

A Study of Indulgence in Risk Behaviours and Level of Awareness Related to HIV/AIDS Amongst Migrant Gold Artisans

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ABSTRACT HIV/AIDS accompanying global economic development where internal as well as external migration is inevitable, will soon assume epidemic proportions if people are not made aware of its far-reaching consequences. The paper attempts to explore the level of awareness related to HIV/AIDS amongst the migrant gold artisans who do not risk themselves but may act as the potential source of its transmission to their spouses and children. Not surprising then that the entire rural community too may be engulfed with HIV/AIDS infection if immediate interventionist measures are not adopted. It is found that the risk behaviours of gold artisans expose them to the risk of HIV infection. Alarming the level of awareness is low which may further compound in absence of authentic or curative measures.

In the absence of any curative magic bullet against HIV/AIDS, the interventionist gurus have touted the panacea of preventive awareness as the only hope in the AIDS era. Governmental, non-governmental and international agencies worldwide have launched aggressive education campaigns to spread awareness regarding transmission and prevention against HIV. However, the virus seems to be winning the race by bringing more and more persons under its scourage, as compared to the number of persons reached by prevention messages. According to latest estimates, approximately 16,000 persons are infected with HIV each day worldwide almost half of them are women (Mann and Tarantola, 1996). In India, according to governmental facts and figures, one per cent of the total population of the country is HIV positive. This may just be the tip of the iceberg, the actual fearful dimension of the reach of HIV may never be known till it manifests itself in the form of AIDS' casualties. Preventive campaigns in India primarily target the urban population leaving the vast majority of rural populace be-

yond the pole of HIV/AIDS awareness. It seems the race between spread of HIV on the one hand, and dissemination of preventive awareness on the other hand, at present is favoured heavily in terms of the former. Awareness is not totally absent - but does it automatically translate into health beneficiary behaviour, or have the two remained largely divorced? An attempt is made in this paper to study this problem with reference to a group of migrants who are engaged in the trade of jewellery making in various cities and urban centres of India. The study attempts to find out (1) the risk behaviours indulged in by the respondents that place them at risk of acquiring HIV infection and (2) to study the prevailing level of awareness about HIV/AIDS and its modes of prevention amongst the respondents. Furthermore, "Migrants who have higher level of awareness about HIV/AIDS will indulge less in risk behaviours as compared to migrants with lower levels of awareness about HIV/AIDS" is proposed to be tested.

METHODOLOGY

The People and the Setting

The respondents for the present study are male migrants belonging to the Domjur Development Block of the district Howrah in West Bengal, India. They have been drawn from five villages falling under the administrative jurisdiction of the Block, viz., Domjur village, Uttar Jhapardah, Dakshin Jhapardah, Makardaha and Daffarpur. All these villages have a well established tradition of men migrating to cities of jewellery making. They fall in the age group of 17 years - 42 years, and are both married (51 per cent) and unmarried (49 per cent). Majority of the respondents are Hindus (85 per cent), the

rest are Muslims (15 per cent). Level of education is low and bulk (46 per cent) comprises functionally literate men. 11 per cent are illiterates while 26 per cent have received education up to primary level (class V). The highest level of education received is up to Middle level (class VIII). The men prefer to opt out of formal education in favour of seeking employment as gold artisans in cities. Lure of better economic opportunities coupled with lack of adequate employment avenues in the village provide the impetus to migration here (77 per cent were unemployed prior to migration).

The total number of respondents is 100. They are working in cities like Bombay (55 per cent), Delhi (18 per cent), Madras (13 per cent), Hyderabad (3 per cent), Surat (8 per cent) and Ahmedabad (3 per cent). That is to state, the respondents follow the circulatory migration pattern (rural-urban-rural) and can be called temporary migrants as they maintain close social and economic ties with their native villages through periodic visits, living in a condition of forced bachelorhood in the cities. These men work in the cities for 15-20 years before returning to their rural hearths to settle down in old age.

The respondents were selected on the basis of: (a) He should be a permanent resident of Domjur Development Block, (b) He should be working as a gold artisan in any city/urban centre of India, (c) He should be periodically visiting his native village, (d) in case he is married, wife should be living in the village, or visiting husband in the city occasionally and (e) if he is unmarried, family should be residing in the village.

