"Situation Analysis: Vulnerability and awareness about HIV/AIDS amongst labour migrants"

A dissertation submitted in partial fulfillment of the requirements
For the award of

Post-Graduate Diploma in Health and Hospital Management

By

Vivek Bhargava

ENROLLMENT NO: PG/10/60

International Institute of Health Management Research
New Delhi

New Delhi -110075

2010-12

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Under the guidance of

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Team Leader
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This is to confirm that I have reported to my internal advisor regarding my dissertation and internship placement. During my internship I will regularly keep in contact with my advisor and keep her updated about my progress. I will also carry out a special study (or, dissertation) on a particular areas/department/programme in consultation with the concerned authority of the organization. I will prepare a brief study proposal on the agreed topic and send to my advisor before January 23, 2012 for approval. I understand that the general internship report and the special study report needs to be approved by my advisor before the presentation and subsequent submission of the final report before April 02, 2012.

Vivek Bhargava

Signature of the graduate student: Date: 8/05/2012.

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TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Mr. Vivek Bhargava** from **International Institute of Health Management & Research, Delhi** has successfully completed his 'Dissertation" at **Technical Support Unit, Delhi Managed** by Raman Development Consultants Pvt. Ltd. from 2nd January, 2012 to 31st March, 2012. While his tenure with the organization he has worked on the project titled **"Situation Analysis: Vulnerability and awareness about HIV/AIDS amongst labour migrants".**

As per our measurements and reporting structure he is hard working and has been excellent During his tenure.

We wish him all the best for all future endeavors.

Yogesh Dubey
Team Leader (Overall & Strategic Planning)
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FEEDBACK FORM

Name of the Student:	Mr. Vivek Bhargava
Dissertation Institution:	Technical Support Unit, Delhi
Area of Dissertation:	Public Health (HIV/AIDS)
Attendance:	Regular
Objective met:	Yes
Deliverable:	Project work, Dissertation report writing, Data analysis and compilation
Strengths:	Dedicated towards work, Sincere and hard working
Suggestions for Improvement:	Plan ahead and manage time effectively

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Certificate of Internship Completion

Date. 7.5.2012.

TO WHOM IT MAY CONCERN

This is to certify that Mr. Vivek Bhargava has successfully completed his 3 months dissertation in our organization from January 02, 2012 to March 30, 2012. During this dissertation he has worked on project **"Situation Analysis: Vulnerability and awareness about HIV/AIDS amongst labour migrants"** under the guidance of me and my team at Technical Support Unit, Delhi.

As per our measurements and reporting structure he is hard working and has been excellent during his dissertation.

We wish him good luck for his future assignments

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Certificate of Approval

The following dissertation titled **"Situation Analysis: Vulnerability and awareness about HIV/AIDS amongst labour migrants"** is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
DR. NITISH DOBHA	
DR DHARMESH CHAL	

Certificate from Dissertation Advisory Committee`

This is to certify that **Mr. Vivek Bhargava,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management,** has worked under our guidance and supervision. He is submitting this dissertation titled **"Situation Analysis: Vulnerability and awareness about HIV/AIDS amongst labour migrants"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Preetha GS
Associate Professor
HMR
New Delhi
April 2012

Mr. Yogesh Dubey
Team Leader
Technical Support Unit
New Delhi
April 2012

ACKNOWLEDGEMENT

A journey is easier when you travel together. Interdependence is certainly more valuable than independence.

This project report is the result of three months training whereby I have been accompanied and supported by many people. It is a pleasant aspect that I now have the opportunity to express my gratitude for all of them.

Firstly I convey my regards and thankfulness to Mr. Yogesh Dubey (Team Leader - Strategic & Overall Planning) for their vital encouragement and support.

I am fortunate to get this opportunity to convey my heartfelt thanks to my faculty and guide Ms. Preetha GS (Associate Professor, IIHMR, New Delhi), for granting me the permission to do this project in RDC.

With immense pleasure I express my gratitude and respectful regard to the RDC staff and the head of departments in RDC.

The acknowledgement would be incomplete if I don't mention about my friends and all my colleagues who helped me throughout the project.

My sincere thanks to all those who have been associated with this work.

-Vivek Bhargava

Abstract

Poverty in developing countries attracts workers from rural areas, resulting in the concentration of large number of labor migrants in urban. Most migrant laborers live away from their families, and hence, may search for companionship, and sexual intimacy. The potential role of migration in spreading HIV/AIDS is further heightened as a result of frequent visit of migrants to their native places and return migration, as well as a high propensity of continued migration especially among transient construction workers. Present study aims at exploring the awareness and vulnerability towards HIV/AIDS amongst the male migrant labour. In the months of January to February 2012 from (19th January 2012 to 29th February 2012), study was conducted through distributing anonymous survey questionnaires. The study sample Comprised of the Migrant Labour class men, who are living away from their family and residing at Sangam vihar, South Delhi area. Convenient sampling is used to assess the Awareness and vulnerability towards HIV/AIDS. Data thus obtained is then analyzed and inferences were made. Since migrant laborers from small towns come to the urban areas (cities and metros) and being away from home get into contact with the high risk groups and their chances of getting infected increases. Social policies relating to health care services should be worked out to help mobile people living with HIV/AIDS easily access HIV information, commodities, HIV testing and treatment as well as other necessary services such as broadening health insurance options available to migrants, including non-regular and un-documented ones.

Key Words – HIV/AIDS, Migrants, Vulnerability, High risk groups.

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Abbreviations

HIV	Human Immuno Deficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
HRG	High Risk Groups
MSM	Men Having Sex with Men
FSW	Female Sex Workers
IDU	Injecting Drug Users
PLHIV	People Living with HIV
STI	Sexually Transmitted Infections
ART	Anti-Retroviral Treatment
BCC	Behaviour Change Communication
CSO	Civil Society Organization
CBO	Community Based Organization
CCC	Community Care Centre
DIC	Drop-In-Centre
ICT	Integrated Counseling and Testing
ICTC	Integrated Counseling and Testing Centers
PPTCT	Prevention of Parent to Child Transmission
NACO	National AIDS Control Organization
STRC	State Training and Resource Centre
SACS	State AIDS Control Societies
TSU	Technical Support Unit
DAPCU	District AIDS Prevention and Control Unit
NGO	Non Government Organization

PART –I

DISSERTATION REPORT

Organization Details:

RDC (Raman Development Consultants) is currently managing the Technical Support Unit (TSU) for Delhi for National AIDS Control Organization (NACO), Ministry of Health & Family Welfare, Government of India funded by The World Bank since April 2008. The TSU supports NACO and Delhi State AIDS Control Society (DSACS) for effective implementation of Targeted Intervention projects in Delhi with high risk groups like Commercial Sex Workers, Men having Sex with Men, Intra Venous Drug Users and Truckers and Migrants being implemented by various civil society organizations. Currently TSU is providing technical support to about 88 CSOs implementing TI projects however the program will be scaled up by initiating 3 more TI projects.

