California State University, San Bernardino
CSUSB ScholarWorks

Electronic Theses, Projects, and Dissertations

Office of Graduate Studies

6-2014

Social Workers' Perception on HIV/AIDS and the Effects on Their Service Delivery

Elsa Rodriguez
California State University - San Bernardino, Rodre370@coyote.csusb.edu

O'Shonda McDowell
California State University - San Bernardino, mcdowelo@coyote.csusb.edu

Follow this and additional works at: http://scholarworks.lib.csusb.edu/etd

SOCIAL WORKERS' PERCEPTION ON HIV/ AIDS AND

THE EFFECTS ON THEIR SERVICE DELIVERY

_____

A Project

Presented to the

Faculty of

California State University,

San Bernardino

_____

In Partial Fulfillment

of the Requirements for the Degree

Master

of

Social Work

_____

by

Elsa Rodriguez

O'Shonda Renee McDowell

June 2014

SOCIAL WORKERS' PERCEPTION ON HIV/ AIDS AND

THE EFFECTS ON THEIR SERVICE DELIVERY

_____

A Project

Presented to the

Faculty of

California State University,
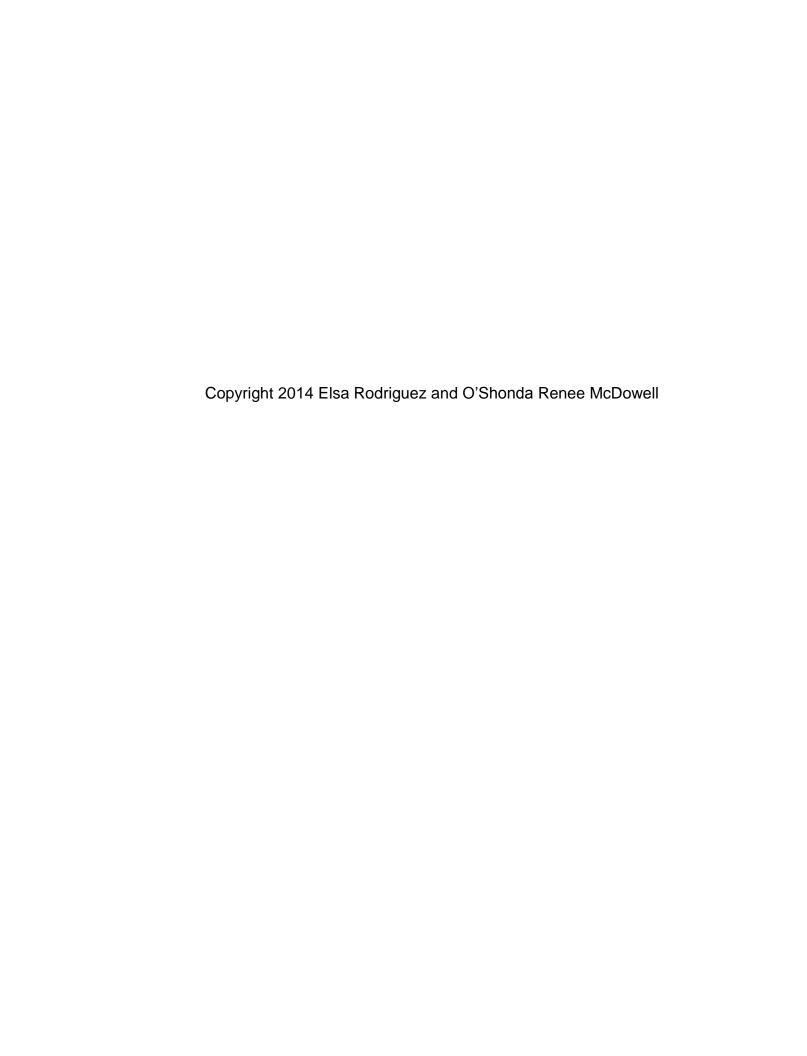
San Bernardino

