Chapter-2

Literature Review
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LITERATURE REVIEW

2.1 Chapter Overview

In this chapter, the researcher has attempted to compile the available literature on observations and recommendations by earlier researchers. The review will help identify the research gap which will play a guiding role in setting up the objectives and scope of the study.

Approximately three out of every ten Indians are internal migrants, even though they have not been accorded precedence by the government, and existing policies of the Indian state have not been fully able to provide social or legal protection to this vulnerable group. This can be ascribed partly to a serious data gap on the nature, extent and magnitude of internal migration (Faetanini, 2013). Lack of information regarding the types of migration in India, their number and associated vulnerabilities has not been addressed properly, their vulnerabilities impacting their health and accesses to the healthcare. “Migrants are disadvantaged throughout the migratory process and at the destination. The degree of vulnerability of migrants in India is different in different situations and so are the challenges that migration poses for health policy-makers” (Chatterjee, 2006). There are many studies dealing with the health and healthcare issues of international migrants (immigrants) are available, however not much has been published on internal migrants: Bulut et al. & Gao had opine that, the issues for internal migrants are not very different from those of international migrants (Bulut et al. 1991; Gao 1994). Taking the guidelines from these words, researcher has been included the various studies (both internal and international migrants, of India as well as of the other part of the world) pertaining to the subject matter of the research.

Four broad areas as shown below have been identified to present the body of knowledge pertaining to the research topic:

1. Causes and consequences of female migration
2. Health issues of migrant women
3. Maternal health issues of migrant women
4. HIV/AIDS and migrant women

This chapter is concluded by a discussion on identification of research gap.

2.2 Study Pertaining to Causes and Consequences of Female Migration

Female participation in the migration become an indispensable aspect of this globalised world, which require to look at it more carefully, as they are more vulnerable and more prone to the vulnerabilities.

Oishi (2002) termed the high share of female migrants to total female population is termed as ‘feminization’ of migration.

In the opinion of Deshingkar and Akter, (2009) & Bhagat (2012) “internal migration is an integral part of development and cities are important destinations for migrants. The rising contribution of cities to India’s GDP would not be possible without migration and migrant workers.”

Bhagat (2011) has studied and analyzed the NSSO data on the magnitude of the internal migrants in India, which suggested that, internal migration constitute about one-third of India’s urban population (NSSO, 2008). We cannot ignore the fact that the increase in the migration rate to urban areas has primarily occurred due to an increase in migration rate for females, which has been rising from 38.2 per cent in 1993 to 41.8 per cent in 1999-2000 to 45.6 per cent in 2007-08. Although women migrants declare to migrate on account of marriage, many of them take up work, joining the pool of migrant workers in urban areas. Internal migration is the key actors of prosperous cities, boosting economic activity and economic growth.

Thadani and Todaro (1979) reiterated the need for treating migrant women as a category distinct from migrant men. They suggested marriage as one variable for studying the mobility of women. They felt that as the inducements for women differ from those of men, a more encompassing framework of analysis with focus on women migrant as a category was necessary.

Many studies have opined that migration of females are mainly caused by marriage or migrated with their family that is associated migration (Bose, 1973; Premi, 1979; Rele, 1969).
Fawcett et al. (1984) defined the female migration on three distinct patterns;

1) Autonomous female Migration: Mainly the middle and upper class women migrate to get the higher education and employment, apparently for social advancement and create demand for marriage. Even the lower middle class and semi-literate women migrated to get employment in some smaller industries.

2) Relay Migration: To support the family income, families sent their daughters to work as domestic servants where they are safe under the custody of a known and reliable person or family, first they sent out their elder daughter and then she is replaced by the younger one and so and so forth, as one by one they get married.

3) Family migration: when wife join her husband in the hope of getting some earning in the destination area.

Premi (1980) has analyzed the secondary data relating mainly to the 1971 census and other related earlier studies and came into conclusion that, the number of female migrants is more than double that of male migrants but their migration is largely limited to the rural-to-rural stream within the district of enumeration. As the distance of migration increased, the sex ratio falls sharply. Author further defines that associational migration accounts for nearly two-thirds of the female migrants but this needs further analysis. The percentage of female workers in 'other services' in rural-to-urban stream largely reflects the degree of their employment in menial and low paid jobs.

2.2.1 Factors for Female Migration

Kettegoda (2006) studied the factors of the female migration in Sri Lanka, he concluded that poverty and lack of employment opportunity are the main push factors. Connell, (1984) found that female migration is primarily on the account of real and perceived spatial inequalities in socio-economic opportunities that crop up owing to non-uniform regional development. Many studies have revealed that female migration are mainly from the poorer section of the society (Hugo, 1993; shanti, 1991; Araya et al., 2005).
Kaustri (1990) found the same in his study conducted with Tamil domestic servants in Delhi that socio cultural factors influence migration. Study also reveals that many migrants belong to low caste and social barriers force them to migrate to other places for work as domestic servant.

Reddy (1991) has studied the causes of migration of female construction workers of Hyderabad city. Based on a sample of 200 families from different location of the city with the objective of identifying the push and pull factors. Economic reasons such as famines, scarcities, indebtedness and the lack of sufficient employment opportunities in their native places were noted as the major push factors. In the case of pull factors, some of the women migrants were fascinated by urban life and some of them wanted to join with their husbands who had already migrated. In spite of the miserable condition of slum life and the frequent social disturbances in the city, the women migrants conditioned to join in, as the condition in their village were even worse when compared to city.

