Uganda[1]

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

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

8.1. Introduction

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

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

8.2. Overview of development trends since 1980

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

Demographic trends

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

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

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

Economic performance and structure of the economy

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

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

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

Poverty and inequality

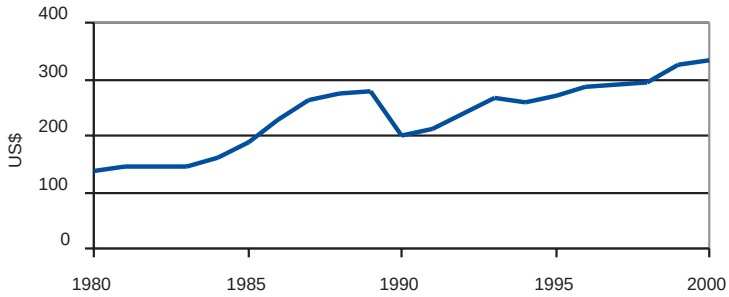
For most of the 1980s, Uganda was embroiled in internal strife that culminated in political and socio-economic stagnation in all aspects of life. Although statistical data on human development indicators for this period are largely unavailable, it is evident that poverty and unemployment were widespread.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

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

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

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

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



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

Human development

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

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

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

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

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

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

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

HIV/AIDS

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

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

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

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

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

Core determinants

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

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

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

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

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

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

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

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

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

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

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

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

The two core determinants in Table 4.1 that were

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

Key consequences

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

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

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

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

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

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

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

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

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

8.4. Development planning and HIV/AIDS in Uganda

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

Development planning in Uganda in historical context

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

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

Currently, the key development planning frameworks include the following:

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

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

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

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

The Poverty Eradication Action Plan (PEAP) 2001

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

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

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

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

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

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

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

Core determinants of HIV infection

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

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

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

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

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

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

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

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

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

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

Key consequences of HIV/AIDS

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

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

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

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

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

The MTEF, 2003/04-2005/06

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

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

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

Core determinants of HIV infection

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

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

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

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

The MTEF allocates funds for community-based projects through the PAF and the Local Government Development Fund (LGDF). This could possibly be interpreted as providing support for social cohesion and social mobilisation. Also, by allocating funds for local elections, the MTEF could be seen to support political voice, particularly since those leaders are to include representatives of marginalised groups in society. However, no reference is made to the involvement of communities, let alone these elected representatives, in economic decision-making. Thus, the MTEF's contribution to these objectives is only partial at best.

The MTEF also makes provision for resources for disaster management and psychosocial support for internally displaced persons. As such, it provides some measure of support in the context of displacement, although this does not seem adequate to address all the needs associated with displacement. Furthermore, the MTEF does not make explicit reference to urban development and the concomitant need for investment in urban services and infrastructure.

Thus, it appears that the MTEF is concerned with addressing a significant number of core determinants of vulnerability to HIV infection. This should not be surprising, since these core determinants are in essence about the fundamentals of development: eradicating poverty and all forms of inequality, promoting the well being of all Ugandans and facilitating empowerment. Yet, the concerns expressed in relation to the PEAP also apply here. More specifically, what seems to be lacking is a comprehensive understanding of, firstly, how these factors may enhance vulnerability to HIV infection in Uganda and, secondly, to what extent proposed macroeconomic growth strategies may have detrimental impacts on these factors. Also, the fact that certain core determinants appear to be covered by the MTEF does not mean that these factors are addressed comprehensively and in all their complexity.

Key consequences of HIV/AIDS

As was noted in connection with the PEAP, the MTEF seems less concerned with the multiple impacts of the epidemic. There are budget lines for VCT services, ARVs and PMTCT projects (which have relevance for reducing AIDS-related adult/infant mortality, the first key consequence of HIV/AIDS identified in the conceptual framework), but these are mostly funded directly by donors. In 2003, the Global Fund to Fight AIDS, Tuberculosis and Malaria approved Uganda's application for US$67 million for two years, of which US$35 million is to be disbursed in the first year (MFPED, 2003b). As mentioned earlier, the parliamentary Standing Committee on HIV/AIDS has lobbied successfully to ensure that these funds are excluded from the MTEF and its budgetary ceilings. Due to the high cost of ARVs, government allocations to the health sector are barely used for the purchase of ARV treatment. As a result, access to life-prolonging treatment is not equitably available to all Ugandans, particularly for those who cannot afford to purchase ARVs on the private market and those who live in remote areas where donor-funded treatment is not readily available.

One of the key consequences of the HIV/AIDS epidemic that is addressed in the MTEF is the need for support for AIDS orphans. Under the PAF, proposed budgetary support for AIDS orphans and the rehabilitation of child soldiers has doubled in the current MTEF, from 1.43 to 2.84 billion Ugandan shillings. Also, the UPE covers the rights of orphans to access to (primary) education and as such the MTEF could be seen to alleviate the plight of AIDS orphans. However, as was noted by Ms Beatrice Were of NACWOLA, education is not the only or the most pressing need of orphans. In the absence of other support measures, like shelter, income, clothing, food and medical care, these orphans are unlikely to benefit from the principle underpinning the UPE.

Like the PEAP, the MTEF does not make reference to the fact that the HIV/AIDS epidemic is likely to enhance poverty, undermine food security, aggravate the burden of care on women and create new categories of poor households and marginalised groups (with the exception of orphans), amongst others. One might argue that relevant interventions aimed at poverty reduction, income generation or equitable access to public services in general may also benefit PLWHA and others who are directly affected by the epidemic. However, this assumption may not hold true, given that this means that the particular dynamics of HIV/AIDS are neglected and remain invisible.

Of particular concern is the support for the Public Sector Reform Programme, which involves the rationalisation of the public sector and retrenchments of public servants, particularly since there is no evidence that the MTEF takes into account the relatively high HIV prevalence rates among public servants noted earlier and the likely erosion of the public service due to HIV/AIDS. Added to this is the fact that there is no explicit support for HIV/AIDS workplace policies and programmes aimed at protecting the rights of employees infected with, and affected by, HIV/AIDS.

To some extent, it could be argued that the MTEF is concerned with ensuring the supply of sufficient and qualified labour by increasing funding for education that has led to the establishment of two extra universities and to an increase in the number of skilled teachers. The Government has also doubled its funding for sponsorships for students at public universities to 4,000. However, these measures have been developed in response to increased pupil enrolment as a result of UPE, rather than as a measure to mitigate the impact of HIV/AIDS on labour.

