HIV/AIDS prevention for migrants and ethnic minorities: three phases of evaluation

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Abstract

There are now a number of HIV/AIDS prevention programmes for migrant and ethnic minority communities throughout the world, both ‘top down’ programmes organised, for example, by governments and large NGOs, and ‘bottom up’ programmes, organised by migrant groups themselves. Evaluation of such programmes, however, is in most cases sorely lacking. The Swiss ‘Migrants Project’ is, to the authors’ knowledge, the only such programme to have been systematically accompanied by evaluation throughout. This paper describes three phases of evaluation of the Migrants Project (exploratory studies, process, and outcome evaluations). The evaluations have highlighted the need for culturally and linguistically appropriate prevention efforts which use already-existing community structures, as well as the need to identify and train people from within communities to carry out local prevention efforts. Outcome evaluation has shown that: a government sponsored HIV/AIDS prevention programme can meet with acceptance by migrant communities; considerable engagement in prevention activities can be mobilised; and AIDS prevention among such communities can be effective. Such efforts can create levels of sensitivity to HIV issues and of protective behaviour that are equal to those of the host country population. The strategy adopted by the programme is thus supported. Key elements are to avoid potential for stigmatising by: (1) placing HIV/AIDS prevention efforts for migrant populations within an overall national HIV/AIDS prevention strategy; (2) informing and sensitising general populations within migrant communities before initiating more targeted prevention with migrant IDUs, MSM, and CSWs; (3) encouraging, facilitating and guiding health promotion efforts which emerge from within migrant communities themselves.

Keywords: AIDS; Prevention; Evaluation; Migrants; Ethnic minority; Peer educators

HIV/AIDS prevention among mobile, migrant and ethnic minority populations

It was with truckers and their sex partners in East and Central Africa that early international attention came to be focused on mobile populations as far as HIV was concerned (Carswell et al., 1989; Wawer et al., 1991). Numerous subsequent studies carried out in developing areas of the world have focused on the social disruption caused by migration linked to uneven economic development. Such disruption has been shown to be related to risk of HIV transmission in Africa (Jochelson et al., 1991; Decosas et al., 1995; Lurie et al., 1997), Asia (Archavanitkul and Guest, 1994; Wolters and Fernandez, 1995; Morris et al., 1996), and Latin America and the Caribbean.

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In the United States, HIV/AIDS research, and AIDS prevention programmes, have focused both on short-term migrant labourers (Mishra et al., 1996; Organista and Organista, 1997) and those whose migration took place long ago and who have become ethnic minorities (Thomas and Morgan, 1991; Marin, 1995; Jemmett et al., 1998). The disproportionate AIDS burden borne by ethnic minority populations in that country was recognised early in the epidemic (Friedman et al., 1988; Hopkins, 1987). In Canada, attention to minority populations has included an ongoing multi-site study of HIV attitudes and risk among six ethnicultural communities (Canadian Journal of Public Health, 1996) as well as a series of studies with residents of Haitian origin in Montreal (Adrien et al., 1994; Leaune and Adrien, 1998).

It is, however, in Europe that perhaps the most systematic and co-ordinated attention has been given HIV matters as they concern migrant populations (c.f. Haour-Knipe and Rector, 1996). Large-scale government- or NGO-sponsored programmes have been established in countries such as the United Kingdom, the Netherlands, Norway, Sweden, and Israel, as have numerous smaller NGO programmes in practically all European countries (Bröring, 1997). Continuously evaluated European umbrella projects exist for migrant sex workers (Mak, 1996; Brussa, 1996; Steffan, 1998). Other European projects include development of AIDS prevention materials for Turkish populations (Yesilyurt, 1998), and action-research interventions on boats carrying North African migrants home for holiday visits (Joucla, 1998). At least two newsletters concerning HIV issues and migrant communities are widely distributed (Migrants against AIDS/HIV Naz Foundation), and a degree of co-ordination and networking is maintained between European groups and programmes (Narimani, 1996; AIDS and Mobility, 1998). Little evaluation research concerning such programmes has been published, however.

This article represents one attempt to help fill this gap. It discusses three phases of evaluation of one of the first European AIDS prevention programmes to be established for non-nationals, the Swiss ‘Migrants Project’. The project is, to the authors’ knowledge, the only such government-sponsored ongoing programme to have been systematically accompanied by evaluation. Both the programme and the evaluation are carried out as elements of the overall Swiss AIDS prevention strategy (Dubois-Arber et al., 1996).

The first section of the article sets the background, sketching the Swiss immigration situation and AIDS prevention strategy. Exploratory studies of immigrants’ HIV/AIDS prevention needs are then briefly presented, as is the Migrants Project. The bulk of the paper then describes the process and outcome evaluations. The section on process evaluation discusses the early development of a new programme. The section on outcome evaluation then presents results from two different angles: that of the activities of peer educators working with the programme, and that of changes in AIDS-related knowledge, attitudes and behaviours in the target communities. The article ends with a discussion of evaluation issues and of programme issues concerning HIV/AIDS prevention and care among migrant or ethnic minority communities.

**Immigrants and AIDS prevention in Switzerland**

Switzerland, a country which brings together people of German, French, and Italian languages and cultures, is also one of the European countries with the highest proportion of inhabitants who are not nationals. About 1,341,000 people from some 180 countries reside in the country, accounting for 19% of the population in 1997 (Office fédéral des étrangers, 1997). Non-nationals may have lived in the country for many years, or for even two or three generations, however. Eighty-eight percent of the non-nationals living in Switzerland are from the European region. About one quarter are Italians who arrived in a wave of labour migration in the 1960s and 1970s. Migration of Italian labourers was followed by that of Spanish, Turkish, Portuguese and Croatian workers. Since the early 1980s new arrivals have mainly been of people seeking asylum, particularly, in recent years, from different regions of the former Yugoslavia.

