A program evaluation: the effectiveness of an HIV intervention at reducing high risk sexual behavior among African American women

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ABSTRACT

SOCIAL WORK

SMITH, N'DIA R. B.S. STATE UNIVERSITY OF WEST GEORGIA, 2004

A PROGRAM EVALUATION: THE EFFECTIVENESS OF AN HIV INTERVENTION AT REDUCING HIGH RISK SEXUAL BEHAVIOR AMONG AFRICAN AMERICAN WOMEN

Advisor: Dr. Sarita Davis

Thesis dated May 2007

This program evaluation examines the effectiveness of The Healthy Love Workshop, sponsored by SisterLove, Incorporated. The purpose of the Healthy Love Workshop is to decrease HIV risk behaviors, reduce the number of sexual partners, increase sexual abstinence, promote the consistent use of condoms, and increase the number of persons taking HIV tests. This workshop specifically focuses on finding ways to reach African American women by using a culturally-oriented approach. The Healthy Love Workshop is an empowering intervention that attempts to open the door to a world of choices and positive decision making for its participants. Women attending the Healthy Love Workshop are compared to women attending the HIV 101 workshop. While the purpose of the HIV 101 Workshop is the same as the Healthy Love Workshop, the former has no cultural component. Participants were randomly assigned to each
intervention in order to compare the knowledge learned from participation in the workshop. A review of the literature will be presented for areas including risky sexual behavior, HIV prevention, and effectiveness of HIV/AIDS prevention programs. The literature also explores the Social Cognitive Theory and the Afrocentric perspective as it relates to the target population. An exploratory design with a pretest and posttest instrument is used to evaluate the sample of 176 women. The sample consists of women of African decent who live in the metro Atlanta area with the following characteristics: between ages 18 to 69; not pregnant; and at risk for contracting HIV/AIDS. The data was analyzed using an independent sample t-test and the Statistical Packages for the Social Science 11.0 for Windows (SPSS). Findings from the analysis show a significant variance between the two groups. The Healthy Love Workshop was a more effective intervention in the area of HIV Testing, Self-efficacy, and HIV Knowledge. The findings imply that there is a need for a more culturally-centered prevention programs to advance HIV/AIDS education. The implications of these results to social work practice and HIV prevention education are discussed.
A PROGRAM EVALUATION: THE EFFECTIVENESS OF AN HIV INTERVENTION AT REDUCING HIGH RISK SEXUAL BEHAVIOR AMONG AFRICAN AMERICAN WOMEN

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
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I would first like to thank God for giving me the will and the strength to complete my Master in Social Work. I would also like to thank my family for their never ending support. I would like to thank my fellow classmates for all of their help and support through this journey. Special thanks goes to my thesis adviser, Dr. Sarita Davis, my mother, Janice Smith, and my fiancée, Mark Terrell for all of their love, support and patience through this endeavor.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>ii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vi</td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td>Background of the Program</td>
<td>1</td>
</tr>
<tr>
<td>Purpose of the Evaluation</td>
<td>5</td>
</tr>
<tr>
<td>Description of the Intervention</td>
<td>8</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>13</td>
</tr>
<tr>
<td>Significance of the Evaluation</td>
<td>15</td>
</tr>
<tr>
<td>Summary</td>
<td>16</td>
</tr>
<tr>
<td>II. REVIEW OF THE LITERATURE</td>
<td>17</td>
</tr>
<tr>
<td>Overview</td>
<td>17</td>
</tr>
<tr>
<td>Defining Risky Sexual Behavior</td>
<td>17</td>
</tr>
<tr>
<td>Types of HIV Prevention Programs</td>
<td>20</td>
</tr>
<tr>
<td>Effectiveness of HIV/AIDS Prevention Programs</td>
<td>23</td>
</tr>
<tr>
<td>Limitations of the Literature</td>
<td>26</td>
</tr>
<tr>
<td>Conceptual Framework</td>
<td>27</td>
</tr>
<tr>
<td>Afrocentric Perspective</td>
<td>33</td>
</tr>
<tr>
<td>Summary</td>
<td>35</td>
</tr>
<tr>
<td>III. METHODOLOGY</td>
<td>36</td>
</tr>
<tr>
<td>Overview</td>
<td>36</td>
</tr>
<tr>
<td>Setting</td>
<td>36</td>
</tr>
<tr>
<td>Sample</td>
<td>36</td>
</tr>
<tr>
<td>Demographics</td>
<td>37</td>
</tr>
<tr>
<td>Measure</td>
<td>43</td>
</tr>
<tr>
<td>Design</td>
<td>44</td>
</tr>
<tr>
<td>Procedures</td>
<td>45</td>
</tr>
<tr>
<td>Statistical Analysis</td>
<td>46</td>
</tr>
<tr>
<td>Summary</td>
<td>47</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>48</td>
</tr>
<tr>
<td>Overview</td>
<td>48</td>
</tr>
<tr>
<td>Summary</td>
<td>52</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>FIGURE</th>
<th>Description</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The Social Cognitive Theory Interaction Model</td>
<td>31</td>
</tr>
<tr>
<td>2.</td>
<td>Afrocentric Perspective for SisterLove, Incorporated</td>
<td>34</td>
</tr>
<tr>
<td>3.</td>
<td>Comparison Results for Pretest</td>
<td>50</td>
</tr>
<tr>
<td>4.</td>
<td>Comparison Results for Posttest</td>
<td>51</td>
</tr>
</tbody>
</table>
TABLE OF CONTENTS CONTINUE

V. CONCLUSION .................................................................................. 53
   Overview .................................................................................. 53
   Limitations of the Study ......................................................... 57
   Summary .................................................................................. 58

VI. IMPLICATIONS FOR SOCIAL WORK PRACTICE ....................... 59
   Overview .................................................................................. 59
   Recommendations .................................................................... 59
   Social Work Implications ...................................................... 60
   Summary .................................................................................. 63

APPENDICES ...................................................................................... 64
   A. IRB Approval Letter ............................................................ 65
   B. Informed Consent ............................................................... 66
   C. Recruitment Advertisement .............................................. 69
   D. Pretest Survey ...................................................................... 70
   E. Posttest Survey .................................................................... 96
   F. Item Level Analysis ............................................................ 108

REFERENCES ..................................................................................... 135
## LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Demographic table for Healthy Love Workshop</td>
<td>38</td>
</tr>
<tr>
<td>3. Demographic table for HIV 101 Workshop</td>
<td>40</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Overview

This chapter explains the HIV and AIDS epidemic and the importance of HIV/AIDS prevention programs for African American women who are "at risk" for contracting HIV or AIDS. The purpose of evaluating a HIV/AIDS prevention program is addressed in this chapter as well as background information of the program to be evaluated. The statement of the problem is defined through a discussion of the impact of HIV/AIDS on African American women. The significance of this evaluation is discussed with concentration on the need for HIV/AIDS prevention programs that ensure effective inputs that can impact successful outcomes. Finally, this chapter concludes with a summary of the remaining chapters.

Background of the Problem

According to the World Health Organization, in 2005, over 40 million people worldwide were living with HIV. Over four million people were newly infected with HIV, and three million AIDS deaths also occurred in 2005 (World Health Organization, 2005). At the end of 2003, in the United States, an estimated one million persons were living with HIV/AIDS (Centers for Disease Control and Prevention, 2006). The HIV/AIDS epidemic also continues to grow in Georgia. By the end of September 2005, there was a total number of 29,180 AIDS cases reported (Georgia Department of Human Resources,
These statistics show that Acquired Immunodeficiency Syndrome (AIDS) as well as Human Immunodeficiency Virus (HIV) is still devastating the society with overwhelming numbers of new cases and deaths all over the world. HIV is the virus that causes AIDS. This virus may be passed from one person to another when infected blood, semen, or vaginal secretions come in contact with either broken skin or mucous membranes of an uninfected person.

In addition, infected women can pass HIV to their babies during pregnancy or delivery as well as transmit the virus through breast feeding. People with HIV have what is referred to as HIV infection. Some of these people will develop AIDS as a result of their HIV infection (CDC, 2006). AIDS stands for Acquire Immunodeficiency Syndrome. Acquired means that the virus is not hereditary, but it develops after birth from contact with a disease causing agent. Immunodeficiency means that the disease is characterized by a weakening of the immune system. Syndrome refers to a group of symptoms that collectively indicate or characterize a disease. In the case of AIDS, this can include the development of certain infections and cancers, as well as a decrease in the number of certain cells in a person's immune system (CDC, 2006).

The ways in which HIV can be transmitted have been clearly identified. HIV is spread by sexual contact with an infected person, by sharing needles and syringes primarily for drug injection with someone who is infected, or through transfusions of infected blood or blood clotting factors. Infection through transfusions is less common in recent years due to thorough blood screenings. Babies born to HIV-infected women may
become infected before and during birth, or through breast-feeding after birth (CDC, 1999).

At the end of 2003, the Centers for Disease Control and Prevention (CDC) reported that 160,433 people were infected with HIV through male to male sexual contact and 98,105 people were infected through male to female sexual contact. Also, 17,328 people were infected with HIV through injection drug use and 4,858 people were infected by some other method (CDC, 2006). The CDC estimated that in the U.S., new infections would occur at the rate of approximately 40,000 persons per year. Of these new cases, African American and Hispanic heterosexual women represent one of the fastest growing HIV-positive subpopulations (Mitchell & Linsk, 2004). These statistics create a new face within the HIV/AIDS epidemic, which is the woman of color. To many women of color, HIV continues to remain an invisible problem.

According to the 2000 census, African Americans make up 12.3% of the U.S. population; however, in the U.S., African Americans accounted for 19,206 (50%) of the estimated 38,730 new HIV/AIDS diagnoses. African Americans are one of the fastest growing populations to be newly infected with HIV and AIDS. It has also been recently discovered that African American women are being disproportionately diagnosed with HIV and AIDS (Crosby, Yarber, DiClemente, Wingood, & Meyerson, 2002). Of the 123,405 women living with HIV/AIDS, 64% were African American. In 2002, HIV infection was the leading cause of death for African American women aged 25 to 34.
years; the third leading cause of death for African American women aged 35 to 44 years; the fourth leading cause of death for African American women aged 45 to 54 years and for Hispanic women aged 35 to 44 (CDC, 2006). Research also shows that African Americans may face challenges associated with greater risk for HIV infection, including: denial, substance abuse and engaging in sexual activities with “partners at risk” (Dyer, 2004).

Many African American women are now dealing with the men on the “Down Low” or men engaging in sex with men (MSM), but do not consider themselves gay or bi-sexual. This underground world has mostly impacted African American women. Many African American women are unaware that their male partners or significant others are living the “Down Low” lifestyle, and they proceed to have unprotected sex with them. In the U.S., HIV/AIDS infection has had a tremendous effect on MSM. In 2004, MSM accounted for 70% of all estimated HIV infections among adult males and adolescents, even though only about 5 to 7% of male adults and adolescents in the U. S. identifies themselves as engaging in MSM activities (CDC, 2006).

The most concentrated region of HIV among African American women is in the Deep South and rural areas (Reif, Geonnotti, & Whetten, 2006). There are six southern states that represent the Deep South which include: Alabama, Georgia, Louisiana, Mississippi, North Carolina and South Carolina. Subsequently, these Southern states have demographically similar HIV epidemics (Reif et al., 2006). The Deep South also has some of the highest levels of poverty and uninsured individuals, which can also be
contributing factors to the high HIV rates (Reif et al., 2006). According to the Georgia Department of Human Resources (2002), Georgia has the eighth highest number of AIDS cases in the United States with 25,245 of AIDS cases reported. Of the 25,245 cases, 4,390 were women. In 2001, women accounted for one in four Georgians diagnosed with AIDS and 84% of women with AIDS in Georgia were African American. Most women do not know whether their sex partner is HIV infected or not (Georgia Department of Human Resources, 2002).

Purpose of the Evaluation

The purpose of this evaluation is to examine the effectiveness of the SisterLove, Incorporated HIV prevention program, specifically the Healthy Love Workshop (HLW) in comparison to the HIV 101 program, which is also offered by the agency. In this evaluation, the specific prevention needs of African American women or women of African descent (women who have African ancestors) that are at risk for contracting HIV or the AIDS virus are addressed. The purpose of the prevention programs are to decrease risky sexual behaviors, reduce the number of sexual partners, increase sexual abstinence, increase the consistent use of condoms and other latex barriers, and increase the number of persons taking HIV tests and getting their test results, specifically for African American women. This organization has never formally evaluated their prevention program to assess the effectiveness of the population in which they provide services. This evaluation was used to identify areas of improvement for future intervention delivery.

SisterLove, Inc. is based in a predominantly African American neighborhood in the metropolitan Atlanta area where they serve African American women in HIV
prevention. SisterLove, Inc. is a small organization with only eight staff members who hold advanced degrees in the field of public health. SisterLove, Inc., founded in July of 1989 by Dazon Dixon Diallo, can trace its beginnings to a volunteer group of women interested in educating communities of women about HIV prevention, self-help, and safer sex techniques in Atlanta. The mission of SisterLove, Inc. is to eradicate the impact of HIV and other reproductive health challenges for African American women and their families. They implement the program through education, prevention, and human rights advocacy in the U.S. and around the world in countries such as Barbados, Brazil, Canada, Nigeria, Philippines, and South Africa. SisterLove, Inc. provides services that address educational and support needs of African American women at risk for contracting HIV as well as those that are living with HIV.

SisterLove has four programs that help them serve their population which include: (1) the Health Education and Advocacy Program, (2) the Bridge Leadership Program, (3) the International Programs, and (4) Careworks Volunteer Program. The Health Education and Advocacy program provides services that educate, encourage, and support empowerment. The HLW is the cornerstone of this program and is an empowering gathering that opens the door to a world of choices and positive decision making for their participants.

The participants also learn the basics of HIV prevention and transmission, safer sex practices, reproductive health and human sexuality while affirming their right to take control of their sexual lives and health. Specially trained volunteers serve as HLW Facilitators. The HLW was originally designed with the needs of women in mind, but it
can be modified to meet the needs of any audience regardless of gender, age or sexual orientation with the message that safer sex can be satisfying, sensual and fun. The Healthy Education and Advocacy Program facilitate individual level interventions, including prevention case management, along with group level interventions. The program is open to women in the community who are living with HIV or who are at risk contracting for HIV.

Next, the Bridge Leadership Program is an effort to integrate a number of issues that intersect with HIV which include the integration of sexual and reproductive health and human rights into a cohesive and innovative program area. The purpose of this program is to implement a strategy to increase involvement of people in HIV, sexual health and human rights issues for women through organizational relationship building and shared activities. This organization also provides a structured program focus for various projects, and it gives greater visibility to the capacity of SisterLove, Inc. to help strengthen and empower individuals and organizations involved in similar or related issues.

The International Programs sponsored by SisterLove, Inc. takes place in South Africa to help combat the spread of HIV. In this program, the goals are to enhance the capacity of local non-government organizations and community-based organizations and leadership abilities to manage and promote sustainable mother-to-child-transmission, and youth-based HIV prevention activities in South Africa. SisterLove, Inc. also provides training, technical assistance, resource development, knowledge and experience with
others throughout the world to assist HIV positive women and those working to combat the effects of HIV in South Africa.

Lastly, in the CareWorks Volunteer Program, volunteers attend group or individual orientations and participate in basic HIV and Safer Sex Workshops that provide an introduction to some of the prevention education services provided in the community. A few volunteer opportunities require additional training that is provided free of charge for those willing to make a commitment to helping SisterLove, Inc. and their community.

Description of Intervention

This study is a comparative intervention in which women were randomly assigned to either HLW or HIV 101 in order to compare their posttest knowledge of HIV, personal self efficacy, HIV testing after participation in the programs. The HLW is an HIV prevention program that considers the role of African American culture within the intervention hosted by SisterLove, Inc. A trained female staff member with five or more years of experience in facilitating HLW and HIV training sessions delivered the HLW intervention to small groups of ten to fifteen participants per session with each session lasting approximately three to four hours.

The first component of the workshop entitled "Setting the Tone" contains two exercises. The first exercise is the creation of the "fantasy name". The goal of this exercise is to help participants relax and feel comfortable about discussing sexuality and sexual behaviors that might place them at risk for HIV infection and transmission. The participants select a sexy fantasy name which they will be referred throughout the
duration of the workshop. Participants introduce themselves by their fantasy name, which helps them feel more comfortable and facilitates the discussion of sexual issues.

The second exercise is referred to as “Synonyms” which helps women recall and acknowledge their feelings, attitudes and beliefs about words often associated with sex and sexuality. The facilitator writes words at the top of a large sheet of paper such as: “penis”, “vagina”, “sex”, and “masturbation”. Each sheet of paper is then attached to walls of the room and participants form small groups near each sheet in order to brainstorm synonyms for each word, while one of the participants writes the synonyms on the sheet. After everyone has provided a synonym, a volunteer is asked to read the list aloud so that everyone feels the effects of hearing words that often trivialize or denigrate human sexuality. This exercise is followed by a discussion.

The second component of the HLW is entitled “The Facts”, and contains three exercises which include: (1) HIV Fundamentals, (2) Sexually Transmitted Infections (STIs), and (3) The Look of HIV. HIV Fundamentals is the central informational component of HLW. The facilitators write down the acronyms “HIV” and “AIDS” on sheets of paper, and then ask the participants for the meaning of each letter. This activity leads to a discussion of HIV and AIDS, and how the virus is transmitted. For STIs, exercise participants learn the names of the most common STIs, the mode of transmission and common symptoms. In the exercise the look of HIV, participants learn about the signs and symptoms of HIV infections and various HIV testing options. The purpose of this exercise is to dispel the myth that one can visibly tell whether someone is living with
HIV and AIDS and to provide information about the incidence rates of HIV and AIDS in the United States.

The third and final component is called “Safer Sex” and is comprised of six activities. The first activity is the risk assessment, which provides participants with information that will help them reconsider their assumptions or beliefs regarding personal risk for contracting HIV or other STIs. In the second activity, condom demonstration, participants are taught correct condom use and disposal. Participants are given a chance to place a condom on a penis model.

The next activity is the condom race where the participants practice the correct condom use in a realistic atmosphere with the lights turned off and music playing. The time pressure of this exercise simulates circumstances when women may need to rapidly place a condom on an intimate partner. The fourth exercise is the female condom demonstration where participants learn basic facts about the female condom and discuss its ability to reduce the risk of transmitting or contracting HIV and other STIs. In the fifth activity, oral sex, participants learn about the signs and symptoms of HIV infections and various HIV testing options. The objective is to demonstrate how participants can reduce their risk of transmitting or contracting HIV and other STIs during oral sex.

The sixth and final activity is the High, Low, and No Risk exercise. Participants are randomly given cards that describe risk activities. They are then asked to read the card and say whether the activity is high risk, low risk or no risk for contracting or transmitting HIV. Participants will receive non-monetary incentives for participating in the workshop. The incentives include risk reduction supplies and printed educational
material on how to prevent HIV. The purpose of this activity is to provide participants with a final opportunity to demonstrate what they have learned about the ways HIV and other STIs are transmitted.

