Chapter 1

Introduction
CHAPTER - 1
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"....cities should be able to provide basic services to migrant workers,"
Draft Twelfth Five year Plan (2012-2017)

(Faetanini, 2013)

1.1 Chapter Overview

The present study attempts to discuss about migrant women, maternal health and HIV/AIDS of Aligarh's suburbs. This chapter is organised into six sections. The first section discusses the background of the study. The second section discusses emergence, types and status of migrant women in India. The third section presents the health issues faced by migrant women. The fourth section discuss about the maternal health. The fifth section deals with the concept of HIV/AIDS. The last section highlights the need, and planning of this study.

1.2 Background of the Study

It has long been understood that health outcomes are profoundly shaped not just by biological factors but also by the social, economic and cultural environment, including people's positions in various social hierarchies. Increasing evidence suggests that it is possible to improve health outcomes, if taking important social determinants of the Health as an area of intervention (UNDP, 2011). This study tries to bring to notice some of the important interrelated social factors of reproductive health (maternal health and protection against HIV/AIDS) which are needed to be addressed on priority basis, especially among the disadvantaged communities like, female migrants who are living in the peri-urban or outer fringe of the cities from where Health facilities are at distant.

Some of the interrelated factors are as follows:

a) Internal migration- as migration is considered to be one of the social determinants of health.

b) Poverty- Poor urban dwellers have poor health outcomes than rich dwellers of the city as poverty has direct relationship with the maternal health. As Bale et
al. (2003) has defined that, "there are some infectious diseases that pregnant women are at risk of contracting in developing countries due to unhygienic conditions and lacks of resources that can help prevent infection in the first place. The prevalence of HIV and STDs are at greater in number in the developing countries, where poverty also contributes to risky sexual behaviour such as prostitution, domestic/sexual violence, substance abuse and migration".

c) Women- as vulnerable gender, less say in the issues of their own body and soul (including Reproductive health). As, Liljestrand & Gryboski (2002) talks about that, "In many countries, women are inaccessible to health care, sometime because of infrastructure, geographical, as well as financial problems. They are dying because they are women, and societies are not giving enough attention to saving them", women are also having low say in the matters of the sexual relationship, sometime they cannot access to the contraceptive services.

d). Health education and awareness- as unawareness and lack of health knowledge always put the poor migrant women in health risks, like maternal morbidity, maternal death, and AIDS etc. as, Shaokang et al. (2002) has analysed that, "health knowledge is one of the key factors enabling women to be aware of their rights and health status in order to seek appropriate health services". Their unawareness, and lack of health knowledge (including health believes and health facilities) put her in lots of unhealthy practices.

According to 2001 Indian Census, 70.7% internal migrants are the women migrants, similar results also come from National Sample Survey (NSS, 2008) that female migrants is far greater than male migrant (UNICEF, 2011),which is needed to be looked at, from all angles specially with better health inclusion perspective.

Migrant women is the focal point of concern in this thesis with the aim to assess their knowledge and condition vis-a-vis maternal health and HIV/AIDS in a medium size city like Aligarh (host place), to measure the gravity of the problem (vulnerabilities) so that policy makers and health professionals (including Social workers) could understand, what has been done and what is needed to be done to improve maternal
health condition and to reduce the risk of HIV through action on social determinants, like health education, awareness generation and health accessibility and availability.

Two important components of Reproductive Health (RH) have been taken in this study, to analyse among the poor internal migrants.

- Maternal Health
- HIV/AIDS

**Maternal Health:** Period of Pregnancy, childbirth and the postpartum are the maternal health aspects. Everyday about 800 women die due to pregnancy related complications worldwide and 99% of them occur in low and middle income countries (WHO, 2012). Maternal mortality is one of the fatal problems under the umbrella of reproductive health problems, over one million children lose their mother’s each year due to pregnancy-related causes and are 10 times more vulnerable to fatality within two years of their mother’s death (UNFPA, 2008).

Despite of many successful initiatives taken up by government of India, many disadvantaged women like, poor migrants are still facing poor maternal care and improper delivery practices, and so, “*India is still far behind the target of the Millennium Development Goal*” (Gaol-5) (Mehta, 2013).

**HIV/AIDS:** HIV/AIDS has taken the other important part of this study (analysis of the awareness level) because of two reasons, first taking into consideration of the Programme of Action of the International Conference on Population and Development (ICPD) 1994, which included maternal health and HIV/AIDS together under the reproductive health agenda and Goal (UNFPA, 2008). HIV surveillance and test has become a compulsory one under the Ante Natal Care (ANC) checkups to minimize the risk of HIV transmission from a positive mother to their child. Secondly migrants are considered as susceptible population with respect to HIV/AIDS, mainly because of their unawareness and other risk prone activities and vulnerabilities. Moreover women’s unawareness and lack of health education put them at more risk, many a time without direct involvement in any risky behavior. To save the migrant women from the HIV, it is needed to make them aware on its modes of transmission and ways of protection.
1.3 Migrant Woman and its Evolution

1.3.1 Migration

The word migration has been derived from the Latin word “Migrare”, to change one’s residence, but by the current “definitions it means rather to change one’s community” (Peterson, 1968), in simple term human migration implies some form of permanent or semi-permanent movement on the part of an individual or a group of people.

“Migration has been the so called push-pull theory. Which describes that some people move because they are pushed out of their former location, whereas others move because they have been pulled or attracted to somewhere else” (Ravenstein, 1889).