Purposive sampling technique has been used for this exploratory-cum-descriptive study. The need to collect in-depth comprehensive information often related to confidential and intimate details (sexual habits) plus the fact that migrants visited their villages during restricted periods made this sampling technique most suitable.

Data for the present study were collected with the help of a structured Interview Schedule (IS), based on the one used by the Tata Institute of Social Sciences (TISS, 1993) for their study on knowledge, attitudes, beliefs and practices of some high risk populations for HIV infection (including seasonal migrants). Guidelines pro-

vided by the World Health Organization (WHO) have been followed. The IS comprised of 3 parts. Part 1 includes details pertaining to socio demographic attributes. In part 2, items regarding practices related to intoxication, promiscuity and other non-sexual procedures that constitute risk of HIV infection are included. Part 3 contains variables to estimate the level of awareness regarding HIV and AIDS.

Each respondent was interviewed individually in order to maintain confidentiality. For analyses of data, frequencies and percentages of responses falling into each category are calculated with help of Microstat software.

In order to calculate the overall average "score of awareness of HIV/AIDS", each correct answer was given a positive score of 'one'. For each respondent, the number of correct answers for all the items included in a variable were summed up to reach an "awareness of AIDS Score". The procedure is similar to that used by Schwalbe and Staples (3). 't' tests were conducted to find out the significance of the difference between the mean of two groups, with respect to variables included in the hypothesis. Since all data had been entered into the computer as coded values, the mean values obtained (in 't' test) are also in terms of coded, and not, actual values.

Risk of HIV infection accrues to an individual from 3 routes of transmission of the virus, viz. (1) Sexual, (2) Parenteral or blood borne, (3) Perinatal. Since the respondents of this study are all adult males, we have considered only the first two routes of transmission to estimate the risk of HIV infection faced by them.

(1) Sexual Route of Transmission or Risk Behaviour Related to Sexual Contact

An effort is made here to explore the risk of HIV infection faced by the respondents consequent to the sexual practices adopted by them, especially with reference to commercial gratification of sexual desires through visits to commercial sex workers (CSWs) during their stay in the city. Inability to directly observe sexual behaviour has led to dependence on narration of the same by the respondents, given the inherent cultural taboos against discussing matters related to sex/sexual practices in the Indian society.

(a) Visits to CSWs: Past and Present

It is found that visits to CSWs in the city is not an uncommon practice among the respondents (37 per cent reported visiting a CSW at least once in the past).

Table 1: Visits to CSWs

S.No.	Visits CSW	Past (n=100)	Present (n=100)	Total (%)
1	Yes	37	29	66 (33.0)
2	No	50	58	108 (54.0)
3	RTA*	13	13	26 (13.0)

*Reluctant to answer

The tendency of migrants living away from their spouses, to indulge in paid sex under conditions of forced bachelorhood have been reported from other parts of the world too (Evans and Baldwin, 1978; Hunt, 1989; Sanders and Sambo, 1991; Jochelson, Mothibeli and Leger, 1991), as well as from India (Shreedhar, 1994; Karkaria, 1994; TISS, 1993; Gharpure, 1992; Ostrow, 1989). These studies establish the fact that indulgence in paid sex greatly enhances the migrants' vulnerability to HIV infection by bringing them into contact with a high risk population, i.e. CSWs. In this study, it is interesting to note that there has been a fall in the number of men visiting CSWs within the time period of 5 years under consideration here (37 per cent vs. 29 per cent in Table 1). The reason, it was learnt, being that acquiring genital infection which instil a fear in the mind cautioned the respondents against further ventures (3 per cent). In other cases, where spurred by peer influence the respondents had initiated visits to red light areas, later on, the practice is discontinued in case the initial experience is not found pleasant enough (5 per cent). However, none of the respondents could state with conviction that they will never visit CSWs again- this puts a question mark on their vulnerability to HIV infection. As long as motivating factors viz., desire to fulfil sexual urges and peer influence instigating the same continues to exist in an environment which lacks parental/familial control, the roads leading to red light areas will remain accessible and beckoning.

