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

4.1. Introduction

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

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

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

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

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

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

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

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

4.3. HIV/AIDS: A three-pronged response

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

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

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

Prevention

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

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

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

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

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

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

Treatment and care

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

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

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

Impact mitigation

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

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

qualified/skilled staff and organisational memory, and reduced productivity in all organisations and all sectors of the economy;

- Collapse of essential public services and erosion of public sector capacity;
- Reduced, possibly adverse, rate of economic growth and unstable, if not diminished, local revenue base;
- Enhanced possibility of social instability, conflict and violence.[xxix]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 4.1. Template to assess possible links between development planning and HIV/AIDS

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

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

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

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

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

National Strategic Framework for HIV/AIDS

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

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

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

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

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

PRSP

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

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

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

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

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

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

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

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

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

MTEF

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

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

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

- Has provision been made in the MTEF for the

provision of ARVs and PMTCT to curb adult and infant mortality (or otherwise for a national resource mobilisation strategy)? Are both men and women targeted? *(See point 2.1)*
- Are sufficient resources allocated to provide for the needs of AIDS orphans for food, housing and care, education, financial support, and so on? *(See point 2.6)*
- Are sufficient resources allocated from the national budget for health to ensure equitable access to health care for men and women living with HIV/AIDS, in particular access to basic medicines and quality care? *(See point 2.7)*
- What is the impact of 'downsizing', 'rightsizing' and rationalising of the public sector on its capacity to fulfil its mandate to facilitate national development? To what extent are such strategies concerned with minimising the loss of capacity, skills and organisational memory in the public sector due to HIV/AIDS? *(See point 2.8)*
- Has sufficient consideration been given to the financial implications of protecting the right to work of both male and female employees infected with HIV/AIDS (for example, through flexible working arrangements and the provision of ARVs)? *(See point 2.9)*
- What level of investment is made to ensure that sufficient and adequately qualified labour is supplied in accordance with the demands of the economy, particularly in those sectors that are badly affected by the loss of labour due to HIV/AIDS? *(See point 2.10)*
- Where will the necessary financial resources come from? What are the expectations in terms of local revenue generation and people's ability to pay taxes and service charges? *(See point 2.11)*
- Does economic decision-making strengthen or undermine democratic principles? To what extent are men and women living with HIV/AIDS, their families and affected communities involved in decision-making concerning national economic development? *(See point 2.13)*
- Is there a framework for the decentralisation of decision-making about resource allocations? *(See points 2.7, 2.11 and 2.13)*

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

Sector plans

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

National Health Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rural / Urban Development Frameworks

Rural Development Framework

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

Urban Development Framework

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

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

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

4.6. Concluding observations

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

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

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

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

The analysis of possible links between particular

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