As for AIDS prevention, a national strategy was originally formulated and institutionalised in 1987. Goals were, and still are, to prevent new infections, to reduce the negative effects of the epidemic (for example by providing optimal care and support to those affected), and to promote solidarity and non-discrimination (Office fédéral de la santé publique, 1993a). AIDS prevention efforts directed towards the Swiss ‘general public’ began with the distribution of an information brochure to all households in 1987, and have been followed with regular prevention campaigns ever since. At the same time, targeted prevention activities have been ongoing, with people who inject drugs, men who have sex with men, and a wide range of other individuals and groups with higher risk of encountering
HIV. The entire HIV/AIDS prevention strategy has been continuously evaluated since the beginning.

It was recognised from the very beginning of such efforts that residents who spoke a different language and were of a different culture from those of the host country should have specific prevention materials. Thus, at the same time as the first materials in the three national languages, an information brochure was developed in eight other languages. Almost half a million of these brochures were distributed in 1987, and the pamphlet was translated into five additional languages the following year. From the beginning, however, it was clear that, valuable as they might be, brochures were highly unlikely to be sufficient as an AIDS prevention strategy.

First phase of evaluation: exploratory studies, 1988 and 1989

Needs evaluation was carried out among non-nationals prior to the establishment of a specific AIDS prevention programme. The first studies took place among two populations in Switzerland with opposite levels of AIDS information, Turkish and Africans (Fleury, 1989, 1990). Fifty-eight in-depth interviews and KAPB questionnaires with Turkish asylum seekers and workers, for example, found that respondents were uncertain about how to protect themselves, and about how HIV is not transmitted. Turkish residents did not necessarily relate to the symbols, such as the rolled condom, that were commonly used in the Swiss AIDS prevention campaigns. HIV was thought to be a problem that concerned only ‘homosexuals’, ‘prostitutes’, or ‘truck drivers’. As for condoms, they were used only if a partner insisted.

Another exploratory study concentrated on seasonal workers (Fleury et al., 1991; Haour-Knipe et al., 1992, 1993). Such workers, who are employed mainly in the construction and hotel industries, stay nine months of the year in Switzerland, returning home to their families for the remaining months. They thus live on the margins of both cultures, absent from home for most of the year, and poorly, or not at all, integrated in Switzerland. The study focused on two of the largest populations of seasonal workers, the Spanish and the Portuguese. A rather lengthy phase of preparation proved necessary before fieldwork could actually begin, however. Official gatekeepers such as union leaders, representatives of immigrant associations, directors of barracks, and religious leaders generally agreed that AIDS prevention efforts were to be desired, but were reluctant to allow researchers to actually talk with seasonal workers. Several thought talking of sexuality would be taboo, unwarranted prying into private lives. The precarious legal situation of some of the potential respondents may have added another level of difficulty.

KAPB questionnaires filled out by 167 such workers, and semi-structured interviews with 45 male and 13 female seasonal workers, revealed that HIV/AIDS knowledge was already relatively good by 1989.
Respondents were uncertain about how HIV is not transmitted, however, as well as about differences between AIDS and other sexually transmissible diseases. Study respondents talked of having been profoundly touched by media stories of people with HIV and AIDS, and their attitudes, as assessed by questionnaire, were largely of tolerance and acceptance of people affected. Some even spontaneously offered to make a financial contribution towards AIDS prevention efforts for seasonal workers. Protection behaviour was less exemplary, and less adequate than that of the Swiss population at the time: only about a quarter of the seasonal workers studied reported always using condoms with casual partners, and a third reported never doing so.

The results from these exploratory studies were used in setting up the national AIDS prevention programme for non-nationals.

Establishment of a programme

In its pilot phase the Federal Public Health Office AIDS prevention programme for non-nationals focused on the same populations as in the baseline studies, the relatively large Spanish and Portuguese communities, and the Turkish, for whom cultural differences with the host country may be marked. The programme officially began in April 1990, with the engagement of a project chief of Swiss nationality. He was followed several months later by co-ordinators for the Turkish, Spanish and Portuguese communities. Additional co-ordinators joined the staff in 1993 then in 1995, to develop activities in other communities such as the Italian and the Albanian-speaking. This paper discusses only the programme’s interventions in the three pilot communities, the Spanish, Portuguese, and Turkish.

The functioning of the programme and its evaluation are shown in Fig. 1.

For each of the communities, and in successive phases, the programme was to begin by promoting awareness and sensitivity towards HIV and AIDS among the general public. Part of this task entailed developing culturally specific prevention materials. A basic and critically important element was recruitment and training of ‘mediators’, or peer educators, people from the target communities who would then be able to carry out further prevention activities. Only at a later stage, once public support had been gained, was the programme to begin targeted HIV/AIDS prevention activities among more specific groups such as injecting drug users, men who have sex with men, and sex workers (Office fédéral de la Santé Publique, 1993a, 1996, 1998; Burgi and Fleury, 1996).

Programme structure and staff

AIDS prevention activities for migrant communities were co-ordinated from within the Federal Office of Public Health, thus creating an essential link with the overall national AIDS prevention strategy. The Migrants Project chief served as an anchor point with the programmes in the different communities. Links with public health and academic institutions provided the programme scientific validity. Cultural validity within the communities was created through the work with a wide variety of ethnic clubs and associations as will be described in the next section.

