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Effects of Migration and HIV Status of Bridge Groups on their Families in India

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Abstract

Migration is a complex process which has a number of outcomes in terms of positive and negative. When it is carried with deadly or hazardous HIV, it impacts the physical, social, psychological and emotional state of the families. Numerous studies have been done on data has been analysed thematically and results were classified into four themes (i) family status (ii) social stigma: (iii) feeling of isolation and guilt; (iv) coping strategies. The paper recommends to prevent the spread of HIV through sex education, rigorous programs and distribution of condoms, mobile provisions for prevention of STIs with IEC activities in the Country HIV/AIDS and are centred on individuals, focusing on prevention strategies to cope with the disease. At the global level, sex workers of all genders continue to face disproportionately high risk of getting infected with HIV. There are multi-layered reasons for high-risk populations to get infected due to the behavioural and social environment experienced by the sex workers. On the other hand, truckers and migrating workers are highly vulnerable to HIV and are prone to sexually transmitted infections due to the nature of their work. Due to a lack of information on the bridge population's sexual behaviours, it limits the decision to initiate HIV prevention interventions. This paper intends to study the impact of migration and HIV status, especially on families of bridge groups called truckers and migrants. Secondary sources and existing literature have been used.

Keywords: *Migrant workers, HIV, Bridge group, Family & Actual Risk Group.*

Introduction

Migration is increasingly recognized as a multidimensional phenomenon that extends beyond the mere movement of people from one place to another. It encompasses a wide range of economic, social, political, cultural, and environmental factors that influence why and how individuals and communities migrate.

Migration studies have consistently been an interdisciplinary domain, integrating various theoretical frameworks and subfields (Brettell & Hollifield, 2014). Historically, the field primarily focused on the social practices shaped by migration and the political dynamics surrounding it (Zolberg, 2000; Guiraudon & Joppke, 2001). Over time, however, these dimensions have become increasingly interconnected, to the extent that some scholars now refer to this intersection as the *sociology of migration politics* (Sciortino, 2000). This evolution underscores the importance of promoting migration as an interdisciplinary area of study to grasp the complex realities of human mobility (Arango, 2004).

The article is an attempt to understand migration through this multifaceted lens, allowing research to move beyond simplistic push-pull models and address the deeper structural conditions shaping human mobility.

The Sociological Understanding of Migration

Classical theories of migration have faced several criticisms, which have contributed to the development of more nuanced contemporary sociological approaches. One key limitation of classical perspectives is their inability to account for the **transnational nature of migration**, as well as the variation in post-migration experiences across different societies. These theories also lack a **gender-sensitive framework**, leaving many questions about the intersection of gender dynamics and migration realities unanswered. Moreover, classical theories often overlook the experiences of **ethnic minorities**, particularly in relation to their processes of adjustment, assimilation, and conflict within host societies. Additionally, the **socio-psychological dimensions** of migration—especially concerning the migrant as "the stranger" and the emotional experiences of those left behind—receive minimal attention in these early frameworks.

In contrast, **contemporary sociological perspectives** view migration as a dynamic and socially embedded practice. This shift has allowed researchers to explore how specific migratory behaviours are shaped by historical context and how these practices evolve over time. Scholars have introduced classifications such as **short-term and long-term cross-border configurations** to distinguish between different patterns of transnational movement (Faist, 2000; Levitt & Glick Schiller, 2004).

A significant advancement in contemporary theory is the rise of **gender-sensitive migration studies** (Lutz, 2010). These approaches recognize gender as a socially constructed category that interacts with migration processes in complex ways. Among the frameworks within this field, the study of **transnational families** has become especially prominent. This concept reflects the transformation in family dynamics brought about by increased mobility, technological advancements, and more accessible communication. Unlike earlier periods where long separations were common, frequent travel has now become possible, although **economic constraints and job-related obligations** still limit the physical reunification of families in many cases.

In sum, contemporary sociological theories have broadened the analytical lens on migration. They extend beyond the classical view of migration as a routine economic process and instead frame it as a **transnational, gendered, and socially embedded phenomenon**. These

perspectives not only explore the motivations behind migration but also delve into the complex realities migrants face before, during, and after their movement, including assimilation and social transformation.

