured interviews, and focus groups made up of relevant participants (e.g., sex workers or injection drug users). These methods accommodate to natural social environments in ways that facilitate

disclosure, allow group dynamics to contribute insights, and express variability within the target group.

Interventions with culturally sensitive content produce far higher levels of program participation. Culturally relevant interventions require culturally appropriate project structures (e.g., location, context, scheduling).Cultural sensitivity includes accessibility, culturally appropriate groupings (e.g., single sex), scheduling, appropriate language or idiomatic formats, and other cultural aspects affecting interpersonal relations and disclosure. Anthropological approaches have been effective in ascertaining the resistance to safe-sex practices found in the cultural dynamics of specific groups.

Community collaboration helps ensure the appropriate management of issues such as gender roles, community differentiation, interpersonal and social dynamics, and other local conditions affecting participation. This requires that interventions be tailored for each population based on the risk behaviors and social factors affecting each specific subculture (e.g., women versus men, ethnic differences, and generational differences). Natural social networks provide invaluable assistance in the diffusion of AIDS prevention programs, helping to ensure that educational messages are provided in linguistically, culturally, and socially appropriate formats. These networks also provide the peer support necessary to produce community-level behavioral change necessary for AIDS prevention. Prevention programs should use peer educators and culturally knowledgeable consultants as role models. Anthropology has also made contributions to AIDS care in areas of understanding sickness, the stigma produced by the HIV/AIDS diagnosis.

Waterston (1997) argues that the popular prevention theories based on educational interventions and behavioral change, while helpful in reducing the spread of HIV, are inadequate because they focus attention on the individual, obscuring the social and economic factors that contribute to HIV infection. Waterston explores an anthropologically informed alternative based on principles of social responsibility and advocacy for social justice through humane social programs, principles engaged by critical and political economy approaches.

5.4 Challenges Faced by Knight Chess Club for Peer Education Program

Knight Chess Club are facing various challenges in giving peer education program. Limited coverage is one the challenge, Jhapa district has 47 VDC's and 3 municipalities and they are covering just two municipalities and 13 VDC only due to the budgetary constraint. So expansion of the program is most.

Treatment Care and support for HIV affected and infected, the infected cases are increasing highly but they are not able to support them in OI (opportunist infection). Care and support is big issue still provision of management of OI and CD4 (component of blood)is most as supportive activities for VCT(voluntary counseling testing) center. Single Lab personal in the lab, during the absent of Lab assistant they were not able to provide VCT service so VCT need to develop as a alternative Lab support providing basic training. Political commitment to fight with HIV, the positive cases are increasing but the political parties are not taking HIV as their issue as said by the program coordinator. Follow up of old clients, the project aim is to reach to migrant as they reach and educate them but once they leave for their destination they don't show up for two

to three years so it is difficult to make repeated visit with migrant. Only the spouses and family could be met. Working under minimum salary/ benefits: The market price is climbing high but the salary and benefits are very low.

Difficulties in time management in the wider areas: The areas are wider and means of public means of transportation are not available everywhere in such situation time has been consuming which could be use for productive work.

Though Knight Chess Club is found to work in the preventive program of HIV/AIDS, still it is facing some challenges, which stands as an obstacle to educate, aware people about such a vulnerable diseases.

In my observation I notice that migrant labor or people are not much conscious. Like for example in the follow up old clients, people come for counseling and once they leave or go for work outside they do not come back so how can the program analyze that whether their counseling is being effective or not.

5.5 Factors Affecting Effectiveness of Peer Education

During my research, I found the knowledge; attitude and behavior were also the major factor affecting the effectiveness of the Peer Education.

People have knowledge about HIV/AIDS and they are well aware of unsafe sex but still in behavior they sometime neglect or become careless and don't use safety device taking risk.

One of the interviews taken with the cooley's wife has made me think about the gender or being dependent on husband. She herself is the

peer volunteer but during their sexual relation she is not able to tell her husband about the safer sex as she is afraid that her husband might be angry if she discuss about it.

