Migration, AIDS And International Relations

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移民、愛滋病與國際關係

【摘 要】

面對今日變動的世界，移民與愛滋病為兩大首要的社會議題。當任何有關愛滋並受到輕視的疾病，以及常常受輕視的團體：移民，連結成為討論的議題時，常造成特有的困難。本文將檢測愛滋病與移民的關係，並探討為何移民人口為何容易受到愛滋的侵害。

愛滋是一種流行病，它已經散布流竄到世界的每一個角落。1980 年代初期愛滋病首度被證實後，即引起了全世界各類團體的一連串回應。然而，愛滋病對國際體系政治的破壞力依舊是被低估了，無庸置疑的，移民是一項錯綜複雜的歷史及政治議題；但是在國際關係的相關討論中卻極少涉及健康議題。單獨關於愛滋病與移民問題的學術論作已經出版了，但是卻很少題材將這兩項議題結合在一起。闡明移民、愛滋與國際關係間的關聯，更是一項嶄新的研究。本文主要研究目的即試圖掌握出上述的關聯，並提出一些可能具爭論性的意見。主要的研究範圍為肯亞，但其他非洲國家的案例也將會被引用。

在國際關係的範疇中，移民與愛滋病流行的研究還有很長遠的路途要走，例如在研究中由學術定位，發展出更正面、創新及完整的研究方法，也將更廣泛的瞭解移民過程中的複雜性。

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Migration and AIDS are two of the crucial social issues facing today's changing world, posing unique difficulties for any discussion of a stigmatised disease, AIDS, and an often stigmatised group, migrants.[1] This article examines the relationship between AIDS and migration and the factors that make migrant populations vulnerable to AIDS. The primary geographic emphasis is Kenya although examples from other African countries are cited. Evidence for this study is based on information collated in Nairobi between August 1998 and January 1999.[2]

AIDS and migration are two salient features of the latter half of this century. Previously, governments' main concern was often that incoming migrants might bring HIV with them. Today, however, while this still occurs, there is increasing recognition that migrants may be more vulnerable than local populations to acquiring the infection during migration, and that they may spread the infection upon return to their respective homes.[3] Moreover, diseases do not need passports to travel between or within countries. It thus seems to be surprising that there is little attention given to health, and related issues in international relations discourse. Very little published material exists which combines the issues of AIDS and migration, but even less that combines these with international relations. It takes boundaries to create migrants. Beliefs,

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1 Haour-Knipe, Mary., & Rector,Richard., Crossing Borders: Migration, Ethnicity and AIDS,(London: Taylor & Francis, 1996),p.1.

2 The author wishes to thank Mr. Shaban.N.Mohamed (Medical Records Assistant) and Mrs. Mulli (Archivist and Medical Records Assistant) at the Medical Records Department, Kenyatta National Hospital, Nairobi for all their kind assistance.

3 "Migration and AIDS," edited by Reginald Appleyard & Andrew Wilson, in International Migration, Vol. 36, No. 4 ,1998,p.446.

religion, skin colour, race, ethnic background, language, nationality, all played a role in the constitution of such boundaries throughout human history.[4] The most recent history of cities, and of migrants pouring into them, has had particularly devastating consequences on health. New boundaries appear faster than old ones disappear, marginalising new-comers, inhibiting positive interaction and neglecting opportunities for development. Most people's journey into the breathtaking fast-growing urban areas terminates in suburbs and slums, and they remain cut off from the glamour of the cities by social and economic boundaries. Undoubtedly migration is a historically and politically highly loaded issue, which explains why studies in this field are not easy to launch.[5]

AIDS is a pandemic, which means it is spreading worldwide and has reached every part of the globe. Since it was first recognised in the early 1980s it has evoked an array of responses in national and international communities. However the ability of the disease to damage the global body politic is underestimated and is an issue that needs to be addressed.[6] The initial response to AIDS was to allocate blame. In the West this was done on a quasi-scientific basis: a significant number of the first cases in the USA were in the Haitian community and consequently to be Haitian was to be a member of a "high risk group".[7] In Europe early cases were mostly among Africans or people who had lived in Africa, which gave rise to the perception that this was an 'African disease'. Even in 1992, the discovery of a large proportion of a small

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4 Junghanss,T., "How unhealthy is migrating," in Tropical Medicine and International Health, Vol. 3, No 12, December 1998,p.933.

5 Ibid.

6 Whiteside, Alan & FitzSimons,David., The AIDS Epidemic: Economic, Political and Security Implications,(London: Research Institute for the Study of Conflict & Terrorism, 1992),p.26.

7 Ibid., p. 27.

number of infected pregnant women in inner London having links with Africa or the Caribbean had resulted in a resurgence of racist views.[8] The position of the homosexual community has been well documented and in most countries they were the group that experienced initial high rates of infection, and AIDS was described as a 'gay plague'. A similar response, of blaming others, was experienced in some developing countries. In Uganda, AIDS was believed by many people to have been introduced by the Tanzanian army and traders. The Tanzanians believed that AIDS came from Uganda. Elsewhere in Africa, people from developed countries were accused of importing the virus, while in the West, Africa was labelled as the origin.

