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International Journal of Collaborative Research on Internal Medicine & Public Health
Vol. 3 No. 5 (May 2011)

International Journal of Collaborative Research on Internal Medicine & Public Health (IJCRIMPH)

ISSN 1840-4529 | Journal Type: Open Access | Volume 3 Number 5

Journal details including published articles and guidelines for authors can be found at:
http://www.iomcworld.com/ijcrimph/

To cite this Article: Giri PA, Shirol SB, Kasbe AM. A comparative study to assess the knowledge and practices regarding sexual health among the migrants and non-migrants in Mumbai city. *International Journal of Collaborative Research on Internal Medicine & Public Health*. 2011; 3(5):341-352.

Article URL: http://iomcworld.com/ijcrimph/ijcrimph-v03-n05-02.htm

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Paper publication: 30 May 2011

A comparative study to assess the knowledge and practices regarding sexual health among the migrants and non-migrants in Mumbai city

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ABSTRACT

Background: Population movements of the scale currently experienced by developing countries have significant implications on the spread of sexually transmitted diseases (STDs) and HIV/AIDS. Mumbai is a large industrial city and has experienced large influx of migrants in the past two decades. The prevalence of multiple risk-traits among the migrants differs significantly by age, marital status, educational level, and living arrangements. Addressing sexual health also requires understanding and appreciation of sexuality, gender roles and power in designing and providing services.

Objectives: The present study was conducted to assess the knowledge and practices regarding various aspects of sexual health among migrant & non-migrant in Mumbai city.

Material and Methods: A Cross-sectional study was conducted from January 2007 to June 2007. It consists of 50 migrants and 50 non-migrants from each of the five zones of Mumbai city. A sample size of 250 migrants & 250 non-migrants from the five administrative zones of Mumbai was considered for the study were interviewed and examined. A semi structured interview schedule was piloted and used to collect necessary information such as clinical history, socio-demographic profile, sexual perceptions and practices, clinical examination and investigations were performed. Results were analysed using Statistical Package of Social Sciences (SPSS) version -13.0

Results: In this study, about 57% migrants perceived that masturbation affects the health & well being; while relatively more non-migrants (69.2%). There was an unrestrained fascination towards consumption of alcohol in both the groups, as 131 (52.4%) migrants and 124 (49.6%) non-migrants were drinking alcohol. More than half of migrants (58.0%) and non-migrants (52.6%) had premarital penetrative vaginal sex with multiple partners.

Conclusion: In the present study, friends followed by movies and television were main source of sexual knowledge among both migrants and non-migrants, with both groups aware of advantage of condom use in preventing HIV/STDs. More non-migrants had misconceptions about masturbation than migrants while both groups did not favor sex medicines.

Keywords: Sexual health, Migrants, Non-migrants, Cross-sectional study

Introduction

Population movements of the scale currently experienced by developing countries have significant implications on the spread of sexually transmitted diseases (STDs) & HIV/AIDS. Mumbai is a large industrial city and has experienced large influx of migrants in the past two decades.[1] The city also falls in the high-risk category in terms of sero-positivity. The living arrangements of migrants have significantly affected the prevalence of risk-taking behavior such as consumption of alcohol, visits to CSWs and extra marital relationship. The risk-taking behavior is more widespread among migrants who were staying either alone or were living with friends in comparison to those who were living with their own family or staying with some other families. The prevalence of multiple risk-traits among the migrants differs significantly by age, marital status, educational level, and living arrangements [1]. Addressing sexual health also requires understanding and appreciation of sexuality, gender roles, and power in designing and providing services.[2] Multiple sexual risk exposes the migrants to varied sexually transmitted diseases (STI's) / reproductive tract infections (RTIs), the most dreadful being HIV. In India estimates suggest that over 3.7 million adults are infected, and AIDS is expected to emerge as the most significant cause of adult mortality in the next few decades [3].The state of Maharashtra has among the highest HIV rates in the country, concentrated in Mumbai and Pune. Migrant populations moving in and out of Mumbai increase the potential for disease transmission into the general population. Alcohol use is widely associated with sexual risks, STDs, and social harm including early sexual debut, multiple partners, inconsistent condom use, lack of protection during intercourse, unwanted pregnancies, and sexual violence [4]. Premarital, marital & extramarital sexual behaviors are directly attributed to sexual health knowledge & practices. Indeed, sexual health is influenced by a complex web of factors ranging from sexual behavior, attitudes and societal factors, to biological risk and genetic predisposition [5]. It encompasses the problems of HIV and STIs / RTIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Understanding sexuality and its impact on practices, partners, reproduction and pleasure presents a number of challenges, as well as opportunities for improving sexual and reproductive health care services and interventions. While sexual health has been implicitly understood to be part of the reproductive health agenda, the emergence of HIV/AIDS, of sexual and gender-based violence and of the extent of sexual dysfunction (to name just some of the developments over the past two decades), have highlighted the need to now focus more explicitly on sexuality and the promotion of sexual health. Hence the present study was conducted to assess the knowledge & practices regarding various aspects of sexual health amongst migrant & non-migrant in Mumbai city.

