MIGRATION AND HIV/AIDS; IMPLICATIONS FOR NASARAWA STATE: A CASE STUDY OF LAFIA NASARAWA STATE NORTH CENTRAL NIGERIA

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ABSTRACT

The tendency for populations to migrate urban areas back to rural places is in evidence in Nigeria, this is a situation where migration to Urban areas was for social economic motives especially employment, education, and health. This can play a significant role in redistribution and equalizing the spread of Hiv/Aids in different places and the implications might manifest rapidly and severely. By ascertaining the role of migration in equalizing the rates, it may help decision makers have clear objectives and target systems that contain the epidemic within the area. Two data sources were used to ascertain the relationship between migration and health; two hundred and thirty (230) copies of questionnaire were distributed to adult's men and women. It was established that there is relationship between migration and health particularly those that travel without their partners. Strategies to enable more frequent contact between migrant's men and women with their families should be encouraged in the study area.

Keywords: Migration, HIV/AIDS, Implications and Nasarawa State

INTRODUCTION

Migration- is the permanent or semi-permanent change of residence from one administrative unit (district, country, province, state or country) to another (Udo 1982). This movement may involve short distance of less than 100km to over 1000km. Migration has been under studied relative to the extensive international research literature on mortality and fertility. Nevertheless, a body of migration work in demography exists, as it does within other disciplines including anthropology, economics, history, law, political science and sociology. While many research questions would benefit from a cross-disciplinary approach and perspective, work that draw on two or more disciplines remains relatively rare. (Brettel and Hollifield 2000). The literature on migration in Africa or Sub-Saharan Africa derives from a range of disciplines, yet little attention is paid to intra-household dynamics, and the macro patterns of migration in Africa is limited by the dearth of national data for quantitative research (Posel 2002). Study on migration and health in some part of Africa has focused largely on tuberculosis and pneumoconiosis suffered by migrant mine workers in areas where mining activities has been carried out for decades as well as from other labour – producing countries in the sub- continent. Recent work has focused on migration and HIV/AIDs (Jochesson *et at* 1991, Lurie *et al* 1991, Lurie *et al* 2000). Given the complete nature and relationship between migration and health, and HIV/AIDs epidemic still on the increase, more policy-relevant research is urgently needed. Health and demographic surveillance system is imperative which

will enable us to measure and track temporary and permanent migration over time, and to link these moves with mortality trends and cause of death data. The trends in migration out of surrounding rural areas from 1998 to 2008, a decade spanning major socio-political transitions as a result of creation of Nasarawa State with capital in Lafia. The paper goes further to examine both negative and positive health outcomes of migration. There are complete relationships between migration and health which operates in both directions and is mediated by socio-political factors, environment and diseases exposure. These relationships can produce either positive or negative effects on both the migrant himself as well as on the family and household members. In order to explore migration as a risk factor, information is needed on the type of migration and reasons for it, factors in both the sending and receiving communities, including political, socioeconomic, cultural and environmental factors, diseases prevalence dietary and lifestyle factors and the integrity or fragmentation of social network. The main purpose of migration is basically economic; a move for work is likely to result in increased income and hence better nutrition and ability to access health care. Education may be more readily available and of higher quality in more developed areas where employment opportunities are readily available. Certain job, however, expose workers to particular occupational hazards, e.g. tuberculosis, pneumoconiosis and accidental work place injury experienced by migrants. Temporary circular migration leads to family breakdown, fragmentation of social networks and psychosocial stress. Extended sexual networks result in sexually transmitted infections (STIs), including HIV/AIDs, which affect temporary migrants themselves as well as their permanent partners residing in the sending communities. Commercial sex workers based in these areas or places employing temporary migrants bear heavy burden of sexually transmitted diseases and HIV/AIDs infections.

