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Knowledge, attitudes and beliefs of social workers towards HIV/AIDS

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KNOWLEDGE, ATTITUDES AND BELIEFS OF SOCIAL WORKERS TOWARDS HIV/AIDS

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
FRANCIS LELLAH SEHNEAH

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
JULY 1990
This explanatory descriptive study examined variables which will help to better understand the knowledge, attitudes and beliefs of social workers towards HIV/AIDS. The study examined three important factors: (a) knowledge of disease transmission and perceived risk; (b) infection control, practices and antibody testing; and (c) attitudes towards refusal to care and other ethical issues.

The findings revealed that there is no significant difference in the knowledge, attitudes and beliefs of social workers towards HIV/AIDS.
ACKNOWLEDGEMENTS

Many people have contributed to the success of this thesis. The people whose contributions are clearly noticeable are my nephew Edward L. Wonkeryou at the University of Pennsylvania and Dr. Raymond C. Meyers, Children Youth Service, Philadelphia, Pennsylvania. They liberally helped in designing the questionnaire, editing the drafts, printing and distributing the questionnaire.

My heartfelt thanks goes to three professors who encouraged and inspired me to study. Dr. Amos Ajo and Professor Hattie Mitchell, School of Social Work at Clark Atlanta University, and Dr. Betty Cook, Morris Brown College, Atlanta, Georgia.

Dr. Mamie Darlington has my eternal gratitude. Without her skills and genius for professional judgement, it would have been impossible to complete this study.

I am grateful to Mr. Doakar Mongrue for having provided me room and board throughout my study; and sincere thanks to my friend John Lam for his valuable assistance and support. Many thanks to my wife, Mary
Ann Sehneah, for her relentless patient for the many years I was away from her, especially Zarwea, my son, Tracy, my daughter, and my friends who endure my unavailability.
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CHAPTER I

INTRODUCTION

Comparatively, little information is available about the knowledge attitudes, beliefs and practices of social workers regarding HIV/AIDS infection. The researcher developed a survey instrument designed to assess social workers' beliefs and practices related to the HIV infection.

Significantly, the main areas of interest to be covered in the survey include: (a) knowledge of disease transmission and perceived risk; (b) infection control practice and antibody testing; (c) attitudes towards refusal to care and other ethical issues; and (c) attitudes towards refusal to care and other ethical issues.

The purpose of the study is aptly illustrated by Blanchet (1988, p. 165) that "the social worker's expertise in assessment can be very effective in the management and direct care of persons with HIV/AIDS." He further argues that a patient's support system, home environment, financial situation, ability to cope, and comprehension of the illness must be examined so that social workers can identify areas
of concern.

Blanchet (1988) recognizes the contribution of Lopez and Getzel in identifying the following themes as essential when evaluating a person with HIV/AIDS: "historical and current instrumental and personal management of daily living; pre-AIDS experiences with illness and death; current availability of kin, including gay partners, friends, and neighbors for material and social support; cumulative impact of AIDS on vital reserves and coping functions; acceptance of personal identity as gay, if applicable; current recognition, meaning, and acceptance of bodily changes and decline; and material resources and entitlements to health and social services."

Harper's magazine (1985) says that HIV/AIDS was first discovered in 1981 when an unusual form of Pneumocystics Carinii killed five young men of Los Angeles. All five were homosexuals who suffered from a profound impairment of their immune systems. The affected men specifically lacked T-4 lymphocytes, a type of white blood cell that is essential to defending the body against infections. Physicians saw this patterns repeated as the number of AIDS cases
escalated. From its inception, HIV/AIDS has been and still remains a cardinal public health problem in the United States like most of the world. It has been discovered and described in Europe, Africa, South America, Australia and part of Asia. AIDS is a disease that has been fatal in most people who have contracted its major symptoms. Many people have had reactions to blood tests indicating that they have been exposed to HIV/AIDS. Because of this, Long (1987, p. 54) observes that "the HIV/AIDS virus infects persons who expose themselves to known risk behavior such as certain types of homosexual activities or sharing intravenous (IV) drug equipment." He further establishes that although the initial discovery of HIV/AIDS was in the homosexual community, HIV/AIDS is found in heterosexual people as well.

Studies done by Friedman et al. (1987, p. 455) suggests that:

A disproportionate number of persons with HIV/AIDS have been Blacks and Hispanics. Members of minority group survive for shorter period of time having been diagnosed as having HIV/AIDS than to
whites with the disease (Center for Disease Control, 1986b; Weston, 1986).

While it is conceivable obvious that the dominant perception of the disease has been that it primarily affects gays, secondary perceptions have been of transmission among individuals of unspecified race by sharing drug-injection equipment or by heterosexual intercourse. Considering this view, it is compelling to submit that one consequence of the neglect of the differential racial effect of HIV/AIDS has been a lack of programs to allocate extra resources to AIDS-related efforts of medical institutions, health education or community groups in minority communities.

The Center for Disease Control (CDC) in Atlanta says that AIDS is an infection of the white blood cell called lymphocyte, the building block of the immune system, by virus. This virus, a new virus, has been given a name—HIV (human immunodeficiency virus). This name clarifies a lot of things muddled by prior names given this virus. It tells us who the virus infects: human. It tells us what it causes: immunodeficiency or breakdown in the immune system. Thus, HIV is the new name of this new virus which
infects predominantly the white blood cell, the lymphocyte, and the building block of our immune system. In so doing it leads to a variety of so-called opportunistic infections and unusual maligemacis (Moffat, 1987, pp. 69-70).

All in all, HIV/AIDS is considered a life-threatening disease and a major public health issue. For example, heterosexual intravenous drug users contract the disease; men and women of Haitian nationality appear to be a considerable risk; infants are likely to get it from infected mothers through the umblical cord; hemophiliacs are contracting HIV/AIDS through their use of pooled blood products; and recipients of blood transfusions have gotten HIV/AIDS. It is believed that women can acquire HIV/AIDS through normal heterosexual contact; that some otherwise healthy people are carriers of the pathogen and can pass it to others; and that some people who seem to belong to no risk group at all have come down with HIV/AIDS.

Statement of the Problem

The study will ascertain whether education,
tenure on job, and ethnicity is significant in affecting attitudes, behavior and whether it plays any significant role in increasing the knowledge of individuals. Why is this a problem? It is a problem because individuals and society might benefit and avoid risk factors if the sexually active of tomorrow are better educated and informed. This is important because social workers in a variety of social settings, including health care workers, must be prepared to address the concern of infected persons with HIV/AIDS and to counsel or refer for counseling those infected with the HIV infection or ARC. Such a preparedness is part of reducing infected persons' risk of transmitting the virus to others. Social workers represent a major channel for providing accurate information, helping to assess risks, and counseling to actively reduce risk of the patient or client. Friedman et al. (1987, p. 457) states thus:

Many thousands of people are believed to have AIDS related complex (ARC) in which serious immunosuppression caused by HIV leads to other medical conditions or diseases, such as lymphadempathy, which
are not per se diagnostic of AIDS. ARC itself is sometimes fatal. It is also evident that the rapid increase in tuberculosis, pneumonia, and endocarditis cases among IV drug users may be due to HIV infection.

A comprehensive report submitted by the Philadelphia Department of Health's Aids Activities Coordinating Office (November 1988, p. 6) states that Philadelphia ranks 10th among American cities in terms of numbers of HIV/AIDS cases, with 1,542 total reported cases in the metropolitan area (including 7 surrounding countries in Pennsylvania and New Jersey). In Philadelphia alone, 657 persons have died since 1981. By comparison, 622 Philadelphians died in the war in Vietnam. The report further submits that of those HIV/AIDS cases reported in 1988, "11.2% in Philadelphia are heterosexuals who used intravenous drugs. Eleven cases reported were among women. Most (55%) of adult cases were Black or Latino men and women. Of 14 reported pediatric cases, of HIV/AIDS, 11 are Black and 3 are Latino." It can be estimated that for every reported case of HIV/AIDS
there are dozens of individuals who are infected with HIV but currently are not ill with HIV/AIDS--maybe 40,000 in Philadelphia. Some have milder HIV/AIDS-related symptoms; however, most people generally feel and appear well, and the majority do not know they possess and carry this virus. Because of this, the school District of Philadelphia, a national leader in the school-based AIDS education, is attempting to offer special training for school nurse practitioners, who will then be able to provide unique counseling and educate students who come to them with health issues.

Mason et al. (1988, p. 255) state that the human immunodeficiency virus (HIV) is estimated to have infected more than a million people in the United States and a million more in other countries. Even though there is no vaccine or effective treatment, HIV infection can be prevented through behavior change. As the leading public health service agency for disease control, CDC has designed and implemented information and education activities in the United States. The target population include the general public, school- and college-aged populations, persons
infected or at increased risk of infection, minorities, and health workers.

Significance of the Study

The writer's interest in the research emanates from reading news articles and books and class discussions about the origin of the deadly disease, Acquired Immune Deficiency Syndrome (HIV/AIDS). As a third world student, knowing that AIDS has disproportionately impacted on Haiti and the continent of Africa, this study provides the student researcher with added advantage in gaining valuable basic information and increased knowledge in HIV/AIDS education. Information and knowledge gained from the study will enhance the writer in his professional practice as a social worker.