The HIV 101 workshop is a single-session intervention that uses a didactic approach to provide basic HIV/AIDS prevention information. The duration of the HIV 101 workshop ranges from two to three hours. HIV 101 workshops are held in convenient community settings where participants are comfortable (e.g., college campuses, churches, participants’ homes, community centers and SisterLove, Inc. offices), and each workshop is comprised of an average of 15 women.

Once participants were assembled, the HIV 101 manual was provided in for both the HLW and HIV 101 workshops and the Evaluation Coordinator began with a brief welcome and overview of the purpose of the evaluation project, the informed consent process, assurance of confidentiality and voluntary participation, financial compensation, various steps involved in the evaluation including pre-intervention through six month follow-up, and the evaluation instruments. The Evaluation Coordinator remained in the workshop to answer questions when necessary and check forms for completion. Persons who do not wish to be included in the evaluation project were given the option to leave the session or participate in the workshop without completing the evaluation forms.

After reading and signing the informed consent form, all eligible participants completed the baseline assessment prior to the implementation of the workshop. Data was also collected at the end of the workshop to assess any changes in knowledge, attitudes, and beliefs. All participants received risk reduction supplies (e.g., male and
female condoms) for taking part in the intervention as well as brochures on how to prevent HIV/AIDS.

The HIV 101 Workshop has four parts: (1) Introduction, (2) HIV/AIDS Facts, (3) STD Facts, and (4) the Look of HIV. This workshop shows respect for others by using nonjudgmental language. The HIV 101 Workshop begins with the “Introduction” activity which shares the purpose of the workshop, and identifies and addresses participants expectations. “The Opening” sets the tone for the workshop and allows the Facilitator to advise participants of what they can expect from the workshop. Participants also learn about the brief history and mission of the agency as well as ground rules and the agenda for the workshop.

In the second part, “HIV/AIDS Facts” provides basic information about behavior that may increase a woman’s risk of contracting or transmitting HIV. This activity also describes how people living with HIV can develop AIDS and allows participants to define the acronyms HIV and AIDS. Participants also learn about the relationship between HIV and AIDS and the most common ways that HIV is spread. “STD Facts” provides basic information about some common STIs and their impact upon those living with HIV. Participants also learn the names, modes of transmission, and symptoms of some of the most common STIs. The exercise also gives women the opportunity to share what they know about STIs.

The purpose of the third and final part, “The Look of HIV” is to dispel the myth that one can visibly tell if someone is living with HIV or AIDS, to describe the differences between anonymous and confidential testing, and provide participants with
information about the incidence rates of HIV and AIDS in the United States. The “Closing” activity gives participants an opportunity to ask any lingering questions and provide feedback regarding the relevance and usefulness of the HIV 101 Workshop. Participants demonstrate their acquired knowledge and skills by summarizing the workshops content through interactive question and answer/feedback session.

Statement of the Problem

Early in the HIV and AIDS epidemic, relatively few women and female adolescents were diagnosed (CDC, 2006). Today, women account for more than one quarter of all new HIV/AIDS diagnoses. There are several challenges facing the African American community that hinder HIV prevention efforts and the ability of African Americans with HIV/AIDS to cope with the disease.

According to the CDC (2006), some of these barriers include: poverty, denial, sexually transmitted infections (STIs), and drug use. Persons who may not have access to HIV testing or treatment because of poverty may be a cause that impacts prevention. Some African Americans may believe that HIV and AIDS is not a concern for the African American community or that HIV and AIDS is mostly a white, gay male disease. Topics such as homosexuality, sex outside of marriage, drug use, and other sensitive issues often makes talking about HIV and AIDS a challenge. Finally, African American may find these discussions even more challenging when already faced with the issues of race (CDC, 2006).

In 2004, African Americans were about 19 times more likely as whites to have gonorrhea and about 6 times more likely to have syphilis. Certain STIs can greatly
increase the chances of contracting HIV. Also, a person who has both HIV and certain STIs has a greater chance of spreading HIV to others. Injecting drugs is the second leading cause of HIV infection for African American women and the third leading cause of HIV infection for African American men. In addition to injecting drugs, people who use other drugs are more likely to take risks, such as unprotected sex when they are under the influence. Drug use can also affect treatment for those with HIV, causing them to not take medicine when needed (CDC, August 2006).

Currently, the CDC supports a wide range of HIV prevention activities in the United States. These prevention activities include: a collection of behavioral and HIV/AIDS case surveillance data that documents trends in the epidemic and risk behaviors, programs conducted by state, territorial, and local health departments, community based organizations, national organizations, education agencies, capacity building to improve HIV prevention programs, program evaluation to monitor the delivery and outcomes of prevention services, and research leading to new strategies for preventing transmission of HIV/AIDS (CDC, 2006). There has been considerable success achieved in the prevention of HIV infection in the United States. Prevention success has reduced incidence rates of HIV infection from more than 150,000 cases per year in the mid-1980s to approximately 40,000 cases per year since the late 1990s (CDC, 2006).

Despite this success, considerable prevention challenges remain. Racial and ethnic disparities have increased during the past twenty five years, especially among African American men and women. Because women are more likely to be infected by men and AIDS cases due to heterosexual contact are increasing, programs that
specifically target men will have a beneficial impact on women (Center for AIDS Prevention Studies, 1998).

HIV prevention programs must continue to evolve to address these challenges, incorporating biomedical advances and findings and innovations in HIV testing technologies, and other breakthroughs (CDC, 2006). Many prevention interventions have been tried with African American women in regards to sexual risky behavior. Most of the programs speak to male and female condoms usage and do not focus on the cultural relevance of the participants. Most of the prevention interventions that speak solely to male condom use are not as effective as the interventions that speak to both male and female condom usage. Other prevention programs addressed a variety of groups for HIV prevention in the intervention, which made it difficult to tell whether the intervention for the prevention of HIV was effective for African American women.

Significance of the Evaluation

This evaluation will help build the capacity of SisterLove, Inc. to evaluate its ongoing HIV prevention programs in the future. The results of the evaluation can be used to assess the effectiveness of the HLW, identify aspects of the HLW that requires improvement, revise and improve the intervention and facilities guides as needed, and share lessons learned on developing, implementing and evaluating the program with various stakeholders. The evaluation determines if the cultural center aspect of the program is effective and what improvements can be made specifically for the cultural piece of the intervention. The results of the study will enable SisterLove, Inc. to identify
staff training needs, opportunities for program improvement and obtain funding to continue implementing the HLW program.

Summary

African American women are at an all time high risk for contracting HIV. Most of the risk comes from risky behaviors with heterosexual males. According to the CDC (2006), there are no confirmed cases of female-to-female sexual transmission of HIV in the U. S. database to date. Although the AIDS cases in the United States are declining, the cases of women being impacted with the virus is increasing this in turn means that not enough is being done in the prevention of women. Even though the government has allocated monies for the prevention for HIV and AIDS since the first case was found more than twenty five years ago, many of the prevention programs have been focused on gay and heterosexual men. The new face of AIDS is indeed the minority woman and more programs should be grounded in meeting the needs of prevention of women of color. The remaining chapters will speak to the literature of other prevention programs for women, which focuses on risky sexual behavior and limitations of the literature, social cognitive theory and how it applies to at risk women. The following chapters discuss the methodology, evaluation, results, and the implications that social work has from evaluation of the program.
CHAPTER II
REVIEW OF THE LITERATURE

Overview

In this chapter, a thorough review of the literature is discussed to justify effective prevention programs for minority women. The literature review focuses on defining risky sexual behavior, including description of what risky sexual behavior entails and the commonalities of at risk women who participate in risky sexual behaviors. The literature will also address types of HIV prevention programs for African American women as well as the effectiveness of some HIV prevention programs that have been previously evaluated and studied. This chapter will also contain limitations in the review of the literature that may be a factor in the evaluation of SisterLove, Inc. The conceptual framework and the relationship in which it has to the HLW intervention will be addressed in this chapter as well. This chapter will also state an Afrocentric perspective which will give a cultural overview of the actions of at risk African American women.

Defining Risky Sexual Behavior

Risky sexual behavior is defined as inconsistent condom use and unprotected sexual intercourse with multiple partners (Brook, Morofele, Zhang, Brook, 2006). In 2003, Klein, Elifson, and Sterk examined HIV risk perceptions among a sample of 250 urban, economically disadvantaged, primarily minority women who perceived themselves to have no risk for contracting HIV. The purpose of this study was to examine the
perceptions of women who are at risk on their condom usage.

In this study, risk behaviors were fairly common among the women who reported that they had no chance of becoming infected with HIV. The findings are probably a reflection of denial and some women's inability to acknowledge that the things they do may be placing them at risk for contracting HIV (Klein, et al 2003). Findings such as these and the present research have led some researchers to conclude that HIV intervention and educational programs need to address denial and the issues underlying denial very carefully (Klein, et al 2003).

In another study completed by Foreman (2003), the author describes influences associated with sexual risk taking among African American college women. The objective of the study was to understand how college women manage the emotional, social, and cultural demands of sexual maturation. The sample of the study included 15 African American women, ages 19 to 33, attending a four year university in Southeast Texas. Each of the women identified as having engaged in sexual intercourse with at least one male partner within the past year. The findings indicate that inoculation with education is not a sufficient intervention for sexually active young women (Foreman, 2003). This study suggests that it is essential to concentrate on strategies to increase personal risk perception, address desires for intimacy, and promote the eroticization of condoms.

The results from a study completed by Timmons and Sowell (1999) indicated that a significant proportion of low income African American and Latina women in intimate relationships had indicators of elevated risk for HIV infection and transmission. The
authors suggested that successful HIV infection prevention interventions need to address negative social and economic factors that define the context of many women's lives (Timmons & Sowell, 1999). The sample included 19 heterosexual African American women ages 18 to 44 years of age. The procedures of this study involved three focus groups sessions with the use of a semi-structured guide and audiotapes of each group session which were transcribed verbatim. Focus group sessions generated a wide range of descriptions of behaviors that women felt contributed to or was associated with the risk of HIV transmission. The sessions also revealed descriptions of preventive practices that women believed were effective in decreasing their risk of HIV infection. Results indicated that women perceived themselves as victims in society and this perception limits their propensity to take action in protecting themselves from HIV.

Recent research has described the relationship between self-esteem and HIV-related risk behaviors and explores what factors predict self-esteem levels of "at risk" women. Sterk, Klein, and Elifson (2004) recruited a sample of 250 minority women who lived in study's catchment areas and were considered "at risk" based on the criteria of being 18 years of age or older and were able to conduct an interview in English. The results showed that despite these potential limitations, this research has revealed that "at risk" women's self-esteem is related to a variety of sexual and HIV-related risk outcomes. A multivariate model was developed to understand the factors that were related to low self-esteem levels, and discovered five factors including race, religiosity, money problems, emotional abuse experiences, and drug problems were predictive of women's self-esteem levels (Sterk Klein, & Elifson, 2004).
Research on how various living conditions impacts engagement in a range of high risk behaviors of low income African American women has also been conducted (Gentry, Elifson, & Sterk, 2005). As previously noted, high risk behaviors also increases risk for HIV infection. The sample included 45 African American women, who were identified as at risk for HIV infection and resided in a high risk neighborhood in Atlanta, Georgia. The objective of the study was to extend knowledge about social conditions, social interactions, and the meaning of high risk behavior in the lives of African American women.

Results revealed that various types of living arrangements place women at risk in different ways and suggest that low income African American women are at high risk for HIV infection. A group often considered homogenous have unique “within group” needs that must be addressed in HIV prevention intervention research. Comparison methods revealed that participants believed their current living arrangements primarily impacted their risk for drug use and high risk sex. The types of living arrangements that emerged and indicate that of the 45 participants, 20 (44%) could have been categorized as “street women” or homeless women (Gentry, Elifson, & Sterk, 2005). The studies presented show that risky sexual behavior can include different activities from having unprotected sex to having multiple sexual partners. The studies above are implications for prevention programs for women who are sexual active with men only.

Types of HIV Prevention Programs

There are four types of HIV prevention programs examined in this chapter which include: (1) HIV prevention programs for women, (2) HIV prevention programs for
African American women, (3) HIV prevention programs and condom usage for African American women, and (4) HIV prevention programs for low income African American women. In 2002, Mize, Robinson, Bockting, and Scheltema completed a meta-analysis of the effectiveness of HIV prevention intervention for women in the U. S. From 1989-1997, twenty four articles were included and the authors evaluated five ethnic groupings over four time periods and three HIV-related sexuality outcome variables. The HIV interventions appeared effective at improving knowledge about HIV and increasing sexual risk reduction behaviors for all ethnicities examined at all follow up periods with one exception. The findings for self-efficacy were found to be less consistent for most ethnicities (Mize, Robinson, Bockting, & Scheltema, 2002). White, Mixed and African American groups all had at least one follow up period in which the feelings of self-efficacy were unchanged by the HIV interventions (Mize et al, 2002). The analysis presented by Mize et al., (2002) elucidates ethnic differences which may have previously been obscured while demonstrating convincingly that HIV interventions are generally effective for women of many different ethnicities. This is encouraging for prevention researchers and workers to have faith that their interventions help stem the tide of this devastating epidemic.

In another study by Sormanti, Pereira, El-Bassel, Witte, and Gilbert (2001), the authors described the significant role of community members during the development phase of a randomized clinical trial which provided HIV prevention intervention for African American and Latina women and their main sexual partners. The sample included 16 women and 13 male partners, who were engaged as “consultants” in a series
of focus groups between two single sex groups, one with men and the other with women, and a third group that brought women and their male partners together. The authors noted that focus group data extended our knowledge about the impact of relationship dynamics on safer sex negotiation and allowed us to design an intervention that is contextually specific and pragmatic. Target community members can provide critical input during the intervention development process and should be recognized as viable and meaningful collaborators in all phases of intervention research (Sormanti et al., 2001).

Additionally, Beadnell, Stielstra, Baker, et al. (2003) explored whether negative emotional behaviors might extend to sexual risk taking along with its antecedents in an adult sample of 78 African American women. The authors noted that ethnic identity has been found to have a ‘protective effect against negative emotional and behavioral outcomes in adolescents of color’. Also, higher ethnic identity was found to be associated with less risk taking. Risk behavior antecedents found to be associated with ethnic identity included those reflecting motivation for the strategies of abstinence and monogamy, but not such factors as STD/HIV knowledge, motivation for condom use, or perceived behavioral skills. Future research might profitably use theory based statistical modeling to understand the association of ethnic identity and risk taking, and mechanism explaining this relationships (Beadnell et al., 2003).

In a study completed by Beadnell, Baker, Knox, et al. (2003), the authors examined attrition from a HIV/STD group counseling intervention in two ways which included: (1) quantitative analyses of the entire sample (n=287) and (2) structured interviews of a subset of 30 women with low attendance. In the interviews, the most
common reasons for low attendance were time conflicts and enrolling primarily to obtain the monetary incentives given for completing research questionnaires. Latent class statistical analysis of the full sample identified two subgroups that differed from each other in the number of psychosocial problems recently experienced. Relative to the ‘nondistressed’ class, the distressed’ class members had higher probabilities of psychological distress, low incomes, heavy substance use, sex for trade, relationship violence, and unstable housing. This group had higher HIV/STD risk, but lower intervention attendance (Beadnell, Baker, Knox et al., 2003). The study findings are consistent with research on the relationship of ethnic identity with other risk behaviors (Beadnell, Baker, Knox et al., 2003). Women with higher ethnic identity differed from those with lower ethnic identity on the main dependent variable, risky sexual acts in a 4-month period. This finding raises the possibility that ethnic identity has a risk reducing role in the realm of sexual behavior similar to that found with other risk behaviors (Beadnell, Baker, Knox et al., 2003). While these studies show a variation of prevention programs that have been implemented for African American women, none of the programs speak to the cultural relevance issue for African American women.

Effectiveness of HIV/AIDS Prevention Programs

Most of the prevention programs show that programs were effective because many of the participants changed their behaviors once they were informed of the implications of sexual risky behaviors. Prevention programs also stated effectiveness by identifying factors that worked in other programs, recognizing that these same factors should also be implemented in prevention programs targeting African American women.
In discussing the effectiveness of HIV/AIDS prevention programs, it is noted in a study by Chillag, Bartholow, Cordeiro, et al. (2002) that community based organizations (CBO) play a frontline role in HIV prevention activities. CBOs face formidable challenges to effective delivery of HIV prevention services including client characteristics such as homelessness and CBO characteristics such as limited resources and staff turnover. Despite these obstacles, CBOs are generally well positioned to deliver services to specific high risk population because they understand their local communities and are connected to the groups they serve. This qualitative study illustrates that structural, sociocultural, organizational, and individual client factors both facilitates and act as barriers to delivery of HIV prevention services. These challenges and successes help identify critical technical assistance needs (Chillag, Bartholow, Cordeiro, et al., 2002). The sample CBOs represented 23 distinct geographic locations, and 21 were located in metropolitan statistical areas with high AIDS prevalence. Participants from 18 CBOs were selected to participate in either a focus group or in 1 of 10 site visits. Representatives from eight additional CBOs participated in a second focus group after the completion of the site visits. The findings show that CBOs are unlikely to directly influence the structural factors that affect access and delivery, but they are able to mitigate the effects of these factor through delivery of comprehensive services that address the range of clients’ HIV related and other needs (Chillag, Bartholow, Cordeiro, et al., 2002). To most effectively address structural and sociocultural factors, strong leadership and coordination are needed at the federal level (Chillag, Bartholow, Cordeiro, et al., 2002).
In a randomized controlled trial by Robinson, Uhl, Miner, Bockting, Scheltema, Rosser, & Westover, (2002) evaluated an innovative culturally specific sexual health intervention was evaluated which targeted, but was not limited to, low income African American women in which HIV and STD prevention strategies were combined with comprehensive sexuality education. The intervention was delivered and evaluated in community based settings to 218 participants who were randomly assigned to a treatment or no-treatment control group. Participants were interviewed at the pretest period as well as at 3 and 9 months after the intervention to assess changes in both sexuality and HIV risk variables.

The authors found that the intervention was effective in improving sexual anatomy knowledge at both the 3 and 9 month follow up periods. For a subset of participants who were engaging in unprotected sex at pretest, the intervention group reported an increase in positive attitudes toward the female condom at the 9 month follow up period (Robinson, Uhl, Miner, et al., 2002). Reasons for the weak treatment effect were discussed in the context challenges inherent in conducting community based research with high risk population and sensitive topics (Robinson, Uhl, Miner, et al., 2002). Recommendations were provided for improving sample attrition, statistical power, and response bias and for altering the intervention in order to strengthen its impact. Recommendations are that the HIV prevention field needs to integrate sexuality variables and research in to their prevention curricula and programs and evaluate these programs in random assignment designs (Robinson, Uhl, Miner, et al., 2002).
In regards to primary prevention of HIV, Exner, Seal, and Ehrhardt (1997) reviewed published reports on primary prevention of sexual transmission of HIV with women, starting from the beginning of the AIDS epidemic through March 1996. All reviewed interventions were conducted in the U.S., Canada, or Puerto Rico, which described a psychological, behavioral, or evaluation component in the report. Manual and computer searches identified 47 studies that targeted women and provided a female specific analysis of intervention effects. Sixteen of the 47 studies which fulfilled more rigorous methodological reporting standards were considered separately.

