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HIV/AIDS:



The multisectoral approach A Focus on Africa

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Abstract

The aim of this paper is to give an overview over the issues related to mainstreaming AIDS into development projects using a multisectoral approach. The focus will be on non-health sectors and -projects as for those it is less obvious than for the health sector how to proceed. The HIV/AIDS epidemic in Africa is closely linked with other transversal topics as poverty, gender and human rights. AIDS is today showing a dramatic impact on many different sectors, as education, transport, health, agriculture, economic and many others. Whether HIV/AIDS is a problem of the health sector or a multisectoral problem is not only a fashionable academic question. It determines what budgets are made available and which sectors and human resources get involved in the fight and allows addressing root causes of the epidemic as the most important factor of poverty.

The response should therefore be a multisectoral one, going beyond elaborating a workplace policy and integrating IEC activities into various project activities. Risk, vulnerability and impact have to be analysed and addressed in a sector specific manner, but all activities should contribute to a coordinated approach towards the aims of the national AIDS policy. Practical examples are given for the education and transport sector.

Some final recommendations given are:

- Project collaborators need to be motivated and receive training in order to be “AIDS competent”
- Contributions from projects need to be worked out and implemented on a voluntary basis
- Activities should reflect the comprehensive multisectoral approach and go beyond the integration of IEC activities
- A limited amount of additional financial resources has to be provided from SDC headquarters to initiate and monitor the process of mainstreaming AIDS
- Prioritisation of a few selected activities that are likely to have the biggest impact will prevent projects getting overwhelmed with additional activities
- Access to and support from technical assistance is a key element for sustainable success. A combination of local and regional or “external” support is proposed.
- HIV/AIDS should officially be declared a transversal issue for SDC supported projects
- **“Complexity should never be a barrier to action.” (Peter Piot, UNAIDS)**

Introduction

The United Nations General Assembly declares HIV/AIDS the most formidable development challenge of our time. The negative impact of the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) on development, particularly in southern Africa, cuts across development sectors and across society. AIDS spreads rapidly, undermining labour forces, business productivity, exports, investments and ultimately national economies. If the epidemic continues at its present rate, the hardest-hit nations stand to lose up to 25 per cent of their projected economic growth over the next 20 years¹. In heavily affected countries, such as Ivory Coast and Zimbabwe, life expectancy is 10 to 20 years shorter than it would have been without AIDS² thus wiping out decades of development achievements in reducing under five mortality and premature deaths. In Botswana, with a prevalence rate of 36%, over three-quarters of the today's 15 years old will eventually die of AIDS, if this rate will continue to apply throughout their lifetime.¹

The time is thus over, where one could consider the HIV/AIDS pandemic a problem concerning the health sector only. There is a direct relationship between HIV infection and

poverty, inequality, the status of women in a society, social disruption, illiteracy, human rights violations and all the other factors, which define the context for development work³. Today it is widely recognised that an effective response to this crisis has to go far beyond the health sector, co-ordinated by strong leading governments, and include other sectors as agriculture, finance, churches, education, transport, tourism, etc. As early as 1987 the World Health Organisation (WHO) proposed such a multi sectoral approach. Kenya's 1992-1996 Medium – Term Plan for AIDS Control argued that “*the Ministry of Health alone will not stop the spread of AIDS*”¹¹. UNAIDS followed in 1996, joined later on by major multi- and bilateral development agencies as the World Bank, GTZ (The German Technical Cooperation) and SIDA (Swedish International Development Agency)⁴.

HIV/AIDS cannot be separated from broader development issues such as poverty, gender and human rights, all of major concern to the Swiss Agency for Development and Co-operation.

The HIV/AIDS problematic is inseparably linked with **poverty**. Poverty induced migration, uncontrolled population growth, prostitution and incomplete families are all risk factors to having multiple sexual partners and thus increase vulnerability to HIV infection. Mass campaigns intending to raise awareness and improve knowledge on prevention and coping strategies often do not reach the poorest, characterised by high illiteracy rates and living often in remote rural areas where access to modern information channels poses a problem. In these regions health services are often of poor quality resulting in insufficient detection and inadequate treatment of classical Sexually Transmitted Infections and Diseases, favouring in consequence the spread of the HIV infection. In addition, lack of accessibility of the poorest to effective antiretroviral therapy is combined with a more rapid progression rate from infection to full blown AIDS triggered by malnutrition and repeated, badly managed infections⁵. Poverty is not only a risk factor for HIV infection, the HIV/AIDS epidemic also exacerbates the phenomenon of poverty by causing premature deaths, AIDS orphans, social disruption or shifts in agricultural practices.