_____

by

Elsa Rodriguez

O'Shonda Renee McDowell

June 2014

Approved by:

Dr. Janet C. Chang, MSW Research Advisor

Dr. Rosemary McCaslin, MSW Research Coordinator

ABSTRACT

This study explores the relationship between social workers' perceptions of the HIV (human immunodeficiency virus) /AIDS (acquired immune deficiency syndrome) population and the effects on their service delivery. This study used a quantitative online survey with a self-administered questionnaire. Data was collected for 60 social worker participants for this study. Participants were provided a postcard to a link of the questionnaire that surveyed participants' regarding demographics, general knowledge, knowledge about contracting HIV/AIDS, HIV/AIDS risk, and service delivery. Implications from the correlation coefficients identify a significant negative relationship between stigma and HIV/AIDS knowledge, suggesting that higher levels of stigma were present based on lower levels of HIV/AIDS knowledge. This study found that social workers were comfortable with PLWHA (people living with HIV/AIDS) and that social workers did not have strong levels of stigma towards PLWHA. A significant negative relationship between stigma and service delivery was found indicating that service delivery decreases based on the levels of stigma on behalf of the social worker. The findings of this study suggest further research and examination of social workers' perception of PLWHA due to underrepresentation of social workers perceived stigma. The study also suggests that social workers need to increase their knowledge about PLWHA and the need for additional cultural competency trainings.

ACKNOWLEDGMENTS

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

Problem Statement

Social workers have been continuously present and providing services to those directly and indirectly affected by HIV/AIDS. Over time, their roles and services have transformed significantly (Strug, Grube, & Beckerman, 2002). As time progressed along with medical advancements, social workers found themselves working with patients in need of medication, proper medical and mental health care, empowering them through their illness, and building a better quality of life (Strug, et al., 2002).

HIV/AIDS is a worldwide epidemic. Currently, there are more than one million people living with HIV/AIDS (PLWHA) in the United States alone (Sikkema, et al., 2010). HIV/AIDS is a critical social problem affecting many individuals around the world. Essentially, continuous research must take place in order to maintain the HIV/AIDS population in a state of precedence among other current social problems.

The history of HIV/AIDS plays a critical role in the way the infected population is portrayed. The most common modes of transmission are unsafe sexual practices and intravenous drug use. That being said, social workers often tie those risky behaviors to the patient and view them as deviant. In addition to that, during the outbreak, HIV/ AIDS critically impacted the gay community;

consequently, homophobic ideation may stimulate particular perceptions towards HIV/AIDS infected clients (Strug et al., 2002).

Although social workers are educated, trained, and serve under a code of ethics, this research explores the continuous bias that results from stigma among social workers and its possible effect on their service delivery towards the HIV/AIDS population.

The National Association of Social Workers' (NASW) Code of Ethics is an implemented ethical structure that is taught in social work education and emphasized in the workplace. It is a tool that social workers use as a foundation to establish effective service for those in need. The NASW Code of Ethics "summarizes broad ethical principles that reflect the profession's core values and establishes a set of specific ethical standards that should be used to guide social work practice" (NASW, 2008). The Code of Ethics consists of six core values: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence.

Purpose of the Study

The purpose of this study is to explore social workers' perceptions of the HIV/AIDS population and the effects on their service delivery. Social workers encompass diverse, professional settings, clinical backgrounds, and work in numerous settings such as private agencies, public agencies, and health care settings. Social workers provide social support in all professional settings to

individuals who are vulnerable and oppressed (NASW, 2008), and are subjected to a vulnerable state (Portillo, Holzemer, & Chou, 2007). Social workers, although trained under a code of ethics, are still capable of stigmatization, which in turn, can affect their service delivery.

Methods

This study was conducted through an online survey system known as Qualtrics. A random sample of social workers registered with the National Association of Social Workers (NASW) were selected and sent postcards with the link to the online survey. In addition, a snowball sampling method was utilized after unsuccessfully obtaining sufficient participants.