Mission

RDC mission is to raise the standard of living of developing countries through enhancing the social, entrepreneurial and leadership capital of people and institutions.

Vision

RDC vision is to bridge gaps between visions, ideas, stakeholders and implementation practices and systems through holistic approaches.

Motto

“Your partner in Development".

Believes

RDC believes in building long term relationships with clients and “working with” rather than “for clients” and provide “value for money to the client".

RDC has implemented GIPA (Greater Involvement of Positive People) and is an equal opportunity employer.

RDC practices ethical and good business practices and is people driven institution. RDC practices transparency and right based approaches and respects diversity.

About Organization

Raman Development Consultants is a limited is a limited liability Institution set up under Indian Laws since 1989.

RDC provides Management Consultancy, Training and Capacity Building and Research Services.

Focus Areas

Focus areas of RDC include Health, Panchayati Raj, Rural Development, Urban Development, Tribal Development, Sustainable livelihood, Public Private Partnership, Infrastructure development, Corporate Social Responsibility, Education and Natural Resource Management.

RDC has a multidisciplinary team of above 30 full time core team members supported by a rich bank of more than 1000 project associates all over India and surrounding countries.

Services

Development Sector:

- Strategy design and development.
- Program design and development.
- Mission and scoping studies, Project definition reports.
- Management planning and control systems, M & E frameworks and studies, Management Information Systems.
- Training and capacity building of human force and institutions.
- Partnership management, Programs and funds/grants management.
- Research- qualitative and quantitative.
- Documentation- Audio-Video formats and print publications.
- Communication research and strategy development for IEC/BCC.

Corporate Sector:

- Corporate Social Responsibility: Designing & Planning of the function, Capacity building and training of the CSR team, Research to indentify needs, Developing projects, Partners, projects and funds management, Monitoring & Evaluation.
- HR Outsourcing: Recruitment & Contracting, Payroll & Database Management, Leave & reimbursement management, Travel assistance, Equipment provision, Incentive planning, Remuneration package planning, Insurance, investment & tax planning, Performance assessment facilitation, Reporting.
- PPP Facilitation: Sector Identification, Project Development, Proposal Development, Negotiations with Clients/donors, Monitoring & evaluation of projects.
- Healthy lifestyle services: Diagnostic studies, Specialist Counseling Services, Lifestyle related packages.
- Organization development: Strategic Change Management, Team Building, Productivity Improvements.
- Training and capacity development especially in soft skill areas.
- Market and consumer research.

NGO/CBO Sector:

- Organizational development and strategic planning.
- Resource mobilization assistance.
- Community mobilization and building peer force.
- Legal assistance for institutional formation.
- Training and capacity building.
- Documentation-audio-video and print formats.
- Linkages and Networking.

PART –II

DISSERTATION REPORT

Chapter I

INTRODUCTION

India has the world's third-largest population suffering from HIV/AIDS [UNAIDS 2010]. However, the estimated number of human immunodeficiency virus (HIV) infections in India has declined drastically in recent years—from 5.5 million in 2005 to below 2.5 million in 2007. These new figures are supported by the World Health Organization and UNAIDS. According to the United Nations 2011 Aids report, there has been a 50% decline in the number of new HIV infections in the last 10 years in India.

Despite being home to the world's third-largest population suffering from HIV/AIDS, the AIDS prevalence rate in India is lower than in many other countries. In 2007, India's AIDS prevalence rate stood at approximately 0.30%—the 89th highest in the world. The spread of HIV in India is primarily restricted to the southern and north-eastern regions of the country and India has also been praised for its extensive anti-AIDS campaign. The US$2.5 billion National AIDS Control Plan III was set up by India in 2007 and received support from UNAIDS The main factors which have contributed to India's large HIV-infected population are extensive labor migration and low literacy levels in certain rural areas resulting in lack of awareness and gender disparity. The Government of India has also raised concerns about the role of intravenous drug use and prostitution in spreading AIDS, especially in north-east India and certain urban pockets. A recent study published in the British medical journal "The Lancet" in (2006) reported an approximately 30% decline in HIV infections among young women aged 15 to 24 years attending prenatal clinics in selected southern states of India from 2000 to 2004 where the epidemic is thought to be concentrated. The authors cautiously attribute observed declines to increased condom use by men who visit commercial sex workers and cite several pieces of corroborating evidence. Some efforts have been made to tailor educational literature to those with low literacy levels, mainly through local libraries as this is the most readily accessible locus of information for interested

parties. Increased awareness regarding the disease and citizen's related rights is in line with the Universal Declaration on Human Rights.

In 2009, 2.4 million people were estimated to be infected with HIV in India. Having a population of around a billion, an increase in 0.1% of HIV prevalence would mean an increase by over half a million in the HIV-infected patients.

The estimated adult HIV prevalence was 0.32% in 2008 and 0.31% in 2009. The states with high HIV prevalence rates include Manipur (1.40%), Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%).

The adult HIV prevalence in India is declining from estimated level of 0.41% in 2000 through 0.36% in 2006 to 0.31% in 2009. Adult HIV prevalence at a national level has declined notably in many states, but variations still exist across the states. A decreasing trend is also evident in HIV prevalence among the young population of 15–24 years. The estimated number of new annual HIV infections has declined by more than 50% over the past decade.

According to Mr Michel Sidibé, Executive Director of UNAIDS, he stated that India’s success comes from using an evidence-informed and human rights-based approach that is backed by sustained political leadership and civil society engagement. India must now strive to achieve universal access to HIV prevention, treatment, care and support.