Further, the writer's interest escalated while during his six months of practicum training at the Grady Memorial Hospital in Atlanta, Georgia. During the course of training, he interviewed seven HIV+ patients. Out of the seven HIV+ patients interviewed, one was a female IV drug user, one homosexual and five male IV drug users. Those seven patients had
one thing in common: They were unemployed, suffered from discrimination in work places, and were alienated by family and friends. Absorbing the acute history of these HIV+ patients, the writer became socially motivated to conduct the research.

In retrospect of the writer's practicum experiences, skills and knowledge gained during these six months period is relevant and will enhance his effectiveness as a social worker in working with HIV+ patients, educating people at risk including minorities and the public at large. It can be argued that the new view or concept calls for social workers to actively analyze and study their practice activities with research method. This basic view lies well within the scope of possibility for a social worker to be both a practitioner and a researcher or a practitioner/researcher. According to the Council on Social Work Education (1982, p. 7), it is essential, therefore, that all professional social workers have, in common, knowledge values, and skills that are generally transferable from one setting, population group, geographic area, or problem to another. It is essential that advanced professional social work
practitioners have the special knowledge and skills appropriate to a specific role, field of practice, population group, or problem area.

Further, the fundamental objective of social work concerns are the relationships between individuals and social institutions. It is equally historically a fact that social work has contributed significantly to the development of these relationships in promoting social and economic justice and protecting the opportunities for people to live and co-exist with dignity and freedom. Zastro (1985, pp. 14-15) says that social work practice has been conceptualized as having four primary goals: (a) enhance the problem-solving, coping and developmental capacities of people; (b) link people with systems that provide them with resources, services, and opportunities; (c) promote the effectiveness and humane operation of systems that provide people with resources and services; and (d) develop and improve social policy.

Finally, the significance of the study is to determine whether by providing risk-reduction education and information for persons affected by and at risks for HIV/AIDS from anyone of the three
unique groups (i.e., White, Black and Latino/Hispanic) including the general public, has a valuable reward. Additional significant question is, why are Whites compared to the two heterogeneous groups? The theoretical answer to the latter question is because Blacks and Latinos/Hispanics are more likely to perceive themselves at high risk for contracting the disease than their White counterparts. It becomes compelling to argue that most studies have failed to sufficiently determine whether the three distinct ethnic groups possess significant enough information about HIV/AIDS. Because previous studies reveal more awareness among the White adolescent groups, this writer used them as a comparison group.
CHAPTER II
REVIEW OF THE LITERATURE

Just as the need for a conceptual base for practice continues, so does the need for research to support practice; the need for social workers to add to its knowledge-base due to the challenge social workers face in the education, care and prevention of the HIV/AIDS infection. Zlotnik (1987, p. 5) stressed that it is important to focus not only on the crises that persons with AIDS and their families face, but also to look at the crises that might be faced by the "helpers" as they work to alleviate the crises of their clients. He further argues that AIDS is a deadly disease, and there needs to be a way to deal with accumulated grief of social workers who are working with persons with AIDS and their families. Because of the stigma associated with this disease, professionals working with persons with AIDS must realize that they are the leaders and there are few resources available to them for training and support.

Carton et al. (1987, p. 5) says that:

The first cases of AIDS were reported in 1981, when previously healthy gay
men with no predisposing factors for immune deficiency were diagnosed with Kaposi's sarcoma or opportunistic infections such as pneumocystis carinii pneumonia. Prior to this, these conditions had been seen in patients with suppressed immunologic functioning. This new phenomenon was labeled Gay-Related Immune Deficiency (GRID). Later renamed acquired immuned deficiency syndrome (AIDS).

In further investigation, Health and Social Work (1987, p. 5) reports that in 1984 and 1985, the virus that causes AIDS, the third Human T-Lymphocyte Virus (HTLV-III/LAV), was isolated almost simultaneously in France and at the National Institute of Health in the United States. This virus directly attack the body's immunologic system, impairing its ability to fight off common organism. A blood test was developed to detect the AIDS antibodies the body produces in response to the invading virus. Primarily used for screening blood, this test determines whether a person has been exposed to the virus. In 1986, the HTLV-III/LAV virus was
renamed the human immunodeficiency virus (HIV), a designation now internationally accepted.

Due to the massive and complex nature of the problems as those associated with HIV/AIDS infection, it can be quite true that the involvement of social workers is just beginning. Social Work (1988, p. 254) reports that recent projections suggests that by 1991 the number of people who have HIV-associated physical and emotional diseases will increase at least fivefold, and that by the beginning of the next decade, more than 50,000 Americans will die from AIDS-related causes each year. Reemphasizing the severity of the problem, Social Work (1988) Cote Mahler, head of the World Health Organization, stated that he could not imagine a worse health problem in this century "...We stand nakedly in front of a very serious pandemic as mortal as any pandemic there has been. I don't know of any killer greater than AIDS, not to speak of its psychological, social and economic maiming." (p. 254)

According to Honey (1988, p. 365), "AIDS affects people of every race and economic group." He says that AIDS has become an epidemic of towering
proportions, affecting people of every race and economic group. To date, however, little attention has been paid to the psycho-social impact of AIDS on predominantly poor, ethnic minority population in the inner city.

Honey (1988, p. 365) reports that as of November 2, 1987, 44,129 cases of AIDS have been reported to the Center for Disease Control. Of this number, 38% involve Black or Hispanic people and 25% report intravenous (IV) drug use. Historically, these groups have been oppressed and misunderstood. "There is a view," he continued, "that members of this population are only impoverished version of White, middle-class Americans. This perception has obscured the social cultural aspects of observed differences in behavior, attitudes, and thinking."

Interestingly, it is important to note that in research done by Karen Hein, M.D. (1989), which is entitled "AIDS in Adolescence, Exploring the Challenge," she states:

Four surveys of teenagers' knowledge, attitudes, and beliefs about AIDS have been conducted in 1985-7 (65-68). Each
used different population bases (suburban versus urban) and different methods of data collection (telephone survey, structured interview, or self-administered questionnaire). The findings can be summarized as follows. Only a small percentage had received formal instruction about the disease in school, although the vast majority of those enrolled desired more information through school. Levels of knowledge varied, but teenagers were less likely to know general routes of transmission than adults. Adolescents thought that casual contact or donating blood were additional sources of infection. Many adolescents thought that one could "tell" who was likely to be infected. Although some teenagers reported changes in casual (nonintercourse) behavior because of fear of AIDS, few reported changes in those sexual behaviors that actually transmit virus. Among adolescents in the United
States, risk of acquisition of HIV has been investigated in relation to knowledge. In San Francisco, white adolescent high school students were more knowledgeable than black adolescents about HIV transmission, etiology, and prevention (69). Perceived risk for contacting AIDS was greater among students with less knowledge. In a survey of homeless youth in Los Angeles, field workers interviewed street youth as well as young people living in shelters regarding their risk status as well as attitudes and knowledge about AIDS (68). In another study in New York, adolescents who reported participating in highest risk behaviors perceived themselves as being at low risk and also continued high-risk behaviors (66). (pp. 26S-27S)

The human immunodeficiency virus (HIV) is the cause of the acquired immunodeficiency syndrome. Since no vaccine is presently available to prevent acquisition of HIV infection, disease control efforts
have focused on education about HIV/AIDS to members of high-risk groups in the hope that they will alter their behavior in a manner to lessen future transmissions.

However, recent studies have demonstrated that there exists a marked disparity among adolescents about their awareness of the primary cause and the transmission of HIV/AIDS. For example, a study done by the National Health Interview Survey in December 1987 among persons 18 years of age and over by response categories according to age, sex, race and education showed differences of opinions as to the cause and transmission of HIV/AIDS.

Educating people at low risk of acquiring HIV infection is also needed to help minimize unnecessary fears about HIV/AIDS, to focus public attention on necessary control measures, and to inform those who may be contemplating life-risk decisions that place them at high-risk for HIV infection. In view of the fact that adolescents are considered high risk, many secondary school will be particularly good places to provide accurate and thorough information about HIV/AIDS. Presently, little information is available
about secondary school students' level of knowledge about HIV infection and AIDS.

