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Development planning and HIV/AIDS in sub-Saharan Africa

Regional Project on HIV and Development

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By Mirjam van Donk

Final Report

Prepared for the UNDP Regional Project on HIV and Development in sub-Saharan Africa

July 2004

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Foreword

By Prof John Ohiorhenuan, Chairperson of the Reference Group and former Resident Representative UNDP, South Africa

Development planning is a contested terrain, particularly in sub-Saharan Africa. Historically, the approach to African development has been externally oriented. For the past four decades, the subcontinent has been negotiating its development with external partners. More often than not, this has meant that the process, instruments and outcomes of development have been determined by external partners, rather than by African societies and their leaders.

At the same time, development planning has been approached as a largely technical, or even technocratic, exercise. Despite the more recent discourse on democratising and decentralising planning processes, development planning still tends to be located in the domain of planners, and more especially of economists. Elected representatives, local communities and organisations representing their interests are only marginally involved in these processes.

In addition, HIV/AIDS is posing a fundamental challenge to the conceptual foundations and the practice of development planning on the subcontinent. The human tragedy and devastation associated with the HIV/AIDS epidemic can no longer be ignored by anyone or any organisation with an interest in Africa's development. Even though many dimensions and impacts of HIV/AIDS are as yet unknown, the time to safeguard the rights of those infected and affected by HIV/AIDS and change the course of the epidemic is now.

Against this background, UNDP initiated the study on "Assessing the Link between National Development Planning and HIV/AIDS in sub-Saharan Africa". It starts from the premise that effective HIV prevention requires a paradigm shift: one that looks beyond individual knowledge and behaviour as the most important factors influencing the spread of HIV to factors in the social, economic and political environment that render certain individuals and social groups more vulnerable to HIV infection than others. Although at the level of rhetoric there appears to be widespread acceptance that HIV/AIDS is a development issue, in practice the factors associated with HIV vulnerability are not sufficiently understood, let alone responded to. It is here where development planning can make the most effective contribution to curbing the spread of HIV. At the same time, development planning has to pre-empt and mitigate the current and anticipated impacts of HIV/AIDS, as these hold the danger of undermining the very goals, targets, tools and instruments of development. Moreover, if development planning continues to ignore the developmental dimensions of HIV/AIDS, it may unwittingly fail to curb – and worse still, even facilitate – the spread of HIV and it may aggravate the impacts of the epidemic.

This report makes a valuable contribution to the required paradigm shift in development planning, especially at a conceptual and practical level. It draws from a broad development literature and local studies at country level to substantiate its findings, analysis and recommendations. It exposes HIV/AIDS as a blind spot in development planning and makes recommendations to ensure that HIV/AIDS becomes a central concern in development efforts in sub-Saharan Africa. It is hoped that the report will find a wide audience and will contribute to better, more attuned and locally owned development planning on the subcontinent.

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The study and this report have benefited from the advice and support provided by members of the Reference Group. Members of the Reference Group included: Prof John Ohiorhenuan (Chairperson), Prof Fantu Cheru, Mr Mamadou Goudiaby, Mr Edward Kapwepwe, Mrs Eleanor Maeresera, Dr Roland Msiska, Mrs Mwanakombo Ngingite, Mr Manual Pinto, Mr Antoine Marie Sie Tioye, Dr Abdoulmaliq Simone, Dr Alex de Waal and Mr Demile Yismaw.

Country assessments have been conducted by Prof Evina Akam (Cameroon), Mr Narathius Asingwire (Uganda), Mr Amadou Ba (Senegal) and Prof Marvelous Mhloyi (Zimbabwe). Chapters 6-9 are based on these country assessments. For the purpose of this report, the four country assessments have undergone significant revision by the Lead Consultant.

Administrative support to the project has been provided by the UNDP Regional Project on HIV and Development in sub-Saharan Africa. Special thanks are due to Dr Roland Msiska, Christophe Ahouansou, Jackie Nzisabira and Leonce Hounkponou.

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Acronyms

AIDS .....Acquired Immune Deficiency Syndrome
ARVs .....Anti-Retroviral Drugs
BEAM .....Basic Education Assistance Module (Zimbabwe)
CAMNAFAW .....Cameroon National Association for Family Welfare
CBHC .....Community Based Health Care
CBO.....Community Based Organisation
CNLS.....National AIDS Council (*Comité Nationale de Lutte contre le SIDA*)
DSDSR .....Rural Development Strategy (*Document de Stratégie de Développement du Secteur Rural*, Cameroon)
EMCCA .....Economic and Monetary Committee of Central Africa
ESAP.....Economic Structural Adjustment Programme (Zimbabwe)
ESIP.....Education Strategic Investment Plan (Uganda)
GDP.....Gross Domestic Product
GICAM.....Cameroon Employers' Federation (*Groupent des Industriels du Cameroun*)
GNI .....Gross National Income
HIPC .....Highly Indebted Poor Countries
HIV.....Human Immuno-Deficiency Virus
HSSP.....Health Sector Strategic Plan (Uganda)
IEC.....Information, Education and Communication
IFIs.....International Financing Institutions
ILO.....International Labour Organisation
IMF.....International Monetary Fund
IRDP .....Integrated Rural Development Planning
LDCs .....Least Developed Countries
LRA .....Lord's Resistance Army
MAAIF .....Ministry of Agriculture, Animal Industry and Fisheries (Uganda)
MACA .....Multi-Sectoral Approach to Control HIV/AIDS
MDGs .....Millennium Development Goals
MERP .....Millennium Economic Recovery Programme (Zimbabwe)
MFPED .....Ministry of Finance, Planning and Economic Development (Uganda)
MINEDUC .....Ministry of Public Education (*Ministère de l'Education Nationale*, Cameroon)
MINEPAT .....Ministry of Economic Affairs, Planning and National Development (*Ministère des Affaires Economiques de la Planification et de l'Aménagement du Territoire*, Cameroon)
MINESUP .....Ministry of Higher Education (*Ministère de l'Enseignement Supérieur*, Cameroon)
MINSANTE .....Ministry of Public Health (*Ministère de la Santé Publique*, Cameroon)
MoES.....Ministry of Education and Sports (Uganda)
MoLG.....Ministry of Local Government (Uganda)
MTCS.....Medium Term Competitive Strategy
MTEF.....Medium Term Expenditure Framework
NAC.....National AIDS Council
NACWOLA .....National Community of Women Living with HIV/AIDS in Uganda
NERP.....National Economic Revival Programme (Zimbabwe)
NGEN+ .....National Guidance and Empowerment Network of People Living with HIV/AIDS (Uganda)

NGO.....Non-Governmental Organisation
NPA .....National Planning Authority
NSFA .....National Strategic Framework on HIV/AIDS
PAF .....Poverty Action Fund (Uganda)
PEAP.....Poverty Eradication Action Plan (Uganda)
PDEF .....Development Framework for Education and Training
(*Plan de Développement de l'Education et de la Formation*, Senegal)
PGAT.....General Plan for National Development (*Plan Général d'Aménagement du Territoire*, Senegal)
PHC .....Primary Health Care
PLWHAs .....People Living with HIV/AIDS
PMA.....Plan for Modernisation of Agriculture (Uganda)
PMTCT .....Prevention of Mother-to-Child Transmission
PNAT .....National Plan for the Development of the Territory
(*Plan National d'Aménagement du Territoire*, Senegal)
PNDS.....National Plan for Health Development (*Plan National de Développement Sanitaire*, Senegal)
PRDI .....Regional Integrated Development Plan (*Plan Régional de Développement Intégré*, Senegal)
PRSP.....Poverty Reduction Strategy Paper
PTIP.....3-year Public Investment Plan (*Programme Triennal d'Investissements Publics*, Senegal)
SAP .....Structural Adjustment Programme
SMEs.....Small and Medium Enterprises
SP .....Sector Programme
SRAT .....Regional Plan for National Development (*Schéma Régional d'Aménagement du Territoire*, Senegal)
STI .....Sexually Transmitted Infection
SWAp .....Sector Wide Approach
UAC.....Uganda AIDS Commission
UIS.....UNESCO Information System
UNAIDS.....Joint United Nations Programme on HIV/AIDS
UNCTAD .....United Nations Commission on Trade and Development
UNDP.....United Nations Development Programme
UNESCO .....United Nations Educational, Scientific and Cultural Organization
UNMHCP.....Uganda National Minimum Health Care Package
UPE .....Universal Primary Education
UPPAP.....Uganda Participatory Poverty Assessment Project
VCT .....Voluntary Counselling and Testing
WHO .....World Health Organization
ZIMPREST.....Zimbabwe Programme for Economic and Social Transformation

Introduction

1.1. Introduction

HIV/AIDS is one of the most critical development challenges in sub-Saharan Africa. It is now widely recognised that HIV/AIDS reverses the achievements in human development in the region and, as a consequence, has the capacity to undermine economic growth and development. The epidemic also poses a serious challenge to governance and public sector management in sub-Saharan Africa. As such, it raises particularly challenging questions regarding the nature, strategic orientation and impact of development planning in the region as yet worst affected by HIV/AIDS.

Arguably, development planning seeks to make the complexities of the real world comprehensible, so that a government can shape and direct the course and nature of development to the benefit of its people and the fulfilment of their basic rights. Past efforts in development planning in sub-Saharan Africa have brought significant improvements, but also great disappointments. From the point of view of development planning, the human tragedy and devastation associated with the HIV/AIDS epidemic clearly adds to the complexity of the real world and makes the realisation of development goals infinitely more challenging. Whilst this report does not, and cannot, provide solutions to these challenges, it seeks to provide some guidance on how to approach them.

1.2. Background to the study

Several African governments and international agencies have sought to curb the spread of HIV and mitigate the devastating impacts of HIV/AIDS. Yet, in relation to the scale and devastating nature of HIV/AIDS, these efforts have at best yielded modest results. The UNDP Regional Project on HIV and Development in sub-Saharan Africa has identified at least three interrelated factors that help to explain the limited successes of country responses to HIV/AIDS in the region.[i]

Firstly, many prevention efforts have tended to ignore the social and economic context that renders certain individuals or social groups more vulnerable to HIV infection than others. Secondly, successes made in a few countries – and the social, political and institutional factors contributing to these successes – are not well studied to provide viable and useful lessons elsewhere. Amongst others, this has led to a replication of interventions that have demonstrated some level of success in a particular context, without due regard for the appropriateness of these interventions in other contexts. Thirdly, few country responses to HIV/AIDS have been sufficiently comprehensive and at scale, taking into account the socio-economic realities of individuals and communities prior to and after HIV infection.

To overcome these fundamental weaknesses, the UNDP Regional Project recognises that there is, firstly, an urgent need for a better understanding of the relationship between HIV/AIDS and development and the determinants of the spread of the epidemic in specific contexts and, secondly, a need for the development of appropriate methods, tools and frameworks for mainstreaming of HIV/AIDS into development programmes at country level. For this reason, the UNDP Regional Project commissioned this study. Its aim is to assess possible links between development planning and HIV/AIDS in sub-Saharan Africa. More specifically, it seeks to ascertain the extent to which development planning may facilitate, or curb, the spread of HIV and may exacerbate, or mitigate, the impacts and consequences of HIV infection on households, communities, organisations and institutions. As such, the study aims to contribute to the first need identified above, namely an enhanced understanding of relevant political and institutional factors in the context of HIV and development.

1.3. Study aim and activities

The specific aim of the study is twofold:

- To develop a typology of development planning on the subcontinent; and,
- To explore possible links between development planning and HIV/AIDS through an analysis of principal development planning frameworks.

To achieve the aim of the study, the following research questions have been formulated:

1. What are the most significant development planning frameworks guiding the development process on the subcontinent?

2. To what extent are HIV prevention and impact mitigation deliberate, or integral, objectives of particular development planning frameworks?

3. How do particular development planning frameworks, consciously or not:

    a. Enhance or diminish an environment of vulnerability to HIV infection; and/or,

    b. Strengthen or undermine the capacity of households, communities, organisations and institutions to cope with the impacts of HIV infection, ill health and possible death?

The study consisted of various phases. The first phase was the development of a Concept Paper *Understanding the Link between Development Planning and HIV/AIDS in sub-Saharan Africa*. The Concept Paper includes a typology of development planning and key development planning frameworks in sub-Saharan Africa. It further presents a tentative conceptual framework for analysis of the possible linkages between certain types of development planning (as reflected in key development planning frameworks) and HIV/AIDS in sub-Saharan Africa.

During the second phase of the study, this conceptual framework was used as a diagnostic tool to assess possible links between development planning and HIV/AIDS in selected countries. Country assessments were conducted in Cameroon, Senegal, Uganda and Zimbabwe. The findings of these country assessments have been reflected in Country Papers.[ii]

The final phase of the study consisted of consolidating the documentation produced into this report and preparing a synthesis of the key findings. The Concept Paper has been restructured and forms the basis for Chapters 2, 3 and 4 in this report. The Country Papers have been edited and revised to ensure coherence and consistency. Furthermore, a synthesis of the findings reflected in the country assessments has been written, which has informed the development of a set of recommendations.

1.4. Project management and execution

As the commissioning authority of this study, the UNDP Regional Project on HIV and Development in sub-Saharan Africa played a key role in providing the necessary administrative support for the execution of the project. It commissioned a Lead Consultant to design and manage the project, to develop the conceptual framework and the research methodology for the study, and to coordinate the work of Local Consultants. The Lead Consultant was also responsible for compiling the final report, which included editing the Country Papers and writing a synthesis of the main findings, amongst others.

Local Consultants were commissioned to conduct the country assessments. To prepare them for this task and to ensure a consistent approach among the various consultants, they participated in a research methodology workshop in Pretoria, South Africa. Each Consultant produced a draft Country Paper and presented this at a Revision Workshop. Subsequently, the Local Consultants revised their draft Country Papers, which in some cases involved additional data gathering.

A Reference Group under the leadership of Prof John Ohiorhenuan (Resident Representative of UNDP South Africa) was established to give overall guidance to the study. An effort was made to ensure that government representatives of the case study countries were part of the Reference Group.[iii] Selected international experts with expertise in development planning and/or HIV/AIDS were also invited to participate in the Reference Group. In addition to providing direction to the study and engaging with the documents produced, members of the Reference Group were tasked with the responsibility to assist local consultants in accessing relevant informants and documents.

1.5. Overview of the report

This report continues by presenting a brief historical overview of development planning in sub-Saharan Africa, starting from the period of decolonisation. Chapter 2 highlights how the first generation of independent African states, faced with some fundamental challenges, was able to make

significant strides in the first two decades after the Second World War. Yet, the economic crisis of the 1970s and 1980s exposed some structural weaknesses of African economies and their management. It further allowed neoliberalism to become the most dominant ideological framework, with far-reaching implications for the development project and development planning in sub-Saharan Africa.

With the declining and discredited role of the state in development, the concept of development planning fell into disuse – even though state control and planning have continued to play a role on the subcontinent. Chapter 3 argues for a reintroduction of the notion of development planning as 'planning for development' and emphasises the vital role of the state in this process. It defines development planning as a complex, participatory and inherently conflictual process of decision-making concerning appropriate priorities, strategies and resource allocations in the interest of the common good and of the implementation of these decisions. It includes a variety of activities at different functional, operational and spatial levels, including economic development planning, sectoral planning (e.g. health and education planning), multi-sectoral planning and integrated area planning (i.e. rural/urban development planning).

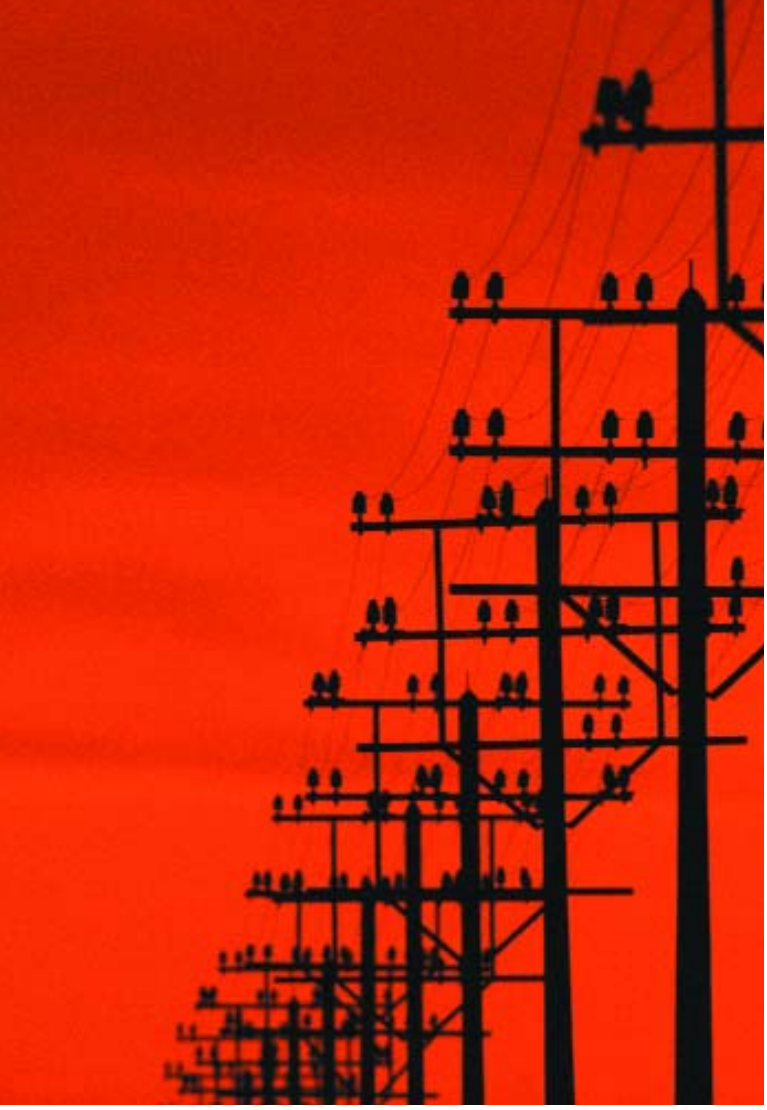
This working definition is followed by a typology of development planning and associated planning frameworks in sub-Saharan Africa. The main types of development planning identified are economic development planning, sectoral planning, multi-sectoral planning and integrated area planning. The section briefly elaborates on those development planning frameworks that are, or are increasingly becoming, most influential in guiding the development process in sub-Saharan Africa. The frameworks under discussion are: the National Development Plan, the Poverty Reduction Strategy Paper (PRSP), the Medium Term Expenditure Framework (MTEF), the National Strategic Framework for HIV/AIDS, Sector Plans (particularly the Sector Wide Approaches – SWAps) and the Rural and Urban Development Frameworks. From the discussion, it emerges that a critical issue concerns the alignment and synchronisation of various planning frameworks. The chapter concludes by presenting an ideal type image of the linkages between the different development planning frameworks.

Chapter 4 maps out a tentative conceptual framework that can be used to review the various development planning frameworks from the perspective of HIV/AIDS. A distinction is made between 'development planning for HIV/AIDS' and development planning aimed at realising other development objectives. 'Development planning for HIV/AIDS' refers to development planning in direct response to specific determinants or consequences of the HIV/AIDS epidemic or a more comprehensive response to HIV/AIDS. The National Strategic Framework for HIV/AIDS is a clear example of this type of planning. The chapter argues that other types of development planning, for which addressing HIV/AIDS is no exclusive – and possibly no explicit – objective, also have relevance for the spread of HIV and impact on the capabilities of individuals, households and organisations to cope with the consequences of HIV and AIDS.

Chapter 4 identifies a set of core determinants of enhanced vulnerability to HIV infection, which have particular relevance from the perspective of prevention of HIV transmission, and key consequences, which are critical from the perspective of impact mitigation (including treatment and care). These core determinants and key consequence are themselves complex development challenges. Clearly, HIV/AIDS makes the resolution of these challenges not only more complex, but also more acute.

The chapter continues by applying the proposed conceptual framework to the main development planning frameworks identified in Chapter 3. The reflection on possible links between particular development planning frameworks and HIV/AIDS is obviously not comprehensive or conclusive. The specific nature of such linkages has to be analysed with reference to particular contexts. Instead, the examples presented here are meant to be illustrative and point to a way of analysing specific development planning frameworks through the lens of the proposed conceptual framework. The chapter concludes that few, if any, development planning frameworks address all core determinants and key consequences of HIV/AIDS. Whilst this may in part be due to the functional and operational scope of particular types of development planning, it also points to a flawed conception of HIV/AIDS and to a lack of alignment between the various planning paradigms.

In attempting to depict the status of development and the nature and impact of development planning for the whole subcontinent, this report has set out on quite an ambitious endeavour. It is clear that within



its scope and space constraints, this report cannot do justice to the rich variety in historical trajectories, socio-economic realities, political and organisational systems or institutional frameworks that exist on the subcontinent. It also cannot adequately reflect the abundance and depth of perspectives on development and development planning, let alone how specific development planning frameworks are made relevant to local realities. Moreover, the report does not explore in detail the nature and manifestation of HIV/AIDS in particular societies. To some extent, these issues have been further explored in the country assessments.

Chapter 5 serves as an introduction to the country assessments, which are presented in Chapters 6 to 9. It outlines the selection criteria that were formulated to guide the selection process for the case studies. Although initially eight countries were selected (Burkina Faso, Cameroon, Ethiopia, Mozambique, Senegal, Tanzania, Uganda and Zimbabwe), four of these (Burkina Faso, Ethiopia, Mozambique and Tanzania) had to be discarded at different stages of the project for organisational and practical reasons. Chapter 5 further provides a brief overview of selected development trends and indicators in the four countries where country assessments were conducted. It concludes by providing some insight into the research questions that guided the country assessments, the research methods used and some of the challenges and difficulties encountered during this phase of the study.

Following the country assessments of Cameroon (Chapter 6), Senegal (Chapter 7), Uganda (Chapter 8) and Zimbabwe (Chapter 9), Chapter 10 draws out the similarities and differences with respect to development planning and HIV/AIDS in the four countries reviewed. The aim of this chapter is not so much to compare these countries and rank their performance. Rather, it seeks to identify possible trends that are likely to have relevance for development planning and HIV/AIDS not only in the four countries reviewed here, but also in other sub-Saharan African countries.

Finally, Chapter 12 provides a conclusion to the report. It outlines a number of key lessons that are drawn from the country assessments and study findings. It concludes with a set of recommendations aimed at informing development planning in the region most affected by HIV/AIDS.

Development planning in sub-Saharan Africa: A brief overview

2.1. Introduction

Sub-Saharan Africa is characteristically represented as a symbol of tragedy, despair and failure. Images of war and political disorder, environmental disasters and famine, economic crisis and mass impoverishment tend to pervade the media as well as the development literature. Its highly disproportionate share of the global HIV/AIDS epidemic seems to further entrench this notion of a lost continent. Whereas these images convey some of the harsh realities on the subcontinent, they are also distorted and one-sided. Positive trends, successes and advancements seldom receive the same amount of attention. Also, responsibility for the subcontinent's woes is often put squarely at the feet of its political leaders and its people, without recognising the complex interplay between internal and external factors, the global and the local, the past and the present.

This chapter seeks to present a more balanced view of the nature of development challenges facing sub-Saharan Africa, of progress achieved and problems encountered, and of how exogenous barriers as much as policy and institutional flaws are contributing to disappointing development, at least in some respects. The intention of this chapter is to give a brief historical perspective on development planning on the subcontinent.

Although the notion of development predates the post-colonial era in sub-Saharan Africa, it gained particular resonance for African people and African leaders in the post-independence period. This applied equally to the first generation of independent African states – the former British, French and Belgian colonies that gained independence after the Second World War – as to the late decolonisations of former Portuguese colonies and to countries that gained political liberation in the 1980s and 1990s. This chapter will reflect on the history of development planning in sub-Saharan Africa, the legacy of colonialism that newly independent states sought to address, the successes achieved, and the factors that eventually influenced the poor track record of development planning on the sub-continent. Although the emphasis here is mainly on the first generation of independent African states, thereby referring to a particular moment in history, these observations seem equally pertinent to states that have become independent or gained political liberation more recently. Clearly, applying such a broad brush to the subcontinent ultimately serves to obscure the variety, depth and complexity, not only of the specific development challenges facing particular countries, but also of their responses to these challenges. It lies beyond the scope of this report to explore such specificities.

2.2. Four fundamental challenges

At the time of independence, African states were faced with four fundamental challenges. How newly independent states responded to these challenges varied, depending on, amongst others, ideological orientation, the relationship with the former colonial power and with the two superpowers of the time, and an assessment of local realities – all of which informed what was perceived as 'the art of the desirable and the possible'.

Firstly, newly independent states needed to instil a national identity and a sense of national unity among the people living in their territories. These territories, following colonial boundaries, tended to host various ethnic groups. In many cases, the imposed boundaries separated people of similar kinship and ethnic background. The challenge for the new African leadership was to promote national unity so that diverse – possibly divided – populations would identify themselves as Ghanaians, Malians, Burkinabé, Malawians, Zambians, or whatever the nationality may have been, and accept the new political leadership as legitimate.[iv]

Secondly, the new political leadership was faced with the challenge of addressing the colonial legacy of 'under-development' and embedded inequalities in education, health, employment and other aspects of social development. Although in the 1940s and 1950s former colonial powers had become increasingly development-minded, the colonial systems for service provision were inherently unequal, often of inferior quality and premised on western notions of development. Education systems, for example, were based on racial segregation and informed by European content. In the late 1950s, less than half of all African children of school going age went to primary school (43%), compared to a secondary school enrolment rate of only three percent. At the time of independence, university enrolment of African students was practically nil (Court and Kinyanjui, 1986). This had significant implications for the number of qualified nationals who could manage the affairs of African states and propel these countries onto a sustainable path of development. For example, in 1964, one year after independence, Kenya counted 36 doctors, 20 electrical engineers, 17 university professors and seven economists among its citizens (Cheru, 2002a:72). Other African states were faced with a similar lack of qualified nationals.

The third challenge for newly independent states was to take control of the economy and improve national economic performance. Under colonial rule, African economies became chiefly customised to the industrial and consumption needs of the 'metropolitan centre', rather than the needs of the local population. Thus, the institutional structure of the economy that post-colonial states inherited was characterised by low-income agriculture, external dependence and a marginal position in world markets (Lewis, 1998). In contrast, former colonial powers and other 'developed' countries were seen as representing the state of development to which African states should aspire.

Finally, newly independent states were faced with the challenge of 'state building' and the need to establish legitimate, viable and effective organisations of governance and development. African states inherited colonial structures of administration, which had been designed to suit the interests of colonial powers. As such, these political and administrative apparatuses were ill-equipped for the tasks of nation-building and national development in newly independent states. Thus, the transformation of political and administrative systems so that these could fulfil the tasks of modernisation became a key focus for the first generation of African leaders.[v]

2.3. Responses to development challenges and progress achieved, 1950s-1999

Given the vastness and the complexity of these challenges, it is hardly surprising that African states opted for the centralisation of decision-making and resources and favoured state intervention in the economy and in the development process in general. This happened regardless of the ideological orientation of respective states, whether these were socialist-oriented or Keynesian-oriented.[vi] Also, conventional wisdom at the time endorsed significant state intervention in the development process, partly because of the commonly accepted notion of 'market failure' in economic theory, particularly in relation to 'latecomer' economies (Ghosh, 2001). In light of the dominant perspective of development as economic growth, development planning was associated with a deliberate government attempt to pursue economic progress and respond to the basic needs of citizens. In accordance with modernisation theory, which identified various stages of development, development planning became a tool to enable 'underdeveloped' countries to follow the appropriate stages of modernisation. For some African states, which associated capitalism with foreign control, this meant pursuing a socialist path of development characterised by state control and state ownership of industries. These included Tanzania, Guinea and, for a while, Mali. Other African states, like Kenya, Côte d'Ivoire and Nigeria, adopted a capitalist path of development. In some instances, African states altered their approach as their allegiance to the two superpowers shifted (e.g. Ethiopia). Yet, as highlighted earlier, both socialist-oriented and Keynesian-oriented regimes supported a strong, interventionist role of the state in pursuing economic progress.

The 1950s and 1960s: the development era

Evidence suggests that in the first two decades of independence, African states made significant strides in relation to the four fundamental challenges outlined above. By pursuing an economic strategy largely based on capital formation through the expansion of exports and import substitution (anticipated to result in rapid industrialisation), African states realised an average weighted growth rate in sub-Saharan Africa of 3.9% in the 1960s - an average that was only to be attained again in the latter part of the 1990s (Ghai, 2000:17). Clearly, these average ratios hide great variations in economic performance among African countries

Table 2.1. Enrolment ratios in sub-Saharan Africa, 1960-1997									
	Primary enrolment			Secondary enrolment			Tertiary enrolment		
	Men	Women	Total	Men	Women	Total	Men	Women	Total
1960	54.4	32.0	43.2	4.2	2.0	3.1	0.4	0.1	0.2
1970	62.3	42.8	52.5	9.6	4.6	7.1	1.3	0.3	0.8
1980	88.7	70.2	79.5	22.2	12.8	17.5	2.7	0.7	1.7
1990	81.9	67.6	74.8	25.5	19.2	22.4	4.1	1.9	3.0
1997	84.1	69.4	76.8	29.1	23.3	26.2	5.1	2.8	3.9
Source: World Bank (2002b: 106)									

and for specific countries over time. The fact that 10 African states realised a sustained growth rate of 6% over more than a decade in the period between 1967 and 1980 is an indication of how successful these states were in achieving economic progress (Mkandawire, 2001:303).

African states also made major improvements in relation to social and physical infrastructure by doubling, at times even tripling, public expenditures on education, health and water (Seidman, 1974). Strong public investment in newly established national health care systems contributed to a significant decrease in infant mortality and maternal mortality, resulting in higher population growth rates and an increase in life expectancy of about four years per decade, rising from 40 years in 1960 to 48 years in 1980 and reaching nearly 52 years in 1990 (Cooper, 2002:107; World Bank, 2002a). Transforming the colonial racial education system to ensure access to education for all nationals became a key priority for newly independent states. This involved tackling racial segregation in schools, 'Africanisation' of the curriculum to ensure that the content of education was appropriate and gave an accurate reflection of local history and culture, and promoting African nationals into positions at all levels of the education system (Court and Kinyanjui, 1986). Education and investment in human capital were seen as central to economic development, which led to an emphasis on primary education and adult education. In addition, many African states adopted a policy of guaranteed employment for university graduates (Cheru, 2002a). As a result, primary enrolment rates increased from 43% to 53%, secondary enrolment more than doubled from 3% to 7%, and university enrolment increased from almost nil to close to 1% between 1960 and 1970 (see Table 2.1). Girls and women clearly benefited from these measures.

In relation to nation building and 'state building' (the first and last challenge identified above), the successes seem less straightforward. Much of the literature on the African state bemoans the autocratic, repressive, 'clientelistic' or corrupt nature of most African states, particularly since the late 1960s. While these negative views of the state in Africa may not always have been justified and may have eventually become self-fulfilling[vii], there is ample evidence that many first generation African leaders closed the political space for debate and dissent on the basis that this would undermine national unity and the legitimacy of the state (see, amongst others, Chafer, 2002; Cooper, 2002). But whilst in the 1960s autocratic government was combined with the notion of developmentalism, by the 1970s African states (quite a few of which were military regimes by that time) were less able to fulfil promises of development and were increasingly tied into patronage politics. An important contributing factor, which is often overlooked, is that African states inherited overdeveloped civil and military bureaucracies and underdeveloped political and legislative systems from former colonial powers (Martinussen, 1999).

The 1970s: crisis in development planning

The early 1970s saw a continuation of the gains made in the preceding ten to twenty years (see also Table 2.1), but with more attention to the distributional dimensions of development. In accordance with shifts in international thinking on development, there was increasing concern with the fact that productivity did not spread throughout the national economy as anticipated, nor did it automatically translate into the fair distribution of growth and improved standards of living for the majority of people (Seidman, 1974). This led some to conclude that African economies experienced "growth without development" (Clower et al, quoted in Seidman, 1974:4). Of particular concern was the new phenomenon of graduate unemployment, which was indicative of the lack of correlation between expanding education opportunities and productive activities in the economy (Court and

Kinyanjui, 1986; Seidman, 1974). African states responded by pursuing internationally recommended development strategies that were more sensitive to social equity (e.g. through the provision of subsidised food, education, health and employment) (Ali, 2001), including those focusing on the spatial dimension of development, more specifically regional planning and integrated rural development (Ayeni, 1999; Belshaw, 2002).[viii]

Yet, after having achieved remarkable progress in the first few decades of independence, the situation began to change dramatically during the course of the 1970s, eventually leading to a 'crisis in development planning' in sub-Saharan Africa. To some extent, this may be considered as the logical outcome of the scope of the fundamental challenges facing African states. The high level of demand for services and the transformation of political and administrative systems forced governments to push their budgets to the limit. As early as the end of the 1960s, it became increasingly clear that some of the planning objectives pursued by African states exceeded state capacity and resources and were unsustainable. Contrary to expectations, external funds were not forthcoming, at least not in the volume required.[ix]

At the same time, there was growing evidence that direct state control in the allocation of imports, credits and raw materials and administrative decisions on prices and the protection of industry had resulted in inefficient resource use, shortages, parallel markets and even corruption (Ghai, 2000). Patronage politics, political instability, civil war and excessive military spending further contributed to this situation, halting the initial progress made.

These issues became particularly pertinent with the economic shocks of the 1970s and the subsequent global downturn in demand for tropical products, the rise of world interest rates and the continued lack of foreign investment in African economies. These global trends exposed the vulnerability of African economies to erratic world markets due to their dependency on primary commodities.[x] Both socialist and capitalist (Keynesian) models of economic development adopted by African states proved incapable of weathering the economic storm, which resulted in economic stagnation, a worsening balance of payments, deteriorating terms of trade, significant levels of poverty and a decline in agricultural production (Falola, 1996). In addition, orthodox measures used to respond to the economic crisis, such as cuts in public expenditure, laying off government employees and devaluation, only aggravated the situation by reducing real incomes of wage earners and cash crop peasants and by increasing unemployment (Seidman, 1974). As a result, public services came under severe pressure and, in many cases, eventually collapsed.

Average economic growth slowed down significantly in the second half of the 1970s, reaching an average of 2.9% per annum between 1975 and 1979 (World Bank, 2002c). Yet, this average figure hides the fact that some countries experienced erratic growth rates or even economic decline. Since the late 1970s and early 1980s, economic stagnation became increasingly widespread on the subcontinent and started to affect those countries that had consistently performed well (Ghai, 2000). Because the total population continued to grow, even moderate economic growth translated into a drop in average per capita income. While in the 1960s two-thirds of sub-Saharan countries showed a positive per capita income, this declined to 62% in the 1970s, only to fall even further to 48% in the 1980s and to less than a third (31%) in the 1990s (Elbadawi and Ndulu, 2001).

By the late 1970s, the international economic crisis propelled a new approach to development and fuelled an aversion to state-led development in mainstream development thinking. In contrast to preceding years, when there was general appreciation for the state as a critical actor in the development process, the pendulum now shifted to the opposite direction and the state became increasingly criticised for being the main obstacle to development. The neoclassical view that the state should withdraw from the development process to enable the market to take its 'rightful' place became ever more influential in international development thinking and practice (Ohiorhenuan, 2002). Development planning became associated with the 'gatekeeper' state[xi], where state interventionism was linked to authoritarian rule and disregard for human rights. Failed experiments in nationalisation and grand-scale social engineering, as in the case of Tanzania and Ethiopia (Cooper, 2002; Scott, 1998), gave proponents of the neoclassical model of development fuel to argue against such central involvement of the state in development. This was reinforced by the dichotomous thinking of the Cold War period, which fed into a strong anti-state sentiment in the West and among its allies in sub-Saharan Africa. This "neoclassical counter-revolution" (Ohiorhenuan, 2002:5) was at the root of the neoliberal paradigm to development, so

Box 2.1. Key characteristics of economic planning in sub-Saharan Africa	
1960s-1970s:	**1980s-1990s:**
• Medium-term planning, based on the two-gap model focusing on growth rate, capital-output ratios by sector and the derived financing gap	• Short-term macroeconomic planning, focusing on recurrent budget deficit and inflation
• State employs instruments of control to realise planning objectives (e.g. credit guidelines & tariff regimes)	• State has a facilitative role, rather than exerting control
• Tax regimes focusing on agriculture and/or mineral export taxes and possibly income taxes on the small 'modern' sector, i.e. public and corporate sectors	• Broadening the revenue base and increasing supply responses through institutional support to investors and exporters
Source: Taken from Ohiorhenuan (2002)	

prominently advocated in the "Washington Consensus" in the 1980s and 1990s.

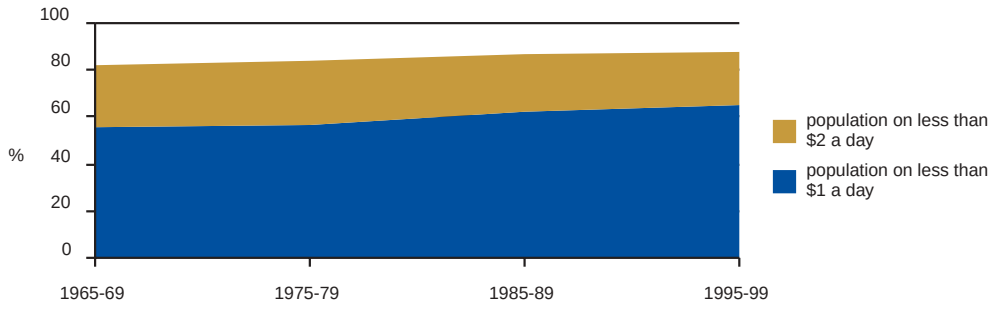
The 1980s: structural adjustment

In the 1980s, a narrow perspective of development as economic growth, best facilitated and distributed through the market mechanism, held sway. Macroeconomic reform and structural adjustment became the buzzwords, associated with measures such as non-inflationary budgetary policies and monetary restraint, the liberalisation of trade and financial flows, exchange rate correction, privatisation and deregulation of domestic financial markets. These measures were considered appropriate means to overcome the structural weaknesses of African economies and their management (including domestic policies and institutional mechanisms), which were seen to lie at the root of the economic crisis gripping the subcontinent. It could be argued that, ultimately, these means became ends in themselves. In sub-Saharan Africa, the economic policy and development debate became completely dominated by structural adjustment programmes (SAPs) (Nissanke, 2001). An underlying tenet of structural adjustment was that countries could "export their way out of the crisis" (UN Economic and Social Council, 2001:12). In the process, the capacities of African states to function as a 'state' were drastically eroded (Mkandawire, 2001). Box 2.1 illustrates some elements of this fundamental shift.

Structural economic reform was made conditional on African states that found themselves unable to service loans made by Northern commercial banks and the Bretton Woods Institutions. In the 1960s and early 1970s, following the 1973 increase in global oil prices, money was made easily available to African states, often regardless of what the resources were used for. In fact, lending countries stand accused of 'loan-pushing', by making large sums of money available for white-elephant projects, the acquisition of arms, or the import of luxury goods, often to undemocratic regimes. In 1979, the interest payments of these loans increased dramatically, resulting in a significant foreign debt problem for many African states. To repay these loans to Northern commercial banks, African states could access structural adjustment loans from the IMF. Yet, these IMF loans came with a host of conditionalities related to policy reforms, including domestic trade liberalisation, relaxation of foreign exchange controls, the privatisation of basic services and an end to social subsidies (Cheru, 2002a). In the 1980s and early 1990s, a large number of African countries had to pay more in debt service charges than they received in the form of development assistance and foreign investment. According to Potter (2000:6), by the end of the last century the total external debt burden of sub-Saharan Africa amounted to 83% of total GNP for the region. As a result, the subcontinent spent four times more on debt interest payments than on health care (Potter, 2000:7).

The economic slowdown that had started in the 1970s became more entrenched and noticeable during the 1980s. The average national GDP growth rate on the subcontinent dropped to 1.7%, only to drop even further in the early 1990s to 0.9% (Belshaw and Livingstone, 2002:5; Ghai, 2000:17). This economic decline has manifested itself in almost all economic and social indicators and in negative per capita growth rates (Elbadawi and Contributors, 2001). Even those who argue that macroeconomic and adjustment policies have resulted in modest per capita income growth in sub-Saharan Africa concur that the growth rates are not comparable to long-term growth rates in other regions, nor that it has been sufficient to address widespread (and growing) poverty (Rwegasira, 2001). Ali (2001) has demonstrated that sub-Saharan Africa has seen a significant increase in poverty, particularly in rural areas, in the second half of the 1980s. He argues that this increase has been

Graph 2.1. Poverty trends in African LDCs, 1965-1999



Source: UNCTAD (2002b)

Table 2.2. Poverty trends in African LDCs, 1965-1999

	1965-1969	1975-1979	1985-1989	1995-1999
Population living on less than $1 a day (%)	55.8	56.4	61.9	64.9
Population living on less than $2 a day (%)	82.0	83.7	87.0	87.5
Number of people living on less than $1 a day	89.6	117.4	170.5	233.5
Number of people living on less than $2 a day	131.7	174.4	239.5	315.1
Average daily consumption of people living on less than $1 a day (PPP at 1985 rates)	0.64	0.66	0.64	0.59
Average daily consumption of people living on less than $2 a day (PPP at 1985 rates)	0.95	0.96	0.90	0.86

Source: UNCTAD (2002a:59)

much more dramatic than is commonly reported, reaching between six to ten percent per annum. In 'intensively adjusting' countries (Ghana, Kenya, Malawi, Tanzania and Zambia), rural poverty increased from almost 57% in 1965 to 62% in 1988. This correlates with a twofold increase in absolute numbers, from just over 18 million in 1965 to just over 36 million people in 1988. In 'other adjusting' countries (Gabon, Gambia and Mali), an increase from 45% (or 2.3 million people) to 61% (5.1 million people) was recorded over the same period. Instead, in 'non-adjusting' countries (Ethiopia and Lesotho), rural poverty declined from 66% to 44%, remaining constant in absolute numbers at 17 million people (Ali, 2001:119). Likewise, Table 2.2 and Graph 2.1 show that poverty trends in Least Developed Countries (LDCs) in Africa have increased steadily since the mid-1960s.[xii]

As intimated earlier, the economic crisis, and more specifically the way in which structural adjustment was designed and implemented[xiii], also halted the rate of improvements in social development achieved in preceding decades, resulting in only moderate improvements at best, if not a reversal. As Table 2.1 shows, primary enrolment ratios declined quite significantly between 1980 and 1990, whilst secondary and tertiary intakes continued to increase, but at more modest rates than before. Another indicator is the dependency ratio. According to UNCTAD's recent report on Least Developed Countries, the dependency ratio in Africa is the highest in the world. Moreover, Africa is the only region that has seen an increase in the dependency ratio between 1970 (0.91) and 1999 (0.95) (UNCTAD, 2002a:89). Even where there is evidence of (modest) quantitative growth, such as in secondary school enrolment and access to health care, this does not necessarily imply qualitative improvements. In fact, anecdotal evidence often suggests a decline in the quality of these services (Edwards with Kinyua, 2000). Clearly, the negative view of the state in neoliberal orthodoxy and the concomitant erosion of state capacity have contributed to a decline in the scope and quality of social services and infrastructure.

In accordance with neoliberal ideology, emphasis was put on the role of the market in the provision of social services, like education and health, coupled with a diversification of service providers and the introduction of user fees as a cost-recovery mechanism. Although the justification for reforms in social sectors was couched in terms of sustainability, efficiency and equity, the nature of the reforms showed that efficiency was the overriding

concern. In effect, as many observers have commented in the context of health planning, the emphasis on user charges generally served to perpetuate, if not aggravate, inequities in access to health care (Blas and Hearst, 2002; Blas and Limbambala, 2001; Nyonator and Kutzin, 1999; Van Der Geest, et al., 2000).[xiv] There was also a dramatic increase in the level of involvement of donor agencies in sectors of social development, particularly in health and education, leading to a considerable proliferation of donor projects, procedures and policies, resulting in a significant amount of duplication, competition and a high administrative burden on recipient countries.[xv]

It is worth noting that it was in this context of structural adjustment and its regressive impact on human development that HIV/AIDS started to emerge, first as a public health concern and subsequently as an epidemic with major implications for all dimensions of development. Although the link between SAPs and HIV/AIDS is not simplistic, it can be observed that SAPs came at a time when households, communities and governments were already quite vulnerable to external shocks and that SAPs tended to exacerbate certain factors associated with enhanced risk to HIV infection (Collins and Rau, 2000; Poku and Cheru, 2001; Schoepf, 2004a). HIV/AIDS will be further discussed in the next period, the 1990s.

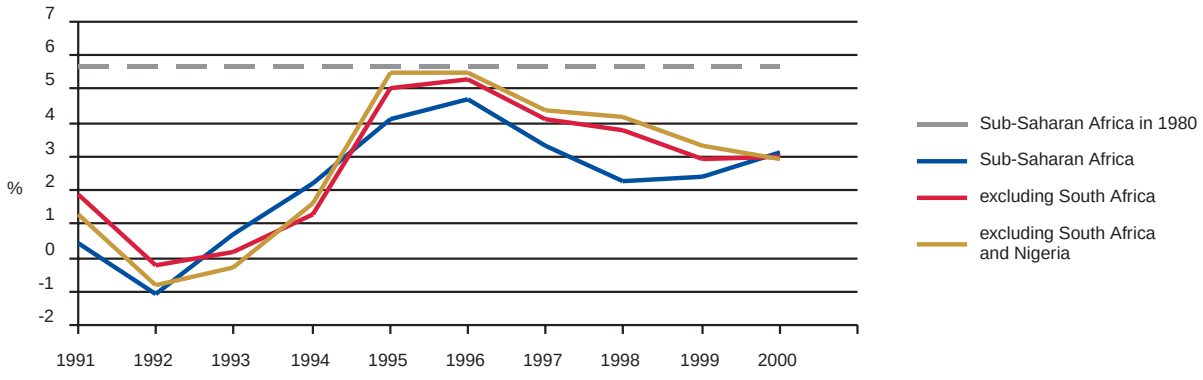
As far as the twofold project of nation-building and state-building is concerned, it could be argued that both came under severe stress in the 1980s. Cooper (2002) argues that the project of building a common national identity came undone in the 1980s, when other forms of identity expression, such as religious identities, became more influential. To some extent, this may have been propelled by the patronage politics pursued by many African leaders at the time. The fact that the political institutions inherited from colonial powers were relatively weak allowed for the emergence of 'strong man politics', where political leaders had strong vertical ties with their supporters – although there were undeniably great variants in political institutions and procedures across sub-Saharan Africa and significant variations in the degree of political space (Cooper, 2002; Goldsmith, 2002). Cold war dichotomies further entrenched this situation, with Western governments and international organisations propping up support for undemocratic leaders and military regimes for geopolitical reasons. At the same time, integral to structural adjustment was the objective to address poor performance and inefficiency in the public sector and state-owned enterprises. The assumption was that African states were overextended, bloated and highly bureaucratic. Yet, as Goldsmith (2000) has aptly demonstrated, the African state was no anomaly in terms of public sector expenditure, public sector employment or public enterprises' share of the economy. In fact, in comparison to other regions these aspects of the African state were actually lower than average, particularly in terms of public sector employment. As a result, structural adjustment measures "have so maladjusted African states that they provide proof of the impossibility of developmental states in Africa" (Mkandawire, 2001:306).

The 1990s: 'structural adjustment with a human face'

As early as the late 1980s, concerns about poverty, equity and the narrow conceptualisation of development in neoliberal thinking resurfaced.[xvi] In the 1990s, these concerns became more pronounced and eventually found their way into development orthodoxy. In 1990, UNDP presented the notion of human development, defined as "the process of enlarging people's choices" (UNDP, 1990:10).[xvii] The resurgence of poverty and equity concerns coincided with a 'rediscovery' of the state as a key actor in the development process, encapsulated in the notion of the 'developmental state'. Because of this renewed attention to the role of the state, the past decade has seen an increasing interest in the institutional environment and 'institution-building' of the state, particularly the local state. In the African context, this emphasis on 'institution-building' may, in part, be fed by the persistently negative conceptions of the African state, which is commonly referred to as the 'rentier state', the 'over-extended state', the 'parasitical state', the 'predatory state', the 'lame Leviathan', the 'patrimonial state', the 'prebendal state', the 'crony state', the 'kleptocratic state', the 'inverted state', etc." (Mkandawire, 2001:293). The focus on institution-building has been accompanied by an emphasis on democratisation and 'good governance', in large part brought on by the end of the Cold War and the subsequent collapse of the bipolar world system. Since 1989, a significant number of African states have moved towards multi-party democracy, albeit at times very closely 'managed' by incumbents to prevent the renewed political space from opening too far.[xviii]

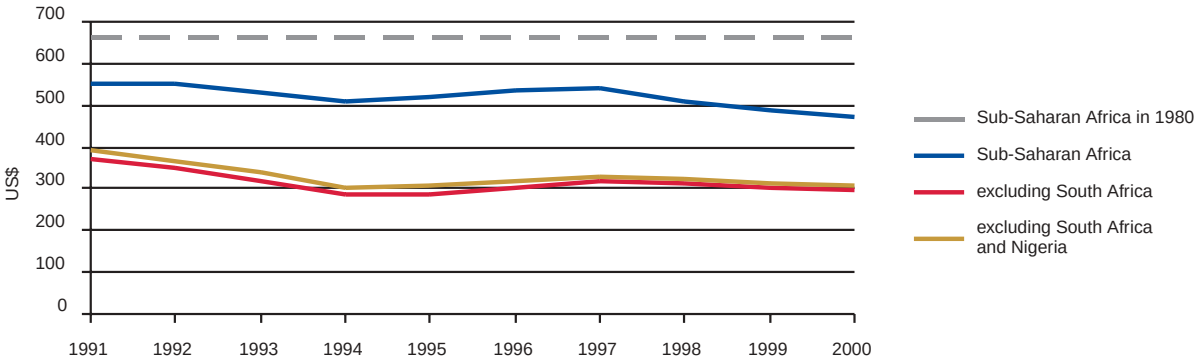
In the second half of the 1990s, economic growth in

Graph 2.2. Trends in GDP growth (%), 1990s



Source: World Bank (2002c)

Graph 2.3. Trends in GNI per capita (US$) in the 1990s



Source: World Bank (2002c)

sub-Saharan Africa showed a marked improvement, resulting in an average annual growth rate of four percent between 1994 and 1997 (Ghai, 2000:17). Graph 2.2 shows how economic growth on the subcontinent has started to improve since 1992. Yet, it has not been able to surpass the 1980 economic growth rate of 5.7%. It is also significant to see what happens when South Africa and Nigeria, considered the 'economic powerhouses' on the subcontinent, are excluded. As Graph 2.2 reveals, their economic fortunes and misfortunes clearly distort the average GDP growth trends in sub-Saharan Africa.

However, possibly more instructive than economic trends measured in average GDP growth are per capita growth rates. As Graph 2.3 shows, GNI per capita has been fairly erratic during the 1990s, but shows an overall decline. This decline is even more pronounced if it is compared with the average GNI per capita in 1980, which was $665 for sub-Saharan Africa, $528 for the subcontinent excluding South Africa, and $448 if Nigeria is excluded as well (World Bank, 2002c).

Other social development indicators show that significant improvements continued to be achieved during the 1990s. For example, between 1988 and 1990, 41% of the population in sub-Saharan Africa reportedly had access to safe water, whilst 26% had access to sanitation. Between 1990 and 1998, this improved to 58% and 48% respectively (UNDP, 2000). According to data in various UNDP Human Development Reports, adult literacy increased from 47% in 1990 to 61% in 2000, with particularly noteworthy improvements in the adult literacy rate among women. Also, the decline in primary school enrolment rates in the 1980s seems to have been halted, with primary enrolment increasing slightly from 75% in 1990 to almost 77% in 1997 (see Table 2.1). Yet, since the early 1990s, life expectancy has started to decline from almost 52 years in 1990 to

just below 47 years in 2001. This reduction in life expectancy of about five years within the space of 11 years is similar to the average increase in life expectancy of four years per decade between 1960 and 1990. This is indicative of the devastating impact of HIV/AIDS on the subcontinent.

It is now widely accepted that HIV/AIDS is a developmental and humanitarian crisis, particularly for those countries on the subcontinent with an advanced epidemic and high adult HIV prevalence rates. The rising adult mortality due to AIDS-related deaths among the most productive section of the population not only results in declining life expectancy, it also leads to a loss of skills, knowledge and expertise so essential for a country's development. It further results in a reduction in labour productivity, an increase in organisational costs related to human resources and slower, if not reduced, economic growth. At the household level, household savings and consumption are depleted, resulting in more and deeper poverty. Due to intra-household transmission of HIV infection, there are growing numbers of orphans (who may or may not be HIV-positive) and child-headed households. Following the breakdown of familial and social networks, women and children will face increasing dependency and vulnerability to infection and (sexual) exploitation. Stigma and fear associated with HIV/AIDS further erode social cohesion, cultivating discrimination and social exclusion. The impact on sectors, like education, health, agriculture and the military, is also considerable. Whilst there is increasing demand for more and qualitative different services to provide the necessary support to those infected and affected by HIV and AIDS, these sectors themselves are faced with increasing absenteeism and a loss of skilled personnel due to the epidemic. As a result, public sector capacity to respond to the challenges of HIV/AIDS and to deliver on its basic mandate is eroded.[xix] These and other consequences of HIV/AIDS are threatening to further undermine the already fragile development capacity of the subcontinent.

2.4. Concluding comments

By way of concluding this historical overview, it is worthwhile to highlight a few key points.

Firstly, between 1960 and 2000, African states have been able to make impressive achievements in relation to almost all social development indicators, although the rate at which these improvements have occurred has slowed down significantly since the late 1970s, and especially in the 1980s. In some areas, there is evidence of a reversal of earlier progress made (e.g. primary school enrolment and the dependency ratio). A look at individual countries is likely to reveal that a reversal has taken place in other aspects of social development as well. In the 1990s, a slow upward trend seems to have taken root again. An exception to this positive trend is life expectancy, which has started to decline in the 1990s, reflecting the demographic impact of the HIV/AIDS epidemic.

Secondly, after realising impressive economic progress in the 1960s and early 1970s, African economies have experienced economic decline and/or a reduction in economic growth since the mid-1970s. This trend is largely due to the vulnerability of African economies to endogenous shocks and pressures, which newly independent states (regardless of ideological orientation) proved unable to overcome and which structural adjustment served to entrench, rather than remedy. Reduced, if not negative, economic growth has occurred in a context of worsening terms of trade, declining volumes of development assistance, lack of foreign investment and high levels of external debt. Where moderate economic growth has occurred, it has not been comparable to economic growth rates in other regions, nor has it been sufficient to overcome endemic and growing poverty.

Thirdly, poverty has increased steadily since 1965, with almost two-thirds of the population in African LDCs living on less than $1 a day and close to an additional 25% hovering just above this poverty line (see Graph 2.1). In sub-Saharan Africa as a whole, almost half the population (about 300 million people) is estimated to be living on less than $1 a day. Similarly, income per capita has declined steadily since 1980, occasional annual improvements notwithstanding (see Graph 2.3).

Fourthly, African states have sought to respond to development challenges in ways that were considered appropriate to the domestic context, albeit often in accordance with ideas and practices that prevailed in the international arena. The next chapter will focus more explicitly on the various types of development planning in sub-Saharan Africa (see Table 3.1 for a summary of the key elements of development planning between 1960 and 1999). The 'crisis in planning', or the failure to achieve the dual objective of sustained economic growth and equitable development, has often been blamed on a host of domestic factors. Even those who do not agree with an exclusive focus on

domestic blockages or weaknesses have identified problems with the methods and instruments used to achieve this dual objective, the assumptions underpinning economic development planning, the inappropriate application of particular growth strategies and institutional blockages (see, amongst others, Degefe, 1994; Edwards with Kinyua, 2000; Ghai, 2000; Seidman, 1974). At the same time, they point to factors in the external environment, including the particular vulnerability of African economies to exogenous shocks (see also Elbadawi and Ndulu, 2001). It is also clear that over time, African states have increasingly found their 'room for manoeuvre' constrained – if not determined – by external perspectives and policy conditions. In addition, the rapid integration of the global economy and the emergence of private capital as an extremely powerful force in the global political economy are acting as significant constraints on the nation state to determine and pursue its development path.

Fifthly, as is clear from the historical overview, the practice of development and development planning in sub-Saharan Africa has been infused with theoretical and ideological perspectives on development, the role of the state in the development process, the notion of the public interest and the object of planning, which have shifted over time. These are all subjects of fundamental debate, which cannot be explored further here. Table 2.3 presents a summary of these debates in relation to specific theoretical frameworks of development that have tended to dominate development practice in sub-Saharan Africa in particular decades. Clearly, though, this delineation is not as neat as Table 2.3 suggests and various perspectives have tended to coexist.[xx]

At the dawn of this millennium, Africans states are faced with some fundamental development challenges related to weak economic performance and limited/structurally skewed integration into the global economy, deepening poverty and widening inequality, high levels of unemployment, a high proportion of the population without adequate access to basic services in their areas of residence and work, and the HIV/AIDS epidemic, amongst others. Development planning will continue to be a key instrument to address these complex and interrelated challenges. The next chapter will identify the main types of development planning and associated development planning frameworks in sub-Saharan Africa. By way of introduction, it will first seek to (re)define and revalidate the concept of development planning.

Table 2.3. Overview of dominant theories of development					
	1950s/1960s	**1960s**	**1970s**	**1980s**	**1990s**
Dominant theoretical framework of development	Modernisation theory	Dependency theory	Alternative development: basic needs and empowerment approaches	Neoliberalism	• Alternative development, i.e. focus on social justice, power & environmental concerns. • Neoliberalism, but with greater emphasis on 'social' aspects of development.
Meaning of development	Universal, unidirectional process of change, which is long-term, progressive and irreversible. Centrality of economic growth that proceeds along stages, with 'trickle down' effect.	Economic growth through national accumulation, with 'development of underdevelopment' in the periphery as its distorted form.	'Human flourishing', i.e. basic needs, participation and equity. Also emphasis on 'development from below'.	Economic growth through structural reform, stabilisation, liberalisation and privatisation.	Human development, i.e. capacitation and enlargement of people's choices. Sustainable development, i.e. explicit focus on the environment.
View of the state	Neutral arbiter to maintain consensual society and conduit of development. Coincided with sense of responsibility of newly independent African states (for unity, development and peace) and confidence in state as agent of economic development.	African states are 'dependent states', seeking access to world markets. Capitalist state as integrating mechanism to preserve the status quo between different class interests (i.e. represents elite interests/national bourgeoisie). Socialist state as initiator and agent of national development in the interest of the working class.	Society as the foundation for development as opposed to state-led development. Only in the 1980s attention to the role of the state, as a counterbalance to the dominant view of the market as the leading actor of development.	Failure of development largely blamed on improper functioning of the state. The market is the organising principle of society and core distributing mechanism à role of state = to protect individual and the market (New Public Management). Also shift towards local state (decentralisation & 'urban management').	'Developmental state', which is responsible for 'enabling environment' to allow the private sector and civil society to play their rightful roles in the development process. More concern with institutional environment and issues of 'institution-building' (particularly in relation to the local state and partnerships).
View of society /public interest	Based on consensus, with a singular public interest, namely pursuit of rational self-interest will serve to maximise social welfare. Also, society as recipient: top-down approach.	Conflictual, with a variety of interests and the possibility of dominance and exploitation.	Pluralist, i.e. variety of interest groups/communities. Generally a positive notion of communities as fairly homogeneous, consensual entities. Increasing recognition of power imbalances, especially between men & women.	Pluralist, yet inherently consensual: individuals acting on the basis of rational choice (self-interest), which maximises the public interest.	Consensual pluralism.
View of planning	Planning as a technical, scientific and comprehensive activity to proceed along the various stages of modernisation.	Planning as a state-controlled and state-managed activity that allows 'underdeveloped' states to catch up with industrialised nations.	Participatory planning as beneficial to national development, where local communities and 'the poor' mobilise and self-organise to ensure that the distributional effects of the development process benefit them.	Planning = state = inefficient: need to refocus towards 'enablement' to increase productivity. Shift towards 'management', whereby even politics is reduced to technocratic and managerial aspects, i.e. what strategic planning is supposed to facilitate participation and partnerships.	Strategic planning (i.e. dynamic framework to enable priority setting and the facilitation of partnerships between public, private and non-profit sectors) and renewed focus on participatory planning. On the basis of strategic planning, conventional area & sectoral planning can be used.
Sources: Martinussen (1999), Nederveen Pieterse (2001)					

A typology of development planning in sub-Saharan Africa

3.1. Introduction

The preceding chapter has highlighted that newly independent African states were able to make significant progress in relation to at least two of the four fundamental challenges outlined above, namely economic growth and social development, through concerted state actions and public sector investment. However, after initial widespread endorsement of strong state intervention in the development process, this view changed quite drastically following the global economic crisis of the 1970s and 1980s. To some extent, this was based on the inability of African states, regardless of ideological orientation, to withstand the economic and social crisis. There was also growing evidence that state control had contributed to inefficient resource use, shortages, parallel markets and corruption (Ghai, 2000). Equally important, if not more so, was the ascendancy of neoliberalism with its ideological critique of both Keynesian-oriented and socialist-oriented approaches to development. As the global political economy changed quite dramatically, the influence of external financing institutions and multi- and bilateral agencies on the development agenda in sub-Saharan Africa became more and more pronounced. The notion of development planning became increasingly disused and discredited in the process. Against this background, this report consciously reintroduces and (re)defines development planning as a means of talking about the central role of the state in the development process. A working definition is proposed, which is further elaborated on below. This is followed by a typology of development planning and a summary of the development planning frameworks that currently seem most critical in guiding the development planning process in sub-Saharan Africa.

3.2. When planning fails: contested perspectives

Despite the pronounced aversion to state intervention, efforts at state control and planning have continued to play a central role on the subcontinent (Martinussen, 1999). African states have continued to produce numerous development plans, usually covering five-year cycles. Yet, there are numerable instances where such plans have not resulted in tangible changes in accordance with stated objectives. Chapter 2 has pointed to the various reasons that have been identified for the disappointing track record of development planning in sub-Saharan Africa, often depending on the ideological standpoint of the commentator. It is clear, though, that the failure of development planning cannot be blamed on domestic factors only. Global terms of trade, escalating external debt and other aspects of the global political economy, regional dynamics on the subcontinent and even climatological conditions all have a significant impact on individual countries and on what type of development is feasible and sustainable. The significance of these endogenous factors also makes clear that there are limits to what development planning can achieve and that it will not be able to solve all dilemmas of development (Conyers and Hills, 1984).

One of the central criticisms levelled against development planning in sub-Saharan Africa is that over the past few decades it has persistently implied an a-historical and a-contextual approach to development in general and to development planning in particular. A contextual interpretation of planning implies that each society should define its development goals and the paths of achieving these goals, based on its history, its economic characteristics, its social systems and political and institutional factors. Yet, the history of planning in sub-Saharan Africa and other developing countries shows a legacy of ‘blueprints’, standardised models and the adoption of uniform strategies, regardless of domestic realities. To a large extent, this is the result of a variety of forms of interference by external financing agencies and of donor conditionality,

where development finance (in the form of aid, trade or debt relief) has been made conditional on the adoption of a certain 'plan'. Wolfe (1996) has observed that this trend towards aid conditionality started in the 1970s, when the United States made aid conditional on the adoption of fixed 10-year development plans, purportedly to make aid more effective. This external influence on, if not manipulation of, development agendas and paths of development in sub-Saharan Africa has resulted in inappropriate and even detrimental development interventions (see, amongst others, Hydén, 1994; Mkandawire, 2001). The fact that these development plans were usually not based on local realities and local needs often resulted in a significant disjuncture between stated intentions and real outcomes. Also, to access badly needed external funds and in order to be seen to observe 'international good practice', some African states simply went through the required motions. Once the plan was produced, it was often forgotten or ignored.

3.3. (Re)defining development planning

In light of this historical baggage, it is probably not surprising that development planning seems to be an ill-defined concept in contemporary development literature. Where the concept is used, it is often presented as a self-evident notion and its theoretical underpinnings are not made explicit. In fact, development planning is often equated with economic development planning, which points towards the dominant interpretation of development as being tantamount to economic growth. Alternatively, most of the literature on planning concerns *urban* planning, which is indicative of the long history of state interventions in controlling, managing and sustaining urban areas. Otherwise, planning is usually defined by its adjectives, such as rural planning, health planning, physical planning, and so on.

This chapter reintroduces development planning as a means of talking about 'planning for development' and, more specifically, state-led and state-managed development (see also Cheru, 2002a). For the purpose of this report, the following working definition of development planning is proposed:

> *Development planning refers to state-led development and is a complex and participatory process of: a) decision-making about the most appropriate priorities, strategies and resource allocations aimed at reconciling the oft-competing goals and values of locally appropriate development in the interest of a common public interest (which can only be served in practical terms by recognising the existence of a multiplicity of interests and power imbalances); and, b) the implementation of these decisions.*[xxi]

In unpacking this working definition, the following points are worth noting:

1. The working definition emphasises the central role of the state in the development process. This is not to presuppose that the state is the only decision-making or implementing agency of development interventions. Clearly, other actors like the private sector, civil society and international development partners also have important contributions to make. The emphasis here on state-led development serves to highlight the critical role of the state in setting the development agenda (i.e. visioning) and the parameters for development, which will enable other actors to work towards the realisation of common development goals. At times, it may imply that the state has implementation responsibility, although responsibility for programme delivery does not rest exclusively with the state. State-led development also suggests that the state has an important oversight role to ensure that both the processes adopted and the outcomes pursued are consistent with the parameters set out at the outset.

2. The definition highlights that development planning is concerned with the public interest. As others have suggested, the object of planning is to contribute to the Good Society (Campbell and Fainstein, 2003). However, there are a wide variety of interests and prevailing power imbalances in any given society. Unless this is recognised, development planning will, inadvertently, serve to entrench the interests of the most vocal, powerful and organised sections of society. This means that the aim of realising the public interest can only be achieved in practical terms if development planning successfully reconciles the multiplicity of interests in accordance with values like social justice and diversity. This points to the centrality of participation, particularly of elected representatives at all levels of government and of local communities and their representative organisations.

3. Embedded in the definition is an appreciation of development planning as both a political

process and an arena of technical competency.[xxii] The political dimension of development planning is reflected in the agenda-setting and visioning role of the state, the emphasis on development planning as a process of making strategic choices about priorities and resources, the recognition of the centrality of participation and partnerships in the planning process, and the oversight role assigned to the state. These all point to the central role of parliaments, members of the Executive and local Councillors in the planning process. The technical dimension of development planning relates to the selection of strategies and associated tools, instruments and techniques best suited to realise certain goals. These include instruments for data collection and interpretation (e.g. information management systems), implementation tools, mechanisms to facilitate participation and manage partnerships, and assessment tools to review progress made. It is worth noting that despite the aura of scientific rationality and neutrality, planning tools and techniques are not value-neutral, neither is their application. The imperative is to ensure that technical knowledge is applied in a way that maximises the politically agreed objectives and priorities.

4. The definition emphasises the importance of locally crafted (through the difficult and conflictual process of public participation and engagement) and domestically owned development plans. The emphasis on 'local' or 'domestic' here further presupposes an acknowledgement of contextual factors that determine both the specific nature of development challenges and the development potential (including organisational capabilities) that exist in a particular society. By implication, nationals and their elected representatives should be the initiators, the beneficiaries and the adjudicators of the development process – roles that are more often than not fulfilled by external actors or agencies (see Ohiorhenuan, 2002).

5. Notwithstanding the emphasis on locally appropriate development and domestic ownership, both the planning process and planning outcomes are informed by guiding principles, such as social justice, democracy, institutional effectiveness and efficiency, economic growth with equity, and ecological integrity. These guiding principles are not only interdependent, but also potentially contradictory. Thus, the challenge for development planning is to promote consistency between these principles as much as possible (see also Van Donk, 2002).

6. Development planning involves a wide range of activities taking place at different functional, spatial and operational levels. Although often pursued as discrete and neatly demarcated rational systems of action with distinct objectives and foci, in the messy reality of the real world there is a significant amount of overlap and potential contradiction, if not conflict, between different planning systems. Thus, there is an obvious need for coherence and consistency between them.

7. The production of a development plan is only one aspect of the planning process. It is not the ultimate purpose of planning – in fact, it may not even always be the most appropriate output (Conyers and Hills, 1984). Instead, plans are means to achieve the stated development goals or objectives.

The working definition outlined above presents a normative interpretation of development planning, rather than a descriptive analysis of development planning as it has been practiced in sub-Saharan Africa to date. At the same time, however, it also reflects current consensus in international thinking on issues such as the role of the state in the development process, the importance of participation and partnerships, the emphasis on local ownership and contextuality, and so on. These themes are underpinning the development planning frameworks that are currently gaining prominence in sub-Saharan Africa. The next section will outline the main types of development planning that are currently most critical in guiding the development process in sub-Saharan Africa.

3.4. Typology of development planning and associated frameworks

As highlighted in the previous section, development planning involves a wide range of activities taking place at different functional, spatial and operational levels. Each type of development planning has a particular historical trajectory and is the focus of extensive theoretical reflection and debate, which cannot be adequately reflected within the scope and space constraints of this paper. The historical overview presented in Chapter 2 referred to some of

the characteristics of economic, sectoral (health and education) and integrated area (rural and urban development) planning in the various decades since 1960, as well as to some of the achievements and limitations of those different types of planning. Clearly, the historical overview did not present an exhaustive discussion of any of these types of planning, but merely highlighted some of the key issues and experiences. Table 3.1 presents a summary overview of key types of development planning in sub-Saharan Africa in the latter part of the previous century.

This section seeks to identify those development planning frameworks that are currently most critical in guiding the development process in sub-Saharan Africa. Due to the purpose and nature of this report, not all development planning frameworks with relevance for sub-Saharan Africa can be presented here. Neither can the brief description of particular development planning frameworks do justice to the variety and depth of planning systems that exist on the subcontinent, let alone in specific countries.

Key types of development planning in sub-Saharan Africa

Following on from the distinctions made in the historical overview and in Table 2.3, we can identify four key types of development planning in sub-Saharan Africa. These are: economic development planning, sectoral planning, multi-sectoral planning and integrated area planning. Each of these types of planning is associated with one or more (possibly overlapping) development planning frameworks.

Economic development planning in sub-Saharan Africa is generally aimed achieving sustainable economic growth, raising social welfare and achieving or retaining national autonomy over the economy (after Mongula, 1994). Most commonly, economic development planning in sub-Saharan Africa is concerned with macroeconomic reform and stabilisation, focusing on the management of the recurrent budget deficit and inflation, trade liberalisation and exchange rate correction, privatisation and attracting foreign and domestic financial investment through the creation of an 'enabling environment'. In light of the negative consequences of structural adjustment, poverty concerns have (in theory, at least) become more integral to economic development planning in the past few years. Many African countries have developed, or are in the process of formulating, a Poverty Reduction Strategy Paper (PRSP) or an Interim-PRSP (I-PRSP).[xxiii] In the words of John Ohiorhenuan (2002:24), the PRSP is supposedly a "poverty-conscious" macroeconomic framework. In other African countries, an alternative poverty reduction framework is in place. Another planning framework under the rubric of economic development planning is the Medium Term Expenditure Framework (MTEF), which is meant to guide financial planning over multi-year planning cycles.

Sectoral planning is the most common form of planning in most countries and the basis from which national development plans are compiled. Sectoral planning is concerned with the various interventions a government can make in relation to specific sectors of the economy, e.g. agriculture, education, health, transport and so on. As West (1996) highlights, sectoral planning refers to interventions in those sectors where government takes a leading role, either because market failure is expected (e.g. in the case of education or health, where relatively low private returns serve as a disincentive to ensure equitable access and adequate coverage), or because private monopolies may cause exploitation of consumers (e.g. in relation to water supply, electricity, and so on). In the latter part of the 1990s, the Sector-Wide Approach (SWAp, or Sector Programmes – SP) became en vogue as a coherent sectoral framework, in part driven by the need for greater coordination and policy coherence between different donor agencies. The most common sectors in which SWAps are developed are health, education and agriculture (Berke, 2002; Lister, 2002).

Multi-sectoral planning, or integrated planning, has emerged in a variety of shapes and forms since the 1970s, for example in Primary Health Care (PHC), integrated rural development planning, gender planning, integrated environmental planning and, more recently, in multi-sectoral planning for HIV/AIDS and in PRSPs. In ideal form, multi-sectoral planning provides coordination and consistency between different sectoral responses and ensures that these responses strengthen and reinforce interventions by other sectors. Although conceptually appealing, the formulation and implementation of multi-sectoral plans have been riddled with contradictions, complexity and frustration. Faced by the devastation and developmental challenges posed by the HIV/AIDS epidemic, many countries in sub-Saharan Africa have developed a National Strategic Framework for HIV/AIDS to guide their national multi-sectoral response to HIV/AIDS. Often, this is preceded or

accompanied by the establishment of a national structure or commission, which is usually responsible for planning and coordinating the national response to HIV/AIDS. In some instances, sub-national organisations are set up, with similar responsibility for planning and coordination at regional/district level.

Integrated area planning emerged as a result of inadequacies in sectoral planning and physical planning, concerned with spatial dimensions of development (often referred to as land-use planning), to address the multi-facetted and interrelated nature of development in specific geographic areas (Conyers and Hills, 1984; Lea and Chaudhri, 1983). The Rural Development Framework and the Urban Development Framework typically provide the basis for rural development and urban development respectively.

The institutional location for the different types of planning outlined above is central government. In addition, decentralised planning at district and/or local level is taking place on the subcontinent. In the past, decentralised planning more often than not meant the devolution of administrative functions, rather than of political authority. National Ministries of Finance and sectoral Ministries have been quite reluctant to relinquish control over recurrent and capital finances (Belshaw and Livingstone, 2002). Increasingly, decentralisation has been linked to local democratisation, which also involves the devolution of political powers. Clearly, the rationale for decentralised planning is very appealing: it is expected to facilitate community participation and integrated planning between different sectors in a particular locality; it is seen as a means to ensure that development plans are more relevant to local needs and to speed up decision making and implementation; and, it is anticipated to encourage more efficient use of resources and to generate additional revenue (Conyers, 2000). In practice, however, decentralised planning does not automatically live up to these expectations and it is proving to be a much more complex and conflict-ridden process. For the purpose of this study, the attention will be on national development planning frameworks rather than local/district plans.

From this brief description of development planning in sub-Saharan Africa, the following development planning frameworks are emerging as being the most prevalent and most influential throughout the subcontinent to guide economic development, sectoral, multi-sectoral and/or area-based planning:

- National Development Plan;
- PRSP (or I-PRSP), or an alternative planning framework for poverty reduction;
- MTEF;
- Sectoral plans, including SWAps;
- National Strategic Framework for HIV/AIDS;
- Integrated Rural Development Framework;
- Integrated Urban Development Framework.

Each of these will be briefly discussed below.

Principal development planning frameworks

Of the main development planning frameworks in sub-Saharan Africa discussed here, the PRSP is increasingly heralded as the centrepiece of development planning, which should in a sense become an integrative mechanism for all national planning endeavours. It is for this reason that disproportionate attention is given to the PRSP in the discussion below. The PRSP has relevance for about two-thirds of countries on the subcontinent, thereby affecting around two-thirds of the total population. Although not all the observations made here will pertain equally to countries without a PRSP, most of these tend to have an alternative poverty reduction framework.

National Development Plan

The national development plan provides the long-term vision of national development, usually spanning 10-20 years, and reflects core objectives, key strategies to meet the objectives, how these strategies will be sequenced and sets out the policy process to pursue the objectives (UNCTAD, 2002a). The following issues should be central in the national development plan:

> … the nature of growth mechanisms underlying the development process, including accumulation of physical and human capital, and productivity growth through an increasing division of labour, technological progress and structural change, as well as the efficiency of resource allocation; the type of structural transformation which may be encouraged as the economy grows; sources of finance for productive investment; the role of trade in the development process; mechanisms for promoting enterprise development and learning; environmental sustainability; and the generation and sustainability of livelihoods for all sections of the population (UNCTAD, 2002a:177).

The UNCTAD report continues to say that “creating

effective and capable States, and also a dynamic domestic entrepreneurial class willing to commit its resources to domestic investment rather than to luxury consumption or holding private wealth abroad, is a central institutional issue which also must be addressed in a developmental approach to poverty reduction" (UNCTAD, 2002a:177-178) – and as such these issues need to be reflected in the national development plan.

PRSP

It has been argued that poverty reduction strategies are becoming the overarching national planning instrument in many countries (UNDP, 2002a). In the majority of sub-Saharan African countries, this correlates with the PRSP. With its emphasis on poverty reduction, public participation and local ownership, the PRSP has been heralded as an innovative planning tool with the potential to realise integrated economic and social development. Whether the PRSP will realise this potential depends to a large extent on the nature and scope of the participatory process, the quality of the analysis, and the depth and breadth of proposed strategies, amongst others.