In 1986, the first known case of HIV was diagnosed by Dr. Suniti Solmon amongst female sex workers in Chennai. Later that year, sex workers began showing signs of this deadly disease. At that time, foreigners in India were traveling in and out of the country. It is thought that these foreigners were the ones responsible for the first infections. By 1987, about 135 more cases came to light. Among these 14 had already progressed to AIDS. Prevalence in high risk groups reached above 5% by 1990. As per UNDP's 2010 report, India had 2.39 million (23.95 lakh) people living with HIV at the end of 2009, up from 2.27 million (22.7 lakh) in 2008. Adult prevalence also rose from 0.29% in 2008 to 0.31% in 2009.

In 1986, HIV started its epidemic in India, attacking sex workers in Chennai, Tamil Nadu. Setting up HIV screening centers was the first step taken by the government to screen its citizens

and the blood bank. To control the spread of the virus, the Indian government set up the National AIDS Control Program in 1987 to co-ordinate national responses such as blood screening and health education.

In 1992, the government set up the National AIDS Control Organization (NACO) to oversee policies and prevention and control Programs relating to HIV and AIDS and the National AIDS Control Program (NACP) for HIV prevention. The State AIDS Control Societies (SACS) was set up in 25 societies and 7 union territories to improving blood safety. In 1999, the second phase of the National AIDS Control Program (NACP II) was introduced to decrease the reach of HIV by promoting behavior change. The prevention of mother-to-child transmission Program (PMTCT) and the provision of antiretroviral treatment were materialized.

In 2007, the third phase of the National AIDS Control Program (NACP III) targeted the high-risk groups, conducted outreach Programs, amongst others. It also decentralized the effort to local levels and non-governmental organizations (NGOs) to provide welfare services to the affected.

REVIEW OF LITERATURE

Migration and sex risk Development projects as well as poverty in developing countries attract workers from rural areas, resulting in the concentration of large number of labor migrants in urban areas (Bloom and Carliner, 1988; Cohen, 1992; and Godwin, 1997). Most migrant laborers live away from their families, and hence, may search for companionship, and sexual intimacy. Further, there are cultural beliefs linked to sexuality, sexual performance and masculine identity, which support the search for female partners. Blue films and other forms of pornography provide sexual fantasies that are played out with readily accessible commercial sex workers who are reported to be willing to respond to men's requests for specific behaviors.

Labour migrants may be exposed to various other environmental risk factors, such as the availability of recreational outlets like beer bars, discos, video parlors, social mixing of people from different areas, the very real possibility of unsafe sex due to drunkenness and drug use, minimal use of condoms, and increasing use of injectable drugs accompanied by exchange of needles and syringes. The potential role of migration in spreading HIV/AIDS is further heightened as a result of frequent visit of migrants to their native places and return migration, as well as a high propensity of continued migration especially among transient construction workers (UNDP, 2000). All of these circumstances, along with disposable wages may result in differences in individual exposure to opportunities for alcohol and drug use and unprotected sex with persons of unknown sexual history.

Sexual beliefs and risky sex a number of qualitative studies on HIV risk behavior conducted on men and women living in low income slums have produced insights into factors promoting risk behavior for example the role of peer pressure or performance anxiety is promoting young men to have sex with sex workers just prior to or following marriage (Raju and Leonard 2000; Verma, Khaitan & Singh 1998; Singh, Bloom, and Tsui 1998; Savara and Sridhar 1992; Pelto 1999; SARTHI 1996). Both married and unmarried men seek risky sexual contacts to avoid excessive semen loss through masturbation (DCT 2000). A booming trade in sex magazines and pornographic literature, and a growing number of telephone hotlines and magazine advice columns indicate that Indian males are seeking answers to questions centered around the male genital organs, the effects of masturbation and nocturnal emission, consequences of loss of

semen, premature ejaculation, concerns about sexual performance, excessive indulgence in sex, partner relationships, homosexuality, normal sexual responses, penis size, condoms, pregnancy, and AIDS (Raju and Leonard 2000; Sachdev 1997).

Human Immuno Deficiency Virus (HIV) and its consequence, Acquired Immuno Deficiency Syndrome (AIDS) certainly count among the least tractable epidemiological disasters facing today's world. It is the worst and deadliest disease that humankind has ever experienced. Theepidemic is not homogeneous and requires well informed, prioritized and effective responses.HIV is a virus that attacks the body's immune system making it unable to fight infections. The National Institutes for Health (NIH) defines AIDS as "the most serious stage of HIV infection that results from the destruction of the infected person's immune system" (Johanson, 2007). HIV and AIDS were initially diagnosed in developed countries and first tracked among populations of homosexual and bisexual males. But as it reached developing countries the epidemic spread increasingly through heterosexual contact, with its scope growing all the faster.

The epidemic substantially affects the demography, health, economy and social fabric of developing countries (Ghosh, 2002). Low level of economic growth increases the vulnerability of HIV/AIDS and related morbidity in all countries in general and developing countries in particular. The estimated number of people living with HIV/AIDS worldwide in 2007 was 33.2 million (30.6-47.1 million), a reduction of 16 percent compared with the estimate published in 2006: 39.5 million (34.7-47.1 million) (UNAIDS, 2007). In 2007 there were 2.7 million new HIV infected and 2 million HIV-related deaths. The most severely affected region, with respect to this global epidemic, is Sub–Saharan Africa. It accounts for the 67 percent of HIV infected people and 75 percent of AIDS death in 2007 (UNAIDS, 2008). When we come to Indian national scenario, results from National Family Health Survey, 2005-06 (NFHS-3), which is a population based survey, indicate that 0.28 percent of adults age 15-49 are infected with HIV.

This translates into 1.707 million HIV positive persons age 15-49 in India at the midpoint of the NFHS-3 survey period. The HIV prevalence rate is 0.22 percent for women and 0.36 percent for Men age 15-49 (NFHS–Report, 2006). In India HIV/AIDS has spread largely through heterosexual intercourse and the epidemic has moved from urban to rural areas.