Overall, the findings demonstrated that HIV prevention programs can be effective in reducing risky sexual behaviors among at risk women. Program effectiveness varied by intervention type, session duration, and whether studies included only women or both men and women. The most efficacious HIV prevention programs were specifically directed toward women, focused on relationship and negotiation skills, and involved multiple, sustained contacts. Evidence also indicated that community level interventions hold promise in reducing risky sexual behaviors among this population (Exner, Seal, & Ehrhardt, 1997).

Limitations of the Literature

A major limitation of the literature reviewed is that none of the studies found take into consideration the beliefs and attitudes of the African American culture and its relationship with African American women’s willingness to participate in risky sexual behaviors. It is important to focus on beliefs and attitudes as it relates to culture because many of these factors could contribute to reasons explaining risky sexual behaviors.
among this population. It is also important to address the taboo behind talking about sexual risky behavior and HIV prevention in the African American community. It is believed that the African American community remains in denial about the HIV/AIDS. As quoted by an anonymous individual (2006), “just because people do not talk about HIV does not mean it does not exist and does not mean that African American’s are not at risk” (Anonymous, 2006, p.23).

Conceptual Framework

The Social Cognitive Theory, which stemmed from the Social Learning Theory and Behaviorism, dates back to the 1900s. In 1913, Behaviorism, a theory introduced by John Watson took an extremely mechanistic approach to understanding human behavior (Stone, 1998). In 1941, Miller and Dollard proposed the theory of social learning; and, in 1963, Bandura and Walters broadened the social learning theory with the principles of observational learning and vicarious reinforcement.

While refuting the traditional learning theory for understanding the learning process, in 1977, Bandura provided his concept of self-efficacy (University of Twenle, 2004). The Social Cognitive Theory has its origins in the discipline of psychology, with its early foundation being laid by behavioral and social psychologists (Stone, 1998). This theory evolved under the umbrella of Behaviorism, which is a cluster of psychological theories intended to explain why people and animals behave the way they do. Also, central to behaviorist study was the notion that contiguity between stimulus and response determined the likelihood that learning would occur (Stone, 1998).
The Social Cognitive Theory explains how people acquire and maintain certain behavioral patterns, while also providing the basis for intervention strategies. Evaluating behavioral change depends on the factors which include: environment, people, and behavior. This theory also provides a framework for designing, implementing and evaluating programs (University of Twenle, 2004). It defines human behavior as a triadic, dynamic, and reciprocal interaction of personal factors, behavior, and the environment (University of Twenle, 2004).

According to this theory, an individual’s behavior is uniquely determined by each of those three factors (Stone, 1998). The first interaction between the person and behavior involves the influences of a person’s thoughts and actions. The second interaction between the person and the environment involves human beliefs and cognitive competencies that are developed and modified by social influences, and structures within the environment. The third interaction between the environment and behavior involves a person’s behavior determining the aspects of their environment and in turn their behavior is modified by that environment (Davis, 2006).

Additionally, the Social Cognitive Theory provides a framework for understanding, predicting, and changing human behavior. The theory identifies human behavior as an interaction of personal factors, behavior, and the environment (Davis, 2006). This theory is helpful for understanding and predicting both individual and group behavior and identifying methods in which behavior can be modified or changed (Davis, 2006). Thus, Social Cognitive Theory is rooted in a view of human agency in which
individuals are agents, proactively, engaged in their own development and can make things happen by their actions (Pajanes, 2002).

As previously mentioned, environment, people, and behavior are three factors that are constantly influencing each other. Behavior is not simply the result of the environment and the person, just as the environment is not simply the result of the person and behavior. The environment provides models for behavior and observational learning occurs when a person watches the actions of another person and the reinforcements that the person receives (University of Twenle, 2004).

The concept of behavior can be viewed in many ways. First, behavioral capability means that if a person is to perform a behavior he must know what the behavior is and have the skills to perform it. While environment refers to the factors that can affect a person’s behavior (University of Twenle, 2004) with the environment factor providing opportunities and social support for individuals. Finally, self-efficacy is the person’s confidence in performing a particular behavior, and it is approaching behavioral change in small steps to ensure success (University of Twenle, 2004).

The Social Cognitive Theory is relevant to health communication in many ways. First, the theory deals with cognitive, emotional and behavior aspects for understanding behavioral change. Second, the concepts of this theory provide ways for new behavioral research in health education. As noted by the University of Twenle (2004), the ideas for other theoretical areas such as psychology are welcome to provide new insights and understanding.
This theory also explains how people acquire and maintain certain behavioral patterns. SisterLove, Inc. takes the African American community beliefs and attitude about HIV (Personal Factors) and respond to them by educating the community about their beliefs, attitudes by giving facts and alternatives (Behavioral Factors) to give the consequence of HIV prevention and risk reduction in the community (Environmental Factors). In the Healthy Love Workshop, SisterLove, Inc. uses the Social Cognitive Theory by creating a festive and nonjudgmental environment in order to reduce the sexual stigma and discomfort that is normally associated with conversations about sexuality and HIV prevention (Personal Factor). The HLW enhances women's behavioral capability by providing skills on how to assess risk and strategies on how to prevent HIV infection and transmission (Behavior Factor). Finally, the participants take this knowledge base out into the community and apply it to their own circumstances where the consequence is risk reduction (Environmental Factor).

SisterLove, Inc. also uses the Social Cognitive Theory in researching the effectiveness of their programs. The pre-test given to participants is a method used to find out personal factors of the individual, while the intervention of the HLW is the behavioral factor, and the post-test represents the consequence of the intervention or the environmental factor of the Social Cognitive Theory. Figure 1 shows the interactions of the three factors that make up the Social Cognitive Theory. The figure also shows that when discussing personal factors of African American beliefs and attitudes on sex practices, and influencing behavior factors by giving the knowledge of seeing individual
sexual behaviors on paper, sexual decision making can be affected which in turn affects environmental factors. Figure 1 also outlines the Social Cognitive Theory and shows how elements of the Social Cognitive Theory are operationalized for the evaluation of the HLW HIV prevention program offered by SisterLove, Inc.

**Environmental Factors**
The consequences of using the knowledge and skills in the intervention

**Personal Factors** - Discussing African-American beliefs and attitudes on sex practices

**Behavioral Factors**
The action of addressing the problem of sexual risky behavior

Table 1 takes the three elements of the Social Cognitive Theory which include: behavioral factors, personal factors, and environmental factors, along with the theoretical definition of the factors to show how SisterLove, Inc. applies these elements in the HLW.
Ultimately, the elements of the Social Cognitive Theory modify or changes risky sexual behavior among African American women.

Table 1 Conceptual Framework: Social Cognitive Theory

<table>
<thead>
<tr>
<th>Elements</th>
<th>Theoretical Definition</th>
<th>Evaluation of HLW HIV prevention program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Factors</td>
<td>Actions in which a person takes the skills in which to perform the actions.</td>
<td>In creating fantasy names and allowing participants to talk about sex and safe sexual acts freely, the HLW is taking actions to make talking about healthy sex a skill, which can be performed in an action regularly.</td>
</tr>
<tr>
<td>Personal Factors</td>
<td>Beliefs and attitudes of a person that is affected by their actions and consequences</td>
<td>The exercise of the synonyms helps the participants to understand that it is natural to talk about sex. By discussing and addressing some of the feelings, attitudes, and beliefs about sex that have a negative impact on the participants, the consequence is a healthy conversation about sexual activity.</td>
</tr>
<tr>
<td>Environmental Factors</td>
<td>Opportunities, social support, and consequences of a person and their surroundings</td>
<td>The exercise of safer sex presents the opportunity for the participants to discuss risk assessment and the social support that may affect risky behavior in sexual activities. This activity also gives the participant a chance to discuss and address consequences of the risky sexual behaviors for themselves, their partners, families, and communities.</td>
</tr>
</tbody>
</table>
Afrocentric Perspective

The oppression of African American women dates back as far as slavery. As a result of oppressing African American women, their sexuality was also silenced. The sexuality of African American women is often described in metaphors of speechlessness, space, or vision; as a void or empty space that is simultaneously ever visible and invisible, where African American women’s bodies are already colonized (Collins, 2000). During slavery, one of the ways in which African American women’s sexuality was silenced was the use for the master’s sexual pleasures. This practice could have lead to feelings of embarrassment and shame of the body for African American women. The result for many African American women was in using their bodies only to please others and not having self pleasure of their own bodies which in turn leads to the lack of respect for their bodies because of the feeling of not being valued by others (Collins, 2000).

Collins (2000) states the following:

Sexuality can be conceptualized as a freestanding system of oppression similar to oppressions of race, class, nation, and gender, as well as part of each of these distinctive systems of oppression. A third approach views sexuality as one important social location that joins these distinctive systems of oppression. This conceptualization views sexuality as conceptual glue that binds intersecting oppressions together. (p.134)

As a result of African American women’s bodies not being of value over decades, it is easy for African American women to engage in risky sexual behaviors, which includes trusting partners who engage in risky behaviors as well as trusting their exclusive partner. SisterLove, Inc. attempts to break the silence of African American women’s sexuality by showing African American women how to be sexual without engaging in risky sexual behaviors. Collins (2000) states that for centuries the African
American women has served as the primary pornographic “outlet” for Caucasian men in Europe and America. We need only think of African American women used as breeders, raped for pleasure and profit of their owners (Collins, 2000) p. 136.

Collins (2000) responds to another author, Walker, in her description of African American by stating:

Alice Walker’s description of the rape of enslaved African women for the “pleasure and profit of their owners” encapsulates several elements of contemporary pornography. First, African American women were used as sex objects for the pleasures of Caucasian men. This objectification of African American women parallels the portrayal of women in pornography as sex objects whose sexuality is available for men. Exploiting African American women as less human because only animals can be bred against their will (p.135).

SisterLove, Inc. also attempts to heal decades of African American women not respecting their bodies, giving value to African American women as a whole. Figure 3 shows that slavery is the root cause of African American women being oppressed, therefore, engaging in sexual risky behaviors.

![Figure 2. Afrocentric Perspective for Sister Love, Inc.](image-url)
Figure 2 shows why the questions of self-efficacy is asked to the women to gauge how the sexual risky behavior affects the women’s self image and her comfort level with the safer behaviors.

Summary

This chapter revealed gaps in the literature showing that HIV prevention programs do not define sexual risky behavior in the same manner. The literature also revealed that there is a consistent gap in developing HIV prevention programs for African American women with cultural competency of the belief system and attitudes towards sex and HIV prevention in mind. The Social Cognitive Theory was used to demonstrate conceptualization between the theory and the HLW, which illustrates how various factors of cultural practices are placed into the intervention. The Afrocentric perspective was also to give insight into the history of sexual risky behavior among African American women and the consequences of the history which dates back to slavery times.
CHAPTER III

METHODOLOGY

Overview

This chapter discusses the environment in which the evaluation was conducted, the description of the sample, and the criteria of participants. The chapter also addresses the intervention qualification and products of the evaluation. An explanation of the instrument, measurement of the variables, and the HIV intervention are all discussed in this chapter.

Setting

The setting for the Healthy Love Workshops took place in areas that were viewed as safe, convenient, and comfortable areas, which included: college campuses, participants homes, community centers, church recreation areas and other facilities in which the participants requested. The setting was completely controlled by the participants through recommendations of settings identified as most comfortable in order to talk freely and discuss issues concerning HIV prevention.

Sample

The sample for the HIV prevention programs included 176 African American women or women of African decent that lived in the metropolitan Atlanta area. This area is considered an economically diverse area with a large African American population. The ages of the participants ranged from 18 to 69 years old. The sample was collected
from women who were willing to spend four hours participating in an intervention on HIV prevention. In order to be considered eligible to participate in the evaluation, potential participants had to meet the following criteria which included: women identifying themselves as being of African descent which included: African Americans, Caribbean, and African immigrants who resided in metropolitan Atlanta, Georgia. The women were not considered eligible to participate in the evaluation if they were pregnant or intended to become pregnant during the evaluation period, did not speak English, had recently participated in a HIV prevention group in the last six months, or required a modified version of the HLW due to religious beliefs that prohibited the use of any type of contraception which included latex barriers such as male or female condoms. Women who were currently participating in other services provided by SisterLove, Inc. were also excluded from the evaluation.

Demographics

The demographic information for the HLW participants included 96 women. The participants from the HLW were all women of some African descent. While the majority of the women (96.8%) were African American, a few identified themselves as being of Hispanic descent (13.2%) and others (4.4%) identified themselves as bi-racial. The ages of the participants ranged from 18 to 59, with 27.5% reporting being between 21 to 29 years of age.

Approximately 46.8% reported their county of origin as the United States of America and 81.1% reported their religion as Christianity. The majority of the women reported their marital status as single (66.3%) and 84.2% reported their sexual attraction
to only men. Approximately 40.0% of the women reported their education level as a high school graduate or having a GED and most of the women (29.5%) worked full-time.

While the majority of the women had health insurance (81.1%), 18.9% were on public assistance. The majority of the participants’ annual household income (29.5%) ranged from $0 to $15,000. Table 2 shows all the demographic information for the participants in the HLW.

Table 2. Demographic Table for HLW (n= 96)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-20</td>
<td>12</td>
<td>13.2%</td>
</tr>
<tr>
<td>21-29</td>
<td>25</td>
<td>27.5%</td>
</tr>
<tr>
<td>30-39</td>
<td>24</td>
<td>26.4%</td>
</tr>
<tr>
<td>40-49</td>
<td>9</td>
<td>9.9%</td>
</tr>
<tr>
<td>50-59</td>
<td>3</td>
<td>3.3%</td>
</tr>
<tr>
<td>60-69</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RACE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>88</td>
<td>96.8%</td>
</tr>
<tr>
<td>White</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bi-racial</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>Hispanic descent (yes)</td>
<td>12</td>
<td>13.2%</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>COUNTRY OF ORIGIN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>78</td>
<td>46.8%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>9</td>
<td>5.1%</td>
</tr>
<tr>
<td>South America</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2</td>
<td>1.1%</td>
</tr>
<tr>
<td>Jamaica</td>
<td>1</td>
<td>.6%</td>
</tr>
<tr>
<td>Guyana</td>
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<tr>
<td>RELIGION</td>
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<tr>
<td>Christian</td>
<td>77</td>
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<tr>
<td>Orthodox</td>
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<td>2.1%</td>
</tr>
<tr>
<td>Catholic</td>
<td>2</td>
<td>2.1%</td>
</tr>
<tr>
<td>Spiritual</td>
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</tr>
<tr>
<td>A.M.E.</td>
<td>1</td>
<td>1.1%</td>
</tr>
<tr>
<td>Jehovah Witness</td>
<td>2</td>
<td>2.1%</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>96</td>
<td>100%</td>
</tr>
</tbody>
</table>
Table 2 Continued

<table>
<thead>
<tr>
<th>SEXUALLY ATTRACTED</th>
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<tbody>
<tr>
<td>Women</td>
<td>14</td>
<td>14.7%</td>
</tr>
<tr>
<td>Men</td>
<td>80</td>
<td>84.2%</td>
</tr>
<tr>
<td>Undecided</td>
<td>1</td>
<td>1.1%</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>MARITAL STATUS</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>63</td>
<td>66.3%</td>
</tr>
<tr>
<td>Married</td>
<td>19</td>
<td>20.0%</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>3.2%</td>
</tr>
<tr>
<td>Divorced</td>
<td>10</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATION LEVEL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than high school</td>
<td>12</td>
<td>12.6%</td>
</tr>
<tr>
<td>GED</td>
<td>38</td>
<td>40.0%</td>
</tr>
<tr>
<td>Associates Degree</td>
<td>7</td>
<td>7.4%</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>23</td>
<td>24.2%</td>
</tr>
<tr>
<td>Graduate</td>
<td>12</td>
<td>12.6%</td>
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The demographic information for the HIV 101 workshop included 80 participants which also included all women participants. While the majority of the participants (95%) were African American, a few of the participants (5%) reported being of African descent. As in the HLW, the majority age group (32.5%) for this workshop was 21 to 29. Also, the majority of the participants (93.8%) reported their county of origin as the United States of America with the majority (64%) reported their religion as Christianity. Approximately 56.3% the women reported their marital status as single and 83.8% reported their sexual attraction to only men.

As in the HLW, the majority of participants (35%) reported their education level as a high school graduate or having a GED and 22.5% of the participants reported working part-time. The majority of the participants (77.5%) were not receiving public assistance and 67.5% reported having health insurance. Finally, most of the participants (42.5%) reported an annual household income of $0 to $15,000. Table 3 shows all the demographic information for the participants of the HIV 101 workshop.

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Table 3 continued

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<th>SEXUALLY ATTRACTED</th>
<th>MARITAL STATUS</th>
<th>EDUCATION LEVEL</th>
<th>EMPLOYMENT STATUS</th>
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<th>HEALTH INSURANCE</th>
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Table 3 continued

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<tr>
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<tr>
<td>Refuse to answer</td>
<td>5</td>
<td>6.3%</td>
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In comparing the HLW participants to the HIV 101 participants, it is clear that most of the demographics for both groups were very similar. The biggest difference was the employment status of participants with the majority of the HLW participants reported full-time employment (29.5%), while participants who were unemployed but seeking (21.1%) falling very closely behind. In the HLW group, the total of unemployed participants that were seeking employment (21.1%) and those not seeking employment (18.9%), which totaled 40% were significantly higher than the majority participants (29.5%) who reported their employment status as full-time. This data specifically speaks to the age group of participants, which included a large number of college students that were unemployed.

Demographics of the HIV 101 workshop participants demographics, specifically in the area of employment were quite different from the HLW participants. While 22.5% of the participants worked only part-time, a significant number of the participants worked full-time (21.3%), while the same percentage of participants (21.3%) was also unemployed and seeking work. There were also a large number of participants (16.3%)
that were disabled. The data showed that the disabled group speaks to the amount of participants who were HIV positive.

Measure

The HIV prevention evaluation tool created for this study was divided into several subcategories. The pretest measure which contained 175 questions was broken up into eight subcategories. These subcategories were as follows: (1) demographics, (2) HIV Risk Assessment, (3) Sexual Behavior, (4) HIV testing, (5) Attitudes towards Condom Use, (6) HIV Knowledge, (7) States of Change for Condom Use, and (8) Condom Use Self-Efficacy. The posttest measure which contained 83 questions was broken up into four subcategories, which included: (1) Attitudes Toward Condom Use, (2) HIV Knowledge, (3) Stages of Change for Condom Use, and (4) Condom Use Self-Efficacy.

For the purpose of this study, only HIV Testing, Self-Efficacy and HIV Knowledge were used to evaluate if participation in the HLW increased these variables among African American women greater than a HIV 101 comparison workshop. For evaluation purposes, ordinal measurements were used to control the variables of HIV Testing, Self-Efficacy and HIV Knowledge and answer very specific questions. Inter-observer reliability was used to gain reliability in the measurements. This type of reliability also speaks to the validity of the research. To show that the measure was valid, the method of a giving sample test to a very small sample was used in order to ensure that the questions were understood and the information would be informative to the research.