The people of eastern Africa face numerous health threats: epidemics, civil wars, population growth and environmental change. AIDS is perhaps the biggest current challenge to Africa's health. AIDS is more than a disease; it is a shock to the modern psyche, which had thought that medical science had the ability to conquer most illnesses. Mankind, in the west at least, expects to live to ripe age in reasonable health. AIDS has appeared unexpectedly and currently science has no answer to it.[9]

HIV/AIDS is a particularly devastating epidemic in many parts of Africa, impacting equally on men and women, as well as on children. Much of sub-Saharan Africa remains predominantly rural, with a majority of the population living in conditions of poverty or near-poverty. With a few exceptions, access to safe and effective health services is quite limited. The economies of many African nations are severely constrained by a variety of factors. In several areas, civil unrest has seriously disrupted health and other social sector programs and millions of people have been displaced from their homes, forcing many into refugee status in their own or neighbouring countries. These and other factors

8 Ibid., p. 27.

9 Ibid., p. 1.

have a direct impact on the health of the populations living in these countries.[10]

Migration, in all its forms has become a way of life for Kenyans. Underdevelopment has meant that rural-urban, urban-urban, rural-rural migration is a constant feature of the *wanainchi's*[11] life. Seldom is the case that one finds a 'settled' person living in a community that has evolved for years. The causes of migration and indeed its consequences are thus a part of an intriguing study.

Socio-economic factors such as migratory labour practices, military movement, and long distance truck drivers play a role in the transmission of HIV/AIDS in many parts of Sub-Saharan Africa. In Kenya, there has been some research into sexual behaviours in high-risk populations such as commercial sex workers, their clients and long-distance truck drivers. Indeed, this research is well documented and will be referred to in this study. However, very little research into the sexual behaviours of the general population in relation to migration has been done, particularly from a background of the political economy of deprivation. Much of our knowledge of sexual behaviour and cultural practices related to sex is based on anthropological monographs, many of which were written before extensive urbanisation, migration, and the introduction of technology brought isolated ethnic groups into more intimate contact with each other and with the west.[12]

At the turn of the 21st century, there is a growing academic interest

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10 Rosenfield,Allan., "Reproductive Health Issues in Africa," in Africa Journal of Reproductive Health, Vol. 1, No. 1, March 1997.

11 The average person.

12 Wools,K.K., Menya.D., Muli,F., Heilman,D., and Jones,R., "Perception of Risk, Sexual Behaviour and STD/HIV Prevalence in Western Kenya", in the East African Medical Journal, Vol. 75, No. 12, December 1998, p.679.

in the intrinsic relationship between the process of industrialisation and the politics of disease in the southern and eastern Africa region. This is particularly relevant since the diagnosis of AIDS/HIV in this part of the world. The HIV/AIDS debate shows how the capitalist system works, especially since the concept of globalisation has come to the fore. It likes to free itself to enter economies and countries unhampered, but systematically create barriers of various kinds for labour movement into, and between, economies. It closes down options for working people while all the time opening up options for itself. It thus calls into question the idea of regionalism and supra-state models in Africa.

Colonial medical discourse concentrated much on the dangers of uncontrolled population movement, which reflected contemporary theories of the spread and control of much disease. It was believed that virgin populations were at risk of disease brought by unclean, infested and unhealthy foreigners. The stream of population movements across the borders and within them had and continues to have serious implications for public health and medical authorities.

Maryinez Lyons has argued, that 'the history of disease is replete with examples of blaming foreigners, often resident across the border of a neighbouring country; it is not so unreasonable to fear the introduction of disease from outside, by outsiders.'[13] Drawing on examples form Uganda in East Africa, Lyons has shown how current speculations about the origins and spread of HIV/AIDS in Africa 'reminds us of the old attitude that disease is often upon us from outside by outsiders.'[14] Migrant workers and mobile ethnic groups are often cited as the major

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13 Lyons, Maryinez.,"Foreign Bodies: The History of Labour Migration as a Threat to Public Health in Uganda", paper prepared for the African Studies Association (UK) conference on African Boundaries and Borderlands, Centre for African Studies, University of Edinburgh, 27th May 1993,p.2.

14 Ibid., p. 1.

vectors of infectious diseases.[15]

Global Statistics

Since HIV was first identified in the 1970s, over 47 million people have been infected, of whom 14 million have died.[16] Last year saw the biggest annual death toll yet: 2.5 million. AIDS now ranks fourth among the world's big killers, after respiratory infections, diarrhoeal diseases and tuberculosis. Of greater concern is the fact that AIDS claims more lives each year than malaria and is still nowhere near its peak. If India, China and other Asian countries do not take it seriously, the number of infections could reach "a new order of magnitude", according to the head of the UNAIDS programme, Peter Piot.[17]

Presently, the worst-hit countries are east and southern Africa. In Botswana, Namibia, Swaziland and Zimbabwe, between a fifth and a quarter of people aged 15-49 are afflicted with HIV or AIDS. South Africa is host to one in ten of the world's new infections, which is more than any other country. According to a report in *The Economist*, in KwaZulu-Natal, the country's most populous province, perhaps a third of sexually active adults are HIV-positive.[18] The Asian sub-continent is already showing worrying signs. Seven million Asians are presently infected by HIV/AIDS.

