

MIGRANT POPULATIONS AND HIV/AIDS

**The development and
implementation of programmes:
theory, methodology and practice**



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UNESCO

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UNAIDS Best Practice – Key Material

AIDS and migration are two of the crucial social issues facing today's changing world. At the end of 1999, UNAIDS and the World Health Organization estimated that almost 34 million people were living with the human immunodeficiency virus (HIV). More than 95% of these infections have occurred in developing countries, where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.

At the same time, an estimated 125 million people live and often work outside of their country of citizenship, while between two and four million migrate permanently each year. At the end of 1997, the world counted some 12 million refugees, with another six million people internally displaced within their countries because of wars and ethnic tensions.

Migrant populations have a greater risk for poor health in general and HIV infection in particular. This is due to the impact of sociocultural patterns of the migrant situation on health, their economic transitions, reduced availability and accessibility of health services, and the difficulty of the host country health care systems to cope with the traditions and practices of the immigrants. The otherness of migrants creates often xenophobia, isolation and hostility by the host community. In addition, as with other people living with HIV/AIDS, migrants who are HIV-positive are subject of stigmatisation and discrimination, and therefore, they hide their HIV status as long as possible, thus making support services unavailable for them.

Even if health and social services would be prepared to assist migrant populations, they often encounter great difficulties to reach out to them. More often than not, migrant populations live in a legal vacuum, having no stay or work permit for the host country and live with the constant fear of deportation. The contact with official government agencies increases that fear and is, therefore, often accompanied by suspicion. The economic situation of migrants gives them no choice for appropriate employment, many of them are forced to accept jobs far below their qualification under conditions which are in the grey area of illegality. Due to their powerlessness, they are frequently subject to all kinds of exploitation, including sexual exploitation. To provide migrant populations with services to prevent HIV infection and care for those living with HIV/AIDS requires innovative and culturally sensitive approaches, some of which are described in this monograph.

International challenges require international responses. In the mid-1990s, it became clear that the relentless spread of HIV, and the epidemic's devastating impact on all aspects of human lives and on social

and economic development, were creating an emergency that would require a greatly expanded United Nations effort. No single United Nations organization was in a position to provide the coordinated assistance needed to address the many factors driving the HIV epidemic, or help countries deal with the impact of HIV/AIDS on households, communities and local economies.

Addressing these challenges head-on, the United Nations took an innovative approach in 1996, drawing six organizations together in a joint and cosponsored programme – the Joint United Nations Programme on HIV/AIDS (UNAIDS). The six original Cosponsors of UNAIDS – UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank - were joined in April 1999 by UNDCP. The goal of UNAIDS is to catalyse, strengthen and orchestrate the unique expertise, resources, and networks of influence that each of these organizations offers. Working together through UNAIDS, the Cosponsors expand their outreach through strategic alliances with other United Nations agencies, national governments, corporations, media, religious organizations, community-based groups, regional and country networks of people living with HIV/AIDS, and other non-governmental organizations.

UNESCO has been a Cosponsor of UNAIDS from the beginning. UNESCO's thematic and practical contributions to UNAIDS stem from its multi-disciplinary approaches to education, scientific research, communication, cultural and human rights. UNESCO mobilizes a vast network of institutions with which it collaborates in advancing the responses to AIDS. Given its comparative advantage in education, UNESCO plays a leading role in assisting Member States in the development of effective education strategies in preventive education.

Together, and with their range of partners and expertise, UNESCO and UNAIDS are uniquely positioned to support the development of measures to respond to the epidemic, and to disseminate experiences and lessons learned. This joint publication is an example of cooperation between the two partners. ■

This publication is based on the experience of the authors and of other researchers and programme developers with various migrant populations in Israel in HIV/AIDS prevention and the related fields of sexual health and sex education. Examples are drawn from the work with two recent waves of immigration from Ethiopia and the former USSR to Israel. Observations were made on similarities between the migrant populations as well as on their unique characteristics in interaction with a host culture. This resulted in developing culturally sensitive HIV/AIDS prevention programmes while responding to the general needs of the migrant populations.

Although a large majority of the population in Israel are immigrants of the last 50 years and their descendants, this publication is based on the authors' work with immigrant groups from Ethiopia and the former USSR. The immigration from Ethiopia numbers about 50,000 people, which came in two major waves in the mid-1980s and over one weekend in May 1991. Most of these Jews came from remote rural areas and lived in a traditional, extended family structure. Coming from a country with a high HIV prevalence, the immigrants had a much higher values than those known for the general Israeli population.

The latest wave of immigration from the former USSR, which started in 1989 and peaked in 1990/91, numbers more than 600,000 people (about 13% of the existing population). These immigrants, academics and professionals, are mainly of urban origin from the European Republics of the former USSR. Some groups of Jews from Georgia, Caucasus and the Asian republics are also present among them.

It should be noted that the special interest in working with migrant populations stems from the perceived increase in vulnerability of immigrants and their special needs, and not in viewing them as posing risk to the host population.

This work is divided into three chapters. Chapter 1 summarizes the background, theories, and principles underlying the development of HIV/AIDS programmes for migrant populations. Three important components, which interact and partially overlap, define the special needs of immigrant populations. These are the socioeconomic conditions caused by uprooting from the old country and the hardships of resettling in the new country; the sociocultural specificity of an immigrant population (a phenomenon that needs to be dealt with also among non-immigrant groups in multi-ethnic societies); and the sociocultural phenomenon of immigration, characterized by transition, cross-cultural interactions, and accelerated dynamics of change.

Chapter 2 focuses on the methods and steps to be taken in developing programmes, projects, and interventions for migrant populations. A tight integration of three elements is central to the model of development. These are the close cooperation between cultural “insighters” and “outsighters”; the need to shorten the development period of programmes and projects without giving up the principle of cultural adaptation to the special conditions of the immigrants’ background; and the need for continuous development according to the changing dynamics and the identification of issues during fieldwork. Another element of this methodology is the interaction between methods, stages of development, and implementation, which supports and enhances the programme.

In Chapter 3, examples of programmes, projects, and interventions demonstrate the methodology and its variations in specific conditions. The resulting diversity, complexity, and specificity that can be achieved through employing the principles described in Chapter 1 and implementing the model and methods detailed in Chapter 2 are almost endless. The emphasis in Chapter 3 is on the systematic adaptation to specific circumstances that resulted in diverse programmes and projects.

Some of the tools and instruments used in developing programmes and projects, training courses, implementation of activities, and monitoring and evaluation are provided as examples in tables and text boxes. Interested readers are encouraged to contact the authors directly for more detailed information on those tools and instruments. ■

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Theoretical considerations and principles of interventions

Introduction

Migrant populations are at a higher risk than the overall population for poor health in general and HIV infection in particular (Zwi & Cabral, 1991; Brindis et al., 1995). There are several reasons for these phenomena, some of which are related directly to the effects of the sociocultural patterns of the migrant situation. Others are related to economic transitions and changes in the availability and accessibility of health services, and the difficulty of the host country health systems to cope with the traditions and practices of migrants. In terms of these factors, HIV/AIDS is not different than other problems, but it is further complicated by the stigma and sense of “otherness” attached to those infected with the virus (Haour-Knipe, 1993).

Epidemiological data from many countries show that migrants could be at particular risk for HIV infection. However, it is important to treat these data with caution, because differences exist between reporting systems of countries and the manner in which data concerning migrants are presented. For example, some sources report the incidence or prevalence of HIV, others the incidence and prevalence only of AIDS. Some countries (e.g., the United States) include data on immigrants together with those on native-born ethnic minorities; making it difficult to calculate rates solely for immigrants. In some European countries, the majority of foreign-born persons with HIV/AIDS are from other European countries or the United States and are not immigrants from developing countries (Haour-Knipe, 1991). Moreover, in many countries, release of data concerning foreigners is limited to protect their privacy and to avoid stigmatization through the misuse of epidemiological data.

AIDS case data for migrants in nine European countries indicate great variations among the countries. For example, by 1990, 45 per cent of the people with AIDS in Belgium, 20 per cent in the Netherlands, and 7 per cent in Norway were foreign residents. Where data on HIV were available, the proportion was 52 per cent in Belgium, 20 per cent in Sweden, and 10 per cent in Norway. The proportion of immigrant populations in these countries was significantly smaller than the percentage of the total of all those being HIV-positive (Haour-Knipe, 1991). In Sweden, HIV prevalence among immigrants from sub-Saharan Africa residing in Stockholm was estimated to be 4 per cent in 1994 (Christenson & Stillstrom, 1995). In Amsterdam, only 0.12 per cent of pregnant women in 1988-1991 were diagnosed with HIV, but 63 per cent of these were foreign nationals (Bindles et al., 1994).

Outside Europe, too, data show that immigrants can be at greater risk for HIV/AIDS. In Israel, the prevalence of HIV among immigrants from Ethiopia rose from 3 per cent in 1991 to 7 per cent in 1996 (Kaplan, Kedem & Pollack 1998). Moreover, these immigrants constituted the predominant transmission group - 50 per cent of all HIVsero-positive adults in Israel at the end on 1999 (Israeli Ministry of Health, 1999). Internal migration has also been found to be a major risk marker. In Uganda, HIV sero-prevalence was 5.5 per cent for people who had not changed address during the surveillance period in a rural region. It was two times greater (11.5 per cent) among people who moved out of the area and almost three times greater (16.3 per cent) for those who joined the study area (Nunn et al., 1995).

The characterization of migration and immigrants

The definition of immigrants or migrant populations can be complicated and will depend on whether one uses nationality or country of origin as a criterion. For the

purpose of defining the boundaries of immigrant populations, examining their epidemiological patterns, and evaluating programmes, these issues are highly important, but they are less so to developers of programmes focusing on prevention within the migrant populations. For them, other dimensions of characterizing migrant populations are of greater significance, particularly those that affect the needs and specific situation of the migrant population and the feasibility of and conditions for HIV/AIDS prevention in that population (Haour-Knipe, 1994). Such dimensions include:

- ❖ **Choice:** Did the immigrants leave their country of origin voluntarily or were they forced to move?
- ❖ **Cultural affinity:** What is the degree of similarity or difference in language, religion, ethnicity, and other factors between the immigrant and the host culture? Additional factors, such as ideology or nationalism, may affect the need for special programmes.
- ❖ **Intention:** Do migrants intend to stay in the host country? Their movement to the new country could be temporary or short-term with the intention to return to the country of origin. Migrant populations may include transients who do not regard the current host country as their final destination and intend to move on (but not back) or settlers who intend, if allowed, to stay in the current host country.
- ❖ **Length of stay:** This factor is highly dynamic and changes continuously throughout programmes. Length of stay is especially significant when the stay is short. When the stay is long, there may be second- and third-generation immigrants who still show distinct sociocultural differences from the host country, as well as from the home country. Significant differences exist between short-term migration (like that of seasonal workers), medium-term migration, and permanent migration. Each type requires a different approach because of the differences in commitment to the “old country” culture.
- ❖ **Legal status:** There are at least three major categories within this dimension: clandestine, semi-legal (or sufferance), and legal. Legal status affects the availability of health and welfare services and the immigrants’ willingness to be in contact with officials.
- ❖ **Needs of the host country:** The needs of the host country could determine the type and social status of migrants allowed into a country, the screening and entry procedures, the amount of involvement of mainstream society with migrant populations, and its investment in them.

These dimensions may interact with each other in influencing HIV/AIDS issues. For example, refugees who were forced to leave their country and reside in refugee camps may see their situation as temporary and aspire to return to their country of origin. This could affect their relationships with the host culture, such as their willingness to learn the language. Seasonal migrant workers, who are similar to the refugees in their intention to return home and the degree of involvement with the host culture, are usually able to realize their intention, while refugees could stay in exile for many years. The needs of the host country could be related to legal status. This could produce a situation in which the migrant population could be reluctant to approach health and welfare services or any project that has any official association. It is therefore critically important to examine the specific situation of migrants closely and characterize them on as many dimensions as possible if meaningful programmes are to be developed. It is also important to distinguish migrants from travellers and tourists, on the one hand, and ethnic minorities on the other.

Certain types of travellers are at higher risk for HIV infection while travelling than in their home country, particularly those who travel to seek sexual experimentation. Their vulnerability is also related to the people with whom they associate in the host countries. Travellers’ stay in a host country is too short and their degree of involvement too small for programmes to target them directly. Instead, they are best reached by general information campaigns through various channels. Travellers are mainly considered as a subgroup of the general population of the home country.

Migration and interventions to reduce the risk of HIV infection

The distinction between immigrant groups and non-migrant cultural or ethnic minorities is more difficult because most immigrant groups are also cultural or ethnic minorities. The difference is mainly in the migrant conditions, which add to the difficulties induced by minority status. The next sections discuss some of the unique factors associated with immigration and relate them to specific cultural differences.

Migration involves both a partial loss of cultural environment of the “old country” and an encounter with the environment, social constructs, and cultural atmosphere of the “new country.” Migration is, therefore, related to a dynamic process of discontinuity and transition, which is strongly dependent on the time elapsed since migration (Mirsky & Parwer, 1992). That process is characterized by the move from a familiar and comprehensible existence to an unknown, confusing, distressing, but possibly exciting and rewarding, life in a new country. Some of these elements are also experienced by the host culture “receiving” the immigrants. Though not at so high a level of cultural transition and loss, the host community does experience cross-cultural encounters and difficulties. The hosts experience these pressures on different matters and from a position of greater power than do the immigrants (Amir, Remennick & Elmelech 1997).

Immigration can precipitate many issues that stem from cultural transitions and cross-cultural encounters:

- ◆ the breaking down of traditional norms and institutions with resulting confused, unstable, and insecure behaviour;
- ◆ difficulties in interpreting the new environment on the basis of pre-immigration cultural patterns;
- ◆ difficulties in accepting new environments, which could cause behavioural discrepancies;
- ◆ the widening of intergenerational gaps;
- ◆ feelings of estrangement and stigma.

These issues could change at a fast pace among immigrants and could interact with other factors that could affect their health (Marmot, 1993/94). Such factors might include the reasons for migrating; the effects of exposure to new environments, including health status, culture, and lifestyle in the old country; the effects of the new country; and the experience of being migrants undergoing social and cultural change.

The issues of HIV/AIDS prevention are unique because they involve intimacy and sexual relations. In these areas, strong familial and social pressures exist for continuity and conformity on both cultural sides, a situation that may create strong tensions not only in the immigrant community but also in the host society (Amir, Remennick & Elmelech 1997). Such tensions could occur at the mainstream and institutional levels, but also among marginal and stigmatized groups within the host society.

The situation is further aggravated by the fact that, in many cultures, the issues of intimate relations and sexual behaviour are shrouded in secrecy and taboo. Such cultures, which are usually more traditional, have a tendency to avoid discussing sexual issues in public. The public stance is denial of the possibility of either premarital or youthful sexual behaviour. For example, the Ethiopian-Jewish tradition did not object to sexual intercourse between young people as long as it was in the context of marriage. Boys and girls were often married at puberty or even sooner. A similar tradition existed among some Jewish immigrants from the former USSR, especially those coming from the Caucasus and the central Asian republics. This was also the tradition in the Jewish communities of eastern, central, and southern Europe at the beginning of the twentieth century, and most of those of North Africa and the Middle East less than 50 years ago.

When they migrate from one society to another, immigrants may misunderstand new situations on the basis of old conceptual frameworks. The example of Jewish immigrants to Israel from Ethiopia and the former Soviet Union is typical. Immigrants from these cultures may observe a high level of physical contact or intimate behaviour among

Israeli young people in public places and interpret it according to the norms of their country of origin. They assume that these young people are sexually active. Moreover, since the physical contact is not always limited to one person, they assume that promiscuous sex is the norm. But according to secular Israeli norms, these are misperceptions. For Israeli young people, who are much more relaxed in their attitude to premarital sex, public physical contact may be pre-intercourse or even non-sexual.

An additional factor is that immigrants from Ethiopia and the former USSR were used to having sexual issues under strong social or institutional controls. Thus many of them do not perceive and recognize the internalized personal controls among Israelis. As a result, they view Israelis, especially Israeli young people, as having no norms or controls or as having norms that are permissive or even promiscuous.

Such misperceptions can cause difficulties in various directions. First, immigrants who view these misperceived behaviours as contrary to their internalized norms can feel estranged from the host culture. Such feelings are hardly conducive to trust in professionals from the host culture who conduct prevention and care programmes. A second route, which may be more risky in terms of HIV transmission, is the adoption by immigrants, especially immigrant youth, of the erroneously perceived promiscuous norms as normative behaviour to be acted upon in the new country (Shtarkshall & Shimon, 1994).

Characteristics of host and immigrant populations

One factor that deals with specific situations but is still generalized is the degree of accordance between the situations in the “old” and “new” country.

Attitudes and norms towards sexuality and sexual behaviour influence HIV/AIDS prevention in an indirect but important manner. Traditions of restricted public discussion and strong normative controls over sex could lead to discordance between publicly expressed norms and highly prevalent individual behaviour. A strong barrier to HIV/AIDS prevention could exist where, for example, there is denial about the possibility of pre-marital sexual behaviour among young people. Programme developers should try to identify such discordance and must address it in their interventions.

Questions about the necessity for special HIV/AIDS education for migrants are often raised based on the issue of their particular risk for HIV transmission. It has already been noted above that epidemiological evidence concerning HIV/AIDS prevalence rates in general and among migrants in particular should be used with caution due to varying reporting systems and other methodological issues that weaken their validity.

An examination of epidemiological and behavioural data suggests that part of the greater apparent risk for HIV infection among migrant populations may stem from other living condition variables and could be reduced by controlling or correcting these variables. Sometimes such corrections show that the migrants’ risk is not greater than that of the general population. For example, the argument that migrants usually have more sexually transmitted diseases and therefore are at greater risk for HIV has been shown to be true only for single men living under isolated conditions in the host culture. When they live with families, the incidence is similar to that of the host population (de Schryver & Meheus, 1990). On the other hand, single status may be related to a specific immigrant group who want to improve their income, but who are employed in low-status jobs. They tend to have multiple partners and commercial sex because of their single status, geographic mobility, and lower chances of creating stable relationships with women in the host culture. In this case, understanding the causes of increased risk cannot change the situation, but it may add to the understanding of the factors that determine the risk and the directions of the interventions.

Factors related to the greater risk of HIV infection among migrant population include demographic and behavioural differences within the immigrant community, difficulties in interactions with and integrating into the host society, less access to medical services, and language and communication problems with health care personnel. Again, a note of caution in interpreting such data is necessary. Migrants may simply be more known to health officials because they are more represented in public services than is the

host population. They may not have the knowledge or the economic resources to use other, more confidential private services. Many countries tend to screen immigrant populations for various infectious diseases but do not have similar screening of the general population. From a public health perspective, this practice may be advisable, but in many countries it has been found to violate human rights and to offend, stigmatize, and alienate the immigrant population, thus creating barriers to preventive action. This was the case in Norway in the late 1980s (Haour-Knipe, 1991) and has become the situation in Israel with Ethiopian immigrants.

When a screening program is implemented and the country also accepts the position that all sections of the population have the right to equal access to information about HIV/AIDS, then educational messages should be culturally adapted so they can be understood and perceived as pertinent. This necessitates the involvement of government in health education. As the situation of immigration is by definition one of constant and rapid change both at the individual and the community levels, HIV education programmes have to be flexible enough to be changed and adapted to different situations.

Another argument for the need for special programmes for immigrant groups is based on observations that migrant groups tend to have sexual partners and form liaisons mostly within their own group. This is determined by selection biases as well as by the limited tendency of people from the host culture to choose sexual partners from marginalized groups. Therefore the greater risk of transmission is internal. In other situations where risk of transmission is external, such as commercial sex, the general assumption is that here the responsibility to prevent transmission of HIV lies with the client as much as with the commercial sex worker. Similar considerations apply for other avenues of transmission. If the prevalence and incidence of HIV are either significantly lower or significantly higher in the immigrant population than the host population, it is important to also include studies of the channels of transmission between the subgroups as part of the basic data needed for prevention.

The comparative prevalence and incidence of HIV/AIDS between the immigrant population and the general host population are immaterial for setting the priority of special immigrant programmes to lower the risk of transmission within this subgroup. However, the fact that these rates are different and that the patterns of transmission may be different are the important points for the design and implementation of such programmes.

When the prevalence of HIV/AIDS among immigrants is higher than in the general population, and this becomes a public issue, their marginality to the general host population further increases their risk. The perception of them as a “risk group” may cause a grave public health problem within both the immigrant community and the host population.

Host population reactions that need to be dealt with are alarmism combined with scapegoating and stigmatization. Irrational fears in the face of a threatening deadly disease are natural and should be recognized as such. But an alarmist reaction is an inadequate social-behavioural response, aggravating the distress of immigrants in general and people with HIV/AIDS among them in particular. It may start with sensationalist media reports that, even if isolated, can cause widespread damage. Such reports may be characterized by inappropriate handling of epidemiological, medical, or behavioural data that, even when correct, can be easily misinterpreted when not presented in the right way. These reports may sometimes serve political or seemingly positive agendas such as the distribution of HIV prevention programmes or drives for funding programmes, but could be followed by shunning, discrimination, breaches of ethics, and even violent reactions.

Stigmatization and shunning can increase the tendency of the immigrant community to deny the issue and, in some cases, can alienate people with HIV/AIDS, make them angry, and drive them into hiding. Thus the risk within the immigrant community can be intensified by outside pressure. When the host population erroneously perceives that the risk stems mainly from the immigrants, members of the host population may be at higher risk because they do not feel the need to comply with protective measures with non-

immigrants. Therefore, while the needs of the immigrants must be dealt with in special programmes and projects, it is also important – not only because of human rights considerations but also because it is in the public interest – to address the general public in a non-discriminatory manner through messages emphasizing appropriate behaviour. It is only when highly specific routes of transmission are identified that there may be a need for special projects for the host population.