India’s urban population has increased from about 286 million in 2001 to 377 million in 2011, and is expected to increase to 600 million (out of a total population of 1.4 billion) by 2030 (Census of India, 2011; Planning Commission, 2011), migration is one of the important demographic factor for this increase population of the cities. So, better inclusion of migrants in cities is a necessary step towards sustainable urban development, based on cultural diversity, social cohesion and human rights” (Kundu, 2012). There is a pressing need to ensure that urban settlements become inclusive spaces as they expand in size and diversity. This would require adequate and affordable housing, health and education services as well as infrastructure and sanitation. Improving migrants’ access to government services and welfare programs can improve the quality of life of migrants. This will in turn lay the foundations for a more inclusive and integrated society and balance economic prosperity and social diversity.

1.3.2 Types of Migration

Migration may be classified on the basis of space (boundary), time (duration), volume, miscellaneous aspects and motivation on the basis of (boundary) international, internal and subdivided into intercontinental, inter state, local, rural – rural, rural –urban, urban-urban, urban to rural migration, similarly on the basis of time we have permanent, periodical, seasonal and temporary migration, irregular or casual migration, daily or pendulum type migration, on the basis of volume we have large scale and small scale migration, on the miscellaneous aspects migration may be
Brain Drain, refugee, forced or involuntary, voluntary labor migration, on the basis of motivation migration may be of physical, economic, political, religious material and demographic type.

This study has taken internal female migration as the unit of study.

1.3.2.1 Internal Migration

The movement of population within a country is called internal migration. The accepted definition of internal migration is change of residence from one community or other clearly defined geographical unit, to another within the national boundary (Zachariah, 1964). “Internal migrants are key actors of prosperous cities, boosting economic activity and economic growth” (Bhagat, 2011).

Internal migration can further be classified into:

- **Intra-district**: Movement of population within the boundary of a district is defined as intra-district migration,

- **Inter-district migration**: Whereas the movement outside the district but within the state is known as inter-district migration,

- **Inter-state migration**: The movement beyond the state and union territory (UT) but within the country is termed as inter-state migration.

1.3.3 Feminization of Migration

The term ‘feminization’ of migration has been coined by Oishi (2002). meaning by the high share of female migrants to total population.

Female migration as noted in Shanti (2006) can be classified into three groups:

a) **Associated migration** or family migration when the women move with the male members of the household.

b) **Autonomous migration** when a women move unaccompanied mainly for work and a sub component of this is the relay migration.
c) *Marriage migration* where the women after getting married leave the natal village/town to join the husband’s family in another village/town due to customary practice of exogamy observed in some countries, like in India.

Marriage or as dependent/associated migration is given as the major cause of migration among females in many Indian studies (Bose, 1973; Premi, 1979; Rele, 1969).

It is estimated that the migrants constituted around 30% of the total population of India. Female migrants constitute 218 million against 91 million for male (Census, 2001). “Female migrants are not high in terms of magnitude only but also from the perspective of development, internal migration of females is an important factor influencing socio-economic development of the country as it has greater potential for reducing poverty, bringing about social change” (Mahapatro, 2012).

Female’s participation in the migration is not sufficiently explored in migration studies, despite of its growing proportion. Female migrants are more vulnerable than the male migrants, as Deputy Director General Ndioro Ndiaye of International Organization of Migration (IOM) said, on International Women’s Day, “Women and girls, especially when forced to migrate or when in an irregular situation, are disproportionately affected by the risks of migration because of their vulnerability to exploitation and violence” (IOM, 2009). It is important to look at the vulnerabilities, of the poor female migrants, their causes and consequences.

### 1.3.4 Vulnerabilities among Migrants

“There are certain groups who are vulnerable and marginalized lacking full enjoyment of a wide range of human rights, including rights to political participation, health and education. Vulnerability within the right to health framework means deprivation of certain individuals and groups whose rights have been violated from the exercising agency” (Yamin, 2005).

#### 1.3.4.1 Excluded from the Policies

They are deprived because of many reasons, one among them is that they are excluded from many governmental schemes in the absence of the identity and residence proofs. In reality migrants face denial of basic entitlements including access
to subsidized food, housing, drinking water, sanitation and public health facilities, education and banking services and often work in poor conditions devoid of social security and legal protection (UNICEF, 2012). They are also portrayed as a "burden" to society, they are given very low priority in policies and practices, sometime because of the knowledge gap on its nature and magnitude as Faetanini (2013) has mentioned in a report of Internal Migrants Initiatives by UNESCO.

1.3.4.2 Living Condition

"Housing conditions to a large degree reflect individual and family social position" (Wang, 2006). "They usually prefer to live in the peripheral areas, to minimize the cost of the house, living in the isolated areas create other problems specially during emergencies (ibid). This research has mainly focussed on the migrants who are living outside the city, as discussed above that they prefer low cost living, in outer fringe or peri urban (suburbs) areas of the city, "migrants also prefer to live with fellow villagers at the work place or in migrant communities often characterized by overcrowding, social disintegration, and lack of social and health services" (Zhang, 2001) they also "faced some environmental problems, such as pollution, including garbage, air, water and noise that due to the financial difficulties of migrants and their desire to reduce expenses" (Xiang, 2005).

"Most migrants can only do simple, unskilled jobs, typically unstable and insecure work, they are often low paid and frequently laid off. Gradually they become the growing poor group in the big cities, lacking a social assistance system and public infrastructure and suffering from health risks which go unnoticed" (Peng et al., 2010) Moreover, "the rapid change of residence due to casual nature of work also excludes them from the preventive care and the working conditions in the informal work arrangements in the city debar them from access to adequate curative care" (Chatterjee & Sheoran, 2007). That is why "One of the main challenges to health care planners is to reach the most marginalized and vulnerable populations and to ensure universal access to affordable and equitable health care services" (Peng et al., 2010).