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15 Chirwa.,Wiseman.Chijere., "Aliens and AIDS in Southern Africa: The Malawi-South Africa Debate", in African Affairs, Vol. 97, No. 386., January 1998, p.57.

16 "AIDS in the Third World: A global disaster," in The Economist, 2nd January 1999,p.50.

17 Ibid.

18 Ibid.

Kenya: National Health Policy and the AIDS Challenge

A healthy population is a basic requirement for successful industrialisation. The Kenyan government recognised this fact and invested heavily on health after independence in 1963. Thus, the life expectancy rate has risen from 40 to 58 years between 1964 and 1994, infant mortality has declined from 126 per 1000 to 60 per 1000 between 1962 and 1994 and immunisation coverage has risen to 70 per cent from under 40 per cent at independence.[19]

But by the 1980s, even before the AIDS crisis had established a stronghold on the continent, much of Africa was plunged into a severe economic crisis. Country after country saw worsening rates of poverty, hunger and disease, including HIV infection.[20] Average incomes fell to 1960s levels – a decline of as much as 50 per cent in some cities. Rather than expanding health services to meet growing needs, governments began slashing and dismantling their heath care programmes. With increased poverty, people could not afford health care and treating AIDS opportunistic diseases became very costly for individual families.

According to '*The Eight National Development Plan, 1997-2001'*, the single most important health challenge that Kenya has faced in its post independence history is the HIV/AIDS pandemic. It is the only known health problem that has the potential to reverse the significant gains made in life expectancy and infant mortality. By 1993, the National AIDS and STD Control Programme (NASCP) had reported a cumulative total of over 39,000 cases of AIDS. This figure rose to 63,179 by 1995, indicating an alarming expansion of the infected population. Indeed, given that many cases go unreported, it is believed that the actual population of AIDS sufferers was as high as 190,000 in 1995, while

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19 The Eight National Development Plan, 1997-2001.

20 Okello, Rose., "Rise in AIDS deaths blamed on poverty", in the Daily Nation, 12th November 1998,p.3.

the HIV positive population was over one million. Worse still the pandemic has not yet stabilised.

While Uganda, the first African country to acknowledge the prevalence of the HIV/AIDS scourge, can now report progress in the fight against the pandemic, Kenya is still caught in half-hearted acceptance and denial of the reality of this 20th century plague. Kenya's case is particularly disheartening because it is one of the worst hit countries in sub-Saharan Africa, after South Africa.

The grim statistics speak for themselves: more than 1,200,000 Kenyans are either HIV-infected or have AIDS according to figures published in late 1998. More than 80,000 of these are children. Nearly every Kenyan knows someone, a friend, a relative, a colleague, or an acquaintance, suffering with AIDS.[21]

AIDS in Kenya is a tragedy of devastating proportions. The lives of infected individuals, their families and communities, the companies they work for, and the country as a whole have been affected by the epidemic. According to Bill Rau, Steven Forsythe from Family Health International and Tom Mboya Okeyo from the National AIDS/STD Control Programme in Kenya,

there is a growing consciousness that, while the epidemiological impact of HIV/AIDS is likely to be significant; the corresponding impact on the social welfare of the family could be even more devastating. Decades of improvements in social welfare are likely to be undermined by the uninhibited progression of the epidemic.[22]

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21 "AIDS: Grim Statistics", in the East African Standard, 10th December 1998,p.6.

22 Rau, Bill., Forsythe,Steven., Okeyo,Tom Mboya., "The economic impact of AIDS: measuring the human and capital costs", in AIDS Analysis Africa, Vol. 6, No. 5, October 1996, p.6.

Transmission of the AIDS virus

There are three significant modes of transmission in Kenya: These are heterosexual transmission, which accounts for about 75%, perinatal transmission which accounts for about 23%; and blood transmission which historically accounted for between 3-5%, but which is expected to decline with improved blood screening.[23]

While the main mode of HIV transmission in Kenya appears to be unprotected heterosexual transmission, there may also be homosexual transmission and contaminated blood use, but information is lacking. Most of those affected fall between 20 and 40 years of age, and the rate of infection in both sexes is about equal.[24] Urban areas are most affected although the rate of rural-urban migration has to be taken into account.

From available evidence it has been established that the prevalence of HIV/AIDS in the regions that border Uganda and Lake Victoria and along major trans-African transportation routes of Kitale, Busia and Kisumu is 20-30 percent of relevant populations. The next highest prevalence rates are 10-20 percent occurring in Nairobi and along the same route to Mombasa on the Indian Ocean. Lower infections rates have been reported in Kisii, Nyeri, Kitui and Garissa at between 2-10 percent.[25]

Mombasa leads in the number of HIV/AIDS cases, followed by Nairobi and Kisumu. The situation in the rural areas where over 85 per

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23 Kenya's Health Policy Framework, November 1994, p.17.

24 Nzioka, Charles.,"AIDS Policies in Kenya: A Critical Perspective on Prevention," in AIDS: Foundations for the Future, edited by Peter Aggleton, Peter Davies and Graham Hart, (London: Taylor & Francis, 1994),p.160.