Similarly, DiClemente, Boyer and Morales (1986) found substantial ethnic differences in knowledge of HIV/AIDS. They stated that all groups correctly reported that "having sex with someone who has HIV/AIDS is one way of getting the disease" and were aware that sharing intravenous needles with drug users was also a major mode of disease transmission. The ethnic differences are even more stark among women and children. According to the University of San Francisco (1981), the HIV/AIDS Health Project maintains that:

At this time 52% of women with HIV/AIDS are Black, 7% are Latinos, and 7% are White. Most of these women are of child bearing age. Consequently, of the pediatric cases reported to the CDC in July 1986, 59% are Black, 22% are Latino and 18% are White. Three-quarters of these babies are from New York, New Jersey, Florida, and California. The CDC reported the first pediatric cases of AIDS in 1982, and
others have been identified retrospective to 1980; almost all these infants become infected in utero; 86% of diagnosed children have at least one intravenous (IV) drug using parent. (p. 1)

In its annual statistical summary, the Pennsylvania Department of Health observed that HIV/AIDS had been recorded in 45 of the state's 67 counties. Thirteen counties, including Philadelphia and its suburbs, account for 640, or about 90%, of the 706 cases. The six year-figures, from January 1981 to December 1986, show 273 cases of the disease statewide last year, up 13% from the 242 cases in 1985. The Philadelphia Inquirer edition of February 13, 1987, explicates that:

The gap between confirmed cases and number of deaths is wider for the last three years. Of the 199 cases in 1984, there have been 93 deaths. Of the 242 cases in 1985, 156 have died. In the 273 cases confirmed last year, 96 have died. On a county-to-county basis, Philadelphia is by far the leader in both
confirmed cases and deaths attributable to HIV/AIDS. In the 406 cases documented in Philadelphia over the last six years, 285 people have died.

According to Gutierrez et al. (1988, pp. 1-2), in Philadelphia, as of June 1, 1988, there had been 927 reported cases of HIV/AIDS, including 60 Hispanic cases (Haffley, 1988). The 6.5% incidence of HIV/AIDS among Hispanics in Philadelphia compares unfavorably to the estimated 3.8% Hispanic population in Philadelphia (Hispanic Policy Development Project, 1984). In view of the current epidemiological data, Hispanic youths are regarded a high-risk group of HIV/AIDS.

In the same vein, Gutierrez et al. (1988) observed that:

Hispanic young adults (average age 21 years) in Philadelphia indicated that large proportion of males had had intercourse at an early age (70% by age 16) and with a variety of partners (65% with 4 or more partners); and they used condoms on a regular basis. While
females in the study had lower incidence of early intercourse (28% by age 16) and a smaller relation with four or more partners, only 4% of the sexually active females use condoms on a regular basis.

The Pennsylvania State Health Department says that 74% of the cases involved homosexual or bisexual men; 9% were identified as intravenous drug users; 8% were homosexual or bisexual men who had used intravenous drugs; and 3% were hemophiliacs. The Philadelphia Department of Health's HIV/AIDS Activities Coordinating Office (AACO) has the responsibility of combating AIDS at the grassroots level by coordinating HIV/AIDS services in a number of ways, including the arrangement and monitoring of contracts between the Health Department and a number of service providers. Through these service providers, the city funds case management residential services, mental health services, home services, home health care, and transportation for people with HIV/AIDS. AACO ascertains that its contract agencies provide community-based HIV/AIDS prevention education, and counseling and testing for minority and high-risk
communities. AACO has several important units to deal with the HIV/AIDS epidemic in Philadelphia which includes Agency Services Division, Medical Affairs, Policy and Planning Division, Surveillance Unit, HIV/AIDS Prevention Services Division, Administration Unit, Counseling Unit and Education Unit, among others. The AACO Annual Report (November 1988, p. 3) says that in addition to meeting the need for community HIV/AIDS education in churches, schools, and neighborhoods on request, the primary charge of the Education Unit of the Prevention Services Division is to educate all city employees about HIV/AIDS. Social support services for persons with HIV/AIDS (PWA) take several different dimensions. They are offered by government agencies and non-profit organizations as part of their services to the handicapped.

It is necessary to note the importance of a research done by Dr. Donald Ellerman which is entitled "Report on the Survey of Persons with HIV/AIDS/ARC." According to Dr. Ellerman (1988, p. 53), persons with HIV/AIDS were asked if they had a social worker, at times known in Philadelphia as a case manager. And
the response, about 56.7% said they did. Dr. Ellerman (1988) further reveals that:

Case managers/social workers proved very valuable service to the persons with HIV/AIDS. Surprisingly, over 31% of respondents (54% of them using a social worker/case manager) wrote that providing mental health support and counseling was the most helpful thing their case manager had done for them. Many PWA's also found help from social workers in the more traditional role of providing information on available services (14%) or obtaining medical services (6%). To 4 persons, their social worker helped them in so many ways that they were at a loss to be specific. However, 9 (10.0%) persons stated that very much had been done for them.

It is believed that 25% of the cases of HIV/AIDS diagnosed nationwide occur in Blacks, even though Blacks make up only 12% of the United States' population. Gay community-based HIV/AIDS
organizations in major cities are lauded by public health officials for their success in disseminating information and providing services to the gay community. In short, many Black gays, as well as the Black community at large, remain largely uniformed about HIV/AIDS risk reduction and many Blacks with HIV/AIDS die without ever having received sufficient supportive services. Replying to this inequity, the National Coalition of Black Lesbians and Gays, with a grant from the U. S. Public Health Service, organized the National Conference on HIV/AIDS in the Black community which was held in Washington, D. C. on July 18, 1986. The conference coordinator, Craig Harris, stipulates accordingly that there is a need for culturally sensitive risk reduction education in the Black community. We must consider how people at risk perceive themselves and address that. For example, Black bisexual men tend not to identify themselves as bisexuals, so they may exclude themselves from information targeted to gay men. We cannot address the issues from our own understanding of them. Once people at risk have defined themselves, we must address those issues.
Craig (1986) further says that: There is also a large percentage of cases in IV drug users among Blacks. We must address these persons in a different way. Existing HIV/AIDS organizations, which have grown out of the predominantly white gay movement of the 60's and 70's, have been very effective in serving their Black political, social, and health organizations to do the necessary outreach network, it is possible to combine resources and create a semblance unity in our approach.

According to the CDC (1987, p. 1), Blacks are three times more likely to have contracted HIV/AIDS than Whites. While Whites have contracted HIV/AIDS at a rate of 168 per million, Blacks have contracted the disease at 520 per million, and Hispanic have contracted it at 454 per million. Thus, Hispanics are 2.7 times more likely than Whites to have contracted HIV/AIDS during this period. Asians and native Americans have had relatively few reported
cases of the disease, 66 and 27 per million, respectively.

The rationale for concern is addressed by Hein (1987, p. 290), and states that most adolescents do not seek health services on a regular basis. This risk states for HIV/AIDS infection must be inferred from data collected for other purposes. This information can be summarized in three categories: (a) sexual behavior and relevant consequences; (b) physiologic considerations; and (c) drug abuse. Hein (1987, p. 292), in her study, support CDC's (1987) findings that in New York State, every day roughly 180 teenagers become pregnant. Minority group status appears to be associated with increased risks to both mother and child. In New York City and some other urban centers, HIV infection has been disproportionately identified in Black and Hispanic groups. Cumulative incidence rates of HIV/AIDS among Blacks and Hispanics are more than three times the rate among Whites.

Interestingly, the opportunity now presents itself to focus attention on the adolescent population as distinct from young adult or children. This group,
according to Hein (1987, p. 295), have a unique set of sociologic circumstances that require special attention now, before wider spread of HIV/AIDS infection is documented in this segment of the population.

Hein (1987, pp. 294-295) further admits that, in Borough of Bronx, drug addiction is currently the major risk factor for HIV/AIDS. Two thirds of all HIV/AIDS cases are associated with intravenous (IV) drug abuse and about 50% of the Borough's 60,000 to 70,000 IV drug users are believed to be positive for HIV antibodies. This group is mostly composed of young adults (aged 20-40 years) who are Black and Hispanic and who are sexually active with multiple partners, making large-scale heterosexual transmission and genuine possibility.

In Hersch's (1988, p. 34) study, published in the January issue of Psychology Today, "Aids and Adolescents," activities that increase risk of HIV/AIDS are not the special province of "bad kids," troubled youths, or the emotionally disturbed. Marcia Quachenbush, Coordinator of Youth Services for the AIDS Health Project of the University of California,
San Francisco, says normal adolescent activities, such as sexual exploration, place all teens at risk. Quachenbush believes that education about how to prevent HIV/AIDS must become a standard part of youth directed community service.

The few recent studies on HIV/AIDS and the adolescent population strongly support Quachenbush's views. These studies indicate high rate of sexual activities among teenagers but little accurate knowledge of the disease and ways to avoid contracting it.

On appreciation of Lee Stunin and Ralph Hingsion accomplishment on their 1986 study at Boston University, School of Public Health, Hersch (1985, p. 34) found in 1986 that 860 randomly selected adolescents, aged 16-19, 70% were sexually active. More than half said they did not worry at all about contracting HIV/AIDS, and of this group, only one in five used effective methods of protection.

Hersch (1988, p. 34), acknowledging researcher DiClemente et al. study, say that their study found widespread misinformation among adolescents in San Francisco. Their 1986 study revealed more anxiety--near 80% were anxious--probably due to extreme
visibility of HIV/AIDS in that city but not much knowledge on how not to catch it. Of 1,326 adolescents studies, 92% indicated that sexual intercourse was one mode of contracting HIV/AIDS. Only 60%, however, were aware that using condoms might prevent transmission. Nearly one in four thought HIV/AIDS could be cured if treated early, others thought one could catch HIV/AIDS by shaking hands or touching someone with the disease.

