

Risk Practices, HIV Infection and Awareness of HIV/AIDS: A Study of Migrant Gold Artisans

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ABSTRACT Concurrent to the processes of industrialization and urbanization, the migrating persons and mobile workforces being away from their families often seek sexual gratification through contact with commercial sex workers that is likely to result in HIV/AIDS infection and its dissemination to the spouses. The paper discusses the changing sexual habits of gold artisans and estimates the level of awareness about HIV/AIDS and perception of self risk to HIV infection. The paper highlights the intervention strategy to reduce the risk of HIV infection.

INTRODUCTION

The developing countries are at present witnessing rapid industrialisation and urbanisation. Concurrent to these processes, almost as a natural concomitant is the process of mobility of labour, both permanent, and temporary or recurrent seasonal, from rural areas to the cities in search of better economic prospects (UNDP 1992). Although entire families may leave their rural home and hearth to settle in the cities, it is not uncommon that in early stages of such economic/occupational migration, men constitute the predominant migrant wave (Wawer, 1996). Sometimes, such a practice of men migrating alone to the cities becomes almost a well-established pattern and over a period of time a culture of migration evolves in which strong economic, social and familial ties continue to exist between their rural homes and urban workplaces with substantial movement back and forth (Obbo, 1993).

The implications of such movements in the era of HIV/AIDS are manifold. It has been recognised that migrating persons, and mobile workforces (like truck drivers, sailors, soldiers, etc.) are more likely to be young, economically productive and sexually active (De Sircar, 1997). Migration and urbanization dilute dictates of so-

cial conformity and erode sexual mores, thus potentially predisposing these persons to such behaviours that increase the risk of acquiring HIV and STD/STIS (De Sircar and Tewari, 1996; Broring and Duifhuizen, 1993).

The temporary migrants live an arduous life in cities characterised by job insecurity and lack of proper housing facilities which make them take up cramped slum accommodations giving rise to squalid living conditions. This lifestyle is also characterised by feelings of loneliness in the absence of family and fear of alien culture. This kind of social isolation, coupled with cash earnings and a lack of parental/familial censure against breaches of social norms, often emboldens the young men to seek physical and emotional succour in alcohol, drugs, gambling and paid sex (Broring and Duifhuizen, 1993). The need for physical intimacy may lead to homosexual liaisons with those who share accommodations (World AIDS, 1994) or, commercial gratification of sexual desires through contact with commercial sex workers (CSWs) (Ijsselmuiden et al., 1993; Jochelson et al., 1991; Sanders and Sambo, 1991). Such liaisons open up transmission routes for HIV and a chilling dimension is added by the fact that often such coitus is unprotected (Viravaidya et al., 1992). This establishes a sexual networking for the migrants, who emerge as vectors, not only jeopardising their health, but also make their spouses vulnerable to acquiring STD/HIV (Huddart and Overholt, 1992; Gharpure, 1992; Chaudhuri et al., 1993).

Studies conducted on migrant labour in South Africa, Mexico and Thailand (Oroth, 1991; Zavriew, 1994; Viravaidya et al., 1992) allows the hypothesis that in the temporary migratory process, a change in the sexual habits and the adoption of new ones will result in an

increase in high risk practices for HIV infection and its dissemination to rural areas. In India too, all these ingredients for a potential rapid spread of HIV from urban to rural areas through migrant labour forces exist. Some indications have been provided in this context by epidemiological studies conducted on long haul truck drivers and small wage earning labourers (Huddart and Overholt, 1992; Gharpure, 1992; Chaudhuri et al., 1993). The present paper explores the dynamics of HIV transmission through the process of migration with reference to a community of migrant gold artisans of West Bengal in India, and attempts to provide strategic guidelines for preventive action through estimation of both risk practices and levels of awareness.

The objectives of the present study are to (1) identify and describe travel patterns and changed sexual habits of gold artisans who migrate from rural areas to urban centres, (2) estimate the effect of such migration on vulnerability to HIV infection amongst the gold artisans, (3) estimate the level of awareness about HIV/AIDS and perception of self risk to HIV infection, and (4) propose an intervention strategy directed to reduce the risk of HIV infection amongst gold artisans.

The study was carried out in the Domjur Development Block of the Howrah District of West Bengal, India. The Domjur Development Block has an almost century old well-established tradition of men migrating to urban centres to take up employment as gold artisans, while their families are left in the village. Although the block comprises 55 villages and the entire block witnesses such migration, five of them viz. Uttar Jhapardaha, Dakshin Jhapardaha, Makardaha, Dattarpur and Domjur village account for more than 50 per cent of the total labour force migrating to cities. The respondents (migrant male gold artisans) for the present study were suitably selected keeping in mind the objectives of the present study. Data were collected with the help of Interview Schedule in 2 phases. The first phase was carried out in February - April 1995 and the second phase in October - December 1995. It is during these two periods that migrants visit their native villages in sizeable numbers in order to participate in famous festivals (Kali Puja and Dusshera and Diwali celebration). Interviews

were also conducted on key informants (health workers, youth club members, village administrators and community leaders) to get an in-depth picture about the concerned issues here. Also, secondary sources like hospital and census records were consulted according to requirement.

A. Socio-Demographic Background

The respondents for the present study are all male gold artisans who have temporarily migrated to various urban centres in India, and maintain social, cultural and economic ties with their rural based families through periodic visits to their native villages.