25 Health Policy Framework, p.16.

cent of the population live is not clear, although there are fears that the strong urban-rural kinship linkages offer paths of transmission.[26]

Available Evidence

Individual studies have documented the increase in infection levels in a number of sites throughout the country. Since 1990, the National AIDS/STD Control Programme (NASCP) has been conducting sentinel surveillance in some of the hospitals for antenatal clinic (ANC) attendees and sexually transmitted disease (STD) patients, as well as collecting data on serostatus from blood donors and selected hospital patients. This data is analysed at the NASCP and the information used to design and evaluate AIDS control programme interventions as well as to estimate the impact of the epidemic.[27]

The sentinel surveillance system for HIV is designed to provide policymakers and programme planners with information on trends of the

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26 Nzioka, "AIDS Policies in Kenya", p. 161.

27 Baltazar, Godfrey., Odido,Helen., Stover,John., Johnston,Alan., Okeyo,Tom Mboya., "Epidemiological Aspects of HIV/AIDS in Kenya", in AIDS in Kenya: Socioeconomic Impact and Policy Implications, U.S. Agency for International Development, AIDSCAP/Family Health International, 1996,p.12.

disease.[28] This form of analysis is effective for understanding the magnitude of the HIV/AIDS problem in certain areas and monitoring the impact of interventions. With suitable adjustments, the data can be used to estimate national prevalence. It is particularly beneficial when targeting areas, which show a high rate of migration and HIV seroprevalence such as urban centres.

Opportunistic infections in HIV/AIDS such as tuberculosis and bacterial pneumonia are responsible for most of the early deaths of people with HIV in Kenya.[29] Many health care facilities, especially in rural areas, do not have the capability to test for HIV infection. These are only a few reasons why facility based data may not represent the entire population. Obviously this means that a large number of those who might be HIV positive are unaccounted simply because they do not fit into the categories mentioned or they do not seek modern forms of medical attention. It is assumed that only about 30 percent of AIDS cases are actually reported.

Western Kenya has had the highest number of AIDS cases in Kenya since 1990, according to Dr. Godfrey Baltazar of the National AIDS and Sexually Transmitted Diseases Control Programme

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28 Knowing the seroprevalence and incidence of a disease can be of crucial importance for planning and evaluating a disease control programme. Surveillance of HIV seroprevalence within a population is an essential part of HIV control programmes, but can be too expensive and time-consuming at district level. See T.Verstraeten, B.Farah, L.Duchateau and R. Matu, "Pooling sera to reduce the cost of HIV surveillance: a feasibility study in a rural Kenyan district," in Tropical Medicine and International Health, Vol. 3, No. 9, September 1998, pp. 747-750, for more on these problems.

29 Okeyo, Tom Mboya., “Highlights of Abidjan Africa AIDS conference”, in the African Journal of Medical Practice, Vol. 5, No. 1, 1998, p. 6.

(NASCOP). In a report in the *Daily Nation*, he said that Nyanza Province had the highest AIDS deaths. It had recorded more than 70,000 deaths from the disease annually. The same report claims that more than 500,000 people have been diagnosed HIV positive in the province.[30]

Nyanza accounts for 500,000 of the 1.5 million cases reported countrywide with an estimated one out of every three people having the virus. Statistics from the Ministry of Health are worrying. The surge in AIDS is manifested by the spiralling infant mortality rate, drop in life expectancy and deaths. In the greater Kisumu (Nyando and Kisumu districts), which is leading with HIV incidence, population estimated growth rate is to drop below 3.3 per cent by the end of 1999. Their life expectancy rate is likely to plummet below 54 years, while the infant mortality rate is to rise above 100/1000 births. Questions are now being raised over the approach taken against the AIDS/HIV invasion in Nyanza.[31]

Cultural factors and behavioural factors, but also migration from neighbouring countries, aggravates the spread of the disease. Several transit points and towns near borders have reported high numbers of HIV/AIDS cases. According to the Isiolo District Medical Officer of Health, Dr. P.N. Kimani, " Isiolo District has the highest number of AIDS cases in Northern Kenya."[32] In the same report the area District Commissioner, John Egesa pointed out that "Isiolo town, as a transit

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30 Otieno, Jeff., "Nyanza leads in AIDS cases", in the Daily Nation, 30th October 1998, p.5.

31 Rambaya, Samuel., "Nyanza regional symposium to discuss AIDS", in the East African Standard, 10th December, 1998,p.24.

32 The district had about 10,000 recorded cases of HIV/AIDS cases in late 1998. See "Travellers behind rise in Aids cases, says medic", in the East African Standard, 2nd December 1998, p.4.

point and a host to many travellers, is now exposed to AIDS."[33]

The Growth of Slums

With growth of middle or high-class houses, slums multiply at an alarming rate. Due to the increasing cost of living caused by the deteriorating economy, the once so-called middle class is slowly moving into slums. In Nairobi, the number of slums and slum dwellers continues to rise. Disease, crime, drugs and prostitution in these slums have thus been on the increase. Migrants from rural areas and other neighbouring countries have little choice but to become part of the millions who live in the Nairobi slums of Kibera, Majengo, Karogocho, Mathare, Dandora, Mukuru, Shauri Yako, Pumwani, Soweto and Kariobangi.[34] Urban slum dwellers, who lack medical care because of unemployment, also return home regularly when ill, carrying urban disease back to their rural villages.[35]

The case of migrants in the Nairobi slums illustrates their plight. In December 1998, the Nairobi Provincial Commissioner, Mr. Kaguthi ordered that all foreigners be flushed out of sprawling Majengo slum.[36] The operation was undertaken to rid the slum of prostitutes from neighbouring countries who have been accused of spreading AIDS in the area. Previously, the local councillor Ashim Mohamed, had alleged that

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33 Ibid.