Further analysis by DiClemente and psychologists Charrie B. Boyer and Edward S. Morales, Hersch (1988, p. 34), states that the data for ethnic differences found that 60% of Black, 58% of Hispanic and 72% of White adolescents were knowledgeable about the use of condom in lowering risk of infection. Most striking was that Black and Hispanic adolescents were about twice as likely to believe that HIV/AIDS could be contracted by kissing, touching or even being near a person with HIV/AIDS. The researchers fear that such misconceptions may divert the adolescents' attention from the need to change truly high-risk behavior.

A comparative study by Chaisson et al. (1989, p. 561) asserted risk factors for human
immunodeficiency virus (HIV) infection in 633 heterosexual intravenous drug users. The HIV seroprevalence was 26% in Blacks, 10% in Hispanics, and 6% in Whites. Intravenous cocaine use significantly increased the risk of HIV infection, with a seroprevalence of 35% in daily cocaine users (odds ratio, 6.4; 95% confidence interval, 3.0 to 13.3). Blacks subjects were more likely to use cocaine regularly.

It can be argued that intravenous (IV) drug use still remains the second most leading risk category among HIV/AIDS cases in developed countries. Chaisson et al. (1989, p. 561) confirmed that in the United Stated, HIV/AIDS among IV drug users has disproportionately affected minorities. Of the 13,808 IV drug users with HIV/AIDS reported to the Center for Disease Control as of August 1, 1988, 51% were Black and 29% were Hispanic. Infection with human immunodeficiency virus (HIV), the etiology agent of HIV/AIDS, has also occurred with increased frequency in minority IV drug users.

Sternberg's (1990, pp. 1, 4) article, "AIDS Cases Tripple in Two Years," revealed an alarming statistics
about the spread of HIV/AIDS in small cities, rural areas, as well as Atlanta. He explained that Georgia has one of the fastest growing AIDS epidemics in the nation.

He further stated that the State Department of Human Resources (DHR) reported that the number of AIDS cases has tripled in the past two years, with the spread of the disease in rural areas and small cities keeping pace for the first time with the growth of Atlanta. Only New York, New Jersey, California and Florida reported higher rates of AIDS during the last year.

Steinberg (1990, pp. 1, 4) argued that state health officials note a "significant epidemic" how emerging central and southeastern Georgia is being fueled primarily by drug abuse and heterosexual transmission of the virus from male drug abusers to their female sexual partners. "Intravenous drug abuse is as much of the problem out there as here," said Dr. Bruce Whyte, a medical epidemiologist in the state's office of infectious diseases. He said sexual transmission of partners of drug-abusing men has markedly increased the reach of the epidemic.
Dr. Whyte said that state epidemiologist had not expected to find AIDS spreading so rapidly among women in smaller cities and rural areas. "That was a surprise to us," he told the Georgia AIDS Task Force. As a result, officials said there has been a sharp increase in the cumulative number of AIDS cases among women in Georgia, from 16 in 1986 to 172 in 1989. There were 20 times as many drug-related AIDS cases among Black women as among White women.

Epidemic experts have documented several other features of the AIDS epidemic in Georgia. The proportion of AIDS cases among homosexual and bisexual men in Georgia decreased from 78% to 68%, and the proportion of cases among IV drug users rose from about 8% to more than 14%. However, minorities make up a disproportionate number of the state's AIDS victims. Black constitute 26% of the state's population but 36% of reported AIDS cases.

Military recruits in Georgia have a higher incidence of AIDS virus infection than the national average. Overall, 1.9 of every 1,000 military recruits in Georgia was 3.1 per 1,000. The rate among black recruits in Georgia was 3.1 per 1,000.
Nearly seven of every 1,000 women tested for exposure to AIDS at Grady Memorial Hospital's obstetrics clinic are infected with the virus. Pediatric AIDS cases in the State increased from 25 in 1988 to 34 in 1989, and epidemiologists said the actual toll probably is far higher.

Outside Atlanta and Savannah, facilities for AIDS patients are scarce, nonexisting in some area, even though there are nearly 500 cases in southern and central Georgia and another 200 in the northern countries. "Once you leave metro Atlanta, resources are scant," said Dr. Paul Jurgenson, a Savannah physician and member of the State's AIDS task force.

Currently, the State provides about $2.7 million for AIDS programs, with $813,760 going to Grady's infectious disease clinic; $90,000 to Grady's pediatric AIDS project; $140 to AID Atlanta; $100,000 for public information and education; $1.2 million for staff and costs; and $281,688 for laboratory services.

DHR has requested an additional $3.6 million for its AIDS program for the upcoming fiscal year, but Governor Joe Frank Harris has recommended an increase of only $716,000, mostly to expand the number of
employees in the county health department, and $258,000 in additional money to Grady. The governor's budget would not allow DHR to open three new AIDS outpatient clinics it had requested in Augusta, Columbus and Macon. Mr. Harris also turned down DHR's request for $50,000 to launch community-based programs, similar to AID Atlanta, in Savannah and Augusta, and $590,000 to replace an expiring private grant that provided meals-on-wheels and other community services to AIDS patients in the metro area.

Senator Pierre Howard (D-Decatur), chairman of the Senate's Human Resources Committee, called the new statistics "a fairly dramatic development" and said he would present them to his committee. "I think it merit our attention," he said. "It's really tragic." State legislators have introduced four AIDS-related bills this session, all of which address the confidentiality of the medical record of AIDS patients.

Theoretical Framework

The theoretical framework for this study is "The Life Model Approach of Social Work Practice Revisited" by Germain and Gitterman. Turner's (1986, p. 618)
"The Life Model Approach" attempts to develop: (a) a conceptual framework (an ecological perspective) that provides a simultaneous focus on people and environments; and (b) a method of practice that integrates practice, principles and skills for work with individuals, families, and groups within an organizational, community, and cultural context.

Appreciating the significance of Germain and Gitterman Life Model Approach, Turner (1986, p. 619) recognizes that ecology is particularly useful practice metaphor as it seeks to understand the complex reciprocal relationships between people and environments; that is, how each acts and influences each other.

Ecology is defined, Turner (1986) as the science concerned with the relations between living organisms in this case, human beings and all elements of their environments. Therefore, it is very important to look at the HIV/AIDS epidemic on a micro level because people with HIV/AIDS represent one end-product of the society as a whole. With this understanding, it is more appropriate to use the ecological system framework. Within the framework, Turner (1986,
p. 628) states that:

For the Life Model, the ecological perspective represents a philosophical concept of human beings as active, purposeful, and having potential for growth, development, and learning throughout life. It offers a view of human beings in constant exchange with their environment, each acting and reacting on and to the other through continuous adaptation. The Life Model proposes a framework for understanding and helping people with these complex transactions. People's needs and problems are viewed as outcomes of stressful person-environment relationships. Intervention is directed to changing those relationships so that people's potentialities for growth, health, and adaptive social functioning are released and environment are made more responsive to their needs, rights, goals, and capacities.

Definition of Terms

The operational definitions for this study are as
follows.

1. Knowledge: Refer to the basic understanding of the practice and care for the people with HIV/AIDS and related diseases (ARC).

2. Attitudes: The way in which social workers act towards people with HIV/AIDS and their reactions regarding whether they should be allowed to attend regular school or if professionals with HIV/AIDS should keep their jobs.

3. Beliefs: Refer to sexual preferences and sexual behavior in the care and prevention of HIV/AIDS.

Key Working Hypotheses

1. There is no significant difference in the knowledge of social workers towards HIV/AIDS.

2. There is no significant difference in the attitudes of social workers towards HIV/AIDS.

3. There is no significant difference in the beliefs of social workers towards HIV/AIDS.
CHAPTER III
METHODOLOGY

Research Design

This is an exploratory and descriptive study. It is designed to explore those factors that contributes to the knowledge, attitudes and beliefs of social workers towards HIV/AIDS in a variety of social service settings.

Sampling

The non-probability convenience sample was used. This consisted of the individuals who were convenient to the researcher and was willing to respond to the researcher's questionnaire. The sampling population was drawn from social workers in Philadelphia and Atlanta working in a variety of social service settings.

Variables used to select this population included confirmed social workers status and ages ranging from 20 through 60. A total of 200 questionnaires was sent out. Of the 200 questionnaires, 105 agreed to participate, 63 were
females, 34 were males, 8 did not identify gender, 50 Whites, 44 Blacks and three Hispanics.

The largest population includes fourteen establishments: (a) Department of Family and Children Services; (b) Temple University Hospital, Philadelphia, Pennsylvania; (c) Social Service Department; (d) Department of Human Services; (e) Social Security Administration; (f) Philadelphia Housing Authority; (g) AIDS Task Force; (h) AIDS Coordinating Activity; (i) Harding Middle School; (j) Adult and Family Services; (k) Suicide and Crisis Intervention Center; (l) Action AIDS; (m) Catholic Social Services; (n) Grady Memorial Hospital, Atlanta, Georgia.

The researcher used a Knowledge Scale, a Misconception Scale of Casual Contagion, and a Scale of Perceived Susceptibility designed by DiClement et al. (1988), together with Frequency Distribution and Percentage.