Objectives

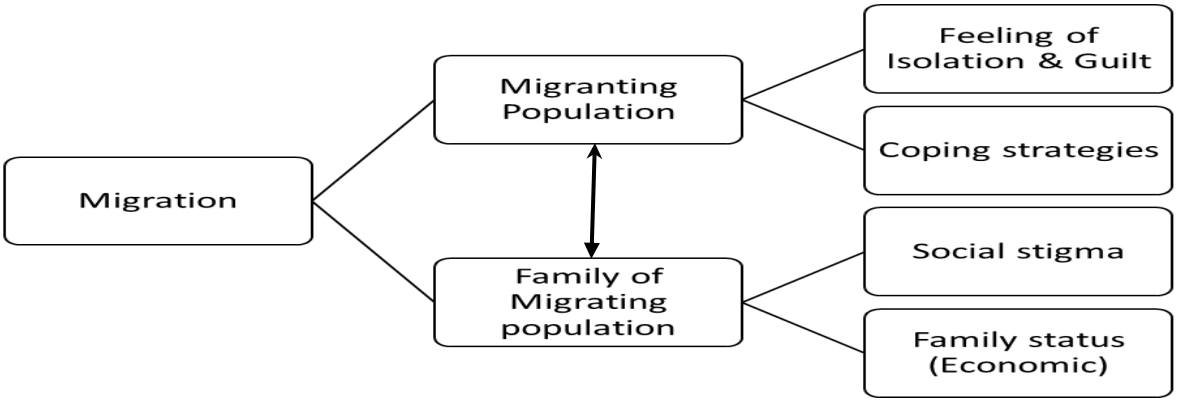
This paper aims to:

1. **Examine migration as a sociological process**, exploring its underlying causes, patterns, and implications within a broader social context.
2. **Analyse the impact of migration** on both the migrant population and the communities they leave behind, focusing on social, emotional, and economic dimensions.
3. **Identify the factors contributing to risky behaviours among migrants**, with particular attention to the link between migration and the spread of HIV.
4. **Propose strategies for early detection of HIV/AIDS**, timely initiation of treatment, and reducing dropouts from healthcare services among migrant populations.

Methodology

This review article is based on **secondary sources**, with a focus on research exploring the relationship between HIV-positive individuals and their families. The time frame of 2000 to 2022 was selected to align with key developments in India's **National AIDS Control Programme (NACP)**, particularly **Phase III**, during which targeted interventions began to take shape.

While precise data on the HIV-positive migrating population in India remains limited, valuable conceptual insights and relevant keywords were obtained from the official websites of **UNAIDS** and **NACO**. Available numerical data were drawn primarily from published research, reputable news sources, and organizations such as the **Hindustan Latex Family Planning Promotion Trust (HLFPPT)** and **END**.



The research problem hence focuses on perspectives of: first, the experiences of HIV-positive individuals who migrate, and second, the situations of those left behind, often the families of

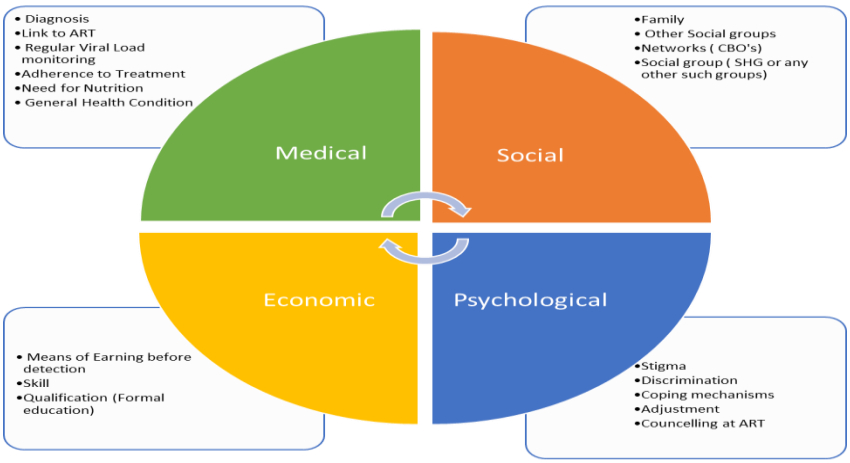
migrants. These themes revealed patterns related to the timing of migration (pre- or post-HIV diagnosis), reasons for mobility, the impact of diagnosis on family members, and their coping strategies.