Majority of the respondents (52 per cent) belong to the age group of 17-25 years (Table 1). Those who fall in the age group of 41 years and above are relatively few. This is because the artisans usually start returning to their villages for good by the time they reach the age of 45-50

Table 1: Socio-demographic background of the sample

S. No.	Attribute	No. of respondents (n = 100)
1. Age		
	(i) 17-25 years	52
	(ii) 26-33 years	25
	(iii) 34-41 years	13
	(iv) 42 years & above	10
2. Religion		
	(i) Hinduism	85
	(ii) Islam	15
3. Marital Status		
	(i) Married	51
	(ii) Unmarried	49
4. Married for How Many Years		
	(i) Less than 5 years	13
	(ii) 5-10 years	19
	(iii) 11-15 years	7
	(iv) 16 years & above	12
5. Education		
	(i) Illiterate	11
	(ii) Functionally literate	46
	(iii) Primary (upto class V)	26
	(iv) Middle (upto class VIII)	17
	(v) High School (upto class X)	0
6. Occupation		
	(a) Before Migration	
	(i) Service	1
	(ii) Farming	6
	(iii) Agricultural labour	8
	(iv) Small business	8
	(v) Unemployed	77
	(b) After Migration	
	(i) Gold artisans	100

years. The pre-requisite of very good eye-sight needed to carry out the intricate details of jewellery making, especially stone inlay work, places a restriction on the number of years an artisan can devote to this vocation. There are only two religious groups represented in the sample, viz. Hindus and Muslims, of whom the former comprises the majority (85 per cent). The sample is almost equally divided as far as marital status is concerned (51 per cent are married and 49 per cent are unmarried). The average age at marriage is 23.38 years.

A large proportion of the respondents (46 per cent) is functionally literate, i.e., although they are able to read and write, they have had no formal education. The highest level of formal education received is up till class VIII. There is a sizeable number of illiterates too. Information provided by key informants reveal that parents often motivate their son (s) to opt for becoming an artisan rather than pursue formal education. Seeing a neighbourhood boy migrate to the city and earn well encourages other parents to set their sons on the same trail. Hence, the decision to forgo formal education in favour of migration is a conscious one made by the family.

Statistics indicate (Table 1) that a very large proportion of the respondents (77 per cent) were unemployed prior to migration. Hence, the root cause of migration lies in the problem of unemployment at the village level, which together with the lure of better economic prospects in the city (as amply demonstrated by those fellow villagers who are already working as gold artisans in the city), provide the dual impetus to the forces of rural-urban migration here. Interestingly, very few who do migrate to work as gold artisans were seen to have the benefit of prior exposure to the craft at the local level (3 per cent). Diverse occupational backgrounds are represented by the migrants - farmers (6 per cent), agricultural labourers (8 per cent), small businessmen (8 per cent) and even salaried persons (1 per cent). Once in the city, on-the-job training for 1-2 years seems to impart the necessary skills to those who have the knack to blossom into gold artisans of good calibre.

Migration to the city has brought about a perceptible change in the income levels of the respondents.

Table 2: Income levels

S. No.	Income (in Rs. per month)	No. of respondents (n = 100)
<i>1. Before Migration (in village)</i>		
(i)	No income	77
(ii)	Less than 500	22
(iii)	500-1000	1
(iv)	Above 1000	0
<i>2. After Migration (in city)</i>		
(i)	Less than 500	0
(ii)	500-1000	3
(iii)	1001-2000	50
(iv)	2001-3000	40
(v)	3001-4000	7
(vi)	4001 & above	0

The income levels reported here are approximations. The respondents were extremely hesitant to report their earnings and it was learnt from informants that income levels are often much higher than acknowledged. This is perhaps because the artisans often make additional money by pilfering gold/gold dust without the knowledge of the employer. Fear of attracting income tax also makes them hesitant in quoting actual earnings. Having higher income than reported also indicates more cash in the hands of the respondents, to be spent while in the city after sending a part of their earnings to the village based families. Such remittances are made either monthly or even after 2-3 months, but the flow is almost regular in its pattern. Although some respondents, like those who have extended families in the village, said that other members of the household also supplement the family income, it is interesting to note that for all, the migrants' earnings form the major source of finance - 54 per cent of the respondents happen to be the sole earning member in their families.

The respondents of the present study are employed as gold artisans in Bombay (55), Delhi (18), Madras (13), Hyderabad (3), Surat (8) and Ahmedabad (3). None of these have any immediate family member living with them in the city. In the city, they live sharing accommodations like tenements or even hutments. Crowding is common with 5-8 persons sharing a room measuring approximately 10'x8'. At times even 8-10 men are housed in such rooms with scarce amenities. In some cases, the living place also serves as the workplace, increasing the congestion.

The men spend long hours (8-10 hours) at work (52 per cent). Some even work for 10-12 hours (44 per cent) or as many as 12-14 hours per day (4 per cent). The work is arduous, and involves long hours sitting in hunched positions and involving minute work like inlay of stones in ornaments. Amenities available provide no respite, as ventilation and lighting are often poor, coupled with the fact that all the cities where the migrants work have long and extremely hot summers.

B. Visit to the Native Village

Being temporary migrants, the gold artisans return periodically to their native villages. However, as far as frequency of such visits is concerned, no clear trend is discernible. Mostly the migrants travel to their villages on the occasions of marriage, birth, death and festivals. Two such festivals during which most migrants visit their families/kins in the village are: (a) a local festival involving the worship of goddess "Kali" held in the Hindu month of "Phalgun" (which roughly corresponds to mid-February to mid-March of the Roman calendar), (b) the festivals of "Dussehra" and "Diwali" held in the months of October - November each year.

