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Knowledge, attitudes, and behaviors about acquired immunodeficiency syndrome among Latina women seeking prenatal care

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KNOWLEDGE, ATTITUDES, AND BEHAVIORS ABOUT ACQUIRED IMMUNODEFICIENCY SYNDROME AMONG LATINA WOMEN SEEKING PRENATAL CARE

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ABSTRACT

KNOWLEDGE, ATTITUDES, AND BEHAVIORS ABOUT ACQUIRED IMMUNODEFICIENCY SYNDROME AMONG LATINA WOMEN SEEKING PRENATAL CARE

by

Eunice Segura

This study identified knowledge, attitudes, and behaviors of Latina women regarding Acquired Immunodeficiency Syndrome (AIDS). Using a descriptive design, data were collected from 30 primarily Spanish speaking women when they came for their first prenatal appointment at a neighborhood clinic. The data collection tool was a questionnaire developed by staff at the University of California, Los Angeles (Flaskerud & Nyamathi, 1989).

The findings demonstrated that the majority of the women scored high on questions relating to knowledge about AIDS and modes of transmission. In the area of prevention, 70% (n=21) responded that the use of a condom was a source of protection, but 67% (n=20) indicated they did not use condoms. In discussions with the respondents after completing the questionnaire, women indicated that they did not necessarily perceive their partner's sexual history as a real risk to themselves. The findings of this study suggest approaches health care workers can use in working and educating Latinos about preventing AIDS.

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Chapter 1

INTRODUCTION

There has been a growing concern about the increase of Acquired Immunodeficiency Syndrome (AIDS) among minorities. Rogers and Williams (1987), AIDS researchers at the Centers for Disease Control, reporting on the disproportionately high incidence of AIDS among blacks and Latinos, noted that Latinos represent 8% of the United States (U.S.) populations, but 14% of AIDS cases. Santa Clara County has kept in step with predicted national trends. The number of Latinos with AIDS has increased in Santa Clara County (Santa Clara County, 1992). In 1989, it was reported that approximately 80% of babies born to mothers with AIDS in the U.S. had contracted the disease, (Nicholas, Sondheimer, Willowghby, Yaffe, & Katz, 1989). This was significant in that pediatric cases were disproportionately represented among minorities, 53% occurring among blacks, and 23% among Latinos (Public Health Reports, 1988).

The federal government recognized that a variety of educational approaches should be employed for particular communities and funds have been made available (Mason, Noble, Kindsey, Kolbe, VanNess, & Rosenberg, 1988). In order to develop educational programs, particular characteristics of target populations need to be studied.

Statement of the Problem

Due to behaviors that are difficult to change, blacks and Latinos may be at greater risk in contracting AIDS (Ellerbrock & Rogers, 1990). Reports indicate that AIDS cases have occurred nearly three times more frequently among black and Latino men than among white men in the U.S. (Rogers & Williams, 1987). In women, AIDS cases have occurred 14 times more frequently among black women and 9 times more frequently among Latina women than among white women.

Transmission patterns among Caucasians with AIDS have differed from the patterns among black and Latino populations. Rogers and Williams (1987) also note that a higher proportion of black and Latino males have reported that they are bisexual, as compared with white males. Intravenous drug use and heterosexual contact has been more commonly reported as transmission routes among blacks and Latinos than among whites in areas most affected by the AIDS epidemic; a disproportionate number of intravenous drug users have been black or Latino (Rogers & Williams). In order to control or slow the spread of AIDS in specific communities, such as the minority heterosexual community, certain interventions need to be developed. Experts agree that in order to develop appropriate interventions, studies must document the relationship among knowledge, attitudes,

and behaviors towards AIDS in the target population where health workers expect to intervene (Schuster, 1988).

Since 1983, the majority of AIDS cases in Santa Clara County were reported to have been among the white population. However, while cases among the white population have shown a decrease, cases among Latinos have increased. There has been a 3 percent increase in all Latino cases since 1983. In the first 500 reported AIDS cases in Santa Clara County during the period of January 1983 to March 1989, Latinos represented 18 percent (92) of the cases. In the second 500 cases reported from April 1989 to June 1992, Latinos represented 21 percent (103) of the total cases (Santa Clara County, 1992). Noting the increase in the trend of total Latino AIDS cases in Santa Clara County and the high incidence of AIDS among Latina women (Rogers & Williams, 1987), it is important to assess current knowledge, attitudes, and behaviors towards AIDS of Latinas living in Santa Clara County. This information is pivotal in developing programs that will assist them in protecting themselves and their families from getting infected with HIV.

Purpose

Since 1981, the number of Latino men and women with AIDS has increased in the U.S. This number tripled in 1982 and 1983 and nearly doubled each year between 1984 and 1986

(Peterson & Bakeman, 1988). The number of women with AIDS has increased rapidly in the U.S. from 1981 to 1989 (Ellerbrock & Rogers). This trend is expected to continue, especially in women of color. Pediatric cases also continue to rise (Ellerbrock & Rogers, 1990). In order to develop effective programs to prevent the spread of AIDS in Latina women and children, certain characteristics of this population needed to be studied. The purpose of this study was to identify Latina women's knowledge, attitudes, and behaviors in relationship to AIDS.

Research Question

The purpose of this study was to identify and describe the knowledge, attitudes, and behaviors of Latina women toward AIDS.

Definition of Terms

For purposes of this study, the following definitions were used:

1. Acquired Immunodeficiency Syndrome (AIDS) is an illness characterized by opportunistic infections in a person whose immune system has been profoundly impaired. For national surveillance purposes, it is an illness characterized by one or more "indicator" diseases established by the Center for Disease Control, depending on

laboratory evidence of Human Immunodeficiency Virus (Heyward & Curran, 1988).

2. Attitude is an enduring system with a "cognitive component," an "affective component," and a "behavioral tendency." The cognitive component consists of beliefs about the attitude object; the affective component consists of the emotional feelings connected with the beliefs; and the behavioral tendency consists of the readiness to respond in a particular way (Freedman, Sears, & Carlsmith, 1981, p. 351).

3. Belief is a person's subjective probability judgment concerning some discriminable aspect of their world. It is usually based on information received from direct observation or inferred from a person's past experience (Fishbein & Ajzen, 1975).

4. Behavior is the human response to specific stimuli or conditions in one's environment (Lefrancois, 1988).

5. Knowledge is the organization of facts derived from personal experience or outside sources considered authorities, that help a person make a decision whether relationship exists (Krathnwohl, 1985).

Summary

This study was conducted due to concern with the rapid increase in the number of Latinos, specifically women and children, with AIDS over the last ten years (Ellerbrock &

Rogers, 1990). Knowledge, attitudes, and behaviors toward AIDS among Latina women were identified in order to develop culturally sensitive educational programs that would help prevent the spread of AIDS.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF RELATED LITERATURE

The rapid increase in the number of Latina women with AIDS during the last few years has been largely attributed to heterosexual contact. Secondly, the number of pediatric cases of AIDS mainly has resulted from infections acquired from HIV-positive mothers (Mays & Cochran, 1988). One of the principal methods presently available to reduce the risk of HIV infection is the use of the condom, but it remains to be seen whether the heterosexual population will include its use as a means of AIDS prevention. For this reason, health specialists have moved from the emphasis of trying to increase public knowledge about the physiological compositions of the AIDS virus to encouraging the public to change their risk behaviors and take steps to protect themselves from infection.

Social psychologists have been involved for some time in understanding and predicting human behavior (Fishbein & Ajzen, 1975). Proponents of the theory of reasoned action have used their theory to predict intentions to practice family planning behaviors (Ajzen & Fishbein, 1980). There are similarities between risk reduction in AIDS and family planning, since both involve sexual and contraceptive behavior (Mays & Cochran, 1988). Noting these similarities, the theory of reasoned action seems most appropriate as a

conceptual framework for a study identifying attitudes and risk behaviors toward AIDS among Latina women.