As for community co-ordinators, it was obvious from the outset that they must be able to speak the language, gain the respect of the community and be at ease in their cultural surroundings. Early on, it also became evident that programme activities developed more readily when co-ordinators were also of the same nationality as the community for which they were responsible. Community co-ordinators were professionals (for example social scientists or teachers). One had been a political refugee. Two had previously participated in HIV/AIDS related research. Such personal characteristics proved to be important, as they influenced the way in which the co-ordinator developed activities within his or her community. Co-ordinators in fact required a great deal of flexibility to develop activities. In ways that were impossible to predict at the outset, they had to be able to define priorities and appropriate work methods concerning a subject that was both sensitive and new at the time: there were

\(^1\)There had been some concern at the outset that some people in target communities might see ‘working for the Swiss government’ with suspicion. The reaction was in fact usually the opposite, however. People from all three communities expressed satisfaction at seeing a compatriot integrated to a degree rarely found when a co-ordinator or ‘mediator’ was formally engaged by a Swiss institution.
very few models in existence on which they could rely. In addition, they had to be able to seize opportunities as they appeared, both to develop prevention activities and to recruit potential peer educators.

Second phase of evaluation: implementation of a new programme

A process evaluation followed the programme’s first 18 months of functioning (Fleury and Haour-Knipe, 1993).

Method

Several complementary sources of information were employed for the process evaluation. Documents concerning the programme were analysed. Evaluators met regularly with programme staff to discuss the activities carried out. Summary forms were developed to describe interventions, and the 122 such forms filled out by programme staff and peer educators were analysed. Evaluators also observed HIV/AIDS prevention activities in each of the communities. Finally, actual or potential ‘mediators’ (19 Spanish and 25 Portuguese teachers, and 16 Turkish football club presidents or coaches) were interviewed by telephone.

Results: Unfolding of the programme

To introduce the new programme, the co-ordinators for each community described having contacted a wide range of institutions and individuals (consulates, embassies and public health, social welfare, labour, and education delegates from the countries of origin; language teachers; religious authorities; Swiss labour officials and trade unions; regional social, health, and AIDS prevention services; regional authorities and organisations dealing with migrants; Swiss AIDS groups; and a large number of emigrant associations, newspapers, journals, sports associations, and young peoples associations). Some 500 Spanish and Portuguese associations and groups were sent a letter announcing the programme, accompanied by a questionnaire on which community groups could request more information. In all three pilot communities, however, the new programme encountered denial similar to that encountered for the baseline evaluation. Co-ordinators were told:

‘AIDS does not affect us.’

‘This subject can not be discussed in our community.’

‘In any case they already know what there is to know. They learn it at school.’

When less than 5% of the questionnaires sent to Spanish and the Portuguese associations were returned, and when preliminary contacts very often were not followed up, programme staff began to feel that they were wasting their time.

What was happening, in retrospect, was that the groundwork was being laid. Questionnaires and telephone calls may not have been returned, but in fact were remembered much later. The program was becoming known, and confidence built, but potential partners usually waited some six months to a year before requesting prevention activities from programme staff. By some 18 months after the beginning of the programme this preliminary latent phase had largely been forgotten, however. It was followed by rapidly accelerating and exponentially increasing demands.

Although they evolved somewhat differently in each of the three communities, three major types of activity could be identified. One was to make information widely available to the general public. For example HIV/AIDS stands at festivals, or condom and leaflet distributions at concerts, provided awareness raising and general AIDS information for large audiences. Another example was a national drawing contest for Spanish and Portuguese children on the theme of AIDS. The winning drawings from the contest were later widely distributed. A second type of activity was to talk about HIV to smaller community groups. Such presentations often took place at the invitation of an association, club, union or employer. Another example was classroom discussions with children and adolescents. A further example was a play about HIV prevention, developed with a group of ‘second generation’ Spanish young people. The play was performed throughout Switzerland as an introduction to prevention sessions, and also made into a video. It should be noted that community co-ordinators usually led such discussions, but they were also very active in convincing community groups to issue invitations to speak, training native-language teachers in HIV prevention, and directing the budding activities of such groups as the Spanish HIV/AIDS theatre troupe. The third type of activity involved personalised interventions with individuals. For example in all three communities a great deal of attention went into the identification, training, and nurturing of those who were to become key peer educators. Most of the programme’s activities in the Turkish community were of this third type. Immigration from Turkey to Switzerland is more recent than that from Spain, for example, and, at the time the programme was being established the network of immigrant associations was less developed. The co-
ordinator for the Turkish community concentrated on building up personal networks, and on identifying leaders and gate-keepers—such as religious leaders (Imams) and football trainers—who might bridge factions within the Turkish community. A number of Imams and football trainers then carried out AIDS information sessions with their congregations and clubs.

Another central element of the programme was to develop culturally specific media. A wide range of posters, brochures, and tapes was developed, and numerous newspaper articles and television and radio programmes about HIV and AIDS appeared in the Spanish, Portuguese, and Turkish media in Switzerland. International co-operation was also stressed. Collaboration with Turkey, Spain, and Portugal included sharing materials developed, participating in the establishment of national AIDS programmes in the home countries, and arranging appropriate support for persons affected when they moved from one country to another.

A number of difficulties were identified in the process evaluation. One problem was that contact people changed rapidly. Migrants migrate: a contact person or supporter in a consulate, club, or community centre might no longer be there a few months later, and a teacher who had integrated AIDS prevention into language courses in a particularly effective way might have returned home the next year. In addition, the connections linking the different structures involved were complex indeed. Partners could be official (e.g. government authorities), interest groups and clubs; or schoolteachers, football players, clandestine sex workers, or religious leaders. Practical difficulties abounded. These ranged from minor logistical difficulties such as the different times of the day that are culturally appropriate for placing telephone calls and appointments, through the ever-present and specifically Swiss problem of language. In a country with three major official languages all participants at a given meeting may not necessarily have shared at least one of the six official linguistic possibilities represented (French, German, Italian, Spanish, Portuguese, and Turkish). Some logistical problems were not unrelated to xenophobia, such as difficulties finding a meeting room for an information session for Turkish workers, for example.