Principles of cross-cultural cooperation

Two main options are available to the developers of national programmes confronted with the need to deal with HIV/AIDS among immigrants: to adapt existing programmes that have been tried with other populations, or to use newly developed programmes that can be targeted and tailored to the needs of the specific immigrant populations. Existing programmes may originate from various sources. HIV/AIDS is a highly entrepreneurial field. Many commercial and non-profit organizations market educational programmes that guarantee universality or adaptability to a wide range of cultural conditions. Many of these focus mainly on knowledge or the technical aspects of condom use and claim the ability to train interveners in short periods of time. Their guarantee of universality is dubious, and the use of such programmes could be especially problematic in dealing with immigrant populations.

As was demonstrated earlier, immigration is a unique cultural situation combining cultural loss and transition with cross-cultural encounters. For these reasons, programmes from the “old country” are not recommended, unless they are just one of many resources for developing a new programme. Although programmes from the old country would cover cultural traditions, thus being an improvement on the so-called “universal” programmes, they do not deal with the cultural loss, the new environment, and the cross-cultural interactions, all of which can have strong bearings on coping with HIV/AIDS. Their adaptation to these conditions may consume as much time and resources as developing a new programme that would take into account as many of these factors as possible. Programmes designed for the general population of the host country should be rejected for similar reasons. This position is strongly reinforced in situations where the patterns and modes of transmission within the immigrant population and the factors affecting them are significantly different from those of the host population or the country of origin.

The time frame for the development of newly designed, specific programmes for immigrant communities may be the major obstacle to the adoption of such policy. The more traditional, linear methods of development may seem inapplicable, especially when urgency is perceived. This may be one of the reasons why decision-makers opt for other, less desirable alternatives. The iterative model for development of programmes and projects that is presented in this document (see page 11), among its other advantages, saves a lot of time while making very few compromises in terms of adaptation to the needs of the target populations. One of the contributing factors to the ability to develop culturally appropriate programmes in a relatively short time is cross-cultural cooperation.

*The pitfalls of
“primitive” or
“noble savage”*

The basic principle of cross-cultural cooperation is mutual respect, which supersedes not only judgement and stigmatization but also glorification and idealization. When the host and immigrant cultures are distant enough, especially when the host culture is urban, industrial, and literate, the images of the primitive and the noble savage may be applied to the immigrant culture in varying degrees of intensity. It is important to note that both the general population of the host country and the immigrant community could fall into this trap. While the danger of the first is almost self-evident, the second is more insidious and may be as pernicious. Both hinder the ability to understand the factors that promote transmission of HIV and their behavioural, social, and cultural determinants.

Stigmatization has an additional damaging effect: it may promote denial and avoidance, especially when it is directed towards a minority group. While stigmatization must be dealt with deliberately at all levels through political, media, and community action as well as education and counselling (Shtarkshall & Davidson, 1995; Shtarkshall, Shimon & Bargai, 1997), idealization and glorification can be dealt with mainly by not indulging in them or by reframing them when they are encountered. Experience shows that most people, if treated with concern and respect, will accept straightforward approaches to sensitive issues that might be prone to stigmatization.

“Cultural insight” and “cultural oversight”

A unique factor in work with migrants, one inherent in the cross-cultural encounter, is the need for people from two cultures to work together. This occurs for two reasons. First, the migrant culture is in a unique situation, in transition between two cultures and developing some specific “old culture” responses to host culture phenomena. Second, people from the host culture who are in contact with migrants are affected by the cross-cultural encounter. The cooperation between members of the two cultures can take many forms and occur at many levels. In developing and implementing programmes and projects for dealing with HIV/AIDS and the broader fields of sexual health and intimate and sexual relations, a specific type of interaction is stressed for working on the cultural components of projects in cross-cultural situations. It is necessary that members of the different cultures contribute their various perspectives if the aim of developing culturally appropriate programmes for this unique situation is to be achieved. The terms “cultural insighters” and “cultural outsiders” have been coined to explain and emphasize the different roles of the members of each culture who collaborate in developing and implementing projects (Shtarkshall & Soskolne, 1994).

The culture of a society could be viewed as the collection of those attitudes, norms, values, and practices that its members may not or will not ask questions about. One of the roles of cultural outsiders is to raise questions about just these attitudes, norms, values, and practices. Such questions may be quite disturbing, or they may seem of no significance to insighters because they view their own attitudes and values as natural. Sometimes only the outsiders recognize an important question, while people from inside the culture are unaware of its significance. On the other hand, the people who are best informed about cultural details and their internal interconnections, variations, and explanations are those from inside the culture – that is, the cultural insighters.

Some examples of cooperation between insighters and outsiders emerged through an international training programme. One participant described a project that attempted to lower the risk of HIV transmission to rural housewives whose husbands engaged in commercial sex. Because such behaviour is described as highly prevalent, rural housewives are considered a priority at-risk group in the country. Members of the international training group probed the participant for the reasons why husbands engaged in commercial sex. Several of the questions raised by outsiders are questions that could be examined almost exclusively by insighters. The resulting examination uncovered phenomena highly relevant to project developers.

- ◆ In that society, there is a dichotomy between sex for procreation and sex for pleasure.
- ◆ As a norm, “honourable” married women attempt to minimize intercourse by many means and do not associate it with pleasure.
- ◆ Discussion of the issue of whether this lack of pleasure is only the husbands’ inattention to the wives’ sexual needs (which is certainly part of it) revealed that married women may feel offended if their husbands try sexual variations or inventiveness in an attempt to increase the wives’ pleasure. A wife may think that her husband is looking at her as a “pleasure woman” and may feel degraded.
- ◆ A husband may feel very uncomfortable or even suspicious and resentful if his wife requested or demanded pleasure from sex and would probably interpret it as her acting in a “loose” manner.

This example illustrates the link between insighters and outsiders. It also implies that, at one time or another, most participants had experienced both roles – insighter on their own projects, outsider on those of others. Having been through this experience repeatedly, they are aware of the importance of insighter–outsighter cooperation. They can look for instances where programmes might benefit from these processes and may be able to distance themselves from immediate emotional reactions. The answers to the questions raised through such a process cannot come instantaneously but rather through a series of questions and answers, mistakes and discoveries.

Another example of the process of insighting and outsighting was the analysis of the custom that a widow has to have sexual intercourse with a close member of her late husband’s family. In an international workshop, members were surprised to find that this custom is prevalent in varying forms in many cultures. Some interesting questions, which may have a strong impact on prevention of HIV/AIDS, were raised. What is the purifying act, intromission or ejaculation? What happens when a condom is used in such a ritual? Does it void it? All members from the cultures where this custom is practised admitted that they had never thought of such questions.

This process is elaborated upon to contrast it with the alternatives: first, the conventional development in which the immigrants participate mainly as subjects (Cornwall & Jewkes, 1995), and, second, a process in which the full responsibility for development of the programmes is delegated to the immigrants, in the tradition of ethnic minority groups. Some argue that, if immigrants can be taught to view their culture from the outside or if individuals from the host culture can be trained as experts on the immigrant population, then there is no need for cooperation. Either could take on the roles of both insighters and outsiders. Yet this may take much more time than training them to cooperate, and their proficiency in the reverse roles may be limited. In addition, an important link between the two communities would be missing in which interactions could be achieved. The interactions in themselves could add to the understanding of the situation and address the reciprocal nature of the cross-cultural encounter, the fact that people from the host culture are also affected by it. Training people from inside a culture to view it from outside and outsiders to gain some insiders’ perspective can best be achieved through extensive collaboration between members of both cultures who engage in cross-cultural efforts.

Specifically in terms of HIV prevention projects, the study of cross-cultural phenomena and coping with the problems they pose can be enhanced and accelerated if people from inside and outside the cultures join forces in the attempt to reducing the incidence of infection. People from each group may have dual roles, that of cultural insighters for their own group and cultural outsiders to the complementary interacting one.

In many instances, the objective of a project is to develop professionals capable of mediating between members of the two cultures who cannot play the dual role of insighters and outsiders because of lack of training and other professional duties. Such is the case in direct interactions between people with HIV/AIDS and physicians or welfare professionals. The need for cultural translation of concepts and the use of comprehensible communication goes far beyond language difficulties.

Programmes based on cross-cultural cooperation do not act only within the defined area of their aims, on issues of sexual health or sexual relations. The participants, whether they are interveners or the target population, could also apply them to other cross-cultural issues. Cross-cultural cooperation in projects can also lead to better cultural understanding and thus enhance the constructive interactions among members of the two populations and facilitate integration of the immigrants into the new environment.

Sometimes community leaders believe that minimizing the extent of the epidemic or even denying its existence is in the best interest of their constituency, usually reflecting the emotions of their community and the atmosphere within it. In order to address these

responses, the reasons for them should be well understood.

First, in most cases, even in populations with high prevalence and incidence rates, the majority of the group is not directly involved at the initial and often also at the later stages of the epidemic. Thus, if stigmatizing behaviour towards people with HIV/AIDS is prevalent, it would affect a vastly larger proportion of the population than just those with HIV/AIDS.

Second, the HIV/AIDS epidemic could remain “invisible” even when the prevalence is already high. As the onset of symptoms may be years after initial infection, people tend to focus on more visible and immediate issues such as discrimination, housing, legal status, entrance into the labour market, providing for families, and other daily survival issues. All these issues could be adversely affected if the community were associated with the epidemic, especially when members of the immigrant community are easily recognizable by their physical appearance, language, dress, or behaviour.

Third, for many migrant populations, especially those arriving from rural, more traditional countries, the biomedical concept of being HIV-positive is either alien or hard to grasp. In such societies, disease is associated with symptoms that handicap people. In many cases, people with HIV respond with suspicion and anger not only when informed about the infection but also at later stages. A typical example of such a case is a person who is already being treated because of a low CD4 count and who says: “I am not ill, I felt OK and there was nothing wrong with me until the doctors started giving me these medicines. It is your medicines that make me ill; they make me vomit, I have no appetite and my whole body aches. When I stop taking the medicine, I feel much better.” The suffering person must have some explanation in order to make sense of such seemingly abusive treatment. If the treating staff does not provide the explanation, the patient will do so. Physicians represent not only the health system, but the whole establishment, and accusations are projected onto them. Several such explanations have been provided by patients: “You test the immigrants therefore you find more among us than among the old-timers”; “This is a way to hold us down”; “You want to use us for experiments with medicines.” Such explanations may seem perfectly logical to people who are in a precarious social or legal position and are either being discriminated against or perceive themselves to be facing discrimination. The leadership cannot be deaf to such voices. It is, therefore, important to accompany treatment with culturally appropriate, comprehensible explanations, which will prepare the patient for changes in health status.

A fourth factor, which particularly affects traditional leaders, is the perception that dealing with the epidemic could conflict with traditional values. Leaders may perceive themselves as the guardians of traditional values and thus feel that their authority is challenged. The sexual nature of the transmission of HIV, whether homosexual or heterosexual, likely goes against traditional norms. When incidence is intensified through modes rooted in old country norms, such as *de jure* or *de facto* polygamy or casual sex, it may be perceived as contrary to the host country values, and must therefore be kept hidden.

Overcoming these barriers requires not only an understanding of specific arguments and patients but also careful work in alleviating fears, familiarizing the migrant leadership with the host country situation, and letting the needs of people with HIV/AIDS be one of the factors around which new leadership could emerge.

Cultural transitions and cross-cultural encounters

In order to deal with HIV/AIDS among immigrants, suitable principles and strategies, which address cultural transition and cross-cultural encounters, have to be employed. These principles support culturally specific messages and modes of message transmission, employing members of migrant populations and sensitization of host country personnel.

Culturally specific messages and modes of message transmission

Two ways of using culturally specific messages are available to developers and implementers of projects and interventions. The first is finding concepts, stories, fables and proverbs, situations, or visual presentations that may fit or approximate the desired messages on HIV/AIDS. The task then is adapting them in such a way that they could be associated with the HIV/AIDS interventions. An example is a message about termites attacking a tree, a situation that would be familiar to immigrants from Ethiopia and that can serve as an analogy to the hidden aspects of HIV infection. A more complex attempt is to shift a traditional cultural concept to a new context, as in the case of the Ethiopian concept of a gobez. This is a brave and clever man who is able to avert damage to his fields and support his family through preventive actions and preparation. HIV is compared to the natural enemies of the farmer, and the condom is equated with the means that the gobez employs (Rosen, 1986, 1989; Chemtob and Rosen, 1992).

The second option is using a traditional mode of communicating cultural lore, but introducing new content. Fables and proverbs are traditional modes of communicating wisdom and expressing opinions in the Ethiopian culture. Several parables have new content to convey important messages in a comprehensible and acceptable manner. Examples include “The parable of the two legs” and “Dangerous steps and levels of risk” (Shtarkshall, Shimon & Bargai, 1997).

Employing members of migrant populations

Employing professionals from the migrant population as interveners (educators, group facilitators, cultural mediators, and case managers) and training them for working in the field of HIV/AIDS serve more than one purpose. When trained, they could enhance the transfer of messages from one culture to another. They are also the most suitable people to act as cultural mediators in the framework of health, welfare, and educational systems, provided that professionals from the host culture learn to value their contribution and cooperate with them.

Being well versed in the nuances of their own culture, they could inject cultural insight into the development process and complement the needed cultural oversight of experts from the host culture. They are thus assigned the roles of informants and co-developers of the programmes. In this model, these roles are integrated into the development, training, and implementation cycles.

The sensitization of host country personnel

Sensitization of host country personnel is a central concept for projects that target people with HIV. It is also an important subject in every other training programme to lower the cultural pressure on the immigrant population in their contact with caregivers.

Immigrant people with HIV find it more difficult than the general population to maintain continuous relationships with health centres. In addition to general alienation and cultural difficulties, language and cross-cultural communication barriers affect the relationship with the health system, especially when both health and sexual issues are involved. Stigmatization and scapegoating, which are prevalent in relation to HIV, can be augmented when immigrants are considered, especially those who are identifiable by their physical appearance, behaviour, dress, or language. Cultural barriers may affect health personnel, who, when working with people with HIV, must deal directly with sexual issues. They may find immigrants’ relationship patterns or “esoteric” sexual practices (e.g., polygamy or early adolescent marriages) hard to deal with or even repulsive.

The alienation of health personnel and the difficulties of their clients may be intensified when the immigrants subscribe to non-biomedical models of health and disease or mix traditional and biomedical models. The resulting frustrations and loss of confidence can lead to reluctance to return for follow-up care and sometimes to loss of contact with the health centres. Health personnel might interpret this behaviour as “resistance” and add it to the bag of characteristics that make the immigrants “hopeless to work with.” There are many instances of very low tolerance of such “nonsense” within the health

system. Mediation by trained people from the immigrant population could help health personnel to establish a more understanding staff–patient relationship and has been successful in increasing the rate of follow-up visits.

Iterative development cycles

Three important elements of the iterative model for programme development converge in this section:

1. the close cooperation between cultural insighters and outsiders;
2. the need to shorten the development period without giving up the principles of adaptation to the special conditions of the immigrant culture;
3. the need for continuous development according to the changing dynamics and the identification of issues during fieldwork.

There are both conceptual and practical considerations for the application of this methodology. First, when working with populations in cultural transition and cross-cultural interaction, the situation is highly dynamic. Therefore it is imperative that mechanisms for changing the programme according to changes within the population be built into the development methods ¹.

Second, in most instances the situation within migrant groups is not only serious but urgent. This is mainly because of the additional factors that increase the potential risk for HIV transmission in immigrant populations. Urgency can push decision-makers into using available programmes, on the assumption that doing something, even if it is not culturally appropriate, is better than doing nothing. This is also on the side of political caution or wisdom. Yet a continuous development process that is non-linear and iterative saves time at the critical period between the initiation of a project and the beginning of field implementation, while making minimal compromises in terms of cultural needs. An assumption of this method, which makes the iterative cycles essential, is that at the initial stages (moving into the training and experimental field implementation), a project and its components are far from being fully developed. In combining the first and third aspects of the iterative process as delineated above, this becomes an advantage rather than a compromise for the sake of time saving.

Third, several components of the iterative cycle are designed for the purpose of incorporating the perceptions, cultural insights, and ideas of people from within the immigrant groups who are actively engaged in confronting HIV/AIDS issues.

Data collection and analysis

Continuous data collection and its analysis and feedback into the system, at all the stages of project development and implementation, are essential parts of the iterative cycle. The principles behind it are that the professionals from both the immigrant and the host culture who are being trained to carry out the interventions of the projects have multiple roles, including that of partners in project development, and that training activities could be designed for the purposes of professional training as well as for intervention and material development.

¹ While evident in international migrations, we stress that such issues could arise also in internal migrations such as rural-urban migrations in multi-ethnic societies. The cultural transition, cross-cultural aspects, and dynamics of this internal migration are sometimes underplayed. Losing the culturally homogeneous environment and the traditional social structures with their checks and balances and being thrown together in close physical proximity with people from different, sometimes hostile, ethnic groups can be as demanding as moving to another country. The often dire conditions can only add to the difficulties of coping with these pressures and therefore pose additional challenges.

Tables 1 and 2 detail the different methods used for data collection and the different stages of the programme and projects within which they are used. Two points have to be emphasized. First, every stage of the process, not only the initial one, includes data collection and analysis components used for amending and refining the interventions. Second, the data collected can be used in many ways, and further development is only one way. The data can also be used as a professional development tool in training and supervision of the interveners and for quality control and process evaluation.

The tables indicate that different methods must be employed at different stages and that each stage needs more than one method of data collection to get a comprehensive picture and to minimize mistakes. By structuring the time frame of the training programme so that it coincides with experimental field implementation of the interventions, distinct iterative cycles of development could be enacted.

Table 1: Use of data collection methods at different stages of programme development

Stages	Initial formulation	Developing messages, interventions and training procedures	Training process #	Trial #	Ongoing implementation #
Methods					
Library research	++	++	++	+	
Field observations	+++	+	+	+	
Non-structured interviews	+++	+	+	+	+
Semi-structured interviews		+++	++	+	+
Focus groups		+	++	+	
Multi-purpose training instruments			+++	++	
Observations of project events			+++	++	+
Self-reporting			++	+++	+++
Self-response questionnaires			++		
Structured interviews				+++	

Iterative cycles of project development

+ the greater the number of crosses, the more common the method

Table 2: Use of data collection methods at different stages of monitoring and evaluation

Stages	Monitoring	Process evaluation	Impact evaluation	Outcome evaluation *	Policy studies **
Methods					
Library research		++	++	++	(+++)
Semi-structured interviews		++	++		
Focus groups			++		
Multi-purpose training instruments		++	+		
Observations of project events	++	+++		++	+
Self-reporting	+++	+++		++	+++
Self-response questionnaires			+++	++	
Structured interviews			+++		(+++)

*Outcome evaluation of HIV prevention will depend on sero-prevalence, modelling, and epidemiological studies of markers like sexually transmitted diseases. On the other hand, outcome evaluation of interim stages (like training of facilitators) could be measured behaviourally, and the marking of the methods refers to them.

**Policy studies, which could be highly important for the development of programmes and projects, should be external to the programmes and projects. They are based mainly on studies of documents.

Developing interventions and educational tools

A central component of the iterative model is the combination of activities that are integral to the training and monitoring procedures and those that contribute to the developmental elements of the programme. These activities start early in the training process and continue throughout the programme. They are also integrated with trial implementation of the interventions, which are conducted in parallel with other activities. Throughout training and monitoring, sensitive issues and hard-to-solve problems are reframed as challenges. The training and development group has to cooperate in proposing new ways to deal with the challenges or amending existing strategies. This group dynamic approach is an important methodology in desensitizing and reorienting most of the trainees to sensitive issues. Collective experiences from the field combined with increased cross-cultural wisdom of the trainees through the span of the project elicit new strategies in dealing with sensitive issues such as condom use. The trainees are able to have face-to-face sessions about these issues without endangering their professional credibility or experiencing uneasiness in discussing the subjects. Often when trainees do not agree with one approach, group activities help to build either a consensus or alternative strategies from which each could find those most suitable to the specific audiences. These solutions have a better chance of not being offensive to certain cultural groups and of fitting to the specific population's needs.

Employment of immigrant groups for the iterative development cycles

The multiplicity of roles, discussed earlier, must be part of the iterative development cycles in order to train the interveners in multiple skills and to create opportunities for the trainees to practise these skills as part of the process. Both need to be deliberate activities that are integrated mainly in the training and trial implementation stages. ■

Programmes, projects, and interventions: A guide to development

Introduction

Immigrant populations are highly vulnerable to various social, economic, and health problems. HIV/AIDS is one of these problems. Immigrant populations also have special needs. Three main components define these special needs:

- ◆ socioeconomic conditions caused by uprooting from the old country and the hardships of resettling in the new country (a situation that may also characterize other marginalized socioeconomic groups);
- ◆ the sociocultural specificity of an immigrant population (a phenomenon that needs to be dealt with also among non-immigrant groups in multi-ethnic societies);
- ◆ the sociocultural phenomenon of immigration, characterized by transition, cross-cultural interactions, and accelerated dynamics of change.

When developing programmes, projects, or interventions for immigrants, a methodology is required that addresses both the increased vulnerability and the specific needs of immigrants. Such a methodology should have a build-in data collection mechanism, allow for on-going revision and amendments of interventions, and employ tools that can bridge the gaps between host and immigrant communities.

Based on experiences with programmes and projects for immigrant populations in Israel, this section provides programme planners with guidelines for project development. These guidelines are not intended to replace standard planning tools. The intention is to feature specific cross-cultural requirements, which need to be taken into account when developing and delivering interventions for immigrants. Planners and implementers using these guidelines are reminded that it is essential to adapt the methodology to the specific political, social, and cultural circumstances of the environment in which they are working, taking into account both the host and the immigrant communities.