Temporary female migration, apart from increasing household's income through remittances, and results in the need for alternative childcare arrangements. Where social networks through extended family are strong enough to assume these child care responsibilities, the net effect of female migration on children can be positive. Children may experience neglect following migration of their mothers. In addition single female migrants will be discouraged from getting married as a result of contact with men at the areas of destination. New emerging infectious diseases, as is currently the case with severe acute respiratory syndrome (SARs), can spread rapidly across the globe due to extensive international cross-border travel. In situations of forced migration, whether internal or cross border, population are often vulnerable and at added risk. Forced migration can be consequent on conflict and war, political or religious persecution, economic hardship, famine and other natural disasters. Population forced to migrate may be compromised by experience precipitating their movement. These may include violence and psychological stress, lack of food, and breakdown of health services. Their mental and physical state at the time of departure, the length and difficulty of their journey, conditions at their destination will all impact on the health of forced migrants. Exposure to new pathogens in the host community together with other crowding, poor nutrition and inadequate health care can result in outbreak of epidemics. In 1994, an outbreak of cholera around Rwanda refugees in Goma, Eastern Zaire resulted in an estimated 12,000

deaths (siddique *et al* 1995). Movement of populations from non-malaria areas to destinations with endemic malaria results in high morbidity and mortality burden consequent on the absence of natural immunity.

MIGRATION AND HIV/AIDS

Temporary migration and HIV infection is affirmed by several authors in South Africa and other parts of Sub-Sahara Africa (Nunn, *et al* 1995), (Pison, *et al* 1993, (Decosas, *et al* 1995), Quin, 1994) (Basset, 1992). Mobility increases the risk of HIV and other sexually transmitted diseases seemingly because migrants are more likely than non-migrants to have additional sexual partners (Lurie, *et al* 1997). This situation can be exacerbated by rural migrants experiencing emotional instability on exposure to the urban environment, which can lead to 'temporary solutions in serial and potentially high-risk sexual relationships' (Evian, 1995). Syphilis was spread in this way throughout Europe, especially in the nineteenth century at the time of industrialization and rapid urbanization. As in Africa, job opportunities attracted people from the rural areas who were particularly susceptible to multiple partnerships and sexually transmitted infections (Shorter, 1992). While the link between circular migration and increase risk of HIV infections was supported by a variety of literatures, identification of gaps in our understanding was done by Lurie who explain the implication for rural communities to which the migrants regularly return and also reports an increase in the frequency contact between labour migrants and their rural partners, both at work and in the rural setting, due to improved transport infrastructure and other factors which include working conditions. This indicates that the link between migration and HIV transmission may be more complex, and research in this aspect is needed to understand the dynamics of this epidemic in both the rural and urban areas as well. The aim of this paper is to establish relationship between migration and health in the study areas and occurrence.

THE STUDY AREA

Lafia apart from being the headquarters of Nasarawa state is also the headquarters of Lafia Local Government Area created in 1976. The area has two development areas created out of the local government in 2002 which include lafia north with headquarters at Shabu and Lafia east with headquarters at Assakio respectively. The total population of Lafia was about 78,247, 90,317, and 329, 922 in 1991, 1996 and 2006 respectively (National Population Commission Lafia 2009). The dominant tribes in the area are Kanuri, Alago, Eggon and Hausa including other indigenous tribes from various Local Government areas that make up the state, also settlers from neighboring states and other parts of the country were in evidence. The major occupations of the people in the area include local craft such as blacksmithing, calabash decoration, cap making and clothes designs.

MATERIALS AND METHOD

Two data sources were used in this paper to examine the relationship between migration and health. These are primary and secondary sources of data collection. Primary source was from the health and demographic surveillance system of Lafia health and population unit. The secondary source was a specialized survey based on the examination of the partnership and risk perceptions of a sample of migrants and non-migrant men and women – variables such as household size, occupation,

marital status, level of educational attainment, reasons and period of migration and the perception of relationship between migration and health. This will indicates and give ample opportunity to intervene and curb the acceleration of the epidemic in the study areas. A random sample of 230 men and women aged 20-49 was drawn from the study area. Field work was concentrated over the weekend's period to increase the chances of contacting migrant at home. The survey interview was conducted using questionnaire covering the most sensitive aspects of sexual partnership practices. A total of 230 interviews were conducted.