By two years after the launching of the programme requests for activities in the three pilot communities often arrived faster than programme co-ordinators could handle them. Such activities, in addition, involved such personal engagement as devoting evenings and weekends to HIV/AIDS information sessions. Fatigue and burnout began to appear as significant risks for staff. As the process evaluation was terminated the programme was identifying and formal training was progressing more slowly than anticipated, and continuity was already a becoming problem.

The process evaluation had served as a reasonably objective external eye for documenting the programme as it developed, but it remained essentially descriptive. At this stage there was only partial indication as to output and coverage (what had been produced, and to what extent programme efforts had actually reached members of the targeted communities). In addition there was no indication as to outcome (whether such activities had led Spanish, Portuguese, and Turkish people living in Switzerland to know about HIV and AIDS, to feel solidarity with those affected, and to protect themselves and their partners).

Third phase of evaluation: output and outcome

An output and outcome evaluation of the Migrants Project took place in 1994 and 1995, after some three to four years of programme activities (Haour-Knipe and Fleury, 1995).

Method

A three-pronged approach was used. Two approaches addressed programme output, and one addressed outcome:

1A (Output). As for the process evaluation, programme activities were monitored by means of descriptive lists established by community co-ordinators. These were discussed during meetings between programme staff and evaluators.

1B (Output). Lists of peer educators were established, including all of those who were currently active, but also some who had only recently been in contact with co-ordinators, and some who had ceased their relationship with the programme. All were sent a letter explaining the evaluation, then a total of 81 (31 Spanish, 24 Portuguese, 26 Turkish) were interviewed by telephone. Interviews in the peer educator’s own language covered HIV/AIDS prevention activities carried out, positive aspects and problems arising, and relationship with—and needs from—the Migrants Project. Eight peer educators were later interviewed in more depth face-to-face.

2 (Outcome). HIV/AIDS-related knowledge, attitudes and behaviours of the general public of the three pilot communities were assessed by means of a self-administered anonymous KAPB questionnaire. The questionnaire was a revised version of that used for the exploratory evaluation, enriched with questions from the biennial telephone survey of the Swiss general population (Dubois-Arber et al., 1997) and from other
European general population surveys (Hubert, 1998). On advice from community co-ordinators, conservative questions were formulated on sensitive issues: there was no question concerning personal drug use for example, and the question about the number of lifetime sexual partners asked simply if there had been one, or more.

Considerable efforts were made to reach a general community sample not necessarily in previous contact with the activities of the Migrants Project. Sampling was done by clusters, combined with quotas defined on the basis of demographic characteristics of each population (sex, marital status, age, and length of stay in Switzerland). Seventy people from the three communities (27 Spanish, 30 Portuguese and 13 Turkish) were trained in group sessions to distribute the questionnaire. Each person was required to recruit ‘lots’ or ‘batches’ of 10, 20, or occasionally 30 respondents, and instructed to go beyond his or her network of acquaintances in search of people to fill out the questionnaire. Questionnaires were distributed simultaneously in the three communities over a period of five weeks during the summer of 1995. Those who distributed them were paid by batch of 10 completed questionnaires returned. A total of 980 questionnaires were returned: 441 Spanish, 385 Portuguese and 154 Turkish. With some minor exceptions the sample obtained was demographically similar to the Spanish, Portuguese and Turkish populations known to reside in Switzerland. This ‘snowball quota’ method with 70 different points of entry into the communities thus reached a ‘general public’, some of whom had participated in Migrants Projects events, and some of whom had not been aware of the programme’s existence.

Data from two other studies provided triangulation: the responses of Spanish, Portuguese, and Turkish residents reached by random digit dialling during the 1994 wave of the bi-annual Swiss telephone survey (Dubois-Arber et al., 1996), and responses by young people of the same nationalities from a 1992 and 1993 national study of adolescent health attitudes and behaviours (Narring et al., 1994, Narring and Michaud, 1995).

Results

Results of this evaluation concern three aspects of the programme: the progress of HIV/AIDS prevention activities carried out (1A), activities and requests concerning peer educators (1B), and AIDS-related knowledge, attitudes and behaviours in the three target communities (2). Programme activities, which were discussed in the previous section, are mentioned only briefly here. The discussion concentrates on peer educators, and on AIDS-related knowledge, attitudes and behaviours in the three pilot communities.

1A (Output). Progress of Programme. During the programme’s second and third years, activities continued to take the several forms already described (interventions with large audiences, small groups and individuals). Somewhat different approaches continued to be used in the three different communities: fewer activities were oriented towards the general public in the Turkish community than in the two others. In accord with programme goals, peer educators increasingly replaced programme co-ordinators in leading community activities. Also in accord with programme goals, more and more specifically targeted prevention activities were seen, for example with drug users and their parents. An association of Spanish homosexuals in Switzerland was created and began to carry out AIDS prevention and support activities.

1B (Output). Peer educators. It was abundantly clear from the beginning of the Migrants Project that an essential element would be to identify and train people from each of the communities who would progressively take on more and more responsibilities for AIDS prevention. One of the aims of the early community sessions conducted by co-ordinators was, in fact, to identify such potential peer educators, and indeed many of those who later took this role were recruited when they showed particular interest at such events.