Conceptual Framework

The theory of reasoned action proposes that people usually consider the implication of their actions and that most actions are consciously controlled (Penrod, 1986). In other words, the most immediate determinant of whether a person will perform a specific action is the intention to perform that action. Ajzen and Fishbein (1980) propose that a person's intention is a function of two determinants. The first one, the personal factor, is "the individual's positive or negative evaluation of performing the behavior; this factor is termed attitude toward the behavior" (p. 6). The authors further explain that attitudes are based on personal beliefs. The second determinant of intention is the person's perception of social pressure to perform or not perform the behavior and is termed subjective norms. The behavioral outcome depends on whether the two determinants are congruent or which of the determinants is of greatest importance (Ajzen & Fishbein, 1980).

Jorgensen and Sonstegard (1984) used the theory of reasoned action in predicting adolescent sexual and contraceptive behavior. Adolescent pregnancy risk was defined as the frequency with which an adolescent female engaged in unprotected sexual intercourse. Two components,

sexual activity and contraceptive behavior, were studied. Adolescents considered at high risk were those who practiced frequent intercourse with no effective contraception. Those who avoided intercourse or used a contraceptive method consistently were considered at low risk.

The sample consisted of 385 adolescent females ages 13 to 18 years. Information was gathered using a self report questionnaire. Questions that measured their attitude towards the behavior included, for example, "I believe that full sexual relations are acceptable for a girl before marriage when she is in love" (Jorgensen & Sonstegard, 1984, p. 48). A Likert scale with choices which included strongly agree to strongly disagree was used. Questions that measured the subjective norm of the theory included items that indicated the adolescent's perception of parental and peers' beliefs regarding sexual intercourse and use of contraceptives. Finally, behavior was measured by questions that addressed the frequency of intercourse and the frequency of birth control use (Jorgensen & Sonstegard, 1984).

Findings showed a significant correlation when predicting adolescent contraceptive behavior on the basis of attitudes toward contraception and normative beliefs of parents. The researchers felt that since the study identified actual behavior rather than behavioral

intentions, more credibility could be attributed to the theoretical model and that it could be generalized to the adolescent population. The findings differed from other studies in that peer norms were only weakly related to any of the pregnancy-risk behavioral measures (Jorgensen & Sonstegard, 1984).

In another study, researchers were able to use the theory of reasoned action in predicting intention to perform breast self-examination (BSE) and BSE behavior in older women (Lierman, Young, Kasprzyk, & Benoliel, 1990). Lierman et al. reported that ninety three volunteers whose ages ranged from 51 to 80 years were recruited. The women completed questionnaires which measured the various components of the theory. The personal evaluation of performing the behavior was defined as "affect" or a general feeling of favorableness or unfavorableness toward BSE. Six items rated on a 7-point Likert scale measured this component. Questions were framed with adjectives such as "good or bad," or "frightening to reassuring." Attitude was measured by behavioral consequence beliefs related to BSE performance and breast cancer. Rating for each belief was also made on a 7-point Likert scale from strongly agree (+3) to strongly disagree (-3).

Subjective norms were identified as nine important social referents. These referents were rated according to

the respondent's perception of whether that person or group wanted her to perform BSE, using a 7-point Likert scale. Questions were, for example, "I think my regular doctor feels I should (+3) should not (-3) perform BSE every month" (Lierman et al., 1990, p. 99). The sample was divided into two groups based on their reported BSE frequency: a) infrequent, 0-3 times in the last 6 months, and b) frequent, 4-6 times in the last 6 months. The frequent performers displayed a more positive attitude toward BSE as indicated by measures of "affect" and "attitude". They also evidenced stronger social normative influences supporting their BSE behavior (Lierman et al., 1990).

Another study examined the applicability of the theory of reasoned action to predicting and understanding how primiparous and multiparous mothers intended to feed their infants (Manstead, Proffitt, & Smart, 1983). Two-hundred and fifty mothers participated in the study. One-hundred and six mothers were in the primiparous test group and 109 in the multiparous test group. They completed a first (predictive) questionnaire when they were at least 24 weeks pregnant. A follow-up questionnaire was sent to each mother 6 weeks after the birth of her baby (Manstead, Proffitt, & Smart, 1983).

A control group who did not complete the first questionnaire was also recruited. Follow-up questionnaires

were sent to these mothers 6 weeks after delivery. Multiparous mothers were not included in the study in an attempt to avoid positive or negative evaluations toward the behavior based on previous experience with a feeding method. Thus, the control group was composed of 85 primiparous mothers (Manstead, Proffitt, & Smart, 1983).

Questions were designed to measure attitudes toward breast feeding and bottle feeding, subjective norms relating to breast and bottle feeding, and intentions to breast-feed or bottle-feed. Items on the questionnaire were rated by a 7-point scale with end points labeled "very likely" and "very unlikely" (Manstead, Proffitt, & Smart, 1983).

After the data were analyzed, findings demonstrated a strong relationship between intentions and behavior. Thus, Fishbein's and Ajzen's condition that the model is only applicable to behavioral prediction when intention and behavior are highly related was met. Attitudes and subjective norms highly correlated with behavior, intentions, and each other (Manstead, Proffitt, & Smart, 1983).

The model reported differences between primiparous and multiparous mothers. As the researchers expected, attitudinal factors were more influential than normative factors in shaping multiparous mothers' intentions, but the two factors exerted approximately equal influence on the

intentions of primiparous mothers (Manstead, Proffitt, & Smart, 1983).

The researchers concluded that the study supported the theory of reasoned action and suggested that the primary beliefs of the behavior should form the focus of the persuasive communication given to a group in any future attempts designed to change infant feeding practices (Manstead, Proffitt, & Smart, 1983). This principle, which focuses on the primary beliefs of a given behavior, can be applied in designing classes to promote risk reduction behaviors in the case of AIDS.

When applying the theory of reasoned action to AIDS prevention, for example, a woman may believe that the use of a condom will help prevent AIDS, but her perception of her partner's expectation (subjective norm) not to use the condom may be the more influential determinant of behavior. Ajzen and Fishbein (1980) further explain that attitudes are a function of beliefs and take into account outcomes. Thus, a person "who believes that performing a given behavior will lead to a mostly positive outcome will hold a favorable attitude toward performing the behavior" (p. 7). In the above example, a woman could believe that the use of a condom may prevent AIDS and that prevention from infection is a desirable outcome. Thus, a woman's personal factor or attitude towards the use of a condom may be a positive one.

But studies have shown that women and their partners in high risk populations are not using condoms (Kegeles, Adler, & Irwin, 1988).

AIDS researchers are asking whether women who are at risk perceive themselves at risk for AIDS infection and what is the degree of danger they perceive (Kegeles, Adler, & Irwin, 1988; Mays & Cochran, 1988). Following the theory of reasoned action, if Latina women perceive AIDS as a danger and value the use of a condom as a protection, the personal factor or first determinant of the intent to act in a risk reducing manner is present. However, it might be that the woman's subjective norm is not congruent with her personal factor. A woman's perception of her partner's attitude towards the condom may be opposed to her own attitude. In other words, recommendations for public education and supporting behavioral changes in Latino men would put the personal factor and subjective norm in congruence for the Latina woman according to the theory of reasoned action.

Public education aimed at influencing Latino men to accept the use of a condom as a means of protection for themselves, women, and unborn children could lead to a greater degree of prevention of AIDS among both Latino men and women.