The history of HIV/AIDS begins with the identification of initial HIV/AIDS cases in 1986, when serological testing found that 10 of 102 female sex workers in Chennai were HIV positive (Nag, 1996). In the face of increasing number of people being identified with HIV, Government of India initiated a systematic response by establishing National AIDS Committee (NAC) and then in 1992, the National AIDS Control Organization (NACO), under Ministry of Health and Family Welfare. NACO is engaged in surveillance and awareness programs related to HIV/AIDS in India (NFHS-3). There are six high HIV prevalence states, identified in India by NACO, which are Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu, Manipur and Nagaland. HIV/AIDS strikes most heavily in the 15-49 age groups, the very people on whom every country relies heavily for economic growth and development. And prevalence of HIV/AIDS is pronounced among some occupational groups, in which sex-workers and their clients are significant. The twin plague of HIV and AIDS certainly spreads through high-risk population to low risk population. High-risk population refers to a group or community of people engaging in practices or behaviours that put them at increasing risk for HIV acquisition and transmission (for example, sex workers, clients of sex workers, injecting drug users and men having sex with men). The spread of HIV infection is governed by behavioral, structural and biological factors (Moses et.al, 2006). Parker et.al, have pointed out that the spread of the international AIDS pandemic has drawn attention to the urgent need for the data on human sexual behavior, yet the absence of an established transition of theory and method in sex research has limited the development of initiatives in this area (Parker et.al, 1991).

Nag 1996, has analyzed the salient findings from the available studies on sexual behavior in India with a focus on those aspects of sexual behavior, which are particularly relevant to HIV/AIDS transmission and prevention .He has discussed the current trends, prevalence and geographic distribution of HIV/AIDS in India. He has also explored the sexual practices among youth, women and men in urban, rural and tribal communities, as well as those who are part of the sex industry. The author has woven in this discourse contemporary behaviour within a cultural and historical context (Nag, 1996). Migration is widely recognized as one of the main facilitating conditions of HIV transmission. Improved understanding of the linkages between migration and HIV risk factors is critical to control further spread of AIDS. It is well known that vulnerability to HIV is often greatest when people find themselves living and working in

conditions of poverty, powerlessness and social instability, conditions which apply to many migrants (UNAIDS, 1998). When it comes to migration it is generally men who first migrate. This is then followed by linked migration spouses and other family members.

Migration makes people redefine their identities as they move from one place to another in search of work (Bailey, 2008). Increased migration to urban centers in many developing countries has resulted in changes in the traditional family structure. Temporary labour migration results in men having to leave behind families and their social groups and redefine their identities. They have to abstain or look for other alternatives to satisfy their sexual needs. HIV/AIDS and migration do not have a linear, cause-effect link but they are linked laterally. HIV prevalence in migrant groups is then a manifestation of economic and social inequalities (UNDP, 2004). Being a migrant is not a risk factor in itself, but the process of migration and integration into local communities can expose the migrant to the risk of acquiring infectious disease (Bailey, 2008).

Ghosh, 2002 has analysed the epidemic of HIV/AIDS in India, with respect to its geographical variation and effect of different behavioral characteristics. It is found in her study that there is urban-rural variation in the distribution of HIV/AIDS, and in southern states it is more visible. It was explained by the higher level of urbanization and related migration in these states, especially in Maharashtra. Among some high-risk groups like sex-workers, their clients and intravenous drug users and labour migrants the prevalence of HIV/AIDS is high. It was found that the spread of HIV/AIDS is associated with high levels of migration, itself a reflection of limited employment opportunities, poverty and economic restructuring. The lack of economic opportunities results in high rural to urban movement. Migration is male dominated, and men are more likely to engage in high-risk behavior patterns. Another important aspect of the migration is the high rural to rural migration by female due to marriage and labour migration. Also in rural India it appears to have a lower incidence of HIV/AIDS than do the country's urban areas; the rural prevalence rate is likely hidden. Rural – Urban connections and paucity of information can influence future increases in HIV infection in rural India (Ghosh, 2002).

Using data from the 1993 Kenya Demographic and Health Survey, link between migration and sexual behaviour and risk of HIV is observed. Results indicate that migration is a critical factor in high-risk sexual behavior and its importance varies by gender and by the direction of movement. Given the predominance of men in urban migration and the large volume of circulatory movement between urban and rural areas, these results have serious implications for HIV transmission throughout Kenya (Brockerhoff and Biddlecom, 1999). In India, a country still dependent on agriculture, the failure of a monsoon among other things, fuels internal migrants. Internal migration in India has long been dominated by short distance migration, with 60 percent of all movements occurring between rural areas at the intra-district level (Singh, 1992). During the last four decades urbanization has increased rapidly with the percentage of the population living in urban areas increasing from 19.9 percent to 28 percent between 1971 and 2001 (census, 2001). The consequences of this process have included the rapid growth of India's cities. The 2001 census showed that all of India's million-plus cities have over one third of their population made up of migrants, with the growth in rural areas being much lower than in urban areas (Chandna, 2006).

According to an estimate of UNDP, there are 200,000,000 people not living in their place of birth (UNDP, 2004). A study conducted in the industrial city of Surat in Gujrat (India) found that male migrant workers, who live alone and have some disposable income, are more likely to indulge in risky sexual behaviour (Gupta and Singh, 2002). Prevailing gender relations have a serious impact on men's sexual health and the sexual health of partner's and families (Rivers and Aggelton, 1999). In India higher percentage of men show high-risk behaviour and the infection is more common among men than among women. Recent figures show that out of the estimated numbers of adults living with HIV, 62 percent are male (NACO, 2006). In India, married men are transferring the virus from sex workers to their wives. One of the very recent studies conducted in Goa (India), found that migrants and mobile men in Goa perceived the economic consequences of being infected with the HIV virus to be more severe in comparison to social and health consequences. Knowledge on HIV and AIDS is locally produced and shared through cultural narratives. The link between culture and space/place is depicted in the manner in which migrants make their places, are othered by the Goan host population and search for sex works. Available literature reveals that HIV/AIDS in India is heterogeneous with respect to the

vast geographical stretch of the country, differences in the income, gender, occupational structure, and socio-cultural variations. Also migration plays an important role in the spread of HIV infection and very less number of studies has been done in this field for India till date. It was perhaps due to the lack authentic data related to the number of HIV infected persons in the country. NFHS-3 offers the opportunity to better understand the magnitude and patterns of HIV infection in the general reproductive age population in India. This data is based on the HIV testing among more than one lakh male and female all over the India. Earlier prevalence estimates were based on the sentinel surveillance. HIV surveillance in designated sites (sentinel surveillance) has expanded and improved considerably leading to more reliable estimates of HIV epidemic and its impact. In addition a growing number of countries have conducted national population based surveys (e.g. NFHS-3 in India) that include HIV testing.

