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

		Objectives	Deliberate objective? (with explicit focus on men/women)	Possible impacts/link (conscious or not, in relation to men/women)
PREVENTION: ADDRESSING CORE DETERMINANTS	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 (%)[iii]											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.