1.4 Migrant Women: Health and Health Issues

As per the 1946 constitution of the World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence
of disease or infirmity (WHO, 1948). "Migration health refers to health issues, conditions and risks related to mobile populations and to the way in which they affect migrants, their families and communities, the population of origin, and the population of destination" (Roux et al., 2006).

Although mobility is not of itself detrimental to health but the circumstance in which migration takes place, together with individual factors such as gender, language, immigration status, and culture, have a significant impact on health-related vulnerabilities and access to services (IOM, 2010).

1.4.1 Health Vulnerabilities

"Migration itself considered as one of the social factors for the poor health outcomes, as migratory movements characterized by increased quantitative growth and qualitative differentiation along the lines of migratory patterns, nature of migrants, their quality and final destination have facilitated a differentiated development pattern creating spaces of vulnerability" (Chatterjee, 2006).

Their health-risks are predetermined by certain factors at the destination areas. They are as follows

a) **Government-related factors**: national policies, public service system, community development, development and housing;

b) **Employer-related factors**: safety at work site, living conditions, insurance coverage, women worker's maternal and reproductive health benefit, etc.

c) **Health-sector related factors**: health/preventive network, service coverage and approaches, service items and prices, and

d) **Individual-related factors**: Social support at the destination, Health beliefs and awareness, behavior related to health and help seeking, *(ibid)*.

Migrants are also vulnerable in terms of their health status. Migration has created health care challenges in both place of origin and destination. Migrants can face serious health problems due to discrimination, language and cultural barriers, their legal position, and their low socio-economic status.
"Poor Healthcare utilization rates among migrants can also because of other factors like,

- Expensive private health facilities,
- Conflicting timing of work,
- Availability of medical practitioners,
- Cost of missing hours or days of work,
- Long distances to access services and associated problems of transportation,
- Perceived alienation from government health systems at the destination,
- Language difficulties,
- Many urban migrant women also prefer having home childbirths" (Borhade, 2012).

"women and children are particularly vulnerable to health problems and are more likely than other groups to suffer from communicable and non-communicable diseases, as well as from reproductive health problems. Migrants' health outcomes are also associated with their language skills and familiarity with the culture of the host community" (Carballo et al., 2005).

Migrant's health is an important issue to be taken care of by the host community to develop a more healthy society in large.

1.4.2 Migrant Inclusive Health Policies

In recent years, the importance of Health and wellbeing of migrants has been receiving greater importance and attention at all level, national and international. In 2008 the Sixty-First World Health Assembly (WHA) Resolution on the Health of Migrants called upon participating nations to promote migrant-inclusive health policies and to promote equitable access to health promotion and care for migrants (Panday, 2014). In response to the Resolution, the WHO, the International Organization for Migration (IOM) and the Ministry of Health and Social Policy of the Government of Spain organized a global consultation on migrant health in Madrid, Spain in March 2010. The following priorities for action were identified:

1. Monitoring Migrant Health- Collecting the migrant's health information for the standardisation.
2. Legal Policy Framework for the Migrants—Adopt national laws that protect the migrant’s rights to health, based on international laws and standard, and implement accordingly, to promote Health accessibility and affordability.


1.5 Maternal Health

Maternal health is an integral part of the reproductive Health, "referring to the health of a woman during her Pregnancy, Delivery, and the Post partum period", (WHO, 2012). This motherhood is a fulfilling experience for many, but for the rest of many it is associated with lots of sufferings, and even sometime death.

1.5.1 The Key Facts about the Maternal Health

Maternal mortality ratio (MMR) has been most commonly used to measure the maternal health, which is the number of deaths per 100,000 live births (UNFPA, 2008).

According to the Fact sheet of the WHO, approximately 1000 women die every day from preventable causes of the pregnancy and childbirth. Out of that 99% deaths occur in developing nations, moreover it is higher in the rural areas than urban areas, more young face more risk of pregnancy than older women. Factsheet of WHO further defined that skilled care during ante natal care, delivery and post natal care can save women and newborn babies (WHO, 2012).

"India’s maternal health condition is not at all satisfactory, it had the largest number of maternal deaths in the world" (Barry, 2007). "In the year 2009, the count of maternal deaths was 212 on every 100,000 live births, although the MMR dropped from 212 deaths per 100,000 live births in 2007-09 to 178 in 2010-12, yet, India is behind the target of 103 deaths per live births which has to be achieved by 2015 under the United Nations mandated MDG” (Mehta, 2014), according to the findings of “Targets Overview of MDGs” it is slow and off track. Clearly, the initiatives have not been effective enough in encouraging political prioritisation of this issue in India or implementing adequate strategies “Maternal mortality remains a major challenge to health systems worldwide, even though a sharpened focus on reduction of maternal
mortality became a defining part of Millennium Development Goal 5" (Ronatsans et al., 2006).

1.5.2 Maternal Health among Migrant Women

"Many studies show that problems such as neonatal mortality, underweight births, premature or complicated deliveries are more common to migrants than non-migrants" (Zhu et al., 2007; Shaokang et al., 2002; Zhao et al., 2009; Qin et al., 2010; Li et al., 2012) this might because of migrant women’s poor health profile(high anaemic and malnutrition condition) which they carry from their areas of origin (Essen et al., 2000), and partly it is that “migrant women often approach the health system at later stages in their pregnancy or may not have undergone relevant monitoring or care under the larger health care system” (Shaokang et al., 2002).

1.5.3 Maternal Death (Maternal Mortality)

In the International Statistical Classification of Diseases (ICD) and related health problems, 10th revision (ICD-10), World Health Organization (WHO) defines maternal death as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes (UNFPA, 2008).