These surveys are geographically more representative than sentinel surveillance and include both men and women. Many countries of Africa and Asia have conducted national population based surveys with HIV prevalence measures. In most of those surveys new estimates of HIV prevalence were lower than estimates of prevalence published before the new survey data became available. NFHS –3, being based on testing, provides the opportunity to study the profile of HIV infected people in the whole India. The paper attempts to examine the differentials of HIV prevalence rate among migrants and non-migrants and to study the overall profile of HIV infected persons of India with respect to background characteristics (including migration status) and to assess the differential between migrants and non-migrants about the HIV/AIDS awareness among HIV infected persons. Paper also tries to assess the overall impact of migration on the HIV infection.

OBJECTIVE

General Objective:

To carry out a study among migrant labour men to explore their vulnerability and awareness towards HIV/AIDS.

Specific Objectives:

1. To explore their knowledge and awareness towards HIV infection.
2. To understand their vulnerability for HIV/AIDS through tracing their contraceptive usage.

Definition of Terms

Migration - Migration is usually defined as the movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons.

Human Immunodeficiency Virus (HIV) – is a retrovirus that breaks down the body's immune systems leaving the victims vulnerable to a variety of opportunistic infections.

Acquired Immune deficiency syndrome (AIDS) – is the terminal stage of HIV infection, and has poor prognosis.

ASSUMPTIONS

1. The survey questionnaire utilized for the study was valid

2. The participants of the study were able to read and comprehend the survey questionnaire

3. The participants of the study provided honest responses to the survey.

CHAPTER II

METHODOLOGY

SAMPLE SIZE:

Total population: 12000

Confidence limit: 95%

Confidence interval: 5

Sample size obtained is 374.

Keeping in mind 10% invalidation of the data sample size calculated is: 410.

SAMPLING

In the months of January to February 2012 from (19^{th} January 2012 to 29^{th} February 2012), study was conducted through distributing anonymous survey questionnaires. The study sample Comprised of the Migrant Labour class men, who are living away from their family and residing at Sangam vihar, South Delhi area.

Convenient sampling is used to assess the Awareness and vulnerability towards HIV/AIDS.

DATA ANALYSIS

Descriptive Statistics were used to analyze the data .Because a majority of the data was categorical, frequencies and percentage distribution were used to describe the sample.

Software Utilized:

MS Excel

CHAPTER III

RESULTS

Table 1

PERCENTAGE OF VULNERABAILITY AND AWARENESS ITEM ANSWERS (LABOUR MIGRANTS)

S. No.	QUESTION	YES (%)	NO (%)
Item no. 1	Have you ever heard of HIV or AIDS?	322(78.5%)	88(21.5%)
Item no. 2	Is there anything a person can do to avoid infection with HIV	348(85.0%)	62(15%)
Item no. 3	Do you think HIV/AIDS can be cured?	75(18.2%)	335(81.9%)
Item no. 4	Do you know whether you are infected with HIV or not?	84(20.5%)	326(79.5%)
Item no. 5	Have you ever been tested for HIV?	31(7.4%)	379(92.6%)
Item no. 6	Do you want to know whether you are infected with HIV or not?	182(44.5%)	228(55.5%)
Item no. 7	Have you changed your sexual behavior because of HIV/AIDS?	131(32.0%)	279(68.0%)
Item no. 8	Have you ever paid money for sex?	302(73.5%)	108(26.5%)
Item no. 9	Have you ever offered gifts, food or drinks for sex?	100(24.4%)	310(75.6%)
Item no. 10	Have you ever used a condom?	278(67.8%)	132(32.2%)
Item no. 11	Last time you had sex, did you use a condom?	173(52.3%)	237(57.7%)
Item no. 12	Is it difficult to get condoms at the factories?	265(64.5%)	145(35.5%)
Item no. 13	Do you discuss HIV/AIDS with your wife/regular partner?	315(76.8%)	95(23.2%)

For Item No. 1 of the questionnaire," Have you ever heard of HIV or AIDS", 322(78.5%) of the participants selected Yes, while 88(21.5%) selected No. For Item No.2" Is there anything a person can do to avoid infection with HIV", 348(85.0%) participants selected Yes while 62 (15%) selected No. for Item No. 3," Do you think HIV/AIDS can be cured", 75(18.2%) participants selected Yes, while 335(81.9%) selected No. For Item No. 4," Do you know whether you are infected with HIV or not", 84(20.5%) participants selected Yes while 326(79.5%) selected No. For item no 5," Have you ever been tested for HIV", 31(7.4%) participant selected Yes , while 379(92.6%) participant selected No. For item no 6," Do you want to know whether you are infected with HIV or not", 182(44.5%) participants selected Yes, while 228(55.5%) selected No. For Item No. 7," Have you changed your sexual behavior because of HIV/AIDS", 131(32.0%) participants selected Yes, while 279(68.0%) selected No. For item no.8," Have you ever paid money for sex", 302(73.5%) participants selected Yes while 108(26.5%) selected No. For Item No.9," Have you ever offered gifts, food or drinks for sex", 100(24.4%) participants selected Yes, while 310(75.6%) participants selected No . For item No. 10," Have you ever used a condom", 278(67.8%) participant selected yes while 132(32.2%) participants selected No. For Item no.11 "Last time you had sex, did you use a condom", 173(52.3%) participants selected Yes while 237(57.7%) selected No .For Item No. 12," Is it difficult to get condoms at the factories", 265(64.5%) participant selected Yes while 145(35.5%) selected No. For Item No. 13," Do you discuss HIV/AIDS with your wife/regular partner, 315(76.8%) participant selected Yes while 95(23.2%) selected No.