Table 3: Frequency of visits and duration of stay

S. No.	Visit	No. of respondents (n = 100)
<i>1. Frequency</i>		
(i)	Less than once a year	60
(ii)	1-2 times per year	40
(iii)	3 times & above	0
<i>2. Duration of Stay (per visit)</i>		
(i)	11-15 days	17
(ii)	16-20 days	37
(iii)	21-25 days	46
(iv)	26-30 days	0

Majority of the migrants (60 per cent) visit their rural homes less than once in a year. Not only this, the duration of stay per visit is not even a month at a stretch in most cases (Table 3). This kind of infrequent visit pattern may, on the one hand, instill feelings of loneliness and emotional deprivation amongst the migrants while living in the city, while on the other hand, provide greater feelings of freedom due to dilution of socio-cultural sanctions of the close-knit village society. The juxtaposition of such feelings had

been identified in other studies (Evans and Balwin, 1987; Hunt, 1989; Sanders and Sambo, 1991; Jochelson et al., 1991; Kane et al., 1993; Pison et al., 1993) as motivating factors leading to indulgences in sexual promiscuity and intoxication - both of which play a crucial role in increasing vulnerability to HIV infection.

Association with family members at times becomes a two-way process, as in some cases members of the family (including wife) also visit the city - although such visits are rare and sporadic in nature.

Table 4: Details of family members, visit to the city*

S. No.	Member of the family	No. of respondents (n = 100)
1.	Wife*	7
2.	Father	9
3.	Brother	3
4.	Son	4
5.	None	77

*Includes more than one reply

+ Since the time migrant has been living in the city
For other members, the record is for the past one year

The family members' visits may be spurred by a number of reasons. The desire to spend vacations, to see the city, to avail of medical facilities and search for job opportunities. Interestingly, irregular visits by the migrants to the village also motivate the rural kins to become city bound. Duration of stay in the city, especially of the spouse, is usually short (for about 7 days) mainly due to accommodation problems. The men live in cramped accommodations, with some of them doubling it as a workplace. In such situations, the presence of a family member especially a female gives rise to concerns regarding privacy. Some of the migrants (9 per cent) also said that they prefer their families to remain in the village as they work for long hours and do not wish the women and children to be unchaperoned in the city. Although such reasons are advanced in support of letting the family live in the village, they do not appear to be very tenable. The economic condition of the migrants is not so dismal that they cannot afford to keep their families, at least spouse and children, in the city, keeping in mind the living standards. After all, men who marry local girls do take up independent accommodations (such migrants are not a

part of the present study). It seems the underlying reason behind the perpetuation of a system of men living with co-workers in the city while families are left at the native place lies in the already established culture of men living and working together in camaraderie, away from the daily hassles of domesticity and strict parental/familial control, which the present respondents seem to prefer over regular family life.

C. Changed Sexual Habits of Migrant Gold Artisans

Sexual relationships, by and large, in conservative rural societies of India are still almost exclusively associated with the state of matrimony. However, dilution of familial censure and societal sanctions, as is the case with men migrating alone from villages in search of better economic opportunities to cities/urban centres, often provides a tacit approval to promiscuity on the part of the men in an essentially patriarchal society - at the sametime holding good the strictures of monogamy on the spouse in the village. It is palpable here too that a change in the sexual habits of the artisans does take place, evidenced by an increase in the number of sexual partners and adoption of new practices such as oral sex.

Indulgence in commercial gratification of sexual desires was evidenced both amongst married (51 per cent), as well as unmarried men (49 per cent) — with the former slightly outnumbering the latter (17 per cent vs. 12 per cent). Interesting to note here is that for most married men, visits to commercial sex workers (CSWs) has mostly been a post-marital experience, and at a relatively higher age of 26-33 years. 40 per cent have reported that their first sexual intercourse

was with their wives. Majority of the sexually active men had had their first cohabitation at the age of 21-30 years (Table 5).

The unmarried men who are sexually active, have had their initial coital experience, either with a CSW or an RSP, in the city. None of them reported any out-of-wedlock sexual partner in the village. Those who are married and are now visiting CSWs indicate an increase in the number of sexual partners, over and above their spouse.

Hence, it can be said that migration from

Table 6: Current sexual partners of migrants

S. No.	Sexual partner	n	% (100)
1.	Only spouse	34	34
2.	Only CSW	12	12
3.	RSP	7	7
4.	Spouse + CSW	17	17
5.	RSP + CSW	1	1
6.	NA	34	34

the village to the city has brought about an increase in the number of sexual partners enjoyed by the migrants as well as initiated those without a coital partner in the village to a sexually active life. Additionally, it was learnt that not only is there an increase in the number of sexual partners whilst living in the city, but there is also the tendency to adopt new practices such as oral sex, which is then incorporated to the sexual practices with their spouses.

Table 7: Route of coitus practised by migrants

S. No.	Route of coitus	Spouse	CSW/others
1.	Vaginal-penile	45	24
2.	Oral	0	5
3.	Vaginal-penile+oral	6	24

Migrants who indulge in oral coital with their spouse reported that they have done so after their visits to CSWs. In fact, some men now indulge in visits to CSWs solely to indulge in this route of coitus (5 per cent). An increase in number of sexual partners together with adoption of newer coital routes increases their risk of acquiring STD/HIV. Not only this, a chilling dimension is added by the fact that most often such coitus, both with the spouse and the CSW is unprotected as use of condom is a rarity — both amongst married and unmarried men.

Table 5: Details of first cohabitation of migrants

S. No.	Details	n	% (100)
1.	Age		
	(i) Between 15-20 years	15	15
	(ii) Between 21-30 years	51	51
	(iii) NA (no sexual partner)	34	34
2.	Duration of Stay (per visit)		
	(i) Wife	40	40
	(ii) Regular sexual partner	2	2
	(iii) CSW	16	16
	(iv) Casual sex partner	2	2
	(v) RTA	6	6
	(vi) NA	34	34

There has been a decline in the number of migrants using condom, as compared to the past.