Material & Methods

Study design: The present study was a cross-sectional epidemiological study.

Study area: Mumbai is located on the western coast India, adjoining the Arabian Sea and known as commercial capital & mega city of India. The study was conducted in five municipal zones of Municipal Corporation of Greater Mumbai (MCGM). Mumbai has been divided into 24 units with demarcated geographical area (wards) and 5 zones comprising of varied number of wards for administrative purpose. A detail study of

different zones & wards of Mumbai was done. The delineation of wards was given special emphasis to avoid duplication or overlapping of areas.

Study population: Study population consists of migrants & non-migrants living in Mumbai city during the period of study. To achieve a complete coverage and representation of migrants, whole of the Mumbai city was included in the study population.

Study sample: The data regarding the movement of migrants in the city was not available at the time of commencement of the study. Some of the migrants are seasonal. As the migrants do not have ration card, voter's card or any official document and are continuously wandering, they escape during the population census documentation. So the intensive search at various data resource points could not yield any concrete picture of number of migrants residing in Mumbai at a given point of time or duration. There were no studies about the sexual behavior of migrants, which could provide some inputs for sample size calculation. A pilot study was conducted to estimate the sample size of the study.

Estimation of sample size:
During the pilot study, it was found that the prevalence of premarital sex among migrants & non-migrants was 42.2% and 29.6% respectively. Using the MedCalc Software and calculating sample size for comparison of two proportions and taking a type I error (Alpha) of 5%, and type II error (Beta) of 20%, a minimum required sample size per group was found to be 249.2. Hence rounding of this figure, a sample size of 250 migrants & 250 non-migrants was decided to be collected from the five administrative zones of Mumbai for the study. To ensure representation from each zone, by proportionate sampling of 50 migrants and 50 non-migrants was enrolled from each of the 5 zones of Mumbai city.

Study period: A study was conducted a period from January 2007 to June 2007.

Study tool: Contact was established with Non Governmental Organizations (NGO's) working for the cause of the migrant population and their help was sought. Visits to working & residential areas and meeting places were made with the help of volunteers from NGO's. The working sites such as construction sites, nakas and residential areas, where migrants can be interviewed were mapped in all zones of Mumbai. All such sites were numbered in each zone and 5 sites were randomly selected. From each site, 10 migrants & 10 non-migrants were included in the study, with their informed consent. The migrants & non-migrants were interviewed individually in a separate room to maintain the privacy and confidentiality. Each interview schedule on an average consisted of 20 minutes. The participants were interviewed with the help of structured interview schedule containing items regarding sexual exposure, condom uses, information regarding HIV/ AIDS knowledge & sexual behavior, where and from whom they obtained information about sex, perception of AIDS risks, and also verbal information about their self-efficacy in avoiding in indulgence in high risk behavior. The ethics committee of the institute approved the study. Socio economic status of migrants & non-migrants was determined as per Kuppuswamy's classification [8].