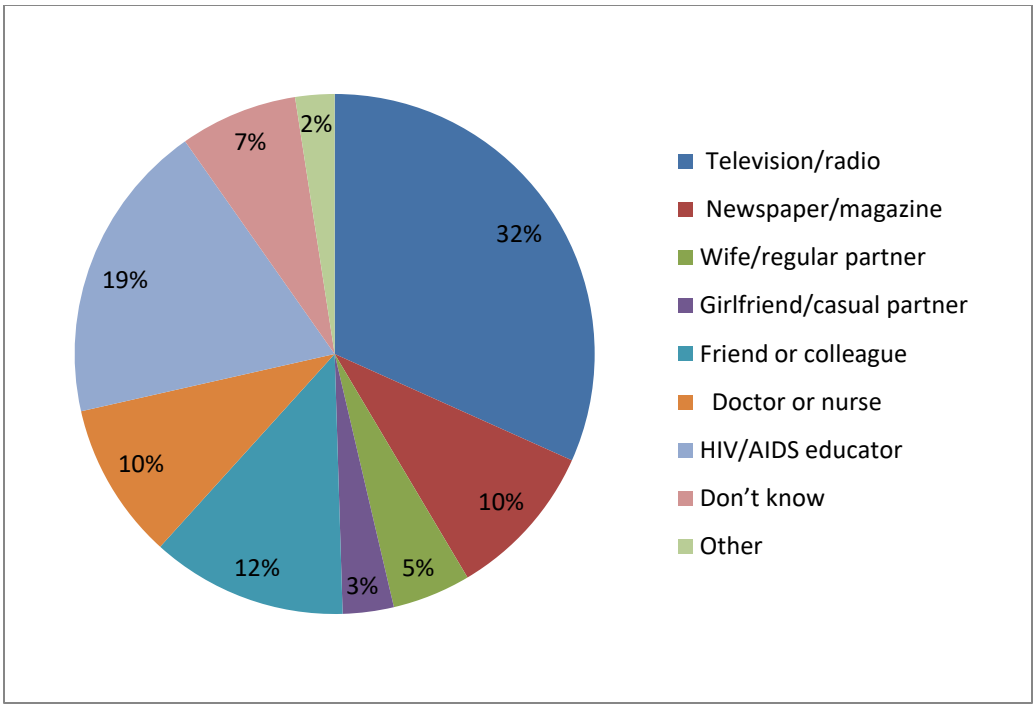

Fig. 1 Source of information about HIV/AIDS

For Q.1 "In the past 4 weeks/month, from what source did you receive information about HIV/AIDS" 130 (32%) participants selected television/radio, 40(10%) selected newspaper/magazine, 20(5%) selected Wife/regular partner , 13(3%) selected Girlfriend/casual partner, 50(12%) selected Friend or colleague, 40(10%) selected doctor or nurse, 77(19%) selected HIV/AIDS educator, 30(7%) selected don't know and 10(2%) selected other sources like street play as the source of information about HIV/AIDS.

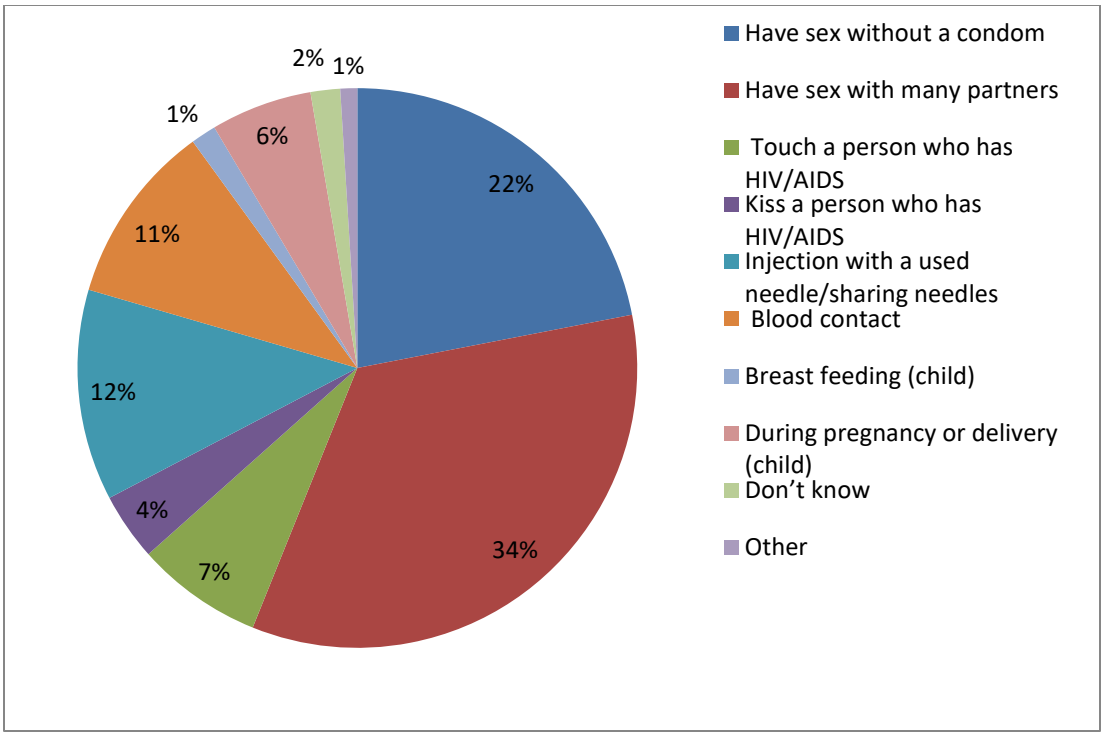

Fig. 2 Source of HIV infection

For Q.2 "How can a person get infected with HIV" 90 (22%) participants selected Have sex without a condom , 140(34%) selected Have sex with many partners, 30(7%) selected Touch a person who has HIV/AIDS , 16(4%) selected Kiss a person who has HIV/AIDS , 50(12%) selected Injection with a used needle/sharing needles, 43(11%) selected Blood contact , 6(1%) selected Breast feeding (child) , 24(6%) selected During pregnancy or delivery (child), 7(2%) selected Don't know and 4(1%) selected other like slept with infected person as the source of HIV infection.