Already, there are some concerns about both the content and the process of the PRSP. In terms of the content, one of the main criticisms is that macroeconomic policies are exempted from a poverty analysis (ActionAid, 2002; Craig and Porter, 2002; Godfrey, 2001; ILO, 2002; UNCTAD, 2002a and 2002b; UNECA, 2002). Instead, poverty is generally addressed through certain pro-poor policies, chiefly in the public provision of health and education, and through the provision of additional safety nets and targeted spending to respond to the adverse effects of macroeconomic reform (seen to be only temporary in nature). African PRSPs most commonly include macroeconomic and structural adjustment policies, like non-inflationary budget policies, revenue generation through a broad-based consumption tax (e.g. VAT), market liberalisation and deregulation and trade liberalisation, yet without assessing the likely impact of these policies on poverty (UNCTAD, 2002b). Past experiences with SAPs show that such policies have detrimental implications for poor people and have resulted in increased and deeper poverty. This has led John Ohiorhenuan (2002:3) to observe that PRSPs seem more concerned with symptoms rather than causes of poverty, or with targeting "the shadow rather than the substance".

ActionAid (2002) has observed that in some African countries, the PRSP reflects some improvement in the quality and depth of poverty analysis, although this finding could not be generalised to all countries. Yet, in most cases, poverty tends to be framed in a "naively technical" (but not neutral) way (Craig and Porter, 2002). Others have noted that the lack of poverty data and capacity for poverty monitoring – in other words, the absence of a 'knowledge infrastructure' – raises questions about the capability of the state to integrate poverty concerns into the macroeconomic framework (Ohiorhenuan, 2002; UN Economic and Social Council, 2002). State capability has already been eroded due to the civil service reforms under structural adjustment (Olowu, 1999). In spite of this, and regardless of the fact that African civil services are much smaller per head of the population than their counterparts in other parts of the world (Goldsmith, 2000; Olowu, 1999), many PRSPs continue to emphasise downsizing of the civil service. This further erodes the capacity of the state to ensure that poverty concerns are integral to macroeconomic analysis and strategy formulation. The combination of weak state capability and the absence of an appropriate knowledge infrastructure are likely factors in what UNCTAD (2002a:170) refers to as "the missing middle" – the fact that PRSPs generally lack clear strategies to meet the stated objectives and targets.

Other concerns with the content of PRSPs relate to the lack of attention given to employment and the need for productive development policies (ILO, 2002; UNCTAD, 2002a), the near absence of a gender perspective on poverty and economic growth (Zuckerman and Garrett, 2003), and the inadequate attention given to trade issues (Ladd, 2002; UNCTAD, 2002a). In addition, there has been weak integration of sector plans into the PRSP (Berke, 2002; UNCTAD, 2002a). Also, the focus on the architecture of the state through the emphasis on 'good governance' has raised mixed responses, particularly when one of the implications seems to be downsizing of the state, without due regard for issues related to the quality and accountability of the civil service.

In terms of the PRSP process, there are indications that in some African countries the PRSP has widened the space for civil society involvement to engage in public policy making, although this is not the case in all countries (ActionAid, 2002). Moreover, the space for civil society engagement narrows substantially as the process of developing and adopting a PRSP progresses. Also, the absence of clear criteria or a mechanism to assess

the quality of participation is an issue of concern (ActionAid, 2002; Godfrey, 2001). Of particular concern are the lack of parliamentary engagement and scrutiny (Craig and Porter, 2002; UNCTAD, 2002a; UNECA, 2002) and the lack of involvement of local Councillors (Craig and Porter, 2002; Ohiorhenuan, 2002). Others have noted that labour ministries, trade unions and employer organisations have not been sufficiently involved (ILO, 2002). Linked to the issue of process is the question about capacity, and more specifically the need for competent citizens and civil society organisations to engage effectively with the PRSP (Cheru, 2002c; Godfrey, 2001).

Concerns related to both process and content of PRSPs raise questions about ownership – a fundamental tenet of the PRSP. The fact that the PRSP has become a prerequisite to qualify for concessionary loans, debt relief and bilateral grants is seen to limit local ownership, especially in light of the dominant role played by international financing institutions in both the formulation and the approval of the PRSP. In light of this, UNCTAD (2002b) has argued that ownership is confined to social development programmes and safety nets, but does not apply to macroeconomic development strategies. Another issue noted is the narrow base of ownership within central government, as it is usually confined to the Ministry of Finance or the Office of the President, with little real engagement of other Ministries (Cheru, 2002c).

These areas of concern notwithstanding, many commentators recognise that the PRSP does hold the potential to be an effective development planning framework. Clearly, some fundamental changes in the conceptualisation, formulation and implementation of PRSPs are required to realise this potential.

MTEF

The MTEF is a key instrument for macro-budget planning and expenditure control in sub-Saharan Africa. Like the PRSP, it has been developed under international guidance and negotiated with donors and IFIs. Various African countries have already adopted the MTEF and it is expected that many of their regional counterparts will follow suit.[xxiv] The MTEF links policy making to planning and budgeting. It covers three to four years, although it is envisaged that this time horizon could be extended as countries gain experience with the MTEF (World Bank, not dated). The MTEF is "… a top down strategic allocation guide and a bottom up cost template" (World Bank, not dated:2). In other words, it combines fiscal targets (the 'hard budget constraint') set by the Ministry of Finance (and endorsed by Cabinet) with allocation of resources to strategic priorities that have emerged from a bottom-up estimation of costs. As such, the MTEF is the outcome of a process of negotiation between central Ministries (particularly the Ministry of Finance) and sector Ministries, in which Cabinet plays a decisive role. Whereas its intention is to promote financial predictability by providing a comprehensive budget, part of the MTEF's objective is "… to encourage the sectors to adopt a culture of strategic management and creating a competitive platform for resource allocation" (World Bank, not dated:3). In addition, the MTEF is becoming increasingly associated with making budgets more performance oriented and transparent.

Because most MTEFs are still relatively young, it is difficult to assess their role and impact in practice. However, a preliminary World Bank assessment found that the most developed MTEFs are found in South Africa, which has a higher capacity than most other countries, and in Uganda, where it has been introduced over a decade ago. In few countries, evidence suggested that fiscal discipline had improved or that it had led to greater financial predictability. Likewise, there was only limited evidence to suggest that the MTEF had facilitated better inter- and intrasectoral coordination. In addition, the review identified a need for better integration between the MTEF and the existing budget process (Le Houerou and Taliercio, 2002).

There is supposed to be a complementary relationship between the MTEF and the PRSP. Both frameworks share a focus on medium-term planning and are aimed at facilitating donor harmonisation. Yet, many observers have noted that in most countries those links are (still) very weak (see, amongst others, ActionAid, 2002; Ohiorhenuan, 2002; UNECA, 2002). Where the link has occurred effectively, for example in Uganda, it has led to unprecedented volumes of international funds, which have been channelled through central agencies directly to sector programmes at community level (Craig and Porter, 2002).

SWAps / Sector Plans

A common manifestation of sector plans in sub-Saharan Africa is found in SWAps. SWAps emerged in the latter part of the 1990s in response to the perceived failings of the project approach to complex issues within particular sectors; the

problems that existed with dual budgeting (in particular, the split between recurrent and capital expenditure); the donor-driven agenda in sectoral planning and associated conditionality; the administrative burden on recipient governments due to a lack of donor harmonisation; and, concerns about sustainability in light of the failure to build local capacity (Lister, 2002). The idea underpinning SWAps is that "all significant public funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on government procedures to disburse and account for all public expenditure, however funded" (Lister, 2002). Like the PRSP and the MTEF, SWAps are medium-term planning frameworks, underpinned by consultation, government leadership and donor harmonisation.[xxv] It is worth noting that SPs (Sector Programmes) or SWAps do not equate with an entire sector, but generally involve only 50% of funding to a particular sector (Berke, 2002).

The experiences with SWAps to date show mixed results, with some clearly guiding sectoral planning and others having become dormant soon after being formulated (Berke, 2002). More recently, the alignment of SWAps and sectoral plans with the PRSP has become an area of focus. It seems that in some instances, the PRSP process has given impetus to new or dormant sector programmes. In other instances, however, SWAps or SPs pre-dating the PRSP seem to have difficulty in adapting to the targets and strategies set out in the PRSP (Berke, 2002). To a large extent, this is indicative of the fact that planning processes and plans produced (whether sectoral, multi-sectoral or otherwise) are not sufficiently aligned and integrated. The issue of alignment and integration of development planning frameworks clearly is a recurrent issue, to which we shall return later.

National Strategic Framework for HIV/AIDS

The objective of the National Strategic Framework for HIV/AIDS is to guide all government sectors to respond effectively to the multiple development challenges associated with the HIV/AIDS epidemic. Although it is too soon to assess the long-term impact of multi-sectoral planning for HIV/AIDS, it has undeniably added significant momentum to the response to HIV/AIDS in sub-Saharan Africa. Amongst others, it has focussed collective energies on analysing the nature and manifestation of the epidemic and on formulating appropriate solutions.

Yet, despite the general consensus that HIV/AIDS requires a multi-sectoral response (as evidenced in most policy documents and plans concerning HIV/AIDS on the subcontinent), when it comes to analysis of and programmatic responses to HIV/AIDS, there tends to be consistent slippage to responses focusing on the individual level and on matters of personal behaviour (Decosas, 2002). To some extent, this could be indicative of the complex nature of multi-sectoral and integrated planning. But it also points to conceptual and methodological issues concerning the 'source' of HIV infection and what is considered the most effective (and morally and politically acceptable) entry point for intervention. Furthermore, it suggests that there can be a 'translation gap' between stated objectives, strategy formulation and implementation. Such distortion is obviously not unique to multi-sectoral planning for HIV/AIDS.

Another concern is that multi-sectoral planning for HIV/AIDS usually does not coincide with other national planning cycles, in particular the budget cycle. Again, this raises the issue of synchronisation of different planning cycles and alignment of development planning frameworks.

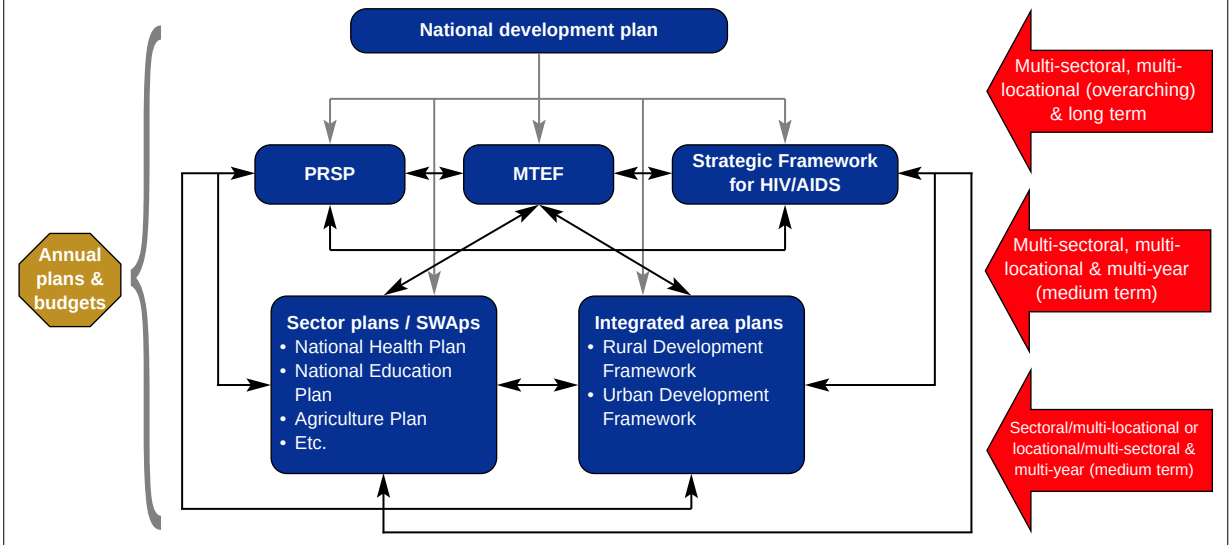
Rural Development Framework

The Rural Development Framework provides the framework for a consistent and coherent policy approach to rural development based on a medium to long-term vision of rural development. Informed by an analysis of rural realities, the Rural Development Framework typically outlines the goals, policy choices and strategies that would be best suited to realise the vision. Its main concerns generally are enhancing the productivity of the rural economy and reducing rural poverty through a combination of measures (e.g. employment creation, the promotion of food security, investment in social development and infrastructure, etc.). The framework also addresses institutional issues, such as the role of the state in the development process and mechanisms to facilitate participatory planning.

Urban Development Framework

The object of the Urban Development Framework is similar to that of the Integrated Rural Development Framework, but with specific reference to urban realities and the need to create sustainable urban settlements. Sub-Saharan Africa is characterised by fairly recent and rapid urbanisation.[xxvi] This brings with it a host of challenges related to the need to create viable, productive, equitable and sustainable urban settlements. Because urban areas also have

Graph 3.1. Ideal type linkages between development planning frameworks



Source: World Bank (2002c)

political, economic, social and environmental significance beyond their borders, the Urban Development Framework typically has to address these impacts as well.

3.5. Issues of integration and alignment

A key challenge facing sub-Saharan African states is to ensure alignment between the key frameworks guiding development planning. Evidence suggests that this is an area where significant space for improvement exists. Currently, most countries have parallel planning processes, with little integration and alignment between these processes and their outputs. Planning cycles are often not aligned, as was noted in the case of the PRSP, the MTEF and Sector Plans as well as in relation to multi-sectoral planning for HIV/AIDS and other planning cycles, particularly the budget cycle. There is also a lack of uniform data and reporting systems, consistent indicators and standardised guidelines for local level involvement that can be used across different planning systems (Berke, 2002; Lister, 2002).

Another, linked, issue is the need to ensure that the various (aligned) planning frameworks are translated into annual plans with clear targets and implementation strategies and into annual budgets. As the preceding overview has highlighted, there is significant room for improvement here as well.

Graph 3.1 represents an ideal type picture of the relationship between key development planning frameworks and their link to annual plans and budgets. The way the planning frameworks are presented does not reflect a hierarchical order, with the possible exception of the national development plan, which is meant to be the overarching framework to guide all other development planning frameworks (see grey arrows). Whilst all development planning frameworks cover multi-year cycles, the national development plan provides a long term vision, whereas the other frameworks are more concerned with the medium term. In addition, the PRSP, MTEF and the National Strategic Framework for HIV/AIDS are multi-sectoral and multi-locational (i.e. relevant for both urban and rural areas). Instead, sector plans are multi-locational, but not multi-sectoral, and integrated area plans are multi-sectoral, but not multi-locational. As Graph 3.1 shows, the relationship between different development planning frameworks is supposed to be mutually enforcing. Obviously, this starts from the premise that the various development planning frameworks are a true reflection of local needs and demands – in other words, that these are domestically designed and owned plans. Otherwise, greater synchronisation is likely to be associated with tighter conditionality and restrained room for manoeuvre for African states and their people.

The next chapter will explore possible links between development planning and HIV/AIDS. It will start by presenting the theoretical starting points for such an assessment. From there, it will apply these theoretical starting points to the various development planning frameworks identified here.

Table 3.1. Overview of key types of development planning in sub-Saharan Africa, 1960s-1990s				
	1960s	**1970s**	**1980s**	**1990s**
Economic development planning	Capital formation as the basis for economic growth, with primary exports and import substitution leading to rapid industrialisation. Also promotion of some form of economic nationalism.	Similar to the 1960s, with more attention given to distributional aspects of growth and to poverty (through planned sectoral investment).	Stabilisation through macroeconomic reform and structural adjustment.	Stabilisation through macroeconomic reform and structural adjustment. Increasing poverty and equity concerns, yet mainly delinked from macroeconomic planning.
Sectoral planning				
Health planning	Establishment of national health care systems and significant state investment to ensure free access to health care for all.	Shift to PHC (at least in theory), with emphasis on equity, participation, intersectoral collaboration & decentralisation.	Health sector reforms articulated in terms of equity, sustainability and efficiency. Drastic cuts in public sector spending and emphasis on the role of the market in service delivery, coupled with significant diversification of service providers. Introduction of user charges to generate revenue and emphasis on community involvement & decentralisation. Significant increase in donor involvement.	Revival of PHC ideas (e.g. 'community based health care'), with emphasis on participation, empowerment & decentralisation. Donors introduce sector-wide approaches (SWAps) for health development since mid-1990s.
Education planning	Transformation of the inherited racial education system (incl. 'Africanisation' of curriculum throughout all levels of the education system) to ensure access for all. Emphasis on primary and adult education; also promotion of higher education through guaranteed employment for graduates.	Shift to vocational and technical skills training, with particular focus on agriculture and rural development, as a means to stem rising levels of unemployment.	Drastic cuts in public sector spending and emphasis on the role of the market in service delivery, coupled with significant diversification of service providers. Introduction of user charges to generate revenue. Significant increase in donor involvement. Emphasis on primary education.	Donors introduce sector-wide approaches (SWAps) for education since mid-1990s. More emphasis on participation and partnerships.
Integrated area planning				
Rural development planning	Physical and infrastructure planning and/or self-help community development (with strong participation component).	Increasing concern with productivity and rural unemployment, focusing on diversification of rural economy, modernisation of agriculture sector and small farm productivity. Also, emergence of Integrated Rural Development Planning (IRDPs) (largely dependent on donor funding), basic needs provision and local development funds.	Elements of earlier forms of rural development planning, yet accompanied by a retreat of the state and increasing involvement of donor agencies, NGOs and local communities. Also, increasing recognition of the interdependence and complex interlinkages between rural and urban development.	Elements of earlier forms of rural development planning, yet accompanied by a retreat of the state and increasing involvement of donor agencies, NGOs and local communities.
Urban development planning	Master planning, focusing on physical/spatial dimensions of planning. Emphasis on urban-based industrialisation policies based on the view that urban development is beneficial for national development.	Significance of economic, social and political factors recognised, leading to large-scale development projects (e.g. squatter upgrading and sites-and-services). Yet, continuation of physical planning through the master plan, with little interlinkages. Strong anti-urban sentiment started to emerge.	Urban management approach, i.e. significant reduction in the role of the state in the implementation of development projects (incl. privatisation & commercialisation of state functions), focus on alternative sources of revenue (incl. private sector investment & service charges), and promotion of local community involvement in delivery and maintenance of urban services & infrastructure.	Shift towards strategic planning (within the urban management approach) as a dynamic framework for priority setting, implementation & the facilitation of participation and partnerships.

Sources: Ayeni (1999); Belshaw (2002); Bloom and Lucas (2002); Cheru (2002a); Court and Kinyanjui (1986); Devas and Rakodi (1993); Halla (2002); Hearst and Blas (2001); Hill (1997); Kinyanjui (1994); Mongula (1994); Mumtaz and Wegelin (2001); Nissanke (2001); Stren (1991); Walt et al. (1999).

Development planning and HIV/AIDS an assessment of principal development planning frameworks

4.1. Introduction

Chapter 2 concluded by referring to the human tragedy and devastation caused by HIV/AIDS in sub-Saharan Africa and highlighted some of the fundamental development challenges associated with the epidemic. Although the scale and nature of these challenges vary between countries on the subcontinent, with Southern and Eastern African countries facing the most severe HIV/AIDS epidemics, containing the spread of HIV and responding to the multiple impacts of the epidemic is a priority for the whole of the subcontinent. Development planning, in its variety of forms, has a critical role to play in this regard. The aim of this chapter is, firstly, to outline a conceptual framework that allows for a more in-depth assessment of the possible links between development planning and HIV/AIDS and, more specifically, of the extent to which development planning, consciously or unwittingly, supports or undermines an effective response to HIV/AIDS. The second part of this chapter then applies this conceptual framework to the development planning frameworks that seem most critical in guiding the development process in sub-Saharan Africa.

At the outset, it may be important to engage with an apparent paradox. This study is chiefly concerned with state-led development, yet evidence suggests that the most effective and sustainable responses to HIV/AIDS are community-initiated and community-led (see, amongst others, Decosas, 2002). Does this not raise questions about the effectiveness and desirability of a top-down and state-led approach? This question clearly oversimplifies some issues. For one, state-led development does not necessarily imply a top-down approach, nor does it assume that the state is the only actor in the design and implementation of planning interventions. As the proposed working definition of development planning has highlighted, participation is an integral element of the process. Furthermore, the state can help to create and strengthen those conditions that enable a community response to flourish. Finally, many of the determinants and consequences of HIV/AIDS transcend the local level and exceed the area of influence of communities and their organisations. These issues justify a focus on state-led development in relation to HIV/AIDS.

4.2. Conceptual shifts for an expanded response to HIV/AIDS

The need to respond to HIV/AIDS has been recognised since the early 1980s. Since then, various conceptual shifts have occurred in relation to HIV/AIDS, which have influenced planning responses. Initially, a narrow biomedical paradigm determined the way HIV/AIDS was problematised and both analysis and planning response were concerned with the medical aspects of the epidemic. This soon led to a concern with ‘risk groups’ and behavioural aspects, including a focus on ‘culture’, often foregrounding individual behaviour and responsibility as the key to preventing further HIV transmission. More recently, there is widespread recognition of the limitations of both the biomedical and anthropological/behavioural paradigms for explaining the nature and spread of HIV and for articulating appropriate planning interventions to curb its spread and mitigate its impacts. Nowadays, HIV/AIDS is conceptualised as a development issue, which emphasises the socio-economic

context in which the epidemic occurs and the interrelatedness of HIV/AIDS with other development concerns, such as poverty and inequality (see, amongst others, Collins and Rau, 2000). This conceptual shift has given rise to the formulation of what UNAIDS (1998) refers to as 'an expanded response'.[xxvii] Such an expanded response finds expression in multi-sectoral responses to HIV/AIDS at country level, most commonly reflected in the National Strategic Framework for HIV/AIDS.

Although the various conceptual frameworks for HIV/AIDS (medical, behavioural or multi-sectoral) undoubtedly result in different planning responses in terms of goals, objectives and strategies, what they have in common is the fact that they could all be considered to fall into the category of *'planning for HIV/AIDS'* (which may be more appropriately called 'planning against HIV/AIDS'). This type of planning has as its objective to consciously respond to the epidemic, either by targeting specific determinants, dynamics or impacts of the epidemic or by developing a comprehensive response to the epidemic.

In addition to 'planning for HIV/AIDS', other types of development planning also have relevance for the spread of the epidemic and its impacts. This concerns *development planning aimed at realising specific development objectives* (e.g. macro-economic growth, poverty reduction, food security, rural/urban development, quality education, etc.). Economic development planning, sectoral planning and integrated area planning as identified in the previous chapter would fall into this broader category. Often, these types of development planning include little to no reference to HIV/AIDS. Even if reference to HIV/AIDS is made, this hardly ever translates into a programmatic focus on HIV/AIDS. Yet, this broad category of development planning can significantly increase or decrease the level of risk and vulnerability to HIV infection and the extent to which individuals, households and organisations are able to cope with the consequences of HIV infection.

This report is concerned with both 'planning for HIV/AIDS' (as embodied in the multi-sectoral National Strategic Framework for HIV/AIDS) and with development planning for other development objectives, specifically economic development planning, sectoral planning (with emphasis on health and education) and integrated area planning (urban/rural development planning). Before exploring the possible links between HIV/AIDS and key development planning frameworks as identified in Chapter 3, we first need to look more closely at the nature, determinants and consequences of HIV/AIDS and propose a conceptual framework that allows for an assessment of the implications for development planning.

4.3. HIV/AIDS: A three-pronged response

There is general recognition that an effective response to HIV/AIDS has three core objectives, which are interrelated:

1. Prevention of HIV transmission;
2. Care and treatment for those infected with HIV;
3. Mitigation of current and future social, economic, political and institutional impacts of AIDS.

Development planning (both 'planning for HIV/AIDS' and other types of development planning) has relevance for each of these objectives, or core components, of a comprehensive response to HIV/AIDS.

Prevention

In seeking to develop appropriate prevention measures, development planning needs to understand and respond to the determinants of the epidemic that constitute a risk environment, rather than merely focusing on individual behaviour and assumed individual responsibility. Behavioural factors related to sexual practices (including sexual mixing, condom use and prevalence of concurrent sexual partners) and to breast-feeding are important dimensions influencing the spread of HIV. Yet, behavioural factors have often been overstated, with the result that too much emphasis has been put on individual choice and responsibility, without adequate regard for the social context in which individual behaviour occurs and the structural constraints it imposes on individual agency (see Baylies, 2000; Collins and Rau, 2000; Poku and Cheru, 2001).

Recent literature on HIV/AIDS suggests that the following determinants contribute to such a risk environment and enhance people's vulnerability to HIV infection:

- Poverty, more specifically lack of income;
- Lack of food security;
- Unequal income distribution;
- Gender inequality;
- Inadequate or unequal access to basic public services, particularly health care and HIV

prevention methodologies;
- Unequal distribution of political power and lack of political voice;
- Migration/mobility, displacement and urbanisation;
- Weak social cohesion;
- Levels of social instability, conflict and violence in society.[xxviii]

Various studies have shown that the relationship between any of these factors and HIV/AIDS is not simplistic. For example, while the majority of people living with HIV/AIDS are poor, many people who are not poor are also infected (Collins and Rau, 2000). Also, not all poor people, women or migrants become infected with HIV, which suggests that it is the interplay between these (and other) determinants that needs to be appreciated.

Of all the factors identified above, migration/mobility and urbanisation are of a slightly different order. In the case of the other factors, the negative (e.g. poverty or inequality) can be turned into a positive (e.g. poverty reduction or the promotion of equality), thereby contributing to a diminished risk environment for HIV infection. In the case of migration and urbanisation, it could be tempted to see the corresponding response as simply curbing migration or controlling entry into urban areas. Yet, such a response is likely to result in a violation of human rights, such as right to freedom of movement. Instead, migration and urbanisation are both manifestations of the wider challenges to development (e.g. survival strategies in response to poverty, lack of employment prospects or conflict) and development challenges themselves, with conditions during the journey and at the place of destination enhancing vulnerability and risk regarding HIV/AIDS (UNAIDS, 2001). Thus, curbing migration or urbanisation is not the appropriate solution.

Treatment and care

In relation to treatment and care, a number of core factors can be identified that influence the capacity of people living with HIV/AIDS and their communities to cope with the consequences of infection. These include factors that could decrease the probability of becoming symptomatic (i.e. HIV/AIDS-related illnesses) and of death, or that could ensure that affected individuals, households and communities are supported and equipped to cope with the health consequences of infection. The following factors are important in this regard:

- Access to appropriate and affordable health care, including access to life-prolonging and life-enhancing treatment (i.e. both anti-retroviral treatment and treatment for opportunistic infections);
- Poverty and lack of food security, in particular because lack of nutrition weakens the immune system and many medicines need to be taken with food.

Again, behavioural factors like patient adherence to medical treatment are also important dimensions of effective treatment and care. However, as with behavioural factors linked to the prevention of HIV infection, such factors need to be understood in the wider context of structural factors that influence individual behaviour. An overemphasis on individual responsibility for adhering to treatment, without acknowledging how factors like poverty, food insecurity and inadequate health care services influence one's capacity to persist with the treatment, exaggerates the amount of discretion individuals can exert. This serves to further disempower people and can easily result in a situation whereby people get blamed for forces beyond their control.

Impact mitigation

HIV/AIDS has multiple devastating impacts beyond individual health status at household, community, society, sector and institutional level, as Chapter 2 has highlighted. Most of these are already evident in worst affected countries, although the scale of these impacts is expected to increase dramatically within the next decade. Other impacts are as yet less evident, but are anticipated, such as the impact on macro-economic growth. On the basis of an expanding body of literature, the following eight key impacts can be extracted, each of which has far-reaching implications:

- Increasing adult mortality and infant mortality, resulting, amongst others, in demographic changes in the population structure and possibly in the gender ratio;
- Significant increase in the number of orphans, leading to an increasing number of child-headed households and households headed by an elderly person, amongst others;
- Increasing levels and depth of poverty and widening income inequalities;
- Increasing burden on women and risk of enhanced gender inequality;
- Collapse of social support systems and loss of social cohesion, especially as a result of stigma and fear;
- Reduction in labour supply, loss of

qualified/skilled staff and organisational memory, and reduced productivity in all organisations and all sectors of the economy;
- Collapse of essential public services and erosion of public sector capacity;
- Reduced, possibly adverse, rate of economic growth and unstable, if not diminished, local revenue base;
- Enhanced possibility of social instability, conflict and violence.[xxix]

Clearly, not all of these impacts are inevitable, nor are they unalterable. Again, this depends on local variables and external factors. One of the astounding observations is that some likely consequences of HIV/AIDS are also considered key determinants of the epidemic, although these do not necessarily manifest themselves in the same way or form. For example, HIV/AIDS is likely to exacerbate poverty by increasing both the level and the depth of poverty. In the process, social groups that were previously less significant as a category of poor people may become significant, like orphans or the elderly, whose livelihood security has been eroded with the death of their children. The commonality between consequences and determinants of the epidemic suggests the possible danger of becoming trapped in a vicious cycle.

4.4. Development planning and HIV/AIDS: a tentative framework for assessment

Development planning, either by design or unintentionally, influences the determinants, dynamics and consequences of the HIV/AIDS epidemic. For example, it can encourage migration, increase income inequalities and undermine food security, which may enhance the risk of HIV transmission. Topouzis (1998) gives examples of how road construction in Malawi and the construction of the Volta River Dam in Ghana both facilitated the spread of HIV by enhancing mobility (Malawi) and causing displacement and reducing economic security, leading many women to engage in sex work to generate income (Ghana). The opposite also holds true: through deliberate efforts to reduce poverty, enhance the status of women or support political voice and participation, development planning can help to prevent the spread of HIV and mitigate the impacts of HIV/AIDS. However, as Baylies (2002) cautions, such 'generic' interventions aimed at addressing specific determinants or consequences of the epidemic may not always be successful, as HIV/AIDS alters the dynamics of poverty, inequality and social exclusion. Thus, development planning in sub-Saharan Africa needs to *consciously* address the core determinants and consequences of the HIV/AIDS epidemic. This applies equally to 'planning for HIV/AIDS' and planning aimed at achieving other development objectives, whether these objectives are overarching, economic, sectoral or area-based.

In broad terms, we can review the link between development planning and HIV/AIDS on the basis of two key questions. First, to what extent does this type of planning aggravate, or help to diminish, an environment that enhances the vulnerability of men (boys) and women (girls) to HIV infection? Secondly, to what extent does this type of planning strengthen or undermine the capacities of individuals, households, organisations and institutions to cope with the impacts of HIV infection, ill health and possible death?

Based on the preceding discussion, these broad questions can be further specified by identifying specific risk factors, or determinants, and potential impacts of the epidemic. The template in Table 4.1 captures a tentative framework that can be used to assess various types of development planning and their probable link with HIV/AIDS. It distinguishes between core determinants, which are crucial from the perspective of prevention, and key consequences, which need to be addressed from the perspective of impact mitigation. Because treatment and care can be considered as one area of mitigating the impact of HIV infection, these aspects are brought under impacts. In particular, treatment would fall under point 2.1 (in terms of access to anti-retroviral treatment) and point 2.7, which relates to equitable access to essential public services, including (but not restricted to) appropriate health care for AIDS-related illnesses.

The template allows us to explore three key issues. Firstly, it asks whether addressing a particular core determinant or key consequence is a deliberate objective of this particular type of planning and if so, whether it specifically targets men or women (see second column). This gender breakdown is important, because HIV/AIDS is so closely intertwined with gender inequalities. Secondly, it allows us to assess whether the strategies and tools promoted to achieve a particular objective are likely to realise the objective, based on past and current empirical evidence (see third and fourth column). In other words, it can assist in determining whether there is a potential 'translation gap' between objectives, strategies and outcomes. This step is basically concerned with the appropriate application

of technical knowledge in pursuit of politically agreed objectives and priorities. But even if addressing a core determinant or key consequence is not a deliberate objective, it does not mean that there is no possible connection or impact of development planning on the determinant or consequence. Thus, the template can also be used to assess the impact of planning interventions on specific determinants and/or consequences, even if addressing these is not an explicit objective (see fourth column). Again, this last question can be disaggregated according to men and women.

Thus, the two broad questions for assessing the link between development planning and HIV/AIDS can be further specified in the following two subsets of questions:

1. In terms of prevention:
    a. Is addressing this particular core determinant a deliberate objective of this type of planning?
    b. If so, is it intentionally gender-inclusive, in other words, are the needs of both men and women recognised?
    c. What strategies and tools are proposed to address this particular core determinant?
    d. Based on empirical evidence, are these strategies and tools appropriate to address this particular core determinant of risk for both men and women?
    e. If addressing this particular core determinant is not a deliberate objective, to what extent is this type of planning likely to enhance or diminish this core determinant of risk for both men and women?

2. In terms of impact mitigation:
    a. Is addressing this particular key consequence (of HIV infection, ill health, death and the HIV/AIDS epidemic at large) a deliberate objective of this type of planning?
    b. If so, is it intentionally gender-inclusive, in other words, are the potentially differential impacts on men and women recognised?
    c. What strategies and tools are proposed to address this particular key consequence?
    d. Based on empirical evidence, are these strategies and tools appropriate to mitigate this particular key consequence of HIV/AIDS on both men and women?
    e. If addressing this particular key consequence is not a deliberate objective, to what extent is this type of planning likely to aggravate or diminish the magnitude of this key consequence for both men and women?

Before applying these questions to the main development planning frameworks on the subcontinent, a few comments are worth making. For one, the concept of poverty and how it is used in the template warrants some attention. Poverty is a multi-dimensional concept and refers to the various inter-related aspects of well-being that influence a person's quality of life and standard of living, which can be material (e.g. food, income, housing, etc.) and non-material (e.g. participation in decision-making and social support networks) (UNDP Regional Project on HIV and Development in sub-Saharan Africa, 2002). Because various dimensions of poverty are mentioned as distinct determinants of HIV/AIDS in the template, poverty is used here more explicitly to refer to the material dimensions of poverty associated with a minimum standard of living and food security.

Some factors appear as both determinants and consequences in the template. From the perspective of development planning, this distinction may not always be necessary. The link of a particular type of development planning to poverty or political voice, for example, may be similar, whether these are identified as core determinants or consequences. However, the reason why some factors are repeated under consequences is because HIV/AIDS tends to aggravate and alter the nature of these development challenges (e.g. poverty, gender inequality, etc.). This points to the potential of HIV/AIDS to perpetuate a vicious cycle of risk and vulnerability to HIV infection and reduced capability to cope with the consequences of the epidemic. The important consideration for development planning is to recognise *how* HIV/AIDS changes, magnifies and intensifies these variables, so that the vicious cycle can be broken.

One of the limitations of tools and models, such as the template in Table 4.1, is that it may suggest that both the determinants and the consequences of HIV/AIDS can be reduced to simplistic causal factors and relationships. Clearly, this is not the intention here. For one, the determinants, dynamics and consequences of HIV/AIDS are variable and depend on a wide range of contextual factors, such

as the scale of the epidemic, the resource base of communities, the nature of social and political systems, the structure of the national and local economy, the resilience of institutions, and the nature of planned interventions to address the multiple challenges of HIV/AIDS, amongst others. Furthermore, vulnerability to HIV infection and capacity to cope with its developmental impacts are made particularly acute by the interplay between the various factors, rather than one single determinant. This means that the template needs to be applied with a healthy amount of caution and discretion.

Also, the relevance of specific risk factors and impacts, and how these manifest themselves, may vary depending on the scope, scale or functional reach of a particular type of planning. The next section will look at the key development planning frameworks in sub-Saharan Africa as identified in Chapter 3 and make some initial observations about how these frameworks address HIV/AIDS. Clearly, at this stage this is not based on an in-depth assessment of the various planning frameworks as formulated and implemented in particular countries on the subcontinent. Instead, the intention here is to draw out some generalities, which may or may not be appropriate or adequate to explain the relationship between development planning as exercised in particular countries on the sub-continent and HIV/AIDS. Chapters 6-9 reflect the findings of country-specific assessments of the links between development planning and HIV/AIDS on the basis of the template in Table 4.1.

Table 4.1. Template to assess possible links between development planning and HIV/AIDS							
DEVELOPMENT PLANNING FRAMEWORK (E.G. PRSP)							
	Objectives	Deliberate Objective?			How? (Strategies & Tools)	Possible Impacts / Link (Conscious or not)	
		Yes/No	Men	Women		Men	Women
PREVENTION: ADDRESSING CORE DETERMINANTS	1.1. Change in individual behaviour (sexual behaviour / breast feeding)						
	1.2. Poverty reduction, i.e. ensuring a minimum standard of living & food security						
	1.3. Access to decent employment or alternative forms of income generation						
	1.4. Reduction of income inequalities						
	1.5. Reduction of gender inequalities and enhancing the status of women						
	1.6. Equitable access to quality basic public services						
	1.7. Support for social mobilisation and social cohesion						
	1.8. Support for political voice and equal political power						
	1.9. Minimisation of social instability and conflict / violence						
	1.10. Appropriate support in the context of migration / displacement						
IMPACT MITIGATION: ADDRESSING KEY CONSEQUENCES	2.1. Reduction of AIDS-related adult/infant mortality (i.e. ARVs, PMTCT)						
	2.2. Patient adherence (focus on 'responsible' individual behaviour of AIDS patients)						
	2.3. Poverty reduction, i.e. ensuring a minimum standard of living & food security, especially for PLWHAs & affected households and individuals (e.g. children & elderly)						
	2.4. Reduction of income inequalities (between HIV-affected and non-affected households & individuals)						
	2.5. Reduction of gender inequalities and enhancing the status of women						
	2.6. Appropriate support for AIDS orphans						
	2.7. Equitable access to essential public services, both for infected/affected persons & households and in general *(due to eroding impacts of HIV/AIDS)*						
	2.8. Effective/enhanced public sector capacity *(due to eroding impacts of HIV/AIDS)*						
	2.9. Job security and job flexibility for infected and affected employees						
	2.10. Ensuring sufficient and qualified/skilled labour supply *(due to loss of labour)*						
	2.11. Financial stability & sustainable revenue generation *(threatened by HIV/AIDS)*						
	2.12. Support for social support systems & social cohesion *(eroded by HIV/AIDS)*						
	2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals (e.g. widows/widowers, children, elderly)						
	2.14. Reduction of AIDS-related stigma and discrimination						
	2.15. Reduction of social instability & conflict *(due to, or aggravated by, HIV/AIDS)*						

Table 4.2. Assessing the link between economic development planning and HIV/AIDS: The stabilisation approach of the 1980s				
		Objectives	*Deliberate objective?*	*Possible impacts/link (conscious or not)*
PREVENTION: ADDRESSING CORE DETERMINANTS	1.1.	Changes in individual behaviour (sexual behaviour/ breast feeding)	No	Little recognition of HIV/AIDS at the time; if so, it would have been considered part of health planning
	1.2.	Poverty reduction: ensuring a minimum standard of living and food security	No	SAPs resulted in increased poverty & reduced food security, especially for women & female-headed households
	1.3.	Access to decent employment or alternative forms of income generation	No	SAPs led to loss of employment (especially for women) and income for low-income groups
	1.4.	Reduction of income inequalities	No	Loss of employment and income for low-income groups aggravated income inequalities
	1.5.	Reduction of gender inequalities and enhancing the status of women	No	The workload of women increased, gender inequality was entrenched
	1.6.	Equitable access to basic public services	No	Drastic cuts in public services and introduction of user charges reduced access for the poor
	1.7.	Support for social mobilisation and social cohesion	No	SAPs resulted in great pressure on social support systems, bringing these to breaking point
	1.8.	Support for political voice and equal political power	No	No explicit link with democratic principles; economic decision-making increasingly by external agencies, disempowering the state and the local population
	1.9.	Minimisation of social instability and conflict / violence	No	SAPs heightened unemployment and economic insecurity, possibly fuelling disillusionment, conflict and violence
	1.10.	Appropriate support during migration / displacement	No	SAPs encouraged labour migration and urbanisation, with insufficient capacity and resources to respond to increased demand

4.5. Exploring possible links between development planning and HIV/AIDS

The remainder of this chapter will seek to illustrate how the template and the two subsets of questions can be applied to the main development planning frameworks in sub-Saharan Africa as identified in the previous chapter. Attention will first be given to the National Strategic Framework for HIV/AIDS, which should ideally inform the analysis of, and programmatic responses to, HIV/AIDS in other development planning frameworks. This will be followed by a discussion of the PRSP, the MTEF, Sector Plans and the Rural and Urban Development Frameworks. It is clear that some observations will be applicable to more than one development planning framework, because of shared overarching objectives or strategies. Such observations will not always be repeated.

A key issue complicating a thorough assessment is that most of these frameworks are still relatively new. This makes it difficult to assess anything beyond what is stated in the document. In some instances, past experiences in pursuing similar objectives or strategies may be of some help. In light of this, Table 4.2 may be instructive. It applies the first half of the template related to HIV prevention to the stabilisation approach of the 1980s. The intention here is not to suggest a simplistic causal relation between SAPs and the spread of the HIV/AIDS epidemic in sub-Saharan Africa. But as highlighted previously, at the time when SAPs were introduced, households, communities and even governments were already vulnerable to core determinants of HIV infection, which tended to be exacerbated by SAPs.

National Strategic Framework for HIV/AIDS

The National Strategic Framework for HIV/AIDS generally acknowledges many of the core determinants and key consequences of HIV/AIDS as identified in Table 4.1. Yet, more often than not this fails to translate into clearly articulated planning objectives, let alone strategies or outcomes. At times, outcomes are formulated, but with no indication of how these outcomes will be achieved. When it comes to programmatic interventions aimed at prevention of HIV transmission, the Strategic Framework tends to focus more exclusively on behaviour change *(point 1.1.)*, with possibly some recognition of the importance of community mobilisation and of support for political voice of potentially vulnerable groups (e.g. youth and women) as key components of a prevention strategy *(points 1.7 and 1.8)*. Through an emphasis on treatment and care and VCT (Voluntary Counselling and Testing) as elements of HIV prevention, the Strategic Framework may also be concerned with equitable access to basic services *(point 1.6)*.

In terms of impact mitigation, the National Strategic Framework for HIV/AIDS often tends to focus more

on visible impacts than on less noticeable ones. Due to cost implications, widespread access to anti-retroviral treatment in the public sector is usually not included, but PMTCT (pilot) projects are more commonly promoted *(point 2.1)*. This may be accompanied by an emphasis on patient adherence *(point 2.2)*. The need to provide special support to PLWHAs, affected households, children and the elderly (e.g. food distribution or income generating projects) is often recognised, but does not always translate into clear programmes and interventions *(point 2.3)*. The Strategic Framework would usually focus on the plight of AIDS orphans, which often translates into a focus on schooling and nutrition programmes *(point 2.6)*. But whether this is expanded to include the more comprehensive needs of orphans and child-headed households, such as housing, care and financial security, remains to be seen.

Access to health care for PLWHAs and affected households is usually addressed through VCT and Home Based Care (HBC) programmes *(point 2.7)*. This tends to be combined with an emphasis on the involvement of the community in care and support, commonly justified as contributing to social mobilisation and community empowerment *(points 2.12 and 2.13)*. Yet, unless this is based on awareness that social support systems themselves are eroded by the HIV/AIDS epidemic, this may in fact have the unintended consequence of further undermining social support systems and social cohesion.

Usually, support for the political voice of PLWHAs *(point 2.13)* and the reduction of AIDS-related stigma and discrimination *(point 2.14)* would be clearly articulated objectives in the National Strategic Framework for HIV/AIDS, with concomitant strategies and programmes. But insufficient attention is commonly given to the eroding impacts of HIV/AIDS on access to services for those not directly affected by HIV/AIDS *(point 2.7)*, on public sector capacity *(point 2.8)* and on financial stability and local revenue generation *(point 2.11)*. Yet, these are quite fundamental for the long term sustainability of any intervention. Even if mention is made of the devastating effect of the epidemic on labour and the need to protect the rights of HIV-positive workers *(point 2.9)*, this is not necessarily linked to the need to adequately respond to the loss of labour *(point 2.10)*.

PRSP

A cursory review of PRSPs suggests that on average, very little attention is given to HIV/AIDS. The estimated national HIV prevalence rate usually gets briefly mentioned in the context of health and often a connection is made between declining life expectancy and the HIV/AIDS epidemic. Some PRSPs devote a section to HIV/AIDS (e.g. Ethiopia), but even though the wider sectoral, economic and institutional impacts are alluded to, this is not reflected throughout the document. As a result, PRSPs tend to reflect over-optimistic projections of the economic growth rate, sector capacity to deliver public services and cost-recovery mechanisms, amongst others.

This also means that in general, PRSPs do not articulate any specific objectives, let alone interventions, to prevent HIV transmission or cope with the impacts of the epidemic. It is implied that such 'specificities' should be dealt with in other frameworks, such as the National Strategic Framework for HIV/AIDS and the National Health Plan.

Poverty reduction *(point 1.2)* is clearly a pronounced objective of the PRSP. In the logic of the PRSP, addressing poverty requires three broad and interrelated areas of intervention: the promotion of economic growth through macroeconomic reform; pro-poor policies, especially health and education; and, additional safety nets and targeted spending. Yet, as shown earlier in the discussion of the PRSP, many of the policies and instruments used to pursue macroeconomic reform are likely to be counterproductive to poverty reduction. Also, the lack of attention given to employment *(point 1.3)*, coupled with the job-shedding implications of trade liberalisation (including in the agriculture sector) and civil service retrenchments means that this particular core determinant of HIV infection is not taken into account. Similarly, addressing income inequalities *(point 1.4)* does not appear to be a key objective of the PRSP. In any case, policy measures such as the deregulation of domestic markets, trade liberalisation and unblocking the capital account are associated with increased income disparities (UNCTAD, 2002b).

Based on an audit of 13 PRSPs, Zuckerman and Garrett (2003) concluded that only three of these address gender issues commendably, if not completely. These are the PRSPs of Malawi, Rwanda and Zambia. Other PRSPs use an outdated approach, which confines gender issues to reproductive health and education, or neglect gender completely. Very few use gender-

disaggregated data, with the Rwanda PRSP being the only one that includes gender-disaggregated expenditures. In light of this, it is safe to assume that most PRSPs do not consciously seek to promote gender equality *(point 1.5)*. Yet, many macroeconomic measures, such as trade liberalisation and privatisation, have particularly negative implications for women.

As mentioned earlier, equitable access to basic services *(point 1.6)* is addressed through specific pro-poor policies in the PRSP. Many PRSPs commit to the provision of universal primary education, leading to the abolition or reduction of school fees for primary education, and to increased public investment for primary (preventive) health care. Yet, fees for secondary and tertiary education remain, despite the fact that poor people do not prioritise primary education over higher levels of education. Similarly, with regard to health care, curative health care is viewed as a private good for which the user should pay, even though poor people in Africa generally emphasise it as important – and inaccessible (UNCTAD, 2002b).

PRSPs typically do not explicitly aim to support social mobilisation and social cohesion *(point 1.7)*. Yet, policy assumptions about the community (e.g. in the provision of essential services), which overestimate the 'carrying capacity' of familial and social networks, are likely to erode social cohesion. To assess whether the PRSP is committed to support for political voice *(point 1.8)*, one could point to the participatory process underpinning the PRSP. Yet, as noted earlier, concerns have been expressed about the extent to which the space for public engagement has really opened up and whether it has opened up wide enough (i.e. to enable broad based participation) and long enough (i.e. from design to decision making, implementation and evaluation). All indications are that economic decision making is de-linked from democratic principles, with central Ministries (e.g. the Ministry of Finance) and IFIs determining the fundamentals.

It is unlikely that the last two core determinants of a risk environment for HIV infection (the minimisation of social instability and conflict, and appropriate support in the context of migration or displacement) are reflected in the PRSP as deliberate objectives. Again, macroeconomic reform strategies may increase economic insecurity, inequality and strife, thereby potentially creating or exacerbating social instability and conflict. At the same time, social development strategies may serve to alleviate some of the factors underlying a conflict situation.

In looking at impact mitigation, it seems fair to say that given the limited analysis of HIV/AIDS and its devastating impacts at individual, household, community, sector-wide, economic and institutional level, few impacts are likely to be consciously counteracted within the PRSP framework. It is clear that PRSPs generally reflect very optimistic economic growth rates (usually around 6-7%)[xxx] and social development targets, without any consideration of how HIV/AIDS is likely to thwart these projections *(see points 2.7 and 2.11)*. Likewise, the continued emphasis on rationalisation of the civil service in many PRSPs is not only likely to undermine public sector capacity to deliver quality services, it could also jeopardise job security of employees infected with HIV as health status and associated performance may become a deciding factor in retrenchments *(points 2.8 and 2.9)*.

MTEF

In assessing the MTEF and its potential links to HIV/AIDS, the focus is more specifically on the resource mechanisms and allocations to address both the core determinants and the key consequences of HIV/AIDS, as identified in Table 4.1. For example, an analysis of the link between the MTEF and HIV prevention is likely to focus on questions such as:

- Is the level of resources allocated for 'targeted spending' and safety nets sufficient or reasonable, given the scale of poverty? *(See point 1.2)* And do the allocations reflect the likely increase in poverty due to HIV/AIDS? *(See point 2.3)*
- What mechanisms are proposed to reduce the levels of income inequality and to ensure a fair distribution of the national income (e.g. the tax system)? *(See points 1.4 and 2.4)*
- What mechanisms and resource allocations are proposed to promote gender equality and enhance the status of women? *(See point 1.5)*
- Would the privatisation and commercialisation of public sector services thwart equitable access to basic public services, particularly for those households that are (increasingly) unable to pay for these services? *(See points 1.6 and 2.7)*

Some of these questions also have relevance for assessing the link between the MTEF and impact mitigation. In addition, other issues worth exploring are the following:

- Has provision been made in the MTEF for the

provision of ARVs and PMTCT to curb adult and infant mortality (or otherwise for a national resource mobilisation strategy)? Are both men and women targeted? *(See point 2.1)*

- Are sufficient resources allocated to provide for the needs of AIDS orphans for food, housing and care, education, financial support, and so on? *(See point 2.6)*
- Are sufficient resources allocated from the national budget for health to ensure equitable access to health care for men and women living with HIV/AIDS, in particular access to basic medicines and quality care? *(See point 2.7)*
- What is the impact of 'downsizing', 'rightsizing' and rationalising of the public sector on its capacity to fulfil its mandate to facilitate national development? To what extent are such strategies concerned with minimising the loss of capacity, skills and organisational memory in the public sector due to HIV/AIDS? *(See point 2.8)*
- Has sufficient consideration been given to the financial implications of protecting the right to work of both male and female employees infected with HIV/AIDS (for example, through flexible working arrangements and the provision of ARVs)? *(See point 2.9)*
- What level of investment is made to ensure that sufficient and adequately qualified labour is supplied in accordance with the demands of the economy, particularly in those sectors that are badly affected by the loss of labour due to HIV/AIDS? *(See point 2.10)*
- Where will the necessary financial resources come from? What are the expectations in terms of local revenue generation and people's ability to pay taxes and service charges? *(See point 2.11)*
- Does economic decision-making strengthen or undermine democratic principles? To what extent are men and women living with HIV/AIDS, their families and affected communities involved in decision-making concerning national economic development? *(See point 2.13)*
- Is there a framework for the decentralisation of decision-making about resource allocations? *(See points 2.7, 2.11 and 2.13)*

Clearly, this list of questions is not exhaustive. Rather, these questions merely point to a way of analysing and interrogating the possible links between macro-budget planning (i.e. the MTEF) and HIV/AIDS.

Sector plans

In sub-Saharan Africa, the health and education sectors are among the worst affected sectors by the HIV/AIDS epidemic. This makes an assessment of the National Health Plan and the National Education Plan in relation to HIV/AIDS particularly pertinent.

National Health Plan

Given the initial conceptualisation of HIV/AIDS as a biomedical concern, health planning has historically focussed most explicitly on HIV/AIDS compared to other types of development planning. It has been particularly concerned with preventing the spread of HIV through the use of prevention technologies, which over time have expanded from the distribution of condoms and STD treatment to Information, Education and Communication (IEC) approaches and to Voluntary Counselling and Testing (VCT). Behaviour change has been a central objective in this regard *(see point 1.1 in the template)*, as has access to appropriate health care, such as STD control *(related to point 1.6)*. These elements are still likely to feature prominently in the National Health Plan.

Equitable access to health care (*point 1.6* – including the removal of gender disparities in access to health care, relating to *point 1.5*) would be a fundamental objective of the National Health Plan. However, past experiences show that the inappropriate design of a system of user fees without adequate provision for exemption and subsidisation has resulted in reduced access to health care for poor households in both urban and rural areas. The commitment in many PRSPs to free primary health care is a welcome departure, yet the continuation of user fees for curative health care still gives cause for concern.

The common emphasis on community-based health care and decentralisation of health planning can potentially strengthen social mobilisation and cohesion and political power at community level *(points 1.7 and 1.8)*. Whether this happens in practice depends on the extent to which decentralisation involves the devolution of all the necessary powers and functions (including the authority to allocate resources). It also depends on whether the expectations of 'mutuality' and the 'carrying capacity' of familial and community networks are realistic, or whether they ultimately serve to weaken these social networks.

Nutrition programmes could be considered as the health sector's contribution to poverty reduction,

more specifically to food security *(point 1.2)*. But the National Health Plan is unlikely to include core determinants like lack of work and income (*point 1.3)*, income inequality *(point 1.4)*, conflict (*point 1.9)* or migration (*point 1.10*), with the possible exception of making provision for STD control and condom distribution along main routes or at places of work to reduce the risk of HIV transmission among migrants.

From the perspective of impact mitigation, the National Health Plan would characteristically be concerned with the reduction of adult and/or infant mortality through the provision of ARVs or PMTCT *(point 2.1)*. However, budget constraints would generally mean that anti-retroviral treatment cannot be made available throughout the public sector and that at best pilot projects are implemented. Where anti-retroviral treatment is provided, emphasis may be put on patient adherence to the treatment *(point 2.2)*.[xxxi] Over-emphasis on patient adherence without due regard for limitations within the health system itself and for external factors that impact on a person's ability to persevere with the required treatment can help to perpetuate AIDS-related stigma *(point 2.14)*.

The National Health Plan is also likely to recognise the need for nutrition programmes and appropriate health care for PLWHAs *(points 2.3 and 2.7)*. The latter point brings to the fore the need for essential medicines, the importance of strengthening and expanding health care infrastructure, and the value of community-based health care, amongst others. Whether this has translated into the provision of free health care for AIDS orphans *(point 2.6)*, especially those of school-going ages, remains to be seen.

Health planning is not only concerned with the supply and demand of appropriate health services, but also with the organisational, financial and human resource requirements. Given the fact that health care workers (mostly women) show high HIV infection and mortality rates in many countries in sub-Saharan Africa, there is an obvious need to assess the human resource implications, the impact on organisational productivity and the consequences for the ability of the health sector to provide quality health care on an equitable basis (see, amongst others, Barnett and Whiteside, 2002; UNDP, 2001a) *(see points 2.8, 2.9 and 2.10 in the template)*. Any type of health sector reform associated with institutional transformation, especially those concerned with rationalisation of the sector, without recognising the eroding effects of the HIV/AIDS epidemic on health care workers and the health care system in general is likely to contribute to the weakening of health care systems.

Likewise, the National Health Plan will have to deal with the issue of financial stability and sustainable revenue generation *(point 2.11)*. HIV/AIDS has significant financial implications, for example the loss of household income, reducing affected households' ability to pay for public services, escalating costs for treatment and care, and costs related to the loss of human resources in the health sector. Unless these implications are acknowledged, the prospect of financial stability will be jeopardised, particularly if its strategies are based on an assumption that health care systems can largely be funded through service charges, without a proper mechanism for cross-subsidisation or clear criteria for exemption of payment. In turn, this may jeopardise the objective of realising equitable access to health care for all, as HIV-affected households are increasingly unable to afford to pay for services.

With the current development discourse providing ideological justification for community-based health care, and faced with the increasing burden on the public health care system to respond to HIV/AIDS, it is tempting to shift responsibility for providing appropriate treatment and care to households (i.e. women and children) and communities. This may be rationalised as a means of recognising and strengthening social support systems and social cohesion *(point 2.12)*, and even of supporting empowerment *(point 2.13)*. However, unless this is accompanied by adequate support for familial and community networks, this may result in "home-based neglect" instead of home-based care (Foster, quoted in Barnett and Whiteside, 2002:308).

National Education Plan

Education has been a central component of HIV prevention efforts by raising awareness about the epidemic and communicating the importance of responsible individual behaviour *(see point 1.1)*. Although there is increasing recognition of the importance of other factors that constitute a risk environment for the transmission of HIV, it is as yet unclear whether this understanding has been translated into education messages and strategies that address factors such as poverty, income inequality or lack of social cohesion, amongst others. Another way in which education planning may purposely help to reduce the spread of HIV is through condom distribution among teachers and other staff.

An espoused objective of the National Education Plan would be the promotion of equitable access to education *(point 1.6)*, including efforts to overcome gender disparities *(point 1.5)*. The shift towards abolishing or reducing school fees for primary education in many PRSPs would be an important contribution to the realisation of this objective, yet this may not (yet) be reflected in the National Education Plan.

A key challenge for the National Education Plan is to ensure that there is an appropriate link between the education provided and the demands of the labour market, to ensure that it contributes to access to decent employment *(point 1.3)*. Past evidence shows that this link has been quite difficult to make. Although the reduction of income inequalities may not typically be included in the National Education Plan, one aspect of this is to ensure that the remuneration of teachers is similar to that of other public sector employees and of employees with similar qualifications in other sectors in the labour market *(point 1.4)*.

Education planning can, consciously or not, either strengthen or undermine social cohesion *(point 1.7)* and political voice and empowerment *(point 1.8)* in similar ways as described under the National Health Plan, possibly negatively affecting women more than men. With respect to violence and conflict *(point 1.9)*, both the content of education and the distribution of education resources could potentially play a role in minimising or exacerbating conflict.

Examples of how the National Education Plan could consciously address key consequences of HIV/AIDS include the following:

- By making anti-retroviral treatment available to infected employees in the education sector and their spouses to reduce adult mortality *(point 2.1)*;
- Through awareness campaigns focusing on patient adherence *(point 2.2)* or on reducing AIDS-related stigma *(point 2.14)*;
- By ensuring that girls and boys infected with HIV are not discriminated against *(points 2.7 and 2.14)*;
- Through efforts to involve women, men or households affected by HIV/AIDS in the design and management of education services *(point 2.13)*;
- By making special efforts to ensure that AIDS orphans or girls and boys living in a household affected by HIV/AIDS do not lose out on education opportunities due to cost considerations or the need to help out in the household *(points 2.6 and 2.7)*;
- By conducting an organisational and sector-wide assessment of the impact of HIV/AIDS on teachers and other personnel in the education sector and formulating appropriate human resource policies, including strategies to ensure that sufficient labour supply is provided to replace AIDS deaths in the sector *(points 2.8, 2.9 and 2.10)*;
- By reviewing the financial implications of HIV/AIDS on the education sector, including an assessment of the ability of HIV-affected households to pay for education *(point 2.11)*.

Rural / Urban Development Frameworks

Rural Development Framework

An assessment of how the Rural Development Framework is likely to address the core determinants and key consequences of HIV/AIDS is reflected in Appendix 1. Gender differentials need to be considered consistently, both in assessing whether addressing a particular core determinant or key consequence is a deliberate objective and in reviewing the possible impacts of rural development planning on specific determinants or consequences. As with the types of development planning discussed earlier, the specific nature of the suggested links here need to be validated with reference to specific countries and planning interventions. Appendix 1 does not reflect the tools and strategies proposed or adopted to meet specific objectives (the third column in Table 4.1), because this is best assessed in relation to specific planning interventions in particular countries.

Urban Development Framework

In most sub-Saharan countries, HIV/AIDS is mainly concentrated in urban areas, although there is increasing evidence that urban-rural interlinkages are rapidly facilitating the spread of the epidemic between urban and rural areas. Urban areas can constitute a particular risk environment for the spread of HIV, particularly for poor and low-income households. Overcrowding, lack of adequate housing and basic services, single sex compounds, high levels of unemployment (particularly as a consequence of the restructuring of the urban economy in line with the dictates of globalisation) and relatively high cost of living all contribute to an environment in which the epidemic thrives. These are among the key challenges that urban development planning has not been able to resolve effectively, even without considering HIV/AIDS.

What HIV/AIDS does is to make these issues even more pressing (Van Donk, 2002).

Many of the possible links between the Urban Development Framework and HIV/AIDS are similar to those identified in Appendix 1 concerning the possible links between the Rural Development Framework and HIV/AIDS. Of course, the economic base, the social structure and the political-institutional context in urban areas usually differ from those in rural areas; likewise, these factors differ between urban areas. Thus, HIV/AIDS will manifest itself differently in these areas and the impacts of the epidemic are likely to throw up particular challenges for urban development planning, which need to be addressed in the Urban Development Framework. Yet, the lines of interrogation are similar to those presented in Appendix 1 in relation to the Rural Development Framework. For this reason, the template in Table 4.1 will not be applied to the Urban Development Framework.

4.6. Concluding observations

This chapter has attempted to provide a conceptual framework that allows for an assessment of possible links between development planning and HIV/AIDS, and more specifically, to assess the extent to which development planning contributes to comprehensive prevention and impact mitigation efforts. This has resulted in a template that distinguishes between core determinants, which constitute an environment of risk and vulnerability to HIV infection, and key consequences, which impact on the capabilities of individuals, households, communities, sectors and institutions to cope with the consequences of HIV infection, ill health and possible death. This tentative conceptual framework is presented in Table 4.1. Whilst conscious of the limitations of such a tool that seems to reduce the complexity of HIV/AIDS to simplistic causal factors and relationships, it is suggested here that the template can be a useful analytical tool for assessing possible links between development planning and HIV/AIDS, as long as it is used with some caution and discretion.

In fact, the template allows for an investigative process that can be both descriptive and strategic. As a descriptive tool, the focus is on how development planning mitigates or exacerbates core determinants and key consequences of the HIV/AIDS epidemic, either directly or indirectly. This is how the template has been used in this study. As a strategic tool, questions to be asked relate to how development planning can, or should, address the determinants and consequences of HIV/AIDS. For this purpose, one could add a column to the template to allow for the articulation of such strategies or interventions. This could eventually inform the development of an indicator system.

It needs to be noted that the main emphasis here is on the link between development planning and HIV/AIDS, in other words, on how development planning (either by design or unintentionally) influences the determinants, dynamics and consequences of HIV/AIDS. In attempting to answer this question, we also need to recognise that HIV/AIDS directly impacts on the planning process and on planning outcomes. The proposed conceptual framework has tried to incorporate this bi-directional relationship, for example by highlighting the eroding impact of the epidemic on public sector capacity to deliver on its mandate and implement development planning frameworks of various kinds. It is beyond the scope of this study to look at the institutional capacities required to ensure that the various planning systems are sufficiently adaptive to respond this challenging situation. This will have to be explored in future work.

The application of the template to the key development planning frameworks in sub-Saharan Africa suggests that few, if any, development planning frameworks address all core determinants and key consequences of HIV/AIDS. For one, this could be because not all these factors have equal relevance for all types of development planning. For example, it is beyond the scope of sector planning to address income inequalities in society (although it is obviously important to ensure similar remuneration for similar work within and across sectors), but this issue should be of concern to the MTEF and the PRSP (and possibly the Rural/Urban Development Frameworks). Secondly, it is also indicative of how HIV/AIDS is conceptualised and understood. Despite virtually universal recognition of HIV/AIDS as a crosscutting development concern requiring a multisectoral response, this insight is not taken to its logical conclusion. Instead, HIV/AIDS remains to be largely relegated to the area of health and other areas of social development, specifically in terms of impact mitigation. Finally, the inadequate attention given to the determinants of HIV transmission and the consequences of HIV infection on individuals, households, communities, sectors and institutions is also indicative of the lack of alignment and synchronisation between different planning paradigms.

The analysis of possible links between particular

development planning frameworks and HIV/AIDS presented above is obviously not comprehensive or conclusive. It is clear that these frameworks need to be reviewed within the context in which they have arisen and which these frameworks purportedly seek to respond to. At the same time, these frameworks need to be related to the specific dynamics of the HIV/AIDS epidemic in particular countries. Chapters 6-9 reflect the findings of selected country assessments in Cameroon, Senegal, Uganda and Zimbabwe. By way of introduction to the case studies, the next chapter will explain the rationale for selecting these countries, present some basic information about these countries and elaborate on key methodological issues.

Introduction to the country assessments

5.1. Introduction

As Chapter 4 concluded, the specific nature of possible linkages between development planning and HIV/AIDS needs to be analysed with reference to particular contexts. For this reason, the study sought to apply the proposed conceptual framework to particular development planning frameworks in selected countries. Because time and resource limitations did not allow for an assessment of all countries in sub-Sahara Africa, the study is drawing on a set of case studies to provide the relevant information. It is worth noting that the purpose of the case studies is not so much to compare the countries under review or to rank their performance, but rather to identify trends and experiences within and across these countries that can highlight and explain possible links between development planning and HIV/AIDS on the subcontinent.

Initially, the intention was to conduct local research in eight countries. Due to organisational and logistical difficulties encountered after the selection was made, three countries (Ethiopia, Mozambique and Tanzania) eventually had to be discarded. Given the tight time frames of the study, it was impossible to replace these three countries at that stage. Country assessments did take place in Burkina Faso, Cameroon, Senegal, Uganda and Zimbabwe. Unfortunately, at the last moment the assessment of Burkina Faso had to be excluded from the study report due to non-compliance with the terms of reference of the study. The remaining four case studies are presented in Chapters 6-9. By way of introduction to these case studies, this chapter elaborates on the rationale for and the process of selecting these countries. This is followed by a cursory overview of key development trends in the four countries in comparison to the key trends in sub-Saharan Africa, as discussed in Chapter 2. The chapter concludes with a discussion on the research methodology adopted for the case studies and the challenges and difficulties experienced during this stage of the project.

5.2. The selection process

At the outset, a number of selection criteria were formulated to guide the selection process of the eight case study countries. As a starting point, countries that are currently in conflict and post-conflict societies that have only recently emerged from conflict have been excluded, because it is unlikely that a proper assessment of the research questions can be conducted in these countries. This also applies to a country like Somalia, where the collapse of state institutions has obviated the possibility of an assessment of state-led development. Also, countries with a total population of less than two million people have been excluded, because it would not be possible to extrapolate the findings to countries with much larger population sizes in the region.[xxxii]

The following selection criteria were applied to the 24 remaining countries:

- *Development planning frameworks*: both countries with and without a PRSP and/or MTEF were to be included;
- *HIV prevalence rate:* the study was to include countries with varying HIV/AIDS epidemics, as measured by the adult HIV prevalence rate;
- *Status of development*: the study had to include countries reflecting differing development status, as measured by UNDP's human development index and its composite parts;
- *Colonial trajectories*: on the assumption that colonial powers were likely to have left their mark on planning systems in post-colonial states, the study was to include countries reflecting a variety of colonial backgrounds;[xxxiii]
- *Political systems and development paths pursued*: the study was to reflect a variety of political systems and ideologies, which informed development paths pursued by

Table 5.1. Selected development planning frameworks in eligible countries (end of March 2003)[xxxvi]	
Countries with PRSP or I-PRSP	**Countries without PRSP**
PRSP: Benin, Burkina Faso, Ethiopia, Guinea, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Tanzania, Senegal, Uganda, Zambia	Eritrea, Nigeria, South Africa, Togo, Zimbabwe
I-PRSP: Cameroon, Chad, Ghana, Kenya, Madagascar	
Countries with MTEF	**Countries without MTEF**
Ghana, Guinea, Kenya, Malawi, Mozambique, Rwanda, South Africa, Tanzania, Uganda	Benin, Burkina Faso, Cameroon, Chad, Eritrea, Ethiopia, Lesotho, Madagascar, Mali, Mauritania, Niger, Nigeria, Senegal, Togo, Zambia, Zimbabwe

respective countries, particularly at the time of political independence;

- *Geographical balance*: the study was to reflect countries from different regions on the sub-continent.

With hindsight, two criteria (colonial trajectories and development paths pursued) were not of chief importance, given that it was not the aim of the study to do a historical analysis of development planning in the selected countries. Furthermore, since the end of the Cold War former ideological differences in development orientation have become less pronounced. In fact, due to the significant level of external influence on the development agenda (including the choice for and content of specific development planning frameworks) in sub-Saharan Africa, there has been a more homogeneous approach to development on the subcontinent – at least on paper.

Development planning frameworks

In line with the focus on development planning in this study, the nature of development planning frameworks was clearly an important selection criterion. Given the central importance of the PRSP as a key development planning framework across the subcontinent, the selected countries had to include countries with and without a PRSP. Of the 24 countries eligible for selection, 14 countries had completed a full PRSP, five an Interim-PRSP and five had not (yet) adopted a PRSP (Eritrea, Nigeria, South Africa, Togo, Zimbabwe). Of these five countries, however, both Eritrea and Togo are potential PRSP countries by virtue of their status as a Least Developed Country (LDC) and/or Highly Indebted Poor Country (HIPC).[xxxiv] Nigeria, although strictly speaking not a PRSP candidate, has also committed itself to the PRSP process and intends to develop an I-PRSP (Ohiorhenuan, 2002). In effect, South Africa and Zimbabwe are the only two countries that are unlikely to adopt a PRSP. It seemed appropriate to include one of these two countries in the selection.

Of those countries that have completed their PRSPs, four countries (Burkina Faso, Mauritania, Tanzania and Uganda) were actually implementing their PRSPs. This made these countries particularly eligible for inclusion in the study.

Similarly, the study sought to include both countries with an MTEF and without an MTEF. At the time of selection, nine countries had adopted the MTEF.[xxxv] With the exception of South Africa, all other countries (Ghana, Guinea, Kenya, Malawi, Mozambique, Rwanda, Tanzania and Uganda) also had an I-PRSP or PRSP (see Table 5.1).

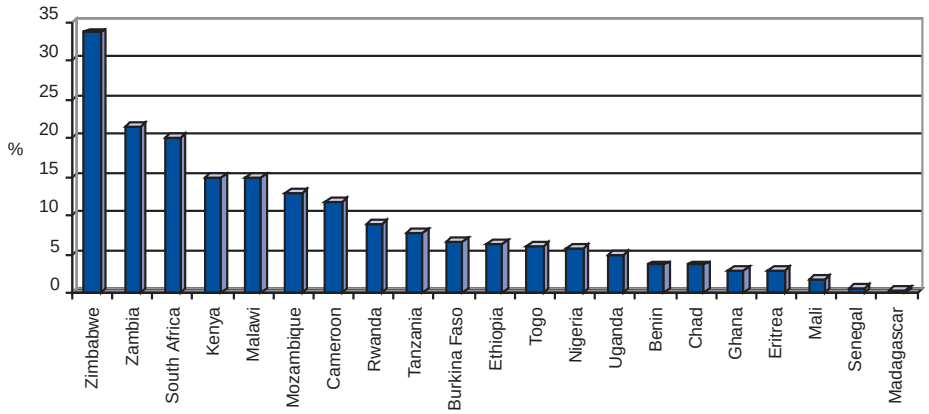
HIV prevalence

The intention was to select countries with varying HIV prevalence rates. Countries for which no data on national HIV adult prevalence was available were discarded, which left 21 countries eligible for selection.[xxxvii] The HIV prevalence rate of these countries varied from less than one percent in Senegal and Madagascar to over 33% in Zimbabwe. It was decided to select countries representing these two extremes, i.e. Zimbabwe and Senegal. Preference was given to Senegal over Madagascar, in part because it has a history of political stability and a robust state, and in part because it has been considered a success story in curtailing the epidemic through a combination of strong leadership, effective mobilisation of all sectors in society and good STI services, amongst others.[xxxviii] The other six countries would ideally reflect varying degrees of intensity of the HIV/AIDS epidemic.

Status of development and other criteria

At the time of selection, Zimbabwe was one of five countries that were classified as medium human development countries, whereas Senegal was among the remaining 16 countries classified as low human development countries.[xxxix] With both Madagascar and South Africa now excluded from the selection process[xl], this leaves a ratio of 4:15. In applying this ratio to the selection process, it was

Graph 5.1. Adult HIV prevalence rate in eligible countries, 2001 (%)



Source: UNAIDS (2002)

decided that two of the selected countries should be medium human development countries and six were to be low human development countries.

With Zimbabwe already having been selected, colonial trajectory and geography became decisive factors for the selection of the second medium human development country. As the only country of the three potential candidates (Cameroon, Ghana and Kenya) located in francophone and Central Africa, Cameroon was considered most eligible for inclusion. With an adult HIV prevalence rate of 11.8%, Cameroon has a more serious HIV/AIDS epidemic compared to most surrounding countries and to other countries in francophone Africa.[xli] This made it particularly suitable for inclusion.

For the selection of the remaining 15 countries classified as low human development countries, other selection criteria, such as colonial trajectories, political systems, geographical location and the scale of the HIV/AIDS epidemic, became significant. For one, it seemed appropriate to include Uganda, given its international reputation as having curtailed the HIV/AIDS epidemic. In 2001, the adult HIV prevalence rate was five percent, compared to an estimated 15% in 1991 (Putzel, 2003). The drop is even more dramatic if we compare the HIV prevalence rate of pregnant women in Kampala, which dropped steadily from 30% in 1992 to 11% in 2000 (UNAIDS, 2002:23). The study wanted to explore to what extent development planning may have played any part in this curtailment. Furthermore, Uganda was considered unique in being a 'no-party' state. Despite this, it has often been heralded as an example of good government in sub-Saharan Africa by donor governments and the World Bank (see, amongst others, Thomson, 2000). Finally, as mentioned above, Uganda was one of the few countries with experience in implementing the PRSP.

Ethiopia also seemed an appropriate inclusion, in part because it is the only country of those under consideration that has never been colonised. Ethiopia was considered a key example of strong state involvement in development planning (through state control of the economy, the nationalisation of land and industries, and the socialisation of agriculture through the establishment of state farms, amongst others), until the harsh economic realities of the 1980s forced it to liberalise public policy and embark on the path of structural adjustment. In apparent recognition of the importance of HIV/AIDS for national development, Ethiopia's PRSP is one of the few to date that devotes a section to HIV/AIDS – which is not to say that HIV/AIDS is sufficiently 'mainstreamed' into development planning, as noted in Chapter 4.

With the inclusion of both Uganda and Ethiopia, other countries in Eastern Africa (i.e. Eritrea and Rwanda, with Kenya already having been excluded) could no longer be considered for selection.

Turning to Southern Africa, where the HIV/AIDS epidemic is most severe, it seemed appropriate to include three countries from this region, compared to two in Eastern and Western Africa respectively and one in Central Africa (i.e. Cameroon). Being classified as low human development countries, Malawi, Mozambique, Tanzania and Zambia were

Table 5.2. Selection process and results of the UNDP study

Selected countries	HIV prevalence (%) 2001*	HDI value 2000*	Life expectancy 2000*	GDP per capita (PPP US$) 2000*	Former colonial power	Geographical location	(I-) PRSP	MTEF
Zimbabwe	33.7	0.551	42.9	2,635	Britain	Southern Africa	✘	✘
Cameroon[i]	11.8	0.512	50.0	1,703	France/Britain[xiii]	Central Africa	✔	✘
Mozambique	13.0	0.322	39.3	854	Portugal	Southern Africa	✔	✔
Tanzania	7.8	0.440	51.1	523	Britain	Southern Africa	✔	✔
Burkina Faso	6.5	0.325	46.7	976	France	West Africa	✔	✘
Ethiopia	6.4	0.327	43.9	668	None	East Africa	✔	✘
Uganda	5.0	0.444	44.0	1,208	Britain	East Africa	✔	✔
Senegal	0.5	0.431	53.3	1,510	France	West Africa	✔	✘

** Taken from UNDP (2002b)*

[i] *Cameroon adopted its MTEF in April 2003, after the selection process was finalised.*

all possibilities for inclusion. Of these four countries, Tanzania had the lowest HIV prevalence rate, albeit still relatively high at 7.8%. Given its history of pursuing a socialist path of development – which involved strong state involvement in and state control of the development process – before becoming highly dependent on donor support (and thus permeable to particular development planning ideologies), Tanzania was considered particularly eligible for selection. It was also among the four countries where the PRSP was being implemented and at least one PRSP Progress Report had been submitted.

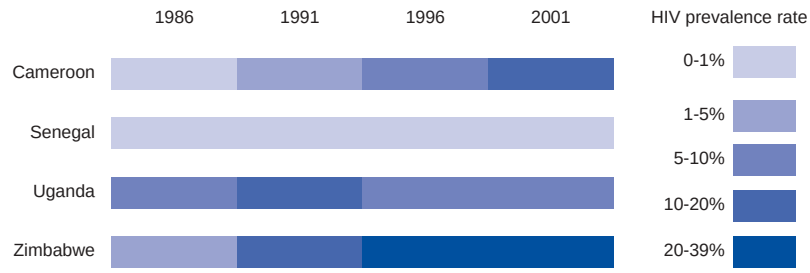
On the assumption that a country's colonial background may have influenced the practice of development planning after independence, Mozambique stood out as the most obvious candidate among the three remaining countries in Southern Africa. Furthermore, Mozambique's PRSP is considered well integrated with the MTEF (Ohiorhenuan, 2002). Given the challenges of alignment between development planning frameworks identified in Chapter 3, it was appealing to include a case study where the evidence suggested otherwise.

