Senegal[1]

7.1. Introduction

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

7.2. Overview of development trends since 1980

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

Demographic trends

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

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

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

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

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

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

Economic performance and structure of the economy

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

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

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

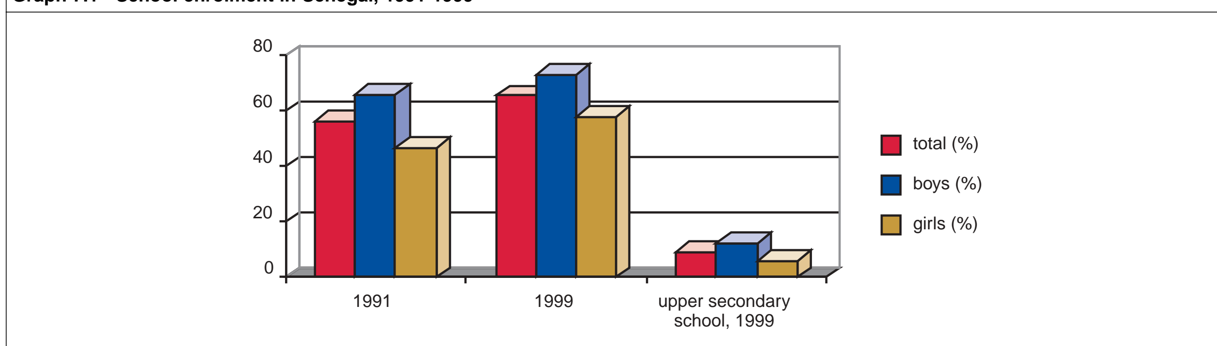
Senegal is a highly indebted country and has been included in the HIPC Initiative. In 1994, its debt stock amounted to 88% of GDP. Its debt profile improved during the 1990s to 72.9% in 1999. Recently, however, concerns have been expressed that under the current terms of debt relief Senegal will pay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

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

Poverty and inequality

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

Graph 7.1 School enrolment in Senegal, 1991-1999



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

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

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

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

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

Human development

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

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

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

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

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

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

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

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

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

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

HIV/AIDS

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

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

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

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

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

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

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

Conclusion

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

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

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

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

Core determinants

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

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

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

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

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

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

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

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

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

Key consequences

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

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

7.4. Development planning and HIV/AIDS in Senegal

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

Development planning in Senegal in historical context

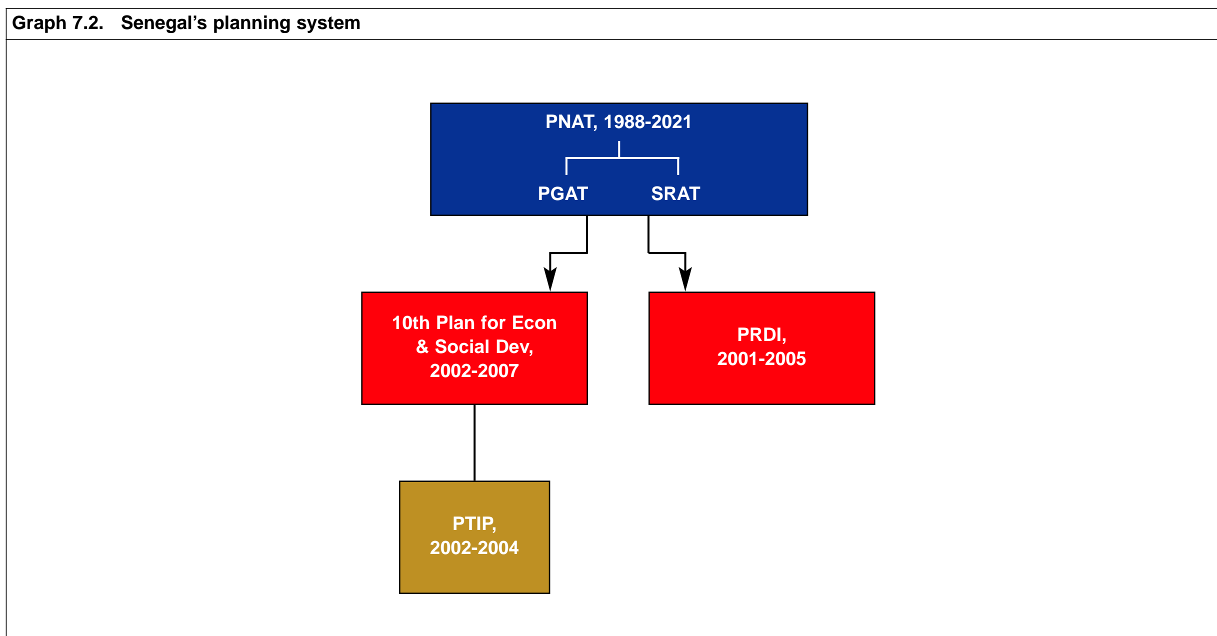
Senegal has a long tradition in the area of development planning. Development planning was initiated in 1960, at the time of independence, and has progressed steadily, integrating aspects and mechanisms that were deemed more appropriate to the changing national and international context.

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

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

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

Graph 7.2. Senegal's planning system



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

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

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

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

The PRSP, 2002-2015

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

Core determinants of HIV infection

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

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

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

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

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

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

The planning process

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

Parliament

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

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

Sector Ministries

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

Civil society organisations

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

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

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

The CNLS

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

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

Development partners/donors

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

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

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

Alignment and implementation of development planning frameworks

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

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

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

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

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

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

Concluding comments

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

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

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

7.5. Conclusion

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

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

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

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

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

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

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

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