Preliminary lists of peer educators established with programme co-ordinators led to findings before the survey even began: as had been the case with other community contact people, considerable mobility took place among migrant community peer educators. A good many of those contacted for the previous telephone survey had left the country three years later (for example half of the Spanish language teachers had already returned to Spain). Another observation was that neither the definition of ‘peer educator’ nor the recruitment and training process were as well defined...
in practice as they had been in theory: there was no easily identifiable moment at which an 'interested participant' became a 'peer educator'. Some could be identified as they passed through a formally arranged course, but others, such as those with professional training (a nurse for example) had needed very little or no such training. Still others had been trained as they worked with project co-ordinators (the organiser of the Spanish gay support group for example). An additional category of community member extremely important for the programme was defined: 'facilitators' were not quite peer educators since they did not usually carry out AIDS prevention activities themselves, but were persons in positions of responsibility and authority in the communities who actively promoted and helped organise such activities. Examples included a number of highly engaged consulate or union officials, or journalists.

Of the 81 peer educators interviewed (8 facilitators, 6 peer educators in preparation, 55 active, and 12 who had ceased such activity) most had lived in Switzerland for over 10 years. Many held positions that predisposed them to an interest in questions related to HIV (psychosocial and medical professions, presidents of associations, etc.). They tended to be more active in their communities than their compatriots. Their motivations and the AIDS prevention activities they carried out varied. For example:

A woman working in an unskilled job in the office of one of the project staff started reading the HIV/AIDS information in her language that she found there, and asking questions. She was active in several community activities and groups. With the encouragement and support of programme staff she carried out numerous community AIDS prevention activities, especially with young people. Her reasons, she said, were to help out, and also to be an example to her own children, who in fact now occasionally accompanied her to community AIDS information sessions.

A religious leader, sent by his country to work with the Diaspora of his community, felt that his mandate included prevention of drug dependencies and of HIV/AIDS. At the beginning of his activities in Switzerland he worked with the Migrants Project co-ordinator for his community, then later autonomously, talking about HIV during religious services and on radio programmes, and also counselling individuals.

A former drug injector became acutely aware of HIV and of AIDS through her involvement in the drug scene, and was put in contact with the Migrants Project by health care professionals. She had had very little involvement in her community before starting her activities with the Migrants Project, but now volunteered in a community centre, counselling drug users in her language, linking with social services, and responding to calls for help. She said her chief motivation came from having overcome her own addiction.

The peer educators interviewed in fact carried out three quite different types of activity. (1) Approximately 4/10 led information sessions or staffed stands, for example at the request of community groups. Such peer educators had usually been recruited at prior information sessions, and trained for their activities either in formal courses or in working with programme co-ordinators. At the time of the survey most still carried out such activities under supervision, but two or three groups were beginning to function independently. (2) For approximately 4/10, such activities took place within the context of their professional activities. An example would be a language teacher who used the theme of HIV for class discussions. These peer educators required training at the beginning of their activities, and new materials from time to time, but needed little follow-up after that. (3) Approximately 2/10 worked with groups or individuals affected by HIV and AIDS. Some worked in close collaboration with the project co-ordinators, others independently. Both their AIDS-related activities and their needs were highly diverse, and often fluctuated widely.

Overall, the programme’s work with peer educators was found to be flexible and creative, but the evaluation highlighted a number of difficulties. Peer educators were recruited by the project co-ordinators, each with his or her own way of working, formally and informally, using previously existing contacts and occasions as they arose. The resulting diversity was excellent. However such forms of recruitment meant that peer educators were in vertical contact with the project co-ordinator, but often had little horizontal contact with each other. Many felt isolated. Peer educators beginning their activities, especially, requested more training and more supervision. The programme co-ordinators, for their part, wished to see peer educators become more independent.

Another problem was that no norms had as yet been developed for the compensation of peer educators. A few were paid for at least some of their activities, more had their expenses met, and some received nothing. The question of possible payment for activities as a ‘Migrants Project peer educator’ was all the more difficult in that those involved were non-nationals, for whom a work permit is required in order to be officially employed in Switzerland. For some, the prospect of becoming a peer educator may have raised false
hopes that such activities would lead to obtaining a work permit, or to a career in the host country.

A final problem was that after carrying out a certain number of AIDS prevention activities, peer educators often found that they were becoming resource persons in their communities concerning HIV issues. This was in line with the programme’s objectives concerning AIDS prevention. What had not been taken into account, however, were care needs. Several peer educators found themselves faced with the very real, and often severe, problems of migrants affected by HIV or by AIDS. Such problems include isolation, linguistic and cultural handicaps, lack of access to health care, questions about whether—and at what point—to return to the home country, and double or triple stigmatisation (as a foreigner, as someone with HIV, and perhaps as a homosexual or drug user). Such problems were rendered all the more acute in that the needs of non-nationals were as yet only very rarely being addressed by host country AIDS groups. Although the mandate of the Migrants Project concerned prevention and not care, few peer educators would brush aside such demands, but at the risk, once again, of overload and burnout.

We will return to these points in the conclusion, but first return to prevention, with an attempt to assess the impact of the efforts discussed among the general populations of the three communities.

2 (Outcome). General public AIDS-related knowledge, attitudes and behaviours. One of the basic principles of the programme, in line with the overall Swiss AIDS prevention strategy, was that before more targeted prevention is to be undertaken, general populations should become conscious of, and knowledgeable about, HIV/AIDS-related matters. The purpose of this segment of the evaluation was thus to assess such awareness among the ‘average’ Spanish, Portuguese and Turkish resident of Switzerland, or the ‘person in the street’. The study populations were aged 17 to 45, the same as the comparison population of Swiss general public, whose HIV-related attitudes and behaviours are tracked with telephone surveys every two years. As discussed above, the survey involved a KAPB questionnaire filled out by a sample of Spanish, Portuguese and Turks that was representative for age, gender, marital status, and length of residence in Switzerland.

As was already the case before the programme was established, knowledge concerning the principal modes of transmission was good, as shown on Table 1.