Interestingly, it is found that more married men at present visit CSWs as compared to un-

married men (17 per cent vs. 12 per cent). It may be plausible to explain this fact in the light of existing taboos on per-marital sex in Indian society where conventionally coitus and marriage are considered synonymous. The same association may be operating as a cultural censure and restraining the unmarried men. On the other hand, the tacit approval to out-of-wedlock liaisons for married men in a patriarchal society may be responsible for married men opting for CSWs in the absence of the spouse for protracted time periods-it may be so that the married men feel sexual deprivation more having already been partners to a coital union.

The risk of HIV infection is compounded by the fact that more often than not no thought is spared towards adoption of safer sex devices, viz. the condom. Condoms are primarily envisaged as contraceptives and not as prophylactics.

Table 2: Pattern of condom use by migrants

S. No.	Use of condom	n (n=100)	%
1	Ever used condom		
	(i) Yes	21	21
	(ii) No	60	60
	(iii) NA	19	19
2	Whether used condom in the past 3 months		
	(i) Yes	9	9
	(ii) No	72	72
	(iii) NA	19	19

The above table indicates that there has been an increase in the number of men option for unprotected sex which plays a crucial role in increasing the possibility of HIV infection.

It is seen that those who have used condoms regularly have done so in out-of-wedlock relationships (2 per cent with RSP and 3 per cent with CSW). Those who are currently using condoms do so rarely i.e. there is no consistency of use (6 per cent with spouse +3 per cent with CSW). What is alarming is that none of the married men currently indulging in paid coitus reported using condom with their wives-paving the way not only for self infection but also opening up vistas for HIV transmission to their spouses, and probably, to the next generation in case the spouse conceives a child.

The desire to seek sexual gratification in case of prolonged absence of the spouse spurs

Table 3: Frequency of condom use by migrants

S.No.	Partners in cohabitation	Frequency of condom use					Total (%)
		A	O	S	R	N	
1	Spouse	—	—	5	6	—	11 (11.0)
2	Regular sex partner	2	—	—	—	—	2 (2.0)
3	CSW	3	—	2	3	—	8 (8.0)
4	NA	—	—	—	—	—	—

Legend = A = Always, O = Often, S = Sometimes, R = Rarely, N = Never

A person using condom 4 out of 4 times in coitus = Always

A person using condom 3 out of 4 times in coitus = Often

A person using condom 2 out of 4 times in coitus = Sometimes

A person using condom 1 out of 4 times in coitus = Rarely

Not using at all = Never

both commercial gratification of sexual desires, as well as adoption of unprotected coitus with CSWs for sensual pleasure.

The if often a difficult task to categorise motives into strict categories—more so, when they have to do with behaviours that do not enjoy social approval. Although some migrants (15 per cent) have candidly stated that it is the absence of spouse and consequent surfacing of sexual desires from time to time that motivates them to visit CSWs, others are less forthcoming in accepting the onus of their action. Peer influence, which has emerged as an important reason behind visits to CSWs here (20 per cent), may be an indication of shifting the responsibility of one's actions to others. Although the importance of peer influence as a motive cannot be understated, over the years, the commonality of living and working conditions has led to the emergence of a cultural pattern where the men tend to not only live and work in similar conditions, but also think and act alike. Peer influence which has its genesis in the stage of recruitment itself (as a fellow artisan has to offer guarantee for young apprentices) slowly acquires an all-pervading role in defining this cultural pattern. A "culture of sexual poverty" is perpetuated as spouses are left in the villages, and surfacing of sexual needs results in indulgence in paid sex—goaded by camaraderie. Conforming to group's norms is a hallmark of this culture. Feeling of deprivation of sexual gratification need not be an individual's reaction to conditions of forced bachelorhood—it is often a reflection of what peers have evolved over the years as a result of common living and working conditions. Once in operation, this 'culture of life sexual poverty'

becomes an inevitable style of life inclusive of indulgence in paid sex essential trait. This culture of sexual poverty thrives in an environment which is characterised by slackened social controls in the absence of parental/familial supervision, common cause of migration and resultant lifestyle that is followed in the city. What is important to note here is that this kind of lifestyle indulged in by the migrants makes them, and through them, their spouses, vulnerable to HIV infection.