Both methods used for establishing reliability and validity could have limitations because of the self-report element of the measures. External validity threats could be the
length of both the pretest and posttest. Another threat could be participants understanding the questions of the surveys. The reliability coefficient for the risky behaviors section of the pretest was .9004 which indicated that the test was very reliable, compared to the reliability co-efficient for the risky behaviors section of the posttest .5162 which indicated that the test was somewhat reliable. The closer the coefficient is to 1.0 the more reliable the test was.

Design

The design for this program evaluation was an experimental design. The classic experimental design was chosen because it is the standard design against which other designs are compared. The experimental research design is the most rigorous and represents the “ideal” for inferring that an intervention either did or did not have an effect. In the experimental design, participants are randomly assigned to one or the other intervention group. This study also contained a pretest/posttest design (Royse, Thyer, Padgett & Logan, 2001).

The purpose of the pretest/posttest design is to find out the knowledge base of the participants prior to the intervention through the pretest. The posttest is designed to find out if the intervention had any effect on the participants and how the participants would apply the information given in the intervention (Royse, Thyer, Padgett & Logan, 2001).

The design for this study is as follows:

\[
\begin{align*}
R_1 & \quad O_1 \quad X_1 \quad O_2 \\
R_2 & \quad O_1 \quad X_2 \quad O_2
\end{align*}
\]

\(R_1\) stands for subjects who were randomly assigned to the first intervention of the HLW.
$O_1$- was a pretest which was taken before the intervention

$X_1$- was the intervention of the HLW

$O_2$- was the posttest after the intervention

$R_2$- stands for subjects were randomly assigned to the second intervention of HIV 101

$X_2$- was the intervention of HIV 101

The strength of this design is for the ability to provide hard evidence that the intervention was responsible for the observed change (Royse, Thyer, Padgett & Logan, 2001). This design can also determine how much information was acquired from each intervention by the use of pretest and posttest design, and which intervention was most effective. A limitation of the design would be that one intervention may address more information on the posttest than the other. This may give a false perception that one intervention was more effective than the other.

**Procedures**

Collection of data started with recruitment for participants. A flash bulletin was put on the SisterLove, Inc. website with a link for individuals interested in participating in the workshops. Fliers were also posted at colleges, community centers, and neighborhoods throughout the metropolitan Atlanta area with contact information for SisterLove, Inc. which included the agency’s phone number.

After contact was made by potential participants, staff members screened the individuals to see if they met the qualification to participate in the evaluation. After the initial screening, an appointment was set up for the workshop with information including
time and location for facilitators to provide to the participants. The data collection was conducted by the evaluation team of SisterLove, Inc.

Data was collected in the form of structured questionnaires with unique identification numbers (ID) for confidentiality purposes. The ID numbers were under lock and key at the headquarters of SisterLove, Inc. which could only be accessed by the workshop facilitators. Participants completed pretests prior to participation in the workshops and posttest after completion of the workshops. Both tests were placed in an envelope with an ID number. Envelopes were taken to SisterLove, Inc. Headquarters to enter identification information in the SisterLove, Inc. database. After the information was entered into the database, envelopes were given to the data entry person to enter into the Statistical Packages for the Social Sciences (SPSS) dataset for analysis of the results. After data was entered, envelopes were placed under lock and key until the end of evaluation period.

Statistical Analysis

The statistical test used to analyze the data was the independent sample t-test. This test was used to compare the risky sexual behavior between the participants of the HLW and the HIV 101 workshop. The identifiers of risky sexual behaviors were questions about condom use, sexual activities, and STI prevention. The pretest results were entered into the SPSS dataset as one component. Next, the posttest results from both the HLW and HIV 101 were entered into the SPSS dataset as another component. Then, the pretest data was run against the posttest data to obtain results of the knowledge and
impact of both interventions on HIV Knowledge, self-efficacy and HIV testing to show views of risky sexual behavior. An independent sample t-test was used to reveal descriptive statistics including means, standard deviations, and percentages.

Summary

This chapter speaks to the methodology that was used to obtain the data for the evaluation. The workshops took place on college campuses, participants homes, and community centers. The sample consisted of 176 women of African descent, ages 18 to 69, and lived in the metropolitan Atlanta area. The participants were participated in a classic research design with a 176 question instrument for the pretest and an 86 question instrument for the posttest. The measure was analyzed using the independent sample t-test.
CHAPTER IV

RESULTS

Overview

This chapter presents the results of the HLW in comparison to the HIV 101 workshop at reducing risky sexual behaviors by measuring HIV testing, self-efficacy, and HIV knowledge. Findings were significant for the three categories of questions. The figures were averaged together to provide a final figure. A significant value was found for both the pretest and posttest. The findings showed that both the HLW and HIV 101 workshop had a similar amount of data in the pretest which was significant. Although the pretest data for both workshops were similar, the results show that the posttest of the HIV 101 workshop had significant variance from the HLW. This indicates that the HLW was a more effective intervention in the areas of HIV Testing, Self-efficacy and HIV Knowledge.

Results

The results showed that in the pretest with the HIV Testing questions, the HIV 101 group varied more on average than the HLW group. The following questions were significant with HIV Testing:

Question 42: How often do you test for HIV?

Question 47: Here is a list of reasons why some people have not been tested for HIV. Indicate all of the reasons why you have not been tested.
Question 52: In the next 3 months if you were offered the opportunity to take an HIV test, what kind of setting are you most likely to use?

Results also showed that in the pretest with the Self-efficacy questions that the HLW group varied more in their answers on average than the HIV 101 group. The following questions were significant with Self-efficacy:

Question 132: I would feel embarrassed to put a condom on myself or my partner.

Question 133: If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.

Results show that in the pretest with the HIV Knowledge questions, the HIV 101 group varied more on average than the HLW group. The following questions were significant with HIV Knowledge:

Question 150: A person can get HIV by sharing a glass of water with someone who has HIV.

Question 152: A woman can get HIV if she has anal sex with a man.

Question 162: Taking a test for HIV one week after having sex will tell a person if she or he has HIV.

Figure 3 shows the comparison for the two workshops in the different question groupings for the pretest. The averages that show the significant questions in the HIV Testing groupings are .771 (HLW) verses .797 (HIV 101). The averages that significant questions in the Self-Efficacy grouping are 4.15 (HLW) verses 3.96 (HIV 101). The averages that show the significant questions in the HIV Knowledge grouping are 1.76 (HLW), verses 1.80 (HIV 101).
Figure 3 Comparison Results for Pretest

The results for the posttest show data that is very different from the pretest data. The findings show that in all three question groupings that the HIV 101 group had significant variance on average compared to the HLW group. The following is the question of significance for the HIV Testing questions:

Question 1: Do you consider yourself to be at risk for getting HIV/AIDS or giving someone else HIV/AIDS?

The following are the questions of significance for the Self-efficacy questions:

Question 37: I feel confident in my ability to discuss condom usage with any partner I might have.

Question 38: I feel confident I could suggest using a condom to my partner without feeling “diseased”.

Question 42: I feel confident in my ability to use a condom correctly.

Question 44: I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.
The self-efficacy questions speak to the Afrocentric perspective and shows that many of the participants in the study are not comfortable or confident in speaking about healthy sex practices or suggesting healthy self practices because of years of sexual oppression. The following questions are significance for the HIV Knowledge questions:

Question 62: All pregnant women infected with HIV will have babies born with AIDS.

Question 63: People who have been infected with HIV quickly show signs of being infected.

Question 64: There is a vaccine that can stop adults from getting HIV.

Question 66: A women cannot get HIV if she has sex during her period.

Figure 4 shows the comparison for the two workshops in the different question groupings for the posttest. The average that show the significant questions of the HIV Testing groupings are 1.54 (HLW) verses 1.78 (HIV 101). The average that show the significant questions of Self-efficacy are 1.88 (HLW) verses 2.10 (HIV 101). The average that show the significant questions of the HIV Knowledge are 1.90 (HLW) verses 1.92 (HIV 101).

\[ t = 2.312, \text{df} = 21, p < .05 \]
Figure 4 Comparison Results for Posttest

Summary

The results show that the HLW pretest significance on average was very similar to the HIV 101 pretest significance, even though for the question group of self-efficacy, the HLW was more significant. This indicates that most of the participants, regardless of the workshop, had many of the same ideas prior to their participation in a workshop. The posttest results prove that the HLW was more effective by making participants more comfortable with discussing sexual behaviors, HIV testing, and dissolving the myths of HIV.
CHAPTER V

CONCLUSION

Overview

This chapter seeks to explain the reasoning behind the results that were given in chapter four. This chapter will share the differences between the significance of the HLW and the HIV 101 workshop. The strengths of the HLW will be addressed in addition to the differences of the workshop components.

Conclusion

The results indicated that the posttest of the HIV 101 workshop had significant variance from the HLW which indicated that the HLW was a more effective intervention in the areas of HIV Testing, Self-efficacy and HIV Knowledge. The differences between the two workshops in the significant averages were very close in the pretest. The results of HIV Testing difference was 0.03, the results of Self-efficacy difference was 0.19 and the results of HIV Knowledge difference was 0.04. This data shows that on the questions of HIV Testing and HIV Knowledge, most of the participants had the same ideas no matter which workshop that they attended.

There was a greater amount of variance in how often participants were tested, which may be because there were some participants who had never been tested while other participants were tested on a regular basis. The reasons that participants reported for
not being tested also varied among the groups which may speak to fears varying from being afraid of needles to being afraid of a partner becoming angry and threatening to leave, or a partner feeling accused of cheating because the other participates in testing.

The settings in which participants reported feeling comfortable for getting tested also varied among the groups. This may be because some of the participants were not aware of testing sites and others did not want to be tested in their community for confidentiality purposes.

The variance among the knowledge variable may be contributed to myths that are in the community about how HIV is contracted, such as a person being able to contract HIV by sharing a glass of water with someone. In both groups, there were participants who understood prior to the interventions how HIV was contracted and passed on as well as those who did not understand issues such as the amount of time it takes to detect HIV in the body after becoming infected. These results show that some participants continue to rely on dialog in order to receive information in the African American community, while others do the research and rely on documented sources for their information about HIV.

The results of the self-efficacy questions had the largest significant average variance of 0.19 in which the HLW group was more significant than the HIV 101 group. These questions spoke of the comfort level of the participants in regards to putting on condoms, speaking about condoms to partners, and encouraging partners to use condoms. The large significant average variance may possibly be attributed to the great amount of variance in both groups. Participants in both groups could have felt very comfortable
talking about condom usage with a partner as well as taking initiative during sex to put on a condom for protection. Some of the participants in both groups were very uncomfortable in talking about condom usage with a partner, which may lead to feelings of embarrassment in attempting to put a condom on their partner or feeling afraid that a partner might reject the participant for suggesting the use of a condom.

Also previously stated, the results indicated that the posttest of the HIV 101 had significant variance from the HLW which indicates that the HLW was a more effective intervention in the areas of HIV Testing, Self-efficacy and HIV Knowledge than the HIV 101 workshop. The differences between the two workshops in the significant averages were very different in comparison to the pretest. The difference in the HIV Testing questions was 0.24, the difference in the Self-efficacy questions was 0.22 and the difference in the HIV Knowledge questions was 0.02. With the HIV 101 being the most significant in all of the posttest questions it shows that the answers varied more with this group than with the HLW group.

It is possible that the reason that more people in the HIV 101 group did not consider themselves to be at risk for contracting HIV/AIDS or infecting others was due to the lack of dialog in the HIV 101 workshop. The participants did not engage in the components of “Fantasy Names” or “Synonyms” which opens up the workshop for discussion about sexual activity as well as terminology that deals with sex. Because those components were not included in the HIV 101 workshop, those participants may not have viewed their sexual behavior as risky. This result is both frightening and puzzling because participants in the HIV 101 group represented a higher number of participants
who were already HIV positive, which may also be a potential explanation as to why the variance was so great between this group and the HLW group. This finding is consistent with a study conducted by Foreman (2003), which suggests that it is essential to concentrate on strategies to increase personal risk perception, address intimacy, and promote the eroticization of condoms.

The self-efficacy questions in the HIV 101 group which were significant in variance may be due to the lack of discussion about self-efficacy, especially as it relates to condom usage. There were four questions that were significant in the posttest of the study, which was the highest number of significant questions in the groups. All of the questions deal with how confident the participant was in dialoging, influencing and using condoms. This great variance could be because the HLW had three components that dealt with that very topic, which included: “Condom Demonstration”, “Condom Race” and “Female Condom Demonstration”.

It is believed that not only does the free flowing conversation that took place within the HLW assist in conversations with partners about condoms; but, the hands on demonstration that was used in the HLW allows participants to see firsthand how to use a condom in high emotional conditions. There is also the issue of denial. It is also believed that some participants are in denial about their feelings regarding discussing condom usage as well as initiating condom use. These results are consistent with the results of Brook et al. (2006) in that programs need to address denial and other underlying issues of denial as it relates to sexual risky behaviors.
In addition, the HIV Knowledge questions were found to be more significant for the HIV 101 group, but did not have as much variance as the other two groups of questions. In fact, even though the questions were significant, the difference in the significance was less than in the pretest. These findings indicated that most of the people did get the facts about HIV Knowledge, but some participants may have still been holding on to myths about HIV. This could possibly be due to the lack of dialog in the HIV 101 workshop; thus, participants were not able to discuss some of their questions after taking the pretest. Since some of the questions were not addressed in the workshop, participants did not get the information.

In conclusion, this study indicates that overall the HLW was more effective than the HIV 101 workshop in reducing risky sexual behaviors because of the addition of the cultural component. These results are consistent with Exner et al. (1997) in that most effective programs are for designed to address the needs of specific population and community level interventions tend to hold much promise.

Limitations of the Study

One of the limitations of the study was the length of the pretest and posttest survey. The lengthy surveys can be viewed as a limitation because the participant may start to get restless and not read the questions carefully, providing wrong answers or not answering questions at all. The length of the workshops was also considered a limitation, since both of the workshops were over three hours long. Participants were informed ahead of time about the length of the workshop; nonetheless, some participants did not stay for the entire workshop in order to complete the posttest possibly missing valuable
information about HIV prevention. The participants who did not stay for the entire workshop may have also given a false indication of the posttest results.

Additionally, some of the participants were also a limitation to the workshop because they did not fall into the high risk categories due to their report of not engaging in sexual activity at the time of the workshop. Also, some of participants were medical students, it is also believed that they previously had quite a bit of knowledge about HIV, which may have given a false indication on the posttest results.

Summary

This study proved to be consistent with similar studies in that it is essential to concentrate on strategies to increase personal risk perception, and address intimacy during a prevention program. This study also proved that programs need to address denial and the underlying issues of denial as it relates to sexual risky behaviors. It is also believed that this study shows that in order for programs to be effective, they should be targeted for specific populations and community level interventions. There were also several limitations acknowledged with the greatest limitation of this study seen as the length of the measure used with the study participants.
CHAPTER VI
IMPLICATIONS FOR SOCIAL WORK PRACTICE

Overview

This chapter addresses the recommendations of improvement for SisterLove, Inc. and the HLW. This chapter explores the benefits of having social workers in the SisterLove, Inc. agency as well as other services that social workers can provide for HIV prevention. Also, implications for social workers involved in the practice, policy, research, an implementation of prevention programs for HIV and AIDS are discussed.

Recommendations

As an evaluator, there are several recommendations for this prevention program that I would like to propose. First, it is important to shorten the length of both the pretests and posttests that are given to participants. Some of the questions included in the both surveys are repetitive. These questions could be cut from the surveys to save time for the most important part workshop, which is the intervention. By shortening the surveys, the length of the workshop would also be reduced which would assist in keeping participants more attentive throughout the duration of the workshop. It is important to remember whenever a learning tool is involved with any workshop that attentiveness of the participants must be a consideration.

A second suggestion would be to individually examine the different categories of the survey. The measure attempted to ask eight different categories of questions about
sexual behavior and high risk actions in order to evaluate the interventions. If the measure consisted of only one or two categories, it may provide the opportunity to clarify the important issues, which could be researched in a more in depth manner. This suggestion may also shorten the survey which in turn would decrease the amount of time needed for the intervention time as well.

Another recommendation would be to not allow late comers to participate in the pretest and posttest. Other participants may become inpatient waiting on those who arrive late in order before completing the lengthy pretest which makes the workshop longer and loses the focus of other participants. The most important thing is that participants are able to engage in the learning process of the workshop which should also be accomplished for those who arrive late.

Also, adding a social worker to the SisterLove, Inc. staff, specifically hired to help facilitate and even evaluate the HLW is another recommendation. Since the workshop is currently run from a public health perspective, it concentrates more on modifying behaviors in order to make a positive change. A social worker could add a more holistic approach by considering the circumstances of the person in their environment, not just the environment of the community, along with the social system in which individuals depends on, and any psychological or social factors that may also play an important role in behavior.

Social Work Implications

Social workers should always be aware of growing population in healthcare epidemics. Prevention programs should be placed in access of the population with the
greatest need. More prevention programs are especially needed for women with sexual risky behaviors, and with an emphasis on prevention programs which are culturally oriented. Social workers should also pair with organizations that are implementing prevention programs to give insight about personal environment and personal struggles. These issues must be addressed in order to impact African American women as well as other groups of women of color. This study showed that many individuals rely on dialog more than formal research in order to receive information in the African American community. It is important for social workers to open conversations about HIV/AIDS in prevention programs so that myths about the infection are not spread; but, rather facts about the infection can be acknowledged and discussed throughout African American communities, and ultimately to African American women who are currently at the highest risk.

More education to the public about HIV protection and the facts about HIV is needed as well. Social workers are in the perfect position to help educate the community about HIV protection because social workers understand that some communities may have barriers and will attempt to utilize the strengths of the community in order to impact and empower the people of the community. Education to social workers about cultural competence within HIV prevention programs is also a great need.

Social workers have a great understanding of meeting the client on their level, which is the most powerful approach when it comes to prevention. A question that should be taken into consideration first is: What information does the client have about HIV prevention? This question presents the opportunity for dialog and exchange of
information, because no matter how much information prevention programs have, the client’s information is also needed.

Social workers advocating for policy change is also a great implication for social work practice. Social workers should speak with government officials and encourage other agencies that are fighting for this cause to advocate for policy changes that will help in addressing preventive measures of contracting HIV such as healthcare for everyone. Social workers could also participate as active members of board in many of the agencies that are addressing the progress of prevention programs and policy change.

Additional research on these populations is always needed. Social workers should also engage in research on different cultural prevention programs to identify which strategies have a higher compliance rate with the prevention strategies. Continuous research should be continued on HIV and the populations in which it is dramatically affecting. Research would also be helpful in determining what prevention methods are best used for each target population including other minority populations that have a high risk of HIV/AIDS such as Hispanic women because of the need to also address cultural issues with this group.