Finally, one francophone country in West Africa still needed to be selected. The qualifier 'francophone' immediately excluded Nigeria, which was in any case considered too complex within the time constraints of this study. Given that a key factor in favour of Senegal's selection was a low HIV prevalence rate of 0.5%, it seemed appropriate to select a country with a relatively high HIV prevalence rate out of the remaining five possibilities (Benin, Burkina Faso, Chad, Mali and Togo). Mali's HIV prevalence rate was 1.7%, compared to 3.6% in both Benin and Chad, 6.0% in Togo and 6.5% in Burkina Faso. Despite having fairly similar HIV prevalence rates, Burkina Faso has a much lower HDI value and GDP per capita compared to Togo. In fact, at the time of selection Togo was close to a medium human development country in terms of its HDI value. Furthermore, Burkina Faso was considered interesting from the perspective that a significant proportion of its citizens work as migrants in neighbouring countries. A decisive factor was that, as in the case of Uganda and Tanzania, Burkina Faso was actually implementing the PRSP and had submitted a Progress Report to the World Bank in November 2002.

Table 5.2 reflects the proposed eight countries for the case studies, with reference to the HIV prevalence rate, human development indicators (HDI value, life expectancy and GDP per capita), historical/colonial trajectories and geographical location. It also indicates which countries have adopted a PRSP or I-PRSP (all except Zimbabwe) and an MTEF.

Unfortunately, due to organisational and logistical difficulties encountered after these eight countries had been selected, Ethiopia, Mozambique and Tanzania eventually had to be discarded. Given the tight time frames of the study, it was not possible to replace these countries at that stage. As a result, the case studies were limited to Burkina Faso, Cameroon, Senegal, Uganda and Zimbabwe. Even though country level research took place in Burkina Faso, this case study had to be excluded during the last phase of the study due to non-submission of the country report. Fortunately, the remaining four countries still reflect an adequate variety in terms of HIV prevalence rates and a fair geographical spread, although the two regions with the highest HIV prevalence rates (Southern and Eastern Africa) are somewhat underrepresented. Importantly, the

Graph 5.2. Spread of HIV over time in selected countries



Source: UNAIDS (2002)

four case studies still include countries with and without a PRSP and MTEF.

5.3. Comparison of development profile of selected countries

This section presents a brief overview of key development trends and indicators in relation to the four case studies – Cameroon, Senegal, Uganda and Zimbabwe. Chapters 6-9 reflect more detailed information pertaining to each specific country. The intention here is to summarise and compare development trends between these countries. The discussion will focus specifically on trends pertaining to HIV/AIDS, life expectancy, poverty and economic growth and will locate these in relation to trends concerning sub-Saharan Africa, as discussed in Chapter 2. Because this section draws on international rather than national sources of information, the data presented here is likely to differ from the data reflected in subsequent chapters.

Adult HIV prevalence rate

Graph 5.2 shows in five-year intervals the national HIV prevalence rate in the four countries included in this report. In 1986, Uganda was one of two countries (with Burundi) on the subcontinent with an estimated HIV prevalence rate of over five percent. In Zimbabwe, the adult HIV prevalence rate was between one and five percent, whereas Senegal and Cameroon had HIV prevalence rates of less than one percent. Only Senegal has managed to keep HIV prevalence consistently below one percent.[xliii] In contrast, Cameroon shows a rapid and consistent increase in the estimated adult HIV prevalence rate over time, which eventually exceeds 10% in 2001.

Quite dramatic increases have been evident in Zimbabwe. In 1991, the estimated HIV prevalence rate in Zimbabwe was between 10-20%. By 1996 this had increased even further beyond 20%, eventually affecting one in three adults (34%) in 2001.

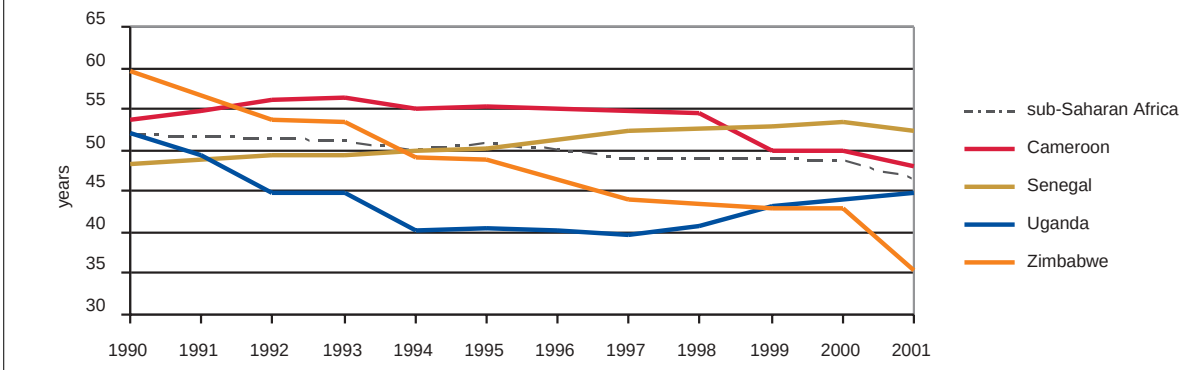
Whilst Uganda already had a significant HIV/AIDS epidemic in 1986, the HIV prevalence further increased to between 10-20% in 1991, after which it decreased to its 1986 levels in 1996. Data for 2001 suggests that this declining trend has been maintained, albeit at a slower rate. Yet, with new infections continuing to occur at a high rate, some doubt has been expressed about the extent to which the HIV/AIDS epidemic has been successfully contained in Uganda (UNAIDS, 2002).

Life expectancy

According to UNDP Human Development Reports, life expectancy in sub-Saharan Africa has declined steadily from just below 52 years in 1990 to just below 49 years in 2000, only to fall even further to 46.5 years in 2001. Yet, a comparison between the four countries shows quite divergent trends. Between 1990 and 2000, life expectancy in Zimbabwe has been cut by almost 17 years, from just below 60 years to just below 43 years. Between 2000 and 2001 alone, another dramatic cut of almost seven years was recorded. Until 1995, Uganda's drop in life expectancy follows a similar pattern as Zimbabwe. However, in the mid-1990s this decline seems to be halted and life expectancy has started to increase again from 1998 by an average of just over one year per annum. Whilst still below its average of 1990 and below the average for the subcontinent, life expectancy reached 44.7 years in 2001.

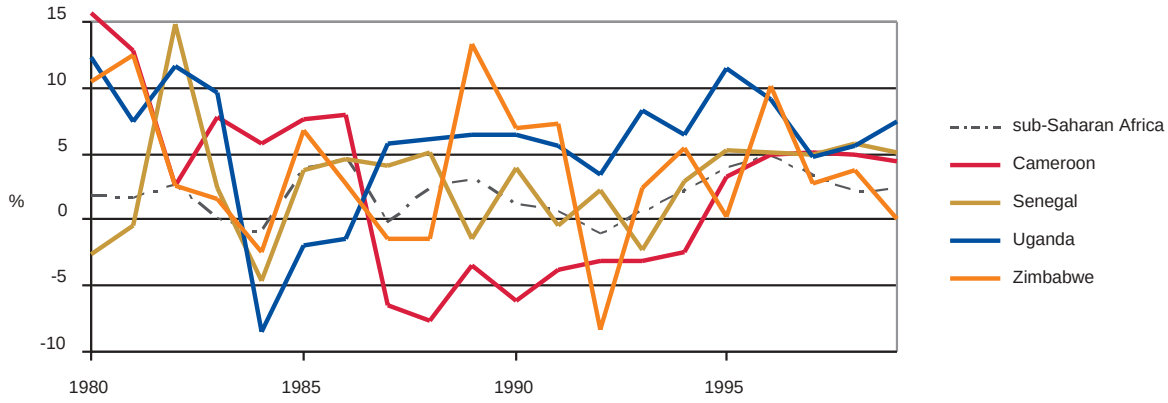
Cameroon, on the other hand, shows an increase in life expectancy from just below 54 years in 1990 to just above 56 years in 1993. Since then, life expectancy has declined quite rapidly with an average of one year per annum, to reach 48 years

Graph 5.3. Life expectancy in selected countries, 1990-2001



Drawn from UNDP Human Development Reports, 1991-2002

Graph 5.4. Trends in GDP growth in selected countries, 1980-1999



Sources: World Bank (1992), (2001)

in 2001. Since the late 1990s, it has been hovering just above the average life expectancy for sub-Saharan Africa.

Senegal is the only country to reflect a consistent increase in life expectancy between 1990 and 2000, gaining a total of five years. Whilst at the beginning of the decade it was initially below the average for sub-Saharan Africa, since the mid-1990s life expectancy in Senegal has become higher than that of the subcontinent as a whole. In 2000, people in Senegal were expected to live five years longer compared to their counterparts in the rest of sub-Saharan Africa.

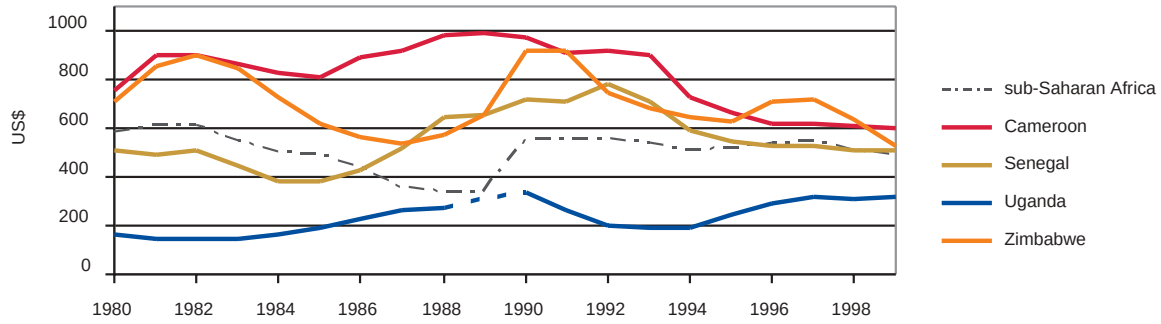
Trends in GDP growth

As Graph 5.4 shows, the economic fortunes and misfortunes of the four selected countries have been rather disparate. In fact, it seems that the only thing these countries have in common is that economic growth has been quite erratic.

With the exception of Cameroon, all countries experienced an economic low in 1984 and recorded a negative growth rate for that year. Uganda, which experienced a steep decline in that year compared to preceding years, is the only country that shows a fairly consistent upward trend since 1984, culminating in a high of 11.5% in 1995. In the latter part of the 1990s, economic growth seems to have slowed down again. Apart from the period 1984-1986, Uganda's GDP growth rate has consistently and significantly exceeded the average economic growth rate for sub-Saharan Africa as a whole.

In contrast, whilst in the first part of the 1980s Cameroon had a significantly higher GDP growth rate compared to the subcontinent as a whole (with the exception of 1982), its economic fortunes were

Graph 5.5. Trends in GNI per capita in selected countries, 1980-1999



Sources: World Bank (1992), (2001)

reversed in the latter part of the decade. In 1987, it recorded its lowest GDP growth rate of -7.7%. Between 1987 and 1994, the country continued to have a negative growth rate, but since 1996 it has managed to achieve a fairly consistent growth rate of around 5% per annum.

Zimbabwe's economic history shows years of unprecedented growth followed by years of unprecedented decline, and vice versa. The highest growth rate was recorded in 1989 (13.4%), whilst the lowest growth rate was recorded in 1992 (-8.4%). The economy showed signs of recovery in the mid-1990s, only to drop below the average for sub-Saharan Africa again after 1996.

Of the four countries, Senegal's economic trends seem to represent most closely the economic trends of the subcontinent, particularly between the early 1980s and the mid-1990s. Since 1995, it has managed to sustain an economic growth rate of at least 5% per annum.

GNI per capita

As Graph 5.5 shows, GNI per capita in Cameroon and Zimbabwe has been significantly higher than the average for sub-Saharan Africa during the past two decades. However, whilst Cameroon still saw an increase in GNI per capita in the latter part of the 1980s, Zimbabwe experienced a significant drop during that same period, declining from $897 in 1982 to $538 in 1987. By 1990, Zimbabwe's income per capita had increased significantly to $920, only to fall consistently to almost half that ($530) in 1999. Cameroon has also experienced a consistent decline in GNI per capita since 1989, recording a loss of close to $400 per capita within a decade (like Zimbabwe).

Whilst Senegal had a relative low GNI per capita in the first half of the 1980s, this changed after 1985. Within the space of seven years, GNI per capita was more than doubled, from $379 in 1985 to $780 in 1992. However, since 1992 a steady and fairly rapid drop in per capita income has been noted, reaching $510 by the end of the decade.

In the early 1980s, Uganda's GNI per capita stood at a third of GNI per capita for the subcontinent as a whole. Since then, the country has seen an increasing trend until 1990, only to decrease to significantly lower levels in the early 1990s. Uganda is the only country of the four countries included in this study to show an increase in GNI per capita since 1994. However, by 1999 it was still only two-thirds of GNI per capita for sub-Saharan Africa.

Concluding comments

The summary of development trends in relation to selected indicators presented above shows that such trends may vary significantly between African countries. For example, the economic growth trends reflect great variations; all these four countries seem to have in common is the fact that economic growth has been erratic over the past two decades. With the exception of Uganda, all case study countries show a decline in GNI per capita during the past ten years, suggesting greater impoverishment and a worsening quality of life for their inhabitants. Yet, the point at which this decline set in and the rate of decline vary greatly between these four countries. In the case of Uganda, GNI per capita still remains significantly below the average GNI per capita for the subcontinent. The selected countries also reflect varying HIV/AIDS epidemics and differing trends in relation to the spread (or possibly curtailment) of HIV. The countries even show divergent trends in

Box 5.1. Principal planning frameworks and related documents
• National Development Plan • PRSP (or alternative poverty reduction framework) & Progress Reports • MTEF (or alternative macro-economic framework) & assessments • National Strategic Framework for HIV/AIDS & Action Plan • National Health Plan & Action Plan • National Education Plan & Action Plan • Rural Development Framework & Action Plan • Urban Development Framework & Action Plan • Reports from the National Planning Commission (if existent) • Any review of these planning frameworks and their implementation • Any other relevant document

life expectancy. As such, these four countries serve as useful reminders of the difficulty, if not fallacy, to generalise about the status of development in sub-Saharan Africa.

5.4. Research methodology for country assessments

This section elaborates on issues related to the research methodology for the country assessments, the research process and some of the key challenges and difficulties encountered during this stage of the project.

Research questions

In accordance with the overall purpose of the UNDP study to assess possible links between development planning and HIV/AIDS in sub-Saharan Africa, the following research questions were formulated for the country assessments:

1. What are the most significant development planning frameworks to guide the development process in this particular country, and what are the key features of these frameworks (i.e. objectives, main strategies and tools) and their implementation?

2. To what extent do these development planning frameworks have HIV prevention and HIV/AIDS impact mitigation (as specified in the conceptual framework in Chapter 4 in relation to core determinants and key consequences of HIV infection) as an explicit, or integral, objective?

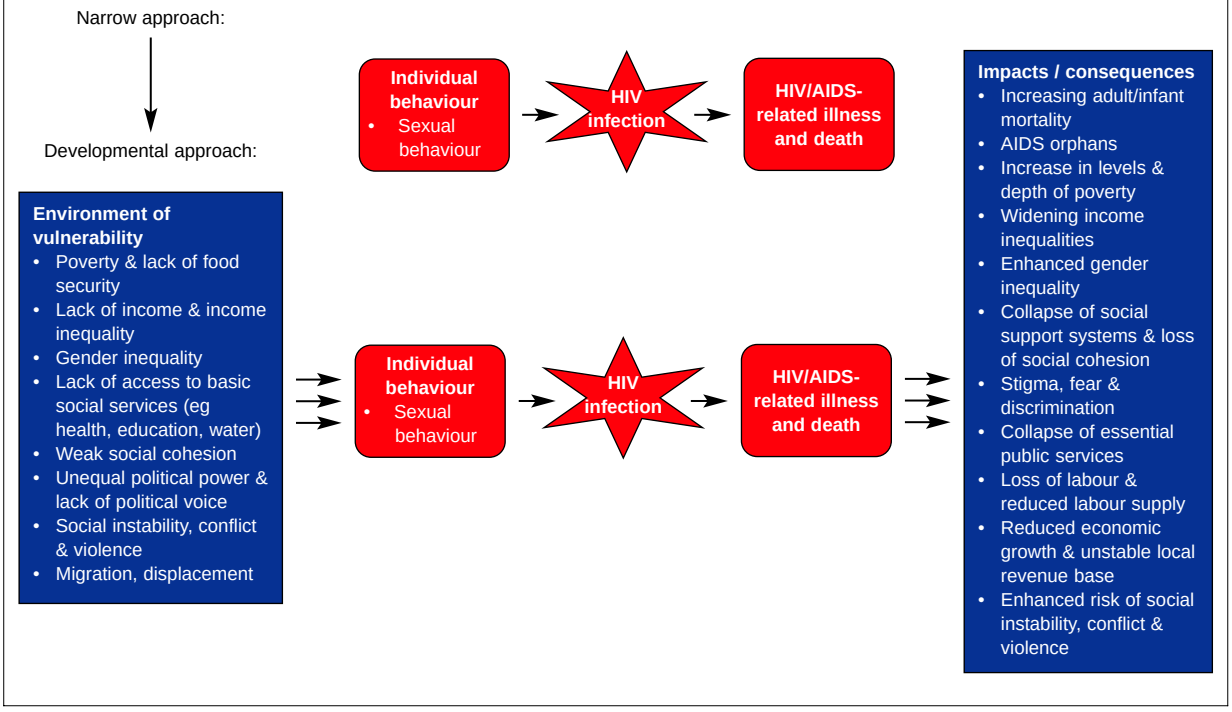
3. Based on empirical evidence, including past experiences in pursuing similar objectives and strategies, how do particular development planning frameworks, consciously or not:
   a. Enhance or diminish an environment of risk and vulnerability to HIV infection; and/or,
   b. Strengthen or undermine the capacity of individuals, households, organisations and institutions to cope with the impacts of HIV infection, ill health and possible death?

Research methodology

The country assessments, or case studies, sought to answer the research questions through a combination of research methods. To address the first question, a review of development planning frameworks and associated documents, such as action plans and evaluations, was deemed most appropriate. Such a review would also be important for assessing if, and how, particular development planning frameworks address core determinants and key consequences of HIV infection (the second research question outlined above). Box 5.1 includes a list of key documents that would most likely be included in such a review, although it was expected that the relative importance of the various planning frameworks was likely to differ between the selected countries.

Yet, it was clear that a review of planning documents alone would be inadequate to provide an explanation in those instances where HIV/AIDS is insufficiently addressed in development planning frameworks or where a disjuncture between stated intent, implementation and outcomes may come to the fore. Thus, to complement the analysis of development planning frameworks, semi-structured interviews with key informants were conducted. These key informants had to include politicians (both Ministers and Members of Parliament), public sector representatives with administrative responsibility for particular development planning frameworks and 'external' stakeholders, such as civil society organisations (including a national organisation of PLWHA, if existent) and the World Bank Country Office. It was envisaged that between 15-25 interviews would be conducted in each

Graph 5.6. From a narrow approach to a developmental approach to HIV/AIDS



country. Questionnaires were developed for specific stakeholders, with questions formulated according to the respondent's specific relationship to, and level of responsibility for, a particular development planning framework.

The interviews also explored the views and perceptions of respondents with respect to factors facilitating the spread of HIV in their country and the impacts of HIV/AIDS. For this purpose, a set of interview graphs was developed that present the conceptual framework underpinning this study (see Table 4.1) in diagrammatic form (see Graph 5.6).

Finally, to allow for an assessment of the extent to which development planning frameworks respond to, and impact on, core determinants and key consequences of HIV/AIDS based on empirical evidence (see research question 3), two complementary research methods were introduced. The first concerns secondary analysis of quantitative data related to the core determinants and key consequences of HIV infection over a specified time frame. The Country Profile was developed as an instrument to facilitate the systematic collection and analysis of relevant data in accordance with the conceptual framework outlined in Chapter 4 (see Appendix 2). The Country Profile seeks to extract trends in relation to those indicators over a time frame of 20 years, between 1980 and 2000/2001. However, given the difficulty in obtaining consistent and continuous data for this whole period, particularly for the first half of the 1980s, it was recognised that in practice it may only be possible to reflect relevant trends since 1985. Strong emphasis was placed on the use of locally produced data, rather than data from international agencies like UN agencies or the World Bank. Furthermore, to complement the analysis of development trends reflected in the Country Profile, a cursory review of national and international literature on the successes and weaknesses of development planning, both past and current, was to be conducted.

Research process

According to the initial project proposal, the whole study (including the country assessments) would be conducted by one consultant. However, at a meeting of the Reference Group in May 2003, it was decided that local consultants should be used to conduct the country assessments. At that stage, a number of country visits had already been planned. Also, there was little flexibility regarding an extension of the project deadline. To ensure local consultants were sufficiently prepared to conduct the country assessments within a relatively short space of time, a preparatory research methodology

workshop was held in Pretoria in June 2003. Five local consultants (from Zimbabwe, Uganda, Senegal, Cameroon and Burkina Faso) participated in this workshop.

The country assessments were conducted between July and August 2003. The consultants produced a draft Country Paper for their respective country, which they presented at a workshop in Pretoria in September 2003. The primary objective of this workshop was to ensure consistency in the scope and depth of the country assessments, in accordance with the terms of reference of the local studies. An interlinked objective was to create an opportunity for self assessment and peer review, which would inform the revision of the draft papers. Following the discussions at the revision workshop, the consultants submitted the revised Country Papers in October 2003. These Country Papers form the basis for Chapters 6-9. For the purpose of inclusion in this report, the papers have been substantially restructured and edited to conform to the terms of reference of the study.

Challenges and difficulties encountered

The issue of time was a key challenge for this phase of the study. The period of identifying and preparing local consultants was seriously circumscribed due to the tight timeframes of the project. This was one of the main reasons why Ethiopia, Mozambique and Tanzania were eventually excluded from the study. In the case of Mozambique, it proved very difficult to identify a local consultant. In the case of Ethiopia and Tanzania, local consultants had been identified and selected, but when they proved unable to attend the preparatory workshop there was no more time to identify alternative candidates.

Fortunately, five consultants from Zimbabwe, Uganda, Senegal, Cameroon and Burkina Faso were willing and able to commit almost immediately to the project. Unfortunately, the bureaucracy was not as fast as the project dates required, particularly in processing contracts, leading to a significant amount of uncertainty, delay and frustration for the local consultants. The quality of the local research process and of the draft Country Papers suffered as a result and, consequently, the contracts had to be extended to allow for the required amendments to, and revision of, the draft Country Papers.

Local consultants indicated that they had difficulties in conducting the required number and mix of interviews within the time allocation of the country assessments. It proved particularly difficult to set up interviews with politicians and senior officials, because of their busy work schedules.

Upon submission of the revised country papers in October, the project experienced another administrative delay, this time in identifying a translation agency for the three papers written in French (Senegal, Cameroon and Burkina Faso). In part, this was caused by a change of staff at the Regional Project.

5.5. Structure of the country assessments

Chapters 6-9 follow a similar structure. After a brief introduction, each chapter presents an overview of the status of development in the respective countries using the compiled Country Profile as a basis for this narrative. Due to a lack of consistent and continuous national data for the two decades under review, there are obvious gaps in these overviews. At times, consultants tried to compensate for the gaps in domestic data by using international data sources, in particular reports from UN agencies or the World Bank. More often than not, this results in quite sudden variances in the data from the one year to the next, which makes it difficult to extrapolate distinct trends with certainty.

The overview of development trends is followed by a reflection on the significance attributed to the core determinants and key consequences of HIV infection (as identified in Chapter 4) by key informants. The reasoning behind this section is that the extent to which policy-makers and planners recognise the factors associated with enhanced vulnerability to HIV infection and the key impacts of HIV/AIDS may help to explain why HIV/AIDS is sufficiently or insufficiently integrated in key development planning frameworks.

The core of Chapters 6-9 revolves around an assessment of the possible links between these planning frameworks and the identified determinants and consequences of HIV/AIDS. After identifying the most significant development planning frameworks in each specific country, the conceptual framework presented in Chapter 4 is used as an analytical tool to conduct such an assessment. The section concludes with some observations on the planning process and on issues of alignment and implementation of the principal development planning frameworks. Each chapter ends with some concluding comments regarding the case study findings. Chapter 10 presents a synthesis of the key findings from the country assessments.

Cameroon[1]

… Western societies should question the way they behave and articulate the social expression of their customs, if they want to help us. It is not enough to send money for condoms, but it is important to consider the quality and morality of attitudes and behaviour in society, for if the system of production were more moderate, we would consume something that was less daring, something that encouraged less excess than these images.[xlv]

6.1. Introduction

In recent years, Cameroon has overtaken Côte d'Ivoire as the country with the most severe HIV/AIDS epidemic in West Africa. The average HIV prevalence rate has increased rapidly from less than one percent in the late 1980s to 11% in 2000. HIV/AIDS gained a foothold at a time when the country was plunged into a serious economic crisis, which led to a marked drop in GDP per capita, increased poverty and reinforced inequalities. Not unlike other countries on the subcontinent, Cameroon embarked on structural adjustment programmes in an attempt to control the economic crisis. Since 2000, and more specifically in 2002 and 2003, the country has introduced a host of development planning frameworks aimed at promoting economic and social development. In light of the rapid spread of HIV and the severity of the epidemic, this seems to have been an opportune moment for Cameroon to integrate comprehensive HIV prevention and impact mitigation measures into development planning. However, this cursory review of development planning in Cameroon suggests that this opportunity has not been fully grasped.

6.2. Overview of development trends since 1980

In the past 20 years, significant progress has been made in relation to socio-economic development and health status in Cameroon. Yet, information on these trends is still limited, as few studies have been carried out in this area. What little information is available comes from sources such as annual reports published by national bodies (such as the Department of National Statistics and Accounting, DSCN), international organisations and NGOs. The two general population censuses of 1976 and 1987 and the Demographic and Health Surveys of 1991 and 1998 currently constitute the principal references in the area of population and development. This section draws on national and international sources in an effort to present a fairly comprehensive overview of development trends since 1980 (See Appendix 2 for the Country Profile of Cameroon and relevant references).

Demographic trends

Between 1980 and 2001, the population of Cameroon almost doubled, increasing from approximately 8.4 to 15.2 million people. Its average annual population growth of 2.7% during this period is not dissimilar to that of sub-Saharan Africa as a whole (i.e. 2.8%) (UNDP, 2003). The relative proportion of women has increased slightly, from 50% in 1980 to 51% in 2001. Cameroon has a youthful population. In 1998, 45% of the population was younger than 15 years, 50% was between 15-64 years and 5% was in the age group of 65 and older. At the time of the 1987 census, 56% of the population was under 20 years of age.

A significant proportion of the Cameroonian population lives in urban areas. In fact, Cameroon is one of the more urbanised countries in West Africa. Whereas in 1984 one in three Cameroonians were living in urban areas, this increased steadily to one in two by 2000/01. In absolute numbers, this growth rate correlates with a more than twofold increase in the urban population, from about 3.4 million in 1984 to approximately 7.5 million in 2000. Over the past two decades, urban growth has increased at a faster pace than population growth, although the rate of urban growth appears to be slowing down in recent years. In the first half of the 1990s, the rate of urbanisation was approximately 5.1% per annum. In the second half of the decade, this dropped to 4.7%, only to decline even further to 4% since 2000.

Apart from natural population growth, international migration and displacement also contribute to demographic growth in Cameroon. Most recent estimates suggest that the number of international migrants, many of whom originated from Chad and from Central Africa, residing in Cameroon was 250,000 between 1985 and 1990 (Segal, 1993). In addition, since the beginning of the 1990s increasing numbers of refugees have come to settle in Cameroon. In 1990, there were only some 4,100 refugees. Within one year, this number had multiplied ten-fold, reaching 42,000. Many refugees came from countries affected by conflict and humanitarian crisis, such as Chad, Rwanda, Congo and the Democratic Republic of Congo. In 1996, 46,000 refugees were registered throughout the country.

Economic performance and structure of the economy

Between 1980 and 2001, three distinct phases can be identified in terms of the performance of Cameroon's economy. In the pre-crisis period (1980-1986), the GDP growth rate, while declining, remained positive. It dropped from an average of 8% in 1980-1984 to 6.9% in the two subsequent years. During the second phase, which corresponds to a severe economic crisis affecting the country, stretching from 1987 to 1997, the GDP growth rate remained negative, averaging –4% per annum. The lowest economic performance was recorded in 1988, when the GDP growth rate was –7.1%. In 1998, the economy seemed to emerge from the crisis. Since then, Cameroon has experienced positive economic growth.

The structure of the economy has changed significantly during the period under review. In 1980, the services sector made the largest contribution to national GDP, amounting to 48%. The agriculture sector and industry contributed 29% and 23% respectively. The sectors most adversely affected by the economic crisis of the late 1980s were services and, to a lesser extent, industry. Towards the end of the 1990s, agriculture had become the prime contributor to the wealth of the country and was responsible for 41% of GDP, followed by services (39%) and industry (20%).

Cameroon's economic crisis was further aggravated by the country's foreign debt. Whereas in 1982 total debt amounted to 3.7% of GDP, by 1988 it had multiplied more than seven times to 27%, only to increase even further to 58% of GDP between 1991 and 1993. It appears to have declined slightly to 54% in 1996. The combination of spiralling external debt and structural adjustment has made it extremely difficult for the state to invest in social development, at a time when GDP per capita declined significantly and poverty deteriorated.

Poverty and inequality

Data on poverty in Cameroon is scarce. The first available data concerns 1996. Despite the lack of prior data, it is assumed that poverty increased in the beginning of the 1990s as a result of three factors: the economic crisis that started in 1987, the fact that there were two salary cuts of around 67% between 1987 and 1996, and the devaluation of the local currency (CFA franc) in January 1994.

In 1996 it was estimated that just over half the population (53%) was living below the national poverty line of 185.490 CFA franc (which corresponds to $1 a day). It was found that poverty affects households in rural areas far more than those in urban areas: six out of ten rural households were living in poverty, compared to four out of ten urban households. According to 2001 data, the incidence of poverty decreased substantially between 1996 and 2001 to 40%.[xlvi] The most significant reduction was recorded in urban areas, where the poverty rate almost halved to 22%. The concomitant decrease in rural areas to 50%, although less stark, was nonetheless significant. In the absence of data concerning the proportion of the population living on less than $2 a day, it remains difficult to properly assess this trend.

Whereas poverty data is not available for the period prior to 1996, it is possible to assess trends related to GDP per capita. Unsurprisingly, the negative performance of Cameroon's economy during the late 1980s and early 1990s resulted in a marked and sustained drop in the GDP per capita, which fell from $1010 in 1988 to $650 in 1997. This correlates with a drop in value of 36% and an average decline of 3.6% per annum. This clearly suggests a deterioration in the quality of life and standard of living of most Cameroonians during the economic recession.

Unemployment statistics, like poverty data, are hard to come by. Government data suggests that the unemployment rate (i.e. the proportion of persons of working age, who seek and do not find work over a given period) halved within a year, from 17% in 1995 to just over eight percent in 1996. As with the sudden drop in the incidence of poverty, it is difficult to determine the validity of this trend and what

factors could have contributed to it. Between 1996 and 2001, the unemployment rate has remained largely consistent at eight percent (MINEFI/DSCN 1997, 1999, 2001). In 1996, the official unemployment rate among men was higher than that among women, namely 10% and seven percent respectively. Although there is no data for the period prior to 1996, it is clear that the economic crisis has had a negative impact on formal employment, which has given rise to the growth of the informal sector. The informal sector accounts for a significant proportion of jobs in urban areas. For example, in 1993 the informal sector accounted for 57% of all jobs in all sectors in Yaoundé (Roubaud and Berthelier, 1993:10).

Finally, inequality indicators show that, despite the reported reduction in poverty between 1996 and 2001, income inequalities have in fact increased. For example, in 1996 the richest 20% of the population consumed seven times more than the poorest 20%; in 2001, this ratio had increased to eight (MINEFI/DSCN 1996, 2001). The noted shift in the Gini index, from 0.406 in 1996 to 0.408 in 2001, confirms this trend.

Human development

Access to safe drinking water and sanitation is critical for the health status of the population. Significant improvements have been recorded in enhancing access to drinking water since the early 1980s, when about a quarter of the Cameroonian population had access (26%). By 2000, twice as many Cameroonians had access, namely 52% of the population. Such averages hide stark geographical differences, particularly between rural and urban areas, with only 24% of rural households having access to safe drinking water (Belshaw and Livingstone, 2002).

A significantly higher proportion of the population has access to sanitation. Here, too, improvements have been recorded between 1984, when just below half the population had access to sanitation, and 2000, when three out of four Cameroonians had access to sanitation. Again, it is anticipated that marked differences exist between urban and rural service provision.

Access to basic health services seems relatively high, with an estimated seven out of ten Cameroonians having access in 1998. Yet, this figure hides the fact that the number of skilled health personnel, especially physicians, is low, despite recorded improvements since 1985. With an average of eight doctors per 100,000 people, Cameroon falls below the WHO norm of a minimum of 10 doctors per 100,000 people. Studies are currently underway to evaluate access to essential medicines. Because health policies related to access to ARV treatment are in the process of being put in place, it is as yet too early to make any assessment in this regard.

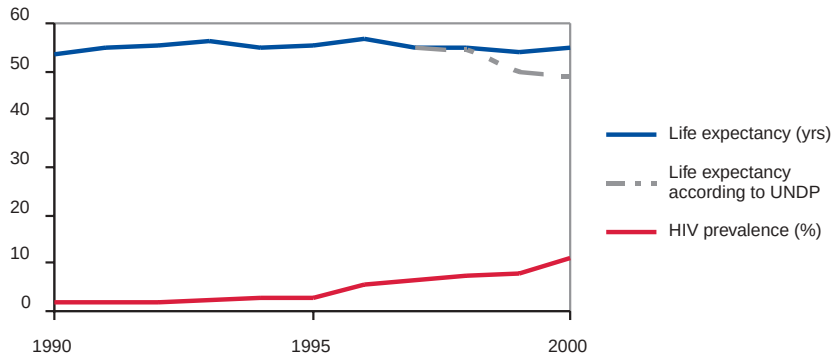
Knowledge acquisition improves the well being of individuals and education is unquestionably a critical factor in the fight against poverty. In Cameroon, much effort has been spent on reducing illiteracy and improving access to education. As a result, the adult literacy rate has risen from approximately one out of two adults in 1985 to approximately three out of four in 1998. The improvement over this period was noted in the case of both women and men and in 1998 adult literacy among women was on par with adult literacy among men in 1985, namely 61%. In 2000, female adult literacy had further increased to 68%, whereas among men it stood at 81%.

This improvement in adult literacy is partially the result of high primary school enrolment of both girls and boys. Unfortunately, there are no national or international (i.e. UNESCO) statistics on the net primary school enrolment ratio, but recent UNESCO figures suggest an improvement in gross enrolment figures from 88% in 1998/99 to 108% in 2000/01 following the introduction of free universal primary education in Cameroon.[xlvii] Yet, only a small proportion of boys and girls goes to secondary school. In 1995, one in four children of eligible ages was enrolled in secondary school. It is more likely for boys to continue their education, with about one in three boys going to secondary schools compared to almost one in four girls (23%).

The workload of primary school teachers remains high and seems to have become more severe over time. Whereas in 1980 the average class size was 48, in 1998 there were on average 53 pupils per teacher.

Finally, life expectancy at birth increased fairly rapidly and constantly during the 1980s and early 1990s. A Cameroonian born in 1981 was expected to live on average until the age of 50, whereas a compatriot born in 1993 was expected to live 6.3 years longer. Although the Country Profile (Appendix 2) suggests both downward and upward variations in life expectancy between 1994 and 2000, consistent data from the annual UNDP

Graph 6.1. Life expectancy and HIV prevalence rate in Cameroon



Human Development Reports indicate that since 1995 a declining trend has set in. In contrast to the anticipated life expectancy of 55 years in 2000 (in the absence of HIV/AIDS) as reflected in the Country Profile, UNDP estimates a life expectancy of 50 years and a further decline to 48 years in 2001 (See Graph 6.1). The gap between male and female life expectancy is not particularly great, namely 46.6 years and 49.4 years respectively. UNAIDS (2001) has anticipated a further nine-year reduction in life expectancy between 2000 and 2005 as a result of HIV/AIDS.

HIV/AIDS

According to data of the Ministry of Public Health (MINSANTE), HIV prevalence has risen rapidly since the start of the epidemic in 1986. HIV prevalence quadrupled from 0.5% in 1987 to 2% in 1992 and in the mid-1990s it exceeded 5%, only to increase even further to 11% in 2000. This trend denotes a significant increase in the number of people living with HIV/AIDS. For example, between 1997 and 1998, the reported number of AIDS cases more than doubled, from less than 1,000 to 2,045. Furthermore, it is estimated that the number of adults living with HIV/AIDS increased from 520,000 to 937,000 between 1999 and 2000 – in other words, an increase of 80%.

Disaggregated data, according to geographical area or sex, is still rare and what exists does not always allow for an assessment of trends over time. In 1990, it was estimated that the HIV prevalence rate in rural areas was 0.4%, compared to an average HIV prevalence rate of between 1.1% and 8.6% in urban areas. According to UNAIDS (2002), HIV prevalence among antenatal clinic attendees outside major urban areas has risen sharply from 1% in 1989 to anything between 6% and 13% in 2000. Whereas the notion 'outside major urban areas' does not correlate with rural areas, it does suggest that the epidemiological burden is shifting (or rather, spreading) from Yaoundé and Douala, which constitute the major urban areas in the UNAIDS classification. Here, the HIV prevalence rate among women attending antenatal clinics was 11% and 12% respectively in 2000.

As in most other countries affected by a severe HIV/AIDS epidemic in sub-Saharan Africa, there are more women than men living with HIV/AIDS. In 2000, it was estimated that for every two men living with HIV/AIDS there are three women living with HIV/AIDS. Put differently, six out of ten adults living with HIV/AIDS in Cameroon are women.

Statistics on AIDS deaths are also incomplete. In 1999, the number of cumulative AIDS deaths was estimated at 52,000. As a result of these deaths (most of which occurred among adults), there has been an upsurge in the number of orphans. Between 1990 and 1995, there was a 12-fold increase in the number of children whose mother or both parents died of AIDS, rising from approximately 3,000 to 36,000. By 2001, it was estimated that 210,000 children in Cameroon were AIDS orphans.

There is no data on HIV/AIDS in the public sector, either in general terms or in relation to specific sectors, like agriculture, education or health. The only study conducted to date found that HIV prevalence among military officers was 15% in 1996 (UNAIDS, 2002). This is a significant increase from 3.3% in 1990.

Whereas the Government initiated a national

programme on HIV/AIDS and established the National Committee for the Fight Against AIDS in 1990, it is only since 1997 that the national response to HIV/AIDS has gained momentum. In part, the delayed response can be attributed to the Government's perception that Cameroon was a low prevalence country. Since 1997, there has been a more concerted effort to curb the spread of HIV and provide treatment and care to people living with HIV/AIDS, which has included bringing down the cost of essential medicines. Part of this renewed impetus concerning HIV/AIDS programming was a focus on the decentralisation of the response.

Conclusion

During the 1980s, Cameroon seemed firmly set to make major advances across a range of social and economic development indicators. The acute economic crisis that set in towards the end of the decade clearly halted this progress. It was during this time that the first cases of HIV were recorded. Within this context of stagnated, if not reversed, development, HIV/AIDS managed to flourish. Currently, one in ten adults in Cameroon is infected with HIV. It is anticipated that before long the devastating impacts of the epidemic will transcend the household and community level to affect the economy and socio-political institutions in Cameroon. The following section reviews to what extent key representatives from Government and other sectors recognise the factors that facilitate the spread of HIV in Cameroon and the impacts of the epidemic. This serves as a prelude to section 6.4, which assesses whether the recently developed development planning frameworks take this reality into account.

6.3. The core determinants and key consequences of HIV infection in Cameroon

For the purpose of this study, 15 interviews were conducted with politicians and government officials, civil society organisations, organised business and international organisations. Given the busy schedules of high level politicians and administrators, it was not always easy to find time to accommodate the request for an interview. The list of organisations and persons interviewed is provided in Appendix 3. This section summarises the feedback from respondents in relation to the core determinants and key consequences of HIV infection in Cameroon.

Core determinants

The majority of respondents highlighted that HIV transmission in Cameroon was facilitated by one of three factors, or a combination thereof: ignorance (nine respondents), poverty (eight respondents) and cultural factors (five respondents). Ignorance was generally associated with the lack of education and at times with the poor dissemination of information. For quite a number of respondents who mentioned both ignorance and poverty, ignorance was considered the primary factor.

The perceived influence of cultural factors ranged from the value placed on procreation in African culture to a 'loss of culture', which is perhaps better summarised as a perceived 'loss of morality'. In particular, there was a strong perception that Cameroonian youth have embraced loose moral values and seek to imitate Western culture. In light of this, behavioural factors were considered important as well, in particular the failure to use condoms. In the words of one respondent: "AIDS is much more a problem related to behaviour than one related to poverty."[xlviii]

Others, however, argued that the emphasis on condom use to prevent HIV transmission served to justify the decline in moral standards:

> States that are subjected to ignorance and poverty, such as ours, are under an obligation to assume a certain number of control measures based on the fear of being punished for one's sins. For example, the condom has been presented as a solution, without any preconditions. The message '100% Youth, 100% Condom' means that people, irrespective of their age, even ten-year olds, have the right to have sexual relations as long as they wear a condom. And yet, one should be telling something different, such as to abstain and reserve the use of condoms for those who are already sexually active. In other words, adults. This easing of moral standards runs the risk of placing additional strain on our country. One should not imitate everything from the outside without adapting it to one's own context.[xlix]

Some respondents suggested that organisational factors, although perhaps not responsible for the spread of HIV, at least contributed to the failure to curb the epidemic. Reference was made to insufficient resource allocation (material, human and financial) at national and global level. Others pointed to the fact that the invisibility of the virus and its impacts at the onset of the epidemic led to a delayed government response. This view was

disputed by the UNAIDS representative, who argued:

> Until 1992, the programme for the Fight Against AIDS in Cameroon was one of the model programmes in Africa. In 1992, there was a change in the leadership and management of the structure. This change created instability and personnel were demotivated, because they were working only part-time on the programme.[l]

Cursory reference was also made to migration, the mixing of people and populations, inadequate health care conditions and even revenge as factors contributing to the spread of HIV in Cameroon. Yet, none of these factors was elaborated on.

A significant number of core determinants identified in Table 4.1 was not mentioned at all by respondents. For example, unemployment, income inequality, the lack of social cohesion, social conflict or inability to express political voice did not surface in the interviews. Only one respondent referred to lack of access to public services, by suggesting that inadequate health care conditions contributed to the spread of the epidemic.

Most notably absent in the discussion on core determinants enhancing vulnerability to HIV infection was gender inequality and the nature of gender relations in Cameroon. Only one respondent referred specifically to women when arguing that poverty constrains one's ability to make decisions. In fact, the few times reference was made to women in the interviews, there seemed to be a tendency to hold women responsible for the spread of HIV:

> Sometimes women accept propositions in the nature of '5000 francs with condom and 10,000 francs without condom' in order to have sexual relations with their partner. … When you are with a woman, you don't know how many men she has already been with.[li]

Contrary to the international view that during inter-generational sex the virus is most likely passed from older men to young women and girls, rather than vice versa, another respondent (representing the equivalent of a National AIDS Council) argued the following:

> When one separates the infection rate of men and women, one finds that it is higher among young women compared to men. It is higher among men in older age groups. This means that they are being infected by these young women.[lii]

If the views of these respondents can be considered representative of the Cameroonian Government and of society in general, it would seem that 15 years into the epidemic there is still relatively little consideration for the systemic development challenges that contribute to a context of vulnerability to HIV infection. The apparent disproportionate emphasis placed on knowledge, values and behaviour, although important elements of HIV prevention efforts, serves to constrain a more comprehensive response to the epidemic.

Key consequences

More than half of all respondents commented on the fact that HIV/AIDS is increasing adult mortality. The same number of respondents also observed that this will have negative implications for national production. Some made specific reference to the effect HIV/AIDS will have on the working population, leading to a reduction in human resources:

> The impact of the disease has not yet reached alarming proportions in the short term. But, if nothing is done, especially given the latent character of the disease before manifesting itself, it will be very serious in the medium and long term, especially in the world of workers: deaths, absenteeism of sick staff, drop in the labour force and hence drop in productivity, especially in the case of those difficult to replace from one day to the next because of the experience that they have acquired.[liii]

An increase in the number of orphans was also readily mentioned, with seven respondents highlighting this as a key consequence of the HIV/AIDS epidemic.

Five respondents pointed to the increase in the disease burden and associated health-related consequences, such as higher medical expenditure due to HIV/AIDS, the crowding out of other diseases and the need to provide treatment and care for people living with HIV/AIDS (including ARVs). The emphasis seemed to be mainly on macro level impacts, rather than on household level impacts and how households cope with the increased disease burden.

Both representatives from the Ministry of National Education (MINEDUC) and the Ministry of Higher

Education (MINESUP) commented specifically on the impacts of HIV/AIDS on the educational system.

> The impact on the educational environment is not yet real, but soon we will be witnessing a drop in educational levels. That is to say that factors such as the enrolment rate will be affected. For example, 100 children enrol in school, but how many complete their studies at the end of seven years? It will be a few years still before we have the figures to show this and it will be reflected in drop out rates …[liv]

Whereas this respondent did not refer to HIV/AIDS among teachers and support staff, his colleague indicated that in higher education there has been an increase in the number of people living with HIV/AIDS among lecturers, not just among students.

A relatively small number of respondents (four) mentioned that HIV/AIDS enhances poverty. Two respondents added that HIV/AIDS leads to 'family problems' or 'family disintegration', whereas stigma and shame was mentioned only once. Other impacts, like loss of income, enhanced income inequality or inability to pay for services or taxes (undermining local revenue generation and threatening financial stability) did not surface in the interviews. Apart from disregarding these household level impacts (which will eventually make themselves felt at larger scales), no attention was given to community level impacts either, such as entrenched gender inequality, the potential erosion of social support systems or the enhanced probability of social conflict and instability. It is possible that some of these impacts of the HIV/AIDS epidemic have not (yet) manifested themselves in Cameroon. Clearly, the most commonly identified consequences relate to adult mortality and its impact on the national economy.

Finally, one respondent suggested that one of the impacts of HIV/AIDS is, in fact, a diversion of development funds towards HIV/AIDS:

> … all the aid that we receive to combat AIDS could be used in other sectors for the development of the country and that is a great loss.[lv]

6.4. Development planning and HIV/AIDS in Cameroon

For two and a half decades since independence in 1960, Cameroon followed the tradition of adopting five-year planning cycles. This tradition was interrupted by the economic crisis that started in the late 1980s. In recent years, Cameroon has embarked on an extensive planning process and has adopted a vast range of development planning frameworks. This section will summarise the history of development planning in Cameroon and identify the primary development planning frameworks that are guiding the current development process in the country. This is followed by a discussion of the extent to which these frameworks take into account the core determinants and key consequences of HIV/AIDS. The final part of this section reviews how the various development planning frameworks have come about and reflects the observations of respondents concerning their alignment and implementation. Because most development planning frameworks were adopted within the year preceding this study, observations regarding their implementation are limited.

Development planning in Cameroon in historical context

Since independence, Cameroon embarked on five-year planning cycles. This process lasted until 1986, when the emergent economic crisis compelled the Government to abandon its development plans and adopt structural adjustment programmes. Between 1960 and 1986, five quinquennial economic and social development plans were elaborated.

Cameroon's first five-year socio-economic development plan after independence was drawn up at the end of 1960.[lvi] Its programme extended from 1961 to 1965. In terms of social development, its aims were to achieve more balanced nutrition, to extend and adapt education, and to ensure better utilisation of the potential of labour. The economic level plan focused on enhancing agricultural potential, developing economic trade and industrialisation.

The second plan covered the period 1 July 1966 to 30 June 1971. The projects envisaged related to the general conditions necessary for development (i.e. re-establishing public order and guaranteeing security for all, strengthening national cohesion and mobilising all the active forces in the country), enhancing production, rural development, opening the country up to the outside world, and strengthening economic independence. To achieve this, the following general areas of intervention were envisaged: 1) training people by making education more available; 2) developing the rural economy by diversifying production, exploiting new arable lands

and developing crafts; and, 3) developing industries, road infrastructures, settlements, urbanisation and administrative systems.

The third plan (1971-1976) focused on rural development through agriculture production, animal farming and forestry; the organisation of production by the State; industrialisation and trade; tourism; education and training (at primary, post-primary, secondary and higher school level); public health; social affairs; and, communication. It also covered the national planning framework, the modernisation of the administration and the budget.

The fourth development plan (1976-1981) was aimed at all socio-economic sectors and placed particular emphasis on the development of the provinces, whereas the fifth and last plan to be executed (1981-1986) made special reference to culture as an aspect of development. This plan considered the development of scientific and technical research, education and training, information science and statistics to be fundamental to the social and economic growth of the country.

The implementation of these various development plans enabled Cameroon to initiate development on the basis of GDP growth rates that were sufficiently high to counterbalance strong demographic growth. The economic recession that took root in the late 1980s throughout the early 1990s frustrated the development process and in some instances led to a reversal of the development gains achieved in the preceding two and a half decades. The first indications of an end to the crisis emerged towards the end of the decade, with the country's participation in the Heavily Indebted Poor Countries (HIPC) initiative and the mitigation of its debt burden. The time seemed right for the authorities to embark on reforms aimed at significantly reducing poverty through strong and lasting economic growth, improved efficiency with regard to expenditure, appropriately targeted poverty reduction policies and improved governance.[lvii]

Between 2000 and 2003, Cameroon has adopted the following key development planning frameworks:

- The Poverty Reduction Strategy Paper (PRSP);
- The Medium Term Expenditure Framework (MTEF);
- The Strategic Framework for the Fight Against AIDS;
- The Health Strategy;
- The Education Strategy;
- Rural Development Strategy (DSDSR).

It is worth noting that Cameroon does not have a national development plan at this stage. It is envisaged that the PRSP and the sectoral strategies will, in the long term, lead to the elaboration of a national development plan.

The PRSP further envisages that Cameroon will adopt an Urban Development Strategy to address the challenges related to urbanisation, such as the growth of informal settlements, the lack of sanitation, gated communities, unemployment, urban poverty, lack of security and an increase in crime. According to the PRSP, the strategy will be aimed at achieving the following objectives:

- To improve the living conditions of the urban population, the majority of which are living in tenuous conditions;
- To develop the economic role of urban areas through the extension, maintenance and repair of urban infrastructure;
- To develop a programme for promoting the social dimension in the urban environment.

The PRSP, 2003-2015

The PRSP, adopted in April 2003, is currently the principal development planning framework in Cameroon. It provides an overview of recent economic and social developments in the country and analyses the poverty situation and the dynamics of poverty in Cameroon. It further identifies seven priority objectives for achieving economic growth and poverty reduction in the short and medium term. These are:

- Promoting a stable macroeconomic context;
- Strengthening growth through the diversification of the economy;
- Stimulating the private sector as an engine for growth and as a partner in the provision of social services;
- Developing basic infrastructures and natural resources and protecting the environment;
- Accelerating regional integration within the context of the Economic and Monetary Community of Central Africa (EMCCA);
- Strengthening human resources and the social sector and incorporating disadvantaged groups into the economy;
- Improving the institutional framework, administrative management and governance.

The implementation period for the PRSP is from 2003 to 2015. At the end of this period, it is

envisaged in the PRSP that Cameroon should be close to reaching its Millennium Development Goals (MDGs), if it has not already achieved these goals.

The PRSP does not have a section devoted exclusively to HIV/AIDS. The only explicit reference to HIV/AIDS in the document occurs in the section on Health, where mention is made of the fight against STIs and HIV/AIDS, the reduction of the cost of ARVs and the relevance of the Strategic Framework for the Fight Against AIDS. Nonetheless, an assessment of the PRSP using the framework provided in Chapter 4 reveals that some of its objectives are, directly or indirectly, aimed at addressing the core determinants of a context of vulnerability to HIV infection. Furthermore, only two key consequences of HIV/AIDS identified in Table 4.1 appear to be covered by the PRSP.

Core determinants of HIV infection

Of the ten objectives identified in relation to addressing the core determinants of HIV infection in Table 4.1, six are explicitly articulated in the PRSP. These include objectives related to HIV/AIDS awareness raising, poverty reduction, access to income, gender equality, access to basic public services and urbanisation/migration/displacement in a specific context.

The PRSP supports the idea of awareness raising campaigns on HIV prevention, with a focus on condom use. To this effect, the PRSP makes reference to Government's intention to implement a sectoral communication plan to support the national Strategic Framework for the Fight Against AIDS. Thus, the document has an explicit focus on changing sexual behaviour to prevent the spread of HIV.

The PRSP explicitly recognises the need to reduce poverty by ensuring a minimum standard of living and food security (objective 1.2). It seeks to achieve this through the rapid creation of wealth to meet the basic needs of the population. The agriculture sector is seen as vital in enhancing food security for the Cameroonian population in general and in ensuring income for the rural population specifically. In relation to the forestry sector, the PRSP envisages that a share of forestry profits will be paid to village communities as a means to address poverty in these communities.

Within the framework of the PRSP, Cameroon envisages diversifying its economy in order to strengthen economic growth, promote job creation and integrate disadvantaged groups into the economy. With respect to the latter, the PRSP seeks to encourage the production of the goods and services urgently required by those who are poor. With respect to employment and access to income, the PRSP seeks to promote income generating activities for the poor, particularly those related to self-employment. The PRSP further mentions that a Declaration of National Policy on Employment will be forthcoming. However, no attention is given to the tension between agriculture reform and efforts to enhance economic competitiveness (especially in the manufacturing sector) - efforts generally associated with at best a stabilisation, at worst a contraction of the labour market and with greater labour disparities due to higher levels of specialisation – and the need for stable employment and decent wages. The emphasis on self-employment suggests that the Government recognises that the economy will not be able to provide enough jobs for all who need work.

The PRSP does, however, suggest that the social welfare system will be extended to support those who have remained on the margins of the system. These include workers in the informal sector, the rural population, those in liberal professions, merchants and other independent workers.

In accordance with the MDG to promote gender equality and empower women, the PRSP notes that the authorities should continue to strive for a better quality of life for women, respect for their rights, recognition of their effective contribution to the country's development process and their improved integration into economic activity. To achieve this, the PRSP refers to the Government's intention to develop a national strategy on the promotion of women before the end of 2003.[lviii] This strategy will focus on i) enhancing the social and legal status of women; ii) improving the quality of life of women; iii) greater equality and equity between the sexes in all sectors of national life; and, iv) strengthening existing institutions and mechanisms to address problems specific to women. To this end, the PRSP continues, at least three actions are to be carried out by the authorities at all levels. Firstly, gender disparity within the education system needs to be eliminated. Secondly, access to reproductive health services for women of child-bearing age and adolescents needs to be enhanced. Thirdly, technologies likely to make the work of women easier need to be promoted. Apart from this reference to a forthcoming strategy on the promotion of women, the PRSP remains silent on

gender inequality and the role of women in the economy, community development and household service provision.

In terms of access to services, access to drinking water remains a priority in the PRSP. The main objective is to reduce the huge gap in service provision between rural and urban areas. Referring to the "Rural Water II" programme, the PRSP is committed to promoting access to drinking water in all parts of the country by 2025 and, in particular, to ensure that 75% of the rural population has access. Reference is also made to enhancing access to sanitation and waste removal in urban areas. A more detailed discussion of urban development challenges as articulated in the PRSP follows below, in the context of migration and urbanisation.

With regard to access to health care, the PRSP highlights the steps taken by the authorities to improve access to basic medicines. The price of medication has therefore dropped by 40% and efforts are made to ensure that such medication is available in all health centres. Furthermore, in terms of education, the PRSP refers to the Government's objective to promote universal access to basic education and to focus on the provision of technical and professional training.

The last objective of Table 4.1 explicitly dealt with in the PRSP relates to urbanisation/migration and to rural and urban conditions respectively. The PRSP announces that the Government will develop integrated planning frameworks for rural and urban development respectively.[lix] With respect to rural development, mention has already been made of the PRSP's emphasis on agricultural production and on extending the provision of water in rural areas. According to the PRSP, the forthcoming integrated urban development strategy will have to address the precarious living conditions of the urban population, characterised by informal housing conditions and lack of basic services. It also has to focus on interventions to strengthen the urban economy, specifically through the extension, repair and maintenance of urban infrastructure. Finally, the strategy is expected to develop a programme to promote the social environment in urban areas. As the PRSP notes, the Government has already initiated a series of priority action plans to deal with the most urgent problems in urban areas, most notably the provision of public transport in Douala and Yaoundé, the provision of sanitation and waste management, state responsibility for the care of street children and those with mental problems, and awareness programmes for sex workers to make them aware of the risks associated with STIs and HIV/AIDS. It could be argued that the concomitant investment in rural and urban development may on the one hand lessen the push factors that lead people from rural areas to migrate to urban areas, whereas on the other hand it will ensure that the new habitat of migrants (and current urban residents) is liveable.

The PRSP does not specifically target displaced populations or refugees as disadvantaged groups, despite the fact that Cameroon has taken in many refugees from the sub-region for almost twenty years because of the instability in Central Africa. Cameroon constitutes the major economic centre of the Economic and Monetary Community of Central Africa (EMCCA) and its proximity to Nigeria, and hence to ECOWAS, strengthens its position in this regard. Within the context of the EMCCA, the Government intends to facilitate the free circulation and right of residence of its (EMCCA) people, so that they are able to contribute to growth in 'advantaged' areas and to ensure that the benefits derived from this kind of activity are also advantageous to their country of origin.

Four core determinants of vulnerability to HIV infection are not explicitly addressed in the PRSP. For one, whereas the PRSP recognises that significant income disparities exist in Cameroon, no specific action or strategy is proposed to deal with this. Furthermore, no reference is made to the potential lack of social cohesion or to the possibility of social instability and conflict as core determinants. Given that Cameroon is a relatively stable country, these factors may not be primary concerns for the country.

Finally, and rather surprisingly, the PRSP does not mention the importance of participatory processes or the need to involve poor communities and marginalised groups in the planning and implementation of development programmes. Instead, reference is made to the promotion of the rule of law and of the security of property and persons as being essential to the process of poverty reduction. As highlighted in the PRSP, the confidence of the people of Cameroon and of investors is dependent on the perception of there being an effective, lawful State in Cameroon, capable of applying the laws and regulations of society in an impartial manner. Thus, the PRSP emphasises the importance of enhancing the protection of civil and political rights of all and of

equal access to justice. To some extent, this could be interpreted as supporting political voice and equal access to political power, albeit rather indirectly.

Key consequences of HIV/AIDS

Few key consequences of HIV infection identified in Table 4.1 are explicitly recognised in the PRSP. In seeking to reduce adult and infant mortality as a result of HIV/AIDS, the PRSP emphasises the effectiveness of integrating both ARV treatment and medication for the treatment of opportunistic infections into the essential medicines plan. It further highlights the importance of popularising HIV/AIDS treatment and of preventing HIV transmission from mother to child.

In an apparent response to the request of the population that the Government provides for those affected by the HIV/AIDS epidemic, the PRSP also envisages that the authorities will take responsibility for AIDS orphans. What exactly such support would entail is not elaborated on.

None of the other key consequences of HIV/AIDS is dealt with in the PRSP. One could argue that the assumption of responsibility for AIDS orphans and the psychosocial assistance referred to in the PRSP could be seen as actions that contribute to a reduction in AIDS-related stigma and discrimination. Yet, no explicit attention is given to stigma and discrimination associated with HIV/AIDS, let alone how to address this in the workplace or society at large. The PRSP also does not highlight the importance of involving people living with HIV/AIDS and affected communities in decision making processes.

Despite its main thrust to reduce poverty in Cameroon, the fact that HIV/AIDS is likely to enhance poverty by pushing poor households towards greater destitution and creating new categories of disadvantaged groups is not elaborated on in the PRSP. Neither is attention given to the impact of the epidemic on people's ability to work and generate an income, nor to the burden of care disproportionately carried by women and other likely gender implications of the epidemic, such as a disproportionate number of girls dropping out of school. There is also no discussion of the fact that HIV/AIDS puts significant pressure on social support systems, which could ultimately erode social cohesion and may even lead to instability and social strife.

The PRSP is equally silent on the fact that HIV/AIDS is likely to create more and more complex demand for government support and services. Whereas the PRSP supports the objective of ensuring equitable access to services like health and education (which could be interpreted as encompassing the needs of those infected with and affected by HIV/AIDS), it does not recognise that the epidemic may jeopardise the very realisation of this objective.

Furthermore, despite the high HIV prevalence rate in the country and anecdotal evidence of an equally high prevalence rate in the public sector, the PRSP does not consider the impact of HIV/AIDS on the public sector to promote development and ensure consistent, quality service provision. In general terms, the PRSP is concerned with improving the capacity of the public sector by focusing on strengthening human and social sector resources, improving the institutional context, administrative management and governance. Yet, the eroding impact of HIV/AIDS on public sector capacity is not taken into account.

Given the fact that the PRSP does not seem to recognise that HIV/AIDS enhances poverty, it is not surprising that no consideration is given to the fact that the Government's ability to generate local revenue (through taxes and service fees) is under threat. At the macroeconomic level, economic growth projections have not taken account of HIV/AIDS and therefore seem highly optimistic, especially given the impact of HIV/AIDS on labour and national production.

In conclusion, as the principal development planning framework in Cameroon developed in recent times, one might have expected the PRSP to be more conscious of the factors facilitating the spread of HIV and of the key consequences of the epidemic. In particular, the bidirectional relationship between HIV/AIDS and poverty is not even touched upon. Instead, observations regarding HIV/AIDS are limited to a narrow conceptualisation of HIV/AIDS as primarily a behavioural and health problem, with an increase in the number of orphans as the only visible social impact being recognised. Unless relevant implementation programmes are able to rectify these gaps and omissions, it is feared that many of the laudable objectives of the PRSP may not be realised.

The MTEF, 2003-2015

The MTEF was adopted at the same time as the PRSP. In fact, it is included in the PRSP and its resource allocations are related to the objectives

articulated in the PRSP. It provides statistics on the growth profile and a framework for medium-term expenditure for the implementation of the various integrated and sectoral development planning frameworks. It also aligns the macro economic framework with the sectoral frameworks, especially those related to education and health, which were formulated prior to the MTEF. The MTEF projects that the share allocated to priority sectors will increase over time, between the 2003 and 2015 period. It is expected to increase from 3.4% to 4% in the case of education, from 1% to 2% in the case of health, and from 0.2% to 0.4% in the case of social development. However, it is worth noting that there is a financial mismatch between the resources allocated to these sectoral strategies within the MTEF and the actual resource requirements reflected in the strategies. This raises questions about the extent to which the objectives set out in sectoral strategies will be fully realised. Finally, the MTEF suggests mechanisms for its monitoring and evaluation.

Core determinants of HIV infection

The MTEF allocates resources to national priority programmes, including the national response to HIV/AIDS. Although no mention is made of MTEF support for HIV/AIDS awareness raising activities and the distribution of condoms specifically, the national programme on HIV/AIDS has a strong focus on these components. Through its funding for this programme, the MTEF could be seen to support individual behaviour change as a means to prevent the spread of HIV in Cameroon.

Between 2003 and 2015, the share allocated to the social, rural and employment sectors combined is expected to increase from 23% in 2003 to 32.4% in 2007 and 44.5% in 2015. This could be seen as an important contribution to enhancing employment opportunities and alternative forms of income. It is, however, unclear how much of this will be allocated to creating employment opportunities. Despite the PRSP's emphasis on self-employment, the MTEF does not make provision for access to credit facilities for those who are self employed or other mechanisms to support the informal sector. Even the intended aim to extend social welfare, as highlighted in the PRSP, is not provided for in the MTEF.

However, because agriculture development is seen as vital in ensuring food security for the Cameroonian population, growing MTEF support for the rural sector (which incorporates agriculture development) from 43 billion CFA franc to 62 billion CFA franc between 2003 and 2007 can be interpreted as an effort to promote food security, especially (but not exclusively) for the rural population. On the other hand, a significant proportion of agricultural products is meant for the global market rather than for domestic consumption, as the discussion of the DSDSR will reveal later.

A strong emphasis in the MTEF is on ensuring more equitable access to social services. For this reason, the MTEF makes provision for the financing of social infrastructures, particularly in relation to education, health and transport. For example, the MTEF envisages an increase in the allocation for the construction of class rooms and the recruitment of teachers from approximately 188 billion CFA franc in 2003 to 271 billion CFA franc in 2007. The number of teachers to be recruited is expected to increase from 1 879 in 2003 to 2 993 in 2006, after which it will decline to 2 357 by 2011. Between 2003 and 2007, the budget for strengthening health infrastructure and equipment will increase from 20.5 billion CFA franc to 24.2 billion CFA franc, and the budget for road construction and maintenance will increase from 272.8 billion CFA franc to 335 billion CFA franc. Provision is also made for increased financing for the recruitment of health specialists during this period.

The MTEF is also concerned with enhancing the effectiveness and management of social sectors. Thus, the allocation to support the decentralisation of the education system, improving the information system and promoting good governance in the education sector will increase from 1.8 billion CFA franc in 2003 to 2.2 billion CFA franc in 2007. Similarly, support for the management process in the health sector will increase from 620 million CFA franc in 2003 to 1.854 billion in 2007. These resources are intended to support the establishment of a tariff/follow-up evaluation system, to improve the sector's absorption capacity, to strengthen health planning and to support a health information system and an audit system.

The MTEF does not allocate resources to address other core determinants of a context of vulnerability to HIV infection, such as gender inequality or income inequality, lack of political voice, social instability or lack of social cohesion.

Key consequences of HIV/AIDS

The 2003 MTEF allocation to addressing STIs and HIV/AIDS is 15.5 billion CFA franc, after which it is

expected to increase to 21.25 billion CFA franc in 2007. Part of the annual budget allocation for HIV/AIDS in the MTEF is meant to finance the reduction in the cost of ARVs in Cameroon. Currently, the cost of ARVs in Cameroon is among the lowest in sub-Saharan Africa. This serves to contribute to the objective of reducing HIV/AIDS-related mortality.

Furthermore, because 19% of the total health budget is specifically allocated to HIV/AIDS and STIs, it could be argued that the MTEF is concerned with ensuring access to health services for people living with HIV/AIDS. To some extent, this could be seen as the MTEF's contribution to safeguard equitable access to public services, particularly for those affected by HIV/AIDS. Yet, the MTEF does not seem concerned with the possibility that HIV/AIDS is likely to lead to overcrowding in hospitals and could be crowding out other diseases. Although the MTEF's contribution to the health sector is anticipated to increase over time, as noted previously, this does not necessarily mean that it is sufficient to address the complex challenges to the health sector and health service provision posed by HIV/AIDS.

Otherwise, the MTEF does not reflect a concern with other key consequences of HIV/AIDS and no provision is made for resource allocation towards preventing or mitigating these impacts. Even though the PRSP mentions that the Government will assume responsibility for AIDS orphans, there is no budgetary provision for this task in the MTEF. There is also no recognition of the fact that the financial stability of the Government may be under threat as households get poorer and less able to pay rates, taxes or service charges as a result of HIV/AIDS. Nor is there any assessment of the anticipated impact of the epidemic on labour, national production and economic growth. Given the rapid spread of the epidemic and its current scale in Cameroon, these key consequences of HIV infection are likely to become manifest within the lifespan of this MTEF.

The Strategic Framework for the Fight Against AIDS, 2000-2010

The Strategic Framework for the Fight Against AIDS was the first strategic development framework to be drawn up since the Government adopted the national programme on HIV/AIDS in 1990. The framework was adopted in 2000 and covers the period 2000-2010. Its aims are to promote:

- The life of children (through the prevention of mother-to-child transmission), youth, adolescents, women and workers;
- The life of people living with HIV/AIDS;
- The safety of blood transfusions and injections; and,
- Greater solidarity towards people living with HIV/AIDS and orphans.

It also aims to sustain, in a viable manner, the social sectors of education and health by integrating specific strategies for each respective sector.

Core determinants of HIV infection

In response to behaviour patterns and life styles adopted by certain individuals, generally harmful to health and with a high risk of HIV infection in particular, the National Health Policy (part of which is incorporated in the Strategic Framework for the Fight Against AIDS) makes provision for strategies and actions aimed at changing individual behaviour. These include IEC strategies (adapted for different target groups) and awareness raising activities promoting breastfeeding within the first six months only. The Strategic Framework for the Fight Against AIDS also makes provision for the integration of Education for Life and Love (EVA) in educational programmes and the establishment or revitalisation of health and/or STI/AIDS clubs in primary, secondary and tertiary institutions. It also includes a focus on promoting community awareness through the use of mass media and the mobilisation of various sectors of the population. Furthermore, the framework aims to promote female condoms and the use of condoms (i.e. 100% condom use) among target groups, especially the military, the military police, customs officials, police officers, prison administration officers, students, sex workers and truck drivers. It further seeks to minimise the risk of HIV infection in young children (between 5-14 years).

The Strategic Framework for the Fight Against AIDS pays significant attention to the vulnerability of women to HIV infection and to the factors contributing to this reality. It recognises that the low level of education among women and their financial dependence on men keep women 'ignorant', contribute to a lack of awareness on HIV/AIDS and constrain their ability to stand up to various demands and pressures from men. Among its objectives are, therefore, to increase women's level of knowledge of HIV/AIDS, to reduce their dependence on men and to make the female condom available. To address the socio-economic status of women, the framework includes a

programme for improving women's access to micro-project finance and income generating activities.

Although support for social mobilisation and social cohesion (as a general development objective) is not an explicit aim of the Strategic Framework for the Fight Against AIDS, by involving community associations, churches, schools and civil society organisations in HIV prevention efforts, the framework could potentially contribute to enhanced social cohesion around a common goal: to curb the HIV/AIDS epidemic. No attention is given to social instability or conflict as a potential factor facilitating the spread of HIV.

The Framework does not elaborate on lack of access to basic public services as a factor contributing to an environment of vulnerability to HIV infection. Strong emphasis is put on improving school enrolment, which may not be surprising given the prominent focus on ignorance as a core factor facilitating the spread of HIV in Cameroon. But no attention is given to the significance of other services, like housing, health, water, and so on.

Rather surprisingly, perhaps, the Strategic Framework for the Fight Against AIDS fails to mention poverty, lack of (stable) employment and income, and income inequality as core determinants enhancing vulnerability to HIV infection. With respect to poverty, mention is only made of the fact that AIDS enhances poverty, not that poverty is a factor facilitating the spread of HIV. The Framework is equally silent on lack of political voice as a core determinant. In fact, it completely disregards the importance of involving marginalised groups (for example, women, rural poor, unemployed youth, and so on) in planning and decision making. No attention is given to migration, urbanisation and displacement and how these factors relate to HIV spread in Cameroon.

Key consequences of HIV/AIDS

The Strategic Framework for the Fight Against AIDS is obviously concerned with reducing HIV/AIDS-related morbidity and mortality. For this reason, it incorporates a focus on voluntary AIDS testing, especially making pregnant woman aware of the need to be tested, and making those who are HIV positive aware of the need to undergo treatment. Specific provision is made for the supply of ARVs to pregnant women (initially in 11 centres across the country) and for preventing the risk of mother to child transmission. The framework also allows for the treatment of opportunistic infections and ongoing treatment and care for people living with HIV/AIDS. This includes putting in place a system for the supply, distribution and subsidisation of ARVs. Implicit in this focus on treatment is a concern with patient adherence.

As mentioned earlier, the framework recognises that AIDS enhances poverty. It therefore views the fight against HIV/AIDS as a fight against poverty. One of its objectives is to reduce the economic consequences of HIV/AIDS. Hence, it aims to increase the number of people infected and affected by HIV/AIDS with access to income generating projects by 20%. To this end, provision has been made for identification and assessment of existing economic opportunities as a precondition for the creation of new opportunities. To some extent, although not an explicit objective in the document, access to income generating opportunities for people living with HIV/AIDS and affected households could help prevent an exacerbation of income inequality in Cameroon.

The framework also aims to take responsibility for the nutrition of 50% of people living with HIV/AIDS, although it does not spell out how this will be achieved. Attention is also given to the nutrition of AIDS orphans. Envisaged support for AIDS orphans further includes a focus on health and education, giving them priority access to bursaries and to ARV treatment, amongst others. The framework specifically aims to reintegrate children living under difficult circumstances, which includes the placement of AIDS orphans in families.

There is no recognition in the Strategic Framework for the Fight Against AIDS that the HIV/AIDS epidemic has different implications for women and men and girls and boys, due to their gender roles and responsibilities. Thus, there is no conscious attempt to alleviate the burden of care for people living with or affected by HIV/AIDS typically carried by women. There is also no discussion of the differential impact of HIV/AIDS on girls and boys, such as the greater likelihood that girls will drop out of school to look after siblings or sick parents.

The framework also does not seem concerned with the fact that the realisation of equitable access to basic public services is likely to be jeopardised by HIV/AIDS. There is a commitment to ensure access to medical and psychosocial care for people living with HIV/AIDS, which could be interpreted as a partial realisation of the fact that HIV/AIDS affects service demand. The framework hopes to achieve

this through the provision of home based care and the diversification of service providers. With respect to the latter, the framework emphasises the importance of involving NGOs, community associations and the private sector in treatment and care of people living with HIV/AIDS.

Yet, the concern with access to services does not extend beyond the immediate health needs of people living with HIV/AIDS to incorporate a prognosis of how the epidemic is likely to affect service demand and the nature of service provision. There is also no reflection on how HIV/AIDS is likely to erode public sector capacity and what measures should be put in place to address this.

Explicit attention is, however, given to the need for legislation that protects the rights of people living with HIV/AIDS, including legislation that protects their labour rights. In other words, it is recognised that HIV status cannot be a reason for failing to recruit a person or for losing one's job. Thus, the framework explicitly seeks to protect job security of employees infected with HIV. Legislation protecting the rights of people living with HIV/AIDS is also a critical instrument to prevent any form of discrimination on the basis of HIV status and to reduce HIV/AIDS-related stigma. A related activity outlined in the framework is training of associations of people living with HIV/AIDS on their rights and duties. No clarification is given as to what these duties would entail.

The framework also emphasises that people living with HIV/AIDS should be equal partners in the national response to HIV/AIDS. This means being involved in the conceptualisation, implementation and evaluation of relevant programmes and projects. Provision is also made for the establishment of a national network for people living with HIV/AIDS. These measures enhance the political voice of people living with HIV/AIDS, although no explicit attention is given to the political participation of social groups which have become marginalised as a result of HIV/AIDS, such as widows or the elderly.

In response to the eroding impact of HIV/AIDS on social cohesion and social support systems, the Strategic Framework for the Fight Against AIDS proposes that parent to child communication on HIV/AIDS and STIs be strengthened to support family cohesion. The shift towards home based care for people living with HIV/AIDS could also be seen as a measure to strengthen social support systems, especially if the stated intention to bolster the capacities of community structures that are expected to provide home based care is realised. Beyond these observations, however, there is no explicit discussion of the eroding impact of the epidemic on social support systems and social cohesion in the document.

Given that the Strategic Framework for the Fight Against AIDS serves as the guiding document for the national response to HIV/AIDS, one would expect it to be most comprehensive in acknowledging the core determinants and key consequences of HIV infection. It is therefore disappointing that the document fails to acknowledge a range of factors enhancing vulnerability to HIV infection, such as poverty and lack of work/income, particularly given the high levels of poverty in Cameroon. It is also disconcerting that no attention is given to the implications of the epidemic for service delivery, including the impact on the capacity of the public sector to deliver services and the extent to which the objective to achieve equitable access to services is likely to be jeopardised.

The Health Strategy, 2001-2010

Improving the health of the population represents both an economic and a social objective, which is central to development and poverty reduction. Noting three areas of insufficiency in the provision of health care – namely in human resources, infrastructure and equipment – the Government has outlined detailed strategies for the health sector, which will allow for the reform of the health system, make access to health services universal and achieve the objective of ensuring health for all.

The Health Strategy was adopted during the course of 2002 and covers the period 2001-2010. Its objectives set by the Government in the area of health, for the period of 2001-2010, fall under the following three categories:

- to reduce, by at least one third, the average morbidity rate and mortality among the most vulnerable population groups;
- to establish health centres providing Minimum Activity Packages (PMA) at one hour's walking distance and for 90% of the population;
- to effectively and efficiently manage the resources in 90% of health centres and public and private health services, at different levels of the health system.