34 Muiruri,Grace., "The increase in slum dwellers now alarming,," in the East African Standard, 1st October 1998,p.2.

35 Hunt,Charles.W., "Migrant Labor and Sexually Transmitted Disease: AIDS in Africa," in the Journal of Health and Social Behaviour, Vol. 30, December 1989, p. 357.

36 "Travellers behind rise in Aids cases, says medic", in the East African Standard, 2nd December 1998, p.4.

there had been a sudden and alarming influx of prostitutes from a neighbouring country whom he blamed for the spread of AIDS in the area.[37]

Evidence from Kenyatta National Hospital in Nairobi

Up to a third of the population of Nairobi City is said to have the virus. No less than 60 per cent of all admissions to Nairobi's main hospital in January 1997 were for this reason, and AIDS patients occupy between a third and half of all hospital beds in the country. Being the national, referral hospital located at the heart of the populous Kenyan capital Nairobi, a metropolis with more than two million people, Kenyatta National Hospital receives almost all referral cases of terminal illnesses, including AIDS, from the city and its environs.[38] Due to the terminal nature of the disease, most HIV/AIDS patients prefer to seek medical services at cheaper public hospitals and the moment KNH remains the only such option available to the city residents.[39]

The progression to HIV-related conditions and to AIDS seems to be faster in Africa and the time period between diagnosis and death is often short; but though these characteristics may be a consequence of opportunistic infections and generally poorer ill-health, they may also perhaps reflect patients' behaviours in presenting later for treatment.[40] According to Professor S.M.Bhatt, the Assistant Dean of the Medical

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37 Ibid.

38 “AIDS: Home care better than hospital,” in the KNH Bulletin: A Newsletter of the Kenyatta National Hospital, Issue No. 35, December 1998, p.4.

39 Ibid.

40 Akeroyd,Anne., "Some Gendered and Occupational Aspects of HIV and AIDS in Eastern and Southern Africa: changes, continuities and issues for further consideration at the end of the first decade", Centre of African Studies, Edinburgh University, Occasional Papers No. 60, 1996, pp. 5-6.

School at the Kenyatta National Hospital in Nairobi, his experience has shown that most of the patients are often reluctant to test for HIV/AIDS as it is known that once they are declared positive, treatment is arrested because of the lack of funds.[41] The available funds are spent on other treatments such as the malaria patients, where recovery is likely. Thus, those suffering from the disease present themselves at the hospital at the very last stage of the illness.[42]

Evidence from Kenyatta also reveals high suicide rates amongst AIDS patients. Dr. Margaret Makanyengo reported that the number of suicide cases related to AIDS at the hospital had escalated to an alarming rate; out of the suicide attempts, more than 60 per cent were by HIV positive patients.[43]

Oral testimonies from social workers at Kenyatta and Nairobi Hospital, a nearby private hospital, revealed the nature of the difficulties that they encountered in dealing with HIV/AIDS patients. At Kenyatta, interviews with Mr.Wairura, Head of Medical Social Workers, Mr.Richard Muthoka (Medical Social Worker and Counselling Psychologist) and Mr. Peter Obaga (Medical Social Worker) showed that most of the patients they counselled were those suffering from HIV/AIDS.[44] Mrs.Pauline Ngatia, the Social Worker at Nairobi Hospital said that from her experience in dealing with AIDS patients that no matter how educated the victims are the causes of AIDS have been attrib-

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41 Interview with Prof. S.M.Bhatt, Assistant Dean of the Medical School, University of Nairobi, Medical Department (Internal Medicine and Infectious Diseases), at the Kenyatta National Hospital, 24th December 1997.

42 Interview with Prof. S.M.Bhatt.

43 "Travellers behind rise in Aids cases, says medic", in the East African Standard, 2nd December 1998, p.4.

44 Interviews held at the Patient Support Centre, Kenyatta National Hospital, 9th September 1998.

uted to witchcraft.[45] She also suggested that AIDS cases were treated as terminal cases simply because they come to the hospital in the last stages of the illness.[46]

Economic Burden

A case of AIDS does not necessarily cost any more to treat and care for than other long-term chronic or terminal illnesses. What makes this disease unique is that it hits people at the peak of their productive years, the time when they would normally be least likely to require medical care; it has a long incubation period; and it is fatal. AIDS does not replace other diseases but adds to their number.[47] The economic costs of HIV are considerable. In Kenya the epidemic is well advanced. This means that the already fragile economy is vulnerable to the loss of even a few skilled people.

The economic effects of AIDS in the developing world are devastating. The cost of treating AIDS is high and places a considerable burden on poorer countries where government expenditure on health is extremely low. The high prevalence of HIV/AIDS in Africa needs to be examined, at least in part, from a political economy of poverty and deprivation both at the micro- and macro-level. At the national level, the reluctance or inability of many African governments to marshal enough resources of their own to tackle HIV/AIDS has forced them to leave open the doors to international philanthropic forces eager to assist in controlling AIDS.[48] This has created a fertile ground for HIV/AIDS to

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45 Interview held in Mrs. Ngatia's Office, Nairobi Hospital, 31st August 1998, 9.30a.m.