Social workers in healthcare settings are very useful in providing prevention information. Many social workers who provide services to individuals in the healthcare setting are presented with a great opportunity to dialog about safe sex practices and it provides the client to give his or her perception of what safe sex practices entails. This is also a great opportunity for the social worker to utilize the biopsychosocial assessment. Using the biopsychosocial assessment allows the social worker to get an in depth view on
the client’s social systems, belief systems, and strengths in order to meet the client on their level and opens up the opportunity to provide specialized prevention information as well as get a general view of the client and the client’s needs.

Summary

The recommendation of shortening the measure which would in turn shorten the length of the workshop would help the attentiveness of the participants. As discussed, social workers would also be of great value to the SisterLove, Inc. agency to provide a holistic view of participants’ behavior. It is believed that social workers should also provide services to other prevention programs, research of HIV prevention, healthcare settings and advocacy of policies that affect HIV prevention.
APPENDIX
Ms. N'Dia Smith <ndia@bellsouth.net>
School of Social Work
Clark Atlanta University
Atlanta, GA 30314


Principal Investigator: N'Dia Smith

Human Subjects Code Number: HRI2006-08-189-1

Dear Ms. Smith:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your revised protocol and approved of it as expedited and exempt from full IRB review in accordance with 45 CFR 46.101b-2. You may begin your study one week from the date of this notice.

Protocol Approval Code is HR2006-08-189-1/A

This approval is valid for one year from the date of this notice. This permit will therefore expire on September 30, 2007. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. Any reaction or problems resulting from this investigation should be reported immediately to the IRB, to the Department Chairperson and any sponsoring agency.

If you have any questions, please contact Dr. Georgiana Bolden at the Office of Sponsored Programs (404) 680-6979 or Dr. Paul I. Musey, (404) 680-6829

Sincerely:

[Signature]

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. Dr. Sarita Davis (sdavis@cam.edu)
Office of Sponsored Programs. Dr. Georgiana Bolden (gbolden@cam.edu)

223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-9000
Founded in 1868 by consolidation of Atlanta University, 1855 and Clark College, 1869
APPENDIX B
INFORMED CONSENT
PARTICIPATION IN THE HIV/AIDS 101 WORKSHOP

Introduction and Purpose: We, at SisterLove, are working with the Centers for Disease Control and Prevention (CDC) to find out how well our HIV/AIDS 101 Workshop works to reduce the kinds of behaviors that may put women at risk of being infected with HIV, the virus that causes AIDS. In other words, we want to evaluate our workshop. We are asking you to take part in this evaluation project because you are a woman of African descent between the ages of 18-55 years old. We are also asking other women like you to take part.

Before you decide to be in this project, please read the rest of this form or listen carefully as it is read to you. You can ask us any questions you may have at any time.

What we will do?

Before we can invite you to be in our evaluation, we will ask you some questions now to make sure that you are eligible to participate. You can choose not to answer any questions that you do not feel comfortable answering. If you are eligible to participate, we will ask you to give us some information that will help us contact you to be sure that you take part in the follow up assessments.

The project will take place over 6 months. If you decide to join, we will ask that you attend one workshop during which we will provide you with information that may help you avoid HIV infection. We will ask you about your health and behavior before and after the workshop. The workshop will last about 4 hours. We will also ask you to take part in 2 follow up surveys at SisterLove’s office in SW Atlanta, or at a location that is convenient to you. We will ask you about your health and behavior during the follow up surveys. The first one will take place 3 months after the workshop, and the second one will take place 6 months after the workshop. Each survey will take about an hour.

Could I be hurt?

Some people may feel uneasy when talking about some issues, how they feel, or answering questions about personal actions. You can choose not to answer any question you are not comfortable answering. Being in
the project is private, but someone not in the project could find out from another participant that you are taking part.

Will I get anything from being in this project?

We believe you will learn how to reduce your risk of contracting or transmitting the HIV virus. You will also help us better understand how the program is working for you and other women like you.

We will use the results of this project to improve the way we give services to women like you. We will write a report about what we learn from this project, and we will give the report to CDC. We will talk about the results of our project at community meetings and national conferences. We may also report what we find out in public health or science journals.

What about my privacy?

Every attempt will be made to protect your privacy. Your records will remain private to the extent that the law allows. You will be assigned a project ID number that will be used instead of your name. This ID number will assist in keeping your information confidential. The number will go on all of your project materials and surveys. We will keep a record of your name, address, and ID number until the project is over, so that we can contact you for follow up during the project. Until then, all collected information, including your contact information and answers to the surveys, will be stored in locked cabinets and on password-protected computer files.

Are there any costs?

There will be no costs to you for taking part in the project. You could receive up to $75.00 if you take part in this project. You will get $20.00 today after you have filled out both surveys. You will get $25.00 after you complete the survey at the end of the first follow up, 3 months from now. You will get $30.00 after you complete the survey at the end of the final follow up, 6 months from now. If you decide not to continue in the project, you will be paid only for the surveys that you complete.

What if I don’t want to join the project or want to stop?

Your choice to be in this project is up to you. It is voluntary. You do not have to join this project. If you decide to join, you can withdraw at any time and nothing will happen to you. If you choose to stop taking part in the project, you can still come to SisterLove, Inc. to receive services, either now or in the future.
How can I find out more?

You may have questions about this project. If you do, you can ask anyone here right now. If you have questions later about this or think you have been harmed by this project, you can call Mrs. Dazon Diallo – the founder and CEO of SisterLove at 404-753-7733 or Ms. Paulyne Ngalame – the Project Coordinator at SisterLove at 404-753-7733, 1285 Ralph David Abernathy Blvd, SW, Atlanta, GA 30310.

Participant Contact: If you have questions about your rights as a person in the project, call P. Mitchell at the AIDS Research Consortium of Atlanta (ARCA) at (770) 991-7790.

P. Mitchell is a representative of the Institutional Review Board (IRB) who reviewed this project. The IRB reviews projects like this one to make sure that the rights of people who take part are protected.

Consent Statement: I have read this form or it has been read to me. I have had a chance to ask questions about this evaluation project and my questions have been answered. I agree to be part of this project. I will receive a copy of this form.

__________________________

PRINT NAME OF PARTICIPANT DATE/TIME

__________________________

SIGNATURE OF PARTICIPANT DATE/TIME

I have read the consent form to the person named above. She has had a chance to ask questions about this project and her questions have been answered. She agrees to be part of this project. She will receive a copy of this form.

__________________________

PRINT NAME OF PERSON OBTAINING CONSENT DATE/TIME

__________________________

SIGNATURE OF PERSON OBTAINING CONSENT DATE/TIME
APPENDIX C

Recruitment Advertisement

Greetings friends and colleagues …

SisterLove, Inc. is currently recruiting groups of women to participate in an HIV/AIDS prevention workshop where we will discuss “what it is”, “who’s getting it”, “how to keep from getting it” and more. This HIV/AIDS prevention intervention targets women of African descent such as African American, Afro Caribbean or African Immigrant women.

We are looking to recruit groups of women of African descent. These groups could include a group of female friends such as a friendship circle, coworkers, family members, sorority groups, alumni groups, church groups, book clubs, immigrant cultural groups, civic groups etc …

In addition to learning about HIV/AIDS, you could receive up to $100 for participating.

If you or someone you know is interested in participating in this project please call SisterLove, Inc. at 404-505-7777
APPENDIX D
PRETEST SURVEY
SisterLove, Inc.
P.O. Box 10558 • Atlanta, Georgia 30310 • 404-753-7733

Today's date: ___________________  ID#: ___________

PLEASE RESPOND TO EACH ITEM.
ALL YOUR ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL

To begin, we would like to ask you to describe yourself.

1. In what month and year were you born?  __________/__________

2. What is your race? (PLEASE CHECK ONLY ONE BOX)
   □ African American
   □ White
   □ Asian / Pacific Islander
   □ Native American / Indigenous
   □ Bi-racial / Multiracial (please indicate the races below)
   ___________________________
   □ Other (please indicate your race): _______________________

3. Are you Hispanic or Latina?
   □ Yes  □ No

4. What is your country of origin? (Please specify)
   ___________________________

5. What is your religion? (Please describe)
   ___________________________

6. What is your gender? (PLEASE CHECK ONLY ONE BOX)
   □ Female
   □ Male
   □ Transgender
   □ Transsexual
   □ Refuse to answer

7. What is your self-identified sexual orientation? (CHECK ALL THAT APPLY)
   □ Homosexual (Gay / Lesbian)
   □ Heterosexual (Straight)
   □ Bisexual
   □ Undecided/Questioning
   □ Refuse to answer
8. Which category best describes you? (PLEASE CHECK ONLY ONE BOX)
   □ I am single (never been married)
   □ I am single (Living with partner)
   □ I am married
   □ I am separated
   □ I am divorced
   □ I am divorced (& re-married)
   □ I am widowed
   □ I am widowed (re-married)
   □ Refuse to answer

9. Do you have children?
   □ Yes
   □ No (If you checked “No”, SKIP TO QUESTION # 10)


   9.b. How many of your children currently live with you? _________

   9.c. Do your children live with you full-time or part-time?
       □ Full-time   □ Part-time

   9.d. Do you consider yourself to be a single parent?
       □ Yes   □ No

10. What is the highest grade or level you completed in school?
    (PLEASE CHECK ONLY ONE BOX)
    □ Less than high school
    Indicate the number of years completed: ____________________________
    □ High school diploma or GED
    □ Some post-graduate
    □ Associate’s degree (Junior College/Community College)
    □ B.A. or B.S. (Undergraduate)
    □ M.A. / M.B.A. / M.S. (Graduate School)
    □ J.D./M.D/Ph.D or equivalent (Post graduate)
    □ Other, please specify the degree ____________________________
    □ Refuse to answer

11. What is your current employment status? (PLEASE CHECK ONLY ONE BOX)
    □ Self Employed
    □ Employed part time
    □ Employed full time
    □ Unemployed, seeking
    □ Unemployed, not seeking
    □ Between jobs
    □ Disabled
    □ Refuse to answer

12. Are you currently receiving Public Assistance?
    □ Yes
    □ No
    □ Refuse to answer

13. Do you currently have health insurance?
14. What is your yearly household income (range)? (PLEASE CHECK ONLY ONE BOX)

☐ $0 - $15,000 per year
☐ $15,001 - $30,000
☐ $30,001 - $45,000
☐ $45,001 - $60,000
☐ $60,001 - $75,000
☐ $75,001 - $90,000
☐ $90,001 - $105,000
☐ $105,001 or higher
☐ Refuse to answer

15. Who do you currently live with?

☐ I live alone
☐ Parents
☐ Roommate / friend
☐ Spouse / partner (If Spouse/Partner, Please answer Question #15a)
☐ Other (specify): ______________________

15.a. If you live with a spouse / partner – is that person:

☐ Same sex
☐ Opposite sex
☐ Refuse to answer

16. What is your current housing status? (PLEASE CHECK ONLY ONE BOX)

☐ Live in my own home or apartment
☐ Live in someone else's home or apartment
☐ Dormitory
☐ Transitional housing such as, halfway house/residential treatment housing
☐ Homeless (On the street)
☐ Shelter or emergency housing
☐ Refuse to answer

17. Were you ever in jail or prison for more than 30 days?

☐ Yes
☐ No
☐ Refuse to answer

18. Do you know anyone personally who is HIV positive or who has AIDS?

☐ Yes
☐ No
☐ Refuse to answer

19. Do you consider yourself to be at risk for getting HIV/AIDS?

☐ Yes (If YES, Please answer Question #19a.)
☐ No
☐ Don’t know
☐ Refuse to answer
19.a. If "yes", how would your rate your level of risk?

- Very high
- Somewhat high
- Somewhat low
- Very low

20. During the PAST 3 MONTHS, have you used recreational drugs?

- Yes
- No (SKIP to QUESTION #22)
- Don't remember (SKIP to QUESTION #22)
- Don't know (SKIP to QUESTION #22)
- Refuse to answer (SKIP to QUESTION #22)

20.a. If you checked "Yes", what kinds of recreational drugs did you use?

(PLEASE CHECK ALL THAT APPLY)

- Marijuana
- Cocaine
- Crack cocaine
- Crystal methamphetamine
- Ecstasy
- Heroin
- Speed
- Other (please specify):________________________

21. During the PAST 3 MONTHS, have you used needles to inject ("shoot") drugs or medications?

- Yes
- No (SKIP TO QUESTION # 22)
- Don't remember (SKIP TO QUESTION # 22)
- Don't know (SKIP TO QUESTION # 22)
- Refuse to answer (SKIP TO QUESTION # 22)

21.a. If you checked "Yes", did you share a needle with someone else?

- Yes
- No (SKIP TO QUESTION # 22)
- Don't remember (SKIP TO QUESTION # 22)
- Don't know (SKIP TO QUESTION # 22)
- Refuse to answer (SKIP TO QUESTION # 22)

21.b. If you shared a needle, did you clean the syringe with bleach before sharing?

- Yes
- No
- Don't remember
- Don't know
- Refuse to answer

22. In the PAST 3 MONTHS, have you been diagnosed with a sexually transmitted disease or infection (STD or STI)?

- Yes
- No
- Don't know
- Refuse to answer

23. In the PAST 3 MONTHS, have you had sex with another person?

- Yes
- No (SKIP TO QUESTION # 39)
- Don't know (SKIP TO QUESTION # 39)
24. In the PAST 3 MONTHS, have you had sex with only men, only women, or with both men and women?
   □ Only men
   □ Only women
   □ Both men and women
   □ Don't know
   □ Refuse to answer

25. In the PAST 3 MONTHS, have you exchanged sex for money or drugs?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

26. In the PAST 3 MONTHS, have you worked as a prostitute/sex worker?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

27. In the PAST 3 MONTHS, have you exchanged sex for other personal reasons?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

28. In the PAST 3 MONTHS, have you had sex with someone who injects ("shoots") drugs?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

29. In the PAST 3 MONTHS, have you had sex with an HIV+ (HIV positive) person?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

30. In the PAST 3 MONTHS, have you had sex with a person whose HIV status you didn't know?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

31. In the PAST 3 MONTHS, have you had sex with someone who was recently incarcerated or in jail?
   □ Yes
   □ No
   □ Don't know
   □ Refuse to answer

32. In the PAST 3 MONTHS, have you had sex with a man who has had sex with other women?
   □ Yes
   □ No
   □ Don't know
33. In the PAST 3 MONTHS, have you had sex with a man who has had sex with other men?
- Yes
- No
- Don't know
- Refuse to answer

34. In the PAST 3 MONTHS, have you had sex with someone who has had sex with a prostitute or sex worker?
- Yes
- No
- Don't know
- Refuse to answer

35. In the PAST 3 MONTHS, have you had sex while intoxicated or high?
- Yes
- No
- Don't know
- Refuse to answer

36. In the PAST 3 MONTHS, have you had sex when you did not want to?
- Yes
- No
- Don't know
- Refuse to answer

37. In the PAST 3 MONTHS, have you had sex when you were forced to (against your will)?
- Yes
- No
- Don't know
- Refuse to answer

38. In the PAST 3 MONTHS, have you been abused by your sex partner(s)?
- Yes (If YES, Please answer Question # 38a)
- No
- Don't know
- Refuse to answer

38.a. If you checked “Yes” to Question 38, what kind of abuse did you experience? (PLEASE CHECK ALL THAT APPLY)
- Emotional or Verbal abuse
- Physical abuse
- Sexual abuse
- Other (please specify)
- Refuse to answer

The next series of questions are about the test for HIV, the virus that causes AIDS. This usually involves a blood test, but could have involved a saliva test (swab in your mouth).

39. Have you ever been tested for HIV?
- Yes
- No (SKIP TO QUESTION # 47)
- Refuse to answer (SKIP TO QUESTION # 47)
40. When was your most recent HIV test? (PLEASE CHECK ONLY ONE BOX)
- 1 – 3 months ago
- 4 – 6 months ago
- 7 – 9 months ago
- 10 – 12 months ago
- 1 year or more

41. At your most recent HIV test, did you receive the test results?
- Yes
- No (SKIP TO QUESTION # 44)
- Refuse to answer (SKIP TO QUESTION # 44)

42. If you received your HIV test results, what were the results:
(PLEASE CHECK ONLY ONE BOX)
- HIV Negative
- HIV Positive
- Refuse to answer

43. How often do you test for HIV? (PLEASE CHECK ONLY ONE BOX)
- Every 6 months
- Once a year
- Every few years
- Whenever I feel at risk
- Other (please specify) ____________________________
- Never (SKIP TO QUESTION # 47)
- Refuse to answer

44. Which of the following reasons would you say was the main reason(s) for your last HIV test? (PLEASE CHECK ALL THAT APPLY)
- Just to find out my HIV status.
- Worried that I was infected.
- Worried about my partner having sex with other people
- Because a doctor, nurse or other health care professional asked me to.
- Because the Health Department asked me to.
- Because a sex partner asked me to.
- For hospitalization or surgical procedure.
- To apply for health insurance or life insurance.
- To comply with guidelines for health workers.
- To apply for a new job.
- For military induction, separation, or during military service.
- For immigration
- Because of pregnancy.
- Some other reason. Specify: ____________________________
- Don't Know
- Refuse to answer

45. Where did you have your last HIV test? (PLEASE CHECK ONLY ONE BOX)
- Private doctor/HMO
- Counseling and testing site (such as AID Atlanta, or ARCA)
- Hospital (inpatient)
- STD clinic
46. When you received your most recent HIV test results, did you tell your spouse (or main sexual partner) about the HIV test results?
☐ Yes (SKIP TO QUESTION #48)
☐ No (SKIP TO QUESTION #48)
☐ Don't Know (SKIP TO QUESTION #48)
☐ Refuse to answer (SKIP TO QUESTION #48)

47. Here is a list of reasons why some people have not been tested for HIV. Indicate all of the reasons why you have not been tested.
(PLEASE CHECK ALL THAT APPLY)
☐ It’s unlikely I’ve been exposed to HIV.
☐ I was afraid to find out if I was HIV positive.
☐ I didn’t want to think about HIV or about being HIV positive.
☐ I don’t believe anything can be done if I am positive.
☐ I’m afraid that my partner might become angry and leave me.
☐ I was worried that my name would be reported and other people would know that I was HIV positive.
☐ I don’t like needles.
☐ I don’t trust the results to be confidential.
☐ I was afraid of losing my job, insurance, housing, friends, family, if people knew I was HIV positive.
☐ I didn’t know where to get tested.
☐ Some other reason. Specify: ________________________________
☐ No particular reason.
☐ Refuse to answer

48. In the next 3 MONTHS, how likely is it that you will take an HIV test and obtain your test results?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—(not sure)
☐ Slightly sure I won’t
49. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use?
   [ ] Standard HIV test (where you have to return several days later to get your results)
   [ ] Rapid HIV test (where your results are given to you immediately)
   [ ] I would not take an HIV test (Skip to QUESTION # 55)

50. In the NEXT 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use?
   [ ] Oral fluid – (where a cotton swab is used in your mouth to obtain saliva)
   [ ] Drawing blood (where you provide blood for the test)
   [ ] Don’t know
   [ ] Refuse to answer

