

LINKING MIGRATION, HIV/AIDS AND
URBAN FOOD SECURITY IN SOUTHERN
AND EASTERN AFRICA

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Editorial Note

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1.1 Introduction

This publication seeks to establish a background for understanding the complex and dynamic linkages between urbanization, migration, HIV/AIDS and urban food security in Southern and Eastern Africa (SEA). As urbanization accelerates, direct food transfers from rural areas are increasing as poor urban households seek to reduce their vulnerability to high food prices and a cash-intensive urban existence. At the same time, urban households or individual migrants remit money back to households in rural areas both inside and outside the country of employment. A significant proportion of remittances are used for consumption purposes, including the purchase of food.¹ These processes are underwritten by various forms of rural-urban, cross-border and circulatory migration.

Migration has clearly facilitated the rapid spread of HIV in the SEA region over the last two decades.² For a number of reasons, migrants and other mobile people are especially vulnerable to HIV/AIDS. The epidemic, in turn, is leading to new forms of migration, including children's migration and return migration of PLWHAs (People Living with HIV and AIDS) to rural areas.³ Not only does this lead to a decline in remittances but it places a greater burden on rural households. Rural food production for urban household members may also be negatively affected by the impact of HIV/AIDS on rural producers. In the context of HIV/AIDS, migrants themselves may be unable to pursue other food security avenues, including urban agriculture.

As HIV/AIDS creates both short term and long term intergenerational impacts within the framework of its long wave epidemiological pattern, the

development context is changing considerably. In order to formulate appropriate policy responses, it is therefore imperative to understand the complex linkages and transfers of people and commodities which characterize the “new social economy of migration” in the SEA.⁴ At the same time, it is important to understand the inter-related connections between migration and HIV/AIDS for two basic reasons. First, migrants are a particularly vulnerable group, both to HIV infection and to resultant food insecurity. Second, a disease which eats away at the fabric of the new social economy of migration will severely test the ability of urban and rural areas to provide a secure food supply for their populations, both at the aggregate and household levels.

It is against this backdrop that this publication documents the key dimensions of the complex connections between urbanization, migration, HIV/AIDS and food security. There is an existing and growing literature on some of these connections; between migration and HIV/AIDS, for example, and between HIV/AIDS and rural food security. However, the linkages between HIV/AIDS and urban food security are less well-established. In addition, attempts to link both HIV/AIDS and urban food security simultaneously with migration are only now being considered, and this project is the first to examine these dynamics at the regional level. That task is rendered more challenging by the fact that migration itself has been undergoing rapid changes in form over the last decade.

The publication is divided into three sections. It is designed to lay the foundation for further discussion and the articulation of a targeted action research agenda which addresses both the knowledge gaps and the policy and programming needs of the region in this field of development.

This paper begins by reviewing the literature on urbanization and migration in SEA, showing how rapid urbanization is not eliminating migration but intensifying its scope and scale. The section also provides an overview of the HIV/AIDS epidemic in SEA and seeks to establish the reciprocal connections in the HIV/AIDS and migration nexus. Finally, the section reviews current evidence on the determinants of food security in urban areas.

The second chapter focuses on the links between migration and HIV/AIDS, migration and food security, and HIV/AIDS and food security. Research on these sets of linkage is proceeding apace although much more is known about the impact of HIV/AIDS on rural than urban food security.

The third chapter draws together these sets of relationships and outlines the key knowledge gaps and emerging research questions for the region. Although the research literature is not yet developed in this regard, various conceptual models have been devised to help understand these relationships. Although

some of these models focus on rural food security and some on urban, this paper argues that the distinction is artificial, and that migration is the “missing link” between the urban and the rural. Migration links the rural and the urban social economies and emphasizes the point that urban food security cannot be isolated from rural food security and vice-versa. Finally, the paper proposes some next steps in developing a fully fledged and policy-relevant research agenda.

1.2 Urbanization and Internal Migration

Urbanization is defined as the process by which an increasing proportion of a country’s population lives in urban areas over time. By this definition, Sub-Saharan Africa (SSA) is urbanizing faster than any other region. Although the urban transition has been relatively recent, more than 50% of SSA’s population should be living (permanently or temporarily) in urban areas by 2030.⁵ Indeed, the urban population of SSA is set to more than double between 2000 and 2020, from 217 million (34.3% of total population) to 487 million (46.2% of total population).⁶ The growth in urban population in many countries of the SEA region has been dramatic between 1990 and the latest census. Although relative changes cannot be compared outright due to the variable time periods involved, rates are relatively modest for countries such as Botswana and Zambia but reach as high as 6% for Mozambique (Table 1).

As illustrated in Table 1, for selected countries of SEA, urban growth rates exceeded population growth rates for the period 1990-2003. For the 21 year period between 1982 and 2003, urbanization increased significantly in most countries, with rates more than doubling for Botswana, Kenya, Lesotho and Mozambique. This massive growth is reflected in the expansion of the number and size of mega-cities. By 2010, SSA will have at least 33 cities which exceed a million people. Metropolitan Johannesburg – the second largest mega-urban region at 3 million – will be at the core of the Gauteng region, which is expected to reach 20 million by 2020.⁷



Table 1: Population and Urban Growth Rates 1990-2003 and Urbanization 1982-2003				
Country	% Population Growth Rate 1990-2003	% Urban Growth Rate 1990-2003	Urban Population (% of total) 1982	Urban Population (% of Total) 2003
Botswana	2.3	3.6	22.5	50.3
Ethiopia	2.3	4.4	10.9	16.6
Kenya	2.4	5.6	17.6	36.3
Lesotho	1.0	4.2	14.6	30.3
Madagascar	2.9	5.1	19.5	31.4
Malawi	2.0	4.4	9.6	15.9
Mozambique	2.2	6.2	14.6	35.6
South Africa	2.0	3.5	48.2	59.2
Uganda	2.9	5.3	9.2	15.3
Zambia	2.2	2.4	39.8	40.3
SSA	2.5	4.6	21.8	36

Source: Kessides⁸ based on World Development Indicators 2005

Within countries, rates of urbanization in major cities commonly exceed 4 to 5% per annum. The average primate city had annual growth rates of 5 to 6%, for example, while some saw rates of 10%, which means a doubling of city populations every ten years (less if annual increases are compounded).

There are four main drivers of urban growth in SSA: natural increase from existing urban residents; reclassification of rural as urban areas; internal rural-urban migration and international (rural-urban and urban-urban) migration. Most of the anticipated growth in the size of cities and towns over the next three decades will occur because of the transformation and reclassification of formerly “rural” settlements on the peripheries of major cities and because of natural increase within cities. Although migration is not the central driver for rapid urbanization, it plays a major role in the growth of cities as well as in strengthening the linkages between rural and urban areas and between the cities of the SEA.