Other key consequences of HIV infection are not explicitly highlighted or addressed in the MTEF. Thus, the MTEF reflects insufficient concern with the medium to long term impacts of HIV/AIDS on households, communities, government sectors, the economy and society in general. Of particular

interest is the fact that the MTEF reflects no comprehension of the impacts of HIV/AIDS on the national (and local) tax base and other means of state revenue collection.

National Strategic Framework for HIV/AIDS Activities (NSFA), 2000/01-2005/06

The UAC has spearheaded the development of a five-year National Strategic Framework for HIV/AIDS Activities (NSFA) in the country. The purpose of the NSFA is four-fold. Firstly, it seeks to relate the fight against HIV/AIDS to the development goals and action plans in the PEAP. Secondly, it brings to the fore the active involvement of all stakeholders in the planning, management, implementation, monitoring and evaluation of HIV/AIDS interventions. Thirdly, it establishes indicators for measuring the progress and impact of HIV/AIDS interventions. Finally, it provides a basis for costing and mobilisation of resources for HIV/AIDS interventions.

The NSFA articulates three principal goals: reducing HIV prevalence by 25% by the year 2005/6 (although the baseline is not given); mitigating the health and socio-economic effects of HIV/AIDS at individual, household and community levels; and, strengthening the national capacity to respond to the HIV/AIDS epidemic.

Core determinants of HIV infection

The NSFA reflects most of the factors that constitute an environment of vulnerability to HIV infection. There is explicit concern with increasing awareness and changing individual behaviour, which is expressed in IEC programmes, VCT services and condom distribution, amongst others. Reference is also made to poverty as a key factor facilitating the spread of HIV and the need to boost food security and incomes. Access to decent employment is mentioned, although it is not an explicit objective of the NSFA. The NSFA recognises that women are a particularly vulnerable group that deserves attention in HIV prevention, although this obviously does not mean that the relationship between gender inequality and HIV/AIDS is adequately understood.

Furthermore, the framework is concerned with equitable access to basic public services, but only insofar as this relates to HIV prevention technologies, like PMTCT, VCT services and the availability and affordability of condoms. Thus, the NSFA gives prominence to VCT to persons wishing to establish their HIV status, PLWHA and members of affected households. However, the mechanisms and means of establishing VCT centres countrywide to enable people to access these services are not clearly spelt out in the framework. VCT services are commonly provided by the private sector, which restricts access for those who want to utilise the services due to costs involved.

Although lack of social cohesion and political voice are not explicitly mentioned as possible determinants of HIV spread, the NSFA does include strategies that may contribute to social cohesion and facilitate the expression of political voice. The framework supports partnerships with and participation of grassroots organisations, like women's associations and other community based groups.

The NSFA does not refer to social instability and conflict as a contributing factor to enhanced vulnerability to HIV infection. Yet, the uneven geographical distribution of VCT (and PMTCT) services does not only challenge the principle of equitable access to these services; it may also contribute to social strife. These services are particularly scarce in conflict areas where rape is a common occurrence. However, the issue of sexual violence especially in conflict zones is not explicitly addressed by the NSFA.

Key consequences of HIV/AIDS

The reduction of adult and infant mortality is an explicit objective in the NSFA and the framework covers PMTCT, access to ARV treatment and herbal treatment for opportunistic infections. Gradual steps have been taken to provide ARVs to PLWHA, although equitable access is still constrained by the high costs involved and the uneven geographical distribution of ARVs. This particularly affects PLWHA living in rural areas, who constitute the majority of all PLWHA in Uganda. Also, public servants and members of the armed forces can access ARV treatment at subsidised cost, which seems to be borne out of a realisation that HIV/AIDS-related morbidity and mortality in the public sector has detrimental implications for public sector capacity. Because the NSFA explicitly deals with the question of providing ARV treatment, it also includes a focus on patient adherence.

The NSFA states that community based organisations, NGOs and more particularly members of the extended family have a primary role to play in providing care and support for PLWHA. However, the framework does not sufficiently take into account that the HIV/AIDS epidemic is putting

serious strain on familial and community networks, weakening them as a result. The implications are at least twofold. On the one hand, it means that PLWHA and their relatives may not receive the care and support that these voluntary networks are expected to provide. On the other hand, social cohesion may be further eroded if there are no support mechanisms in place that will enable these networks to fulfil those critical social functions.

Explicit attention is given to the plight of orphans, who are considered a vulnerable group requiring support from a variety of stakeholders. The NSFA further calls for the representation and participation of PLWHA in decision-making structures and processes and incorporates an explicit focus on the need to reduce HIV/AIDS-related stigma. The NSFA specifically recognises that HIV/AIDS has caused job insecurity and discrimination at the workplace. Some organisations subject prospective employees to a mandatory – but covert – HIV screening test before recruitment and those who are infected with HIV are denied employment. PLWHA are often discriminated against in the workplace and their job contracts may be terminated on the basis of their prevalence status. Although the NSFA mentions these negative trends, it does not offer practical remedies as to how this situation can be arrested.

It seems, though, that the NSFA incorporates only those consequences of HIV infection that are more immediate and visible. Longer term and/or less discernible impacts of the epidemic, such as the loss of labour and associated skills, the likely loss of state revenue, the changing nature of demand for public services (beyond health care needs and the needs of orphans), to mention but a few, are barely mentioned in the framework. Income inequality is not recognised as a possible driver of HIV spread, nor is it mentioned as a potential consequence of the epidemic.

These omissions aside, in comparison to most other development planning frameworks in Uganda the NSFA reflects a more comprehensive understanding of the core determinants and key consequences of HIV/AIDS. This is hardly surprising. However, a critical challenge of the NSFA is that its effective implementation is contingent on a range of stakeholders. Also, it is unclear how the implementation of the NSFA will be funded. These issues raise questions about the extent to which the NSFA will be translated into concrete programmes and mechanisms for intervention.

The Plan for Modernisation of Agriculture (PMA) 2000

The PMA is a holistic, strategic framework for eradicating poverty through multi-sectoral interventions that enable people to improve their livelihoods in a sustainable manner. In a country where about 85% of the population is based in rural areas and is dependent on agriculture, the PMA largely represents a *rural development plan*. It aims to accelerate agricultural growth in Uganda by introducing profound technological change throughout the sector. The vision of the PMA is poverty eradication through a profitable, competitive, sustainable and dynamic agricultural and agro-industrial sector. In other words, it seeks to eradicate poverty by transforming subsistence agriculture to commercial agriculture. The framework is part of the Government of Uganda's broader strategy of implementation of the PEAP.

The PMA reflects the following broad objectives:

- Making poverty eradication the overriding objective of agriculture development;
- Deepening decentralisation to lower levels of local governments for efficient service delivery;
- Removing direct Government in commercial aspects of agriculture and promoting the role of the private sector;
- Supporting the dissemination and adoption of productivity-enhancing technologies;
- Guaranteeing food security through the market and improved incomes, thereby allowing households to specialise, rather than through household self-sufficiency; and,
- Ensuring that all intervention programs are gender-focused and gender-responsive.