Women die as a result of complications during and following pregnancy and childbirth. Most of these complications develop during pregnancy. Other complications may exist before pregnancy but are worsened during pregnancy. The major complications that account for nearly 75% of all maternal deaths are:

- Severe bleeding (mostly bleeding after childbirth)
- Infections (usually after childbirth)
- High blood pressure during pregnancy (pre-eclampsia and eclampsia)
- Complications from delivery
- Unsafe abortion (Say et al., 2014).

Most maternal deaths are preventable from the above said reasons, as the health-care solutions to prevent or manage complications are well known.
Among the indirect causes of maternal death (20 per cent) are diseases that complicate or are aggravated by pregnancy, such as malaria, anaemia and HIV. Women also die because of poor health at conception and a lack of adequate care needed for the healthy outcome of the pregnancy for themselves and their babies. Evidence also shows that the inaccessibility to skilled care delivery, inadequate health infrastructure and personnel and social phenomenon such as diet, social behaviour among others are also causes of maternal deaths (WHO, 2012). Lack of birth preparedness also causes maternal death.

1.5.4 Maternal Health Care

Through access to basic medical care, most of the maternal death can be prevented (WHO, 1994). All women need access to antenatal care in pregnancy, skilled care during childbirth, and care and support in the weeks after childbirth. It is particularly important that all births are attended by skilled health professionals, as timely management and treatment can make the difference between life and death (WHO, 2012).

A pregnant woman should go with:

- Antenatal check-up
- Iron tablets or supplements
- Tetanus Toxoid injection
- institutionalized deliveries or skilled care at birth
- postnatal care
- Family planning services etc.

Government of India is committed to provide the recommended maternity care services to improve maternal health status in India by the implementation of safe motherhood programme, under the guidelines given by ministry of health and Family welfare (1997), that all pregnant women should be registered, and first antenatal checkups should be given at latest, pregnant women must go for ANC at least for three times, get Tetanus Toxoid injection (TT), and take supplementary Iron for at least 100 days (DLHS, 2002-04), all such recommendation are based and specially designed after International Conference on Population and Development (ICPD) which was held in Cairo, Egypt from 5th to 13th September 1994, which has earned a
place in history as one of the most significant global conferences ever. It drastically transformed the views and population policies and programmes. At the same time, "the unparallel exposure it received through newspapers, radios, television and internet helping to bring issues relating to reproductive health, reproductive rights and women's empowerment to attention of millions of women and men around the world" (Singh, 1998). Despite of all such policies, programs, and awareness generation strategies, millions of women (especially disadvantaged and poor) still vulnerable in her Reproductive Health aspects, because of many interrelated direct and indirect reasons/factors.

1.5.4.1 Prenatal Care and Women's Health

"The importance of adequate prenatal care and delivery assistance to the health and well-being of women and children is well established" (Short and Zhang, 2004).

Minimum four antenatal care visits is recommended by World Health Organisation (WHO), Pregnant women are also tested for HIV, if positive, they receive help and guidance in living with the virus and avoiding transmission to their babies (MDG, 2013), but only half of pregnant women in developing regions receive this recommended four visits (UN report on MDG 2013), National family health surveys (NFHS) found that in India after all such recommendations and actions, still a large percentage of Indian women received no prenatal care during their pregnancies. Thus, "there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centres" (Bhalla, 1995), which is also need to work on.

National Family Health Surveys show increase in antenatal care, but the target is not achieved according to NFHS-1, 65%; NFHS-2, 66%; and NFHS-3, 77%, women were getting any type of antenatal care. In access to antenatal care rural urban gap is also very wide. In urban areas (84% in NFHS-1; 86% in NFHS-2; and 91% in NFHS-3) on the contrary in rural areas (59% in NFHS-1; 60% in NFHS-2; and 72% in NFHS-3) women were having access to any type of antenatal care. Migrant women even after migration to the urban areas, usually keep their beliefs intact, at least for the initial years.
1.5.4.2 Nutrition

In India, 55% women are anemic and every third woman is under-nourished (NFHS-3).

"Malnourishment in women can be harmful to both mother and baby during pregnancy and childbirth for many reasons. If the woman has suffered from malnourishment most of her life, her body is likely to be underdeveloped, with a narrow birth canal, making labour difficult and increasing the risk of obstructed labour and foetal death" (Bale et al., 2003).

"Lack of vitamins and minerals in the body can be fatal for both mother and child, as there is an increased risk of sepsis, anaemia or other complications" (ibid). Literacy of the women, their empowerment, ante natal and post natal care, sanitation and safe drinking water are all equally important in combating malnutrition.

"The Public Distribution System (PDS) should be made portable to include multi-locational migrant populations, as many Migrants do not enjoy PDS. Disha Foundation have started to fill this gap, but clearly NGOs cannot match the scale of the government and this issue requires renewed attention for to combat the problem of under nutrition among pregnant women" (Faetanini, 2013).

"under Chapter III of the initial draft of The National Food Security Bill 2011, guarantee food and nutritional security in India, states that, “The migrants and their families shall be able to claim their entitlements under this Act, at the place where they currently reside” (Ibid).