Significantly, circular migration is still the dominant form of migration in most African countries. Traditional one-way movements from rural to urban destinations are much less important than circular and seasonal migration.⁹ In other words, the census-based urbanization figures for countries shown in Table 1 include significant numbers of people who are living temporarily in the cities and who maintain a rural home or base which they return to on a regu-

lar basis and keep in close contact with. In West Africa, for example, Gugler recently replicated a Nigerian study he originally carried out in 1961 and found not only that urban-rural ties continue to be strong but reach beyond immediate kin to kinship groups, non-kin groups, villages and larger political entities. He argues that these ties are prevalent throughout Africa and that rural-urban migrants who maintain them and incur their costs are motivated by “present or future material rewards, political opportunities, social status and cultural commitments.”¹⁰

In order to maintain strong social relations within the village, migrants still spend time in villages for weddings, funerals, harvests and business, followed by the necessity to spend more time in town to acquire more cash. The circular nature of this constant movement back and forth signifies “the simultaneous and overlapping presence of urban and rural spaces in migrants’ lives.”¹¹ The circular nature of rural-urban migration is also highlighted in several recent Southern African studies. In Zimbabwe, by 1994 only half as many migrants as in 1988 felt their future lay in Harare, indicating increased insecurity around urban life, employment and earning potential among in-migrants.¹² The importance of rural-urban social relations is also highlighted in Andersson’s study of Buhera migrants in Harare.¹³ He argues that the social security of rural-urban migrants is not spatially situated in rural agricultural production but rather socially situated in the rural-urban network. These networks are expressions of socio-cultural dispositions and are a more appropriate lens through which to view the motivation behind migration.

In Lilongwe, although rural-urban migration seldom results in permanent urban residence, migrants frequently spend periods of time in urban areas in order to improve conditions of life in villages.¹⁴ In South Africa, one study emphasizes the resilience of urban-rural links even when the rural areas are so impoverished that they provide little by way of a livelihood for rural households.¹⁵ In this case, migration centres on basic needs and income security, with job-related migration just one aspect of migrating families’ search; infrastructure, social capital and institutional climate all influence migration demand. The results of the study indicate the instability of KwaZulu-Natal’s rural population, rooted in the collapse of the natural resource base, overcrowding, violence, dispossession and hardship.

There is evidence that secondary cities have become important destinations for migrants. In Tanzania, migration during the 1980s targeted smaller towns (20,000-50,000 population) – where it was easier for urban households to secure food – over larger and primate cities.¹⁶ Similarly, Owuor’s study on urban rural-links between the secondary town of Nakuru in Kenya and its rural



hinterland demonstrates that urban-rural linkages are not only important for rural households, but are becoming an important element of the livelihood (or survival) strategies of poorer urban households.¹⁷

There is also evidence that circular migration between rural and urban areas is increasing due to high costs in the city.¹⁸ For many of the disenfranchised, such as landless peasants or those exposed to shocks of violence, deprivation and uncertainty, rural-rural migration is quite significant.¹⁹ Significantly, the Namibia Migration Project found that at the national level, rural-rural migration accounted for half of all internal lifetime mobility.²⁰ It is important to recognize, therefore, that rural and urban boundaries are artificial distinctions to extended or “stretched households”, who often disperse members widely to different spaces, locales and economic activities in order to support sustainable livelihoods.²¹ This mobility allows individuals and families to gain new experiences and income that can be used when, where and however they decide, according to collective and individual strategies. While the household is increasingly “stretched” spatially, it is also differentiated internally, not least along gender lines.

The gendered nature of migration drivers and processes needs to be recognized. Internationally, the “feminization” of migration refers more to shifts in the character of women’s movements, rather than a dramatic increase in numbers (which have always been greater than traditionally recognized). In SEA, there are both qualitative and quantitative changes in internal migration under way. The absolute number of female migrants has been increasing rapidly. But the reasons for migration have also been shifting and diversifying.²²

Gender and age are significant in migration decision-making and selectivity.²³ Where home employment opportunities are limited, women may be more apt than males to migrate for employment in order to support other household members. This migration may also afford women an escape from social and family constraints and provide them with greater independence.²⁴ In addition, young men with limited access to family land and waged work may also be driven to migrate.²⁵ Within Southern Africa, for example, more women are entering the work force and more women are becoming household heads and these factors are helping to drive female migration. In South Africa, women comprised 30% of the African adult labour migration population in 1993, and this had risen to 34% by 1999. Between 1997 and the year 2000, the proportion of females among temporary migrants increased from 15% to 25% for older adult women and from 5% to 15% for young adult women – both significant increases within a short three year period.²⁶ The primary destination for young adult women, older adult women and female children is the

province of Gauteng, which is the industrial heart of South Africa. Women are also moving their families out of rural villages into nearby small towns on a permanent basis.

Data from 2002 reveals that the three main prompts for permanent internal migration of adult females are at the start or end of marriage, a move to a new dwelling for the household or a move to live with another partner.²⁷ The predominant driver for temporary female migration in 2002 was for work, which constituted the reason for more than 80% of moves of women aged 35 and older. Other reasons for temporary migration included for school/study and to live with another.²⁸ In Namibia, the increase in female migration to Windhoek over the past ten years, and the fact that urban female-headed households are poorer on average than any other household type, both indicate the feminization of rural poverty.²⁹

Chronic poverty is no longer an exclusively rural problem, however, but is increasingly concentrated in urban areas. In SEA, the urban poverty rate is within 20% of the rural rate in Ethiopia, Kenya, Malawi and Mozambique. At present, at least one third or more of the urban population in Ethiopia, Kenya, Madagascar, Malawi, Mozambique and Zambia is poor.³⁰ Increased pauperization, combined with rapid urbanization, has created massive growth in the slum population of Sub-Saharan Africa as a whole. Between 1990 and 2001, the African urban slum population increased by 65 million, at an average annual rate of 4.5% compared with a total population growth of 2.7%. By 2001, 166.2 million people, or 72% of Sub-Saharan Africa's urban residents, were living in slums. Based on these estimates, and without effective interventions, the continent's slum population may double every 15 years, compared with a total population doubling period of 26 years.³¹

Problems of insecure tenure, overcrowding, and lack of clean water and sanitation and resultant health problems are severe and add to social and economic vulnerability of urban residents. National and municipal governments are under severe pressure to handle the implications of rapid urbanization with respect to basic service provision, housing, transportation, health care, education and employment – all of this within the constraints of economies debilitated by the impacts of structural adjustment programs, globalization, and the impact on the labour force and social systems of HIV and AIDS.