Study definitions: Definitions of migrants & non-migrants for study purpose were derived from the definitions of Population census of India 2001.[6]

Migrant: 'A migrant is an individual, who is not born in Mumbai or residing in Mumbai for ≤ 2years from the date of interview'.

Non-migrant: 'A non-migrant is an individual, who is born in Mumbai or residing in Mumbai for more than 2 years from the date of interview'.
Working definitions were elaborated as a result of a WHO-convened international technical consultation on sexual health [7] and subsequently revised by a group of experts from different parts of the world.

Sex: 'Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred'.

Sexuality: 'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors'.

Sexual health: The World Health Organization (WHO) definition of sexual health is "A state of physical, emotional, mental and social well-being related to sexuality; not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled".

Sexual rights: Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to attain the highest attainable standard of sexual health, including access to sexual and reproductive health care services; seek, receive and impart information related to sexuality; sexuality education; respect for bodily integrity; choose their partner; decide to be sexually active or not; consensual sexual relations; consensual marriage; decide whether or not, and when, to have children; and pursue a satisfying, safe and pleasurable sexual life. The responsible exercise of human rights requires that all persons respect the rights of others.

Data entry and analysis: Data was entered in MS Excel and analyzed by using Statistical Package of Social Sciences (SPSS) version-13.0. Statistical significance was set at $P \leq 0.05$.

Results

As observed from **Table 1**, out of the total 250 participants of each group, more than one-third of migrants (40.0%) & non-migrants (37.6%) were in the age group of 20 to 24 years. One-fifths of migrants as well as non-migrants had completed their silver jubilee of life. All the 500 participants (250 migrants & 250 non-migrants) studied were males. According to the Kuppuswamy's scale of socioeconomic status classification, more than half of migrants & non-migrants were in the socioeconomic class IV, followed by Class V

and Class III. On educational front, 29 (11.6%) had completed primary school education, 157 (62.8%) passed secondary education, 10 (4.0%) pursued higher secondary education & a marginal of six (2.4%) had completed graduation. Comparatively, among the literate non-migrants, 18 (7.8%) had completed primary education, 145 (58.4%) had passed secondary education, 23 (9.2%) pursued higher secondary education & 10 (4.0%) had completed graduation (p=0.049). Occupation wise, majority 120 (50.4%) migrants and 100 (40.0%) non-migrants were engaged in unskilled jobs such as construction laborer & allied fields. Fifty-one (20.4%) migrants & 65 (26.0%) non-migrants were working in semi-skilled jobs while a substantial number of migrants 73 (29.2%) & non-migrants 85 (34.0%) were employed in skilled jobs (p=0.061).

As observed from **Table 2**, it was found that friends followed by movies and television were the major source of sex information for migrants as well as non-migrants. Both groups believed that regular use of condom does reduce the risk of HIV and STIs, more among non-migrants than migrants (74.8% vs 66.6%, p-value = 0.031). About 57% migrants perceived that masturbation affects the health & well being; relatively more non-migrants (69.2%) (p =0.014). Of the 142 (56.8%) migrants who believed that masturbation affects male health, majority 105 (73.9%) stated that masturbation causes weakness, and 25 (17.6%) declared it causes flaccidity of penis, the proportion being 71.7% and 15.6% respectively among non-migrants (p=0.458). A sizeable proportion of migrants and non-migrants (196, 78.4%; and 203, 81.2%) did not support the use of sex tonics (p=0.494).

As observed from **Table 3**, only 78 (31.2%) non-migrants having a premarital sexual exposure as compared to 126 (50.4%) among migrants **(**p < 0.0001). Most common partner in premarital sex among migrants was commercial sex worker (46.8%) while that among non-migrants (51.3%) was girlfriend (p<0.0001). Amongst the 126 migrant males who had premarital sexual exposure, only 13 (10.3%) reported of using condom during penetrative vaginal intercourse, the figure being 18 (23.1%) among the non-migrants (p <0.0001).

