Working paper 4

Technical cooperation and the HIV epidemic

Applying best practice to the ILO Programme on HIV/AIDS and the world of work

by
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Preface

The ILO's long experience in technical cooperation activities globally, at both regional and country-level, provides a firm basis for mobilizing governments, employers' and workers' organizations − its tripartite constituents − to address the impact of HIV/AIDS in the world of work. This means helping governments and their social partners to fight the epidemic through advisory services, training and policy guidance on prevention, care and social protection. The *ILO Code of Practice on HIV/AIDS and the world of work*, developed through tripartite consultations and adopted in June 2001, provides practical guidelines for technical cooperation activities intended to help reduce the spread of HIV and mitigate its impact on workers and their families.

The study draws on relevant technical cooperation experience worldwide – undertaken by the ILO and other agencies - in support of activities to address the complex issues of HIV and AIDS. Its objective is to strengthen the global ILO Programme on HIV/AIDS and the world of work. This new ILO programme is moving forward from the development of the Code of Practice to its implementation as a tool for HIV/AIDS workplace policies and practices that are effective and sustainable.

The study evaluates experience in delivering technical support in response to HIV/AIDS, drawing lessons on how best to plan and deliver activities in this area. It is evident from the range of experience reviewed that many issues need to be considered in establishing mechanisms for effective technical support. More specifically, and in relation to the needs of the ILO's traditional partners, the study reviews experience in relevant areas such as capacity development, institution building, employment promotion, legal reform and programme implementation.

Finally, the study establishes the parameters for effective technical cooperation by the ILO: first, as it develops activities designed to mainstream HIV/AIDS within its own programmes, and secondly, as it assists governments, employers' and workers' organizations to address HIV/AIDS and its impact in the world of work.

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Introduction

The impact of the HIV/AIDS epidemic on the world of work is fundamental and pervasive, especially in sub-Saharan Africa. In a situation where a quarter to a third of the economically active population is infected with HIV, and where those infected experience long periods of morbidity and premature death, it is necessary to re-think the *modus operandi* of much of the work of all development institutions. This is particularly the case for the ILO, precisely because concern for the skills and capacities of the working population is central to the organization.

Many of the assumptions applied to development assistance – for example in education and training – are being undermined as a result of the epidemic. Investment in training which is economically worthwhile if someone can be assumed to continue working until the age of 60, or even beyond, may have to be re-thought if people are dying at the age of 35 or 40. The HIV epidemic creates a new context for development, and necessitates reassessment of many basic assumptions. Technical cooperation in particular must be re-thought, since much of the technical cooperation undertaken is aimed at building medium or long-term capacity through the enhancement of human skills. The major modes of operation assume continuities of such capacity, which can be further built on and which can ensure a degree of sustainability. These assumptions may no longer be valid.

One of the strange and largely inexplicable features of the global response to the HIV epidemic has been the almost total neglect of issues of technical cooperation. This is puzzling, given that the epidemic raises development problems on a scale that demands a re-thinking of how best to strengthen national and regional responses to the complex set of issues that are raised. It is as if what needed to be done was self-evident, and it was well-known how best to support policy development and programme implementation. The reality has been quite different. These problems of designing and delivering effective and relevant policies and programmes for AIDS have been compounded by the assumption that the lessons of best practice technical cooperation would be applied. Unfortunately this has proven not to be the case, with results that are only too apparent in the low levels of effectiveness of country and global responses to the epidemic.

This paper has several objectives. The most important objective is to provide guidance to the ILO in taking forward its activities on AIDS in the workplace. In section 1 there is a brief summary of the epidemiological situation with respect to HIV/AIDS, with a focus on the devastating crisis that is emerging in sub-Saharan Africa. But as will be seen the epidemic is truly global and the regions now with the fastest rates of new HIV infections are Eastern Europe and Central Asia.

Section 2 establishes some of the most important lessons to be learnt about general best practice in respect of development and technical cooperation. As will be seen there have been many conferences, workshops and studies of technical cooperation, but the lessons of these and of practical experience have still not been fully absorbed by the development community. It is not surprising, therefore, that donors and other organizations have generally failed to establish technical cooperation modalities that are effective. But these lessons do need to be applied, if donor support to countries is to make a difference and prevent a deepening development crisis as the impact of the epidemic is felt throughout the economic and social system.

Section 3 brings together different elements of experience in strengthening capacity through technical assistance in the area of HIV/AIDS, within a framework that defines the epidemic as a development issue. The first part of the section covers issues of internal organizational changes that are required if HIV/AIDS is to be mainstreamed in an organization. It also includes a brief review of the lessons of technical support for capacity building for research on the epidemic in several countries in sub-Saharan Africa. This is followed by a fairly detailed review of the experience of one development agency, UNDP, in sustaining technical support in one high prevalence country (Botswana). Finally, this section considers the lessons of experience in attempting to integrate HIV/AIDS in organizations where there have previously been few or no relevant activities in this area.

Section 4 attempts to draw out the conclusions of the previous discussion and to establish the parameters of effective technical support within the ILO as it develops its activities on HIV and AIDS. The focus is on how to integrate HIV across the organization's activities, not just in the HIV/AIDS Programme, and on how best to take forward technical support in respect of the impact of HIV on the world of work. This section is necessarily speculative, but it is believed to be well founded in the light of the review of experience, and of a general donor agreement on the need for more effective technical cooperation. There is now amongst the donors, rather belatedly, a better understanding of what all this means in practice.

1. HIV prevalence – the evidence

1.1. Sub-Saharan Africa

Of the global total of 42 million persons living with HIV in 2002 about 70 per cent (29.4 million) are in sub-Saharan Africa. In Africa infection is concentrated in the socially and economically productive groups aged 15-45, with slightly more women infected than men. There are significant differences in the ages of infection of girls and boys, with infection occurring at younger ages for girls (with girls and young women in some countries outnumbering boys and young men by factors of three or four in the age range 15-20). It is estimated that 27 million persons have died from HIV-related illnesses since the start of the epidemic worldwide, of whom more than 21 million were Africans. [1]

It follows that the cumulative affected population in Africa, taking into account spouses, children and elderly dependents, must be of the order of 250 million (29 million currently living with HIV plus 21 million who have died times a factor of five to represent those directly affected). This is a staggering proportion of the total population in sub-Saharan Africa – something like one-third of Africans are directly affected by the HIV epidemic. Few people can remain unaffected in indirect ways, i.e. through the illness and death of relatives, friends and in their workplaces and their communities.

Levels of HIV prevalence in parts of Africa are extremely high - in Southern Africa there are increasing numbers of countries with HIV infection rates among adults in excess of 20 per cent. The gap between rural and urban HIV rates -– previously substantial – is now narrowing rapidly in many countries. For some urban populations HIV is now as high as 40-50 per cent -- rates of infection earlier considered wholly improbable. For example in Botswana HIV prevalence in the capital city, Gaborone, rose from 15 per cent in 1992 to 39 per cent in 1998. In the case of Francistown the prevalence was estimated at 43 per cent in 1998, and 10 of the country's 15 sentinel sites now have HIV rates in excess of 33 per cent. The overall HIV prevalence rate for the adult population in 1999 was 36 per cent, making Botswana the country with the highest level of any country. It is now projected that over the next 10 years that Botswana will lose a quarter or thereabouts of its total population to AIDS. This is in a country which has done remarkably well since independence and where there has been sustained social and economic development. But it is still a country where about half the population lives in poverty, concentrated particularly amongst female-headed households.