Viewing HIV through a **social lens** reveals how the disease is exacerbated by **inequality, stigma, marginalization, and prejudice**—conditions that are often entrenched in the social fabric. Public health scholar **Jonathan Mann** strongly advocated for a **Human Rights Approach**, which emphasizes addressing these broader social conditions faced by people living with HIV. His work argued that combating the disease requires more than medical treatment; it necessitates social justice and protection of human dignity (Fee & Parry, 2008; Mann, 1998; Mann & Tarantola, 1998).

The social epidemiology and HIV

Social epidemiology examines how health and disease are influenced not only by biological or behavioural factors but also by broader social and environmental contexts. This perspective is especially critical in understanding conditions like **HIV/AIDS**, where transmission often involves deeply personal and interpersonal interactions. Since sexual behaviours are culturally constructed, each society defines what is considered acceptable or taboo based on its **socio-cultural, religious, and political frameworks** (Kippax, 2008).

It therefore becomes imperative to make a distinction between 'risk' and 'vulnerability'. Theoretically speaking, in the context of HIV, the risk is an epidemiological concept, as it is the possibility that one may acquire HIV infection; on the contrary, vulnerability is a social concept as it is influenced by social and environmental factors that control an individual's behaviour.



Social Epidemiology of PLHIV

The above diagram is an attempt to identify common factors that act as triggers in the case of the HIV-positive migrant population. It illustrates the multidimensional challenges faced by people living with HIV, highlighting four interconnected areas: medical, social, psychological, and economic. Medically, managing HIV involves timely diagnosis, access to antiretroviral therapy (ART), consistent viral load monitoring, and proper nutrition. Socially, the support from family, peers, and community-based groups (CBOs and SHGs) helps reduce stigma and encourages treatment adherence, strengthening the individual's resilience.

Economically, the impact of HIV can disrupt livelihoods, making skills development and educational qualifications crucial for sustainable income. Psychologically, PLHIV often experience stigma, discrimination, and emotional distress, which demand strong coping mechanisms and counselling support. The interdependence of these four dimensions underscores the need for a holistic and integrated approach to HIV care, addressing not only medical treatment but also the broader social, mental, and economic challenges to ensure better outcomes for individuals and communities.

In order to fully comprehend the situation, it is necessary to understand the situation from the micro level. Many elements act as push-pull factors contributing to different reasons for migration. Since the reason for migration is individualistic in nature, hence its impact on the individual and on the family also becomes personalized.

Migration and HIV: Indian scenario

Various epidemiological studies have indicated that migrant workers and truckers are the strongest influencers on the spread of HIV, which spreads across different geographical boundaries. Although this movement is greatly influenced in terms of frequency of travel, duration, familial conditions, and nature of employment, their role as a Bridge group cannot be undermined.

The research paper intends to study migration and its relation with HIV from a social epidemiological point of view, highlighting the migrant working population, including both truckers and migrant labourers in India, their role in acting as possible spreaders of disease like AIDS/ HIV, and highlighting the risk and vulnerability of their families.

i) Truckers

In the Indian context, the mobility of truck drivers has been increasingly recognized as a significant factor in the spread of HIV. According to the **Annual Report of the Ministry of Road Transport and Highways (2020–21)**, India possesses a vast road network of

approximately 6.2 million kilometres, including 136,440 km of national highways, 176,818 km of state highways, and over 5.9 million km of other roads.