Core determinants of HIV infection

There is a clear correlation between the objectives of the PMA and a number of core determinants of vulnerability to HIV infection. For example, the PMA explicitly strives to eradicate poverty, improve household food security and contribute to increased incomes of the poor. To achieve this, it proposes strategies aimed at enhancing productivity, increasing the market share of the poor and realising food security through the market instead of emphasising self-reliance. It further aims to provide "gainful employment through secondary benefits of PMA implementation, such as agro-processing factories and services".

The PMA puts great confidence in the market mechanism to deliver on these development

objectives. This is reinforced by the fact that the provision of farming implements and seedlings that are fast yielding and at the same time not labour intensive is clearly articulated as a non-government function. The PMA does, however, provide for extension staff at local government (sub-county) level to provide technical support towards increased agricultural output and food security. To some extent, this could be seen to contribute to more equitable access to public services, although the emphasis is clearly on increasing production and productivity.

The PMA also has an explicit focus on gender relations and the multiple roles fulfilled by women. More specifically, it encourages narrowing the literacy gap between men and women and improving gender relations and changing gender roles within the household. It further deals with the issue of land reform to ensure that women have access to land and proposes time-saving techniques to reduce the labour burden on women.

Although the PMA does not explicitly aim to support social mobilisation and social cohesion, it does recognise the importance of social capital. Reference is made to social relations within the household and within communities and the fact that membership of community groups enhance the ability of small-scale farmers to save, access credit and obtain information on available technologies. The PMA further recognises the importance and usefulness of involving CBOs and NGOs in service provision, due to their ability to mobilise communities. It appears, though, as if the PMA embraces an instrumental interpretation of social mobilisation, i.e. as a means to increase productivity rather than a development objective with intrinsic value. The PMA does not explicitly refer to the issue of political voice and empowerment of Uganda's rural population (through participatory development), although it does recognise the importance of strengthening local organisations and farmers' associations. Neither does the PMA respond to social instability, displacement, migration or urbanisation as key drivers of the HIV/AIDS epidemic.

Key consequences of HIV/AIDS

The PMA acknowledges the consequences of HIV/AIDS on agricultural production through the loss of skilled and unskilled labour, the loss of household assets and the increased use of domestic savings for medical care and funeral expenses.[xcviii] According to the PMA, HIV/AIDS robs individuals, communities and the country of valuable resources for development by causing high levels of adult morbidity and mortality. It further articulates that the negative consequences of HIV/AIDS can lead to hopelessness, school drop out, street children and substance abuse, all of which may lead to enhanced vulnerability to HIV infection.

Yet, despite its emphasis on food security and poverty reduction, the framework does not explicitly address the needs of HIV/AIDS-affected households, which are rotating daily around food security, nor does it propose strategies to support families who lack labour for tilling the land due to HIV/AIDS. As mentioned earlier, the provision of seedlings that are fast yielding and not labour intensive is seen to lie beyond the realm of government responsibilities. Likewise, no explicit reference is made to the fact that HIV/AIDS adds to the burden of care traditionally carried by women or to the fact that women are disproportionately at risk of losing assets, land and other forms of security when their husbands die of HIV/AIDS-related illnesses. Furthermore, the PMA remains silent on how to address the needs of AIDS orphans and although it recognises that the epidemic is leading to a loss of labour, it does not spell out how to respond to this dynamic. The framework simply mentions in passing that "the welfare of those affected by HIV/AIDS" may warrant attention, but does not explicate who this may concern or what attention might be required.

The PMA does not express any recognition of the fact that HIV/AIDS may also affect extension staff and other employees in the agriculture sector, which could undermine the capacity of the sector to deliver appropriate services and facilitate agriculture development. Within the context of Uganda's civil service reform, the PMA has abolished the Extension Directorate of the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) and has transferred responsibility for extension staff to districts in accordance with the decentralisation policy. However, the ability of districts to recruit extension staff is constrained due to reduced local revenue, which is in part a consequence of the HIV/AIDS epidemic. The PMA fails to recognise this. Also, because the PMA is oblivious to the significance of HIV/AIDS for employees in the agriculture sector, it is not surprising that it does not concern itself with the issue of job security and job flexibility of HIV-infected staff.

Other key consequences of HIV/AIDS are not

referred to at all in the PMA. Clearly, merely mentioning the need to mitigate the impacts of HIV/AIDS – and possibly listing some of these impacts, as the PMA does – is not sufficient. What appears to be lacking in the PMA is an understanding of how HIV/AIDS is likely to thwart the objective of turning subsistence farmers into commercial farmers to enhance agriculture productivity, which is underpinning the overarching goal of creating a dynamic agriculture sector.

The Health Sector Strategic Plan (HSSP), 2000/01 - 2004/05

The overall purpose of the HSSP is to reduce morbidity and mortality from major causes of ill health in Uganda and overcome health disparities as a contribution to poverty eradication. Three principal aims are outlined in the HSSP. The first aim is to improve access of the population to the Uganda National Minimum Health Care Package (UNMHCP). Linked to this is the second aim, which is to improve the quality of delivery of this health care package. The third aim is to reduce inequalities between various segments of the population in accessing quality health services.

These aims are linked to a set of specific objectives of HSSP, which are concerned with relating the ongoing health sector reforms to health development, articulating the essential linkages between the various levels of the national health care delivery system and involving all stakeholders in health development. Other objectives of the HSSP are: to provide a framework for three-year rolling plans at all levels; to exhibit a health sector strategic framework with coherent goals, objectives and targets for the next five years; and, to indicate the level of investment in terms of costs required for achieving the policy objectives that have been agreed upon by the Government of Uganda and its development partners.

Core determinants of HIV infection

Given the earlier conceptualisation of HIV/AIDS as largely a medical issue, the health sector has been very consistent and clear on HIV/AIDS prevention and control since the mid-1980s. Under the heading "Control of Communicable Diseases", the HSSP focuses on prevention and control of STD/HIV/AIDS transmission and the mitigation of the personal effects of AIDS. The national targets in the HSSP on prevention and control focus on individual behaviour change through practices such as increased and sustained use of male and female condoms and seeking VCT. The HSSP envisages that VCT services are to be provided by all health units (Health Centre III and above), yet resource constraints in health units make this ambitious aim unrealistic. Currently, most providers of VCT services are non-governmental and can only reach a small proportion of the Ugandan population.