Gender is a factor directly related to poverty and consequently to the risk of HIV infection. Women are more likely to live under poverty situations and to be illiterate. Their economic dependence of men makes them more vulnerable to engage in risky sexual activities often lacking the power to control their sexual relations and insist on the use of condoms for their own safety and that of their partner. They are often blamed for spreading the infection. Infected mothers suffer the double tragedy of coping with their own infection at the same time as risking to pass on the virus to their un- or new-born baby. Women tend to be infected several years earlier than men and this has major implications for prevention. Girls and elderly women may find themselves at the head of households. The resulting poverty of the family they are responsible for again exposes girls to sexual exploitation and early marriages. Finally, it is also women who face most of the additional burden in caring for the sick and the orphans of deceased extended family members.

The AIDS epidemic also raises **human rights** and ethical issues. Stigmatisation and marginalisation of people living with AIDS and access to treatment and care also for those most in need are just two of them.

In consequence, the German “Gesellschaft für Technische Zusammenarbeit”, GTZ, for example, has declared HIV/AIDS a transversal topic for all development projects⁶.

The multisectoral approach

When the epidemic first broke out, most interventions were organised within the health sector. Since the 80ies health education campaigns, safe blood supplies, condom social marketing and treatment of Sexually Transmitted Diseases (STDs) and opportunistic infections have been prioritised as strategies. As a result, some important successes have been registered (Uganda, Thailand). On the whole however, the epidemic continued to spread unabated and it was recognised that the health sector alone could not change the course. The call for a multisectoral response arose. The aim of this strategy is to generate greater political commitment by national governments, to mobilise more resources from within and outside countries, and to replicate on a national scale a more comprehensive programme that includes an increased number of interventions targeted to virtually all groups in society⁷. Whether HIV/AIDS is a problem of the health sector or a multisectoral problem is not only a fashionable academic question. It determines what budgets are made available and which sectors and human resources get involved in the fight and allows addressing root causes of the epidemic as the most important factor of poverty.

This paper will focus on the non-health sectors and their potential contribution to the so-called multisectoral approach, sometimes labelled “expanded” or “intensified”. This should however not mean that sustained behaviour change among those most likely to contract and spread HIV, the core activity that is necessary to stop the epidemic, should now be dropped or that the health sector should not continue to play a central role. Involving sectors with more limited knowledge and capacity to act poses a real risk that implementation capacity will be stretched more thinly and in the end less will get done⁷. Priorities need to be set and a small set of core objectives with cost-effective and evidence based interventions needs to be identified in the framework of the national policy on HIV/AIDS.

Equally, a certain number of prerequisites need to be considered when addressing the epidemic in a multisectoral way. The importance of the first two prerequisites listed below is underlined by a statement of Dr Gro Harlem Brundtland, the director general of WHO, who said in Durban on 11 July 2001: *“Wherever there is inequity, conflict or lack of mutual respect, the virus feeds on our divisiveness.”*

Prerequisites to a successful multisectoral collaboration are^{5,8}:

- Effective co-ordination amongst the various sectors and of the activities
- A strong commitment of national governments and high ranking decision makers of development agencies and donors to a multisectoral approach, institutional support
- “AIDS competence” of those involved (capacity building, training in communicating sensitive issues, realising one’s own limits, etc)
- Commitment and motivation of those implementing the strategy resulting from the awareness of the particular urgency, acknowledging the relevance to their own work rather than perceiving it as another additional burden imposed by headquarters theoreticians
- The necessary resources need to be made available
- Accepting that quick fixes will not be successful but that multisectoral involvement is a gradual process most successful in already established, well running projects
- Assuring monitoring, follow up and professional backstopping in order to sustain the process

