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The effects on and AIDS education program on a HIV infected psychiatric patient

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ABSTRACT
SOCIAL WORK

SELAZZIE, MAHSEYAHU BEN B.S. MORGAN STATE UNIVERSITY, 1977

THE EFFECTS ON AN AIDS EDUCATION PROGRAM ON A HIV INFECTED PSYCHIATRIC PATIENT

Advisor: Dr. Melvin Williams
Thesis dated: May, 1992

This study evaluated the effects of an AIDS education program on a HIV infected psychiatric patient diagnosed with schizophrenia. An AIDS education program was designed by the researcher and administered to the patient over a 12 week period. The program presented educational information about HIV infection, AIDS, safer sex practices and condom use. A Sequential Criterion Referenced Educational Evaluation Test (SCREE Test) was utilized. A questionnaire was utilized as a post test that tested the patient's: (a) knowledge of disease transmission and risk reduction behavior, (b) knowledge of safer sex practices, (c) knowledge of condom use, (d) knowledge of AIDS drug treatment (e) knowledge of antibody testing. The results indicated a significant increase in knowledge about HIV infection, AIDS, safer sex practices and condom uses.
THE EFFECTS OF AN AIDS EDUCATION PROGRAM
ON A HIV INFECTED PSYCHIATRIC PATIENT

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
MAHSEYYAHU BEN SELASSIE

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

MAY 1992
ACKNOWLEDGMENTS

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All praises and thanks to the Most High for blessing me with Queen Kokahvah Zauditu-Selassie, to be my wife. Without her love and understanding, this study could not have been possible. To my son Moshe, thank you for being a strong African Prince. May you go beyond your father.

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CHAPTER I
INTRODUCTION

The National Commission on Acquired Immune Deficiency Syndrome reports that since scientists first began to understand the dynamics that govern transmission of the human immunodeficiency virus (HIV), it has been possible to predict with chilling accuracy the toll the epidemic would exact in sickness and lives lost. As the nation enters the second decade of the HIV epidemic, the accuracy of predictions made in the mid-1980's, stand as a silent rebuke.¹

The Commission further states that as the epidemic worsens, opportunities to mobilize effective responses diminish each day that we fail to act decisively. Education for prevention of further HIV spread through the avoidance of risky behaviors has been greatly under utilized and more must be done. If we examined the facts, one begin to understand the impact that AIDS has had in this county.²

²Ibid., 14.
SIGNIFICANCE OF PROBLEM

The Acquired Immunodeficiency Syndrome (AIDS) pandemic has been identified as the number one public health problem in the world. Considering the magnitude of this epidemic and the potential for further spread, AIDS prevention has become a high priority of public health practitioners, scientists and governmental officials. Since a vaccine is not currently available to prevent the spread of AIDS, it is all the more urgent that effective interventions be developed and disseminated among practitioners.3

As a framework for HIV prevention, it is important to consider the extent and distribution of AIDS in the United States. Since the first cases were identified in 1981, over 202,843 people in the United States have been diagnosed with AIDS, and more than 60% of these people have died. Worldwide, the total number of AIDS cases now exceeds 1,000,000 with AIDS primarily concentrated in the Americas, Africa and Europe.4

Ninety-eight percent of United States AIDS cases have occurred in adults and adolescents, with the remainder occurring among children under 13 years old. Since the beginning of the epidemic, homosexual and bisexual men have


accounted for the largest number of persons with AIDS, while persons reporting a history of intravenous drug use are the second largest category. Homosexual and bisexual men comprise 60% of adolescents and adults with AIDS. IVDUs account for 21%, and individuals who are both homosexual-bisexual and (IVDUs) constitute an additional 7%. The remaining adolescent/adult exposure categories include heterosexual contact (5%), blood transfusion recipients (20%), hemophilia/coagulation disorders (1%), and undetermined (3%). For children with AIDS, the majority of cases (59%) occur among children born to IVDUs or their sexual partners.\(^5\)

While the number of persons diagnosed with AIDS to date is staggering, persons infected with HIV who have not yet developed AIDS are also of concern. Many more people are infected with HIV than have AIDS. The Centers for Disease Control estimates that approximately one million persons in the United States are infected. Many, perhaps all, of these individuals may eventually develop AIDS. Since many infected individuals have no symptoms and do not know that they are infected potential for further transmission is considerable, and prevention efforts are made all the more difficult.\(^6\)

\(^5\)Ibid., 4.