Estimates by the **Asian Institute of Transport Development (AITD)** suggest that India is home to over 5 million truckers, based on the assumption of more than 2.5 million trucks operating with two drivers each. Reports from **Health Management Research** indicate a similar figure of 5 to 6 million truckers, with 40–50% engaged in long-distance transport. Among these, approximately 15–20% are identified as clients of female sex workers (FSWs), categorizing them as a high-risk "sub-segment" within the broader client population. Due to their continuous movement across regions, these truckers often act as **bridging populations**, transmitting HIV from high-prevalence areas to regions with lower prevalence rates.

With the expansion of transport infrastructure, the number of truck drivers is projected to grow significantly in the coming decade. Long-distance truckers and their helpers often remain on the road for extended periods—sometimes over a month—resulting in prolonged separation from their families. This lifestyle contributes to a higher incidence of **risky sexual behaviors** compared to short-distance drivers. These behaviors may include maintaining multiple sexual relationships, some of which involve fixed partners along the route, casual encounters at rest stops, or engagement with sex workers, thereby increasing their vulnerability to **sexually transmitted infections (STIs)**, including HIV.

Several socio-structural factors contribute to the risk-taking behaviour of truckers, which must be considered in understanding their overall vulnerability to HIV. Despite a relatively high level of awareness about HIV/AIDS, many drivers do not translate this knowledge into preventive practices. This disconnect is often attributed to harsh working conditions, including long hours, hazardous routes, risk of accidents, theft, and violence, which diminish concern for personal health and safety.

Key vulnerability factors among truckers include:

- Prolonged separation from spouses or regular partners
- Stress induced by poor road infrastructure, tight deadlines, and long working hours
- Use of alcohol to cope with isolation and fatigue
- Easy access to sex work networks at highway halts and transport hubs
- Ready cash availability, making truckers potential clients of the commercial sex industry
- Limited access to health services and condoms along highways
- Sexual exploitation or high-risk behaviour among helpers and assistants due to deprivation
- Low awareness and denial about male-to-male STI transmission

ii) Migrant Workers

Migrant labour is inherently a difficult concept to define; it can be understood from economic, legal, and social perspectives as well. According to Encyclopaedia Britannica, Migrant workers are those individuals who are usually unskilled and move from one state or country to another, offering their services, which might be on a temporary or seasonal basis. NACO, in order to deal with this potential high-risk group, has defined them as those men and women within the age group of 15- 49 years who travel at least once a year or more from source to destination. Those who return to their source location at regular intervals are called "circular migrants".

There are several factors that contribute to the high levels of vulnerability among migrant workers. The major factors can be identified as under:

1. Relative freedom in the new setting, as well as peer pressure to experiment with new norms.
2. Stressful migration driven by drought/disasters
3. Loneliness, drudgery, and long periods of separation from spouse/sexual partner
4. Having disposable income, clubbed with limited choices for affordable entertainment and recreation. This usually means drinking and, sometimes, drugs as well as sex with FSWs and other casual sex relationships.

Issues and challenges

According to the last HIV surveillance, which was conducted in 2017 by NACO, there were around 0.86% HIV positive truckers and 0.51%Migrant labourers out of the total HIV positive population in India (*SANKALAK: status of National AIDS response*, 2021). The above numbers are just an estimation; however, the actual number can be higher, as these numbers consist of only those who are registered at ART centres, and those who are unaware of their HIV status remain unchecked.

Studies have highlighted a lack of voluntary HIV testing, awareness about the disease and its mode of transmission, and ineffective counselling pertaining to the spread of disease and disease management contribute to the creation of misconceptions and myths related to HIV. Factors such as education, gender, self-perceived knowledge, socioeconomic status also help in the testing services, whereas the major factor that affects the most is the societal factors, which are associated with HIV, is the stigma and its consequences lessen the testing. These factors influence the health-seeking behaviour of the individual and PLHIV as well.