Review of Literature

Epidemiology of AIDS

Well into the eighth year of the AIDS epidemic, Heyward and Curran (1988) of the Centers for Disease Control (CDC) were reporting that AIDS had become a major cause of morbidity and mortality in the United States. It had become the leading cause of death in the country among people with hemophilia and intravenous drug use. The meaning became more significant when the public heard examples of what the impact had been in specific areas. In San Francisco alone, the death toll as early as 1986 had already exceeded the number of deaths of soldiers and sailors from that city for World War I, World War II, the Korean War and the Vietnam conflict combined (Francis & Chin, 1987).

Reporting of AIDS cases began in 1981. By July 1988, a total of 66,464 adults and children had been reported as AIDS cases to the CDC. Of that total number, more than half (37,535) had died (Heyward & Curran, 1988).

The profile of the cases between 1981 and July 1988 included 63% homosexual or bisexual men without a history of IV drug use, 7% homosexual or bisexual men with a history of IV drug use, and 19% heterosexual men and women who were IV drug users. Three percent of reported cases were associated with transfusions. Nearly all transfusions occurred before 1985, at which time serological screening of blood donors

was instituted; the remaining 1% were hemophiliacs. Transmission was undetermined in 3% of the cases largely due to incomplete information on the frequency of sexual contact (Heyward & Curran, 1988).

By 1988, the Public Health Service had developed mathematical models to project the future course of the HIV infection and AIDS in the United States. It was estimated that by the end of 1992, the cumulative case count would reach 365,000 (Heyward & Curran, 1988). Cumulative cases in the United States to January 31, 1992 have been 209,693 (Santa Clara County, 1992).

Incidence of AIDS among Latinos

As the epidemic progressed, the national profile was showing that the incidence rates of AIDS was several times higher in people of color than among whites (Allen & Curran, 1988). The number of reported cases had consistently increased every year since 1981. Among the black population the number of diagnosed cases had quadrupled in 1982 and doubled in 1983 and 1984. Similar trends occurred in the Latino population. The number of cases tripled in 1982 and 1983 but less than doubled for each year between 1984 and 1986 (Peterson & Bakeman, 1988). Significant for this study was the fact that while Latinos represent 8% of the United States population, they represent 16% of all AIDS cases. This proportion has increased from 1987 when Latinos

represented 14% of all AIDS cases (National Coalition of Hispanic Health and Human Services Organizations [NCHHHSO], 1991).

Epidemiology of AIDS in U.S. Women

The first female AIDS case in the U.S. was reported in 1981. By 1982, there were fewer than 100 cases among women, and in the same year perinatal transmission was first described. The following year, the number of cases among women rose to almost 200; this included the first cases of heterosexual transmission in the U.S. In 1985 the number of cases had risen to more than 1,000 and transmission of HIV through breast milk was initially suggested. By 1989, about 8 years after the first report of a woman with AIDS, cases had increased to more than 10,000, and women accounted for 9% of all AIDS cases in the U.S. (Ellerbrock & Rogers, 1990). In reviewing the literature it has been found that the rate of increase of HIV infection, not diagnosed AIDS cases, in 1990 was greater in women than in any other defined population in North America (Ellerbrock & Rogers, 1990). In several cohort studies of HIV seropositivity (certain defined inner city populations, Job Corps candidates, and armed services recruits) the male/female ratio has approached parity. Between 1985 and 1988, the rate of mortality quadrupled for women with AIDS in the U.S. Thus the pattern of HIV infection in the U.S. has been

gradually shifting toward the pattern observed in Central Africa, Latin America, and other third world countries. This pattern is what the World Health Organization calls Pattern II or higher incidence of HIV infection due to heterosexual contact (Carpenter, Mayer, Stein, Leibman, Fisher, & Fiore, 1991).

Latina Women and AIDS

By 1989, it had been observed that approximately 80% of babies born to mothers with AIDS had contracted the disease (Nicholas, Sondheimer, Willowghby, Yaffe, & Katz, 1989). Of the pediatric cases of AIDS, 53% occurred among blacks and 23% among Hispanics (Public Health Reports, 1988). This gave the U.S. Public Health Service an indirect method of assessing the prevalence of AIDS among women of color. By July 1991, Latinas accounted for 21% of AIDS cases among women and overall incidence is projected to continue to increase (NCHHHSO, 1991).

Aids Transmission

The AIDS virus has been isolated in a variety of body fluids, including blood, semen, vaginal fluid, tears, and saliva. Epidemiologic studies have shown that the fluids that best provide sufficient virus for transmission seem to be limited to blood, semen, and vaginal secretions (Francis & Chin, 1987). The virus is effectively transmitted by sexual contact between men, from men to women, and from

women to men. Perinatal transmission can apparently occur in utero, during parturition, or during postpartum breast-feeding (Francis & Chin, 1987).

The pattern of infection transmission has been changing for women. In 1982 only 12% of the women diagnosed with AIDS were presumably infected by their male sexual partners. By 1986 the number had increased to 26%. Of the women infected through sexual activity, 77% were black or Latina. In New York City alone, estimates are that the prevalence of HIV infection is thought to be 50% among intravenous drug using women and 20% among those whose sexual partners are intravenous drug users. Of these women 80% were most likely black or Latina (Mays & Cochran, 1988).

AIDS and Women's Issues

A major trouble area for women with AIDS has been gynecological manifestations which are often undetected by primary care physicians. Infections, malignancies, and disorders of the genital tract in the HIV-infected woman are just starting to be followed in clinical trials (Wofsy, 1991, Summer). Vaginal candidiasis is common among women, but particularly so among HIV-infected women. In one study candida vaginitis was observed to be present for periods of 6 months to 3 years before the diagnosis of HIV infection was established. The authors recommended that recurrent vaginitis serve as a sentinel marker for possible HIV

infection in otherwise asymptomatic women (Carpenter, Mayer, Stein, Leibman, Fisher, & Fiore, 1991).

Some researchers are evaluating the interaction between the human papilloma virus (HPV), HIV infection, and HIV-induced immunosuppression. Findings suggest that HPV is not more frequent among HIV-infected women, but the consequences, notably cervical interstitial neoplasia (CIN), are more frequent, more severe, and more aggressive, especially in women with more advanced HIV disease (Wofsy, 1991, Summer).

In a number of studies evaluating cytologic screening in HIV-infected women, there has been a significant increase in abnormal PAP smears. Many physicians feel that HIV-infected women who are significantly immunosuppressed should have a PAP smear every six months. PAP smears may not uniformly identify CIN and colposcopy would be more ideal, yet many women at high risk for HIV infection may be attending primary care settings where these procedures and a trained gynecologist may not be readily available. Apparently the rate of progression from CIN to cervical cancer is more rapid in HIV infection, but more documentation is needed (Wofsy, 1991, Summer).

Since 1980, AIDS has been the most frequent cause of death for women between the ages of 25 and 29 (Mays & Cochran, 1988). The incidence of AIDS in women of

childbearing age has great significance for women. Besides the loss of productive persons and medical expenditures incurred as in men, women can transmit AIDS to their unborn or breast-feeding children. Mays and Cochran (1988) believe that reductions in the number of pediatric AIDS cases will depend upon the choices and behaviors of infected women. However, many women are unaware of their infection status.

Women have traditionally been the caregivers in the home. Those who have been infected may also have to care for dying partners while they themselves are physically compromised. The time from the diagnosis of AIDS to death can be relatively short. Through September 1989, the median survival time for women with AIDS, from diagnosis to death, was reported to be 9 months. In addition, less than 20% of all diagnosed cases in women survived 3 years (Ellerbrock & Rogers, 1990).

In one Rhode Island study of 161 HIV infected women, 102 of whom had acquired HIV infection via intravenous drug use (IVDU) and 59 via heterosexual intercourse, it was found that Latina women were more likely than whites, $p<.05$, blacks, $p,<.05$, and the group as a whole $p<.02$, to be married at the time of diagnosis (Carpenter et al., 1991). Within this group, the investigators were able to obtain precise information about the location of all dependent children from 94 seropositive women. Ninety two percent of

the children of women with heterosexual transmitted infection were living with their mothers, but only 25% of children of women with IVDU acquired infection were with their mothers. In the IVDU group, foster homes have become the predominant source of care. Grandparents and other relatives have assumed responsibilities for women with heterosexual acquired infection.