\(^6\)Ibid., 17
CHAPTER II

LITERATURE REVIEW

Just as the need for a conceptual base for practice continues, so does the need for research to support practice. There is a greater need for practitioners to add to the knowledge base, due to the challenge practitioners face in the education, cure and prevention of the HIV/AIDS epidemics.

Leukefeld and Battjes points out that perhaps the most significant advance in the prevention of HIV transmission has been the development of laboratory tests for detecting HIV antibodies in biological fluids. This technology has permitted screening of the blood supply, virtually eliminating transfusion associated transmission of HIV. For people who are already infected, recent research suggest that early treatment of asymptomatic HIV infection with azidothymidine (AZT) may delay the onset of AIDS. Leukefeld and Battjes also states that efforts to prevent HIV infection through vaccine development are encouraging, yet effective vaccine will not be available for a number of years. These above authors also contend that efforts to prevent the spread of HIV over the next several years must
rely primarily on behavioral change strategies.¹

A further review of the literature reveals that Goisman has stated that patients with chronic mental illness, may share risk factors for HIV infection. These may include frequent anonymous sex or, a tendency toward multiple sexual partners and a decreased likelihood of using contraceptives (including condoms). There may also be an increased incidence of high risk sexual activity.²

Goisman and associates have also indicated that education is a key line of defense against the AIDS epidemic. Clinicians and educators generally recognize the need for educational programs to address specific needs of their patients and students. Goisman also stated that no less than other people, patients with chronic mental illness need adequate and comprehensible information for protection against AIDS.³

Goisman and associates suggest that despite the AIDS epidemic, development of prevention and risk-reduction programs has been slow, especially for patients with chronic mental illness. These patients may be at particular risk


²Ibid., 4

for HIV transmission and acquisition due to characteristics of their illness. Despite a paucity of such program descriptions in the literature and widespread concern that exposure of such patients to educational material related to sexuality or AIDS, would be overstimulating, an effective and safe program to teach risk-reduction, can be designed.\textsuperscript{4}

Goisman and associates conclude that chronically mentally ill individuals, can tolerate and benefit from a focused didactic program aimed at increasing knowledge of sexuality and AIDS. The authors suggest that a knowledge-based program would decrease risky behavior and that a community mental health center is an appropriate setting for such a program.\textsuperscript{5}

On the other hand, Goldfinger states resistance to AIDS prevention and health education for chronically mentally ill patients is shaped by core values about mental health and illness, sexuality and sexual orientation, drug abuse, race, religion and gender. Goldfinger also contends that AIDS prevention efforts that include easy access to condoms for patients, force practitioners to recognize that the mentally ill are sexually active in our facilities, that we often cannot control the sexual behavior of patients, that patients may have multiple partners, that they have same-sex

\textsuperscript{4}Ibid., 189

\textsuperscript{5}Ibid., 196
partners, and that such behavior may be divorced from relationships and attachment. He also pointed out that without adequate clarification of values, clinicians have become preoccupied with the duty to warn third parties, rather than with the duty of educating patients who are at risk for HIV infection.6

Institutional barriers to AIDS prevention make it likely that traditional methods of program development will fail. The lack of administrative support, resistance of staff, "turf issues", the stigma of being at risk for HIV infection, the confidentiality of an individual's HIV status—may work against a coordinated effort in AIDS education. Despite these barriers, we have found that clinical programming can be effective when educational efforts are directed to the patients themselves, either through outreach to existing patients or through patient's voluntary participation in a drop-in group.7

Knox recommends that staff at community health centers should be encourage to participate in the development of AIDS educational programs. They could provide prevention strategies that can be designed to change behaviors that increase the risk of exposure to the virus, in a psychiatric