51. In the NEXT 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use?
   [ ] Confidential (where you give your name but your name and results are kept private)
   [ ] Anonymous (where you are only identified by a number and no one knows your name)
   [ ] Don’t know
   [ ] Refuse to answer

52. In the NEXT 3 MONTHS if you were offered the opportunity to take an HIV test, what kind of setting are you most likely to use?
   [ ] Home based test (where you take the HIV test kit home to use)
   [ ] In a clinical setting (such as your doctor’s office)
   [ ] At a health fair
   [ ] Other (please specify location) _______________________
   [ ] Don’t know
   [ ] Refuse to answer

53. In the NEXT 3 MONTHS if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results?
   [ ] Over the phone
   [ ] Return to the testing site
   [ ] Don’t know
   [ ] Refuse to answer

The next questions are about knowing your partner’s HIV status. ALL ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL

55. How likely are you to consider a potential partner’s HIV status before beginning a physical relationship with that partner? CHECK ONLY ONE BOX
   [ ] Very likely
   [ ] Somewhat likely
   [ ] Somewhat unlikely
   [ ] Very unlikely
56. Would your feelings about someone change if they asked you to have an HIV test before entering into a physical relationship? CHECK ONLY ONE BOX
   □ More favorable feelings (would be happy about it)
   □ My feelings would not change
   □ Less favorable feelings (would not be happy about it)
   □ Don’t know
   □ Refuse to answer

57. How likely would you be to delay or refuse sexual contact with someone until you saw the results of their HIV test? CHECK ONLY ONE BOX
   □ Very likely
   □ Somewhat likely
   □ Somewhat unlikely
   □ Very unlikely
   □ Don’t know
   □ Refuse to answer

58. How likely would you be to initiate a discussion about HIV testing if your partner does not bring up the subject? CHECK ONLY ONE BOX
   □ Very likely
   □ Somewhat likely
   □ Somewhat unlikely
   □ Very unlikely
   □ Don’t know
   □ Refuse to answer

59. How much do you agree or disagree with the following statement: “The only way anybody can know with 100% certainty about their partner’s HIV status is to have him or her tested for HIV.” CHECK ONLY ONE BOX
   □ Strongly agree
   □ Agree
   □ I neither agree nor disagree
   □ Disagree
   □ Strongly disagree
60. In the PAST 3 MONTHS, how many partners have you had sex with?
(Please circle one)

0  1  2  3  4  5  6  7  8  9  10 or more

61. In the PAST 3 MONTHS, have you had vaginal sex, anal sex, or oral sex with a man who you consider to be your PRIMARY sex partner?
- Yes
- No (Skip to question #80)
- Don't know (Skip to question #80)
- Refuse to answer (Skip to question #80)

62. In the PAST 3 MONTHS when you had sex with your PRIMARY male sex partner, were you ever under the influence of alcohol?
- Yes
- No
- Don't Remember
- Refuse to answer

63. In the PAST 3 MONTHS when you had sex with your PRIMARY male sex partner, did you ever use drugs to get high before or during sex?
- Yes
- No
- Don't Remember
- Refuse to answer

64. In the PAST 3 MONTHS, did you have vaginal sex with your PRIMARY male sex partner (that is, he put his penis into your vagina)?
- Yes
- No (Skip to question #68)
- Don't know (Skip to question #68)
- Refuse to answer (Skip to question #68)

65. In the PAST 3 MONTHS, did you use condoms when you had vaginal sex with your PRIMARY male sex partner?
- Yes
- No (Skip to question #68)
- Don't know (Skip to question #68)
- Refuse to answer (Skip to question #68)

66. In the PAST 3 MONTHS, how often did you use a condom during vaginal sex with your PRIMARY male sex partner?

- Each and every time
- Almost every time
- Sometimes
- Almost never

67. In the PAST 3 MONTHS, what kind of condoms did you use during vaginal sex with your PRIMARY male sex partner?

- Male condoms
68. In the PAST 3 MONTHS, did you have anal sex with your PRIMARY male sex partner (that is, he put his penis into your anus or butt)?

☑ No (SKIP TO QUESTION # 72)
☑ Don’t know (SKIP TO QUESTION # 72)
☑ Refuse to answer (SKIP TO QUESTION # 72)

69. If you had anal sex with your PRIMARY male sex partner, did you use condoms?  

☑ Yes
☑ No (SKIP TO QUESTION # 72)
☑ Don’t know (SKIP TO QUESTION # 72)
☑ Refuse to answer (SKIP TO QUESTION # 72)

70. In the PAST 3 MONTHS, how often did you use a condom during anal sex with your PRIMARY male sex partner? CHECK ONLY ONE BOX

☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

71. In the PAST 3 MONTHS, what kind of condoms did you use during anal sex with your PRIMARY male sex partner? CHECK ONLY ONE BOX

☐ Male condoms
☐ Female condoms
☐ Both male & female condoms

72. In the PAST 3 MONTHS, did you have oral sex with your PRIMARY male sex partner (that is, you put your mouth on or around your partner’s penis, or anus, or butt)?

☑ No (SKIP TO QUESTION # 76)
☑ Don’t know (SKIP TO QUESTION # 76)
☑ Refuse to answer (SKIP TO QUESTION # 76)

73. In the PAST 3 MONTHS, if you had oral sex with your PRIMARY male sex partner, did you use condoms or some other barrier such as a dental dam or plastic wrap?

☑ Yes
☑ No (If you checked “No”, SKIP TO QUESTION # 76)
☑ Don’t know (If you checked this, SKIP TO QUESTION # 76)
☑ Refuse to answer (If you checked this, SKIP TO QUESTION # 76)

74. In the PAST 3 MONTHS, how often did you use a barrier such as a dental dam or plastic wrap during oral sex with your PRIMARY male sex partner?

☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

75. What kind of barrier(s) did you use during oral sex with your PRIMARY male sex partner? PLEASE CHECK ALL THAT APPLY

☐ Male condoms
☐ Dental dam
☐ Plastic wrap
76. The **LAST TIME** you had vaginal, anal or oral sex with your PRIMARY male sex partner, did you use a condom?
   - Yes
   - No (SKIP TO QUESTION # 78)
   - Don't know (SKIP TO QUESTION # 78)
   - Refuse to answer (SKIP TO QUESTION # 78)

77. When was the **LAST TIME** you had vaginal, anal or oral sex with your PRIMARY male sex partner but did not use a condom?
   - In the last 30 days
   - More than 30 days and less than 6 months.
   - 6 months ago or more
   - Never
   - Refuse to answer

78. How often do you use a condom during sex with your PRIMARY male sex partner?
   - Each and every time
   - Almost every time
   - Sometimes
   - Almost never (SKIP TO QUESTION #79)
   - Never (SKIP TO QUESTION #79)
   - Refuse to answer (SKIP TO QUESTION #79)

78a. How long have you been using a condom “every time” or “almost every time” you have sex with your PRIMARY male sex partner?
   - 30 days or less
   - More than 30 days but less than 3 months
   - 3 months but less than 6 months
   - 6 months or more

79. In the NEXT 3 MONTHS, how likely is it that you will start using a condom every time you have sex with your PRIMARY male sex partner?
   CHECK ONLY ONE BOX
   - Extremely sure I will
   - Quite sure I will
   - Slightly sure I will
   - Undecided – not sure if I will or won’t
   - Slightly sure I won’t
   - Quite sure I won’t
   - Extremely sure I won’t
   - Refuse to answer

80. In the PAST 3 MONTHS, have you had vaginal sex, anal sex, or oral sex with men who were NOT YOUR PRIMARY sex partner?
   - Yes
   - No (SKIP TO QUESTION #99)
   - Don’t know (SKIP TO QUESTION # 99)
   - Refuse to answer (SKIP TO QUESTION # 99)
81. In the PAST 3 MONTHS when you had sex with men who were NOT your PRIMARY sex partner, were you under the influence of alcohol?
    □ Yes
    □ No
    □ Don’t Remember
    □ Refuse to answer

82. In the PAST 3 MONTHS when you had sex with men who were NOT your PRIMARY sex partner, did you use drugs to get high before or during sex?
    □ Yes
    □ No
    □ Don’t Remember
    □ Refuse to answer

83. In the PAST 3 MONTHS, did you have vaginal sex with a man who is NOT YOUR PRIMARY sex partner (that is, he put his penis into your vagina)?
    □ Yes
    □ No (SKIP TO QUESTION # 87)
    □ Don’t know (SKIP TO QUESTION # 87)
    □ Refuse to answer (SKIP TO QUESTION # 87)

84. In the PAST 3 MONTHS, if you had vaginal sex with a man who is NOT your PRIMARY male sex partner, did you use condoms?
    □ Yes
    □ No (SKIP TO QUESTION # 87)
    □ Don’t know (SKIP TO QUESTION # 87)
    □ Refuse to answer (SKIP TO QUESTION # 87)

85. In the PAST 3 MONTHS, how often did you use a condom during vaginal sex with a man who is NOT your PRIMARY sex partner?
    CHECK ONLY ONE BOX
    □ Each and every time
    □ Almost every time
    □ Sometimes
    □ Almost never

86. In the PAST 3 MONTHS, what kind of condoms did you use during vaginal sex with a man who is NOT your PRIMARY sex partner?
    CHECK ONLY ONE BOX
    □ Male condoms
    □ Female condoms
    □ Both male & female condoms

87. In the PAST 3 MONTHS, did you have anal sex with a man who is NOT your PRIMARY sex partner (that is, he put his penis into your anus or butt)?
    □ Yes
    □ No (SKIP TO QUESTION # 91)
    □ Don’t know (SKIP TO QUESTION # 91)
    □ Refuse to answer (SKIP TO QUESTION # 91)

88. In the PAST 3 MONTHS, if you had anal sex with a man who is NOT your PRIMARY sex partner, did you use condoms?
    □ Yes
    □ No (SKIP TO QUESTION # 91)
89. In the PAST 3 MONTHS, how often did you use a condom during anal sex with a man who is NOT your PRIMARY sex partner?
CHECK ONLY ONE BOX
☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

90. In the PAST 3 MONTHS, what kind of condoms did you use during anal sex with a man who is NOT your PRIMARY sex partner?
CHECK ONLY ONE BOX
☐ Male condoms
☐ Female condoms
☐ Both male & female condoms

91. In the PAST 3 MONTHS, did you have oral sex with a man who is NOT your PRIMARY sex partner (that is, you put your mouth on or around his penis, or anus, or butt)?
☐ Yes
☐ No (SKIP TO QUESTION # 95)
☐ Don’t know (SKIP TO QUESTION # 95)
☐ Refuse to answer (SKIP TO QUESTION # 95)

92. In the PAST 3 MONTHS, if you had oral sex with a man who is NOT your PRIMARY sex partner, did you use condoms or some other barrier such as a dental dam or plastic wrap?
☐ Yes
☐ No (SKIP TO QUESTION # 95)
☐ Don’t know (SKIP TO QUESTION # 95)
☐ Refuse to answer (SKIP TO QUESTION # 95)

93. In the PAST 3 MONTHS, how often did you use a barrier during oral sex with a man who is NOT YOUR PRIMARY sex partner?
☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

94. What kind of barrier(s) did you use during oral sex with a man who is NOT YOUR PRIMARY sex partner? PLEASE CHECK ALL THAT APPLY
☐ Male condoms
☐ Dental dam
☐ Plastic wrap
☐ Other (specify): ________________________________

95. The LAST TIME you had vaginal, anal or oral sex with a man who is NOT YOUR PRIMARY sex partner, did you use a condom?
☐ Yes
☐ No (SKIP TO QUESTION # 97)
☐ Don’t know (SKIP TO QUESTION # 97)
☐ Refuse to answer (SKIP TO QUESTION # 97)
96. When was the **LAST TIME** you had vaginal, anal or oral sex with a man who is NOT YOUR PRIMARY sex partner but did not use a condom?
- [ ] In the last 30 days
- [ ] More than 30 days and less than 6 months.
- [ ] 6 months ago or more
- [ ] Never
- [ ] Refuse to answer

97. How often do you use a condom during sex with a man who is NOT YOUR PRIMARY sex partner?
- [ ] Each and every time
- [ ] Almost every time
- [ ] Sometimes
- [ ] Almost never (SKIP TO QUESTION #98)
- [ ] Never (SKIP TO QUESTION #98)
- [ ] Refuse to answer (SKIP TO QUESTION #98)

97a. How long have you been using a condom “every time” or “almost every time” you have sex with a man who is NOT YOUR PRIMARY sex partner?
- [ ] 30 days or less
- [ ] More than 30 days but less than 3 months
- [ ] 3 months but less than 6 months
- [ ] 6 months or more

98. In the NEXT 3 MONTHS, how likely is it that you will start using a condom every time you have sex with a man who is NOT YOUR PRIMARY sex partner?
CHECK ONLY ONE BOX
- [ ] Extremely sure I will
- [ ] Quite sure I will
- [ ] Slightly sure I will
- [ ] Undecided - not sure if I will or won’t
- [ ] Slightly sure I won’t
- [ ] Quite sure I won’t
- [ ] Extremely sure I won’t
- [ ] Refuse to answer

99. In the PAST 3 MONTHS, have you had sex with a WOMAN (vaginal sex, anal sex, or oral sex)?
- [ ] Yes
- [ ] No (SKIP TO QUESTION #114)
- [ ] Don’t know (SKIP TO QUESTION #114)
- [ ] Refuse to answer (SKIP TO QUESTION #114)

100. In the PAST 3 MONTHS when you had sex with a WOMAN, were you under the influence of alcohol?
- [ ] Yes
- [ ] No
- [ ] Don’t Remember
- [ ] Refuse to answer

101. In the PAST 3 MONTHS when you had sex with a WOMAN, did you use drugs to get high before or during sex?
- [ ] Yes
- [ ] No
- [ ] Don’t Remember
- [ ] Refuse to answer
102. In the PAST 3 MONTHS, did you have vaginal sex with a WOMAN using a sex toy (where she puts something like a dildo, dong, vibrator, etc. in your vagina OR you put something in her vagina)?
☐ Yes
☐ No (SKIP TO QUESTION # 106)
☐ Don't know (SKIP TO QUESTION # 106)
☐ Refuse to answer (SKIP TO QUESTION # 106)

103. In the PAST 3 MONTHS, if you had vaginal sex using a sex toy with a WOMAN, did you and your partner share the toy (that is, the toy entered both your vagina and your partner’s vagina)?
☐ Yes
☐ No (SKIP TO QUESTION # 106)
☐ Don’t know (SKIP TO QUESTION # 106)
☐ Refuse to answer (SKIP TO QUESTION # 106)

104. In the PAST 3 MONTHS, how often did you use a condom when you shared a toy during vaginal sex with a WOMAN?
☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

105. In the PAST 3 MONTHS, what kind of condoms did you use during vaginal sex with a WOMAN?
☐ Male condoms
☐ Female condoms
☐ Both male & female condoms

106. In the PAST 3 MONTHS, did you have anal sex with a WOMAN using a sex toy (where she puts something like a dildo, dong, vibrator, etc. in your butt OR you put something in her butt)?
☐ Yes
☐ No (SKIP TO QUESTION # 110)
☐ Don’t know (SKIP TO QUESTION # 110)
☐ Refuse to answer (SKIP TO QUESTION # 110)

107. In the PAST 3 MONTHS, if you had anal sex using a sex toy with a WOMAN, did you and your partner share the toy (that is, the toy enters both your anus and your partner’s anus or butt)?
☐ Yes
☐ No (SKIP TO QUESTION # 110)
☐ Don’t know (SKIP TO QUESTION # 110)
☐ Refuse to answer (SKIP TO QUESTION # 110)

108. In the PAST 3 MONTHS, how often did you use a condom when you shared a toy during anal sex with a WOMAN?
☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

109. In the PAST 3 MONTHS, what kind of condoms did you use during anal sex with a WOMAN?
☐ Male condoms
☐ Female condoms
☐ Both male & female condoms

110. In the PAST 3 MONTHS, did you have oral sex with a WOMAN (that is, you put your mouth on or around your partner’s vagina, or anus, or butt)?
87

111. In the PAST 3 MONTHS, if you had oral sex with a WOMAN, did you use condoms or some other barrier such as a dental dam or plastic wrap?
☐ Yes
☐ No (SKIP TO QUESTION #114)
☐ Don’t know (SKIP TO QUESTION #114)
☐ Refuse to answer (SKIP TO QUESTION #114)

112. In the PAST 3 MONTHS, how often did you use a barrier during oral sex with a WOMAN?
☐ Each and every time
☐ Almost every time
☐ Sometimes
☐ Almost never

113. In the PAST 3 MONTHS, what kind of barrier(s) did you use during oral sex with a WOMAN? PLEASE CHECK ALL THAT APPLY
☐ Male condoms
☐ Dental dam
☐ Plastic wrap
☐ Other (specify): ____________________________________________________________

114. In the NEXT 3 MONTHS, how likely is it that you will use a FEMALE condom every time you have vaginal or anal sex?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided--not sure if I will or won't
☐ Slightly sure I won't
☐ Quite sure I won't
☐ Extremely sure I won't

115. It is a hassle to use condoms.
☐ Strongly Agree
☐ Agree
☐ Neutral / don't know
☐ Disagree
☐ Strongly Disagree

116. People can get the same pleasure from "safer" sex as from unprotected sex.
☐ Strongly Agree
☐ Agree
☐ Neutral / don't know
☐ Disagree
☐ Strongly Disagree
117. Using condoms interrupts sex play.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

118. The proper use of a condom could enhance sexual pleasure.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

119. Condoms are irritating.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

120. I think “safer” sex would get boring fast.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

121. “Safer” sex reduces the mental pleasure of sex.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

122. Condoms ruin the natural sex act.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

123. Generally, I am in favor of using condoms.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

124. Condoms interfere with romance.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
125. The sensory aspects (smell, touch, etc.) of condoms make them unpleasant.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

126. With condoms, you can't really "give yourself over" to your partner.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

127. I feel confident in my ability to put a condom on myself or my partner.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

128. I feel confident I could purchase condoms without feeling embarrassed.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

129. I feel confident I could remember to carry a condom with me should I need one.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

130. I feel confident in my ability to discuss condom usage with any partner I might have.
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

131. I feel confident I could suggest using a condom to my partner without feeling “diseased.”
- [ ] Strongly Agree
- [ ] Agree
- [ ] Neutral / don't know
- [ ] Disagree
- [ ] Strongly Disagree

132. I would feel embarrassed to put a condom on myself or my partner.
- [ ] Strongly Agree
133. If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

134. If I were unsure of my partner’s feelings about using condoms, I would NOT suggest using one.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

135. I feel confident in my ability to use a condom correctly.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

136. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any
   sexual contact (e.g. hugging, kissing, caressing, etc.)
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

137. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

138. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

139. If my partner and I were to try to use a condom and did not succeed, I would feel embarrassed to try to use
   one again (e.g. not being able to unroll condom, putting it on backwards, or awkwardness).
140. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I sleep around.

141. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.

142. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think they had a sexually transmitted disease.