46 Ibid.

47 The AIDS Epidemic, p.11.

48 Nzioka, Charles., "AIDS Policies in Kenya: A Critical Perspective on Prevention," in AIDS: Foundations for the Future, edited by Peter Aggleton, Pe-

be socially and politically constructed in a variety of ways. It is, therefore, inevitable that the question of security will remain crucial if such an overreliance on international charity is to dominate national AIDS control programmes. Charles Nzioka argues that "if it is the case that the extent of HIV/AIDS in Africa is misrepresented, and that that frightening statistics on the continent are a fabrication, it is also that case that this is part of the price to be paid for charity."[49]

Structural Adjustment Policies

Many analysts charge that not only are the massive health care cuts largely the result of harsh economic austerity measures but also result from escalating poverty now characteristic of more than 70 developing countries (40 of them in Africa) since the early 80s. The timing of the introduction of structural adjustment policies (SAPs) is also questionable. Some analysts have argued that in Africa, SAPs have been particularly disastrous for victims of HIV/AIDS. Medicines are prohibitively expensive, basic drugs and equipment are unavailable in most health facilities, hundreds of clinics are closed or grossly understaffed, malnutrition has increased, and water-filtration and sanitation budgets have been slashed, prompting a resurgence of such communicable diseases as cholera, hepatitis and typhoid.

Some researchers maintain that SAPs helped to increased HIV transmission. In 1995, Peter Lurie, a research scientist who spent years studying AIDS in developing countries and is now at the University of Michigan, reported with two colleagues in the journal *AIDS* that SAPs, besides reducing medical care, may have created conditions favouring the spread of HIV infection by increasing levels of poverty, driving subsistence farmers off their land and promoting mass migration to urban

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ter Davies and Graham Hart,(London: Taylor & Francis, 1994),p.160.

49 Ibid.

centres where HIV is widespread. The development of a transportation infrastructure has also played a major part in the spread of AIDS/HIV. Peter Lurie suggests that

Transportation networks that developed in the 1980s, often as explicit components of Structural Adjustment Programmes (SAPs), tend to support the export-led economies promoted by SAPs, rather than the commercial needs of subsistence farmers. These networks connect outlying areas to export centres rather than to other outlying areas, often linking rural areas to urban centres with high HIV rates. Truck drivers and other workers may carry HIV from cities to casual sex partners along roadways. High rates of HIV among truck drivers have been reported in Kenya, as high as 27 percent.[50]

High-transmission areas play a key role in the spread of HIV in Africa: they are nodal points, feeding the rural epidemic. HIV is not evenly distributed within populations or geographical areas. The pattern of distribution is related to social, economic and ecological factors. Population movement, population density, border areas, urbanisation, poverty, civil disturbances such as war, imbalances of the sexes and the pattern of social networks and lifestyles are all important in determining the dynamics of the epidemic and the resulting levels of prevalence.[51]

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50 Lurie, Peter., "IMF and World Bank policies may have contributed to the spread of HIV in developing countries," Centre for AIDS Prevention Studies, University of California, San Francisco, 18 May 1995.

51 Mwizarubi, Blastus., Hamelmann,Christoph.,& Nyamuryekung'e., "Working in high-transmission areas: truck routes in HIV prevention and AIDS care," in Africa: a district level approach, edited by Japheth Ng'weshemi, Ties Boerma, John Bennett & Dick Schapink, (The Netherlands: Royal Tropical Institute, 1997),p.137.

Urbanisation

Rapid urbanisation, the sprawl of cities into wider geographical areas and rapid growth of mega-cities are among significant transformations of human settlements. Urban areas will strongly influence the world of the twenty-first century, and urban and rural populations will be increasingly interdependent for their economic, environmental and social well being. Among the economic and social factors influencing this process are population growth and voluntary and involuntary migration, real and perceived employment opportunities.[52]

In sub-Saharan Africa, the period between 1960 and 1990 has been marked by a rapid rise in urbanisation. During this period, urban population growth was higher here than in any other region of the world. In developing countries, urban populations are increasing 3.6 percent a year which is four-and-a-half times faster than urban areas in industrialised countries and 60 percent faster than rural areas in developing countries. It is estimated that 39 percent of this increase is the result of migration.[53] The decline of the rural subsistence economy forced rural farmers to leave their families to search for work in the cities.[54] Modern migration from rural areas to urban areas for many people is a way of resisting marginalisation and to find a better condition of life. This has important implications for the AIDS epidemic. Urban centres are focal points of the drug trade and sex industry, including sex tourism from industrialised countries.

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52 Senelwa, Kennedy., "Majority will live in towns by 2005," in the East African Standard, 7th January 1999,p.24.

53 Lurie, Peter., "IMF and World Bank policies may have contributed to the spread of HIV in developing countries", Centre for AIDS Prevention Studies, University of California, San Francisco, 18 May 1995.