This has made me think that being peer volunteer she is not able to share or say and educate her husband about HIV/AIDS, analyzing this issue I believe that it would be difficult for the other wife to share as well .The society where I conducted my field study is male dominated and mostly men earn and their wife look after their families. So the wife hesitates to share or tell their husband about HIV/AIDS education though they are aware. This is also one of the factors affecting the effectiveness of Peer Education.

The sad truth is that we work and educate people about HIV/AIDS but we don't do M&E (monitoring and evaluation) as well as we should (Personal communication with program coordinator of Knight Chess Club). However, Knight Chess Club went on to note that programs and organizations do not necessarily have to do M&E if they base their programs off of effective ones in other countries. He stated, Funds are limited and organizations make a choice between a) performing larger interventions of perhaps unknown efficacy, and b) performing smaller interventions and channeling funds into monitoring and evaluating those small interventions (Personal communication with program coordinator of Knight Chess Club).This decision to spend funding on program execution instead of evaluation may be wise in certain circumstances; however, it puts a limitation on this research study's ability to access evaluative program information on HIV/AIDS prevention, education, and treatment organizations in Jhapa. Lastly, during the research process, the greatest collection of information was gathered from only one organization. This could perhaps result in the illusion that the Knight

Chess Club program is most effective based on the fact a greater deal of relative information was attained regarding Knight Chess Club in comparison to the other examined programs.

CHAPTER SIX
SUMMARY AND CONCLUSIONS

6.1 Summary

HIV/AIDS has become an ever increasing problem since 1980s.Now it has a global problem. This problem has become much more alarming and critical in Africa and Asian countries. Nepal is not an exceptional to this. Many governmental and nongovernmental organizations at national and international levels have been involved in HIV/AIDS control and management. Most of the programs related to HIV/AIDS control and management are focused on raising people's knowledge, attitude and behavior towards reproductive health, STDs, and HIV/AIDS. In other words, people's knowledge, attitude and behavior towards reproductive health, STDs, and HIV/AIDS are consider as most crucial factors in the HIV/AIDS control and management. It may also be noted that the management awareness program and the control of HIV/AIDS has been mostly targeted to youths, adolescents and the migrants labors. They have also provided youth friendly services (YES), voluntary counseling and testing (VCT) services and peer education program for the prevention of HIV/AIDS. Thus the people's knowledge ,attitude and behavior towards reproductive health, STDs, and HIV/AIDS are considered as most crucial factors in the HIV/AIDS control and management. For the prevention of HIV/AIDS and awareness of STDs among migrant population programs like peer education has been launched in Jhapa. With this consideration in the background, this study was undertaken to find out the effectiveness peer education on the comprehensive HIV/AIDS prevention program among migrant population and their spouse in Jhapa district.

This study is undertaken in Mechinagar -10, Kakarvitta, Jhapa district . This study is based on description. Mostly qualitative data were collected from the field through the various uses of tools and techniques in order to fulfill the stated objective and to answer the research question. The data was gathered from primary and secondary sources. The primary data was gathered from the field through the observation, interview (unstructured) and key informant interview. The data and information collected through interview were processed manually. Both the qualitative and quantitative data were collected. The collected information were classified and tabulated as per the objective of the research. The quantitative data was also used to know the numbers of people infected by HIV virus and to see the process of increasing or decreasing the numbers of infected people as per the demand of the objective of the research. The data is presented in the tabulation form for the information.

From the study it was found that yearly, the HIV infection people is increasing and as said by UNAIDS most of the HIV victims are drug abuse, Migrant labor etc. So it is important to aware people about HIV/AIDS to prevent them from such vulnerable diseases. Peer education has been one of the important strategies in the prevention of HIV/AIDS diseases, and it's been helping the migrant labors from the vulnerable diseases like HIV/AIDS. Most of the migrant labor has understood HIV/AIDS through the peer education and about the sexually transmitted diseases .They have understood the unsafe sexual contacts, blood transfusion are the main mechanisms of HIV/AIDS transmission. Some of the migrant labor has misconception that HIV/AIDS is transmitted due to the bad deeds or fate. Use of condoms during sexual intercourse, not having sex with unknown person and use of sterilized surgical

instruments are suggested as the main measures for the prevention of HIV/AIDS through the peer education. Due to the peer education program given by the Knight Chess Club in kakarvitta to the migrant labors it have been found that it's very useful to them and the people are keen interest to know more about the HIV/AIDS.