To achieve these objectives, eight programmes have been formulated. These include programmes aimed at improving the accessibility and quality of health services, tackling the major diseases responsible for morbidity and mortality (i.e. malaria, tuberculosis, HIV/AIDS) and the promotion of the Extended Immunisation Programme for the prevention of diseases in children. Women and children, considered particularly vulnerable groups, are among the principal beneficiaries of these health programmes.

Given the particularly serious problem posed by the HIV/AIDS epidemic, the Health Strategy incorporates the main thrusts of the Strategic Framework for the Fight Against AIDS. Thus, it aims to prevent the spread of HIV and to minimise the consequences of HIV infection. It also aims to protect persons infected and affected by HIV/AIDS in all spheres through the provision of care and by preventing their marginalisation. Furthermore, given the fact that both the Health Strategy and the Strategic Framework for the Fight Against AIDS fall under the responsibility of the Minister of Health, it is to be expected that there will be a significant amount of overlap and synergy between the two documents.

Core determinants of HIV infection

In accordance with the Strategic Framework for the Fight Against AIDS, the Health Strategy emphasises the objective of changing individual behaviour through IEC programmes, developing communication and promoting the use of condoms. With respect to the latter, the Ministry of Public Health (MINSANTE) envisages making male and female condoms available at affordable prices and establishing a structure to manage and promote condom use. The Health Strategy sets targets of a 25% reduction in the HIV infection rate among those aged between 15 and 24 years and of a 50% reduction in mother to child transmission of HIV infection in 2003.

The main thrust of the Health Strategy is to improve access to health services and to improve the standard of health care. A number of strategies are suggested to achieve this goal, such as making essential medicines available and accessible (preferably in the form of generics) and establishing a pharmaceutical and rural laboratory system. The Strategy also seeks to promote the establishment of health villages and health centres and intends to make district health centres viable by expanding the health care provided. In recognition of the importance of human and financial resources for the accessibility and quality of health services, the Health Strategy elaborates on the mobilisation of resources and how staff competencies will be improved. With respect to the former, the focus is on introducing a system of cost-recovery through user charges, setting tariffs for all treatment protocols and implementing these tariffs to ensure the financial accessibility of health care for the population, and ensuring increased financing for the public health sector. To enhance staff competencies, the strategy proposes training of health care personnel in appropriate methods and establishing a mechanism for the provision of training at regular intervals.

Interestingly, the Health Strategy promotes the extension of social security to disadvantaged social groups, such as people from rural areas and people working in the informal sector. This inclusion is suggestive of an attempt to forge synergy between the Health Strategy and the Strategic Framework for the Fight Against AIDS, as it is unusual for the health sector to put programmes in place to realise this objective. In fact, the Health Strategy merely mentions this point and refers this objective to the relevant authority in Cameroon.

Equally unusual for a health strategy is the acknowledgement that gender gaps in education need to be addressed and that an improvement in the socio-economic position of women is necessary. Yet, when it comes to enhancing women's access to health services, the document limits itself to concerns about the high fertility rate and the high maternal mortality rate in Cameroon. Thus, the programmatic emphasis is on ensuring access to health care for mothers.

By encouraging communities to establish health centres in each district in an effort to share the disease burden, the Health Strategy could, unintentionally, strengthen social cohesion. The strategy also makes provision for involving religious organisations and members of religious communities in its implementation, which could potentially enhance social mobilisation. Whether these outcomes will be achieved will depend on what kind of support will be provided to communities and their associations in fulfilling these roles.

There is no explicit focus on health service provision in urban or rural areas specifically, nor does the Health Strategy elaborate on the health care needs of migrants or refugees in the country. There also

does not appear to be a strong emphasis on ensuring the participation of communities or particular social groups in health planning, except perhaps that the strategy makes provision for the establishment of platforms that facilitate dialogue between the various organisations involved in its implementation. However, within this context reference is only made to sector Ministries and private partners, not to communities or civil society organisations.

In general terms, a development planning framework related to the health sector is unlikely to engage with issues related to employment and income inequality. With respect to the Health Strategy, too, enhancing access to employment and reducing income inequalities are not articulated as objectives. There is, however, a concern with improving the remuneration of health care workers, which could contribute to a reduction in income inequality between those in the health sector and those in other sectors of the formal labour market. Also, the planned recruitment of new health care personnel is likely to provide an employment opportunity to those who are appropriately qualified.

Key consequences of HIV/AIDS

Because of the close synergy between the Strategic Framework for the Fight Against AIDS and the Health Strategy, both documents identify similar key consequences of HIV/AIDS and propose equivalent interventions to address these consequences. Thus, the Health Strategy elaborates on the reduction of HIV/AIDS-related mortality, support for AIDS orphans, safeguarding the food intake of people living with HIV/AIDS and the protection of their rights in similar ways as the Strategic Framework for the Fight Against AIDS.

Other key consequences of the epidemic are not mentioned at all in the Health Strategy. It does not even include a discussion on the enhanced disease burden due to HIV/AIDS and the pressures this puts on the public health sector, nor is mention made of the extent to which health workers may be infected with HIV and what this means for the capacity of the sector. Of course, in the absence of data on the proportion of health workers infected or affected by the epidemic, and at what level of the health system they are located, it would be difficult to project what consequences this may have for the sector as a whole. Yet, given the rapid growth of the epidemic particularly in the late 1990s, it is not unreasonable to expect the Health Strategy to engage explicitly with these two inter-related sets of consequences.

Linked to this is the silence on the need to protect the rights of those employed in the health sector, who may be living with HIV/AIDS or who may otherwise be affected by the epidemic. Likewise, although cost recovery is established as a guiding principle for health service provision, the fact that an increasing number of households and individuals will most likely be unable to afford health service charges is not touched upon. As a result, access to health care may be jeopardised for those who cannot afford it and at the same time the financial stability of the health sector may be at risk.

To conclude, the Health Strategy shows a significant amount of overlap with the Strategic Framework for the Fight Against AIDS, even up to the point where some points are raised that are not commonly associated with a health sector intervention. In the final analysis, however, the strategy does not seem to deal with a number of factors that are critical to the health sector, particularly in relation to addressing the key consequences of HIV/AIDS.

The Education Strategy, 2001-2011

The Education Strategy was adopted in 2001 and is directly related to the MDGs. The National Programme of Action for Education for All (PAN-EPT) was elaborated and adopted in 2002.

The Education Strategy sets out four key objectives:

1. To broaden access to education while correcting disparities, encouraging early childhood education and increasing access to primary, general secondary and technical secondary school education;
2. To improve the quality of education on offer by reducing school drop out, improving the quality of pedagogical training, adapting teaching programmes, improving the accessibility and availability of textbooks and good quality teaching materials, and by combating HIV/AIDS in the educational environment.
3. To develop an efficient partnership through the institution of participatory governance of educational institutions; involving the social and business community in the design of technical, technological and professional training programmes; developing and implementing a national policy on private education, and developing and promoting a partnership model between the State and role players in the field of private education.
4. To improve the management and governance of the educational system through improved

financial management and improved management of the Ministry of National Education's system of communication and through the promotion of good governance in the educational system.

Core determinants of HIV infection

An assessment of the Education Strategy in relation to Table 4.1 reveals that only a few core determinants of HIV infection are addressed in the document. One of the central objectives of the Education Strategy is to raise awareness about HIV/AIDS among pupils and students and to ensure they engage in safe sexual behaviour. Specific activities under this objective relate to an evaluation of knowledge, attitudes and behaviour concerning HIV/AIDS and sexual behaviour in the school environment, training of teachers and other actors on how to incorporate HIV/AIDS into the curriculum and, more generally, 'sensitisation'.

The overarching aim of the Education Strategy is to improve the coverage, accessibility and quality of education in Cameroon, especially at primary and secondary school level. A related concern is to reduce the high drop out rate, particularly in primary school. To achieve this aim, and in accordance with the Constitution of Cameroon and the Basic Education Act of 1998, the strategy makes provision for free, and compulsory, primary education. It also seeks to facilitate the accessibility and availability of text books and other educational material and to improve the quality of teaching. In an attempt to address regional disparities, priority education zones are identified which are targeted for increased school enrolment rates. These zones are mainly located in the three northern provinces (Adamaoua, Far North and North) and in certain disadvantaged neighbourhoods in the main cities. Study bursaries are made available to eligible children, specifically within the priority education zones, with a bias toward girls.

The Education Strategy is clearly concerned with addressing gender disparities at all levels of education. Thus, it seeks to increase not only enrolment rates among girls, but also their retention rates to avoid girls leaving school prematurely. The strategy does not specify how this will be achieved.

Other core determinants of vulnerability to HIV infection are not explicitly addressed in the document. It could be argued that the involvement of parent associations in the management of schools enhances social mobilisation and facilitates the expression of political voice for at least one interested party in the education of children, namely parents.

Also, as noted in the case of the Health Strategy, the planned expansion in the recruitment of new teachers at all educational levels throughout the period covered by the Education Strategy will promote access to employment for some young graduates. Obviously, the recruitment drive stems from the need to ensure the provision of equitable, quality education, rather than being the education sector's conscious contribution to overcoming unemployment (or under-employment) in the country.

Key consequences of HIV/AIDS

Under the objective of raising awareness about HIV/AIDS in the school environment, attention is given to the need to advocate for children's rights in a context of HIV/AIDS. More specifically, the Education Strategy aims to protect the right to education of learners living with HIV/AIDS and of AIDS orphans by stipulating that they should remain at school, where they ought to be provided with psychological and social support. Through this measure aimed at overcoming HIV/AIDS-related discrimination, the strategy safeguards equitable access to education for learners infected with and affected by HIV/AIDS.

This is, however, the extent to which the Education Strategy engages with the key consequences of HIV/AIDS. Despite its intention to overcome gender disparities in education, there is no recognition of the fact that this goal may not be achieved – and in fact, that gender disparities may even be aggravated – as a result of HIV/AIDS, with girls more likely to drop out of school to assist their families in times of need. One possible explanation is because the strategy identifies only two categories of learners affected by the epidemic: those living with HIV/AIDS and AIDS orphans. No reference is made of the impact of HIV/AIDS on children, and in particular on their educational prospects, who do not fall into either category.

Although the Education Strategy recognises that there is a high probability that learners living with HIV/AIDS and AIDS orphans will drop out of school whereby their access to education is in jeopardy, it does not engage with the impact of the epidemic among teachers and other educational staff. Thus, there is no consideration for the impact of HIV/AIDS

on the capacity of the education sector and on the provision and quality of education.[lx] It is true that provision is made to recruit more teachers over time to ensure better coverage of education across the country. Yet, these projections do not take into account the loss of teaching staff due to HIV/AIDS, nor are the financial implications of having to replace these teachers and other personnel worked out.

The strategy also does not seek to contribute to enhanced food security through a nutritional programme or school feeding scheme for AIDS orphans or other vulnerable children, nor is there an explicit focus on stigma-reducing activities within the educational environment. Finally, the Education Strategy does not engage with the prospective impact of the HIV/AIDS on the labour market and what role the education sector can play in replacing the skills and qualifications that may be negatively affected.

This cursory review suggests that the Education Strategy incorporates a number of obvious – and important – interventions aimed at addressing some core determinants and key consequences of HIV infection. Yet, it has also revealed that a significant number of factors are not dealt with in the strategy, despite their relevance for the education sector.

The Rural Development Strategy (DSDSR), 2002-2004

The Rural Sector Development Strategy Paper (DSDSR) provides a critical analysis of the contribution of the agricultural sector to the national economy. It acknowledges the importance of this sector and the role it will continue to play in the future. The DSDSR envisages that this role can only be achieved through practical programmes which aim, amongst others:

- To increase the productivity of agricultural production and stock (cattle and fish) farming;
- To encourage private initiatives, particularly those of women in programmes to combat poverty;
- To ensure continued and lasting long-term results, referred to as the "challenge of the environment".

It is worth noting that the DSDSR is principally an economic development framework. Other dimensions of rural development are supposedly captured in the PRSP. This economic thrust has implications for the reflection of core determinants and key consequences of HIV infection in the DSDSR.

Core determinants of HIV infection

The DSDSR makes no mention of HIV/AIDS or the importance of preventing the further spread of the epidemic in rural areas. Accordingly, no attention is given to changing sexual behaviour as a means to prevent HIV transmission.

As noted above, one of the aims of the DSDSR is to specifically encourage private initiatives of women. Recognising that women are a disadvantaged socio-economic group, the framework seeks to enhance their ability to generate income. In fact, gender inequality is the only core determinant of vulnerability to HIV infection explicitly dealt with in the DSDSR.

Other than that, the underlying assumption of the DSDSR seems to be that enhanced agricultural productivity will automatically reduce poverty and create employment opportunities in rural areas. It does not consider the distributional effects of potential economic growth in rural areas or the labour implications of particular types of agricultural reform strategies. The DSDSR advocates the use of new agriculture, stock-raising and farming technology to increase output. It also encourages private initiatives and profit distribution to farmers as an incentive to improve productivity. Unless accompanied by poverty reduction and labour enhancing measures, such interventions more often than not lead to a loss of jobs (especially in lower skilled positions), more poverty and enhanced income disparities. Also, whereas the DSDSR emphasises enhanced food production, this is not necessarily to the benefit of food security for the rural population or for the country as a whole. Rather, given the emphasis on trade, agricultural products would not necessarily be produced for the domestic market.

No mention is made in the DSDSR of the need to extend service provision and infrastructure development into rural areas. Given the service delivery gaps in rural areas (as noted in the overview of development trends in Cameroon), this omission seems rather surprising. However, the DSDSR is principally designed as an economic development framework, aimed at strengthening the rural economy and agricultural production. Any other aspect of rural development that does not fall inside this – admittedly narrow – interpretation of economic development is supposed to be addressed by the PRSP. The same applies to the development challenges related to migration and urbanisation, which are not dealt with in the DSDSR.

Table 6.1. Explicit objectives in Cameroon's development planning frameworks						
	PRSP	**MTEF**	**AIDS Strategy**	**Health Strategy**	**Educ. Strategy**	**DSDSR**
Core determinants of HIV infection						
1.1. Change in individual behaviour	++	+	++	++	++	-
1.2. Poverty reduction (minimum standard of living & food security)	++	+?	-	-	-	-
1.3. Access to decent employment or alternative forms of income	+	-	-	+?	-	-
1.4. Reduction of income inequalities	-	-	-	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	-	++	+?	+	+
1.6. Equitable access to quality basic public services	++	++	-	++	++	-
1.7. Support for social mobilisation & social cohesion	-	-	+?	+?	-	-
1.8. Support for political voice & equal political power	-	-	-	-	-	-
1.9. Minimisation of social instability & conflict / violence	-	-	-	-	-	-
1.10. Appropriate support in the context of migration/displacement	+	-	-	-	-	-
Key consequences of HIV/AIDS						
2.1. Reduction of AIDS-related adult/infant mortality	+	+	++	++	-	-
2.2. Patient adherence	-	-	-	?	-	-
2.3. Poverty reduction	-	-	++	+?	-	-
2.4. Reduction of income inequalities	-	-	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	-	-	-	-	-
2.6. Appropriate support for AIDS orphans	+	-	++	++	+	-
2.7. Equitable access to essential public services	-	+?	-	-	+	-
2.8. Effective/enhanced public sector capacity	-	-	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	+	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	-	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-	-	-
2.12. Support for social support systems & social cohesion	-	-	+?	-	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	-	-	+	-	-	-
2.14. Reduction of AIDS-related stigma and discrimination	-	-	+	+	+	-
2.15. Reduction of social instability & conflict	-	-	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly						

For the same reason, there is no focus on involving rural communities or rural women in decision making and implementation of rural development plans. The DSDSR does encourage communities to establish 'economic interest groups' (GIE) or 'common interest groups' (GIC), which could be interpreted as a measure supporting social mobilisation. However, in accordance with the economic slant of the RSDPS, these groupings are clearly based on economic criteria, rather than cultural or other social criteria.

Key consequences of HIV/AIDS

Because the RSDPS does not take cognisance of HIV/AIDS, how it manifests itself in rural areas or what its implications are for rural development, none of the key consequences of HIV/AIDS identified in Table 4.1 come to the fore in the document. This is despite the anticipated impact of HIV/AIDS on labour and production, amongst others. Although the HIV prevalence rate in rural areas is considered to be lower than the urban prevalence rate in Cameroon, this does not mean that the rural economy (which is the preoccupation of the DSDSR) will not be adversely affected. Of course, other impacts of the epidemic in rural communities, such as those related to poverty, loss of work and income, gender relations and rural service provision also have to be factored in.

Table 6.1 summarises the preceding assessment of the extent to which Cameroon's primary development planning frameworks address the core determinants and key consequences of HIV/AIDS. It is clear that, with the exception of the DSDSR, all frameworks highlight the importance of raising awareness about HIV/AIDS and of changing sexual behaviour to prevent the further spread of the epidemic. Most frameworks also highlight the need to address gender disparities. Another common concern is related to the equitable provision of quality services. The least attention is given to

socio-political factors, such as the importance of participatory planning processes and the value attached to social cohesion and mobilisation. Lack of employment or secure income and income inequality are also not considered in the various development planning frameworks, except for the statement in the PRSP to promote self-employment. Although poverty reduction is supposedly the main objective of the PRSP, in practical terms it proposes very few concrete measures to achieve this. Like the DSDSR, the assumption seems to be that enhanced economic growth in itself will be sufficient to reduce poverty.

With respect to the key consequences of HIV infection, the three most commonly recognised factors are those related to mortality, AIDS orphans and, to a lesser extent, HIV/AIDS-related stigma and discrimination. Beyond these impacts, the development planning frameworks do not engage with the implications for public service provision, in terms of both supply and demand, but also in relation to financial resources. Even though the majority of respondents highlighted the impact of the epidemic on labour and national production, these factors are not taken into account in any of the frameworks. Again, the frameworks are largely silent on the socio-political implications of the epidemic. Most surprisingly is perhaps the general lack of attention given to poverty as a key consequence of the HIV/AIDS epidemic.

The planning process

The preceding discussion has alluded to some important dissimilarities between what respondents identified as core determinants and key consequences of HIV/AIDS and what is reflected in the development planning frameworks of Cameroon. To some extent, such discrepancies might be explained by the nature of planning processes in the country. Another plausible explanation is that the interviews took place at a time when levels of awareness of HIV/AIDS may have been higher than when the frameworks were developed.

Parliament

When asked about Parliament's involvement in the formulation of the principal development planning frameworks in Cameroon, the Member of Parliament interviewed suggested that Parliament has not played a primary role in the development of these frameworks. He described the role of Parliament as one of debating and ratifying draft bills and policy documents, rather than one of inputting into the design of these documents. In fact, he went as far as to say that unless there is a document for Parliament to peruse, it is unlikely that an issue will be discussed in Parliament. One would imagine that all the development planning frameworks have been tabled in Parliament for ratification, but this could not be gauged from the interview or from other respondents.

With respect to HIV/AIDS specifically, he further noted: "Although the seriousness of the epidemic would seem to call for an examination and debate in a plenary session of Parliament over a number of days, this has not happened." He added to this,

> In the context of HIV/AIDS, Parliament is informed about what is happening. Its members serve on committees for the Fight Against AIDS at local or regional level. A Member of Parliament is therefore a simple link in the knowledge about the phenomenon and the possibility of controlling it, but Parliament does not play a principal role.[lxi]

Sector Ministries

Given the fact that the Ministry of Economic Affairs, Planning and National Development (MINEPAT) has set up a committee with representatives of 16 sector Ministries and the technical partners in Cameroon within the context of the national development programme, one would anticipate a significant amount of multi-sectoral involvement in the formulation of principal development planning frameworks. During a number of interviews, reference was made to the involvement of different Ministries and departments in the formulation of certain development planning frameworks. In particular, the PRSP and the Strategic Framework for the Fight Against AIDS seem to have been underpinned by multi-sectoral involvement. With respect to the latter, it initially started as an initiative of the Ministry of Health, but gradually other sectors and civil society organisations have become involved. With respect to the sectoral strategies for health and education, reference was made to the fact that these have been drawn up with the coordination of MINEPAT.

Civil society organisations

The representative of the Cameroon National Association for Family Welfare (CAMNAFAW) indicated that his organisation had been involved in the formulation of the National Health Plan, the National Programme of Action for Education for All (PAN-EPT) and other policies in these sectors.

Because of its involvement in elaborating strategies for the health sector, which included HIV/AIDS-related strategies, the organisation also played a part in the Strategic Framework for the Fight Against AIDS. CAMNAFAW only became involved in the PRSP after it had been adopted as the principal development planning framework for Cameroon by making a submission to Parliament in December 2002. The organisation did not engage with macroeconomic planning or with the DSDSR, because these pertained to issues that were considered to be outside its area of competence.

Whereas government representatives argued that there had been significant civil society involvement in the planning process, particularly with regards to the PRSP, it was also noted that in practice such involvement may be limited because the role of some parties tend to be symbolic or "figurative" and, more than that, "in the end, it is always the civil servants who draw up the documents."[lxii]

The CNLS and organisations representing PLWHA
The National Committee for the Fight Against AIDS (CNLS) – which falls under the Ministry of Health – undoubtedly played a central role in formulating the Strategic Framework for the Fight Against AIDS in Cameroon. Beyond this, however, there was no indication that the CNLS was involved in the formulation of other development planning frameworks in the country. Unfortunately, the President of the Association of People living with HIV was relatively new in this position and was therefore unable to comment on the extent to which the organisation had been involved in the formulation of the Strategic Framework for the Fight Against AIDS, let alone of other development planning frameworks.

Development partners/donors
The interviews suggested that there has been significant involvement of the World Bank, UNAIDS, the French Development Cooperation, the German Development Cooperation (GTZ) and the European Union in the elaboration of Cameroon's principal development planning frameworks. Moreover, most of these frameworks are funded, in more or less significant ways, by these international agencies. The World Bank representative referred to his organisation's involvement in the PRSP, Strategic Framework for the Fight Against AIDS and the DSDSR as 'maximum participation'. UNAIDS's role in the formulation of the Strategic Framework for the Fight Against AIDS seems to have been substantial, not just by providing financial and technical support in the process leading up to its formulation, but also by elaborating the draft of the actual framework. UNAIDS continues to be involved in monitoring the implementation of the framework.

Private sector
An interview conducted with a representative from the Cameroon Employers' Federation (GICAM) highlighted the role of the private sector in the process of development planning in the country. As the representative argued, "There is not a single strategic framework for development that has been introduced without representation from GICAM".

Alignment and implementation of development planning frameworks
As the discussion of the various development planning frameworks has shown, a significant amount of alignment exists between the Strategic Framework for the Fight Against AIDS and the Health Strategy. This has been facilitated by the fact that both frameworks have been elaborated under the political leadership of the Minister of Health. It is clear from Table 6.1, though, that there is little evidence of alignment in HIV/AIDS programming between the Strategic Framework for the Fight Against AIDS and other frameworks.

Furthermore, due to its status as the principal development planning framework in Cameroon, the PRSP clearly seeks to fulfil an alignment function. The document identifies critical development challenges facing the country and refers to other planning frameworks (e.g. the urban and rural development strategies) and policy documents (e.g. the forthcoming policy on the promotion of women) for a more detailed elaboration of appropriate strategies.

In the course of the interviews, conflicting views on alignment of development planning frameworks emerged. For some, synchronisation was evident in the fact that the PRSP served as the principal planning framework that guided all other development planning frameworks. In the words of one respondent:

> Cameroon is a member of the United Nations and has had to adhere to all objectives set at international level, especially the Millennium Development Goals, and everything done at national level is directly related to these millennium goals through the PRSP, which today represents the economic and social policy framework for the country. All strategies

> of sector Ministries and of different sectors of activity (rural, social) work in synergy to achieve the objective embodied in that document or the PRSP.[lxiii]

Others pointed to the role of the Prime Minister in directing the work of government sectors, thereby suggesting that this resulted in a fair amount of institutional coordination. One respondent (a civil society representative) went as far as to suggest that "… civil society follows in the footsteps of Government"[lxiv], thereby suggesting that the whole of Cameroonian society aligns itself with government efforts aimed at the development of the country.

Yet, other respondents argued that there was very little coordination in efforts to promote development, whether it was aimed at poverty reduction or addressing HIV/AIDS, for example. Specific reference was made to the lack of coordination in the area of HIV/AIDS programming in particular, with some respondents suggesting that "everyone develops his or her own plan of action" and even that "there is total shambles around the question of AIDS in Cameroon". [lxv] It could be pointed out, though, that these observations seem less concerned with the alignment of planning frameworks at the macro level, but more with the lack of synergy and coordination of specific programmes and activities in the sphere of implementation.

Furthermore, although there is evidence of a certain amount of streamlining, especially with respect to the PRSP and MTEF on the one hand and the Strategic Framework for the Fight Against AIDS and the Health Strategy on the other hand, the fact that different development planning frameworks cover different time frames and follow different planning cycles is also likely to further complicate effective alignment.

With respect to implementation, it is worth noting that most of Cameroon's development planning framework had been adopted within the year preceding this assessment. As such, observations regarding the implementation of these frameworks were clearly limited. On a few occasions, reference was made to the process of decentralisation, identified by some as an example of 'good' implementation, whereas others regarded it as less successful and a challenge to the effective implementation of development planning frameworks.

One respondent commented specifically on the challenge in translating the good objectives reflected in Cameroon's development planning frameworks into practical and effective strategies and programmatic interventions. In other words, the relevant knowledge and insights to address development challenges seems to be there, but what remains is the 'how to' question.

With respect to the Strategic Framework for the Fight Against AIDS specifically, it was observed that the fact that everything in the framework was considered a priority served to hinder its effective implementation. It was also noted that there is a need for clear and reliable indicators that allow for an assessment of the implementation and impact of respective development planning frameworks. This, of course, links to another point noted during the interviews, namely the lack of basic data on which everyone agrees. As noted in Chapter 3, the lack of consistent and reliable data militates against the alignment of development planning frameworks.

Finally, the financing gap between the resources provided for in the MTEF and the resource requirements in other development planning frameworks, especially the sectoral frameworks, is indicative of poor alignment and will most certainly affect their effective implementation negatively.

Concluding comments

This section started by locating development planning in Cameroon in historical context. The six development planning frameworks discussed here have all been elaborated in recent years, since 2000, which indicates a renewed interest in development planning. It seems external partners have been very involved in this process, both in the design of these frameworks and by making resources available for their implementation. The formulation of the various development planning frameworks took place at a time when the HIV/AIDS epidemic in Cameroon took on unprecedented proportions. Thus, an opportunity existed to incorporate a comprehensive approach to HIV prevention and impact mitigation in these frameworks. However, this cursory assessment has revealed that this opportunity was not fully grasped. Even though the Strategic Framework for the Fight Against AIDS was the first to be developed, and therefore could have influenced the other planning frameworks in Cameroon, there is little evidence to suggest that this has actually occurred. There is also no indication that the CNLS was directly involved in the formulation of other development

planning frameworks, which could have facilitated better alignment on HIV/AIDS programming. It should be noted, though, that even the Strategic Framework for the Fight Against AIDS does not address all core determinants and key consequences of HIV infection.

6.5. Conclusion

The 1990s were challenging times for Cameroon. The economic recession that started in the late 1980s led to spiralling external debt, a steady decline in average GDP per capita, growing levels of poverty and informality and a general decline in the quality of life of Cameroonians. The first HIV/AIDS cases were observed when the country fell into economic crisis. Within a decade, HIV/AIDS had taken on epidemic proportions, with latest statistics suggesting that the HIV prevalence rate reached 11% in 2000.

Towards the end of the 1990s, Cameroon appeared to bounce back from the economic crisis. However, the benefits of positive economic growth are not shared equally among the population, as growing gaps between the rich and poor make evident. Perhaps there is a connection between the improved performance of the economy and the renewed concern with HIV/AIDS. In any event, by the end of the decade it becomes clear that HIV/AIDS has flourished and that a concerted effort is necessary to respond to the epidemic. This culminates in the Strategic Framework for the Fight Against AIDS in 2000.

Since then, development planning seems to have gained prominence again, as it had in the 15 years preceding the economic crisis. Within two to three years, Cameroon has adopted a range of development planning frameworks, in accordance with international thinking on development and on what are considered the most appropriate frameworks and instruments to facilitate development.

The timing of the development of these frameworks seemed most opportune to allow for HIV/AIDS to be incorporated. Yet, as this assessment has revealed, Cameroon's development planning frameworks at best cover a minimum package of prevention, treatment and care, and impact mitigation (limited to a concern with orphans). In particular, the emphasis is very strongly on HIV prevention through awareness raising and behaviour change. Little, if any, attention is given to the social, economic and political environment in which individuals think, relate and act. Thus, the significance of other core determinants of vulnerability to HIV infection, such as poverty and gender inequality, is not adequately recognised. Similarly, hardly any attention is given to the key consequences of HIV/AIDS, at micro and macro level. Although it is too soon to assess the implementation of the various development planning frameworks, it seems unlikely that all objectives and targets will be realised as a result of HIV/AIDS.

Although interview respondents generally highlighted poverty as a factor facilitating the spread of HIV, here too the main emphasis was on ignorance, loose moral values and inappropriate behaviour as the main reasons for becoming infected with HIV. Most remarkable was the lack of consideration for the status of women and the link between HIV infection and gender relations. Respondents did recognise a number of key consequences of HIV/AIDS that are not explicitly dealt with in the development planning frameworks. Those most commonly mentioned related to the loss of labour and the implications for national production. Given the country's recent emergence from an economic crisis, this concern with macro level impacts is perhaps not surprising. Still, what is remarkable is the silence on the link between HIV/AIDS and the loss of ability to work and generate an income, the added burden of care for women/girls and the pressure on social support systems to cope with the consequences of the epidemic.

In conclusion, it seems the key development planning frameworks in Cameroon at best cover what is considered the traditional mainstay of HIV/AIDS programming. Instead, a broader conceptualisation of HIV/AIDS is required, one that recognises the intricate interplay between HIV/AIDS and other development challenges. Given that these frameworks need to be translated into specific programmes and plans, there is a window of opportunity to rectify the noted gaps and omissions.

Senegal[1]

7.1. Introduction

Senegal is one of the poorest countries in the world. Despite recent improvements in education, health and basic service provision, it ranks low on a range of human development indicators. Thus, its socio-economic environment reflects a number of factors that have been identified in this study as core determinants of vulnerability to HIV infection. Yet, Senegal has one of the lowest HIV prevalence rates in sub-Saharan Africa. In fact, like Uganda, Senegal is widely seen as a success story in containing the HIV/AIDS epidemic. This raises interesting questions about the relevance of the premise of this study, namely that factors in the social, economic, political and technological environment constrain people's ability to consciously behave in ways that protects them and others from HIV infection. Within the context of this study, it is not possible to do a comprehensive assessment of the reasons and factors that have contributed to Senegal's ability to contain the HIV/AIDS epidemic. Here, the focus is on exploring possible links between development planning and control of, or responsiveness to, the HIV/AIDS epidemic in Senegal. As this chapter will conclude, even though it would appear that the conceptual approach of the study is not directly applicable to a low HIV prevalence country like Senegal, a case can still be made for a broader conceptualisation of HIV/AIDS in its principal development planning frameworks.

7.2. Overview of development trends since 1980

Drawing on national data, this section attempts to distil a number of development trends in Senegal between 1980 and 2000 (See Appendix 2 for the Country Profile of Senegal and relevant references). However, this exercise is hampered by a lack of consistent and regular national data that allows for such an assessment. In particular, local data for the 1980s and even early 1990s has proven difficult to access. As a result, it is difficult to reflect development progress and setbacks over time.

Demographic trends

In the past two decades, Senegal has experienced quite rapid population growth. Between 1980 and 1990, Senegal's population grew from about 5.6 million inhabitants to 7.3 million inhabitants. Average annual population growth was 2.7% for the period between 1976 and 1988 and the total fertility rate was 6.5. Since then, there has been a slight decrease in the rate of population growth, although it remained over 2 percent during the 1990s. The reduced growth rate can be attributed to a decline in the fertility rate and an increase in the use of modern contraception. In 1997, the total fertility rate was estimated at 5.7 children per woman (Ministère de l'Economie, des Finances et du Plan, 1997). The contraceptive prevalence rate increased from 2.4% in 1986 to 12% in 1999 (Ministère de la Santé Publique, 1999). According to the latest population census (RGPH), in 1999 Senegal's population totalled just below 9.3 million people.

Senegal's population is very young: almost six out of ten Senegalese (57%) are under 20 years of age. The gender profile is similar to that of the subcontinent as a whole, with women making up 52% of the total population. Senegal is a multi-ethnic country. The main ethnic groups are Wolof (43%), Pulaar (24%), Serere (15%), Diola (5%) and Mandinka (4%). The majority of the population is Muslim (94%). Four percent of the population is Christian, whilst other religions represent one percent.

The population of Senegal is not distributed equally. Dakar, which covers only 0.3% of the surface area of the country, is home to almost a quarter (24%) of the population. It is the most densely populated region, with 4.404 inhabitants per km^2. In comparison with other countries in sub-Saharan Africa, Senegal's population is significantly urbanised. In the early 1990s, four out of ten Senegalese lived in urban areas; at the close of the decade, this had increased to just below one in two (44%). In abso-

lute numbers, this means an increase in the size of the urban population from 3.2 million in 1993 to over 4.2 million in 2000. The average urban growth rate accelerated during the 1990s from 3.9% in 1988 to 4.2% in 2000. UN-Habitat (2003) projects the urbanisation rate to decrease to 3.7% between 2000-2015 and to 2.8% between 2015-2030.

Between 1988 and 1993, the number of migrants in Senegal has increased significantly. Whereas in 1988 it was estimated that there were just below one million migrants in the country, by 1993 this had increased to close to 1.5 million. More recent data could not be obtained. Although no data could be found reflecting the number of Senegalese emigrants living outside of the country, the size of the Senegalese diaspora is considered to be fairly considerable. According to official figures from the Ministry of External Senegalese, there were 7 000 Senegalese people with academic qualifications living abroad in 2001.

Since independence, Senegal has largely experienced political stability. However, in the south of the country, a separatist movement has sparked a rebellion. This has created instability in the affected area. Because of its links with parties in the Gambia, the rebellion has also increased tensions between Senegal and the Gambia.

Economic performance and structure of the economy

During the 1980s, Senegal experienced an economic downturn. The economic difficulties of that time arose not only as a result of the oil crisis, but also of internal, structural economic problems associated with the inadequate articulation and integration of the various economic sectors. This led the Government to adopt a structural adjustment programme in the 1980s. Although the economic crisis predated structural adjustment, it was further aggravated by the adoption of structural adjustment programmes. Following the economic downturn of the 1980s, weak economic growth was recorded during the first four years of the 1990s. The average economic growth rate for this period was 1.3%. This figure hides significant annual differences, ranging from 3.9% in 1990 to a negative growth rate of 2.2% in 1993. In the second half of the 1990s, the economy seemed to recover from its slump. Since then, strong and consistent economic growth of over five percent per annum has been recorded. This persistent growth trend has been attributed to the devaluation of the CFA franc in 1994 and to structural and sectoral reforms.

Senegal has a relatively diverse economy, which is dominated by services, and more specifically government services. During the 1980s and early 1990s, the services sector's contribution to national GDP hovered just below 50%. Its share of GDP increased from an average of 48.7% over the period 1990-1995 to 50.6% over the period 1996-2000. Similar trends are observed in the industry sector, which has experienced consistent growth since 1980. Its contribution to national GDP grew from 16% in 1980 to 18.6% in 1990 and to 20.6% in 2000.

In contrast, agriculture's share of national GDP has decreased from 12.9% in 1980 to 9.5% in 2000. Whereas this sector's contribution to the economy remained relatively stable during the 1980s, this decline occurred mainly during the 1990s. Agricultural performance has been hampered by lack of rainfall, limited diversification of products and outdated production techniques. Although the agriculture sector does not contribute the largest share of national GDP, it is the largest sector of employment for the rural population in Senegal. Thus, a decline in this sector will impact negatively on rural households.

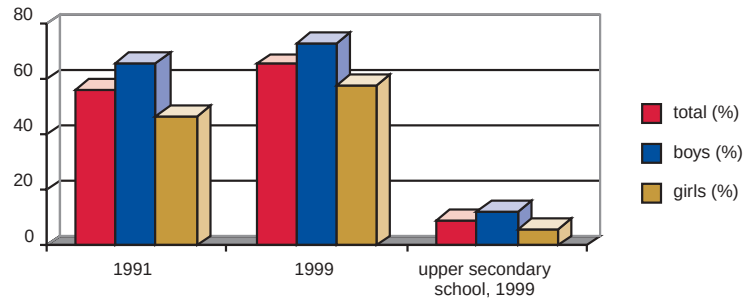
Senegal is a highly indebted country and has been included in the HIPC Initiative. In 1994, its debt stock amounted to 88% of GDP. Its debt profile improved during the 1990s to 72.9% in 1999. Recently, however, concerns have been expressed that under the current terms of debt relief Senegal will pay more, rather than less, in debt servicing (Cheru, 2001).

On balance, the economic situation in Senegal signals an upward trend since the mid-1990s. Yet, the average economic growth rate of five percent remains below the two-figure targets set in the 9th Plan for Economic and Social Development (1996-2001), which are deemed necessary to improve the living conditions of the population.[lxvii] As subsequent sections show, poverty and poor living conditions are a reality for the majority of Senegalese.

Poverty and inequality

The rate of poverty is very high in Senegal. Although data of the 1980s is not available, it is widely accepted that poverty increased during the years of economic crisis and structural adjustment. In 1994, the first budget investigation (ESAM I) estimated that close to three out of five households (57.9%) were living below the poverty line.[lxviii] According to the PRSP, the proportion of households living in poverty has decreased to 53.9% in 2001. It

Graph 7.1 School enrolment in Senegal, 1991-1999



attributes the observed reduction in poverty to a concerted Government effort to increase household income during the period 1995-2001. Yet, as noted in Chapter 5, annual statistics from UNDP and the World Bank indicate that GNI per capita has in fact decreased during this period, from an average of $600 in 1995 to $500 in 2000. In 2001, GNI per capita was estimated at $480 (World Bank, 2003).

Notwithstanding the high level of urbanisation in Senegal, more than half the population still resides in rural areas. A significant proportion of the rural population derives their income and employment from agriculture, which is by far the most significant sector of rural employment in the country. The agriculture sector's declining share of GDP noted above is likely to have particularly negative implications for rural residents. Because work in this sector is seasonal (during the three months of the rainy season), the level of underemployment is very high. It is against this background that the 9th Plan for Economic and Social Development (1996-2001) estimates that just over one in three (38%) rural residents is employed.

Unemployment is generally high in the country, particularly among young adults: 35% of those between 20-24 years are unemployed. The 9th Plan for Economic and Social Development (1996-2001) further estimates that four out of ten urban residents between 20-34 years of age are unemployed. As the Country Profile illustrates, between 1988 and 1994 both male and female unemployment has increased by about six to eight percentage points respectively.[lxix] As a result, the informal sector has grown significantly over the past two decades. According to the 9th Plan for Economic and Social Development (1996-2001), the informal sector contributes over 50% to GDP and is more dynamic than the formal sector.

Recent official figures suggest that the rate of male employment is significantly above the rate of female employment. The proportion of male employment in Senegal's nine regions ranges from 56.3% in Ziguichor to 85.2% in Louga. For women, the lowest employment rate is recorded in St Louis (7.5%), whereas the highest proportion of female employment is 34.9%, in Fatick. In all but one region (Diourbel), the regional unemployment rate among men exceeds that of women. However, in seven out of nine regions, the urban unemployment rate among women tends to parallel and even considerably exceed the male unemployment rate (DPRH 1995).

Given the high levels of poverty and unemployment, it is not surprising that inequality is also a reality in Senegal. Although national figures suggest that the Gini coefficient for the country as a whole is 0.3, UNDP (2003) puts it significantly higher at 0.41. Inequality is most severe in urban areas. According to Senegal's Poverty Reduction Strategy Paper (PRSP), the Gini coefficient for the city of Dakar is 0.5. It seems that the improved economic performance of Senegal in the latter part of the 1990s has been accompanied by a widening of the gap between the rich and the poor.

Human development

Senegal is among the twenty countries at the bottom end of the UNDP Human Development Index. Across a range of indicators, it ranks below the average for sub-Saharan Africa. Over the past two decades, however, Senegal has made strides in improving access to basic services and education. In contrast, health has been most adversely affected by the economic recession of the late 1980s and early 1990s and the process of economic reform.

During the 1990s, access to safe drinking water improved significantly. In 1992, just over half the

population had access to safe drinking water; by 1999 this had improved to seven out of ten Senegalese. Achievements were also realised with respect to improved access to sanitation, albeit at an evidently slower pace. Whereas in 1992 59.9% of households had access to sanitation, five years later this had increased to 65%.

In comparison with other countries in sub-Saharan Africa, a very high proportion of the population of Senegal is illiterate. In 2001, it was estimated that seven out of ten women and close to five out of ten men (48.9%) were illiterate (Ministère de l'Economie, des Finances et u Plan, 2001a). Put differently, only one in three Senegalese people over the age of 15 years is considered literate. To address this situation, recent years have seen concerted efforts to provide education for all. As a result, the primary school enrolment rate increased from 56% in 1991 to almost 70% in 2000 (see Graph 7.1). The rate of increase has been higher among girls, yet the enrolment rate among girls remains significantly below that of boys. In 1999, 58% of girls and 73% of boys were enrolled in primary school. As these figures imply, four out of ten girls and three out of ten boys within the eligible age group do not attend primary school.

A significant gap is noted between primary and secondary school enrolment (see Graph 7.1). In lower secondary school, the enrolment rate is 21.9%; in upper secondary school it is only nine percent. This indicates that school drop out among teenagers is high, with long term implications for their future and their integration into the labour market. Gender disparities are particularly pertinent here, with only 6% of girls attending secondary school compared to 12.4% of boys.

The increase in both primary and secondary school enrolment rates suggests that progress towards improving human development is being realised. However, the quality of education is likely to be adversely affected by the average size of a classroom. In 2000, there was on average one teacher for every 51 pupils. Because of the lack of prior data, relevant trends could not be ascertained.

With respect to health, the economic recession and the devaluation of the local currency under economic restructuring has had a particularly negative impact on public health (Oppong and Agyei-Mensah, 2004). One example of this is the decline in the doctor to population ratio: between 1987 and 1988, the number of doctors per 100 000 inhabitants declined from 7.5 to 5.7, only to decline further to 5.4 by 1990. Towards the end of the 1990s, a slight improvement was recorded, with 6 doctors per 100 000 inhabitants. Put differently, this means that there is one doctor for every 17 000 people. This does not compare favourably with the WHO standard of one doctor per 5 000 to 10 000 people. Other indicators also suggest that there is significant scope for improving the health status of the population of Senegal. For example, in 1999 Senegal had:

- One nurse for every 8 700 inhabitants (compared to the WHO standard of 1:300)
- One midwife for every 4 600 women of reproductive age (compared to the WHO standard of 1:300)
- One health station per 11 500 inhabitants (compared to the WHO standard of 1:10 000);
- One health centre per 175 000 inhabitants (compared to the WHO standard of 1:50 000);
- One hospital per 545 800 inhabitants (compared to the WHO standard of 1:150 000).

In light of these low health standards, it is not surprising that the maternal mortality rate in Senegal is relatively high. In 1992, the Demographic and Health Survey (EDS II) recorded a maternal mortality rate of 510 deaths for every 100 000 live births (Ministère de l'Economie, des Finances et du Plan, 1993a). In 2001, this had increased to 560 deaths for every 100 000 live births (UNDP, 2003).

On a more positive note, the average life expectancy of Senegalese people has increased consistently since the early 1980s. A Senegalese person born in 1986 had an anticipated average life expectancy of 48 years. By 1997, this had increased to 54 years and in 2000 life expectancy at birth had improved to 56 years. According to Senegal's Population Policy adopted in March 2002, women have a slightly longer life span (57 years) compared to men (55.1 years). Unlike a significant number of other countries on the subcontinent, there is no reduction in average life expectancy as a result of HIV/AIDS.

HIV/AIDS

HIV was first diagnosed in Senegal in 1986.[lxx] Since then, the HIV prevalence rate among pregnant women at sentinel sites has remained fairly stable, hovering around one percent. In 2001, the adult HIV prevalence rate in the country was 1.4%. Yet, significantly higher HIV prevalence rates have been recorded among sex workers, ranging from 15% to

30% at different sites. It has been noted that the HIV prevalence rate among sex workers has fallen sharply between 1991 and 1996 (Oppong and Agyei-Mensah, 2004:76). This correlates with an observed decline in STIs among pregnant women and particularly among sex workers during the same period. The STI prevalence rate among the general population declined from 1.6% in 1991 to 1.3% in 1996.

According to the Strategic Framework for the Fight Against AIDS (2002-2006), by the end of 2000 there were 80 000 persons living with HIV/AIDS in Senegal, 77 000 of whom were between the ages of 15-49 years. In contrast to many other sub-Saharan African countries affected by the HIV/AIDS epidemic, there are more men than women living with HIV/AIDS. According to the document, for every nine Senegalese men infected with HIV there are seven women.[lxxi]

The number of cumulative deaths since the start of the HIV/AIDS epidemic in Senegal is estimated at 30 000. As a result, there are approximately 20.000 AIDS orphans. There is no data on the HIV prevalence rate in the public sector, but it is not expected to significantly exceed the average prevalence rate in the general adult population. In contrast to countries with a severe HIV/AIDS epidemic, the impacts of HIV/AIDS in Senegal tend to be confined to the micro and meso level (i.e. individual, household and community level).

In large part, the consistently low HIV prevalence rate in Senegal has been attributed to political commitment, openness and proactive management of the spread of HIV. When the first HIV cases were diagnosed, the Government responded swiftly and decisively. It was one of the first countries in sub-Saharan Africa to set up a National AIDS Council and a National AIDS Programme in 1986. This programme had a strong IEC component, targeting the general population and sex workers specifically with relevant information on the prevention of STIs and HIV/AIDS. Recognising the limitations of an IEC approach, Senegal also adopted a number of complementary programmes, with strong emphasis on participation, effective communication for behaviour change and intervention.[lxxii] Together, these programmes facilitated a coordinated and multisectoral approach to HIV/AIDS from early on. In addition, Senegal has a well-established STI programme, which has historically incorporated a strong focus on the sexual health of commercial sex workers.

As a result of these efforts (and the fact that sex education was included in the school curriculum in 1992), studies have found a very high level of HIV/AIDS awareness among youth and sex workers. There has also been a significant increase in condom use by men having casual sex (Oppong and Agyei-Mensah, 2004:75). Apart from the important role played by the political leadership in the national response to HIV/AIDS, religious leaders have also played an active part in the fight against HIV/AIDS throughout the years. Currently, the fight against HIV/AIDS in Senegal continues to involve a variety of role players, ranging from different Ministries and structures of local governance to NGOs, women's groups and religious organisations. Structures of local governance also engage in HIV/AIDS awareness raising programmes.

There are also important epidemiological and socio-cultural factors that help to explain the low HIV prevalence rate in Senegal. The one factor relates to what has been referred to as 'epidemiological advantage'[lxxiii]: the type of HIV that predominates in Senegal is less infectious than the dominant strand of HIV found in Southern and Eastern Africa. Cultural practices like circumcision, particularly when it occurs at a young age, have also been linked to a reduction in the spread of HIV (UNAIDS, 1999). Yet, even the presence of these and other factors that may serve to limit the spread of HIV does not diminish the importance of decisive and effective Government action as the case of Senegal has shown.

Conclusion

Given the lack of consistent and regular data, it is difficult to assess trends with respect to a range of development issues. In particular, there is insufficient national data on poverty, unemployment and access to basic services since 1980. It is clear that the economic crisis and structural adjustment in the 1980s (and early 1990s) has impacted negatively on the quality of life and standard of living of the majority of the Senegalese population. Notwithstanding more recent advances made, in many respects Senegal continues to rank below the average levels of development for sub-Saharan Africa. Interestingly, in Senegal a significant number of core determinants of vulnerability to HIV infection are at play. Yet, despite high levels of poverty and unemployment, lack of access to basic services and a high urbanisation rate, the HIV prevalence rate has remained relatively low. In large part, this has been attributed to the openness and responsiveness by the Government since the first

cases of HIV were identified. Senegal's ability to maintain a consistently low HIV prevalence rate within a poor socio-economic environment raises interesting questions for this study. In particular, it challenges the universal applicability of the analytical template in Chapter 4, which distinguishes between a number of core determinants and key consequences of HIV/AIDS.

7.3. The core determinants and key consequences of HIV infection in Senegal

For the purpose of this study, 16 interviews were conducted with representatives from Ministries, government departments, the National Planning Committee, Members of Parliament, the National AIDS Council (CNLS), the World Bank and civil society organisations. The list of organisations and persons that participated in the study is provided in Appendix 3. This section summarises the core determinants and key consequences of HIV infection in Senegal as identified by respondents and the Strategic Framework for the Fight Against AIDS.

Core determinants

The most frequently identified factors facilitating the spread of HIV can be divided into the following three categories: a) individual behaviour, b) socio-economic conditions, and c) customs and traditions.

Under individual behaviour, respondents referred to increased prostitution, especially among young adolescents (15-17 years). Given that HIV prevalence is significantly higher among sex workers compared to the general population, this concern with prostitution is not surprising. Mention was also made of promiscuity. It was observed, though, that promiscuity is often the result of difficulties in finding decent accommodation. This reflects an understanding that behaviour is not always a matter of individual choice, but that socio-economic factors can influence sexual behaviour.

Among the social and economic conditions identified that enhance vulnerability to HIV infection are poverty, lack of access to basic social services, gender inequality, low school enrolment and illiteracy, migration and conflict (in the South of the country). It was highlighted that poverty leads to social disintegration and a breakdown in social cohesion. With respect to migration, specific reference was made of those areas where out-migration is substantial. Here, the out-migration of predominantly young men means that they find themselves placed beyond the social control of their families and communities. As a result, they may be more tempted to engage in risky sexual behaviour, like frequenting sex workers, engaging in male prostitution, and having unprotected sex with concurrent and/or successive partners.

It was also noted that poverty and urbanisation have contributed to a situation whereby girls get married at an increasingly younger age and where sexual activity before marriage has become more common. For example, the 1997 Demographic Health Survey found that the first sexual encounter of Senegalese youth is occurring at an increasingly young age. By the age of 15, close to one in six girls (16%) has already had sexual relations; for young women aged 18 years, this proportion goes up to more than one in two (55%).

The third set of factors that are seen to facilitate the spread of HIV in Senegal relate to customs and traditions. The most frequently mentioned customs or traditions that may contribute to HIV transmission - under certain conditions and especially among emigrants carrying the virus – are levirate and sororat.

Levirate is an ancestral custom practised especially among ethnic groups like the Soninkas and the Toucouleurs. According to this custom, when a husband dies his wife is given in marriage to the brother of the deceased. In this instance, when the deceased husband has been infected with HIV and has transmitted this infection to his wife[lxxiv], the latter may pass the virus onto her new spouse. Alternatively, if the new spouse is carrying the virus, he will most likely transmit it to his new wife. The custom of sororat involves that upon the death of a married woman, her unmarried sister is given in marriage to the surviving husband. Here, too, if either party (the surviving husband or the sister) has contracted HIV, the other person is at risk of becoming infected as well.

Despite high levels of unemployment, respondents did not highlight this as an explicit core determinant of vulnerability to HIV infection. It may, however, have been implied in the suggestion that sex work among youth is increasing and that some communities have high levels of out-migration of young men specifically. Likewise, no explicit attention was given to income inequality or lack of political voice and unequal political power.

In light of the low HIV prevalence rate, it is worth reflecting on the socio-cultural factors that seem to

help reduce, rather than enhance, vulnerability to HIV infection in Senegal. Apart from high levels of HIV/AIDS awareness and condom use, circumcision and relatively late sexual debut (although recent trends suggest that this is changing) seem pertinent. It has also been noted that polygamy, a common practice in Senegal, is closely associated with fidelity within the poly-partner union (Oppong and Agyei-Mensah, 2004). In other words, the common assumption that polygamy facilitates the spread of HIV does not hold true, at least not in Senegal.

Key consequences

A number of key consequences of HIV infection were most readily identified by respondents. These include an increase in the general mortality rate (adult and infant) and added pressure on health structures as a result of increased demand for health care. Reference was also made to an intensification of poverty and a reduced ability to work and earn an income. Other observed impacts of HIV/AIDS include an increase in the number of orphans, a decline in the number of pupils and a higher risk of school drop out. Finally, it was suggested that HIV/AIDS worsens family problems, more specifically because people living with HIV/AIDS tend to experience rejection.

The main consequences identified by respondents are those at individual and household level, pertaining to health, income/poverty and children. Other key consequences of HIV infection, such as enhanced income and gender inequality, reduced public sector capacity, reduced ability to generate local revenue, loss of social cohesion or social instability, were not highlighted by the respondents. Most probably, this is because HIV/AIDS in Senegal is not as severe as in other countries in the region where the cumulative effect of the epidemic is making itself felt in these key consequences. If current HIV prevalence levels prevail, the impacts of the HIV/AIDS epidemic in Senegal will remain largely concentrated at individual, household and community level and in particular sectors, like health. Education may also be affected (in terms of school drop out and reduced enrolment), but to a lesser extent.

7.4. Development planning and HIV/AIDS in Senegal

The consistently low HIV prevalence rate in Senegal seems to challenge the conceptual approach underpinning this study, namely that factors in the social, economic, political and technological environment constrain people's ability to consciously behave in ways that protects them and others from HIV infection. This section seeks to assess to what extent the principal development planning frameworks of Senegal incorporate a developmental perspective on HIV/AIDS. In the process, it will comment on whether such a perspective is relevant for a low HIV prevalence country. First, it presents a cursory overview of the history of development planning in Senegal.

Development planning in Senegal in historical context

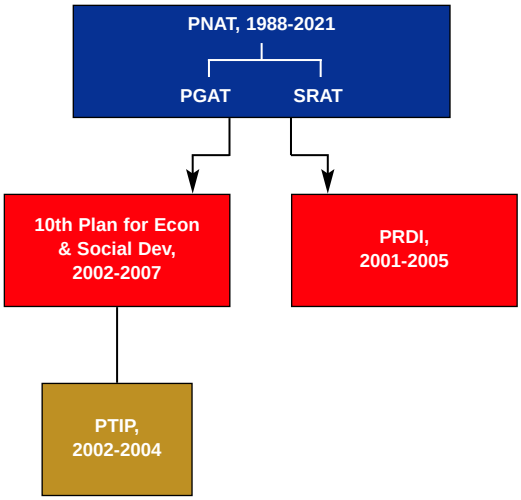
Senegal has a long tradition in the area of development planning. Development planning was initiated in 1960, at the time of independence, and has progressed steadily, integrating aspects and mechanisms that were deemed more appropriate to the changing national and international context.

During the first planning phase, development planning occurred along four-year cycles, based on objectives. Each development plan covered the approaches, objectives and projects to be implemented within the national territory. These plans, which relied almost entirely on outside funding and which were not always properly managed, did not always produce convincing results. During this first phase, several unplanned projects were executed while others were not carried out although they were planned. Real implementation rates varied between 40% and 47%.

The economic crisis that set in during the 1970s and 1980s led to the adoption of structural adjustment programmes. The period of structural adjustment marks the start of a planning crisis: the development plan was relegated to the background and adjustment programmes became the only point of reference, for development partners as well as for political decision makers and technicians. Structural adjustment programmes soon reached their limits and contributed to the deepening social crisis, especially to increased poverty.

Since 1987, there is evidence of a return to development planning in Senegal. At that time, Senegal adopted the National Plan for the Development of the Territory (PNAT, 1988-2021), which embodies a long term vision for the development of the country. The PNAT (1988-2021) functions as Senegal's overarching development plan which promotes the equitable distribution of economic and social development in the national territory. It consists of two components: the General

Graph 7.2. Senegal's planning system



Plan for National Development (PGAT) and Regional Plans for National Development (SRATs). The PGAT is a spatial planning document with three principal thrusts: the diagnostic budget, the presentation of scenarios and strategies, and specific proposals for lasting development. SRATs are long-term regional development plans and have been elaborated for the eleven regions of Senegal.

Both the PGAT and the SRAT are articulated in medium term planning frameworks. The 10th Plan for Economic and Social Development (2002-2007) is the contemporary version of the PGAT. Although its predecessor (the 9th Plan for Economic and Social Development) lapsed by the end of 2001, the 10th Plan has as yet not been formally adopted by the Government of Senegal. It is, however, expected to be adopted in the near future. Because the principal approach and development objectives of the 10th Plan are similar to those of its predecessor, it is included in the discussion below.

The medium term framework stemming from the SRAT is the Regional Integrated Development Plan (PRDI). Each region develops a PRDI in accordance with the objectives of the SRAT. Each PRDI is informed by an assessment of the development potential and challenges in the region. Senegal has 11 administrative regions subdivided into 33 departments. Together, these departments comprise 91 districts, 60 communes and 320 rural communities.

Thus, Senegal's planning system combines a long term vision (the prospective plan, covering more than 30 years) with medium-term planning (five or six year plans) and incorporates planning at national, regional and local levels. It also has a short-term component, the 3-year Public Investment Plan (PTIP, 2002-2004). The latter brings together all the programmes that have to be carried out for the implementation of the Plan for Economic and Social Development. The PTIP is revised every year, so as to realise selected projects, and represents the executive level of the planning system. Because its objectives are the same as those of the Plan for Economic and Social Development, it is not explicitly included in the following assessment of principal development planning frameworks in Senegal.

Graph 7.2 summarises the preceding discussion in graphic form. In addition to these planning frameworks, Senegal has adopted sectoral plans, a PRSP and a Strategic Framework for the Fight Against AIDS. The next section will therefore focus on the following key development planning frameworks:

- The 10th Plan for Economic and Social Development;
- The Poverty Reduction Strategy Paper (PRSP);
- The Strategic Framework for the Fight Against AIDS;
- The National Plan for Health Development (PNDS);

- The Development Framework for Education and Training (PDEF);
- The Regional Integrated Development Plans (PRDI) of the Kaolack region.

The 10th Economic and Social Development Plan, 2002-2007

The 10th Economic and Social Development Plan is a strategic, medium-term plan for the period 2002 to 2007. Its overall objectives relate to enhancing social investment and infrastructure development for human development, increasing economic productivity, providing secure income of farming communities through improved performance of agriculture, environmental resource management, governance and regional integration.

Core determinants of HIV infection

The 10th Plan places particular emphasis on HIV/AIDS and the need to sensitise and inform people of the risks of HIV infection. Apart from this emphasis on knowledge and behaviour change, the 10th Plan also mentions the need to provide relevant training to health care workers and to invest in appropriate equipment for laboratories and blood banks. There is no discussion in the document of factors in the socio-economic environment that may contribute to vulnerability to HIV infection. Thus, the 10th Plan reflects HIV/AIDS as a behavioural (related to knowledge) and medical/clinical concern.

A few other core determinants of vulnerability to HIV infection are addressed in the 10th Plan, albeit without reference to their potential relationship with HIV/AIDS. These include poverty and lack of income, the status of women, access to services and the role of local communities in service provision.

The 10th Plan argues that development programmes should benefit the poor in accordance with the HIPC Initiative, of which Senegal is a beneficiary. More specifically, the Plan aims to halve extreme poverty by 2007. The 10th Plan expresses specific concern with the lack of secure income in rural communities. It further notes that 75% of the income of farmers comes from peanuts. In an attempt to address this situation, the Plan emphasises the need to diversify and intensify agricultural production, restructure systems of production and take advantage of the domestic market. Another intervention related to labour and income concerns the extension of social protection for workers, especially for those working in the informal sector.

The main thrust of the 10th Plan is to promote robust economic growth, which can then be used to invest in social sectors like water, sanitation, education, health and transport. The Plan promotes the adoption of a capital investment and maintenance policy for basic social services. It also indicates that provision will be made for sufficient qualified personnel by strengthening the strategic and implementation capacity of those involved in the delivery of these services. Referring to the 20/20 Initiative[lxxv], the 10th Plan also outlines a strategy for the mobilisation of adequate financial resources to extend basic service provision. Particular emphasis is put on the need to guarantee access to services for vulnerable groups, although the 10th Plan does not specify which groups are considered 'vulnerable' in this regard. One exception is the proposal to establish a fund that subsidises access to health care for poor people.

The 10th Plan highlights that local communities have an important role to play in the provision of basic education, primary health care and other services. This could indicate implicit support for social mobilisation and social cohesion. It could also be based on an economic rationale to share the costs and burdens of service provision, particularly in a resource constrained environment.

Only cursory reference is made in the 10th Plan to the status of women and gender equality. Although one of its objectives is to integrate gender into all policies and programmes of development, at national and sectoral level, the Plan does not further elaborate on what this means. Instead, it refers responsibility for overcoming gender disparities in education, health and employment back to specific sectoral strategies. The only exception is the stated intention to eliminate discrimination against women in terms of access to social protection measures.

The 10th Plan does not discuss migration/displacement or the rebellion in the south of the country. It also does not mention the importance of participatory development and the need to enhance the involvement of vulnerable groups in planning and decision making.

Although the 10th Plan does not reflect on socio-economic and political determinants that may enhance vulnerability to HIV infection, this is not to say that it can not make a contribution to vulnerability reduction. If significant progress is made with respect to poverty reduction, the provision of secure income, gender equality and improved access to services, people are less likely

to adopt livelihood strategies that put them at risk of HIV infection. Of course, this is based on the premise that the core determinants, to a greater or lesser extent, do enhance vulnerability to HIV infection, even in a context where the HIV prevalence rate is low.

Key consequences of HIV/AIDS

The 10th Plan only articulates prevention activities for HIV/AIDS; it does not mention any current or future impacts of the epidemic, either at household, community, national or sector level. Clearly, most of these impacts do not make themselves felt in Senegal; other consequences remain largely invisible at individual and household level. Yet, even with a low HIV prevalence rate, one would have expected the 10th Plan to at least refer to access to treatment and care of people living with HIV/AIDS (including possibly ARV treatment), support for AIDS orphans, reduction of HIV/AIDS-related stigma and discrimination and the political participation of people living with HIV/AIDS. Given the scale of the HIV/AIDS epidemic in Senegal, it seems plausible that the implicit assumption is that these concerns ar to be addressed by the Strategic Framework for the Fight Against AIDS.

The PRSP, 2002-2015

The PRSP was adopted in 2002, following a participatory process. Its formulation is a precondition to qualify for debt relief under the HIPC Initiative. Three pillars underpin the approach to poverty reduction in Senegal. The first pillar is the creation of wealth through sustained economic growth and the equitable distribution of the benefits of such growth. Investing in human capital and meeting basic social needs is the second pillar of the PRSP. To achieve this, the PRSP aims to put in place high quality and equitably distributed basic infrastructures and to provide indispensable services to people, like education, health, water and transport. The third pillar is to improve the living conditions of vulnerable groups. Specific reference is made to support for social groups like women, children, youth, the aged, people with disabilities, displaced persons and refugees.

Core determinants of HIV infection

With respect to HIV/AIDS, the PRSP notes that the HIV prevalence rate is growing despite Government efforts to contain the spread of HIV. It further states that disclosed cases do not reflect the reality of the situation and that infection levels are likely to be higher. In light of this, the PRSP places emphasis on the implementation of an awareness programme around attitudes and behaviour to prevent HIV infection. It also supports an awareness raising programme on the implications of early marriage, which is seen as a factor that may contribute to vulnerability to HIV infection. As far as this intervention takes as its starting point the rights of young women and girls, it could also be seen to contribute to enhanced gender equality.

The PRSP does not explicitly mention other core determinants of vulnerability to HIV infection, like poverty, lack of work and income, inadequate access to services, and so on, as potentially contributing factors to HIV spread in Senegal. Many of these factors are dealt with in the PRSP, but not in relation to HIV and efforts to reduce vulnerability to HIV infection.

Poverty reduction is obviously a central theme in the PRSP, which aims to halve the incidence of household poverty by 2015. Specific reference is made to both urban poverty and rural poverty. The document points to the development of a nutrition policy targeting children in poor households and the promotion of community nutrition centres in disadvantaged areas. Both interventions can be seen to contribute to enhanced food security for poor households. In addition, the PRSP aims to enhance food security through diversified and competitive local production.

The acceleration of economic growth is considered a core strategy for poverty reduction. Yet, the PRSP recognises that economic growth by itself does not automatically translate into the equitable distribution of such growth. The PRSP expresses particular concern with the high level of income inequality in the country, which is evident in a Gini coefficient of 0.50. However, lack of income seems to be of greater concern to the PRSP than income inequality. Given the high level of unemployment and poverty in Senegal, this is hardly surprising. One of the PRSP's objectives is to promote increased and diversified sources of income for the population. In part, the envisaged support for fishery and arts and crafts could be interpreted as a practical intervention in this regard. The PRSP also makes provision for micro credit for small producers.

The PRSP further recognises that lack of work is one of the primary causes of poverty and, conversely, that access to employment is critical for poverty reduction. It therefore highlights the importance of supporting labour-intensive activities. At the same time, however, emphasis is placed on

agricultural reform (i.e. enhanced productivity and the modernisation of agriculture) and on the need for a sound macro-economic environment. In practical terms, both issues tend to be associated with strategies that often have detrimental implications for labour. These potential ambiguities are not further explored in the PRSP. The PRSP also signals the Government's intention to transfer increasing responsibility for promoting economic growth and creating jobs to the private sector. It does not, however, critically explore the contradictions between private sector interests and growth strategies pursued by the private sector on the one hand and, on the other hand, their likely impact on labour.

Significant emphasis is placed on promoting infrastructure and ensuring equitable access to basic social services, like water, health and education. Social service provision is seen as central for human development. Thus, the PRSP promotes universal primary education. It also emphasises the importance of training and literacy programmes. It further elaborates on the need to improve access to, and the quality of, health services, particularly for poor households. To achieve this, the PRSP supports the construction and renovation of health structures and health care equipment. Furthermore, reference is made to the decentralisation of health services and the establishment of community based health services in rural and peri-urban areas. The PRSP highlights the importance of increasing cooperation between local government and community organisations to develop local infrastructure and of strengthening capabilities at community level.

Although women are recognised as a vulnerable social group, there is no clearly articulated approach on gender (in)equality in the PRSP. At one instance, the PRSP focuses on the need to alleviate the domestic tasks of rural women through infrastructure development. Likewise, displaced persons and refugees are seen to be a vulnerable group in need of specific support measures. Yet, the PRSP does not engage explicitly with migration, urbanisation, displacement or social instability, let alone how these factors could contribute to a context of vulnerability to HIV infection.

The PRSP recognises that solutions to local problems will be more sustainable if local communities are able to participate in the design and implementation of appropriate interventions. It therefore supports a participatory approach to local development. One way in which the PRSP sees community involvement express itself is through community financing of local projects.

To conclude, the PRSP only deals explicitly with unsafe behaviour and lack of knowledge of HIV/AIDS as a core determinant of vulnerability to HIV infection. Some other core determinants are taken up in the PRSP, but not in relation to their possible relationship with HIV infection. The same observation has been noted with respect to the 10th Plan. The fact that the HIV prevalence rate in Senegal is low seems to allow for such a restrictive approach to HIV prevention.

Key consequences of HIV/AIDS

With respect to the impacts of HIV/AIDS, the PRSP incorporates a concern with treatment and care for people living with HIV/AIDS. It specifically mentions the need to take care of children living with HIV/AIDS in community nutrition centres. This could be seen as a dual measure to ensure food security of these children whilst preventing a situation whereby these children experience HIV/AIDS-related discrimination.

Apart from these two instances, no key consequences of HIV/AIDS are given explicit attention in the PRSP. Clearly, the low intensity of the HIV/AIDS epidemic in Senegal means that most key consequences of HIV/AIDS outlined in Table 4.1 are not experienced in the same way as in countries with a severe epidemic. Yet, it is rather surprising that no mention is made of the plight of AIDS orphans or of the issue of stigma and discrimination. The PRSP also does not refer to the need to involve people living with HIV/AIDS and their associations in planning and decision making processes. The assumption seems to be that these concerns are to be addressed within the context of the Strategic Framework for the Fight Against AIDS.

The Strategic Framework for the Fight Against AIDS, 2002-2006

In 2001, the National AIDS Council (CNLS) was established in the President's Office.[lxxvi] The Council developed the Strategic Framework for the Fight Against HIV/AIDS (2002-2006), which was adopted by the Government in January 2003. Apart from mapping out the HIV/AIDS epidemic in Senegal and articulating targeted strategies for HIV prevention and care for people living with and affected by HIV/AIDS, the Strategic Framework also outlines the role and management of the CNLS.

The Strategic Framework identifies five strategic priorities, each of which are further specified in terms of objectives and actions. The strategic priorities are:

- HIV prevention (focusing on distinct modes of transmission, i.e. sexual transmission, blood transmission and mother to child transmission, and provision of VCT);
- Provision of medical and psycho-social care for people living with and affected by HIV/AIDS;
- Epidemiological surveillance;
- Research;
- Coordination, Advocacy and Management.

The Strategic Framework further includes detailed action plans related to target groups (youth, women, those in uniformed service and migrants, truck drivers and refugees/displaced persons), sectors (education and labour) and stakeholders (religious communities, traditional healers, NGOs and CBOs). Interestingly, the Strategic Framework spells out the need to ensure that HIV/AIDS awareness programmes are incorporated in the PRSP and in development projects.

Core determinants of HIV infection

In terms of HIV prevention, the Strategic Framework aims to capitalise on the gains made with respect to HIV/AIDS and keep the HIV prevalence rate below 3% for the duration of its lifespan. Whereas the safety of blood transfusions and the prevention of mother-to-child transmission are also addressed in the Strategic Framework, particular emphasis is put on changing individual (sexual) behaviour in the context of HIV/AIDS. An explicit objective is: 'to promote sexual behaviour that minimises the risk of HIV/AIDS'.

To achieve this, the Strategic Framework identifies various target groups for awareness raising and behaviour change programmes, as mentioned earlier. With respect to youth, for example, the document aims to strengthen their capacity by integrating HIV/AIDS more effectively into formal and non-formal education.

Whereas women are identified as a target group for HIV/AIDS awareness activities, there is no explicit recognition of gender inequality as a factor enhancing vulnerability to HIV infection. Similarly, the document makes provision for a specific AIDS and Migration Programme, which aims to change the sexual behaviour of truck drivers, migrants, refugees and displaced persons. Yet, as noted in the discussion of the PRSP, there is no explicit engagement with the processes of migration and displacement, let alone the underlying causes, and how these processes and causes may contribute to a context of vulnerability to HIV infection in Senegal.

To increase public awareness on HIV infection and HIV prevention methods, the Strategic Framework for the Fight Against AIDS seeks to draw in the support of traditional healers, religious leaders and religious communities, NGOs and community groups. These efforts aimed at social mobilisation can further strengthen social cohesion in Senegal. Put differently, it can help minimise the relevance of weak social cohesion as a core determinant of HIV infection. The Strategic Framework also intends to develop structural and operational capacities in alliance with religious communities. This could be interpreted as another measure in support of social mobilisation around HIV prevention.

The Strategic Framework pays significant attention to STI treatment in both public and private health care settings. It aims to integrate STI services in reproductive health centres and make STI treatment available in all regions and districts. These measures could contribute to equitable access to services, albeit restricted to STI treatment. Beyond this, no reference is made to lack of access to basic social services as being a factor in enhanced vulnerability to HIV infection.

Thus, the extent to which the Strategic Framework for the Fight Against HIV/AIDS addresses the core determinants of vulnerability to HIV infection is limited. It reflects a very detailed approach to promoting safe sexual behaviour across a range of target groups. It is also concerned with social mobilisation to effectively respond to HIV/AIDS, and more specifically to keep HIV infection levels low. Other core determinants, like poverty, lack of employment and income, gender inequality, migration/displacement or inadequate access to basic public services, are not made explicit in the Strategic Framework.

Key consequences of HIV/AIDS

Improving the quality of life of people living with HIV/AIDS is spelled out as another objective in the Strategic Framework for the Fight Against HIV/AIDS. More specifically, the Strategic Framework supports the Senegalese Initiative for Access to ARVs (ISAARV) and seeks to make access to ARV treatment available in the 11 regions of the country. Currently, there are a number of pilot

projects on ARV treatment in Senegal. In addition, emphasis is placed on the availability and accessibility of treatment of opportunistic infections and the decentralisation of counselling services for people living with HIV/AIDS. In terms of health management, specific attention is given to health service provision to commercial sex workers.

The Strategic Framework also highlights the need to prevent HIV transmission from mother to child, although this does not translate into universal provision of PMTCT (prevention of mother-to-child transmission) programmes. It seeks to integrate PMTCT in all health programmes, like reproductive health programmes and nutrition programmes. One of its objectives is to provide medical and psychosocial care to pregnant women and to the babies of mothers infected with HIV. Specific provision is made for VCT and epidemiological surveillance of women of reproductive ages.

Reference is also made to the need for income generating projects for people living with HIV/AIDS. Such measures can help relieve the burden of poverty that has resulted from HIV infection and prevent the exacerbation of income inequalities between households affected by HIV/AIDS and households that are not directly affected by HIV/AIDS-related illnesses and death. Yet, no mention is made of added responsibilities placed on women and girls as a result of HIV/AIDS.

The Strategic Framework gives only marginal attention to AIDS orphans and children affected by HIV/AIDS. It only highlights the importance of ensuring nutritional support, a concern that is echoed in the PRSP. Presumably, the intention is to prevent the exclusion of these children from the community nutrition programmes for children from poor households (see PRSP).

The document further refers to the need to address HIV/AIDS-related stigma and discrimination. No other key consequences of HIV/AIDS are expressly articulated in the Strategic Framework for the Fight Against HIV/AIDS. Although equitable access to health services for people living with HIV/AIDS is taken into account, there is no discussion of the impact of HIV/AIDS on the health sector, or on any other sectors. Even if such consequences are not particularly severe in Senegal, this does not explain why the document remains silent on the importance of involving people living with HIV/AIDS and their networks in decision making processes. The limited attention given to the plight of AIDS orphans also gives some cause for concern.

It seems appropriate that Senegal's main concern is to keep the adult HIV prevalence rate low and to focus specifically on those social groups that show disproportionately high HIV infection rates. Yet, that does not mean that all key consequences of HIV/AIDS highlighted in Table 4.1 can be ignored. Clearly, certain consequences, like stigma, AIDS orphans and the participation of people living with HIV/AIDS, warrant more attention than currently allowed for in the Strategic Framework.

The National Plan for Health Development (PNDS), 1998-2007

The National Plan for Health Development (PNDS) has as its overarching objective to improve the state of health of the people of Senegal. It has articulated 11 strategic priorities to achieve this overarching goal, which primarily deal with: the accessibility and quality of care; health sector reform and human resource development; the mobilisation and rationalisation of financial resources; and, support for a variety of service providers, amongst others. The PNDS focuses on reproductive health, epidemiological control, STIs and HIV/AIDS and on controlling endemic diseases, notably malaria, bilharzia, onchocercosis and tuberculosis. The PNDS is implemented via the Programme for Integrated Health Development (PDIS, 1998-2002). To address some of these challenges, the PDIS makes provision for the construction of 245 new health stations at community level, two health centres at district level and two hospitals. It is worth noting that the PNDS also incorporates a focus on social development.

A special STI/HIV/AIDS Division has been set up in the Department of Health to respond more effectively to HIV/AIDS (and STIs). It is tasked with the responsibility to monitor the HIV/AIDS epidemic and to identify appropriate ways of preventing the further spread of HIV in Senegal. It is beyond the scope of this study to assess to what extent the work of this Division engages with, and seeks to address, the core determinants and key consequences of HIV infection.

Core determinants of HIV infection

One of the 11 strategic priorities of the PNDS is concerned with health education and the promotion of individual and collective protection measures. Apart from hygiene and purification, mention is also made of IEC. At the same time, the PNDS supports exclusive breastfeeding of babies and infants,

despite the fact that mothers can pass HIV onto their babies through breastfeeding.

Another strategic priority in the PNDS – which incorporates a focus on social development – is to improve the quality of life of poor households and of vulnerable groups. The document recognises that the number of households living below the poverty line has increased. It is therefore proposing a multi-pronged approach to poverty reduction. Proposed actions include income generating projects for disadvantaged households and the social integration of these households through productive projects. Its ambitious target is to reduce the number of vulnerable people by 10% per annum.

Also, in an attempt to address the lack of food security experienced by poor households, the document aims to reduce chronic and moderate levels of malnutrition by one fifth or more of the 1990 value. It is specifically concerned with malnutrition among young children (0-5 years) and aims to reduce the rate of severe malnutrition among these children by 25% and the rate of moderate malnutrition by 30%. The PNDS also sets a target to increase the proportion of those with access to safe drinking water (based on an allocation of 27 litres per inhabitant per day) to 61%. Many of these interventions are aimed at reducing the high infant and child mortality rate in Senegal.