7Ibid., 93
Rebinowitz concluded that the health profession has the responsibility to help the HIV infected patient to disclose to others at risk and this can be facilitated through focused educational efforts. Almost all authorities agree, that the only reason to do so, is to prevent a proven risk of harm to the patient or to others known to the professional, that would result from silence.⁹

Barlett's study revealed that condom counseling is an essential skill for health professionals involved in HIV care and prevention education. Barlett estimated that with appropriate education and information, 12,000 to 14,000 lives could have been saved in 1991. He also believes that the only true "safe sex" is abstinence or a mutually monogamous relationship with an HIV negative partner.¹⁰ Barlett points out that for those persons at high risk for HIV infection, who do not wish to follow these measures, use of a condom can contribute significantly to stemming the spread of the HIV epidemic. Latex condoms act as a physical


barrier to the transmission of HIV.\textsuperscript{11}

The National Commission on AIDS reports that most of the disagreement about HIV prevention is not over goals, but over methods to achieve goals and over who should decide which methods ought to be used. The National Commission also notes that there are a number of simple, readily available technologies that will contribute significantly to reduction in the spread of HIV infection. Yet AIDS education and prevention efforts continue to be stymied by an unwillingness to talk frankly about sexual and drug use behaviors that risk that spread of HIV. The National Commission further states that constraints on discussions of sex, whether imposed by law, political considerations, issues of morality, language, or culture, have been a substantial barrier to the creation and implementation of effective HIV education programs.\textsuperscript{12}

Leukefeld and Battjes suggests that HIV prevention should be recognized as a major challenge for the prevention community as well as others. HIV is spread through private, and in the case of intravenous drug use, illicit behaviors that are not easily discussed by professionals or the general public. Sexual practices and needle use have not

\textsuperscript{11}Ibid., 17

been common areas of discussion; but HIV preventive interventions require frank and detailed discussions of these behaviors.\textsuperscript{13}

Leukefeld and Battjes also points out that HIV prevention has historical roots in behavior change strategies and approaches that have been developed within the broader health promotion-disease prevention arena. Relying on these strategies and adapting them for HIV prevention has been a major challenge and focus in preventing the spread of HIV and AIDS. The authors contend that adapting existing prevention strategies and developing new behavioral strategies are critical to controlling the spread of the disease. Many persons engaging in high risk behaviors continue to believe that HIV will not affect them. Thus, the prevention challenge is considerable. Fortunately, this tendency to deny risk is changing as the epidemic progresses, especially persons in major urban areas.\textsuperscript{14}

\textbf{Theoretical Framework}

The theoretical framework for this study are the two major components of health education. These two components are the educational process and the informational. Bedworth and Bedworth concluded that the educational process is


\textsuperscript{14}Ibid., 5.
predicated upon the findings and principles of the behavioral sciences. It concentrates on those principles concerned with human motivation, the developmental process, the nature of learning, individual potentials and expectations, and social needs. The informational content is based upon the research findings of the various health sciences. The health content provides each individual with accurate health information regarding those health problems that can be prevented, controlled and/or treated. The information can assist the individual to make beneficial health decisions. This includes both health-related and health-directed behaviors.15

**Purpose of Study**

Goisman has pointed out that education is a key line of defense against the AIDS epidemic. Clinician and educators generally recognize the need of their patients and students. However, there has been an delay in comprehensive AIDS education development, perhaps in part due to staff or societal discomfort with sex or HIV education. No less than other people, patients with chronic mental illness need adequate and understandable information for protection

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against infection. They also have a right to know.\textsuperscript{16}

This study examined the effects of an AIDS education program on an HIV infected psychiatric patient, with a diagnosis of schizophrenia. An AIDS education experience was requested by the patient and the Fulton County, Public Defenders Office, to enhance the client's chances of being released from the Georgia Regional Hospital.