Table 8: Use of condom by migrants

S. No.	Use of condom	No. of respondents (n = 100)
1. Ever Used a Condom		
(i) Yes		21
(ii) No		60
(iii) NA		19
2. Whether Used Condom in Past 3 Months		
(i) Yes		9
(ii) No		72
(iii) NA		19

Interestingly, none of the married men who visit CSWs, reported using a condom with the latter. The reason for this lies in envisaging the condom primarily as a contraceptive rather than a prophylactic. The role of condom in safer sex, in minimising the chances of transmission of STD/STI's and HIV is largely unknown. Hence, it is used with the spouse in case one is not desirous of having children. Moreover, since visits to CSWs is expressly to derive sexual satisfaction, the use of condom is dispensed with on grounds of it 'hindering sexual pleasure' — a reason that holds good often in case of the spouse too.

Taking cognisance of all the factors enumerated above let us endeavour to estimate the

Table 9: Frequency* of condom use by migrants

S. No.	Partner in coitus	Frequency of use			Total (%)
		A	O	S	R N
1.	Spouse	-	-	5	6 - 11 (11.0)
2.	RSP	2	-	-	- 2 (2.0)
3.	CSW	3	-	2	3 - 8 (8.0)
4.	NA	-	-	-	- -

risk of HIV infection amongst the migrant artisans.

Estimate for unmarried men
Total number of unmarried men = 49
No. of unmarried men visiting CSWs = 12
No. of unmarried men using condom = 3 (25 per cent)
No. of unmarried men not using condom = 9 (75 per cent)

Of those unmarried men (n=12) visiting CSWs at present 75 per cent can be said to be at risk of acquiring HIV consequent to unprotected coitus. Those having protected sex (25 per cent) can be said to be relatively safer. However, an

important fact to bear in mind is that the use of condom is not a foolproof guarantee against HIV infection.

Estimate for married men
Total number of married men = 51 (n=51)
No. of married men who have monogamous relation with their spouse = 34 (66.67 per cent)
No. of married men visiting CSWs = 17 (33.33 per cent)
No. of married men using condom = 6 (11.76 per cent)
No. of married men not using condom = 45 (88.24 per cent)
No. of married men using condom with spouse = 6 (11.76 per cent)
No. of married men using condom with CSW = 0 (nil)

Since none of the married men visiting CSWs are using condom during paid coitus, it may be presumed that they are at risk of contracting HIV through such risk-laden practice. Also, they are exposing their spouses to risk of HIV infection by their reluctance to opt for safer sex practices within wedlock too.

It will be worthwhile to mention here that although no case of heterosexual anal sex and homosexuality have been reported by the artisans with any coital partner, it remains that such non-admissibility may be due to stricter sanctions and taboos operating in these areas especially the latter. However, conditions favouring homosexual liaisons exist in the form of close physical contact with fellow workers in living and working quarters where camaraderie rules. All accommodations are shared and men live in proximity for protracted periods of time. The possible existence of homosexual relationships make the risk more acute and situation more grim in the context of HIV infection.

In addition to the basic facts that have emerged from the analysis of data, which leads us to conclude that the migrant artisans are at risk of HIV infection, there is a need to delve further in order to understand the underlying reasons that perpetuate the risk proneness of the migrants. Looking into the process of migration, which follows a set pattern for the artisans, may provide some clues towards answering this question. Majority of the migrants have a common cause to migrate i.e. paucity of opportunities for better economic conditions in the village given the restricted avenues for employment there. Once in the city, the men develop over the years, a way of life emanating from shared living and

working conditions. This instils a homogeneity -not only in terms of how they work and live, but also the way they act and think. Shared camaraderie, a lifestyle devoid of familial/parental control, slackened social sanctions, once away from the locus of control of norms that operate in the village, give rise to feelings of freedom to indulge in behaviours which do not enjoy societal endorsement (like indulgence in paid sex). Where such conditions occur, the consequences emerge in the form of development of a style of life - a style that tends to perpetuate itself as 'a culture of sexual poverty'. It is not that families cannot be supported in the city, given the average standards of living amongst the poor. It is a shared decision, an unspoken contract that has been evolved over the years. Artisans feel the need of fulfilment of sexual urge-this need is not essentially an individual's reaction to his condition of forced bachelorhood. Where camaraderie rules, an individual's experience of sexual deprivation in the absence of spouse/RSP may actually be a reflection of what his compatriots perceive. The role of peer influence has its genesis in the recruitment process where guarantee given by a senior artisan is a prerequisite demanded by the employers for accepting young apprentices. Dissociation from the locus of cultural ethos in the village makes the men undertake practices which they have never done, at their native place. There seems to be an easy acceptance and settling in a lifestyle in the city, where family can only serve as a restraining factor. For the migrants, periodic visits to the native place, visits to CSWs in groups in the city and sending money home periodically, bring life to a full circle. Unaccountability of socially disapproved behaviour in an environment that lacks peer censure, emerges as the focal point in perpetuating the cultural pattern of indulgence in paid sex due to experiencing of felt sexual deprivation or 'sexual poverty'. Unfortunately, today this culture, which the men hesitate to opt out of, poses a threat to the life through risk of HIV/AIDS by sexual transmission of the virus.

D. Awareness of HIV/AIDS

Awareness about HIV/AIDS does exist among the artisans; however, such awareness falls far short of having assumed proportions of

well balanced factual and credible knowledge about the nature of the disease, its transmission routes and modes of prevention. Lack of sound knowledge has precipitated risk as it reduces the ability to perceive self risk and opt for prevention in a sustained manner.