According to Adepoju (1988) the lack of facilities in the rural areas like Schools, modern housing facilities and health services are the reasons women with children move to larger cities.

2.2.2 Vulnerabilities faced by the migrant women.

Kanta (2012) defined that, women and child migrants are the most vulnerable. Women and children mostly migrated as associated migrants in India. They usually suffer from many atrocities and vulnerabilities because of low and reduce choices and lack of social support in the new area of destination. In the case of semi-skilled, low-skilled or unskilled women migrants, this can translate into their entry into the low paying, unorganized sector with high exposure to exploitation and abuse.

Study also define the direct relationship between the poverty (of the migrants) and other vulnerabilities, as poverty is a multidimensional concept implying not only lack of adequate income, but a host of other facts such as lack of choice, sense of powerlessness, vulnerability, and lack of assets, insecurity and social exclusion. In the light of the above discussion, this study, infers that socio-economic determinants like education, health and healthcare are descriptive about basic minimum access to development by the stakeholders irrespective of the type of occupation adopted by
them. Contextually, study find that a highly visible percentage of women workers continue to live a life full of subsistence, compromises and most of their own access in terms of right to life is subsidized. The most important determining factor to such in access and denial primarily evolves out of poor literacy and lack of awareness resulting in self-exclusion from the mainstream opportunities.

Banerjee (1985) in a survey of unorganized women workers in Kolkata found that most of the migrant women were in prime working age and concentrated in very low return, low skill, low status urban occupations, being in reproductive age and poor condition, much chance is there for their abuse and vulnerabilities.

According to Kabeer (2006) migrants remain on the periphery of society, with few citizen rights and no political voice in shaping decisions that impact their lives.

According to Chatterjee & Sheoran (2007) short stay at a place due to casual nature of work excludes female migrants from the preventive care and the working conditions in the unorganized work arrangements in the city deprive them from access to adequate curative care.

2.3 Studies Pertaining to Health Issues of Migrant Women

Meadows et al. (2001) said that, women’s overall wellbeing and health is influenced by factors like social, political, and economic as well as by their biology. Women’s life experiences and own beliefs have bearing on the health of women. As Meana et al. (2001) described that “women’s perceptions that they have little control over their illnesses or that their god will protect them from ill health can deter women from seeking healthcare”.

As discussed earlier, several studies have also highlighted that migrant women have less access to healthcare services (Kusuma et al., 2010; Antai et al., 2010, Shaokang et al., 2002) and medical care seeking behaviour is not satisfactory (Kusuma, 2010). Moreover, migrants are not enjoying the same benefits as urban residents enjoy in the urban areas nor benefitted much in rural places.

Borjas (1987) in a study of Mexican migration to the United States (US) argues that usually migrants come from lower socioeconomic area, raising the possibility that their health conditions could be worse than those of non-migrants.
According to IOM (2003) the relationship between health and migration is dynamic in nature and reflects the complexity of various migratory flows as defined by Kevin J. Thomas, (2007) the relationship varies among different kinds of migrants and is also affected by their reasons for moving.

Li (2010) conducted a survey in Dengaun Village of Beijing in 2010. This survey contributes to the understanding of the health seeking behaviour among rural-to-urban migrant workers and indicates that sometime the state of the health services system is not very supportive towards migrant workers. He suggested that equity should be assured in access to health care services among migrant groups.

Sundquist (1995) questioned the equity and integrity of the health care system at the host place towards migrants. To give the answer it is necessary to examine the factors affecting the health and healthcare. According to the author, both migration status and low social position work against them in combination but both are independent factors.

Peng (2007) has studied the health seeking behavior and their related factors of the migrant workers in Beijing China, an investigation of rural-urban migrants who fell ill conducted in Shanghai in 2005 demonstrated that 11% migrants preferred not to take any treatment, while 65% went for self-medication, as to reduce spending on their treatment, although 24% migrants went to hospital after becoming ill, out of them 48% migrants chose private clinics. This study also highlights that how migrants used these medical services during the time of their illness. During normal disease, they usually buy medicine without prescription from a pharmacy/self-treatment and if they fail to treat the illness themselves, the first choice for them is the county or city level hospital, next is the provincial level hospital. The basic level of medical service accounts for 20.4% followed by private clinics that is 5.9%; the community health service accounts for 14.5%; the self-medical service standing at 18.3%.

Hong et al. (2006) suggested that lack of any health insurance and the high cost of health services are the main reasons which have led to the under-utilization of health care services among migrants, which have rendered migrants to adopt ineffective behavior and methods of health care such as unsupervised self-medication, going to unregistered clinics, or just living with the problem without seeking any medical care.
Peng et al. (2010) conducted a study in Beijing, China to find out the factors regarding health seeking behavior among the migrants and to explore feasible solutions to the obstacles migrant workers in China faced in accessing health care facilities. A sample of 2,478 migrant workers was chosen through multistage stratified cluster sampling method.

Migrants in the cities of China live in a vulnerable state with an unfair share of urban infrastructure and social public welfare. Study indicates that the current health service system does not encourage migrants from seeking required care of good quality. Study suggested that feasible measures should be taken to reduce the health risks associated with current hygiene practices and there should be equitable access to health care services among migrant workers.