It is estimated that there are presently some 11 million children in Africa who have lost one or both parents to HIV-related illnesses, and that by 2010

[1] UNAIDS/WHO: *AIDS Epidemic Update* (December 2001). See also UNAIDS/UNICEF/WHO: *Young People and HIV/AIDS: Opportunity in Crisis* (2002).

these numbers are projected to increase to about 20 million.[2] The most severely affected countries in terms of AIDS orphans in the year 2001, according to UNAIDS, are Ethiopia (989,000); Kenya (892,000); Malawi (468,000); Nigeria (995,000); Uganda (884,000), Tanzania (815,000), Zambia (572,000) and Zimbabwe (782,000). These are truly staggering numbers. In some countries the proportion of all children under 15 years of age who have lost one or both parents to AIDS may be as high as 20 per cent, possibly even higher, by the end of the first decade of the new millennium. It should be noted that AIDS orphans account for only a proportion of the total number of orphans from all causes, so that the overall problem is even more serious. These trends have direct implications for intergenerational poverty and impose immense challenges for policy makers.

HIV infection is not confined to the poorest people even though the poor account absolutely for most of those infected in Africa. There is limited evidence for a socio-economic gradient to HIV infection, with rates higher as one moves through the educational and socio-economic structure (see the UNAIDS *Report on the Global HIV/AIDS Epidemic, 1998*, where there is a discussion of the apparently puzzling fact that HIV is higher amongst the most literate).[3] It follows that the relationships between poverty and HIV are far from simple and direct, and more complex forces are at work than just the effects of poverty alone. Indeed many of the non-poor in Africa have adopted and pursued life styles that expose them to HIV infection, with all the social and economic consequences that these entail. It follows that the capacity of individuals and households to cope with HIV and AIDS will depend on their initial endowment of assets - both human and financial. The poorest by definition are least able to cope with the effects of HIV/AIDS. Even the non-poor find their resources diminished by their experience of infection (morbidity and death), and there is increasing evidence in urban communities of an emerging class of those recently impoverished by the epidemic.

The effects of HIV and AIDS are reflected in the changes in life expectancy (Table 1) which is the best summary indicator of the effects of HIV/AIDS on countries with high levels of HIV prevalence. These data are remarkable for what they illustrate of the demographic impact of the epidemic on African populations. In many countries adult mortality has doubled and trebled over the past decade and this is directly attributable to HIV and AIDS.

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[2] UNAIDS/UNICEF/USAID: *Children on the Brink 2002: A Joint Report on Orphan Estimates and Program Strategies* (July 2002).

[3] The information on these issues is limited. It may be worth noting the conclusion of a recent study that found, " there is very little hard data that supports the contention that teachers are a high risk group….[nevertheless] the epidemic will still have a serious impact on the teaching profession…(pages 77-78), Centre for International Education, University of Sussex: *The Impact of HIV/AIDS on the Education Sector in sub-Saharan Africa: A synthesis of the findings and recommendations of three country studies* by Paul Bennell et.al. (UK, 2002).

What is now being experienced by these populations are levels of life expectancy which were typical of the 1950s.

Table 1. Estimated and projected life expectancy at birth in 9 countries with highest HIV prevalence

Country	1985-1990	1995-2000	2005-2010
Botswana	62.5	47.4	43.5
Kenya	57.5	52.0	48.3
Malawi	45.3	39.3	44.0
Mozambique	46.2	45.2	36.6
Namibia	56.0	52.4	38.1
Rwanda	48.2	40.5	43.5
South Africa	57.9	54.7	44.7
Zambia	50.4	40.1	46.5
Zimbabwe	56.8	44.1	44.0

Source: UN Population Division, *The Demographic Impact of AIDS*, 1998.

1.2. Other regions

While the HIV epidemic is presently most severe in sub-Saharan Africa it is by no means confined to that region. As noted above, the area where HIV incidence is growing most rapidly is Eastern Europe and Central Asia. There were an estimated 250,000 new infections in 2001, raising the number of people living with HIV to 1.2 million. Infections have accelerated rapidly in the Russian Federation, where the true level of HIV prevalence is estimated to be many times the officially reported level. In the Ukraine it is now estimated that more than 1 per cent of the adult population is infected with HIV. Similarly rapid growth is reported in other countries such as Estonia and in several of the Asian Republics. The epidemic, which was concentrated among the drug-using population, is now spreading to other groups and there is now an increased danger of a generalized epidemic.

The epidemic was late in coming to Asia and the Pacific and by 1999 only Myanmar, Thailand and Cambodia had documented significant levels of infection with HIV. This has now radically changed. In 2001 almost one million new infections were reported for the region as a whole, bringing the total number of those living with HIV to well over seven million. Most worrying are the increasing levels of infection in countries with extremely large populations, especially China and India. In China there may now be more than one million people infected with HIV, with many regions experiencing rapid increases in infection - often associated with injecting drug

use but also socio-economic disparities and extensive migration (*AIDS epidemic update 2001*, UNAIDS/WHO).

In India the adult HIV rate is less than one per cent (some four million people infected) but this is absolutely higher than any other country except for South Africa. Again there are important differences in rates of HIV incidence between states and between major urban centres. Other countries such as Indonesia, Nepal and Vietnam are all displaying evidence of rapid growth in new infections, even if for the moment that evidence is drawn from a relatively low base of HIV prevalence. However, it should be noted that low levels of prevalence, often less than one per cent for adults, hide very significant sub-regional variation within countries, It would be a mistake to assume that low overall prevalence meant the situation was not exceedingly grave for some population sub-groups and for some localities within specific countries.

Finally there are an estimated 1.8 million adults and children infected with HIV in Latin America and the Caribbean. In this region the transmission of HIV is exacerbated by the great income and wealth inequality, poverty and labour mobility. It is worth noting that the Caribbean, which has an estimated 440,000 people living with HIV, has the second highest level of HIV prevalence of any region. Thus HIV prevalence is above 4 per cent in Haiti and just under in the Bahamas, but rates are also significant in many other countries (including Belize, Honduras and Guyana). As with Asia and the Pacific, the low rates of HIV prevalence among adults should not be taken as evidence that the epidemic is dormant and under control for the evidence shows quite the opposite. All countries continue to face the possibility of rapid growth in HIV infections and within certain sub-groups this is already a reality.

The data on HIV prevalence is important in itself as an indicator of the probable morbidity and mortality facing many millions of people. However, it is only one indicator of the gravity of the situation facing many developing countries. It has become increasingly clear that the epidemic has its origins in the structural conditions in many countries, such as income and wealth inequality, high levels of poverty, high levels of rural and urban unemployment, gender relations and patterns of economic development. It is also clear that the epidemic is systematically reversing decades of development and is undermining capacity to achieve sustained social and economic advances, not least through its impact on human capital and on losses of skills and experience essential for sustained development. Technical cooperation needs to targeted to respond to these structural conditions, and only then will it be effective in mitigating the impact of the epidemic on development.