Much of the literature on internal rural-urban migration to date has concentrated on the remittance of urban goods and cash to the rural areas, with little note being taken of social linkages or rural-urban flows of cash, goods and produce.³² From the perspective of rural livelihoods, many researchers have made the argument that environmental stress due to high population growth



fuels rural-urban migration in the context of declining agricultural output.³³ Migration, then, is a means by which rural households can diversify their economic base.³⁴ The ways in which rural and urban households are mutually tied by social links and relations of reciprocity are not well-articulated in the literature.³⁵ The new social economy of migration needs to be better understood before the implications of HIV/AIDS for food security can be grasped.

1.3 Cross-Border Migration

SEA has a long history of cross-border intra-regional migration, dating back to the mid-nineteenth century. These movements tended to be rural-urban in character but also include urban-urban movements and, particularly in border zones, rural-rural movements. Longstanding patterns, forms, and dynamics of migration have undergone major restructuring in the last three decades with considerable implications for livelihood strategies of the poor and for poverty reduction policies. These changes include the following:

- The end of colonialism and apartheid, which were political systems designed to control internal migration and exclude most outsiders, have produced new opportunities for internal and cross-border mobility and new incentives for moving.
- SEA's integration into global and continental labour markets and trade networks has opened the region up to forms of migration commonly associated with globalization (such as temporary work schemes and skills migration.)³⁶
- Growing rural poverty has pushed more people out of rural households in search of a livelihood.
- Environmental factors (including climate change, natural disasters and land degradation) continue to cause hardships and shocks which push people out of rural areas.
- Economic and political crisis and growing unemployment in some states have forced people to seek work in other countries.
- The feminization of poverty in rural SEA has produced a significant gender reconfiguration of cross-border migration streams.³⁷
- The countries of the SEA have experienced recurrent waves of forced (refugee) migration over the last three decades. The cessation of threat confronts countries of origin and asylum with issues of repatriation and integration of returning migrants.

According to the latest UN estimates, there are more than 14 million international migrants in Sub-Saharan Africa. East Africa hosts 4.4 million international migrants, many of whom are refugees from Ethiopia and the Sudan.³⁸ Within Southern Africa, the number of foreign-born migrants in South Africa was over 1 million in 2001. Short-term legal visitors to South Africa from other Southern African Development Community (SADC) countries also increased more than tenfold after 1990 to more than seven million per year at the present time.³⁹

The states of SEA are conventionally divided into migrant-origin (e.g. Mozambique, Malawi, Lesotho, Zimbabwe) and migrant-destination states (e.g. South Africa, Botswana, Namibia). In practice, most states both send and receive migrants, though in varying numbers. Several international migration streams can be identified in the SEA. All have been undergoing significant change including:

- Restructuring of traditional contract labour systems
- Growth in the volume and complexity of cross-border mobility
- Declining levels of legal migration to and within the region
- Expansion in undocumented migration and human trafficking
- Increase in skills brain drain from the region
- Large-scale resettlement and reintegration of refugees
- Feminization of cross-border migration
- Growth in intra-regional informal cross-border trade
- Rapid urbanization and growing cross-border urban-urban migrant networks

Legal and undocumented cross-border migration throughout SEA has exploded in the last decade. The pressure on limited border control resources has been enormous with long delays and inefficiency experienced at many border posts. Corruption is an endemic problem at many posts as travelers seek to bypass cumbersome and time consuming bureaucracies and gain unlawful entry. In addition, the region has experienced a major influx from other parts of the continent as well as significant growth in tourism arrivals from overseas. Intra-regional tourism has also grown to significant levels.

The reasons for the new mobility are many and varied (Table 2). The majority of intra-regional migrants to South Africa do not, contrary to popular opinion, enter to work or to look for work. Representative SAMP surveys of migrants in 6 SADC countries reveal a multiplicity of motives.⁴⁰ Cumulatively, in 6 SADC countries less than 25% went to South Africa to work or look for work. However, there was considerable inter-country variation: Mozambique (67%),



Zimbabwe (29%), Lesotho (25%), Namibia (13%) and Swaziland (9%). Other major reasons included: visiting/tourism (Namibia and Swaziland 58%), Lesotho (36%), Mozambique (17%), and Zimbabwe (16%); and trading and shopping (Zimbabwe (42%), Lesotho (22%); Swaziland (12%), Mozambique (6%), and Namibia (3%). Other reasons included to study, conduct business, and seek medical treatment.

Historically, the primary form of legal cross-border migration for employment (labour migration) in Southern Africa was male migration to the mines of South Africa, Zambia and Zimbabwe, and the commercial farms and plantations of South Africa, Swaziland and Zimbabwe. By the 1990s, only the South African gold and platinum mines continued to employ large numbers of foreign migrants; other mining sectors in South Africa (such as coal mining) and elsewhere in the region (Zambia, Zimbabwe) had moved to a local and/or more stabilized workforce.⁴¹ During the 1990s, the South African mines experienced major downsizing and retrenchments which created considerable social disruption and increased poverty in rural supplier areas. The mines laid off local workers at a much faster rate than foreign workers. As a result, the proportion of foreign workers rose from 40% in the late 1980s to close to 60% today. This “externalization” of the workforce was particularly beneficial to Mozambique. Mozambicans now make up 25% of the mine workforce, up from 10% a decade ago (Table 3).

Reason for Entry	Country of Origin				
	Botswana %	Lesotho %	Mozam. %	Namibia %	Zimbabwe %
Work	7	17	45	11	15
Seek work	3	8	22	2	14
Business	6	2	2	8	7
Buy and sell goods	2	3	2	2	21
Shopping	24	19	4	1	21
Visit family	23	34	12	13	39
Medical	5	6	4	4	2
Holiday	14	2	5	19	3
Study	3	1	1	3	2
Other	12	8	2	12	3

Source: SAMP POS database at <http://www.queensu.ca/samp>

Year	Country of Origin					Total
	S.Africa	Botswana	Lesotho	Mozam.	Swaziland	
1990	232,338	14,497	98,788	43,951	16,618	406,192
1991	208,961	11,979	93,072	46,102	17,291	377,405
1992	185,177	12,000	92,727	49,022	16,157	355,083
1993	175,158	11,827	87,326	44,255	15,802	334,368
1994	170,876	10,939	87,248	49,250	15,101	334,414
1995	123,038	9,525	87,098	53,321	14,611	287,593
1996	126,762	9,608	80,485	54,891	14,241	285,987
1997	126,326	8,552	71,415	52,520	11,980	270,793
1998	104,483	7,229	56,132	49,507	9,518	226,869
1999	95,923	5,376	44,958	42,002	6,308	194,567
2000	95,146	5,373	50,472	44,245	8,079	203,315
2001	99,260	4,763	49,477	45,893	7,840	207,233
2002	115,824	4,227	54,154	51,355	8,697	234,257
2003	112,438	4,205	54,478	53,828	7,970	232,919
2004	120,146	3,924	48,962	48,918	7,598	180,586

Source: SAMP POS database at <http://www.queensu.ca/samp>

Remittance levels have remained stable in Mozambique but fell during the 1990s to many areas, especially Lesotho, Swaziland and the Eastern Cape. This has presented a major challenge for households formerly reliant on mine remittances. Poverty levels have increased, as have domestic and family tensions. Other family members, particularly women, have begun to migrate in response. Various efforts have been made to soften the impacts of retrenchments but the overall impact has been devastating for rural areas and households once reliant on migrant remittances.