Piet (1999) in their study in Bangladesh, highlighted that demand factors are the most important reasons of going without treatment in case of emergency obstetric care. These factors that play the role in the identification of illness by the individual and further seek required health care and these factors influence the demand.

Butsch (2008) concluded that the governmental health care services, which should in theory, provide subsidized or free treatment to the poorest are not able to reach their target group because of lack of knowledge of recipient about these services and also the proximity to services. Knowledge about the services, variable work schedules, service hours often highlighted as barriers to healthcare access.

Subariya (2007) conducted a study in Peru, discussed that, women who have lived in urban areas of Peru throughout their lives are more likely to seek an institutional source for modern contraception methods, antenatal care compared with migrant women. Among them, women who have migrated from rural areas are less likely to seek support from private or public sources for their reproductive and child health needs than urban non migrant and urban to urban migrants. The study also highlighted that most of women who have migrated from rural area have no education or only a primary level of education, have no health insurance or live in households that are in the lowest wealth category compared with urban non-migrants and urban migrants. Further study explained that the factors like, education, health insurance or wealth category are significantly associated with women’s likelihood of using reproductive health care.
Kevin (2007) explains that, socioeconomic factors have a strong association with the health outcomes, author studied this relationship among the migrant groups and showed the relationship between the different factors of the Socio Economic Status (SES) nexus to the health. Author further explained that the earlier studies have taken occupation, educational levels, and income as important measures of socioeconomic Status while some of the recent studies have included new measures like household assets and living standard in socioeconomic status, as Ray (1993) has pointed out that, poor living standard includes lack of drinking water supply, unhygienic sanitary condition, unhealthy cultural practices expose the migrants to the number of health risks.

Chatterjee (2006) discussed the migration among women and children and its associated vulnerability, the poor and overcrowded living condition of the migrants enhanced the risk of infectious disease, lack of food and safe drinking water could resulted into malnourishment and consequent lowered immunity, moreover, poor personal hygiene and poor environmental sanitation, are reasons and factors of the diseases among the migrant population, poses complex public health challenge.

Awareness and education are so much interwoven to each other, which is require for the solution of this problem of poor maternal health and HIV/AIDS knowledge, Srivastava (2003) highlighted, that migrant workforce in India is either illiterate or has little education unlike other countries in Southeast Asia and East Asia. This lack of education further aggravates the situation. There are some other factors which also work as an important determinant force in defining their health beliefs and attitude. One of them is stay impact (time they spend in the host area). Similar finding have also been discussed by Leclere et al. (1994) that duration of stay or residence in the host area effects the acculturation and adjustment process, more the duration of stay at the host place more the alignment with the local norms and values that changes the health behavior.

There are some more studies conducted on migrant population based on health care utilization in India (Swain and Misira, 2006; Babu et al., 2010; Das et al., 2010; Kusuma et al., 2010; More et al., 2010).

Trieu (2010) studied poor migrant’s health condition and the role of insurance schemes in health promotion, as China is experiencing the largest internal migration in human history. Health care is a major concern along with the insurance scheme covering the
migrant population. In this study medical insurance schemes, of Beijing and Shanghai, were studied. The analysis shows that providing catastrophic insurance via the extension of the urban employee medical insurance is an efficient way to expand basic medical coverage to this population and to other urban poor. Moreover, target and inclusive public Health programs should be available for the migrant population. Hong Trieu has further suggested that, insurance for the poor should be governed by government, and private sector can be involved in management of the programs. Along with the correct and managed insurance scheme for this population it is also important for the host government, to provide some special and additional resources for public health to enhance the migrant’s health.

Author have suggested after an analysis of the Beijing and Shanghai model of insurance scheme that more inclusive model can help to ensure an urbanization process so that migrants can easily be socialize into urban area rather than keeping themselves away from the mainstream being felt alienated.

Peters et al. (2003) opined that the large number of people migrating into slums need authorities to deliver better on essential public health services, concerted efforts are required from both central and state Governments. Since, access improves if health care services become better aligned with clients’ needs and resources, it is important to know both the clients’ (migrants) perspectives as well as the system’s response. It is obvious from the existing migrant health scenario in Delhi that disparities in healthcare access to migrants exist and the gaps may widen further, if appropriate steps are not taken. In this background, innovative approaches are needed to better align the healthcare services with the migrants’ needs, expectations and resources.

Akram (2013) conducted a study in the Western Utter Pradesh, on migrant construction worker, the paper was divided into seven sections: Health and Human Rights concerns of MCWs, availability of basic health goods (BHGs), exposure to unhygienic condition and pollutants, disease injuries and disabilities, treatment compensation and economic burden, policies, constraints and suggestions. The findings of this study suggested that the health condition of the migrant workers is very miserable. They are the victims of several diseases, ailments and injuries because of changing physical environments, limited dwelling space, scarcity of basic amenities, and several other constraints.
The study further elaborates the health condition of the migrant women, which is much pathetic. The migrant women, usually not taking any Ante Natal Care, Post Natal Care services because of their migratory condition, except few, many were suffered from the various reproductive and sexual health problems. Use of contraceptive and more specifically of CONDOM were very rare; According to this paper STDs among them can’t be denied, and many of the unmarried or single living workers are exposed to STDs and even to AIDS.