(2) Parenteral of Blood borne risk of HIV infection

None of the respondents are commercial blood donors. However, they have reported having donated blood in the past 5 years whenever a family member, relative or friend was in need of it. They have also participated in blood donation camps.

In the light of the fact that indulgence in paid sex, often unprotected, makes the migrants vulnerable to HIV infection, donation of blood to other may open up additional possibilities of HIV transmission from them to others. The other side of the picture, viz. transfusion, or receiving blood, also, does not present a comforting picture. Often surgery undergone (13 per cent) or therapeutic needs (1 per cent) have necessitated transfusion of blood for the respondents. And, often private hospitals/ blood banks (8 per cent) or even a commercial donor (1 per cent) is sought to procure blood; others have received blood from family members (3 per cent) or government hospitals/blood banks (1 per cent). These sources often supply blood of questionable quality, especially with reference to HIV status—opening up

yet another source of HIV infection in the migrants.

Table 4: Details of blood donation

S. No.	Details of donation	n (n=100)	Total %
1	Number of times donated		
	(i) Only once	8	8
	(ii) 2-3 times	10	10
	(iii) 4-5 times	2	2
	(iv) NA	80	80
2	Reasons for notating blood		
	(i) Voluntary blood donation camp	5	5
	(ii) Friend/relative was in need	9	9
	(iii) Both	6	6
	(iv) NA	80	80

Apart from potential blood borne infection, innocuous procedures like tonsuring, and getting habitually shaved at a saloon continue to pose additional risk of HIV for the respondents. More so, since they are largely ignorant about the role of sterilisation to combat the possible transmission of infection through equipments utilised in these procedures.

The spectre of HIV infection looms large in the light of another fact. Infection of genitals consequent to sexual intercourse has been reported by the migrants in quite large numbers (26 per cent). The presence of sexually transmitted diseases/infections (STD/STI) is well known to increase the risk of HIV infection in an individual.

Table 5: History of STD/STI

S.No.	Suffered STD/STI	N (n=100)	Total (%)
1	Yes	26	26
2	No	72	72
3	RTA	2	2

All of the hereinbefore mentioned facts amply indicate that the respondents face the risk of acquiring HIV/AIDS to no small degree. Their lifestyle well perpetuated to from almost a culture, at present ensures that risk behaviours for HIV infection will continue to flourish putting the respondents directly at risk of HIV/AIDS, and, transform them into vectors, paving the path for the virus new and unsuspecting targets in their spouses.

Let us now look at the level of awareness that the respondents possess vis-a-vis HIV/AIDS and the extent of self-threat perceived by them.

The number of correct answers received from each respondent, in reply to the queries related to awareness of HIV/AIDS, have been summed up to reach an awareness of AIDS score (3). However, each item has also been subjected to percentage analysis to get an overall picture.

Table 6.1 to 6.12 present the levels of awareness possessed by the respondents, as seen consequent to the queries posed to them in this regard.

Table 6.1: Awareness of AIDS and HIV

S.No.	Whether aware of	N (n=100)	Total (%)
1	AIDS		
	(i) Yes	60	60
	(ii) No	40	40
2	HIV		
	(i) Yes	26	26
	(ii) No	74	74

Table 6.2: Awareness regarding relationship between HIV and AIDS

S.No.	Relationship	N (n=100)	Total (%)
1	HIV to the casual factor of AIDS	11	11
2	Both are same	15	15
3	Unaware	74	74

Table 6.3: Nature of AIDS

S.No.	What is AIDS	N (n=100)	Total (%)
1	It is lethal disease	28	28
2	It reduces immunity	8	8
3	God's curse	9	9
4	Just another disease	15	15
5	Unaware	40	40

The responses received from the migrants as depicted in Table nos. 6.1 to 6.12 and the accompanying figures amply indicate that although the men are aware of a disease called AIDS, awareness, at best is sketchy and is expressed in terms of established paradigms of HIV/AIDS. Misconceptions abound regarding the nature of HIV/AIDS (Table 6.3), transmission routes of HIV/AIDS (Table 6.4), curability of HIV/AIDS (Table 6.7) and modes of prevention (Table 6.9). Alarming, the respondents nurse the belief of