In order to estimate the level of awareness that exists among the respondents they were asked certain questions covering areas like

- (i) meaning of AIDS
- (ii) meaning of HIV
- (iii) relationship between HIV and AIDS
- (iv) nature of AIDS
- (v) transmission routes of HIV/AIDS
- (vi) genderwise vulnerability to HIV/AIDS
- (vii) who all are at risk of acquiring HIV/AIDS
- (viii) curability of HIV/AIDS
- (ix) symptoms of HIV/AIDS
- (x) determination of HIV status
- (xi) visual cues to HIV/AIDS status
- (xii) modes of prevention of HIV/AIDS

Before embarking on the results of the awareness level (Tables 10.1 - 10.9), it is important to point out that the artisans have primarily quoted the electronic media i.e. radio and television as their sources of information for HIV/AIDS. Apart from this, word-of-mouth from friends, peers and acquaintances too are sources from which awareness has been achieved. Posters on HIV/AIDS put up by the government and other agencies as part of their campaign to increase awareness about HIV/AIDS also benefit the artisans. However, the men said that often posters and hoardings are in the local vernacular of the place where they work and as such contents are not entirely decipherable since they belong to a different linguistic group. This problem is especially faced by those artisans who live and work in cities like Hyderabad, Madras and Surat. Those living in Bombay and Delhi are able

Table 10.1: Awareness of AIDS and HIV

S. No.	Whether aware of	No. of respondents (n = 100)
1.	Aids	
	(i) Yes	60
	(ii) No	40
2.	HIV	
	(i) Yes	26
	(ii) No	74

Table 10.2: Awareness regarding relationship between HIV + AIDS

S. No.	Relation between HIV & AIDS	No. of respondents (n = 100)
1.	HIV is the causal factor & AIDS	11
2.	Both are same	15
3.	Unaware	74

Table 10.3: Awareness of transmission HIV + AIDS

S. No.	What is AIDS	No. of respondents (n = 100)
1.	It is a lethal disease	28
2.	Reduces disease fighting ability of the body	8
3.	God's curse	9
4.	Just another disease	15
5.	Not aware	40

Table 10.4: Awareness of transmission routes HIV/AIDS

S. No.	Does HIV/AIDS spread by	No. of respondents			
		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.	Tattooing	4	19	77	100
9.	Tonsuring	10	20	70	100
10.	Ear/nose piercing	2	10	88	100
11.	Public toilets	10	5	85	100
12.	Shared needles	15	2	83	100
Average correct knowledge =		16.75 per cent			
Average incorrect knowledge =		14.0 per cent			
Average ignorance level =		69.25 per cent			

Table 10.5: Genderwise vulnerability of HIV + AIDS

S. No.	Does HIV/AIDS occur amongst	No. of respondents (n = 100)
1.	Males only	7
2.	Females only	0
3.	Both males & females	41
4.	Don't know	52

Table 10.6: Individuals/groups considered vulnerable to HIV + AIDS

S. No.	Individuals/groups	No. of respondents
1.	CSWs	46
2.	Blood/blood product recipients	25
3.	Babies born to infected mothers	1
4.	Don't know	48

Table 10.7: Knowledge about curability of HIV + AIDS

S. No.	Is HIV/AIDS curable	No. of respondents (n = 100)
1.	Yes	35
2.	No	7
3.	Don't know	58

Table 10.8: Awareness about HIV/AIDS being preventable

S. No.	Is HIV/AIDS preventable	No. of respondents (n = 100)
1.	Yes	38
2.	No	11
3.	Don't know	51

Table 10.9: Awareness of modes of prevention of HIV/AIDS

S. No.	Modes of prevention spread by	No. of respondents			
		Y (%)	N (%)	DK (%)	Total (%)
1.	No sex with CSWs	29	6	62	100
2.	No sex with infected partner	14	24	62	100
3.	Sex with only 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 equipment	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 knowledge =		11.18 per cent			
Average incorrect knowledge =		10.90 per cent			
Average ignorance level =		77.90 per cent			

to better utilise public advertising campaigns as often messages are in the national language "Hindi" which the migrants can understand and even read to some extent.

One interesting source of awareness cited by the migrants was the CSW. Awareness programmes launched in the red light areas in the cities by government and non-governmental organisations to combat the rapid spread of HIV/AIDS have made their impact felt by utilising CSWs as sources of information of HIV/AIDS as they insist on adoption of safer sex (like use of condom).

Awareness about AIDS and HIV, particularly the latter, is far from universal. The media (audio-visual and print) continues to refer to the

disease as "AIDS" with minimal reference to its etiologic agent. The fact that 'AIDS' and 'HIV' have not yet acquired a local nomenclature, unlike many other diseases (like chicken pox, cholera, etc.) makes awareness regarding what the acronyms stand for non-existent.

Owing to the fact that awareness about HIV is almost non-existent, it is found that relationship between HIV and AIDS is also largely not understood, nor, known. Even among those who are aware of both HIV and AIDS, confusion exists as often they are categorised as one and the same.

The key association as far as the nature of AIDS is concerned lies in its lethality and fatality. The immuno-suppressant nature of the disease is largely unknown — it is envisaged as some fatal disease that strikes people dead.

Although the respondents (41 per cent) are aware of the fact that both males and females are equally vulnerable to HIV/AIDS, misinformation also exists as some (7 per cent) consider that the disease affects males only. However, surprisingly, none related HIV/AIDS exclusively to females.

The awareness that certain individuals/groups are more vulnerable to acquiring HIV/AIDS, is focussed on CSWs who have been identified by the majority as being the most vulnerable group. Awareness regarding vulnerability of receivers of blood/blood products is low. So is the fact that babies born out of infected mothers can be HIV+. These replies are in consonance with those received in the context of transmission route of HIV/AIDS (Table 10.4). Since a large number of respondents, in keeping with the dominant paradigm of HIV/AIDS, have identified CSWs as primarily vulnerable to infection, awareness programmes will need to stress that "it is not what one is" but "what one does" that creates vulnerability.