143. I feel confident I could stop to put a condom on myself or my partner even in the heat of passion.

144. I feel confident that I could use a condom with a partner without “breaking the mood.”

145. I feel confident I could use a condom during intercourse without reducing any sexual sensations.

146. I feel confident that I would remember to use a condom even after I have been drinking.
92

147. I feel confident that I would remember to use a condom even if I were high.

☐ Strongly Agree
☐ Agree
☐ Neutral / don’t know
☐ Disagree
☐ Strongly Disagree

148. If my partner didn’t want to use a condom during intercourse, I could easily convince him or her that it was necessary to do so.

☐ Strongly Agree
☐ Agree
☐ Neutral / don’t know
☐ Disagree
☐ Strongly Disagree

149. Coughing and sneezing DO NOT spread HIV.

☐ True
☐ False
☐ Don’t know

150. A person can get HIV by sharing a glass of water with someone who has HIV.

☐ True
☐ False
☐ Don’t know

151. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.

☐ True
☐ False
☐ Don’t know

152. A woman can get HIV if she has anal sex with a man.

☐ True
☐ False
☐ Don’t know

153. Taking a shower or washing one’s genitals/private parts, after sex keeps a person from getting HIV.

☐ True
☐ False
☐ Don’t know

154. All pregnant women infected with HIV will have babies born with AIDS.
155. People who have been infected with HIV quickly show signs of being infected.
   □ True
   □ False
   □ Don't know

156. There is a vaccine that can stop adults from getting HIV.
   □ True
   □ False
   □ Don't know

157. People are likely to get HIV by deep kissing and putting their tongue in their partner’s mouth, if their partner has HIV.
   □ True
   □ False
   □ Don't know

158. A woman cannot get HIV if she has sex during her period.
   □ True
   □ False
   □ Don’t know

159. There is a female condom that can help decrease a woman’s chance of getting HIV.
   □ True
   □ False
   □ Don’t know

160. A person will not get HIV if she is taking antibiotics.
   □ True
   □ False
   □ Don’t know

161. Having sex with more than one partner or with someone who has more than one partner can increase a person’s chance of being infected with HIV.
   □ True
   □ False
   □ Don’t know
162. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.
   □ True
   □ False
   □ Don't know

163. A person can get HIV from oral sex.
   □ True
   □ False
   □ Don't know

164. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.
   □ True
   □ False
   □ Don't know

Please check one response for each item.

165. Bleeding from your vagina when you are NOT on your menstrual cycle is a sign that you may have a sexually transmitted infection (STI).
   □ True
   □ False
   □ Don't Know

166. If an STI is NOT treated, it will probably go away by itself.
   □ True
   □ False
   □ Don't Know

167. STIs CAN be spread through oral sex.
   □ True
   □ False
   □ Don't Know

168. Using a latex or polyurethane barrier is a good way to prevent getting an STI or giving one to someone else.
   □ True
   □ False
   □ Don't Know

169. If you use a condom, it is impossible to get an STI.
   □ True
   □ False
170. A discharge from a man’s penis is a sign that he has an STI.
   □ True
   □ False
   □ Don’t Know

171. Having vaginal or anal sex without a condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

172. Having vaginal or anal sex with a lambskin condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

173. Having vaginal sex with a female condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

174. Masturbating (touching/stimulating yourself until you cum).
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

175. Sharing a toothbrush with a person who may have HIV / AIDS.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

176. Sharing razors with a person who may have HIV / AIDS.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

Survey complete – thank you for your time and cooperation!
APPENDIX E
POSTTEST SURVEY
P.O. Box 10558 • Atlanta, Georgia 30310 • 404-753-7733

Today’s date: ________________ ID#: __________

PLEASE RESPOND TO EACH ITEM.
ALL YOUR ANSWERS WILL BE KEPT STRICTLY CONFIDENTIAL

1. Do you consider yourself to be at risk for getting HIV/AIDS or giving someone else HIV/AIDS?
   □ Yes
   □ No
   □ Don’t Know
   □ Refuse to answer

1.a. How would you rate your level of risk?
   □ Very high
   □ Somewhat high
   □ Somewhat low
   □ Very low
   □ No risk

2. In the next 3 MONTHS how likely is it that you will take an HIV test and obtain your test results?
   □ Extremely sure I will
   □ Quite sure I will
   □ Slightly sure I will
   □ Undecided-(not sure)
   □ Slightly sure I won’t
   □ Quite sure I won’t
   □ Extremely sure I won’t
   □ I am HIV positive

3. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use?
   □ Standard HIV test (where you have to return several days later to get your results)
   □ Rapid HIV test (where your results are given to you immediately)
   □ I would not take an HIV test

4. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use?
   □ OraSure-(where a cotton swab is used in your mouth to obtain saliva)
   □ OraQuick-(where your results are given to you immediately)
   □ Don’t know

5. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use?
   □ Confidential (where you give your name but you name and results are kept private)
   □ Anonymous (where you are only identified by a number and no one knows your name)
6. In the next 3 MONTHS if you were offered the opportunity to take an HIV test what kind of setting are you most likely to use?
   □ Home base test (where you take the HIV test kit home to use)
   □ In a clinical setting (such as your doctor’s office)
   □ At a health fair
   □ Other (please specify location)
   □ Don’t know

7. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results?
   □ Over the phone
   □ Return to the testing site
   □ Don’t know

8. How likely are you to consider a potential partner’s HIV status before beginning a physical relationship with that partner?
   □ Very likely
   □ Somewhat likely
   □ Somewhat unlikely
   □ Very unlikely
   □ Don’t know
   □ Refuse to answer

9. Would your feelings about someone change if they asked you to have an HIV test before entering into a physical relationship?
   □ More favorable feelings (would be happy about it)
   □ My feelings would not change
   □ Less favorable feelings (would not be happy about it)
   □ Don’t know
   □ Refuse to answer

10. How likely would you be to delay or refuse sexual contact with someone until you saw the results of their HIV test?
    □ Very likely
    □ Somewhat likely
    □ Very unlikely
    □ Don’t know
    □ Refuse to answer

11. How likely would you be to initiate a discussion about HIV testing if your partner does not bring up the subject?
    □ Very likely
    □ Somewhat likely
    □ Very unlikely
    □ Don’t know
    □ Refuse to answer

12. How much do you agree or disagree with the following statement: “The only way anybody can know with 100% certainty about their partner’s HIV status is to have him or her tested for HIV”.
    □ Strongly agree
    □ Agree
    □ I neither agree nor disagree
    □ Disagree
13. In the next 3 MONTHS, how likely is it that you will use a MALE condom every time you have vaginal or anal sex with your PRIMARY male partner?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—not sure if I will or won’t
☐ Slightly sure I won’t
☐ Quite sure I won’t
☐ Extremely sure I won’t

14. In the next 3 MONTHS, how likely is it that you will use a FEMALE condom every time you have vaginal or anal sex with your PRIMARY male partner?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—not sure if I will or won’t
☐ Slightly sure I won’t
☐ Quite sure I won’t
☐ Extremely sure I won’t

15. In the next 3 MONTHS, how likely is it that you will use a condom or some other barrier such as a dental dam or plastic wrap every time you had oral sex with your PRIMARY male partner?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—not sure if I will or won’t
☐ Slightly sure I won’t
☐ Quite sure I won’t
☐ Extremely sure I won’t

16. In the next 3 MONTHS, how likely is it that you will use a MALE condom every time you have vaginal or anal sex with a man who is NOT YOUR PRIMARY male partner?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—not sure if I will or won’t
☐ Slightly sure I won’t
☐ Quite sure I won’t
☐ Extremely sure I won’t

17. In the NEXT 3 MONTHS, how likely is it that you will use a FEMALE condom every time you have vaginal or anal sex with a man who is Not your PRIMARY male partner?
☐ Extremely sure I will
☐ Quite sure I will
☐ Slightly sure I will
☐ Undecided—not sure if I will or won’t
☐ Slightly sure I won’t
☐ Quite sure I won’t
☐ Extremely sure I won’t
18. In the NEXT 3 MONTHS, how likely is it that you will use a condom or some other barrier such as a dental dam or plastic wrap every time you had oral sex with a man who is Not your PRIMARY male partner?

- □ Extremely sure I will
- □ Quite sure I will
- □ Slightly sure I will
- □ Undecided—not sure if I will or won’t
- □ Slightly sure I won’t
- □ Quite sure I won’t
- □ Extremely sure I won’t

19. In the NEXT 3 MONTHS, how likely is it that you will use a MALE condom every time you have vaginal or anal sex with a woman?

- □ Extremely sure I will
- □ Quite sure I will
- □ Slightly sure I will
- □ Undecided—not sure if I will or won’t
- □ Slightly sure I won’t
- □ Quite sure I won’t
- □ Extremely sure I won’t

20. In the NEXT 3 MONTHS, how likely is it that you will use a FEMALE condom every time you have vaginal or anal sex with a woman?

- □ Extremely sure I will
- □ Quite sure I will
- □ Slightly sure I will
- □ Undecided—not sure if I will or won’t
- □ Slightly sure I won’t
- □ Quite sure I won’t
- □ Extremely sure I won’t

21. In the next 3 MONTHS, how likely is it that you will use a condom or some other barrier such as dental dam or plastic wrap every time you had oral sex with a woman?

- □ Extremely sure I will
- □ Quite sure I will
- □ Slightly sure I will
- □ Undecided—not sure if I will or won’t
- □ Slightly sure I won’t
- □ Quite sure I won’t
- □ Extremely sure I won’t

22. It is a hassle to use condoms?

- □ Strongly Agree
- □ Agree
- □ Neutral / don’t know
- □ Disagree
- □ Strongly Disagree

23. People can get the same pleasure from “safer” sex as from unprotected sex.

- □ Strongly Agree
- □ Agree
- □ Neutral / don’t know
- □ Disagree
- □ Strongly Disagree
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

25. The proper use of a condom could enhance sexual pleasure.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

26. Condoms are irritating.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

27. I think “safer” sex would get boring fast.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

28. “Safer” sex reduces the mental pleasure of sex.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

29. Condoms ruin the natural feel of sex.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

30. Generally, I am in favor of using condoms.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

31. Condoms interfere with romance.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
32. The sensory aspects (smell, touch, etc.) of condoms make them unpleasant.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don't know
   - Disagree

33. With condoms, you can't really “give yourself over” to your partner.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don't know
   - Disagree

34. I feel confident in my ability to put a condom on myself or my partner.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don’t know
   - Disagree

35. I feel confident I could purchase condoms without feeling embarrassed.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don’t know
   - Disagree

36. I feel confident I could remember to carry a condom with me should I need one.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don’t know
   - Disagree

37. I feel confident in my ability to discuss condom usage with any partner I might have.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don’t know
   - Disagree

38. I feel confident I could suggest using a condom to my partner without feeling “diseased”.
   - Disagree
   - Strongly Disagree
   - Strongly Agree
   - Agree
   - Neutral / don’t know
   - Disagree

39. I would feel embarrassed to put a condom on myself or my partner.
   - Disagree
   - Strongly Disagree
   - Agree
40. If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

41. If I were unsure of my partner’s feelings about using condoms, I would NOT suggest using one.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

42. I feel confident in my ability to use a condom correctly.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

43. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any sexual contact (e.g. hugging, kissing, caressing, etc.)
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

44. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

45. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree

46. If my partner and I were to try to use a condom and did not succeed, I would feel embarrassed to try to use one again (e.g. not being able to unroll condom, putting it on backwards, or awkwardness).
   □ Strongly Agree
   □ Agree
   □ Neutral / don’t know
   □ Disagree
   □ Strongly Disagree
47. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I sleep around.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

48. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

50. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I thought they had a sexually transmitted disease.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

51. I feel confident I could stop to put a condom on myself or my partner even in the heat of passion.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

52. I feel confident that I could use a condom with a partner without “breaking the mood”.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

53. I feel confident I could use a condom during intercourse without reducing any sexual sensations.

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

54. I feel confident that I would remember to use a condom even after I have been drinking (e.g. alcohol, beer, or wine.)

- Strongly Agree
- Agree
- Neutral / don’t know
- Disagree
- Strongly Disagree

55. I feel confident that I would remember to use a condom even if I were high (e.g. crack, cocaine or marijuana).
□ Strongly Agree
□ Agree
□ Neutral / don’t know
□ Disagree
□ Strongly Disagree

56. If my partner didn’t want to use a condom during intercourse, I could easily convince him or her that it was necessary to do so.
□ Strongly Agree
□ Agree
□ Neutral / don’t know
□ Disagree
□ Strongly Disagree

57. Coughing and sneezing DO NOT spread HIV.
□ True
□ False
□ Don’t know

58. A person can get HIV by sharing a glass of water with someone who has HIV.
□ True
□ False
□ Don’t know

59. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.
□ True
□ False
□ Don’t know

60. A women can get HIV if she has anal sex with a man.
□ True
□ False
□ Don’t know

61. Taking a shower or washing one’s genitals/private parts, after sex keeps a person from getting HIV.
□ True
□ False
□ Don’t know

62. All pregnant women infected with HIV will have babies born with AIDS.
□ True
□ False
□ Don’t know

63. People who have been infected with HIV quickly show signs of being infected.
□ True
□ False
□ Don’t know

64. There is a vaccine that can stop adults from getting HIV.
□ True
□ False
□ Don’t know
65. People are likely to get HIV by deep kissing and putting their tongue in their partner’s mouth, if their partner has HIV.
   - True
   - False
   - Don’t know

66. A woman cannot get HIV if she has sex during her period.
   - True
   - False
   - Don’t know

67. There is a female condom that can help decrease a woman’s chance of getting HIV.
   - True
   - False
   - Don’t know

68. A person will not get HIV if she is taking antibiotics.
   - True
   - False
   - Don’t know

69. Having sex with more than one partner or with someone who has more than one partner can increase a person’s chance of being infected with HIV.
   - True
   - False
   - Don’t know

70. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.
   - True
   - False
   - Don’t know

71. A person can get HIV from oral sex.
   - True
   - False
   - Don’t know

72. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.
   - True
   - False
   - Don’t know

73. Bleeding from your vagina when you are NOT on your menstrual cycle is a sign that you may have a sexually transmitted infection (STIs).
   - True
   - False
   - Don’t know

74. If an STIs is NOT treated, it will probably go away by itself.
   - True
   - False
   - Don’t know

75. STIs CAN be spread through oral sex.
76. Using a latex or polyurethane barrier is a good way to prevent getting an STI or giving one to someone else.
   □ True
   □ False
   □ Don’t know

77. If you use a condom, it is impossible to get an STI.
   □ True
   □ False
   □ Don’t know

78. A discharge from a man’s penis is a sign that he has an STI.
   □ True
   □ False
   □ Don’t know

79. Having vaginal or anal sex without a condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

80. Having vaginal or anal sex with a lambskin condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

81. Having vaginal sex with a female condom.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

82. Masturbating (touching/stimulating yourself until you cum).
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

83. Sharing a toothbrush with a person who may have HIV/AIDS.
   □ High risk
   □ Low Risk
   □ No risk
   □ Don’t know

84. Sharing razors with a person who may have HIV/AIDS.
   □ High risk
☐ Low Risk
☐ No risk
☐ Don't know
### HIV TESTING

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Frequency</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Have you ever been tested for HIV? 96</td>
<td>1.2500</td>
<td>.50262</td>
<td></td>
</tr>
<tr>
<td>40. When was your most recent HIV test? 96</td>
<td>2.3542</td>
<td>1.90279</td>
<td></td>
</tr>
<tr>
<td>41. At your most recent HIV test, did you receive the test result? 96</td>
<td>.9479</td>
<td>.53054</td>
<td></td>
</tr>
<tr>
<td>42. If you received your HIV test results, what were the results? 96</td>
<td>.8854</td>
<td>.63028</td>
<td></td>
</tr>
<tr>
<td>43. How often do you test for HIV? 96</td>
<td>2.5000</td>
<td>2.09762</td>
<td></td>
</tr>
<tr>
<td>44. Which of the following reasons would you say was the main reasons for your last HIV test? 96</td>
<td>3.7604</td>
<td>4.98153</td>
<td></td>
</tr>
<tr>
<td>45. Where did you have your last HIV test? 96</td>
<td>1.0625</td>
<td>.73717</td>
<td></td>
</tr>
<tr>
<td>46. When you received your most recent HIV test results, did you tell your spouse about the HIV test results? 96</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47. Here is a list of reasons why some people have not been tested for HIV. 96</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48. In the next 3 months how likely is it that you will take an HIV test and obtain your test result? 95</td>
<td>3.0104</td>
<td>2.14474</td>
<td></td>
</tr>
<tr>
<td>49. In the next 3 months if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use? 96</td>
<td>1.5521</td>
<td>.75212</td>
<td></td>
</tr>
<tr>
<td>50. In the next 3 months if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use? 96</td>
<td>1.4375</td>
<td>.94938</td>
<td></td>
</tr>
<tr>
<td>51. In the next 3 months if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use? 96</td>
<td>1.2813</td>
<td>.81697</td>
<td></td>
</tr>
<tr>
<td>52. In the next 3 months if you were offered the opportunity to take an HIV test, what kind of setting are you most likely to use? 96</td>
<td>1.9896</td>
<td>1.14703</td>
<td></td>
</tr>
<tr>
<td>53. In the next 3 months if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results? 96</td>
<td>1.6250</td>
<td>.88556</td>
<td></td>
</tr>
</tbody>
</table>

### SELF EFFICACY
127. I feel confident I could purchase condoms without feeling embarrassed.
128. I feel confident I could remember to carry a condom with me should I need one.
129. I feel confident in my ability to discuss condom usage with any partner I might have.
130. I feel confident I could suggest using a condom to my partner without feeling “diseased”.
131. I would feel embarrassed to put a condom on myself or my partner.
135. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any sexual contact.
136. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.
137. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.
140. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.
141. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I thought they had a sexually transmitted disease.
142. I feel confident I could stop to put a condom on myself or my partner even in the heat of passion.
143. I feel confident that I could use a condom with a partner without “breaking the mood”.
144. I feel confident I could use a condom during intercourse without reducing any sexual sensations.
145. I feel confident that I would remember to use a condom even after I have been drinking.
146. I feel confident that I would remember to use a condom even if I were high.
147. If my partner didn’t want to use a condom during intercourse, I could easily convince him or her that it was necessary to do so.