2.4 Studies Pertaining to Maternal Health Issues of Migrant Women

Reduction in maternal mortality remains a major challenge to health systems worldwide, it is high on the priority list of Millennium Development Goal 5 (Ronsmans et al., 2006). India’s maternal mortality rate falls, the rate of decline are 16% in 2011-12 from 2007-09, but still a long way to go (Mehta, 2013).

Essén et al. (2000) defined a phenomenon “the maternal migration effect” that the migrant’s attitude towards the maternal care is based on their pre-migration culture or the impact of their native place does have strong roots even after the migration especially in the first generation migration, this study was on international migration of Somali women in Sweden.

This study suggested that, although the migration is from a high-mortality to a low-mortality setting, even though first generation immigrant women of reproductive age might remain influenced by childbearing experiences or hearsay about others’ experiences from their homeland. Such influences could pose negative consequences to maternity outcomes in the host setting, even if women have easy access to well-equipped care facilities. They further emphasized that, knowledge about which pre-migration factors can impact a woman’s post-migration experience could be crucial to providing effective maternity care.

Shaokang et al. (2002) in their study on internal migrants in China, noted that lack of seriousness towards antenatal care is one of the determining factor of poor maternal health outcomes, and that migrants utilise Antenatal services less often as compare to permanent residents.

With recent urbanization in China, which has resulted in women migration from rural to big cities has posed much higher maternal mortality rates than local residents.
Knowledge about health enables the women to claim their right of appropriate health services. This study aims to assess the attitude and knowledge about maternal health care and the factors that contribute to making migrant women knowledgeable in Shanghai, most migrant women are from rural areas, not well educated and have a lower socioeconomic status. These migrant women do not have maternity insurance which is not the case with the permanent residents. Author further believes that, the insurance system in China today cannot cover such a large population.

They also highlighted that migrants have to face number of hurdles in order to access available health services therefore the system should be redesigned keeping the varied problems and obstacles faced by migrants in perspective. In the overall health care, maternal and child health is one of the most crucial part of health for this population as the living conditions and marginalization put their health in jeopardy.

Vulnerable living status along with lack of awareness about maternal health influences their utilization of maternal health care. It is very clear that any woman with poor knowledge on maternal health would have least access to health care services. Well-designed maternal health education and accessible services are in demand for this population.

An important finding in this study was that the socio-economic status, education of husband, annual income, residence and delivery experiences were the main factors influencing the knowledge level of maternal health care among rural migrant women.

Study also suggested that the education program of maternal health should be carried out in places where migrant women gather including suburb communities, labour-density factories and serviced area in great demands.

There is direct relationship between education and maternal health (NFHS-3). One of the study conducted in Namibia, revealed that, women with post-secondary education were over twice as likely to deliver with a skilled attendant compared to those with no education, and seven times more likely to obtain a caesarean section (Zere et al., 2010).

Zhao et al. (2009) discussed that rural to urban migrant women lack on maternal health knowledge in Shanghai. Financial difficulties pose obstacles in attending Antenatal care. Maternal health knowledge is influenced by factors like family income, education level of women, and the urban residence of husband. Findings
from this study suggest that these vulnerable group should be educated using various methods of education which address the health problems of rural to urban migrants. Using the insights, educators, policy maker and healthcare providers, need to develop policies, strategies and services which address the needs of migrant women.

Lewis (2003) has very correctly pointed out that, programmes based on the right kind of information helps to good extent in preventing the maternal deaths even in a resource-poor population.

Qin et al. (2009) & Zhu et al. (2007 & 2010) Li et al. (2012) analysed and concluded the same results regarding the trends in maternal mortality in resident vs. migrant women in Shanghai, China, they find that delivering in the maternity hospital not only reduced the cost of delivery services but also reduced mortality from obstetric haemorrhage by 97.3% from 2000 to 2009 and this resulted in MMR decline by 78.9% among migrant women. Study further analyse that, maternal deaths among both residents and migrant women due to direct obstetric causes are reduced owing better coordinated working of obstetric department with other departments at emergency care and referral centres. Obstetricians and physicians capability and awareness can be enhanced through health education and training. Apart from this safer motherhood can also be ensured by increasing the awareness and ability of self-help health care among pregnant women. Reduction in maternal health can be achieved by establishing low cost delivery in maternity hospitals for the migrants.

Yuan et al. (2013) states on maternal health condition among the migrant population vs. permanent residents of the three provincial capital i.e. Beijing, Shanghai, Shenzhen, in China revealed that in all the three areas the MMR was higher among the migrant population than the permanent residents, permanent residents are at more advantageous position than rural-to-urban migrants as far as maternal health is concerned in the cities. The prevalence of modern contraceptives among rural-to-urban migrants is lower than permanent residents, resulting in induced abortions in small private clinics for unmarried migrants.

They further analysed that, as these household are not officially registered in cities, migrants are denied to most public-funded programs and Govt. schemes, such as housing, education and health services the result is that migrants are in vulnerable position and poor standard of living and working environments. The low-income
status also restricts their access to health services (which they must pay for themselves) and other goods or services.

The poor knowledge and importance about maternal health services, pregnancy, fertilization and contraception along with economic consideration leads to less utilization of maternal health services and contraceptives.