Data Collection Procedure (Instrument)

The instrument that will provide the necessary data for this research project is a 26-item
self-disclosure questionnaire developed by DiClemente et al., 1988 and Martin et al, 1988. Information from this questionnaire was used to measure social workers' knowledge, attitudes and beliefs towards HIV/AIDS.

The questionnaire was designed to measure:
(a) social workers' knowledge, attitudes and beliefs about HIV/AIDS testing and employment policy;
(b) social workers' knowledge about the transmission of HIV/AIDS infections by ethnicity.

The questionnaire, in its entirety, consisted of 31 items: 4 questions on demographic, 3 questions on attitudes, 14 questions on knowledge, 5 questions on impact of HIV/AIDS on profession, and 5 questions on behavior and risk assessment. These tests have been used several times in the past and have been proven to be highly reliable and valid.

Data Analysis

The collected data was coded and analyzed. The descriptive statistics was used to analyze the data. This included frequency distribution and percentage.
CHAPTER IV

PRESENTATION OF RESULT

Before delving into the characterization of the findings of this study, the author used the following null hypotheses:

1. There is no significant difference in the knowledge of social workers towards HIV/AIDS.
2. There is no significant difference in the attitudes of social workers towards HIV/AIDS.
3. There is no significant difference in the beliefs of social workers towards HIV/AIDS.

Using the Knowledge Scale, the Misconception Scale of Casual Contagion and the Scale of Perceived Susceptibility designed by DiClemente et al. (1988), together with Frequency Distribution and Percentage, the result of the study supported the hypothesis that: "There is no statistically significant differences in the knowledge, attitudes and beliefs of social workers towards HIV/AIDS.

On the question asked, "What would happen at your place of employment to an employee who refuses to treat/care for HIV/AIDS infected patients/clients,"
the majority, 50% of social workers did not know if their places of employment had a policy regarding refusal to care. This was significantly true despite increased support for establishment of written policies about HIV/AIDS infection. Further, 19% said that the policies should not include any sanctions. Among the respondents supporting sanctions, 15% supported loss of current job; 10% favored letter of censure; and 8% preferred a transfer of employee.

The majority, 51%, of social workers did not know if sanctions have been formulated into a written employment policy. Twenty-two percent said that sanctions have been formulated into a written employment policy and 20% said it has not been publicized in their place of employment. A smaller percentage said that sanctions have been used against professional social workers/health care workers.

On the question regarding social workers' knowledge about HIV/AIDS transmission by ethnicity was generally good. The finding suggest no significant difference in the knowledge about the transmission of HIV/AIDS infection among social workers. With respect to question 1 (see Table 3,
Appendix A), 91% of social workers correctly answered that "unprotected man to woman sex with an infected partner was one way of contracting HIV/AIDS. However, 88% Whites and 86% Blacks were aware that "unprotected man to woman sex with an infected partner" was one way of contracting HIV/AIDS. On question 3 (see Table 3, Appendix A), 81% of social workers indicated correctly that "unprotected man to man sex with an infected partner" was one mode of contracting HIV/AIDS. But 84% Whites and 91% Blacks were aware that "unprotected man to man sex with an infected partner" was one mode of spreading the disease (HIV/AIDS). However, 99% Whites and 93% Blacks reported that HIV/AIDS cannot be transmitted through "kissing," 84% Whites and 73% Blacks reported said that HIV/AIDS can be transmitted by having sexual intercourse with an IV drug user (see Table 3, p. 82). Most social workers, 96% Whites and 89% Blacks, answered correctly that "sharing needles" was one mode of transmitting HIV/AIDS (see Table 3, Appendix A).

Surprisingly true, 72% Whites and 86% Blacks believed that HIV/AIDS can be "inherited from mother at birth" (see Table 3, Appendix A). Moreover, 88%
Whites and 71% Blacks correctly answered that HIV/AIDS can be transmitted through "blood transfusion" (see Table 3, Appendix A). Interestingly, almost all social workers, with the exception of 2% Blacks, did not know that "HIV/AIDS is caused by virus" (see Table 3, Appendix A).

Answers to the questions on "behavior and risk assessment" was generally good. A large majority of social workers, 95%, exhibited good basic knowledge regarding persons becoming infected with HIV/AIDS after having sexual intercourse only once with an infected person. About 83% indicated that school teachers, social workers and health care workers infected with HIV/AIDS should be allowed to keep their jobs.

In response to the question "Have you discussed HIV/AIDS with your boyfriend(s) or girlfriend(s) before sexual intercourse, 56% disclosed that they had; 34% said that they had not; and 15% did not know. But 48% said that they have made changes in their sex life, and 41% have not made any changes in their sexual life because of HIV/AIDS. However, 32% attributed their changes to "decrease in the
number of sexual partners and 30% to "regular use of condoms" (see Table 4, Appendix A).

On the question regarding how social workers obtain their information on HIV/AIDS, 79%, the majority, indicated that they got their information from TV and radio; 71% from newspapers and magazines; 47% from doctors or clinic staff; and 31% from the telephone hot-line.

On what has been their most important sources of information about HIV/AIDS, 40%, the majority, indicated newspapers and magazines; 30% from the AIDS Task Force; 27% from lectures and other sources; 26% from doctors or clinic staff; and 16% from radio and TV.

The vast majority, 55%, answered that the best way to learn about HIV/AIDS in the future is from pamphlets and brochures about HIV/AIDS; 42% preferred lectures or public meetings; 15% like clergy and doctors; and 11% preferred conversations with friends and co-workers.

Fifty-seven percent of social workers reported that a patient has the right to know if their obstetrician/gynecologist is HIV/AIDS positive, 25%
disagreed even though 55% preferred mandatory testing for all practitioners.

The vast majority, 84%, of social workers agreed that an obstetrician/gynecologist is ethically obligated to care for HIV/AIDS infected patients where care will greatly affect the quality of life. Moreover, 83% suggested that "special training programs" need to be created to train surgeons, obstetricians and gynecologists how to treat HIV/AIDS infected patients.

However, 44% suggested that separate HIV/AIDS wards be established in a city hospital, and 34% disagreed on the grounds that it will be discriminatory; 16% disagreed that hospital policy concerning refusal to care for HIV/AIDS infected patients be different for physicians, nurses and social workers; 17% agreed and 17% did not know.

The study did find substantial ethnic differences in the knowledge of HIV/AIDS (see Table 3, Appendix A). All three groups demonstrated high knowledge about the primary modes of transmitting HIV/AIDS: (a) sexual intercourse with an infected person; and (b) intravenous drug use. But greater percentage,
84% of Whites were aware that having sex with IV drug users is a major mode of HIV/AIDS transmission as compared to 73% of Blacks. On the contrary, Blacks, 86%, were more aware that HIV/AIDS can be inherited from mothers at birth as compared to 72% Whites.

Moreover, the study found three high risk behaviors among respondents: (a) the majority, 52%, of the respondents have not made changes in their sex life regarding HIV/AIDS; (b) the majority 68%, of respondents have not had any decrease in the number of sexual partners; and (c) the majority, 70%, of the respondents do not believe in the use of condoms as a preventive device. It was also noted that 44% of respondents never discussed HIV/AIDS with their boyfriends or girlfriends before sexual intercourse.

Regarding educational level, education was significant in the knowledge of HIV/AIDS as evidenced by the high percentage (see Table 1, Appendix A) of the respondents who answered correctly to the three basic modes of HIV/AIDS transmission. However, education did not have an impact on the high-risk behavior of social workers (see Table 4, Appendix A).

The survey was favorably supported by social
workers to develop a special training program to train surgeon and obstetrician/gynecologist to treat HIV/AIDS patients. Interestingly, the majority, 60%, of the respondents reflected that there should be no separate policy for physicians, nurses, and social workers regarding refusal to care for HIV/AIDS patients.

Significantly, tenure on the job, majority 65.57%, supported the findings as evidenced by social workers' knowledge about HIV/AIDS. But it did not impact on the high risk behavior of social workers.
CHAPTER V
SUMMARY AND CONCLUSION

In summary, the results of this study supported the null hypothesis. There was not enough evidence to the contrary to disprove that there is a significant difference in the knowledge, attitude and beliefs of social workers towards HIV/AIDS (Table 3). There were significant ethnic differences found in the knowledge of HIV/AIDS (Table 3, Appendix A), and secondly, the study identified a marked disparity in the sexual behavior of social workers (Table 4, Appendix A). Moreover, education did not play a significant role in the knowledge of HIV/AIDS (Table 3, Appendix A), and education did not have any impact on the high-risk behavior of social workers (Table 4, Appendix A). Unfortunately, it is scary that the two group, Whites (12% and 16%) and Blacks (14% and 27%) answered incorrectly to two primary modes of transmitting HIV/AIDS (Table 3, Appendix A).

Conclusion

In conclusion, the study has reviewed the conceptual framework (the life model approach) as
it related to the dilemmas of the HIV/AIDS epidemic as originally expressed in order to identify implications for social work practice and future research. The essence of this study was to understand the role of social workers and their knowledge about HIV/AIDS relative to the care of people with HIV/AIDS and the prevention and spread of the HIV/AIDS virus.