1.5.4.3 Need of Iron in Pregnant Women

Pregnancy and lactation place huge iron demands on the mother and her child. A 1994 report from the World Health Organization, concluded that a woman living in a developing country is practically always on the verge of iron deficiency anemia either because of pregnancy, which requires the transfer of 300 mg of iron to the fetus during the third trimester and an additional 500 mg of iron to accommodate an increase in red blood cell mass, or lactation, in which each episode transfers 0.75 mg of iron from mother to child. Moreover, even before she becomes pregnant, a woman of childbearing age suffers substantial iron losses from menstruation (WHO, 1996).
1.5.4.4 Place of Deliveries/Birth Attendants

As a follow-up to the 1998 guidelines, in 2003 WHO has published "Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice" (WHO, 2006) "the updated guidelines has focused on births taking place with skilled attendance, since skilled attendance is so important to maternal survival" (Campbell et al., Lancet, 2006), as per the WHO (2004) skilled birth attended are the accredited health professionals as midwives, nurse, and doctors who are trained in skills needed to manage normal pregnancies, and in identification of the complications in women and new born babies (Ditton et al., 2009).

1.5.4.5 Post Nataal Care /Post-Partum Care (PNC/PPC)

"The postnatal period begins immediately after the birth of the baby and extends up to six weeks (42 days). The period soon after childbirth poses substantial health risks for both mother and newborn" (Matthews, 2010), like "bleeding and infection following childbirth account for many maternal deaths" (Ronmans, 2006), post-partum haemorrhage accounts for nearly one-quarter of maternal deaths worldwide (WHO, 2006). Yet "the postpartum and postnatal period receives less attention from health care providers than pregnancy and childbirth" (Matthews, 2010).

"Post-partum care for women could not only prevent 60% of maternal deaths but also the acute and chronic morbidity arising from pregnancy and delivery-related complications. Post-natal care is an important opportunity to support exclusive breastfeeding, immunization, family planning and prevention of HIV infection" (Alfredo, 2008).

1.5.5 Indirect Factors

Apart from the direct factors/reasons which have resulted into the good or bad maternal health outcomes, there are some factors which are indirect but have some very strong impact on the results of maternal health.

1.5.5.1 Poverty

"There is no doubt that the main threat to good health is poverty" (Skold, 1998), including maternal health. There are many infectious diseases that pregnant women are at risk of contracting due to unhygienic conditions. Moreover, "poor women often
unable to afford health services that are available, preventing them from receiving treatment” (Bale et al., 2003). Because of poverty and their interrelated factors, malaria, HIV and other STDs are more prevailing in developing countries, poverty also contributes to high-risk sexual behaviour. This vital poverty-health relationship is reflected in the Millennium Development Goals (MDGs).

Poor Migrant Women, as being poor and being a woman, more in vulnerable situation, moreover in a new and unknown surrounding (host place).

1.5.5.2 Status of Women

“In rural India, women are three times more likely than men to go without treatment for long-term ailments, a trend that persists even amongst the non-poor. When treatment is sought, significantly smaller sums of money are spent on treatment of women than on men” (Iyer et al., 2007).

“Social scientists are increasingly recognizing that reproductive behaviour is strongly related to gender inequality, especially the way inequality is rooted in a society’s kinship structure and cultural context” (Ravichandran et al., 2005).

1.5.5.3 Age of Marriage

The age of marriage (or entry into sexual union) and the proportion of women remaining single determine the number of women exposed to the risk of pregnancy and the duration of time for which they would be exposed to the risk of pregnancy. In India, marriage continue” to be both early and nearly universal, but there are significant interstate variations in the mean age of marriage. Therefore, marriage is a very strong determinant of reproductive health of women in a country like India, where mostly sexual life starts after marriage.

For most women in India, sexual activity starts in adolescence and within marriage (UNICEF, 1990). Early marriage was perpetuated in the past by tradition, beliefs about preservation of a girl’s chastity, family honour and the need to reduce expenditure, yet it is still present in many parts of India.

1.5.5.4 The Role of Female Education

Female education (including maternal health education) could lead:

- A decrease in demand (ideal or desired) for children
- An increase in age at marriage
- An increase in the use of contraception,
- A decrease in the incidence and duration of breast feeding and postpartum care (Bale et al., 2003).

"Where education is available to women, maternal and reproductive education has proven highly beneficial to both mother and child, as women become aware of available family planning services, what to do and not to do during pregnancy, and what danger signs to look at during pregnancy and labour" (ibid).

It is also clearly indicated in the findings of NFHS that there is a direct relationship between education of mother and in access to antenatal care. The direct relationship between education and use of maternal health services partly results from the fact that formal schooling exposes women to information about reproductive health and pregnancy care. Education also enhances women’s self-efficacy (confidence in taking independent choices) and has been associated with other important precursors of safe motherhood, such as use of contraception, more equitable marital relationships, and greater economic independence, (Grown et al., 2005, Santow, 1995 cited in UNDP working paper 2013). Comprehensive knowledge of HIV/AIDS is also strongly associated with education (NFHS-3).

1.5.5.5 Fertility and Women’s Health

Many of the health problems of Indian women are related to or exacerbated by high levels of fertility. "Numerous pregnancies and closely spaced births erode a mother’s nutrition status, which can negatively affect the pregnancy outcome" (Jejeebhoy, 1995).

Despite a large increase in the number of women using contraceptives, (41% in NFHS-1; 48% in NFHS-2; and 56% in NFHS-5) and limiting their fertility, there is still unmet need for contraceptive use in India.

1.5.5.6 Use of Contraception

"Maternal mortality and morbidity are two main health concerns that are related to high level of fertility” (Lewis, 2003). Contraceptive use is one of the major determinants of fertility in modern times. “India has officially accepted a nationwide
family planning programme since 1952, but the use of contraceptives did not spread widely. The programme has since 1960s, been collecting statistics on the distribution and acceptance of four methods provided by the programme (condoms, Intra Uterine Device (IUD), oral pill, and sterilization)” (Visaria, 1999).