Nanda (2000) studied socioeconomic determinants of health among women based on a study of households of rural areas of three north Indian States. The paper aims to understand women illness, in context of social economic and demographic conditions. Results of the study give an insight to the spectrum of female health status in a poor society. In spite of limitations of morbidity data, preponderance of vaccine preventable and hygiene related disease shows the primacy of economic deprivation leading to ill health among women. The age pattern of morbidity among women reveals that female disadvantage in health begin to intensity around the age of twenty coinciding the marriage and child birth, and persisting till the onset of old age. The educational attainments of women indicate that the number of years spent in school, has the potential to lower the prevalence rates of illness. While poor accommodation, larger household size, more membership, lesser share of females in the household increases their vulnerability.

Pandey et al. (2004) studied the pattern of utilization of Antenatal care services and assistance received during delivery in three states, namely, Chhattisgarh, Jharkhand, and Uttaranchal. The objective of the paper is to examine the pattern and correlates of utilization of ANC services and to examine the assistance received during delivery in these states. The study presents that the utilization of ANC services in a given population depends upon availability and accessibility of services, socio economic status of the house hold and distance of the health facility. Women living in urban areas are more likely to go for ANC services compare with their rural counter parts. Women with lower birth order are more likely to use ANC services than women with higher birth order. The finding suggested that there is need to apprise rural women and those with higher birth order about the importance of ANC services in all the three states. This can be achieved by strengthening existing outreach services and Information Education Communication (IEC) activities. The role of mass media emerges as an important correlate of ANC.
Borhade (2012) discusses the reasons and factors behind the poor healthcare utilization rates among migrants, which according to him factors like conflict in the timing of work with visitation to medical practitioner, costly treatment at private health facilities, cost of missing of days work, distance and transportation problem to access health services, language barrier and perceived alienation at host place. He further explained that home deliveries are preferred by many urban migrant women.

Alisjahbana (1995) has suggested that that the special attention has to give to the practice of traditional birth attendants, who are considered a risk due to a lack of training and hygienic equipment.

Elizabeth et al. (1990) has examined a model project which was implemented in North Carolina to make available primary health care services to migrant farm worker women and children. The project emphasized coordinated efforts to provide services for migrant farm worker mothers and children, such as transportation services, language translation, follow up, and advocacy. An outreach strategy involved case finding, home visits, and services by lay health advisors. By the third year the project started to show the increase in the average number of antenatal visits, the proportion of women entering antenatal care in their first trimester, and in the use of well-child services. The project incorporated effective methods for giving culturally appropriate health care services to migrant farm worker mothers and children using bilingual public health professionals. Limitations in resources require health agencies to work closely to share knowledge and services so that the complex needs of the migrant population can be met. The project demonstrated how establishment of communication between the two systems of care, the migrant health center and the maternal and child health programs, enriched the services available to migrant farm worker women and children and improved their health status. This project also highlights the importance of the health education through proper communication (no language barrier) through local language, does affect the health beliefs and enhance the motivational level).

Agarwal (2007) conducted a study in a slum of Delhi with the migrants, to find out the factors of maternal health care utilization. Many socioeconomic factors like women's literacy and occupation of their husbands showed a significant link with respect to utilization of antenatal care services. This paper comparing the results with
the reports of the survey carried out throughout the sample districts of India, which is averaging 75% had ANC across the country, similar results regarding the level of Ante Natal, have been found that most of the migrant women (76%) had Ante natal care. Mothers availing ANC preferred dais to a lesser extent (13.1%) than those having no ANC (66%). Despite the target of universal immunization of pregnant women against tetanus, 17% in the present study were unprotected against tetanus. Similar to an evaluation survey report, this study showed there are some slum dwellers of Delhi who lack interest and awareness in maternal health despite the availability of health facility nearby. In a study it was also found that due to better awareness there was improvement of maternal health-care services utilization in subsequent pregnancy over time. Findings suggest that accessibility to well-equipped modern maternity facility and awareness have significant impact on health seeking behaviour of women. Furthermore this study has highlighted that the awareness is more important among such population, since it may not be possible to establish a health facility with all modern equipments in every slum area, but, once they become aware for the need of the maternity care then they will definitely go nearby health centres for better pregnancy outcome.

David et al. (2006) has done an analysis of migration and contraceptive use in Guatemala the study was based on Demographic Health Survey data from 14 different countries of Africa, study shows the association between the duration of stay in the urban setting that of usage of contraceptives. The result revealed the increase in the usage of contraceptives in the second and third year after migration among rural to urban migrants.

Xiaoming et al. (2007) conducted a study in some selected rural communities in china to examine the potential association between Rural to Urban migration and sexual risk behaviors by comparing between 553 return migrants and 441 non migrants from the same rural areas in China. this study reveal that ,after controlling socio demographic characteristics, return migrants in rural areas had higher level of sexual risk, including unprotected sex, than non-migrants, These findings highlights the importance for education and prevention efforts on HIV/AIDS among urban migrant population and return migrants in rural areas.
Mishra et al. (2014) explore relationship of internal migration with current use of modern contraception methods among currently married women age group between (15- 49) years in India. This paper uses National Family Health Survey-3 (NFHS-3) data of India. Study findings shows that about 48% of non-migrant women were using modern contraception methods than 40.4% of migrant women. Further, current use of modern contraception methods was higher among urban non-migrant (55.1%), urban to urban migrant (51.0%) and rural to urban migrant women (43.2%). Overall result shows that rural to urban migrant women are least users of modern contraceptive methods. The results of multivariate regressions indicated few factors which were significantly associated with women’s likelihood of current use of modern contraception methods. That was age, education, occupation, number of living children, religion and household wealth.