Limitation of the Study

This study concerns itself with the knowledge, attitudes and beliefs of social workers. Further, it does not concern itself with the knowledge, attitudes and beliefs of doctors, nurses, obstetricians/gynecologists and health care workers. Because previous study done by Martin et al. (1988) and other relevant studies failed to acknowledge the contribution of social workers in the care and prevention of HIV/AIDS.

Suggested Research

For social workers, the study suggests that there is a dying need for extensive in-service training and public awareness to be focused in all social agencies
and hospital settings to educate social workers and all health care professionals about the care and prevention of HIV/AIDS. Zlotnik (1987, p. 5) says that education care providers, persons who are caring for people with AIDS, need to be educated in: (a) the prevention and contagion; (b) the medication and their side effects; (c) the anticipated cause of the disease; (d) how to deal with the stress; (e) how to meet their own needs as well as the needs of the persons with AIDS; and (f) the mourning process and how to facilitate its occurrence.

Several key implications became visible during this study and it set the agenda for future research in three basic areas:

1. Educate care providers: Because education will reduce fears and help anticipate needs.

2. The need to provide community education: Zlotnik (1987, p. 5) advised that community education must exist through schools, businesses, religious institutions, community programs, and within families. Education should include factual information as well as opportunities for clarification of values. He further stressed that everyone should know about
AIDS, and to think what role they can play in responding to the AIDS crises. Community education should include model values clarification program to help develop a more sensitive societal response.

3. The immediate need for a comprehensive case management services: The management system will be helpful in assisting person with HIV/AIDS and their families to find services and to enable them to use services effectively. Zlotnik (1987, p. 4) recommends that case management should include eight basic functions: (a) client identification and outreach; (b) individual and family assessment and diagnosis; (c) service planning and resources identification; (d) linking clients to needed services; (e) service implementation and coordination; (f) monitoring of service delivery; (g) advocacy to obtain service; and (h) evaluation.

Another area of interest is the ethical and legal issues. Case example: removing children with HIV/AIDS from schools, voluntary and involuntary testing, an loss of jobs so that there is straight rules and regulations set. HIV/AIDS education will service as a means of knowledge building and
increasing skill levels, thereby reducing the high-risk behavior among social workers.
CHAPTER VI
IMPLICATION FOR STUDY

The study suggests that education is the most promising tool yet available in the control of HIV/AIDS infection. Thus, some noticeable misconceptions about the threat of casual contagion of HIV/AIDS among social workers suggests the need for preventive HIV/AIDS education not only to decrease potential high-risk behavior, but also to reduce unnecessary feeling of anxiety regarding susceptibility. O'Kane (1987, p. 28) suggests that a major obstacle to developing AIDS programs is the "terror factor." As a nation and as a health care provider, we have had to combat our fear of AIDS. An extreme state to terror has immobilized some health care facilities. Some hospitals may not yet feel forced into developing programs but they can turn away patients with AIDS. Once the patients are admitted, the administration then has to deal with disruptions in the psyche of some staff members. Hysteria and hypervigilance have at times been their earlier responses.
It is necessary that social workers be educated and prepared to address the concerns of infected persons and to counsel or refer for counseling those infected with HIV/AIDS. A variety of educational approaches must be used to inform and educate social workers. These approaches should include, but not be limited to: workshops, training centers, an ongoing and in-service training program. Why is this important? It is important because the role of the social worker as a patient advocate is an important one. A social worker provides patients with sources of information about community programs, and they can help patients to process information about the disease so as to make decisions concerning their own treatment.

In C. Everett Koop (1988), Surgeon General of the United States' report on AIDS to the people of the United States, it states that "information and education can change individual behavior since this is primary way to stop the epidemic of AIDS." This report deals with the positive and negative consequences of activities and behaviors from a health and medical point of view. He further states
At the beginning of the AIDS epidemic many Americans had little sympathy for people with AIDS. The feeling was that somehow people from certain groups "deserved" their illness. Let us put those feelings behind us. We are fighting a disease, not people. Those who are already afflicted are sick people and need our care as do all sick patients. The country must fight this epidemic as a unified society. We must prevent the spread of AIDS while at the same time preserving our humanity and intimacy.

Significantly, Ryan and Emery (1989), according to the Code of Ethics, social workers are mandated to: provide appropriate professional services during public emergencies; work to improve the agency's policies and procedures; critically examine and keep current with emerging knowledge relevant of social work; and act to ensure that all persons have access to the resources, services and opportunities they
require. In order for practitioners to follow this mandate, agencies will be required to discharge the following responsibilities.

Responsibility to Workers

Provide Initial Training and Continuing Education

All social workers must receive basic AIDS prevention and transmission education, including infection control information. Training must include content on psychosocial and legal issues, ethical dilemmas and responsibilities, medical treatment and community resource information. Training must be ongoing to update workers on scientific and treatment developments, new modalities and services.

Provide Burn-out Prevention, Supervision and Support

All social workers must receive appropriate supervision from AIDS-knowledgeable supervisors. Work settings serving AIDS clients must provide a support group for practitioners during routine work hours, to process the complex psychological and ethical considerations that emerge in working with AIDS. Each setting must develop a burn-out prevention plan that
will enable practitioners to continue working with HIV affected clients during the course of the epidemic. (Because many agencies have not provided comprehensive AIDS training for all staff and may have only a few AIDS-knowledgeable staff, these workers are often assigned all HIV-related clients and suffer frequent burn-out as a result.)

**Support, Respect and Insure Practitioners Adherence to the NASW Code of Ethics with Regard to Serving HIV Affected Clients**

This includes holding both the agency and the worker accountable for upholding the Code of Ethics in developing and delivering services, providing advocacy and assuring the necessary changes in policy and legislation to promote social justice and social change.

**Responsibility to Clients**

**Develop and Implement Appropriate Client Services**

This includes offering support groups for clients and families, providing case management services and providing clinical and other social work services by
knowledgeable and sensitive practitioners.

**Provide Access to Appropriate Community Services**

All agencies must develop a resource network with outside organizations and agencies that provide HIV-related services in order to be able to refer clients to critically needed services.

**Provide Education and Prevention Information**

During an epidemic of a fatal, sexually transmitted disease, all agencies have a responsibility to educate clients about risk reduction behaviors, including safer sex practices, non-needle sharing and needle cleaning. All schools and programs of social work must include AIDS contents in the curricula and continuing education programs.

Therefore, on a micro level, the use of an ecological system framework seems most appropriate. The analysis presented in this study suggests that social workers are valuable assets in providing education and services to the people with HIV/AIDS, community, and the larger society. Kopps (1988, p. 270) states that in an ecological system
framework, service providers aim change efforts at the dynamic interaction between the individual and society. This framework expands rather than restrict flexibility necessary to address complex problem.
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education settings. A paper prepared for the
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APPENDICES
Appendix A: Tables
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Table 2  
Attitudes towards HIV/AIDS Testing and Employment

1. What should your employment policy be regarding HIV/AIDS screening?

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<td>5</td>
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<tr>
<td>B. Mandatory admission test for HIV/AIDS high-risk patients</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>C. Policy stating there will be no HIV/AIDS testing</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>D. Elective test that is anonymous, offered to all patients/clients, done on the job site by an agent other than employer</td>
<td>55</td>
<td>52</td>
</tr>
<tr>
<td>E. Should not have employment policy regarding HIV/AIDS screening</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100</td>
</tr>
</tbody>
</table>

2. Should your employer have policies regarding health care workers/social workers who refuse to care for HIV/AIDS positive patients?
Table 2   Attitudes towards HIV/AIDS

(Continued)

<table>
<thead>
<tr>
<th>A. Yes</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. No</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>C. N/A</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100</td>
</tr>
</tbody>
</table>

If yes to question 2 above, should these policies apply; N/A if not applicable to your job environment.

A. All Employees?   67   64
B. Social Workers?  17   16
C. Nurses? N/A      8    8
D. Physicians? N/A  5    5
E. Health Care Workers? N/A  8    8

Total 105 100

3. What would happen at your place of employment to an employee who refuses to treat/care for HIV/AIDS infected patients/clients?

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>1. Lose current job</td>
<td>15</td>
</tr>
<tr>
<td>2. Transfer to another unit</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 2 Attitudes towards HIV/AIDS

(Continued)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Letter of censure</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>4. Financial penalties</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. No sanctions</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>105</td>
<td>100</td>
</tr>
</tbody>
</table>

B.