Terminology

Three related terms are used in this section: programmes, projects, and interventions.

A **programme** is a series of interlinked projects. It is developed for the general purpose of lowering the risk of HIV/AIDS and dealing with its issues in a specific immigrant population. A programme is usually developed on a national or state level and must include policy and strategy components. It is composed of various levels of interventions (e.g., communication, education, counselling), employs different channels (e.g., distribution of pamphlets, use of print and/or electronic media), and may include non-behavioural components (e.g., regulations, procedures, and protocols, or changes in the price and availability of condoms). A programme has more than one project. These may run in a series, in parallel or partially overlapping, and may be modified with the dynamics of time and sociocultural changes.

In contrast to a programme, a **project** has more limited aims and objectives, defined by factors such as population, problem, context, or situation. Thus, within the programme for immigrants from Ethiopia to Israel, there are various projects:

- ◆ The informational/educational project for the general population of immigrants (1992–93), *Your Life Is in Your Own Hands*;
- ◆ The training of veteran Israeli professionals working with the Ethiopians immigrant community (1992–93 and 1994);
- ◆ The sexual health–sexual responsibility educational project for young adults in vocational training residential institutions (1993–94);
- ◆ The project for case managers/cultural mediators working with people living with HIV/AIDS (PLWHA) and their sexual partners (1995–present).

Interventions are discrete components of a project and have limited, specific objectives. Each usually utilizes one methodology, one channel of communication, and one level of interaction with the audience. Interventions are developed according to basic cultural and educational premises and are interlinked and integrated within a programme to achieve its aims and objectives. A specific intervention can be employed in more than one project, and there are interventions that are specially designed to link projects.

Stages of development

The initial stages of programmes and projects have some similarities and a few distinct strategies. Early project development usually should start after the programme's broad goals and the specific objectives for each project are set. However, in many instances, urgency dictates an almost simultaneous occurrence, and some activities in these stages are similar, especially the initial collection of data from various sources, including a search of the literature.

Tables 3 and 4 summarize the main stages in the development of a programme, of projects within it, and their interventions. This chapter focuses on the description of the methodology of developing programmes and projects, while Chapter 3 demonstrates their application through description of the actual development of several projects.

Table 3: Steps and stages for programme development

Stage	Steps and activities
Initial basic formulation	<ol style="list-style-type: none"> 1. Formation of a programme team 2. Literature review 3. Basic studies of pattern and routes of HIV transmission of immigrant populations 4. Policy formulation 5. Development of strategies 6. Recruitment of community leadership to participate in programme development 7. Initiation of multisectoral cooperation
Programme development	<ol style="list-style-type: none"> 1. Identification of subpopulations, critical issues, and projects to address them 2. Defining goals and objectives for each project 3. Establishment of multiprofessional project teams 4. Defining relations and interactions between projects 5. Implementation of all the stages of the particular projects
Monitoring and continuing development and implementation	<ol style="list-style-type: none"> 1. Setting up programme monitoring and evaluation mechanisms 2. Regular meetings of programme steering committee 3. Follow-up and integration of the evaluations of each project 4. Changes in policies and strategies

Table 4: Steps and activities in the development of a project

Stage	Steps and activities
Early project development	<ol style="list-style-type: none"> 1. Development of goals and specific objectives 2. Formative studies 3. First cycle of the development of modes of intervention, messages, and means of delivering them (including defining the characteristics of the interveners) 4. Planning of monitoring and evaluation according to the goals and objectives of the whole project and its intermediate stages (e.g., training)
Development of basic training	<ol style="list-style-type: none"> 1. Development of training concepts and team 2. Adapting training methods to the messages and modes of delivery 3. Selection of interveners 4. Pre-training collection of data from selected interveners
Implementation of basic training	<ol style="list-style-type: none"> 1. Development of knowledge and attitudes and teaching of basic skills 2. Data collection about responses to the messages and means, barriers and missing links 3. Second cycle of developing modes, means, and messages. Activities are structured into the training programme to utilize the cultural insight of the trainees and engage them as partners in further developing the project components 4. Process and outcome evaluation (initiating)
Continuing training with experimental implementation and monitoring as integral components	<ol style="list-style-type: none"> 1. Structuring the continuing training programme to include skill development interlinked with feedback from the field experience and its utilization in further refinement of the project and its implementation 2. Data collection of the field experiences (focusing alternately on the skills of the interveners and on responses of the audience to the interventions) 3. Additional cycles of project refinement and re-implementation
Ongoing interventions with monitoring and process evaluation	<ol style="list-style-type: none"> 1. Delivery of the interventions 2. Data collection and analysis (focusing on monitoring and evaluation) 3. Additional cycles of project amendments (for changes in conditions and opening new channels)
Outcome evaluation	<ol style="list-style-type: none"> 1. Collection of post-intervention and follow-up evaluation data for analysis 2. Assessment of the impact on the target population at the completion of the project in relation to its objectives 3. Recommendations for future action/inaction within the framework of the programme

Teams to develop and supervise programmes and projects

Central elements in the development of HIV/AIDS programmes for immigrants include the development team and the steering committee. These two teams serve complementary functions. While the development team usually represents professional expertise, interest, and ethnic balance, the steering committee represents formal and informal responsibilities, organizations and groups, vested interests, and the leadership of the communities involved.

The teams usually evolve in an ad hoc manner, and concerned professionals may be over-represented. But as the central role of both types of teams is the development of policies and strategies, it is important to strive for recruitment from all concerned sectors and segments of the populations targeted and to integrate them in the policy and strategy development process.

□ The steering committee

The steering committee represents all aspects of the host and immigrant communities, including their governmental and non-governmental organizations (see Box 1). The main tasks of the committee include the development of the general objectives of a programme or project as well as broad guidelines for implementation, monitoring, and evaluation. The committee also establishes the project development team. Usually the steering committee is not involved in the development of concrete project activities.

Box 1: The evolution of a steering committee and a professional team

The head of the Israeli National AIDS Steering Committee asked representatives of various organizations and communities to form the interagency steering committee for an HIV education project for Ethiopian immigrants to Israel. The Israeli National AIDS Steering Committee decided to target the adult population among approximately 24,000 Ethiopian immigrants residing in absorption centres and hotels at the end of 1991. An anthropologist, who had studied the community and its concepts of health and disease, and a physician, who had training in public health and medical anthropology and who had previously worked within the community on hepatitis B virus and HIV infection, submitted an initial proposal to the head of the Israeli National AIDS Steering Committee. To reinforce their initiative, they approached members of the Hebrew University–Hadassah School of Public Health. Two staff members, who had experience in health education, including work with Ethiopian young people and HIV prevention and in social-behavioural research and social work interventions with people of marginalized groups and people with HIV, agreed to join them. A team of four was thus formed under the auspices of the school of public health. The different areas of experience of members of the team were highly relevant to the project. The team proceeded to develop a full proposal for the education project, with an initial conceptualization of the educational components and the methodology of the project, the structure and content of the training, and ideas about implementation, monitoring, and evaluation.

The expanded proposal was submitted to the Israeli National AIDS Steering Committee. The proposal was accepted and funded for the duration of February–August 1992. Early in the project, the team recruited two coordinators, who were significant contributors to the project: a cultural coordinator who was a veteran immigrant from Ethiopia with experience in HIV/AIDS education, and a project education and field coordinator, who was a qualified teacher and sex educator. During the work of the team, it became apparent that a wider interagency steering committee would be beneficial, and it was therefore, widened. ■

□ The development team

It is important that the development team represents several areas of expertise and interest as well as pertinent ethnic groups. The team can include professionals with experience in medicine, public health, anthropology, sociology, social psychology, education, social work, and communication, as well as research, evaluation, cultural and cross-cultural issues, and development and implementation of interventions addressing human sexuality, substance use, and HIV/AIDS. The balance of expertise can vary with the goals and objectives of each project. Members of both the immigrant and the host communities should be represented on the development team. It is especially beneficial to include veteran immigrants – that is, immigrants who have lived for a long time in the host community. They can contribute valuable insights from both the host and the immigrant communities.

In order for such a team to be manageable, the number of members should be limited to include a representative selection of the needed professions and areas of interest and expertise. It is recommended that each member of the team have several of the required characteristics. The optimal number of members for such a team is between four and seven.

National policy development

A major aim of HIV programmes for immigrant populations is integrating a comprehensive and appropriate migrant population policy within a national policy. This can be quite a difficult and complicated task due to the barriers created by the special situation of most migrant populations. These barriers include economic and social marginalization, stigmatization (especially if they migrate from regions with a high prevalence of HIV), and cultural difficulties such as language problems and alternative models of health and disease, all of which demand greater effort, investment, and perseverance in risk reduction. These elements could easily be mistaken for non-compliance or lack of interest in prevention, and they could lead policy-makers in the opposite direction. These difficulties may reduce the readiness of politicians to invest efforts and funds in prevention, or may lead them to invest only when the HIV situation among the migrants is perceived as a threat to the general host population. The use of culturally inappropriate interventions could aggravate the situation. When such interventions fail to have the desired impact, the result may be mistakenly interpreted as denial or lack of interest.

Denial about HIV/AIDS is a common barrier in many situations and social groups. It should be taken as a normal response; one that requires careful study before it can be addressed. Denial may be intensified among migrant groups who are marginalized. Sometimes data about HIV are used incautiously and in a manner that could aggravate marginalization. Stigma perceived by the immigrant community could also be a projection of internal stigmatization of people with HIV within the immigrant community. Recognizing these situations does not mean that denial has to be accepted, even in the presence of stigmatization, if the denial persists and impedes risk reduction efforts in the community. Groups need to explore other means to cope with stigmatization beside denial and blaming, and interventions to deal with these barriers should be developed in cooperation with the community.

The following recommendations for the development of national policies to deal with migrant populations and HIV/AIDS are based on the view that migrant populations have special needs and not that these populations constitute a threat. The recommendations are directed primarily towards reducing the risk of HIV transmission within the migrant populations and only secondarily at defending the general host population from the migrant population.

◆ **Recommendation 1: A dedicated policy strategy team**

A special group should be responsible for formulating policies, at the national or regional level, for the prevention of HIV transmission among immigrants. These policies should be coordinated and integrated with other national HIV policy and strategies. It is important that this group include representatives from the immigrant population, as well as professionals who have knowledge of the community or who work in the field of sociocultural transitions or migrations and HIV/AIDS. The group should include people with direct links to executive authority and budget allocation and should have access to all sources of epidemiological data about patterns of prevalence, incidence, and routes of transmission of HIV/AIDS in the immigrant population. It should also have the authority and means to gather sociocultural data about the factors determining the above and about the specific difficulties and distribution of power within the immigrant group.

◆ **Recommendation 2: Including activists and community leadership**

Leaders of the community as well as community groups or organizations with special interest in reducing the incidence of HIV transmission and caring for people with HIV/AIDS should be involved in policy-making.

◆ **Recommendation 3: Intergration of groups' ideas, plans, and agendas**

Activist and interest groups within the migrant populations, for professionals, and organized around HIV/AIDS issues should prepare their agendas and policy recommendations from their unique perspectives. Such working documents could enhance the development of policies and strategies by helping to identify special concerns and issues.

◆ Recommendation 4: Transparency

All policies and strategies should be easily accessible to the community and all parties involved.

◆ Recommendation 5: The formation of teams

Programme and project steering committees and professional project teams should be formed to direct and oversee the execution of the programme and projects.

◆ Recommendation 6: Special programmes and adequate funding

The special needs and sociocultural conditions of migrant populations require specific programmes and projects and adequate funding.

◆ Recommendation 7: Integration of universal with specific messages

Universal HIV prevention messages should be included, but appropriate messages specific to the target population should be incorporated even when they seem to be alien or controversial to the host culture. An example is the message to sterilize equipment used for traditional medical practices, even if the general approach is that these practices ought to be stopped.

◆ Recommendation 8: Destigmatization

Destigmatization and acceptance of both the general migrant population and people with HIV among them are essential and have a strong bearing on prevention as well as on appropriate care.

◆ Recommendation 9: Sensitizing host population professionals

Programmes for immigrants should also include a training component for professionals from the host culture to deal with the immigrant population in a culturally sensitive manner and with cross-cultural competence.

Collecting and analysing data

An important feature of the methodology is the ongoing, deliberate, and structured data collection and analysis with feedback into the development and implementation at all stages of any project. Such collection, analysis, and feedback are essential parts of the continuous iterative development of programmes and projects, and interventions within them, of monitoring training processes and experimental interventions, and of evaluations. Ongoing data collection, analysis, and feedback serve two main purposes: shortening the initial development period and allowing implementation to start at the earliest time possible, even within three to four months; and offering the flexibility required to adapt the programme in response to the dynamic changes that constantly occur in the living conditions and sociocultural circumstances of migrant populations.

It is also important to collect and analyse data about the prevalence, incidence, patterns, and routes of HIV transmission in the immigrant population. These can be distinctly different from those of the host population and reflect various aspects, or combinations of aspects, of the sociocultural uniqueness of the immigrant situation. The contributions of these distinct factors to the differences between the immigrant and host populations must be considered in the development of HIV/AIDS policies and strategies. Cultural differences that influence transmission routes could include marriage or sexual liaison patterns or sexual practices. Parenteral transmission routes could be rooted in cultural traditions and rites, or in alternative medicine. Examples of the differences stemming from the immigrant situation are diverse, and may include exploitation or participation of immigrants in the sex industry, low socioeconomic status, and less access to the health system, which may influence patterns of transmission through alternative medicine practices.

Population characteristics

The following characteristics of the population should serve as the focus for the collection of pertinent information to support the case for action, the initial formulation of the programme, the selection of the target population, and the primary development of projects, their interventions, and their messages.

- ❖ **Health status.** This includes HIV/AIDS prevalence and incidence as well as main modes of transmission. Other epidemiological and clinical facts, including prevalence of other sexually transmitted diseases and tuberculosis, are also required.
- ❖ **Risk behaviour.** Risk behaviours can include sexual behaviour, intravenous drug use, and skin-piercing practices. Identifying the magnitude of risk behaviour and the groups that it affects is crucial. In addition to the more recognized practices that are established as risk factors for HIV, every culture may have additional practices that can increase the risk of infection. These can include sexual practices such as heterosexual anal intercourse as means of contraception or preservation of virginity, dry intercourse, bloodletting by healers with the use of traditional tools, and uvulectomy.
- ❖ **Attitudes, beliefs, and practices.** What is the prevalent health model – traditional or modern, or a combination. What are the specific characteristics of such models that may promote or hinder risk reduction efforts and caring for people with HIV/AIDS?
- ❖ **Legal status.** The legal status of immigrants in the host country may influence their vulnerability and their contacts with prevention and care projects. Immigrants usually have less access than the general population to the health system. This may increase their use of alternative medicine practices – which, in turn, increases the risk of HIV transmission – and reduce the likelihood of medical follow-up of people with HIV and symptomatic patients. Also, immigrants who reside in a country illegally or semi-legally may avoid any contact with programmes or projects, as these may expose them. Sometimes the legal status of temporary residents given to immigrants allows for deportation of people with HIV, which may impose an additional barrier to prevention efforts.
- ❖ **Motives for migration and period of migration.** A great difference exists between immigrant communities, depending on whether people fled from their country because of political, ethnic, or religious persecution, or chose to migrate for economic reasons. For example, if men migrate for better jobs, they sometimes do so without their families, a fact that has implications for their social behaviour. Many of the immigrants to Israel chose to migrate for ideological or religious reasons.
- ❖ **Demographic characteristics of the target population.** Any information on the demographic composition of the immigrant population could be essential for evaluating their vulnerability to HIV transmission. Age, gender, and marital status are the primary variables to be considered. For example, if the proportion of children and young people in the population is high, they should be targeted separately; if most of the migrants are single men, the risk for HIV increases. The study of marital status may be problematic, as the term may be culturally specific (see Box 2).

Box 2: Marital status

The recorded status “unmarried” can vividly illustrate the complications of cross-cultural communications. Many of the young men and women among Ethiopian immigrants to Israel, while legally unmarried, are “promised.” This was a highly binding status among the Jews in Ethiopia and was usually consummated in marriage when the girl reached puberty. The postponement of marriage, in conditions of relatively low social control, exposed young men and women to situations that many of them were not ready to handle.

Also, out of respect for the religious tradition of the community, most of the youth and young adults were sent to religious boarding schools for vocational training, language learning, and cultural orientation. These were gender segregated and not geared to deal with married couples. Moreover, the schools together with the community decided not to separate families. Therefore, one of the conditions of acceptance into the programme was that the candidate be unmarried. This tempted quite a few immigrants to declare themselves unmarried, especially when they did not arrive in Israel with their husband or wife. ■

Similarly, the education level or literacy rate could determine immigrants' previous exposure to various channels of prevention messages and appropriate future methods for development of the programme. The education level in the population is also connected to the pace of mastering the language of the new country, and the readiness of the immigrants to communicate with members of the host country. For example, immigrants to Israel from the former USSR who were well-educated professionals (intelligentsia) found it especially difficult to communicate in a language that they did not master well. Health professionals reported that these people rarely asked questions, made comments, or volunteered information.

Other important demographic data should be collected, including information on religion and religiosity, living conditions, geographic distribution, and housing arrangements. It is important that the collection of statistic facts be supplemented by an understanding of the meaning of these facts for the population. For instance, does being married mean that no sex with another person is accepted, or is it common and culturally normative to have sex outside marriage?

❖ **Social position within the host society and social changes resulting from the immigration.** A review of the status of migrant populations in the new country must be carried out (e.g., their socioeconomic status, work opportunities, and degree of assimilation, and the presence of stigmatization). Inappropriate job opportunities or employment in mainly low-income jobs because of either low level of education or unfamiliarity with the language could place immigrants at low socioeconomic levels. Even immigrants with high educational levels may experience a downward occupational drift because of differences in professional knowledge and technology between the country of origin and the new country, and licence limitations (as has been the case with immigrant health professionals from eastern European countries in Western countries). This situation is likely to cause stress, and can sometimes lead to risk-taking in order to increase income and to better social position (e.g., exploitation or participation of immigrants in the sex industry).

Immigration may also result in changes of authority within the immigrant community. For example, elderly immigrants coming from traditional societies find it most difficult to adjust to the new country and so slowly lose their social power. A role reversal sometimes occurs when young children help their parents in their contacts with institutions and then find it difficult to be submissive at home.

Methods for data collection

At various stages of a project, similar data collection methods may serve different purposes. Some methods are more appropriate at the initial development stages, while others are more appropriate for later stages, monitoring, and evaluation.

Methods of data collection and analysis should be diverse. It is recommended that developers and implementers of programmes for immigrants use at least four different methods of data collection, preferably more. Data collection can be overlapping and complementary; data collected using various methods may even be ambivalent or seemingly contradictory. Sources of information may also be diverse: professional literature, general knowledge, or governmental publications regarding legal, social, and medical facts; professionals or volunteers from governmental or non-governmental organizations working with the population or in HIV transmission prevention; key members, professionals, or "regular" persons from the target population.

Box 3 and Tables 1 and 2 (pages 12 and 13) list several data collection methods that could be used at various stages of project development and implementation. These are standard methods, which are described in many methodological textbooks. The following subsection offers short descriptions that emphasize the specific demands of data collection for migrant populations.

Box 3: Methods of data collection

- Literature review
- On-site observations
- Non-structured and semi-structured interviews
- Focus groups
- Training activities designed for review of project materials by immigrant professionals in training and proposals for developing new materials/interventions
- Structured observations of project activities
- Reports on the implementation of activities
- Questionnaires
- Structured interviews. ■

□ Literature review

The literature review is an important component of data collection in the formulation stage. Several different types of literature need to be reviewed:

- ◆ Relevant epidemiological, social, cultural, and educational data from the country of origin of the immigrants. For example, in our work we used such resources on the immigrants from Ethiopia and the former USSR. This information should be used with the understanding that the sociocultural situation of an immigrant population in the host country is different than in the country of origin.
- ◆ Data from other host countries in which migrants from the target populations reside. Because of the difference in situation, context, and culture, the use of such data is limited to looking for similarities in the ways other cultures view this group, gaining a different perspective on its uniqueness.
- ◆ General studies, guides, and manuals on HIV/AIDS prevention and care, which may include recommendations and methods on cross-cultural aspects of HIV/AIDS prevention.
- ◆ Studies on the immigrant populations in the host country. These are important because they represent the issue of cultural transitions and cross-cultural interactions unique to the combination of both the host country and immigrants, and the interactions between them. The previously collected materials could be of a basic research nature in the fields of anthropology, sociology, psychology, or health. They need not be limited to the field of HIV/AIDS. Related areas include infectious diseases, sexuality, sexual and reproductive health, adolescence, and immigration.
- ◆ Studies on the theory of cross-cultural relations and of their application in the development of interventions to promote cross-cultural sensitivity and competence.

Other areas that need to be covered include theories of health behaviour and health education; the development of interventions to reduce the risk of HIV transmission, especially those dealing with theory-based development; and sexual health and sex education.

□ On-site observations

In this anthropological method, researchers introduce themselves to a community and talk to its members about a wide range of subjects, which may include topics of specific interest to the community. If the opportunity arises, the researchers could introduce the issue of migration into the discussion and collect valuable information. This method should be used during the initial development process to identify not only culturally specific factors that may determine routes of transmission or barriers to prevention, but also cultural themes that can be utilized for interventions. In some cases, the inclusion of this method could be too time-consuming, and programmes should, if possible, use

existing data. For example, many of the initial data in the information and education project for immigrants from Ethiopia were based on observations made in the course of developing a programme for the prevention of hepatitis B transmission within this community (Chemtob et al. 1991). Because the modes of transmission are similar, the findings could be transferred to the HIV/AIDS field and the information could be used to develop ideas about culturally appropriate methods for a programme for HIV transmission prevention.