<table>
<thead>
<tr>
<th>Spanish (n = 441)</th>
<th>Portuguese (n = 385)</th>
<th>Turkish (n = 154)</th>
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| HIV/AIDS knowledge (percentage of respondents who said:)
| The ‘AIDS virus’ can be transmitted by: |
| Sexual relations | 98% | 94% | 97% |
| Re-using a syringe | 96% | 94% | 89% |
| The ‘AIDS virus’ can NOT be transmitted by: |
| Using public toilets | 72% | 63% | 64% |
| Mosquito bites | 73% | 64% | 58% |
| Drinking from the same cup as someone who has AIDS | 80% | 70% | 64% |
| To be protected against the ‘AIDS virus’ today one can: |
| Use condoms | 99% | 96% | 88% |
| Not re-use a syringe | 94% | 89% | 79% |
| To be protected against the ‘AIDS virus’ today one can NOT: |
| Currently get vaccinated | 80% | 60% | 48% |
| Rely on choosing only sex partners who look clean and healthy | 74% | 51% | 58% |
| HIV/AIDS attitudes (percentage of respondents who:)
| Agree that someone who has AIDS: |
| Needs sympathy and solidarity | 93% | 91% | 80% |
| Should be isolated from the rest of the population | 5% | 7% | 14% |
| Would accept someone with AIDS as: |
| Colleague | 96% | 93% | 78% |
| Acquaintance or friend | 97% | 94% | 69% |
| Proximity of HIV/AIDS and drug problems in the community (percentage of respondents who:)
| Know one or more people HIV positive or living with AIDS | 28% | 11% | 13% |
| Think there are drug problems ‘in my community in Switzerland’ | 78% | 78% | 73% |
| Know at least one person who injects drugs | 35% | 18% | 20% |
Nine out of ten of the Spanish, Portuguese and Turkish who responded to the questionnaire knew of transmission by sexual relations and by re-using syringes. Knowledge concerning how HIV is not transmitted was still imperfect, but at least six out of ten now knew that one cannot ‘catch’ AIDS by using public toilets, through mosquito bites, and by touching or sharing dishes. As for modes of protection, almost everyone now cited condoms and most also knew of not re-using syringes. Two items of false knowledge still posed problems, especially among Portuguese and Turkish respondents: many thought it was already possible to be vaccinated against AIDS. And about half of the Portuguese and Turkish who filled out the questionnaire thought that an effective method of protection against HIV is to limit sexual relations to partners who look clean and healthy.

Table 1 also summarises attitudes towards those who have AIDS. Such attitudes were found to be generally positive: the vast majority of those questioned agreed that people with AIDS should receive sympathy and solidarity. Very few thought they should be isolated from the rest of the population. Responses were similar when it came to slightly more personal contact: more than 90% of the Spanish and Portuguese would seem to have few hesitations about working or continuing a relationship with someone who has AIDS. On almost all of these items the responses of the Turkish were less positive than those of the two others.

To what extent do these attitudes remain hypothetical? Twenty-eight per cent of the Spanish respondents reported knowing someone affected by HIV, a proportion very similar to the 26% of the Swiss who reported the same on the telephone survey. This proportion was smaller in the Portuguese and the Turkish communities. As for drugs, if similar proportions in the three communities thought there might be drug problems in their own communities, more Spanish, again, reported knowing one or more persons who inject. Data from the two studies used for triangulation go in a similar direction: higher proportions of Spanish than of Portuguese and Turkish adults admitted to having ever consumed hard drugs in the Swiss telephone survey, and higher proportions of Spanish adolescents to having consumed haschisch more than once or twice. In both cases the proportions of Spanish respondents reporting such behaviours were the same as proportions of Swiss who did so.

As for protective behaviours, the condom is far from being unknown in any of the three pilot communities: almost two thirds of the Turkish respondents had at one time or another used a condom, as had four fifths of the Spanish and three quarters of the Portuguese. Proportions were very similar to those in the host population, as shown in Table 2.

As for protection in situations of potential HIV risk, condom use reported by the target populations for the pilot phase of Migrants Project was at least as adequate as that reported by the Swiss population. Six out of ten Turkish and Portuguese respondents, and almost eight out of ten Spanish, reported using condoms at least at the beginning of a new stable relationship. As for casual sexual relations, over half of the Spanish and Portuguese, and more than eight out of ten of the Turkish reported always using condoms. On the other hand about one in ten migrants reported never doing so on such occasions. Indications were, moreover, that condom use had increased since before the programme began. It was not possible to replicate the ‘seasonal worker’ study carried out in 1990, but

<table>
<thead>
<tr>
<th></th>
<th>Spanish (n = 375)</th>
<th>Portuguese (n = 336)</th>
<th>Turkish (n = 132)</th>
<th>Swiss (n = 2139)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever used a condom</td>
<td>81%</td>
<td>75%</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>New steady partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>(n = 69)</td>
<td>(n = 81)</td>
<td>(n = 42)</td>
<td>(n = 206)</td>
</tr>
<tr>
<td>Condoms used</td>
<td>77%</td>
<td>59%</td>
<td>60%</td>
<td>66%</td>
</tr>
<tr>
<td>Relations with</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>(n = 85)</td>
<td>(n = 67)</td>
<td>(n = 30)</td>
<td>(n = 266)</td>
</tr>
<tr>
<td>Casual partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condoms used:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>54%</td>
<td>54%</td>
<td>83%</td>
<td>49%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>33%</td>
<td>34%</td>
<td>7%</td>
<td>18%</td>
</tr>
<tr>
<td>Never</td>
<td>12%</td>
<td>12%</td>
<td>7%</td>
<td>31%</td>
</tr>
</tbody>
</table>

a Sexually active respondents only.

b In the previous year.
c Previous 6 months.
d (Self-administered questionnaire for non-Swiss, telephone interview for Swiss).