CHAPTER THREE
METHODOLOGY
The Settings

AID Atlanta is the largest and oldest community based HIV service organization in the southeastern United States. The agency was started in 1982 by dedicated volunteers, it now employs over 40 professional staff and services thousands of people with HIV and AIDS each year. AID Atlanta's service area includes 16 counties in and around metropolitan Atlanta. The agency is the leader in the consortium of Atlanta's major AIDS service providers, ensuring that people with HIV infection receive a continuum of high quality care. AID Atlanta's Department of Health and Social Services provide case managements services to persons living with HIV.\textsuperscript{1}

Client Background and Presenting Problem

This study was designed around a single client who requested an AIDS education program, that would enhance his chances of being released from the Georgia Regional Hospital. The client has a diagnosis of paranoid schizophrenia. The client is also being assisted by the Fulton County Public Defenders Office, and was assigned a

\textsuperscript{1}AID Atlanta: Handbook for Intern Casemanagers. 1991.
case manager by AID Atlanta.

One of the major issues regarding this client was his sexual aggressiveness towards other patients. The Public Defenders Office indicated that the Georgia Regional Treatment staff had reservations about the client's behaviors, sexual aggression, his HIV infection, and its consequences when released to his home community. The treatment staff had tried several different types of approaches of behavior modification but only found limited success in psychotropic medications.

The client and Lawyer requested an AIDS education program that he could understand and would impact on the client's sexual aggression and increase his awareness of AIDS related issues and risk-reduction responsibilities.

The patient is a 28 year old African American male with an HIV status of symptomatic (fever, diarrhea, severe weight loss, swollen lymph nodes, and neuropsychiatric problems). The client has identified himself as being bisexual and has never married. His date of diagnosis as HIV positive was 1985. This patient has a history of drug abuse and has tried to take his own life. Unemployed when first hospitalized, the client had also been a college student. The patient has been confined in Georgia Regional Hospital
for over three years.

**Outcome Measures**

The outcome measures were designed based on a treatment hypothesis which stated that, "if an infected individual is exposed to an individualized AIDS education program, learning would take place and the results would be significant." To test this treatment hypothesis, a Sequential Criterion Referenced Educational Evaluation Test was constructed for this study.

The Scree Test was 26 items, scored from zero to one (0-1) with 0 representing, I did not know and 1 for, "I knew". The Post-Test questionnaire was a 35 items objective type (True-False and Multiple-Choice). The responses were scored using a grading system of 0-100. The Scree Test and Post-Test were designed to measure:

(a) The client's knowledge of HIV transmission and risk reduction behavior.

(b) Knowledge of safer sex practices.

(c) Knowledge of condom use.

(d) Knowledge of AIDS drug treatments.

(e) Knowledge of HIV antibody testing.
The Condom Skills Demonstration utilized a banana and 4 condoms. This portion was not scored. It served as an information tool as to the proper use of a condom.

**Intervention Strategy**

One hour sessions were held once a week. The objective of the first two weeks were to establish a baseline. During the baseline period, there was no AIDS educational materials or information provided by the researcher.

The intervention was started the sixth week. The client was provided an assortment of AIDS education materials, articles, videos and information (List of materials provided in the appendices). The client was instructed by the researcher to read all materials because the information would appear on the Scree Test. The client was also instructed to raise questions about any item or information he did not understand.

After the tenth week, the client was asked to give a Condom Skills Demonstration. The client was given a banana and 4 condoms and asked by researcher to demonstrate the proper technique in putting it on. The objective of the skills test was to observe the degree of knowledge in condom use. The objective of the overall intervention phase was to increase the client's knowledge base.
A Post-Test was given after the intervention period. The objective of the post-test was to ensure that the client possesses the knowledge indicated on the baseline and intervention instrument. The post-test period was also used to clear up any questions by the client, pertaining to any areas covered in the study.