Although the respondents are aware that AIDS is fatal, hope springs eternal in the human breast as the dominant viewpoint is that it is curable especially if "detected early". The proportion of those who think AIDS is preventable is lower than those who think it is curable.

A queer characteristic of HIV/AIDS is that it is largely asymptomatic. The natural tendency to associate a disease with a symptom(s) has led the respondents to report symptoms of HIV/

AIDS like rashes/sores, fever, etc. And, in the same strain, there can be seen a tendency to depend upon visual cues to indicate an infected status. Very few could correctly state that a person "looking healthy" can be infected with HIV and transmit it to others as well.

Although some artisans (30 per cent) are aware that a blood test can disclose HIV status, almost an equal number said that "physical examination" by a medical practitioner could also detect it. Of those who are aware of blood test being the correct method of detecting HIV positive status, none could name the tests, viz. Elisa and Western Blot.

In order to assess the prevalent notions amongst the migrants about HIV/AIDS being a disease that is transmitted directly from one person to another, without a known vector, all the respondents were asked 12 questions on transmission routes of HIV/AIDS. The results are presented in table 10.4.

It is found that large scale ignorance exists regarding the transmissibility of HIV/AIDS and its routes. Only 16.75 per cent of the respondents have correct knowledge about transmission routes of HIV/AIDS.

If we look at the correct/incorrect replies received for each item, it is interesting to note that most of the respondents are aware of the sexual route of transmission of HIV/AIDS (46 per cent). Similarly, an important characteristic of HIV/AIDS that it does not spread by touching an infected person is known to a sizeable portion of the respondents (37 per cent). However, whether this awareness has the ability to translate itself to a compassionate non-stigmatizing attitude towards an infected person remains to be seen as none of the respondents have had any first hand contact with a person infected with HIV/AIDS.

Awareness about parenteral transmission of HIV/AIDS is found to be low (26 per cent). The highest percentage of incorrect replies has been obtained with reference to transmission of HIV/AIDS through sharing of food, utensils and other personal belongings like clothes (33 per cent are of the opinion that HIV/AIDS can be transmitted by such forms of contact). Transmission through insect/mosquito bite is another area where level of misinformation is high. So is the

case regarding invasive procedures like tattooing, tansuring and piercing of nose/ear. This is of particular interest as the respondents have in the past 5 years undergone invasive procedures like tansuring (12 per cent), tooth extraction (10 per cent) and minor surgery (13 per cent), and did not report undertaking any specific steps to ensure against transmission of blood-borne diseases. Getting habitually shaved at a saloon, in the city as well as while visiting the native village is a very popular practice adhered to by almost all the artisans. Needless to state requests made for new/sterilised equipment are almost non-existent.

Since HIV/AIDS is mainly associated with sex, knowledge of prevention is also primarily centred around the sexual mode of transmission, viz. 'no sex with CSWs' (29 per cent), or 'infected partner' (14 per cent), 'sex with one partner' (16 per cent) and even 'abstinence from sex' (2 per cent). The emphasis on avoiding CSWs as a preventive mode against HIV/AIDS indicates that respondents harbour the notion that CSWs are major contributors to HIV infection in society. This association, though an important one, may dilute the locus of prevention through non-sexual modes, and instil a false sense of security amongst those who do not visit CSWs but may still be vulnerable to HIV infection through other routes.

It is important to take cognisance of the fact that the respondents are in urgent need of awareness programmes so as to highlight not only preventive measures associated with the sexual mode of transmission but at the same time, propagate the message of safer sex as they practice unsafe coitus with CSWs. Solutions like "abstinence from sex" and "no sex with infected partner" will be hard to follow in practical situations. Also, there is an urgent need to highlight preventive measures associated with non-sexual, invasive and blood-borne routes of transmission. A number of respondents (30 per cent) have expressed their faith in the power of medicine to make them immune to infection, or provide a cure in case infection occurs. The fatal nature of the disease needs to be stressed as also the fact that even if a preventive/curative medicine/vaccine is made available in the near future, its universal availability at an affordable price will remain a distant dream for the majority (Gorman,

1996).

Prevalence of misconceptions may be a result of the fact that the artisans have never attended any awareness programme. Although patchy awareness gleaned from indirect/impersonal sources of information like the electronic media has acquainted the artisans with the term "AIDS", it has not done much to impart factual knowledge about the nature of infection and its prevention. Consequently fallacies rule.

In order to find out the extent of self-risk perceived by the respondents they were asked about the chances they thought they had of acquiring HIV/AIDS, the likely source of infection, importance given to personal safeguard against infection and willingness to take the HIV test.

In the light of the risk behaviours indulged in by the artisans, it is indeed alarming to note that a sizeable proportion (26 per cent) perceive no chance at all of acquiring HIV/AIDS.

Majority of them, however, are not sure of the extent of vulnerability they have and this may be due to the sketchy nature of awareness that exists regarding HIV/AIDS (Table 11).

Infected blood has been cited as the most likely source of infection to self (23 per cent).

Table 11: Estimate of self-risk to HIV + AIDS

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

The possibility of getting infected through sexual transmission has been identified albeit by a smaller percentage of respondents (15 per cent). An overwhelming number (62 per cent) are however totally ignorant about the likely source(s) of infection (Table 12).

A peculiarity that can be observed here is that in spite of being aware of the sexual route

Table 12: Likely source of infection

S. No.	Likely source of infection	No. of respondents (n = 100)
1.	By sexual route	15
2.	Through infected blood	23
3.	Don't know	62

of HIV infection and indulging in sexual promiscuity by visiting CSWs, there is a dissociation from perceiving self risk. This can emerge as a facilitator in the transmission of HIV.