Both the study groups (migrants and non-migrants) had various rationales for indulging in premarital sex. The two most reported reasons among migrants were for casual sex (26.2%) and sexual pleasure or tension & heat in body (17.5% each) while that among non-migrants was peer pressure (27.8%) and sexual pleasure (24.1%) (p=0.038). More non-migrants had multiple premarital sex partners than migrants (47.4 and 42.1% respectively) (p < 0.0001). Ten (43.5%) out of 24 extramarital sexually exposed migrants had extramarital sex for sexual pleasure, nine (39.1%) had for experimenting sexual fantasies, but more non-migrants 16 (64.0%) had extramarital sex for sexual pleasure and two each (8.0%) had extramarital sex for experimenting sexual fantasies and unsatisfied marital sex (p=0.038). More than half migrants 157 (62.8%) said that they would like to approach allopathic doctor for sexual problem, 43 (17.2%) preferred Ayurvedic doctor, 27 (10.8%) favored homeopathic doctor, while 22 (8.8%) said they will chose an herbal man (Jadibutiwala). A similar scenario was seen in non-migrants (p =0.176).

Discussion

In the present study, astoundingly, earliest sexual debut was seen at the age of 13 years & the average age of sexual debut was found to be 17.37 ± 1.72 years. A study conducted by Sunder Lal [9] (2002), has found out that the median age of initiation of sexual debut is 15-16 years**.** The non-migrants showed a different pattern of sexual exposure as compared to

migrants with only 78 (31.2%) non-migrants having a premarital sexual exposure as compared to 126 (50.4%) among migrants.

Of the 126 migrant males with history of premarital sexual exposure, 59 (46.8%) had a penetrative vaginal sex with commercial sex worker (CSW), 42 (33.3%) had a sexual contact with girlfriend and 23 (18.3%) had a sex with girlfriend (GF) as well as CSW. Only two (1.6%) migrants had sex with neighboring females. Studies conducted in this context were scarce & one study conducted in age group of 15-30 by Sachdev P [10] (1998), explored that 39.3% of males and 20.4% of females had engaged in premarital sex.

Among the 78 non-migrant males with premarital sexual exposure, 25 (32.1%) had a penetrative vaginal sex with CSW, 40 (51.3%) had a sexual contact with GF & 12 (15.4%) had a sex with GF as well as CSW and only one (1.3%) non-migrant male had sex with neighboring females. A study conducted by Alexandar M et. al [11] (2007) found out that 20-26% had engaged in some form of physical intimacy and 16- 18% had vaginal sex.

Amongst the 126 migrant males who had premarital sexual exposure, only 13 (10.3%) reported of using condom during penetrative vaginal intercourse, the figure being 18 (23.1%) among the non-migrants. Such low figures suggest the need for early intervention, as early sexual debut with minimum knowledge of safe sex puts the individual in high risk category of acquiring HIV/ AIDS, STI & Teenage pregnancy. Similarly a study conducted by Nidhi Singh et al [12] (2008) suggests that condom usage in premarital sex to be as low as 13%. A study by Anarfi J.K. [17] (1993) revealed that 66% of migrants did not use condoms.

A total of 204 subjects (126 migrants and 78 non-migrants) stated following reasons for their premarital sexual exposure, in descending order of frequency: Casual (23%), sexual pleasure (20%), peer pressure (19.5%), tension (13.7%), outburst of love (10.2%), experimentation (6.3%), forced by girl (4%) and body requirement (3.4%). A study conducted by Ravi K. V et al [13] (2004) revealed that pressure from peers & adults influence the sexual relationships & often encourage indulging in high risk behavior. Outburst of love (5, 6.3%), and body requirement (4, 5.1%) and forced by girl (3, 3.8%) were the other reasons to support their motive of premarital sex**.**