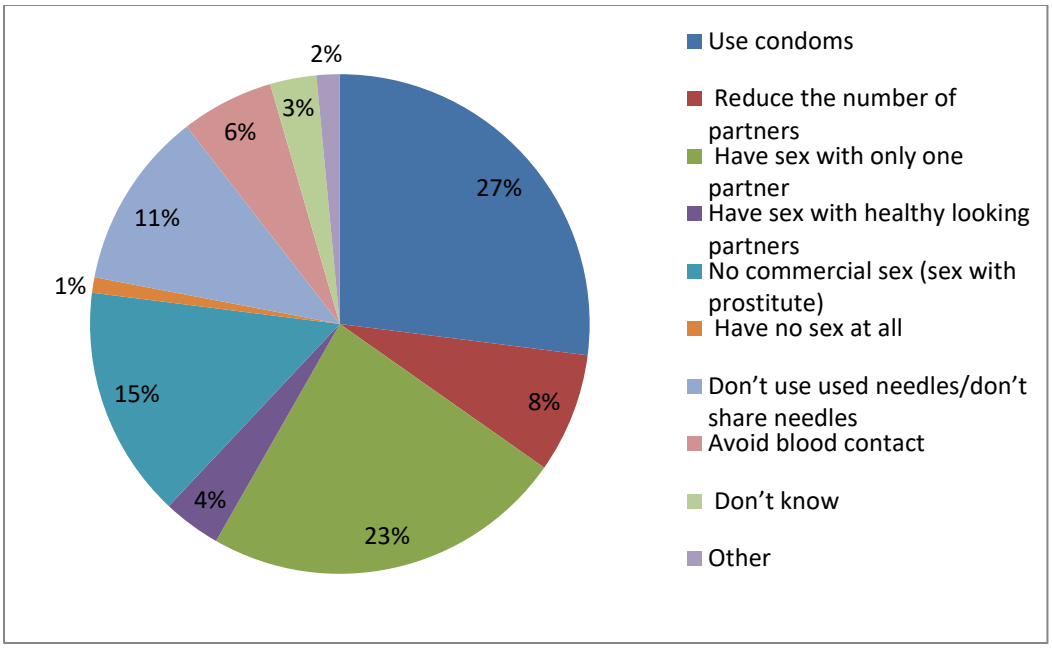

Fig. 3 Perceptions on HIV prevention

For Q.3 "How can you prevent HIV infection" 108 (27%) participants selected Use condoms , 31(8%) selected Reduce the number of partners , 94(23%) selected Have sex with only one partner, 15(4%) selected Have sex with healthy looking partners , 60(15%) selected No commercial sex (sex with prostitute) , 4(1%) selected Have no sex at all ,46(11%) selected Don't use used needles/don't share needles, 24(6%) selected Avoid blood contact, 12(3%) selected Don't know and 6(2%) selected other like have sex with whom you know as the medium of HIV prevention.

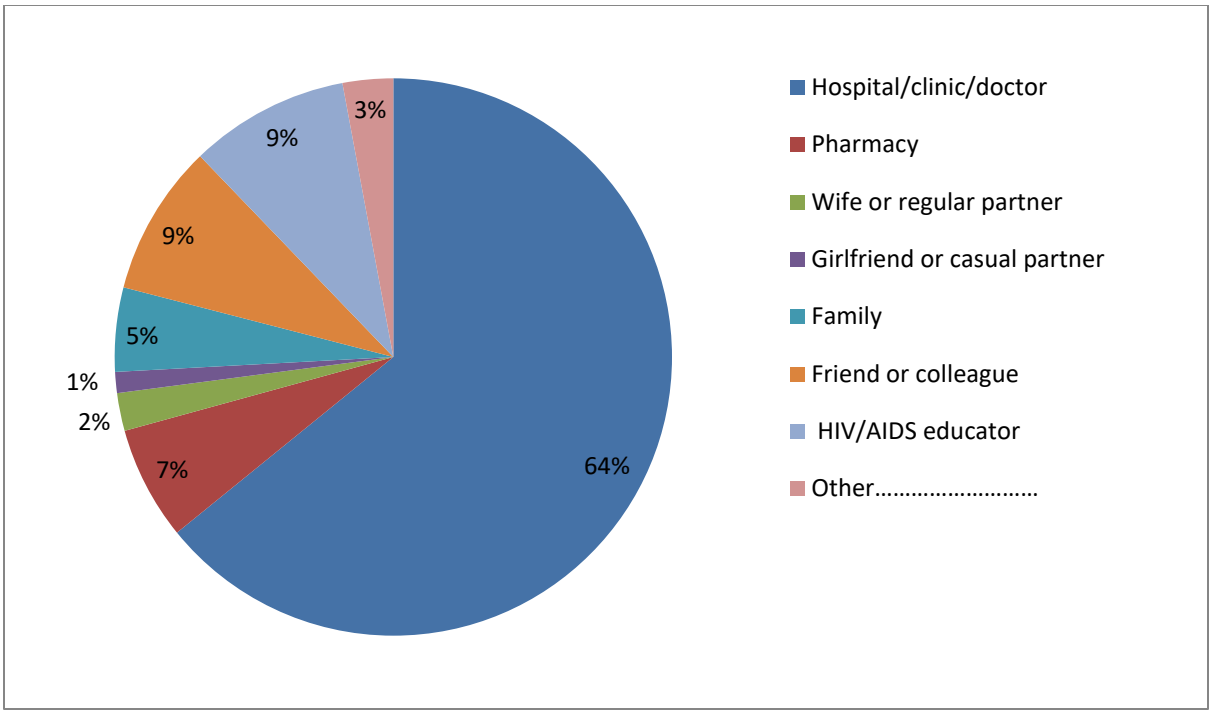

Fig. 4 Response after getting HIV/AIDS

For Q.4 "If you were worried that you are infected with HIV, where would you go" 263 (63%) participants selected Hospital/clinic/doctor , 27(7%) selected Pharmacy, 9(2%) selected Wife or regular partner , 5(1%) selected Girlfriend or casual partner , 20(5%) selected Family , 36(9%) selected Friend or colleague ,38(9%) selected HIV/AIDS educator , 12(3%) selected other like home as the destination after came to know the HIV status.