With respect to women's health and gender equality, the PNDS seeks to reduce acts of violence against women and girls. It also pays specific attention to school enrolment among girls: the PNDS mentions the objective to increase the gross school enrolment rate from 58% to 60% and the ratio among girls to 44%. Maternal health care is clearly an area of concern in the PNDS. The document recognises that the maternal mortality rate is very high, primarily as a result of the lack of adequate antenatal consultation, poor quality of care during pregnancies, the high proportion of unassisted deliveries, and other factors. Other concerns noted in the PNDS are the rate of abortions, both spontaneous and provoked, and female genital mutilation, both of which it aims to reduce by 50%. One of its strategic priorities is to provide better reproductive health care programmes.

Through its dual emphasis on improving access to health and social development services and improving the quality of care, the PNDS is clearly concerned with ensuring equitable access to health care and social services. Added to this are two other strategic priorities, human resource development and institutional support, which can also contribute to improved service provision, particularly at decentralised (community) level. Evidence of this intention to improve the health of the population is also found in the budget allocation for health and social development. Between 1996 and 2001, its share of the national budget has increased from 7.25% to 8.24%. This correlates with a growth for the operational health budget in absolute terms from 18.7 billion CAF franc to 25.5 billion CAF franc.

On the one hand, the focus on the private sector and traditional healers seems to suggest that the Government recognises the important role these two sectors play in improving the status of health of the Senegalese population. On the other hand, it could indicate the Government's intention to diversify health care service providers. To what extent such measures, particularly the increased involvement of the private sector in health provision, will lead to improved or possibly reduced access to health care is at this stage unclear.

Thus, the PNDS addresses a fair amount of core determinants of HIV infection, although it rarely acknowledges the potential link between these factors and enhanced vulnerability to HIV infection. No mention is made of the importance of involving local communities and vulnerable groups in health planning and implementation, which could enhance social mobilisation and enable the expression of political voice. Although poverty and access to income are discussed, the issue of income inequality does not feature in the document. The PNDS also does not elaborate on migration, urbanisation, displacement and social instability and the challenges in ensuring equitable access to health and care in such settings. This is not to dispute the fact that an investment in the overall health of the population, and particularly of those social groups that tend to be marginalised, can be crucial in reducing vulnerability to HIV infection.

Key consequences of HIV/AIDS

In comparison to other health concerns in Senegal, like the high infant and child mortality rate, the high maternal mortality rate, the high fertility rate, the persistence of local endemic diseases (e.g. malaria, bilharzia, onchocercosis and tuberculosis) and the resurgence of long-term diseases, HIV/AIDS is possibly a more manageable condition. This may explain why the PNDS only deals with two obvious implications of HIV/AIDS, namely the need for treatment and care of people living with HIV/AIDS

and nutritional support for AIDS orphans and vulnerable children. It follows the Strategic Framework for the Fight Against AIDS in this regard.

It seems that, in comparison to the demands posed by other health concerns in the country, the impact of HIV/AIDS on the health system is marginal. There is no evidence of hospital overcrowding due to HIV/AIDS or the crowding out of other diseases and afflictions. Also, the number of health care workers infected with HIV is likely to be low. As a result, HIV/AIDS is unlikely to lead to a collapse of the health sector's capacity to provide quality health care to the people of Senegal. The fact that HIV/AIDS, at this stage at least, poses only a minor threat to the public health sector does not mean that the rights of infected and affected health care workers should not be taken into account. The PNDS does not concern itself with this issue. It also does not explicitly engage with stigma and discrimination experienced by people living with, or affected by, HIV/AIDS when seeking medical attention.

Furthermore, the PNDS remains silent on the gender implications of HIV/AIDS. Enhanced poverty due to HIV/AIDS, lack of access to appropriate treatment options and the burden of care for people living with HIV/AIDS and their relatives (including orphans) disproportionately affect women and girls. In this way, the consequences of HIV/AIDS are likely to be particularly detrimental to the health and wellbeing of women and girls.

Although local communities and users of service providers contribute significantly to health funding (namely six percent and 11% respectively, compared to 53% from the state and the remaining 30% from development partners), the PNDS is not concerned with the fact that households affected by HIV/AIDS may not be able to pay for health services. This would not only limit their access to health care, but it could potentially also undermine the financial resource base of the health sector. Because Senegal is faced with a relatively moderate HIV/AIDS epidemic, the latter impact is unlikely to be a real threat, although the former (reduced access to appropriate health care) could well be a reality.

The Development Framework for Education and Training (PDEF), 2000-2010

The 10-year Development Framework for Education and Training (PDEF, 2000-2010) is conceptualised within the framework of the United Nations Special Initiative for Africa, which has as its objective to support sectors like education, health and agriculture in the region. The PDEF aims to enhance the performance of the educational system. It has four objectives:

- To extend access to education and training;
- To improve the quality and efficacy of the educational system at all levels;
- To create the conditions for the efficient co-ordination of educational policies, plans and programmes; and,
- To rationalise resource mobilisation and resource utilisation.

The PDEF was revised in April 2000 to integrate the objective of free universal education.

Core determinants of HIV infection

HIV/AIDS hardly features in the PDEF, except that provision is made for a focus on health and nutrition in the curriculum. Within this context, and more specifically under sex education, attention is given to HIV/AIDS. The emphasis here is on raising awareness to inform responsible behaviour. Apart from this inclusion, the PDEF does not acknowledge that there may be other socio-cultural and economic factors that could enhance vulnerability to HIV infection.

This is not to say that other core determinants of vulnerability to HIV infection are not addressed in the PDEF. Clearly, the PDEF is concerned with promoting equitable access to education. This is, in essence, the rationale for its existence. The pronouncement that access to education is free and universal is an important intervention in this regard. Particular emphasis is put on improving access to education for children from poor communities and children with disabilities. The PDEF further elaborates on the need to remove all those factors that restrict access to education for girls. As such, addressing gender disparities in education is a key objective of the PDEF.

The PDEF recognises that school enrolment and school attendance of children from poor communities and girls in particular can be hampered by factors in the socio-economic environment. It therefore refers to the need for accompanying measures, like water supply and improved nutrition in poor communities, financial support for the acquisition of education materials and greater resource mobilisation in favour of children (especially girls) from poor backgrounds. Emphasis is also put on the promotion of hygiene in schools.

None of the other core determinants of vulnerability to HIV infection seems to be addressed in the PDEF. Even factors that could be addressed by a development framework for education, like the involvement of local communities and parents in educational planning and decision making or access to education for migrants, displaced persons or refugees and their children, are not explicitly mentioned.

Key consequences of HIV/AIDS

The PDEF does not recognise or explicitly address any of the potential key consequences of HIV/AIDS. Clearly, the relatively low HIV prevalence rate in Senegal means that the macro level and sector level implications of HIV/AIDS will be marginal compared to countries with a severe HIV/AIDS epidemic. In other words, in Senegal HIV/AIDS is unlikely to erode the capacity of the education sector to provide quality education. Also, it will not have significant implications for the financial stability of the sector. Yet, there are consequences of the epidemic that have particular implications for education and that should be of concern to a framework such as the PDEF. These include continued access to education for children living with HIV/AIDS, AIDS orphans and children living in a household affected by HIV/AIDS. Specific attention needs to be given to the situation of girls, who may be the first to be taken out of school to help out in the household.

It is also important to recognise the rights of teachers and other educational staff who may be infected by HIV. Although the HIV prevalence rate among teachers is considered to be low, there is no empirical data reflecting the levels of HIV infection within the education sector. An active stance needs to be taken on addressing HIV/AIDS-related stigma and discrimination in the educational environment, regardless of whether this affects pupils or teachers.

The Kaolack Regional Integrated Development Plan (PRDI), 2001-2005

Senegal has a long history of decentralised planning. Since 1987, Regional Integrated Development Plans (PRDIs) have been elaborated. Each PRDI defines the principal development objectives that will strengthen the development potential of a particular region. In addition, the PRDI must identify the strategies and actions likely to promote the economic and social development of the region. This also involves identifying opportunities for public and private, domestic and foreign investment. A regional commission, under the leadership of the President of the Regional Council, is charged with its elaboration. The PRDIs are meant to inform the national plan for economic and social development.

For the purpose of this study, the PRDI of the Kaolack region in West/central Senegal is reviewed. Of the eleven administrative regions, Kaolack has the highest HIV prevalence rate in Senegal, namely 1.8%, followed by the Dakar region (1.3%). The Kaolack region is host to 12% of the total population. Its population is very young: eight out of ten inhabitants are youth. Because of its location, along the main route between Dakar and Senegal and bordering The Gambia, the region serves as a hub of migration, especially of immigrants from neighbouring countries.

The PRDI of Kaolack was adopted on 22 April 2000. It covers a five-year period, between 2001 and 2005. The PRDI's objectives relate to environmental resource management, economic development (especially in agriculture, industry and arts and crafts), promoting employment, promoting the development of women and youth, improving the quality of life of its inhabitants and institutional capacity development. With respect to each of its objectives, the PRDI elaborates on key strategies and action plans.

Core determinants of HIV infection

The PRDI elaborates on HIV/AIDS in the Kaolack region. It identifies specific target groups that are considered to be at risk of HIV infection. Thus, the PRDI articulates IEC and other HIV/AIDS awareness raising activities, like showing films or organising AIDS week, aimed at youth and women. The focus on women actually occurs under the heading of mother/child, although some proposed interventions are not confined to women in their parental role.

With respect to women/mothers, attention is also given to nutrition and weight programmes. However, the content of these programmes seems to be confined to the ambit of health education for mothers, rather than ensuring food security through food programmes. Other strategies and activities under the mother/child heading are more explicitly concerned with enhancing the quality of life and status of women. For example, the PRDI aims to relieve the burden of domestic work placed on women, improve women's income, enhance their management capacities and support the involvement of women in decision making processes. To

achieve these objectives, the PRDI strives to increase the number of women in decision making structures and promote women in leadership positions. It further indicates that there will be awareness raising activities concerning the social and economic rights of women and gender awareness training.

With respect to enhancing women's income, the PRDI mentions that a fund for the economic advancement of women will be established, that savings and credit institutions will be set up and that income generating projects for women will be developed. Attention is also given to improving access to transport and markets, specifically for products prepared by women. The PRDI aims to set up markets in every principal town in the region. Finally, the PRDI seeks to enhance the accessibility and quality of maternal and reproductive health care. Reference is made in this regard to developing antenatal care programmes, increasing the number of health workers and establishing health insurance bodies.

Attention is also given to access to employment, income and credit for youth. The PRDI mentions that training and apprenticeship centres will be created and that a fund for the economic advancement and integration of youth will be set up. It further supports the establishment of economic interest groups (GIE) among youth.

In more general terms, the PRDI explicitly mentions the need to promote labour intensive production activities. It further indicates that provision will be made to support the informal sector and small enterprises. Specific reference is also made to the provision of support to the arts and crafts sector, including interventions to improve the qualifications of those working in the sector. Another sector singled out for support is fishery. Finally, another measure in the PRDI aimed at ensuring secure income is the envisaged support for social protection of workers.

In terms of access to services, the PRDI stipulates that it aims to improve the quality of life of its inhabitants through infrastructure development and basic service provision. An improvement in the living environment and pollution control are also identified as contributing to a better quality of life. The PRDI elaborates on the importance of improving access to transport and health care, particularly with respect to youth, women and children.

The PRDI does not refer to social mobilisation and social cohesion, except perhaps indirectly, through its support for economic interest groups among youth and by promoting the establishment of professional associations. Although it seeks to strengthen the capacity of farming communities in the region, this seems to be understood in economic terms, rather than socio-political terms. Likewise, it does not elaborate on involving local communities or particular social groups in local planning and decision making, apart from the recognition that the involvement of women in these processes needs to be enhanced.

Even though migration and displacement are common occurrences in the Kaolack region, the PRDI does not analyse these trends, let alone how these trends could be related to vulnerability to HIV infection. There is an understanding that the region's disproportionate HIV prevalence rate is related to its status as a regional transit zone. But when it comes to articulating interventions, the PRDI responds by proposing awareness raising programmes for specific target groups (i.e. women and youth). This approach is obviously in accordance with the National Strategic Framework for the Fight Against AIDS and has been found in other development planning frameworks as well.

Key consequences of HIV/AIDS

Given the fact that few development planning frameworks in Senegal pay attention to the key consequences of HIV/AIDS, it is not surprising that the PRDI is equally silent on the implications of the epidemic. Of course, this does not mean that this silence is completely justified. Arguably, the PRDI could have reflected on the impact of HIV/AIDS on household poverty and the ability to work. Given its strong emphasis on supporting the development of women, it could also have considered the implications of HIV/AIDS on women, particularly in relation to the need for an overall improvement in service provision in the region. In other words, inadequate access to health care and other support services for people living with HIV/AIDS will most likely mean that women have to provide the required care and support.

Even if most socio-economic implications of HIV/AIDS are not evident in the region, it does not explain why no attention is given to AIDS orphans. Other obvious omissions concern the silence on HIV/AIDS-related stigma and discrimination and the lack of reflection on the need to involve people living with HIV/AIDS in decision making. As noted earlier, it seems that these concerns are seen to fall under the functional and operational ambit of the Strategic Framework for the Fight Against AIDS.

Table 7.1. Explicit objectives in Senegal's development planning frameworks						
	10th Plan	PRSP	AIDS Strategy	PNDS	PDEF	PRDI
Core determinants of HIV infection						
1.1. Change in individual behaviour	++	++	++	+	+	++
1.2. Poverty reduction (minimum standard of living & food security)	++	++	-	++	+	+
1.3. Access to decent employment or alternative forms of income	+	++	-	+	-	++
1.4. Reduction of income inequalities	-	+	-	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	+?	-	++	++	++
1.6. Equitable access to quality basic public services	++	++	+?	++	++	++
1.7. Support for social mobilisation & social cohesion	+?	+?	+	-	-	-
1.8. Support for political voice & equal political power	-	+	-	-	-	+?
1.9. Minimisation of social instability & conflict / violence	-	-	-	-	-	-
1.10. Appropriate support in the context of migration/displacement	-	+?	-	-	-	-
Key consequences of HIV/AIDS						
2.1. Reduction of AIDS-related adult/infant mortality	-	+	+	+	-	-
2.2. Patient adherence	-	-	-	-	-	-
2.3. Poverty reduction	-	+	+	-	-	-
2.4. Reduction of income inequalities	-	-	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	-	-	-	-	-
2.6. Appropriate support for AIDS orphans	-	-	+	+	-	-
2.7. Equitable access to essential public services	-	-	+	+	-	-
2.8. Effective/enhanced public sector capacity	-	-	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	-	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	-	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-	-	-
2.12. Support for social support systems & social cohesion	-	-	-	-	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	-	-	-	-	-	-
2.14. Reduction of AIDS-related stigma and discrimination	-	+?	+	-	-	-
2.15. Reduction of social instability & conflict	-	-	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly						

Based on the preceding assessment it could be argued that the primary development planning frameworks in Senegal show a significant amount of consistency and coherence with respect to HIV/AIDS. For one, all these frameworks recognise that the spread of HIV needs to be contained. There is also clear agreement that HIV/AIDS needs to be addressed by all sectors and in all development programmes. Finally, it is accepted that the best way to respond to HIV/AIDS is through targeted awareness raising programmes, aimed at a variety of social groups. Thus, all six development planning frameworks discussed here propose similar strategies to influence knowledge and behaviour in order to prevent HIV spread. This common approach to HIV/AIDS clearly arises out of an embedded tradition of HIV/AIDS programming, which has been prevalent in Senegal since the second half of the 1980s. In addition to this focus on awareness and behavioural interventions, Senegal also has an established biomedical/clinical response to HIV/AIDS, particularly in terms of STI treatment, epidemiological surveillance and ensuring the safety of blood transfusions.

In most development planning frameworks, the concern with HIV/AIDS is limited to the focus on targeted awareness raising interventions, as Table 7.1 illustrates. There is no exploration of the impact of the socio-cultural, political, economic and technological environment on the ability of people to act in a 'rational' manner. Also, little, if any, attention is given to the consequences of HIV/AIDS, like enhanced poverty, the growing number of orphans, stigma and discrimination, the role of people living with HIV/AIDS in planning and decision making, or the enhanced burden of care on women and girls. In a country with a low and relatively stable HIV prevalence rate, it seems reasonable that the approach to HIV/AIDS is more focused and restricted than in countries with a severe HIV/AIDS epidemic. Yet, a case could be made for the

inclusion of a broader developmental perspective on HIV/AIDS, both in terms of recognising core determinants of vulnerability to HIV infection and with respect to key consequences of HIV/AIDS. The final section of this chapter will further elaborate on this.

The planning process

Section 7.3 revealed that respondents tend to have a broader perspective on factors facilitating the spread of HIV and the likely impacts of HIV infection in Senegal compared to what is reflected in most development planning frameworks. One possible explanation for this may be found in the way planning processes have unfolded in Senegal. The feedback from respondents in this study suggests that the formulation of the principal development planning frameworks in Senegal has benefited from a fair amount of dialogue and stakeholder participation.

Parliament

Parliament is involved in the drafting and adoption of all strategic documents on economic and social development. It has therefore been involved in defining the broad strategic approaches of the 10th Plan for Economic and Social Development and in drawing up the PNDS and the PDEF. With respect to the PRDI, each Member of Parliament has participated in conceptualising the regional development plan of his or her region.

Parliament also has an oversight role in terms of implementation of the development planning frameworks. Yet, it was noted that Members of Parliament could not sufficiently monitor implementation on the ground due to a lack of capacity and resources and a heavy parliamentary schedule.

Sector Ministries

The most extensive involvement of sector Ministries seems to have occurred in the development of the 10th Economic and Social Development Plan. Sector Ministries participated in cross-sectoral planning commissions, which were involved in the design of the development plan. The work of these planning commissions was put to a macroeconomic commission, which synthesised the work of the planning commissions and ensured that it was in line with macroeconomic objectives. This commission also worked out strategies before referring the draft plan back to the planning commissions for the formulation of actions to achieve the strategic orientations. In turn, these action plans were submitted to the macroeconomic commission for approval. This process suggests that sector Ministries have been quite involved in the design of the 10th Plan, although it is also clear that economists have had a significant amount of influence on the process.

Civil society organisations

The involvement of civil society organisations in the formulation of development planning frameworks has been facilitated through the national commissions, which were established by the Government to lead the process of drafting these documents. Also, the planning process that informs Senegal's strategic planning documents (like the PRSP, PNDS and PDEF) generally involved technical workshops with different stakeholders, like sector Ministries, the unions, NGOs and other representatives from civil society. Yet, a relatively small section of civil society is likely to participate in such events, as it requires a particular level of expertise, influence, capacity and resources.

As the World Bank representative observed, even if local communities and their representatives were involved in the diagnostic phase of the development planning frameworks, this does not necessarily mean that they were consulted when it came to defining the strategic approaches of the different plans and programmes.

Even if its role in the design of development planning frameworks may be relatively small, civil society is quite involved in the implementation phase. On the basis of the principle of *faire-faire* (making people do things), the Government has decided to delegate responsibility for the execution of many development programmes and projects to associations, networks and NGOs. This is particularly the case with respect to programmes stemming from the PRSP and HIV/AIDS programmes. Thus, many programmes aimed at reducing poverty and illiteracy, IEC and other HIV/AIDS awareness campaigns and income-generating projects are being implemented by organisations at grassroots level.

The CNLS

The CNLS is made up of a range of stakeholders, including Ministers, health officials, a UNAIDS representative, a representative of the Women's Association for the Fight Against AIDS (SWAA) and representatives of the Network of People Living with HIV/AIDS. The Prime Minister is the chairperson of the CNLS. One of its tasks is to engage in advocacy

and to ensure that HIV/AIDS awareness programmes are incorporated in the PRSP and in development projects. Given that all principal development planning frameworks include HIV/AIDS awareness programmes, one could argue that the CNLS has fulfilled this task effectively.

Development partners/donors

As far as development partners are concerned, the World Bank clearly occupies a privileged position. This applies to both the volume of its investment and the extent of World Bank involvement in planning processes in Senegal.

The World Bank has been involved in the formulation process of the PRSP and initiated a number of meetings with development partners to discuss problems pertaining to the financing of the PRSP. Together with the IMF team, the World Bank participated in a review of procedures for contracts and financial management with a view to facilitating the implementation of programmes. It has also financed the last household survey (ESAM-2).

With respect to the Strategic Framework for the Fight Against AIDS, the World Bank was a central actor in its elaboration and adoption. Its implementation is financed by the World Bank to the extent of US $30 million for the period 2003-2008. The World Bank also financed the first phase of the PNDS (between 1998 and 2004) to the extent of US $50 million and it supported the Project for Combating Endemic Diseases to the extent of US $14 million between 1997 and 2004. It has also contributed financial resources to the development of Regional Plans for Health Development (PRDS).

Alignment and implementation of development planning frameworks

The discussion of the links between Senegal's principal development planning frameworks and HIV/AIDS concluded that, at least with respect to HIV/AIDS, the frameworks show a significant amount of alignment and coherence. This is evident in a fairly restricted approach to HIV prevention, mainly through awareness raising programmes for different target groups.

In general terms, Senegal's planning system facilitates a significant amount of alignment between development planning frameworks (see Graph 7.2). It combines planning at different scales (local, regional and national) and with different timeframes (short, medium and long term). The preceding discussion has also highlighted that most development planning frameworks share similar development objectives, especially with respect to economic growth, poverty reduction and investment in social and human development. Evidence of considerable alignment can further be found in the proposed strategies and programmes to realise these objectives across Senegal's various development planning frameworks.

However, such alignment and policy coherence can be undermined in the process of implementing development objectives and strategies. Respondents identified a number of problems with respect to the effective implementation of the development planning frameworks. One of these is the high levels of illiteracy in the country, which hampers the involvement of those at community level in the design and implementation of these documents.

Mention was also made of the fact that financial resources are inadequate in relation to needs. Lack of resources obviously constrains the effective implementation of strategies and programmes that could realise the objectives of development planning frameworks. Particular concern was expressed about the lack of flexibility of development partners in granting finance and the complexity of their procedures. As a result of these complex procedures, it is difficult to mobilise financial resources for development programmes.

Specific reference was made to the challenges related to the decentralisation of planning. Although Senegal supports the decentralisation of planning processes (including resource mobilisation) in principle, in practice it is finding it difficult to adhere to this approach. Particular difficulties were noted with respect to the decentralisation of finance to the local level and the ability to generate local revenue.

With respect to HIV/AIDS, it was emphasised that the high level assumption of responsibility for developing HIV/AIDS management strategies (with the President's Office driving this process) contributed to an environment that is favourable to the implementation of the Strategic Framework for the Fight against HIV/AIDS. In other words, many respondents agreed that political commitment is a critical factor for the effective implementation of HIV/AIDS interventions.

Concluding comments

This section has highlighted that Senegal has a fairly intricate and well-established planning system.

There appears to be a significant amount of alignment and policy coherence between the principal planning frameworks guiding development processes in the country. Such alignment is particularly evident in how these documents deal with HIV prevention. The analysis further found that none of the development planning frameworks explicitly recognises factors in the socio-economic, political and technological environment as potentially enhancing vulnerability to HIV infection. Although many of these factors are dealt with in some way or other, there is no explicit exploration of their relevance for HIV spread in Senegal. The documents are equally silent on current and anticipated consequences of HIV infection. To a large extent, this is because a low HIV prevalence country is not faced with the same scale and intensity of these impacts as a country with a high HIV prevalence rate. Yet, the assessment has also pointed to some notable gaps in Senegal's principal development planning frameworks.

An issue of concern is the observed lack of capacity and financial resources to implement the strategies and realise the goals of the development planning frameworks. For Senegal to change its status as a low human development country, it needs significant investment in its social sectors. The stated policy intentions towards increased private sector involvement and cost sharing with local communities signal the Government's aim to involve all stakeholders in the development process. Yet, given the high levels of poverty in the country it seems unlikely that communities will be able to share the financial burden of local development.

7.5. Conclusion

Although Senegal's socio-economic environment reflects a host of factors that are associated with enhanced vulnerability to HIV infection, Senegal has had a consistently low adult HIV prevalence rate. Clearly, the significance of these factors in enhancing vulnerability to HIV infection appears to be less than the conceptual framework of this study seems to suggest. However, it also needs to be noted that there are other factors at play that could not be explored in the context of this study. These include the role of political leadership and the proactive response of the medical establishment in Senegal. Reference also needs to be made to the 'epidemiological advantage' and socio-cultural factors, like the practice of male circumcision and widely shared values on sexual practices and behaviour. Recent evidence suggests, though, that these factors are undergoing changes that give cause for concern for the spread of HIV in the near future. For one, as noted earlier, attitudes towards sexuality seem to be changing, particularly among Senegalese youth. It has also been suggested that commercial sex work, especially among 15-17 year olds, is on the increase. Furthermore, since 1996 there is evidence of a slow epidemiological shift towards HIV-1, the more aggressive and virulent strand of the virus. These recent trends suggest that Senegal may not be able to keep the average HIV prevalence rate as low as it has been in the past few years.

The assessment of Senegal's principal development planning frameworks has revealed that all documents share a concern with awareness raising and behavioural change to prevent HIV spread. Another commonality between these documents is the lack of attention given to environmental factors that are likely to influence individual decisions and facilitate or constrain rational behaviour. Although it could be argued that these factors are less relevant or influential in a low HIV prevalence country like Senegal, this does not necessarily mean that the conceptual framework underpinning the analysis of this study can be discarded.

For one, the common value base and shared religious identity of the majority of the Senegalese population suggests that social cohesion in Senegal is strong. Given that lack of social cohesion has been identified as a core determinant of enhanced vulnerability to HIV infection, it seems plausible that the apparent level of cohesion in Senegal contributes to reduced vulnerability.

Secondly, although both the ratio and the total number of people living with HIV/AIDS may be low in comparison to other countries in sub-Saharan Africa, this does not mean that the core determinants associated with enhanced vulnerability to HIV infection are not at all pertinent for HIV spread in Senegal. For example, to what extent are those involved in casual, unprotected sex compelled to do so because of poverty? With respect to commercial sex workers, to what extent do they engage in sex work as a survival strategy and as a means to escape poverty? How can one explain the observed increase in the number of teenagers who engage in sex in exchange for money? How does one explain the disproportionate HIV prevalence rate among migrants? Could loss of social support, inadequate shelter and overcrowding, precarious livelihood strategies or

despair at not finding stable work perhaps play a part here? To what extent do gender relations and gender inequality contribute to a higher HIV prevalence rate among Senegalese women?

These are just some examples of the need for a deeper understanding of the factors that may influence the actions and choices of those that are currently identified as target groups of HIV/AIDS awareness raising programmes. Moreover, the emphasis on knowledge and values for choosing appropriate behaviour could serve to entrench HIV/AIDS-related stigma and discrimination. After all, this approach holds the danger of ultimately holding individuals responsible for their HIV status.

It is obvious that, as long as current HIV prevalence levels prevail, a number of key consequences of HIV/AIDS are unlikely to become manifest in Senegal. On the one hand, this makes effective HIV/AIDS impact mitigation more manageable and less costly for the Government of Senegal (and other role players). On the other hand, this could also mean that the main consequences of HIV/AIDS largely remain hidden from planners, policy makers and development practitioners. Instead, the negative consequences will be experienced by individuals, households and perhaps communities where the epidemic may be concentrated.

These consequences are likely to include: reduced ability to work and loss of income, enhanced poverty, demands for treatment and higher medical costs, an increase in the number of AIDS orphans, school drop out (by orphans and children living in households affected by HIV/AIDS), stigma and social exclusion, and a higher burden of care on the shoulders of women and girls. All these impacts jeopardise the prospect of equitable economic and social development in Senegal. As such, the principal development planning frameworks of Senegal need to reflect greater concern with the key consequences of HIV/AIDS.

Uganda[1]

Uganda is a global guinea pig for interventions. It is the international lab, the sacrificial lamb for humanity.[lxxviii]

In a situation where one is uncertain of tomorrow, it becomes difficult to get involved in planning. We are now struggling with the transition from this state of despair and struggling to be recognised so that we can be involved in planning forums.[lxxix]

8.1. Introduction

Uganda has a global reputation of curtailing the HIV/AIDS epidemic. Whereas in the late 1980s and early 1990s the national HIV prevalence rate was estimated to be around 15%, with a high of almost 30% recorded in the worst hit areas of the country, in 2002 it stood at 6.5% (Ministry of Health, 2002). A host of factors appear to have contributed to this success, many of which have thus far remained elusive. It is widely recognised, though, that early public recognition of HIV/AIDS by the political leadership created a critical window of opportunity to mobilise Ugandan society in the fight against HIV/AIDS. President Yoweri Museveni's direct involvement in, and coordination of, the nationwide response has been in stark contrast to the reluctance of many of his counterparts in other African countries to address HIV/AIDS head-on. At the same time, Uganda had strong political organisations at grassroots level, which seemed to have played an important role in the mobilisation of communities around HIV/AIDS. Uganda was also one of the first countries to shift towards a multisectoral response to HIV/AIDS and set up the Uganda AIDS Commission to facilitate such a response.

It is beyond the scope of this chapter to reflect on the history of the HIV/AIDS epidemic in Uganda or to identify all the factors that have helped to curb the epidemic in the past decade, nor will this chapter focus on the merits and shortcomings of the mechanisms set up to facilitate the national response to HIV/AIDS. Rather, its concern is to review to what extent existing development planning paradigms adequately respond to potential factors of vulnerability to HIV infection, the systemic nature of HIV/AIDS and the severity of the epidemic and its impacts in Uganda. The overview of key trends in relation to the core determinants and key consequences of HIV infection in the next section attempts to locate the relationship between development planning and HIV/AIDS within a historical context.

8.2. Overview of development trends since 1980

This section presents an overview of the development trends in Uganda since 1980. It looks specifically at trends in relation to demographic changes, economic structure and performance, (income) poverty and inequality, human development and HIV/AIDS. The data presented here is drawn from various publications from the Government of Uganda, UN Agencies and the World Bank and has been collated in the Uganda Country Profile (see Appendix 2 for the Country Profile and relevant references). Given the political turmoil that characterised Uganda in the first half of the 1980s, statistical data on key indicators for that period is limited.

Demographic trends

Uganda's population growth rate of 3.4% is among the highest population growth rates in sub-Saharan Africa. This growth rate is higher than that of Kenya (2.7%), Tanzania (2.9%) and Zimbabwe (2.2%) (MFPED, 2002). Within a period of two decades, the country's population doubled from 12.6 million in 1980 to 24.7 million in 2002 (UBOS, 2002).

During this period, Uganda also experienced very rapid urban growth. Whereas in 1980 just below nine percent of the population lived in urban areas, 20 years later this had almost doubled to 16%. In absolute numbers, the increase is even more dramatic. In 1980, just over one million Ugandans were living in urban areas. By 2000, close to a four-fold increase had taken place, with about 3.6 million Ugandans living in urban areas. Not surprisingly, the

urbanisation rate is high, with recent figures suggesting that the average annual urbanisation rate during the 1990s was 4.6%. It is, perhaps optimistically, estimated to reach on average 5.9% per annum between 2000 and 2010 (UN-Habitat, 2003)[lxxx]. Urbanisation is influenced by a host of political, economic, social and environmental factors. Among those factors are civil conflict and political stability. The number of refugees and internally displaced persons in the country has increased from 40 000 in 1985 to 83 000 in 2001. The insurgency by the Lord Resistance Army (LRA), which has characterised northern Uganda for the last 17 years and has recently spread into eastern Uganda, has forced many people into the towns of Gulu, Lira and Soroti, because these are considered safer than the villages.

Economic performance and structure of the economy

Since the National Resistance Movement (NRM) assumed power in 1986, and owing to the macro-economic policies that have been implemented by the regime, Uganda has consistently registered positive economic growth during the past 17 years. The economy has expanded at an average rate of six percent per annum, which is one percentage point below the set target of seven percent. However, over the past three years, the economy of Uganda registered a decline to five percent growth (MFPED, 2003a). This was mainly due to the deteriorating external terms of trade, as a result of the rise in the world price for oil and the decline in coffee prices, and to the ban imposed by the European Union on Uganda's fish exports.

Uganda is largely an agricultural society and agriculture has traditionally been the most important economic sector. This remains the case, despite the fact that there has been a marked decline in agriculture's contribution to Uganda's GDP from just over half (53.8%) in 1990 to 42% in 2000. The post-liberalisation years of the 1990s have seen an increase in the services and, to a lesser extent, industry sectors.

Uganda was one of the first countries to qualify for debt relief in the mid-1990s. It has been held up as an international example of good practice in linking debt relief to poverty reduction through the mechanism of the Poverty Action Fund (PAF).[lxxxi] Yet, in 1999 its external debt service ratio was still about 26% of its GNP (see Ohiorhenuan, 2002), which is only marginally less than the debt service ratio of 26.8% in 1986.

Poverty and inequality

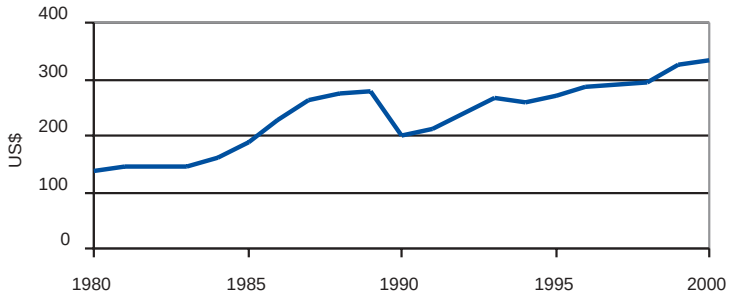
For most of the 1980s, Uganda was embroiled in internal strife that culminated in political and socio-economic stagnation in all aspects of life. Although statistical data on human development indicators for this period are largely unavailable, it is evident that poverty and unemployment were widespread. In 1984, an estimated 44% of the population lived on less than one dollar a day. By 1992, this had increased to 56% of the population, after which a steep and remarkable decline is recorded to 44% in 1997 and 35% in 2000, although not all regions have benefited equally from this poverty reduction process (Government of Uganda, 2002a). The reduction of poverty occurred faster in the Central region, followed by the West, Eastern and Northern regions. Political insecurity in the greater part of northern Uganda has crippled most productive activities including cultivation, as people fear to go to their gardens because of the abductions by the rebels of the LRA. The result has been a marked fall in incomes and an increased dependence on handouts as more people are driven into camps for refugees and displaced persons.

Unfortunately, no data regarding the proportion of people living on less than $2 a day could be found for the 1980s or 1990s. Available data for 2000 suggests that two-thirds of Ugandans are living on less than $2 a day, which is indicative of high levels of systemic poverty. Poverty remains particularly acute in rural areas, where the majority of Ugandans live. In fact, more than 91% of the chronically poor live in rural areas (MFPED, 2003a:57).

If the 1992 poverty statistics presented above are accurate, poverty has increased substantially in the 1980s and early 1990s.[lxxxii] Yet, as Graph 8.1 shows, during the 1980s GDP per capita also increased steadily. This suggests growing income inequality. Whereas the sudden drop of $80 (almost 30% of the value) between 1989 and 1990 might help to explain an increase in poverty in the early 1990s, all else being equal it would not explain why poverty levels would have exceeded the levels recorded in the mid-1980s – that is, unless it has been accompanied by growing levels of income inequality. Data from Uganda certainly confirms this, putting the Gini coefficient at 0.44 in 1994.[lxxxiii] A steady increase in income inequality has also been observed in the latter part of the 1990s (Craig and Porter, 2002).

Consistent data reflecting the rate of unemployment in Uganda is hard to come by. Recent national

Graph 8.1. GDP per capita in Uganda, 1980-2000



statistics suggest that in 1997 over seven percent of the Ugandan labour force was unemployed. The unemployment rate among women was higher than among men, namely eight percent and just below seven percent respectively. By 2000, the official unemployment rate had declined to just over seven percent for women and five percent for men. This is, however, in contrast with trends reflected in the latest African Development Report, which suggests that there has been a decline in the labour force participation rate (and thus an increase in unemployment) from 52% in 1980 to 50% in 1995 and 49% in 1999 (World Bank, 2003).

Human development

Indicators of human development in Uganda show that significant improvements have been achieved over the past 17 years. The proportion of the population accessing safe and clean water has almost trebled, from around 20% in 1990 to 58.8% by June 2003 (Directorate of Water Development, 2003). Progress has also been recorded in the proportion of the population with access to sanitation, which increased from 30% in 1986 to 47% in the first half of the 1990s, only to increase further to 50% by 2000.

Literacy rates have also increased considerably. In 1990, almost half the adult population was considered literate. By 2000, this had increased to two-thirds of Ugandan adults, or 68%. Statistics indicate that literacy rates for men are higher than those for women throughout this period. The literacy rate among women increased from 35% to 51% during the past decade; the corresponding rates for men are 62% and 85% respectively.

The Government of Uganda has, however, embarked on deliberate efforts to address this gender imbalance at all levels of education. Due to its policy of Universal Primary Education (UPE), the proportion of girls in relation to the total number of children going to primary school has increased from 46% in 1996 – a year before the implementation of the UPE policy – to 49% in 2001. In other words, the gender ratio in primary schools has improved to 51:49 for boys and girls respectively. Similar trends are visible with respect to secondary enrolment. While in 1996 40 out of every 100 children in secondary schools were girls, by 2000 this had increased to 44 out of 100. Given that this change in the gender ratio has occurred within an overall increase in primary and secondary enrolment, this does not suggest a decline in school enrolment of boys (see below). Unfortunately, no statistics could be found regarding the proportion of girls and boys in primary school as a ratio of all girls and boys of eligible age respectively. Data from UNESCO's Information System (UIS) suggests that in 1999/2000, only 12% of Ugandan children of eligible age were in secondary school. More specifically, only one out of ten girls (10%) attended secondary school compared to one out of seven boys (14%) within the appropriate age group.[lxxxiv]

Over time, teacher to pupil ratios have increased quite dramatically. During the 1980s, the average ratio per annum was one teacher for every 34 pupils. In 2000, the ratio stood at one to 58, which suggests a 70% increase in the average class size. According to the Government's figures, since the introduction of UPE primary school enrolment has risen from 2.7 million pupils to 7.2 million by 2002 (MoES, 2003). This dramatic increase in enrolment of pupils since 1997 has clearly not been supported by a concomitant increase in the training and recruitment of new teachers.

With regard to health indicators, per capita expenditure on health is US$9 per annum, which

falls far short of the required US$28 to ensure a minimum health care package for every Ugandan, as stated in the Background to the Budget, Financial Year 2003/04 (MFPED, 2003a). Also, the physician to population ratio has not improved significantly since 1990, partly due to the problem of brain drain. The average ratio stands at one doctor per 25,000 people, which is far below the WHO norm of one doctor per 1,000 people. Due to the onset of HIV/AIDS and the extent to which it results in a loss of life among health professionals, the doctor to population ratio may actually worsen.

Finally, life expectancy is one indicator of human development which shows a declining trend in the 1990s, although latest figures suggest that this trend may have stabilised, if not reversed. In 1980, average life expectancy at birth was just over 46 years. This improved consistently during the 1980s to reach 52 years in 1990. Since then, a significant drop in life expectancy has been noted and in 1997, the average Ugandan was expected to have a life span of just below 40 years (see also Graph 5.3). While this had improved to 44 years by the end of 2000, the life expectancy of the new generation is still below the average life expectancy of those who were born in 1980. This is undeniably the consequence of the HIV/AIDS epidemic.

HIV/AIDS

HIV/AIDS emerged in Uganda in the last quarter of 1982. The then Uganda Peoples Congress (UPC) Government was chiefly concerned with retaining power amidst a rebellion by the National Resistance Army/Movement (currently in power) and ignored the issue. Due to a lack of systematic interventions, HIV/AIDS reached epidemic proportions by the end of the 1980s with a 30% HIV prevalence rate recorded in the worst hit areas of the country. Since the early 1990s, national surveillance reports and other sources have consistently indicated a downward trend in the HIV infection rate, from 15% in the early 1990s to 8% in 2000 and 6.1% in 2001, with a slight increase to 6.5% in 2002 (Ministry of Health, 2002).

However, this average figure hides important regional differences. The HIV prevalence rate in urban areas is twice as high compared to the rate in rural areas, namely 8.8% and 4.2% respectively. Because the majority of Ugandans live in rural areas, in absolute numbers this proportion is reversed: whilst there are roughly over 300,000 urban residents living with HIV/AIDS, this compares to about 700,000-750,000 rural Ugandans living with HIV/AIDS.

Yet, the decline in HIV prevalence notwithstanding, Uganda is currently facing the consequences of those high infection rates in earlier days. At the end of 2001, the cumulative number of reported AIDS cases in Uganda was 60,173. Of those reported cases, 55,707 (92.5%) were adults and 4,466 (7.5%) children under the age of 12 years. Due to the level of underreporting, it is estimated that by the end of December 2001 Uganda had 1,050,555 people living with HIV/AIDS (PLWHA). Of these, 945,500 were adults and 105,055 were children under 15 years old (Ministry of Health, 2002). In other words, about one in every 20 Ugandans is currently living with HIV/AIDS.

An estimated 947,552 Ugandans have died of HIV/AIDS-related illnesses since the onset of the epidemic, including 852,797 adults and 94,755 children. An estimated 1,500 more women than men have so far succumbed to HIV/AIDS. While this difference is negligible in relation to the cumulative number of AIDS deaths among men and women, it becomes more significant if seen in conjunction with the fact that women are making up an increasing proportion of those infected with HIV. Whilst in 1990 women constituted 50% of adults infected with HIV, during the 1990s this increased consistently to reach 56% in 2001. In future, women will constitute a disproportionate proportion of those requiring treatment and care and, ultimately, of the number of AIDS deaths.

The HIV/AIDS epidemic has had far reaching consequences for individuals, families, communities and the country as a whole. The epidemic has created a large population of sick people, which has placed a heavy demand on national health services. The care and treatment of PLWHA is likely to be further constrained by inadequate funding to the health sector. Although there are no statistics on the proportion of the population accessing anti-retroviral drugs (ARVs), ARVs have been made available in major government hospitals in the country and big private clinics. Yet, these services are still too expensive for the majority of PLWHA and are mainly located in urban settings.

The devastating impact of the epidemic is epitomised in the growing number of children who have lost one or both parents to HIV/AIDS. It is estimated that there are 1,650,000 orphans in Uganda (Wakhweya et al., 2002). According to the Uganda Demographic and Health Survey 2000-2001, 14% of children under the age of 18 years in Uganda are orphans (UBOS, 2001). The rapid

increase in the number of orphans has overburdened traditional systems of care and support.

Because HIV/AIDS disproportionately affects those who are economically active, HIV/AIDS-related morbidity and mortality impact negatively on the welfare of families and, in due course, on the economy (see Asingwire, 2001; UNDP, 2002; Wakhweya et al., 2002). Labour shortages have already been recorded in various sectors, including agriculture, education and health and in industrial settings, particularly in areas hardest hit by the HIV/AIDS epidemic. Loss of labour in the agriculture sector does not only erode the livelihood of small-scale and subsistence farmers, it also has serious consequences for Uganda's economy as the sector is considered the backbone of the economy. Moreover, the sector provides a source of livelihood and food for over 90% of the country's population.

Of particular concern is the fact that the HIV prevalence rate among public servants appears to be on the increase in the past few years. Unfortunately, there is no comparative data for the period before 1995, but since 1995 HIV prevalence among public servants has increased from 3.3% to 5.6% in 2001. This is likely to have serious implications for the public sector and its ability to deliver on its mandate. It further suggests that the public sector will be faced with significant costs for staff benefits, treatment, replacement and training, amongst others.

In contrast to neighbouring countries, Uganda has witnessed concerted efforts in the fight against HIV/AIDS from quite early on. In the late 1980s, the Government pursued an "open policy"[lxxxv] on HIV/AIDS and in 1990/91 it adopted a Multi-sectoral Approach to Control HIV/AIDS (MACA). This emphasised the notion of collective responsibility of individuals, community groups, different levels of government and other agencies for the prevention of HIV infection. To accord political clout and commitment to the fight against HIV/AIDS, the Government established the Uganda AIDS Commission (UAC) in 1992 by an Act of Parliament to coordinate the national response to HIV/AIDS. The UAC formulated the National Operational Plan for HIV/AIDS Prevention, Care and Support (1994-1998) to provide implementation guidance for agencies involved in HIV/AIDS-related work within the framework of the MACA.

Despite these and other efforts, HIV/AIDS continues to pose one of the most serious challenges to development in Uganda. The impacts of earlier infections – some of which are already making themselves felt – will be pervasive, affecting all demographic and socio-economic categories of the population, with considerable short and long-term ramifications for households, communities, society and the economy. Also, an HIV prevalence rate of over six percent is still high, suggesting that HIV/AIDS has not been brought under control and that the consequences of the epidemic will be with Ugandans for some time to come.

Conclusion

In light of its turbulent political past, Uganda has been able to realise significant development achievements in a relatively short space of time. These gains are evident in falling levels of poverty, increasing adult literacy rates and school enrolment rates (particularly for girls) and a fairly consistent rate of positive economic growth, amongst others. Such gains even extend to HIV/AIDS, as reflected in the significant reduction in the adult HIV prevalence rate since the mid-1990s. Clearly, though, the need to address HIV/AIDS as a priority area prevails, both from the perspective of prevention and to ensure comprehensive impact mitigation, which includes the need for appropriate treatment and care. Otherwise, the development gains noted in this section may end up being short-lived.

Section 8.4 will explore the extent to which development planning frameworks in Uganda contribute to an environment in which vulnerability to HIV infection is minimised and the negative impacts of the epidemic are effectively prevented, reversed or mitigated. First, it is useful to explore the perspectives of policy makers, planners and other interested parties on the core determinants and key consequences of HIV infection in Uganda.

8.3. The core determinants and key consequences of HIV infection in Uganda

Interviews were conducted with 18 key informants in Uganda (see Appendix 3 for a list of persons and organisations interviewed). Amongst others, these key informants were asked to identify the core determinants that enhance vulnerability to HIV infection and the key consequences of HIV/AIDS in Uganda. The appreciation of an environment of vulnerability and risk to HIV infection and an understanding of key impacts of HIV/AIDS among policy-makers and planners can potentially influence the extent to which HIV/AIDS is integrated in key development planning frameworks. The

answers from the respondents were compared to the core determinants and key consequences identified in Chapter 4.

Core determinants

A number of respondents suggested that initially the main reason for the spread of HIV in Uganda was related to individual understanding and risky sexual behaviour. As one of the respondents stated:

> At first we had a problem of lack of awareness and misconception about the disease. People were behaving in risky ways because they did not have enough information. We have now tackled that problem and that is why the prevalence rate is going down.[lxxxvi]

Most respondents readily recognised the importance of poverty, lack of food security and lack of income. According to one of the respondents: "If people got out of poverty, they would withstand the temptation to catch AIDS"[lxxxvii]. A more elaborate explanation of how poverty may relate to HIV infection was given by another respondent:

> HIV is spread in this country mainly through sexual relations. So one has got to understand why people engage in risky sexual relations, why they cannot abstain, why they cannot remain faithful, why they cannot use condoms. I think poverty among some groups of people is playing a role in the spread of HIV. To some people, young girls and women, sex is a means of livelihood.[lxxxviii]

One of the respondents added that there is an important difference between rural and urban poverty, arguing that women and girls living in harsh urban environments may be compelled to engage in sex as a means of survival whereas in remote rural areas the risk of HIV infection may be much lower.[lxxxix]

Another respondent went as far as to caution against a possibly unintended and undesired consequence of effective anti-poverty measures by arguing that an "… increase in the incomes of the poor may increase incomes of men mainly and their potential lusts, including multiple marriages and casual or commercial sex."[xc]

Whilst lack of income was generally understood to be a contributing factor to vulnerability to HIV infection, only one respondent alluded to the significance of income disparities:

> Poverty makes people vulnerable to temptations, while those with money lure women into sex. In a way, both the wealthy and the poor are vulnerable to the epidemic, but especially the poor.[xci]

A number of respondents pointed to gender relations and gender inequality as an important determinant of vulnerability to HIV infection. Interestingly, relatively few respondents actually highlighted this as an important factor, even though gender relations are closely intertwined with sexual relations and one's power to determine sexual behaviour. Whether this is because gender inequality is such an obvious factor in determining vulnerability to HIV infection for most respondents or whether this omission points to a lack of appreciation of the centrality of gender dynamics remains to be seen.

With respect to access to basic services, some respondents pointed to the weak health care system and the lack of infrastructure to distribute medicines or provide basic health care at community level. Others highlighted the lack of education as a particular concern, although this seemed to be more about access to knowledge and information to adopt safe sex behaviour than about equitable access to education for children and youth.

Mention was also made of conflict, social instability and displacement as factors that may enhance vulnerability to HIV infection, particularly with reference to northern Uganda and other affected areas. Although some respondents agreed that migration and urbanisation could be important factors as well, this was only recognised after they were shown a diagram which depicted these factors. As the previous section has shown, the majority of people living with HIV/AIDS in Uganda are living in rural areas, yet urban areas have a significantly higher proportion of people living with HIV/AIDS (i.e. in relation to the total urban population).

Importantly, one of the respondents emphasised hopelessness as a factor enhancing vulnerability to HIV infection. He argued that AIDS is only one of many causes of early death in Uganda, like malaria and other illnesses, armed conflict, road accidents and so on. As a result, the importance of HIV/AIDS as a cause of death – in the more distant future – tends to be underplayed.[xcii]

The two core determinants in Table 4.1 that were

least obvious to respondents were weak social cohesion on the one hand and unequal political power and lack of political voice on the other hand. This could be because these factors do not hold particular relevance for the Ugandan context as was suggested by one of the respondents, who argued: "Had it not been for the strong social cohesion, our society would have been depleted by HIV/AIDS."[xciii] However, it could also be because these factors have not become part of the mainstream thinking on HIV/AIDS in the same way factors like poverty, gender inequality and social instability appear to have.

Key consequences

All respondents pointed to the fact that HIV/AIDS increases adult morbidity and mortality, which lead to a myriad of other consequences. For one, the increasing demand for adequate health care to treat HIV/AIDS-related illnesses and opportunistic infections means "more resources needed for more beds, more nurses because of the nature of the long illness, more wards, more houses for nurses, more counsellors – thus more money."[xciv]

Many respondents mentioned the disintegration of families and the increase in the number of orphans as a direct consequence of adult mortality. The plight of orphans was seen as particularly distressing, while some respondents emphasised that traditional systems of care are unable to cope with the consequences of the epidemic and can no longer provide the necessary support to orphans. Some specifically mentioned the emergence of child-headed households, whereas others pointed to the vulnerability of children to sexual abuse.

Furthermore, it was widely recognised that AIDS-related deaths lead to a loss of (skilled and unskilled) labour, with negative implications for production and productivity, particularly in the agriculture sector. This was likened by one respondent to "lost opportunity", arguing that the loss of the middle strata of the population constitutes missed opportunities for the future and for Uganda's prospect to be internationally competitive. One of the respondents acknowledged that the loss of labour due to HIV/AIDS also occurs within government structures, as reflected in a loss of experienced staff and political leaders, who are both difficult and costly to replace. He further gave an example of the implications of AIDS-related deaths in the military services for the defence of the country.

Also highlighted by a number of respondents, although possibly not as frequently as anticipated, was the impact of HIV/AIDS on poverty. Reference was made to the reduction in household production due to the loss of able bodied persons to the epidemic. One of the respondents recognised that the increase in poverty at household level has significant implications for Uganda's efforts to boost the economy through agriculture reform:

> When a person falls sick, he or she sells assets and becomes poor. Productivity is low as less land is under cultivation. Thus, it is difficult to have agriculture transformation. Such sick people are too poor to afford high technology to increase output.[xcv]

Others mentioned that HIV/AIDS puts further strain on already limited social services and infrastructure, although they did not want to go so far as to say that this results in a collapse of essential public services. There was also recognition that stigma and discrimination of PLWHA is a reality in Uganda.

The key consequences least likely to be mentioned were widening income disparities, enhanced gender inequality, loss of social cohesion, reduced economic growth and unstable local revenue base, and enhanced risk of social instability. Only one respondent suggested that income disparity is a key consequence of HIV/AIDS. Likewise, one respondent pointed to the possibility of increased gender violence, whereas another respondent suggested an enhanced risk of social instability, conflict and violence. Yet, with the possible exception of the indirect inference quoted above, none of the respondents mentioned that HIV/AIDS may have negative consequences for Uganda's economy, even though there seemed to be general agreement among respondents that productivity and production are likely to decline. Likewise, no mention was made of the likely decline in the ability of households to pay local taxes or service fees and what this means for the public sector's ability to provide and maintain services and infrastructure.

Interestingly, one of the respondents suggested that there have been at least two positive impacts of the HIV/AIDS epidemic. On the one hand, it has led to increasingly "focused and well-informed activism for many good purposes", whereas on the other hand is has resulted in "adaptable planning and implementation strategies" through the use of new concepts like 'mainstreaming' and 'multi-sectoral approach', and so on.[xcvi]

Based on these interviews, it appears that there is a high level of awareness in Uganda of many of the core determinants and key consequences of HIV infection, although some factors are more readily identified than others. If this observation is true, one may expect that development planning frameworks would take these determinants and consequences into account. The next section will review to what extent this expectation is accurate.

8.4. Development planning and HIV/AIDS in Uganda

This section identifies the most significant development planning frameworks in Uganda and explores the extent to which these planning frameworks adequately address the core determinants of vulnerability to HIV infection and the key consequences of HIV/AIDS. It is based on an application of the conceptual framework reflected in Chapter 4. By way of introduction, this section presents a very brief overview of the historical context of development planning in Uganda. The main part of this section is an assessment of the possible links between these planning frameworks and the identified determinants and consequences of HIV/AIDS. This is followed by some observations on stakeholder participation in the formulation of the development planning frameworks that are currently most significant in guiding the development process in Uganda. These observations are largely drawn from the feedback from key respondents in the study. The section concludes with some remarks on issues related to the alignment of the various development planning frameworks and their implementation.

Development planning in Uganda in historical context

The first decade of Uganda's political independence (1962-1970) was characterised by centralised state involvement in development planning. During this period, there were well-formulated and harmonised central development plans, which resulted in unprecedented improvements in the health, education and general wellbeing of Ugandans (Asingwire, 1998). This state of affairs began to change in 1971 when the regime in power (Amin's regime) developed a non-pragmatic central approach to address national socio-economic issues. The process of development planning fell prey to the unconventional style of military decrees, which replaced laws. With the ousting of Amin in 1979, the subsequent regimes embraced structural adjustment policies, which also served to redefine the role of central government in development planning.

Towards the end of the 1980s, particularly in 1992, the government adopted a decentralised system of planning, which culminated in the devolution of power and responsibilities to lower levels of government (at district and sub-county levels). Central government maintains the role of policy formulation and developing key planning frameworks (with inputs from lower levels of government), setting standards and guidelines as well as overall supervision and monitoring.

Currently, the key development planning frameworks include the following:

- The Poverty Eradication Action Plan (PEAP), which serves as Uganda's PRSP;
- The MTEF;
- The National Strategic Framework for HIV/AIDS Activities in Uganda;
- The Plan for the Modernisation of Agriculture (PMA);
- The Health Sector Strategic Plan (HSSP);
- The Education Strategic Investment Plan (ESIP).

The long term vision for Uganda's development is reflected in Vision 2025, which constitutes the country's national development plan (Government of Uganda, 1999). Vision 2025 carries Uganda's broad and long-term development proposals over a period of twenty-five years. Its two-year formulation process ended in 1999 with a major focus on macro-economic development of the country as the gateway to economic development. The importance of the Vision 2025 is rooted in its status as a blueprint for all other planning frameworks in Uganda. Because its key focus is reflected in the main objectives of the PEAP, the latter serves as the main focal point for development planning in Uganda.

What follows is an assessment of how the key development planning frameworks outlined above, either by design or unintentionally, may influence the core determinants and key consequences of HIV/AIDS in Uganda. Such an assessment is complicated by the fact that all these frameworks are relatively new, at the earliest dating back to 2000. As a result, it is on the whole too soon to comment on the actual implementation of these frameworks, let alone what intended and unintended outcomes are being achieved. Whilst it is difficult to assert the links between these frameworks and HIV/AIDS with great certainty, it is however possible to draw on some lessons from the past and from the precursors of these planning

frameworks. Clearly, the assessment presented here is exploratory and tentative.

The Poverty Eradication Action Plan (PEAP) 2001

Uganda's Poverty Eradication Action Plan (PEAP) was initially launched in 1997, and subsequently revised in 2001, as the national comprehensive development planning framework to guide sector plans, district plans and the budget process. The PEAP also serves as Uganda's PRSP. The long-term goal of the PEAP is to reduce poverty to, or less than, 10% by the year 2017. It has four pillars:

- Sustainable economic growth and structural transformation;
- Good governance and security;
- Increasing the ability of the poor to raise their incomes;
- Improving the quality of life of the poor.

The principles set out in the PEAP guide the formulation of the Sector Wide Approaches (SWAps). The public expenditure implications of these SWAps are implemented through the budget under the Medium Term Expenditure Framework (MTEF). SWAps are therefore the main vehicle to deliver the goals under the four pillars of the PEAP.

The PEAP recognises HIV/AIDS as a crosscutting issue in Uganda's development process. By virtue of its status as the principal development planning framework in the country, it is implied that all sectors have to incorporate the response to HIV/AIDS into their planning, although no guidelines are offered on what is expected or how to do this. The PEAP further highlights the importance of the National Strategic Framework for HIV/AIDS Activities in Uganda and the role of the UAC as the coordinating structure for the national response to HIV/AIDS.

However, during the interviews quite a few respondents indicated that the reference to HIV/AIDS as a crosscutting issue was mentioned "in passing". Some even warned that this meant in practice that HIV/AIDS tended to lose its prominence as a critical aspect of development planning. As one of the respondents said:

> When AIDS was a specific programme it had prominence, but when it shifted to a crosscutting issue it lost that prominence. It is thinly spread.[xcvii]

Arguably, the recognition that HIV/AIDS is a crosscutting issue does not have to lead to a loss of meaning or importance, as long as the understanding of how HIV/AIDS interrelates with other development challenges is made explicit. This is where the distinction between core determinants of vulnerability to HIV infection and key consequences of HIV/AIDS, as presented in the conceptual framework of this study, can be helpful.

Core determinants of HIV infection

Arguably, the four pillars of the PEAP (i.e. sustainable economic growth and structural transformation; good governance and security; increased ability of the poor to raise their incomes; and, increased quality of the life of the poor) are directly targeted at a number of core determinants of vulnerability to HIV infection. Poverty reduction is undoubtedly at the heart of the PEAP, which emphasises the need to ensure food security and improve the quality of life of the poor. The PEAP further supports employment creation through labour intensive technologies and through the expansion of the services sector. In accordance with the findings of the Government's Uganda Participatory Poverty Assessment Project (UPPAP – see Government of Uganda, 2002a), the PEAP also recognises the importance of infrastructure development to enable the poor to raise their income. UPPAP indicated that the poorest segment of Uganda's society lack the ability to escape poverty due to a lack of productive assets, access to markets, production skills, credit, transport, basic services and communication facilities. The PEAP envisages that by creating this enabling environment the poor will be helped to get out of poverty.

In doing this, the PEAP will also contribute to more equitable access to services, as rural areas in particular have been identified as key recipient areas of such developments. The PEAP has set out specific measures for improving the quality of life of people living in poverty through the provision of basic services such as health care, safe water supply and education. In addition, by abolishing the user fees for public health services, the PEAP seeks to promote more equitable access to these services. Amongst others, this could have positive implications for the early detection and treatment of STIs, the availability of VCT services and the dissemination of health education. Yet, in the absence of concomitant investment in the public health care system and the necessary human resources, the elimination of user fees may actually result in a significant increase in demand whilst the quality of care is reduced.

At the same time, the PEAP embraces a number of strategies that may actually militate against realising these development objectives, despite the fact that these strategies are purportedly aimed at reducing poverty, creating jobs and ensuring reliable income. For example, the emphasis on the modernisation of the agriculture sector is likely to be associated with the loss of employment and of livelihoods for small-scale and subsistence farmers. Likewise, through the Medium Term Competitive Strategy (MTCS) the PEAP promotes the export of non-traditional agricultural exports, which may serve to divert attention away from domestic needs in the interest of pursuing foreign currency.

Another concern is that the PEAP includes an unrealistic economic growth projection of seven percent per annum, a target which has not been achieved over the past few years. Not only does this mean that fewer resources are available for investment in social development, it may also inform a more stringent application of macroeconomic reform strategies (in the hope that this may help 'fix' the problem) that prove detrimental to the eradication of poverty and inequality.

The PEAP does not make reference to the need to overcome income inequalities in Uganda, even though income inequality is substantial and appears to have been increasing, as suggested in the overview of development trends. The closest it comes to recognising the distributional nature of development is when it mentions the importance of addressing regional imbalances between a poorer Northern Uganda and a relatively well off Central region, but this is not explicitly or exclusively related to the distribution of income.

Reduction of gender inequality is discussed under crosscutting issues, with the PEAP calling for "increasing sensitivity to gender issues". Yet, the PEAP gives little specific guidance on how gender equity should be pursued, other than endorsing practices concerned with increasing the representation of women in the Legislature and in local Councils and with increasing the school enrolment of girls through the UPE. It does recognise, however, that the reduction of unequal bargaining power within the household can help minimise domestic violence. Cursory mention is also made to the fact that women could potentially benefit from the new jobs created as part of the MTCS, but no specific suggestions are offered to ensure that this will be case.

Under the second pillar, concerned with good governance and security, the PEAP provides for the political participation of Ugandans in planning processes. Specific reference is made to the need to involve poor people and marginalised groups, like women and persons with disabilities, in these processes. Likewise, the decentralisation of service provision, infrastructure development and fiscal responsibilities is seen as a critical step in linking good governance to poverty reduction.

Addressing other core determinants of vulnerability to HIV infection, like minimising conflict and providing adequate support during displacement, also falls within the domain of good governance and security. The PEAP carries the Government's commitment to end the 17-year old insurgency in northern Uganda and to end cattle rustling by the Karimajong, both of which lead to the displacement of communities. Although reference is made to the need for support for internally displaced persons, the PEAP only specifies psychosocial support, but falls short of elaborating how this should be done. It seems to favour a partnership approach with the private sector and relief organisations to provide basic services for displaced communities, yet no details are provided as to what services might be required and which stakeholder would provide those services.

To sum up, the PEAP seems concerned with most core determinants that contribute to a context of vulnerability to HIV infection. Thus, it could be a critical tool in curbing the spread of HIV. This potential is not sufficiently harnessed, though. For one, it is not sufficiently informed by an in-depth understanding that vulnerability to HIV infection is linked to these factors, let alone *how* this may be the case within the Ugandan context. Secondly, the PEAP remains silent on a number of critical factors, like income inequality (as PRSPs generally are, as noted in Chapter 4). It also does not make explicit reference to social cohesion and community resilience as key components of a strong and dynamic society, which development interventions need to support. Surprisingly, the PEAP does not seem concerned with the rapid growth of Uganda's urban areas and the need for adequate shelter, basic services, income generating opportunities and other development needs in these areas. Finally, even for those core determinants that the PEAP explicitly aims to address, questions arise in some instances about the lack of guidance on how to realise these objectives. In other instances, there are concerns about the unintended and possibly

ambiguous impacts of proposed strategies, particularly those concerned with economic reform.

Key consequences of HIV/AIDS

Few of the key consequences of HIV/AIDS are explicitly recognised and addressed in the PEAP. For example, although poverty reduction is a central concern of the PEAP, it does not reflect on how HIV/AIDS enhances poverty at household and community levels, let alone what the implications are for Uganda's poverty reduction strategies. It falls short of making explicit proposals to ensure food security and adequate income for PLWHA and affected households, including households headed by children or the elderly. It also does not reflect on the imminent threat of HIV/AIDS-induced famine due to the loss of agricultural labour.

Although the PEAP proposes skills development to increase employment opportunities in agriculture and the service industry as a means to reduce poverty, it does not deal with the question of how to cushion the loss of skilled and productive labour due to HIV/AIDS. Instead, there has been a reduction in financing for higher education. Loss of labour leads to declining productivity, especially in the agricultural sector which accounts for a significant proportion of the country's GDP. Yet, the PEAP is silent on the long-term implications of HIV/AIDS on the economy and maintains optimistic economic growth projections. It remains equally quiet on the importance of protecting the job security for infected and affected workers within the broader framework of respect for workers' rights.

More specifically, it does not mention the relatively high HIV prevalence rate among public servants and the possible implications for worst affected sectors to deliver on their developmental mandate. Instead, there is currently a ban on recruitment into the public service. This, coupled with the absence of a clear articulation of how HIV/AIDS is likely to increase demands on the state and the lack of insight into the impact of HIV/AIDS on household ability to pay taxes and service fees, suggests that the PEAP does not take into account the eroding impacts of HIV/AIDS on the capacity and financial stability of the public sector.

To be fair, the PEAP does mention the necessity to attend to the needs of 'disadvantaged groups', which are further specified as people with disabilities, orphans, street children, the landless poor, PLWHA, internally displaced persons and refugees, abducted children, the elderly, widows and prisoners (particularly children). As such, it could be implied that the PEAP is concerned with addressing some of the key consequences of HIV/AIDS insofar as these are related to the specific needs of PLWHA and their relatives (e.g. orphans, widows and the elderly). Yet, the PEAP does not relate this to specific experiences resulting from the epidemic, like impoverishment, the loss of employment of PLWHA, gender discrimination or the added burden of care on women, the loss of shelter and food security for orphans, amongst others. One exception is the reference to include PLWHA in decision-making processes, which is not only about ensuring political voice of PLWHA, but can also contribute to the reduction of HIV/AIDS-related stigma.

In conclusion, the PEAP falls far short of a comprehensive assessment of how the HIV/AIDS epidemic is likely to complicate and alter the development challenges facing Uganda. This is evident in the fact that few key consequences of HIV/AIDS are actually recognised in the PEAP. To some extent, this may be because preventing or mitigating particular impacts of the epidemic is (implicitly) relegated to certain sectors. Yet, given that the PEAP constitutes the principal development planning framework in Uganda, this would not be sufficient justification.

The MTEF, 2003/04-2005/06

Uganda's MTEF is considered one of the most developed in sub-Saharan Africa by the World Bank (Le Houerou and Taliercio, 2002). It was the first country on the subcontinent to introduce the MTEF as an instrument for macro-budget planning in 1992. Since then, it has been developed to enable an analysis of the links between inputs, outputs and outcomes while ensuring consistency of expenditure levels with overall resource constraints. The MTEF is a rolling three-year framework for negotiating and setting sector targets and for budget allocation within the context of domestic and external financing ceilings. The expenditure implications of the PEAP are translated into concrete spending decisions through the MTEF. The priorities articulated are implemented through sector plans, which are financed through the central budget.

Thus, the extent to which the MTEF contributes to the minimisation of vulnerability to HIV infection and the maximisation of comprehensive HIV/AIDS impact mitigation measures depends in large part on whether sectors identify the core determinants

and key consequences of HIV/AIDS as strategic priorities within the financial planning process. To date, relatively few sectors have provided a vote for HIV/AIDS activities. In key sector ministries where HIV/AIDS-related interventions have been developed, such as the Ministries of Education and Sports, Agriculture, Animal Industry and Fisheries, and Information, these activities have been largely funded by donors as projects outside sector plans – and thus lie outside the scope of the MTEF. Yet, it is too simplistic to assume that the MTEF itself would not in any way have a bearing on the spread of the epidemic and its impacts, not least on the capability of households, communities and organisations to cope with the consequences of HIV/AIDS.

Core determinants of HIV infection

Cursory analysis suggests that the MTEF aims at addressing most of the core determinants of vulnerability to HIV, at least to a certain extent. Through budgetary support to IEC programmes in the education and health sectors, the MTEF supports individual behaviour change as a means to prevent HIV spread. It further prioritises measures to increase incomes of the poor by allocating funds to rural roads, agricultural extension and restocking. These measures are intended to enable poor rural farmers to increase their production and to access markets through improved roads. The MTEF also promotes micro finance institutions to ensure increased access to credit for the poor, which is envisaged to spur income generating activities. The majority of active borrowers from these institutions are women who engage in commercial activities, most of whom are located in urban areas (MFEPD, 2003a). In prioritising support for women entrepreneurs, the MTEF can be seen to contribute to gender equality.

By supporting micro finance institutions for income generating activities of the poor, the framework could be seen to include some – albeit implicit – support for employment creation. Apart from this implicit inference, the MTEF does not provide expressed support for programmes aimed at creating and protecting employment, nor is it concerned with the distribution of national income and the reduction of income inequalities. Also, as mentioned in relation to the PEAP, the macroeconomic growth and reform strategies endorsed by the MTEF may actually contribute to job insecurity, impoverishment and gender inequality. Yet, an analysis of why and how this would be the case – let alone how it could be prevented – is glaringly absent.

With regard to access to basic services as a core determinant, funds are allocated to measures aimed at improving the quality of life of the poor through Primary Health Care, primary education, community rehabilitation, water supply and sanitation. Through increased funding for UPE the MTEF endorses equitable access to (primary) education. MTEF priorities for education include expansion of primary school buildings, teacher development programmes, textbooks and tuition. It also includes a vote for lunch for children who attend afternoon classes. Embedded in the UPE is a concern with equitable access to education for girls and as such the MTEF implicitly supports this gender-specific objective.

With regard to health services, Primary Health Care received one of the highest budget increases of nine percent compared to the previous MTEF (2001-2003) (MFPED, 2003a). Together with the abolition of user fees, the increased allocation of resources to districts and health sub-districts is an integral measure of ensuring equitable access to health care for all Ugandans, particularly those who are poor. It has been documented that the abolition of user fees has contributed to an increase in outpatient department utilisation by 40% between 2000 and 2003 (MFPED, 2003b:52). Yet, concerns remain whether the health system is adequately equipped and resourced to cope with such an increase in demand and ensure the provision of quality care.

The MTEF allocates funds for community-based projects through the PAF and the Local Government Development Fund (LGDF). This could possibly be interpreted as providing support for social cohesion and social mobilisation. Also, by allocating funds for local elections, the MTEF could be seen to support political voice, particularly since those leaders are to include representatives of marginalised groups in society. However, no reference is made to the involvement of communities, let alone these elected representatives, in economic decision-making. Thus, the MTEF's contribution to these objectives is only partial at best.

The MTEF also makes provision for resources for disaster management and psychosocial support for internally displaced persons. As such, it provides some measure of support in the context of displacement, although this does not seem adequate to address all the needs associated with displacement. Furthermore, the MTEF does not make explicit reference to urban development and the concomitant need for investment in urban services and infrastructure.

Thus, it appears that the MTEF is concerned with addressing a significant number of core determinants of vulnerability to HIV infection. This should not be surprising, since these core determinants are in essence about the fundamentals of development: eradicating poverty and all forms of inequality, promoting the well being of all Ugandans and facilitating empowerment. Yet, the concerns expressed in relation to the PEAP also apply here. More specifically, what seems to be lacking is a comprehensive understanding of, firstly, how these factors may enhance vulnerability to HIV infection in Uganda and, secondly, to what extent proposed macroeconomic growth strategies may have detrimental impacts on these factors. Also, the fact that certain core determinants appear to be covered by the MTEF does not mean that these factors are addressed comprehensively and in all their complexity.

Key consequences of HIV/AIDS

As was noted in connection with the PEAP, the MTEF seems less concerned with the multiple impacts of the epidemic. There are budget lines for VCT services, ARVs and PMTCT projects (which have relevance for reducing AIDS-related adult/infant mortality, the first key consequence of HIV/AIDS identified in the conceptual framework), but these are mostly funded directly by donors. In 2003, the Global Fund to Fight AIDS, Tuberculosis and Malaria approved Uganda's application for US$67 million for two years, of which US$35 million is to be disbursed in the first year (MFPED, 2003b). As mentioned earlier, the parliamentary Standing Committee on HIV/AIDS has lobbied successfully to ensure that these funds are excluded from the MTEF and its budgetary ceilings. Due to the high cost of ARVs, government allocations to the health sector are barely used for the purchase of ARV treatment. As a result, access to life-prolonging treatment is not equitably available to all Ugandans, particularly for those who cannot afford to purchase ARVs on the private market and those who live in remote areas where donor-funded treatment is not readily available.

One of the key consequences of the HIV/AIDS epidemic that is addressed in the MTEF is the need for support for AIDS orphans. Under the PAF, proposed budgetary support for AIDS orphans and the rehabilitation of child soldiers has doubled in the current MTEF, from 1.43 to 2.84 billion Ugandan shillings. Also, the UPE covers the rights of orphans to access to (primary) education and as such the MTEF could be seen to alleviate the plight of AIDS orphans. However, as was noted by Ms Beatrice Were of NACWOLA, education is not the only or the most pressing need of orphans. In the absence of other support measures, like shelter, income, clothing, food and medical care, these orphans are unlikely to benefit from the principle underpinning the UPE.

Like the PEAP, the MTEF does not make reference to the fact that the HIV/AIDS epidemic is likely to enhance poverty, undermine food security, aggravate the burden of care on women and create new categories of poor households and marginalised groups (with the exception of orphans), amongst others. One might argue that relevant interventions aimed at poverty reduction, income generation or equitable access to public services in general may also benefit PLWHA and others who are directly affected by the epidemic. However, this assumption may not hold true, given that this means that the particular dynamics of HIV/AIDS are neglected and remain invisible.

Of particular concern is the support for the Public Sector Reform Programme, which involves the rationalisation of the public sector and retrenchments of public servants, particularly since there is no evidence that the MTEF takes into account the relatively high HIV prevalence rates among public servants noted earlier and the likely erosion of the public service due to HIV/AIDS. Added to this is the fact that there is no explicit support for HIV/AIDS workplace policies and programmes aimed at protecting the rights of employees infected with, and affected by, HIV/AIDS.

To some extent, it could be argued that the MTEF is concerned with ensuring the supply of sufficient and qualified labour by increasing funding for education that has led to the establishment of two extra universities and to an increase in the number of skilled teachers. The Government has also doubled its funding for sponsorships for students at public universities to 4,000. However, these measures have been developed in response to increased pupil enrolment as a result of UPE, rather than as a measure to mitigate the impact of HIV/AIDS on labour.

Other key consequences of HIV infection are not explicitly highlighted or addressed in the MTEF. Thus, the MTEF reflects insufficient concern with the medium to long term impacts of HIV/AIDS on households, communities, government sectors, the economy and society in general. Of particular

interest is the fact that the MTEF reflects no comprehension of the impacts of HIV/AIDS on the national (and local) tax base and other means of state revenue collection.

National Strategic Framework for HIV/AIDS Activities (NSFA), 2000/01-2005/06

The UAC has spearheaded the development of a five-year National Strategic Framework for HIV/AIDS Activities (NSFA) in the country. The purpose of the NSFA is four-fold. Firstly, it seeks to relate the fight against HIV/AIDS to the development goals and action plans in the PEAP. Secondly, it brings to the fore the active involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS interventions. Thirdly, it establishes indicators for measuring the progress and impact of HIV/AIDS interventions. Finally, it provides a basis for costing and mobilisation of resources for HIV/AIDS interventions.

The NSFA articulates three principal goals: reducing HIV prevalence by 25% by the year 2005/6 (although the baseline is not given); mitigating the health and socio-economic effects of HIV/AIDS at individual, household and community levels; and, strengthening the national capacity to respond to the HIV/AIDS epidemic.

Core determinants of HIV infection

The NSFA reflects most of the factors that constitute an environment of vulnerability to HIV infection. There is explicit concern with increasing awareness and changing individual behaviour, which is expressed in IEC programmes, VCT services and condom distribution, amongst others. Reference is also made to poverty as a key factor facilitating the spread of HIV and the need to boost food security and incomes. Access to decent employment is mentioned, although it is not an explicit objective of the NSFA. The NSFA recognises that women are a particularly vulnerable group that deserves attention in HIV prevention, although this obviously does not mean that the relationship between gender inequality and HIV/AIDS is adequately understood.

Furthermore, the framework is concerned with equitable access to basic public services, but only insofar as this relates to HIV prevention technologies, like PMTCT, VCT services and the availability and affordability of condoms. Thus, the NSFA gives prominence to VCT to persons wishing to establish their HIV status, PLWHA and members of affected households. However, the mechanisms and means of establishing VCT centres countrywide to enable people to access these services are not clearly spelt out in the framework. VCT services are commonly provided by the private sector, which restricts access for those who want to utilise the services due to costs involved.

Although lack of social cohesion and political voice are not explicitly mentioned as possible determinants of HIV spread, the NSFA does include strategies that may contribute to social cohesion and facilitate the expression of political voice. The framework supports partnerships with and participation of grassroots organisations, like women's associations and other community based groups.