1. Sanctions have been formulated into a written employment policy. 23 22

2. Been utilized against any professional social workers/health workers. 1 1

3. Been publicized in your place of employment 21 20

4. Don't know 60 57
Table 3 Social Workers' Knowledge Statement by Ethnicity

I. Which do you think principle ways HIV/AIDS is transmitted in the minority Community?

<table>
<thead>
<tr>
<th>Responding Correctly</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unprotected man to woman sex with an infected partner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>B. Black</td>
<td>38</td>
<td>86</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>2. Toilet seats.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Black</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Unprotected man to man sex with an infected person.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>42</td>
<td>84</td>
</tr>
<tr>
<td>B. Black</td>
<td>40</td>
<td>91</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>4. Kissing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>B. Black</td>
<td>3</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 3 Social Workers' Knowledge Statement

<table>
<thead>
<tr>
<th>Responding Correctly</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Having sex with IV drug users.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>42</td>
<td>84</td>
</tr>
<tr>
<td>B. Black</td>
<td>32</td>
<td>73</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td><strong>6. Shaking hands</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Black</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>7. Sharing needles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>48</td>
<td>96</td>
</tr>
<tr>
<td>B. Black</td>
<td>30</td>
<td>89</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td><strong>8. Being in some room with HIV/AIDS infected person.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Black</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>9. Infected from mother at birth.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>36</td>
<td>72</td>
</tr>
</tbody>
</table>
Table 3  Social Workers' Knowledge Statement

(Continued)  Responding Correctly

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Black</td>
<td>38</td>
<td>86</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>10. Blood transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>44</td>
<td>88</td>
</tr>
<tr>
<td>B. Black</td>
<td>31</td>
<td>71</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>2</td>
<td>67</td>
</tr>
<tr>
<td>11. HIV/AIDS in cause by virus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. White</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>B. Black</td>
<td>43</td>
<td>98</td>
</tr>
<tr>
<td>C. Hispanic</td>
<td>3</td>
<td>100</td>
</tr>
<tr>
<td>Questions</td>
<td>Responses</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>1. Can a person become infected with HIV/AIDS after having sexual intercourse only once with an infected person?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Yes</td>
<td>95</td>
<td>92.48</td>
</tr>
<tr>
<td>B. No</td>
<td>2</td>
<td>1.91</td>
</tr>
<tr>
<td>C. Don't know</td>
<td>8</td>
<td>7.62</td>
</tr>
<tr>
<td>D. Total</td>
<td>105</td>
<td>100.00</td>
</tr>
<tr>
<td>2. Do you think that school teachers, social workers and health workers who may have HIV/AIDS should be allowed to keep their jobs?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Yes</td>
<td>87</td>
<td>82.86</td>
</tr>
<tr>
<td>B. No</td>
<td>10</td>
<td>9.52</td>
</tr>
<tr>
<td>C. Don't know</td>
<td>8</td>
<td>7.62</td>
</tr>
<tr>
<td>D. Total</td>
<td>105</td>
<td>100.00</td>
</tr>
<tr>
<td>3. Have you ever discussed HIV/AIDS with your boyfriend or girlfriend before sexual intercourse?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4  Behavior and Risk Assessment

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Continued)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>A. Yes</td>
<td>56</td>
</tr>
<tr>
<td>B. No</td>
<td>34</td>
</tr>
<tr>
<td>C. Don't know</td>
<td>15</td>
</tr>
<tr>
<td>D. Total</td>
<td>105</td>
</tr>
</tbody>
</table>

4. Have you made changes in your sex life because of HIV/AIDS?

| A. Yes                                                                        | 48        | 45.71    |
| B. No                                                                         | 41        | 39.05    |
| C. Don't know                                                                 | --        | 84.76    |
| D. Total                                                                      | 89        | 100.00   |

5. If you answered yes to question 4 above, was one of the changes:

| A. Decrease in the number of sexual partners                              | 32        | 30.48    |
| B. Regular use of condoms                                                | 30        | 28.57    |
| C. Other                                                                   | 10        | 9.52     |
Table 5  Sources of Knowledge on HIV/AIDS

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>Percent</td>
<td></td>
</tr>
<tr>
<td>1. How do you obtain your information.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Circle all that apply.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Over the TV or radio</td>
<td>65</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>B. From newspapers/magazines</td>
<td>83</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>C. From doctors or clinic staff</td>
<td>49</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>D. From telephone hot line</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>E. Other</td>
<td>33</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>2. What has been your most important source of information about HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Radio/TV</td>
<td>17</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>B. Newspapers/magazines</td>
<td>42</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>C. Doctors or clinic staff</td>
<td>26</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>D. AIDS Task Force</td>
<td>31</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>E. Telephone hot line</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>F. Other</td>
<td>28</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>3. Which of the following would be the best way for you to learn more about HIV/AIDS in the future?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questions</td>
<td>Responses</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>A. Newspapers, radio or TV</td>
<td></td>
<td>35</td>
<td>33</td>
</tr>
<tr>
<td>B. Lectures or public meetings</td>
<td></td>
<td>44</td>
<td>42</td>
</tr>
<tr>
<td>C. Conversations with friends or co-workers</td>
<td></td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>D. Discussions with clergy or doctors</td>
<td></td>
<td>16</td>
<td>15</td>
</tr>
<tr>
<td>E. Pamphlets or brochures about AIDS</td>
<td></td>
<td>58</td>
<td>55</td>
</tr>
</tbody>
</table>
Table 6 Impact of HIV/AIDS on Profession

<table>
<thead>
<tr>
<th>Separatism</th>
<th>Response (in Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60 57</td>
</tr>
<tr>
<td></td>
<td>29 28</td>
</tr>
<tr>
<td></td>
<td>10 10</td>
</tr>
</tbody>
</table>

1. A patient should have the right to know if her obstetrician/gynecologist has HIV/AIDS.
   A. Yes 88 84
   B. No 1 1
   C. Don't know 7 7

2. An obstetrician/gynecologist is ethically obligated to care for HIV/AIDS infected patients where care will greatly affect the quality of life.
   A. Yes 87 83
   B. No 2 2
   C. Don't know 3 3

3. Special training programs should be created to train surgeon and obstetrician/gynecologist to treat HIV/AIDS infected patients.
   A. Yes 87 83
   B. No 2 2
   C. Don't know 3 3
Table 6  Impact of HIV/AIDS on Profession

<table>
<thead>
<tr>
<th>Separatism</th>
<th>Response (in Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Continued)</td>
<td></td>
</tr>
<tr>
<td>4. Separate &quot;HIV/AIDS&quot; wards should be established in the city's hospitals.</td>
<td></td>
</tr>
<tr>
<td>A. Yes</td>
<td>46 44</td>
</tr>
<tr>
<td>B. No</td>
<td>39 34</td>
</tr>
<tr>
<td>C. Don't know</td>
<td>17 16</td>
</tr>
<tr>
<td>5. Hospital policy concurring refusal to care for HIV/AIDS infected patients should be different for physicians, nurses and social workers.</td>
<td></td>
</tr>
<tr>
<td>A. Yes</td>
<td>18 17</td>
</tr>
<tr>
<td>B. No</td>
<td>63 60</td>
</tr>
<tr>
<td>C. Don't know</td>
<td>18 17</td>
</tr>
</tbody>
</table>
Appendix B: Glossary of AIDS Terms
Glossary of AIDS Terms

The Human Resources Department, GMHI (1988, p. 51) provided the following definitions:

1. Acquired immune deficiency syndrome (AIDS): A condition that reduces the body's ability to fight diseases, leaving it vulnerable to infections and diseases that usually do not affect people with normal immune systems.

2. AIDS-related complex (ARC): ARC patients are infected with the HIV and have signs and symptoms of AIDS but not the "full-blown" (or "frank") disease. ARC is different from AIDS in that a life-threatening opportunistic infection/diseases has not occurred.

3. Antibody: A substance produced by the body in response to a specific foreign invader (an antigen) to fight infection. Antibody can be detected in the blood and usually means a person has had the disease and is protected from having it again. The presence of antibody to the HIV virus does not mean a person has had AIDS or has protection against developing AIDS.

4. Antigen: A substance (for example, a virus or bacteria) that is foreign to the body and stimulates the immune system to produce antibodies.
5. Contagious: Easily transmitted from one person to another—directly or indirectly—by the organism that causes the disease.

6. Dementia (encephalopathy): Disabling cognitive and/or motor dysfunction, persistent loss of behavioral developmental milestone in a child.

7. HIV: The virus the causes AIDS. Previously referred to as HTLV-III or LAV.

8. HIV antibody screening test: A test performed on all donated blood that reveals the presence of antibodies of HIV. If antibodies are detected, the blood is destroyed. The test has also been used by individuals, seeking to determine their likely infection status. If antibodies are detected, they are presumed to have been infected. Testing can be anonymous (test results identified by number only, not name, and shared only with the individual holding the number) or confidential (test results can be linked to a person's name, but are only shared with appropriate, selected others in confidence).

9. Human T-Cell Lymphotropic Virus Type II (HTLV-III): Virus that causes AIDS which was name used in America until 1986 when the name was changed
by the International Committee on the Taxonomy of Viruses.

10. Immune System: A system within the body that helps the body resist disease-causing organisms such as bacteria, viruses, or other infections agents.

11. Immunosuppressed: A state of the body when the immune system defenses do no work normally—usually as a result of illness or administration of certain drugs used to fight cancer or prepare the body to accept transplanted donor organs—leaving a person vulnerable to infections.

12. Incubation period: The interval between infection and appearance of the first symptom. See "Latency."

13. Infection: The state or condition in which the body or a part of it has been invaded by a pathogenic agent which multiplies and causes injurious effects.