Oberai et al. (1983) in Ludhiana district of Punjab, addressing the effect of rural-to-urban migration on fertility. Study finds that in general fertility is higher among migrants as compared to non-migrants. Study believes that there are economic factors relating higher fertility to higher rates of migration.

Petal (2003) defined migrant’s awareness about contraceptive use effects the rate of change of fertility in urban as well as place of origin that is rural areas, awareness also affects the spread of HIV and other STIs. The rate at which the knowledge and experience is acquired in urban areas by migrants from rural areas increase their control on fertility with respect to new opportunities and constraint they face. Migrant population is considered to be the important vector of HIV spread.

2.5 Studies Pertaining to HIV/AIDS

According to Johanson (2007) 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. The epidemic 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.
Nunn et al. (1995) A study conducted in Uganda, find out that the individuals who had moved within the past 3 years were three times more likely to be infected with HIV than residents who had not moved in the past ten years. This signifies the direct relationship between migratory movements and HIV.

NFHS (2006) indicated that 0.28 percent of adults age 15-49 are infected with HIV. This constituted into 1.707 million HIV positive persons age 15-49 in India at the midpoint of the NFHS-3 survey period. There is 0.22 percent HIV prevalence rate among women and 0.36 percent for men age 15-49.

Nag (1996) has discussed about the root of spread of HIV/AIDS in India, it largely spread 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. 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 behavioural, structural and biological factors (Moses et.al, 2006). There is ample empirical evidence which upholds a higher level of positive correlation between labour migration and HIV vulnerability.

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).

According to Bailey (2008) generally men first migrate in the process migration this is then followed by linked migration spouses and other family members. Increased migration to urban centers in many developing countries has resulted in changes in the traditional family structure. HIV prevalence in migrant groups is 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.

Xiang (2005) stated that there are some reasons that may lead the migrants to be vulnerable to health risks, such as high levels of mobility, supposedly active premarital and extramarital sexual activities, low income, lack of awareness, and lack of social contact with the local community.

Ghosh (2002) has studied the intensity and impact of HIV/AIDS in India, in different geographical variation and impact of different behavioural characteristics. It is found in this study that there is variation in the urban-rural distribution of HIV/AIDS, as in southern states it is more in number, higher level of urbanization and related migration in these states are considered as the major factor, 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. 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. The unawareness is one of the major root causes for the spread of this problem.

Brockerhoff et al. (1999) using data from the 1993 Kenya Demographic and Health Survey, link between migration and sexual behaviour and risk of HIV is revealed. Results opine 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 has implications for HIV transmission throughout Kenya.

According to Bhagat (2005) In India, migrants are not registered either at the place of origin or at the place of destination. In absence of this, Census and National Sample Surveys (NSS) are two main sources of data on internal migration in the country. This paper examines the two national sources of data on internal migration
related to the definitions of migrants, duration of migration, streams and reasons of migration. It brings out that given the importance of internal migration in view of HIV/AIDS and public health impacts, also there is a need to account the seasonal migrations/or floating populations in the country.

There are some factors and reasons which make migrants more vulnerable for the HIV like,

(a) 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 & Biddlecom, 1999).

(b) Week Morals and Values

Migrants are more likely to experience weekend social and normative control over their sexual risk behaviors (Stack, 1994).

(c) Unawareness

Kandaswami et al. (2004) conducted a study in the state of Tamil Nadu with migrant labourers (including truck drivers) constitute the major portion of those affected with HIV/AIDS, especially in District Namakkal, the study reveals that migrant workers are more vulnerable to HIV/AIDS than the local population because of their poverty, lack of power, lack of health awareness and unstable life-style. Sometimes, wrong and mythical notions about sex might lead to their high-risk behavior. The author studied the psychological, social and economic status of these HIV/AIDS infected migrant laborers and the analysis draw conclusions on preventive measures to be taken to stop the spread of HIV as well as take steps to counsel and rehabilitate the affected. Research observes from the study that the large-scale patronization of Commercial Sex Workers (CSWs) by heterosexual (and often married) men is to a great extent responsible for the spread of the disease. Further it is to be noted that most of the infected are illiterate or with very low educational qualifications (secondary/high school dropouts), low levels of awareness about HIV/AIDS and are addicted to habits like smoking, drinking and visiting CSWs that too mainly from rural areas. Further most of them were persons with low sense of personal accomplishment and they took
pride in their flimsy life-styles. Another major fact that the researcher could reveal during this research on migrant workers with HIV/AIDS was that, several of them, (respondents of the study) were unaware of how HIV/AIDS spreads. This was very shocking for it shows to us that the ad and awareness campaigns in the media have not had their sufficient impact and secondly in the case of women whose glaring ignorance about this disease has rendered them helpless in averting it mainly in rural areas. While knowledge of AIDS has been widespread, the knowledge of its method of spread is not so well known, sadly, even among the high-risk groups. This is not to say that the campaigns have failed in their objectives, this is to merely suggest that methods have to be developed to have greater outreach and awareness among the vulnerable categories of the people.

