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).

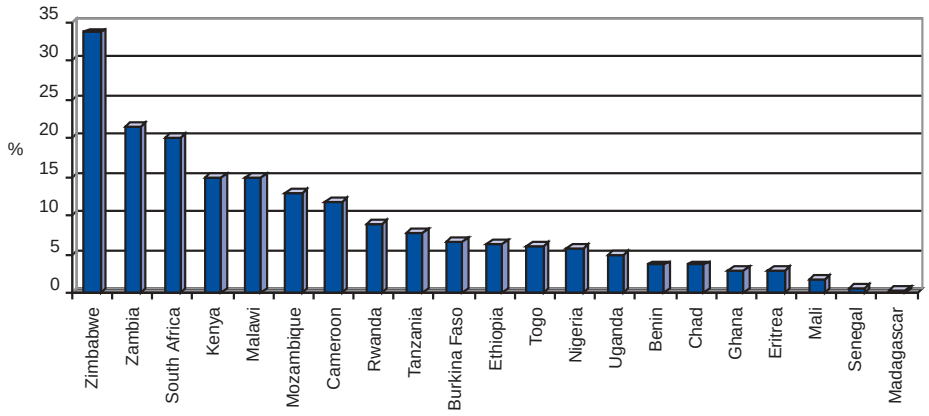
HIV prevalence

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.

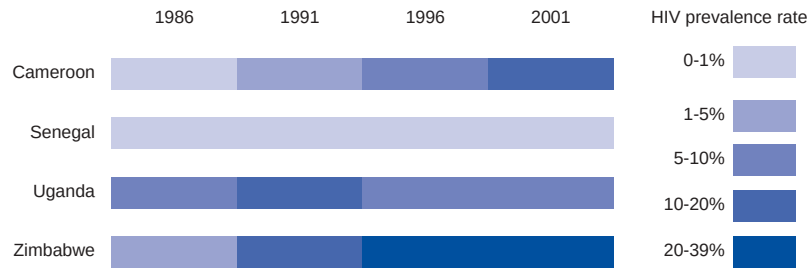
On the assumption that a country's colonial background may have influenced the practice of development planning after independence, Mozambique stood out as the most obvious candidate among the three remaining countries in Southern Africa. Furthermore, Mozambique's PRSP is considered well integrated with 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.

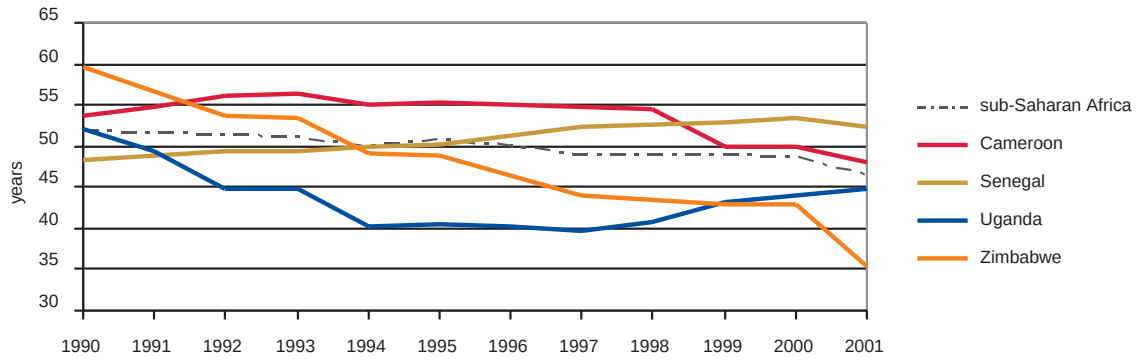
Whilst Uganda already had a significant HIV/AIDS epidemic in 1986, the HIV prevalence further increased to between 10-20% in 1991, after which it decreased to its 1986 levels in 1996. Data for 2001 suggests that this declining trend has been maintained, albeit at a slower rate. Yet, with new infections 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.

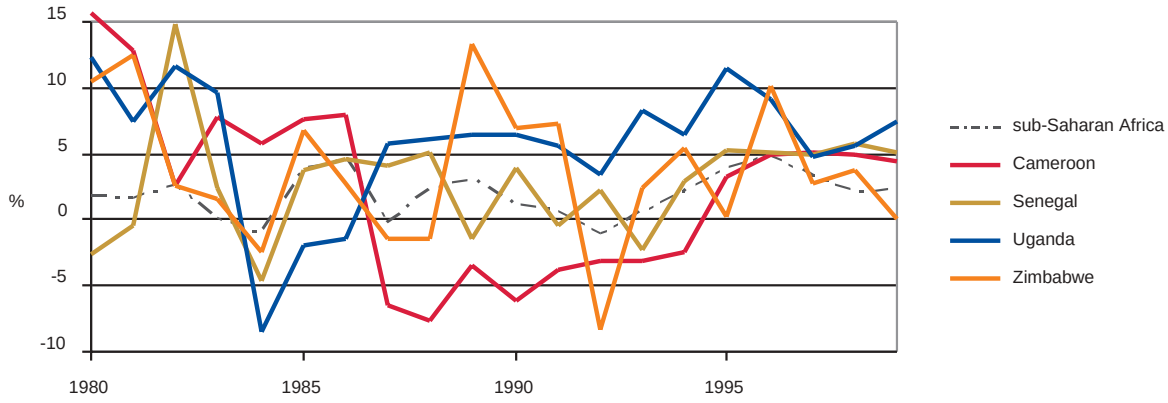
Cameroon, on the other hand, shows an increase in life expectancy from just below 54 years in 1990 to just above 56 years in 1993. Since then, life expectancy has declined quite rapidly with an average of one year per annum, to reach 48 years

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.