Of the 24 migrants with extramarital sexual exposure, 6 each (25%) had sex with CSW and neighbor respectively, and 12 (50%) had sex with both GF & CSW. In contrast, 25 non-migrants with extramarital sexual exposure, ten (40%) had sex with CSW and each of five (20%) migrants had sex with GF plus CSW, CSW and neighbor respectively. A similar study by Anarfi J.K. [17] (1993) revealed that about 66% of ever-married males and 50% of ever-married females have had at least two sexual partners. Sixteen percent of internal migrants and 42% of international migrants had at least two sexual partners. A Survey conducted by makers of Kohinoor condoms [14] in 2000 suggests that 13% of married males engage in extramarital sex. Subjects were reluctant to discuss extramarital sexual affairs, so the incidence quoted here needs further studies to substantiate. The deviation among migrants & non-migrants with respect to their sexual partners, in extramarital sexual exposure was found to be statistically significant ($p = 0.038$). About 57% migrants perceived that masturbation affects the health & well being and relatively more non-migrants (69.2%) believed that masturbation has impact on health.

Ten (43.5%) out of 24 extramarital sexually exposed migrants had extramarital sex for sexual pleasure, nine (39.1%) had for experimenting sexual fantasies, three (13.0%) indulged in extramarital sex on pretext of wife being away and one migrant had sex outside marital relationship as he was not satisfied in marital sex. More non-migrants 16 (64.0%)

had extramarital sex for sexual pleasure, five (20.0%) indulged in extramarital sex on pretext of wife being away and two each (8.0%) had extramarital sex for experimenting sexual fantasies and unsatisfied marital sex. Studies in this context in India are rare and a study conducted in Nigeria by Obi Samuel N [15] (2006) found that 55% had extramarital sex for sexual pleasure, 20% for sexual fantasies and 3% due to unsatisfied sex with wife. A study by Anarfi J.K. [17] (1993) revealed that sixty-seven percent of men said that it was common for men to have extramarital affairs when their wives were breastfeeding.

There was an unrestrained fascination towards consumption of alcohol in both the groups, as 131 (52.4%) migrants and 124 (49.6%) non-migrants were drinking alcohol. A similar study conducted by Jugal Kishore et. al [16] (2001) to assess the health status of 744 industrial workers, revealed 36% prevalence of alcohol consumption. A study conducted by Alexandar M et. al [11] (2007) also revealed that exposure to alcohol; drugs or pornographic films and having more frequent interaction with peers were positively associated with romantic and sexual relationships.

Conclusion

In the present study, majority of the migrants and non-migrants were in the age group of 20-39 years, and from lower socio-economic status. Friends followed by movies and television were main sources of sexual knowledge among both migrants and non-migrants, with both groups aware of advantage of condom use in preventing HIV/STDs. More non-migrants had misconceptions about masturbation than migrants while both groups did not favor sex medicines. More migrants had premarital sex than non-migrants, more with CSW. Peer pressure was most common reason for premarital sex among non-migrants while it was casual sex which predominated among migrants. One-tenths of the married migrants & non-migrants indulged in extramarital sexual affairs. Allopathic followed by Ayurvedic doctors were most preferred by both groups for treatment of sexual problems. Sex education should concentrate predominately on the physical aspects of sexual health in three key areas: Sexual behavior and lifestyles, sexually transmitted infections including HIV, and access to services.

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Tables:

Table 1: The socio-demographic characteristics of the study population

Socio-demographic characteristics	Migrants (n=250)	Non-migrants (n=250)
1. Age		
15-19 yrs	26 (10.4)	34 (13.6)
20-24 yrs	100 (40.0)	94 (37.6)
25-29 yrs	61 (24.4)	52 (20.8)
30-34 yrs	24 (9.6)	36 (14.4)
35-39 yrs	30 (12.0)	27 (10.8)
40 yrs & above	09 (3.6)	07 (2.8)
Chi-square value= 4.777, df= 5, p-value=0.4437 (Not significant)		
2. Marital Status		
Married & living with wife	71 (28.4)	91 (36.4)
Married but away from wife	89 (35.6)	30 (12.0)
Unmarried #	86 (34.4)	122 (48.8)
Separated #	02 (0.8)	02 (0.8)