□ Non-structured and semi-structured interviews

Interviews could be used at various stages of project development and implementation for the identification of prevention themes, of strengths and weaknesses of interventions, and of specific barriers to prevention, for the development of messages, and for process evaluation. The difference between the two types of interviews is in the degree of direction that the interviewer provides. In a non-structured interview, the interviewee has maximum control over the selection of topics of discussion and their depth and the juxtaposition of the subjects, within the general area of the interview as selected by the interviewer. The interviewer's role is deliberately limited to introducing the area in a preferably neutral manner and asking probing questions. The non-structured interview complements mainly on-site observations and is applicable in the earliest stages of collecting the basic data for the development of a programme or project.

Box 4: Sample semi-structured interview for trainees

Interviews about HIV/AIDS and sexual issues with Ethiopian immigrants to be trained as educators/facilitators.

AIDS

1. What do people say about AIDS? The reasons or explanations they give for the way they think. The feelings that people express about AIDS and the people who have it.
2. What do people think/say about how you get AIDS and about how it is passed on?
3. How can a person know if he or she has HIV/AIDS?

Sexually transmitted diseases

1. The explanations that people give about getting specific sexually transmitted diseases (e.g., gonorrhoea).
2. The issues of sexual relations with people who have sexually transmitted diseases and the way that these people have to behave.

Sexual relations

1. The differences between Ethiopia and Israel in the relations between men and women and in sexual relations.
2. What people feel and think about the differences.
3. The ways people cope with the differences (e.g., the difference in the age of marriage and the arrangement of matches; the ways they manage without parents to arrange marriages).
4. Definitions of "manhood", "man." The meaning of being a man in relation between a man and a woman.
5. The definitions and descriptions of "woman," "womanhood," and a "good woman."
6. Times, contexts, and arrangements in which people have sex. What is not permitted and the way people transgress.
7. What happens to a woman who is 18–20 years old? How do people feel about what happens?
8. Who can have sex? Who cannot have sex? With whom?
9. Widowhood and divorce in relations to sex and "arrangements."
10. The ways men and women signal to each other about their wish to have sex or their refusal to do so beside saying it explicitly.

Procreation

1. When does a woman become pregnant? How many times do you have to have sex in order to become pregnant (to make a woman pregnant)?
2. When do people have a new family? What happens to the old family? When does a man have another wife? ■

In a semi-structured interview, the interviewer prepares a list of content areas in which the development team is interested. This list is used as a general guide and a checklist against which the interview is monitored. The example provided in Box 4 demonstrates its use in the early stages of the development of a project, while Box 5 demonstrates its use at a later stage, the second and third cycles of an iterative development, when the interviewees have already been exposed to an intervention programme or to parts thereof. The interviewers may also prepare a set of questions, episodes, or other means by which they can elicit information in the desired areas. The advantages of semi-structured interviews for the development of intervention programmes are numerous. First, they are open enough to elicit needed cultural information, but they still focus on areas with higher probability of applicable information without being restricted by assumptions. Second, the analysis of their results, while using predetermined categories, has a built-in flexibility that allows the recognition of new categories and relationships.

Box 5: Semi-structured interview for a migrant youth population

Content areas for interviewing migrant youth in a sexual health educational programme

It is suggested that the following domains be included in every interview:

1. Attitudes and opinions about sexuality; men, women, and the relationships between them
2. Responses to the intervention programme on sexual health (for the purpose of ongoing development).

This could be achieved without unnecessarily prolonging the interview (more than one and a half hours) by focusing on only two or three of the areas of the first domain and building the questions about the educational programme around these responses. The items need not relate to the same topics but rather can be used as entry points to the subjects of the intervention programme. The choice of areas could be planned in advance or decided during the interview. In planning a set of interviews, care must be taken to cover a variety of content areas, keeping some overlap between different interviews.

Attitudes and opinions about sexuality; men, women, and the relationships between the genders

- (a) Couple formation and couple relations (intimacy in relationships).
- (b) Typology of men and women according to their sexuality and relations between the genders (good–bad, desirable–undesirable, successful, respectable, etc.).
- (c) Currently important matters for young men and women (similarities and differences, priorities in relationships, life plans).
- (d) Sexual relations and their implications (including sexual intercourse within relationships and casual sex; differences between reported and practised norms and behaviour).
- (e) Perceptions of Israeli reality in these areas and interpretations of this.
- (f) Birth control and contraceptives (including differences between contraception and preventive measures against sexually transmitted diseases and HIV transmission; differences for men and women; motivations and barriers to the use of contraception and to specific contraceptives, with an emphasis on condoms).
- (g) Pregnancy and its implications (including unplanned pregnancy, pregnancy in marriage, pregnancy termination, etc.).
- (h) Sexual health; sexually transmitted diseases and HIV/AIDS: attitudes, risks, transmission, and prevention.
- (i) Changes in the attitudes and behaviours of your gender and the opposite one in your ethnic group since your immigration. How do the changes affect you; how do you feel about them; how do you deal with them?
- (j) For women: your attitudes towards and feelings about men; the way you deal with men in different circumstances and contexts; what women believe men think about women and want from them.
For men: what happened to Ethiopian women in Israel; how does this affect both genders, what are the changes in women's behaviour towards men here?
- (k) If new immigrants were to arrive from Ethiopia, and you were to meet them at the airport, or if they were joining your vocational training or absorption centre, what would be the most important thing for you to tell them about life in Israel regarding men and women?

Responses to the sexual health education programme

- (a) How do you feel about this programme? What was good (beneficial, comfortable) about it? What wasn't good (disturbing, difficult, embarrassing) about it?
- (b) What was the most important thing in this programme? What was least important? If it were necessary to shorten the programme because of time or budget constraints, what items would you choose to retain? What parts would you advise the people responsible for running the programme to dispense with? Would the advice about retaining and dispensing with parts be the same if the programme were for groups of your own gender or the opposite one?
- (c) What subjects were difficult to learn from the programme and could benefit from strengthening or changing methods?
- (d) Which subjects would you recommend not to teach/present to groups of your own gender (the opposite gender)?
- (e) Which methods of presentation/instruction/communication did you enjoy most? Least? (e.g., discussion, group activities, teaching with or without slides and overhead transparencies, movies).
- (f) In your opinion, is it advisable to conduct such a programme for men and women together or separately? ■

□ Focus groups

In focus groups, information can be collected at both the initial development stages and in response to interventions at the implementation stages. In such a group, members of the target group are asked to discuss a specific subject relevant to the project or intervention. The data collector takes notes on the responses. The data could include a range of opinions, attitudes, and reactions expressed within a relatively homogeneous group in response to an identical cue. The observation of the dynamic of interactions between the participants of the group could provide additional valuable information.

□ Training activities for members of immigrant communities

During courses at which members of the immigrant population are trained to implement activities, important information could be collected. Such information consists of the response of the trainees to the activities or messages that are proposed for the project (see Box 6). Training courses for members of the target group constitute a special form of focus group that allows the trainees to respond to the proposed material from the view of a future intervener and, by amending it, to adapt the course to their specific needs and level of confidence. Their cultural insight and reactions provide them as well as the trainers with a much better understanding of the response of the target audience to the proposed activities, messages, or educational instruments. Data gathering is done in small working groups and in interaction with representatives of the project development team, whose members act as facilitators.

Box 6: Responding to fear and shunning in a training session

Taped situation

Friends discuss over coffee the fact that a next-door neighbour is ill with AIDS. A woman states her fear, the fact that she would not go into this apartment, that she does not allow her children to play with the children of that woman, and that she wants her evicted from the building.

Process: The activity form and taped situation are introduced. The participants are asked to write their responses individually, during the presentation of the tape and immediately after it. After the participants record their responses on the form, they are discussed in small groups with facilitators and the outcome reported to the whole group. At the end of the intervention, the (anonymous) forms are collected for analysis.

Comments: The training objective and the data collection objectives are intertwined. We wanted to gain a better understanding of the factors affecting fear and promoting shunning of people with HIV/AIDS within the community, a phenomenon that was reported widely. Assuming that our trainees had very similar responses, we aimed at allowing them to air and explore their own feelings and response. The next objective was to look with them for ways of dealing with their emotions and of helping others to do so.

Activity form

This tape holds an authentic conversation of friends meeting over a coffee, when the talk turns to the topic of AIDS.

- (a) Listen to the tape and, while you listen, make notes of the thoughts, feelings, and responses that the talk arouses in you.
Thoughts:
Feelings:
Other responses:
- (b) What would you say or do if you were the neighbour of the woman who was infected with the AIDS virus?
- (c) As an educator delivering information on AIDS prevention, what would you advise regarding behaviour towards the woman infected with HIV? ■

□ Structured observations of project activities

Structured observations of programme or project activities could provide valuable information for development and training as well as for monitoring and evaluation purposes (see Boxes 7 and 8). Data collection could be done by trained observers who do not participate in the implementation of the activity but who are familiar with the basic premises of the programme or project and its methodology.

Structured observations could result in identifying problems that need to be attended to and difficulties facing interveners and in refining or amending interventions. One of the great advantages of such observations is that as they are carried out by people who are familiar with the project and who participated in planning and debriefing sessions. They can feed back their information relatively quickly into the system. Such observations are especially useful at the stages of training and experimental implementation of projects.

Box 7: Review of posters

Immigrant professionals being trained as educators were asked to review posters, using this form. It may be used individually or in small groups.

Visual Aid Review Form

Poster no.: _____

- What subject would you use this poster for?
- What do you like about this poster?
- What do you dislike about this poster?
- What would you change?
- In what way would you like to change it?
- Are there things that need to be added?
- Are there things that need to be removed/erased? ■

The observers may be members of the immigrant population or of the host community, who may not even understand the language. They look for the responses of the participants to the processes and content of the interventions, whether they are training sessions or implementation of education or counselling sessions. It is not only the content of the responses that is noted, although this may be very important, but also the emotional and attitudinal responses and the interactions among the participants. Variations in responses and respondents are also important – for example, whether men and women, young and old, respond differently to specific stimuli. Several important insights can be gained from observing the facial and body responses to the verbal and visual messages, the interactions between the facilitator and the audience, and the level and tone of the verbal comments.

Box 8: Guidelines for observation of training sessions

Number of participants: _____

In lectures/group interactions of all types

1. Describe the means and strategies used by the lecturers to involve the participants and the degree of persistence and effectiveness of these means.
2. Describe the dynamics of interaction among participants, and between them and the instructor (e.g., discussions taking place within the group; discussions among participants, taking place apart from the group; persons expressing uneasiness by not joining, or by their non-verbal communication, such as facial expressions, avoiding eye contact, and withdrawal from the group circle).
3. Identify, from the questions and answers, elements that are important for the participants' understanding of, or their failure to understand, the content. Are there difficult elements that are repeated? Also identify from the responses of the trainees successful strategies and interactions.

In interactive workshops

4. Describe the degree of interaction and cooperation in fulfilment of tasks within the small groups (general involvement or individuals who lead the rest).

In demonstration workshops (information models)

5. Describe the degree of willingness by the participants regarding fulfilment of tasks, degree of knowledge, fluency, and confidence shown by the demonstrator (give name). Describe the responses of other participants to each demonstrator. ■

□ Reports on the implementation of activities

This method complements the observations of the trial implementation during the training courses. It provides the subjective perspective of the intervener. Forms for self-reports should focus the attention of the implementers on two distinct areas: their own issues in implementing activities, and the response of their audience. Further directions focus their attention on strengths and barriers in working through the interventions.

□ Questionnaires

This method can be used at all stages for various purposes and with distinct formats and lengths. Questionnaires can be given to the target population at the development stage to evaluate baseline knowledge, attitudes, and behaviour in order to plan the intervention and to compare these findings with those at the outcome evaluation stage. They can also be used for process evaluation, especially in training. Their advantage is that in a group situation they are time saving and promise anonymity to the participants.

There are several constraints to their use. First they need adequate translation into the native language of the immigrants and adaptation to their culture. Second, their use is recommended only for populations with high literacy rates. Third, they are recommended only in conditions where close monitoring is possible (i.e., in group situations) to avoid response bias such as social desirability or fear of stigmatization. Fourth, many immigrant communities, especially those coming from less democratic societies, are wary of questionnaires and distrust the promise of anonymity.

□ Structured interviews

Structured interviews are most useful for collection of baseline data from the target population and for outcome evaluations. During structured interviews, the interviewer uses formats similar to those of questionnaires. Due to the sensitive nature of subjects related to HIV/AIDS in working with migrant populations, this method has a number of advantages over questionnaires. Structured interviews provide opportunities to:

- ◆ build trust and alleviate suspicion during the interview
- ◆ enhance valid and reliable answers
- ◆ elicit more detailed explanations to difficult questions
- ◆ respond to unforeseen reactions to the questions in the interview
- ◆ provide HIV/AIDS-related information.

Some points of caution are important:

- ◆ This method is more expensive than the use of questionnaires and, therefore, requires sufficient funding.
- ◆ It requires careful training of the interviewers to avoid the possibility of them influencing the interviewees and to reduce response biases such as social desirability to a minimum.
- ◆ In small immigrant populations with close social ties, the interviewers may find that they have to interview their own acquaintances or relatives.
- ◆ In many traditional societies, only same-gender interviewers are acceptable. It may also be difficult to interview couples without the presence of the other partner.
- ◆ The quality of data may sometimes suffer because it is not always possible to find qualified people from the immigrant population to work as interviewers and they themselves have difficulties working with structured formats.
- ◆ Often, the interveners may be the only available trained personnel who must also carry out the data collection. The combination of the two roles may affect the quality of data through reduced objectivity.

Involving community leaders

The importance of involving the leadership and organizations of the immigrant community in the development of policies and strategies cannot be stressed often enough. Their involvement is in itself an intervention strategy that needs to be carefully planned and, at a later stage, examined. The support of the formal and informal leadership of the community during policy and strategy development as well as during development and implementation of interventions is essential to the success of programmes and projects.

It is not recommended that the development and implementation of interventions be delegated to the leadership or to teams composed only of the immigrant group. An alliance and true cooperation between the migrant population and the host community need to be created. The reasons for this include:

- ◆ The immigrant population is in a cross-cultural situation, which requires the inclusion of developers and implementers from the host culture as much as those from within the immigrant group.
- ◆ Preventive interventions for the migrant population have to deal with bridging gaps and mediating between the migrant population and the host population and segments within it (such as education and health professionals, who deal with the migrants in close proximity).

It is, therefore, important not only to identify leadership and interest groups within the migrant population, but also to create links with professional and interest groups within the host population. Representatives of the immigrant community leadership should be included in steering committees for specific projects, and professionals from the immigrant community should be included in the development and implementation teams.

During the development of policies, it is important to consult and negotiate with leaders of a wide range of groups, which represent the various opinions and interests within the immigrant community. Those members of the group who are ready to take responsibility for the implementation of activities or addressing the issue of the development and implementation of the interventions in public should be linked with each other.

The needs of immigrants with HIV/AIDS

Due to the additional burdens imposed by their life in the host society, immigrant people with HIV are usually in a much worse situation than those in the host community. Thus, health care for immigrant people with HIV might need to be more interdisciplinary than usual, including psychosocial and cultural issues in the services. Such issues, if not understood, can become obstacles to maintaining continuous relationships with health centres, thus resulting in neglect and deterioration of health status. The issue of stigmatization becomes a greater issue than for the rest of the immigrant populations because people with HIV/AIDS tend to be more isolated than others. This situation may be aggravated when the stigma of AIDS is great within the immigrant population. The role of mediators who are members of the community is very important for enhancing communication between the health and other welfare systems and people with HIV, their partners, and families. Many health centres recognize that they need the help of people from within the community in their interactions with patients. But they often opt for the most convenient solution, that of employing “someone” – and not always the same person on a permanent basis – as a translator. There is an important distinction between translators and mediators. The latter act not only in translating the language but in bridging the cultural gap between the personnel of the host society and the immigrants by explaining to each side the meaning of what is being said.

Thus, in projects for people with HIV/AIDS, it is recommended that the following points be considered:

- ◆ Recruitment and training of cultural mediators should be done as soon as HIV

infections within an immigrant population are discovered. Maintaining good relationships from the outset is easier than reconnecting with frustrated and angry people.

- ◆ A project should be started only when there are skilled people from the immigrant community who can be trained to work as mediators. Although professionals (e.g., registered or practical nurses, social workers, paramedics) are preferred, if they are not available others may be employed after being sufficiently trained.
- ◆ Even if people with HIV have been living in the new country for a while and have a basic knowledge of the language, it is better to involve a mediator to overcome cultural barriers. One should, however, be cautious of the possibility that immigrants may prefer to avoid any contact with people from their own community for fear of stigmatization. The advantages of working with a mediator should be explained to them, but patients should be given the option of not involving a mediator, especially if contacts to the medical service centre have to be maintained.
- ◆ The main role of mediators is to establish communication between people of two different cultures. Beyond their general cultural understanding, their ability to mediate will be enhanced if they know members of the community. Therefore, it is recommended that the mediators be appointed to work also as case managers of people living with HIV/AIDS and have a broad role in identifying problems and referring them to the appropriate service.
- ◆ Because of the relative isolation of people with HIV in the immigrant community, and their reluctance to come for regular follow-up visits, mediators have to be much more active in reaching out to people than is usually done in the host community. Therefore, it is recommended that the mediators be placed at a community health service and not at an HIV clinic. This would serve two purposes. First, mediators may have better access than health service personnel to people living with HIV/AIDS and could be more familiar with the various community services. Second, mediators would not be identified as workers in the HIV clinic, even if they accompanied a patient for medical visits. Thus, when they go on home visits, the neighbours cannot guess the purpose of the visit, and therefore potential stigmatization can be avoided.
- ◆ Having case managers for the immigrants does not imply that the multidisciplinary care as provided by an HIV clinic to all other people living with HIV/AIDS from the host country is transferred to the community. Rather, the case managers become a means to enhance care and work as a liaison. They do not substitute for other professionals.

Training programmes: data collection and developing interventions

The goals and general objectives of the training programme can be summarized as follows: teaching essential and relevant knowledge, developing appropriate attitudes and professional skills according to the goals and objectives of the specific projects, and continuously supervising, monitoring, and developing the performance of the trainees. In working with immigrant populations, trainees must have skills in cultural sensitivity and cross-cultural competence as well as extensive knowledge of HIV/AIDS. Additional goals and objectives do not supplant those of professional development, but are integrated with them. They constitute mainly the continuing gathering of relevant information and the testing of messages, their channels of delivery, and modes of interventions. The trainees also have an active collaborative role in the future iterative cycles of amending and developing project activities.

To achieve these goals, several principles and methods of training were integrated with specific modes of data collection and analysis as delineated earlier in this section. As many of these modes as possible should be used, especially multipurpose instruments

that are designed for the purpose of training as well as of eliciting data. The training period should be designed to include field experience and trial implementation of interventions, combined with supervision. In some cases, there is the need for continuous training and development throughout the whole period of the project.

Basic information about sexuality and sexual development (including HIV/AIDS and contraceptives) and immigration is included within the initial steps of the training course, and is presented in an interactive format. The next stage usually includes additional information on topics more specific to the project, such as sexuality, adolescence, stages of behavioural change, basic teaching skills, and health and welfare services. These are usually taught by the same methods that the trainees have to develop, thus exposing them to teaching methods and skills. The trainees start to practise their teaching skills with their colleagues in simulation activities and then move on to supervised fieldwork, concomitant with continuing training. At this stage, the training sessions focus on supporting trainees in overcoming difficulties and building confidence in their teaching skills. Additional development in cross-cultural understanding and competence is achieved through their participation in the development and testing of channels for message transmission, educational interventions, and materials. Detailed descriptions of the components of a training programme and its structure are summarized in Boxes 9 and 10.

Box 9: Elements of a facilitators' training programme on sexual health for adolescents

1. Topics in adolescence, sexuality, and sexual behaviour, from a multidimensional perspective (psychosocial, personal, interpersonal, peer group, and societal).
2. Topics in immigration, adolescents' family interactions and how these are affected by immigration, and the culture of the immigrants from Ethiopia and the former USSR.
3. Encountering the sexuality of youth and the interaction among them on sexual contents (including the wide range of variations within and between groups).
4. Re-experiencing and reframing cultural transition and cross-cultural interactions (for both immigrant and veteran facilitators).
5. Principles of sex education and their implementation.
6. Principles, methodology, and implementation of cross-cultural educational work aimed at gaining insight into difficulties and coping with them, bridging cultural gaps, and facilitating cross-cultural communications.
7. Experiencing educational interventions adapted to the aims of the programme: working on sexual health and responsibility, learning to cope with the effects of cultural transition and cross-cultural encounters, and bridging the cultural gaps.
8. Collecting and analysing data about the response of the facilitators in training and of the youth to the types of interventions and their content.
9. Amending existing interventions and designing and implementing new ones in collaboration with the facilitators in training. ■

Box 10: Interventions, principles, and strategies

- Use experiential and participatory interventions oriented towards the common issues of immigration that have an impact on HIV/AIDS while eliciting the specific cultural content that is typical of the immigrant culture; deal directly with the cultural transition and cross-cultural encounters.
- Use interventions that allow the participants, educators, and facilitators to elicit and include the culturally specific content of each immigrant community. Such interventions are also adaptable to groups of different demographic characteristics or different levels of homogeneity.
- Employ culturally specific messages and traditional modes of message transmission.
- Employ professionals from the immigrant population as implementers.
- Assign to immigrant professionals the roles of implementer, informant, and collaborator in developing the projects and interventions and their strategies. ■

Trial field implementation: iterative project development

In addition to shortening the development period, initiating trial field implementation at an early stage of a project as an integral part of the training of interveners (as early as a quarter but usually a third to half of the way through the training programme) serves several cyclical purposes. First, it gives the interveners a chance to experience and try out their acquired knowledge, skills, and intervention strategies while still being able to further develop them under supervision, thus adding to their sense of security and competence. Second, it allows the developers to test the proposed interventions in “real-life” conditions and discover the strengths, weaknesses, and constraints imposed by the methodology. It takes the development one step further than the approximate conditions of collecting the responses of the educators after exposing them to the interventions in training. Adding data collection and feeding it back into developmental cycles at this formative stage provide another dimension to the training of the interveners, reframing their task definition and further augmenting their self-image and commitment. Third, it enables the development team, now strengthened by the interveners in training, an examination of the wider picture of the project beyond the separate interventions. They may notice missing parts and have a chance to review main messages, channels of communications, and methodology at an early stage, when amendments are possible and feasible. Fourth, it adds the target population as a different group of reviewers, who have different perspectives and interests. Both the interveners and the audience are the desired participants of participatory research (Cornwall & Jewkes, 1995) and the end criterion in formative research (Mathews et al., 1995). Involving them at this early stage also, in a sense, adds quality control at the start.