With respect to condom use, in societies such as Uganda where sexual decisions are mainly the sacrosanct domain of men, the ability of women to use or insist on using condoms is severely constrained. This issue is not addressed by the HSSP, possibly because of the perception that addressing issues such as gender inequality, poverty and conflict lies beyond the mandate of the health sector, as suggested by the Director of Health Services in the Ministry of Health, Prof. Francis Omaswa, during the course of this study.

One could, however, argue that the promotion of female condoms is informed by the recognition of women's rights and is intended to give women more power in sexual relations. In more general terms, the HSSP seeks to contribute to gender equality through the promotion of gender balance in the selection of community health care workers, who play important roles in community-based health management systems.

The HSSP includes a relatively small focus on food security by addressing the need for nutritional supplements and growth promotion, with a specific focus on children. However, comprehensive interventions to ensure food security and raise incomes are left to the PMA and the PEAP.

To ensure equitable access to health care, the HSSP stipulates that health care is free. The abolition of user fees in all government health units was clearly aimed at ensuring access to health care for all Ugandans. However, as noted earlier, the removal of user fees has left a resource gap (mainly in terms of human resources, available drugs and other health facilities like hospital beds) in the face of increasing demand, which the Government has been grappling to fill – thus far without much success. Scarcity of drugs in government health units where they are supposed to be free has meant that equitable access to health care is becoming an illusion as acknowledged by the Government: "Abolition of user fees and subsequent increase in demand for public health services put a strain on the drug supplies in health facilities and drug stock-outs remain a regular feature" (MFPED, 2003b:53).

The HSSP further acknowledges the importance of social mobilisation for community empowerment and views the health sector's contribution to this objective in the promotion of Primary Health Care (PHC) and Community Based Health Care (CBHC). PHC and CBHC are further heralded as valuable approaches to enable the participation of local communities in the management and monitoring of health services – in other words, to support political voice and empowerment.

In recognition of the fact that migration and mobility can facilitate the spread of HIV, the HSSP makes provision for the supply of condoms along main transportation routes. In more general terms (i.e. not explicitly focused on HIV transmission through sexual behaviour) provision is also made for emergency health care, including reproductive health care, in camps for displaced people. Thus, some support services are made available in response to certain needs associated with migration or displacement. The HSSP also recognises that appropriate health services can help minimise conflict and social instability and refers to the need to provide these services in hard to reach areas that are potential sources of conflict and social instability.

To conclude, the HSSP seeks to respond to quite a number of core determinants of vulnerability to HIV infection, although the scope of proposed interventions is clearly circumscribed by what is considered an appropriate health response. In other words, addressing factors like lack of income, unemployment or unequal gender relations is seen to fall beyond the scope of the health sector.

Key consequences of HIV/AIDS

Not surprisingly, the HSSP aims at reducing HIV/AIDS-related adult and infant mortality through the promotion of ARVs and PMTCT. It sets the target of reducing mother-to-child transmission from around 25% to 15%. The HSSP further emphasises the ability of PLWHA to earn an income and support them and their families in tandem with ARV treatment. It also focuses on the need to ensure improved nutrient requirements for PLWHA, which is related to the issue of food security.

Other ways in which the HSSP recognises some of the key consequences of HIV/AIDS are reflected in references to the need to provide counselling and psychological support to individuals and families affected by HIV/AIDS, the significance of involving associations of PLWHA in decision-making and project implementation, and the support for IEC to fight AIDS-related stigma.

The HSSP pays particular attention to "training, recruitment, rational deployment, motivation and retention of qualified staff across the country". This is clearly a pressing objective, given that only about 43% of positions in health units are filled by qualified staff (MFPED, 2003b). Yet, no reference is made to HIV/AIDS-related morbidity and mortality among health professionals, which is likely to further deplete the health system's human resources. It also does not make mention of the need for an HIV/AIDS workplace policy to protect the rights of HIV-infected staff.

The lack of qualified health workers also impacts on the quality of care afforded to PLWHA and people requiring other forms of health care. In particular, the distribution of human resources across the country is unequal with remote areas (including those characterised by insecurity and rebel activity) finding it particularly hard to find and retain qualified staff. Added to this is the reality of resource constraints and the lack of adequate medical supplies. As a result, access to equitable health care both for PLWHA and the general population is severely under threat, particularly given the fact that HIV/AIDS is aggravating the burden of disease.

In light of the heavy resource demands posed by the need for treatment and care of a significant number of PLWHA, the Government encourages communities and families to shoulder this role. Yet, the ability of the extended family to function as a 'shock absorber' in such contingencies has been greatly overstretched and is further being weakened by systemic and growing poverty. Furthermore, the responsibility to care for the sick in Uganda chiefly falls on women, yet this dynamic remains invisible in the HSSP and no additional support or resources are made available to enable them to fulfil this role.

A key strategy to ensure that the health sector is adequately resourced to specifically address the burden of disease associated with HIV/AIDS pursued by the Government is to raise funds from donors and the Global Fund to Fight AIDS, Tuberculosis and Malaria. This is clearly aimed at ensuring financial stability of the health sector, especially in light of the fact that user fees have been abolished.

In conclusion, the HSSP explicitly engages with a number of key consequences of HIV infection,

although not necessarily to the full breadth and depth that these issues require. It remains largely silent on other possible consequences, such as the implications of HIV/AIDS for women and gender relations or the eroding effects of the epidemic on health care staff and institutions.

The Education Strategic Investment Plan (ESIP), 1998-2003

The main emphasis of ESIP has been on achieving Universal Primary Education (UPE), a policy that was introduced in 1997 (MoES, 2003). The main objectives of ESIP are threefold: to commit the Government to key human resource development and social equalisation goals; to create new balances between the public sector and private sector; and, to reform the bureaucracy and public financing mechanisms.

The priorities, targets and focus of ESIP arise out of these main objectives. Thus, ESIP is concerned with assuring universal access to primary education, creating equity and eliminating disparities in the education sector, and enhancing the quality and relevance of instruction, particularly at the level of primary education. Further, ESIP seeks to strengthen the role of central Government as the 'policy power house' for the education sector whilst at the same time building the capacity of districts to assume full responsibility to plan and deliver quality education services at primary and secondary levels.

Core determinants of HIV infection

The ESIP makes provision for targeted IEC in schools as a means to promote responsible sexual behaviour among youth. Although it falls outside the conventional ambit of the education sector to ensure food security and adequate income in society at large, education (like health) is considered a critical component of human development that can enable people to avoid (or escape) poverty in their adult life. The ESIP supports the establishment of vocational institutions and community polytechnics for skills development, which can be interpreted as the framework's contribution to the promotion of access to decent employment and income.