Table 6.4: Awareness of transmission routes of HIV/AIDS

S. No.	Does HIV/AIDS spread by	N (n=100)			
		Y	N	DK	Total
1	Route of blood	25	26	49	100
2	Route of sex	46	00	54	100
3	Perinatal route	1	3	96	100
4	Touching an infected person	13	37	50	100
5	Sharing food/utensils	33	14	53	100
6	Sharing razor/blade	26	9	65	100
7	Mosquito bite	23	16	61	100
8	Tonsuring	4	19	77	100
9	Ear/nose piercing	2	10	88	100
10	Public toilets	10	5	85	100
11	Shared Needles	15	2	83	100

Average correct awareness = 16.75 per cent

Average incorrect awareness = 14.50 per cent

Average ignorance level = 69.25 per cent

Table 6.5: Genderwise vulnerability to HIV/AIDS

S.No.	Does HIV/AIDS affect	N (n=100)	Total
1	Males only	7	7
2	Females only	0	0
3	Both	41	41
4	DK	52	52

Table 6.6: Vulnerable individuals/groups

S. No.	Vulnerable individuals/groups	N (n=100)	Total
1	CSW	46	46
2	Blood recipients	25	25
3	Babies born to infected mothers	1	1
4	DK	48	48

Table 6.7: Awareness of curability of HIV/AIDS

S.No.	Is HIV/AIDS curable	N (n=100)	Total
1	Yes	35	35
2	No	7	7
3	DK	58	58

Table 6.8: Awareness about HIV/AIDS being preventable

S.No.	Is HIV/AIDS preventable	N (n=100)	Total
1	Yes	38	38
2	No	11	11
3	DK	51	51

curability and power of modern medicine, and indicate depending on visual cues to identify and infected person. Awareness of detection methods elude them (Table 6.12). Particularly interesting is the fact that HIV/AIDS is primarily

Table 6.9: Awareness of modes of preventing HIV/AIDS

S. No.	Modes of prevention	N (n=100)			
		Y	N	DK	Total
1	No sex with CSWs	29	6	65	100
2	No sex with infected partner	14	24	62	100
3	Sex with one partner	16	2	82	100
4	Abstinence from sex	2	0	98	100
5	Isolate/boycott infected person	10	2	88	100
6	Avoid pregnancy	1	3	96	100
7	Avoid homosexuality	2	0	98	100
8	Use of sterilised/disposable needles	15	2	83	100
9	Use of medicine	30	2	68	100
10	Avoid receiving blood	25	26	49	100
11	Use of condoms	15	17	68	100

Average correct awareness = 11.18 per cent

Average incorrect awareness = 10.90 per cent

Average ignorance level = 77.90 per cent

Table 6.10: Awareness of symptoms of HIV/AIDS

S.No.	Symptoms	N (n=100)	Total
1	Fever	6	6
2	Weight loss	4	4
3	Rashes/sores	2	2
4	DK	88	88

Table 6.11: Visual cues to HIV/AIDS status

S. No.	Determination of HIV status	N (n=100)	Total %
1	Can a healthy looking person be infected		
	(i) Yes	3	3
	(ii) No	10	10
	(iii) DK	87	87
2	Can a healthy looking person transmit HIV		
	(i) Yes	5	5
	(ii) No	14	14
	(iii) DK	81	81

Table 6.12: Awareness of method of detection of HIV/AIDS status

S.No.	Method of detection	N (n=100)	Total
1	Blood test	30	30
2	Medical examination (physical)	21	21
3	Visible symptoms	9	9
4	DK	40	40

envisaged as a 'sex related' disease, as is reflected by the awareness regarding transmission and prevention of HIV/AIDS (Tables 6.4 & 6.9). The role of non sexual transmission, through innocuous day-to-day activities that form an integral part of their lives (like getting shaved in a saloon, getting tonsured) has rarely attracted attention. Consequently, the preception of self risk too is low.

It is indeed alarming to note that in spite of following a lifestyle fraught with chances of acquiring HIV infection, as well as possessing awareness to some degree regarding the nature and transmissibility of the virus, the migrants by and large close their eyes to chances of self infection-this increases their vulnerability to infection.