Sometimes only going through field trial in parallel with the training and as part of the development cycles will combine all of the above to give the desired results. Such was the case in developing strategies to introduce posters detailing condom use to an audience of Ethiopian immigrants under the project *Your Life Is in Your Own Hands* (see Box 7). In the development of these posters, there were three cycles of amendments: first with the project development team and then with the educators in training (see Box 12, which shows a sample questionnaire to determine participants’ reactions to the posters). But only observations of field trials and self-reports of the educators who presented them revealed continuing difficulties with the two posters detailing the use of condoms. One more cycle was conducted, composed of two separate activities during the continuing training and supervision component, which ran parallel to the field trial implementation.

These cycles were not dedicated to amending the posters, which were central to risk-reduction strategies in the community. Rather, they were dedicated to developing strategies that would make it possible for the educators to present the posters and to reduce the level of embarrassment of the audience viewing them. The difficulties were analysed until the group of professionals from the host and immigrant cultures (this time including the educators in training) could come up with detailed descriptions and a typology of the difficulties.

The immigrant educators expressed strong concerns about the uneasiness that the posters elicited in their audience. While these could have been projections of their own embarrassment, observations confirmed that the educators are highly attuned to the emotions expressed by the audience. They were a very good resource not only for understanding the difficulties but also for finding alternative ways to cope with them. These strategies were explored in a later activity, the results of which are given in Box 11. When new waves of immigrants arrived between 1996 and 1998, new posters were developed in order to avoid uneasiness and embarrassment among the audience. The drawings on the new posters were not so realistic and did not depict women.

Box 11: Means suggested by trainees to increase the acceptance of posters detailing condom use

1. The educator apologizes for the crudeness of the drawings and admits their impropriety but justifies their use by citing the grave danger the audience is already aware of.
2. Combine 1 with the educator asking the permission of the audience to use the posters (especially the permission of the elders, who could be people above 40-45). A variation of this method is that people who feel embarrassed are given permission not to look or to leave the room (if the condom presentation is at the end of the activity).
3. The educator shows a later poster in the series, the one detailing a couple speaking to a physician, prior to presenting the posters on condom use and then bases showing these drawings on the advice of the physician.
4. The educator orally explains condom use without demonstrating it. If this elicits confusion from the audience, the educator admits to the availability of the posters but expresses reluctance to use them unless the audience requests it and feels that they can cope with the embarrassing visual presentation. ■

Box 12: Essential elements of a training programme

1. Structure a training programme to integrate the professional development objectives with the data gathering and project development objectives.
2. Recognize the central elements of the training process: professional development, experiential-participatory methods, utilization of field experience, and the learning group as a supportive environment.
3. Design and implement multipurpose training activities that, in conjunction with the professional training, are also aimed at gathering relevant data for the further development and evaluation of the programme.
4. Design and implement activities and interventions that are structured to recruit the trainees as partners in the further development and amendment of the programme.
5. Constantly monitor and evaluate the training process and its outcome. Use the gathered information for further training and for supervision sessions. The evaluation should include changes in HIV-related knowledge and attitudes as well as in educational skills and efficacy. Several methods of monitoring and evaluation should be employed. ■

Monitoring and evaluation: continuous parallel processes

This section does not aim to repeat general guidelines for monitoring and evaluation of HIV/AIDS prevention programmes, which have been published elsewhere (e.g., Patton, 1987; WHO, 1989; Paccaud, Vader & Gutzwiller, 1992; Cole et al., 1995), but to highlight their features for HIV education for immigrant populations and their integration with iterative development cycles. It is, however, important to clarify the terminology. Monitoring and process evaluation examine the operation and quality of activities and usually take place during the course of the project. Outcome (also termed effectiveness) evaluation examines the effect of the programme in relation to its objectives and usually takes place at the completion of the programme (Cole et al., 1995). Monitoring and evaluation are sequential steps only in principle: in reality they are parallel. In programmes for immigrant populations it is recommended that they be designed as parallel steps with ongoing feedback in the iterative process.

There are several obstacles to evaluative methods for projects with immigrant populations:

- ◆ It is difficult to find evaluation methods that will accurately measure changes in behaviour in every culture, and especially in traditional societies that refrain from talking about sexual practices. The evaluations may thus tend to concentrate more on process evaluation such as the assessment of dissemination of information, or outcome evaluation of knowledge and beliefs, and to a lesser degree on behavioural change.
- ◆ Other factors, external to the programme, influence trends in behaviour and are very difficult to study. The pace of changes in immigrants' lives is sometimes so rapid

that they can adjust to no further modifications. Many frequently move from one place to another in search of employment or housing. The result might be difficulties maintaining steady relationships. Those who are HIV-positive may have difficulty keeping medical follow-up appointments or may avoid transfer to another clinic for fear of exposure to more people. Media coverage linking the immigrant community with HIV/AIDS may aggravate feelings of stigmatization or discrimination and may initiate or aggravate defensive responses such as denial or projection. One may encounter statements like “They [the health care system or the host society at large] invent this story in order to discriminate against us.” People living with HIV/AIDS may lose their trust in health care personnel and refuse to come for check-ups, or may even deny that they are seropositive or that they have to use condoms. Such situations may be aggravated by statements such as “Your blood tests are OK,” which may mean totally different things to health personnel and people with HIV. The latter may be unfamiliar with both the language and the biomedical model used by health professionals.

- ◆ It is difficult to maintain collection of data at regular time periods because the immigrants are mobile and cannot always be located, especially if they are clandestine migrants fearing deportation. They may also refuse to cooperate after the first interview if they perceive the topics to be too intimate. The establishment of an appropriate follow-up period sufficient to observe changes as a result of a programme is always difficult, but more so with immigrants because of other influences and changes.
- ◆ An extensive evaluation of the effectiveness of a programme requires expert personnel and considerable amounts of time and funds. Process evaluation may be less expensive, simpler, and possible to achieve, yet modest outcome evaluations can be carefully selected.
- ◆ Sometimes external factors, like the allocation of funds or the timing when funds are made available, can determine the mode of evaluation.

Following are some examples of the ways in which various data collection methods detailed in previous sections could be used for monitoring and evaluation purposes. It is recommended that several methods be used in order to receive information from diverse sources and from different perspectives. One of the reasons is the difficulty in eliciting information from some immigrant populations.

Monitoring the training, the responses to materials, and the implementation should provide information about how and to what extent the activities of the project are being carried out and identify causes of success or failure. Methods include:

- ◆ observations of the training sessions and interventions
- ◆ self-report by the trainees of trial field implementation
- ◆ monitoring reports by the project coordinator
- ◆ interviews.

Monitoring the training should provide information on:

- ◆ how many people were recruited
 - ◆ how many successfully completed the training
 - ◆ what the main problems were in their approach to HIV
 - ◆ how they responded to the materials and interventions presented to them and to their trial implementation
- how many of those trained were actually assigned to the project.

Monitoring interventions should provide information on the structural elements of the implementation of the project and the target audience as well as additional information on the training and the trainees. For the project implementation, monitoring should provide information on:

- ◆ access and exposure to the programme
- ◆ the number of people attending the education sessions
- ◆ the number of lectures given and materials distributed during a period of time
- ◆ the number of home visits made to people with HIV

- ◆ the composition of the groups in terms of gender or age.
For monitoring population response, information includes:
- ◆ the reactions of and differences among various groups
- ◆ which materials worked better with which audience
- ◆ the reactions of people from outside the population to the implementation of the project.
In terms of the training and trainees, monitoring should identify:
- ◆ difficulties in implementing specific interventions or presenting some of the materials
- ◆ differences among presenters (age, gender, professional experience) and the interaction of these with the composition and circumstances of the target audience (age and gender composition in relation to the presenter's age and gender).

Evaluation of the outcomes of the training is aimed at assessing knowledge and attitude changes, by interviews or self-report questionnaires before and after the course, and assessing the building of education skills by observation and self-evaluation (see Box 13). Evaluation of the effect of the interventions on the target population may be carried out by self-report questionnaires and interviews to evaluate knowledge, attitudes, and intended or actual (if possible) behaviour changes.

Box 13: Questionnaire for monitoring trial implementation of interventions

Please complete this form for every presentation that you deliver.

1. Name of instructor: _____
2. Date of lecture: _____
3. Place of lecture: _____

Data on participants in your lectures:

4. Number of participants at lecture:
 - (a) men _____
 - (b) women _____
5. Approx. number over the age of 14: _____
6. Breakdown of participants by age (mark relevant age groups with a circle):
 - (a) 14-18
 - (b) young adults (15-40)
 - (c) older adults (over 40)
 - (d) mixed
7. For this group, this meeting was (circle your answer):
 - (a) first meeting on AIDS
 - (b) second meeting on AIDS
 - (c) third meeting on AIDS
8. During your lecture, did you use the posters we prepared?
 - (a) yes
 - (b) no
9. If yes, did you use all the posters?
 - (a) yes
 - (b) no (state which posters you didn't use and why)
10. What form of responses did the group show? (circle the nearest answer)
 - (a) they only listened and did not ask questions or make comments
 - (b) they listened and asked a few questions
 - (c) they listened, asked questions, and joined a discussion on the subject of the lecture
11. If the group was mixed men and women (or women only) what was the degree of active participation of the women?
 - (a) they were silent
 - (b) only very few spoke or asked questions
 - (c) some of them spoke and asked questions
 - (d) many of them spoke and asked questions
12. What were the main questions asked (what did they not know, and what was of interest to them)?
13. What did they say about the relationship one should have towards people with HIV, or people ill with AIDS, and the necessity of disclosing who is infected?
14. Include exceptional responses during the course of the lecture, or afterwards (such as matters they did not wish to have mentioned, expressions of anger at a particular subject, positive responses to an idea, a particular example, or any other responses). ■

These methods should be carefully adapted. For example, if anonymity is an important factor, no follow-up of the same people is possible for short- or long-term evaluation. Instead, two separate random samples may respond to the same questionnaire at different points in time. If structured interviews are used, both closed and open questionnaires can be developed for populations not accustomed to surveys. An open question like “What are the ways to contract the HIV virus?” may elicit one answer. Then the interviewer can probe, asking “What else?” a few times, until the respondent says that he or she does not know of any other ways. This may elicit all the correct modes of transmission that the person knows about as well as misperceptions.

Sensitizing the host country population

The social atmosphere around and within distinct groups can affect risk behaviour and risk reduction efforts within such groups. Hence, the importance of social interventions to change subcultures (Friedman, des Jarlais & Ward, 1994). The way HIV-positive people within an immigrant group are treated by the host community, the general immigrant population, and caregiving personnel could be important determinants of risk reduction.

The host population’s reaction to immigrants with HIV is part of their general reaction to HIV/AIDS. The migrant population is the target of attempts to counteract adverse and potentially damaging publicity. Therefore the management of adverse public reaction should be treated within the formulation of general HIV/AIDS information, communication, and publicity policies and strategies, and not as a part of the specific policy developed for the migrant population.

Following are some specific issues and recommendations that are related to the public reaction in connecting HIV/AIDS and immigrants and that need to be confronted as part of the general strategy. Adverse reactions are present in all countries and in all segments of the population. Experience shows that a sensible, consistent communication policy is essential to preventing them. An intervention programme should be ready to contain the damage if and when it arises.

Box 14 lists several strategies for communicating information to the media on issues of HIV/AIDS programmes for immigrant populations. These are easier recommended than carried out. It is especially difficult to stay low key and use rational argumentation in low tones when faced with severe cases of inflammatory publicity.

Box 14: Suggestions for dealing with the media

1. Keep information about HIV/AIDS programmes and projects for immigrants low key (although not to the extent of making them secretive).
2. Whenever called to issue statements, emphasize the relevant data and caution against misinterpreting epidemiological information.
3. Recognize reactions of fear (even when they are irrational), emphasizing controlled behaviour and the risk to public health from uncontrolled behaviour.
4. Stay with rational arguments and use a low tone when responding to incorrect or emotional communications and accusations.
5. When justifying the need for special programmes for immigrants, focus on the immigrants’ specific cultural needs and the prevention of HIV transmission among the immigrants’ subgroup, not among the general population of the host culture.
6. Identify members of press and inform them of key messages and information on the project regularly (even before being approached for questions or interviews). ■

Despite the difficulties, these are the only possible means to contain damage from adverse publicity. In many instances, they could be carried out with the help of allies within the media and the general public. It has to be pointed out that neither the media nor the general public should be viewed as opposition. On the contrary, only with the cooperation of caring and responsible members of both groups can correct and relevant data be distributed and an accepting atmosphere for prevention efforts be achieved.

Dealing with the attitudes and behaviour of professionals working with immigrant populations poses an interesting conundrum. On the one hand, they are members of the host population and may share their attitudes towards HIV/AIDS, but, on the other hand, their personal and professional responsibilities are directly related to the specific immigrant population and to difficulties in understanding their culture.

It is recommended that training opportunities be set up for professionals working as caregivers to the immigrant population and for those who work with people living with HIV/AIDS. These should focus on cultural sensitivity, competence in cross-cultural communication, and elements of the immigrants' culture that are relevant for HIV/AIDS transmission and prevention and for care for people living with HIV/AIDS.

These training programmes, although essential for conducting daily interactions, may be insufficient to answer all the needs for cross-cultural competence, especially for those professionals working with people with HIV/AIDS. Other means of responding to such needs should be considered and enacted as part of the immigrants' programme. These may take the form of cross-cultural teams in addition to employment of cross-cultural mediators. In designing such programmes, it is not enough to train immigrant professionals. It is important to sensitize host country professionals to the need for such teams or interveners and their potential functions and contributions. They should also be made aware of modes of constructive cooperation with these teams in order to effectively implement interventions. ■

Israeli programmes: Demonstrating principles of the method

Introduction

This chapter describes the variations, diversity, and complexity in practice of the principles and methodology discussed in the first two chapters. Variations are dictated by the differences in needs and conditions, and also by constraints imposed by reality. It is exactly these features of flexibility and adaptability that may make this model useful in different contexts.

The general approach is that HIV/AIDS risk reduction should be introduced through a wide range of interventions (not necessarily limited to HIV/AIDS) and integrated into as many other relevant programmes as possible. This approach was applied to the immigrant situation. Some of the instruments and interventions that were developed for these projects are included here to demonstrate principles and methods. An example is the data collection and activities that led to the development of the Language of Sex intervention. Although that project is currently part of the Gesher la' Keshet programme, the data that led to its development were collected and analysed mainly in the immigrant Russian professionals training programmes and a study of immigrants from the former USSR.

This chapter looks at four specific programmes on for youth, immigrants from Ethiopia, case managers, and sensitizing health and welfare personnel.

An educational programme for immigrant youth

In many countries, young people in general are considered to be a priority population for HIV/AIDS interventions, even if epidemiological data do not warrant this. Major social and cultural factors are involved in this appraisal. Youth are perceived as representing continuity as well as the future of collective identities. Immigrant adolescents can have a higher vulnerability to HIV/AIDS than host country youth, because of additional challenges in the relationships field resulting from their immigrant status.

Presented here is an educational programme for immigrant youth, called Gesher la' Keshet². The programme addressed HIV/AIDS risk reduction by integrating specific interventions into a comprehensive sex education programme. It focuses on issues common to immigration – cultural transitions, cultural loss, and cross-cultural encounters – while eliciting the specific cultural content unique to each immigrant group. The programme is also flexible enough to allow for work with different compositions of groups, homogeneous or heterogeneous. The rationale for developing such a programme and for dealing with HIV/AIDS through a comprehensive sex education programme, rather than through AIDS education only, is part of the presentation.

The educational project presented here is part of a programme for immigrant youth from various countries. It incorporates the experience and results of three earlier projects and represents the evolution of an educational approach that started in 1987 with an experiment in developing a programme entitled the Sexual Health Programme for Male Immigrants from Ethiopia in Residential Vocational Training Centres.

At that time, only the rudiments of methods to develop such a programme were available, and the understanding of the complexities and difficulties of immigrant youth was limited. The main concerns were cultural differences and the need for cultural sensitivity. After experience with three projects – which separately addressed immigrant youth from Ethiopia and the former USSR – a method for developing culturally sensitive,

2 Literally in Hebrew “ABridge to Relationship”

participatory sex education programmes is available, consisting of training facilitators and implementing integrated sex education programmes that also address HIV/AIDS.

Background

Alarming reports from varying sources on sexual behaviour raised concerns about potential threats to the health and welfare of immigrant youth. It was reported that immigrant youth engaged in sexual practices with little protection, increasing their risk of HIV infection.

These reports described a variety of phenomena related to sexual behaviour and sexual health. Health, education, and welfare caregivers also mentioned alarming number of requests for pregnancy terminations among immigrant youth. Some research findings (Sabatello, 1992) indicated that the rate of requests for abortions among the recent wave of immigrants from the former USSR was twice the rate of the general population. As abortions in Israel are not funded by the health services except for cases of underaged girls, rape, or health risks, there were concerns about immigrant women resorting to illegal abortions. Other findings indicated the low use of contraceptives among immigrants from the former USSR, among both youth and married couples. It was also observed that the health and educational system had difficulties relating to the needs of the immigrants. Furthermore, there were strong indications of immigrants' misperceptions of the behaviour of Israeli youth and misunderstandings of norms, boundaries, and communications.

Theoretical considerations led to the development of the concepts that immigrants were a unique group whose needs extended beyond simple aids for cultural adaptation, that immigrant adolescents and young adults were a unique group who were more vulnerable than other adolescents or immigrants, and that the issues of sexuality brought additional specificity and complexities to the development of programmes.

In summary, these considerations were:

- ◆ Adolescence and young adulthood are stages of development in which intimate and sexual relations develop. Among a significant proportion of adolescents this development process is characterized by sexual experimentation, serial monogamy or multiple partnerships, and low protective behaviour (Hein, 1988).
- ◆ In adolescence, much energy is invested in various developmental tasks (which can be highly rewarding and enriching). In some societies, adults impose a special burden on adolescents through expectations and conflicting messages (Muuss, 1982; Hurrelmann, 1989; Bronfenbrenner, 1989).
- ◆ During adolescence, peer group norms gain relative power, at least temporarily, over personal and familial norms. In many such instances, peer groups are organized around defying adult norms and authority, and engaging in risky behaviour.
- ◆ People who leave their familiar environment could undergo a crisis similar to that of adolescence. When a crisis resulting from migration is superimposed on adolescent developmental tasks, young persons experience additional stress.
- ◆ In addition to the cultural transitions resulting from migration and the crisis of adolescence, HIV/AIDS prevention targeting sexual relations could add further stress to the life of youth, because this area is sensitive and a taboo in many cultures.
- ◆ The stress resulting from adolescence, migration, and sexual relations is aggravated for immigrant adolescents who come from cultures where sexual behaviour is governed by strong social controls. Migration tends to lower these controls and disrupt traditional authority, and thus create the task of developing new controls over sexual behaviour.

Why can't HIV/AIDS education alone deliver the services?

Previous experience in the field of reproductive health with adolescents and young adults in general led to the conclusion that, even in situations of immediate risk, the longer and more comprehensive road of sex education is much more appropriate for dealing with issues of HIV/AIDS than are stop-gap AIDS education programmes (Shtarkshall & Bargai, 1987, 1989; Shtarkshall, 1994). The main arguments follow.

- ◆ In many countries, including those absorbing migrant populations, the issues of immediate relevance, importance, and concern to the majority of adolescents and young adults do not necessarily focus on HIV/AIDS. Rather, they focus on the development of intimate and sexual relations and on the risks of pregnancy and sexually transmitted diseases, which are of much higher incidence than HIV/AIDS.
- ◆ In countries with moderate and low prevalence of HIV, it is questionable whether young people can be defined as being at risk because of the prevalence of risk behaviours among them. They are, however a unique subgroup at risk in the future. Because it is questionable whether one can work with youth on issues of future relevance, it is necessary to encourage within this group the development of protective behaviour and reduce the rate of high-risk behaviour on the basis of current relevant issues (Coleman, 1989).
- ◆ The skills needed to cope with developmental issues in adolescence are similar to the ones needed for the prevention of HIV transmission. The barriers to such coping behaviour are also the same as those that impede the development of low-risk behaviour. Therefore with low additional educational investment, efforts developing general coping skills will have an impact on risk behaviour related to HIV transmission.
- ◆ Experience with immigrants and the theoretical considerations about the uniqueness of immigrant adolescents and their needs in the area of intimate and sexual relations, delineated above, only reinforce the conclusion: educational programmes dealing with the wider perspectives of intimate and sexual behaviour, with a focus on sexual health care, are the preferred choice for immigrant youth. Such programmes must also be culturally adapted and designed to cope with the unique issues of cultural transitions and cross-cultural interactions.