The ESIP focuses on the full enrolment of girls as an explicit objective under the principle of universal access to education. It also reflects a concern with the accessibility of adult education for women learners. As such, the promotion of gender equality is a central component of the overall objective to ensure equitable access to education services across the country. The ESIP awards high priority to assuring universal access to primary education (through support for UPE), focusing on increasing net enrolment ratios and retention rates, improving attendance and making instructional time more effective. The main intention is to enable children from poor segments of society to complete primary education. The framework also makes provision for special targeted services aimed at the urban poor, pastoral nomadic communities, persons with disabilities and people living in resettlement camps for displaced persons.

One of the concerns is that ESIP only provides resources to cover tuition fees for primary education. The exclusion of other education costs (e.g. for uniforms, books, lunch and other scholastic materials) means that children from very poor households either do not enrol or drop out. Furthermore, whilst the ESIP gives high priority to primary education, it does not place corresponding emphasis on secondary education. As a result, many children who have completed primary school are unable to continue their education. For them, the chances of gaining meaningful employment and avoiding/escaping poverty remain slim.

The ESIP further reflects on the importance of diversifying education service providers and involving both NGOs and the private sector in the provision of education. Yet, no explicit reference is made to the importance of involving local communities and poor households in the management and monitoring of education services, which could contribute to enhanced social cohesion and the expression of political voice.

Key consequences of HIV/AIDS

The ESIP engages with very few likely consequences of the HIV/AIDS epidemic. One exception is the explicit emphasis on the reduction of HIV/AIDS-related stigma and discrimination through IEC interventions. With respect to AIDS orphans, the assumption is that they will benefit as much from the policy on UPE as other children do. Yet, as one of the respondents pointed out, access to education is unlikely to be a priority for AIDS orphans. A whole range of additional support measures are needed (including food programmes at schools, for example) to address the various needs of AIDS orphans and to enable them to continue their schooling.

With an estimated HIV prevalence rate among teachers of about four percent in 2000, the

Table 8.1. Explicit objectives in Uganda's development planning frameworks						
	PEAP	**MTEF**	**NSFA**	**PMA**	**HSSP**	**ESIP**
Core determinants of HIV infection						
1.1. Change in individual behaviour	-	++	++	-	++	++
1.2. Poverty reduction (minimum standard of living & food security)	++	++	+	++	+	-
1.3. Access to decent employment or alternative forms of income	++	+	+	+	-	-
1.4. Reduction of income inequalities	-	-	-	-	-	-
1.5. Reduction of gender inequalities & enhancing the status of women	+	+	+?	+	+?	+
1.6. Equitable access to quality basic public services	++	++	+	+	++	++
1.7. Support for social mobilisation & social cohesion	-	+?	+?	+	++	-
1.8. Support for political voice & equal political power	++	+?	+?	-	+	-
1.9. Minimisation of social instability & conflict / violence	+	-	-	-	+	-
1.10. Appropriate support in the context of migration/displacement	+	+	-	-	+	+
Key consequences of HIV/AIDS						
2.1. Reduction of AIDS-related adult/infant mortality	-	+	++	-	++	-
2.2. Patient adherence	-	-	+	-	+	-
2.3. Poverty reduction	-	-	-	-	++	-
2.4. Reduction of income inequalities	-	-	-	-	-	-
2.5. Reduction of gender inequalities & enhancing the status of women	-	-	-	-	-	-
2.6. Appropriate support for AIDS orphans	-	++	++	-	-	+?
2.7. Equitable access to essential public services	-	-	-	-	-	-
2.8. Effective/enhanced public sector capacity	-	-	-	-	-	-
2.9. Job security & job flexibility for infected and affected employees	-	-	+	-	-	-
2.10. Ensuring sufficient & qualified/skilled labour supply	-	-	-	+?	-	-
2.11. Financial stability & sustainable revenue generation	-	-	-	-	+	-
2.12. Support for social support systems & social cohesion	-	-	-	-	-	-
2.13. Support for political voice and equal political power, particularly for PLWHAs and affected households and individuals	+	-	++	-	+	-
2.14. Reduction of AIDS-related stigma and discrimination	+	-	+++	-	+	++
2.15. Reduction of social instability & conflict	-	-	-	-	-	-
+ = to some extent or in part; ++ = to a greater extent; +? = possibly, but mostly indirectly						

education sector is obviously directly affected by HIV/AIDS-related morbidity and mortality, with associated consequences for the ability of the sector to deliver quality services. The ESIP includes concrete plans for increased teacher recruitment and professional development by providing support for more teacher-training institutions and waiving tuition fees for primary school teachers. These are significant steps that can potentially offset human resource demands. However, the rationale for these measures is based on the increased pupil enrolment and corresponding demand for more teachers as a result of UPE, rather than as a planning strategy to shoulder the human resource burden resulting from HIV/AIDS.

It is encouraging, though, that the Mid-Term Review of the ESIP recognises that HIV/AIDS has negative impacts on the education sector, albeit rather tentatively: "The main feature of the impact of HIV/AIDS on the education sector is the number of orphans in schools, who lack resources to fully take advantage of their opportunities. … Teacher morbidity is probably also an issue, but the current monitoring system does not permit an assessment of its importance" (MoES, 2003:163-164).

By way of concluding this overview of possible links between the various development planning frameworks in Uganda and HIV/AIDS, Table 8.1 indicates whether these frameworks explicitly seek to respond to the various core determinants and key consequences of HIV infection. As the preceding discussion has attempted to highlight, the fact that certain factors are explicitly highlighted does not necessarily mean that strategies for addressing these factors are clearly articulated. It also does not mean that the proposed strategies are unambiguous in achieving supposed objectives.

Table 8.1 confirms that addressing the core determinants of HIV infection is central to most development planning frameworks, although the emphasis may vary between the various frameworks. Strong emphasis is put on changing individual sexual behaviour as a direct means of

preventing HIV spread. Poverty reduction, access to income and equitable access to services are also key objectives of most development planning frameworks, although less emphasis appears to be on employment creation (particularly by the state) and the political dimensions of poverty (e.g. support for political voice, empowerment and social cohesion). Glaringly absent in all frameworks is a concern with the distributional dimensions of poverty and wealth, i.e. income inequality. Yet, even where development planning frameworks address factors that are considered core determinants of vulnerability to HIV infection, more often than not this is done without recognising the potential link between these factors and HIV spread.

As Table 8.1 further highlights, the development planning frameworks tend to have a very limited focus on the key consequences of HIV/AIDS and the extent to which the epidemic causes or aggravates particular development concerns (e.g. poverty and gender inequality) or undermines others (e.g. social cohesion or public sector capacity). The only impacts readily recognised are HIV/AIDS-related mortality, AIDS orphans, HIV/AIDS-related stigma and the necessity of involving PLWHA in decision-making processes.