The research finding as discussed above show that the Peer education program which is the prevention program of HIV/AIDS run by Knight Chess Club in Mechinagar-10 karkavitta Jhapa to the migrant labor is effective. The migrant labor is benefitted with the program of peer education. They have become aware about the HIV/AIDS and STDs and when they have any doubts or queries about the HIV/AIDS or STDs they go to the counseling center which is provided by Knight Chess Club.

The peer education program is able to aware people about HIV/AIDS among labor migrant. While doing study, researcher found that all of them have heard about HIV/AIDS. However they are not equally familiar with other types of STDs such as Hepatitis B, Genitals Warts, Trichomoniasis, syphilis , Gonorrhea and Chlamydia. The main source of information about STDs and HIV/AIDS are radio, TV, pamphlets, magazines. The media of the knowledge and information seem to have a tendency of focusing mainly on the publicity of HIV/AIDS, ignoring other types of STDs. This is perhaps the reason why HIV/AIDS is the mostly wide known type of STDs.

The peer educators are mostly the wife of the migrant labor or the daughter from the migrant family. This helps to flourish awareness messages of HIV/AIDS in the migrant society. Most of the migrant labor have understood about the HIV/AIDS and sexually transmitted fatal

diseases, their wives who are the peer volunteer shares the sexual issues among them which help in the prevention of vulnerable diseases.

In some of migrant family though wife is the peer volunteer. I found that the wife does not talk or share the sexual issues with her husband and have unsafe sex .When I asked about the reason she said that she is afraid to tell her husband about using the condom and have fear that if she says to use the safety device her husband may be angry and leave her. As most of the migrant society are male dominated, and though the wife has the knowledge about HIV/AIDS do not share with their husband due to the fear of their husband.

The peer education program conducted by Knight Chess Club is limited to certain places mostly the urban areas or the villages which is close to town. The urban areas have relatively higher level of knowledge and information about STDs and HIV/AIDS as compared from the rural area. A number of factors may be responsible for such a difference. Firstly, the traditional cultural values and social norms of restricting the people on talking about sex related issues in the family prevails more in rural areas than urban areas. Secondly, the people of urban areas are more exposed to the media of knowledge and information such as radio, T.V, telephone, computer, magazine etc. Fourthly, the STDs and HIV/AIDS related programs carried by various governmental and nongovernmental organizations are mostly concentrated in urban areas. And fifthly, the publicity of STDs and HIV/AIDS through various health education and information materials (HEIC materials),such as radio, T.V., posters, pamphlets public speech, slogans, celebration of condom day/ HIV/AIDS day, procession, hoarding board ,etc are more concentrated in urban areas than in rural areas.

Peer education as the behavior-change strategy is based on both individual cognitive as well as group empowerment and collective action theories. For example, Social Learning Theory Asserts that people observing the behavior of others and that some serve as models who are capable of eliciting behavior change in certain other individuals (Bandura 1986).The Theory of Reasoned Action States that Person's perception of social norms or beliefs that people important to them hold about a particular behavior can influence behavior change (Fishbein and Ajzen 1975).The Diffusion of Innovative Theory posits that certain individuals(opinion leaders) from a given population act as agents of behavior change by disseminating information and influencing norms in their community (Rogers 1983).Peer education draws on elements of each of these theories in its assumption that certain members of a given *peer* groups (peer educators)can be influential in eliciting individual behavior change among the peers.

As the above statement says, that peer educators can be influential in bringing behavior change among the peers, we can see the example of respondent who is the wife of peer educators.

"Phila mero budo lai tha vhayara pani natha pako jasto garthiyo,tara miss (peer educators)lay hami lai AIDS ko bare ma jankari deyapachi ulatai malai k garnu parcha k garnu hudaina bhanera bhancha".

Which means before, her husband had information about HIV/AIDS but he never told anything about it when his wife got information from Peer Volunteer now her husband shares her about the sexual issues.

Here, we can see the behavior change in husband after his wife was aware about HIV/Aids. Before he knew about it but never shared with his wife thinking that she could not understand due to the lack of knowledge.