Multi sectoral involvement is not completely new. In most cases, however, early actions were limited to low-profile scattered activities that lacked a systematic approach and originated from a personal commitment of concerned individuals rather than a policy backed by the institution itself. Earlier involvement of non-health projects seemed to be restricted to general AIDS awareness talks and condom distribution for their staff and the target population⁴. Prevention messages were included into various project activities ranging from literacy training in classrooms to professional training courses for adolescents. This was also the main approach applied since the early nineties in a few selected pilot countries where SDC was present^{8,9}. As early as 1993, the Swiss agency for Development and Cooperation in Mali has introduced HIV prevention activities in all its assisted projects¹⁰. SDC was considered for years a model when talking about practical application of the multisectoral approach. In the mean time, based on the lessons learned, others have moved from this initial, rather narrow to a properly integrated approach, analysing each sector's role and comparative advantage in the fight against HIV/AIDS. Besides "risk", "vulnerability" and "impact" are important aspects to be taken into account.

It is today argued that AIDS specific responses alone are unlikely to contain the spread or mitigate the impact of the epidemic. A shift from AIDS specific responses (e.g. caring for AIDS orphans) to an approach that addresses broader development problems across sectors, highlighting the specificity of HIV where necessary¹¹ (e.g. organising care for orphans, including AIDS orphans) is underway.

We have reached thus today a stage of a rather holistic approach where it is recognised that more traditional strategies as prevention, care and support have to go along with impact mitigation and efforts to change contextual, socio-economic factors that determine the vulnerability of people to HIV infection and AIDS (*UNAIDS*)¹¹. Integrating AIDS into poverty alleviation strategies as well as identifying those most at risk of contracting and spreading HIV clearly underline the role and responsibility of non-health projects in the response at national and decentralised levels.

The interrelation between HIV/AIDS and development sectors/projects

Today most of the important stakeholders agree on the necessity of a multisectoral approach. The main question remaining, however, is *how to do it?*

As a first step, each project needs to assess how HIV/AIDS may affect its target groups, staff, objectives and operations, as well as human and financial resources. In a second step, projects need to identify project elements, which could either reduce the spread or the impact of the epidemic or lead in the worst case to enhancing it¹¹. It is important to be aware of the possibility that development projects may contribute to the spread of HIV/AIDS. Some possible negative consequences of constructing and opening new roads are described below. As another example, project staff receive comparatively high salaries and are often mobile, participating in training sessions, missions abroad or within their own country. This may increase opportunities for new sexual relationships and increase their vulnerability to infection.

The essential questions to raise are:

- ◆ **What is the impact of the HIV/AIDS epidemic on development sectors/projects/programmes?**
- ◆ **In which way can/do development sectors /projects influence the HIV/AIDS epidemic?**

In a given country or project, the first step of the process will therefore involve understanding the HIV/AIDS impact in the wider society and the project context, as well as on the project itself. Staff, counterparts and target population may be affected. Equally, objectives may be threatened or need to be revised in the view of the epidemic. Operations may need to be redefined and additional resources may be necessary to cope with the impact of the epidemic. The HIV/AIDS epidemic creates costs- financial and others- that will be increasingly important with increasing prevalence in a given country. The costs due to the epidemic imposed on development projects are similar to those for private companies and are shown below. Certainly, the list is not exhaustive.

Costs caused by the HIV/AIDS epidemic to development projects

Staff absenteeism due to HIV/AIDS related morbidity

- Staff absenteeism due to funeral attendance
- Staff absenteeism due to responsibilities in care for sick family members
- Costs for medical treatment of sick staff
- Costs for replacement of sick staff
- Recruitment costs of deceased staff
- Training costs of replacement staff
- Lack of institutional continuity due to staff rotation
- Loss of investments (training, experience, etc) and productivity
- Costs of specific additional HIV/AIDS activities

(adapted from "Integration, International Review of Population, Family Planning and Maternal and Child Health, December 1994"⁵)

Building on an overall situational analysis, sector and project specific appropriate action responses have to be identified. Annex 1 shows a list of key questions and possible actions to be taken in response that should be asked at the beginning of such a process. The impact assessment and the design of the response have to be done locally, adapted to the specific context and in a participative way. When deciding about possible action responses it is important to prioritise and start with a few selected actions that are known to have a considerable impact on the situation. To do less in a professional and sustainable way is more than to try getting involved in too many activities risking to lose the focus and advance into fields where one's capacities are running out.