This study clearly speaks that the migrants are vulnerable to HIV mainly because of their unawareness and specially the women, and suggested for the correct and more awareness generation programs for to make the migrant population aware on the issue of the HIV/AIDS.

(d) HIV and Awareness

From the very beginning of the global response to the AIDS pandemic, prevention has been marginalized. Treatment has dominated. This systematic imbalance in clinical and public-health programmes is largely responsible for the fact that around 2.5 million people become newly infected with HIV each year. This statement pointing towards the more emphasis should be given to the awareness generation, to control this problem (Lancet, 2008).

Bertozzi, et al. (2008) discusses the same fact that the global fund took a vertical approach to disease control rather than a horizontal approach to building health-system capacities. Most of its HIV/AIDS money went into treatment. HIV prevention in the general population of married women and the provision of comprehensive sexuality education and health services to adolescents appeared not to have any priority.

This is the reality, that the major concerned of all the agencies on HIV/AIDS is towards the treatment aspect, we cannot deny the fact that it actually of much importance to provide timely and subsidies treatment to the infected persons, but as
we all know that the only way out or to combat from this disease is through the correct knowledge and awareness, so one can protect their life, through correct protection and prevention. Many factors have been identified related to the vulnerability of migrants. It has seen from some studies that with the passage of time the migrants become aware on the health services, contraceptives as well as on the HIV/AIDS.

Ford and Chamratrithirong (2007) has done the analysis pertaining to the duration of stay and its effects on migrant population from Cambodia and Myanmar, the initiatives taken by the Thailand Govt. to spread the Knowledge on AIDS, the risky sexual behavior of the migrant population. The vulnerability towards AIDS of migrants can be attributed to reasons like alcohol consumption, lack of peer and family restraint, long separation from their spouses, low level of education along with low perceived risk of HIV and limited access to health care. The study reveals that the average duration of stay of these migrants was around five years and the period of their stay increases the level of AIDS awareness as well as the use of condom with regular partner.

Further discussed and suggested that the level of knowledge and the behavior of migrants often put them in a vulnerable position of inflicting with HIV. Although the initial time of migration is most critical but the HIV risk is always remain there throughout their stay so the focus should be on minimizing the HIV spread.

(e) Lack of Access to Information and Resources to Prevent from HIV, like CONDOM

Chatterjee (2006) conducted a study for the CEHAT organization on migration and health, speaks that “being migrants or mobile parse is not a risk factor but the situation encountered and behaviour displayed makes them vulnerable and risk prone towards HIV/AIDS. Migrant and mobile people may have little or no access to HIV information, prevention (condoms, STI management), health services (International Organization of Migration, 2005).

In the opinion of Edgar at el. (1992) individual will take necessary actions for prevention only when they have proper inform and motivation to respond to the situation accordingly. The communication about HIV/AIDS is a continuous process
and any break in the stream of communication make the individual to back slide to unsafe mode of doing sex. Edger emphasized on some important points or given some suggestions for avoiding the lethal disease was as follows:

- prevention
- communication about the Health risks
- health behaviour
- Safe sex; condoms and education

Jacornord (1998) explained the role of print media in the prevention and control of HIV/AIDS this is through television that awareness against HIV can be effectively produced and raised in the society where literate rate is very low. In the societies like India, that print, electronic media can help to educate population, in the context of HIV/AIDS prevention. Interpersonal channels have been also proven successful to address the issue of HIV/AIDS.

Bates et al. (2002) studied and analyse the situation of the ‘floating population’ on HIV/AIDS perspective in China, which as per the estimate is around 100 million, these mobile workers are unregistered and undocumented, and are without housing subsidies, education or Healthcare. As the situation of these roaming workers is vulnerable therefore making them the significant carrier and source of HIV. The composition of this group is of people who are young or of middle age group both men and women are the part of it and this is the age when one is sexually active. The education level among them is quite low, they are involved in drugs and over half of them work in entertainment industry which can include commercial sex industry. As they are the fringe group of the society therefore, it is difficult to provide HIV awareness, monitoring and treatment. This study also suggested for the special awareness generation programs and policies for this excluded population to save them from the unknown epidemic (for them) HIV.

Chamratrithirong (2010) has analyzed the impact of the PHAMIT program on AIDS knowledge and condom use among the migrants in Thailand, the paper revealed that the knowledge regarding HIV and use of Condom has increase with duration of residence in Thailand due to the presence of the HIV prevention programs, such as the PHAMIT program. The program trains networks of volunteers to provide outreach
education and condom distribution to migrants in the irregular workplace, living quarters, and entertainment centers. Drop in centers also provide a place for migrants to get information and services.

Sarker (2011) suggested that, rural to urban migration occurs because of poverty and lower level of human capital and the choice of risky occupation contribute towards the spread of HIV/AIDS. The study defined the migration, is the dominant factor that makes migrants more vulnerable to HIV/AIDS and the relation between migration and HIV is not known to most of the migrants and which renders them susceptible to the infection of HIV. The government and non-government organisations should develop strategies both at national and regional level to facilitate the easy access to HIV/AIDS prevention programmes for migrants which includes information and health services to migrants as to safeguard themselves against HIV/AIDS.

(f) HIV and women

Women are considering as the most disadvantaged population in terms of information and awareness aspects, now especially in terms of HIV.