Similar observations were found in a study by Baumen and Siegel (Baumen and Siegel, 1987) who stressed that having low levels of perceived risk of contracting HIV/AIDS can result in higher risk taking. Applying this contention to the respondents of the present study it can be said that inability to perceive risk may, in fact, increase the vulnerability of the migrants in the light of the fact that they are indulging in unsafe coitus with CSWs. The reason behind dissociating oneself from risk may stem from the fact that awareness about HIV/AIDS is sketchy amongst most respondents. In fact, it is often restricted only to being aware of the term "AIDS" which is coupled with the practice of dispensing with the use of preventive devices such as condoms to gain physical pleasures.

Parallely, not much thought is spared to safeguarding oneself from possible HIV infection.

None of the artisans place safeguarding as "extremely important" in their agenda of living.

Table 13: Importance given to saving oneself from HIV + AIDS

S. No.	Importance given	No. of respondents (n = 100)
1.	Not at all important	3
2.	Somewhat important	39
3.	Quite important	4
4.	Extremely important	0
5.	Don't know	54

39 per cent agree that it is somewhat important to safeguard themselves. Replies of this genre can be a fallout of low perception of self risk and indicates that the fatality of the disease is not being taken seriously. More than half of the respondents (54 per cent) have expressed that they don't know how much importance they should give HIV/AIDS in their daily life.

There is a strong need for self-education here in order to enable the artisans to realistically assess the threat they and their families face. Findings on risk behaviours indulged in by the artisans indicate that the potential for infection is quite high. In the light of these facts, there emerges a strong and urgent need to educate the

artisans in realistic evaluation of self risk.

HIV antibody testing is a resource for people who chose to consciously acknowledge risk. Wermoth et al. (1992), in this context, have stated that willingness to be tested indicates some acknowledgement of risk. Thus, in order to corroborate the replies received for the queries on perception of self risk, the respondents' willingness to take the HIV test was also noted.

A small proportion (10 per cent) of the respondents agreed to take the HIV test. Some (11 per cent) outrightly refused to do so stating that

Table 14: Willingness to take the HIV test

S. No.	Willingness	No. of respondents (n = 100)
1.	Yes	10
2.	No	11
3.	Only on doctor, recommendation	27
4.	Not sure	52

since they did not perceive any risk of infection, testing would be a useless exercise. In case doctor recommends HIV testing, the respondents expressed that they will do the needful (27 per cent). This indicates that there is a need to train people in self-evaluation of risk to encourage voluntary testing. Dependence on doctor's recommendations which will come, in most cases in later stages of infection, further ensures that the infected person continues to transmit the virus to unsuspecting others. Majority of the respondents (52 per cent) however, are unsure of their position on testing.

Testing has its shortcomings as a preventive strategy—it may encourage people to maintain cautious behaviour but for others, a negative result may fuel a system of denial in which risky behaviour is rationalised (Wermuth et al., 1992). Hence, willingness expressed here is only taken to be an indirect indication of acknowledgement of self-risk, and not consent to proceed with actual testing.

E. Intervention Strategies

In the absence of a cure, the only possible way to combat the ever proliferating pandemic of HIV/AIDS is to prevent its spread through changes in human behaviour—it is behaviour that makes one risk prone, and thus, it can be

posited that adequate changes in health refractory behaviour is the key to preventing the spread of HIV/AIDS.

One is faced with a peculiar situation vis-à-vis the migrants here. The back and forth movement of the migrant artisans makes it very difficult to work out practical and localised intervention which is contextually appropriate. There is the problem of language. The place of work often represents an alien culture, including a foreign language and ethos which leaves messages propagation and preventive practices largely undecipherable. It also renders them non-personal and accords a generic nature to the messages.

The artisans' mother tongue is Bengali, hence, it is appropriate that intervention should be designed in this vernacular which will take cognisance of the ethos of their culture. Another important point is that as visits to the villages are infrequent and of short duration — thus, to provide awareness and intervention strategies aimed at functionalising prevention in a sustained manner, it has to be a regionally coordinated activity. That is to state that though the migrants can be targetted for intervention during their visits to the villages, it will have to be carried forward to their place of stay, i.e. the city, while still maintaining the local idiom yet appropriate to the nitty-gritty of the particular socio-economic and cultural context of the migrants' lifestyle in the city.

Keeping the above mentioned points in consideration, it is proposed that an intervention strategy for purposes of preventing large scale spread of HIV/AIDS amongst the migrant artisans should have 3 components, each targetting a specific area of concern in order to bring about comprehensive changes in all major areas concerned, viz., awareness, attitudes and behaviours. Any intervention strategy designed to fulfill these objectives must have a well orchestrated and multipronged approach, i.e. it should ideally comprise the following components:

- (a) Informational Component
- (b) Strategical Component
- (c) Plans and Policy Component

(a) *Informational Component*: The level of awareness about HIV/AIDS amongst the migrant artisans is found to be at its best sketchy, incom-

plete and fuelled with lots of misgivings about the nature of the disease. Hence, the first step towards providing any intervention would be to equip them with facts about the disease in a detailed manner and in a way that is understandable, credible and persuasive.

A good start can be provided by display of posters and pamphlets on HIV/AIDS in the native tongue at strategic locations in the village (like youth clubs, a gram panchayats, local dispensaries, shops, bus-stands and places of community gathering) and also provide them for distribution and display at the living and workplaces in the city. Display of such material may set the ball of conversation rolling and spark the inquisitiveness to know more about HIV/AIDS. Posters and pamphlets of this nature are already available with the government of West Bengal. However, a scrutiny of the same indicates that often the language used is non-colloquial and generalised (like "body fluids"). It is recommended to make them simpler, colloquial and more specific to be decipherable by the majority who are only functionally literate.