Specifically in the case of India, a consistent pattern whereby men seek testing as a response to the development of symptoms or reflecting on their past risky behaviour, whereas women test following the discovery of their husbands' HIV-positive status was witnessed. The unawareness and uncertainty about the HIV status of the migrating population also contributes to their vulnerability and also of their family. (Dandona et al. 2009; Joseph et al. 2010; S. Solomon et al. 2006; Vajpayee et al. 2009). Furthermore, married women are also largely unaware of their own risk, despite accumulated evidence that marriage is the biggest risk factor for monogamous married women in India. (Gangakhedkar et al. 1997; Mehta et al. 2006)

The non-uniform way in which the epidemic threatens different sub-populations, as with the distribution of power and autonomy between different genders and generations within Indian households (Bloom et al. 2001). The dominance of unsafe Sexual practices, lack of use of condoms and other preventive measures, adds fuel to the fire.

Policies related to HIV positive Migrant population

Recognizing the heightened vulnerability of truckers and migrant workers to HIV, the **National AIDS Control Programme Phase III (NACP-III)** designated these mobile populations as key target groups within its prevention framework. The primary objective was to curb HIV transmission among high-risk groups (HRGs) and prevent further spread to the general population. For truckers, the program was implemented at three strategic levels: (1) **National Networked Targeted Truckers Interventions**, (2) **Structural Interventions** at both national and state levels, and (3) **Localized Interventions** for high-risk truckers. These interventions were supported by clear guidelines covering program selection criteria, infrastructure development, supply chain logistics, human resource management, and financial oversight, aiming to address the unique risks faced by this group and ensure their integration into broader HIV prevention strategies.

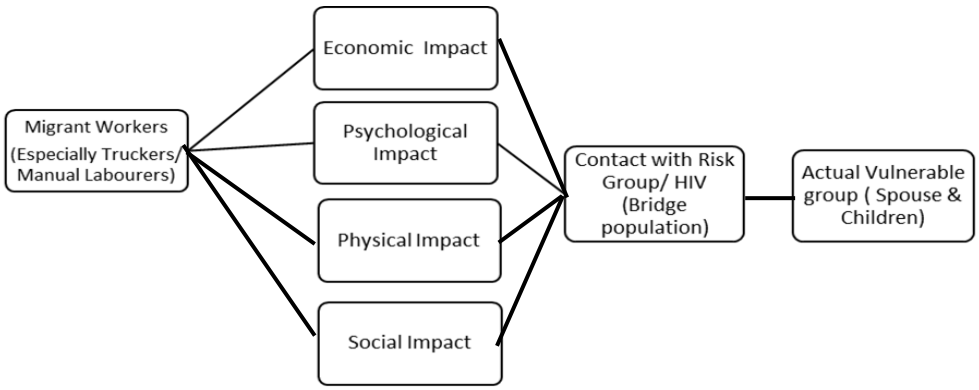
In a similar vein, **NACO** designed a comprehensive intervention package for **high-risk migrant populations**. This included (1) **Outreach and Communication** efforts to engage migrants; (2) **Peer-led, NGO-supported behaviour change communication (BCC)** strategies, incorporating differentiated outreach based on risk typology, large-group activities (e.g., street theatre, games), and interpersonal communication; (3) **Essential health services**, such as condom promotion, referrals to STI clinics, and linkage to services like ICTC, ART, and substance use treatment; (4) **Enabling environments**, created through advocacy with stakeholders and connections to welfare programs; and (5) **Community mobilization**,

focusing on empowering migrant communities to take ownership of the intervention through capacity-building and local program centres.

Despite substantial efforts under NACP to raise awareness and deliver services to both high-risk and general populations, challenges remain. According to **SANKALAK (3rd Edition, 2021)**—the flagship empirical report of NACP assessing data from 2020—India had an estimated **23.19 lakh** (ranging between 18.33 lakh to 29.78 lakh) adults living with HIV (PLHIV), with an **adult prevalence rate of 0.22%**. Although this reflects a significant decline compared to earlier decades, several states continue to report rates above the national average. These include **Andhra Pradesh, Delhi, Goa, Karnataka, Maharashtra, Meghalaya, Punjab, Puducherry**, and **Tamil Nadu** (NACO, 2021).

Research Findings

HIV has a very prominent and lifelong effect on the lives of migrating populations. There are four predominant factors that have a direct impact on the lives of PLHIV and their families.