2. Best practice in technical cooperation

2.1. General principles

The effectiveness of technical cooperation was questioned long before the advent of the HIV/AIDS epidemic, and many of the concerns raised are even more valid in this new context. In any event, the impact of technical cooperation is inherently difficult to assess, and many of the standard methods of assessment make use of intermediate but easily measurable variables such as the numbers of people who are trained or who attend workshops, the production of documents or the publication of survey results. These are outcomes which, although valuable, are not necessarily indications of improvements in the well-being of populations living in those societies, and certainly not of sustained improvements in peoples' lives.

In the context of HIV/AIDS, the relationship between such intermediate outcomes and general welfare may be even less direct. Of the numbers of people who attend training programmes, seminars and workshops, for example, – who are assumed to have a continued enhancement in the effectiveness of their skills – some significant proportion will become unable to work at all, and others will be negatively affected by a working environment in which morbidity and mortality among colleagues becomes the norm and in which totally new challenges arise for which many people may have no relevant experience.

It may be useful to start with some general discussion of technical cooperation, beginning with the question of what is meant by technical cooperation (TC).[4] TC refers to a range of activities designed to support the development of national capacity. The main instruments of TC are providing access to training – long-term and short-term, including workshops and seminars; the provision of expertise, policy and technical advice; assistance in the preparation of surveys and studies contributions to science, research and technological development; institutional support through twinning arrangements and ongoing access to high-level expertise; and inter-country and regional activities designed to strengthen regional institutions, share best practice and enhance capacity to address supra-national issues in areas such as the environment.

Technical cooperation is significant in terms of resource flows: it accounts for around one-third of all development assistance. In the case of the ILO, technical cooperation expenditures, while they have been declining over a number of years, accounted for $90.9 million in 2000, and $97.1 million in

[4] For an excellent review of many of the issues of TC see UNDP: *Rethinking Technical Cooperation: Reforms for Capacity Building in Africa* by Elliot J Berg, coordinator, (1993). For a more succinct survey of the issues see UNDP: *Capacity Development: Lessons of Experience and Guiding Principles* (1994).

1999 (GB.282/TC/2, November 2001). Of the 2000 total, around 27 per cent involved expenditure on experts, 26 per cent on other personnel, 24 per cent on training, and 9 per cent on subcontracting. Of the experts on assignment in December 2000, 134 out of a total of 193 were from developed countries. In reviewing some of the project evaluations conducted during 2000, the Governing Body document indicates that there was more success in achieving immediate objectives than in building capacity in a sustainable way. Some of the problems that arose included excessive centralization of resources in Geneva, inadequate attention to linkages with other activities and to cooperation with other partners, project time horizons which were too short, and the need for projects to be more demand-driven.

These problems of TC practice are not unique to the ILO. As noted above, many doubts have arisen over decades about the effectiveness of TC in general. Major criticisms include the following:

- it has frequently involved activities which are donor- and supply-driven;
- it has overemphasized the use of expatriate 'experts' on a long-term basis, of variable quality but high cost;
- activities undertaken in the context of TC projects have often proved to be unsustainable and have involved little development of national capacity;
- opportunity costs of resources are not taken into account, either by the donor or the recipient;
- as a result of TC, donors have contributed to the creation of an internal and external brain drain which has deprived national institutions of scarce, high-level personnel;
- much TC has involved the establishment of parallel administrative mechanisms which undermine the capacity of national governments.

In short, much TC has failed in its main objective of building national capacity, and has involved the wasteful and inefficient use of resources.

The dubious quality of much TC and its limited usefulness – in some cases even its negative consequences - have been the subject of many international conferences and studies, for example by OECD/DAC, UNDP and the World Bank, by bilateral donors and by institutes such as the European Centre for Development Policy Management in Maastricht. The outcome of the conferences, research projects and evaluations has usually been agreement on the lack of effectiveness of TC and the enunciation of a set

of principles which, like motherhood and apple pie, no-one could possibly object to.

The problem has been in trying to translate the principles into practice, since the problems of TC may be endemic in the aid relationship and in the organizational structures of donor agencies, both multilateral and bilateral. Donor decision-making about TC frequently reflects the changing foreign policy agenda within donor nations or the changing political complexion of donor governments rather than changing needs and priorities within recipient countries. It is thought by many recipients that bilateral donors in particular prefer expatriate experts as 'gatekeepers', in control of project resources, because donors are uncertain about probity, accountability and transparency if all project resources are under national control. In the context of the HIV/AIDS epidemic, an even more thoroughgoing re-thinking of technical cooperation is urgently needed.

The general principles agreed in most documents and conference reports on TC are similar (see, for example, *International Journal of Technical Cooperation*, Volume 1 No. 1, Spring 1995). These principles usually include the following:

- Technical Cooperation (TC) should involve the promotion of national ownership of all activities, and should affirm the central role of national actors in planning, design and management of TC activities;

- TC should more effectively support long-term, sustainable capacity development in public, private and NGO sectors;

- TC should promote a stronger and more effective public sector response and reduce the internal and external brain drain;

- TC should support overall national development strategies, and should be integrated with national programmes;

- TC should ensure more effective donor coordination within the framework of the above objectives.

In addition to analyses and discussions of the problems of TC in general and the enunciation of new principles to guide future activities, there have been many innovative approaches to TC, which have broken away from the conventional model of long-term expatriate experts directing donor-formulated projects. This includes innovations specifically designed to address the problems arising as a result of HIV/AIDS, about which there will be more detail below. The problem has then arisen of how to share the results of the experiences and how to multiply good practice - how to ensure that pilot projects do not simply remain pilots without broader consequences and

implications for TC elsewhere. This sharing of the results of innovative approaches has been positive but of limited scope.

2.2. Technical cooperation and HIV/AIDS

Nowhere has the challenge to improve the design and delivery of TC been greater or more urgent than in the context of the HIV/AIDS epidemic. TC has in general proved to be at its weakest in precisely those areas which are needed for an effective response to the epidemic.

Of greatest importance is a multi-sectoral approach with high-level coordination capacity and the political influence needed for effectiveness. The approach also needs to be multi-layered, involving national level policy capacity, and implementation capacities at all levels down to communities. Activities need to galvanize a coordinated, collective and cooperative response by the public, private and NGO sectors and by large numbers of donors, multilateral, bilateral, government and NGOs. Issues of immense controversy need to be addressed effectively, such as norms of sexual behaviour and gender relations, including the gender division of labour, both in employment and in the household, involving challenges to male-dominated structures at all levels. It also involves an examination of employment opportunities for women in societies where sex work represents one of the few avenues for income generation. In addressing the HIV/AIDS epidemic, it is not enough for TC to become more effective at achieving objectives in a conventional sense, with projects organized on traditional lines. What needs to happen is a much more fundamental rethinking of TC than has occurred hitherto.

Many of the assumptions that are part of the analytical framework for TC and indeed for development assistance in general, need to be rethought as a result of the HIV/AIDS epidemic. We will mention three major areas, involving long-term training, technological requirements and basic life-skills.