6 Comparisons with the Swiss population are to be made with a certain amount of caution since the methods of collecting data were different.
among a sub-sample of respondents with similar status who filled out questionnaires five years later, appropriate condom use had almost tripled, and non-use of condoms for casual relations was reported to be rare.

Discussion

Successive needs, process and output/outcome evaluation of the Swiss Federal Office of Public Health AIDS prevention programme for non-nationals have raised a number of issues, for evaluation and for programmes.

Evaluation issues

The evaluation issues raised concern methods and approaches, and also relations between the programme, the evaluation and the communities.

Multiple methods were used for each phase of the evaluation. The programme and its activities were assessed with qualitative and quantitative methods, and by triangulation with other studies. A number of different points of view were taken, including those of community leaders and gatekeepers, of programme staff, of potential, active and former peer educators, and of the Spanish, Portuguese or Turkish ‘person in the street’. Together, the varied approaches gave a rounded image of the development of the programme. Behavioural indicators, rather than epidemiological data, were used to assess programme effectiveness. In any population, epidemiological changes come far too late to reflect the effectiveness of a particular programme, and where mobile populations are concerned there are reasons to be especially critical of epidemiological data (Haour-Knipe and Dubois-Arber, 1993). As for the specific behavioural indicators used, respondents were assured that the questions asked were the same as for the Swiss. In this first endeavour, in fact, and on the advice of community informants, a conservative option was taken: respondents were offered very circumspect response categories on sensitive questions. In the end the evaluation team heard of no negative community reaction to the questionnaire, and those studied were never as afraid of the questions asked as the researchers were of asking them. Finding equilibrium between information and acceptability is difficult, but were they to be asked again questions with

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7 A researcher on the baseline evaluation became a member of the programme staff; one of the evaluators had worked on the original brochures for non-national communities, and also developed courses and trained peer educators; and the Swiss co-ordinator was his country’s representative on an European Union concerted action led by another of the evaluators.

the same populations would be more daring. For example, and as does the survey of the comparison Swiss population, they would cover the number of lifetime sexual partners or personal drug use.

As for relations between programme and evaluation, extensive collaboration between evaluators and programme staff was essential. The evaluators were external to the programme, but at the same time close to it: relations between evaluation and programme had started before the programme was established, and some of the members of each team had already worked together in various configurations on issues surrounding AIDS and migration.7 Tensions between programme and evaluation nevertheless occurred: programme staff may have felt latent anxiety about ‘being evaluated’, and staff at some points felt the evaluation took too much time from programme activities. At times both sides failed to understand constraints limiting the other.

The evaluation took place in considerable interaction with peer educators. Prior to the process evaluation telephone survey, those to be contacted had been notified by letter. According to programme co-ordinators, and in retrospect, some peer educators had seen both the letters and the subsequent interviews as a sort of official recognition of their activities with the Migrants Project. A number of active and potential peer educators were involved in the distribution of the KAPB questionnaire. Others who worked on this part of the evaluation had not previously been aware of the existence of the programme: one or two of these became interested, and later became peer educators. It was peer educators, also, who did telephone interviews, tested draft questionnaires, or translated responses to open questions.

Considerable effort was made throughout each of the studies to make sure that any questions raised could be answered. Interviewers were trained to discuss HIV if requested after data was gathered, and questionnaire and interview respondents were systematically provided addresses and telephone numbers at which further confidential information could be obtained. Considerable effort also went into informing communities before the studies took place. Before a questionnaire concerning AIDS was distributed, articles explaining the study were published in Spanish- and Turkish-language newspapers in Switzerland, and programme co-ordinators for all three communities discussed the study on the radio. Both such media efforts stressed the study’s links with the overall Swiss AIDS strategy evaluation.

Results of the various studies have been ‘given back’ to the communities in several forms. Quotations emerging from the baseline study were worked into an AIDS information comic book in Portuguese for seasonal workers. The principal results from the outcome
KAPB study were written up in brochures in Spanish, Portuguese and Turkish. The results were also presented and discussed at a workshop for peer educators and friends of the programme. A quite different form of feedback came long afterwards, at the 1998 world AIDS conference in Geneva. Several of the peer educators who had helped with the evaluation served as volunteers at the conference, and were able to see a presentation of some of the results.

Programme issues

In many instances, the suggestion that migrant or ethnic minority populations be addressed by specific AIDS prevention or care programmes has been greeted with suspicion and hostility (Dalton, 1990; Thomas and Quinn, 1991; Takahashi, 1997). In other instances, such as those discussed in this paper, such a suggestion may be met with superficial polite interest, but with passive resistance when it comes to actually establishing activities. The development of the Swiss ‘Migrants Project’ suggests some ways of circumventing such resistance. For example it was noted that in relation to both the programme and the exploratory studies it was invariably the middle-level gatekeepers who posed obstacles: both the ‘highest’ levels within communities (e.g. consulates) and the ‘ordinary’ seasonal worker or association member greeted researchers or programme activities far more easily. An answer would thus seem to be to start by gaining the support of such authorities as embassies and consulates that is invaluable in increasing general public acceptability of such efforts. HIV/AIDS prevention activities should then be commenced with whatever opening appears. When such activities are shown not to be threatening, and acceptable to the target audience, then more opportunities progressively open up. Indeed, in the programme evaluated here, such requests expanded rapidly enough to give the programme difficulty metabolising them.

The HIV/AIDS prevention programme described here reflects theoretical bases developed during a European Union concerted action assessing AIDS prevention (Haour-Knipe, 1994; van Duifhuizen, 1996). Important elements are:

1. Avoiding potential for stigmatising, or for being perceived as being stigmatising, by basing the programme on right to know rather than on prevalence of HIV, of AIDS, or of risk behaviours in a particular migrant community. The programme put in place by the Federal Office of Public Health was part of the overall Swiss AIDS prevention efforts, and was widely publicised as being so. Minority populations thus did not perceive themselves as being singled out as being in particular need of AIDS prevention for some reason (Bayer, 1994). They simply took an equal place among other residents of the country.