Deserted #	02 (0.8)	05 (2.0)
Chi-square value= 38.666, df= 2, p-value < 0.0001 (Significant)		
3. Socioeconomic status		
Class I **$**	00 (0.0)	00 (0.0)
Class II **$**	00 (0.0)	00 (0.0)
Class III	37 (14.8)	44 (17.6)
Class IV	152 (60.8)	161 (64.4)
Class V	61 (24.4)	45 (18.0)
Chi-square value= 3.279, df= 2, p-value 0.1941 (Not significant) **$= not included in calculation.**		
4. Education		
Illiterate	48 (19.2)	54 (21.6)
Primary	29 (11.6)	18 (7.2)
Secondary	157 (62.8)	145 (58.0)
Higher Secondary	10 (4.0)	23 (9.2)
Graduate or above	06 (2.4)	10 (4.0)
Chi-square value= 9.525, df= 4, p-value 0.0492 (Significant)		
5. Occupation		
Unskilled	126 (50.4)	100 (40.0)
Semi-skilled	51 (20.4)	65 (26.0)
Skilled	73 (29.2)	85 (34.0)
Chi-square value= 5.592, df= 2, p-value 0.0610 (Not significant)		

(Figure in parenthesis indicates percentage**)**
#- Row data pooled and Chi-square test applied.

Table 2: Assessment of the knowledge regarding sexual health among study population

Particulars	Migrant	Non-migrants	X^2 value (p-value)
1. Source of sex information-	**(n=250)***	**(n=250)***	
Friends	206 (82.4)	193 (77.2)	1.787/0.1813
Movies	79 (31.6)	77 (30.8)	0.009/0.9231
Television (TV)	64 (25.6)	63 (25.2)	0.010/0.9182
Newspaper	04 (1.6)	05 (2.0)	1.0000 ^
Internet	00 (0.0)	04 (1.6)	0.1235 ^
2. Can regular use of condom reduce the risk of HIV/ AIDS, STDs?	**(n=250)**	**(n=250)**	
Yes	165 (66.6)	187 (74.8)	4.233/0.0397 **$**
No	85 (34.4)	63 (25.2)	
3. Does masturbation has any effect on health-	**(n=250)**	**(n=250)**	
Yes	142 (56.8)	173 (69.2)	8.530/0.0141
No	85 (34.0)	58 (23.2)	
Don't know	23 (9.2)	19 (7.6)	
4. If masturbation has effect on health, specify-	**(n=142)**	**(n=173)**	
Weakness	105 (73.9)	124 (71.7)	1.559/0.4587
Flaccid penis	25 (17.6)	27 (15.6)	
Loss of libido	01 (0.7)	18 (10.4)	
Reduces erection of penis #	05 (3.5)	00 (0.0)	
Reduction in penis size #	03 (2.1)	01 (0.6)	
Decrease weight, giddiness and loss of luster on face #	02 (1.4)	02 (1.2)	
Sexual problem later in life, can't satisfy the partner #	01 (0.7)	01 (0.6)	
5. Should sex medicines be taken to improve or maintain sexual health-	**(n=250)**	**(n=250)**	
Yes	51 (20.4)	44 (17.6)	0.4678/0.4940 **$**
No #	196 (78.4)	203 (81.2)	
Don't know #	03 (1.2)	03 (1.2)	

* - Multiple responses
^ - Fisher's Exact Test applied.
$ -Yates correction applied.
- Row data pooled and Chi-square test applied.