54 James, John.S., "World Bank in AIDS Prevention Controversy", in AIDS Treatment News Archive, 16 June 1995.

Migrant male workers may leave a single sexual partner in the countryside for multiple casual partners in the urban centres. After being infected with the HIV virus, the men return to their homes in rural areas, and may infect their wives or other partners. A consequence of this migration is that men are more likely to have multiple sexual partners, and women are financially dependent and less likely to be able to negotiate for safe sex when their men return.[55] According to John James "economic development, which disrupts traditional ways of life and leads to greater mixing of people through commerce and migration, is conducive to the spread of disease, including AIDS."[56]

Throughout the world, escalating civil unrest, wars, 'ethnic cleansing', ecological changes, economic imbalances, individual search for a better life or just plain restlessness and curiosity, push or pull people to relocate.[57] Few communicable diseases have provoked the public fear, political concern, and human wastage as HIV and AIDS.[58] With those mostly affected being the young and economically productive people, HIV/AIDS is not simply a medical problem, but a social and economic one.

It appears that in the developed world HIV will largely be confined to those whose lifestyle puts them more at risk from the virus and groups who are marginalised. These include intravenous drug users, prostitutes who do not practice safer sex, the poorly educated, and impoverished inner city dwellers. In the developing world it is a disease which spreads

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55 Ibid.

56 Ibid.

57 Haour-Knipe & Rector, Crossing Borders, p.1.

58 Carballo, Manuel., & Siem,Harald., "Migration, Migration Policy and AIDS", in Crossing Borders: Migration, Ethnicity and AIDS, edited by Mary Haour-Knipe & Richard Rector,(London: Taylor & Francis, 1996), p. 31.

throughout society.[59]

Certain situations may promote commercial (paid) and transactional sex (in return for goods) as well as occupations or lifestyles that can lead to frequent sexual partner change and/or multiple partners. These types of sex are more common when women lack adequate sources of income and, at the same time when many men have a ready source of income and are separated from their wives or cannot form stable partnerships.[60]

As regards the 'high-risk' occupational groups, the argument is that there are some occupations that lead to the emergence of high-risk groups that are more likely to transmit or contract HIV/AIDS. Among the occupations often cited are long-distance truck driving, itinerant trade, tourism, bar attending, provision of night entertainment, and prostitution. Research findings have shown that everywhere in Africa long-distance truck drivers are a source of sexually transmitted diseases. Levels of HIV/AIDS infection are higher along the routes most densely travelled.[61] Among men in Africa, an occupation that appears to be associated with increased risk of HIV infection is long-distance truck driving, a profession that requires prolonged absences from home and family. Kenya's highways serve as a gateway for many other African countries relying especially on the Nairobi-Mombasa highway for trade and export.

A team of experts from the Department of Microbiology at the University of Nairobi carried out an original investigation. Truck drivers along the Mombasa-Nairobi highway were enrolled at the roadside research clinic where a standardised interview and serologic evaluation for

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59 Ibid.

60 "Working in high-transmission areas: truck routes", p.137.

61 "Aliens and AIDS in Southern Africa", p. 61.

HIV and syphilis were conducted.[62] Seroprevalences of HIV were similar among truck drivers, assistants, and mechanics. Infection with HIV was directly correlated with duration of driving and trips outside Kenya and was inversely correlated with number of trips per month. The HIV-seropositive men reported fewer home visits to their wives and more frequent visits to prostitutes. Seventy-five percent of HIV-positive and 72% of HIV-negative men reported a history of prostitute contact.[63]

It is increasingly recognised that movement of people is associated with a greater risk of HIV/AIDS. This is well documented in the case of truckers. What has not been recognised is the fact that migration is a way of life for millions of people, and indeed, is essential for the survival of them and their families. The accepted wisdom is that the bulk of the migrants in and from Africa are young and male. However, women also migrate.

Among women in Africa, the profession of prostitution confers an extraordinarily high risk of HIV virus.[64]An important aspect of migration in Kenya is the movement of rural women to the larger cities. Most of the women who migrate to cities are adolescents or young adults from very poor families. They do not have the right to own land and once married, face a life of servitude as labourers on their husbands' fields. Commonly women are fully responsible for raising their children. Through the migrant labour process and the enclave development system, the African workers, largely male, concentrated at the site of industry, agriculture, or in Kenya, the *Jua Kali*[65] sector. In many cases the result-

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62 Bwayo,J., Plummer,F., Omari,M., et al., "Human Immunodeficiency virus infection in long-distance truck drivers in East Africa", in Archives of Internal Medicine, Vol. 154, June 27 1994,p.1392.

63 Ibid., p.1392.

64 Ibid., p. 1391.

65 The Informal Sector in Kenya.

ing depletion of males from the rural villages and farms caused a marked deterioration in women's ability to carry on alone and to provide for their families.[66] In recent decades, many unmarried rural women saw no means of adequate support for a family and thus migrated to the city at a young age. Charles Hunt, a sociologist from the University of Oregon, suggests that family conflict and separation also have caused many young women to migrate to the cities and to concentrations of male labour...unfortunately, very few women have found wage labour…some, perhaps many, of these women become prostitutes and enter the marginal or secondary labour market in the areas surrounding the large concentrations of men and development[67]

In several African countries, prostitution is a profession chosen by many women who migrate to cities as it enables them to support their families in the rural areas. This is particularly due to rising unemployment and changing social patterns.