As stated above, there are several factors that might work simultaneously to identify the migrating population as the High-Risk Group. But in the case of those living with HIV, their family appear to be the actual vulnerable group. The impact of being diagnosed with HIV is not restricted to the individual alone; the family also faces the consequences of the isolation and stigmatisation that come as baggage in the case of HIV. Here again, a clear distinction in case of gender difference and acceptance is visible where the males are spared from direct interrogation pertaining to cause of disease whereas females especially in cases where the wife is positive and the husband is not HIV positive, may face severe stigmatisation, discrimination, violence and abandonment (Desai 2005; Saggurti and Malviya 2009).

The process of coping and adjusting to the disease, which is chronic and later terminal, is not easy. It is very difficult to say how an individual copes and adjusts to the sudden shock of being detected with HIV. The stigma attached to being HIV positive sometimes leads to a situation

where the patient socially associates himself with other HIV related diseases like cancer and tuberculosis (Chandra et al. 2003). The impact of being detected with HIV is visible at the level of both the individual and their family:

i) Detection of HIV- (family status and HIV)- As already stated, it is very rare in India that an individual gets himself tested voluntarily for HIV; in other than such cases, an individual is suffering from some kind of medical condition or is pregnant in the case of females. The decline in health, shock, anxiety, and denial all these factors work simultaneously, making it difficult to cope. Apart from this, loss of work/job due to ill health, meeting family or social responsibilities, and the hunt for alternative sources for earning, add to the already deteriorated situation.

(ii) Social stigma- The social stigmatisation of HIV due to its association with sexually deviant and socially disapproved behaviour and on the other hand, the pathological nature of HIV being chronic, incurable and after a given point of time terminal and the individual's experience of this transition is what distinguishes it from other diseases. (Pisani 2008). The family also bears the brunt of stigmatisation, family isolation from community, out casting, abandonment by family (siblings, spouses, parents, etc), change in family dynamics, and the blame (in case of females is quite common.

(iii) Feeling of isolation and guilt- as stated above, the impact of stigma associated with HIV is clearly visible at two levels: self-stigma and stigma by others towards the HIV positive individual. Self- stigmatization is a difficult aspect of an individual's acceptance of their status, and the guilt of involving the family along makes the process even more complicated. The lack of counselling at ART centres and also the self-perceived notions about the disease and half-cooked knowledge about how to live with the disease also isolate the individual from family, friends, and any other social support system.

(iv) Coping strategies- it is very difficult to pinpoint how and what takes an individual to cope and adjust and help them to move on forward in their lives. Similarly, it is very difficult to say how much time one needs to cope; this completely depends upon the individual and the situation they are in. With help from their family, financial and food security, support from the community, counselling, knowledge about their rights, and linkage to the service providers, all can contribute to their sustainable future.

Suggestions

The early detection and treatment of HIV is essential to reduce its rate of prognosis and lead a healthy and long life. However, due to lack of clarity about the HIV status and thereafter lack

of enrolment in ART, and subsequently a large number of dropouts in treatment have resulted in the spread of the epidemic. Despite targeted programs and initiatives by NACO, any member of the general population does not have access to free HIV testing until they become ill or face some other medical complication. The difference in health-seeking behaviour based on class, gender, and education further contributes to the gap in detection and treatment.

The predominance of private health setups over government in matters of male sexual health, especially traditional methods of treatment, access to HIV testing by spouses of migrant workers, particularly women, and, in some cases, misdiagnosis, also adds to the growing number of people living with HIV.

The institutionalised government setups need to make additional efforts in order to connect more and more members of the high-risk groups to take up testing and treatment to reduce not only the rate of incidence but also provide longevity of life to those who are living with it. The following suggestions can be provided on the basis of the paper:

- Need for gap assessment in government policy and implementation.
- Promotion of volunteer testing and promotion of preventive measures.
- Sex education and awareness about modes of HIV transmission and the risk involved in unsafe sexual practices.
- Reducing stigmatization and involving the community to bring their PLHIV back into the mainstream.
- Reducing the doctor-patient ratio, providing specialised training to health practitioners to cater to the needs of specifically HIV patients.

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