First, there needs to be a reconsideration of the effectiveness of long-term training as a means of building national capacity, since very large numbers of highly trained people, embodying significant levels of scarce resources, will not be able to exercise their skills and capacities over the full span of a normal working life. This does not imply the end of high level skill formation, indeed the problem is precisely an increasing scarcity of highly skilled people (there has been some evidence of higher incidence of HIV infection among the higher skilled population, but even if the same incidence of HIV affects all categories of labour, the epidemic is leading to increasing scarcity of high-level personnel).

The problem is that, in the face of this increased scarcity of highly trained people, approaches to increased skill formation must change from those that have predominated in the past, because of a combination of intense scarcity with the economic necessity for shorter periods of training due to reductions in the length of effective working lives. For example it may be more appropriate to consider shorter periods of training with long-term twinning arrangements to support institutions, rather than relying on individuals to continue to function effectively, since institutional collapse is a real possibility in key institutions in many countries.

Secondly, there are changing technological needs in societies that were once thought of as labour-abundant, where labour is now becoming increasingly scarce, partly as a result of morbidity and mortality and partly as a result of increased numbers of people involved in caring for sick family members. Changes in agricultural technology, for example, may be warranted to maintain levels of productive capacity in food and exportable commodities in the context of a shrinking labour supply. The need to sustain levels of export production may be particularly acute in situations where households divert their dwindling labour resources to food production to meet immediate household needs.

Thirdly there is a marked reduction in the transfers of basic skills from parents to children, which are assumed to occur as a normal part of children's socialization – in areas such as agriculture, livestock, house-building and maintenance, household management and food processing, herbal medicine and hygiene. That these skills can no longer be assumed to be transferred from one generation to the next is because parents of young children are dying and children as young as seven are being left as heads of households. These changes are taking place in societies in which user charges are increasingly the norm for basic services such as primary education. In addition to the problems of paying fees and providing school clothing, children are unable to attend school because they are now becoming carers and providers at an extremely early age.

These changes have serious implications for the nature of the labour force in the future and the needs of societies for forms of education and training to reach people who cannot be assumed to have the basic skills that in the past were a normal part of growing-up and that form the foundation upon which all skill formation is based. This in turn has implications for development assistance in general and TC in particular. This is most obviously the case in terms of the basic education of the working population where the increasingly large numbers of children with little or no formal education will have deep implications for the future course of social and economic development in the most severely affected countries. [5]

[5] These issues are well set-out in UNESCO, International Institute for Educational Planning: *Planning for Education in the Context of HIV/AIDS* by M.J.Kelly (Paris, 2000).

3. Strengthening capacity to respond to HIV/AIDS

3.1. Capacity development

The key instrument for achieving effective programmes for HIV and AIDS is capacity development, although this is rarely understood to be the case, and very few projects and programmes explicitly address the complex issues of how to achieve it as an objective.[6] It is, therefore, scarcely surprising that so many projects fail to achieve their objectives, and are thus so often unsustainable and ineffective.

The term capacity development can be defined as follows:

Capacity is the ability of individuals and organizations to perform functions effectively, efficiently and sustainably. The term 'capacity development' is preferred to 'capacity building'; while capacity strengthening is important so are the retention of existing capacity, improvements in the way in which existing capacity it being utilized, and the retrieval of capacity which has been eroded or lost. Thus capacity development does NOT take place only through the training of additional staff or the creation of new organizations, but requires an enabling environment to ensure that people are used effectively, retained within organizations and structures that need their inputs, and are motivated to perform their tasks.

All projects and programmes need to develop a capacity development strategy and should be assessed on the basis of whether they address the key issues that this involves. Central to an assessment of a project or programme is whether in the formulation of a capacity development strategy *a capacity assessment* was undertaken, and on the basis of this assessment whether conditions relating to capacity that ensured that the project was both feasible and sustainable were put in place.

A capacity assessment facilitates examination of the strengths and weaknesses of the existing arrangements for undertaking the project or programme, the reasons for weaknesses in existing capacity and why these have persisted over time, and factors that undermine existing capacity such as losses of skilled labour due to HIV-related mortality. Such an assessment would also generate insights into past failures and successes in regard to capacity strengthening and how to build on the latter in implementing activities.

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[6] Technical Advisory Paper no. 3, Management Development and Governance Division, UNDP: *Capacity Assessment and Development – In a Systems and Management Context* (1998).

Only once a capacity assessment had been undertaken would the precise form of the required technical support be evident. Thus donors would be able to tailor their assistance to meet the revealed needs of projects and programmes with a focus on strengthening capacity in conditions where it is being systematically eroded by the impact of HIV/AIDS. In addition, the epidemic will reduce the ability to maintain capacity through its impact on human capital. This makes the task of technical cooperation doubly difficult in a world of HIV and AIDS.

The role of donor organizations

It is evident that donors have a clear interest in supporting the capacity development strategies of national governments through the full integration of their programme activities with those already underway or planned at country level. This makes it essential that donors formulate their activities for capacity development within coherent frameworks that ensure consistency with each other's plans, and also consistent with national needs and capacities. It may be necessary for donors to support the establishment of coordination machinery, and the strengthening of national capacity to effectively coordinate donor activities.

Now donors also need to avoid those activities that are destructive of national capacity, such as agency recruitment of key staff away from national uses, and the distortion of national pay scales through excessive payments to some nationals. The objectives of donors should be to support national capacity development through human resource investment, and to strengthen the policy environment for a more effective delivery of projects and programmes that are relevant for sustainable development. Achieving these objectives may in some cases require that donors to initially seek to strengthen capacity to undertake capacity development as a first step towards more effective general performance.

How does one ensure that capacity development is integral to all projects and programmes?

It is clear from research that putting in place a capacity development strategy and activities for its implementation at the design stage of projects is a sine qua non for more effective performance. It follows that unless the capacity development issues noted above are addressed at the design stage, and relevant activities identified and implemented as integral to projects and programmes, then there will be only very partial and weak overall performance. Monitoring and evaluation benchmarks will need to be developed at the design stage of projects and programmes.

An intriguing example of the myopia of donors can be observed through consideration of an innovative UNDP project in the 1990s to strengthen the

capacity to undertake applied policy research on the HIV epidemic in a number of African countries. As noted above there is still far too little research on issues relevant to policy and programme needs in most countries. The UNDP project aimed to strengthen the capacity to undertake multi-disciplinary research on the epidemic, with a focus on local determination of research priorities so as to ensure relevance to local needs.

The results of this attempt to strengthen research capacity are reported elsewhere, but what is of relevance here is the attitude of other donors to the project. UNDP deliberately avoided funding identified research projects, since it was seen as being important for strengthening research capacity that the national teams of researchers be responsible for presenting their project proposals to donors as part of the overall process. However donors saw the issue in quite other terms. What they observed were research proposals produced by researchers who were supported by a UNDP project who ought in their view to be funded by UNDP. But this attitude by donors undermined one of the long-term objectives of the project which was in part to strengthen the overall capacity to undertake applied research on the epidemic independently of any pre-existing commitment to funding.