HIV KNOWLEDGE
| 148. | Coughing and sneezing do not spread HIV. | 96 | 1.4063 | .76197 |
| 149. | A person can get HIV by sharing a glass of water with someone who has HIV. | 96 | 1.9583 | .52147 |
| 150. | Pulling out the penis before a man climaxes/cums keeps a women from getting HIV during sex. | 96 | 1.9375 | .49868 |
| 151. | A women can get HIV if she has anal sex with a man. | 96 | 1.3333 | .59235 |
| 152. | Taking a shower or washing one's genitals/private parts, after sex keeps a person from getting HIV. | 96 | 1.9792 | .52273 |
| 153. | All pregnant women infected with HIV will have babies born with AIDS. | 96 | 1.8750 | .50783 |
| 154. | People who have been infected with HIV quickly show signs of being infected. | 96 | 2.0104 | .47005 |
| 155. | There is a vaccine that can stop adults from getting HIV. | 96 | 2.1250 | .48666 |
| 156. | People are likely to get HIV by deep kissing and putting their tongue in their partner's mouth, if their partner has HIV. | 96 | 1.9271 | .58480 |
| 157. | A women cannot get HIV if she has sex during her period. | 96 | 1.9688 | .44611 |
| 158. | Their is a female condom that can help decrease a women's chance of getting HIV. | 96 | 1.5521 | .72358 |
| 159. | A person will not get HIV if she is taking antibiotics. | 96 | 1.9063 | .41239 |
| 160. | Having sex with more than one partner or with someone who has more than one partner can increase a person's chance of being infected with HIV. | 96 | 1.3438 | .62959 |
| 161. | Taking a test for HIV one week after having sex will tell a person if she or he has HIV. | 96 | 2.0000 | .68056 |
| 162. | A person can get HIV from oral sex. | 96 | 1.4271 | .70703 |
| 163. | Using Vaseline or baby oil with condoms lowers the chance of getting HIV. | 96 | 1.9792 | .58000 |
ITEM-LEVEL ANALYSIS FOR HIV 101 PRETTEST

(QUESTIONS FOR HIV TESTING, SELF-EFFICACY, AND HIV KNOWLEDGE)

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Frequency</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV TESTING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Have you ever been tested for HIV?</td>
<td>80</td>
<td>1.3875</td>
<td>.72030</td>
</tr>
<tr>
<td>40. When was your most recent HIV test?</td>
<td>80</td>
<td>3.0750</td>
<td>5.81089</td>
</tr>
<tr>
<td>41. At your most recent HIV test, did you receive the test result?</td>
<td>80</td>
<td>.9000</td>
<td>.60796</td>
</tr>
<tr>
<td>42. If you received your HIV test results, what were the results?</td>
<td>80</td>
<td>1.1000</td>
<td>1.23862</td>
</tr>
<tr>
<td>43. How often do you test for HIV?</td>
<td>80</td>
<td>2.2875</td>
<td>2.37174</td>
</tr>
<tr>
<td>44. Which of the following reasons would you say was the main reasons for your last HIV test?</td>
<td>80</td>
<td>.4625</td>
<td>.79466</td>
</tr>
<tr>
<td>45. Where did you have your last HIV test?</td>
<td>80</td>
<td>3.1750</td>
<td>4.49972</td>
</tr>
<tr>
<td>46. When you received your most recent HIV test results, did you tell your spouse about the HIV test results?</td>
<td>80</td>
<td>1.0375</td>
<td>.89221</td>
</tr>
<tr>
<td>47. Here is a list of reasons why some people have not been tested for HIV.</td>
<td>80</td>
<td>.1875</td>
<td>.39277</td>
</tr>
<tr>
<td>48. In the next 3 months how likely is it that you will take an HIV test and obtain your test result?</td>
<td>80</td>
<td>3.1375</td>
<td>2.24873</td>
</tr>
<tr>
<td>49. In the next 3 months if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use?</td>
<td>80</td>
<td>1.6625</td>
<td>.87067</td>
</tr>
<tr>
<td>50. In the next 3 months if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use?</td>
<td>80</td>
<td>1.4500</td>
<td>1.06617</td>
</tr>
<tr>
<td>51. In the next 3 months if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use?</td>
<td>80</td>
<td>1.2875</td>
<td>.98333</td>
</tr>
<tr>
<td>52. In the next 3 months if you were offered the opportunity to take an HIV test, what kind of setting are you most likely to use?</td>
<td>80</td>
<td>2.0000</td>
<td>1.51783</td>
</tr>
<tr>
<td>53. In the next 3 months if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results?</td>
<td>80</td>
<td>1.5000</td>
<td>1.01881</td>
</tr>
<tr>
<td>SELF EFFICACY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>127. I feel confident I could purchase condoms without feeling embarrassed.</td>
<td>80</td>
<td>1.7750</td>
<td>1.12481</td>
</tr>
<tr>
<td>128. I feel confident I could remember to carry a condom with me should I need one.</td>
<td>80</td>
<td>1.7625</td>
<td>1.07024</td>
</tr>
</tbody>
</table>
129. I feel confident in my ability to discuss condom usage with any partner I might have.
130. I feel confident I could suggest using a condom to my partner without feeling "diseased".
131. I would feel embarrassed to put a condom on myself or my partner.
135. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any sexual contact.
136. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.
137. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.
140. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.
141. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I thought they had a sexually transmitted disease.
142. I feel confident I could stop to put a condom on myself or my partner even in the heat of passion.
143. I feel confident that I could use a condom with a partner without "breaking the mood".
144. I feel confident I could use a condom during intercourse without reducing any sexual sensations.
145. I feel confident that I would remember to use a condom even after I have been drinking.
146. I feel confident that I would remember to use a condom even if I were high.
147. If my partner didn't want to use a condom during intercourse, I could easily convince him or her that it was necessary to do so.

HIV KNOWLEDGE
148. Coughing and sneezing do not spread HIV.
149. A person can get HIV by sharing a glass of water with someone who has HIV.
150. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.
151. A woman can get HIV if she has anal sex with a man.
152. Taking a shower or washing one’s genitals/private parts, after sex keeps a person from getting HIV.
153. All pregnant women infected with HIV will have babies born with AIDS.
154. People who have been infected with HIV quickly show signs of being infected.
155. There is a vaccine that can stop adults from getting HIV.
156. People are likely to get HIV by deep kissing and putting their tongue in their partner’s mouth, if their partner has HIV.
157. A woman cannot get HIV if she has sex during her period.
158. There is a female condom that can help decrease a woman’s chance of getting HIV.
159. A person will not get HIV if she is taking antibiotics.
160. Having sex with more than one partner or with someone who has more than one partner can increase a person’s chance of being infected with HIV.
161. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.
162. A person can get HIV from oral sex. 
163. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.
ITEM LEVEL ANALYSIS FOR HEALTH LOVE WORKSHOP POSTTEST

(QUESTIONS FOR HIV TESTING, SELF-EFFICACY, AND HIV KNOWLEDGE)

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV TESTING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you consider yourself to be at risk for getting HIV/AIDS or giving someone else HIV/AIDS?</td>
<td>94</td>
<td>1.5426</td>
<td>.61635</td>
</tr>
<tr>
<td>1.a. How would you rate your level of risk?</td>
<td>94</td>
<td>1.9362</td>
<td>1.74016</td>
</tr>
<tr>
<td>2. In the next 3 MONTHS how likely is it that you will take an HIV test and obtain your test results?</td>
<td>94</td>
<td>2.6596</td>
<td>2.05595</td>
</tr>
<tr>
<td>3. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use?</td>
<td>94</td>
<td>1.5106</td>
<td>.81313</td>
</tr>
<tr>
<td>4. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use?</td>
<td>94</td>
<td>1.5106</td>
<td>.81313</td>
</tr>
<tr>
<td>5. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use?</td>
<td>94</td>
<td>1.4787</td>
<td>.74385</td>
</tr>
<tr>
<td>6. In the next 3 MONTHS if you were offered the opportunity to take an HIV test what kind of setting are you most likely to use?</td>
<td>94</td>
<td>1.4255</td>
<td>.72571</td>
</tr>
<tr>
<td>7. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results?</td>
<td>94</td>
<td>1.9255</td>
<td>.87054</td>
</tr>
<tr>
<td>SELF-EFFICACY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. I feel confident in my ability to put a condom on myself or my partner.</td>
<td>94</td>
<td>3.1383</td>
<td>1.53526</td>
</tr>
<tr>
<td>35. I feel confident I could purchase condoms without feeling embarrassed.</td>
<td>94</td>
<td>1.7660</td>
<td>1.13047</td>
</tr>
<tr>
<td>36. I feel confident I could remember to carry a condom with me should I need one.</td>
<td>94</td>
<td>1.5213</td>
<td>.85167</td>
</tr>
<tr>
<td>37. I feel confident in my ability to discuss condom usage with any partner I might have.</td>
<td>94</td>
<td>1.4043</td>
<td>.62766</td>
</tr>
<tr>
<td>38. I feel confident I could suggest using a condom to my partner without feeling “diseased”.</td>
<td>94</td>
<td>1.3085</td>
<td>.58708</td>
</tr>
</tbody>
</table>
39. I would feel embarrassed to put a condom on myself or my partner.  
40. If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.  
41. If I were unsure of my partner’s feelings about using condoms, I would NOT suggest using one.  
42. I feel confident in my ability to use a condom correctly.  
43. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any sexual contact (e.g. hugging, kissing, caressing, etc.).  
44. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.  
45. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.  
46. If my partner and I were to try to use a condom and did not succeed, I would feel embarrassed to try to use one again (e.g. not being able to unroll condom, putting it on backwards, or awkwardness).  
47. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I sleep around.  
48. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.  
49. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I thought they had a sexually transmitted disease.  
50. I feel confident I could stop to put a condom on myself or my partner even in the heat of passion.  
51. I feel confident that I could use a condom with a partner without “breaking the mood”.  
52. I feel confident I could use a condom during intercourse without reducing any sexual sensations.
54. I feel confident that I would remember to use a condom even after I have been drinking (e.g. alcohol, beer, or wine.)
55. I feel confident that I would remember to use a condom even if I were high (e.g. crack, cocaine or marijuana).
56. If my partner didn’t want to use a condom during intercourse, I could easily convince him or her that it was necessary to do so.

HIV KNOWLEDGE
57. Coughing and sneezing DO NOT spread HIV.
58. A person can get HIV by sharing a glass of water with someone who has HIV.
59. Pulling out the penis before a man climaxes/cums keeps a woman from getting HIV during sex.
60. A women can get HIV if she has anal sex with a man.
61. Taking a shower or washing one’s genitals/private parts, after sex keeps a person from getting HIV.
62. All pregnant women infected with HIV will have babies born with AIDS.
63. People who have been infected with HIV quickly show signs of being infected.
64. There is a vaccine that can stop adults from getting HIV.
65. People are likely to get HIV by deep kissing and putting their tongue in their partner’s mouth, if their partner has HIV.
66. A women cannot get HIV if she has sex during her period.
67. Their is a female condom that can help decrease a woman’s chance of getting HIV.
68. A person will not get HIV if she is taking antibiotics.
69. Having sex with more than one partner or with someone who has more than one partner can increase a person’s chance of being infected with HIV.
70. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.
71. A person can get HIV from oral sex.
72. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.

ITEM LEVEL ANALYSIS FOR HIV 101 WORKSHOP: POSTTEST

(QUESTIONS HIV TESTING, SELF-EFFICACY, AND HIV KNOWLEDGE)

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>FREQUENCY</th>
<th>MEAN</th>
<th>STANDARD DEVIATION</th>
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<tbody>
<tr>
<td>HIV TESTING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Do you consider yourself to be at risk for getting HIV/AIDS or giving someone else HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. a. How would you rate your level of risk?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. In the next 3 MONTHS how likely is it that you will take an HIV test and obtain your test results?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, what kind of test are you most likely to use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following methods are you most likely to use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, which of the following reporting methods are you most likely to use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. In the next 3 MONTHS if you were offered the opportunity to take an HIV test what kind of setting are you most likely to use?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. In the next 3 MONTHS if you were offered the opportunity to take an HIV test, how would you like to receive your HIV test results?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SELF-EFFICACY

| 34. I feel confident in my ability to put a condom on myself or my partner. |
| 35. I feel confident I could purchase condoms without feeling embarrassed. |
| 36. I feel confident I could remember to carry a condom with me should I need one. |

VARIABLE FREQUENCY MEAN STANDARD DEVIATION

| HIV TESTING | 1.7875 | .54410 |
| 1.5875 | 1.76243 |
| 2.3625 | 2.05151 |
| 1.6125 | .77122 |
| 1.6125 | .77122 |
| 1.4250 | .82332 |
| 1.6875 | 1.02616 |
| 1.9625 | .98654 |
| 3.3125 | 1.61162 |
| 1.6875 | 1.10915 |
| 1.5375 | 1.03047 |
37. I feel confident in my ability to discuss condom usage with any partner I might have.  
38. I feel confident I could suggest using a condom to my partner without feeling "diseased".  
39. I would feel embarrassed to put a condom on myself or my partner.  
40. If I were to suggest using a condom to a partner, I would feel afraid that he or she would reject me.  
41. If I were unsure of my partner's feelings about using condoms, I would NOT suggest using one.  
42. I feel confident in my ability to use a condom correctly.  
43. I would feel comfortable discussing condom use with a potential sexual partner before we ever had any sexual contact (e.g. hugging, kissing, caressing, etc.)  
44. I feel confident in my ability to persuade a partner to accept using a condom when we have intercourse.  
45. I feel confident that I could correctly remove and dispose of a condom when we have intercourse.  
46. If my partner and I were to try to use a condom and did not succeed, I would feel embarrassed to try to use one again (e.g. not being able to unroll condom, putting it on backwards, or awkwardness).  
47. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I sleep around.  
48. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I have a sexually transmitted disease.  
50. I would not feel confident suggesting using condoms with a new partner because I would be afraid he or she would think I thought they had a sexually transmitted disease.  
51. I feel confident I could stop to put a condom on myself or my partner.
partner even in the heat of passion.
52. I feel confident that I could use a
condom with a partner without
"breaking the mood".
53. I feel confident I could use a
condom during intercourse without
reducing any sexual sensations.
54. I feel confident that I would
remember to use a condom even
after I have been drinking (e.g.
alcohol, beer, or wine.)
55. I feel confident that I would
remember to use a condom even if I
were high (e.g. crack, cocaine or
marijuana).
56. If my partner didn’t want to use
a condom during intercourse, I
could easily convince him or her
that it was necessary to do so.

HIV KNOWLEDGE
57. Coughing and sneezing DO
NOT spread HIV.
58. A person can get HIV by sharing
a glass of water with someone who
has HIV.
59. Pulling out the penis before a
man climaxes/cums keeps a woman
from getting HIV during sex.
60. A woman can get HIV if she has
anal sex with a man.
61. Taking a shower or washing
one’s genitals/private parts, after sex
keeps a person from getting HIV.
62. All pregnant women infected
with HIV will have babies born with
AIDS.
63. People who have been infected
with HIV quickly show signs of
being infected.
64. There is a vaccine that can stop
adults from getting HIV.
65. People are likely to get HIV by
deep kissing and putting their
tongue in their partner’s mouth, if
their partner has HIV.
66. A woman cannot get HIV if she
has sex during her period.
67. There is a female condom that
can help decrease a woman’s chance
of getting HIV.
68. A person will not get HIV if she
is taking antibiotics.
69. Having sex with more than one
partner or with someone who has
more than one partner can increase a person's chance of being infected with HIV.

70. Taking a test for HIV one week after having sex will tell a person if she or he has HIV.

71. A person can get HIV from oral sex.

72. Using Vaseline or baby oil with condoms lowers the chance of getting HIV.

<p>| Item Level Analysis: Pretest HLW and HIV 101 workshop |
|---------------------------------|----|----|--------|
| (Remaining questions) | Which workshop | Frequency | Mean | Standard Deviation |
| | | | | |
| participants identification | HLW | 96 | 163.8854 | 53.95102 |
| | HIV 101 | 80 | 254.7250 | 54.79674 |
| 1. birth month and year | HLW | 95 | AUG 1977 | JUL 1592 |
| | HIV 101 | 78 | OCT 1969 | MAY 1596 |
| 2. race | HLW | 96 | 1.2813 | 1.37422 |
| | HIV 101 | 80 | 1.2500 | 1.09660 |
| 3. Hispanic or Latina | HLW | 96 | 1.9479 | .26635 |
| | HIV 101 | 80 | 1.9500 | .21932 |
| 4. country of origin | HLW | 96 | 1.23 | 1.183 |
| | HIV 101 | 80 | 1.34 | 1.423 |
| 5. religion | HLW | 96 | 1.4479 | 1.62785 |
| | HIV 101 | 80 | 1.3875 | 1.40067 |
| 6. gender | HLW | 96 | 1.0313 | .22725 |
| | HIV 101 | 80 | 1.1875 | 1.24365 |
| 7. sexually attracted to | HLW | 96 | 1.9583 | .32173 |
| | HIV 101 | 80 | 1.8875 | .38954 |
| 8. best describes you | HLW | 96 | 1.4896 | .97327 |
| | HIV 101 | 80 | 1.9500 | 1.31110 |
| 9. children living | HLW | 96 | 1.5313 | .52220 |
| | HIV 101 | 80 | 1.4875 | .69344 |
| 9a. number of children | HLW | 96 | 1.0313 | 1.55904 |
| | HIV 101 | 80 | 1.3500 | 1.77250 |
| 9b. number of children live with | HLW | 95 | .6947 | 1.17667 |
| | HIV 101 | 80 | .7375 | 1.19856 |
| 9c. children live with full or part-time | HLW | 96 | .5625 | .70804 |
| | HIV 101 | 80 | .7625 | .79943 |
| 9d. single parent | HLW | 96 | .6771 | .87653 |
| | HIV 101 | 80 | .8750 | .97273 |
| 10. highest grade completed | HLW | 96 | 2.9792 | 1.45080 |
| | HIV 101 | 80 | 3.2375 | 1.40743 |
| 11. employment status | HLW | 96 | 3.5729 | 1.47787 |
| | HIV 101 | 80 | 3.7750 | 1.82788 |</p>
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150. sharing water spread
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151. pulling out keeps from spreading
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152. spread from anal sex
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153. washing privates keeps from spreading
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154. pregnant + women have + babies
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158. sex during period prevents spread
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159. female condom decreases spread
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162. test after sex tells infection
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163. spread from oral sex
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164. Vaseline lowers spreading
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165. bleeding when not on period
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166. STI go away alone
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167. STI through oral sex
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169. condom use impossible to get STI
### Item Level Analysis: Posttest HLW and HIV 101 workshop

(Remaining Questions)

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14. likely to use female condom
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   HLW 94 2.3191 1.85039

15. likely to use barrier
   HIV 101 80 2.6375 2.21756
   HLW 94 2.9787 2.09443

16. male condom every time
    HIV 101 80 3.3875 2.37867
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17. female condom every time
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non primary

18. dental dam non primary
    HIV 101 80 2.0250 2.01246
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19. male condom sex with
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    women

20. female condom sex with
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    women

21. dental dam sex with
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    women

22. hassle to use condoms
    HIV 101 80 1.3625 2.27948
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23. same pleasure from safer sex
    HIV 101 80 1.3375 1.84146
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24. Interrupts sex plan
    HIV 101 80 3.5625 1.55770
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25. proper use of condoms
    HIV 101 80 2.5500 1.55001
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26. Condoms are irritating
    HIV 101 80 3.6750 1.33857
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27. safer sex boring
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28. reduces mental pleasure
    HIV 101 80 4.0000 1.12509
    HLW 94 4.1809 0.93857

29. ruin natural feel of sex
    HIV 101 80 4.1750 .99078
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30. I am in favor of using
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31. interfere with romance
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32. sensory aspects
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33. give yourself over
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34. confident to put on condom
    HIV 101 80 3.1383 1.53526
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35. purchase condoms
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36. carry a condom
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