In order to address the HIV/AIDS problematic, interventions can be planned for three levels:

- ◆ Interventions targeting the level of decision makers : policy level, ministries and counterparts, heads of development agencies (Coordination offices and project leaders), etc (elaborating a national SDC policy in the framework of the MOH's policy)
- ◆ Interventions targeting local and international staff of Coordination offices and projects (after elaborating a work place policy)
- ◆ Interventions at the level of the target population of a project (after elaborating a project specific sector policy and approach)

All these interventions should be inspired and based on the national strategic framework and action plan on HIV/AIDS of the host government. Annex 2 presents a schematic overview of the integration process at a country level.

A typical way of proceeding in a country where SDC intervenes could pass the following steps:

1. Regional Divisions facilitate the awareness raising and capacity building of the heads of the Coordination Offices (e.g. Nairobi workshop, 2001)
2. Coordination offices analyse the context specific HIV/AIDS situation of their country
3. Coordination offices adapt the proposed workplace policy together with their staff to the local context
4. Coordination offices meet with project team leaders in order to raise awareness and decide on a national SDC multisectoral approach
5. Project Team leaders elaborate with their teams a project- specific approach of integrated HIV/AIDS activities (staff and target population level) according to objectives defined after the initial HIV/AIDS situational analysis

This is the usual procedure which has been successfully tested and applied by both SDC (e.g. in Mali) and GTZ (Senegal, Mali, Togo, Kenya, etc).

In the following part, two sectors in which the SDC East- and South Africa section invests with projects will be presented and some of the issues mentioned above made more explicit in the given particular context. The bi-directional relationship with the HIV/AIDS epidemic will be briefly presented for the non-health sectors of transport and education. Due to constraints as to the length of this paper, a selection of sectors only is presented. Similar information, however, exists for many other sectors, as the agricultural and economic sectors and of course the health sector.

What HIV/AIDS can do to transport and what transport can do to HIV/AIDS

(Based mainly on the “AIDS Brief Transport Sector”¹² and “Reducing HIV vulnerability in the land transport sector of SE Asia”¹³)

The transport sector is essential for economic and social development. It provides vital links between centres of production and markets and gives people the opportunity to meet. Transport creates connectivity (it connects people and goods at all levels) and mobility of both those who work in the sector and their clients. Mobility affects the vulnerability of people to contracting HIV/AIDS and helps spreading the epidemic. Poor connectivity on the other hand (e.g. extended waiting times at border crossings, ferries, long loading and unloading times) has a similar effect. At many such waiting points for public and private transport, restaurants and fast food shops, usually run by women, offer also the possibility of obtaining sexual services.

Being mobile often implies spending time away from home. Research in South Africa revealed that 71 % of long distance truck drivers had spent 15 or fewer days at home in the six months prior to the study. This of course creates opportunities for sexual activities with new partners. A study in KwaZulu –Natal found that 35% of drivers surveyed had had two or more partners in the week prior to the study and condom use was absent or irregular¹³. The role of

truck and other drivers in spreading the epidemic is known from many other countries, such as Tanzania, Thailand and India. Transport increases thus the vulnerability to infection of those employed, of clients and the regular partners of the first. On the Dar-es Salaam high way in 1996, HIV prevalence was found to be 28% for truckers and 56% for their female partners¹³. Transport not only increases the vulnerability of those working in road, maritime and air transport and of their clients. It has the same effect on those involved in the construction of transport infrastructure, who as other workers in the transport sector, are relatively well paid and often far from their families for extended periods of time. This again creates opportunities for risky sexual behaviour. The construction of new roads and bridges can also link low- and high risk prevalence areas, cities and villages.

Besides increasing peoples vulnerability, the HIV/AIDS epidemic has an impact on transport in terms of labour and productivity costs as mentioned above (absenteeism, training and replacement costs ,etc).