The content of information should especially incorporate and stress those risk prone behaviours that the target populations practice, viz.

- (a) risks involved in having multiple sexual partners, especially CSWs.
- (b) risks involved through parenteral route of transmission and invasive procedures.

In the same strain, information regarding safer sex practices (like use of condom, non-penetrative coitus) and the use of sterilised/disposable equipment for any invasive procedure (like vaccination, surgery, tonsuring, shaving) must also be highlighted.

A demystification of the nature of HIV/AIDS, its transmission routes, modes of prevention, detection methods and association with STD/STIs also need to be highlighted together with the overall need to be more health and hygiene conscious.

(b) *Strategical Component*: Providing information is only the first step towards effective intervention. To ensure that information received is translated into awareness, perception of self, risk and ultimately prevention on a sustained basis, it has to be ensured that it is transformed

into action. This should include:

- (i) Development of outreach materials with the participation of target groups for prevention;
- (ii) Training of committed peer educators from amongst the target population and
- (iii) Provision of support services in the form of STD/STI prevention and easy availability of condoms.

The techniques of group intervention and individual counselling will have to be judiciously integrated to provide the best possible intervention according to the needs of the migrants. Beginnings can be made at the village level by holding small group discussions under the guidance of a group leader — who can be the local doctor, health worker, or any community leader. Such small, intimate, inter-personal discussions can provide information in a credible and persuasive manner as well as thaw reservations about discussing the disease. Such group discussions will also help to identify responsible peer leaders who can then be provided with additional training and expertise to carry the message forward to other fellow migrants, both in the village, as well as continue the process in the city. Training can be provided through discussions, quizzes, brain storming and lecture-demonstrations; in areas like proper usage of condom by simulating situations and finding ways of how to deal with them when they occur actually.

Apart from risk reduction techniques, at a broader level, attitudes and social norms must be attended to. Group discussions under the supervision of a trained person (ideally a peer) can help build up a more positive attitude towards HIV/AIDS in general and PWA/PWHIV's in particular, as well as inculcate a sense of responsibility for the social consequences of sexuality. These steps can help to build self-regulative skills and translate information into effective preventive action. Providing opportunities for guided practice and corrective feedback in applying skills in risk situations together with skill enhancement in sexual negotiability can promote self-efficacy amongst the migrants. Also, group participation can mean enlisting peer and social support for desired changes in risk reduction behaviour.

(c) *Plans and Policy Component*: This component must ensure provision of infrastructural facilities like provision of blood supply in the village and setting up of anonymous HIV/AIDS and STD/STI testing facilities within the already

existing structure of health care to minimise discrimination and stigmatization. Provision of counselling facilities must also be included. For this, at the village level, training has to be provided to the health care personnel like local health workers who already enjoy easy rapport and accessibility vis-a-vis the target population.

The spouses of the migrant artisans largely avail of the health care services provided by the network of primary health centres and family welfare clinics. An integration of family welfare and STD/STI prevention and control to provide symptomatic testing of the latter during routine ante-natal check-ups can go a long way in targetting the next of kins of the migrants who are at no small risk of acquiring HIV consequent to risk practices indulged in by their sexual partners.

A connected effort on the part of the local bodies, social workers, medical personnel and community leaders in tandem with the target group can not only lead to increase in knowledge about HIV/AIDS but also instill the responsibility to adopt risk reduction practices in the interest of one's immediate family in particular and society in general. Timely intervention can help by not only translating knowledge to sustained preventive action but it can also bring out the strengths of the existing social networks, build up a unique support system and safety net for those who acquire the dreaded infection. There is only hope that the people and society concerned will rise to accept the challenge.

CONCLUSION

It is palpable that a change in sexual practices does occur amongst the migrant gold artisans once they start living and working in urban centres. This change occurs in the adoption of multi-partner sex with CSWs, as also, inclusion of new practices such as oral sex. Such newer practices are then incorporated into their sexual practices with spouses during periodic visits to the native village. Infrequent contact with family instils not only feelings of emotional deprivation but also emboldens the migrants to indulge in risk behaviours frowned upon by norms of established social code of conduct like indulgence in commercial gratification of coital desires. Not only this, such coitus is health refractory in nature as safer sex is dispensed with in favour of obtaining sensual pleasures. This

pattern has come to be so deeply etched in the very phenomenon of migration of villagers to become gold artisans in cities that it has assumed the proportions of a culture of "sexual poverty".

Awareness about AIDS exists albeit fallacies and misconceptions abound. A peculiar situation thus arises — the migrant artisans are not totally ignorant about the behaviours that constitute risk, and in spite of such awareness they not only continue to practice unprotected coitus with CSWs, but also perceive negligible self risk of HIV infection. This situation may be the outcome of self inefficacious thinking nurtured within the peculiar social context of their living: the social context that fosters promiscuity in the absence of controls and censure against socially disapproved behaviour.

A multipronged, well orchestrated and regionally coordinated intervention strategy is called upon to not only heighten awareness amongst the migrants but to ensure that by proper strategy such awareness is translated into sustained preventive action against HIV/AIDS. At a broader level, it should involve social networks and existing infrastructural facilities to catalyse changes in attitudes and beliefs vis-a-vis the disease and the diseased. The ultimate goal being to convert the community into a "safety net" — both, to dissuade people from indulging in risk practices as well as to emerge as effective support systems for those who acquire infection. Intervention strategy is not to be developed as a panacea to be imposed on the irreversible process of migration, or recalcitrant migrants but rather provide them with choices of safety and health over refractory behaviour in the era of HIV/AIDS.

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