**Research Design**

An AB experimental design was used to evaluate the effects an AIDS education program would have on the client's knowledge base and risk reduction behaviors. The treatment hypothesis, which started that, "If an infected individual is exposed to an individualized AIDS education program, learning would take place and the results would be significant." This design provided a simple logical structure which permitted a comparison between the two elements (A & B).
CHAPTER FOUR

PRESENTATION OF FINDINGS

The data collected in this study, provided information in working with schizophrenic HIV individuals. A graph providing a visual basis for developing causal inferences about treatment effects are displayed in figure 1. Visual inspection of Figure 1 reveals shifts in the level or slope of the data occurring after the onset of treatment in a consistent fashion across replications. These data patterns can be interpreted as visually significant and supportive of causal inferences. In this AB design graphs, the first phase, (A) is the baseline, and the second phase is the intervention period, which commences 3 weeks after baseline and distribution of AIDS education materials.

The Scree Test provided the scores across both the baseline and intervention phases. Each point on the horizontal axis corresponds to when the client was able and available for testing. In Figure 1, the data points during intervention indicate a consistent increase in scores when compared with the baseline (baseline lowest score = 69%, intervention highest score = 100%).
FIGURE 1. SCREE TEST PROGRESS CHART
The overall mean at the end of intervention was 88.45. When the baseline mean of 75 was compared to the intervention mean, there was a 13.45 point increase in mean differences. This represented a 18% increase in the client's knowledge-base.

**Post-Test**

To test if the client possessed the knowledge as indicated on the Scree Test, a Post-Test (see appendix B) was given that required in-depth knowledge of all the information covered during the treatment phase. The score of the Post-Test was 88.5.

Further analysis of the client's knowledge areas suggests that this study's educational objectives were met (see table 1). There were 20 terms on the Post-Test that pertained to the client's knowledge of HIV transmission and risk-reduction behaviors; the client scored 16 out of 20 correct answers, 80%. On the client's knowledge of safer-sex practices, 5 out of 5 answers were correct, 100%. His knowledge of AIDS drug treatments were excellent at 100%, scoring 3 out of 3. His knowledge of the correct antibody testing was 100% with 1 out of 1 correct. The client's general knowledge of AIDS related issues was 62.5%. scoring a 5 out of a possible 8.

The client was also given a banana, (simulated erect penis) and 4 condoms and was required to demonstrate how to put it on properly. The client tried 3 times before he left
enough room at the tip of the banana. The researcher did not score the Condom Skills Demonstration, but utilized it as a information and education component.

The results of this study supported the treatment hypothesis that: If an infected individual is exposed to an individualized AIDS education program, learning would take place and the results would be significant.

Finding from the review of literature substantiate this conclusion. Goisman found his patient pre-to-post AIDS knowledge improved considerably. The general attitude of most researchers is that education can make a difference and can save lives.¹

Table 1. Post-Test Knowledge Subject Areas

<table>
<thead>
<tr>
<th>Subject Areas</th>
<th>Number Correct</th>
<th>Subject Areas Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission</td>
<td>(16/20)</td>
<td>80.0%</td>
</tr>
<tr>
<td>Safer - Sex</td>
<td>(5/5)</td>
<td>100.0%</td>
</tr>
<tr>
<td>AIDS Drug Treatments</td>
<td>(3/3)</td>
<td>100.0%</td>
</tr>
<tr>
<td>Anti-Body Testing</td>
<td>(1/1)</td>
<td>100.0%</td>
</tr>
<tr>
<td>General Knowledge</td>
<td>(5/8)</td>
<td>62.5%</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td></td>
<td><strong>88.5%</strong></td>
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CHAPTER FIVE
SUMMARY AND CONCLUSIONS

The results of this study demonstrated that it was possible to educate a schizophrenic patient, to a limited degree, on an individual basis. It should be noted that during the two phases, the client had no incidence of sexual acting out, as reported by hospital staff. The client was also given more freedom to interact with other patients that were on his unit. The client was bound in a harness most of the day but as his sexual behavior improved, he was allowed to roam without restraints. Although the results supported the treatment hypothesis, they are not conclusive. Because of the psychiatric medication's impact upon the client's level of functioning, and not knowing what it added or took away, the reader must review these results with caution. With that in mind, the reader can consider the practical significance of these findings.