2. Implied is thus a need for prevention programmes before HIV enters communities (Stimson, 1996).

3. Encouraging, facilitating and guiding health promotion projects which emerge from within migrant communities themselves (Thomas and Morgan, 1991; Marin et al, 1995; Piot and Aggleton, 1998). Co-ordination was central, but the programme worked from within communities. Outcome evaluation, especially, showed that after three or four years of programme activities developed in collaboration, respondents in all three communities welcomed the idea of having a government-sponsored AIDS prevention programme specifically addressed to them. Moreover, considerable community engagement in prevention activities was mobilised, by individuals, by associations and by a wide variety of other groups, including religious. An added advantage of working in an indirect, branching-out, way is to put helpful layers of distance between the official bodies responsible for the programme and extremely marginal members of the communities.

An additional strategy used in the Swiss programme was to inform and sensitize general populations within migrant communities before starting more targeted prevention. One reason for starting prevention activities with general populations was to avoid the risks of stigmatising and of finger pointing mentioned above. As the programme progressed, in fact, requests for other prevention subjects emerged from the communities. For example at the beginning of the programme drug abuse problems were seen by experts and key informants as being too sensitive to discuss within the target communities. But after two or three years of AIDS prevention activities parents began to request help with drug problems among their adolescent children.

Another reason to start AIDS prevention by raising solidarity and support among general populations was to increase understanding for the affected and more marginal groups within communities who would be approached later. The attitudes expressed during the exploratory studies had been tolerant, but latent stigma was nevertheless present at the time of the first two phases of the evaluation discussed here (1988–1993). HIV and AIDS seemed to be surrounded in an aura of secrecy, and it was not unusual for someone in an audience to propose mandatory HIV testing. Few people seemed to have knowingly encountered HIV in their daily lives, and people from the target communities who were HIV positive often talked of feeling they had to hide their serostatus. By the time of the outcome evaluation such need for secrecy had diminished somewhat. Very few people were still calling for
mandatory HIV testing. Along with Swiss colleagues doing the same, some Spanish and Portuguese people with HIV or AIDS were talking about their experiences in school-based prevention sessions. Some support groups had appeared. Much remains to be accomplished, certainly, and instances of terrible isolation were still to be found, but the climate had now become a little bit safer for mobilising support. Results from the outcome evaluation lent indirect support to the strategy: AIDS-related knowledge and attitudes were slightly less positive in the Turkish community, where in fact activities had concentrated more on working through individual contacts and towards more targeted prevention, and less on widely informing the general population.

**Conclusions**

A number of emerging issues, or unresolved problems, remain. The status of peer educators needs to be clarified, their training and supervision formalised, formal and informal mechanisms of support provided, and their recognition and autonomy increased. The focus of the Migrants Project has now widened: to targeted prevention, to prevention of drug and general substance abuse problems, and also to other immigrant populations within Switzerland. However this widening remains unevaluated: it remains to be explored just how the shift is best negotiated. It would seem obvious that experience acquired in the pilot phase of the programme should serve as a model, but at the same time new problems are raised. One such problem is that of addressing HIV among mobile populations who have other sources of preoccupation. For people seeking refuge from war, to take just one example, HIV may seem a far-distant threat in relation to other urgent problems. With widening of programme focus, too, comes a potential for tensions between the programme and others who may be active in the field: the need for increased collaboration with other institutions brings opposite side of the coin, rivalry and concern about territoriality.

More broadly, migrant health in general is still not adequately addressed. Perhaps the most difficult emerging issue is that of HIV and AIDS care. The needs of migrants affected by HIV and AIDS were not anticipated when the project described here was set up. Programme co-ordinators and peer educators need increased support to address such needs. Also badly needed is increased collaboration and integration with host country institutions. More generally, and particularly important in the light of more effective HIV treatment, there is increasing evidence that in several countries migrant populations present later for both HIV testing and for care (Anderson et al., 1996; Agence de prévention du sida, 1997; Haour-Knipe, 1997). The question needs to be examined in Switzerland as in other countries, and any gaps in access to voluntary testing or to treatment addressed.

In a context in which even basic minimal health care for migrants often falls between gaps of national health programmes (Bollini and Siem, 1995) such lacks are even more germane where preventive programmes are concerned (Haour-Knipe, 1991; IOM, 1998). Discussions of migrant or mobile populations and HIV, in addition, must take place against a background of ill-informed conventional wisdom about migration—and of hostility towards migrants—on one hand (Papademetriou, 1997–8) and of fears of further stigmatising already vulnerable populations on the other (Sabatier, 1988; Haour-Knipe, 1993, Decosas et al., 1995). Migration throughout the world is unlikely to diminish in the foreseeable future. Nor, in spite of reasons for guarded optimism as far as treatment is concerned, has the AIDS epidemic been conquered. Outcome evaluation of the Swiss HIV/AIDS programme for immigrant populations has shown that, given commitment of government authorities, prevention among such communities can be effective. Such programmes can create levels of sensitivity to AIDS issues, and of protective behaviour, that are similar to those of the host country population. The key to such prevention is in interventions that are community-based and also in the commitment and engagement of those involved at all levels. The link, thus, between migration and HIV (Decosas and Adrien, 1997) can be intercepted, and the right of all people to prevention respected.

It is ironic that it is only when an epidemic came along that promotion of migrant health came to be taken seriously. The challenge now will be to put together what has been learned, to maintain what has been gained, and to apply these advances to other health issues for migrant populations.

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