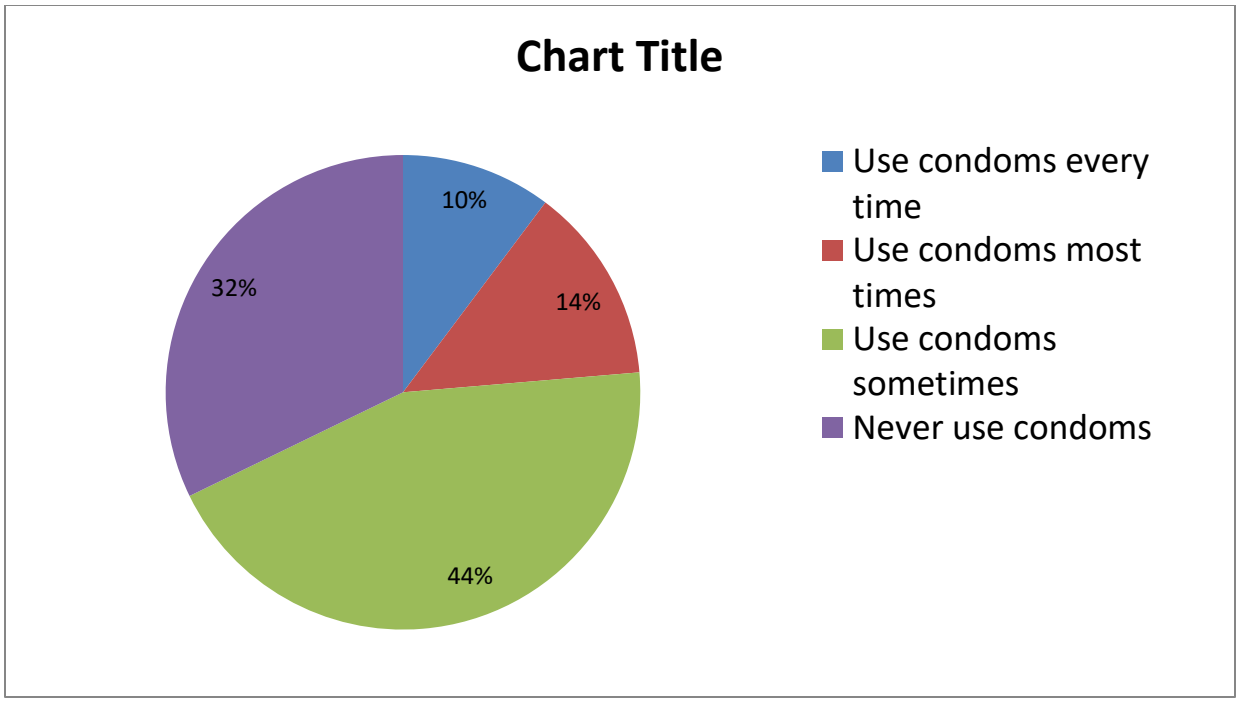

Fig. 5 Condom usage

For Q.5 "How often do you use a condom" 42 (10%) participants selected Use condoms every time, 75(18%) selected Use condoms most times, 190 (47%) selected Use condoms sometimes, 103(25%) selected Never use condoms during sexual encounters.

Discussion

In the fight against HIV/AIDS in India, it is important to pay attention to specific groups, communities or locations. Migrants or mobile populations are one of these groups at high risk. In this report I have tried to give an overview of the current debate around the vulnerability and awareness of migrants towards HIV/AIDS in the Indian context. The factors or processes that contribute to this vulnerability are diverse, complex and not completely understood. Interventions aimed at factory workers, mobile populations and their communities in general, must take into consideration their unique pressures, constraints and living environments in order to address their vulnerability effectively. Rather than condemn individual behavior, these interventions must situate sexual behavior in its social context.

Certainly, the traditional interventions are extremely important. People must be encouraged to practice safe sex through education and the distribution of condoms. But this is not sufficient. These interventions must be combined with care initiatives, with the prevention and treatment of STDs. 279(68.0%) of the respondent migrants aren't changed their sexual behavior even after having the knowledge of HIV/AIDS and it clearly reflects in their condom usage as 237(57.7%) of the migrant respondent aren't used condom in their last sexual encounter. 326(79.5%) Migrant respondents are not aware about their HIV status or even they don't willing to know their status of HIV as 228(55.5%) persons said that they don't want to know whether they are infected with HIV or not.

It's also depicts the percent distribution of HIV positive cases by occupation, in which highest percentage of cases are in non-agricultural group (58 percent). However among males, there are more than 72 percent cases are in this group other background characteristic depicted. Results show that the highest percentage of cases are in 'others' category which comprises the general and other backwards caste, having the 69 percent of cases, it is followed by 19 percent of cases in the scheduled caste and 12 percent in the scheduled tribes. The other important background characteristics which shown in this table is the current marital status, which is divided into two categories; 'single' and 'currently married', in married categories there are 67 percent of cases and in single category there are 33 percent of cases.

Awareness of HIV/AIDS and behavioral characteristics among migrants and non-migrants

One important question in this regard is the ever heard of AIDS, 78.5 percent of migrants have the knowledge regarding it. Other question related to the prevention of AIDS infection, is the reduction of chance of AIDS having only one sex partner with no other partner. In this regard migrant males have some awareness (82 percent). Responding to the question whether the use of condom always during the sex reduces the chances of AIDS, 84 percent of migrants say yes.

Limitations

Since Convenient sampling techniques is used, the results cannot be generalized, it is also important to note that the instrument used in this study did not address all of the items related to Vulnerability and awareness on the HIV/AIDS. Some of the items in the Vulnerability section of the instrument could have been better worded in a manner that best summarized the information that was to be collected.

Recommendation

On the basis of this rapid assessment and given both the complexity of the issues involved and the diversity of the region, it is inappropriate to make firm and very specific recommendations on the type of intervention or on the policies that need to be put in place to address mobility related HIV vulnerability.

- Improve the documentation of best practices, evidence based information and data needed for pre-departure, on-site, and post-return migrants. Policies to raise awareness of migrants and their families about HIV/AIDS are needed.

- Provide specific instructions and domestic mechanisms for business community to carry out their social responsibilities relating to HIV/AIDS and migrants. Consider policies to provide financial support for businesses in undertaking these responsibilities.

- Migrants living with HIV/AIDS and their families should be supported to integrate into the community without any discrimination.

- Social policies relating to health care services should be worked out to help mobile people living with HIV/AIDS easily access HIV information, commodities, HIV testing and treatment as well as other necessary services such as broadening health insurance options available to migrants, including non-regular and un-documented ones.

- Economies should consider adopting policies to reduce harms associated with and sex work, while respecting human rights.

- Enhance meaningful participation of different stakeholders in order to facilitate multi-sectoral and development-focused approaches to mobile workers and HIV prevention.

- Support the development of national strategies on HIV and mobility.

- Relatively little research has been done on the vulnerability of family members of migrants and mobile workers. Additional research on issues of economic and social vulnerability when an adult breadwinner travels would be appropriate to develop a more holistic understanding of relevant challenges.

- Specific studies on the behaviour and attitudes of migrants are not available. These intermittently risk-taking young men are increasingly globally mobile and receive substantial salaries. The potential for risky sexual behaviour is high as is the likelihood of returning with and spreading sexually transmitted infections if they do not practice safe sex and do not test themselves upon return.

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