The migrant stream that attracts most public, media and official attention is “undocumented”, “illegal” or “irregular” migration.⁴² Irregular migration tends to be driven by economic circumstances and, in some cases, desperation. Enforcement in all countries tends to focus on identifying and deporting violators. In terms of sheer volume, South Africa is easily the regional leader, having deported over one million people since 1994.⁴³ Significantly, the vast majority of deportees from South Africa (upwards of 80%) are sent home to only two countries: Mozambique and Zimbabwe. Studies of sectors where irregular migrants are employed have revealed consistent violation of labour standards,

sub-minimum wages, economic and sexual exploitation, and great instability and fear among migrants. These sectors include commercial agriculture in rural areas and construction, services and secondary industry in the cities.⁴⁴

SAMP research has shown that the majority of cross-border migrants in Southern Africa are also circular migrants.⁴⁵ In other words, although many migrants stay for longer than initially intended their visits are generally temporary not permanent. Across a whole range of indices, migrants prefer living in their own countries. The major migrant-receiving countries are seen as superior only in terms of employment and economic opportunity and, sometimes, health facilities. In every other respect – personal and family safety, educational opportunities, access to land, cultural life and so on – home countries are viewed as preferable. The obvious conclusion is that economic stability and growth at home would be the single most important factor in slowing labour migration across borders.

Like internal migration, cross-border migration in Southern Africa is profoundly gendered. In the colonial period, women were generally prohibited from migrating. As the primary reason for migration in the region was wage employment, men dominated internal and cross border migration. Today women and men are differently involved in and affected by migration. Although women are increasingly part of the movement of skilled migrants within the region and out of it, and have proportionally higher educational levels than male migrants, they are more likely to be involved in less skilled and informal work. They are also more likely to be irregular migrants, with attendant disadvantages, as it is harder for them to access legal migration channels.⁴⁶ Women are migrants in their own right, as well as partners of migrant male spouses.⁴⁷

A SAMP study found that male respondents were more likely to have been to South Africa than female (Mozambique: 41% of men and 9% of women; Zimbabwe: 25% and 20%; Lesotho: 86% and 76%).⁴⁸ But the reasons for migration tend to differ along gender lines (Table 4).

The main sectors of employment for women include agriculture (particularly seasonal work), domestic work, the service sector and trade. Men are more likely to have formal employment, particularly in the industrial (especially mining), agricultural and construction sectors. Women migrants were more likely to be disadvantaged by the migration experience than their male counterparts. They are more likely to be single or widowed, but less likely to be in formal sector employment or to own property than their male counterparts.⁴⁹ Migration is a significant livelihood strategy for women and women-headed households.⁵⁰ Although women constitute a significant part of cross border and internal migratory movement, they are also left behind as employment and earning opportunities favour men.

Table 4: Gender Differences in Migration to South Africa from 6 SADC States		
Purpose of Most Recent Visit to SA	% Males	% Females
Work	33	7
Look for work	17	3
Business	3	3
Buy and sell goods	4	10
Shop	13	23
Visit family/friends	17	38
Holiday	3	3
Medical	2	8
Other	8	5

Source: SAMP database, <http://www.queensu.ca/samp>

Another particularly common, and growing, form of women's migration is motivated by opportunities for trading in other countries. Indeed, the urban areas of the SEA are being increasingly integrated into transnational continental and regional informal trade networks.⁵¹ Informal traders or small entrepreneurs are amongst the most enterprising and energetic of contemporary migrants. Trading is a key means of livelihood for many households in some countries and needs to be better understood and, wherever possible, facilitated by policy changes governing entrance, exit and customs duties. Informal sector cross border trade is important to the transfer of goods and commodities in the region. Initial studies of informal cross-border trade in the region suggest that it:

- Is significant to the movement of food and agricultural goods in the region,
- Plays a role in regional food security,
- Plays a part in the development of small and medium enterprises,
- Is a household livelihood strategy particularly for female-headed households,
- Engages a significant number of women,
- Constitutes a significant proportion of cross-border traffic in the SADC and COMESA regions,
- Has been largely ignored by policy makers who have yet to engage with this trade.⁵²

However, more needs to be known and understood about the extent of informal sector cross border trade in the region and its role in livelihood strategies and food security, and an income earning opportunity for women. Further research is required to better understand the relationship between these entrepreneurs their businesses, poverty alleviation, agricultural commodity and consumption chains and food security. Furthermore, research could inform the development of training programs to enable them to develop their businesses as well as access financial resources.

Cross-border migration has a strong relationship to poverty, social exclusion, and poverty alleviation.⁵³ Data on the remittance behaviour of cross-border migrants and receiving households is limited. Similarly, little information is available on their impact on national economies, economic development, inequality and financial systems in the region.⁵⁴ Furthermore, remittances in the form of goods are not recorded. Data on cash remittances is hard to gather as foreign exchange regulations, weak financial infrastructures and high transfer costs in formal systems encourage the use of informal channels for transferring money.

Despite the lack of reliable data, it is apparent that remittances to home areas do contribute significantly to household livelihoods and food security. Remittances may be in goods or cash. Remittances can play a key role in the livelihoods of migrant households allowing for social, or human capital investment in education, health and housing and food. They may also be used as capital to invest in income earning household inputs and to capitalize entrepreneurial activities.

1.4 The HIV/AIDS Epidemic

As Iliffe and Gillespie have both indicated, AIDS epidemics are multi-dimensional, long-term, phased phenomena.⁵⁵ The first wave of HIV infection is followed by a wave of opportunistic infections, tuberculosis being the most common. The onset of AIDS illness and death occurs several years later. In the final stage, depending on the prevalence of the disease and availability of treatment, there is an accumulation of macroeconomic and social impacts at household, community and national levels. At the local level, Barnett and Topouzis identify three main stages that a community may pass through: ⁵⁶

- a) AIDS initiating; with very low HIV prevalence rates and no AIDS impacts,
- b) AIDS-impending; where HIV prevalence rates are rising but most infected

people are still in the asymptomatic phase before becoming ill, and

- c) AIDS-impacted; when households and communities feel the impact of AIDS as infected people succumb to AIDS-related illnesses and eventually die.