According to Huang (2001) females rural migrants are more vulnerable than male migrants because, of less education and lack of job training in majority of the case, gender plays an important role in modifying the association between migration status and risk behaviour.

Bury et al. (1992) argued that although AIDS inflicted women are relatively not in large number, the education should focus on those who are positive and in the case of pregnancy how important it is to protect oneself and the unborn child. Female constitute 49% of total population, and share a great risk of developing HIV/AIDS as females are with added risk of un-education, social deprivation and discrimination.

Balk et al. (1997) in a study of 30,000 married women on analysis of their knowledge revealed that very few had ever heard of HIV, and out of those who heard of this syndrome, a large proportion of them didn’t know the details of transmission and associated illness.

Chatterjee (1999) conducted a study with 350 married women in Mumbai, explore that out of those 350, one third claimed to have never heard of AIDS, most of the
women who had not heard of AIDS also didn’t know about Condoms. In another study of pregnant women in Delhi, only 39% had ever heard of AIDS (Singh, et al. 2002).

Newmann et al. (2000) has defined that the rising sero positive prevalence rate among women of reproductive age is cause for considerable concern, especially due to the potential for HIV transmission from mother to child, this can be attributed to the limited healthcare access, poor maternal health indicators, and higher rate of breast feeding among women in developing countries.

Singh et al. (1999) and Lingam, (1998) have studied the vulnerabilities of the migrant laborers in an industrial area of New Delhi, as they are continuously living in poor surroundings and hazardous working conditions. Basic needs are missing and most of the workers are indulge in multi partner risky sexual behavior like not using condom. Moreover drug and alcohol abuse is common which provides all the necessary ingredients for the spread of HIV.

According to Adrienne et al. (2009) the Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo in 1994 provides a comprehensive framework in order to achieve sexual and reproductive health and rights, which includes the prevention and treatment of HIV/AIDS, and furtherance of other development goals. The United Nations Millennium Development Goals has set the universal access to sexual and reproductive health within the umbrella of improving maternal health, but combating HIV remains a separate project with malaria and tuberculosis. Author presents a brief history of key decisions made by WHO, other United Nations’ agencies, the United Nations Millennium Project and major donors that have led to the separation of HIV/AIDS from its logical programmatic base in sexual and reproductive health and rights. This fragmentation does a disservice to the achievement of both sets of goals and objectives. In urging a return to the original ICPD construct as a framework for action, author call for renewed leadership commitment, investment in health systems to deliver comprehensive sexual and reproductive health services, including HIV/AIDS prevention and treatment, comprehensive youth programmes, streamlined country strategies and donor support. All investments in research, policies and programmes should build systematically on the natural synergies inherent in the ICPD model to
maximize their effectiveness and efficiency and to strengthen the capacity of health systems to deliver universally accessible sexual and reproductive health information and services.

Zaba et al. (2013) found that mortality of women with HIV were eight times more than the non HIV during pregnancy and the six week postpartum period (UN 2010). Based on these findings, the 2012 UN resolution on Status of Women to eliminate preventable maternal mortality will not be achieved until and unless pregnant women with HIV are not provided with living conditions which can improve their problem. 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.

Shadravan (2010) conducted a study on cross border migrants from Bangladesh to India (Mumbai, Kolkata), study found migration on the account of poor economic condition is most common reason for migration, during this journey across the border migrants face harassment, violence and discrimination and are at risk of HIV for many risky encounters and vulnerable situations. Author found that the overall knowledge for HIV among the migrants was very poor. Their situation was aggravated by misconception about the spread of HIV, the lack of service and its utilization further compounded their situation across the border. Author further found migrants were not aware about the dual purpose of the condom. The use of condom was high among those, who were aware about its use as the prevention against the STIs and HIV.

Author finally suggested that, migrant population should inform about the HIV and related concepts. A comprehensive Social and Behavior Change Communication strategy/plan focusing on behavioral change among different target audiences like general community including the migrant and their families, health professional, service providers, and law enforcers at source and destination to ensure reduction in HIV and migration related stigma and discrimination.

Green (2001) studied the role and increased recognition of the Faith based Organization (FBOs) in Uganda’s response to HIV. In 1987 the major FBOs became involved in AIDS prevention, with WHO and later USAID funding. They promoted
fidelity and abstinence, and Green argues that some impact studies such as UNAIDS 'Best Practices' show that AIDS prevention activities carried out by FBOs in Uganda had significant direct impact on particular populations targeted. Green contends that FBOs that have advocated abstinence and fidelity in Uganda have had significant impact on overall infection rate decline. On the basis of this, Green argues for more equity between resource allocation to the promotion of condom use and to abstinence and fidelity promotion, and for the greater involvement of FBOs in tackling HIV.

2.6 Research Gaps

1. Although there are studies that have been taken up by earlier researchers on migrants and their health, especially HIV/AIDS and its relationship to the migration, the researcher has not been able to come across any study specifically on the maternal health issues of migrant women along with HIV, other than some studies conducted in China.

2. Researcher has not come across any study on the same issue done on medium size cities, rather more studies have been in larger or metro cities.

3. Researcher reviewed some studies of similar nature on migrant slum dwellers but very few studies have been taken up so far on the issue of migrant women of suburbs/ periphery of the city or on scattered migrant population.

4. No study has been taken up by any one on the same issues in Aligarh City so far.