The planning process

If development planning frameworks do not adequately address the core determinants of vulnerability to HIV infection and/or the key consequences of HIV/AIDS – despite the fact that key informants from Parliament, sectors and civil society organisations appear to recognise the importance of many of these factors – this might be indicative of some flaws in the planning process. In other words, there may not have been sufficient scope for these stakeholders to critically engage with the formulation or revision of these development planning frameworks. At least some of the respondents interviewed during the course of this study suggested that this was part of the problem and that many issues had been left out of the frameworks because of a lack of joint planning. This section will look at the involvement of Parliament, government departments (sectors), civil society organisations, the UAC and organisations representing PLWHA, and donor agencies (particularly the World Bank) in the planning process.

It is worth noting that until recently, Uganda did not have an operational National Planning Authority (NPA) or an alternative body to guide the national planning process. Although the NPA was set up in 2002, it did not begin operations until August 2003 when the Secretariat and Board members were inaugurated. Thus, at the time of undertaking this study the NPA had not yet been involved in any national planning activity. Its primary function, as specified in the National Planning Authority Act of 2002 (Government of Uganda, 2002b), is to produce comprehensive and integrated development plans for the country.

Parliament

The Members of Parliament interviewed were unanimous in their view that there has been limited, if any, involvement of Parliament in the formulation of Uganda's key development planning frameworks. Repeated reference was made to the central role of technocrats in respective Ministries in formulating these frameworks, and in particular to the fact that these matters were decided on between the Ministry of Finance, Planning and Economic Development (MFPED) and the World Bank. According to the Chairperson of the Standing Committee on Economy:

> This [the formulation of national key development planning frameworks] has tended to be a matter of the Executive and responsible sectors, who believe that Parliament is just there to make laws. Most of the programmes are failing because Parliament is not involved in this.[xcix]

Other respondents also expressed frustration about the fact that Parliament's role in the planning process is confined to the allocation of resources or to law-making:

> Parliament participates … when the Government needs to borrow money … or to make a law. This is the time Parliament gets to know what Government is planning.[c]

Although Parliament is supposed to fulfil a monitoring function, Members of Parliament indicated that even this role was minimal. Moreover, some added that it would be unreasonable for Parliament to be involved in monitoring, if it does not participate in the formulation of development planning frameworks.

Not surprisingly, in the view of politicians the level of public involvement in the planning process has also been minimal. Rather, as one of the respondents commented, had these various plans been truly

home-grown, it would have been impossible to avoid public involvement. Instead, the frameworks are considered donor-driven. This view was echoed by the Chairperson of the Standing Committee on HIV/AIDS:

> At times, the prescriptions in the plans are wrong and based on wishes and assumptions of Ministry of Finance people and the World Bank.[ci]

However, some hope was expressed that Parliament's involvement in the planning process may be enhanced with the recent (2002) establishment of the Standing Committee on HIV/AIDS, which was seen as an important mechanism to streamline parliamentary participation on issues related to HIV/AIDS. This Committee has already noted some success in lobbying the Executive to exclude the allocation from the Global Fund to Fight AIDS, Tuberculosis and Malaria from the budgetary ceilings in the MTEF.[cii] It was noted that Parliament is getting involved in the revision of the PEAP.

Sector Ministries

According to various key informants in sector Ministries, the formulation of the various sectoral development planning frameworks is largely a responsibility of each respective sector with guidance in terms of budgetary ceilings from the MFPED (which are expressed in the MTEF). In some instances, reference was made to the involvement of other sectors in the preparation of specific sectoral plans. For example, the Ministry of Health (MoH) engaged with the Ministry of Water, Lands and Environment (MoWLE), the Ministry of Education and Sports (MoES), the Ministry of Local Government (MoLG) and the Ministry of Gender, Labour and Social Development (MoGLSD) in the development of the HSSP. Likewise, the Ministry of Agriculture, Animal Industry and Fisheries (MAAIF) facilitated consultations with other sectors to shape the PMA. The formulation of ESIP did not only involve the MoES and the MFPED, but also the MoLG.

The most extensive cross-sectoral involvement seems to have taken place in relation to the PEAP and the NSFA. Most respondents indicated that their departments had been involved in the formulation of the PEAP or were currently involved in its revision. In the case of the MoLG, this also meant facilitating the involvement from districts and lower level governments in the process.

Yet, the involvement of government sectors in determining the resource envelope is less clear and could not really be gauged from the interviews. The impression was created that budgetary ceilings are largely preset and that sector Ministries have to develop plans and activities that fit within these ceilings. However, it was difficult to corroborate this perception.

Civil society organisations

Most development planning frameworks claim to have been based on extensive collaboration and stakeholder involvement. In the case of the PEAP 2001-2003, for example, it has been suggested that unlike during the formulation of its predecessor (the PEAP of 1997), it has been based on extensive involvement by all sector working groups involved in the MTEF process, key line ministries and representatives from CSOs. However, this assertion is not always corroborated by key informants in this study. A by now familiar observation was made that donors and certain Ministries are the main, if not sole, actors in this process:

> Most of the planning frameworks … are basically donor-driven. The donor and Ministry of Finance and possibly the Ministry responsible develop these plans. I don't think there is much involvement of various stakeholders. The would-be stakeholders are merely informed or learn of the process in the papers.[ciii]

This view was confirmed by a representative from an NGO:

> CSOs are invited when there is dissemination. The PEAP was more or less a Ministry of Finance thing. There was less participation in its formulation. When there is no full participation, it becomes difficult to monitor such programmes.[civ]

Representatives of the UAC commented that a wide range of civil society organisations had been involved and consulted in the formulation of the NSFA. These included faith based organisations, national and international NGOs, academic institutions, an association of Traditional Herbal Practitioners (THETA) and networks or PLWHA. With the exception of the latter, this view could not be supported by respondents in this study. However, one of the representatives of the UAC added that there may have been logistical reasons why certain stakeholders at decentralised levels may not have been sufficiently involved.

UAC and organisations of PLWHA

Whilst the UAC was clearly instrumental in the formulation of the NSFA, this study was particularly interested to explore its involvement in the formulation of other development planning frameworks. According to the UAC representatives interviewed, the organisation is very involved in the revision of the PEAP:

> The Commission is participating actively in the revision of the PEAP. We are trying to ensure that the revised PEAP explicitly highlights HIV/AIDS issues rather than relegating them to one of the pillars. … HIV/AIDS was only considered under Pillar 4 [improving the quality of life of the poor] … now PEAP is being reviewed and HIV/AIDS will be mainstreamed in all the four pillars.[cv]

However, it appears the Commission has not been involved in other development planning frameworks reviewed here. It does, however, give support and guidance to sectors in the development of thematic policies, for example on orphans, home-based care (HBC), PMTCT and so on.