In the context of the global epidemic, Africa remains the most affected region, with 25.8 million people living with HIV (Table 5). Even though Africa is home to just over 10% of the world's population, two thirds of people living with HIV are in Africa, as are 77% of all women with HIV. In 2005, an estimated 2.4 million adults and children died from AIDS-related illnesses and another 3.2 million became infected with HIV.

Year	Adults & children living with HIV	Adults & children newly infected with HIV	Adult prevalence (%)	Adult & child deaths due to AIDS	No. of women (15-49) living with HIV	% HIV-infected adults (15-49) who are female
2005	25.8 million	3.2 million	7.2	2.4 million	13.5 million	57
2003	24.9 million	3.0 million	7.3	2.1 million	13.1 million	57

Source: Compiled from UNAIDS, 2005

Declines in adult national HIV prevalence have been recorded in just three countries: Kenya, Uganda and Zimbabwe.⁵⁷ Life expectancy for people living in eight countries (Angola, Central African Republic, Lesotho, Mozambique, Sierra Leone, Swaziland, Zambia and Zimbabwe) is forty years or less, largely due to the HIV/AIDS pandemic. In 20 countries, average citizens are poorer today than they were a decade ago and in 11 countries more people go hungry than they did a decade ago.⁵⁸

Table 6 shows the number of persons living with HIV/AIDS and emphasizes the fact that even where prevalence rates are much lower, hundreds of thousands to millions of people are still affected. South Africa leads the way with 5.3 million persons, followed by Zimbabwe at 1.8 million, and then Tanzania, Ethiopia, Mozambique and Kenya, all of which are over 1 million, with Malawi and Zambia both approaching 1 million. Access to ARTs vary widely within each country: at least one third of those who need ART in Botswana and Uganda are receiving treatment, while in Zambia, Kenya, and Malawi 10-20% of those in need of ART were receiving it by mid-2005. Most needs

went unmet. In South Africa, by mid 2005, at least 85% of those who needed ART were not receiving any, and this figure was 90% or higher for Ethiopia, Lesotho, Mozambique, Tanzania and Zimbabwe.⁵⁹

As Table 6 shows, with the exception of Cape Town, urban HIV prevalence far exceeds national HIV prevalence and in many Eastern African countries the urban rate is two to three times the rural HIV rate. As established above, cities and towns are growing at exceptional rates, with rapid expansion of informal settlements. Hundreds of thousands of people are forced to live in conditions without basic services, security of tenure and in extreme overcrowding. These conditions enhance personal vulnerability and lead to much higher HIV prevalence.

Table 6: National and Urban HIV Prevalence in Southern and Eastern Africa, 2005			
Country	National HIV Prevalence Rate	Urban HIV Prevalence Rate	People Living With HIV/AIDS
Zimbabwe	21% (2004)	Harare 25%	1,800,000
South Africa	21.5% (2003 est.)	Cape Town 15% Durban 28%	5,300,000
Malawi	20%	Blantyre 28%	900,000
Mozambique	16%	Maputo 17.3%	1,300,000
Zambia	16.5% (2003 est.)	Lusaka 22%	920,000
Namibia	21.3% (2003 est.)	Windhoek 24%	210,000
Uganda	7%	Kampala >9%	530,000
Kenya	7%	Busia/Meru/Nakura/ Thika 9%	1,200,000
Tanzania	7%	Urban 11% (2x rural areas)	1,600,000
Rwanda	5.1% (2003 est.)	Urban 6.4% (rural 2.8%)	250,000
Burundi	6%	Bujumbura suburb 13%	250,000
Ethiopia	4.4%	Urban 12-13%	1,500,000
Somalia	0.6%	Mogadishu 0.9%	43,000
<i>Sources: UNAIDS 2005; The World Factbook 2005.</i>			

1.4.1 Southern Africa

Southern Africa remains the epicenter of the HIV/AIDS epidemic, with high HIV prevalence rates throughout the region, excepting Angola. The only national epidemic in the region which shows some evidence of ebbing is in Zimbabwe. Here, data from a national surveillance system shows that HIV prevalence among pregnant women dropped from 26% in 2002 to 21% in 2004 (although the role of unreliable government statistics in this decrease is not known). At 1.7 million people, and a poverty rate of 70%, the capital city of Harare has an overall HIV prevalence rate of 25%. However, HIV prevalence in women who attended antenatal or postnatal clinics dropped from 35% in 1999 to 21% in 2004 in Harare. Even though the rate of new infections could be slowing and mortality rates leveling off, 20% of pregnant women still test HIV positive and infection levels remain amongst the world's highest.⁶⁰ Nationally, life expectancy at birth dropped from 51.8 years in 1995 to 38.2 years in 2001. The WHO recently reported that Zimbabwean women now have the shortest average life expectancy in the world at 34 (compared with Zimbabwean males at 37). Although the WHO attributes this solely to HIV/AIDS, Zimbabwean doctors indicate that the failed health care system (in the midst of severe economic and political crisis) has meant that more women are dying from pregnancy and childbirth.⁶¹

In Bulawayo, the country's second largest city with a population close to one million, between 1990 and 2000, the overall death rate of 13.7 (per thousand population) had more than doubled, and HIV-related diseases were the leading cause of death in all age groups from 1 to 64 years.⁶² Between 1995 and 2001, life expectancy in Bulawayo dropped by more than a decade from 52.4 to 41.2 years.⁶³

The Zimbabwe situation has been further exacerbated by the Government's Operation Restore Order (Operation Murambatsvina), a major nationwide demolition and eviction program which started in Harare and spread to all other urban centres in 2005. With the demolition of thousands of homes, business premises and vending sites, it is estimated that 700,000 people lost their homes, their livelihoods or both, and indirectly another 2.4 million people were affected. Hundreds of thousands have been rendered homeless, without access to any basic services, and education for thousands has been disrupted. This disproportionately affected the poor and disadvantaged, who are now deeper into poverty and more vulnerable. Many of the sick, including those with HIV and AIDS, no longer have access to health care.⁶⁴ There is a major concern that increased vulnerability and population mobility, including



spousal separation and livelihood insecurity, could negatively impact the HIV/AIDS epidemic.⁶⁵