The NSFA does not refer to social instability and conflict as a contributing factor to enhanced vulnerability to HIV infection. Yet, the uneven geographical distribution of VCT (and PMTCT) services does not only challenge the principle of equitable access to these services; it may also contribute to social strife. These services are particularly scarce in conflict areas where rape is a common occurrence. However, the issue of sexual violence especially in conflict zones is not explicitly addressed by the NSFA.

Key consequences of HIV/AIDS

The reduction of adult and infant mortality is an explicit objective in the NSFA and the framework covers PMTCT, access to ARV treatment and herbal treatment for opportunistic infections. Gradual steps have been taken to provide ARVs to PLWHA, although equitable access is still constrained by the high costs involved and the uneven geographical distribution of ARVs. This particularly affects PLWHA living in rural areas, who constitute the majority of all PLWHA in Uganda. Also, public servants and members of the armed forces can access ARV treatment at subsidised cost, which seems to be borne out of a realisation that HIV/AIDS-related morbidity and mortality in the public sector has detrimental implications for public sector capacity. Because the NSFA explicitly deals with the question of providing ARV treatment, it also includes a focus on patient adherence.

The NSFA states that community based organisations, NGOs and more particularly members of the extended family have a primary role to play in providing care and support for PLWHA. However, the framework does not sufficiently take into account that the HIV/AIDS epidemic is putting

serious strain on familial and community networks, weakening them as a result. The implications are at least twofold. On the one hand, it means that PLWHA and their relatives may not receive the care and support that these voluntary networks are expected to provide. On the other hand, social cohesion may be further eroded if there are no support mechanisms in place that will enable these networks to fulfil those critical social functions.

Explicit attention is given to the plight of orphans, who are considered a vulnerable group requiring support from a variety of stakeholders. The NSFA further calls for the representation and participation of PLWHA in decision-making structures and processes and incorporates an explicit focus on the need to reduce HIV/AIDS-related stigma. The NSFA specifically recognises that HIV/AIDS has caused job insecurity and discrimination at the workplace. Some organisations subject prospective employees to a mandatory – but covert – HIV screening test before recruitment and those who are infected with HIV are denied employment. PLWHA are often discriminated against in the workplace and their job contracts may be terminated on the basis of their prevalence status. Although the NSFA mentions these negative trends, it does not offer practical remedies as to how this situation can be arrested.

It seems, though, that the NSFA incorporates only those consequences of HIV infection that are more immediate and visible. Longer term and/or less discernible impacts of the epidemic, such as the loss of labour and associated skills, the likely loss of state revenue, the changing nature of demand for public services (beyond health care needs and the needs of orphans), to mention but a few, are barely mentioned in the framework. Income inequality is not recognised as a possible driver of HIV spread, nor is it mentioned as a potential consequence of the epidemic.

These omissions aside, in comparison to most other development planning frameworks in Uganda the NSFA reflects a more comprehensive understanding of the core determinants and key consequences of HIV/AIDS. This is hardly surprising. However, a critical challenge of the NSFA is that its effective implementation is contingent on a range of stakeholders. Also, it is unclear how the implementation of the NSFA will be funded. These issues raise questions about the extent to which the NSFA will be translated into concrete programmes and mechanisms for intervention.

The Plan for Modernisation of Agriculture (PMA) 2000

The PMA is a holistic, strategic framework for eradicating poverty through multi-sectoral interventions that enable people to improve their livelihoods in a sustainable manner. In a country where about 85% of the population is based in rural areas and is dependent on agriculture, the PMA largely represents a *rural development plan*. It aims to accelerate agricultural growth in Uganda by introducing profound technological change throughout the sector. The vision of the PMA is poverty eradication through a profitable, competitive, sustainable and dynamic agricultural and agro-industrial sector. In other words, it seeks to eradicate poverty by transforming subsistence agriculture to commercial agriculture. The framework is part of the Government of Uganda's broader strategy of implementation of the PEAP.

The PMA reflects the following broad objectives:

- Making poverty eradication the overriding objective of agriculture development;
- Deepening decentralisation to lower levels of local governments for efficient service delivery;
- Removing direct Government in commercial aspects of agriculture and promoting the role of the private sector;
- Supporting the dissemination and adoption of productivity-enhancing technologies;
- Guaranteeing food security through the market and improved incomes, thereby allowing households to specialise, rather than through household self-sufficiency; and,
- Ensuring that all intervention programs are gender-focused and gender-responsive.

Core determinants of HIV infection

There is a clear correlation between the objectives of the PMA and a number of core determinants of vulnerability to HIV infection. For example, the PMA explicitly strives to eradicate poverty, improve household food security and contribute to increased incomes of the poor. To achieve this, it proposes strategies aimed at enhancing productivity, increasing the market share of the poor and realising food security through the market instead of emphasising self-reliance. It further aims to provide "gainful employment through secondary benefits of PMA implementation, such as agro-processing factories and services".

The PMA puts great confidence in the market mechanism to deliver on these development

objectives. This is reinforced by the fact that the provision of farming implements and seedlings that are fast yielding and at the same time not labour intensive is clearly articulated as a non-government function. The PMA does, however, provide for extension staff at local government (sub-county) level to provide technical support towards increased agricultural output and food security. To some extent, this could be seen to contribute to more equitable access to public services, although the emphasis is clearly on increasing production and productivity.

The PMA also has an explicit focus on gender relations and the multiple roles fulfilled by women. More specifically, it encourages narrowing the literacy gap between men and women and improving gender relations and changing gender roles within the household. It further deals with the issue of land reform to ensure that women have access to land and proposes time-saving techniques to reduce the labour burden on women.

Although the PMA does not explicitly aim to support social mobilisation and social cohesion, it does recognise the importance of social capital. Reference is made to social relations within the household and within communities and the fact that membership of community groups enhance the ability of small-scale farmers to save, access credit and obtain information on available technologies. The PMA further recognises the importance and usefulness of involving CBOs and NGOs in service provision, due to their ability to mobilise communities. It appears, though, as if the PMA embraces an instrumental interpretation of social mobilisation, i.e. as a means to increase productivity rather than a development objective with intrinsic value. The PMA does not explicitly refer to the issue of political voice and empowerment of Uganda's rural population (through participatory development), although it does recognise the importance of strengthening local organisations and farmers' associations. Neither does the PMA respond to social instability, displacement, migration or urbanisation as key drivers of the HIV/AIDS epidemic.

Key consequences of HIV/AIDS

The PMA acknowledges the consequences of HIV/AIDS on agricultural production through the loss of skilled and unskilled labour, the loss of household assets and the increased use of domestic savings for medical care and funeral expenses.[xcviii] According to the PMA, HIV/AIDS robs individuals, communities and the country of valuable resources for development by causing high levels of adult morbidity and mortality. It further articulates that the negative consequences of HIV/AIDS can lead to hopelessness, school drop out, street children and substance abuse, all of which may lead to enhanced vulnerability to HIV infection.

Yet, despite its emphasis on food security and poverty reduction, the framework does not explicitly address the needs of HIV/AIDS-affected households, which are rotating daily around food security, nor does it propose strategies to support families who lack labour for tilling the land due to HIV/AIDS. As mentioned earlier, the provision of seedlings that are fast yielding and not labour intensive is seen to lie beyond the realm of government responsibilities. Likewise, no explicit reference is made to the fact that HIV/AIDS adds to the burden of care traditionally carried by women or to the fact that women are disproportionately at risk of losing assets, land and other forms of security when their husbands die of HIV/AIDS-related illnesses. Furthermore, the PMA remains silent on how to address the needs of AIDS orphans and although it recognises that the epidemic is leading to a loss of labour, it does not spell out how to respond to this dynamic. The framework simply mentions in passing that "the welfare of those affected by HIV/AIDS" may warrant attention, but does not explicate who this may concern or what attention might be required.

The PMA does not express any recognition of the fact that HIV/AIDS may also affect extension staff and other employees in the agriculture sector, which could undermine the capacity of the sector to deliver appropriate services and facilitate agriculture development. Within the context of Uganda's civil service reform, the PMA has abolished the Extension Directorate of the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) and has transferred responsibility for extension staff to districts in accordance with the decentralisation policy. However, the ability of districts to recruit extension staff is constrained due to reduced local revenue, which is in part a consequence of the HIV/AIDS epidemic. The PMA fails to recognise this. Also, because the PMA is oblivious to the significance of HIV/AIDS for employees in the agriculture sector, it is not surprising that it does not concern itself with the issue of job security and job flexibility of HIV-infected staff.

Other key consequences of HIV/AIDS are not

referred to at all in the PMA. Clearly, merely mentioning the need to mitigate the impacts of HIV/AIDS – and possibly listing some of these impacts, as the PMA does – is not sufficient. What appears to be lacking in the PMA is an understanding of how HIV/AIDS is likely to thwart the objective of turning subsistence farmers into commercial farmers to enhance agriculture productivity, which is underpinning the overarching goal of creating a dynamic agriculture sector.

The Health Sector Strategic Plan (HSSP), 2000/01 - 2004/05

The overall purpose of the HSSP is to reduce morbidity and mortality from major causes of ill health in Uganda and overcome health disparities as a contribution to poverty eradication. Three principal aims are outlined in the HSSP. The first aim is to improve access of the population to the Uganda National Minimum Health Care Package (UNMHCP). Linked to this is the second aim, which is to improve the quality of delivery of this health care package. The third aim is to reduce inequalities between various segments of the population in accessing quality health services.

These aims are linked to a set of specific objectives of HSSP, which are concerned with relating the ongoing health sector reforms to health development, articulating the essential linkages between the various levels of the national health care delivery system and involving all stakeholders in health development. Other objectives of the HSSP are: to provide a framework for three-year rolling plans at all levels; to exhibit a health sector strategic framework with coherent goals, objectives and targets for the next five years; and, to indicate the level of investment in terms of costs required for achieving the policy objectives that have been agreed upon by the Government of Uganda and its development partners.

Core determinants of HIV infection

Given the earlier conceptualisation of HIV/AIDS as largely a medical issue, the health sector has been very consistent and clear on HIV/AIDS prevention and control since the mid-1980s. Under the heading "Control of Communicable Diseases", the HSSP focuses on prevention and control of STD/HIV/AIDS transmission and the mitigation of the personal effects of AIDS. The national targets in the HSSP on prevention and control focus on individual behaviour change through practices such as increased and sustained use of male and female condoms and seeking VCT. The HSSP envisages that VCT services are to be provided by all health units (Health Centre III and above), yet resource constraints in health units make this ambitious aim unrealistic. Currently, most providers of VCT services are non-governmental and can only reach a small proportion of the Ugandan population.

With respect to condom use, in societies such as Uganda where sexual decisions are mainly the sacrosanct domain of men, the ability of women to use or insist on using condoms is severely constrained. This issue is not addressed by the HSSP, possibly because of the perception that addressing issues such as gender inequality, poverty and conflict lies beyond the mandate of the health sector, as suggested by the Director of Health Services in the Ministry of Health, Prof. Francis Omaswa, during the course of this study.

One could, however, argue that the promotion of female condoms is informed by the recognition of women's rights and is intended to give women more power in sexual relations. In more general terms, the HSSP seeks to contribute to gender equality through the promotion of gender balance in the selection of community health care workers, who play important roles in community-based health management systems.

The HSSP includes a relatively small focus on food security by addressing the need for nutritional supplements and growth promotion, with a specific focus on children. However, comprehensive interventions to ensure food security and raise incomes are left to the PMA and the PEAP.

To ensure equitable access to health care, the HSSP stipulates that health care is free. The abolition of user fees in all government health units was clearly aimed at ensuring access to health care for all Ugandans. However, as noted earlier, the removal of user fees has left a resource gap (mainly in terms of human resources, available drugs and other health facilities like hospital beds) in the face of increasing demand, which the Government has been grappling to fill – thus far without much success. Scarcity of drugs in government health units where they are supposed to be free has meant that equitable access to health care is becoming an illusion as acknowledged by the Government: "Abolition of user fees and subsequent increase in demand for public health services put a strain on the drug supplies in health facilities and drug stock-outs remain a regular feature" (MFPED, 2003b:53).

The HSSP further acknowledges the importance of social mobilisation for community empowerment and views the health sector's contribution to this objective in the promotion of Primary Health Care (PHC) and Community Based Health Care (CBHC). PHC and CBHC are further heralded as valuable approaches to enable the participation of local communities in the management and monitoring of health services – in other words, to support political voice and empowerment.

In recognition of the fact that migration and mobility can facilitate the spread of HIV, the HSSP makes provision for the supply of condoms along main transportation routes. In more general terms (i.e. not explicitly focused on HIV transmission through sexual behaviour) provision is also made for emergency health care, including reproductive health care, in camps for displaced people. Thus, some support services are made available in response to certain needs associated with migration or displacement. The HSSP also recognises that appropriate health services can help minimise conflict and social instability and refers to the need to provide these services in hard to reach areas that are potential sources of conflict and social instability.

To conclude, the HSSP seeks to respond to quite a number of core determinants of vulnerability to HIV infection, although the scope of proposed interventions is clearly circumscribed by what is considered an appropriate health response. In other words, addressing factors like lack of income, unemployment or unequal gender relations is seen to fall beyond the scope of the health sector.

Key consequences of HIV/AIDS

Not surprisingly, the HSSP aims at reducing HIV/AIDS-related adult and infant mortality through the promotion of ARVs and PMTCT. It sets the target of reducing mother-to-child transmission from around 25% to 15%. The HSSP further emphasises the ability of PLWHA to earn an income and support them and their families in tandem with ARV treatment. It also focuses on the need to ensure improved nutrient requirements for PLWHA, which is related to the issue of food security.

Other ways in which the HSSP recognises some of the key consequences of HIV/AIDS are reflected in references to the need to provide counselling and psychological support to individuals and families affected by HIV/AIDS, the significance of involving associations of PLWHA in decision-making and project implementation, and the support for IEC to fight AIDS-related stigma.

The HSSP pays particular attention to "training, recruitment, rational deployment, motivation and retention of qualified staff across the country". This is clearly a pressing objective, given that only about 43% of positions in health units are filled by qualified staff (MFPED, 2003b). Yet, no reference is made to HIV/AIDS-related morbidity and mortality among health professionals, which is likely to further deplete the health system's human resources. It also does not make mention of the need for an HIV/AIDS workplace policy to protect the rights of HIV-infected staff.

The lack of qualified health workers also impacts on the quality of care afforded to PLWHA and people requiring other forms of health care. In particular, the distribution of human resources across the country is unequal with remote areas (including those characterised by insecurity and rebel activity) finding it particularly hard to find and retain qualified staff. Added to this is the reality of resource constraints and the lack of adequate medical supplies. As a result, access to equitable health care both for PLWHA and the general population is severely under threat, particularly given the fact that HIV/AIDS is aggravating the burden of disease.

In light of the heavy resource demands posed by the need for treatment and care of a significant number of PLWHA, the Government encourages communities and families to shoulder this role. Yet, the ability of the extended family to function as a 'shock absorber' in such contingencies has been greatly overstretched and is further being weakened by systemic and growing poverty. Furthermore, the responsibility to care for the sick in Uganda chiefly falls on women, yet this dynamic remains invisible in the HSSP and no additional support or resources are made available to enable them to fulfil this role.

A key strategy to ensure that the health sector is adequately resourced to specifically address the burden of disease associated with HIV/AIDS pursued by the Government is to raise funds from donors and the Global Fund to Fight AIDS, Tuberculosis and Malaria. This is clearly aimed at ensuring financial stability of the health sector, especially in light of the fact that user fees have been abolished.

In conclusion, the HSSP explicitly engages with a number of key consequences of HIV infection,

although not necessarily to the full breadth and depth that these issues require. It remains largely silent on other possible consequences, such as the implications of HIV/AIDS for women and gender relations or the eroding effects of the epidemic on health care staff and institutions.

The Education Strategic Investment Plan (ESIP), 1998-2003

The main emphasis of ESIP has been on achieving Universal Primary Education (UPE), a policy that was introduced in 1997 (MoES, 2003). The main objectives of ESIP are threefold: to commit the Government to key human resource development and social equalisation goals; to create new balances between the public sector and private sector; and, to reform the bureaucracy and public financing mechanisms.

The priorities, targets and focus of ESIP arise out of these main objectives. Thus, ESIP is concerned with assuring universal access to primary education, creating equity and eliminating disparities in the education sector, and enhancing the quality and relevance of instruction, particularly at the level of primary education. Further, ESIP seeks to strengthen the role of central Government as the 'policy power house' for the education sector whilst at the same time building the capacity of districts to assume full responsibility to plan and deliver quality education services at primary and secondary levels.

Core determinants of HIV infection

The ESIP makes provision for targeted IEC in schools as a means to promote responsible sexual behaviour among youth. Although it falls outside the conventional ambit of the education sector to ensure food security and adequate income in society at large, education (like health) is considered a critical component of human development that can enable people to avoid (or escape) poverty in their adult life. The ESIP supports the establishment of vocational institutions and community polytechnics for skills development, which can be interpreted as the framework's contribution to the promotion of access to decent employment and income.

The ESIP focuses on the full enrolment of girls as an explicit objective under the principle of universal access to education. It also reflects a concern with the accessibility of adult education for women learners. As such, the promotion of gender equality is a central component of the overall objective to ensure equitable access to education services across the country. The ESIP awards high priority to assuring universal access to primary education (through support for UPE), focusing on increasing net enrolment ratios and retention rates, improving attendance and making instructional time more effective. The main intention is to enable children from poor segments of society to complete primary education. The framework also makes provision for special targeted services aimed at the urban poor, pastoral nomadic communities, persons with disabilities and people living in resettlement camps for displaced persons.

One of the concerns is that ESIP only provides resources to cover tuition fees for primary education. The exclusion of other education costs (e.g. for uniforms, books, lunch and other scholastic materials) means that children from very poor households either do not enrol or drop out. Furthermore, whilst the ESIP gives high priority to primary education, it does not place corresponding emphasis on secondary education. As a result, many children who have completed primary school are unable to continue their education. For them, the chances of gaining meaningful employment and avoiding/escaping poverty remain slim.

The ESIP further reflects on the importance of diversifying education service providers and involving both NGOs and the private sector in the provision of education. Yet, no explicit reference is made to the importance of involving local communities and poor households in the management and monitoring of education services, which could contribute to enhanced social cohesion and the expression of political voice.

Key consequences of HIV/AIDS

The ESIP engages with very few likely consequences of the HIV/AIDS epidemic. One exception is the explicit emphasis on the reduction of HIV/AIDS-related stigma and discrimination through IEC interventions. With respect to AIDS orphans, the assumption is that they will benefit as much from the policy on UPE as other children do. Yet, as one of the respondents pointed out, access to education is unlikely to be a priority for AIDS orphans. A whole range of additional support measures are needed (including food programmes at schools, for example) to address the various needs of AIDS orphans and to enable them to continue their schooling.

With an estimated HIV prevalence rate among teachers of about four percent in 2000, the

Table 8.1. Explicit objectives in Uganda's development planning frameworks						
	PEAP	**MTEF**	**NSFA**	**PMA**	**HSSP**	**ESIP**
Core determinants of HIV infection						
1.1. Change in individual behaviour	-	++	++	-	++	++
1.2. Poverty reduction (minimum standard of living & food security)	++	++	+	++	+	-
1.3. Access to decent employment or alternative forms of income	++	+	+	+	-	-
1.4. Reduction of income inequalities	-	-	-	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	+	+?	+	+?	+
1.6. Equitable access to quality basic public services	++	++	+	+	++	++
1.7. Support for social mobilisation & social cohesion	-	+?	+?	+	++	-
1.8. Support for political voice & equal political power	++	+?	+?	-	+	-
1.9. Minimisation of social instability & conflict / violence	+	-	-	-	+	-
1.10. Appropriate support in the context of migration/displacement	+	+	-	-	+	+
Key consequences of HIV/AIDS						
2.1. Reduction of AIDS-related adult/infant mortality	-	+	++	-	++	-
2.2. Patient adherence	-	-	+	-	+	-
2.3. Poverty reduction	-	-	-	-	++	-
2.4. Reduction of income inequalities	-	-	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	-	-	-	-	-
2.6. Appropriate support for AIDS orphans	-	++	++	-	-	+?
2.7. Equitable access to essential public services	-	-	-	-	-	-
2.8. Effective/enhanced public sector capacity	-	-	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	+	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	+?	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-	+	-
2.12. Support for social support systems & social cohesion	-	-	-	-	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	+	-	++	-	+	-
2.14. Reduction of AIDS-related stigma and discrimination	+	-	+++	-	+	++
2.15. Reduction of social instability & conflict	-	-	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly						

education sector is obviously directly affected by HIV/AIDS-related morbidity and mortality, with associated consequences for the ability of the sector to deliver quality services. The ESIP includes concrete plans for increased teacher recruitment and professional development by providing support for more teacher-training institutions and waiving tuition fees for primary school teachers. These are significant steps that can potentially offset human resource demands. However, the rationale for these measures is based on the increased pupil enrolment and corresponding demand for more teachers as a result of UPE, rather than as a planning strategy to shoulder the human resource burden resulting from HIV/AIDS.

It is encouraging, though, that the Mid-Term Review of the ESIP recognises that HIV/AIDS has negative impacts on the education sector, albeit rather tentatively: "The main feature of the impact of HIV/AIDS on the education sector is the number of orphans in schools, who lack resources to fully take advantage of their opportunities. … Teacher morbidity is probably also an issue, but the current monitoring system does not permit an assessment of its importance" (MoES, 2003:163-164).

By way of concluding this overview of possible links between the various development planning frameworks in Uganda and HIV/AIDS, Table 8.1 indicates whether these frameworks explicitly seek to respond to the various core determinants and key consequences of HIV infection. As the preceding discussion has attempted to highlight, the fact that certain factors are explicitly highlighted does not necessarily mean that strategies for addressing these factors are clearly articulated. It also does not mean that the proposed strategies are unambiguous in achieving supposed objectives.

Table 8.1 confirms that addressing the core determinants of HIV infection is central to most development planning frameworks, although the emphasis may vary between the various frameworks. Strong emphasis is put on changing individual sexual behaviour as a direct means of

preventing HIV spread. Poverty reduction, access to income and equitable access to services are also key objectives of most development planning frameworks, although less emphasis appears to be on employment creation (particularly by the state) and the political dimensions of poverty (e.g. support for political voice, empowerment and social cohesion). Glaringly absent in all frameworks is a concern with the distributional dimensions of poverty and wealth, i.e. income inequality. Yet, even where development planning frameworks address factors that are considered core determinants of vulnerability to HIV infection, more often than not this is done without recognising the potential link between these factors and HIV spread.

As Table 8.1 further highlights, the development planning frameworks tend to have a very limited focus on the key consequences of HIV/AIDS and the extent to which the epidemic causes or aggravates particular development concerns (e.g. poverty and gender inequality) or undermines others (e.g. social cohesion or public sector capacity). The only impacts readily recognised are HIV/AIDS-related mortality, AIDS orphans, HIV/AIDS-related stigma and the necessity of involving PLWHA in decision-making processes.

The planning process

If development planning frameworks do not adequately address the core determinants of vulnerability to HIV infection and/or the key consequences of HIV/AIDS – despite the fact that key informants from Parliament, sectors and civil society organisations appear to recognise the importance of many of these factors – this might be indicative of some flaws in the planning process. In other words, there may not have been sufficient scope for these stakeholders to critically engage with the formulation or revision of these development planning frameworks. At least some of the respondents interviewed during the course of this study suggested that this was part of the problem and that many issues had been left out of the frameworks because of a lack of joint planning. This section will look at the involvement of Parliament, government departments (sectors), civil society organisations, the UAC and organisations representing PLWHA, and donor agencies (particularly the World Bank) in the planning process.

It is worth noting that until recently, Uganda did not have an operational National Planning Authority (NPA) or an alternative body to guide the national planning process. Although the NPA was set up in 2002, it did not begin operations until August 2003 when the Secretariat and Board members were inaugurated. Thus, at the time of undertaking this study the NPA had not yet been involved in any national planning activity. Its primary function, as specified in the National Planning Authority Act of 2002 (Government of Uganda, 2002b), is to produce comprehensive and integrated development plans for the country.

Parliament

The Members of Parliament interviewed were unanimous in their view that there has been limited, if any, involvement of Parliament in the formulation of Uganda's key development planning frameworks. Repeated reference was made to the central role of technocrats in respective Ministries in formulating these frameworks, and in particular to the fact that these matters were decided on between the Ministry of Finance, Planning and Economic Development (MFPED) and the World Bank. According to the Chairperson of the Standing Committee on Economy:

> This [the formulation of national key development planning frameworks] has tended to be a matter of the Executive and responsible sectors, who believe that Parliament is just there to make laws. Most of the programmes are failing because Parliament is not involved in this.[xcix]

Other respondents also expressed frustration about the fact that Parliament's role in the planning process is confined to the allocation of resources or to law-making:

> Parliament participates … when the Government needs to borrow money … or to make a law. This is the time Parliament gets to know what Government is planning.[c]

Although Parliament is supposed to fulfil a monitoring function, Members of Parliament indicated that even this role was minimal. Moreover, some added that it would be unreasonable for Parliament to be involved in monitoring, if it does not participate in the formulation of development planning frameworks.

Not surprisingly, in the view of politicians the level of public involvement in the planning process has also been minimal. Rather, as one of the respondents commented, had these various plans been truly

home-grown, it would have been impossible to avoid public involvement. Instead, the frameworks are considered donor-driven. This view was echoed by the Chairperson of the Standing Committee on HIV/AIDS:

> At times, the prescriptions in the plans are wrong and based on wishes and assumptions of Ministry of Finance people and the World Bank.[ci]

However, some hope was expressed that Parliament's involvement in the planning process may be enhanced with the recent (2002) establishment of the Standing Committee on HIV/AIDS, which was seen as an important mechanism to streamline parliamentary participation on issues related to HIV/AIDS. This Committee has already noted some success in lobbying the Executive to exclude the allocation from the Global Fund to Fight AIDS, Tuberculosis and Malaria from the budgetary ceilings in the MTEF.[cii] It was noted that Parliament is getting involved in the revision of the PEAP.

Sector Ministries

According to various key informants in sector Ministries, the formulation of the various sectoral development planning frameworks is largely a responsibility of each respective sector with guidance in terms of budgetary ceilings from the MFPED (which are expressed in the MTEF). In some instances, reference was made to the involvement of other sectors in the preparation of specific sectoral plans. For example, the Ministry of Health (MoH) engaged with the Ministry of Water, Lands and Environment (MoWLE), the Ministry of Education and Sports (MoES), the Ministry of Local Government (MoLG) and the Ministry of Gender, Labour and Social Development (MoGLSD) in the development of the HSSP. Likewise, the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) facilitated consultations with other sectors to shape the PMA. The formulation of ESIP did not only involve the MoES and the MFPED, but also the MoLG.

The most extensive cross-sectoral involvement seems to have taken place in relation to the PEAP and the NSFA. Most respondents indicated that their departments had been involved in the formulation of the PEAP or were currently involved in its revision. In the case of the MoLG, this also meant facilitating the involvement from districts and lower level governments in the process.

Yet, the involvement of government sectors in determining the resource envelope is less clear and could not really be gauged from the interviews. The impression was created that budgetary ceilings are largely preset and that sector Ministries have to develop plans and activities that fit within these ceilings. However, it was difficult to corroborate this perception.

Civil society organisations

Most development planning frameworks claim to have been based on extensive collaboration and stakeholder involvement. In the case of the PEAP 2001-2003, for example, it has been suggested that unlike during the formulation of its predecessor (the PEAP of 1997), it has been based on extensive involvement by all sector working groups involved in the MTEF process, key line ministries and representatives from CSOs. However, this assertion is not always corroborated by key informants in this study. A by now familiar observation was made that donors and certain Ministries are the main, if not sole, actors in this process:

> Most of the planning frameworks … are basically donor-driven. The donor and Ministry of Finance and possibly the Ministry responsible develop these plans. I don't think there is much involvement of various stakeholders. The would-be stakeholders are merely informed or learn of the process in the papers.[ciii]

This view was confirmed by a representative from an NGO:

> CSOs are invited when there is dissemination. The PEAP was more or less a Ministry of Finance thing. There was less participation in its formulation. When there is no full participation, it becomes difficult to monitor such programmes.[civ]

Representatives of the UAC commented that a wide range of civil society organisations had been involved and consulted in the formulation of the NSFA. These included faith based organisations, national and international NGOs, academic institutions, an association of Traditional Herbal Practitioners (THETA) and networks or PLWHA. With the exception of the latter, this view could not be supported by respondents in this study. However, one of the representatives of the UAC added that there may have been logistical reasons why certain stakeholders at decentralised levels may not have been sufficiently involved.

UAC and organisations of PLWHA

Whilst the UAC was clearly instrumental in the formulation of the NSFA, this study was particularly interested to explore its involvement in the formulation of other development planning frameworks. According to the UAC representatives interviewed, the organisation is very involved in the revision of the PEAP:

> The Commission is participating actively in the revision of the PEAP. We are trying to ensure that the revised PEAP explicitly highlights HIV/AIDS issues rather than relegating them to one of the pillars. … HIV/AIDS was only considered under Pillar 4 [improving the quality of life of the poor] … now PEAP is being reviewed and HIV/AIDS will be mainstreamed in all the four pillars.[cv]

However, it appears the Commission has not been involved in other development planning frameworks reviewed here. It does, however, give support and guidance to sectors in the development of thematic policies, for example on orphans, home-based care (HBC), PMTCT and so on.

Organisations representing PLWHA are hardly involved in the planning process. The one exception is the NSFA, which was commended for being based on extensive involvement with associations of PLWHA. Whilst the two organisations interviewed both indicated lack of human resource capacity to be involved in the formulation, implementation and revision of the various planning frameworks, one of the respondents gave a particularly insightful commentary on why no attempt has been made to involve these organisations in planning processes:

> The reason for the government not involving us is based on perceptions that when you are living with HIV/AIDS, you are a patient and hence you should merely be a recipient of plans and policies. Because of stigma, most people who are professionals living with HIV have not come out openly so the technocrats in government think that we do not have the capacity to contribute constructively to planning processes. People outside there think that we cannot manage challenging tasks … that one is likely to die before accomplishing the task.[cvi]

She further gave an example of the qualitative difference their involvement would make to planning interventions:

> The assumption is that with UPE all children, including those affected and infected with HIV/AIDS, will go to school. Had we been involved in the formulation of UPE, we would have prioritised correctly the needs of the affected and infected children. … Although it is important, provision of free primary education alone is not a solution to getting orphans to school. There is nothing to eat, one is sick, cannot get medication, clothing, etc. How would you expect such a child to think of school?[cvii]

Development partners / donors

A significant number of respondents pointed to the extensive involvement of donor agencies in the formulation and approval of the various development planning frameworks. On many occasions, particular reference was made to the World Bank.

According to a World Bank representative in Uganda, the World Bank has been involved mainly in terms of funding studies and consultancies to inform the formulation of these frameworks. However, it also provides technical support, as in the case of the PEAP. The representative added that the World Bank has also been involved in the preparation or revision of sectoral planning frameworks, but only to the extent that it has specialised staff for particular sectors. Thus, with respect to health and education the World Bank's involvement has been substantial. As a major funding agency for the implementation of these frameworks, the World Bank engages in regular reviews of the MTEF and the PEAP based on the Poverty Status Reports.[cviii]

By way of concluding this section, it appears that some development planning frameworks have been informed by more extensive consultation and stakeholder participation than others. Of particular concern is the negligible involvement of Parliament in both the formulation and monitoring of these key instruments to guide the development process in Uganda, although it has been noted that this may be changing now. Also disconcerting is the fact that civil society organisations and organisations with a particular mandate to address HIV/AIDS (including UAC and organisations of PLWHA) do not seem to have played a significant role in the planning process, some notable exceptions aside. Of course, this case study does not claim to present a fully representative picture of planning processes in Uganda. However, the findings of the small sample

of representatives interviewed in the context of this study suggest that development planning remains largely the prerogative of a relatively small group of government officials, particularly those with an interest in financial and economic planning, and donors, including multilateral organisations like the World Bank. A number of respondents have expressed the hope that the recently established NPA may play a facilitating role in this regard, which could ensure more active participation of a variety of local stakeholders.

Alignment and implementation of development planning frameworks

Within the context of Vision 2025, the PEAP is considered the main development planning framework in Uganda and is supposed to guide budget planning, sector planning and district planning. As mentioned in Chapter 3, the link between the PEAP and the MTEF in particular is considered quite strong, in part possibly because the MTEF has become well established in Uganda. However, respondents expressed widely differing views on whether other development planning frameworks were sufficiently aligned with the PEAP as well as with other frameworks. Some of those who argued that this was not the case suggested that this was because there had not been sufficient time to synchronise these frameworks sufficiently. Again, the hope was expressed that the recently established NPA would play a central role here in future. Indeed, one of the enacted functions of the NPA is to coordinate and harmonise development planning in the country. It is also charged with monitoring and evaluation of the effectiveness and impact of development programmes and of the performance of the national economy.

Another explanation for the observed lack of alignment between the various development planning frameworks proffered was that planning still tends to be done on the basis of sectoral projects, in large part because donor funds are made available to sectors rather than for budget support. As a result, there has been a lack of coordination between the various sectors and the respective planning processes.

Table 8.1 confirms that there are some questions, if not concerns, about the alignment of the various development planning frameworks from the specific vantage point of HIV/AIDS. For example, although the NSFA makes reference to the various drivers of the HIV/AIDS epidemic in Uganda, few other development planning frameworks have actually taken these factors on board in the way that these are articulated in the NSFA. Even if other frameworks address specific core determinants of vulnerability to HIV infection, more often than not there is no evidence that this is at least in part informed by an understanding of the link with HIV/AIDS. As far as the key consequences of HIV infection are concerned, one could be tempted to argue that all there may be is an 'alignment by omission', since most development planning frameworks are largely silent on these factors. On a more positive note, though, the current revision of the PEAP, and in particular the above-mentioned efforts to ensure that HIV/AIDS is an integral component of all four components of the PEAP, might be considered an attempt by the Government to ensure better alignment of key development planning frameworks.

Some respondents argued that the problem is not so much alignment, but that the challenge lies in the implementation of these frameworks:

> Whereas the planning frameworks themselves might be fairly aligned, I am not sure that the various implementers are following the existing frameworks. Especially in the field of HIV/AIDS, the implementation is so much in the hands of NGOs, CBOs and other forums in the private sector. Who is ensuring that they are following the frameworks?[cix]

Other respondents added factors like lack of capacity and limited resources for the effective implementation of the development planning frameworks. These factors were considered particularly relevant for districts. In the case of the NSFA, this observation was also made in relation to sector Ministries, as these organisations have to translate the objectives and priorities of the NSFA into action. One of the challenges in this regard is the formulation of indicators, which allow for the evaluation of strategies in the NSFA that other parties have to execute. This task is further complicated by the fact that proper baseline data on HIV/AIDS was lacking at the time the NSFA was developed.

Concluding comments

As the preceding discussion has sought to highlight, Uganda appears to have a relatively strong planning system with the PEAP playing a critical role as the guiding development planning framework, which is integrally linked to financial planning through the MTEF. Yet, the extent to which the various

frameworks both appreciate and respond to the core determinants of vulnerability to HIV infection and the key consequences of the HIV/AIDS epidemic leaves much to be desired. Even if particular core determinants or key consequences of HIV/AIDS are recognised, macroeconomic reform arguments tend to supersede other development objectives related to poverty reduction, empowerment and the reduction of all forms of inequality (particularly income inequality) and priority is given to strategies associated with these types of economic and associated institutional reforms. To a certain extent, this is also indicative of the fact that the various development planning frameworks are chiefly determined by the political and funding priorities of bilateral and multilateral donors, with relatively little input from parliament, civil society organisations and organisations with a specific mandate to address HIV/AIDS (i.e. UAC and associations of PLWHA) – although great variances have been noted in the involvement of stakeholders regarding the formulation of the various development planning frameworks.

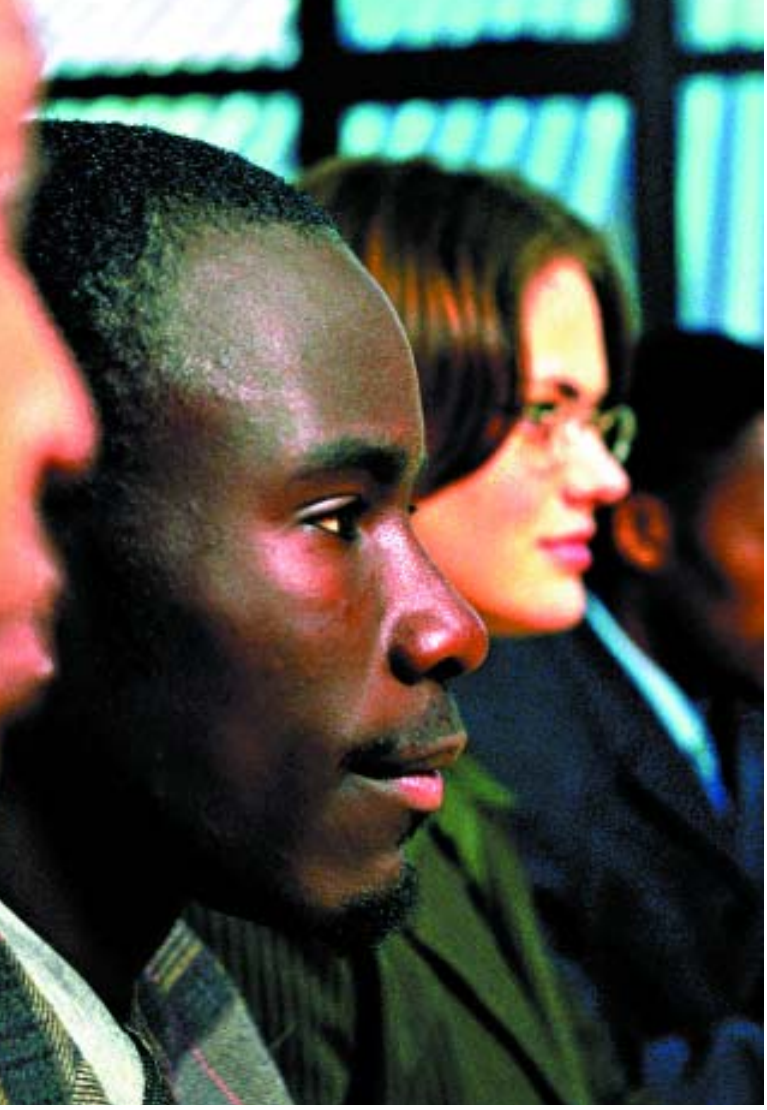
8.5. Conclusion

Curtailing the spread of HIV and mitigating the impacts of the HIV/AIDS epidemic has been an explicit goal of the Government of Uganda for almost two decades. The resolve with which Uganda has tackled the HIV/AIDS epidemic at a relatively early stage has made the country a model for other countries in the region, which are faced by the tragedy and devastation caused by HIV/AIDS. Yet, during the course of this study it has become clear that significant scope exists to better align development planning in Uganda with the development challenges posed by the HIV/AIDS epidemic.

Although it has emerged that there is significant correlation between the identified core determinants of vulnerability to HIV infection and the key planning frameworks guiding the development process in Uganda, not all core determinants are recognised as critical for the development of the country, let alone for stemming the spread of HIV. The main emphasis is on individual behaviour change and on general development objectives like poverty reduction, ensuring access to income and equitable access to services. Less attention is given to other drivers of the epidemic, particularly to the political dimensions of vulnerability and to the distribution of national wealth and income. These factors were also less readily mentioned by the respondents consulted during the course of this study. However, the fact that certain objectives in the relevant planning frameworks correlate with core determinants of vulnerability to HIV infection does not automatically mean that these factors are adequately addressed. As this chapter has highlighted, precedence is given to strategies aimed at realising macroeconomic and associated institutional reforms, without adequate critical reflection of how these strategies may thwart the realisation of development goals like poverty reduction, equality and empowerment.

Whereas it is possible to identify some links, albeit tentative, between development planning and HIV/AIDS in Uganda in the area of prevention, the same cannot be said for impact mitigation. A few exceptions aside, the various development planning frameworks hardly give any attention to the core consequences of HIV/AIDS identified in Chapter 4. Given Uganda's early response to the HIV/AIDS epidemic, it seems rather surprising that the only core consequences of HIV/AIDS explicitly mentioned concern the more obvious impacts, such as AIDS-related mortality, orphans, stigma and discrimination, and the need to involve PLWHA in decision-making processes. What could be considered the secondary impacts of increased adult mortality, in communities as much as in organisations, are not explicitly mentioned or addressed.

Yet, the key consequences of HIV/AIDS threaten to undermine, if not reverse, the development gains achieved since the mid-1980s. From the interviews it was clear that the respondents were more attuned to these negative impacts of HIV/AIDS for the development of Uganda and its people, although by far not all key consequences were mentioned. To a certain extent, this raises questions about the planning process and the degree to which different stakeholders can influence the formulation, revision and implementation of Uganda's development planning frameworks. This study has found that the level of consultation and stakeholder participation varies significantly between the different development planning frameworks. In general, though, there has been very limited involvement of Parliament and of civil society organisations in general and of specific organisations with a mandate to represent the interests of PLWHA and affected communities. Instead, planning seems to be the forte of government officials, particularly those in the MFPED, and the donor community, more specifically the World Bank. Many respondents have expressed their concern about this situation.



Mainstreaming HIV/AIDS into development planning implies going further than the mere recognition in the PEAP that HIV/AIDS is a cross-cutting issue. The unfortunate implication of this reference in the PEAP seems to be that HIV/AIDS has lost prominence as a critical aspect of development planning. Instead, what is required is a critical assessment of how each development planning framework may neglect or – worse still – aggravate the core determinants of vulnerability to HIV infection and the key consequences of HIV/AIDS. This involves not only a superficial assessment of the correlation between these factors and the stated objectives in the various frameworks, but more importantly of the proposed strategies and instruments (and their underlying assumptions) to realise these objectives.

Zimbabwe[1]

Children are our future and when we lose them we are virtually losing the future.[cxi]

The fight against HIV/AIDS can only be successful in a democratic context.[cxii]

9.1. Introduction

Zimbabwe is currently experiencing one of the worst HIV/AIDS epidemics in the region, only second to Botswana. At the same time, Zimbabwe is experiencing a serious humanitarian crisis which has several complex and interlinked challenges in addition to HIV/AIDS, such as poverty, food shortages largely associated with recurrent droughts and floods, an overburdened health system, the deteriorating economy and high levels of inflation, brain drain and unemployment. For instance, a SADC Food, Agriculture and Natural Resources Vulnerability Assessment Committee reported that the number of people in Zimbabwe requiring food aid rose from 6.7 million in 2001 to 7.2 million in 2002 (amounting to 62% of the population) and that national grain production in 2001/2002 was 65% less than average production for the past five years (SADC, 2002). This humanitarian crisis is occurring within a fast deteriorating socio-economic context where perennial poverty undermines the ability of the country to adopt and sustain HIV/AIDS intervention and economic developmental programmes – a vicious cycle demanding a two-edged planning and implementation approach. The extent to which Zimbabwe will be able to break this cycle of suffering will depend on the development planning approaches taken and the degree to which such plans are effectively implemented. Clearly, what is required is effective mainstreaming of HIV/AIDS into all humanitarian programmes and development planning. Yet, as this chapter will demonstrate, development planning in Zimbabwe has largely become a fire-fighting exercise aimed at addressing the most immediate problems exerting the most threatening political pressure.

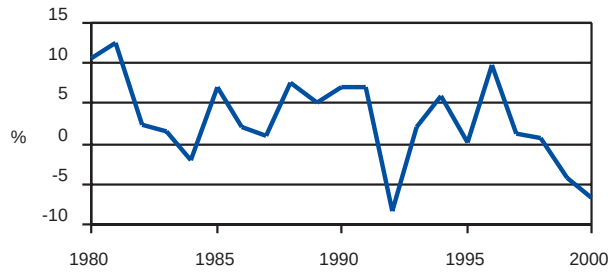
9.2. Overview of development trends since 1980

Zimbabwe has very limited systematic national data on most indicators of interest that are meant to inform this overview of development trends in the country. For instance, Zimbabwe does not have information even on national HIV prevalence levels since there is no system in place for the production of such estimates. Different institutions also use different estimates for the same indicators within the same period of time. Furthermore, within the current economic and political context certain indicators have become politically sensitive and there is politicisation of particular estimates. An effort has been made to draw most of the data reflected in this section from national documents. This has been complemented by data from other sources besides government documents in order to come up with some semblance of trends (see Appendix 2 for the Country Profile of Zimbabwe and relevant references).

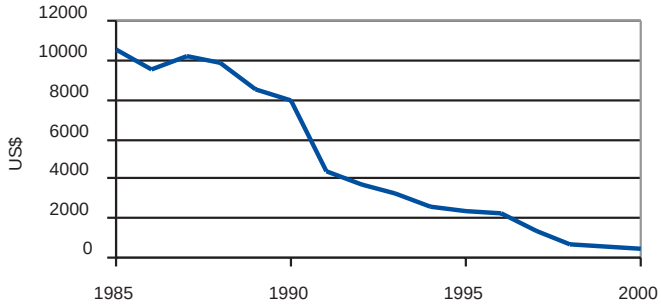
Demographic trends

In the 1980s and early 1990s, the population of Zimbabwe increased rapidly from an estimated 7.5 million in 1982 to 10.4 million in 1992. This correlates with a population growth rate of 3.1% during this period. During the mid-1990s, however, the population growth rate slowed down and by the turn of the century there was even evidence that the population started to decline. Whereas in 1997 the total population had increased to 11.8 million, by 2002 it had declined to 11.6 million people. Between 1992 and 2002, the average population growth rate was 1.1% (Central Statistical Office, 2003a). The increase in Zimbabwe's population during the 1980s was largely due to improved health status combined with high fertility rates. The subsequent reduced growth rate is the result of a combination of declining fertility and increasing mortality largely due to HIV/AIDS. For instance, fertility declined from a total fertility rate of just below seven (6.9) children in 1984 to four children in 2002 (CSO, 1994 and 2003a). This has largely been attributed to the increasing use of contraceptives. For example, while in 1984 about 27% of married women aged between 15-49 years used contraceptives, this

Graph 9.1. GDP growth (%) in Zimbabwe, 1980-2000



Graph 9.2. GNI per capita in Zimbabwe, 1985-2000



proportion increased to 36% in 1988, 42% in 1994 and about 50% in 1999.

The population is fairly gender balanced with women comprising 51% of the population in 1982 and 1992. This proportion increased slightly to 52% in 1997. Zimbabwe is still predominantly a rural country, although the proportion of the population living in urban areas has increased significantly during the past 15 years. For instance, in 1982 one in four Zimbabweans (26%) lived in urban areas, compared to one in three (34%) in 1997. This is comparable to the average for sub-Saharan Africa.[cxiii] In absolute numbers, it means that the urban population has more than doubled from an estimated 1.9 million in 1982 to 4 million in 1997. With a projected annual urban growth rate of 2.8% between 2000 and 2015, urbanisation in Zimbabwe is expected to be below the average of 3.5% for Africa as a whole (UN-Habitat, 2003).

Economic performance and structure of the economy

As Graph 9.1 shows, economic growth in Zimbabwe has fluctuated sharply during the past two decades. This growth is greatly influenced by the variations in agricultural output, which has been affected by recurrent droughts and floods. For instance, the 1991/92 drought resulted in a steep decline in the growth rate from 7.1% in 1991 to a negative rate of 8.4% in 1992. Subsequently, the economy showed some improvement reaching a GDP growth rate of 5.8% in 1994, after which it fell again to 0.2% in 1995. Again, this was largely due to the 1995 drought. In 1996, positive growth of about 9.7% was recorded. This increase was attributed to the good agricultural output, which increased by about 19.4%, and also good performance in tourism and the manufacturing sector, which grew by 6.8% and 4.8% respectively (Government of Zimbabwe, 2001). However, from 1997 a declining trend has set in, with the economic growth rate reaching a low of -6.8% in 2000. During this period, national savings have been slashed in half from 18.2% of GDP in 1996 to less than nine percent of GDP in 2000. Between 1995 and 2000, investment has fallen by about 62%. Spiralling inflation has aggravated Zimbabwe's economic crisis. In October 2002, inflation rates were estimated at about 139.9% and by December 2002 year-on-year inflation had reached 198.9%. Six months later, in June 2003, the rate of inflation had reached a record of 364.5%, only to increase even further to 455% in October 2003 (Central Statistical Office, 2003b; The Herald, 2 October 2003).

Poverty and inequality

Zimbabwe is experiencing acute poverty. During the 1990s, at least one in three Zimbabweans (36%) were living on less than US$1 a day and almost two out of three Zimbabweans (64.2%) were living on less than US$2 a day. By the end of 2002, an estimated three out of four (74%) people were expected to live on less than US$2 a day (Central Statistical Office, 2003a). Unemployment has also increased phenomenally over the years, from 18% in 1982 to 60% by 1999. The decline in living standards is further evident in the trends reflecting GNI per capita, which has dropped from US$10,523 in 1985 to US$395 in 2000 (see Graph 9.2).

Although historically government efforts have been geared towards the reversal of inequalities, income inequality in the country is particularly high, although trends cannot be discerned from the data available. In 1990, Zimbabwe's Gini coefficient was 0.57 compared to 0.45 for sub-Saharan Africa. UNCTAD has classified Zimbabwe as a highly unequal society in which the richest 20% of the population receive 60% of national income (quoted in UNDP, 1998). It is very likely that these disparities will increase as the current economic crisis deepens.

Human development

During the first two decades of Zimbabwe's independence, significant improvements have been recorded across a range of development indicators. For instance, the proportion of the population with access to safe water has increased from 80% in 1992 to 83% in 1997. During the same period, the proportion of the population with access to sanitation has increased from 68% to 72%. Unfortunately, comparable data from the decade preceding 1992 is unavailable.

Zimbabwe now boasts one of the highest literacy rates in sub-Saharan Africa. There have been notable improvements over time, from 62% in 1982 to 80% in 1990, eventually reaching 88% in 1999. During this period, literacy rates among men are consistently higher than among women, although the gender gap is slowly closing. In 1982, adult literacy rates for men and women were 70% and 56% respectively. By 1999, the respective rates for men and women were 92% and 84%. Yet, more recently a slight decline has been recorded in primary school enrolment, from 89% in 1992 to 88% in 1997. This decrease applies equally to boys and to girls. Interestingly, a slightly higher proportion of girls attend primary school compared to boys (88% and 87% respectively). In contrast, secondary school enrolment has increased from 67% in 1992 to 71% in 1997. Whereas gender disparities are much starker at secondary school level compared to primary school level, with 65% of girls and 77% of boys reportedly attending secondary school in 1997, the five years preceding 1997 have seen a significant increase in the proportion of girls going to secondary school. In 1992, only 59% of girls attended secondary school, compared to 76% of boys in the relevant age group.

The teacher to pupil ratio increased from one to 35 in 1990 to one to 41 in 1999, after which it reportedly fell again to one to 37 in 2000. Similar trends are noticeable in the health sector, where the number of physicians per 100,000 people declined from 15 in 1980 to 13 in 1995. While there are no up to date figures, it is assumed that this proportion has further declined given the recent exodus of professionals out of Zimbabwe.

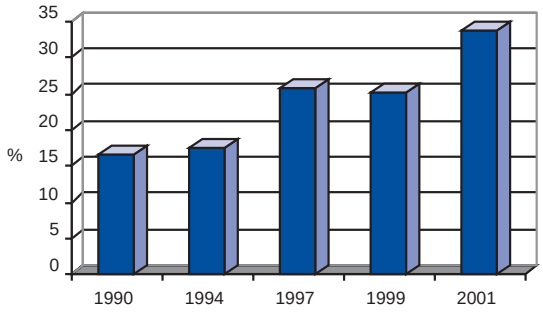
Not surprisingly, mixed trends are noticeable in relation to life expectancy during the past two decades. While a Zimbabwean born in 1982 had an average life expectancy of 58 years, a person born eight years later had an estimated life span of 62 years. The life expectancy of women was generally higher than that of men, reaching 62 years and 58 years respectively in 1990. Yet, in the early 1990s this positive trend is reversing largely as a result of the HIV/AIDS epidemic. According to national sources, life expectancy in Zimbabwe declined to 54 years in 1997, after which it fell even further to 40 years in 2001 (Population Reference Bureau, 2001). This life expectancy is about 29 years lower than what it would have been without HIV/AIDS. Adult mortality is still expected to rise as the increasing number of people already infected with HIV develop HIV/AIDS-related illnesses and die. This situation is exacerbated by the fact that ARV treatment is not readily available in Zimbabwe.

HIV/AIDS

Since the first HIV/AIDS case was identified in 1985 in Zimbabwe, infection rates have increased at an alarming rate. As noted before, national data on HIV prevalence rates are very scanty and are drawn from sub-samples. Yet, a brief assessment of these different estimates gives a good indication of national HIV/AIDS trends.

Within Zimbabwe, data supports a north-to-south spread of HIV infection. For example, in 1985 3% of blood donors in the northern part of the country, in the city of Harare, were HIV-positive, compared to

Graph 9.3. HIV prevalence rates in Zimbabwe, 1990-2001



less than one percent in the south of the country, in the city of Bulawayo. While data from ante-natal attendees at surveillance sites across the country suggested that infection rates ranged from 7.5% to 20.3% in 1990, these rates increased to between 18.7% and 32% in 1994/5. In 1996, the median HIV prevalence rate in Masvingo, Chiredzi and Beitbridge had reached 47%. There was not a single province in Zimbabwe which was spared from the epidemic as of 1995 (Ministry of Health and Child Welfare, 1996).

At national level, data from sentinel surveillance surveys show that within a time span of 15 years HIV prevalence increased from less than one percent in 1983 to 22% in 1996, meaning that over one in five adult Zimbabweans was infected with HIV in that year. This rate increased by about 32% in only one year, increasing to 29% in 1997. At the end of 2001, it was estimated that one in three adults (33.7%) is living with HIV/AIDS – representing an increase of more than 200% compared to 1990 (see Graph 9.3).[cxiv] Just over half of those adults are women (52%). It is estimated that approximately 35% of women attending antenatal clinics have tested positive for HIV in 2001 (Ministry of Health and Child Welfare, 2003a). It is particularly disconcerting that 28% of pregnant young women aged 15-19 years have tested positive. In fact, infection rates among young women in this particular age group were reported to be at least five times higher than those among their male counterparts since 1987 (Ministry of Health and Child Welfare, 2003b; NACP/Ministry of Health, 1998; UNAIDS, UNICEF and WHO, 2002).

Although information on other sexually transmitted infections (STIs) is mainly anecdotal, rates of infection are also known to be high. For instance, HIV infection rates among male STD patients from Murewa, Karoi, Mutoko and Bindura districts ranged from 7% in 1987 to 70% in 1994. Whereas over one million STIs were reported in 1989, this had declined to 826,261 in 1997. While figures prior 1989 are not available, it has been noted that the number of STDs increased from 1985 and peaked around 1989 (Ministry of Health, undated).

Given the high HIV prevalence rate and the continued high rates of infection, mortality has significantly increased across all age groups, thereby eroding the gains that have been made in the area of health and human development since Zimbabwe's independence. For example, infant mortality rates per 1,000 births initially declined from over 100 in 1980 to 66 in 1992. By 1997, this had increased again to 80 per 1,000. Given that at least 30% of children born to HIV-infected mothers get the virus and die within the first five years of life, mortality of the under fives increased from 26 to 36 out of 1,000 between 1992 and 1997 (Central Statistical Office, 1998). The Ministry of Health and Child Welfare (2003b) and UN agencies have estimated that about 60-70% of deaths among children younger than five years old are attributable to HIV/AIDS (see UNAIDS, UNICEF and WHO, 2002).

While the cumulative number of AIDS cases was considered to be 110,000 in 1995, it is estimated that about 2.3 million people in Zimbabwe are currently living with HIV/AIDS. Already, AIDS claims at least 2,500 lives a week (note that other sources estimate the number of AIDS deaths per week to range from 4,000-6,000) and has left more than 780,000 children orphaned (UNAIDS, 2002).

Conclusion

This brief overview of development trends in Zimbabwe has highlighted a number of important

improvements, particularly in the areas of health, education, access to basic services and the realisation of gender equality. Yet, it has also pointed to some critical development challenges that continue to leave their mark on Zimbabwe and its people, not least of which are the high and increasing levels of poverty, unemployment and income inequality and the erratic, if not poor, performance of the economy. Added to this is the devastating HIV/AIDS epidemic, which seems to spread largely unabated. The high levels of polarisation characterising the political terrain make it particularly difficult to address these complex and interlinked challenges with the resolve and collaboration required.

9.3. The core determinants and key consequences of HIV infection in Zimbabwe

This section draws on the interviews that were conducted with 21 key informants from different organisational backgrounds in Zimbabwe (see Appendix 3 for a list of persons and organisations interviewed). It reflects the feedback given by the respondents in relation to the core determinants that enhance vulnerability to HIV infection and the key consequences of HIV/AIDS in Zimbabwe as identified in Chapter 4. In light of the political situation in the country and to protect the identity of respondents, quotes are usually not attributed to specific individuals.

Core determinants

The respondents identified underlying factors to the spread of HIV in Zimbabwe at two levels: individual risk behaviour and contextual factors. Some respondents emphasised the loss of traditional values, the "collapse of the moral fibre" and the "moral decadence" characterising today's sexual behaviour, particularly of the youth of Zimbabwe. A politician argued:

> There has been an erosion of sexual values from a traditional perspective due to the infiltration of Western cultures into our cultural framework. It looks like the media has changed young people's orientation and thinking. In our days at 15 we would swim with girls and nothing happened. Now things have changed drastically. The problem is that most parents are too busy that they can't afford to spend time with their children …

Others, however, pointed to traditional practices, such as wife inheritance and polygamy, and to traditional cultural values condoning sexual promiscuity by men as contributing factors to the spread of HIV in Zimbabwe.

The most important environmental factors underlying the exposure to HIV infection that many respondents highlighted were the perennial poverty and lack of food, unemployment, gender inequality, migration, lack of access to basic services and denial. Often, these factors were understood to be interrelated. For example, a number of respondents suggested that poverty compels people to migrate to urban areas, leaving behind their spouses and families, which ultimately contributes to the breakdown of families.

Poverty and lack of food security were frequently mentioned in one breath. Respondents maintained that poverty exposed women especially to HIV infection and that women's vulnerability to HIV infection is further enhanced by the fact that sexual negotiation is stifled by unequal gender relationships. A representative from a civil society organisation articulated the link between poverty and gender inequality as follows:

> Chief among them [the factors facilitating the spread of HIV in Zimbabwe] is poverty and gender imbalance, two factors which invariably lead to sexual abuse. This has often resulted in young girls and women marketing sex for income. Further, due to poverty, these same people cannot access treatment and eventually die from otherwise preventable diseases. School children who travel to and from school on a daily basis have been put at greater risk. The temptation to get into relationships with commuter omnibus drivers and conductors in exchange for free rides becomes very great. In addition to that, some of them take recourse to sugar-daddies. Food scarcity and, where the food is available, imbalanced diets exacerbate the problem.

Reference was also made to the lack of access to basic services, particularly the collapse of the health system, and to the high cost of drugs as factors underlying the spread of HIV/AIDS.

Respondents further noted that the families were being split due to migration necessitated by the need to get jobs. In turn, most migrants fail to get decent accommodation and end up living in crowded accommodation that compromises privacy. The land resettlement programme was particularly mentioned by most respondents as enhancing the

spread of HIV/AIDS. It was argued that land resettlement areas are poorly serviced and have limited opportunities for income generation. As such, a context is created in which commercial sex is likely to flourish whilst the provision of information and the treatment of STDs are greatly compromised. A politician made the following observation:

> Land reform is a top issue here. What do you think happens when young men and women are quarantined in the bushes without condoms? I would like to say land reform has been characteristically lawless, unplanned and haphazard. Again in the resettlement areas there are no health infrastructures and facilities. There are no toilets or clinics and how would one expect people to survive under those conditions?

A few respondents regarded the lack of services and infrastructure in the land resettlement areas as a temporary setback. As a government official argued: "Resettlement without social services, in the short run, undermines prevention and mitigation efforts." Others, however, were less inclined to consider these drawbacks of a temporary nature.

A large number of respondents emphasised denial of the existence and the severity of HIV/AIDS as a contributing factor to the spread of the epidemic. The Government of Zimbabwe was seen to have been slow in recognising the seriousness of the situation and in articulating its response in the initial stages of the epidemic. Some respondents remained critical of what they perceived as a lack of commitment and political will to address HIV/AIDS:

> For too long government denied HIV/AIDS as a reality and when they finally admitted, it was very late. The admission again is still incomplete even now because there is a tendency to distance ourselves from the disease. Government officials prefer to cite cases of HIV/AIDS in other countries instead of making references to their own constituencies. Citations usually go something like: "in Uganda, so many people have died of AIDS". It's a pity these guys know the statistics of other countries more than their own.

Denial was mentioned not only by representatives from civil society, but also by government officials and politicians, including government Ministers, as shown in the following two quotes:

> One of the important factors is state denial which continues even up to this date despite all the deaths recorded so far. Efforts have been made by prominent government officials to conceal their HIV status and this has only worked to reinforce the stigma. Cause of death for top officials is not made public. During their long battle with the disease, there is no talk about their health. When they finally die, media reports only mention that they died after "a short illness". What the public is given for consumption is the end of the story without an elaboration of how the death came about.

> Chief among the factors has been denial in government and in the general public. In fact, government left everything to the individual initially, only to come in very late in the fight. It took us rather long to come to the full realisation that we are up against a terrible monster.

A few respondents expressed their concern about the lack of disclosure and the fact that HIV status cannot be divulged even to sexual partners. While lack of disclosure is in part necessitated by insurance companies which discriminate against those infected with HIV, the result is the continued stigmatisation of HIV/AIDS which in turn undermines prevention efforts. It further shows the extent to which HIV/AIDS-related discrimination has become institutionalised.

Certain core determinants, like income inequality, weak social cohesion, unequal political power and lack of political voice, and social instability and conflict, were not readily identified by respondents. This omission does not necessarily mean that these factors are irrelevant to the situation in Zimbabwe. Instead, it may reflect that there are very obvious overriding and pervasive concerns that affect people on a daily basis and preoccupy their minds. Some of these determinants, however, did emerge more implicitly in the interviews. For instance, politicisation of development programmes was cited as a key impediment to successful programme implementation. Politicisation here means that people's access to programmes and services is determined by their political affiliation. The omission may also partly reflect limited freedom of speech on political matters and/or complacency.

Key consequences

Respondents acknowledged a range of devastating effects of HIV/AIDS. Most commonly mentioned

were increased mortality and the consequent reduction in life expectancy, a rise in the number of orphans and child-headed households, increasing levels of poverty and a loss of productivity due to high levels of morbidity and mortality among the labour force. Some respondents added that the loss of productivity has implications for the national economy and undermines economic growth.

Regular reference was made to the fact that HIV/AIDS results in more poverty both at national and at household level, where domestic resources continuously get diverted to health services and funerals. It was further noted that HIV/AIDS-induced poverty exposes the most vulnerable groups, women and children, yet again to the risk of HIV infection, thereby entrenching a vicious cycle. The reduction in agricultural productivity was seen to aggravate household poverty and lack of food security as it increases the prevalence of malnutrition. Malnutrition, in turn, has a synergistic relationship with HIV/AIDS, indeed with disease in general. It was highlighted that lack of food security serves to undermine treatment and care of people living with HIV/AIDS, largely because people find it difficult to take tablets without food.

In addition, it was noted that HIV/AIDS has contributed to the general collapse of public services, more particularly of the health sector. The Minister of Health noted that at least 70% of hospital beds are occupied by patients with HIV/AIDS-related illnesses. Another respondent made reference to the implications of losing trained personnel in the education sector due to HIV/AIDS:

> … at Doma (pseudonym) Teachers College we lose about 10 lecturers per year and about 120 students per cohort. The reversal of developmental gains erodes investments made in education. It's something like we are investing in the grave! About 3.5% to 5% of our teachers are dying and these are the most productive people who are dying.

In general, respondents were clearly aware that the HIV/AIDS epidemic is eroding the country's most valuable resources: its people, who fulfil crucial roles as parents, breadwinners, workers, farmers, professionals and so on.

A few respondents made mention of the added burden on women to care for an increasing number of dependents. More specifically, the shift to Home Based Care was criticised by some as aggravating gender inequality, particularly where it involves, in the words of one of the respondents, "turning women into nurses without resources".

Stigma and discrimination were also highlighted as critical consequences of HIV/AIDS. A person living with HIV/AIDS noted that this has detrimental implications for efforts to curb the spread of HIV:

> Our society believes that AIDS is a culmination of one's history in sexual perversion. Subsequently, sufferers resort to a dangerous complex of denial which in turn leads to further infection and physical degeneration.

Some respondents mentioned that HIV/AIDS erodes social support systems as members of the extended family succumb to HIV/AIDS. In addition, it was noted that most people still suspect witchcraft whenever someone dies and that often relatives or neighbours blame each other for such witchcraft, which fuels distrust and weakens social cohesion.

The fact that HIV/AIDS has the potential to widen income inequalities, aggravate the risk of social instability, conflict and violence, or undermine the local revenue base did not emerge during the course of the interviews. Given that the first two factors were also not mentioned as potential drivers of the epidemic, this omission is probably not surprising. Again, this is not to suggest that these key consequences of HIV/AIDS do not hold relevance for Zimbabwe.

9.4. Development planning and HIV/AIDS in Zimbabwe

This section aims to review to what extent current development plans in Zimbabwe, consciously or unwittingly, enhance or diminish an environment of vulnerability to HIV infection and address the key consequences of the HIV/AIDS epidemic. First, some observations are made regarding the nature of development planning in Zimbabwe since independence in 1980. In light of the current economic and political crisis, it is evident that Zimbabwe currently does not operate on the basis of medium-term development plans. Rather, short-term economic stabilisation plans have become the hallmark of development planning in Zimbabwe. After reviewing the link between HIV/AIDS and the short-term plans that have been adopted to get Zimbabwe out of the current crisis, this section concludes with some observations on stakeholder participation and on the alignment and implementation of these plans.

Development planning in Zimbabwe in historical context

After independence in 1980, development planning in Zimbabwe can be characterised as a determined state effort to redress the colonial legacy of inequality. The country was characterised by imbalances in many aspects of development between the white minority and the black majority: in education, health and economic opportunities. The Government set out to redress these imbalances with the Growth with Equity Policy of 1981, followed by the Zimbabwe Transitional National Development Plan (1982-1985) and Zimbabwe's first five-year National Development Plan (1986-1990). The overarching development plan entailed national objectives and targets, which had to be operationalised and implemented through sector plans. Line ministries received a budgetary allocation from the Ministry of Finance for this purpose. This became the chief mode of planning for the 1980-2000 period.

The first development planning frameworks were based on a socialist ideology and the broader development strategy was of an allocative nature, favouring a redirection of resources towards the social services sector during the first decade of independence. Priority was given to health and education, which were considered, first, as a basic human right and, secondly, as an investment that stimulates national development. Subsidisation and price controls were the main tools to achieve equity.

As the overview of development trends has highlighted, health and education levels significantly improved after 1980. However, national resources could not cope with the vastly expanding social services sector, largely because of low investments and low and unpredictable economic growth (Government of Zimbabwe, 1991). The development plans aimed at redressing imbalances in the economy subsequently precipitated economic decline, high unemployment rates and increasing poverty. In an effort to curb these developments, the Government adopted an externally prescribed stabilisation programme. The main objective of the Economic Structural Adjustment Programme (ESAP)[cxv] was to redirect resources away from the social sectors to the productive sector. The cost of social services was transferred back into the hands of individuals. Clearly, the adoption of the ESAP signalled a fundamental change in state ideology as reflected in the shift from a regulated economy to a market economy. Development plans became externally financed, which gave the financiers significant power to demand certain achievements and conditions. Most of these goals were not met as the economic situation continued to worsen. Initially, the social sector was not included in the ESAP. It was appended when it became apparent that people were suffering from even harder economic times. The ESAP was only partially implemented. While efforts were made to liberalise the economy, less was done to reduce government spending which contributed to increasing inflation. Poverty and food shortages continued to increase, in part due to recurrent droughts and floods. Coupled with the rampant spread of HIV and the emergent consequences of the epidemic, these trends formed the ingredients of a serious humanitarian crisis.

In April 1996, the Government replaced the ESAP with a 'home-grown' reform package, the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST) (Government of Zimbabwe, 1998). Like its predecessors, ZIMPREST was a five-year development plan expected to run from 1996-2000. Unlike ESAP, ZIMPREST balanced its attention between the productive and social sectors. However, the launch of ZIMPREST was not until 1998. This was largely because external financiers did not support it and there were no resources to fund the plan. The escalating economic crisis compelled the Government to let go of medium-term national development plans and adopt short-term recovery programmes concentrating largely on stabilising the economy and stimulating economic growth. Thus, in 2001 the Government launched the Millennium Economic Recovery Programme (MERP) as an 18-month economic recovery programme (Government of Zimbabwe, 2001). Again, due to lack of resources which was exacerbated by the withdrawal of the international donor community, the MERP was rendered ineffective and in February 2003 the Government launched yet another home-grown 12-month stabilisation programme, the National Economic Revival Programme (NERP): Measures to Address the Current Challenges (Government of Zimbabwe, 2003). The NERP has been informed by the Tripartite Negotiation Forum (TNF), which has broadened economic policy decision making to include the Government, the private sector and labour. As such, it has been met with more optimism by donors, the private sector and other stakeholders than its precursors.

It follows that Zimbabwe does not currently have a strategic development plan per se, but a short-term economic stabilisation plan. By the same token,

long-term sector plans have been suspended and have been replaced by short-term plans in accordance with the NERP. The following development plans form the basis of the discussion here of the possible links between development planning and HIV/AIDS in Zimbabwe:

- The National Economic Revival Programme (NERP);
- The National HIV/AIDS Strategic Framework;
- The 2003 Revival Action Plan: Ministry of Health and Child Welfare;
- The Plan of Action for the Ministry of Education, Sports and Culture as a Production Unit of the Confidence Building, Culture and Entertainment Sectoral Committee of the NERP.

It is obvious that these short-term plans, with the exception of the National HIV/AIDS Strategic Framework, are devoid of the long-term development goals characteristic of customary development planning frameworks. As such, it seems reasonable to expect that the extent to which these plans consciously and effectively address the identified core determinants and key consequences of HIV infection – which are generally associated with complex, systemic development challenges – would be rather minimal. On the other hand, however, the relatively short lifespan of these plans might also create an opportunity for HIV/AIDS to be integrated more explicitly and more effectively compared to long-term indicative planning frameworks. The following assessment will seek to determine which of these two propositions holds true for development planning in Zimbabwe.

The National Economic Revival Programme (NERP)

As noted earlier, the NERP is currently the overarching development plan from which sector plans are drawn. It was launched in February 2003 and has the following overall aims:

- To restore conditions necessary for full agricultural production;
- To reverse de-industrialisation;
- To increase capacity utilisation in the manufacturing sector; and,
- To resuscitate closed mines and companies (Government of Zimbabwe, 2003: i).

In accordance with these overall aims, the plan reflects the following objectives:

- To give full support to the primary sectors which include agriculture and mining;
- To boost the secondary sector of manufacturing;
- To give support to the small and medium enterprises (SMEs);
- To support the service sector, which includes finance and insurance, construction, transport and communication, education and health;
- To support the tourism industry while assuring guaranteed and sustainable supply of energy; and,
- To harness and efficiently utilise the country's human resources.

As noted earlier, in accordance with the aims and objectives outlined in the NERP the Ministry of Finance and Development sets budgetary limits for the implementation of the planned programmes by line ministries, currently described as production units. Therefore, this assessment will concentrate not only on the strategies set out in the NERP, but also on the extent to which the respective strategies are funded. This theme will be further elaborated on in the final subsection, which looks at issues related to the implementation of development planning frameworks. Where appropriate, reference will be made to the feedback from the key informants during the interviews.

Core determinants of HIV infection

In the area of prevention, the NERP places emphasis on individual behaviour change, especially of the working population. Interventions specifically aimed at changing individual behaviour include IEC, the provision of VCT services and condom promotion. HIV prevention is also to be achieved through the reduction of parent-to-child transmission, treatment of STIs, prevention of occupational exposure and post-exposure prophylaxis, and screening and provision of safe blood – all of which are related to the core determinant of access to basic services. Budgetary provision is made for STI treatment, while VCT services are provided jointly by the public and non-public sector, especially NGOs. Although VCT services are highly subsidised, in many parts of the country people do not have easy access to these services.

The NERP also deals with environmental factors which enhance vulnerability to HIV infection and contribute to the spread of HIV. However, it is obvious that the main emphasis in the NERP is on boosting Zimbabwe's key economic sectors, increasing production and reducing inflation. Cognisant of the negative and pervasive impact of poverty on individual wellbeing, particularly of women, youth and the disabled, the NERP makes

provision for a Social Protection Fund with an estimated Z$15.8 billion for 2003. In addition, there is a Health Assistance Fund to assist vulnerable groups. Attention to poverty reduction is also given through support for SMEs and income-generating projects and resources are set aside for this purpose. The Government has set up an Empowerment Fund targeted at income generating activities, which can be accessed through the relevant ministries (e.g. Youth Development, Gender and Employment Creation and Small and Medium Enterprises Development). Yet, given the levels of poverty and unemployment in the country, the need for such projects outstrips supply by far.

Land redistribution is specifically intended to reduce income inequalities once the resettled households begin to be productive. To ensure sustainable agricultural production and equitable income, however, these households require sufficient capital inputs. Again, funds are not adequate for this component.

While the long-term goal of land resettlement is to equalise the distribution of national income, in the short-term at least the migration of people into new areas is associated with reduced and less equitable access to public services and infrastructure. This point was also conveyed by a significant number of respondents, although they held different views on whether this was a temporary problem that could be overcome in the short-term or whether this concerned a more systemic drawback. Most new settlements do not have adequate services or public infrastructure such as schools, health facilities, good sanitation and safe water. It has been noted that farming areas tend to be conducive environments for the spread of HIV/AIDS for the following reasons: the farming population is young, tends to be sexually active and has cash to spare amidst boring environments; these areas foster a high gender mix with minimal kinship ties to monitor sexual behaviour; the high prevalence of STIs is accentuated by limited resources and access to treatment; the farm managers, extension workers and skilled artisans provide negative role models since they are promiscuous; unemployment, limited income and the resultant poverty force women to engage in commercial sex work; and, interventions against HIV/AIDS tend to be fragmented (Kwaramba, 2003). Thus, unless these core determinants of vulnerability to HIV infection are effectively addressed as part of the land reform programme, the expansion of the farming community in its current form might actually fuel the HIV/AIDS epidemic. On the other hand, through its explicit focus on access to land for women, the land reform programme can make a contribution to the reduction of gender inequality and enhancing the status of Zimbabwean women.

What is of concern, however, is the politicisation of access to resources, services and land that characterises present-day Zimbabwe. The fact that such access is determined on the basis of political affiliation defeats the aspiration of equitable development for all Zimbabweans, undermines social cohesion and serves to fuel conflict and social instability – all of which have been identified as core determinants of enhanced vulnerability to HIV infection.

With respect to political voice and empowerment, mention has already been made of the fact that unlike its predecessors, the NERP was the outcome of a wider consultation on economic matters involving the private sector and labour. Yet, there has virtually been no involvement of civil society, which is suffering the brunt of a deteriorating economy. In the interviews, some respondents pointed out that there is no functional political system to consult with people or hear their voices. It was also intimated that in the current political climate the expression of political voice is being undermined and that certain political voices are being suppressed:

> There have been a lot of impediments. Right now MPs cannot meet with their communities because of laws such as the Public Order and Security Act. In one shot, lack of democracy impedes involvement. The fight against HIV/AIDS can only be successful in a democratic context.

Key consequences of HIV/AIDS

Few key consequences of HIV/AIDS are highlighted in the NERP and where mitigation strategies are developed, these are only partially implemented due to limited resources.

To reduce AIDS-related morbidity and mortality, the NERP has set aside funds to purchase medicines for the treatment of opportunistic infections, including anti-retroviral drugs. Several billions of Zimbabwean dollars have been allocated to purchase ARVs, which would be introduced in phases. However, as the Minister noted, the Ministry of Health has not yet been able to buy the drugs due to lack of foreign currency. An official from the

National AIDS Council indicated that these drugs are imported at parallel market rates of US$ 1 to Z$ 5,300 or more, which makes it unaffordable for the Government. Thus, regardless of the budgetary allocation, in reality people living with HIV/AIDS still have little to no access to appropriate treatment due to the unavailability of these drugs in the public health sector and the exorbitant costs of treatment.