The sectoral response should be targeted at four main areas of concern:

- The people who work in transport
- Professionals engaged in the management of the sector and side economies living of the transport sector
- Travellers
- People employed in building and maintaining the transport infrastructure

The most commonly and certainly most effective responses used have been behaviour change interventions and social marketing of condoms targeted to all of the above mentioned risk groups. A particularly successful approach is the so-called peer education, where drivers and female sex workers themselves serve as multipliers for information and distributors or vendors of condoms. In a Senegalese GTZ supported project (“FANKANTA”) IEC (Information, Education, Communication) talks including a video presentation of sexually transmitted diseases and AIDS were regularly organised at the local “gare routière” (the bus stop). Bus drivers as well as project drivers and those of the counterpart health services acted as outreach information workers and condom distributors. This helped to bring condoms into remote villages, where the project and the health personnel were running activities, as well as to soldiers stationed at one of the many military checkpoints in the region of Kolda. USAID developed a car key ring in which a condom is hidden. Many Senegalese buses most commonly used for overland and in-city transport are painted with publicity on HIV/AIDS or condoms.

Other, less conventional responses of the transport sector may be to pay part of the transport crews’ salary at their home base instead of at the point of delivery, reducing waiting times due to more efficient border crossing formalities or free trade agreements and allowing their families to follow road construction workers where it is not possible to hire local employees. Some trucking companies in South Africa have established rest stops. The benefits are security, meals and rest facilities for the drivers. Even though established for general security reasons, there is evidence of a decrease in risky sexual encounters. The list of possible activities of the transport sector is far from exhaustive and it needs to be stressed again, that responses have to be context specific and locally elaborated.

What HIV/AIDS can do to education and what education can do to HIV/AIDS

(Based mainly on “What HIV/AIDS can do to education and what education can do to HIV/AIDS”¹⁴ and the “AIDS Brief Education Sector”¹⁵)

Where AIDS is widespread, education-an essential building block of development- is being impaired. The epidemic is eroding the supply of teachers and diluting the quality of education. **In the first 10 months of 1998, for example, Zambia lost 1300 teachers- the equivalent of about two-thirds of all new teachers trained annually (UNAIDS). In a region of the Central African Republic, 107 of 173 schools had to be closed because of shortage of teachers.** (Prof Krawinkel, Universität Giessen, personal communication) . AIDS also reduces the amount of money available for school fees, and forces an increasing number of children- more girls than boys- to drop out of school in order to help at home. As teachers become ill and unable to work, some schools are closing¹.

HIV/AIDS has the potential to¹⁴

- Affect the demand for education (children are dying, fewer children have the means to go to school-especially AIDS orphans-,fewer children are able to complete school as they have to replace parents in farming activities)
- Affect the supply of education (teachers fall ill and die, reduced productivity of sick teachers, loss of school managers, etc)
- Affect the availability of resources for education (AIDS affected families’ incomes drop, reduced public funds for education as society becomes poorer and pays less taxes, funds deviated from education to the health sector, sick teachers consume funds to cover treatment costs and continue salary payment during sick leave, etc)
- Affect the potential clientele for education (AIDS orphans, children who are heading households are expected to undertake income-generating activities)
- Affect the process of education (erratic school attendance of children of AIDS affected families, erratic teaching activities of affected teachers, young girls are exposed to increased risk of sexual harassment as they are seen as `safe`, etc)
- Affect the content of education (need to incorporate STD/HIV/AIDS and sex education into curricula, need to develop life-skills and early work related training in order to prepare them for the role that awaits the children in society)
- Affect the role of educators (need counselling skills, new image of schools as a centre of information dissemination to students, teachers and the community as a whole)
- Affect planning and management of the education system (coping with rotation and absenteeism of students and staff, training replacement staff, capacity building of teachers, difficult financial management under heavy budget constraints, etc)
- Affect donor support for education (concern that effectiveness of their input is undermined by the epidemic, funds shifted from education to health, etc)

In response to the impact, it is imperative that the political and administrative heads of education systems declare policy and establish a principled position and implementable framework within which managers and educators can work. System managers and teachers need to be prepared for their new role and get appropriate training. If possible, educators should be deployed within their home districts or along with their family in order to reduce their vulnerability to the infection. Access to schooling has to be possible for the children of AIDS affected families and orphans. And of course, schools need to be the place where children get information and learn to shape their future behaviour. Schools must provide them

with skills to prevent HIV infection and cope with the impact of AIDS on their small “world”. Schools need to play a central role in breaking stigma and taboo. Teachers and headmasters play an important social role in helping children and their families cope with losses and reorganise family life afterwards.

