Tourism and AIDS – The Mauritian Experience

C. Chan Kam

Mauritius is a small island of less than 2000 km\(^2\), lying about 1000 km off Madagascar in the Indian Ocean. With a population of one million it is one of the most densely populated countries in the world. Since the mid-1970s, Mauritius has started a love affair with tourism which shows no signs of turning sour. Apart from a few uneasy moments in the early 1980s, the affair has been passionate, with the number of tourist arrivals having steadily increased in the last 5 years and accelerated over the last 2 years. 1987 saw well over 210,000 visitors flocking to Mauritius. The forecasts at a seminar on tourism 3 weeks ago were optimistic, with the number expected to top 300,000 by 1992.

In economic terms the tourist industry is now the third main source of foreign exchange earnings – over 120 million dollars yearly – after the traditional sugar industry and that other behemoth, the manufacturing industry. A look at the countries which bring us most of our visitors shows that the great majority are from France, Reunion Island (a neighbouring French “department”), and South Africa. There are increasingly large groups from western Europe, viz. the United Kingdom, Italy, Germany, Switzerland, and a sprinkling from the Far East, Australia, United States, Kenya and Zimbabwe.

Until recently there were no dissenting voices when it came to promoting tourism. An aggressive marketing strategy abroad was accompanied by the rapid development of infrastructures at home. Promoters feel we are still well below the threshold of tolerance as far as accommodation of tourists is concerned. But in the last year or so cautionary, if not dissenting, voices have been heard as the effects of this rapid development have become more tangible, both on our natural environment and socioculturally. Indeed the sociocultural upheavals of the last decade resulting from the changes linked not just to tourism, but specially to the manufacturing industry, have yet to be fathomed.

In the midst of all this we now have AIDS. That many Mauritians now equate the threat of AIDS with tourists or foreigners is increasingly obvious. This simplistic view is fuelled by the official statistics – one case of AIDS and three seropositives. The case of AIDS was a Mauritian, but on the other hand all seropositives identified to date have been visiting foreigners. This public perception of AIDS is also reflected in the stance of some policymakers who are advocating the screening of certain foreign nationals or even all visitors likely to stay more than 1 year. The situation regarding a legal/administrative framework for AIDS is, as in most countries, very fluid and there is as yet no official policy. Needless to say there are some very sound economic reasons
why the authorities are handling the matter carefully and it is the unstated un-
official policy not to recommend the screening of international travellers.

But, economy and finance aside, Mauritius has, I feel, deep-rooted com-
mitments to the maintenance of the ideal of individual liberties above all else,
and it is this particular attachment, more than the need for pragmatism or real-
isim, which will, I hope, govern future policies. When in addition the cold facts
and figures also underline the futility of mass screening and of restrictive or
coercive measures I can only conclude that our current approach to tourism
and HIV is not only practical but also sound public health policy.

Since the initiation of the official AIDS Prevention Programme a little over
6 months ago we have concentrated our efforts on information and education
of OUR population at all levels. We have been careful in not targetting groups
but rather in emphasizing the need to avoid high-risk behaviour. This is where
the cookie crumbles and where we face our most difficult challenge. I have
talked about the social upheavals of the last 10 years and it is quite clear to
all of us involved in Health Promotion that, when it comes to sexual behav-
avour, in particular the gap between information and a change of behaviour and
attitudes is enormous. The tourist industry has no doubt played its part in
those changes of attitudes and behaviour. We firmly believe, however, that
there is no better alternative to continuing and continuous education and in-
formation of our population to minimize the impact of HIV through appropri-
ate low-risk behaviour.

In this context we have had awareness sessions with hotel managers, per-
sonnel managers and health officers in the tourist industry and we are reinforc-
ing our programme in the hotel sector as well as the general public with the
help of trainers in AIDS education whom we trained over the last 4 months.
We are also developing our own audiovisual support – videos, radiocassettes,
mobile exhibitions, posters, TV spots, and other publicity material. We are
also organizing meetings with the media and with elected parliamentarians so
as to gain their necessary support in sensitizing public opinion. Indeed the suc-
cess of our prevention programme will not be measured by the number of
AIDS cases or of seropositives but by the changes in attitudes vis-à-vis our visi-
tors and HIV carriers.

Besides information, repeated serosurveys to gauge the prevalence of HIV
infection are carried out and hotel employees are regularly included in those,
on a voluntary, informed consent basis. The tourism industry has so far been
fairly cooperative and, in many cases, hotel management have instituted
awareness programmes on AIDS and other STDs for their staff and have
made condoms more readily available.

While we believe in relying especially on the informed low-risk behaviour
of our nationals at home and in preparing guidance for Mauritians travelling
abroad to minimize the spread of HIV, we are also aware that control can only
be achieved through global cooperation and that similar measures should be
taken worldwide. We are preparing material targetted very discreetly at tour-
ists and visitors where we shall seek to emphasize the POSITIVE aspects of
HIV in Mauritius, notably the low prevalence.