What the UNDP project indicates is how difficult it is to change the approach of donors, who seem committed to processes that emphasize ownership at the expense of effective performance. This is in spite of efforts to ensure that donor assistance to countries is coordinated and mutually supportive of the national response to HIV and AIDS. Far too often the assistance provided by donors is reflective of donor preferences and inconsistent with the country's strategic plan, and fails to build on what has already been achieved. As noted above, donors continue, in the area of HIV as well as more generally, to engage in practices relating to pay and recruitment of staff that is destructive of the overall capacity to undertake development.

It is as if donors are reluctant learn from experience, since local agreements on good practice in areas such as competitive recruitment of national staff for donor-supported projects are observed in word but not in deed. What these practices do is to reduce the overall performance of the country, create all sorts of problems for the retention of experienced personnel for government, upset agreed pay relationships, and lead finally to problems of unsustainability with respect to programme activities. These general effects of donors on organizational capacity and performance are unfortunately also true of their support for the national response to HIV in most countries. This state of affairs needs to be urgently reformed.

3.2. Botswana - technical support for programme development

In 1992 UNDP established a special unit, the HIV and Development Programme (HDP), with dedicated resources to address the development

implications of the epidemic. The remit was global, and the Programme undertook a range of activities including support to UNDP Country Offices (COs) in areas of programme development, technical support to National Strategic Plans for AIDS, strengthening of legal and ethical networks and of networks of people living with HIV and AIDS. The range of activities was broad, with an emphasis on strengthening capacity to respond to the epidemic both in countries with high and low HIV prevalence. As we shall see in the next section, the Programme also undertook important tasks within UNDP in the mainstreaming of HIV/AIDS.

HDP was involved in providing programme support to the Botswana Country Office and to the Government of Botswana (GoB) during the years 1992-2000. There has been a sustained relationship ever since the original request for assistance came from the UNDP Resident Representative, and UNDP continued to maintain over these years a close set of working relations both with the Office and the Government. This entailed a number of programme support missions plus more or less continuous comment on the policy and programme proposals of the CO and of GoB.

There are three broad lessons to be drawn from this experience of technical support to Botswana in the response to HIV and AIDS – a country that is facing a severe epidemic (see above) and where national capacity is severely constrained:

- One of the important conclusions of this activity is the need for a sustained relationship between HQ and the CO, a relationship that builds on the trust, experience and expertise of those involved in ways that cannot be achieved through ad hoc consultancies.

- Furthermore, the relationship should ensure that there is somewhere and somebody who can embody the institutional memory of what has previously been undertaken by the CO – ideally this should be part of the normal operations of the CO, who should have ready access to reports and so on, but in practice because of staff turnover (including that of internationals) this cannot always be assumed to be present. Thus HDP was able to draw on its records and its memory about what has been previously done in Botswana over a period of years.

- It is also the case that HDP, because of its involvement in policy development and programme support in other countries, was able to transfer its learning to Botswana so as to better achieve a more rapid internalization of the lessons of what works and what doesn't.

What has been the substance in general of the support provided? The core of UNDP's responsibility within UNAIDS is strengthening understanding of the implications of the HIV epidemic for development, and

assisting countries to put in place effective policies and programmes for addressing both the socio-economic causes and the consequences of the epidemic. The instruments used by HDP for achieving this dual set of objectives have been many – from publications and training to programme support, and general activities aimed at integrating HIV and AIDS in the main areas of programme focus of UNDP (poverty, gender, governance and the environment).

Thus,

- HDP has engaged directly in activities that strengthen the human resource base of COs and countries through workshops on HIV and development and in other ways (often in conjunction with the UNDP Bureau for Africa's regional HIV project) for both national staff and others, and for government and civil society.

- It has assisted COs in other ways - through programme support aimed at strengthening the development of multisectoral national plans, and in strengthening both COs and governments in key programme areas such as applied research on socio-economic aspects of the epidemic, demographic modeling of the epidemic, impact on heath systems, and support for improved capacity for addressing human rights and ethical issues and HIV, and strengthening organizations of people living with HIV and AIDS.

At the core of these activities is the process of capacity development. The role of HDP and UNDP generally is to strengthen the capacity of countries in responding to the complex problems generated by their experience of the epidemic. This is quite different from the pervasive beliefs of many others, particularly those with a public health background, who see their role as delivering expert advice to passive recipients who are expected then to intervene in the conventionally accepted fashion. The approach of HDP has been more circuitous, less directive, but ultimately more locally relevant and empowering.[7]

Programme activities

What are the kinds of assistance, in detail, that HDP has provided to the Botswana CO and its partners in government and civil society? Bearing in mind that Botswana is just one country amongst many that have attempted to draw down technical support from HDP, and also taking into account that the resources of HDP were extremely limited; that HDP had itself suffered

[7] The HIV and Development Programme of UNDP was closed in 2000 in spite an evaluation report that argued for an extension of its activities, and at a time when the development impact of the epidemic was finally beginning to receive the attention of the international community. Why this decision was taken remains a puzzle to outsiders.

extensive staff turnover, and that it had other global responsibilities (especially those relating to its membership of UNAIDS).

UNDP in Botswana needed to put together a complex and coherent programme in support of GoB and related to its responsibilities within UNAIDS. Funding was not (and is not) a problem given the extensive financial support from GoB for the UN system, but human resource constraints are general and pervasive in the country (affecting both UNDP and others in government). So there were three main tasks in the first phase of technical support to the CO, UNAIDS and GoB. These were as follows:

1. Assisting UNDP in putting together its Programme Support Document (PSD) for HIV/AIDS;

2. Strengthening the capacity of the technical support group of the UN agencies in the country (UNAIDS) so that they developed an instrument for coordinated programme support to the government;

3. Assisting GoB in the development of a new National Strategic Plan for HIV/AIDS.

These were important steps: time consuming but essential if the UN system was to relate its programme activities to the needs of GoB (as articulated in its Strategic Plan). Otherwise the UN, and UNDP, would have simply been imposing its ideas on GOB, and would have done so without an overall framework for its HIV/AIDS activities in the country. It should be noted that the conceptual work in Botswana on coordinated planning subsequently became the model used widely within UNAIDS (and in other countries).

Following work with the CO and its partners in government the next broad group of activities have related to support for programme development to implement the PSD. This has moved forward at a pace largely determined by GOB who have rightly wanted to retain control of what was done and how it was done. But it has entailed considerable delay in implementing the PSD. The role of HDP in this has been to work alongside local consultants and others in developing key programme areas – providing technical and other support in respect of both policy development and programme design. The kinds of things that have happened under the PSD and that involved HDP have been studies of the demographic impact of HIV, assessment of the impact of the epidemic on the health sector, a study of the macroeconomic impact of HIV, and so on. There has also been joint programme development with GoB, UNDP and HDP on integrating HIV in key ministries (such as Department of Human Resources, Ministry of Finance and Economic Planning, Ministry of Labour and Ministry of Agriculture).

HDP, together with the Regional Bureau for Africa's regional project on AIDS, has supported training for community leaders (as part of the mobilization of communities), and has been extensively involved in discussions relating to the reform of the machinery of government for HIV to reflect the broader policy and programme aims of Botswana (which has shifted responsibility to the President's Office and thus largely away from the Ministry of Health). Part of this process has entailed workshops for parliamentarians and ministers on HIV as a development issue, and for senior staff in all government departments.