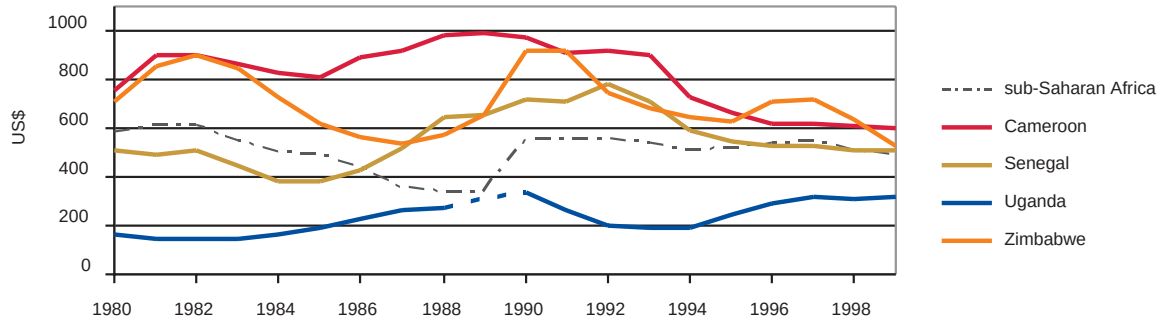
Trends in GDP growth

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?

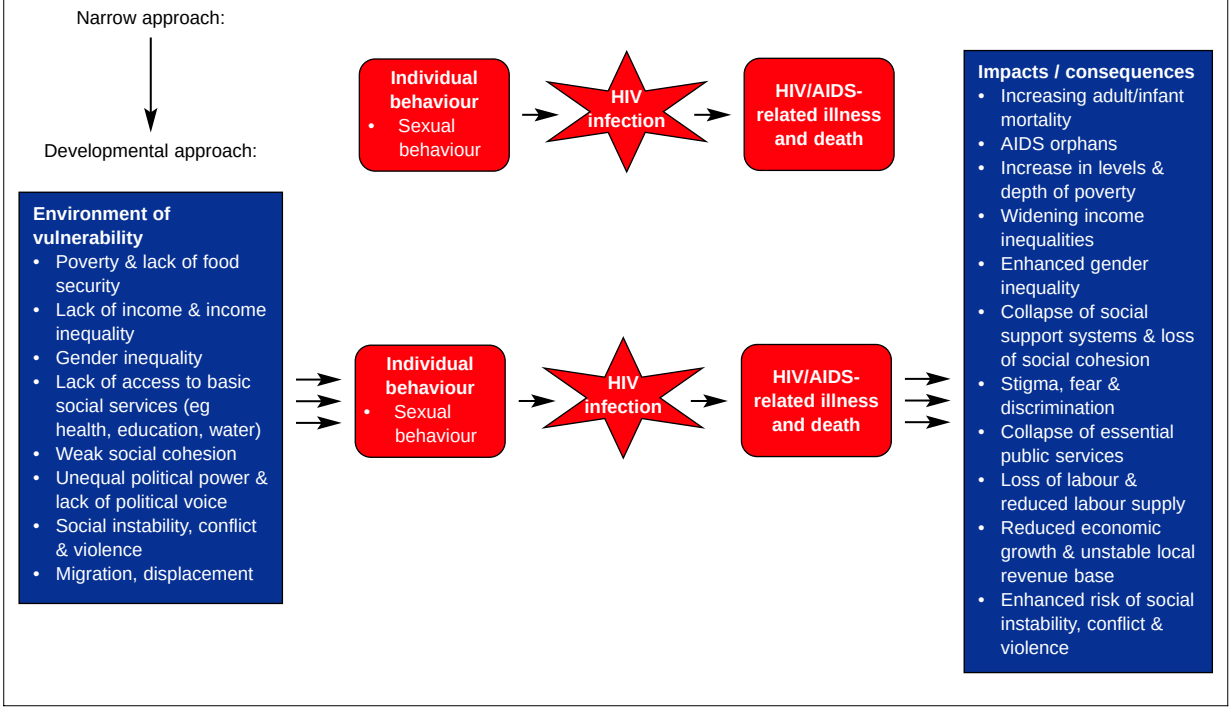
3. Based on empirical evidence, including past experiences in pursuing similar objectives and strategies, how do particular development planning frameworks, consciously or not:
   a. Enhance or diminish an environment of risk and vulnerability to HIV infection; and/or,
   b. Strengthen or undermine the 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.