“Preventing maternal deaths in a resource-poor population is possible, but requires the right kind of information” (Lewis, 2003), including correct information dissemination on modern contraceptive methods, especially regarding the use of condom, as a method of dual protection as it protects them from pregnancy and STI/HIV, majority not aware about its importance as a dual protector, moreover the problem associated with the users is that they are inconsistent with its use as well (not use it at every sexual contact).

1.5.6 MDG (International Initiative)

The Millenium Development Goals (MDGs) are eight international development goals that were established by the United Nations in 2000, the member states and international organizations committed to help to achieve the Millennium Development Goals by 2015.

United Nations Millennium Declaration had shortlisted some indicators for global monitoring of reproductive health, they are as follows:

- Total fertility rate
- Contraceptive prevalence
- Maternal mortality ratio
- Antenatal care coverage
- Births attended by skilled health personnel
- Availability of basic essential obstetric care
- Availability of comprehensive essential obstetric care
- Perinatal mortality rate
- Prevalence of low birth weight
- Prevalence of positive syphilis serology in pregnant women
- Prevalence of anemia in women
- Percentage of obstetric and gynecological admissions owing to abortion
- Reported prevalence of women with genital mutilation
Prevalence of infertility in women
- Reported incidence of urethritis in men
- Prevalence of HIV infection in pregnant women
- Knowledge of HIV-related preventive practices (WHO, 2006).

Most of the above mentioned indicators of the reproductive health which encompass the maternal health and HIV/AIDS (Goal-5 & Goal-6) have been taken up in this study to find out the reproductive health status of the poor migrant women.

**Goal 5: Improve Maternal Health**

**Target 5A:** The maternal mortality has to reduce by three quarters, between 1990 and 2015, and increased proportions of births attended by skilled health personnel.

**Target 5B:** Universal access to reproductive health e.g. Contraceptive prevalence, Antenatal care coverage etc.

"Improving maternal health is 1 of the 8 Millennium Development Goals" (Gao et al., 2002). To promote the maternal health and to reduce the MMR and morbidity MDG has been specially designed and put the maternal health as an important goal, to be achieved by the 2015. To Combat the HIV/AIDS is another very important Goal taken up the MDG.

**Goal 6: Combat HIV/AIDS**

**Target 6A:** HIV/AIDS have halted by 2015 and began to reverse, through increase condom use, and with comprehensive correct knowledge dissemination.

**1.6 HIV/AIDS**

HIV/AIDS has emerged as most formidable public health problem. It is an important cause of death across the world and it is estimated that every minute one in every five youth is infected with HIV. India is among the most affected nations in terms of HIV/AIDS, since this epidemic mostly affects the youth in their productive and reproductive years, it poses a serious challenge to economic production and growth in developing countries like India. There is need to identify such factors that could prevent its spread, for that it is also important to look at the most vulnerable population, who are easy and soft target of this epidemic, like Male Sex with
Male (MSM), Intra Venus (IV) drug users, sex workers, and migrant population (both male and female) etc.

AIDS an acronym for “Acquired Immuno Deficiency Syndrome” it represents the late clinical stage of infection with a virus called HIV (Human Immunodeficiency Virus). A person infected with virus is called HIV positive and she/he may look healthy but can at this point infect others from his body fluids (HIV lives in high concentrations in certain fluids such as sperm, vaginal fluids, breast milk) if these fluids in infected persons come into contacts with the another persons;

- By sexual transmission, natural and un-natural from one person to another of same sex or either sex,
- By transmission of contaminated blood or blood products,
- By sharing contaminated needles or razors and tooth brush,
- During pregnancy, child birth and possible breast feeding from women to child (Jaiswal, 1992).

HIV is not transmitted through the air, casual contact, by insect, by food and water.

1.6.1 HIV status in India

- Only 32.9 percentage of population aged 15-24 years are having the comprehensive correct knowledge of HIV/AIDS (NACO, 2006).
- HIV prevalence among pregnant women aged 15-24 years was 0.86% in 2004 and in 2010-2011 it reduces to 0.39 % (HIV Sentinel Surveillance).
- In India around 90 % women acquired HIV infection from their husbands or intimate sexual partners (UNDP, 2011).

1.6.2 Migration and HIV

"In India, available literature reveals that HIV/AIDS has spread largely with high level of migration (in high rural to urban movement), itself a reflection of limited employment opportunities, poverty and economic restructuring" (Ghosh, 2002). Internal migrants suffer from a high HIV burden (3.6%), which is ten times the HIV prevalence, among the general population (NACO, 2010). "There are many factors that have been identified related to the vulnerability of migrants for HIV/AIDS, they usually have lower levels of healthcare utilization and medical treatment, because of
lack of knowledge, issues of expenses, limited access to health care and health education, also along with the lack of HIV awareness and social support networks and health services at the new place play a main role for the HIV risk (Gupta and Singh, 2003; Mishra, 2004). “Other important reasons which make them vulnerable for HIV includes poor employment condition, peer norms, alcohol use, separation from spouses, lack of family restraint” (IOM 2005; Ford et al., 2007; Borhade, 2012), which all needed to be analyzed in detail.

1.6.2.1 Separation from Family

“Migrants are more likely than non-migrants to experience extended family separation, a condition that allow or promote casual/commercial sex at the destination for to coping with isolation” (Brockerhoff et al., 1999). “Being away from home probably also means a breakaway from family supervision, which may lead to venturing into risky sexual behavior. This may be particularly so for women, as families arguably exercise more control and scrutiny over female than male members’ sexual behavior, in the place of origin” (Yan, 2003).