School children may serve as peer educators for their friends who are not enrolled in school. By enrolling girls in schools, their vulnerability to the risk situations of prostitution, streetism and economic dependence of men will be reduced. In the long term, education has the potential to alleviate root causes of the epidemic as poverty, ignorance and gender discrimination- all of which help spread the epidemic.

All of the above said is not only true for the formal education sector, but for all organised learning occasions, as literacy classes for women or professional training for adolescents.

Some recommendations to SDC based on essential lessons learned

The most important prerequisite to success is a clear motivation of the decision makers and the project teams to become involved in such a multi-sectoral approach. Project heads may already feel overburdened with their work. *“Integrated Rural Development projects are not a vendor’s tray to be loaded with each and every topic”* argued the GTZ Director for Multi-sectoral Urban and Rural Development Programmes¹¹. Facilitating awareness building and acquiring AIDS competence for SDC staff on all levels is therefore absolutely essential. Initial investments in that sense need to be followed by ongoing support and opportunities for exchange and continued learning.

Activities have to be elaborated on a voluntary basis in a participatory way by the project teams themselves. Their capacities, particularities and interests need be considered. This means that different projects will have different activities (quality and quantity).

AIDS is today showing a dramatic impact on many different sectors, as education, transport, health, agriculture, economic and many others. The response should therefore be a multisectoral one, going beyond elaborating a workplace policy and integrating IEC activities into various project activities, but all activities should contribute to a coordinated approach towards the aims of the national AIDS policy. Risk, vulnerability and impact have to be analysed and addressed in a sector specific manner.

There is often the worry that additional AIDS activities will consume important financial resources, which will then be missing for project core activities. Experience has shown that integration of HIV/AIDS prevention activities in development projects can be achieved within the given project budget frames without creating a need for important additional funds. Collaboration and co-ordination with the local health managers (NGOs and public services) allows sharing resources. Condoms and educational materials as well as audio-visual aids are often available. If the properly integrated approach discussed earlier is applied, sector activities may not be AIDS specific and still make a positive impact on the epidemic. For the initial investments of training of all levels of staff, additional resources need to be allocated. These resources could, however, come from a special pool from head quarters or regional sections, rather than from project budgets.

When deciding about possible action responses it is important to prioritise and start with a few selected actions that are known to have a considerable impact on the situation. To do less in a

professional and sustainable way is more than to try getting involved in too many activities risking to lose the focus and advance into fields where one's capacities are running out.

Technical assistance and basic training in HIV/AIDS related aspects are necessary in order to ensure the quality aspect of such interventions. It is the role of the technical assistant to stimulate discussions and motivate together with the co-ordination office the non- health projects to get involved. These integrated activities have to be monitored and evaluated. Initial assistance could, if necessary, be provided from an expert sent by headquarters or the regional division. One of the main tasks of such an initial assignment should however consist in identifying local resources that could continue to provide the necessary support to those involved. This is not only more cost effective, it also guarantees more context specific appropriateness of the advice and contributes to the sustainability of any such initiative. GTZ, for example, has, based on voluntary candidature, designated one person per country as "AIDS Focal person", mainly in charge of the workplace policy and –activities. Local NGOs can be contracted to organise training. Head of local health projects may take on the role of a coordinator of AIDS related activities. The additional workload of co-ordination and support should however not be underestimated and financial resources for contracting out part of this task should be made available.

And finally, as poverty reduction, the promotion and protection of human rights and the empowerment of women are transversal objectives for SDC development projects, facing the challenges imposed by the HIV/AIDS epidemic should be of similar concern to the institution. It would be highly recommended to declare the HIV/AIDS epidemic a transversal issue for all SDC supported projects.

In conclusion, the final recommendation can be drawn from a quote of Peter Piot, the director of UNAIDS **"Complexity should never be a barrier to action."**

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