The added burden of planning for care of children who are left behind can be more than overwhelming for families that have been affected by AIDS. All these factors are financially immense problems for most families, but more so for Latino families in the U.S. who usually are earning minimum wage and have no health insurance nor any significant savings in the bank (De La Cancela, 1989).

Knowledge, Attitudes, and Behaviors

Some of the early studies regarding attitudes toward AIDS were conducted among adolescents. In 1985 researchers studied the responses of 1,326 adolescents in the San Francisco Unified School District (DiClemente, Zorn, & Temoshok, 1986). They reported that 92% of the students correctly identified sexual intercourse as a mode of contracting AIDS. However, only 60% were aware that use of a condom may lower the risk of getting the disease. The researchers concluded that there could be an inconsistency

between knowledge of transmission and consequential behavior.

In a second published report the data were again reviewed and ethnic differences were found (DiClemente, Boyer, & Morales, 1988). While all groups correctly reported that sexual intercourse with someone who had AIDS was one way of getting the disease, a greater proportion of the white adolescents (72%) were aware that using condoms could lower the risk of disease transmission. In contrast, only 60% of black adolescents and 58% of the Latino adolescents knew that using condoms lowered the risk of HIV infection. The researchers found the results alarming since the youth studied came from a high density AIDS epicenter where it was presumed that correct information would be more readily available.

In another study conducted in San Francisco, sexually active adolescents were studied over one year. This study examined changes in attitudes, intentions, and condom use. Data were collected from 234 females and 91 males. Participants were adolescents who were receiving service at a university clinic or health maintenance organization (Kegeles, Adler, & Irwin, 1988). In addition, during the period that the survey was conducted, the San Francisco Unified School District added a one-class segment on AIDS in the curriculum, and information via television, newspapers,

billboards on buses, aimed specifically at teenagers, had increased. The results of the study showed that adolescents generally believed that condoms were effective in preventing sexually transmitted diseases, but that they had little intention to use them. Both in the initial survey and the one conducted one year later females demonstrated little intention to have their partners use condoms. They also indicated that they were uncertain about whether or not their partners wanted to use condoms. The males believed that their partners wanted them to use condoms and were likely to intend to use them. However, the strength of this intention decreased during the remainder of the year of the study. Thus the study found that attitudes had greater influence on behavior than knowledge (Kegeles et al., 1988).

Attitudes alone may not be the only factor behind high risk behavior in the epidemic of AIDS. Mays and Cochran (1988) hold that behaviors in women at risk are more linked to personal identity problems and the lack of social networks that provide emotional and tangible support. They believe that changes are required in perceived self-efficacy, self-esteem, and perceived controllability of the future.

A study of women who attended a family planning clinic may support the theory of self-efficacy. A sero survey of HIV infection in women who attended a family planning clinic

in San Francisco was conducted (Darney, Myhra, Atkinson, & Meier, 1989). The characteristics of the population by ethnicity was 59% Latino, 17% white, 25% black, 6% Asian, and 2% other. Caucasian and black women reported higher incidence of risks than did Latinas and Asians. Of the 1,000 women who participated, 14% claimed one or more risk factors, but none had HIV antibodies. There were various explanations for the zero prevalence. One is that women who attend family planning clinics may behave in ways which place them at lower risk than their counterparts (Darney et al., 1989). The fact that these women attend a family planning clinic shows that they are assuming some control in their lives.

Cultural Aspects Relating to AIDS

Some of the early surveys on AIDS knowledge and attitudes indicated that Latinos were less well informed on many issues regarding AIDS than other racial/ethnic groups (Marin & Marin, 1990). Based on this premise, Marin and Marin conducted a study to identify the effects of gender and acculturation of 460 subjects on AIDS knowledge. The majority of the respondents (76%) reported being born outside of the U.S. and had lived in the U.S. for an average of 11.9 years. Most participants (74%) chose to respond in Spanish. Also, 73% were classified as low in acculturation to the U.S. culture based on their answers to the

acculturation scale used in the interview. The findings indicated that differences in gender were minimal. Latinos who were less acculturated most often reported a belief in casual transmission of AIDS. This suggested a possibility that attitudes toward working with or having a child go to school with someone with AIDs could be affected (Marin & Marin, 1990).

Regard for family and reluctance to discuss sexual issues have been described as strong cultural values in the Latino community (De La Cancela, 1989). Based on these two opposing values, Marin, Marin, and Juarez (1990) conducted a study to assess the willingness of Latinos to intervene with a family member at risk for AIDS. Their research explored the reactions of Latinos and non-Latino whites to talking to a hypothetical intravenous drug-using relative about various AIDS prevention strategies. They found that Latinos were generally more willing to talk to the drug user or his wife about prevention. Latinos also reported lower embarrassment to approach very intimate topics which surprised the researcher, given traditional cultural values that make sexual issues very private.

In a previous study by Marin and Marin (1989) gender and level of acculturation did not affect responses dealing with highly personal and private questions about sexual behaviors. That study was conducted using anonymous

telephone interviews, verbal, and private face-to-face interviews. In the 1990 study, Latinos were also more likely to believe that a family member was the most appropriate person to talk to someone at risk, which the researchers thought explained their greater willingness to talk to this hypothetical relative (Marin et al., 1990).

Familismo and the important role of the family was taken into account when piloting a prevention strategy in a Detroit Latino community. The methods used were story telling and problem solving (Carpio, Carpio-Cedraro, & Anderson, 1990). A story was presented with children as the main characters in a family with a person with AIDS. At the end of the story participants were asked to respond to the children's concerns in the story. Evaluation showed that the majority of participants were very willing to discuss difficult issues in the story such as drugs and sex. Furthermore, Carpio and colleagues found that individuals shared personal matters with the researchers such as limitations on communicating sexual information to their children. Over all, the AIDS-educators found that the strategy was effective in increasing knowledge and skill development in overcoming attitudinal barriers and misinformation about AIDS.

Some researchers are suggesting that factors beyond cultural values need to be considered when planning a

prevention program in a community (De La Cancela, 1989; Mays & Cochran, 1988). They propose that specific sociopolitical circumstances in minority communities be considered. De La Cancela (1989) found that lower wage earning capacity and fragile social conditions influence individuals in such a way that they can only control life experiences on a day to day struggle. It is less likely that people in these circumstances can realize a long term vision to avoid chronic illnesses such as AIDS. It is believed that community-based intervention, sensitive to issues relevant to the specific community and offering ongoing support to those who are making behavioral changes in an effort to prevent AIDS, will be more effective in the long run (Mays & Cochran, 1988).

Summary

The theory of reasoned action has shown that most behavior is consciously controlled when a person's attitude towards the behavior and a person's perception of social pressure regarding the behavior are in congruence. The literature has shown that Latinas' attitudes towards reducing the risk of AIDS and their perceptions of social pressure about the risk reducing behavior are not always congruent. In order to reduce the increasing trend of Latinas with HIV infection, prevention programs need to incorporate methods that will help women recognize their

real risk versus perceived risk of AIDS. In addition, community programs need to reach the partners and give on-going support to both Latino men and women for changes in risk behaviors.