Table 3: Assessment of the practices regarding sexual health among study population

Particulars	Migrant	Non-migrants	Z value (p-value)
1. Type of Sexual exposure-	**(n=250)**	**(n=250)**	
Premarital	45 (18.8)	41 (16.4)	**28.030/ < 0.0001**
Premarital and Marital	70 (28.0)	28 (11.2)	
Premarital, Marital & Extramarital	11 (4.4)	09 (3.6)	
Marital	61 (24.4)	75 (30.0)	
Marital & Extramarital	10 (4.0)	14 (5.6)	
Extramarital	03(1.2)	02 (0.8)	
No exposure	50 (20.0)	81 (32.4)	
2. Premarital sexual exposure with-	**(n=126)**	**(n=78)**	
CSW	59 (46.8)	25 (32.1)	**24.656 / <0.0001**
Girlfriend	42 (33.3)	40 (51.3)	
CSW & Girlfriend	23 (18.3)	12 (15.4)	
Neighbor #	02 (1.6)	01 (1.3)	
3. Condom use during pre-marital sex-	**(n=126)**	**(n=78)**	
Yes	13 (10.3)	18 (23.1)	**24.827/ <0.0001 ¥**
No	113 (89.7)	60 (76.9)	
4. Reasons for pre-marital sex-	**(n=250)**	**(n=250)**	
Casual	33 (26.2)	14 (17.7)	**13.271/ 0.0389**
Peer pressure	18 (14.3)	22 (27.8)	
Sexual pleasure	22 (17.5)	19 (24.1)	
Tension & Heat in the body	22 (17.5)	06 (7.6)	
Outburst of love	16 (12.5)	05 (6.3)	
Experimentation	07 (5.6)	06 (7.6)	
Forced by girl #	05 (4.0)	03 (3.8)	
Body requirement #	03 (2.4)	04 (5.1)	
5. Premarital sex partner-	**(n=126)**	**(n=78)**	
Single	73 (57.9)	41 (52.6)	**19.611/ <0.0001 ¥**
Multiple	53 (42.1)	37 (47.4)	
6. Drug abuse-	**(n=250)**	**(n=250)**	
Yes	23 (9.2)	20 (8.0)	**0.1018/ 0.7497 $**
No	227 (90.8)	230 (92.0)	
7. Extramarital sexual exposure with-	**(n=24)**	**(n=25)**	
CSW #	06 (25.0)	10 (40.0)	**6.833/ 0.0774 ¥**
Girlfriend #	00 (0.0)	05 (20.0)	
CSW & Girlfriend	12 (50.0)	05 (20.0)	
Neighbor	06 (25.0)	05 (20.0)	
8. Condom use during extra-marital sex-	**(n=24)**	**(n=25)**	
Yes	04 (16.7)	10 (40.0)	**3.288/ 0.1932 ¥**
No	20 (83.3)	15 (60.0)	
9. Reasons for extra-marital sex-	**(n=24)**	**(n=25)**	
Sexual pleasure	10 (43.5)	16 (64.0)	**6.175/ 0.1034 ¥**
Experimenting sexual fantasies	09 (39.1)	02 (8.0)	
Wife away #	04 (16.6)	05 (20.0)	
Due to unsatisfied marital sex #	01 (4.3)	02 (8.0)	
10. Extra-marital sex partner-	**(n=24)**	**(n=25)**	
Single	11 (45.8)	06 (24.0)	**2.598/**

Multiple	13 (54.2)	19 (76.0)	**0.2728 ¥**
11. Consumption of Alcohol -	**(n=250)**	**(n=250)**	
Yes	131 (52.4)	124 (49.6)	**0.2881/**
No	119 (47.6)	126 (50.4)	**0.5914 $**
12. Whom would you approach first for treatment of sexual problem-	**(n=250)**	**(n=250)**	
Allopathic doctors	157 (62.8)	161 (64.4)	**4.943/**
Ayurvedic doctors	43 (17.2)	55 (22.0)	**0.1760**
Homeopathic doctor	27 (10.8)	16 (6.4)	
Jadibutiwala #	22 (8.8)	15 (6.0)	
Ayurvedic doctor / Allopathic doctor #	01 (0.4)	03 (1.2)	

¥= Remaining cases in each group included in calculation of statistical test.
^ -Fisher's Exact Test applied.
$ -Yates correction applied.
-Row data pooled and Chi-square test applied.