In recognition of the fact that HIV/AIDS enhances poverty, the NERP makes provision for an AIDS levy. The AIDS levy is a 3% income tax which is collected on a monthly basis for the support of HIV/AIDS activities. The AIDS fund is administered through local communities. Again, though, the resources are insufficient to address existing (and increasing) need. Also, there is a general complaint that the AIDS levy is not administered well. While the AIDS levy together with the abovementioned Social Protection Fund and Health Assistance Fund are commendable efforts to mitigate the impact of HIV/AIDS on poor households, there is minimal publicity. As a result, there is limited knowledge of the existence of such funds to the extent that most vulnerable groups remain unassisted.

The NERP also recognises the need to shield orphans and other disadvantaged children from the effects of poverty induced by HIV/AIDS and other economic hardships. The AIDS levy is one way in which such support is provided. Through the NERP, the Government of Zimbabwe partly finances a fund called Basic Education Assistance Module (BEAM), together with the National AIDS Council and the private sector. BEAM is a community-managed support programme which makes it more responsive to the needs of the most disadvantaged children. BEAM also ensures the supply of basic teaching/learning resources to schools. The Minister of Education, Sports and Culture noted that support for the BEAM fund had doubled from Z$300 million to over Z$600 million in 2003. Approximately 418,000 children had benefited from BEAM by July of 2001. This figure is estimated to have doubled in 2002, thus representing about 20% of the entire primary and secondary school population (Mupawaenda and Murimba, 2003).

The NERP only addresses the abovementioned three key consequences of HIV/AIDS: adult mortality, HIV/AIDS-induced poverty and orphans. The other twelve key consequences outlined in Chapter 4 are not explicitly addressed. Yet, this does not mean that these factors have no relevance for the NERP or, vice versa, that the NERP is irrelevant to these potential consequences of HIV/AIDS. For instance, the public sector is negatively affected by HIV/AIDS-related morbidity and mortality. At the same time, deteriorating salaries propel professional and skilled workers to seek their fortunes elsewhere, in other sectors and even in other countries. Also, given the precarious economic situation there is a real risk that job security of workers infected with HIV/AIDS is threatened, particularly where the deteriorating economy compels companies to retrench workers. Furthermore, stigma and discrimination flourish in the absence of programmes specifically designed to address these issues, whilst persistent denial enhances the two.

Also, as some respondents noted, user fees are inhibiting access to essential public services and particularly to life-enhancing and life-prolonging treatment for PLWHA. Concern was also expressed for the nature of HBC programmes, which essentially mean that the burden of care is placed on women without adequate support or resources to fulfil this task. In the absence of such support, it is not only the HIV/AIDS epidemic that aggravates gender inequality; it is further exacerbated by the 'unfunded mandate' imparted on women by the state.

To conclude, this assessment has sought to demonstrate that there is a certain amount of correlation between the objectives of the NERP and the core determinants of HIV infection.

However, it has also indicated that this correlation is at times ambiguous. Given the emphasis on economic stabilisation and increased productivity in the NERP, it is perhaps not surprising that this is the case. Also, the fact that the NERP is a short-term plan may explain why less attention is given to certain (more systemic) core determinants of HIV infection and to consequences of HIV/AIDS that are yet to make themselves felt. The assessment of possible links between HIV/AIDS and the NERP is summarised in Table 9.1. Because the annual sector plans are directly derived from the NERP, some aspects of subsequent assessments may already have been mentioned here. In that case, an attempt will be made to avoid repetition.

The National HIV/AIDS Strategic Framework

The National HIV/AIDS Strategic Framework is currently the only medium-term development planning framework that has not been suspended or replaced by short-term plans. It does not have

Table 9.1. Possible links between HIV/AIDS and the NERP			
	Objective	**Explicit**	**Possible impacts or links**
1.1	Change in individual (sexual) behaviour	Yes	Recognises the need for IEC, VCT, condom promotion & prevention/treatment of STIs and allocates resources to such programmes, although possibly not sufficient.
1.2	Poverty reduction (ensuring a minimum standard of living and food security)	Yes	Support for Social Protection Fund and Health Assistance Fund. Yet, need is much greater than these funds can satisfy; also lack of awareness about these funds. Support for SMEs + income-generating projects, with resources set aside for this purpose. Again, scale of these initiatives is small compared to need. Food security is further enhanced by involvement of private sector and duty free importation of basic food commodities.
1.3	Access to decent employment or alternative forms of income	Yes	Employment is enhanced through support for SMEs and income generating activities. Yet, not necessarily sustainable employment creation and also not widespread enough to deal with the high level of unemployment in the country.
1.4	Reduction of income inequalities	Yes	Through the land reform programme. Yet, can only be realised if newly settled households become productive, for which they require capital and other forms of support that is currently not made available.
1.5	Reduction of gender inequalities and enhancing status of women	Yes	Through the land reform programme, which is considered gender sensitive. Also recognition that women, like youth and disabled persons, are particularly marginalised by the current economic crisis, yet no explicit focus on women in terms of support for income generation or employment creation.
1.6	Equitable access to quality basic services	No	Not explicitly stated in the document which is geared towards the productive sector. Yet, access to services and land on the basis of political affiliation undermines this objective. Insufficient resources to ensure equitable access to services such as VCT across the country. User fees further limit access.
1.7	Support for social mobilisation and social cohesion	No	Political instability and politicisation of distribution of resources has increased tension between groups, thereby undermining social cohesion.
1.8	Support for political voice and equal political power	No	The NERP based on consultation between government, private sector and labour. Yet, no involvement of civil society and no system to facilitate such involvement. Political tension still limits political voice.
1.9	Minimisation of social instability and conflict/violence	No	Political instability has tended to increase social instability characterised by erratic conflicts. Where access to services and land is politicised, tension and the potential for conflict between groups have increased.
1.10	Appropriate support during migration and displacement	No	Limited access to basic services and infrastructure, like health, education, sanitation and clean water in resettlement areas.
2.1	Reduction of AIDS-related mortality	Yes	Allocation for the provision of drugs to treat opportunistic infections, including ARVs. Yet, lack of foreign currency means drugs cannot be purchased. Food insecurity + increasing poverty expedite progression to AIDS and eventual death.
2.2	Patient adherence	No	Lack of food security undermines adherence.
2.3	HIV/AIDS-induced poverty reduction	Yes	Introduction of the AIDS levy, yet concerns about administration of the levy and whether it is sufficient to meet the needs.
2.4	Reduction of income inequalities (aggravated by HIV/AIDS)	No	Income of affected households deteriorates as breadwinners succumb to HIV/AIDS and household resources including livestock and agricultural implements get sold to support the sick and to pay for funerals.
2.5	Reduction of gender inequalities & enhancing the status of women (threatened by HIV/AIDS)	No	Unlikely as women carry the burden of care for sick relatives and orphans. Girls drop out of school to care for sick parents or siblings. HBC programmes not adequate in providing the necessary resources and support to women, thereby shifting the burden of care onto the shoulders of women.
2.6	Appropriate support for AIDS orphans	Yes	Programmes and measures to support orphans are in place (e.g. BEAM and AIDS levy), but resources are limited.
2.7	Equitable access to essential public services (eroded by HIV/AIDS)	No	In a context where access to services is generally difficult due to inflation, poverty and unavailability of drugs, vulnerable households and PLWHA may be even more disadvantaged.
2.8	Effective/enhanced public sector capacity (eroded by HIV/AIDS)	No	Public sector is losing staff due to HIV/AIDS and brain drain. Due to financial instability, the public sector cannot retain qualified staff who leave because of deteriorating salaries.
2.9	Job security & job flexibility for infected/affected employees	No	Economic crisis fuels retrenchments. In the absence of anti-discrimination legislation, workers with HIV/AIDS may be particularly vulnerable.
2.10	Ensuring sufficient & qualified labour supply (eroded by HIV/AIDS)	No	The NERP does not focus on the creation or protection of sustainable employment, which probably explains why it does not focus on how HIV/AIDS erodes labour supply and the national skills base.
2.11	Financial stability & local revenue generation (threatened by HIV/AIDS)	No	The stabilisation of the economy and of spiralling inflation is central to the NERP, yet no attention to how HIV/AIDS erodes public sector resources and local revenue.
2.12	Support for social support systems & social cohesion (eroded by HIV/AIDS)	No	Possibly through support for the principle of home based care, yet in the absence of well-funded and supported HBC programmes social systems are likely to be further eroded.
2.13	Support for political voice & equal political power (PLWHA, etc)	No	Economic decision-making at best seen as a process involving government, private sector and labour. Civil society in general and PLWHA or affected households in particular are not consulted or involved in this process.
2.14	Reduction of AIDS-related stigma & discrimination	No	In the absence of programmes aimed at reducing stigma and discrimination, these will perpetuate and political denial will reinforce stigma.
2.15	Reduction of HIV/AIDS-related social instability & conflict	No	Present-day Zimbabwe is a highly conflictual society and the denial and stigma associated with HIV/AIDS may serve to aggravate this situation.

stated goals with specific targets, but rather has general objectives which are:

- To reduce the transmission of HIV and other sexually transmitted infections (STIs);
- To reduce personal and social impact of HIV/AIDS/STIs; and,
- To reduce the socio-economic consequences of the epidemic (NAC, 1999).

Core determinants of HIV infection

In relation to the first objective outlined above, the framework identifies three modes of HIV transmission that need to be targeted for prevention, namely sexual transmission, mother-to-child transmission and transmission through blood. Behaviour change is a central strategy in reducing sexual transmission of HIV. The framework emphasises abstinence, reduction of sexual partners, faithful monogamy and condom use, in addition to treatment of STIs.

The framework also concentrates on the economic and socio-cultural determinants of infection. Among the economic determinants, the framework highlights the unstable macro-economic environment, rising poverty, the weak informal sector and the lack of economic growth in the communal and resettlement areas. Reference is also made to declining public sector funding for education, health and social services, which translates into lack of access to quality public services. Moreover, gender inequalities in the provision of, and access to, public services like education, health and housing, are recognised as contributing to the enhanced vulnerability of women to HIV infection. The framework further specifically mentions increasing urbanisation which, in the absence of appropriate public services, leads to a decline "in living, health and moral standards". To address these determinants of vulnerability to HIV infection, the framework calls for mainstreaming of HIV/AIDS in economic planning and development programmes and in sectoral planning, which is where budgetary provision for HIV/AIDS prevention and care activities should be made.

Among the cultural determinants of the spread of HIV identified in the framework are "the dissolution of the extended family systems with the attendant loss of socializing and support groups" and "cultural and religious traditions and sensitivities which disempower certain population groups and perpetrate their vulnerabilities by modulating access to information, interpersonal skills, services, etc." The National HIV/AIDS Strategic Framework suggests that these retrogressive cultural values can be remedied by involving traditional and local leadership structures in HIV/AIDS programmes.

The framework further refers to the importance of involving the community into HIV/AIDS prevention and support efforts to foster community ownership of HIV/AIDS programmes. As such, it recognises the importance of community mobilisation for reducing the spread of HIV, although it is clear that the framework is specifically concerned with social mobilisation to prevent the spread of the epidemic, rather than community mobilisation as a broader development imperative.

The framework is silent on a number of core determinants of vulnerability to HIV infection. Apart from the reference to the weak informal sector, no attention is given to the need for decent employment or other sustainable ways of income generation for the people of Zimbabwe. Nor is income inequality mentioned as a key driver of the epidemic. The framework also does not address the link between HIV spread and social instability, conflict, migration and displacement and it remains silent on the issue of political voice and empowerment of marginalised groups.

Key consequences of HIV/AIDS

The second and third objectives of the National HIV/AIDS Strategic Framework are concerned with addressing the consequences of HIV/AIDS at personal, community and society level. Paramount is the need to provide sustained care and support for PLWHA and those affected by the epidemic. Within this context, the framework recognises the significance of an accessible, responsive and well resourced health delivery system, including the need to ensure that acceptable standards of health care are being adhered to. It also emphasises the need to strengthen the primary health care system and the importance of community participation in care and support activities. As such, it advocates for the need to develop a continuum of care from health care facilities down to the level of households.

Specific reference is made to the need to reduce HIV/AIDS-related stigma and to promote policies and legislation that safeguard the rights of those infected with, and affected by, HIV. Attention is also given to the need for clear orphan care and support strategies. In addition, the framework emphasises the importance of ensuring gender sensitivity in HIV/AIDS-related policies, plans and programmes. Finally, the framework is concerned with

strengthening a local grassroots response to the epidemic, which would be achieved by, among others, developing sector specific strategies.

It is worth mentioning that the National HIV/AIDS Strategic Framework is indicative of the overall policy direction on HIV/AIDS, rather than reflecting the detail of implementation. In other words, a number of key consequences of the HIV/AIDS epidemic are articulated as objectives that need to be addressed, without specifying how this can be done or which stakeholder should be involved. Where strategies are proposed, these are more of a supportive nature and relate specifically to the National AIDS Council (NAC). The proposed activities for the NAC include the provision of information on best practices, lobbying, encouraging relevant organisations to support mitigation efforts and overall coordination. The framework also includes a section on resource mobilisation for the implementation of HIV/AIDS programmes and refers to the need to involve the private sector and to ensure sector budgeting for HIV/AIDS.

Other key consequences of HIV/AIDS as identified in Chapter 4 are not explicitly mentioned or addressed. Thus, there is no focus on how HIV/AIDS is likely to enhance poverty and inequality, aggravate the burden of care on women and further entrench gender inequality (apart from the reference in passing to ensure gender sensitivity in relevant policies and plans). The framework also does not engage with the impacts of the epidemic on the public sector, its capacity to provide quality services or its financial resource base. The issue of job security and the impact of HIV/AIDS on labour in general are also not given attention and the framework is conspicuously silent on the need to support political voice of those directly affected by HIV/AIDS and the impacts of HIV/AIDS on social cohesion and social stability. Many of these omissions have also been observed in the preceding assessment of the NERP.

The 2003 Revival Action Plan, Ministry of Health and Child Welfare

The Ministry of Health adopted a ten-year Strategic Plan (1997-2007), which had as its overall objective to create conditions to improve the quality of health of Zimbabweans into the new millennium (Ministry of Health and Child Welfare, 1999). The Strategic Plan covered long term goals and a range of broader issues related to the health sector and the provision of health services. However, it is now dormant as it has been replaced by the 2003 Revival Action Plan of the Ministry of Health and Child Welfare (Ministry of Health and Child Welfare, 2003c), which was developed to fit in with the immediate goals and objectives of the NERP. This assessment focuses on the one year Revival Action Plan. The overall objectives of this plan are twofold, namely to spend the limited available resources on those diseases and conditions which cause the highest morbidity and mortality, and to create an enabling environment to address the health problems in Zimbabwe.

Although HIV/AIDS is nowadays considered a development problem, the Ministry of Health and Child Welfare continues to play a pivotal role in HIV/AIDS interventions. It has the largest budget allocation to deal with the different aspects of HIV/AIDS compared to any other line ministry. In both the 10-year Strategic Plan and its current substitute, the 2003 Revival Action Plan, HIV/AIDS is given top priority.

Core determinants of HIV infection

As far as addressing the core determinants of HIV infection is concerned, the Revival Action Plan deals only with two issues: changing individual sexual behaviour and food security. No attention is given to the remaining eight economic, social or political determinants of HIV infection.

Preventive measures to change sexual behaviour include the generic measures of abstinence, condom use, reduction of sexual partners, faithful monogamy and the treatment of STIs. These are also reflected in the National HIV/AIDS Strategic Framework. The Ministry has expanded the target population for prevention activities to include health workers, more specifically to prevent work-related exposure to HIV infection. To this end, the Ministry will train health workers on infection control while ensuring availability of protective clothing and safe disposal equipment. Awareness campaigns form an integral part of the proposed interventions.

While there is no programme directly targeted towards poverty reduction, the Revival Action Plan attempts to ensure food security through its nutrition programme. This programme includes a focus on vulnerable children, mainly of pre-school going age. However, although over Z$2 billion has been budgeted for this programme, implementation has been constrained due to the fact that no local company has been able to make the blend needed for the food supplement. Foreign currency is required to import the blend, yet this commodity is

currently in extremely short supply. During the interviews, the Minister of Health and Child Welfare noted that the Ministry would like to extend supplementary feeding to cover primary school children and the elderly, but that resources to support such an expansion were not available.

Key consequences of HIV/AIDS

The Revival Action Plan also reflects quite a restricted focus on the potential impacts of HIV/AIDS. The only explicit intervention related to the key consequences of HIV/AIDS is concerned with the reduction of HIV/AIDS-related mortality. For this purpose, provision is made for the acquisition of drugs to treat opportunistic infections and ARVs, which would be phased in in the public health system. The Plan also makes provision for post-exposure prophylaxis for health workers. Again, the main obstacle to the implementation of these measures is the lack of foreign currency.

Other key consequences of HIV/AIDS are not addressed in the Revival Action Plan. It is obvious, though, that the epidemic puts serious strain on the health system. As mentioned earlier, the Minister estimates that about 70% of hospital beds are occupied by patients with AIDS-related diseases. Yet, the Plan does not engage with what this means for health service provision in general, nor does it reflect on the loss of health care workers due to HIV/AIDS. In addition, the health sector is losing qualified staff due to emigration. Undoubtedly, the level of vacancies and the high staff turnover are negatively affecting the efficiency and quality of health services.

In order to increase access to health services, there has been a shift to support a community home based care programme. However, this programme relies heavily on community volunteers whose sustained involvement is quite tenuous in a poverty stricken economy, unless such volunteers are given some form of remuneration. For instance, it was noted during the interviews that those involved in care do not have access to very basic necessities, such as protective clothing, soap and food. Yet, no budgetary provision has been made for some form of monetary remuneration, nor are other forms of support provided. In addition, it should be noted that community care is heavily dependent on women, which adds to the burden on women thereby enhancing gender inequality. In light of these flaws, the community home based care programme may end up relegating the care of patients to individuals and institutions that are ill-equipped for this task.

The Plan of Action for the Ministry of Education, Sports and Culture

Despite the fact that education was given priority in national development planning since independence, the Ministry of Education, Sports and Culture has not adopted a strategic planning framework. Instead, the Ministry used the Education Act as its guiding document. Strategies for change were articulated in circulars. The argument for using circulars instead of medium-term strategic plans was that it was administratively easier for the Ministry to change circulars whenever a change of strategy was deemed necessary. This partly reflects the laxity and fluidity of planning in the country. Thus, there is no explicit development planning framework for education in Zimbabwe. The Ministry is currently considered a production unit of the Confidence Building, Culture and Entertainment Sectoral Committee of the NERP and as such has an annual plan in accordance with the NERP. The plan has a number of objectives for the Ministry as a whole, some of which are specifically concerned with education:

- To build capacity to facilitate the effectiveness of the NERP;
- To increase access to education;
- To improve nutrition, health and safety in schools;
- To enhance patriotism through the national flag and the national anthem;
- To provide a legal framework to commercialise cultural activities and the arts;
- To undertake aggressive and vigorous development and promotion of arts and culture;
- To undertake aggressive and vigorous development and promotion of sport;
- To vocationalise the education curriculum; and,
- To promote behaviour change in the light of HIV/AIDS.

Core determinants of HIV infection

Like the Revival Action Plan of the Ministry of Health and Child Welfare, the Plan of Action for the Ministry of Education, Sports and Culture only partially covers the first two key determinants of vulnerability to HIV infection, namely behaviour change and poverty reduction. The Plan of Action aims to realise a change in sexual behaviour by strengthening life skills of school children and education staff.

With respect to poverty reduction, the Plan seeks to contribute to enhanced food security by running school supplementary programmes and establishing nutrition gardens at institutions of learning. In

Table 9.2. Explicit objectives in Zimbabwe's development planning frameworks				
	NERP	**NASF**	**RAP: health**	**PoA: education**
Core determinants of HIV infection				
1.1. Change in individual behaviour	++	++	++	++
1.2. Poverty reduction (minimum standard of living & food security)	++	+	+	++
1.3. Access to decent employment or alternative forms of income	+	-	-	+
1.4. Reduction of income inequalities	+	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	+	-	-
1.6. Equitable access to quality basic public services	-	+	-	-
1.7. Support for social mobilisation & social cohesion	-	+	-	-
1.8. Support for political voice & equal political power	-	-	-	-
1.9. Minimisation of social instability & conflict / violence	-	-	-	-
1.10. Appropriate support in the context of migration/displacement	-	+	-	-
Key consequences of HIV/AIDS				
2.1. Reduction of AIDS-related adult/infant mortality	++	-	++	-
2.2. Patient adherence	-	-	-	-
2.3. Poverty reduction	+	-	-	-
2.4. Reduction of income inequalities	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	+?	-	-
2.6. Appropriate support for AIDS orphans	+	+	-	+
2.7. Equitable access to essential public services	-	+?	-	-
2.8. Effective/enhanced public sector capacity	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-
2.12. Support for social support systems & social cohesion	-	+	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	-	-	-	-
2.14. Reduction of AIDS-related stigma and discrimination	-	+	-	-
2.15. Reduction of social instability & conflict	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly				

addition, income generation projects in schools are intended to help reduce income-based poverty. The Plan further aims to contribute to poverty reduction by offering youth opportunities for vocational training. This has hitherto been ignored as a strategy to enable future adults to earn a living, as was reinforced by the Minister of Education, Sports and Culture during the interview:

> We only have 23% of our graduates with O-levels passing and the rest fail. … Such youngsters cannot even be apprentices. … The public service is elitist. They do not allow space for low academic achievers, which renders about 80% of our youth jobless. … We need our schools and curricula to be practical and provide skills. The world was not transformed by intellectuals, but by technicians.

Key consequences of HIV/AIDS

If little attention is given in the Plan of Action to the core determinants of vulnerability to HIV infection, there is even less focus on the key consequences of HIV/AIDS. The Plan only deals with one aspect, namely providing assistance to orphans. Such assistance mainly takes the form of a contribution to school fees through the BEAM (see the discussion of the NERP) and the AIDS levy.

As noted under the NERP and the Revival Action Plan for health, the fact that most determinants and consequences of HIV/AIDS are not recognised in the Plan of Action does not mean that these factors have no bearing on the education sector. What these possible links between HIV/AIDS and education planning are has been explored in Chapter 4.

Table 9.2 summarises the preceding discussion by highlighting whether the main development plans in Zimbabwe explicitly seek to respond to the various core determinants and key consequences of HIV infection. Table 9.2 illustrates clearly that relatively

little attention is given to these factors in the various planning frameworks. All four frameworks put significant emphasis on behaviour change and, to a greater or lesser extent, on poverty reduction and the need to ensure food security for the people of Zimbabwe. The NERP does address some of the economic determinants underpinning the spread of HIV, yet the political dimensions of vulnerability to HIV infection are ignored by all four frameworks. Even less attention is given to the various key consequences of the HIV/AIDS epidemic. To some extent, these omissions could be explained by the fact that the development plans discussed here generally have a relatively short life span and are chiefly concerned with 'quick fixes' to resolve the current economic and political crisis.

The planning process

Given that respondents generally identified a more comprehensive range of factors facilitating the spread of HIV in Zimbabwe and, similarly, of the impacts of HIV/AIDS compared to what is reflected in the key planning frameworks, it might be instructive to reflect on the planning process in Zimbabwe. As the brief historical overview of development planning has highlighted, planning in Zimbabwe is traditionally the domain of officials in the Ministry of Finance and Economic Development. During the past two decades, this Ministry has played the lead role in guiding the national planning process and stipulating budgetary ceilings to guide sector planning by line ministries. The one diversion occurred in the early 1990s, when the World Bank and the International Monetary Fund became instrumental in the formulation and monitoring of the ESAP. However, with the withdrawal of the donor community from Zimbabwe, the involvement of the World Bank and other donors in development planning has become minimal. More recently, since 2000, development planning has been informed by the involvement of two other stakeholders additional to the Government, namely the private sector and labour. These three parties have made an input into the NERP. Sector plans have subsequently been drawn up by the respective line ministries, which may or may not have engaged with other stakeholders in this process.

Parliament

During the interview phase, it was suggested that parliamentary involvement in the formulation of the key plans guiding the development of Zimbabwe has been insufficient. It was noted that there had been some workshops for parliament when the National HIV/AIDS Strategic Framework was developed, but other than that there was no clear role for parliamentarians in the formulation, implementation or monitoring of this framework. However, there had been some parliamentary involvement in sector planning through the relevant portfolio committees. It was suggested that such plans usually incorporate recommendations made by these committees.

Civil society organisations

Based on the interview findings, it appears that civil society is hardly involved in the planning process, let alone the implementation or monitoring of the development planning frameworks. As mentioned earlier, there is no mechanism or system to facilitate the involvement of communities and local organisations in the planning process. As one of the respondents observed:

> People and various organisations are not consulted. Even in cases where they are consulted, the final drafts only reflect what the authors wish to see done. In the end, one is forced to think that the initial consultation is just a cover up strategy.

Respondents pointed in particular to the level of suspicion between the Government and NGOs as an impediment to a consultative planning process. Whereas some argued that the Government failed to consult civil society organisations, others suggested that NGOs were chiefly to blame for this state of affairs and for failing "to break the political indifference". Quite a number of respondents representing different organisational contexts emphasised the need for an interface between the Government and civil society organisations on the development challenges facing Zimbabwe. They argued that the lack of such an interface breeds antagonism between the respective parties, a situation which in turn stifles the implementation of development plans.

NAC and organisations representing PLWHA

In contrast to the other development plans discussed in this chapter, the National HIV/AIDS Strategic Framework has been informed by relatively widespread participation from a variety of organisations representing PLWHA, including the NAC. However, representatives from these organisations noted that they had not been involved in the formulation of the NERP or other development plans. At best, their involvement has extended to the formulation of specific HIV/AIDS policies or programmes in line ministries. As one of the

respondents explained:

> AIDS is normally regarded as a health issue. This medical perspective has only tended to result in many efforts revolving around the Ministry of Health and Child Welfare. Government tends to perceive NGO activities as an appendage to those of the Ministry of Health and Child Welfare. We are largely called upon by the Ministry of Health and Child Welfare when they are discussing issues of HIV/AIDS. The multi-sectoral nature of the epidemic is not seriously considered.

Other respondents echoed the view that the lack of involvement of organisations with expertise in HIV/AIDS is because the Government does not sufficiently appreciate HIV/AIDS as a development issue that requires mainstreaming of HIV/AIDS into all aspects of development.

Alignment and implementation of development planning frameworks

Respondents differed quite strongly in their opinion whether the current development planning frameworks are sufficiently aligned, although there was more unanimity on the inadequate implementation of current development plans. It needs to be noted, though, that most respondents seemed to interpret the question about alignment of the development planning frameworks as being about the responsiveness of these frameworks to the needs of the country and its people, rather than the synchronisation of the various frameworks. As such, they tended to mention issues such as insufficient grassroots involvement in the planning process, turning people into "passive consumers" of government plans and interventions, and the political turmoil characterising the country. As one of the respondents said, when asked about the alignment of the key development planning frameworks in Zimbabwe:

> Those who make policies panel beat the policy documents into shape from their perspective. No wonder the policies are not people-oriented.

Given the fact that the 2003 Revival Action Plan and the Plan of Action for the Ministry of Education, Sports and Culture are directly derived from the NERP, it stands to reason that these plans show a significant amount of alignment with the goals and objectives of the NERP. This is not the case with the National HIV/AIDS Strategic Framework. In fact, the Director of the NAC has intimated the need for its revision so that it is consistent with the overarching planning framework (currently the NERP) and the annual cycle of development planning currently operating in the country.

At the beginning of this section, it was suggested that there might be more scope to integrate HIV/AIDS into short-term development plans rather than long-term indicative planning frameworks. This hypothesis would be proven if there was evidence of strong and explicit alignment between the National HIV/AIDS Strategic Framework and the other development plans discussed here. However, this does not really seem to be the case. Whereas a number of core determinants and key consequences of HIV infection are explicitly addressed in the NERP and associated sectoral plans, these do not necessarily correlate with the objectives outlined in the National HIV/AIDS Strategic Framework. As mentioned before, this is probably because development planning in Zimbabwe has largely become a fire-fighting exercise aimed at addressing the most immediate problems exerting the most threatening political pressure. Various respondents argued that HIV/AIDS is not considered one of those pressing political issues.

With respect to the implementation of the current development planning frameworks, most respondents agreed that implementation is at best poor, haphazard and uncoordinated. Some specifically mentioned that there is no clear implementation strategy and no strategy to monitor the implementation of proposed interventions. In a number of instances, this observation was specifically related to the National HIV/AIDS Strategic Framework. Reference was also made to the need to decentralise the implementation of the various development plans, yet given the current resource constraints facing Zimbabwe this was recognised as being extremely difficult.

The issue of inadequate resources emerged as a consistent theme during the course of the interviews, particularly from the side of government officials and politicians. In the absence of external funds, budgetary allocations were seen to be insufficient for a number of reasons. For one, Zimbabwe is faced with a humanitarian crisis manifested in lack of food security, increasing poverty and high levels of inflation. As noted, earlier, the number of people in need of government food aid increased from 6.7 million to 7.2 million within the past year. This comprises about 63% of the total

population. Thus, a very large proportion of the population requires government support for a wide range of issues, such as school fees and medical assistance. It is beyond the national budget to meet such a great level of demand. Secondly, and linked to the previous point, the Government itself has a high budget deficit, which undermines its ability to cope with the current crisis. Thirdly, parallel foreign exchange rates have compounded the erosion of public sector investments. Inherent in national budgets which are based on the official exchange rate is under-budgeting, since the actual procurement of imported goods and services depends on the parallel market.[cxvi] Finally, compounding the budgeting problem is the spiralling inflation, which increases the cost of goods and services within days.

Some, however, suggested that the issue is not just the lack of resources for implementation, but also the inappropriate targeting of resources. Given the political dynamics in the country, it is hardly surprising that some respondents believed that current priorities on expenditure in Zimbabwe are wrong.

9.5 Conclusion

Zimbabwe is faced with a development crisis characterised by high and increasing levels of poverty and unemployment, lack of food security, an unstable and deteriorating economy, spiralling inflation, political instability and a very severe HIV/AIDS epidemic. The current political and economic crisis has forced the Government to abandon long-term development planning and resort to annual plans in an attempt to rein in the most pressurising problems. As a result, these plans at best only partially address the long term, systemic development challenges that are usually the focus of development planning.

It is largely for this reason that the current development plans and frameworks do not adequately address the core determinants and key consequences of HIV/AIDS in Zimbabwe. The most comprehensive of the plans discussed in this chapter is the NERP, which is chiefly concerned with the economic determinants driving the spread of HIV (poverty, lack of income and income inequality) and with individual behaviour as a core determinant of HIV spread. There is consistent silence on the political determinants of vulnerability to HIV infection in all four documents discussed here. This issue also did not surface during the interviews with key informants, which could be indicative of a lack of appreciation of these factors and/or perhaps of the oppressive nature of the current political system, which does not foster independent political thinking. In contrast, whereas the planning documents are equally silent on the need to ensure adequate support during migration and displacement, this was clearly recognised by a large number of respondents as a contributing factor to the spread of HIV, with specific reference to the land resettlement programme. If the development plans ignore a significant number of core determinants of vulnerability to HIV infection, even less attention is given to the key consequences of HIV/AIDS. As such, one can conclude that HIV/AIDS is not sufficiently integrated into development planning in Zimbabwe.

In addition to the fact that development planning in Zimbabwe is currently operating on the basis of crisis mode, the nature of the planning process may also serve to explain these omissions. Historically, development planning in Zimbabwe has been a highly centralised process in which officials in the Ministry of Finance and Economic Development used to formulate an overarching development plan which provided sector ministries with budgetary ceilings. While the current economic stabilisation programme, the NERP, has been prepared with input from the private sector and labour, no official mechanisms are in place to facilitate the involvement of communities and civil society organisations in the planning process. The lack of such mechanisms further aggravates the current antagonism that characterises the relationship between the Government and civil society organisations.

It has also been suggested that HIV/AIDS is still largely understood as a health issue, despite the fact that in official discourse HIV/AIDS is referred to as a development issue. Respondents consulted during the course of this study pointed to the disproportionate responsibility allocated to the health sector to address the HIV/AIDS epidemic. This programmatic slippage into largely health-driven interventions may be an additional explanatory factor for the inadequate integration of HIV/AIDS into development planning.

Finally, this chapter has identified that a significant gap exists between the expressed intent and the actual implementation of development plans. The issue of resources is clearly critical here as the current economic crisis, particularly the lack of foreign currency, erodes budgetary allocations even

before these can be spent. It is beyond the scope of this assessment to review the nature and causes of the current economic and political crisis in Zimbabwe, or to comment on interventions pursued by the Government to try and curb the crisis. Undoubtedly, though, what has emerged from this assessment of Zimbabwe is that it is very difficult to separate development planning from its political context.

Synthesis of country assessments

10.1 Introduction

The preceding chapters have reflected on the extent to which development planning in Cameroon, Senegal, Uganda and Zimbabwe takes account of HIV/AIDS or could otherwise contribute to reduced vulnerability to HIV infection. This chapter tries to tease out a number of similarities and differences regarding development planning and HIV/AIDS in these four countries. The purpose is not so much to compare these countries and rank their performance. Rather, the aim of this chapter is to identify possible trends and distil lessons learned from the country assessments to make development planning more effective in a context of HIV/AIDS.

The first step in this assessment is to examine to what extent HIV/AIDS is explicitly addressed in the principal development planning frameworks of Cameroon, Senegal, Uganda and Zimbabwe. This means, firstly, to assess which of the ten core determinants of enhanced vulnerability to HIV infection are addressed in the various development planning frameworks, with explicit recognition of their potential link to HIV spread. Secondly, it involves a review of the extent to which the frameworks recognise and respond to the key consequences of HIV/AIDS. In both instances, the findings are compared to what respondents in the four countries identified as core determinants and key consequences of HIV/AIDS respectively.

But as the preceding chapters have shown, often development planning frameworks do engage with factors that are associated with enhanced vulnerability to HIV infection, yet without recognising this relationship. Thus, the next step is to review to what extent development planning in the four countries seeks to respond to the core determinants of enhanced vulnerability to HIV infection, but without recognising whether and how these factors may facilitate the spread of HIV.

Table 10.1 summarises the findings from the country assessments. A red mark (✓) indicates that the link with HIV/AIDS is recognised, either in terms of HIV spread (core determinants) or in terms of the impacts (key consequences) of HIV/AIDS. Sections 10.2 and 10.3 discuss this further. A black mark (✓) indicates that this particular factor is identified, but without reference to HIV/AIDS. Section 10.4 further elaborates on these factors. Where the tick mark is reflected in brackets, it means that the relevance of this factor is merely alluded to or is otherwise reflected more indirectly.

10.2. Development planning and HIV prevention: reducing vulnerability?

The 22 development planning frameworks reviewed in the course of this study show almost universal recognition that the HIV/AIDS epidemic poses a threat to life, well-being and development. Except for Cameroon's DSDSR, all other development planning frameworks mention HIV/AIDS. As Table 10.1 shows, there is widespread concern with HIV prevention through awareness raising programmes aimed at behaviour change. Apart from Cameroon's DSDSR, only Uganda's PEAP and PMA do not explicitly support such interventions.

Beyond this concern with lack of knowledge and 'risky' behaviour as factors facilitating the spread of HIV, very little attention is given to other factors that may contribute to the spread of HIV in the four countries under review. In fact, whatever consideration is given to socio-economic or political factors is limited to the National Strategic Frameworks for HIV/AIDS. None of the other 18 development planning frameworks even mentions that these contextual factors may enhance vulnerability to HIV infection.

Even in the national frameworks for HIV/AIDS, not all core determinants of enhanced vulnerability to HIV infection are highlighted. In fact, there is not

necessarily conformity between the frameworks of Cameroon, Senegal, Uganda and Zimbabwe with respect to the factors identified. This could, of course, suggest that the various frameworks respond to local dynamics, rather than following a global template. For example, Zimbabwe's NASF is the only framework that refers to displacement as a contributing factor to HIV spread. More specifically, it acknowledges that the harsh socio-economic realities in resettlement areas and communal areas enhance vulnerability to HIV infection. As such, the NASF clearly identifies a particular reality in Zimbabwe and relates it to the HIV/AIDS epidemic.

However, the country assessments have revealed that displacement is not a uniquely Zimbabwean experience. In all four countries, displacement in some form or other is a reality. In Uganda, the insurgency in the north and east of the country has forced many people to leave their homes and villages. They have moved into towns and into camps for displaced persons. In Senegal, the rebellion in the South is having a similar effect, albeit on a smaller scale. Moreover, the country is host to a significant number of foreign migrants and refugees. The same applies to Cameroon. All four countries also have high levels of internal migration and urbanisation, yet the relationship with HIV spread is not fully explored. The only way in which this is addressed is through a target group approach for HIV/AIDS awareness raising and condom distribution. Cameroon's Strategic Framework for the Fight Against AIDS identifies truck drivers as a target group, whereas Senegal's equivalent also includes a focus on migrants and refugees. The only exception is the reference made in the HSSP of Uganda, which highlights that migration and mobility are associated with the spread of HIV. However, again the intervention here is to target mobile populations for condom distribution, rather than exploring the nature of the relationship between migration and HIV/AIDS in more detail.

Similarly, although poverty is high in all four countries, only the NSFA of Zimbabwe and the NSFA of Uganda associate poverty, inadequate food security and lack of work with enhanced vulnerability to HIV infection. The Strategic Framework for the Fight Against AIDS of Cameroon and Senegal both recognise that HIV/AIDS can lead to poverty, but not that poverty can facilitate the spread of HIV.

The relationship between gender inequality and vulnerability to HIV infection seems particularly unexplored. Whereas all four frameworks identify women as a vulnerable group, this does not mean that sufficient attention is given to the nature of gender relations and how this relates to HIV spread. Zimbabwe's NSAF recognises that gender inequalities in the provision of, and access to, public services like education, health and housing contribute to the enhanced vulnerability of women to HIV infection. Likewise, Cameroon's Strategic Framework for the Fight Against AIDS highlights that low levels of education of women and their financial dependence on men undermine their capability to protect themselves from HIV infection. In contrast, the frameworks of Uganda and Senegal do not reflect on the causes underpinning the enhanced vulnerability of women to HIV infection.

All four National Strategic Frameworks for HIV/AIDS refer to the importance of involving local communities and other stakeholders in the national response to HIV/AIDS. It seems, however, that this emphasis on social mobilisation is not so much borne out of an explicit recognition that weak social cohesion could enhance vulnerability to HIV infection. Rather, the assumption is that social mobilisation is essential for the legitimacy and effectiveness of HIV/AIDS programmes.

None of the National Strategic Frameworks for HIV/AIDS mentions lack of political voice or unequal political power as a core determinant of vulnerability to HIV infection. What is most surprising is that no explicit mention is made of the importance of involving marginalised groups in planning and decision making processes. Uganda's NSFA is the only framework that makes cursory reference to the participation of grassroots organisations, like women's associations and other community based groups. Even here, political empowerment does not appear to be an explicit objective in efforts to curb the spread of HIV.

Table 10.1. Consideration given to HIV/AIDS in the development planning frameworks of Cameroon, Senegal, Uganda and Zimbabwe

	CAMEROON						SENEGAL						UGANDA						ZIMBABWE			
	PRSP	MTEF	NSFA	Health	Educ	DSDSR	10 Plan	PRSP	NSFA	PNDS	PDEF	PRDI	PEAP	MTEF	NSFA	PMA	HSSP	ESIP	NERP	NASF	RAP	PoA
Core determinants of vulnerability to HIV																						
1.1. Individual behaviour	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔		✔	✔		✔	✔	✔	✔	✔	✔
1.2. Poverty/lack of food security	✔	(✔)					✔	✔		✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔
1.3. Lack of work/income	✔			✔			✔	✔		✔		✔	✔	✔	✔	✔			✔			✔
1.4. Income inequality								✔											✔			
1.5. Gender inequality	✔		✔	(✔)	✔	✔	✔	(✔)		✔	✔	✔	✔	✔		✔	(✔)	✔	✔	✔		
1.6. Inadequate/unequal access to services	✔	✔		✔	✔		✔	✔		✔	✔	✔	✔	✔		✔	✔	✔				
1.7. Weak social mobilisation/cohesion			(✔)	(✔)			(✔)	(✔)	(✔)						(✔)	(✔)	✔			(✔)		
1.8. Lack of political voice/unequal power								✔				✔	✔		(✔)		✔					
1.9. Social instability/conflict													✔				✔					
1.10. Migration/displacement	✔							(✔)					✔	✔			✔	✔		✔		
Key consequences of HIV/AIDS																						
2.1. AIDS-related mortality	✔	✔	✔	✔				✔	✔	✔				(✔)	✔		✔		✔	(✔)	✔	
2.2. Responsible behaviour/patient adherence																						
2.3. Poverty			✔	✔				(✔)	✔							✔	✔		✔			
2.4. Income inequality																						
2.5. Gender inequality																						
2.6. AIDS orphans	✔		✔	✔	✔				✔	(✔)				✔	✔			(✔)	✔	✔		✔
2.7. Inadequate/unequal access to services		(✔)			✔											(✔)				(✔)		
2.8. Erosion of public sector capacity																						
2.9. Job security/flexibility under threat			✔												✔							
2.10. Reduced labour/skills supply																✔						
2.11. Eroded financial stability/revenue																	(✔)					
2.12. Weak/undermined social cohesion																						
2.13. Lack of political voice/power of PLWHAs			✔										✔		✔		✔					
2.14. Stigma and discrimination			✔	✔	(✔)				✔				✔		✔		✔	✔		✔		
2.15. Social instability & conflict																						

✔ *With explicit recognition of possible links with HIV/AIDS*

✔ *Without recognition of possible links with HIV/AIDS*

Box 10.1. Most commonly identified factors of vulnerability to HIV infection by respondents

Cameroon:
- Ignorance, (inappropriate) behaviour & values
- Poverty
- Culture (mainly loss of culture)

Senegal:
- Behaviour
- Poverty, linked to lack of services
- Gender inequality
- Culture: specific customs (levirate & sororate)

Uganda:
- Ignorance & (inappropriate) behaviour
- Poverty
- Gender inequality (mentioned by only a few)
- Conflict/instability

Zimbabwe:
- Individual risk behaviour & loss of values/morality
- Culture/customs (mainly loss of culture)
- Poverty/lack of food and work
- Gender inequality
- Lack of services
- Migration

A number of development planning frameworks – more particularly the Health Plans and the National Strategic Frameworks for HIV/AIDS – identify STI treatment as an important intervention aimed at HIV prevention. To the extent that this is informed by an understanding that lack of or inequitable distribution of STI services enhances the spread of HIV, this intervention could be interpreted as addressing the sixth core determinant of vulnerability to HIV infection (inadequate/unequal access to basic social services). Yet, it may be stretching the imagination to suggest that the provision of STI treatment is informed by such an analysis. More broadly, there is no reflection in any of the development planning frameworks surveyed that lack of access to basic social services (water, sanitation, housing, education, health, and so on) could enhance vulnerability to HIV infection.

In conclusion, apart from the focus on HIV prevention through HIV/AIDS awareness raising programmes (and STI treatment) in almost all 22 development planning frameworks, there is hardly any explicit recognition of factors that are associated with enhanced vulnerability to HIV infection. The few exceptions concern the frameworks that have been explicitly formulated to guide the national response to HIV/AIDS, but even here there seem to be some glaring omissions. In general, development planning frameworks do not reflect an analysis of the extent to which the socio-economic and political environment influences people's ability to protect themselves and others from HIV infection.

This suggests a considerable disjuncture between the present-day discourse on HIV/AIDS as a developmental concern and the practice of development planning in sub-Saharan Africa. Whereas globally there is growing understanding of the link between HIV spread and developmental concerns like poverty and the absence of secure work/income, lack of access to essential social services, inequalities on the basis of gender or income, social and political marginalisation, instability or displacement, such links are not articulated in the relevant development planning frameworks. Given that most development planning frameworks surveyed in this study have been developed in recent years (mostly in or after 2000), it is surprising that these inter-linkages are not further explored. Instead, responsibility for formulating a comprehensive, developmental response to HIV/AIDS still seems largely confined to the National Strategic Frameworks for HIV/AIDS.

Factors facilitating HIV spread according to interview respondents

In all four countries, interview respondents did mention some factors in the socio-economic and political environment that are associated with enhanced vulnerability to HIV infection. Box 10.1 summarises the main factors identified by respondents. Poverty was the most commonly referred to factor. In some instances, reference was also made to gender inequality as facilitating the spread of HIV, but this was given surprisingly little attention. In Cameroon, there was even an

indication that women were held responsible for the spread of HIV, rather than recognising that their enhanced vulnerability stems from their subordinate socio-economic status. The feedback from Zimbabwe suggests that the level of awareness of factors associated with enhanced vulnerability to HIV infection is fairly high. In addition to poverty, lack of work and gender inequality, reference was also made to lack of services and migration as facilitating the spread of HIV. In Cameroon, Senegal and Zimbabwe, reference was also made to culture (at times articulated as the loss of culture) and specific customs as potentially enhancing the spread of HIV. This dimension is not taken into account in the conceptual framework, except perhaps to the extent that it is implied in gender relations and in the nature of social cohesion in a particular country or community. Clearly, though, even in the interviews the main emphasis was on individual knowledge, morality and behaviour as a critical determinant in the spread of HIV.

10.3. Development planning and the key consequences of HIV infection

The next step is to review the extent to which development planning frameworks identify what the implications of HIV/AIDS are – or are likely to be in the near future – and propose interventions in response to these consequences. The most likely consequences of HIV/AIDS are reflected in the bottom part of Table 10.1.

As Table 10.1 shows, a significant number of development planning frameworks specifically highlight the need to provide treatment and care of people living with HIV/AIDS. To reduce HIV/AIDS-related mortality, provision is commonly made for ARV treatment, PMTCT programmes and the treatment of opportunistic infections. It is worth noting, however, that these life saving and life enhancing treatments are not necessarily universally available in the countries reviewed here. More often than not, where made available in the public sector, such treatments are only provided on selected sites (pilot projects) or can only be accessed in bigger, better-resourced health centres. The availability of these treatments also depends on the allocation of resources. Zimbabwe's NERP is a case in point: although in principle it supports the provision of ARVs in the public health sector, in practice the lack of foreign currency makes it impossible to implement this objective. The MTEF of Uganda includes budget lines for ARV treatment and PMTCT programmes, but these interventions are mainly funded by donors and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

None of the four Education Plans specifically mentions the need to reduce HIV/AIDS-related mortality. This is perhaps not surprising, except that in countries with a high HIV prevalence rate (particularly Zimbabwe and Cameroon, but also Uganda) the education sector is often one of the sectors most affected by the epidemic. There is likely to be an increase in HIV/AIDS-related mortality among teachers and other education staff and among pupils – or at least, children of school going ages who may or may not be enrolled in school.

Likewise, development planning frameworks for rural (Cameroon's DSDSR and, to all intents and purposes, Uganda's PMA) and regional (the PRDI of the Kaolack Region in Senegal) development do not mention HIV/AIDS-related mortality, let alone suggest interventions to reduce it. The PMA of Uganda does recognise that HIV/AIDS has a negative impact on labour and skills, but this is not linked to health-related interventions to minimise this impact.

A significant proportion of development planning frameworks also refers to the phenomenon of AIDS orphans, although this does not necessarily translate into programmes or projects to support AIDS orphans. In cases where specific measures are proposed, these are more often than not related to access to education and, to a lesser extent, nutrition. Apart from the National Strategic Frameworks for HIV/AIDS, Education Plans commonly articulate a concern with AIDS orphans.

The third most likely consequence of HIV/AIDS identified in development planning frameworks concerns stigma and discrimination. However, only in the frameworks of Uganda and Cameroon is this reflected beyond the National Strategic Framework for HIV/AIDS. HIV/AIDS-related stigma and discrimination is mentioned in Senegal's Strategic Framework for the Fight Against AIDS, but it does not seem to be given a lot of emphasis. Although it is no justification, perhaps the lack of attention given to HIV/AIDS-related stigma and discrimination in Senegal's development planning frameworks is because Senegal's HIV/AIDS epidemic is still fairly contained.

Surprisingly little attention is given to political voice and political participation of people living with

HIV/AIDS. In Uganda, this is a concern shared among a number of development planning frameworks. Cameroon's Strategic Framework for the Fight Against AIDS also emphasises the imperative of involving people living with HIV/AIDS in the national response to the epidemic. Beyond these inclusions, it does not seem to be a concern for most development planning frameworks. Even in those cases where explicit reference is made to the participation of people living with HIV/AIDS, this is not accompanied by a broader concern with the involvement of people affected by HIV/AIDS, such as widows/widowers, children, or the elderly (especially elderly women).

Equally little recognition is given to the fact that HIV/AIDS is likely to enhance poverty. In each country, only one or two development planning frameworks mention this. Even if reference is made to poverty as a result of HIV/AIDS, it does not always lead to the formulation of specific projects. For example, the HSSP and the PMA of Uganda both underline the need for people living with HIV/AIDS to earn an income, yet neither framework proposes clear strategies in this regard. In contrast, the Strategic Frameworks for the Fight Against AIDS of Senegal and Cameroon make provision for income generating projects for people living with HIV/AIDS. The Senegalese version also focuses on the nutritional needs of orphans and vulnerable children, which is echoed in the PNDS. The Health Strategy of Cameroon includes a concern with the food intake of people living with HIV/AIDS. Finally, the NERP of Zimbabwe is the most detailed in terms of proposing an instrument to address poverty as a result of HIV/AIDS: it introduces the AIDS levy, which, amongst others, is intended to benefit households affected by HIV/AIDS. However, as the country assessment of Zimbabwe has shown, a number of problems exist with respect to its effective use.

The impact of HIV/AIDS on demand for and access to services is also rarely taken into account in the development planning frameworks under review. This may be reasonable for a country with a consistently low HIV prevalence rate like Senegal, but not for countries with a (past or current) high HIV prevalence rate. Of the 16 development planning frameworks of Cameroon, Uganda and Senegal, only Cameroon's Education Strategy elaborates on the impact of HIV/AIDS on service provision. It is specifically concerned with access to education, stating that school drop out by orphans and other vulnerable children should be prevented and that they should be provided with psychological and social support. Uganda's PMA merely mentions that HIV/AIDS can lead to school drop out and increase the number of street children, without further elaborating on what impact this would have on the future of children or on the education system. The NASF of Zimbabwe recognises the importance of a proper health system that provides quality care to people living with HIV/AIDS, but it does not go into detail on the impact of HIV/AIDS on the health system – i.e. the need for more and more complex treatment, hospital overcrowding, the risk of crowding out of other diseases - or on any other sector for that matter. Similarly, by virtue of its budgetary provision for health services in general and HIV/AIDS treatment more specifically, it could be argued that the MTEF of Cameroon contributes to equitable access to health care for people living with HIV/AIDS. It does not, however, reflect on changing health care needs as a result of HIV/AIDS and what the implications are for the health sector.

As Table 10.1 shows, no attention is given to the impact of HIV/AIDS on the public sector and its capacity to deliver services and fulfil its functions. Even in countries affected by a serious HIV/AIDS epidemic (including Uganda), there is no evidence that this consequence is taken into account. Whereas a number of development planning frameworks focus on human resource development (particularly the sectoral frameworks), which in some cases translates into investment in personnel expansion, this is not related to HIV/AIDS-related morbidity and attrition. More disconcerting is the focus on rationalisation of the public sector, like in Uganda's PEAP and MTEF, without taking account of the eroding impacts of HIV/AIDS. In other words, none of the development planning frameworks reflects on the likelihood of reduced productivity and performance and the potential loss of personnel, skills and organisational memory as a result of HIV/AIDS. It is plausible that this is largely the result of a lack of data on HIV prevalence in the public sector in general and specific sectors in particular. Few studies have been done to ascertain the HIV prevalence rate in the public sector and what this means for the quality and quantity of service provision.

Similarly, no consideration is given to the financial implications of HIV/AIDS – both at household and sectoral level – and what this means for sector budgets and the ability to raise local revenue (through taxes and user fees). It could be argued

Box 10.2. Most commonly identified key consequences of HIV/AIDS by respondents

Cameroon:
- Increased adult mortality, with negative implications for national production (and labour)
- Orphans
- Enhanced disease burden
- Poverty

Senegal:
- Increased mortality and disease burden
- Poverty and reduced ability to work
- Orphans, risk of reduced school enrolment and higher school drop out
- Rejection / family disintegration

Uganda:
- Increased mortality and disease burden
- Family disintegration and orphans
- Loss of labour, linked to reduced production and productivity
- Increased household poverty (few references)

Zimbabwe:
- Increased mortality and reduced life expectancy
- Orphans and child-headed households
- Loss of labour, linked to reduced productivity
- Impact on women (mentioned by only a few)
- Stigma/discrimination (mentioned by only a few)

that strategies aimed at securing donor funds and funds from the Global Fund for the Fight Against AIDS, Tuberculosis and Malaria, as articulated in Uganda's HSSP, are intended to prevent a resource gap in the health sector, particularly following the abolition of user fees. The question is whether these resources are sufficient to ensure the financial stability of the sector.

Another underrated consequence in development planning frameworks is the impact of HIV/AIDS on labour. Uganda's PMA is the only framework that refers to the loss of skilled and unskilled labour in rural areas as a result of HIV/AIDS, yet beyond this observation it does not propose strategies to address this. Equally little attention is given to HIV/AIDS in the workplace and the issue of workers rights. Only the Strategic Frameworks for HIV/AIDS of Uganda and Cameroon emphasise the need to protect employees from HIV/AIDS-related discrimination. No consideration is given to the fact that HIV/AIDS may affect labour supply in the sense of the need for greater job flexibility for those infected and affected by HIV/AIDS.

No reference is made to enhanced income inequality and gender inequality as a possible result of HIV/AIDS. Thus, no account is taken of the enhanced burden of care on women and girls as a result of HIV/AIDS, or the likelihood of girls being taken out of school to help out in HIV/AIDS-affected households – with negative implications for their development and life prospects. There is also no reflection on the possibility that women may lose assets such as land, housing and savings when their husbands fall ill or die of HIV/AIDS-related illnesses.

The fact that HIV/AIDS may undermine social cohesion and enhance social instability and conflict, possibly resulting from a combination of fear/stigma, resource scarcity and increasing demands, is also not acknowledged in any of the development planning frameworks.

Finally, none of the development planning frameworks explicitly emphasises the need for people living with HIV/AIDS with access to ARV treatment to be responsible and adhere to the treatment provided. It seems plausible that such an emphasis is too individually focused to be reflected in documents concerned with national, regional or sectoral development. Rather, such a concern may be expressed more explicitly at project level.

Key consequences of HIV/AIDS identified by interview respondents

In the interviews, the most commonly referred to consequences of HIV/AIDS are increased mortality, enhanced burden of disease, orphans and poverty (see Box 10.2). Whereas in Senegal most of the consequences identified are mainly experienced at household and individual level, in Cameroon the emphasis was on macro level impacts. Here, significant concern was expressed with the impact of HIV/AIDS on national production and labour. In

contrast, in Senegal mention was made of the debilitating impact of HIV/AIDS on a person's ability to work, the potential of school drop out of orphans and vulnerable children and the risk of family disintegration. In light of the scale of the epidemic in Senegal, it seems appropriate to focus on micro level impacts rather than macro level impacts. However, in the case of Cameroon due consideration should also be given to the impacts of HIV/AIDS at household, community and sector level. In Uganda and Zimbabwe, impacts at varying levels and scales were identified. Even here, though, there were some obvious omissions, particularly regarding the implications for service demand and service provision (e.g. public sector capacity and financial stability), gender inequality, social cohesion and HIV/AIDS-related stigma and discrimination (including in the workplace). Only in Zimbabwe were some observations made regarding stigma/discrimination and the impact of HIV/AIDS on the care role of women. As with the core determinants, a significant number of factors were not readily identified by respondents as key consequences of HIV/AIDS.

10.4. Development planning: an implicit contribution to HIV vulnerability reduction?

Even if development planning frameworks do not reflect an appreciation of the contextual factors that may enhance vulnerability to HIV infection, this does not mean that these factors are not of concern to development planning. As the country assessments have illustrated, the 18 development planning frameworks (which excludes the National Strategic Frameworks for HIV/AIDS) do, to a greater or lesser extent, seek to address development challenges like poverty, inadequate access to services, and so on. Even though the possible link with HIV spread remains unexplored, interventions in this regard could contribute to reduced vulnerability to HIV infection.

As Table 10.1 shows, poverty and inadequate/unequal access to essential services are the most commonly identified development challenges in the frameworks reviewed. Gender inequality is also widely recognised, although in some instances (Senegal's PRSP, Uganda's HSSP and Cameroon's Health Strategy) this is rather implicit. Of course, the fact that gender inequality or the subordinate status of women is mentioned does not always mean that clear strategies are proposed to transform gender relations. At times, it means women are identified as a marginalised or vulnerable group and that clearly circumscribed interventions targeting women are proposed, rather than a comprehensive response to the causes of their marginalisation.

Unemployment, underemployment and low earnings from labour are three key causes of poverty (UNDP, 2003b:xx). Yet, few development planning frameworks have an explicit focus on employment creation, employment protection and fair earnings. Of the 11 development planning frameworks that identify lack of work and income as a development concern, only two of these, the PRSP of Senegal and the PEAP of Uganda, recognise the importance of supporting labour-intensive productive activities to enhance access to employment. Most other documents seem to assume that opportunities for employment and income generation will largely be created in the informal sector. Thus, Cameroon's PRSP emphasises self-employment. A similar focus can be found in Zimbabwe's NERP, which aims to support SMEs and income generating projects, and even in the PoA, which refers to income generating projects at school. In Senegal, the PNDS and PRDI highlight the need for income generating activities for poor households and women and youth respectively. In the 10th Plan, the focus is also not so much on employment creation, but on ensuring stable incomes through agriculture reform and the extension of social protection to the informal sector. Even though the PRSPs of Senegal and Uganda are explicitly concerned with employment creation in the formal sector, these documents (not unlike other development planning frameworks) also opt for structural reform (especially of the agriculture sector), privatisation and other strategies associated with labour specialisation, enhanced income inequalities and jobless growth, if not a contraction of the labour market. These inherent ambiguities are not explored in either PRSP.

Income inequality is rarely discussed in development planning frameworks. Yet, like issues related to labour, the distribution of income is closely associated with the structure of the national economy, economic restructuring processes and which economic sectors are prioritised. For example, a recent report by UNDP South Africa observes that manufacturing is associated with more equal earnings than economic sectors based on high levels of labour specialisation (UNDP 2003b:74-75). Income inequality is only mentioned in the PRSP of Senegal and in Zimbabwe's NERP. With respect to the latter, the assumption is that land redistribution will serve to equalise national wealth and income. However, as noted in Chapter 9, no funds are made

available to small scale farmers to become productive and take advantage of these redistributive measures. Although the PRSP of Senegal recognises that income inequality in Senegal is high, it does not propose strategies to address this. Rather, its main concern is with ensuring regular income for the Senegalese population.

Although social mobilisation is reflected in a number of documents, this is not so much borne out of an appreciation that weak social cohesion or lack of social mobilisation impede development. Rather, support for social mobilisation is either seen as a political imperative, linked to the view that participation in development programmes results in ownership of these programmes and their outcomes, or it is viewed in instrumentalist ways, possibly linked to cost-sharing measures, as in the case of the PRSP of Senegal.

Surprisingly little attention is given to the importance of enhancing participation in decision making and the expression of political voice, particularly given the emphasis on this in international development literature. None of the development planning frameworks of Zimbabwe and Cameroon engages with this issue. In the PRSP of Senegal, mention is made of the fact that the participation of local communities contributes to the sustainability of projects. Because it does not specify marginalised groups, it reflects quite a homogenous interpretation of a community. The PRDI of Kaolack only specifies the need to enhance women's involvement in planning and decision making processes. Of all the development planning frameworks reviewed in this study, Uganda's PEAP appears to reflect the most elaborate view on participatory processes. It specifies that efforts need to be made to involve poor people and marginalised groups, which include women and people with disabilities, in decision making processes. Perhaps a more implicit perspective is found in the HSSP, which supports a shift to primary health care and community based health care. Both are associated with greater involvement of local communities in health planning.

Although social instability and conflict is not unique to Uganda, only its PEAP and HSSP highlight this as a development concern. It is therefore perhaps not surprising that displacement only features in the development planning frameworks of Uganda, which refer to displacement stemming from the conflict in the north and east of the country. More specifically, the PEAP, MTEF, HSSP and ESIP articulate concern with the living conditions of displaced persons in camps and seek to provide appropriate support services. The PRSP of Senegal also recognises that displaced persons and refugees are a vulnerable group in need of specific support measures. It does not, however, further engage with the underlying causes of displacement, despite the rebellion in the south of the country, or with the dynamics and experiences of displacement. Cameroon's documents also do not reflect on this, even though the country is host to a significant number of foreign migrants and refugees. While the resettlement programme in Zimbabwe is associated with displacement, none of the development planning frameworks explicitly engages with this dynamic and what this means in terms of services and infrastructure, for example.

With respect to urbanisation, Uganda's MTEF and ESIP do express some concern with lack of services in urban areas. In addition, the PRSP of Cameroon delegates responsibility for urban and rural development to specific strategies, without further elaborating on the scale and challenges of urbanisation.

In conclusion, a number of factors associated with enhanced vulnerability to HIV infection are taken into account in development planning frameworks, yet without considering how these factors may relate to HIV spread. It is also clear from Table 10.1 that not all core determinants of enhanced vulnerability to HIV infection are commonly identified as development concerns. Significant variances exist between countries and between specific development planning frameworks within countries. To some extent, such differences could stem from specific contextual realities in Zimbabwe, Uganda, Senegal and Cameroon. Moreover, different development planning frameworks are likely to have differing emphases: a health strategy and a rural development strategy are unlikely to overlap completely in terms of the development concerns identified. Yet, as the preceding discussion has highlighted, not all variances and gaps identified can be adequately explained by referring to local realities or the specific ambit of a development planning framework. In some instances, it seems that there are obvious omissions and conceptual flaws in the documents guiding development processes. Furthermore, even though the spread of HIV can be reduced if these factors are effectively addressed, the main concern is that there is no adequate comprehension of the contextual influences on vulnerability to HIV infection. In other words, HIV prevention efforts will be most effective

if the environment of vulnerability is properly understood and adequately responded to.

10.5. Concluding remarks

The country assessments reflect on development planning and HIV/AIDS in countries with different political, economic and social trajectories and characteristics, and with different HIV/AIDS epidemics. As such, the four countries reviewed in this study are indicative of the heterogeneity that characterises sub-Saharan Africa, even if these countries may not adequately capture the level and depth of this variety. Because of the differences in political economy, socio-cultural characteristics and HIV/AIDS in sub-Saharan African countries, there can be no single blueprint for development that applies to all these countries in the same manner. Equally, the national response to HIV/AIDS has to be grounded in, and respond to, local realities and dynamics.

The imperative to recognise contextual differences raises interesting questions for this study. In particular, the case of Senegal illustrates quite clearly that the analytical framework and theoretical assumptions underpinning this study cannot be universally applied to countries on the subcontinent. In fact, if anything, Senegal's country assessment serves to highlight the gaps in the template (Table 4.1), the most obvious one being a lack of appreciation of socio-cultural dynamics. In part, this omission can be explained by the fact that socio-cultural factors are rarely considered in development planning frameworks. Another reason is that this study has sought to broaden the conceptual understanding of HIV/AIDS from a narrow concern with individual knowledge and behaviour, which often implies a (limited) focus on culture and values. In the process, socio-cultural dimensions of the epidemic have been largely ignored, except to the extent that these dimensions are reflected in the nature of gender relations and social cohesion in specific countries.

To conclude this chapter, the following classification captures the main findings of the country assessments regarding possible links between development planning and HIV/AIDS in Cameroon, Senegal, Uganda and Zimbabwe:

1. *Specific core determinants and/or key consequences of HIV/AIDS are not mentioned at all.*

   At least four reasons can be identified for this situation. For one, certain factors may not be relevant given the socio-economic and political realities and the scale of HIV/AIDS in a particular country. For example, the relatively low scale of HIV/AIDS in Senegal means that public sector capacity is unlikely to be eroded as a direct result of the epidemic. Secondly, certain factors may not be relevant for a particular development planning framework. For example, education plans are rarely concerned with lack of income, although Zimbabwe's PoA clearly refutes this logic. Thirdly, addressing these factors is perhaps not considered a political priority. For example, the case of Zimbabwe suggests that in a context where political and/or economic insecurity is paramount, HIV/AIDS is unlikely to be a priority for the political leadership. Similarly, reversing the economic crisis seemed to be the main concern for Cameroon in the 1990s. Only when its economic (mis)fortunes seemed to be turned around did HIV/AIDS emerge on the political agenda as a development concern. By that time, the epidemic was already in an advanced stage. Finally, the significance of these factors for national development in general and HIV/AIDS in particular may not be recognised. The country assessments and this chapter have highlighted a number of instances where the lack of attention given to specific factors is indicative of conceptual oversight, rather than irrelevance.

2. *Specific core determinants of enhanced vulnerability to HIV infection are mentioned, but without specific reference to HIV/AIDS.*

   In other words, these factors are articulated as development concerns, but no consideration is given for whether and how these factors may enhance vulnerability to HIV infection. The reasons for this could be similar to those mentioned above, although this chapter and the preceding chapters have highlighted many instances where the last reason (lack of appreciation/understanding for the link with HIV infection) is the most likely one.

3. *Specific core determinants and/or key consequences of HIV/AIDS are mentioned (with or without recognising the potential link with HIV/AIDS), but no clear strategies or plans are formulated to respond to these factors.*

   Although at times this may be because the

formulation of specific interventions falls beyond the scope of a particular development planning framework, the country assessments have also highlighted instances where the lack of strategy formulation seems to be an omission. For example, simply mentioning the fact that HIV/AIDS enhances poverty without suggesting measures to overcome HIV/AIDS-induced poverty, like Uganda's HSSP and PMA do, obviously does not address the problem.

4. *Specific core determinants and/or key consequences of HIV/AIDS are mentioned (with or without recognising the potential link with HIV/AIDS) and strategies or plans are proposed, but no resources are allocated to implement the proposed strategies.*

   The issue of financial resources is critical for the effective implementation of stated goals, plans and strategies. This is most obvious in the case of Zimbabwe, although the country assessment of Senegal also illustrates this point. Clearly, if foreign (and domestic) funds cannot be accessed and the foreign exchange rate is exorbitant, the best intended plans are unlikely to be realised.

5. *Specific core determinants and/or key consequences of HIV/AIDS are mentioned (with or without recognising the potential link with HIV/AIDS), strategies or plans are proposed, resources are allocated, yet action plans and activities are not implemented.*

   Past experience in Senegal has shown that the implementation rate of planned interventions could be less than 50%. However, it is beyond the scope of this study to evaluate the implementation of development plans and strategies. Therefore, little insight can be given as to the reasons for lack of implementation.

Conclusion and recommendations

11.1. Introduction

The overview of development planning in sub-Saharan Africa (Chapter 2) concluded that development planning remains a key instrument to address complex and interrelated challenges like poverty, unemployment, inequality, weak economic performance and limited integration into the global economy, unequal access to essential services and HIV/AIDS. As the country assessments of Cameroon, Senegal, Uganda and Zimbabwe have revealed, addressing these complex challenges is certainly at the heart of recent development planning efforts in these countries. The experiences in these countries further suggest that there has been a re-emergence of development planning in sub-Saharan Africa in recent years with the state playing a more central – and perhaps more confident – role in guiding the development process.

This study has concerned itself with reviewing possible links between development planning and HIV/AIDS. More specifically, it has sought to investigate to what extent development planning in the region currently worst affected by HIV/AIDS is informed by a *development perspective* on HIV/AIDS. Such a perspective views the spread of HIV not simply as the result of lack of knowledge of HIV or of inappropriate (if not irresponsible) behaviour. Rather, it recognises that certain factors in the external environment hinder people's access to and use of appropriate knowledge, prevention technologies, support services and discretionary power. It also appreciates that, depending on the severity of the epidemic, HIV/AIDS has negative impacts at different scales and timelines, that the distributional effects of HIV/AIDS are not shared evenly in society and that HIV/AIDS can pose a serious threat to the development of people, communities and society as a whole.

To facilitate an assessment of whether development planning in sub-Saharan Africa reflects a development perspective on HIV/AIDS, the template in Table 4.1 has been developed. It basically enables a review of the extent to which development planning frameworks understand and respond to the socio-economic and political context of behaviour and disease. The template reflects a number of core determinants that have become associated with enhanced vulnerability to HIV infection. It further summarises what have been identified as the most significant consequences of HIV/AIDS in countries worst affected by the epidemic. The significance of the core determinants and key consequences identified in Table 4.1 clearly depends on local realities, including the scale and manifestation of the HIV/AIDS epidemic in a particular context. Whereas the template has been used as a diagnostic tool in this study, it can also be adapted for use as a strategic tool to facilitate the formulation of appropriate strategies and interventions in development planning frameworks.

Overall, the study findings suggest significant conceptual weaknesses in this regard: despite the fact that most development planning frameworks reviewed in this study have been formulated within the last two to five years, these documents tend to reflect a rather narrow conceptualisation of HIV/AIDS. This finding confirms the starting point of this study as outlined in Chapter 1, namely that insufficient attention is given to contextual factors that can render certain individuals and groups in society more vulnerable to HIV infection than others. Similarly, the socio-economic and political realities of individuals, social groups and communities after HIV infection are not sufficiently taken into account and responded to.

The weak conceptualisation of HIV/AIDS in development planning frameworks is indicative of a disjuncture between the global and national discourse on HIV/AIDS and the reality of development planning. In the 70 interviews

conducted as part of this study, respondents tended to identify a broader range of core determinants of vulnerability to HIV infection and key consequences of HIV/AIDS compared to what is reflected in development planning frameworks. Interestingly, in the four countries reviewed there seem to be different emphases, which cannot all be explained by differing socio-economic and political realities. Even here, significant omissions have been noted as factors that are likely to have relevance in respective countries were not readily identified by respondents.

Perhaps it is important to state that it is not the intention of this report to be dismissive of those interventions that tend to constitute the mainstay of HIV/AIDS programming – most of which were also emphasised during the interviews. There undoubtedly is a need for awareness raising, condom distribution and social debates on values, as much as for treatment and care for people living with HIV/AIDS and support for orphans. Rather, the central argument in this report is that these interventions need to be recast and embedded in a broader developmental perspective on HIV/AIDS.

In concluding this report, this chapter summarises the main lessons and conclusions based on the country assessments in Zimbabwe, Uganda, Senegal and Cameroon. It ends with a set of recommendations aimed at broadening the understanding of, and strategic response to, HIV/AIDS in development planning.

11.2. Key lessons and conclusions

The following 15 lessons and conclusions are extracted from the country assessments and the study findings:

1. *Development planning frameworks reflect insufficient recognition that certain factors in the socio-economic and political context render certain groups in society more vulnerable to HIV infection than others.*

   As the country assessments have shown, National Strategic Frameworks for HIV/AIDS are most likely to highlight contextual factors that are associated with enhanced vulnerability to HIV infection. Even here, however, the number of factors identified tends to be limited. Also, it tends to be beyond the scope of these frameworks to propose strategic responses to factors such as poverty, gender inequality and lack of work. It is therefore critical that relevant development planning frameworks recognise, and explicitly engage with, the core determinants of enhanced vulnerability to HIV infection.

2. *Equally, development planning frameworks do not reflect sufficient appreciation of the multiple impacts of HIV/AIDS on households, communities, particular social groups, sectors and institutions, both now and in the near future*.

   Only a few key consequences of HIV/AIDS are readily identified and responded to in development planning frameworks. The most commonly identified consequences include disease, mortality and orphans. Although the National Strategic Frameworks for HIV/AIDS tend to articulate more consequences of the HIV/AIDS epidemic than other development planning frameworks, the study findings suggest significant omissions in this regard. Again, it is beyond the scope of the National Strategic Framework for HIV/AIDS to engage with, and respond to, the full range of key consequences of the epidemic. In particular, the various impacts on the demand, supply and resource base of social services are likely to be relevant for most development planning frameworks, yet these consequences are hardly ever recognised.

Based on the country assessments and study findings, the following six points are offered as possible explanations for the inadequate attention given to core determinants and key consequences of HIV/AIDS in development planning:

3. *The factors associated with enhanced vulnerability to HIV infection and the key consequences of HIV/AIDS are variable and depend on local realities, including the specific nature and manifestation of HIV/AIDS in particular countries and communities.*

   Certain factors identified in this study as core determinants of enhanced vulnerability to HIV infection may not be relevant, or at least not in the same way, in specific countries and communities. Similarly, not all key consequences of HIV/AIDS may manifest themselves in the same manner and with the same intensity across countries. For example, in low HIV prevalence countries like Senegal some of the key consequences identified are

unlikely to be experienced. Thus, the analytical tool presented in Table 4.1 needs to be interpreted in relation to specific local realities and dynamics.

Clearly, this requires a careful assessment of whether and how these factors are relevant or not. In the four countries reviewed in this study, there is no evidence that based on such assessments it has been concluded that certain core determinants and/or key consequences are not applicable. Rather, the lack of attention given to these factors in relation to HIV/AIDS seems indicative of conceptual flaws and omissions, especially since the National Strategic Frameworks for HIV/AIDS and interview respondents tend to highlight some of these factors.

4. *There is lack of alignment on HIV/AIDS between development planning frameworks, especially between the National Strategic Framework for HIV/AIDS and other frameworks.*

   Although the National Strategic Frameworks for HIV/AIDS are likely to mention a number of contextual factors that influence HIV spread, this is rarely echoed in other development planning frameworks. In a variation on the commonly used acronym, alignment on HIV/AIDS between principal development planning frameworks is at best restricted to a concern with HIV prevention through ABC: Awareness raising, Behaviour change and Condom distribution. Similarly, the key consequences identified in the National Strategic Frameworks for HIV/AIDS are not necessarily reflected across development planning frameworks, even if these consequences may hold particular significance for specific planning frameworks. This suggests that there is insufficient alignment on HIV/AIDS between principal development planning frameworks.

5. *The conceptualisation of HIV/AIDS as a development issue is weak*.

   A more fundamental cause for the lack of attention given to core determinants of enhanced vulnerability to HIV infection and key consequences of HIV/AIDS in development planning frameworks is found in the narrow, if not weak, conceptualisation of HIV/AIDS. Despite the widespread rhetoric that HIV/AIDS is a development issue, in terms of strategy formulation it remains largely couched as a behavioural, medical and possibly (through the focus on orphans and poverty in HIV/AIDS-affected households) welfare concern.

   Linked to this is the fact that there seems to be an implicit assumption that HIV/AIDS can be confined to the National Strategic Framework for HIV/AIDS. However, especially in countries with a serious and/or rapidly spreading HIV/AIDS epidemic, HIV/AIDS needs to be addressed as a crosscutting issue, in much the same way as poverty and gender inequality are to be engaged with across development planning frameworks.

6. *There is a lack of qualitative and quantitative data on the nature of vulnerability to HIV infection and the impacts of HIV/AIDS that serves to inform development planning.*

   Without country-specific (and community-specific) information on how contextual factors render certain social groups more vulnerable to HIV infection, it is difficult to appreciate how development planning can help minimise a context of vulnerability to HIV infection. Also, some of the impacts of HIV/AIDS are not yet manifest, whereas others remain uncertain. As a result, these factors are easily overlooked in development planning. In particular, there is a paucity of data on the HIV prevalence rate in the public sector, what impact this has on the performance, quality and effectiveness of the public sector and its ability to deliver on its core mandate, what the financial implications are, and so on. Even though development planning frameworks are generally concerned with the performance, effectiveness and financial stability of the public sector, these potential implications of HIV/AIDS are rarely reflected. Similarly, the limited focus on the education needs of AIDS orphans evident in a number of development planning frameworks is in part due to a lack of data on the needs and experiences of these children.

7. *Development planning is not always initiated and driven by local stakeholders in response to local realities.*

   The country assessments have indicated a number of instances where external agents

appear to have been very influential in the formulation and approval of development planning frameworks. This does not necessarily have to mean that these frameworks do not take account of local realities. However, by virtue of providing a significant proportion of resources for development planning in sub-Saharan African countries, bilateral and multilateral agencies can wield significant influence on the development agenda and development paths pursued on the subcontinent. As a result, national discretion and authority in development planning may be significantly curtailed (see also Katz, 2002; Schoepf, 2004b).

Particularly disconcerting is the relatively marginal role played by elected representatives in the formulation, review and monitoring of principal development planning frameworks. This seems contradictory to the global discourse on the importance of local ownership of development processes. With respect to HIV/AIDS, recent years have seen an increasingly stronger emphasis on national leadership to take responsibility and play a leading role in the response to HIV/AIDS. Arguably, elected representatives can only fulfil this role effectively if they are centrally involved in development planning.

8. *People living with and affected by HIV/AIDS and organisations representing their interests are not sufficiently involved in development planning processes.*

   The country assessments indicate that there is limited involvement of people living with HIV/AIDS and organisations representing their interests (including the equivalent of a National AIDS Council) in the formulation, implementation and monitoring of development planning frameworks. More often than not, their involvement is restricted to the National Strategic Framework for HIV/AIDS, although they may also be consulted on specific HIV/AIDS policies and programmes at sector level. Even less attention seems to be given to engage with those directly affected by HIV/AIDS, like spouses, widows/widowers, AIDS orphans and children living in child-headed households, elderly women who look after AIDS orphans, and so on.