Relevance for Practice

In community based AIDS organizations such as AID Atlanta, where education is a significant part of their on-going programs, this study can serve as a model for infected individuals who may not have the knowledge base on how to reduce risks to self and others. The individualized and
personal attention seems to validate the importance and urgency of the information provided. Case managers may want to consider as part of their client's service plan, an individualized personal package based on the client needs and level of understanding.

Implication For Social Workers

As the AIDS epidemic changes and present new challenges, social workers will have to become more research oriented, in order to dispel the myths that certain populations can not be taught the fundamentals of education, that will save lives. We all know the AIDS epidemic will not go away. All public, private and non-profit sectors of the health and social agency fields in each community will need to confront the urgency of these issues. Social Workers will need to adapt catalytic roles in engaging consumer and self help groups to organize a comprehensive community response to AIDS.

With the escalating number of cases, a coordinated approach to policy, planning and financing is essential to prevent the fragmentation of services and care from falling on any one organization or sector of society. Civil liberties and ethical issues will need to be carefully examined and questioned. Only with such efforts, can humanistic social work in this public health crisis be achieved.
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Ravinowitz, Robert., John C. Fletcher and Maxwell Boveman, Helping the HIV-Infected Patient Disclosed to Others at Risk. AIDS Patient Care, 3(1) (February 1987): 9-11.


APPENDICES
APPENDIX A

AIDS Education Materials Used.

I. Pamphlets

2. AIDS - Think About It - 1987
3. Safer Sex - 1990
4. Legal Answers About AIDS - 1989
5. AIDS and You - 1991
7. Man to Man - 1988
8. Don't Share AIDS - 1987
12. Condoms and AIDS - 1990

II. Articles

3. "Safer Sex" [no author]
III. Films - Video

1. Strictly Fresh - 1989
2. How to Use a Condom - 1988
HIV/AIDS KNOWLEDGE AND SAFER SEX EVALUATION

Complete every item on this test. If you know the correct answer, score the item as 1. If you do not know the correct answer, score the item as 0. The questionnaire evaluates your knowledge about HIV/AIDS and Safer Sex at this point in your life. Please take your time and do the best you can. Thank you.

__ 1. Did you know that a body lotion or massage oil cannot safely be used as a condom lubricant?

__ 2. Did you know that teenage mothers infected with the AIDS virus can transmit the virus to their newborn babies?

__ 3. Did you know that a latex condom containing monoxymol 9 will protect you and your partner from contracting the AIDS virus?

__ 4. Did you know that the greatest concentration of HIV is found in semen, blood, and saliva?

__ 5. Did you know that Georgia law requires HIV infected persons to inform their sexual partners of their HIV status?

__ 6. Did you know that household items shared by infected and non-infected family members cannot result in HIV transmission to a non-infected person?

__ 7. Did you know that mutual masturbation without having sexual intercourse is considered safer sex?

__ 8. Did you know that hugging & body rubbing, without intercourse, is considered safer sex?

__ 9. Did you know that giving or receiving a massage is considered safer sex?

__ 10. Did you know the difference between being HIV+ and having full-blown AIDS?

__ 11. Do you know that abstaining from sexual intercourse is the best way to avoid sexual transmission of HIV?

__ 12. Did you know that people who have shared IV drug needles account for the second largest group of AIDS cases?
13. Did you know that having sex without a condom has a definite or probable link to HIV transmission?

14. Did you know that oral sex with ejaculation in the mouth has a definite or probable link to HIV transmission?

15. Do you know what cunnilingus with a vaginal dam is?

16. Do you know the difference between the ELISA and Western Blot HIV antibody tests?

17. Do you know that lamb skin condoms have pores large enough or the AIDS virus to pass through?

18. Do you know the difference between AZT and Interferon?

19. Do you know the difference between the Incubation period of the AIDS virus and latency?

20. Do you know the difference between opportunistic infections and remission?

21. Do you know that persons who test positive for the HIV antibody test are at a higher risk for clinically active tuberculosis?