Table 7: Assessment of self-risk to HIV/AIDS

S.No.	Chance of acquiring HIV/AIDS	N (n=100)	Total
1	No chance at all	26	26
2	Ver small chance	23	23
3	Moderate chance	1	1
4	Good chance	0	0
5	Not sure	50	50

Now, the question that arises is, do migrants who have higher levels of awareness about HIV/AIDS indulge less in risk behaviours as compared to those migrants with lower levels of awareness about HIV/AIDS?

The above query was tested as the following hypothesis "Migrants who have higher levels of awareness about HIV/AIDS will indulge less in risk behaviours as compared to migrants with lower levels of awareness about HIV/AIDS".

In order to test the hypothesis, the respondents were divided into 2 groups, splitting them on the basis of the average "awareness of AIDS score". Those who had achieved a score lower than the average, were classified as those who had "lower levels of awareness" as compared to those whose score was higher than the mean/average score. Next, 't' tests were conducted to find out the significance of the difference between the mean of two groups.

The 't' values are found significant in the context of risk of HIV infection through sexual promiscuity (visit to CSWs), though not in the predicted direction, that is to state that, migrants with relatively higher levels of awareness about HIV/AIDS are found indulging in visits to CSWs in significantly higher numbers ($p<.05$) as compared to those with lower levels of awareness. These findings are supported by Ostrow (1989); Becker and Joseph (1988) and Stall et al (1990).

The apparently contradictory effect of awareness on risk behaviour related to indul-

Table 8: 't' values for the difference of mean between lower and higher level of awareness of HIV/AIDS

S. No.	Variable	Level of awareness about HIV/AIDS		't'
		Lower	Higher	
1	Sexual promiscuity visits to CSWs	1.7600	2.0000	-1.8091*
2	Parenteral route			
	(i) Donated blood	1.8852	1.9487	-1.0072
	(ii) Received blood	1.8361	1.5897	2.8193**
3	Invasive procedure			
	Skin piercing practice	6.7541	6.6154	.2908

* $p<.05$, ** $p<.01$

gence in paid sex by the migrants can be explained in terms of "self-inefficacious thinking" which creates discrepancies between awareness and self protection action. This is also probably the reason why migrants, on the one hand, are aware of HIV/AIDS, and on the other hand, indulge in risk prone behaviours, still continue to perceive low levels of self risk to HIV infection.

Low levels of self-efficacious thinking could be the result of stronger motivational forces for sexual promiscuity amongst the migrants here, e.g. infrequent contacts with spouse leading to periodic surfacing of sexual urges, in an environment which lacks familial control. In such a situation, the tendency to indulge in activities leading to satiation of sexual urges may take precedence over the role of awareness in deterring sexual promiscuity.

In the context of parenteral transmission, although the results show significant difference between the two groups, they fail to throw any light on risk behaviour in association with level of awareness, as all cases of transfusions were surgical or therapeutic in nature.

Thus, the results obtained fail to substantiate the hypothesis.

CONCLUSION

The migrant artisans are exposed to risk of HIV infection by adoption of behaviours that facilitate transmission of HIV, particularly, sexual promiscuity in the form of indulgence in paid coitus. Awareness levels are low, and the presence of self-inefficacious thinking inhibits the process of translating awareness into

sustained preventive practices to minimise exposure to HIV/AIDS. The culture of sexual poverty which provides the setting to the operation of risk behaviours is firmly entrenched given the established patterns of migration and resultant lifestyle in the cities. Unaccountability of socially disapproved behaviour in an environment that lacks familial control and peer censure perpetuates the practice of visiting CSWs. The lack of any intervention offered to the migrants makes the picture grim. The need of the hour is to provide such intervention which will equip the migrants with knowledge about HIV/AIDS, its prevention and a rational evaluation of self risk.

Today, unfortunately the culture of sexual poverty which the men hesitate to opt out of, poses a threat to their lives. At present, there seems to be no way out as long as these contexts of social living continue to exist. Whether the culture of sexual poverty will be abandoned in favour of adoption of a lifestyle devoid of risk behaviours, and reinstall the notions of safety over health refractory behaviour, remains to be seen.

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