The development team

The programme was developed by a team that comprised people with various professional and ethnic background:

- ◆ a behavioural scientist with experience in sex education
- ◆ a sex educator, who also served as programme coordinator
- ◆ an educational counsellor specializing in sex education through group dynamics
- ◆ two immigrants from Ethiopia - a male nurse and a female social worker
- ◆ a consultant from the former USSR, who has worked on a study of immigrants from the former USSR.

Other parties important to the development process were the training facilitators: these consisted of a group of Israelis and immigrants from both Ethiopia and the former USSR who worked with immigrant youth, and another more general group of Israelis and Ethiopian immigrants. They all participated in the development of the project and added their unique perspectives to its structure and interventions.

Goals

Although the goals and objectives of the programme were much wider, the focus here is on those directly related to sexual health and particularly to the prevention of HIV transmission. The goals and objectives concerning the generalized issues of intimate and sexual relations in the cultural transition and cross-cultural encounter are expounded in the Gesher la'Keshet facilitators' manual (Shtarkshall, Shimon & Bargai, 1997). The general goal concerning sexual health was to lower the barriers to safe behaviour, focusing on those barriers resulting from immigration and developing the skills needed for preserving health in intimate and sexual relations. The objectives were:

- ◆ to enable the participants to identify and confront their personal difficulties in adopting strategies to preserve their health, including condom use, and to make them aware of possible difficulties for their partners;
- ◆ to develop interpersonal skills needed for using or requesting the use of preventive measures;

- ◆ to familiarize the participants with the appropriate help agencies and lower the barriers to seeking help;
- ◆ to cope with the stigma associated with HIV/AIDS and ethnic origin and to develop strategies other than avoidance and denial to deal with them.

All these objectives can have specific cultural and cross-cultural aspects that need to be dealt with together with the more generalized issues that are common to the population as a whole. For example, some of the barriers may be specific to the country of origin, like the difficulty immigrants from Ethiopia have with “skin-coloured” or yellowish white condoms, or the experience of immigrants from the former USSR with the thickness and low quality of condoms (a nickname for condoms there was “galoshes” – rubber boots). Cross-cultural issues may arise if partners are of mixed origins. Another difficulty that may be specific to immigrants is the heightened distrust of authorities, even helping authorities, stemming from traditions of the country of origin and the difficulties in negotiating with authorities in the new environment. In their country of origin, many immigrants from the former USSR had encountered instances of non-confidentiality within and among institutions where confidentiality is often assumed. The goals and objectives of special programmes for immigrants must address these difficulties. In addition, they must augment the goals of programmes for the general population, and not supplant them.

Cross-cultural sex education

The two methodologies that converged in the developing and implementing of the educational programme *Gesher la’Keshet* were that of interactive sex education and cross-cultural approaches. The first methodology, a developmental-humanistic approach using experiential and interactive group methods, has been the core of sex education in the national general school system in Israel (e.g., Raz & Wieseltir -Raziel, 1980; Pazi, 1987; Shtarkshall & Bargai, 1987, 1989; Smilansky, 1989; Boneh, Shtrum & Bargai, 1992). It has also been tried in unique cross-cultural situations (Shtarkshall, 1987; Appelbaum & Erez, 1990; Aliyat Hanoar, 1992). The second methodology is that of dealing with cultural transitions and cross-cultural encounters not only in unique situations but also in a generalized manner.

The integration of these two methodologies resulted in the adaptation and application of the developmental-humanistic approach in sex education to the immigrant situation in a planned manner. The focus is on the special situation and needs of immigrant populations and on cross-cultural encounters. Rather than considering the cultural issues of a specific group or of a specific encounter, the educational programmes are based on educational instruments that can elicit and illuminate the cultural content and variability from each unique situation. The advantage of this approach is that a given programme can be used not only with immigrant groups but also with homogeneous group from the host population, mixed groups of immigrants from various countries, or groups including both Israelis and immigrants. Focusing on group processes allows the group to be viewed as a microcosm in which cross-cultural encounters are enacted in a protected environment.

As the principles of experiential interactive and integrative group processes are deliberately applied to the immigrant and cross-cultural situations, the preference is not to focus on teaching “optimal” or “socially desirable” solutions, an option that many of the immigrants understandably seek. Instead, the aim is to create situations in which participants can explore their own attitudes, feelings, and behaviours, perceive their own impact on other people, and experience their response. This method enables group members to examine the interactions among the components of specific situations, and then choose to reintegrate different options into their own lifestyles. Such methods require complementarity between the educational messages and the means by which the messages are expressed. For example, if a programme deals with issues of internal locus of control and responsibility for one’s action and independence, it should not be taught in an authoritative manner with the participants remaining passive and not participating in the decision-making process.

As in any group work, balances between process and content, private and public, old and new, must be maintained by expert facilitation. Group processes occurring in public are visible to all the participants. However, participation of individuals will differ widely and is strongly dependent on personal characteristics as well as on cultural traditions and the intervention of the facilitator. If group members are to share their feelings and problems and further process these feelings and problems, they must feel comfortable and trust both the facilitator and the group. It is critical that even those who do not share their thoughts and experiences verbally can still deal with many of these issues internally as part of the group dynamics. Structured in this way, the programme can be used with socioculturally heterogeneous groups with varying traditions of trust and sharing. This is an important point among immigrants from both Ethiopia and the former USSR, and additionally among refugees and illegal immigrants.

In cross-cultural work, it is most important to recognize that each group is unique. In order to deal with this uniqueness, group diagnostic components and flexibility are structured into the educational interventions. In addition, the facilitators are trained and encouraged to “rethink the intervention,” and to constantly adapt it to the needs and characteristics of each group.

The next stage is the development of the educational means through which these principles and other derived issues are applied. There are 32 educational units or instruments from which facilitators can build the skeleton of their programme for a specific group (see Box 15). The design of the programme for a specific group – the choice of units, their order, and the process through which these choices are reached – is an important facilitators’ skill and is included in their training. It can also become an integral part of the intervention itself.

Box 15: Educational units for HIV/AIDS prevention

1. Coping with resettlement, departing from the old culture (2 units).
2. Comparing issues of intimate and sexual relations in the old country and the new country; making choices and examining costs and benefits (5 units).
3. Interpreting the new environment within its own frame of reference - the cross-cultural encounter; seeking help (3 units).
4. Learning about sexuality, sexual health, and methods of contraception in a group setting (5 units).
5. Discussing intimate and sexual relations: context, choice, control, and coping; making choices and negotiating methods of contraception (6 units).
6. Discussing pregnancy and sexually transmitted diseases; planning the future and making difficult choices (2 units).
7. Discussing sexual behaviour and learning about sexual health - HIV/AIDS and sexually transmitted diseases (5 units).
8. Coping with stigma (4 units).

There are 32 units in total within these 8 domains. Those that appear in domains 4, 5, 6, 7, and 8 are directly relevant to reducing the risk of HIV transmission. ■

Based on past experiences, the number of meetings of each group ranges from 4 to 14. Thus, it is not possible or even desirable for each group to be guided through all of the educational encounters. For example, although there are three units dealing with stigma, it is recommended that each group use the one most suitable to its needs. It is also recommended that no more than two units be used from the section on comparing realities. Thus, the facilitators must choose the units most suitable for each group, designing and introducing original units as they see fit. It may also be necessary to rearrange the order of units. Every planned action should be considered as only initial and tentative for two reasons: first, the facilitators do not know the specific group and may base their choice of educational units on past experiences (stereotyping); second, the dynamics of group work may change the initial wishes of the group itself.

In the training and the programme manual, a structure for the selection, development, and modification of a programme is introduced as part of the intervention itself

(Shtarkshall, Shimon & Bargai, 1997). Facilitator trainees have pointed out that these components of the training deal with issues very similar to those that occur in the programme itself: learning to plan for an unknown future, examining perceptions of reality and amending these perceptions when necessary, identifying and correcting stereotypes, or negotiating and balancing power.

Sexual health and HIV/AIDS: a comprehensive programme

Even if general aspects of intimate and sexual behaviour are dealt with in some units – like those devoted to initiation of intercourse, pregnancy and contraception, and gender issues – those issues directly connected to sexual health and HIV/AIDS can be covered in more detail in other units. For example, although negotiating methods of contraception and the use of condoms were part of other units, they can be repeated in a unit on prevention of HIV/AIDS. This unit can go into detail on all possible options, like non-penetrative intercourse, disclosure of previous risk behaviour and HIV status, conjoint testing, and abstinence. A unit on condoms can deal with how to correctly use condoms (technical aspects) as well as issues of culturally specific and other barriers to their use. Incorporation of HIV/AIDS issues should take into account as an important component the adaptation of universal messages to specific cultural situations and the development of messages tailored for specific cultural groups.

The training process

The principles and methodologies of the training process have been described in Chapters One and Two. They were applied to this project in the form of the combined training-development-trial implementation process. While the structuring of the training programme in parallel with the development and the trial implementation allowed the development team and the facilitators in training to experience all three processes, the inclusion of interventions at appropriate points in time allowed these to be integrated into a unified experience.

Training workshops conducted before the development of the Gesher la'Keshet programme were dedicated mostly to methods and skills. Subsequent training sessions, although continuing to develop methods, focused on the implementation and use of these methods and skills in the further development of the programme. The earlier training workshops dealt mainly with: (a) sensitizing the facilitators to the cultural transitions and cross-cultural issues in the areas of intimate and sexual relations, and (b) training facilitators on group dynamics and group facilitation skills, while familiarizing the facilitators with the contents of the educational programme and introducing them to the concept and methods of continuous development. Elements such as feedback from field experience appeared in most of the sessions and were used for both facilitating skills and for amending the programme. An additional component is supervision, which was carried out either on-site, after an observation of a session, or in regional meetings. The collection of data throughout the training process and trial implementation allowed the move from isolated projects to comprehensive programmes addressing HIV/AIDS among immigrants.

Evaluation

Due to budgetary constraints, no overall evaluation of this programme was made. Instead, several smaller evaluation exercises were conducted on specific projects. An evaluation of the training programme and trial implementation of a project for female immigrants from Ethiopia has been conducted. An external evaluation of another facilitator-training programme and a process evaluation of field implementation by the trained facilitators of a project for immigrant youth from the former USSR are being conducted.

In the evaluation of the training programme for facilitators, the following instruments were used:

- ◆ pre- and post-workshop questionnaires
- ◆ observation of events and activities in the training programme
- ◆ observation of trial implementation, focusing on the facilitator
- ◆ self-evaluation reports.

In the evaluation of the training programme and trial implementation of a project for female immigrants from Ethiopia, the following instruments were used:

- ◆ semi-structured interviews
- ◆ non-structured interviews in which the participants were asked to respond to intimate or sexual scenarios, emphasizing the ways they look for solutions and the considerations they employ, rather than the results themselves
- ◆ questionnaires before and after the training and trial implementation
- ◆ observations of educational sessions, focusing on participants
- ◆ self-evaluation reports of the facilitators.

The results of these evaluation exercises are forthcoming. As large parts of the trial implementation were conducted in parallel with the training of facilitators, direct and indirect feedback was received on both the training and implementation. Some anecdotal information was important for the evaluation. For example, one of the major aims of the training was to empower the facilitators to use the educational programme in a flexible way, adapting it to the needs of specific groups, and to design activities according to the educational principles and methodology. The fact that several facilitators in the training, without being so directed, developed new interventions and even whole new units and shared the experience with their colleagues was viewed as highly indicative of the success of the training.

Diffusion and implementation

A strategy for the diffusion and continuation of a programme is required if a large population is targeted. This educational programme had a potential target population of more than 150,000 youth, ranging from young adolescents to young adults, in various educational settings (absorption centres, hostels, boarding schools, day schools, and special programmes for youth in distress). The first part of the strategy involved handing over programme diffusion and continuation to an organization that had vested interests in, and the structure and mechanisms to carry out, the promotion of educational programmes. The organization selected was the Israeli Family Planning Association. The second part of the strategy was to ensure collaboration between the developing team and the selected organization. The developing team should not be completely dissociated from the continuing implementation of the programme, but should remain involved with the training, supervision, and further development of the programme.

The third part of the strategy was to work in two parallel tracks. These were to offer implementation of the programme by trained facilitators employed by the Israeli Family Planning Association in formal and informal educational organizations, and to have leading trainers offer training on the programme to the staff of such educational organizations. It is the second track, the introduction of the programme into the structure of existing educational organizations, that has been most successful. In 1997, the education sector decided to adopt the programme into different country-wide educational projects. These included the Unit for the Promotion of Youth of the Ministry of Education, which deals with adolescents at risk in out-of-school settings; First Home, a six-month programme of the Jewish Agency in which young adults who immigrate without families are housed, taught Hebrew, and acclimatized to the country in kibbutzim (communal settlements); and the Female Adolescents in Distress programme of the Ministry of Welfare. Currently, the Israeli Family Planning Association is negotiating the introduction of the programme into two other educational settings.

There is an unexpected but very important spin-off from these training programmes. Many organizations found it difficult to introduce the notion of volunteer organizations and volunteer work to the immigrant groups. This is highly understandable if one remembers that “volunteer” activities in the former USSR were mostly a euphemism for coerced participation in political activities. However, many of the immigrants trained as facilitators in this programme are now also volunteers in other activities of the Israeli Family Planning Association dedicated to reproductive and sexual health of the immigrant communities.

Project for the general population of immigrants from Ethiopia³

Introduction

In the early 1990s, several factors converged to create a very serious situation in relation to HIV infection among immigrants from Ethiopia. After a large wave of immigration in the mid-1980s, a second large wave of about 20,000 arrived in 1991, most of them in an airlift organized by the Israeli government at the end of the civil war in Ethiopia. Between these two waves of immigrations, HIV had spread rapidly in Ethiopia, mainly in the urban centres (Ethiopian Ministry of Health, 1990). Despite the knowledge that infectious diseases were prevalent in the population, all immigrants had been first brought to Israel and then examined for various health conditions including hepatitis B, tuberculosis, malaria, and HIV. These examinations indicated that over 200 of the 13,000 people tested were HIV-positive. The Ministry of Health decided to refer all HIV-positive people to HIV centres for follow-up and to provide them with medical care. No prevention programme for this immigrant population was initiated at that time, but there was deep concern about the possibility of further transmission. In a meeting of representatives of various governmental groups (mainly the Ministries of Health and Absorption) and other organizations working with immigrants, it was agreed that this condition required the immediate development and implementation of a culturally appropriate education programme to reduce the risk of HIV transmission in this population. It was proposed to target the general population of immigrants as a first priority.

The steering committee and project development team

The head of the Israeli National AIDS Steering Committee asked representatives of various organizations and the leadership of the migrant community to become the inter-agency steering committee of the project. That committee decided to target the adult population among approximately 24,000 Ethiopian immigrants residing in absorption centres and hotels at that time. A proposal was submitted to the Israeli National AIDS Steering Committee by a public health physician and an anthropologist, and, to reinforce the initiative, members of the Hebrew University-Hadassah School of Public Health were approached. Two staff members with experience in health and sex education, HIV prevention, social-behavioural research, and social work interventions agreed to join the project. A team of four, all with previous experience in interventions with Ethiopian immigrants or with marginalized groups, was formed under the auspices of the Hebrew University-Hadassah School of Public Health. An expanded proposal was submitted to the steering committee National AIDS Steering Committee.

Early in the project, the team recruited two coordinators: a cultural coordinator, who was a veteran immigrant from Ethiopia with previous experience in HIV/AIDS education, and a project education and field coordinator, who was a teacher and sex educator. Initial background data were limited, as the urgency of the situation did not leave time for a lengthy process of data collection to obtain data specifically on HIV. The information was collected mainly during the project, an example of an iterative process.

The overall perspective

❖ **Timetable.** The project lasted eight months. The preparatory stage was completed within two months; the training and implementation of activities were conducted for six months. The experimental lectures for the target population started within two weeks of the initial training workshop and continued until the end of the project. During the following year, many requests for additional lectures, mainly for new immigrants, were submitted to the project coordinator, but only sporadic lectures were given, by four or five educators who were still available.

³ This Section was prepared by RAShtarkshall, V Soskolne, D Chemtob, and H Rosen. Parts of this section were published earlier in Chemtob et al., 1993; Chemtob et al. 1995; and, Soskolne et al. 1995.

❖ **Budget.** The total budget of the project, US\$50,000, was contributed by a non-governmental organization as part of its activities and programmes for new immigrants. The total budget was initially earmarked to cover the salaries of the educators, the two coordinators of the project, and their expenses, but it was used mainly for the development and production of the educational materials, including posters, booklets, pamphlets, and audio cassettes. Some of the educators were employed by one of the collaborating organizations and included project activities as part of their job commitment on a one-day-per-week basis. The four senior professionals of the development team were not salaried by the project. Their participation was considered part of their duties in their respective organizations.

❖ **Responsibility.** The personal dedication of many individuals and the willingness of some organizations to devote the time of their employees made the implementation of the project possible. However, the project could not have continued under such circumstances. The Israel Ministry of Health had to become fully responsible for continuing these activities to make the project sustainable. Unfortunately, this did not occur, and for more than four years, until 1997, no educational activities were carried out by the Ministry.

❖ **Other constraints.** The main problem was the need to start the project immediately, which left very little time for planning and preparation of the logistics, the training course, and specific interventions. For example, the first educational sessions were conducted as lectures because the posters were still being designed. They were completed with the cooperation of the trainees four to five weeks after the start of educational sessions, and only then was the visual channel of communication added. The budget did not allow the development team to plan for all components of the project in the desired form. No funding was allocated for outcome evaluation. Only after repeated requests by the development team was additional funding granted, and that only towards the final stages of the project. Consequently, no “before-after” comparisons were possible. Exposure of individuals to the project was used as a proxy variable in lieu of baseline data. However, the iterative design process made it possible to start a project under such conditions.

Methods and stages of development

- The methods used in this programme can be divided into the following components:
- ◆ structuring the programme and interorganizational negotiations, including the selection of trainees;
 - ◆ collecting data essential for the formulation of the training courses and educational strategies;
 - ◆ organizing the training process and delivering the messages to the community of immigrants at large;
 - ◆ preparing and adapting culturally appropriate training materials (e.g., posters that had been prepared in Ethiopia and had to be changed extensively);
 - ◆ monitoring and evaluation.

□ Collection of background data

As background data for the development of the educational programme, the information summarized below was obtained through the following sources:

- ◆ epidemiological data from the Israel Ministry of Health
- ◆ general and professional knowledge about the state of immigrants and of the attitudes and beliefs of the Ethiopian immigrants
- ◆ in-depth interviews.

A format for semi-structured interviews was developed covering the following content areas:

- ◆ the general perception of HIV/AIDS as a disease with a hidden component, and of the people who are HIV-positive
- ◆ the reactions to proposed behavioural practices
- ◆ the readiness of people to discuss sexual issues.

Using the same format, all development team members interviewed both participants in the training programme and people from the target community. The focus of the interviews was on sexual networks, number of sex partners, and frequency of change of sexual partners. Some of the interviews were conducted prior to the commencement of the workshop and others during the period of the training. The interviews were transcribed and analysed for material relevant to the training programme and to the trainees' work with the target population.

□ Legal status and motives for migration

All Jews who immigrate to Israel receive citizenship rights immediately, irrespective of their health status. The motives for immigration from Ethiopia are religious and national – that is, identification with the Jewish state. However, the last wave of immigration in 1991 was accelerated by the political situation in Ethiopia at the end of the civil war and the fall of the Menegistu regime. People arrived with only a few belongings, almost as refugees. Upon arrival, all immigrants are entitled to health care and social, occupational, and economic support services through government-subsidized programmes. General health education programmes are provided by the medical insurance companies or by the Ministry of Health, but HIV/AIDS education is not routinely provided to the immigrants.

□ HIV/AIDS and other special health needs

According to data from the Ministry of Health, the male-to-female ratio of HIV-positive persons was slightly greater than 1, indicating that heterosexual intercourse is the main mode of HIV transmission. It was difficult to establish how much of the infection occurred as a result of the use of non-sterile tools either for blood-letting in traditional medical practices or in medical settings in Ethiopia. Some of the persons with HIV were children, babies, or pregnant women. Most of those found to be infected with HIV were still asymptomatic, indicating infection in recent years. Tuberculosis rates were high, and some of the patients already had AIDS. These data suggest that the prevention of heterosexual and vertical HIV transmission had to be the main target.

□ Health beliefs and practices

Traditional health attitudes and beliefs and extensive use of traditional healers are generally prevalent among this population. The modern biomedical model of health and disease is less prevalent. For example, the concept of infectiousness during the asymptomatic stage of HIV infection is incomprehensible. In the tradition of the immigrants from Ethiopia, only someone who presents symptoms is viewed as being a risk to others. Usually, such a person is isolated in order to prevent transmission to others. To make the project acceptable to the immigrant population, it was essential to integrate the traditional model familiar to immigrants with the modern biomedical model prevalent in Israel.

□ Social situation

Most of the immigrants came from a rural region in northern Ethiopia and spoke only Amharic. A modern way of life was generally alien to most of them. Their culture is characterized by a predominantly oral transfer of knowledge and values, using proverbs and fables. Literacy rates are low.

The immigrants of the target population had just started to learn Hebrew in special classes in their residential locations. Children over five attended compulsory kindergartens and schools. Usually, they mastered the Hebrew language quickly and often served as translators for their parents in contact with Israeli services, a fact that sometimes threatened traditional parent-child roles.