There have been recent studies on prostitution in towns in Kenya and several have addressed the problem of AIDS/HIV. Susan Beckerleg's work on Watamu illustrates one such case. Watamu, a coastal village in Kenya underwent rapid modernisation during the 1960s and attracted large numbers of immigrants and tourists. The growth of the town and the movements of the immigrants were unregulated and a freewheeling uncontrolled atmosphere came to characterise the town. As the original Bajuni settlers lost their land, and the economic base of agriculture and fishing declined, mass tourism further undermined Swahili

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66 Hunt, Charles.W., "Migrant Labor and Sexually Transmitted Disease: AIDS in Africa," in the Journal of Health and Social Behaviour, Vol. 30, December 1989,p.356.

67 Ibid.

cultural and social values.[68]

Parents lost control over the conduct of their offspring, many of whom worked on the margins of the tourist industry. The use of legal and illegal drugs became commonplace in Watamu, but it was the introduction of 'brown sugar' in the 1980s, which wreaked havoc on a section of the community. Even if the drug problem is not common knowledge outside the Swahili community, prostitution and the probability of a high rate of HIV are. Yet little or nothing has been done to raise AIDS awareness.

The failure of the Bajuni to establish a secure footing in the formal tourist industry left the field open to Kenyans from other parts of the country. Luo and Kikuyu came from up-country to work in the hotels. The original Swahili settlers saw little value in the land they had settled, and allowed the newcomers to occupy and buy plots. There was an influx of independent traders, craftsmen and prostitutes.[69] Beckerleg's study shows that more than 60 per cent of the people questioned in Watamu counted themselves as migrants. Her work warrants other such studies to prove the hypothesis that areas which have a high number of migrants also have high rates of AIDS/HIV prevalence.

Conclusion

The spread of HIV infection is linked with poverty, high levels of preventable diseases, inadequate resources for health, rapid urbanisation, commercial sex and the prevalence of sexually transmitted diseases. No such society can avoid the epidemic. Several studies in Tanzania, Kenya,

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68 Beckerleg, Susan., "'Brown Sugar' or Friday Prayers: Youth Choices and Community Building in Coastal Kenya", in African Affairs, Vol. 94, No. 374, January 1995, pp. 35-36.

69 Ibid., p.25.

Zambia and Uganda have shown high levels of sexually transmitted disease and HIV among long-distance truck drivers and their assistants, commercial sex workers, bar and guesthouse workers, miners, fishermen, soldiers, migrant labourers and smugglers.[70] The results from these studies prove that for the developing world, there can be no doubt that HIV and AIDS are the major challenge of the 1990s and the next century.

There will not be a decline in the total population, but the HIV epidemic could significantly reduce the rate of population growth by the year 2005. The death of many young adults in Kenya could have critical effects. Many of those affected will be the skilled and educated persons in the workplace and this will impact on productivity and training. This will be particularly critical since an agrarian economy relies on a healthy labour force to sustain itself.

According to Dr. Martin Kayo, a programme manager for the National AIDS/STD Control Programme in Kenya, Policymakers around the world are beginning to develop a greater awareness about the potentially devastating health aspects of HIV/AIDS. Mathematical models have shown that AIDS is not only likely to affect adult mortality rates, but also child mortality rates, the corresponding spread of tuberculosis and the number of children orphaned by parents dying of AIDS. Despite this greater understanding about how AIDS is to affect demography, many policymakers still do not have the information needed to understand what AIDS is likely to mean in terms of real human impact. In fact, it is unlikely that HIV/AIDS will be made the priority that it needs to be unless policymakers understand that HIV/AIDS is intricately linked to a

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70 For instance: Mbugua, G. G., Muthami, L.N., Mutura, G.W., et al., "Epidemiology of HIV infection among long-distance truck drivers in Kenya", in the East African Medical Journal, 1995, Vol. 72, pp. 515-518.

country's national development.[71]

As the world's population grows, differential pressure on ecosystems will invariably lead to larger and larger population movements, both within and between countries. Population policy, environmental protection, and economic development may provide the long-term answer to many problems brought about by migration.

The results of a conference on 'Migration and AIDS', suggest that in the short-term, a policy of providing accessible and acceptable basic health and social services to migrants at their destination has a chance of creating the sense of security and the sense of community that is necessary for health. As long as migrants are excluded from community life and victimised as the carriers of HIV, they will continue by default to organise themselves into anti-communities driven only by the need for daily individual survival. Rapid spread of HIV is one of the consequences of this type of dysfunctional social organisation. However, if we understand the migration routes, the profile of the migrants, their motivation, and their needs, we can decrease their vulnerability to HIV and other disease.[72]

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71 Kayo, Martin., in AIDS in Kenya: Socioeconomic Impact and Policy Implications, U.S. Agency for International Development & Family Health International, 1996.

72Migration and AIDS-a symposium at the European Conference on Tropical Medicine, Hamburg, October 22-26,1995, published by J Decosas, F Kane J.K.Anarfi, K.D.R.Sodji & H.U.Wagner as "Migration and AIDS", in The Lancet, Vol. 346, September 23, 1995, p. 828.