Organisations representing PLWHA are hardly involved in the planning process. The one exception is the NSFA, which was commended for being based on extensive involvement with associations of PLWHA. Whilst the two organisations interviewed both indicated lack of human resource capacity to be involved in the formulation, implementation and revision of the various planning frameworks, one of the respondents gave a particularly insightful commentary on why no attempt has been made to involve these organisations in planning processes:

> The reason for the government not involving us is based on perceptions that when you are living with HIV/AIDS, you are a patient and hence you should merely be a recipient of plans and policies. Because of stigma, most people who are professionals living with HIV have not come out openly so the technocrats in government think that we do not have the capacity to contribute constructively to planning processes. People outside there think that we cannot manage challenging tasks … that one is likely to die before accomplishing the task.[cvi]

She further gave an example of the qualitative difference their involvement would make to planning interventions:

> The assumption is that with UPE all children, including those affected and infected with HIV/AIDS, will go to school. Had we been involved in the formulation of UPE, we would have prioritised correctly the needs of the affected and infected children. … Although it is important, provision of free primary education alone is not a solution to getting orphans to school. There is nothing to eat, one is sick, cannot get medication, clothing, etc. How would you expect such a child to think of school?[cvii]

Development partners / donors

A significant number of respondents pointed to the extensive involvement of donor agencies in the formulation and approval of the various development planning frameworks. On many occasions, particular reference was made to the World Bank.

According to a World Bank representative in Uganda, the World Bank has been involved mainly in terms of funding studies and consultancies to inform the formulation of these frameworks. However, it also provides technical support, as in the case of the PEAP. The representative added that the World Bank has also been involved in the preparation or revision of sectoral planning frameworks, but only to the extent that it has specialised staff for particular sectors. Thus, with respect to health and education the World Bank's involvement has been substantial. As a major funding agency for the implementation of these frameworks, the World Bank engages in regular reviews of the MTEF and the PEAP based on the Poverty Status Reports.[cviii]

By way of concluding this section, it appears that some development planning frameworks have been informed by more extensive consultation and stakeholder participation than others. Of particular concern is the negligible involvement of Parliament in both the formulation and monitoring of these key instruments to guide the development process in Uganda, although it has been noted that this may be changing now. Also disconcerting is the fact that civil society organisations and organisations with a particular mandate to address HIV/AIDS (including UAC and organisations of PLWHA) do not seem to have played a significant role in the planning process, some notable exceptions aside. Of course, this case study does not claim to present a fully representative picture of planning processes in Uganda. However, the findings of the small sample

of representatives interviewed in the context of this study suggest that development planning remains largely the prerogative of a relatively small group of government officials, particularly those with an interest in financial and economic planning, and donors, including multilateral organisations like the World Bank. A number of respondents have expressed the hope that the recently established NPA may play a facilitating role in this regard, which could ensure more active participation of a variety of local stakeholders.

Alignment and implementation of development planning frameworks

Within the context of Vision 2025, the PEAP is considered the main development planning framework in Uganda and is supposed to guide budget planning, sector planning and district planning. As mentioned in Chapter 3, the link between the PEAP and the MTEF in particular is considered quite strong, in part possibly because the MTEF has become well established in Uganda. However, respondents expressed widely differing views on whether other development planning frameworks were sufficiently aligned with the PEAP as well as with other frameworks. Some of those who argued that this was not the case suggested that this was because there had not been sufficient time to synchronise these frameworks sufficiently. Again, the hope was expressed that the recently established NPA would play a central role here in future. Indeed, one of the enacted functions of the NPA is to coordinate and harmonise development planning in the country. It is also charged with monitoring and evaluation of the effectiveness and impact of development programmes and of the performance of the national economy.

Another explanation for the observed lack of alignment between the various development planning frameworks proffered was that planning still tends to be done on the basis of sectoral projects, in large part because donor funds are made available to sectors rather than for budget support. As a result, there has been a lack of coordination between the various sectors and the respective planning processes.

Table 8.1 confirms that there are some questions, if not concerns, about the alignment of the various development planning frameworks from the specific vantage point of HIV/AIDS. For example, although the NSFA makes reference to the various drivers of the HIV/AIDS epidemic in Uganda, few other development planning frameworks have actually taken these factors on board in the way that these are articulated in the NSFA. Even if other frameworks address specific core determinants of vulnerability to HIV infection, more often than not there is no evidence that this is at least in part informed by an understanding of the link with HIV/AIDS. As far as the key consequences of HIV infection are concerned, one could be tempted to argue that all there may be is an 'alignment by omission', since most development planning frameworks are largely silent on these factors. On a more positive note, though, the current revision of the PEAP, and in particular the above-mentioned efforts to ensure that HIV/AIDS is an integral component of all four components of the PEAP, might be considered an attempt by the Government to ensure better alignment of key development planning frameworks.

Some respondents argued that the problem is not so much alignment, but that the challenge lies in the implementation of these frameworks:

> Whereas the planning frameworks themselves might be fairly aligned, I am not sure that the various implementers are following the existing frameworks. Especially in the field of HIV/AIDS, the implementation is so much in the hands of NGOs, CBOs and other forums in the private sector. Who is ensuring that they are following the frameworks?[cix]

Other respondents added factors like lack of capacity and limited resources for the effective implementation of the development planning frameworks. These factors were considered particularly relevant for districts. In the case of the NSFA, this observation was also made in relation to sector Ministries, as these organisations have to translate the objectives and priorities of the NSFA into action. One of the challenges in this regard is the formulation of indicators, which allow for the evaluation of strategies in the NSFA that other parties have to execute. This task is further complicated by the fact that proper baseline data on HIV/AIDS was lacking at the time the NSFA was developed.

Concluding comments

As the preceding discussion has sought to highlight, Uganda appears to have a relatively strong planning system with the PEAP playing a critical role as the guiding development planning framework, which is integrally linked to financial planning through the MTEF. Yet, the extent to which the various

frameworks both appreciate and respond to the core determinants of vulnerability to HIV infection and the key consequences of the HIV/AIDS epidemic leaves much to be desired. Even if particular core determinants or key consequences of HIV/AIDS are recognised, macroeconomic reform arguments tend to supersede other development objectives related to poverty reduction, empowerment and the reduction of all forms of inequality (particularly income inequality) and priority is given to strategies associated with these types of economic and associated institutional reforms. To a certain extent, this is also indicative of the fact that the various development planning frameworks are chiefly determined by the political and funding priorities of bilateral and multilateral donors, with relatively little input from parliament, civil society organisations and organisations with a specific mandate to address HIV/AIDS (i.e. UAC and associations of PLWHA) – although great variances have been noted in the involvement of stakeholders regarding the formulation of the various development planning frameworks.