In South Africa, HIV prevalence among pregnant women has reached its highest level yet: 29.5% of women attending antenatal clinics were HIV positive in 2004.⁶⁶ More than one in three women aged 25-34 and almost one in three women aged 20-24 were estimated to be living with HIV. The worst-affected province is KwaZulu-Natal, with a prevalence of 40%, but prevalence is also high, between 27% and 31%, in the Eastern Cape, Free State, Gauteng, Mpumalanga and North West provinces. The incredible speed of the evolution of the epidemic in South Africa – with national adult HIV prevalence at less than 1% in 1990 increasing to almost 25% by 2000, has meant a concomitant increase in mortality: Death rates of those 15 years and older increased by 62% from 1997-2002 and deaths in the 25-44 age group more than doubled during that time. At present, South Africa experiences an estimated 900 deaths a day from the epidemic.⁶⁷ Urban HIV prevalence rates cover a wide range: Cape Town (population 2 million) has a prevalence of 15% while Durban (population of 3 million) has a 28% prevalence rate. The Actuarial Society of South Africa estimates that it will be another 10 years before the pandemic breaks.⁶⁸

Exceedingly high prevalence rates – often over 30% for pregnant women – are still recorded in Botswana, Lesotho, Namibia and Swaziland. In Swaziland, HIV prevalence among pregnant women increased from 34% in the year 2000 to 43% in 2004. Prevalence is even higher at 56% among pregnant women in the 25-29 year old group. Within Swaziland, there is little regional variance in HIV prevalence among pregnant women and the overall national HIV prevalence is 39%.⁶⁹ In Lesotho, HIV prevalence is 27% amongst antenatal clinic attendees, down slightly from 29% in 2003.⁷⁰ National HIV prevalence has reached 31%. Botswana also has a national prevalence rate of 39%, although national prevalence among pregnant women has remained between 35% and 37% since 2001, which may indicate some stabilization. For pregnant women 25 years and older, prevalence soared to 43% in 2003.⁷¹

Malawi experiences wide regional variation in prevalence from 7% in the central region to 33% at the southern tip, with national prevalence around 20%. Two negative trends here are increasing prevalence at rural clinics and rising prevalence amongst young pregnant women (15% for 15-19 year olds and 20% for 20-24 year olds).⁷² In Blantyre, with a population which exceeds 700,000 and an urban poverty rate of 54%, the HIV prevalence rate is 28%.⁷³

The epidemic in Mozambique is increasing, with rising levels in all regions

and an estimated increase in national adult HIV prevalence from 14% to slightly above 16% in the 2002-2004 period. In the capital city, Maputo, with a population of 966,837, HIV prevalence is 17.3%. Population migration and mobility is a driving force, since HIV is spreading faster in provinces which have main transport links with Malawi, South Africa and Zimbabwe. High infection rates are also evident in Gaza province, which borders Zimbabwe and South Africa, and is a major source of migrants for South African industry and farms, and in Sofala province, which is divided by Zimbabwe's main export route.⁷⁴

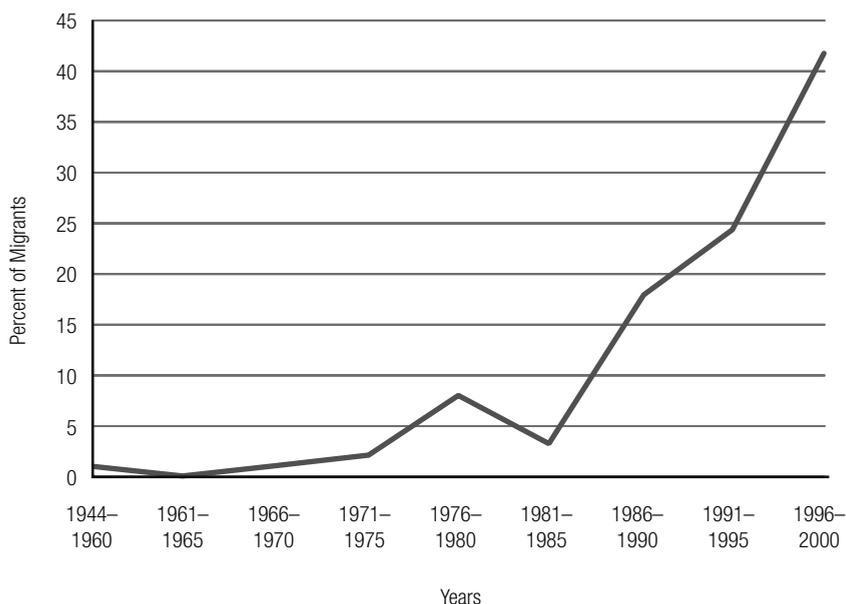
In Zambia, HIV prevalence among 15-44 year old pregnant women has remained at 18-20% since 1994. However, rising prevalence for 15-19 year-olds attending antenatal clinics between 1998 and 2002 indicate that new infections continue to occur at significant rates. In the capital city of Lusaka (population 1.6 million), there is a 52% urban poverty rate and an HIV prevalence of 22%. Altogether, urban residents are twice as likely as rural residents to be infected with HIV. The highest levels of infection are once again tied to population mobility and are tied to cities and towns situated along major transport routes. This includes Kabwe, Kapiri, Mposhi, Livingstone and Ndola, where 22-32% of pregnant women were HIV positive in 2002.⁷⁵

Angola has the lowest HIV prevalence rate within the region with an estimated 2.8% of pregnant women testing positive. However, the capital city of Luanda had reached a prevalence of 4.4% in 2004. A prevalence rate of 33% has been found amongst commercial sex workers, indicating potential for major epidemic growth.⁷⁶ The highest prevalence is located in the two provinces of Cunene and Kuando-Kubango, both of which share a border with Namibia, in a region where migration is significant.⁷⁷

There is considerable geographical variation in levels of HIV prevalence in Namibia, from 8.5% in Opuwo in the remote northwest, to 42% in Katima Mulilo, which is situated in the Caprivi strip which borders Angola, Botswana and Zambia, an area of high mobility. Some parts of Namibia therefore experience rates equivalent to the worst hit areas of Swaziland, Botswana and South Africa. The mobility of the mining and fishing labour force results in high rates in the coastal towns of Luderitz, Swakopmund and Walvis Bay (22%-28%).⁷⁸ Windhoek, the capital city (population 233,000) has a prevalence rate of 24%, and has experienced dramatic in-migration since independence in 1990, as illustrated in the graph below (Figure 1).



Figure 1: Rural-Urban Migration Trend for Windhoek: 1944-2000



Source: Frayne, B. 2001, note 4.

HIV/AIDS in Urban Southern Africa

Southern Africa has the highest HIV prevalence rates in the world. It is also home to 30% of all global persons living with HIV/AIDS. Botswana and Swaziland have the highest prevalence rates in the world at 39% and the only country that has shown any decrease in prevalence has been Zimbabwe, although these figures are questionable and also predate the impact of Operation Restore Order. HIV prevalence in urban areas is higher than national prevalence levels as are regions along borders and transport routes which experience high levels of mobility. These serious national AIDS epidemics are set to continue for some time.