Chapter 3

METHODOLOGY

There has been an increase in the number of AIDS cases among the Latino population in the U.S. (NCHHHSO, 1991). Health workers have been concerned about a similar trend in Santa Clara County (Santa Clara County, 1992). Workers at a neighborhood clinic that serves a large number of Latino clients have been concerned about the number of young, single, Spanish speaking Latinas, who may be at risk for HIV infection, and are followed for prenatal care at the clinic. Since education is a major tool for prevention of AIDS, this study identified factors that would be important in an AIDS prevention educational program for Latinas. It was decided to identify factors among the Spanish prenatal population that would help future educational programs for AIDS prevention. This chapter describes the method used in conducting a study that identified knowledge, attitudes, and behaviors toward AIDS among a sample of Latina Spanish speaking clients seeking prenatal care.

Design

The research design used in this study was descriptive. Polit and Hungler (1990) state that the purpose of descriptive studies is to observe, describe, or document aspects of a situation. This study identified or documented knowledge, attitudes, and behaviors towards AIDS among

Latina women in Santa Clara County. Questionnaires or surveys are frequently used in descriptive research (Oyster, Hanten, & Llorens, 1987). The questionnaire used in this study was developed by staff at the University of California, Los Angeles (Flaskerud & Nyamathi, 1989).

Approval for Human Subjects Study

The research protocol and instrument were submitted to and reviewed by the Human Subjects Review Board of San Jose State University (see Appendix A). Letters of consent in English and Spanish (see Appendix B) were included, explaining how the study would help assist medical personnel and counselors in identifying what knowledge people had about preventing and controlling the spread of AIDS.

Subjects/Setting

A convenience sample of 30 Latina women was selected. The selection criteria included: (a) Latina women seeking prenatal care, (b) women whose language of preference was Spanish, and (c) women between the ages of 17 and 35.

During the course of their routine prenatal intake appointments at a neighborhood clinic, clients were informed of the study and invited to participate by clinic personnel. A detailed explanation of the study, including the consent and individual rights form, and any benefits or risks the study involved were explained to subjects who agreed to participate in the study.

Clients were informed that their participation was completely voluntary and that they could withdraw or stop at any time without jeopardizing their health care at the clinic or relations with San Jose State University. Possible risks included the discomfort with the subject matter and anxiety a participant could have if she felt she may be at high risk for HIV infection. This was discussed with each subject. Subjects were then provided a quiet, private room in which to complete the questionnaire.

Data Collection

One day a week over the course of three months, prenatal clients attending a local neighborhood clinic seeking care for the first time in their current pregnancy were invited to participate in the study. To maintain confidentiality, a name and number was not assigned to any questionnaire. Subjects spent between 15 to 30 minutes completing the questionnaire. One subject requested that the questions be read aloud as she marked her individual questionnaire. Subjects then put the questionnaires into one large manila folder provided at the desk they used and returned it to the researcher. Afterwards, subjects were given an opportunity to individually ask the researcher questions they had about AIDS and some of the questions on the survey. The 3rd, 7th, and 16th items on the questionnaire stimulated more discussion than other items.

These items asked (a) whether there was any discomfort with homosexual or bisexual men, (b) whether their partners used condoms, and (c) whether they or their partners had sex with other people.

Instrument

The tool used was a questionnaire developed by Dr. Jacquelyn H. Flaskerud (Flaskerud & Nyamathi, 1989) and colleagues at the University of California, Los Angeles. Items in the questionnaire included 16 questions about knowledge, attitudes, and behaviors of respondents in relation to AIDS and 8 sociodemographic questions.

Responses were divided into yes and no categories. In order to reduce non-response to items, the author of the questionnaire added a don't know category. Knowledge items included knowledge of symptoms of AIDS, transmission, and prevention. One item asked about the presence of community resources. Attitude items included questions about attitudes toward sexuality, drug use, and fears. Practice items included questions about current sexual and drug use. The second part included 8 sociodemographic items: (a) age, (b) number of years of education, (c) marital status, (d) family income, (e) number of children age eighteen and younger, (f) religion, (g) ethnic group, and (h) birthplace.

The questionnaire was evaluated for content validity by experts in AIDS research at the UCLA Schools of Nursing,

Medicine, and Public Health. It was translated into Spanish by a Latina nurse educator and back-translated into English by a different bilingual Latina translator to "establish semantic equivalence between the English and Spanish versions" (Flaskerud & Nyamathi, 1989, p.341). They used the Kuder-Richardson formula (KR-20) to determine instrument reliability and internal consistency was .82 for the knowledge scale, .58 for the attitudes scale, and .60 for the behaviors scale (Flaskerud & Nyamathi, 1989).

The questionnaire consisted of 3 subscales: 10 items relating to knowledge, 3 items relating to attitudes, and 3 items relating to behaviors. The 10 items relating to knowledge is the only subscale in which there is a possibility of a perfect score of 10. A score of 10 means that the subject has more knowledge about AIDS. There are no right/wrong answers in the other two subscales as these questions relate to attitudes and behaviors.

Data Analysis

Data was organized in a frequency distribution per item. Chi-square was then utilized to examine the relationship between the following variables: (a) knowledge score and years of education, (b) knowledge and age, (c) knowledge and marital status, (d) knowledge score and attitude score, and (e) knowledge and behavior scores.

Results were organized into tables showing the frequency distribution. The frequency and mean of the ten questions relating to knowledge about AIDS was also summarized in a table. There was no total score for the subscales of attitudes and behaviors, but the frequency distributions are shown. (see Appendix E).

Chapter 4

FINDINGS AND INTERPRETATION

This chapter presents the analysis of the findings from the study. The purpose of the study was to identify Latina women's knowledge, attitudes, and behaviors in relationship to AIDS. The means for the subscales of knowledge and selected demographic variables are described. Frequency distributions were summarized for the subscales of attitudes and behaviors.

Demographic Variables

Thirty Spanish speaking Latina women participated in the study (see Table 1). Ages ranged from 17 to 38 years with a mean age of 26 years and a mode of 29 years. The years of education ranged from 3 to 16 years with a mean of 8.5 years of school and a mode of 6 years of school (see Table 2). Two subjects responded that they had 16 years of education and five did not respond.

Marital status was divided into 4 categories. The categories included married, single, divorced, or separated. The majority, 46% (n=13), responded that they were single. Thirty seven percent (n=11) indicated that they were married. Ten percent (n=3) were separated and 3% (n= 1) were divorced.

Table 1

Age Distribution of the Sample (n=30)

Age	n	%
17	1	3
18	2	7
19	1	3
20	2	7
21	2	7
23	2	7
24	2	7
25	1	3
26	1	3
29	3	10
30	1	3
31	2	7
33	1	3
36	1	3
38	1	3
No response	7	23

Table 2

Education (n=30)

Years of Schooling	n	%
3	2	7
4	2	7
5	2	7
6	8	27
8	2	7
9	2	7
10	2	7
11	2	7
13	1	3
16	2	7
No response	5	17

Eighty three percent (n=25) of those responding were born in Mexico and one was born in the United States. Four individuals chose not to respond to this item.

Table 3

Marital Status (n=30)

Status	n	%
Married	11	37
Single	13	43
Divorced	1	3
Separated	3	10
No response	2	7

Findings from the AIDS Questionnaire

Knowledge

There were ten items on the questionnaire that related to knowledge of AIDS, including symptoms of AIDS, modes of transmission, prevention, and knowledge of community resources. There was a possible score of 10; the higher the score, the more knowledge subjects had about AIDS. The mean score, for the sample in this study was 6.85.