Lessons for technical cooperation

These are easy to identify and list. It is clear that many COs do not have the substantive capacity they need, and need to have access to other technical sources of support. In part (as in Botswana) this may reflect general human resource constraints in a country; and it may also reflect the comparative newness of the issues so there are no ready-made solutions that can be taken 'off the shelf'. It cannot be concluded that this kind of expertise is available in the UNAIDS Secretariat or elsewhere among the UNAIDS cosponsors – it is often simply not there and may need to be created.

That COs sought the assistance of HDP may also reflect the fact that there may be few sub-regional/regional places to turn to for support and advice, and will also reflect the fact that they quite rightly believe that HQ should have the capacity to support their programme development. It is also clear that having capacity in an HQ unit has important benefits that cannot be substituted by decentralizing staff to COs. There are real losses of cross country learning involved in moving to decentralized support systems, and real gains through economies of scale in learning and programme delivery when HQ capacity is properly resourced.

Nevertheless it is important to ensure an appropriate balance between units located at HQ, regional structures and country operations. Many donors, including the ILO, have shifted activities to the regions in a search for greater relevance to regional differentiation. This is obviously desirable when responding to the HIV epidemic given the fact that regions are at quite different stages of the epidemic, and that regions and countries are experiencing epidemics that differ widely in their causes and consequences. Mobilizing regional structures in the response to the epidemic becomes yet another task that will entail capacity development. This task will require a partnership between units at HQ and regional structures both in strengthening capacity and in ensuring that organizational policy frameworks are consistently applied.

Finally, it is clear that effective programme support for COs has to be based on a long term relationship and cannot be fulfilled by a consultancy-

based system. It requires a sustained relationship based on knowledge of the issues and of the COs needs, and an ability to work collaboratively with UNDP staff and government over many years. The issues of development and the epidemic are complex. There are many factors that induce inertia, including weak understanding of the development issues plus simply not knowing what to do. The temptation is to 'tell' people what to do – but therein lies the error of much of the development experience of the past 50 years. To do 'better' development means strengthening local capacity in problem solving and in programme delivery – and this takes time and very significant amounts of technical resources. Time horizons need to be flexible: determined by national processes and local mobilization, and not by donors.

3.3. Integrating HIV/AIDS in technical cooperation

Integrating HIV/AIDS is a complex problem and takes many forms, but is again primarily an issue of capacity development. It is also important for effective technical cooperation in that an important objective of the response to HIV/AIDS is the integration of HIV in all relevant policy and programme areas within organizations. Paradoxically the establishment of institutions and units etc. with a specific mandate for HIV/AIDS may have negative as well as positive benefits. Thus the setting up of UNAIDS, which is a structure with the primary task of coordinating the activities of the cosponsoring organizations (eight UN agencies), may lead to a relative neglect of the issues within the partner institutions. Indeed a former Administrator of UNDP once argued that the organization did not need any specific capacity to address development and AIDS on the grounds that UNAIDS would do whatever needed to be done. This is an excellent example of 'category error' since the intention of UNAIDS is not to substitute for the activities of the various cosponsors but to be additive by forming a mechanism for co-ordination and communication.[8]

There is an important lesson embodied in the example of UNDP in that capacity to provide effective technical support in donor organizations (and in many international NGOs) often needs itself to be created and strengthened. This has remained the case in respect of building an expanded response to HIV/AIDS even though several decades have elapsed since the start of the epidemic. Achieving the objective of capacity strengthening within donor organizations is itself far from easy to achieve, and yet is essential if what they do is to be both relevant and effective.

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[8] *The Five Year Evaluation of UNAIDS* (Draft Report, August 2002) considers some of these issues but is weak on review of the substantive contribution of UNAIDS as a system response to the epidemic. In part this is due to the fact that the evaluation team were precluded from an assessment of the work of the cosponsors at country level. For a review of some of the issues raised by the Evaluation Report see the paper prepared for UNAIDS: *High Level Consultation on UN Country Response to AIDS: Urgent Action for an Intensified and Unified Approach* by Desmond Cohen, (October 2002) (hivdev.org.uk).

It follows that an important objective for organizations that want to engage in technical cooperation is the strengthening of their own capacity. In doing so they may choose to establish specific units and programmes with a remit for HIV/AIDS and this may indeed in some cases be the appropriate institutional response. However there are problems with this approach in that it may signal to the rest of the organization that HIV/AIDS need not concern them and that they can continue with 'business as usual'. Herein lies an important problem for donor and other organizations that seek to meet the challenges to organizational needs through institutional structures that may be perceived as removing the need for a more general response and broader changes in ways of doing things.

There are thus two linked issues: setting up specific organizational responses to the epidemic may lead to general neglect of the issues facing the institution as a whole, and secondly, setting up a unit etc. entails developing capacity within the programme itself if it is to deliver in an effective manner the functions that have been determined for it. It follows that one of the important tasks that a unit will have is to ensure that elsewhere in the organization HIV/AIDS is fully integrated in core functions. Similarly, with tasks external to the organization, where technical cooperation will need to ensure that institutional partners integrate HIV in their core activities, and do not simply see the issues as peripheral to what they do.

Lessons for integration

In this context the essential task is to bring about sustained organizational change so that functions are aligned with a new set of tasks. This is never easy, and is made doubly difficult in respect of the integration of HIV/AIDS for a number of reasons – all of which will need to be addressed through specific activities. In the first place the epidemic raises many contentious issues and as such means questioning deeply held moral, religious and often ideological beliefs, such as, for example, that those injecting drugs do not deserve programmes to enable them to be supported (and rehabilitated) given that they are seen as having 'voluntarily' chosen this way of life.[9] Thinking in this way obviously misses the point, that whatever the personal culpability, there are major social benefits from programmes such as harm reduction from which everyone gains. Part of the task of technical cooperation is to support the re-thinking that is necessary if effective programmes are to be developed and implemented. This is never easy, and requires sustained efforts if there are to be long-term changes.

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[9] These issues are treated by the author in a paper prepared for the Open Society Institute, New York: *HIV and AIDS in Eastern Europe and the Former Soviet Union: Developing and Implementing Effective Responses* (November 2001) (hivdev.org.uk).

Secondly, the HIV epidemic was originally defined as a problem of public health and to a significant degree this remains true until today. This in spite of the fact that research and experience over several decades have resulted in a much deeper understanding of the epidemic, such that the issues are now perceived as primarily developmental in the sense that the epidemic has its foundations in the structural conditions of societies, such as poverty, and that it has serious implications that are severe for sustained social and economic development.

What follows from this observation is that efforts have to be made to overcome what in the literature is often called 'normal professionalism'. What this means is that problem definition and solution are seen as the sole province of those with the 'right' expertise, in this case public health specialists. It follows that part of the problem of achieving integration of HIV/AIDS in organizations and programme areas previously excluded requires re-defining the issues so that they are seen as relevant. Overcoming this constraint has often proven difficult, in part because those professionals occupying the existing terrain have largely determined the approach to the epidemic, and have strong reasons to prevent changes in existing resource allocation.