1.6.2.2 Weak Morals and Values

“Migrants are more likely to experience weakened social and normative control over their risky sexual behaviors” (Stack, 1994; Yang, 2004). Migration risky sexual behaviors coincide in urban areas. “Commercial sex and the unprotected sex that is associated with it is a key source of HIV and STI transmission, and is mainly an urban phenomenon” (Connell et al., 2012).

1.6.2.3 Unsafe Sex

Unsafe sex and low Condom use in India, is responsible for 87.4 percent of reported HIV cases (World Bank, 2012). According to NFHS-3 the use of modern contraceptive methods is lower in migrants in comparison to non-migrants figure standing at 43.2% and 55.1% respectively. Inferring from the above two statements one can surely say that migrant population is more susceptible to HIV/AIDS contraction owing to low contraceptive usage.
1.6.2.4 Unawareness

"Migrants are vulnerable to HIV mainly because of their unawareness and specially the women who are more unaware so, more vulnerable" (Kandasamy et al., 2004).

NFHS-3 reveals that the greatest differentials in knowledge are seen by education and wealth quintiles, this shows that "poor and illiterate population are more at risk and specially when they are at unknown surroundings, because migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), health services" (Chatterjee, 2006).

"Lack of awareness for HIV/AIDS, shows to us that the advertisements and awareness campaigns in the media have not had their sufficient impact and in the case of women whose glaring ignorance about this disease has rendered them helpless in averting it. (Kandaswami et al., 2004). Only three women out of every five have heard of AIDS (NFHS-3). Although knowledge of AIDS has been widespread (heard of it) but, the knowledge of its method of spread is not so well known, sadly, even among the high-risk groups" (Kandaswami et al., 2004).

1.6.3 Migrant Woman and HIV/AIDS: Biological and Societal Realities

The migrant population as one of the vulnerable population, women are the major victims of this virus because of her biological and societal realities.

1.6.3.1 Low Status of Women

Women are more vulnerable to the HIV, because of their biological construction as well as because of unequal power relation, low status, limited access, lack of awareness, low say in negotiation for safer sex and inferior status in the family and society. These factors make women vulnerable in all her reproductive perspective.

Sidibe has suggested that "give women and girls the power to protect themselves from HIV...This requires investment in universal access to comprehensive sexual and reproductive health service and education. This epidemic unfortunately remains an epidemic of women. This is because of her biological anatomy and physiology as well as her social positioning" (Sidibe, 2008).
1.6.3.2 Biological Construction of Women

"Women are at higher risk of getting HIV from the male partner during the unsafe sexual intercourse than the male for the same reason. Women are exposed to considerable amounts of seminal fluid during sex, if ejaculation occurs, and can keep that for hours and days. The vagina is particularly vulnerable to invasion by bacteria, viruses and other germs. It is an ideal place for bacteria to grow, as it is warm and moist. It also provides an easy entrance into the body" (Coombs, 2003).

As, "women are at more risk for sexually transmitted infections (STIs) than men she is also in addition, often have fewer obvious symptoms, and therefore don't get treatment until the infection has been present for a long time. Having an STI increases the risk of HIV transmission in several ways" (ibid).

1.6.3.3 Mother to Child Transmission

Testing of pregnant women is especially important so action can be taken to prevent a baby from becoming infected with HIV. In view of the importance of HIV testing in the overall planning of prevention and control, as well as care and support programmes, the Ministry of Health and Family Welfare has made considerable efforts to increase the accessibility and availability of voluntary counselling and testing centres (VCTC) across the country under NACP-II (NACO, 2005). Proper prenatal treatment can reduce the risk that an HIV-positive mother has for her child.

1.6.4 HIV and Maternal Health

The Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 offers a comprehensive framework for achieving sexual and reproductive health and rights, including the prevention and treatment of HIV/AIDS with maternal Health aspects. Germain et al. (2009) has analyzed that, HIV was diverted from sexual and reproductive health and even from other STIs into a separate and often competing programme and funding stream despite the Programme of Action defined prevention, diagnosis and treatment of HIV/AIDS and other sexually transmitted infections (STIs) as one of the core elements of sexual and reproductive health services.
WHO also taken this very seriously, for this the *Bulletin of the World Health Organization* has invited papers on “bridging the gaps that exist” between sexual and reproductive health and HIV.

A meeting in Boston on “Maternal Health, HIV/AIDS: Examining Research Through A Programmatic Lens” held on June 10-13, 2013, at which brought together researchers, programmers and policymakers, under the auspices of the Maternal Health Task Force (MHTF) at the Harvard School of Public Health, the United States Agency for International Development (USAID), and the Centers for Disease Control and Prevention (CDC). This meeting was one of the first to bring maternal health and HIV experts together to have a substantive discussion of the existing evidence and priority research gaps in the field of maternal health and HIV (Kendall et al., 2014).

The meeting participants identified the following three priorities:

1) Improving cause of death, understand the relationship between HIV and maternal mortality and morbidity, to assess the impact of scaled-up access to ART on maternal health outcomes;

2) Evaluating models for effectively integrating Maternal and Child Health and HIV care, as well as incorporating malaria, tuberculosis, preconception counseling and postpartum contraception services;

3) Creating an enabling environment for women to enter and remain in HIV and Maternal and Child Health (MCH) care (ibid).

According to Calvert (2013) mortality during pregnancy and the six week postpartum period found that women with HIV were eight times more likely to die than their HIV-negative. It also become difficult to know the HIV status of the poor women who are not going for any Antenatal Checkups. In 2012 only 38% of pregnant women in low and middle income countries received HIV counseling and testing (WHO, UNICEF, 2013) as 2012 resolution by the UN Commission on the Status of Women opine that to eliminate preventable maternal mortality will not be achieved unless HIV among women of reproductive age is addressed and care of pregnant women living with HIV is improved (United Nations, 2010).