1.4.2 East Africa

Turning to East Africa, although national prevalence within Uganda peaked at over 15% in the early 1990s, this has declined and may be the result of a major national campaign. At present, national prevalence lies at 7%, although it rises to 10% for Ugandans in the 30-39 year group. In urban areas in

Uganda, HIV prevalence among women was almost twice as high as men (13% versus 7.3%). Overall infection rates were highest for the capital city of Kampala (population 1.2 million) at more than 9%, and for the Central and North-Central regions.⁷⁹ Little is documented about the effect of conflict on HIV prevalence rates; however, there is currently a RENEWAL study underway in Uganda which examines the situation of internally displaced people in the refugee camps.⁸⁰ Moreover, the continued conflict in northern Uganda may contribute to a renewed increase of HIV and AIDS in the country, particularly amongst children and women.

Kenya's epidemic peaked in the late 1990s with a national adult prevalence of 10%, which dropped to 7% in 2003. Infection levels for urban residents peaked in the mid 1990s, prior to that of rural residents, which later dropped but at a slower rate than urban areas. Kenya has the distinction of being only the second SSA country whose national HIV infection rates have declined steadily. The clearest example of this turnaround has been amongst pregnant women in the urban centres of Kenya – especially in Busia, Meru, Nakuru and Thika – where HIV prevalence dropped from 28% in 1999 to 9% in 2003. There have also been falls in other urban areas, including the capital, Nairobi (population between 3 and 4 million). The decline in Kenya's national prevalence rates can be attributed to several factors, including behavioural change, the mature stage of the epidemic where death rates can exceed new infection rates, and the deaths of the more at-risk population which removes them from the transmission circuit.⁸¹ While these declines appear remarkable in the broader regional context, it is important to emphasize that in Kenya, as elsewhere, prevalence rates vary significantly across the country, potentially masking hard-hit communities who may be bypassed by interventions as a result.⁸² For example, the fishing communities of the Lake Victoria Basin have a lifestyle that exposes them to viral transmission and their prevalence rates of 31% are testimony to this. Similarly disproportionate prevalence rates have been recorded among fisherfolk in the adjacent countries of Tanzania and Uganda.⁸³

Although the prevalence rate in mainland Tanzania is fairly low at 7%, it is twice as high in urban (11%) than in rural areas. Altogether, it is estimated that 1.5 million people are living with HIV/AIDS. Although 12 years ago antenatal clinic HIV prevalence reached 20% in Mbeya and 36% at some clinics, it now appears to have stabilized. Antenatal infection rates have declined in Dar es Salaam and Mtwara since 2002, but they have risen in the capital city of Dodoma (population over 300,000). However, according to a recent survey in rural parts of the country, 40% of married men admitted to having



extramarital affairs which presents an alarming trend for the possibility of new infections.⁸⁴

Urban areas in Rwanda also mirror patterns found elsewhere, with prevalence twice as high as for rural areas (6.4% median prevalence in 2003 compared with 2.8% for rural areas) and with the capital city of Kigali (2005 population of 851,024) the worst hit. HIV prevalence fluctuations range widely in Burundi, from 2% in Kiremba to 13% in a suburb of the capital city of Bujumbura with an estimated national prevalence rate of 6%.⁸⁵

Urban HIV prevalence rates in Addis, Ethiopia, are almost three times the national level of an estimated 4.4%. Pregnant women in towns and cities have had HIV prevalence rates between 12 and 13% since the mid 1990s. However, with 85% of the population situated in rural areas, more people in rural areas are now being infected than in urban, with rural prevalence increasing from 1.9% in 2000 to 2.6% in 2003.⁸⁶ While this may be the trend, rural poverty is chronic, severe and in many cases worsening with time, raising general vulnerability to HIV and AIDS through poverty mitigation (usually survival) behaviours involving mobility. For example, women and girls, facing destitution from asset losses, move to towns to begin making a living in the commercial sex worker industry and expose themselves to HIV.⁸⁷ The challenges facing Ethiopia are significant: there are more than 1.5 million people living with HIV (2004) and more than 4.5 million orphans, of whom at least 500,000 are AIDS orphans. AIDS caused an estimated 30% of deaths in 2003, and in mid-2005, fewer than 10% of people who needed ART were receiving it.⁸⁸ Deaths due to AIDS have already brought down life expectancy which was expected to fall by 4.6 years in 2003.⁸⁹ It is noteworthy that in terms of disease stage and prevalence rates, Ethiopia is now where South Africa was in 1994.

HIV prevalence rates are low for both Eritrea and Somalia. In 2003, Eritrea had a low national adult prevalence of 2.4%, with regional ranges from under 2% to more than 7%. In Somalia, a 2004 national survey of pregnant women recorded an average rate of 0.6%, with the highest infection rates found in the capital city of Mogadishu (0.9%).⁹⁰ With 7% of women attending one clinic in Mogadishu found to be HIV positive, it appears that urban concentration is once again the dominant pattern. Knowledge of HIV transmission is very low, which indicates the need for a prevention and education program, but in societies where sexuality and sexual practices are not openly discussed, such programs face significant obstacles.

Urban HIV in Eastern Africa

National adult HIV prevalence rates are much lower in East African countries compared with Southern African countries although HIV prevalence rates still remain high. Cities and towns tend to exceed national and rural prevalence rates. Although epidemics appear to be stable, they remain serious and will continue for many years to come. Socio-economic and socio-cultural factors which create and enhance vulnerability need to be addressed.

1.5 Determinants of Urban Food Security

The right to food has been recognized by various international declarations, including the Universal Declaration of Human Rights.⁹¹ Food security is usually defined as “access by all people at all times to sufficient food for an active healthy life.”⁹² Definitions of food security usually include food supply, access, adequacy, utilization, safety and cultural acceptability of food for all people at all times.⁹³ Barrett outlines four major elements of a useful operational conception of food security:⁹⁴

- the physiological needs of individuals (nutritional requirements and energy expenditure levels);
- the complementarities and tradeoffs among food and other basic necessities (most notably health care and education, among other things);
- changes over time, and people’s perceptions of and responses to these changes (for example, consumption smoothing) and, especially;
- uncertainty and risk (vulnerability, and people’s perceptions and responses to risk).