Finally, it is now clear to many that involving a much greater array of organizations, groups, levels of government and so on is essential if there is to be an effective response to the epidemic. This follows from the argument that the epidemic is developmental and undermines sustained development. Bringing into the response a different set of actors requires technical support to those organizations etc. that have previously not been involved. Thus in most countries the response to AIDS has been largely confined to Ministries of Health with the result that activities have been largely limited to issues the ministry is familiar with. However, a multisectoral response requires a broader set of activities, and the involvement of both the public and private sectors. It follows that technical support needs to be re-focused to those organizations, and political and community structures, whose involvement is essential.

The evidence, in so far as it exists at all, is that achieving integration is extremely difficult.[10] Within many donor organizations it is still the case that efforts focused on HIV/AIDS are at best confined to specialized units. Many UN agencies have lagged behind in their response to AIDS, in spite of the fact that it has been clear for many years that the epidemic was undermining their purposes. Even in organizations such as UNDP, which realized in the 1980s that the epidemic was developmental, there has continued to be a culture that perceived the issues as being the province of health professionals. Other agencies, such as the International Fund for Agricultural Development

[10] For a survey of some of the problems and approaches to integration in one organisation see Issues Paper no. 33, UNDP: *Mainstreaming the Policy and Programming Response to the HIV Epidemic* (1999).

[IFAD], the ILO and the FAO,[11] have only recently begun to address the issues of AIDS although it has been clear for at least a decade or more that their involvement was essential. Progress has at best been slow in spite of research on the epidemic and in spite of extensive advocacy and training with the staff of many agencies. It follows that improving the relevance and effectiveness of technical support will be difficult, given the revealed evidence of achieving policy and programme integration of HIV/AIDS within precisely those organizations that are charged with its delivery. But this is where efforts have initially to be concentrated if there is to be a more effective level of performance with respect to TC.

Achieving better outcomes has not been confined to donor organizations but is also generally true of other institutions. There are exceptions to this general statement but in practice increasing the involvement of non-health based organizations in both the private and public sectors has proved to be an uphill task. The reasons are summarized above, but whatever the specific causes of the lack of policy and programme integration it is a fact of life in most countries. It is not due to a lack of workshops on issues to do with AIDS, for there have been huge numbers of these. Staff at many levels have been involved in study tours, where they have seen what other countries are doing in the response to AIDS, but with very little practical outcome; and consultants have produced a mountain of reports with little evident effect.

The result is that national responses to HIV/AIDS continue to be largely focused on health-related issues, with a neglect of the broader determinants and consequences of the epidemic for sustained development. If this conclusion is valid, then it follows that integration of AIDS in non-health areas and the mobilization of new partners in the response to the epidemic will continue to be a challenge. But it is one that technical cooperation must meet, in spite of the poor record so far in achieving integration. In part the problem is how to improve on the existing performance, through more innovative approaches to what is undoubtedly an issue of great importance.[12]

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[11] FAO has had a focal point for HIV/AIDS for many years and has undertaken some valuable research on the impact of the epidemic on agriculture. Nevertheless, there has been little progress in integrating HIV/AIDS in the core activities of the organisation. This is surprising given the conclusions of its own research that the epidemic has led to the loss of an estimated 7 million from the labour force in African agriculture, and is having devastating effects on food security in the region.

[12] An example of the distance still to be travelled is the more or less complete failure to integrate HIV/AIDS in the recent plan for African development (the New Partnership for Africa's Development, 2002). For a review of these issues and a detailed set of suggestions on how to integrate HIV/AIDS in NEPAD see the paper prepared for UNAIDS**:** *The New Partnership for Africa's Economic Development: Integrating HIV/AIDS* by Desmond Cohen and Sheila Smith (October 2002) (hivdev.org.uk).

4. Strengthening technical cooperation in the world of work

A key statement of the importance of HIV/AIDS to the ILO is contained in the preface to the *Code of Practice on HIV/AIDS and the world of work*. The Director-General of the ILO, Juan Somavia, states that "HIV/AIDS is a major threat to the world of work: it is affecting the most productive segment of the labour force and reducing earnings, and it is imposing huge costs on enterprises in all sectors through declining productivity, increasing labour costs and losses of skills and experience. In addition, HIV/AIDS is affecting fundamental rights to work……The epidemic and its impact strike hardest at vulnerable groups including women and children, thereby increasing existing gender inequalities and exacerbating the problems of child labour" (ILO, 2001).

There could not be a clearer statement of the importance of HIV/AIDS both to the ILO and to its constituent members. What is surprising is that the ILO delayed the establishment of any specific responsibility for HIV/AIDS until November 2000 when a new unit, the Programme on HIV/AIDS and the world of work (ILO/AIDS), was set up in the Social Protection Sector. The Director-General emphasized, however, that in view of the diversity and multisectoral nature of the implications of the epidemic, HIV/AIDS issues and concerns should be mainstreamed into other ILO programmes and activities both at headquarters and the field.

The ILO's objectives are:

- To raise awareness of the economic and social impact of HIV/AIDS in the world of work;
- To help governments, employers and workers address HIV/AIDS through technical cooperation, training and policy guidance on prevention, care and social protection;
- To fight stigma and discrimination related to HIV status.

It is clear that the focus of the ILO's activities will be those employed in the formal sector, who account for only a small proportion of those in work in developing countries. But the Code is emphatic in not excluding those in the informal sector and it states quite categorically that, "Governments should extend and adapt their HIV/AIDS prevention programmes to [workers in informal activities] including income generation and social protection. Governments should also design and develop new approaches using local communities where appropriate" (Article 5 (l)). There is a further extended discussion in Appendix 1 of the Code where 'The special needs of the informal sector' are identified and discussed. Workers are seen as especially

vulnerable to the consequences of HIV/AIDS due to their lack of access to health and social protection benefits, while informal sector enterprises are similarly seen as unstable due to the inadequacy of their capital base and the narrowness of the managerial structure.

To summarize: the ILO has set for itself an ambitious set of objectives with respect to HIV/AIDS in relation to the world of work. In moving forward with these aims it is guided by a comprehensive Code which is itself the outcome of tripartite discussions with its core constituents (governments, and employers' and workers' organizations) at a Meeting of Experts held in May 2001. Part of the task of the ILO/AIDS Programme is not only to provide technical support in moving the Code of Practice forward, but also to ensure that its principles are integrated throughout the organization.

4.1. Strengthening the ILO's capacity

This needs to be seen as the most urgent task if the Organization is to achieve its mandate in respect of HIV/AIDS. For as the Code recognizes, the aim is not simply to ensure that specific objectives relating to AIDS are achieved, important though these are, but that HIV and AIDS be integrated across the Organization as a whole. As argued above in section 3, bringing about these organizational changes is a long term and resource intensive task, but it is essential if the ILO is to move forward effectively with its programme objectives, including the full integration of HIV/AIDS in its core activities.

There are two key questions. Firstly, what needs to be done to integrate HIV/AIDS across the ILO? And, secondly, do the resources exist within the organization for integration to become an attainable objective?