Some adults had started to work as unskilled labourers in low-paid jobs. Although many were receiving social security benefits, they were barely sufficient to meet even minimal needs. Religious leaders used to have influence in the community, but a group of political leaders, who were more familiar with Israeli society, had started to gain more influence among community members. Most of the recent immigrants were isolated

from the rest of the Israeli society because of the large gap between the two cultures. Even though they were not openly discriminated against, they were the only ethnic group in Israel with black skin. The health care and welfare workers were usually Israelis completely foreign to the immigrants. In order to improve communication, many services had started to employ veteran immigrants as translators. Unfortunately, these people were given no special training.

□ Vulnerability and risk factors

Risk factors related to HIV transmission was investigated through structured and semi-structured interviews with key members of the immigrant community. Every member of the development team interviewed two to ten persons.

The interviews indicated that open discussion of sex is not common in the target population. Even married couples do not usually talk about sex, or the use of contraceptives, including condoms. Male dominance in the initiation of sex and during the sexual act is very clear. Men may have several female partners, and it is not uncommon for a married man to have a sexual relationship with another woman, usually one who is divorced or widowed. Divorcees and widows submit to these relationships because they need economic support. Married women do not have extramarital relationships. Single women are often virgins until they marry or have had a few serially monogamous relationships.

Most of the sexual networks occur within the community, including mixing between veteran and new immigrants. A generally negative attitude towards condom use is based on religious and cultural beliefs in the value of fertility. Among veteran immigrants, some changes may occur, mainly among young adults who started their sexual experiences in Israel.

Less information was obtained about other HIV-related risk behaviours. However, the impression was that intravenous drug use or homosexuality were uncommon and highly stigmatized.

In summary, the mainly endogamous sexual networks within a relatively small community of about 50,000 people and the prevalent negative attitudes towards condom use increased the development team's fears about the possibility of further HIV transmission in the target population.

Purpose and objectives

The purpose of the project was to decrease the risk of HIV transmission among immigrants from Ethiopia in Israel. The general goals were:

- ◆ to provide the immigrant community with accurate information on HIV/AIDS in a culturally acceptable form;
- ◆ to encourage tolerance and support of persons with HIV and their families;
- ◆ to promote adoption of risk reduction behaviour to prevent the transmission of HIV, including condom use and sterilization of traditional medical instruments.

The specific objectives were:

- ◆ to improve the level of accurate knowledge about the modes of transmission of HIV and the prevention of transmission and to decrease misconceptions about HIV/AIDS;
- ◆ to promote positive attitudes towards condoms and to encourage condom use;
- ◆ to promote positive attitudes towards people with HIV/AIDS.

Project approaches

The main approaches planned for the educational intervention were as follows.

- ◆ The prevention of the transmission of HIV had to be embedded in a framework juxtaposing biomedical Israeli with traditional Ethiopian health concepts. Adaptation of proverbs and traditional beliefs was required to integrate the traditional health models with the biomedical model and with the situation in Israel. Familiar Ethiopian concepts and beliefs were to be used to transmit prevention messages.
- ◆ The most popular modes of communication in the population, oral and visual, were to be used as the main channels of intervention. Lectures in small groups with the

aid of posters were planned first; other audio and written materials were developed later.

- ◆ Messages of HIV prevention were to be introduced into educational materials (e.g., the concept of infectiousness during the incubation period, the main routes of transmission and prevention, the proper use of condoms).
- ◆ Specific strategies to encourage discussion of sexual practices were to be developed, as were empowering and participatory methods for intervening in this population.

Training

Training started with a three-day workshop with 34 trainees and continued over three months in three weekly and four biweekly meetings running parallel with the interventions. Trainees asked to meet longer than planned because they felt the need to discuss upcoming issues, participate in the completion of additional educational materials, and get the support of the professional team and their other colleagues. Twenty-nine trainees completed the whole training course.

The trainees were nurses, social workers, and other professionals. Some of them had been employed as translators or facilitators in the absorption centres. They were all veteran immigrants from Ethiopia fluent in both Amharic and Hebrew. Because they were to be trained as health educators and cultural mediators, their careful selection was important. Some of them were also recruited to collect data needed for the training and the planning of interventions.

The training consisted of group activities and a series of lectures given by professionals. The sessions included the following subjects:

- ◆ information on HIV/AIDS and hepatitis B, their modes of transmission, and prevention strategies
- ◆ understanding and accepting attitudes and beliefs of different cultures; changing attitudes
- ◆ techniques for educational interaction
- ◆ cultural mediation and bridging skills
- ◆ management of conflicts and emotions that may arise during the educational work.

Development of educational messages

It was important to develop acceptable messages that could relate directly to issues and concerns of the target population. During the training process, previous experiences with prevention messages were combined with new concepts and new ways to transmit messages. Only a few central messages were developed and refined throughout the project. These included:

- ◆ “HIV/AIDS is a serious but a controllable problem. It is up to each and every one to protect himself or herself against being infected.” This was embodied in the idea that “Your life is in your own hands,” which was also the name of a poster series, as well as in the message to “Be gobeze” – that is, to be victorious over one’s enemies, including HIV (Chemtob and Rosen, 1992).
- ◆ “It is better to do things when you can prevent them than to cry when you are already suffering and nothing can be done anymore,” which is taken from a well-known Amharic proverb (Rosen, 1989).
- ◆ “Each member of the community can protect himself/herself, his/her family, the Ethiopian Jewish community and all the people of Israel.” This message was planned to tap the solidarity of the group and their wish to be an integral part of Israeli society.
- ◆ “There is hope.” People who are infected with HIV should not despair and perceive immediate death as the only consequence. It is possible to postpone the development of the disease and to raise the quality of life for infected people through early detection and proper, continuous care.
- ◆ “There is no need to know which person is infected.” Protection lies in behaving as if everybody could be infected. This is a message to the population of immigrants as

well as the general public. An exception is the case of sexual partners of people with HIV. While the latter situation should be dealt with in individual counselling, this exception to the rule may also be an important educational message.

- ◆ “There is no need to shun people with HIV/AIDS. One can do the right and honourable thing. Befriend them and help them in a dire situation, while taking the necessary precautions.” This can be an extremely important message for groups emigrating from areas of endemic infectious diseases and less developed health systems. In such cultures, the tradition of shunning people and even families with infectious diseases is an important health measure.

Experimental implementation

After the second training session, the trainees started to deliver, under supervision, teaching sessions about HIV/AIDS to the immigrant community. This activity, combined with the monitoring and the continuing training sessions, can be considered as teaching under supervision. The training sessions became much more interactive, combined with work in small groups, and only a few lectures. For example, trainees had to demonstrate how they lectured about a subject of their choice, participate in role-playing, listen to tapes of demonstration lectures and discussions, write down their reactions and then discuss them in the group. The feedback regarding their field experiences was a central component. Trainees had to report about each teaching session using the self-monitoring sheet. In each meeting, many of the educators brought up issues about which they wanted to consult the other educators and professional team or that they wanted to share with them. A great part of the meetings was also devoted to the development and amendment of the educational materials.

Development and amendment of educational materials

The trainees were regarded by the development team as cultural experts and were asked to assist in the development process by reviewing and amending educational materials and messages from the preliminary plans and drafts. They were consulted about the appropriateness of materials and messages, using a structured format for responding and suggesting alterations or new ideas. The review and amendment process was often iterative. This is an example of cooperation between people internal and external to the culture of the target population.

The first of the educational materials was a set of 16 posters, designed as visual aids for educational presentations. These posters were developed by incorporating some features of posters from Ethiopia and of the World Health Organization. They were later reconceptualized to fit the situation and the environment in Israel through the reviews and amendment suggestions from the trainees. The relevant messages and information were printed on the back of each poster in Amharic and simple Hebrew.

The posters were later published in booklet form for use in face-to-face counselling. They were distributed to the educators as well as to Israeli health personnel in HIV clinics or in primary-care community clinics who participated in training workshops about the appropriate use of the booklets.

As the project proceeded, the educators suggested widening the channels of communication and adding other teaching materials. These had become more essential as the mandate for the educational lectures was coming to an end and it was necessary to employ other modes of information dissemination to the target population. The additional methods included audio cassettes, radio programmes, pamphlets, and newspaper articles.

Training methods

Diverse methods were used to build the teaching skills of the trainees, including traditional lectures, the use of proverbs and fables, learning through action, participatory methods, group dynamics, and supervision.

Trainers stressed the importance of relating to the cultural traditions of the target population as well as the use of methods to induce change. For example, in order to overcome passivity in learning situations and reluctance to discuss controversial or

embarrassing issues, the trainees were engaged in active discourse through methods that were previously developed for working with Ethiopian men on their sexual health.

Participatory methods were central in working with the trainees. These methods assume that the content of the messages and the process by which they are delivered should be complementary. The design of several units for the initial workshop and the continuing training sessions introduced the principle that, during the training course, the same methods are used that the trainees have to use in their work. For example, at the first sessions the trainees were encouraged to raise whatever questions they had about HIV/AIDS and to which they hoped to get answers during the training programme. These were classified into knowledge, attitudes, behaviours, and medical or social issues. During the subsequent presentations, many of these questions were answered in a respectful, non-judgemental way. This demonstrated how the trainees could respond to their audience with empathy. The fact that several trainees raised further potentially embarrassing questions indicated the success of this strategy.

The trainees were asked to share their anxieties prior to delivering a lecture. After sharing their difficulties and looking into their meaning, the members of the group were asked to suggest methods of overcoming them. Many brought up ideas that could be adopted by other participants. In addition to lowering anxieties, this exercise was also a learning process, which increased teaching options, and helped trainees perceive themselves as independent generators of information.

Other training methods included mutual interviewing, simulation games, or role-playing. These enhanced the trainees' self-confidence as lecturers and facilitators of group discussions and as individual counsellors.

Adapting a traditional Ethiopian teaching mode, trainers made use of proverbs, fables, and stories to integrate traditional concepts and means of transferring knowledge into the educational messages at the training level, in the development of materials, and at the level of transmission to the community. People who had previous experience in this mode demonstrated to the trainees how they could use proverbs in delivering educational messages. Familiar Ethiopian messages were integrated into the posters and audio cassettes. For example, to deal with the fact that the notion of viruses or germs did not exist as part of the traditional cultural vocabulary, it was suggested to the trainees to compare the viruses to "little worms," "small living creatures," or "mouldy bread."

In Ethiopian culture, the unique concept of *gobez* refers to an individual who is clever, brave, hardworking, and manly. It reflects a goal that most young men strive to achieve. The trainees were encouraged in their presentations to connect being *gobez* to health awareness, caring for one's partner, using a condom, and ultimately, being responsible for one's overall sexual behaviour. Another method was the invention of new fables to emphasize some important points. One such point was the difficulty in reframing the concept of risk, which was usually perceived in a dichotomous way (dangerous/not dangerous), into gradual terms. This was illustrated through the use of an interactive story about "steps of danger," where trying to jump off one stair is shown to be much less risky than jumping from a height of 20 stairs.

It was also important to work on the attitudes and emotions of the trainees to enhance their teaching skills and to lower anxiety about their role as educators. Several experiential workshops were dedicated not only to airing attitudinal and emotional issues, but also to relating them to the trainees' task and to neutralizing their negative impact.

Mediation skills and expected difficulties in mediation were dealt with by practising two-directional mediation between the veteran health professionals and the lay clients – that is, the immigrants. Emphasis was given to assertiveness, sensitivity, listening, and tact. Different ways to explain what each side means beyond their verbal expression were explored and jointly discussed with the participants.

The interventions

The main mode of intervention was lectures with the aid of the posters in small groups of 20-25 persons from the target community. The project coordinator mapped the residential areas in each region in the country and gave each educator a list of locations in which he/she had to work. At the time of the project, most of the immigrants were living in hotels or absorption centres (compounds of small apartments). Each centre was run by staff who took care of the immigrants' needs and who could assemble the residents in a central hall for meetings. The district director notified the centres that an educator would contact them, and the centre managers were asked to cooperate by informing the residents and encouraging them to attend the lectures. Sometimes, the centre manager requested that big groups attend the lecture to get "maximum exposure in minimum time," but generally the lectures were presented to small groups. Each educator delivered between two and six lectures per week, depending on the importance of his/her position and the geographical distribution of immigrant centres in his/her region.

Depending on the audience and the educators, many of these lectures became more interactive and turned into group discussions. Towards the end of the project, when the audio cassettes were prepared, the attendees were given the cassettes so that they could listen to further information and discussions.

As the interventions continued, it became apparent which educators were skilled in providing additional interventions, like small group discussion, mediation in HIV, or community clinics. These interventions were conducted at the request of the clinics or the management of the absorption centres, and were not part of the overall project strategy.

When the audio cassettes were produced, an initial trial distribution was conducted in a sample of absorption centres. The cultural coordinator, who had also conducted many of the interventions, went to each household in the sample, explained the purpose of the cassettes and asked for permission to leave a copy for the use of the people in the household. He returned a week later and asked for their response. This monitoring revealed positive responses in general to the cassette, and usually the tape initiated many questions. These visits turned into family or group educational sessions or individual counselling. After this, more than 5,000 audio cassettes were distributed to the management offices of all centres in the country, with a request to distribute them to all households at the site. Additional cassettes were sent to HIV or community clinics for distribution.

Written information was prepared in the form of two pamphlets. One gave general information about HIV/AIDS, the other specific instructions and illustrations about the correct use of condoms. Sensitivity and the desire to avoid offending the community stood behind the decision to separate the pamphlets. Whoever was not interested in or was embarrassed by the second pamphlet could at least get basic information on HIV/AIDS. The illustrations of condom use were drawn on the opposite edges of two pages, which were then partially folded over so that the drawings were not immediately exposed when one opened the pamphlet.

In collaboration with Israeli radio, programmes in Amharic were prepared and broadcasted. Each broadcast, which had been planned to last about 10-15 minutes, started with a professional giving a short presentation in Hebrew on a different topic. This was immediately translated into Amharic by one of the educators from the project. Then the listeners were invited to phone the studio and present questions to the Israeli and Ethiopian professionals. After the first broadcast, so many phone calls came in that the broadcasts were extended to 30 minutes. The impression at the time was that the response was very positive and proved how powerful this medium is for the community. People said that they called from public telephone booths because they did not yet have phones in their temporary housing.

Monitoring and evaluation□ **Monitoring of the training sessions**

Process and outcome evaluation of the trainees was conducted using qualitative and quantitative, structured and semi-structured approaches, reports, and direct observations.

Even the selection of the individuals for the training was an integral part of the monitoring and evaluation process. It included an evaluation of their ability to associate themselves with the subject, despite its stigmatizing potential, and their ability to deliver the sensitive messages in public.

The monitoring and the educators' evaluation were done by:

- ◆ Direct observation of the educational activities by trained observers (people who spoke Amharic or the teaching staff). In addition, a structured report was submitted by the observer and some of the lectures were recorded.
- ◆ A self-monitoring form completed by the trainees, which included data on the number of persons attending, the composition of the group by gender and age, difficulties encountered, reactions during and after the lecture, and other important issues.
- ◆ Outcome evaluation using structured self-report questionnaires in Hebrew to assess changes in HIV-related knowledge and attitudes at three stages: the beginning of a three-day training workshop, the end of the workshop, and the completion of the whole training programme four months later.

The attitudes and feelings of the trainees about teaching these subjects and their perceptions of their teaching skills were measured only after the training workshop and at the end of the training programme. The results showed that most of the trainees' significant improvement in HIV-related knowledge and the changes to more positive attitudes occurred during the workshop; only minor additional changes occurred after the whole course. A large proportion of the trainees felt they had acquired much knowledge and had developed teaching skills.

□ Monitoring the intervention

Monitoring of the educational sessions was conducted as part of the monitoring of the training as described above. In addition to the formal monitoring and evaluation records, many informal reports by the trainees themselves indicated that breakthroughs in understanding often seemed to follow the presentation of new ideas in familiar terms. The project coordinator had been constantly monitoring implementation by making sure that educational materials reached the population - the presentation of the lecture sessions and later the distribution of the audio cassettes to all residential locations (100 per cent coverage of locations) and the distribution of pamphlets to health and welfare services. In total, about 250 lectures were presented by the educators, and 5,000 audio cassettes and about 15,000 pamphlets were distributed.

□ Outcome evaluation

The main results of the project, even before the impact evaluation was carried out, included:

- ◆ The training of a group of health educators who could deliver HIV/AIDS educational sessions to the general population of immigrants from Ethiopia. A core of this group have since continued to participate at different levels in additional activities.
- ◆ The development of culturally appropriate educational messages and methods and alternative ways to deliver them. These educational materials have since been used for other population groups of these immigrants.

One surprising outcome was the initiative of the educators to establish a telephone hotline on HIV/AIDS in Amharic. The professional staff aided them in finding the appropriate organization to host and supervise them (the Israel Family Planning Association). Since that time, the hotline has run once a week, each session lasting three hours.

□ Impact evaluation

As it was not possible to collect pre-intervention data from the population, the evaluation was conducted by interviews with two random samples, each consisting of 315 adults, comparing attendees with non-attendees three months and one year after the intervention began. At the time of the first round of interviews, no educational method but the lecture sessions had been implemented. The second round of evaluation was conducted after the

distribution of the pamphlets to all services, shortly after the distribution of the audio cassettes, but just before the first radio broadcast.

A semi-structured questionnaire was developed for the interview. Data collection had to be conducted as part of a more casual encounter, in which the interviewer spent some time “socializing,” drinking coffee offered in the traditional Ethiopian way, and becoming better acquainted with the person before the questions could be asked. In most cases, same-gender interviewers were arranged. Most of the questions were open, and the interviewers were instructed to probe to elicit the maximum possible information but without pressure and in a non-judgemental fashion. Thus, qualitative analyses of the responses preceded the quantitative analysis.

The results showed that 60 per cent of the first sample and 32 per cent of the second sample attended the lectures. This difference could be explained by the fact that some of the interviewees in the second sample arrived in the country after the lecture sessions were terminated and some actually forgot they had attended the lecture. The main outcomes were that, in both samples, those who attended the education sessions had significantly better knowledge of correct modes of HIV transmission and prevention, more positive attitudes towards people with HIV, and more positive attitudes towards condom use compared to non-attendees. However, no differences were found in misperceptions or in willingness to use condoms. Logistic regression analysis showed that more positive attitudes towards condom use were found among people who had attended the lectures, had better HIV-related knowledge, were younger than 45 years, were literate, and were in the first wave of evaluation, and among men.

These results indicate that the education programme achieved most of its aims. It succeeded in improving the level of correct knowledge about modes of HIV transmission and prevention, although it did not decrease misperceptions. It enhanced positive attitudes towards condom use and positive attitudes towards people with HIV/AIDS, but the more positive attitudes towards condom use were not sufficient to increase willingness to use condoms. The analysis showed that women and the less educated should be targeted for further education to enhance positive attitudes towards condom use. Beyond that, there was a decay of knowledge and of positive attitudes over time. This is expected because the intervention did not continue. The results proved that a one-time lecture, even if complemented by other modes of education, is not sufficient and that ongoing interventions of various modes are required.

Case managers: working with Ethiopian HIV-positive immigrants

Two fundamental ideas underlay the project of mediation and case management of people with HIV, their families, and sexual partners. First, proper care of people with HIV is related to the prevention of transmission of HIV. Second, because of the pattern of sexual partners among immigrants, the greatest risk for transmission of HIV within the immigrant population is through immigrants who are HIV-positive. There is a much smaller risk for transfer into the general host country population. Therefore, a comprehensive prevention programme to lower the risk of HIV transmission within an immigrant population must include a component of working with immigrants who are already infected.

Background

As a result of HIV screening after immigration, most of the HIV-positive persons among the Ethiopian immigrants to Israel are known to the health authorities. This creates a unique opportunity in which public health interventions could be targeted specifically to these persons to prevent further transmission. It is the responsibility of public health services not only to prevent HIV transmission, but to provide counselling and care once people are screened.

In Israel, follow-up of HIV-infected persons is provided by HIV/AIDS clinics in public hospitals. Although all medical services for HIV-infected persons are covered by

insurance, psychosocial services and behavioural intervention for the HIV-positive population are minimal. Because of cultural differences and communication problems between immigrants and the medical and paramedical staff, the absence of such services and interventions creates a serious problem.

In response to that situation, a subcommittee of the Israel National AIDS Steering Committee recommended to the Ministry of Health that a case managers project directed at immigrants who are HIV-positive should be established as part of a comprehensive programme for the immigrant population. By this time, the funding for the information and education project for the general population of Ethiopian immigrants had been used up and the project discontinued. Thus, new immigrants were not exposed to any education programme, and the veteran immigrants had not received any ongoing education. The recommendations of the subcommittee included re-establishment of education programmes for the general population and for specific sectors within it according to their specific needs and a special project targeting people with HIV. An initial project, limited to a few public health districts, was supported by the Ministry of Health.

Steering committee and project team

A steering committee was established with representatives of the Ministries of Health, Absorption, Labour, and Welfare, the American Jewish Joint Distribution Committee, Inc., and the Braun School of Public Health. The committee agreed on the structure of the project, and appointed a project team, which included the Director of Public Health Services and the Director of Public Health Nursing at the Ministry of Health and two social scientists from the Braun School of Public Health.

In order to avoid stigmatization of its workers and those being treated by them, the project was named Prevention of Infectious Diseases among Ethiopian Immigrants. The steering committee met regularly at three-month intervals to monitor the project and recommend changes. It was agreed that the committee would have the authority to recommend the closing of the project, if necessary.

Project development

□ Target population

All HIV-positive Ethiopian immigrants who had been identified when screened after immigration or otherwise found to be HIV-positive were targeted. As the number of case managers was limited and none were employed full-time, the HIV/AIDS centres and the relevant health district authorities created priority lists of people who had lost contact with medical or care centres and their personnel. Existing data indicated that these people needed the most support and should be targeted with prevention interventions.