   Yet, the involvement of those living with and affected by HIV/AIDS is paramount in any effort aimed at better understanding and more effectively responding to HIV/AIDS (Kesby, 2004; Rugalema, 2004). Organisations representing their interests and the National AIDS Council (or equivalent) also need to play a central role in all development planning efforts to facilitate the required conceptual shift towards the factors associated with enhanced vulnerability to HIV infection.

The preceding explanations for the inadequate attention given to core determinants and key consequences of HIV/AIDS in development planning are interlinked and can even be mutually reinforcing. For example, the weak conceptualisation of HIV/AIDS stems in part from a lack of data on the nature of vulnerability to HIV infection in a particular context. It may also be attributed to inadequate involvement of those most directly affected by HIV/AIDS. At the same time, as a result of the narrow conceptualisation of HIV/AIDS the relationship between HIV/AIDS and factors associated with enhanced vulnerability to HIV infection remains obscured (which means that relevant data is not collected) and those directly affected by HIV/AIDS may at best only be consulted on a limited range of issues.

9. *Development planning could potentially reduce vulnerability to HIV infection, even if the context of vulnerability is not properly understood*.

   Throughout this study, reference has been made to instances where development planning seeks to address factors associated with enhanced vulnerability to HIV infection, without explicitly recognising that these factors may be related to HIV spread. If the stated goals and objectives to realise human rights and improve the quality of life of the population are achieved, vulnerability to HIV infection could be significantly reduced. Thus, 'doing development' can be considered the most effective intervention to prevent the spread of HIV. Arguably, though, vulnerability reduction will be most effective if the specific nature of vulnerability in particular contexts is understood and responded to.

10. *However, development planning is unlikely to realise this potential if the core determinants of vulnerability to HIV infection and the key*

consequences of HIV/AIDS are not sufficiently taken into account.

Although the previous point suggested that development interventions can potentially curb the spread of HIV, this should not be accepted too easily. For one, the goals and objectives of development are likely to be thwarted by HIV/AIDS, especially in countries with a severe and/or rapidly growing epidemic. In the country assessments reference has already been made to the fact that economic growth targets seem highly optimistic given the envisaged economic consequences of HIV/AIDS. Similar observations can be made with respect to other development targets and objectives.

Secondly, as noted throughout this study, the proposed strategies, instruments and processes of development may (unintentionally) serve to enhance vulnerability to HIV infection. For example, stimulating macroeconomic growth does not necessarily mean that labour intensive productive activities are supported – in fact, in the global economy of today economic growth sectors tend to be those characterised by high levels of labour specialisation, a relatively small number of employees and significant income disparities. Similarly, public sector reform associated with the rationalisation of the public sector is likely to result in job losses, especially in countries where the public sector is one of the few sectors of stable employment.

Finally, as noted in Chapter 4, certain consequences of HIV/AIDS are in turn associated with enhanced vulnerability to HIV infection. However, because HIV/AIDS tends to alter the dynamics of poverty, inequality and social exclusion, standard development interventions are unlikely to be effective in ensuring that these consequences do not enhance vulnerability to HIV infection.

This study has sought to explore possible links between development planning and HIV/AIDS in sub-Saharan Africa through an analysis of principal development planning frameworks. By focusing specifically on these frameworks, which reflect the strategic orientations for development in a particular country, but leave out most of the detailed actions, a number of issues could not be fully explored in this study. The following general observations can be made regarding the research focus and the limitations of the study.

11. *It is difficult to separate development planning from the political, economic and institutional context.*

    Of the four country assessments presented in this report, the case of Zimbabwe makes it most clear that development planning is directly influenced by the political, economic and institutional situation in the country. More specifically, in times of political instability and/or economic crisis, political priorities are likely to change. Development plans may be put aside or suspended, until the priorities of the day are seen to be resolved. Also, stated objectives and strategies are unlikely to be realised if there are no resources (domestic and/or external) or if the necessary organisational capacity to deliver is lacking.

12. *It is difficult to review intent, without reflecting on strategies, instruments, resource allocations, implementation processes and outcomes.*

    To some extent this is related to the previous point. The stated goals and objectives for development may look good on paper (in development planning frameworks), but need strategies, instruments and tools, capacity and resources (human, financial, technological) for implementation. The country assessments have highlighted numerous instances where development planning frameworks take account of specific core determinants and/or key consequences of HIV/AIDS. Yet, mentioning something does not mean that the issue is properly understood or that it will be addressed. It was beyond the scope of the study to do an in-depth assessment of the implementation and outcomes associated with development planning. At times, reference has been made to past experiences in adopting certain approaches and associated instruments to illustrate the potential gap between stated intent and development outcomes.

13. *The fact that development planning frameworks do not reflect sufficient recognition of the core determinants of enhanced vulnerability to HIV infection and the key consequences of HIV/AIDS does not mean that no HIV/AIDS interventions are*

formulated that are of relevance to these factors.

A development planning framework is one instrument among many that governments can employ to guide the development process in their countries. With respect to HIV/AIDS, some of the more detailed actions and policy interventions may be reflected elsewhere. For example, the country assessments revealed that little if any attention has been given to HIV/AIDS in the workplace in development planning frameworks. Yet, it is possible that separate policies exist aimed at protecting the rights of employees living with HIV/AIDS and addressing HIV/AIDS-related stigma and discrimination in the workplace. Such interventions have not been reviewed in this study.

However, development planning frameworks reflect the strategic orientations for economic, sectoral, social and human development of a country, based on a conceptualisation of pertinent development challenges and opportunities. As such, these frameworks ought to engage with the context of vulnerability to HIV/AIDS and the key consequences of the epidemic. Obviously, this is particularly pertinent for high HIV prevalence countries and/or countries where HIV spread seems to accelerate, although low HIV prevalence countries would also benefit from understanding better what contextual factors may facilitate the spread of HIV.

14. *The response to HIV/AIDS needs to be decentralised, yet decentralised planning has remained largely unexplored in this study.*

    The focus of this study is on the stated intentions and perspectives reflected in development planning frameworks. As a result, hardly any attention is given to decentralised planning and the role of decentralised structures in the implementation of these frameworks. Yet, it is widely recognised that an effective response to HIV/AIDS combines community level planning and development planning at broader geographic scales. The area of decentralised planning and HIV/AIDS could be the subject of future research.

15. *The template for analysis is intended as a strategic tool to be applied with discretion, not a rigid instrument.*

    The template as an analytical tool does not necessarily capture all the factors that may influence the spread of HIV, nor does it articulate all consequences of the epidemic. More specifically, it does not expressly identify socio-cultural factors, although the nature of gender relations and social cohesion are obviously culturally specific. Socio-cultural factors can provide an important explanation for the differences in HIV spread across countries and communities, as the case of Senegal has demonstrated most clearly. Socio-cultural factors also influence how those infected and affected by HIV/AIDS experience the epidemic. However, such factors are rarely explicitly considered in development planning frameworks, which is partly why this study has not reviewed the socio-cultural dynamics of HIV/AIDS. Also, as noted in Chapter 10, the narrow concern with individual knowledge and behaviour to prevent HIV spread often implies a focus on culture, albeit a rather restricted one. The purpose of the study is to broaden the conceptual understanding of HIV/AIDS to include a concern with socio-economic and political factors.

    The country assessments have also shown that the second factor identified as a key consequence (the emphasis on responsible behaviour for those living with HIV/AIDS, i.e. patient adherence) is not explicitly articulated as a concern in development planning frameworks. Presumably, this is because the emphasis on patient adherence reflects too much of a focus on the individual to be incorporated in these documents. This obviously does not mean that there is no concern with responsible behaviour of people living with HIV/AIDS. However, this is more likely to be reflected at the level of policies and programmes pertaining to treatment, for example.

11.3. Recommendations

Based on the country assessments and study findings, this study proposes a number of recommendations to ensure that development planning takes account of contextual factors that are associated with enhanced vulnerability to HIV infection and of the impacts of HIV/AIDS. The recommendations are articulated around seven themes:

a. Enhancing understanding and strengthening capacity

b. Review and revision
c. Data collection & management
d. Planning process
e. Alignment of development planning frameworks
f. Allocation of resources
g. Potential areas of further research

a. ENHANCING UNDERSTANDING AND STRENGTHENING CAPACITY

There is a need to broaden the conceptualisation of HIV/AIDS in development planning frameworks. To achieve this, the insights and capacities of those involved in development planning processes need to be enhanced. The following actions are recommended in this regard:

- **Disseminate this report to a wide range of stakeholders with interest in – or somehow involved in – development planning and HIV/AIDS in sub-Saharan Africa** (e.g. Members of Parliament; planners across sector Ministries, especially in national Ministries of Finance and Economic Development; the National AIDS Council or equivalent; country offices of bilateral and multilateral agencies; civil society organisations; tertiary institutions; other relevant stakeholders).

- **Present the study findings at regional and/or country level meetings with relevant stakeholders.**

- **Use the findings of this study to develop tools and techniques that can facilitate the comprehensive integration of HIV/AIDS into development planning.**

- **Provide training (or other forms of support) to strengthen the capacity of planners and policy makers to reflect a broader conceptualisation of HIV/AIDS in development planning. Such interventions could be facilitated by UNDP in collaboration with the National AIDS Council (or equivalent).**

- **Within the proposed activities of awareness raising, training and tools development, particular attention needs to be given to the interplay between gender inequality and HIV/AIDS. In other words, a gender perspective on HIV/AIDS needs to be integral to these activities.**

b. REVIEW AND REVISION

The enhanced understanding of the contextual factors associated with vulnerability to HIV infection and of the key consequences of HIV/AIDS needs to be reflected in principal development planning frameworks and related action plans. The following actions are recommended in this regard:

- **Review principal development planning frameworks in accordance with the analytical framework presented in this study and, where possible and appropriate, revise these frameworks accordingly.**

- **Review the action plans and programmatic interventions arising from principal development planning frameworks in accordance with the analytical framework presented in this study and, where possible and appropriate, revise accordingly.**

c. DATA COLLECTION & MANAGEMENT

There is a need for uniform data systems and indicators on HIV/AIDS, factors associated with vulnerability to HIV infection and key consequences of HIV/AIDS at country level that can be used across development planning frameworks. The following actions are recommended in this regard:

- **Establish and maintain an information management system that takes account of the factors associated with enhanced vulnerability to HIV infection and the (current/anticipated) key consequences of HIV/AIDS.**

- **Conduct country- and/or community-level vulnerability assessments to better appreciate the specific nature of vulnerability to HIV infection in particular contexts. Both quantitative and qualitative data on the core determinants of enhanced vulnerability to HIV infection need to be collected.**

- **Conduct impact assessments and modelling of the anticipated impacts of HIV/AIDS, especially on the public sector in general and on specific sectors. This would involve an assessment of: the HIV prevalence rate across sectors and skills levels; the human, financial and organisational implications; and, the implications of HIV/AIDS on service demand.**

- **Use the findings of vulnerability assessments and impact assessments/modelling to inform the revision, or future development, of development planning frameworks.**

- **Based on the proposed information management system, develop indicators that can form the basis for appropriate planning interventions and for effective monitoring and evaluation.**

d. PLANNING PROCESS

The democratisation of the planning process is an essential ingredient of locally appropriate and effective development that takes account of HIV/AIDS. Particular attention needs to be given to the role of elected representatives, people living with HIV/AIDS and organisations representing their interests (including the National AIDS Council or equivalent). The following actions are recommended in this regard:

- **The role of elected representatives at national and sub-national level in the design and monitoring of development planning frameworks needs to be recognised and enhanced. Where necessary, appropriate support measures should be considered, such as awareness raising and capacity building on integrating HIV/AIDS in development planning.**

- **The involvement of people living with and affected by HIV/AIDS and of organisations representing their interests in development planning needs to be enhanced and, where necessary, supported. Their involvement should not be confined to HIV/AIDS-specific programmes and interventions, but to development planning processes in general.**

- **The National AIDS Council (or equivalent) should be centrally involved in the formulation and monitoring of principal development planning frameworks, not just of the National Strategic Framework for HIV/AIDS.**

- **The role of external actors (particularly multilateral and bilateral agencies) in the formulation, approval and monitoring of national development planning frameworks needs to be cautiously assessed against the development imperative of locally appropriate and domestically owned development planning.**

e. ALIGNMENT OF DEVELOPMENT PLANNING FRAMEWORKS

Efforts to ensure better alignment of principal development planning frameworks with respect to addressing the context of vulnerability to HIV infection and mitigating the key consequences of HIV/AIDS are needed. The following actions are recommended in this regard:

- **Ensure the substantial participation of the National AIDS Council (or equivalent) and people living with HIV/AIDS (and organisations representing their interests) in the formulation, monitoring and review of these frameworks. This may require the formulation of standardised guidelines for involvement of these stakeholders.**

- **Align planning cycles as much as possible and ensure that planning processes are mutually supportive, rather than running parallel to one another.**

f. ALLOCATION OF RESOURCES

The effective implementation of the strategic priorities expressed in development planning frameworks is largely contingent on the allocation of financial resources (although other resources are obviously also critical). Given the low level of domestic resources in

relation to the scale of needs in most sub-Saharan African countries, the allocation of resources is a shared responsibility between national governments and external agencies. The following actions are recommended in this regard:

- **Countries need to ensure adequate financing for programmes that are considered strategic priorities in development planning frameworks. This may warrant the development of a resource mobilisation strategy, but it is also critical to allocate domestic resources.**

- **External (bilateral and multilateral) agencies should seek to simplify funding procedures and minimise funding conditionalities as much as possible in an effort to support local priorities and needs of recipient countries.**

g. POTENTIAL AREAS OF FURTHER RESEARCH

Because development planning is such a multifaceted and multidimensional process, many issues have remained unexplored in this study. Future areas of investigation could include the following:

- **Review experiences in decentralised planning in relation to HIV vulnerability reduction and comprehensive HIV/AIDS impact mitigation.**

- **Review to what extent specific instruments and processes of development (pursued to realise the strategic orientations in development planning frameworks) may result in outcomes that are likely to enhance (or, alternatively, diminish) a context of vulnerability to HIV infection.**

- **Review the role of elected representatives in ensuring that development planning frameworks adequately address the context of vulnerability to HIV and the consequences of the epidemic and identify what factors restrict their ability to set strategic priorities and monitor the implementation process in this regard.**

- **Review the extent to which people living with and affected by HIV/AIDS and organisations representing their interests (including the National AIDS Council or equivalent) are involved in development planning and identify what factors restrict their substantive participation in this regard.**

- **Assess what social, economic, political and institutional factors are likely to have contributed to effective HIV vulnerability reduction and/or impact mitigation in particular countries and review to what extent such lessons can be replicated (or adapted) elsewhere.**

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Chapter 6. Cameroon

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Appendix 1. Assessing the link between rural development planning and HIV/AIDS				
	Assessing the link between rural development planning and HIV/AIDS in the Rural Development Framework			
PREVENTION: ADDRESSING CORE DETERMINANTS		**Objectives**	**Deliberate objective? (with explicit focus on men/women)**	**Possible impacts/link (conscious or not, in relation to men/women)**
	1.1.	Change in individual behaviour	No	Response to HIV/AIDS still largely located in health sector.
	1.2.	Poverty reduction, i.e. ensuring a minimum standard of living and food security	Yes, but unlikely to differentiate between men and women	Explicit anti-poverty focus through provision of social services/infrastructure likely to contribute to poverty reduction. Yet, strategies linked to agriculture reform and increased productivity without due regard for employment creation and food security likely to entrench/increase poverty. Strategies that lead to the loss of land are likely to enhance poverty, particularly for women & female-headed households.
	1.3.	Access to decent employment or alternative forms of income generation	Usually insufficient attention given to the importance of work	Agriculture reform through liberalisation of markets likely to result in loss of employment for rural poor and small-scale farmers.
	1.4.	Reduction of income inequalities	Usually little attention given to social differentiation in rural areas	Interventions resulting in loss of land, employment and income will aggravate income disparities. Depends also on whether diversification of rural economy is associated with labour-intensive growth and/or highly skilled labour, which could aggravate income inequalities. Women least likely to benefit from opportunities.
	1.5.	Reduction of gender inequalities and enhancing the status of women	Likely focus on rural women	Gender-blind planning likely to entrench, possibly worsen, the subordinate status of rural women; e.g. economic opportunities for men may exacerbate gender inequalities. Also, depends on whether it leads to legal reform (e.g. access to land)
	1.6.	Equitable access to basic public services	Possibly, but unlikely to differentiate between men and women	Improvements in rural infrastructure and services likely, yet user charges may restrict access for rural poor, thereby perpetuating unequal access.
	1.7.	Support for social mobilisation and social cohesion	No, except when participatory planning is perceived as such	Community development / participatory approach may strengthen social cohesion; in absence of adequate support, it may undermine social networks and shift undue responsibility to communities, in particular to rural women.
	1.8.	Support for political voice and equal political power	Possibly, which may include specific reference to rural women	Often rhetoric about 'empowering the rural poor', yet in practice mixed results. Decentralisation and local democratisation could facilitate this.
	1.9.	Minimisation of social instability and conflict / violence	No	Loss of food security and income may fuel competition over scarce resources, particularly in mineral-rich areas, with women disproportionately affected.
	1.10.	Appropriate support during migration / displacement	Possibly, but unlikely to differentiate between men and women	Lack of employment opportunities, food security and basic services as potential 'push' factors, often leading to multi-locational households (rather than migration of whole family). Yet, inconclusive whether rural development will (or should) curb migration. Rural development programmes may result in displacement of small-scale farmers or entire rural communities.

Assessing the link between rural development planning and HIV/AIDS in the Rural Development Framework			
	Objectives	**Deliberate objective? (with explicit focus on men/women)**	**Possible impacts/link (conscious or not, in relation to men/women)**
IMPACT MITIGATION: ADDRESSING KEY CONSEQUENCES	2.1. Reduction of AIDS-related adult/infant mortality	Unlikely	No reduction, unless provision for ARVs and PMTCT has been made. Food insecurity and other dimensions of poverty likely to speed up ill health and death.
	2.2. Patient adherence	Unlikely	Possible emphasis if treatment is available (e.g. through pilot schemes); other disregarded dimensions of poverty likely to thwart patient adherence.
	2.3. Poverty reduction, i.e. ensuring a minimum standard of living and food security for PLWHAs and affected households & individuals (e.g. children, elderly)	Possibly	Possibility of greater impoverishment and food insecurity, unless interventions recognise the particular dynamics of HIV/AIDS and its impacts on rural households (especially female-headed households) and rural labour.
	2.4. Reduction of income inequalities (between HIV-affected and non-affected households & individuals)	Unlikely	Indications of increasing concentration of land ownership due to HIV/AIDS, i.e. land sold to cover medical and funeral costs, with particularly disadvantageous implications for rural women.
	2.5. Reduction of gender inequalities and enhancing the status of women	Possibly	Possibility of entrenching the subordinate status of rural women, which has become even more fragile due to HIV/AIDS and the loss of traditional systems of social security.
	2.6. Appropriate support for AIDS orphans	Unlikely	Likely to ignore the plight and special needs of orphans unless deliberate component of rural development planning, thereby exacerbating their fragile position in society.
	2.7. Equitable access to essential public services, both for infected/affected persons & households and in general *(due to eroding impacts of HIV/AIDS)*	Possibly	Depends on the nature and type of service provision (e.g. public sector/private sector/NGO) and the design of the fee system (particularly whether HIV/AIDS-affected households may be excluded on financial grounds).
	2.8. Effective/enhanced public sector capacity *(due to eroding impacts of HIV/AIDS)*	Probably	Emphasis on managerial aspects, cost-efficiency and rationalisation in whatever form likely to result in a 'leaner' public sector. This transformation may undermine the capacity of institutions to respond to the eroding effects of HIV/AIDS and the increase in demands from infected/affected households and communities.
	2.9. Job security and job flexibility for infected and affected employees	Unlikely	If 'right-sizing' or 'down-sizing' is pursued, job security unlikely to be guaranteed for most public sector employees. Health status or level of productivity may become grounds for retrenchment.
	2.10. Ensuring sufficient and qualified/skilled labour supply *(due to loss of labour)*	Possibly?	There may be a focus on labour supply in certain job categories or professions, but these may not be the same categories that will see loss of labour due to HIV/AIDS.
	2.11. Financial stability & sustainable revenue generation *(threatened by HIV/AIDS)*	Probably	Emphasis on cost-recovery through user charges likely to fail, unless cross-subsidisation measures are built in.
	2.12. Support for social support systems & social cohesion *(eroded by HIV/AIDS)*	No	Community development programmes could potentially strengthen or weaken social support systems, depending on how they are designed and implemented.
	2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households (e.g. widows/widowers, children, elderly)	Possibly?	Participatory planning approaches may promote or impede empowerment of rural men and women, PLWHAs and affected households, depending on design and implementation.
	2.14. Reduction of AIDS-related stigma and discrimination	Unlikely	Retrenchments using health status as criterion likely to enhance stigma and discrimination.
	2.15. Reduction of social instability & conflict / violence *(due to, or aggravated by, HIV/AIDS)*	No	Inequitable distribution of land, resources and employment opportunities and lack of hope and future prospects may fuel conflict and violence.

Appendix 2. Country Profiles

Country Profile of Cameroon

Country Profile of Senegal

Country Profile of Uganda

Country Profile of Zimbabwe

Country profile of Cameroon																							
Indicators / Data		1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
1. Demographic Trends																							
1.1.	Total population (millions)[cxvii]	8.39	8.60	8.83			10.05		10.49	10.8	11.11	11.43	11.86	12.19	12.54	12.90	13.28	13.66	14.17	14.69	14.7	15.1	15.2
1.1.1.	Women (% of total)[cxviii]		50.13									50.97						50.96			50.95		
1.2	Urban population (% of total)[cxix]					34.33			37.8	39	40	41	41.5	42		44	45	45.4	47.2	48.8	47.9	49	49.5
1.3.	Urbanisation rate[cxx]													5.1			4.7					4	
1.4.	Number of local & foreign migrants in the country (thousands)[cxxi]						250					250											
1.5.	Number of refugees & internally displaced persons (thousands)[cxxii]											4.1		42	44			46.4					
2. HIV/AIDS																							
2.1.	Adult HIV prevalence rate (%)								0.5	1.4				2			3	5.5		7.2	7.7	11	
2.1.1.	Among women (%)																						
2.1.2.	In urban areas (%)[cxxiii]											1.1-8.6											
2.1.3.	In rural areas (%)[vii]											0.4											
2.2.	Number of adults (15-49) living with HIV/AIDS (thousands)[vii]																				52	937	
2.2.1.	Women (% of total)[vii]																				55.77		
2.3.	AIDS deaths (adults & children) (thousands)[vii]																				52		
2.4.	AIDS orphans (thousands)[vii]											3					36				270		210
2.5.	HIV prevalence rate among public servants (%)																						
2.5.1.	Among teachers (%)																						
2.5.2.	Among health workers (%)																						
2.5.3.	Among military officers (%)											3.3						15					
2.6.	STI prevalence rate (%)																						
3. Income poverty and inequality																							
3.1.	Population living on less than $1/day (%)																	53.3					40.2
3.1.1.	Women (% of total)																						
3.1.2.	In urban areas (%)																	41.4					22.1
3.1.3.	In rural areas (%)																	59.6					49.9
3.2.	Population living on less than $2/day (%)																						
3.3.	Unemployment rate (% of labour force)[cxxiv]																17	8.4					8
3.3.1.	Among women (%)																	6.8					
3.3.2.	Among men (%)																	9.8					
3.4.	GINI coefficient																	0.406					0.408
4. Human development																							
4.1.	Life expectancy (yrs)[cxxv]		50	48			52		53.4			53.7	55.1	55.3	56.3	55.1	55.3	56.7	54.7	54.7	54	55	
4.2.	Population with access to safe water (%)[cxxvi]			26			33			42			48		50							52	

Indicators / Data	198.0	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
4.3. Population with access to sanitation (%)[cxxvii]					48				46			50									75	
4.4.a. Population with access to essential drugs (%)																						
4.4.b. Population with access to basic health care services (%)[cxxviiia]						41			70		80					41			70			
4.5. Population with access to ARV treatment (%)																						
4.6. Contraceptive prevalence (% of population)[cxxix]	2	3						16									19					
4.7. Physicians (per 100,000 population)[cxxx]	6.2					8.9		8.4		8.7		8	8.3	7			8	8				
4.8. Adult literacy rate (%)[cxxxi]						48		59.5		48	54.1	54	56.5	60.8	62.1	63.4	61.4	71.7	73.6			
4.8.1. Among women (%)	36					35.6		44.9		36	42.6	43	45	49	49.5	52.1	55.2	64.6	52	61	68	71
4.8.2. Among men (%)	62					61.1		65.9		61	66.3	67	70	73.1	74	75.1	72	79	75	77	81	83
4.9. Primary enrolment rate (%)[cxxxii]							109					111										
4.9.1. Among women (%)			97	98			100				93		93									
4.9.2. Among men (%)			117	118			119				108		109									
4.10. Secondary enrolment rate (%)[cxxxiii]																27	45.2					
4.10.1. Among women (%)			16				20		21		20	23										
4.10.2. Among men (%)			27				32		31		31	32										
4.11. Pupil : teacher ratios[cxxxiv]	48.2					50.9	50.2	51.3	53.2	52.7	51.1	52	50.7	52	52	52	48.2	51.4	53			
4.11.1. In urban areas																						
4.11.2. In rural areas																						
5. Economic structure & performance																						
5.1. Ratio of agriculture : industry : services (% of GDP)	29:23 :48																	41:20 :39				
5.2. GDP growth (%)[cxxxv]	8	6.9	9.9	-4.5	-7.1	-4	-4							0.36								
5.3. GDP per capita growth (%)[xix]	2.4								3									5.3				
5.4. GDP per capita (US$)[xix]									1010		960	860						650				
5.5. Total ODA (as % to GNP)																						
5.6. External debt service (as % of GNP)[cxxxvi]		3.7							27		47.9	58		57.5			54					

Country profile of Senegal																							
Indicators / Data		1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
1.	**Demographic Trends**																						
1.1.	Total population (millions)	5.6	5.8	5.9	6.1	6.3	6.4	6.6	6.8	6.9	7.1	7.3	7.5	7.7	7.9	8.1	8.3	8.6	8.8	9.0	9.3	9.6	9.9
1.1.1.	Women (% of total)									52.5					51.7	52.3							
1.2.	Urban population (% of total)														41							43.6	43.8
1.3.	Urbanisation rate									3.9						4.0						4.2	
1.4.	Number of local & foreign migrants in the country (thousands)									987					1.461								
1.5.	Number of refugees & internally displaced persons (thousands)																						
2.	**HIV/AIDS**																						
2.1.	Adult HIV prevalence rate (%)																				1.2		1.4
2.1.1.	Among women (%)										0.90	1.5	1.4	0.7	0.10		1.9	1.7	1.6	2.1			
2.1.2.	In urban areas (%)																						
2.1.3.	In rural areas (%)																						
2.2.	Number of adults (15-49) living with HIV/AIDS (thousands)																					77	
2.2.1.	Women (% of total)																						
2.3.	AIDS deaths (adults & children) (thousands)																					30	
2.4.	AIDS orphans (thousands)																					20	
2.5.	HIV prevalence rate among public servants (%)																						
2.5.1.	Among teachers (%)																						
2.5.2.	Among health workers (%)																						
2.5.3.	Among military officers (%)																						
2.6.	STI prevalence rate (%)												1.6					1.3					
3.	**Income poverty and inequality**																						
3.1.	Population living on less than $1/day (%)															59							
3.1.1.	Women (% of total)																						
3.1.2.	In urban areas (%)																						
3.1.3.	In rural areas (%)																						
3.2.	Population living on less than $2/day (%)																						
3.3.	Unemployment rate (% of labour force)																						
3.3.1.	Among women (%)									30.3						38							
3.3.2.	Among men (%)									29.7						35.3							
3.4.	GINI coefficient[cxxxvii]																	0.30					
4.	**Human development**																						
4.1.	Life expectancy (yrs)							48		52									54				55.1
4.2.	Population with access to safe water (%)													52							70		78
4.3.	Population with access to sanitation (%)													59.9					65.2				

Indicators / Data	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
4.4. Population with access to essential drugs (%)																						
4.5. Population with access to ARV treatment (%)																						
4.6. Contraceptive prevalence (% of population)													4.1					7.1		6		
4.7. Physicians (per 100,000 population)						6.03	6.04	7.46	5.73		5.42									6		
4.8. Adult literacy rate (%)																						33
4.8.1. Among women (%)																						30
4.8.2. Among men (%)																						51.1
4.9. Primary enrolment rate (%)									52			56.5	55	54.3	54.4	54.6	57	60	62	65.6	68.3	
4.9.1. Among women (%)												47	46	45.9	46.1	46.6	50	53	56	58.1		
4.9.2. Among men (%)												66	64	62.7	62.8	62.7	64	67	68	73.1		
4.10. Secondary enrolment rate (%)																		20.6		21.8		
4.10.1. Among women (%)																				6.0		
4.10.2. Among men (%)																				12.4		
4.11. Pupil : teacher ratios																					51	
4.11.1. In urban areas																						
4.11.2. In rural areas																						
5. Economic structure & performance																						
5.1. Agriculture : industry : services																						
5.1.1. Share of agriculture to GDP	12.9	11.8	14.4	15.0	10.2	10.9	12.5	11.8	12.9	10.1	11.8	10.5	19.5	9.6	10.8	10.3	10.8	9.2	8.1	8.2	9.5	10.2
5.1.2. Share of industry to GDP	16.0	17.1	17.1	17.1	17.5	17.2	17.2	17.9	18.4	18.3	18.6	18.5	19.0	18.9	18.3	19.5	19.5	19.6	20.1	20.5	20.6	20.7
5.1.3. Share of services to GDP	48.7	48.0	47.6	47.0	47.8	47.0	48.6	48.3	47.4	49.1	47.9	49.1	48.9	49.0	48.6	48.6	48.9	50.6	51.9	51.6	50.6	50.6
5.2. GDP growth (%)											3.9	-0.4	2.2	-2.2	2.4	4.8	5.6	5.2	5.7	5.1	5.5	
5.3. GDP per capita growth (%)	-5.7	-3.7	12.3	-0.4	-6.4	1.1	1.9	1.3	2.9	-4.0	1.1	—3.0	0.5	-4.8	0.2	2.4	2.4	2.3	3.0	2.3	2.8	2.8
5.4. GDP per capita (US$)																						
5.5. Total ODA (as % to GNP)																						
5.6. External debt service (as % of GNP)															88.1		80.1			72.9		

Sources: This Country Profile draws mainly on national sources, which include Ministère de l'Economie, des Finances et du Plan (1988) (1993a), (1993b), (1997), (2001b), (2004) and Ministère de la Santé Publique (1999), the National Strategic Framework for the Fight Against AIDS 2002-2006 and other publications on economic and social development by Senegal's statistical office. UNDP (2001) has also been consulted.

Country profile of Uganda																							
Indicators / Data		1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
1. Demographic Trends																							
1.1.	Total population (millions)	12.6	12.9	13.2	13.6	13.9	14.2	14.5	14.8	15.2	15.5	15.8	16.7	17.3	17.9	18.5	19.3	19.8	20.4	21	21.8	22.2	22.8
1.1.1.	Women (% of total)	50.8											50.9				50.8					50.5	50.4
1.2.	Urban population (% of total)	8.7	9	9.2	9.5	9.7	9.9	10.2	10.2	10.7	10.9	11.2	11.3	11.7		12			13	14.9		16	16
1.3.	Urbanisation rate	3.9											5.8										4.6
1.4.	Number of local & foreign migrants in the country (thousands)																						
1.5.	Number of refugees & internally displaced persons (1,000)																0.4			0.65	0.23	0.82	0.83
2.	**HIV/AIDS**																						
2.1.	Adult HIV prevalence rate (%)												30[cxxxvii]	18	15		14					6.1	6.5
2.1.1.	Among women (%)											11.7			15.8								
2.1.2.	In urban areas (%)																						8.8
2.1.3.	In rural areas (%)																						4.2
2.2.	Number of adults (15-49) living with HIV/AIDS (thousands)											0.01	0.022	0.03	1.3	0.042					1.29	1.11	0.95
2.2.1.	Women (% of total)											5.02	50.5	51.6	52.3	52.7	53.1	53.6	53.8	53.9	58.8		56.3
2.3.	AIDS deaths (adults & children) (thousands)																				0.84	0.01	
2.4.	AIDS orphans (thousands)											177			0.78								2
2.5.	HIV prevalence rate among public servants (%)																3.27	3.38	3.7	2.75	5.01	5.98	5.56
2.5.1.	Among teachers (%)																3.7			5		3.56	2.16
2.5.2.	Among health workers (%)																						
2.5.3.	Among military officers (%)																						
2.6.	STI prevalence rate (%)																						
3.	**Income poverty and inequality**																						
3.1.	Population living on less than $1/day (%)					44.4													44		44.4	35	35
3.1.1.	Women (% of total)																						
3.1.2.	In urban areas (%)													28							10		
3.1.3.	In rural areas (%)													60							39		
3.2.	Population living on less than $2/day (%)																					65.6	55.1
3.3.	Unemployment rate (% of labour force)													65.3					7.4				
3.3.1.	Among women (%)													24.1					8.0			7.3	7.1
3.3.2.	Among men (%)													41.2					6.7			5	4.6
3.4.	GINI coefficient													0.43	0.43	0.44	0.44						
4.	**Human development**																						
4.1.	Life expectancy (yrs)	46.5		48					48.3			53	48.1	43			41.9		42	40.9	43.2	43	43
4.2.	Population with access to safe water (%)						20					20	25.8	23.9	26.6	30.2	34.0	39.4	40.1	46	50	51.8	53.8
4.3.	Population with access to sanitation (%)					47.6		30				16			46.7	46.7	46.7	47.6	47.5	48		49.8	51.9

Indicators / Data	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
4.4. Population with access to essential drugs (%)																						
4.5. Population with access to ARV treatment (%)																						
4.6. Contraceptive prevalence (% of population)											5	5				15					23	23
4.7. Physicians (per 100,000 population)											4	4						5	4			
4.8. Adult literacy rate (%)						57					48	51	51			62		61		66.1	68	77
4.8.1. Among women (%)						45					35		37			50					51	59
4.8.2. Among men (%)						55					62		65			74		73		51	85	83
4.9. Primary enrolment rate (%)	50																	70	85		76	87
4.9.1. Among women (%)	40.9	42.6	42.6	43.5	43.5	44	45	45	44	45	44.4	44.8	44.1	44.2			46.3	46.6	47.3	47.5	48.2	48.9
4.9.2. Among men (%)																	53.7	53.4	52.7	52.5	51.8	51.1
4.10. Secondary enrolment rate (%)	5	5	8			10	12	13	14			13	13	14				50				
4.10.1. Among women (%)	28.9	30.4	31.3	32.5	32.7	33	35	33	34	35	36.6	37.7	30.7				40	38	40.5	41.4	44.1	44.1
4.10.2. Among men (%)																	60	62	59.5	58.6	55.9	55.9
4.11. Pupil : teacher ratios	34	35	36	35	34	33	34	34	34	34	28	33									58	54
4.11.1. In urban areas																						
4.11.2. In rural areas																						
5. Economic structure & performance																						
5.1. Agriculture as % of GDP	70.5	52	50.2	53.1	51.5	50.5	55	55.5	55	55.1	53.8	49.8	48.5	49	47.7	45.7	44.1	43.3	42.9	56.3	41.9	40.9
5.2. GDP growth (%)	2.9				-4.7	0.2	1.1	6.7	7.7	6.5	5.5	4.4	3.16	8.4	5.3	10.6	8.5	4.7	7.8	7.8	5	5.6
5.3. GDP per capita growth (%)										3.4	2.6	1.02	1.34	1.00	1.74	2.5	2.71	2.5	4.9	4.9		4
5.4. GDP per capita (US$)	136	146	144	147	161	187	226	261	276	280	200	210	240	265	260	270	285	290	296			
5.5. Total ODA (as % to GNP)								4.3	4.3	9.2	14.5	16.6	16.6	13.4	13.8	10	9.8	11.4	10.2	9.2		
5.6. External debt service (as % of GNP)							26.8				3.4									2.9		

Country profile of Zimbabwe																							
Indicators / Data	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
1. Demographic Trends																						
1.1. Total population (millions)[cxxxix]			7.5										10.4					11.8				
1.1.1. Women (% of total)			51										51					52				
1.2. Urban population (% of total)[i]			25.7					28.4					31					34.2				
1.3. Urbanisation rate																						
1.4. Number of local & foreign migrants in the country (thousands)																						
1.5. Number of refugees & internally displaced persons (thousands)																						
2. HIV/AIDS[CXL]																						
2.1. Adult HIV prevalence rate (%)	<1										16.5				17.4		22	25.8		25.1	35	33.7
2.1.1. Among women (%)																						
2.1.2. In urban areas (%)																						
2.1.3. In rural areas (%)																						
2.2. Number of adults (15-49) living with HIV/AIDS (thousands)																						2.3
2.2.1. Women (% of total)																						52
2.3. AIDS deaths (adults & children) (thousands)																						200
2.4. AIDS orphans (thousands)																						780
2.5. HIV prevalence rate among public servants (%)																						
2.5.1. Among teachers (%)																						
2.5.2. Among health workers (%)																						
2.5.3. Among military officers (%).																						
2.6. STI prevalence rate (%)																						
3. Income poverty and inequality																						
3.1. Population living on less than $1/day (%)[cxli]											36											
3.1.1. Women (% of total)																						
3.1.2. In urban areas (%)																						
3.1.3. In rural areas (%)																						
3.2. Population living on less than $2/day (%)[xli]											64.2										65	
3.3. Unemployment rate (% of labour force)			18																		60	
3.3.1. Among women (%)																						
3.3.2. Among men (%)			10.9										22.1					8.7				
3.4. GINI coefficient[cxlii]											56.8											
4. Human development																						
4.1. Life expectancy (yrs)[i]			58								62							54				40
4.1.1. Of women (yrs)[i]			59								62							57.2				
4.1.2. Of men (yrs)[i]			57								58							52.6				

Indicators / Data	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
4.2. Population with access to safe water (%)													80					83				
4.3. Population with access to sanitation (%)			50										68					72				
4.4. Population with access to essential drugs (%)																						
4.5. Population with access to ARV treatment (%)																						
4.6. Contraceptive prevalence (% of population)[cxliii]					26.6				36.1						42.2					50.4		
4.7. Physicians (per 100,000 population)	15					15					14					13						
4.8. Adult literacy rate (%)[i]			62.3										80.4					85.6		87.8		
4.8.1. Among women (%)			55.6										75.1					82.1		84.3		
4.8.2. Among men (%)			69.5										86.1					90.3		91.7		
4.9. Primary enrolment rate (%)[i]													89.0					87.7				
4.9.1. Among women (%)													89.2					88.1				
4.9.2. Among men (%)													88.7					87.4				
4.10. Secondary enrolment rate (%)[i]													66.5					70.9				
4.10.1. Among women (%)													58.8					65.4				
4.10.2. Among men (%)													76.1					76.6				
4.11. Pupil : teacher ratios[cxliv]												39	39	39	39	40	39	39	39	39	41	37
4.11.1. In urban areas																						
4.11.2. In rural areas																						
5. Economic structure & performance																						
5.1. Ratio of agriculture : industry : services (% of GDP)[cxlv]						2:2:6	2:2:6	3:1:6	2:2:6	1:3:6	2:2:6	2:2:6	1:3:6	2:2:6	2:2:6	2:2:6	2:2:6	2:2:6	2:2:6	2:2:6	3:1:6	
5.2. GDP growth (%)[cxlvi]	10.6	12.5	2.6	1.6	-1.9	6.9	2.1	1.1	7.6	5.2	7.0	7.1	-8.4	2.1	5.8	0.2	9.7	1.4	0.8	-4.1	-6.8	
5.3. GDP per capita growth (%)[viii]	7.3	8.8	2.8	0	-4.6	4.0	-1.0	-2.0	4.3	2.0	3.7	3.9	-11.2	-1.4	2.3	-3.1	6.2	-1.8	-2.3	-7.0	-9.5	
5.4. GDP per capita (US$)[viii]						10523	9483	10186	9814	8538	7995	4350	3658	3225	2584	2346	2235	1301	639	608	395	
5.5. Total ODA (as % to GNP)																						
5.6. External debt service (as % of GNP)																						

Appendix 3: Key respondents in country assessments

List of key informants (Cameroon)

1. Mr. Alioum, Director of the Human Development Division, Ministry of Economic Affairs, Planning, and Regional Development (MINEPAT)
2. Mr. Bakuzakundi, Focal Person for HIV/AIDS, World Bank
3. Mr. Bitomo, Deputy Director in charge of HIV/AIDS, Ministry of Higher Education (MINESUP)
4. Dr. Gnaore, Resident Representative, UNAIDS
5. Mr. Bernard Mbangue, Director of Research and Projects, Ministry of Public Health (MINSANTE)
6. Hon. Joseph Mboui, Member of Parliament and President of the Commission on Education and Research
7. Mr. Emerant Mebenga, Director of Administrative Affairs and Finance, Urban Community Yaounde
8. Ms Madeleine Mitlassou, Director ad interim, Public Communication, Ministry of Communication (MINCOM)
9. Mr. Mouliom, President of the Association of Persons Living with HIV/AIDS in Cameroon
10. Dr. Jembia Musoko, Representative of the Permanent Secretary to the National Committee for the Fight Against AIDS (CNLS)
11. Mr. Bernabé Nkolo Essimi, Director of Community Development Division, Ministry of Economic Affairs, Planning and Regional Development (MINEPAT)
12. Mr. Sadjo, Focal Point for HIV/AIDS, Cameroon Employers' Federation (GICAM)
13. Mr. Claude Tchamba, Director of Research and Planning, Ministry of Finance and the Budget (MINFIB)
14. Mr. Angel Youmbi, Programme Officer, Cameroon National Association for Family Welfare (CAMNAFAW)
15. Mr. Richard Youta, Director of Prospective Planning, Ministry of National Education (MINEDUC)

List of key informants (Senegal)

1. Colonel Adama, Head of the Division of Reproductive Health
2. Mr Diatta, Director of the AIDS Service
3. Mr Cheikh Ahmadou Bamba Diop, Division of Reproductive Health
4. Mr Sidy Diop, Director of the HYGEA Office
5. The Honourable Deputy Madior Diouf, Department of Economic and Financial Co-operation
6. Mrs Ndèye Mayé Diouf, President of the National Assembly Health Commission
7. Mr Demba Kone, Director of the Youth Advancement Programme
8. Mr Aboubacry Demba Lom, Director of Planning, Ministry of Economic Affairs and Finance
9. Dr Abdoulaye Ly, Head of the STI/HIV/AIDS Division, National AIDS Council (NCLS)
10. Dr Aïssatou Diack Mbaye, Health Specialist, Population and Nutrition, World Bank
11. Mr Ousmane Ndoye, Economist, Head of Planning Division, Ministry of Planning and Sustainable Development
12. Mr Maguatte Niang, Economist Planning Department
13. Mr Ousmane Samb, President of the NGO on Population, Women and Development
14. The Honourable Deputy Famara Sarr, Co-ordinator of the Network of Parliamentarians for Population and Development
15. Mrs Rokhaya Sene, Director of Human Resource Planning and Chair of the Planning Commission on Human and Sustainable Development, Ministry of Economic Affairs and Finance
16. Mrs Aminata Kane Toure, Economist Planning Department

List of Key Informants (Uganda)

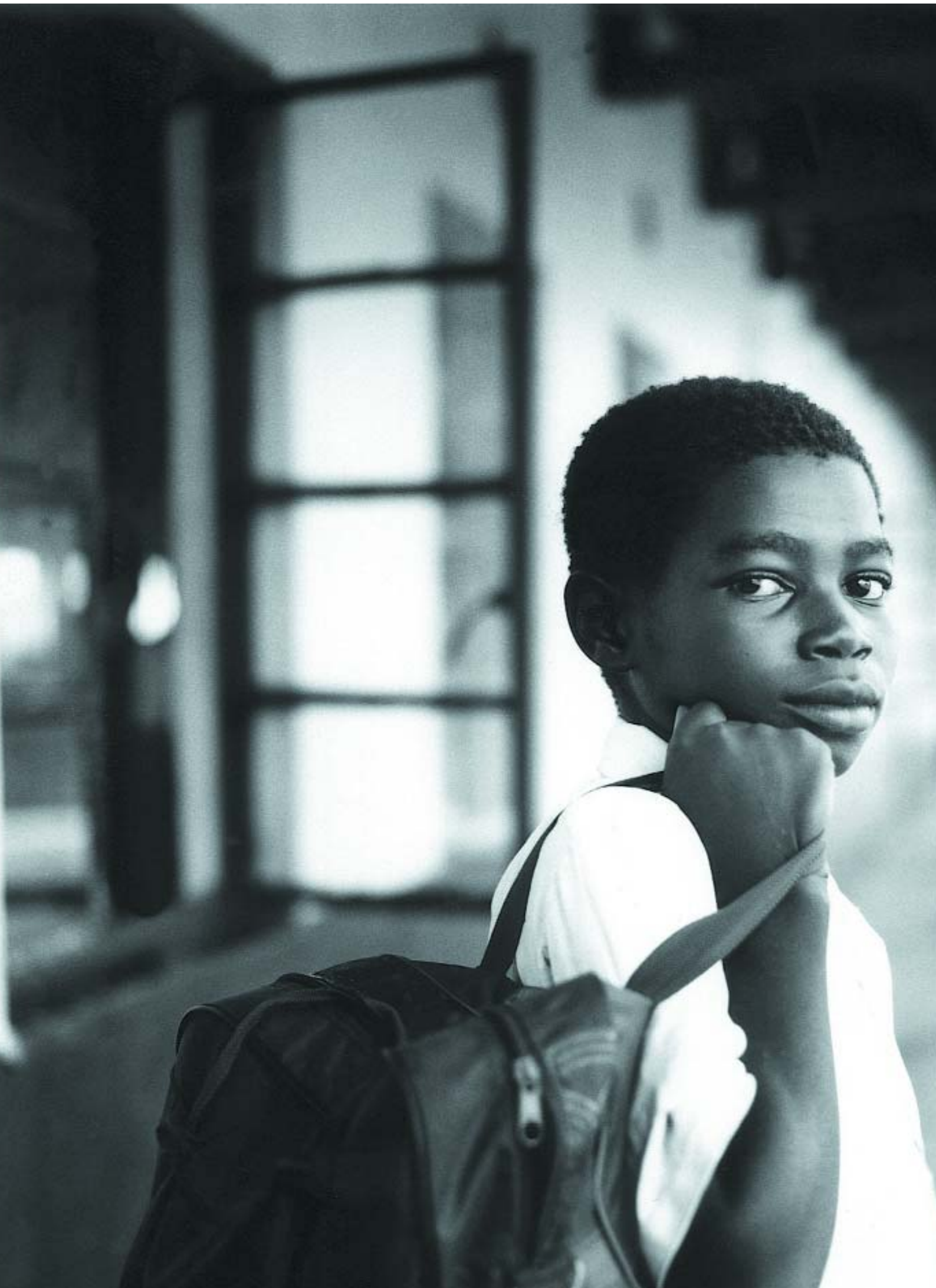
1. Dr. Emanuel Baingana-Kasheka, Director, Monitoring and Evaluation, Uganda AIDS Commission
2. Ms. Catherine Barasa Asekenyi, HIV/AIDS Technical Advisor, Ministry of Education and Sports
3. Mr. Paul Bogere, Assistant Commissioner Human

Resource Development, Ministry of Public Service and Secretary of the Partnership Forum (AIDS)

4. Ms. Celia Tusiime Kakande, World Vision International – Uganda
5. Mr. Robert Khaukha, Planner and AIDS Focal Person, Ministry of Agriculture, Animal Industry and Fisheries (MAAIF)
6. Dr. Frank Mabirizi, Deputy Chairperson, National Planning Authority
7. Hon. Nathan Mafabi-Nandala, Chairperson of the Parliamentary Committee on Economy
8. Ms. Elizabeth Mushabe, HIV/AIDS Partnership Development Officer (represented the Director of Policy and Research of UAC)
9. Hon. Isaac Musumba, Minister of State for Finance, Planning and Economic Development
10. Hon. Proscovia Musumba, Chairperson of the Parliamentary Committee on Presidential and Foreign Affairs
11. Mr. Patrick Mutabwire, Commissioner, Local Councils Development, Ministry of Local Government
12. Mr. Peter Okwero, World Bank, Uganda Country Office
13. Prof. Francis Omaswa, Director of Health Services, Ministry of Health
14. Hon. Manuel Pinto, Director, Office of Parliamentary Professional Development
15. Mr. Tony Takenzire, Project Officer, National Guidance and Empowerment Network of People Living with HIV/AIDS (NGEN+)
16. Hon. Elioda Tumwesigye, Chairperson of the Standing Committee on HIV/AIDS
17. Ms. Beatrice Were, Coordinator of the National Community of Women Living with AIDS in Uganda (NACWOLA) and Founding Member of the National Guidance and Empowerment Network of People Living with HIV/AIDS (NGEN+)
18. Mr. Edward Were, Statistician, Uganda AIDS Commission

List of Key Informants (Zimbabwe)

1. Mr. L. C. Bowora, Director: Planning, Research and Development, Ministry of Gender, Youth Development and Employment Creation
2. Mr. G. Chaibva, Member of Parliament (Harare South)
3. Cde. Aeneas Chigwedere, Minister of Education Sports and Culture
4. G. Chiome, Youth Program Manager (WASN)
5. Dr. D. Chitate, Director, National AIDS Council
6. Dr. Ignatius Chombo, Minister of Local Government and National Housing
7. Mr. M. Dzinoreva, Deputy Secretary, Administration and Human Resources Development, Ministry of Local Government and National Housing
8. Mr. Dzinotizei, Director, Division of Economic Affairs
9. E. Gunduza, Women's Program Manager (WASN)
10. Mrs. J. Koulem, Director, Poverty Reduction Forum
11. Mrs. C. Matizha, Deputy Director, Gender Issues
12. Dr. N. Matshalage, Deputy Director, SAFAIDS
13. Ms Marvelous Muchenje, The Center for People Living Positively With AIDS
14. Mr. J. Mudehwe, Executive Director: National Association of Non-governmental Organisation (NANGO)
15. Ms Muhambi, Director, Zimbabwe Aids Network
16. Mr. Mugudza, Director, Youth Development and Vocational Training and National Youth Service
17. Cde. Elliot Manyika, Minister of Gender, Youth Development and Employment Creation
18. Mrs. Nemasasi, Director, Budgets, Ministry of Finance & Economic Development
19. Dr. David Parirenyatwa, Minister of Health and Child Welfare
20. M. Sandasi, Acting Director, Women and AIDS Support Network (WASN)
21. L. Tafa, Gender Program Assistant Manager (WASN)



Endnotes

Chapter 1. Introduction

[i] These factors are recognised in the background document to the UNDP Regional Project on HIV and Development titled "Building Capacity for Reducing HIV Spread and Consequences on Development".

[ii] Although a country assessment was also conducted in Burkina Faso, it was eventually excluded from the final report because the submitted Country Paper did not provide enough comparable information and analysis in accordance with the terms of reference of the study.

[iii] It proved difficult to identify a representative from Cameroon and Mozambique before the first meeting of the Reference Group. Once the project got underway, it was decided that it was not feasible or desirable to introduce new members to the Reference Group after it held its first meeting. Mozambique, like Tanzania and Ethiopia, eventually fell through as a case study. The Reference Group also included a representative from Zambia, because initially Zambia was considered a potential case study. A revision of the preliminary selection process eventually resulted in the exclusion of Zambia.

Chapter 2. Development planning in sub-Saharan Africa: A brief overview

[iv] In countries that gained political liberation at a later stage after a long period of conflict, like Zimbabwe or South Africa, the search for a common national identity clearly held particular resonance.

[v] One could argue that linked to this was a fifth challenge for African states, namely to develop a vibrant civil society and strong social linkages between the state and other social actors. In fact, prior to independence many future African leaders seemed to espouse to this notion. However, in practice such links were rarely developed. Instead, strong social actors were seen as a potential threat, initially to the legitimacy of the political leadership, but increasingly to its control (see Cooper, 2002).

[vi] Although capitalist in ideological orientation, a fundamental tenet of Keynes' model was the appropriateness of relatively comprehensive state intervention in the promotion of economic development.

[vii] See Mkandawire (2001) for a critique of the negative (and self-fulfilling) views of the African state.

[viii] For a more detailed overview of rural development planning in sub-Saharan Africa since the 1960s, see Ayeni (1999), Baker and Pedersen (1992), Belshaw (2002) and Lea and Chaudhri (1983).

[ix] Tanzania's First and Second Five Year Plans, formulated in the late 1960s and early 1970s, expected that around 80% of development funds would be provided by foreign funds. Likewise, Nigeria's national development plan of 1962-1968 assumed that 50% of resources required would come from foreign aid (Seidman, 1974).

[x] In the 1960s, countries like Ghana and Tanzania had already experienced the impact of falling world prices on their economies. Between 1955 and 1965, Ghana successfully doubled its cocoa output. However, the sharp drop in world cocoa prices in 1965, from £500 to £90 a ton, led to economic crisis. Similarly, falling world prices for Tanzania's major exports between 1962 and 1967 resulted in a loss of $22 million – roughly twice the inflow of foreign funds in that period (Seidman, 1974:83).

[xi] The gatekeeper state refers to a situation where the state/political leadership controls the narrow channels of advancement that exist in society, in particular the intersection between internal and external economies. Colonial states were by definition gatekeeper states. As a means of legitimising control, gatekeeper states put strong emphasis on national unity and national discipline (Cooper, 2002).

[xii] The figures include Haiti, but exclude Island LDCs in sub-Saharan Africa.

[xiii] In the words of Fantu Cheru (2002b:303): "While many elements of macroeconomic adjustment are critically important for promoting economic growth and social development, the context in which these policies have been applied is largely motivated to ensure that debtor nations fulfil their interest and principal payments to creditor institutions." He further notes that this "single-minded preoccupation" has had a regressive impact on human development.

[xiv] Most of these critics have not opposed the system of user fees in principle, but have pointed to problems with

the design of fee policies (e.g. price levels; criteria for exemption and subsidisation mechanisms; payment for registration to see medical personnel as opposed to payment for prescribed treatment), the lack of complementary policies to enhance the financial sustainability of the health sector, and the lack of understanding of the impact of broader contextual factors (e.g. willingness and ability to pay, institutional capacity for the collection and management of revenue, etc.).

[xv] Court and Kinyanjui (1986:371) make the following observation concerning the high level of donor involvement in the education sector: "Africa has been host to innumerable projects, experiments, and models which in some cases reflect the wholesale transplant of established foreign models – Swedish folk development colleges, Cuban agriculture schools, British libraries, Canadian technical colleges – and, in others, reflect the powerful and often passing fashions of donor conviction."

[xvi] For example, the 1987 Brundtland Report introduced the notion of sustainable development, which was based on the view that the goals of poverty eradication, socio-economic development and environmental protection were mutually supportive, consistent and non-conflictual. (See Barraclough (2001) for a discussion of this concept).

[xvii] Initially, human development was interpreted as having three essential components, related to longevity, education and a decent standard of living, whilst political freedom and human rights were also recognised as important 'choices'. Throughout the 1990s, the concept has been further enriched by including considerations regarding environmental sustainability (1992), participation (1993 and 2000) and gender equality (1995), amongst others.

[xviii] In 1988, there were 28 one-party states, nine military oligarchies, seven multi-party constitutions, two racial oligarchies and one monarchy in sub-Saharan Africa. In contrast, in 1999 the subcontinent had 42 multi-party constitutions, two military oligarchies, one monarchy, one state with no central government (Somalia), one 'no party' government (Uganda) and one one-party system (Eritrea) (Thomson, 2000: 216). Yet, various stages of democratic transitions have been identified, varying from 'precluded transitions' (2), 'blocked transitions' (12), 'flawed transitions' (13) and 'democratic transitions' (16) (Bratton and Van de Walle, in Thomson, 2000).

[xix] For a more detailed description of the multiple impacts of HIV/AIDS, see, amongst others, Barnett and Whiteside (2002); Cheru (2002b); Collins and Rau (2000); UNDP (2001a).

[xx] In highlighting those perspectives that have been most influential for development planning in sub-Saharan Africa, disproportionate attention is given to mainstream, often donor-driven, perspectives on these issues. This is not to imply that there has been a lack of alternative, possibly more radical, perspectives on development in sub-Saharan Africa, or that such perspectives are less valid. However, it has been argued that these perspectives, particularly from African scholars, have been less influential in shaping planning theory and practice than the views (and resources) of international financial institutions and multilateral and bilateral agencies (Hydén, 1994; Kinyanjui, 1994; Mkandawire, 2001).

Chapter 3. A typology of development planning in sub-Saharan Africa

[xxi] This working definition is drawn from, amongst others, Campbell and Fainstein (2003), Conyers and Hills (1984) and Martinussen (1999).

[xxii] See Mazza (2002) for a scathing critique of what he regards as the abandonment of technical knowledge in planning.

[xxiii] According to information on the World Bank website, as of April 2003, 15 sub-Saharan African countries had developed a PRSP (Benin, Burkina Faso, Ethiopia, Gambia, Guinea, Malawi, Mali, Mauritania, Mozambique, Niger, Rwanda, Senegal, Tanzania, Uganda and Zambia). An additional 13 countries on the subcontinent had developed an I-PRSP (Cameroon, Cape Verde, Central African Republic, Chad, Côte d'Ivoire, DRC, Ghana, Guinea-Bissau, Kenya, Lesotho, Madagascar, Sao Tome & Principe and Sierra Leone).

[xxiv] The following countries had already adopted the MTEF in the 1990s: Ghana (since 1996), Guinea (1997), Kenya (1998), Malawi (1996), Mozambique (1997), Rwanda (1999), South Africa (1997), Tanzania (1998) and Uganda (1992).

[xxv] Some critical commentators have argued that, whereas better coordination of donor involvement and resource flows is to be applauded, the emphasis on donor coordination hides the fact that the issue is sometimes about rationalising aid. Also, given the emphasis on a 'good policy environment' as interpreted by the World Bank and bilateral donor agencies, the SWAps seem to be more concerned with a fairly restricted focus on public sector management rather than issues of coordination and governance and are (still) linked to donor conditionality (see, amongst others, Walt et al., 1999).

[xxvi] Although sub-Saharan Africa has the lowest proportion of people living in urban areas compared to other regions, it has one of the highest urban growth rates in the world. Between 1960 and 1980, the average annual urban growth rate in sub-Saharan Africa was 5.2% (Mumtaz and Wegelin, 2001); between 1980 and 1988, it increased to 6.2% per annum (Stren, 1991).

Chapter 4. Development planning and HIV/AIDS: An assessment of principal development planning frameworks

[xxvii] See also Tarantola (2001). An expanded response

combines improvements in the quality, scope and coverage of prevention, care, support and impact mitigation efforts with interventions that address societal factors that make people vulnerable to HIV/AIDS.

[xxviii] It is beyond the scope of this paper to elaborate on these factors in detail. These factors have been identified by Barnett and Whiteside (2002), Baylies (2000) and (2002), Collins and Rau (2000), Craddock (2004), Decosas (2002), UNAIDS (2001), UNDP (2002a) and UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002), amongst others. Interested readers can refer to these publications for more a more detailed discussion of how these factors link with HIV/AIDS.

[xxix] See, amongst others, Barnett and Whiteside (2002); Cheru (2002b); Collins and Rau (2000); UNDP (2001a); UNDP Regional Project on HIV and Development in sub-Saharan Africa (2002).

[xxx] At a meeting of the ECA's African Learning Group on PRSPs in November 2002, it was noted that the average 7% growth rate needed to meet the Millennium Development Goal of reducing poverty by half in 2015 will not be met (UNECA, 2002).

[xxxi] The emphasis on patient adherence is possibly more strongly expressed by pharmaceutical companies than by health departments in the region.

Chapter 5. Introduction to the country assessments

[xxxii] Countries that are in conflict or have recently emerged from conflict include Angola, Burundi, CAR, Congo, Côte d'Ivoire, DRC, Guinea Bissau, Liberia, Sierra Leone and Sudan. In 2000, 14 countries had a total population of less than 2 million: Botswana, Cape Verde, Comoros, Djibouti, Equatorial Guinea, Gabon, Gambia, Guinea Bissau, Lesotho, Mauritius, Namibia, Sao Tome & Principe, Seychelles and Swaziland.

[xxxiii] It was further felt that this would also ensure an adequate balance between Francophone, Anglophone and Lusophone Africa.

[xxxiv] Eritrea has LDC status, whereas Togo has both LDC and HIPC status.

[xxxv] Cameroon adopted its MTEF shortly afterwards, in April 2003, which is why it is reflected in Table 5.1 as a country without MTEF.

[xxxvi] Taken from the World Bank website: www.worldbank.org.

[xxxvii] No HIV prevalence data is available for Guinea, Mauritania and Niger.

[xxxviii] See UNDP (2001b) and Barnett and Whiteside (2002).

[xxxix] This is according to the 2002 UNDP Human Development Report (UNDP, 2002b), which classified Zimbabwe, South Africa, Kenya, Ghana and Cameroon as medium human development countries. It needs to be noted that in the 2003 Human Development Report (UNDP, 2003) these classifications have changed. For example, Zimbabwe, Kenya and Cameroon are now considered low human development countries, whereas Togo is classified as a medium human development country.

[xl] Given that only one of the two countries unlikely to adopt a PRSP would be included, the choice for Zimbabwe automatically disqualified South Africa. Similarly, by choosing Senegal over Madagascar to reflect a country with a very low HIV prevalence rate, Madagascar was no longer eligible for selection.

[xli] With the exception of the Central African Republic (12.9%), all other neighbouring countries showed significantly lower adult HIV prevalence rates, e.g. Nigeria (5.8%), Chad (3.6%), Congo (7.2%) and Equatorial Guinea (3.4%). No data was available for Gabon. Most other francophone countries have adult HIV prevalence rates well below 5%.

[xlii] Cameroon was a German colony until Germany's defeat in World War One. In 1919, the League of Nations distributed its territories among other colonial powers. One part of Cameroon was allocated to France, whereas another part was allocated to Britain.

[xliii] Other sources also using five-year intervals but starting at 1984 suggest that in 1994 the adult HIV prevalence rate in Senegal exceeded 1%, a trend that persisted in 1999 (Craddock, 2004:2). Recent UNAIDS (2002) data suggests that in 2001 Senegal's HIV prevalence rate was again below 1%.

Chapter 6. Cameroon

[xliv] This chapter draws on the country assessment conducted by Prof Evina Akam. Prof Evina Akam would like to extend his sincere thanks to Mrs Claire Essomba Toutou and Mrs Lucie Olomo, Miss Rakototondrabe Patricia, Messrs Emmanuel Etolo, Ahmidou Kone and Léon Mudubu Konandé for their contribution to the country assessment.

[xlv] Mr. Mbangue, Director of Research and Projects, Ministry of Health (MINSANTE).

[xlvi] Both data sets for 1996 and 2001 come from the same source, namely the ECAM I and II surveys (MINEFI/DSCN 1996 and 2001). It is, however, unclear whether the observed reduction in poverty was the result of active government effort or whether there are perhaps variations in the methodological approaches to measure poverty between the two surveys.

[xlvii] This information is found on the UIS (UNESCO Information Service) website.

[xlviii] Mr. Bitomo, Deputy Director in charge of HIV/AIDS, Ministry of Higher Education (MINESUP).

[xlix] Mr. Mbangue, Director of Research and Projects, Ministry of Health (MINSANTE).

[l] Dr. Gnaore, Resident Representative, UNAIDS.

[li] Mr. Emerant Mebenga, Director of Administrative Affairs and Finance, Urban Community Yaounde.

[lii] Dr. Jembia Musoko, Representative of the Permanent Secretary to the National Committee for the Fight Against AIDS (CNLS).

[liii] Mr. Bakuzakundi, Focal person for HIV/AIDS, Cameroon Employers' Federation (GICAM).

[liv] Mr. Richard Youta, Director of Prospective Planning, Ministry of National Education (MINEDUC).

[lv] Mr. Claude Tchamba, Director of Research and Planning, Ministry of Finance and the Budget (MINFIB).

[lvi] Before independence, two four-year plans were elaborated and implemented between 1946 and 1959. These two plans were aimed essentially at infrastructure development, such as the port of Douala, railways, national roads, airports, and so on.

[lvii] This is noted in the PRSP's Preface by the Prime Minister.

[lviii] By June 2004, only a draft version of the strategy had been developed (*Stratégie Sectorielle de Promotion de la Femme – Strategy for the Promotion of Women*).

[lix] At the time of this study, the integrated Rural Development Strategy (RSDSP) had been finalised. The Urban Development Strategy was still outstanding.

[lx] In 2003, the higher education sector prepared its HIV/AIDS plan, which was informed by a situation analysis of HIV/AIDS in higher education. This included an assessment of sexual practices and HIV/AIDS among students, administrative and support personnel and, to some extent, among lecturers. In the plan, it is clearly recognised that HIV/AIDS affects teaching staff and other personnel (interview with Mr Bitomo, Deputy Director in charge of HIV/AIDS in the Ministry of Higher Education, MINESUP).

[lxi] Hon. Joseph Mboui, Member of Parliament. Although it did not emerge during the interviews, it is worth noting that recently a parliamentary group on HIV/AIDS has been established.

[lxii] Mr. Claude Tchamba, Director of Research and Planning, Ministry of Finance and the Budget (MINFIB).

[lxiii] Mr. Alioum, Director of the Human Development Division, Ministry of Economic Affairs, Planning, and Regional Development (MINEPAT).

[lxiv] Mr. Youmbi, Programme Officer, Cameroon National Association for Family Welfare (CAMNAFAW).

[lxv] These quotes can be ascribed to Mr. Mouliom, President of the Association of People living with HIV, and Mr Sadjo, Focal person for HIV/AIDS, GICAM, respectively.

Chapter 7. Senegal

[lxvi] This chapter draws on the country assessment conducted by Mr Amadou Ba.

[lxvii] In the 9th Plan for Economic and Social Development (1996-2001), it is stated that the Government of Senegal aims for a double-digit economic growth rate, without specifying what the targeted or ideal growth rate is.

[lxviii] The national poverty datum line is defined on the basis of consumption and is set at 2.400 calories per adult per day.

[lxix] In 1988, male and female unemployment both stood at 30%. By 1994, male unemployment had increased to 35% whereas female unemployment had increased to 38%.

[lxx] The type of HIV identified (HIV-2) is considered a less virulent strain of the virus. It is still the most common type of HIV diagnosed in Senegal (see, amongst others, Oppong and Agyei-Mensah, 2004; Putzel, 2003).

[lxxi] These figures vary considerably from those reflected in UNAIDS (2001), which estimates that by the end of 2000 there were 27.000 people living with HIV/AIDS in Senegal, of whom 24.000 were between 15-49 years. The gender ratio in the UNAIDS report is also very different: of these 24.000 adults, 14.000 are women and 10.000 are men. This means that the ratio is reversed: for every 10 women infected with HIV, there are 7 men. The reason for these discrepancies could not be clarified.

[lxxii] These three approaches have been referred to as APP (participatory approach to prevention), CCC (communication for behaviour change) and ICC (intervention for behaviour change).

[lxxiii] See, amongst others, Putzel (2003:11).

[lxxiv] This interpretation assumes that men are more likely than women to bring HIV into the spousal relationship. Oppong and Agyei-Mensah (2004:74) refer to a 1997 study in Dakar, which found that 99% of married women reported that they had no other sexual partner than their husbands in the preceding 12 months. Among married men, the figure was 88%.

[lxxv] The 20/20 Initiative is an agreement between developing countries and donor countries to allocate 20% of public expenditure and 20% of development assistance to enable universal access to basic social services.

[lxxvi] This was not the first national structure to coordinate the national response to HIV/AIDS. Since 1986, Senegal's HIV/AIDS programme had been coordinated by the National Multidisciplinary Committee for the Prevention of HIV/AIDS. The establishment of the CNLS is seen as an attempt to conform to a World Bank organisational template in order to access World Bank funds for HIV/AIDS (see Putzel, 2003).

Chapter 8. Uganda

[lxxvii] This chapter draws on the country assessment conducted by Narathius Asingwire.

[lxxviii] Hon. Proscovia Musumba, Chairperson of the Parliamentary Committee on Presidential and Foreign Affairs.

[lxxix] Ms Beatrice Were, Coordinator of the National Community of Women Living with AIDS in Uganda (NACWOLA) and founding member of the National Guidance and Empowerment Network of People Living with HIV/AIDS (NGEN+).

[lxxx] According to UN-Habitat (2003), the projected annual urban growth rate for Africa is 3.66% compared to 2.05% for the world for the period 2000-2010.

[lxxxi] For diverging views on Uganda's Poverty Action Fund, see Cheru (2002b) and Craig and Porter (2003).

[lxxxii] If the 1992 data reflects an anomaly, levels of poverty would have remained fairly consistent during the 1980s and 1990s whilst GDP per capita has seen a steady increase. Thus, the argument that income inequality has increased would still hold true.

[lxxxiii] This differs quite significantly from the Gini coefficient of 0.37 reflected in the latest UNDP Human Development Report (2003), which is calculated on a consumption basis. Adjustment to an income basis would mean raising the Gini coefficient by six percentage points, resulting in a similar Gini coefficient (of 0.43) as indicated in national statistics.

[lxxxiv] This data is drawn from www.uis.unesco.org.

[lxxxv] This stands in marked contrast to the position of other African states at the time, which tended to ignore and obscure the epidemic either due to fear of undermining their tourism industry and the prospect of foreign investment or for political reasons. Uganda initiated its first public awareness campaigns on HIV/AIDS in 1986.

[lxxxvi] Prof Francis Omaswa, Director of Health Services, Ministry of Health.

[lxxxvii] Hon. Musumba Isaac, Minister of State for Finance, Planning and Economic Development.

[lxxxviii] Mr Patrick Mutabwire, Commissioner, Local Councils Development, Ministry of Local Government.

[lxxxix] Hon. Elioda Tumwegsigye, Chairperson of the Standing Committee on HIV/AIDS.

[xc] Mr Edward Were, Statistician, Uganda AIDS Commission.

[xci] Mr Paul Bogere, Assistant Commissioner, Human Resource Development and Chairperson of the HIV/AIDS Committee, Ministry of Public Services.

[xcii] Hon. Proscovia Musumba, Chairperson of the Parliamentary Committee on Presidential and Foreign Affairs.

[xciii] Hon. Elioda Tumwegsigye, Chairperson of the Standing Committee on HIV/AIDS.

[xciv] Hon. Isaac Musumba, Minister of State for Finance, Planning and Economic Development.

[xcv] Mr Robert L Khaukha, AIDS Focal Person, Ministry of Agriculture, Animal Industry and Fisheries.

[xcvi] Mr Edward Were, Statistician, Uganda AIDS Commission.

[xcvii] Hon. Proscovia Musumba, Chairperson of the Parliamentary Committee on Presidential and Foreign Affairs.

[xcviii] In contrast, the recent "Background to the Budget, Financial Year 2003/04" includes a review of the performance of Uganda's economy in 2001/02, with particular emphasis on the agriculture sector (MFPED, 2003a). It does, however, not cite HIV/AIDS-related morbidity and mortality as a potential reason for the poor performance of the sector. It is not clear whether this is because of a lack of data concerning the impact of HIV/AIDS on agriculture or whether it stems from an inability to understand these linkages. It is worth noting that the review was conducted by the MFPED, which also played a central role in the formulation of the PMA.

[xcix] Hon. Nathan Mafabi-Nandala, Chairperson of the Parliamentary Committee on Economy.

[c] Hon. Proscovia Musumba, Chairperson of the Parliamentary Committee on Presidential and Foreign Affairs.

[ci] Hon. Elioda Tumwegsigye, Chairperson of the Standing Committee on HIV/AIDS.

[cii] Ibid.

[ciii] Mr Paul Bogere, Assistant Commissioner Human Resource Development and Chairperson of the HIV/AIDS Committee, Ministry of Public Service.

[civ] Celia Tusiime Kakande, World Vision Uganda.

[cv] Ms Elizabeth Mushabe, UAC.

[cvi] Ms Beatrice Were, Coordinator of the National Community of Women Living with AIDS in Uganda (NACWOLA) and founding member of the National Guidance and Empowerment Network of People Living with HIV/AIDS (NGEN+).

[cvii] Ibid.

[cviii] Dr Peter Okwero, World Bank, Uganda Country Office.

[cix] Ibid.

Chapter 9. Zimbabwe

[cx] This chapter draws on the country assessment conducted by Prof Marvellous Mhloyi.

[cxi] Respondent in an interview conducted for the purpose of this study.

[cxii] Respondent in an interview conducted for the purpose of this study.

[cxiii] In 1997, an estimated 32.4% of people living in sub-Saharan Africa were living in urban areas. By 2001 this had increased to 34.8% for sub-Saharan Africa and an estimated 36% for Zimbabwe (UNDP, 2003).

[cxiv] According to the Ministry of Health and Child Welfare (2003b), the average adult HIV prevalence rate is 24.6% in 2003, ranging between 20-28%, a figure which is substantially below the 2001 estimate. However, it is acknowledged that this could be due to methodological differences in projections.

[cxv] The ESAP was adopted in January 1991 as a five-year planning framework, covering the period 1991-1995.

[cxvi] At the time of writing this chapter, the official exchange rate was pegged at Z$55 for US$1 compared to over Z$5,000 for US$1 on the parallel market.

Endnotes for Country Profiles

Country Profile of Cameroon

[cxvii] MINEFI (1992); UNDP (1998a); MINEFI (1999:107); DSCN (1983:36); CEC (1992:31); UNFPA (1999, 2000, 2001); Timnou (1993:43).

[cxviii] DSCN (1983:36); Timnou (1993:43); UNDP (1998a).

[cxix] MINUH (1990:221); Timnou (1993:43); UNDP (1991:18); UNDP (1997:193); UNDP (1998a:40-41); UNFPA (1993:48); UNFPA (1995:67); MINEFI (1999:107).

[cxx] UNFPA (1993:48); UNFPA (1995:67).

[cxxi] Segal (1993:25).

[cxxii] Segal (1993:64), UNFPA (1994, 1996, 1998).

[cxxiii] World Bank (1992), UNAIDS (2000), Bellet-Edimo et al (2000:3).

[cxxiv] DSCN (1997); MINEFI/DSCN (2000b).

[cxxv] UNICEF (1984-2001); UNDP (2000).

[cxxvi] UNICEF (1987-2001); UNFPA (1994); UNDP (1998a).

[cxxvii] UNICEF (1987-2001); UNDP (1991-1997, 1998b); UNDP (1993a); UNDP (1998a); UNDP (2000); MINEFI (1999).

[cxxviii] UNICEF (1987-2001); UNFPA (1993-1998); UNDP (1987-1997, 1998b).

[cxxix] UNICEF (1989, 1992); UNDP (1997, 1998b); MINEFI (1999); MINEFI/DSCN et UNICEF (2001).

[cxxx] CEC (1994); UNDP (1998a); UNDP (2000).

[cxxxi] UNFPA (1993), UNICEF (1987-2001); UNDP (2000); CEC (1994); MINEFI (1999).

[cxxxii] UNICEF (1987-1997).

[cxxxiii] UNICEF (1987-2001); UNDP (2000).

[cxxxiv] DSCN (1983, 1997, 1998, 2000); MINEFI (1999).

[cxxxv] World Bank (1980, 1990, 1995, 1996, 1999); UNDP (1991, 1994, 1996, 1997, 1998).

[cxxxvi] World Bank (1980, 1990, 1995, 1996, 1999).

Country Profile of Senegal

[cxxxvii] Taken from the PRSP, 2002-2007.

Country Profile of Uganda

[cxxxviii] This particular figure does not represent the national picture but some areas worst hit by HIV/AIDS at the time. The national figure is around 18.

Country Profile of Zimbabwe

[cxxxix] Central Statistical Office (1985a), (1994) and (1998).

[cxl] NACP/Ministry of Health (1998) and UNAIDS (2002b).

[cxli] World Bank (2001a) and (2001b).

[cxlii] Deininger and Squire (1996).

[cxliii] Central Statistical Office (1985), (1989) and (1999). Includes any modern method of contraception.

[cxliv] At primary schools. Drawn from various reports of the Ministry of Education, Sport and Culture (various years).

[cxlv] The ratios were computed by first summing the percentage contribution to total GDP or each of the three sectors to obtain their total contribution to GDP. The second step involved computing the proportional contribution of each sector to their total contribution of GDP.

[cxlvi] Central Statistical Office (2002). GDP growth (%) is reflected at constant (1990) prices, whereas GNI per capita (US$) is reflected at current prices.