Despite the fact that HIV/AIDS peer education programs rely heavily on unpaid or low paid field staff peer programs it is observe through the study that it still need to continually generate funding for peer education incentives, professional / supervisory salaries, educational materials, training costs and office space and equipments to make the program more effective.

The sad part according to the program coordinator of Knight Chess Club is that in the budget of village Development committee there is no program related to HIV/AIDS, though they have some budget in health sector but not in HIV/AIDS sector in particular. In an informal talk, researcher came to know that, the HIV/AIDS program are highly donated by others country or INGOs, so the V.D.C. people say that the budget which come there is for other developmental process as other development Program do not have the donors. Here, the development programs mainly means the infrastructure like roads, buildings, hospitals, bridges etc.

He further says that HIV/AIDS peer education should be supported by government as part of their commitment in providing health care as the basic of human right.

6.2 Conclusion

To make the awareness or the peer education program effective, the study recognized the importance of the community involvement for HIV/AIDS prevention, education and treatment programs, it also touched

upon the fact that the program without access to consistent and reliable resources would not be as effective as well funded initiatives. The study also recognized that a program could not be effective relying on funding alone, presence within the community is extremely important. Thus to make the program or peer education effective there should be the combination of community efforts and assistance of the Club who is implementing the peer education program.

The result of this study demonstrates the great importance of community involvement in the implementation of HIV/AIDS prevention, education and treatment program and initiatives. Cultural traditions can play a considerable role in a community's unwillingness to accept the presence of unfamiliar or new things, especially when it comes to rarely discussed subjects such as sexual behavior. Ultimately, it is the decision of an individual to accept the resources given to him or her. Large scale organization could spend billions of dollars a year on treatment and education but if no one is willing to listen or come for help, the service will be futile. Thus, as this research paper has demonstrated, program acceptance, support and execution within a community are absolutely crucial in order for an initiative to be successful in the prevention, education and treatment of HIV/AIDS in Jhapa.

A common limitation to effective HIV/AIDS treatment programs is the availability of Anti-Retroviral (ARV) Treatment. Anti-Retroviral Treatment is the medication regiment used to enhance an individual’s immune system functioning and is currently the most effective form of HIV and AIDS treatment. Each person requires an individualized drug regimen, usually consisting of over five different types of medications. Not only are ARVs expensive, but they must be taken at very specific times on a regular basis. This is a discipline that requires a sufficient

amount of education on each individual drug and poses a challenge in providing the people of Jhapa infected with HIV or AIDS with adequate and regular treatment. Nonetheless, universal access to ARVs for all individuals who meet the medical criteria is the ultimate goal of the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS).

Monetary issues are not the only factors limiting certain individuals' access to ARV treatment. As stated by Jones (2005), "Scaling up ARVs takes place…against a more general backdrop of health interventions that seldom reach the poor and reflect a skewed distribution of basic health services within and between countries." This issue of equity in access to treatment is rarely addressed, particularly in documentation of criteria for services, by the organizations that have the capability of providing such treatment (Jones, 2005). Ultimately, the problem proves to be that while the amount of ARVs that can be provided through UNAIDS, WHO, and other similar organizations is limited, there is still no written criteria on how to determine who should be first in line for receiving this treatment.

Much of the social research conducted on HIV/AIDS in Nepal has been in the form of knowledge, attitudes and perceptions/ behavior (KAP/B) studies. The majority of the findings above (concerning the cultural factors that contribute to the spread of HIV/AIDS) are, in fact, the result of such KAP/B studies. This type of study is a product of the Health Belief Model and the Theory of Reasoned Action (Tones 1994) that posits lack of awareness as the primary factor contributing to the spread of diseases and education as the primary weapon to fight it. As it will be seen later Nepali Policy Planners, informed by this Western

Applied Anthropology perspective, made "awareness building" the major focus in Nepal's First prevention Strategies and programs.

Although, most of the people stated that peer education is perceived to be an effective strategy, not all programs had collected outcome data to support this hypothesis. Given this situation, I felt that more high-quality rigorous studies to document the effectiveness and cost effectiveness of peer education are needed to sustain donor funding , help improve programs and to make the program more effective.

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