Table 4

Response to Knowledge (n=30)

Statement	Yes % (n)	No % (n)	Don't Know % (n)	NR[a] % (n)
Knowledge				
1. AIDS caused by virus	90(27)	-	7(2)	3(1)
2. People with AIDS usually die	90(27)	7(2)	3(1)	-
4. Get AIDS from sharing needles	80(24)	10(3)	7(2)	3(1)
6. Get AIDS from mother to baby	97(29)	3(1)	-	-
8. Persons with AIDS lose weight	80(24)	3(1)	13(4)	3(1)
10. AIDS agencies available in community	67(20)	3(1)	3(1)	27(8)
11. Get AIDS from sex with carrier	90(27)	3(1)	-	7(2)
12. Persons with AIDS have fever	60(18)	3(1)	30(9)	7(2)
13. Get AIDS from blood transfusion	63(19)	13(4)	17(5)	7(2)
14. Can protect self by using condom	70(21)	13(4)	10(3)	7(2)

Note. [a]NR = nonresponse

The distribution of responses to questions based on knowledge about AIDS is presented in Table 4. Over 80% of the participants were knowledgeable about the mode of transmission. Eighty percent (n=24) responded that sharing needles was a means of transmission. Ninety seven percent (n=29) responded correctly that a mother could transmit the virus to her unborn baby during pregnancy. Ninety percent (n=27) responded correctly about the possibility of sexual transmission of AIDS.

In the area of prevention, 70% (n=21) correctly responded that the use of a condom can help protect a woman from AIDS. Sixty-six percent of the subjects (n=20) responded correctly about the resources for testing and treatment in the community.

Eighty percent (n=24) responded that loss of weight is a symptom of AIDS and 60% (n=18) were aware that fevers and infections could also be symptoms.

Attitudes

There were three items that related to attitudes. Fifty percent (n=15) responded that they felt uncomfortable being with men whom they knew had sex with other men or both men and women. This item, one of three, prompted more discussion than other items in the individual follow-up sessions. The researcher asked whether they thought bisexuality existed among Latino men and whether women in

Table 5

Response to Attitudes and Behaviors (n=30)

Statement	Yes % (n)	No % (n)	Don't Know % (n)	NR[a] % (n)
Attitudes				
3. Uncomfortable talking to homo/bisexual men	50(15)	20(6)	20(6)	10(3)
5. Take my child from school if child with AIDS enrolled	23(7)	50(15)	23(7)	3(1)
9. Uncomfortable talking about AIDS/sexuality	17(5)	67(20)	13(4)	3(1)
Behaviors				
7. Partner uses condoms	27(8)	67(20)	3(1)	3(1)
15. Self or partner uses injected drugs	3(1)	83(1)	3(1)	10(3)
16. Self or partner has sex with others	3(1)	83(1)	3(1)	10(3)

Note. [a]NR = nonresponse

general were aware of the possibility that their partners may be bisexual. Several women volunteered that they knew of bisexual men, but none thought their own partners had ever experienced homosexual encounters. More than half of the respondents were more concerned with possible sexual relations their partners might have had with other women. The consensus was that it was important for women to know all the possible sexual partners of the men in their lives.

Fifty percent (n=15) of the women responded that they would not take their child out of school if it came to their attention that there was a child with AIDS in the school. Twenty three percent (n=7) responded they would take their child out of school, seven did not know what they would do, and one did not respond.

It was noteworthy that 67% of the women (n=20) responded that they were not uncomfortable discussing AIDS and human sexuality. Seventeen percent (n=5) responded that they were uncomfortable with such discussions and 13% (n=4) responded that they did not know. Literature in the early 1980's indicated that one of the possible barriers to AIDS education in the Latino population was reluctance to discuss human sexuality (De La Cancela, 1989). This was not the case in this study. The reason may be that these subjects may have had more opportunity to discuss human sexuality, since part of their prenatal care included required

attendance at prenatal classes. One class is dedicated to family planning methods. Some of the sexually transmitted diseases are also discussed in this class. These subjects may have participated in the classes from previous pregnancies.

Behaviors

Three items were related to sexual and drug use practice. Twenty seven percent of the women (n=8) responded that they and their partners used condoms and 67% (n=20) responded they did not use condoms. One person responded that she did not know, which leads one to speculate whether she knew know what a condom was. One did not respond to this question. Injectable drugs were not an identified risk for the majority of the participants. Eighty three percent (n=25) responded that they did not use drugs; one person responded, yes, one person did not know, and three did not respond. Eighty three percent of the women (n=25) responded that neither she nor her partner had sexual relations with other persons. One responded yes, and three did not respond.

Relationships between sociodemographic variables and the three subscales were also studied. Chi-square statistics were used to examine the relationship between the knowledge score and selected sociodemographic variables. Groupings included: (a) knowledge and age, (b) knowledge and

years of education, and (c) knowledge and marital status. No significant relationship was identified between these variables.

Following the completion of the questionnaire, the researcher reviewed the questions and gave participants the opportunity to clarify any of the information on the questionnaire. Many women spontaneously indicated what answers they had given.

For example, when commenting on item 16, which asked whether the participant or her partner had sex with others, many said, "I answered no for myself, but I really don't know about him." There were other women who stated that they and their partners had discussed monogamy in relationship to AIDS. They stated that the men were just as interested in protecting their own health and feared sexual experiences outside the relationship. A few women stated they had told their partners not to bring diseases home to them. Those women were quite articulate and projected a strong sense of self-esteem and self-preservation. However, generally there seemed to be a need to discuss how to approach the subject of safer sexual practice with their partners.

The majority of the women stated that they had misread the item which asked if people could get infected donating blood. Sixty three percent said yes, although they thought

the question read receiving a transfusion. For this reason, a good discussion followed regarding how and when blood is tested and what a client can do to prepare for major surgery when transfusions may be needed.

Summary

Consistent with findings in the review of literature most of the women in the study scored high on questions in the subscale of knowledge about AIDS; that is, they responded correctly to questions relating to the mode of transmission. In the area of prevention, the majority responded that the use of a condom was a source of protection; but in regard to behaviors, two thirds responded that they did not use condoms. In discussions with the respondents on items related to attitudes, it was noted that women did not necessarily perceive their partners' sexual history as a real risk to themselves. However, the literature shows that one of the problems for Latinas is the high number of bisexual men who have transmitted the AIDS virus (Rogers & Williams, 1987).

The findings of this study show that educational programs for the prevention of AIDS in Latinas need to support women in their risk perception and risk reducing behaviors.

Chapter 5

DISCUSSION

This descriptive study identified knowledge, attitudes, and behaviors of Latina women living in Santa Clara County related to AIDS. Ajzen and Fishbein's (1980) theory of reasoned action was used as the conceptual framework to help identify any incongruity between Latina women's attitudes towards AIDS and actual risk behaviors. The theory also could serve as a framework in order to develop community educational programs that will support behavioral changes and thus, help prevent the spread of AIDS in the Latino population. The data collection tool was a 16 item questionnaire about knowledge, attitudes, and behaviors (Flaskerud & Nyamathi, 1989).

The sample consisted of 30 primarily Spanish speaking women seeking prenatal care at a neighborhood clinic. The sample included women between the ages of 17 and 35 years with a mean of 8.5 years of education. The majority were single mothers who were born in Mexico. Findings demonstrated that most women were knowledgeable about the transmission of AIDS, but were not taking preventative steps to reduce their risk in getting infected.

Conclusions

More than half of the women who participated in this study were either single, divorced, or separated. This

raises the possibility of multiple sexual partners as a possible risk for HIV infection. Findings in the subscales were not surprising in that the majority were knowledgeable about the mode of transmission. The majority of the subjects responded correctly about the possibility of sexual transmission of AIDS. Although more than half of the subjects correctly responded that the use of a condom can help protect a woman from AIDS, only a few responded they or their partners used condoms. This concurred with the literature that educational programs need to support prevention of sexual transmission of HIV in ways other than giving just information (Mays & Cochran, 1988).

Consistent with findings in the literature (Marin, Marin, & Juarez, 1990), more than half of the women in the study were not uncomfortable with conversations that included human sexuality. The reason could be that the women may have had previous opportunities to discuss this topic in the clinic setting. Another reason may be that pregnant Latina women consider the welfare of their unborn children so important as to overcome any embarrassment or hesitancy to discuss sexuality.