14. Intravenous drugs: Drugs injected by needle directly into the vein.

15. Kaposi's sarcoma: A rare form of blood vessel cancer, first appearing as raised purplish skin lesions. These lesions may occur externally
or internally as the cancer progresses from skin to internal organs.

16. Latency: A period when virus is in the body but rests in an inactive dormant state.


18. Lymphocytes: Specialized white blood cells responsible for the immune response—B and T-lymphocytes.

19. Nonoxynol-9: A ingredient found in some contraceptive products which inactivates the AIDS virus (HIV).

20. Opportunistic infection: An infection that is not a threat to a person with a healthy immune system but can cause a life-threatening infection in a person with an immune system that is damaged (for example, in a person with AIDS).

21. Prenatal: Occurring in the period preceding, during, or after birth.

22. Protective sex: Sexual practices, such as the use of latex condoms with spermicide containing nonoxynol-9, which can reduce the risk of contracting the AIDS virus (HIV).
23. Seroconversion: The point at which antibodies to specific antigens are produced by B-lymphocytes and become detectable in the blood.

24. Seopositive: Producing a positive reaction to a blood test—the HIV antibody test. "False positive" and "false negative" refer to incorrect positive and negative results of the HIV antibody screening test.

25. Syndrome: A set of signs and symptoms that occur together.

26. Vaccine: A preparation of killed, live attenuated, weakened, or living virulent organisms or part of microorganisms, that can be administered to produce or increase immunity to a particular disease.

27. Virus: Submicroscopic organisms that grow and reproduce only inside living cells and thus cause disease.
Appendix C: Letters
April 21, 1989

Dr. Harrett M. Mitchell
3316 Pamlico Drive, S.W.
Atlanta, Georgia 30311

Dear Professor Mitchell:

As per our recent telephone conversation, I am forwarding for your review, criticisms, and suggestions the following significant documents: 1) Chapters 1 & 2 of my thesis, 2) the final proposal of my thesis, and 3) a letter from the Philadelphia School District which is self-explanatory. The Philadelphia School District insists that a letter emanates from Atlanta University indicating the approval of my thesis' proposal. To this effect, I request that you please write a letter to the Philadelphia School District, and forward me a photocopy.

Let me know your actions as soon as you complete reviewing the documents specified above. Specifically, I would welcome Dr. Ajo's comments on my suggested survey's questionnaire.

Thank you, and hope to hear from you soon.

Sincerely,

Francis L. Sehneah

Francis L. Sehneah

F-L

DOCUMENTS.
Ms. Laura Roach, Project Director  
AIDS Community Awareness Project  
The Philadelphia Urban Coalition  
121 N. Broad Street, 6th Flr.  
Philadelphia, PA 19107-1906

Dear Sir:

I am a graduate student of Clark Atlanta University School of Social Work and I am conducting a research/survey to assess the knowledge attitudes and beliefs of social worker's about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AID) and AIDS Related Complex (ARC). It is intended as a partial fulfillment for the requirements of Master of Social Work Degree.

In this connection, I would like to ask you to please allow your employees to participate in the attached survey by answering all questions on the survey. Once an employee completes the questionnaire, please allow him/her to return it to you to be combined in the self addressed stamped envelope I have attached.

Thank you for your co-operation and help in this urgent matter. I hope to hear from you soon.

Sincerely,

FRANCIS L. SEHNEAH
Appendix D: Questionnaire
QUESTIONS CONCERNING HIV/AIDS/ARC

This survey is designed to assess social workers' knowledge, attitudes and beliefs about Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC). It is intended as a partial fulfillment for the requirements of Master of Social Work degree. The results of this survey will remain confidential, and will NOT be used for any other purpose. PLEASE DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE.

Throughout this questionnaire, the term "HIV/AIDS-infected patients" is meant to include asymptomatic patients who test positive for HIV antibodies as well as patients with a known diagnosis of AIDS or ARC (regardless of antibody status).
SECTION A: EMPLOYMENT POLICY

In this section we are interested in WHAT YOUR CURRENT EMPLOYMENT'S POLICY would be, not what you think it ought to be.

1. What would happen at your place of employment to an employee who refuses to treat/care for HIV/AIDS-infected patients/clients? (Circle all appropriate responses):

1. Lose current job
2. Transfer to another unit
3. Letter of censure
4. Financial penalties
5. No sanctions
6. I don't know
7. Other (PLEASE SPECIFY):

2. Have these sanctions (circle all that apply):

1. been formulated into a written employment policy?
2. been utilized against any professional social worker/health worker?
3. been publicized in your place of employment?
4. don't know
5. Other (PLEASE SPECIFY):
SECTION B: In this section we are interested in WHAT YOU BELIEVE YOUR EMPLOYMENT POLICY CONCERNING HIV/AIDS SHOULD BE, not what it currently is.

1. What should your employment policy be regarding HIV/AIDS screening.

1 Mandatory admission test for all employees
2 Mandatory admission test for all HIV/AIDS high-risk patients
3 Employment policy stating "there will be NO HIV/AIDS testing."
4 Elective test that is anonymous, offered to all patients or clients, done off the job site by an agent other than the employer.
5 Should not have employment policy regarding HIV/AIDS screening.

2. Should your employer have policies regarding health care workers/social workers who refuse to care for HIV/AIDS-positive patients?  ____Yes  ____No  ____NA

a. If yes to question 2 above, should these policies apply; N/A if not applicable to your job environment: (Circle all that apply).

1 All Employees?
2 Social workers?
3 Nurses?  N/A
4 Physicians?  N/A
5 Health care workers?  N/A
SECTION C: In this section please answer all questions.

1. Which do you think are the principal ways HIV/AIDS is transmitted in the minority community?

1. Unprotected man to woman sex with an infected partner
2. Toilet seats
3. Unprotected man to man sex with an infected person
4. Kissing
5. Having sex with IV drug users
6. Shaking hands
7. Sharing needles
8. Being in same room with HIV/AIDS infected person
9. Inherited from mother at birth
10. Blood transfusions

2. Can a person become infected with HIV/AIDS after having sexual intercourse ONLY ONCE with an infected person?

1. Yes
2. No
3. Don't know
1. Do you think that school teachers, social workers and health workers who may have HIV/AIDS should be allowed to keep their job?

1. Yes
2. No
3. Don't know

4. Have you ever discussed HIV/AIDS with your boy friend or girl friend before sexual intercourse.

1. Yes
2. No
3. Don't know

5. Have you made changes in your sex life because of HIV/AIDS?

1. Yes
2. No
3. Don't know

6. If your answer to question 5 above is yes, was one of the changes:

1. Decrease in the number of sexual partners
2. Regular use of condom
3. Other change (please describe) _____________________________

______________________________
7. How do you obtain your information? (Circle all that apply)

1. Over the TV or radio
2. From newspapers/magazines
3. From doctor or clinic staff
4. From telephone hot line
5. Other (Please describe)__________________________

8. What HAS BEEN your most important source of information about HIV/AIDS?

1. Radio/TV
2. Newspaper/magazine
3. Doctor or clinic staff
4. AIDS Task Force
5. Telephone hot line
6. Others (PLEASE Specify)__________________________

9. Which of the following would be the best way FOR YOU to learn more about HIV/AIDS in the future?

1. Newspaper, radio, TV
2. Lecture or public meeting
3. Conversation with friends or co-workers
4. Discussion with clergy or doctor
5. Pamphlets or brochures about HIV/AIDS
SECTION D: In this section please answer all questions.

1. HIV/AIDS is caused by a virus.
   1. Yes
   2. No
   3. Don't Know

2. A patient should have the right to know if her obstetrician/gynecologist has HIV/AIDS.
   1. Yes
   2. No
   3. Don't know

3. An obstetrician/gynecologist is ethically obligated to care for HIV/AIDS-infected patients where care will greatly affect the quality of life.
   1. Yes
   2. No
   3. Don't Know

4. Special training programs should be created to train surgeons and obstetricians/gynecologists to treat HIV-infected patients.
   1. Yes
   2. No
   3. Don't Know
5. Separate "HIV/AIDS wards" should be established in this city's hospitals.
   1. Yes
   2. No
   3. Don't Know

6. Hospital policy concerning refusal to care for HIV/AIDS-infected patients should be different for physicians and nurses and social workers.
   1. Yes
   2. No
   3. Don't Know

COMMENTS:______________________________

______________________________
Background Information

In order to help us understand your responses, please tell us more about yourself and your agency.

Gender: 1) Male___ 2) Female___

Black_______ Latino/Hispanic_______ White_______

Asian/Pacific Island____ Other__________

Age: 1) 20-29___ 2) 30-39___ 3) 40-49___ 4) 50-59___

5) 60+___

What is your level of education?

1) No degree___ 2) BA/BS___ 3) BSW___ 4) MA/MS/M.Ed.____

5) MSW___ 6) Other degree (please specify)______________

How many years and months have you been a social worker in your social services agency?___years___months

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY

PLEASE RETURN THIS COMPLETED QUESTIONNAIRE IN THE ATTACHED ENVELOPE WHICH HAS BEEN ADDRESSED TO THE RESEARCHER.