Table 1: Occupation of House Hold

	RURAL	
Migrants	No	%
Civil Servant	150	65
farming	30	13
Trading	30	13
Private sector employee	20	9
Total	230	100

Source: Field work 2009

Figure 2 shows that civil servants dominate in area because of the nature of activities in such areas. What determined mostly the extent of occupation in an area is the nature of activities taken place in that particular area. This clearly indicates the nature of economy of rural and urban environment of Nasarawa state and other urban centers in Nigeria operates.

Table 2: Marital Status

	RURAL	
Marital Status	No	%
Single	15	6
Married	170	74
Divorced	30	14
Widow	15	6
Total	230	100

Source: Field work 2009

Marital status of the sampled respondents shows that 74% are married in area, only 14% and 25% are divorced but the question remained that those married in the course of movement leave their partners at home and may have contact with other sex partners at the area of destination which has health implication when they return home.

Table 3: Level of Education Attainment

	RURAL	
	No	%
Primary School	25	11
Secondary School	60	26
Tertiary	102	44
Non	43	19
Total	230	100

Source: Field work 2009

Table 2 revealed that those people that have attended tertiary institutions dominate with 44% and those that attended either primary or secondary education were also significant in the area. These very clearly indicate that people interviewed should be aware of the implications of the relationship between migration and health as it affects their health status in the area where they come from.

Table 4: Migration Types

	RURAL	
	No	%
Daily	40	17
Weekly	79	34
Monthly	89	39
Permanent	22	10
Total	230	100

Source: Field work 2009

Table 6 revealed that monthly and weekly migrants dominate in the area with 39% and 34% respectively. This migrant that move either daily, weekly or monthly are likely to have health implications in their source region, and are also likely to have contact with other women who have serious health implications when they return and have contact with their partners at home.

Table 5: Perception of the Relationship between Migration and Health

	RURAL	
	No	%
Very high	30	13
High	168	73
Low	28	12
None	4	2
Total	230	100

Source: Field work 2009

From table 5, it clearly shows that 73% of those interviewed in the area are aware of the relationship between migration and health. This can be attributed to the educational attainment of house hold interviewed.

Table 6: Types of Diseases

	RURAL	
	No	%
HIV/AIDs	200	87
Syphilis	18	8
Others	12	5
Total	230	100

Source: Field work 2009

Majority of people interviewed have accepted that HIV/AIDs is the major disease migrants encountered as a result of having sex during the period of movement, 87% of respondents interviewed in the area agree that HIV/AIDs is the major disease. However, syphilis and other types of sexually transmitted diseases are not so pronounce. This is a clear indication of the relationship between migration and health and its negative consequences on both the receiving and sending communities.

Table 7: Migration with Partners

	RURAL	
	No	%
YES	105	46
NO	125	54
Total	230	100

Source: Field work 2009

Table 7 indicates that 54% of those interviewed migrate without their partner in the area; however those migrants who move with their partners are also significant. Those that move with their partners may be respondents that are aware of the implication of migration and health and doesn't want to take chances.

CONCLUSION

Migration, particularly temporary migration is more pronounced patterns of movement, since migration is articulated with development and survival strategies, Intractable high levels of male/female labour migration coupled with frequent home visits and low level of personal HIV risk perception in the area indicate the potential spread of HIV in this setting as explosive. Extensive sexual networks of men and women employed and migration patterns indicate probably high levels of HIV transmission within the area. Strategies to enable more frequent contact between migrant's men and women with their families should be encouraged in the area. The relationship between migration and health needs to be further explored and better understood if the negative impacts of migration are to be successfully mediated by health and social development interventions.

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