While the majority of the women expressed comfort in discussing human sexuality and AIDS in the clinic setting with the researcher, they shared that they felt they needed help in initiating conversations with their children

regarding sexual development, reproduction, and sexually transmitted diseases. Similar concerns were expressed in a study in which parents participated in a hypothetical story telling exercise about a child whose mother had AIDS. In that study parents confided to the researchers their own limitations in communicating sexual information to their children (Carpio, Carpio-Cedraro, & Anderson, 1990). Over all, participants expressed gratitude for the individual opportunity to have questions answered in Spanish about AIDS and related issues.

The positive responses of the subjects to the individual sessions with the researcher were found to be very productive in this study. These findings support other studies which have examined culturally sensitive approaches to Latinas regarding prevention of health problems. In a research program comparing pregnancy among Latinas and Anglo women, researchers found that Latina women thought it was a good idea to deliver their babies in a hospital because of the attention they received. None of the Anglo women gave this response. Anglos were more concerned with safety, personnel, and equipment (Ito, 1987). The author interpreted the attention Latina women need as personalismo or the informal trust of individuals rather than formal institutional associations. The authors concluded that if interested and sympathetic health care workers could develop

a personalismo dynamic with their Latina prenatal clients, motivation for preventive health behaviors would be greatly strengthened (Ito, 1987).

Scope and Limitations

This study was conducted in response to the rapid increase in the number of Latinos, specifically women and children with AIDS over the last ten years (Ellerbrock & Rogers, 1990). It was limited by the small number of subjects due to financial and time constraints. The small sample and the non-random selection of subjects preclude wide generalization of the findings.

Recommendations

The findings of this study have implications for health care workers who are working with Latinos in preventing AIDS. Clients, both women and men at primary care clinics, should be given individual time following their regular scheduled appointments by personnel specifically trained for AIDS prevention and education. These educators would be able to receive immediate feedback concerning clients' understanding of AIDS prevention and related issues. Besides speaking Spanish, these educators would need to develop personalismo with their clients. If the clinic had more than one health educator, the time in the clinic could be rotated every other month; allowing the second health educator time to conduct other community-based group

projects. A balance between individual teaching sessions and community group sessions keeps health workers informed as to the message the public is receiving in relationship to AIDS prevention.

In addition, AIDS prevention medical personnel featured biweekly on a regularly scheduled local Spanish radio program would be a great asset to the community. A short 15 minute segment could include a quick 3 question quiz with an opportunity for people to call in with their answers, questions, or comments. This approach would incorporate a dimension of personalismo.

Stronger efforts to reach heterosexual Latino men must be made, in order to support Latinas in negotiating for safer sex. More research is needed to locate heterosexual Latino men and offer surveys and education similar to that provided to the women in the clinics.

Finally, research using qualitative analysis may give the Latino population an opportunity to increase dialogue and help health workers in finding solutions towards stopping the spread of AIDS in the Latino population.

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APPENDIX A

Approval by Human Subjects Institutional Review Board

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Eunice Segura, Nursing
440-21 Moffett Blvd.
Mountain View, CA 94043

From: Serena W. Stanford Serena W. Stanford
AAVP, Graduate Studies and Research

Date: November 5, 1991

The Human Subjects Institutional Review Board has approved your request to use human subjects in the study entitled:

"Knowledge, Attitudes, and Behaviors about Acquired Immunodeficiency Syndrome Among Latina Women Seeking Parental Care"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

CC: Frances Munet-Vilaro

APPENDIX B

Consent Letter (English/Spanish)

To the patients at the clinic.

Eunice Segura is a Nurse who is completing a Master's Degree at San Jose State University. She is conducing a study with Latina women about knowledge, attitudes and practices about Acquired Immunodeiciency Syndrome (AIDS).

The results of this study will help doctors, nurses, and counselors to see if people understand how to prevent and control AIDS.

I (the participant) understand that:

1. I will be asked to complete a questionnaire with sixteen general questions about the control and prevention of AIDS. This will take about 15 minutes to complete.

2. I may feel uncomfortable completing some of the questions. If this occurs I will be able to discuss it with the nurse (Eunice Segura) conducting the survey.

3. Some of the benefits I will receive from participating in this study will be receiving educational information about AIDS (including written pamphlets) and having my questions answered by a professional in Spanish if I so desire.

4. (omit)

5. The results from this study may be published, but any information from this study that can be identified with me will remain confidential and will be disclosed only with my permission.

6. There are no financial risks for the participant. All the costs will be covered by the study.

7. Any questions about my participation in this study will be answered by Eunice Segura (408-299-6120). Complaints about the procedures may be presented to Bobbye Gorenberg, graduate advisor in the Nursing department at San Jose State University (408-299-3134). For questions or complaints about research subject's rights, or in the event of research-related injury, contact Serena Stanford,

PhD. (Associate Academic Vice President for Graduate Studies & Research) at 924-2480.

8. My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with San Jose State University or the clinic.

9. I have received a copy of this consent form for my file.

My signature indicated that I have read the information provided above and that I have decided to participate.

_____ _____

(Date) (participant's signature)

_____

(investigator's signature)

SJSU SAN JOSE STATE UNIVERSITY

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DOCUMENTO DE CONSENTIMIENTO

A los pacientes de la clínica:

Eunice Segura es una enfermera que está estudiando la maestría en pedagogía en la Universidad de San José. Ella está llevando a cabo un estudio con mujeres Latinas acerca del conocimiento, actitudes y prácticas relacionadas al Síndrome de Immuno Deficiencia Adquirida (SIDA).

Los resultados de este estudio van a ayudar a los doctores, enfermeras, y consejeros a identificar si las mujeres Latinas entienden cómo prevenir y controlar la transmisión del SIDA.

Yo (la participante) entiendo que:

Voy a contestar una serie de 16 preguntas generales sobre el control y prevención del SIDA lo cual me tomará aproximadamente 15 minutos.

En caso de que las preguntas me fueran incómodas, entiendo que las puedo discutir con la enfermera (Eunice Segura).

Los beneficios que yo podría recibir al participar en este estudio son: información educativa sobre el SIDA, (verbal y escrita) y tener la oportunidad de hacer mis preguntas y recibir la contestacion en español.

Los resultados de este estudio pueden ser publicados; pero cualquier información acerca de mi identidad permanecerá confidencial y no serán revelados sin mi autorización.

No tendré ningún compromiso financiero; todo gasto será cubierto por el estudio.

Cualquier pregunta sobre mi participación en este estudio será contestada por Eunice Segura (415-966-8316). Los reclamos

sobre este procedimiento pueden ser dirigidos a: Doctora Bobbye Gorenberg, coordinadora de los estudios especiales del Departamento de Enfermería de la Universidad de San Jose (408-924-3134). Las Preguntas e inconformidades sobre los derechos de los participantes se pueden dirigir a Serena Stanford Ph.D. (Vice-presidenta Asociada de la oficina de Estudios Graduados e Investigación) 408-924-2480.

Doy mi consentimiento sin presión de ninguna clase: y podría dejar de participar en el estudio o parte de él, en cualquier momento sin perjudicar mi relación con la Universidad de San Jose o la Clínica

He recibido copia del documento de consentimiento.

Mi firma indica que he leído la información de este estudio y he decidido participar.

_____ _____

(fecha) (firma del participante)

_____

(firma del investigador)

APPENDIX C

Questionnaire (English/Spanish)

AIDS Questionnaire *

(with key)

Directions: Choose the best answer by checking (✓) Yes, No or Don't Know to the right of each statement.