□ Collection of background data

The main sources for background data were health care workers of Ethiopian and non-Ethiopian origin who had been working with this population in HIV/AIDS clinics. They provided details on the major problems, which resulted mainly from cultural barriers – from misperceptions and misunderstanding by both the immigrant patients and the Israeli health care providers. Some of the health care workers presented their experience with trying alternative ways to address problems. Other pertinent information on Ethiopian immigrants in Israel and their health beliefs, attitudes, and behaviour was known from the collection of data prior to the information project for the general immigrant population and its outcome evaluation.

At that time, no data were found in the literature about the use of bicultural mediators or case managers with immigrants in other countries. Downing (1992) has stated that the use of cultural mediators as a means to provide culturally sensitive health care is recommended but is often dealt with only at the level of individual institutions or individual practitioners and not at the national level.

□ Goal and objectives

The main goal of the project was to prevent further HIV transmission in the immigrant community and to minimize the harmful effects of HIV infection on patients, their

families, and partners. The project aimed to provide culturally sensitive behaviour modification and counselling. The specific objectives were to:

- ◆ decrease cultural barriers through case managers and mediators;
- ◆ reach out to people with HIV;
- ◆ promote and reinforce reduction in HIV-related risk behaviour;
- ◆ increase partner notification;
- ◆ provide emotional and social support to persons with HIV and their families;
- ◆ decrease the rate of HIV transmission to sexual partners or infants.

□ Planning the interventions

The job description of the case managers included:

- ◆ Reaching out to HIV-positive persons registered in their region.
- ◆ Periodic follow-up of HIV-positive persons through home visits or in any other location as decided with the patient.
- ◆ Mediation between all agencies that should be involved in the care of the patient and family, included receiving their instructions and conveying them to the patient and explaining to staff members of concerned agencies the problems raised by the patient. The case manager had to refer patients to the appropriate services once a problem was identified, instruct them about the necessary procedures, and ensure that they completed the process. Only on special occasions would the case manager accompany the patient.
- ◆ Regular counselling of HIV-positive persons, their families, and partners. The idea was to use culturally specific behavioural modification interventions by integrating all educational tools developed by the HIV/AIDS information programme for the Ethiopian immigrants together with intensive individual or couple counselling. The counselling included information on HIV infection and how it can be lived with and managed, the means by which to maximize the chances of remaining healthy, the responsibilities that HIV-positive people have for themselves and their sexual contacts, and effective strategies to avoid transmission. Partner notification was discussed at the initial contact and at follow-up, and assistance in disclosure of diagnosis to partners or family members was offered.

□ Structure, staffing, and selection of case managers

The project was administered by the Department of Public Health Nursing at the Ministry of Health. The case managers were placed at district health departments, under the administrative supervision of public health nurses. The decision about whom to contact was made jointly by the public health nurse and the regional HIV clinic staff. The case managers were to be present at the clinic once a week. The project was innovative in its collaboration between community public health services and hospital clinics. The idea behind this decision was that the case managers would be identified as community workers in a health promotion programme – the prevention of infectious diseases – and not as workers in hospital HIV/AIDS clinics. This was an important way of maintaining confidentiality, because the case managers were to contact the patients at their homes.

All case managers were professionals, mainly nurses. Each was employed half-time. This was partly to avoid burnout but also to help conceal public identification with HIV/AIDS by employing people working in other jobs. Most of the case managers had been working in other health education projects in the community or as hospital nurses.

The two social scientists from the school of public health developed the training and the interventions, provided ongoing training and supervision, and monitored and evaluated the programme in collaboration with the public health services of the Ministry of Health. A coordinator was employed on a part-time basis. Her duties included coordinating activities throughout the country, preparing each case manager individually for the job, monitoring and following up on case managers' work, reviewing their reports and providing them with feedback, transferring the forms for evaluation, and taking care of the administration of the project.

□ Planning of monitoring and evaluation methods

The case managers were instructed to report their activities routinely to the supervising district nurse with copies to the project coordinator.

The forms for the data collection served for monitoring and evaluation and as a tool for supervision. They were divided into three parts. The first section was to be filled in after the initial contact, leaving space for possible changes during the follow-up period. It included data on personal characteristics (gender, age, year of immigration, marital status and number of children, work, type of residence, fluency and literacy in Hebrew or Amharic) and medical status (date of diagnosis, stage of the disease, whether medication had already been recommended and, if so, whether it was taken). No medical data were taken from the patient's clinic files.

The second section, which provided data on behavioural and psychosocial problems discussed during each meeting with the patient, was to be completed for each contact. It was designed as an open-ended form to facilitate the work of the case managers. The case managers were instructed to report all problems raised during the visit. They were also instructed to detail after the first visit the number and type (regular and casual) of sexual partners during the last month, the use of condoms, and the disclosure of diagnosis to partners and family, and to probe for this information on every visit. Other problems (e.g., work, housing, marital conflict) were to be written down only if raised by the client. Any changes in HIV status of partner(s) or pregnancy of a female patient or partner of a male patient were reported as well. This section was used mainly for monitoring the intervention, supervision, and outcome evaluation.

The third section was to sum up the monthly activities with community services in relation to each patient, the total number of patients treated at the medical service centres during this month, and the total number of contacts with case managers.

The second and third sections were to be used for the outcome evaluation. This evaluation, to be conducted after a year, would assess changes in sexual behaviour, pregnancy rates, and the rate of partner notification by the patients, and would measure such variables as the number of patients served by each case manager in each region, the number of contacts with each patient per month, and the duration of follow-up. The last and most important objective – the decrease in HIV infection rate – was to be evaluated at the end of the project.

Training and supervision

The planned supervision of the case managers was carried out by the district health nurses, the project coordinator, and the professional team. The nurses were to supervise the case managers on a weekly basis, mainly on administrative matters and ways to approach patients. They were less familiar with HIV issues and with the specific cultural problems of this community. The professional supervision and training on HIV/AIDS and the interventions with the patients were delegated to the professional team. Group supervision and training took place every month. The project coordinator supervised the case managers on individual cases.

After an initial two-day training seminar, the case managers started working. The follow-up training sessions were used for the development of changes in interventions in an iterative process. As in other projects in this community, the case managers have acted as aids to the professional team in the development of interventions. They are the “insighters” who have suggested alternative modes of intervention to the professional team and to each other.

Each training session was usually divided into two parts. The first, more academic part included presentations on specific subjects (e.g., HIV transmission and prevention, clinical treatment of HIV-positive persons and AIDS patients, psychological stress of persons with HIV, models of behaviour change and how they could be applied to this population, approaches to discussion of the use of condoms, family issues, and social security benefits). The second part was usually more interactive, either role-playing to demonstrate encounters with patients, or group supervision of cases presented by the case managers.

Experimental implementation

It was decided that the case managers would mainly do outreach in the community, but would also work once a week at the regional HIV/AIDS centres in the hospitals and receive referrals there from the staff. People who were known to have HIV and who had not yet been seen by the medical staff of the HIV clinic in the region or who had not attended the clinic for follow-up visits were targeted as the first priority for outreach. Any other referral by the HIV clinic or community services was to be accepted by the case managers, as were patients identified by the case workers themselves.

The case managers were advised to present themselves as professionals of the district health office who wanted to assist the family with health problems. If the patient disclosed his or her HIV status to the case managers, they could proceed to talk about HIV-related issues. However, in most cases, people were reluctant to talk about problems, and the first visits were “social calls.” The case managers were encouraged to keep visiting the patient and, when it was suitable, to mention “Awhile ago you received a letter from the hospital to ask you to come for a visit. This is important for your health and I suggest that I make an appointment for you.” Under no circumstance were they to disclose or mention the possibility of HIV to the patient. When the patient came to the clinic to repeat the ELISA test, the case managers were asked by the physician to assist in mediation when the result was revealed to the patient. They later accompanied the patient as instructed by the clinic medical staff and the social worker. Patients who had already visited the HIV clinic and were notified of their HIV status were reminded by the case managers that they had been at the clinic and asked to come for a follow-up visit. When they agreed, the date and time were set up for them. Once it was clear that the reason for the contact was HIV, the case managers were free to continue working with the patient and the family members. Follow-up visits or meetings at other places were set up as needed.

There is great respect in the immigrant community for medical professionals. The case managers were advised to create an atmosphere of acceptance for the patients and to establish contacts. The main messages that the case managers were to convey included the following:

- ◆ “We are here to listen to you and to help you. Your situation is difficult and we, as people from your community, understand you and can mediate between you and the medical services. You are not alone, we are here with you and we will keep your HIV status confidential.”
- ◆ “The staff at the HIV clinic can help persons with HIV. There are drugs to delay the onset of AIDS and to make those with symptoms feel better.”
- ◆ “To be HIV-positive is a serious but a controllable problem. You can control it by going to the doctor and by having safe sex. It is your responsibility to yourself and to others.” Some of the specific messages embodied here had cultural meaning specific to this community and were similar to those used in the information project to the general community. These included “It is better to do things when you can prevent problems than to cry when you are suffering,” “Be gobeze - a wise person who protects his family,” and “Your life is in your own hands.”
- ◆ “The problem of HIV exists in many communities and in many countries. Everywhere in the world people with HIV have difficulties in maintaining the use of condoms but many have found ways to overcome barriers.”

Ongoing interventions, training, and monitoring

During the first year of the implementation of the project, the iterative process led to some major changes as the project stabilized and lessons learned from mistakes and successes could be included. The ongoing monitoring and supervision sessions revealed two major types of problems: the personal barriers of the patients, and administrative problems and system barriers.

□ **Personal barriers**

Denial of HIV status. Denial is the strongest argument of asymptomatic patients. The community perception is that, without symptoms, there is no infection, and therefore no

risk of transmission to others. Denial was quite common and was often the reason for resistance to continuing contact, to attending the HIV clinic, or to disclosing HIV status to partners and family. The main approach was not to argue with the patient but to try to explain HIV by calling it “the hidden disease” and comparing it to situations from agricultural life (e.g., termites) or even social conflicts, which are at first hidden and become visible only when they are more serious. The case manager explained that physicians have a way to test the blood to see if the disease is hiding there and how much it has progressed, and can give medicine to slow down the progression.

Fear of stigma. The level of stigmatization of HIV/AIDS in the community presents a very high barrier to treatment. Patients resisted contact with the case manager for fear of being “found out” by others in the community. They also resisted disclosing diagnosis to family members or partners and changing their sexual behaviour. Fear of stigma by family members or regular partners could be overcome by offering help in disclosure, but it was still a great barrier for unmarried young adults. In a few cases, the partner broke off the relationship after the patient revealed his or her HIV status.

This project could not have an impact on changing the attitudes of the whole community without a parallel education for the total community. Thus, the case managers could only assure a patient that they were professionals who had to keep information confidential. They suggested meeting places other than the home or clinic, like coffee houses or parks. In many cases, this has become the best way to establish and maintain the contact.

Lack of basic knowledge on HIV/AIDS and on the proper use of condoms. Lack of knowledge about HIV/AIDS or the use of condoms was relatively easy to solve by repeated education and demonstration of the use of condoms.

Resistance to condom use. Reactions to condoms often depended on the marital status of the HIV-positive person or the type of relationship that this person had. There were several reasons for resistance to using condoms.

- ◆ Most of the people in the community are religious, and the Jewish faith favours large families and opposes prevention of pregnancy. There was little that could be said to married couples who wanted to have unprotected sex because they wanted more children, especially if these couples believed that it was healthy to have many children. Arguments that pregnancy can cause deterioration in the health of an HIV-positive woman, or that unprotected sex with an HIV-negative woman poses a risk for her, are usually not accepted by men or, in a few cases, by women either. Thus, there were quite a few cases of pregnancies. In some cases, there was more than one pregnancy in the same family within the first 15-month period of the project.
- ◆ Many HIV-positive men regarded impregnation of their wives as a sign of their virility and health. In these cases, the case managers tried to discuss the concept of virility as being responsible for one’s family, wife, and children, and thus protecting one’s wife.
- ◆ Some patients did not believe in the ability of condoms to prevent infection.
- ◆ Some patients indicated their belief that condoms decrease sexual pleasure. In this case, the case managers explained that condoms are made from a special material that is extremely thin and does not inhibit sexual pleasure. If the patient consented, the case manager then proceeded to demonstrate a condom.
- ◆ Some patients feared that if they suggested or used a condom, it would indicate to their partners that they were HIV-positive. The most common approach to overcome this obstacle was to tell patients to suggest to their partners that until they were completely confident about the relationship they should both agree to use condoms to avoid pregnancy. Another approach was to say that there was talk about HIV in the community and that it might be better to get tested before having a relationship. Very few adopted this approach.
- ◆ Patients who denied their HIV status refused to use condoms. One case manager suggested overcoming this obstacle by reversing the situation. She told a patient that

although he believed he was HIV-negative, he could not know the status of his partner. As she might be HIV-positive, he should wear a condom to protect himself from getting infected.

Fatalistic beliefs. This barrier included the belief that the disease is ordained or is a stroke of fate. There is nothing a person can do to change the situation. Most patients saw it as an act of God or of a bad spirit, as a punishment or curse. The only way to overcome this barrier was to persuade patients by quoting the Bible: “God makes all things happen but man has a potential to change the situation by making a choice.” Case managers tried to persuade patients that they needed to change their behaviour and show that they were responsible for others; then God would make things better for them.

Lack of empowerment of women in sexual matters. Many wives of infected men said that they could not refuse sex because of their dependency on their partner. The need to empower women was widespread and had to be accomplished in very sensitive ways. Many case managers met with the partners separately and with both of them together. The best argument was the importance of preserving the health of one’s wife, so that she should take care of the children and also support the husband when needed. In some cases, the fear of being abandoned by their spouse encouraged men to practise safe sex.

□ Administrative problems, system barriers

System barriers were not related to the difficulties of the people with HIV but were imposed on them and on the case managers by the system.

Reporting. Many of the case managers found the forms too demanding, and some changes were initiated to make them more manageable. However, during the first months a high proportion of forms were missing information. Persistence by the coordinator and the professional team, as well as restructuring of the forms (some closed-ended items in addition to the freestyle reporting of each contact) improved the reporting.

Coordination between the district health nurse and the HIV clinic. Sometimes the case managers received contradictory demands from the district health nurse and the HIV clinic staff. Alternatively, there were problems with the level of cooperation between community services and hospital staff, and with the case managers. The coordinator organized meetings of both services to solve problems, and such meetings became a routine in many regions.

Mobility. Due to moves from temporary to permanent housing, the target population is characterized by high mobility. For this reason, the case managers encountered great difficulties in locating patients. Sometimes it took 5-12 visits until they managed to locate and contact the person.

Isolated efforts. No parallel education campaign for the general population existed to continue what the information project had started in 1992-93. No ongoing educational efforts attempted to change misperceptions and decrease stigmatization of or prejudice and discrimination towards HIV-positive people. Yet, without the norms in the environment of these patients being modified, the difficulties to persuade them to change their behaviour are greater.

Attrition and shortage of suitable case managers. A great turnover resulted from some case managers being replaced when found unsuitable for such sensitive work. However, of the first five case managers three were still employed as of January 1997 and have contributed tremendously to the project.

Disbelief. Some personnel, usually concentrated in an agency, district, or clinic, even among those participating in the project, did not believe that behavioural interventions of the Ethiopian case managers could change the situation. These people sometimes employ the criteria of all-or-nothing when discussing the issue in order to prove their point. Such disbelief tends to be self-fulfilling, as these people are less cooperative with the case managers, sometimes unintentionally undermining their efforts.

Interim outcome evaluation

At the end of the first year, ongoing monitoring and several discussions with the district health offices and the regional HIV clinics showed that the project was expected to continue. The public health nurses and the hospital staff valued the work of the case managers. They saw it more realistically and understood the tremendous barriers to behaviour change in the immigrant community. The problems of cooperation had disappeared, and the case managers were viewed more positively and as professionals who make important contributions. Moreover, there was a demand to expand the project to other regions. By the end of the first year, funding of the project was extended for another year and the project was implemented in four additional districts, employing eleven additional case managers.

Initial data analysis showed that about 13 per cent of the persons with HIV had not been located. Only 5 per cent refused any contact with the case managers after several trials. Most of the patients were seen once or twice a month.

Great improvement in the rate of regular clinic follow-up was seen during the year. The first priority was to reach out to people who were not coming to the clinic, but at the end of the year 48 per cent were attending the clinic regularly and 24 per cent were attending sporadically. Twenty-one per cent were not attending the clinic and data were missing for 7 per cent. These results indicate that efforts have to be focused on understanding the reasons for refusal to attend the clinic.

Disclosure of diagnosis to sexual partners was still problematic. About 33 per cent of the patients said that they did not have sexual partners at all, 47 per cent disclosed the diagnosis to partners or other family members, and 20 per cent did not disclose.

Condom use was the item with the most reporting problems by the case managers, with 47 per cent missing data. Towards the end of the first year, the forms were changed, and reporting has improved. Because of the inadequate data, analysis could be carried out, but the case managers say there is still a lot of reluctance to use condoms.

At the end of the first year, the subjects that case managers raised with their supervisors have changed from issues of how to approach patients and how to overcome resistance to contact, to issues of initiation of behaviour change (condom use) and maintenance of changes.

Sensitizing health and welfare personnel

Background and rationale

The policy of concentrated care for immigrants to Israel – and especially for those from Ethiopia, who were considered in special need for support – had important implications because it brought a large group of caregivers in absorption centres into close contact with the immigrants. The level of education of these caregivers varied from academic training of physicians, nurses, social workers, and some of the teachers, to almost no education among house helpers and administrative and maintenance staff. With regard to the high prevalence of HIV infection among the immigrants, the reactions and attitudes of caregivers also varied. Yet, surprisingly, these were not correlated to the educational background of the staff members.

Calls for sensitizing and training staff came from the AIDS centres even prior to the introduction of mediators and case managers⁴. At that time, the centres used lay translators and experienced great difficulties in communicating with their clients. The centres requested guidance in working with immigrant people with HIV and AIDS.

The need for interventions, focusing not only on some AIDS centres, but also on district nurses, was also expressed by immigrant professionals working with people living with HIV. Those professionals indicated that part of the failure to maintain contact between AIDS centres and immigrants – in some AIDS centres the dropout rates were over 60 per cent – was due to cross-cultural problems. Details of such cases were described

⁴ There are eight HIV/AIDS treatment/care centres in large medical centres around the country. Although the centres are distributed regionally, people with HIV/AIDS can choose the centre they want to be associated with and change centres at will. These centres are also responsible for testing, which in Israel is confidential but not anonymous.

repeatedly in training and supervision sessions for case managers of people with HIV and their partners. As described earlier, case managers were professionals from the immigrant community, working in cooperation with district nurses, AIDS centres, and with a central team of developers and trainers.

One of the monthly training and supervision sessions for case managers was used to develop strategies to overcome such difficulties and problems, and to increase the retention rate of the AIDS centres. One way to do that, proposed by a case manager, was to inform the health personnel directly about instances in which their behaviour was responsible for the loss of contact with specific clients. Several case managers felt uncomfortable with this strategy, although it was viewed as highly effective. Cultural norms and respect for professional status inhibited them from approaching physicians, nurses, or social workers with critical and judgmental remarks.

Instead, it was decided to design joint training and sensitization sessions with the AIDS centre personnel and regional community nurses, and, at the annual meetings, with all staff members of the centres. For these sessions, fictitious cases based on the reports of the case managers, were prepared and discussed. These case descriptions, in which a specific AIDS centre or a region could not be identified, were used as non-threatening examples to practise cross-cultural problem-solving skills and increase capacity to work in a multicultural context.

Design of the sensitization programme

Two sets of sensitization regional seminars were organized by the team that had worked on the project for the general population for Ethiopian immigrants (see Section “Project for the general population of immigrants from Ethiopia”): one for a mixed audience of caregivers in residential centres and HIV centres, and another for social workers working in municipalities into which immigrants were moving. The structure and content of these seminars were essentially the same, although in the set for social workers the emphasis was more on psychosocial issues.

About 300 people participated in the first series of six regional seminars, and about 250 in the second series of three seminars for social workers for which there was no enrolment or fee.

A one-day seminar included the following:

- ◆ Learning about HIV/AIDS (a lecture and discussion that allowed the participants to improve their knowledge and express their concerns and fears).
- ◆ Learning basic elements of the culture of the immigrants to increase the caregivers’ understanding of factors that have an impact on HIV/AIDS, including their medical and health model and their views on sexual health and intimate behaviour. This session sometimes included presentation of the posters that were used to explain HIV/AIDS to the immigrants.
- ◆ Group sessions on coping with practical issues in which the concerns of the participants were involved.

Although there was no formal evaluation, an informal feedback session raised persisting concerns of the participants and discussed whether they gained some insights into coping with those concerns. The majority reported an increase in their understanding of HIV/AIDS, improvement in coping with issues of HIV/AIDS among immigrants, and improvement in working with their own fears. Some reported an increase in their knowledge but no change in their concerns and fears, and a very small minority reported an increase in fear.

Introducing a counselling aid to the staff of the AIDS centres

In the effort to ameliorate the situation at the AIDS centres, and until a better solution could be introduced, the set of posters explaining HIV/AIDS was printed in a booklet form, suitable for individual counselling. Guidelines explaining the changes in tone and approach needed to transform the posters from an educational to a counselling instrument were also printed. In a two-hour orientation session, conducted by one of the developers,

the staff of each centre was introduced to the use of these counselling aids, its central messages, and cultural background.

As the intervention was very short and informal, and the number of participants in each orientation session small, no evaluation was attempted. Some information could be collected about the use of the booklets and the satisfaction of the staff with them from numerous anecdotal reports. ■

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