It is too early to reach a firm conclusion about the answers to these two questions but it is possible to draw some lessons from the experience of other organizations as a guide to what needs to be put in place. In the first place none of the programme objectives can be achieved instantaneously, and it is a long term task to ensure that HIV/AIDS is integrated effectively in the core activities of the ILO. As with gender issues it is a matter of changing the modes of thinking as well as the working practices of professionals, so that in their day-to-day work they understand the way that HIV affects their responsibilities, and they realise that what they are doing has effects on the epidemic (and the response to it). This emphatically does not mean going through the motions of taking into account the issues of HIV/AIDS through purely cosmetic practices (such as ticking boxes), but instead genuinely re-assessing working practices to ensure their relevance in the context of HIV and AIDS.

The ILO has extensive use of external contractors (consultants) and it follows that if the organization is to be relevant and effective across the whole

range of its activities then they too will have to change the ways in which operate. How to achieve this is far from clear, although other organizations have made efforts to ensure that consultants remodel their thinking and their activities. Thus it is possible to schedule workshops for consultants in specific areas of work within the ILO, so as to strengthen their capacity with respect to HIV/AIDS. For example, what can be done in areas such as workplace discrimination which the ILO Code sees as important in preventing access to care and support of HIV affected workers and their dependents?

In the final analysis what will determine whether the ILO is effective in integrating HIV/AIDS in its activities, not just those specific to the AIDS Programme, will be the attitude and commitment of management. This means that managers need to subject themselves to relevant training so as to understand the need for changes in the way normal activities are undertaken. They then need to be held accountable for the activities for which they are responsible so that there is no mistaking the commitment of the ILO as a whole to programmes that do make a difference to the global and country response to AIDS.

This paper has given primacy to capacity strengthening internal to the ILO as being of extreme importance, for unless this happens then no amount of advocacy will lead to changes in the way that technical support is developed and provided. This means urgently addressing the issue of how to develop the capacity to strengthen the capacity within the ILO since it is clear that the AIDS Unit simply does not have the resources to achieve this objective as presently constituted. Resources need to be committed to strengthen the capacity of the ILO/AIDS Programme, as a necessary step in building the overall technical capacity of the organization as a whole. Part of the task of any expanded AIDS Programme would be the development and application of tools for strengthening the programming capacity elsewhere in the organization.

4.2. Mobilizing the ILO's traditional partners

The main areas of focus for the ILO on HIV/AIDS are set out in the Code of Practice, where the aims are to support the establishment of effective workplace programmes for prevention and for care and support. These are worthwhile objectives, but in themselves they are insufficient in that most of the labour force, as noted above, is not to be found in formal or even informal sector activities (in the sense used by the ILO to mean small scale urban enterprises). Most of the population engaged in work in developing countries is to be found in rural activities, primarily in agricultural production. It could be argued that the rural population is the sphere of other agencies that are also within the UN system, such as FAO, WFP and IFAD, and to a degree this is a valid observation. But the welfare of those that have been identified as the core constituency of the ILO is not independent of the rural working

population, and it would follow that the ILO needs to integrate its activities with those of other organizations. It is the aim of UNAIDS as a coordinating instrument for technical cooperation to make sure that agencies with complementary programmes do in fact work together. Unfortunately the evidence so far is that instruments for coordination and for joint programming have been generally ineffective or non-existent.[13]

Perhaps more central to the ILO's concerns as presently defined is the relative absence of its traditional partners from the global and country response to AIDS. In many countries the government has taken the lead in establishing National AIDS Programmes and while these have become increasingly multisectoral over time they still display a strong public health bias. Most countries now have Strategic National Plans for AIDS but it is rarely the case that employers' and workers' organizations have played a role either in their formulation or in their monitoring. Also in many countries there are National AIDS Councils (and in some places National AIDS Commissions on the model of Uganda), but these again have both weak representation of employers and workers and devote little time to their interests.

Where Strategic Plans and their related activities do address the world of work they do so in an extremely limited way. In most cases the issues are seen as primarily about health in the workplace with a focus on prevention of HIV transmission. But the issues of HIV/AIDS in the world of work are much more than HIV prevention, and include many of the policy and programme areas detailed in the ILO Code. Furthermore there are absolutely critical issues that are central to managing the impact of the epidemic on socio-economic development that arise from losses of human resources. In many countries skilled and professional resources are being lost in huge numbers in formal and informal, state and private sector activities. The scale of this problem for Africa and its consequences are mapped out in ILO Working Pare No. 2 on Human Capital and are not detailed here. [14]

What follows from the foregoing? It is clear that technical cooperation activities cannot be confined to the workplace. It is essential that employers, workers and governments must be brought into a closer relationship on issues relating to HIV/AIDS and the general development impact of the epidemic. This relationship will need to be supported explicitly by the ILO so as to ensure that policies and programmes are developed and implemented that address the world of work as defined in the ILO Code. Bringing on board

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[13] See the *UNAIDS Five Year Evaluation* (August 2002), and the paper by Cohen (October 2002) for the UNAIDS Stakeholders Meeting in New York, op.cit.

[14] ILO: *Human Capital and the HIV Epidemic in sub-Saharan Africa* by Desmond Cohen (June 2002). See also ILO: *Labour Market and Employment Implications of HIV/AIDS in sub-Saharan Africa* by Desmond Cohen (September 2002).

employers' and workers' organizations, and strengthening their capacity, will be a *sine qua non* for more effective involvement in both the strategic response to the epidemic and in local (often workplace) programmes.

These activities have to move the response beyond issues of care and prevention, important though these are, to broader issues of sustaining livelihoods of those in work (and their dependents). This will mean working with the ILO's traditional partners in order to ensure that key services, such as education and health, are maintained given their critical roles in skill formation, in employment, and in labour productivity. Pursuing the aims of the Code of Practice can only be done in conjunction with more political activities, and within frameworks that see the interests of those in work as being also more broadly determined by general developments, such as those relating to human resource losses in key public and private sectors. Being involved in managing human capital losses within the public services is, of course, a major undertaking but one where the ILO needs to be extensively involved.

Conclusions

The task facing the ILO if it is to be relevant and effective in the global response to HIV/AIDS is daunting, but it is one that has to be faced. What is clear is that the ILO has a central part to play in the global, regional and country response, and that it needs to ensure that its programmes are consonant with the problems that exist. The organization requires comprehensive strategies, including those defined in the Code of Practice, if it is to make an effective contribution. Defining the problems will help, and technical cooperation activities will need to be aligned with problem identification. Only then will TC be relevant and effective.

This is perhaps easier said than done, given the woeful rate at which the lessons of TC experience have been absorbed by UN agencies and bilateral donors. But applying good practice has to be the way forward, and it is possible to apply the lessons of effective TC. What is clear in general about technical cooperation activities is also true in the case of HIV/AIDS, that TC is time consuming and resource intensive if it is to be effective. The pace at which matters move, and the determination of what is important and how it should be addressed are finally matters for the recipients of technical support. Where these matters are determined by donors, projects and programmes are generally unsuccessful, and often irrelevant and unsustainable. It is worth ending with the observation by Robert Chambers writing on poverty that, “It’s not where we are at, but where they are at.”