Changing the negative synergies between HIV and poor maternal health outcomes into opportunities to promote the health and well-being of women of reproductive
age, both those who are living with HIV and those who are not, is an urgent international public health priority (UN, 2010). “The debates on exclusion of migrants in healthcare access have also come under criticism because in order to ensure the wellbeing of citizens there is need to make sure that the health of migrants is considered especially in the fight against diseases such as HIV/AIDS” (Smith, 2001).

1.7 Rights for Migrants

When the migrants are uneducated and poor, creating awareness about their rights and knowing to whom to turn for information and support in negotiations is critical, for that NGOs and social workers could play a very critical role.

Migrants has to be given all the rights, which they possess by virtue of being a human and an Indian citizen irrespective of their place of origin and destination, the problem with them somewhere lies in their unawareness towards their rights, so it is the role of the policymakers to make the inclusive programs available to them, based on the rights based approach.

Role of the social worker here is to sensitise them towards their rights, as well as make them aware for the benefits of the maintaining their reproductive health.

1.7.1 Migrants as Citizen of India

Migrants have the right to settled anywhere in this country as per the Constitution of India (Article 19), which gives the right to all citizens to “move freely throughout the territory of India, to reside and settle in any part of the territory of India”.

1.7.2 Health Rights

“The universal declaration of Human rights stated in article 25, ‘everyone has the right to a standard of living adequate for the health and well being of himself and his family (UN 1948) The preamble to the WHO constitution affirms that it is one of the fundamental rights of every human being to enjoy the highest attainable standards of health. Article 21 of the constitution of India also identifies health as an integral aspect of human life” (Desai, 2007).

During the 1990s, a series of important United Nations conferences emphasized that the wellbeing of individuals and respect for human rights should be the central theme
to all development strategies. Particular emphasis was given to reproductive Rights as a cornerstone of development, and to the empowerment of women as being an important element in ensuring the exercise of these rights.

1.7.2.1 CEDAW

India is a signatory of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and ratified the convention in 1993.

In Article 12, CEDAW guarantees non-discrimination in access to health care, including affordable services and information relating to family planning, and the post-natal period.

Article 11 (2) requires state parties to undertake appropriate measures to prohibit dismissal of women workers on the grounds of pregnancy, to introduce maternity leave, to promote the development of a network of childcare and to provide pregnant women with special protection from work that may be harmful.

Article 12 requires state parties to undertake appropriate services where necessary during ante and post-natal stages of pregnancy.

Article 12 (1) requires state parties to eliminate discrimination against women in the area of health care and to ensure that men and women have equal access to health services, including family planning services.


1.8 Need, Objectives and organization of the study

1.8.1 Need for the Study

India is high in maternal mortality and morbidity, moreover, every day HIV is affecting many, to control its spread and to minimize the MMR there is an urgent need of integrated policy and program with proper and suitable awareness generation at mass level.
There are many programs initiated by the Government of India for the betterment of the women’s health and more specifically their reproductive health, but there is no specific program for the migrant’s health and more specifically migrant women’s health, although there are programs for the slum development under the Urban Development schemes, but such programs are not addressing the need of those who lives in suburbs. This study tries to highlight the reproductive health condition of those migrant women, whose needs are not counted, being the residents of the suburbs.

For that (Landau, 2009; IOM, 2010; Vearey, 2010) have rightly said that, “concerted efforts are needed to address the vulnerabilities of the large migrant population, especially when it becomes difficult for them to access and afford health facilities. An increasing recognition that “healthy migration” is required to achieve development targets in the region”.

Attaining development targets – including targets set by the national governments, as well as the internationally ratified Millennium Development Goals (MDGs) requires (among other measures) a focus on the health of internal and cross-border migrant populations. In order to ensure that the developmental benefits of migration are realized, a process of “healthy migration” needs to be facilitated. It is needed to ensure that all migrant populations are able to access positive Social Determinants of Health (SDH), including access to public healthcare systems. The SDH encompass “the full set of social conditions in which people live and work” (Commission on the Social Determinants of Health, cited by Clark, et al, 2007).

Maternal health condition and awareness of the migrant women for HIV/AIDS is very crucial to analyse, as this is an important population in terms of their number, presence and importance in the new economic based, diverse society, to bring more healthy society and to improve the poor health statistics of a nation we should work more and exclusively for this population, e.g. migrant women and more specifically, with those who are living in the periphery of the city.

Need of the study paved the way for the objective of this study, which is discussed in the third chapter.
1.8.2 Organization of the Study

The thesis has been divided into 5 chapters.

Chapter 1 gives an overview of background of the study. This chapter gives a brief idea about the migration and its related vulnerabilities and health vulnerabilities and its relation with maternal health and HIV/AIDS situation, followed by need of integrating the HIV and maternal health in the reproductive health component, and organisation of the study.

Chapter 2 provides a review of literature related to the present research including many articles, working papers, and other empirical research of same nature. This chapter also highlights the gaps in the existing literature.

Chapter 3 deals with the Problem statement, scope of the study, research objectives, research design, questionnaire development and its administration. Further, this chapter briefly describes the research strategy and tools of analysis employed in this study and then the problems faced during the field work/data collection and limitations of the study are discussed. Finally, operational definition is given at the end of this chapter.

Chapter 4 discussion on the result obtained from analysis has been presented, along with the citation of the selected cases.

Chapter 5 contains the conclusion and discussions are drawn based on the findings of the present research. This chapter also gives some suggestive measures, and direction for future research.