22. Are you familiar with NAPWA?

23. Can you name 3 different brands of latex condoms?

24. Do you know how many times you can use the same condom?

25. Do you know the difference between using water based lubricants and petroleum jelly with a condom?

26. Did you know that only a blood test can determine whether or a person is infected with the AIDS virus?
APPENDIX C

HIV/AIDS KNOWLEDGE TEST

This questionnaire test your knowledge about HIV/AIDS at this point in your life. Please chose the correct answers to the best of your ability. Please take your time. Thank You.

1. Teenagers are too young to contract and HIV infection. T or F.

2. If a pregnant teenage mother is infected with the AIDS virus, her new born baby will be infected also. T or F

3. Only a homosexual can become HIV infected. T or F

4. A sexually active individual has a greater risk of contracting the AIDS virus (HIV) if she/he only use a "non-lubricated" condom. T or F

5. The AIDS virus can be contracted by hugging, dry kissing or massaging an HIV infected person. T or F

6. Approximately 55% of infected persons will develop AIDS within ten years after infection. T or F

7. AZT can cure AIDS. T or F

8. DDI can cure AIDS. T or F.

9. Each and every individual infected with the AIDS virus, will sooner or later, die of AIDS. T or F

10. Kemron can cure AIDS. T or F

11. Items shared by infected and non-infected family members, can result in HIV transmission to those who are non-infected. T or F

12. Blood, semen, vaginal secretions and possibly breast milk are the only body fluids proven to transmit HIV. T or F

13. The greatest concentration of HIV is found in saliva, blood and semen. T or F

14. There is a great risk of contracting HIV if you donate blood. T or F
15. A person could catch the AIDS virus if he/she is in the same room with an HIV infected person. T or F

16. An HIV infected individual does not have to inform their sex partners of their HIV status. T or F

17. The AIDS virus (HIV) can live on a clean drug needle. T or F

18. Going without sexual intercourse, is the best way to avoid sexual transmission of HIV. T or F

19. AIDS cases among teenagers and young adults are increasing fairly rapidly. T or F

20. The Centers for Disease Control estimates that 35,000 college students and as many as 100,000 teenagers are infected with the AIDS virus. T or F

21. The Centers for Disease Control has found very little evidence of AIDS in the African American community. T or F

22. Women are a low risk group and only account for 1% of AIDS nationwide according to the CDC. T or F

23. An HIV infection can be controlled through proper nutrition. T or F

24. AIDS is the seventh leading cause of death for 15 to 24 year old. T or F

25. All teens believe they can take risks and nothing will happen. T or F

26. You cannot talk about AIDS without talking about sex. T or F

27. People who have shared IV drug needles account for the second largest group of AIDS cases. T or F

28. People who are drunk or high are more likely to engage in unprotected sex. T or F
29. Choose one of the following unsafe activities that have a definite or probable link to HIV transmission.
   a. Vaginal sex without a condom.
   b. Anal sex without a condom.
   c. Oral sex without a condom.
   d. Sex while taking mood or mind-altering drugs.
   e. All of the above.
   f. None of the above.

30. Choose one of the following safe activities that do not transmit HIV.
   a. Abstinence
   b. Hugging
   c. Dry kissing
   d. Flirting
   e. All of the above
   f. None of the above

31. AIDS stands for: choose one
   a. African Infectious Disease Systems
   b. All Infection Defense Systems
   c. Acquired Immune Disease Syndrome
   d. Acquired Immune Deficiency Syndrome

32. Mosquitoes can transmit AIDS. T or F

33. HIV can be transmitted through food handling. T or F
34. HIV stands for: choose one
   a. Human Incubation vectors
   b. Human Immunodeficiency Virus
   c. Hemophilia Infected Virus
   d. Hydrogen Infused Virus

35. Which of the following tests is considered more specific when detecting HIV antibodies.
   a. ELISA
   b. Western Blot
   c. African Block
   d. Non-oxynol - 9

YOU HAVE COMPLETED THE QUESTIONNAIRE! THANK YOU!!