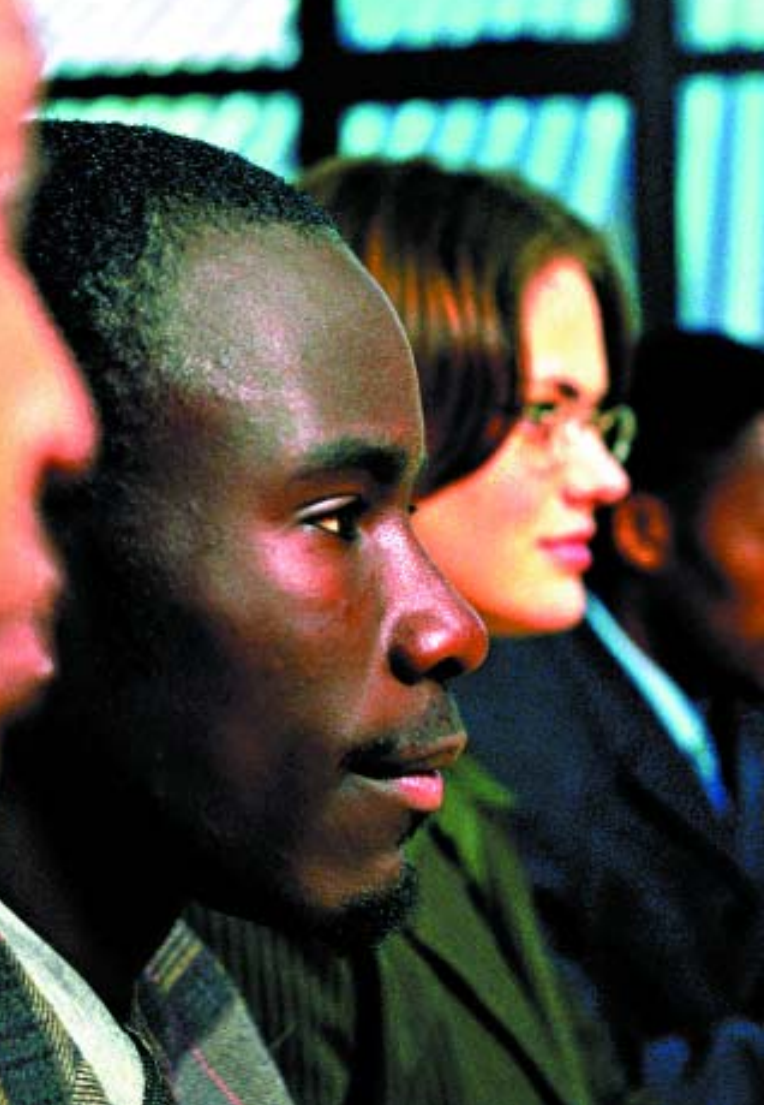
8.5. Conclusion

Curtailing the spread of HIV and mitigating the impacts of the HIV/AIDS epidemic has been an explicit goal of the Government of Uganda for almost two decades. The resolve with which Uganda has tackled the HIV/AIDS epidemic at a relatively early stage has made the country a model for other countries in the region, which are faced by the tragedy and devastation caused by HIV/AIDS. Yet, during the course of this study it has become clear that significant scope exists to better align development planning in Uganda with the development challenges posed by the HIV/AIDS epidemic.

Although it has emerged that there is significant correlation between the identified core determinants of vulnerability to HIV infection and the key planning frameworks guiding the development process in Uganda, not all core determinants are recognised as critical for the development of the country, let alone for stemming the spread of HIV. The main emphasis is on individual behaviour change and on general development objectives like poverty reduction, ensuring access to income and equitable access to services. Less attention is given to other drivers of the epidemic, particularly to the political dimensions of vulnerability and to the distribution of national wealth and income. These factors were also less readily mentioned by the respondents consulted during the course of this study. However, the fact that certain objectives in the relevant planning frameworks correlate with core determinants of vulnerability to HIV infection does not automatically mean that these factors are adequately addressed. As this chapter has highlighted, precedence is given to strategies aimed at realising macroeconomic and associated institutional reforms, without adequate critical reflection of how these strategies may thwart the realisation of development goals like poverty reduction, equality and empowerment.

Whereas it is possible to identify some links, albeit tentative, between development planning and HIV/AIDS in Uganda in the area of prevention, the same cannot be said for impact mitigation. A few exceptions aside, the various development planning frameworks hardly give any attention to the core consequences of HIV/AIDS identified in Chapter 4. Given Uganda's early response to the HIV/AIDS epidemic, it seems rather surprising that the only core consequences of HIV/AIDS explicitly mentioned concern the more obvious impacts, such as AIDS-related mortality, orphans, stigma and discrimination, and the need to involve PLWHA in decision-making processes. What could be considered the secondary impacts of increased adult mortality, in communities as much as in organisations, are not explicitly mentioned or addressed.

Yet, the key consequences of HIV/AIDS threaten to undermine, if not reverse, the development gains achieved since the mid-1980s. From the interviews it was clear that the respondents were more attuned to these negative impacts of HIV/AIDS for the development of Uganda and its people, although by far not all key consequences were mentioned. To a certain extent, this raises questions about the planning process and the degree to which different stakeholders can influence the formulation, revision and implementation of Uganda's development planning frameworks. This study has found that the level of consultation and stakeholder participation varies significantly between the different development planning frameworks. In general, though, there has been very limited involvement of Parliament and of civil society organisations in general and of specific organisations with a mandate to represent the interests of PLWHA and affected communities. Instead, planning seems to be the forte of government officials, particularly those in the MFPED, and the donor community, more specifically the World Bank. Many respondents have expressed their concern about this situation.



Mainstreaming HIV/AIDS into development planning implies going further than the mere recognition in the PEAP that HIV/AIDS is a cross-cutting issue. The unfortunate implication of this reference in the PEAP seems to be that HIV/AIDS has lost prominence as a critical aspect of development planning. Instead, what is required is a critical assessment of how each development planning framework may neglect or – worse still – aggravate the core determinants of vulnerability to HIV infection and the key consequences of HIV/AIDS. This involves not only a superficial assessment of the correlation between these factors and the stated objectives in the various frameworks, but more importantly of the proposed strategies and instruments (and their underlying assumptions) to realise these objectives.