Food security is no longer viewed as a failure to produce enough food nationally, but rather as a failure of livelihoods to provide an adequate supply at the household level.⁹⁵ Dowler maintains that food insecurity is a synonym for food poverty, which reflects the fact that food insecurity goes beyond physical efficiency of food consumption to include the ability “to acquire or consume an adequate quantity or quality of food in socially acceptable ways, or the uncertainty that one will be able to do so.”⁹⁶ These conceptions are reflected in factors which help to measure the degree of food insecurity. A population or livelihood group is considered acutely food insecure if:

- people experience a large reduction in their major source of food and are



unable to make up the difference through new strategies;

- the prevalence of malnutrition is abnormally high for the time of year, and this cannot be accounted for by either health or care factors;
- a large proportion of the population or group is using marginal or unsustainable coping strategies; and
- people are using 'coping' strategies that are damaging their livelihoods in the longer term, or incur some other unacceptable cost, such as acting illegally or immorally.⁹⁷

Sub-Saharan Africa is the only region in the world where the number of people who live in extreme poverty has almost doubled over the last two decades: from 164 million in 1981 to 314 million today.⁹⁸ Chronic urban poverty is critically linked with urban food insecurity. As urban areas within SEA grow at unprecedented rates, the infrastructure and tax bases of cities cannot meet the increased demands for services and this has led to increased crowding and a deteriorating urban environment.⁹⁹ This means that access to health care, water, housing and education are all problematic.¹⁰⁰

Levels of urban poverty appear to be increasing in much of Africa. Unemployment and underemployment are characteristic of urban economies which have been in decline since the 1970s and 1980s, exacerbated by rapid urbanization rates.¹⁰¹ Cities and towns are cash-intensive and residents often have to pay for goods and services (such as fuel and housing) that they do not have to pay for in rural areas. High costs for non-food essentials means that urban dwellers spend a smaller proportion of their incomes on food because they must pay for goods such as housing, energy, transportation, household items, education, health care and personal items.¹⁰² Also, prices vary not just between rural and urban areas but also between urban areas.

As poor households struggle to meet urban expenses, the type, quantity and quality of food consumption tends to be an area of cut-back since it is not viewed as a fixed, absolute expense. Thus, households are thrust into food insecurity. Kironde, for example, found that in Tanzania the income needed for 2000 calories per day was 19.7% higher in towns (excluding Dar es Salaam) than rural areas and 98.2% higher in Dar than in rural areas.¹⁰³ Many recent urban poverty assessment studies reaffirm this trend. For example, in Accra, Maxwell et al found that urban households buy more than 90% of their food and 40% of households could be classified as insecure with respect to calorie intake. In low-income settlements in Dhaka, for sake of comparison, 50% of the population was below the chronic poverty line and 42% was below a local line of minimum food plus 20% for basic necessities.¹⁰⁴

The analysis of food insecurity is usually focused upon risk factors and whether households can cope with shortfalls. In the city, this revolves around access to cash for food and basic necessities, which is tied directly to wages and prices, but also includes factors such as overcrowding, an unhygienic environment and the lack of a functional safety net.¹⁰⁵

Food prices are integral to the food security of urban dwellers. Urban retail markets in most developing cities are small and scattered, and although this may not be efficient, they do serve the needs of the poor, who are forced to buy food every day and in small quantities since they lack the cash to buy in bulk. For many years, food prices in urban areas were kept cheap through subsidies, overvalued exchange rates and trade restrictions. However, structural adjustment programmes during the 1980s and 1990s reversed these policies and led to food prices that often increased much faster than wages.¹⁰⁶ The urban poor are further hampered by their dependence on low wage, casual, temporary or seasonal work and thus their cash flows are intermittent and influx, which directly impacts upon their ability to buy food.

In Southern Africa, in particular, many people are undernourished due to poor quality diets and infections. A poor diet usually means inadequate quantities of protein, carbohydrates and micronutrients which are all necessary for various human functions. Pregnant women who live in environments which lack iodine need to consume iodized salt for the normal development of the foetal brain. In addition, if people do not consume enough fruits and vegetables, deficiencies in vitamins A, C and other nutrients make them more susceptible to disease.¹⁰⁷ Research in many developing countries shows that poor nutrition leads to reduced productivity.¹⁰⁸ A recent study by the International Food Policy Research Institute (IFPRI) in 15 developing countries revealed that poverty and malnutrition increase along with urbanization. Using WHO data, the study found that the urban share of underweight children increased in 11 of the 15 countries and the absolute number increased in 9 of the 15 countries.¹⁰⁹

Children are particularly vulnerable to the effects of malnutrition and malnourishment. Malnutrition in the form of stunted and underweight children worsened in South Africa during the late 1990s.¹¹⁰ A recent UNICEF study of childhood nutritional status in Southern Africa over a ten year period showed deterioration in conditions in Zimbabwe and Zambia in 2001-2003. Overall, 2.3 million children were underweight in the 6 countries studied, with more than 30% of children in Malawi and Mozambique showing stunted growth. In all countries except Lesotho and Swaziland, urban and peri-urban areas started with the lowest levels of underweight children but deteriorated the most over the ten years, while most rural areas tended to improve.¹¹¹



Although African cities are growing at an unprecedented rate and urban poverty is back on the agenda with respect to both research and donor priorities, Maxwell contends that urban food security has become politically invisible. He cites several reasons for this:¹¹²

- urban food security is fairly invisible to urban planners and managers as they scramble to deal with more urgent visible political issues such as unemployment, the informal sector, overcrowding, decaying infrastructure and declining services – even though food security and malnutrition are all linked to these other problems;
- unless there are major problems with food supply or sudden increases in food prices, food insecurity rarely becomes a political issue and therefore is dealt with at the household level; and
- development theory has reinforced the notion that food insecurity and poverty are generally rural problems.

One aspect of urban food security which has largely been ignored in the literature is that of urban food remittances from extended and immediate family in the rural areas. Frayne explores this issue in Namibia, and finds that rural sources of food are important for migrant and non-migrant households alike in the context of limited employment and high rural-urban migration.¹¹³ In this study, 66% of Windhoek households had received food over the past year from friends and relatives in the rural areas and 58% were sent food from 2-6 times in the past year.

The reciprocity between rural and urban households is key here, with urban households sending cash remittances to rural families in the semi-subsistence sector which drives the purchase of food and other necessities in the rural areas and thereby contributes to the availability of a 'rural surplus' for remitting to the urban household. Thus, social networks are the infrastructure that enables the flow of goods between rural and urban areas.¹¹⁴ However, there are gender differences in amounts and types of food received and for women it is the lack of well-established links to the north as well as rights to land that account for the fact that they receive smaller amounts of food.

Potts also found in Zimbabwe that households which have access to rural production are remitting increasing amounts of food to urban areas.¹¹⁵ In addition, Oucho reports that it is usually rural households with access to urban remittances who are the most productive farmers in East Africa, which may apply to Southern Africa. In his study, Oucho found that 48% of urban remittances are used either to buy or improve land and that the strength of ties between rural and urban households stimulates the rural economy at both household and community levels.¹¹⁶