		Yes	No	Don't Know
1.	AIDS is a disease caused by a virus.	✓		
2.	People who get AIDS usually die from it.	✓		
3.	I feel uncomfortable being with men who I know have sex with other men or both men and women.			
4.	I could get AIDS from sharing needles (shooting up) with someone who is infected with the AIDS virus.	✓		
5.	If a child with AIDS were to attend my child's school, I would take my child out of the school.			
6.	A mother with AIDS can pass the AIDS virus to her unborn baby.	✓		
7.	My husband or sexual partner uses condoms when we have sex.			
8.	People who have AIDS usually have lost a lot of weight.	✓		
9.	I feel very uncomfortable talking about AIDS because when you talk about AIDS you talk about sex.			
10.	There are some places in my community where I can get tested or treated for the AIDS virus.			
11.	I could get AIDS from having sex with someone who has AIDS or is carrying the AIDS virus.	✓		
12.	People who have AIDS usually have fevers and infections.	✓		

	Yes	No	Don't Know
13. I could get AIDS from donating blood.	____	✓	____
14. I can protect myself from getting AIDS by always having my partner use a condom (rubber) when having sex.	✓	____	____
15. My sexual partner or I use drugs (shoot up).	____	____	____
16. My sexual partner or I have sex with other people.	____	____	____

THANK YOU!

* Dr. Jacquelyn H. Flaskerud, School of Nursing, UCLA, 10833 Le Conte Avenue, Los Angeles, CA 90024-1702. Reprinted with permission.

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Cuestionario del SIDA *

Instrucciones: Escoja la mejor respuesta marcando con el simbolo (✓) si, no o no se a la derecha de cada oracion.

		SI	NO	NO SE
1.	El SIDA es una enfermedad causada por un virus.	____	____	____
2.	La gente que contacta el SIDA generalmente se muere a causa de esta misma enfermedad.	____	____	____
3.	Me siento incomoda estar con hombres que yo se tienen reliaciones sexuales con otros hombres o con hombres tanto como mujeres.	____	____	____
4.	Yo podria contactar el virus del SIDA al compartir agujas con alguien que tiene el virus.	____	____	____
5.	Si un niño con el SIDA fuera a la escuela donde va mi hijo, yo sacaria a mi hijo de esa escuela.	____	____	____
6.	Una Madre con el SIDA puede pasar el virus del SIDA a su hijo durante el embarazo.	____	____	____
7.	Mi compañero sexo usa condones cuando tenemos relaciones sexuales.	____	____	____
8.	Las personas que tienen SIDA usualmente han rebajado mucho peso.	____	____	____
9.	Me incomoda mucho conversar acerca del SIDA porque hablando del SIDA uno habla del sexo.	____	____	____
10.	Hay algunas agencias en mi comunidad donde me pueden hacer el examen y dar tratamiento por el virus del SIDA.	____	____	____

	SI	NO	NO SE
11. Yo podria contactar el SIDA al tener relaciones sexuales con alguien que esta infectado con el SIDA o alguien que es portador del virus.	____	____	____
12. Las personas que tienen SIDA generalmente tienen fiebres (calenturas) e infecciones.	____	____	____
13. Yo podria contactar el SIDA dando tranfusion de sangre.	____	____	____
14. Me puedo protejer de contactar el SIDA si hago a mi compañero sexo que siempre use un condon durante las relaciones sexuales.	____	____	____
15. Mi compañero sexo o yo usamos drogas inyectadas.	____	____	____
16. Mi compañero sexo o yo tenemos relaciones sexuales con otras personas.	____	____	____

Muchas Gracias!

El proximo juego de preguntas son hacia usted.

1. Que edad cumplio en su ultimo cumpleaños?

_____ Años.

2. Cuantos años fue a la escuela? Cuente desde el primer grado y circule el año mas alto que estudio.

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

8 graduado de primaria

12 graduado de secundaria

16 graduado de colegio

3. Cual es su estado civil?

_____ Casado

_____ Soltero

_____ Divorciado

_____ Separado

_____ Viudo

4. Cual es el ingreso mensual total de la familia incluyendo todas las entradas?

_____ $ 0 - 832

_____ $ 833 - 1666

_____ $1667 - 2499

_____ $2500 - 3332

_____ $3333 - 4166

_____ $4167 o mas

5. Cuantos hijos de diez y ocho años o menos viven en su casa?

_____ cuantos hijos

6. Cual es su Religion?

_____ Protestante

_____ Catolica

_____ Budista

_____ Judia

_____ Otra

_____ Ninguna

7. Cual es su raza o grupo etnico?

_____ Negra, no Hispana

_____ Hispana o Latina (Haga circulo a su raza o etinco)

(Mexicana, Puerto Riquena, Cubana, Guatemalteca, Salvadorena, Nicaraguana u otra.)

_____ Blanca, no Hispana

_____ Asiatica (Haga circulo a su raza o etinco)

(China, Japonesa, Filina, Islas del Pacifico, Vietnamita, Combodiana, Thaliana, Laotiana u otra.)

_____ Indio Americana/Nativo Americana

_____ Otro, por favor especifique cual raza o grupo etnico

_____

7. En que Pais nacio Ud.?

_____ Estados Unidos

_____ Otro Pais, por favor especifique _____

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APPENDIX D

Responses to Knowledge about AIDS

Table 4

Response to Knowledge (n=30)

Statement	Yes % (n)	No % (n)	Don't Know % (n)	NR[a] % (n)
Knowledge				
1. AIDS caused by virus	90(27)	-	7(2)	3(1)
2. People with AIDS usually die	90(27)	7(2)	3(1)	-
4. Get AIDS from sharing needles	80(24)	10(3)	7(2)	3(1)
6. Get AIDS from mother to baby	97(29)	3(1)	-	-
8. Persons with AIDS lose weight	80(24)	3(1)	13(4)	3(1)
10. AIDS agencies available in community	67(20)	3(1)	3(1)	27(8)
11. Get AIDS from sex with carrier	90(27)	3(1)	-	7(2)
12. Persons with AIDS have fever	60(18)	3(1)	30(9)	7(2)
13. Get AIDS from blood transfusion	63(19)	13(4)	17(5)	7(2)
14. Can protect self by using condom	70(21)	13(4)	10(3)	7(2)

Note. [a]NR = nonresponse

APPENDIX E

Response to Attitudes and Behaviors

Table 5

Response to Attitudes and Behaviors (n=30)

Statement	Yes % (n)	No % (n)	Don't Know % (n)	NR[a] % (n)
Attitudes				
3. Uncomfortable talking to homo/bisexual men	50(15)	20(6)	20(6)	10(3)
5. Take my child from school if child with AIDS enrolled	23(7)	50(15)	23(7)	3(1)
9. Uncomfortable talking about AIDS/sexuality	17(5)	67(20)	13(4)	3(1)
Behaviors				
7. Partner uses condoms	27(8)	67(20)	3(1)	3(1)
15. Self or partner uses injected drugs	3(1)	83(1)	3(1)	10(3)
16. Self or partner has sex with others	3(1)	83(1)	3(1)	10(3)

Note. [a]NR = nonresponse

APPENDIX F

Permission to Use the Questionnaire

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF NURSING
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1702

December 7, 1990

Eunice Segura
440-21 Moffett Blvd.
Mountain View, CA 94043

Dear Ms. Segura:

Enclosed please find a copy of the questionnaire in Spanish and English you requested. I also give you my permission to use them. If you have any questions, you may call my assistant Cecilia Rush (213-825-6892).

Sincerely,

Jacquelyn H. Flaskerud, cer

Jacquelyn H. Flaskerud, RN, PhD
Professor

JHF:cer

Enclosures

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SCHOOL OF NURSING
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024-1702

July 12, 1993

Eunice Segura
165 Bonny Street
Mountain View, CA 94043

Dear Ms. Segura,

You have my permission to reprint the questionnaires in the appendix of your thesis. I look forward to receiving a copy of the results from the 30 spanish speaking participants in the study.

Congratulations!

Sincerely,

Jacquelyn H. Flaskerud, RN, PhD
Professor