The survey includes a Likert-type scale that was be used with perception questions. These questions include a point scale that will provide a neutral value, such as "neither agree nor disagree". It will also include nominal questions (ex. age, gender, race, and region), and ordinal questions (e.g. years of experience in the social work field).

Stigma (independent variable) and service delivery (dependent variable) were tested and analyzed using univariate and bivariate analysis, percentages, frequencies, and t-tests.

The research hypotheses for this study are as follows:

1. There is no relationship between stigma and service delivery.

2. There is no relationship between stigma and knowledge of HIV/AIDS risk.

3. There is no relationship between stigma and knowledge of contracting HIV/AIDS.

4. There is not relationship between stigma and general knowledge of HIV/AIDS.

Significance of the Project for Social Work Practice

This study identifies social workers' perceptions and the effects on service delivery for patients who have been diagnosed with HIV/AIDS. The study is imperative to the social work profession as it helps determines the presence stigma continues to be present perceived by social workers toward PLWHA.

Contributions of the study are beneficial for social work practice, policy, and further research. This study will bring awareness to social workers, such as self-awareness of behaviors resulting from stigma and the obstacles that are in place and affect treatment, care, and prevention (Tomaszewiski, 2012). This study can further assist social work practice by requiring professionals to complete trainings and educational workshops that prepare social workers in servicing the HIV/AIDS population. This study contributes to the social work practice by emphasizing the continuous need for social workers to participate in

educational trainings. From that, they can develop greater awareness about their clients and the populations served; provide educational information to the community, work to dispel myths and stereotypes regarding PLWHA, and help social workers to be more culturally competent in practice with all clients (NASW, 2013).

HIV/AIDS and stigmatization from service providers remains an issue; many policies and coalitions encourage social workers to take political actions to advocate for PLWHA and promote anti-discrimination (NASW, n.d.). It is anticipated that the results of this study will help in developing policies by emphasizing that stigma is unethical and negatively affects the needs of PLWHA. Additionally, social work organizations signify the importance of respecting and advocating for PLWHA. The International Federation of Social Workers' (IFSW) policy on HIV/AIDS addresses the significance of having respectful partnerships with persons living with HIV/AIDS, and the social work profession's ongoing advocacy to reduce stigma (IFSW, 2012). The study will support and contribute to the policies of the NASW and the IFSW, by advocating for HIV/AIDS clients and their right to receive adequate services without discrimination.

Much of the previous research that has explored the stigmatization of PLWHA involves health care professionals; however, limited research has been conducted regarding perceptions of social workers towards PLWHA. By exploring the perceptions of social workers and the effects on service delivery, organizations and readers will be informed that stigmatization continues while

encouraging awareness and additional training for social work to improve their service delivery skills.

This particular study is favorable to all phases of the Social Work Generalist Model (Generalist Model phases of treatment: engagement, assessment, planning, implementation, evaluation, termination, and follow-up) being that negative perceptions can affect the client-social worker relationship throughout any phase of treatment. Above all, the engagement phase is the most fragile when dealing with negative perceptions. During engagement, the social worker aims at building sufficient rapport with the client in order to build a trustworthy relationship for effective services. If negative perceptions emerge from the social worker and the engagement phase is not fulfilled, services beyond that point may not be effective.

CHAPTER TWO

LITERATURE REVIEW

Introduction

The literature used provides valuable information on HIV/AIDS- related

stigmas. A brief history on AIDS and the outbreak provides insight on the way the

illness was viewed then and also how social workers' roles have changed over

time.

<u>Stigma</u>

Stigmatization is a complex phenomenon; it is a process in which an

individual or group is devalued by another. Stigmatization develops from the

Social Learning Theory. The theory suggests that people learn behaviors by

others that model (Bandura 1971). Stigma occurs when an individual or

individuals possess an undesirable difference. As a result, society devalues the

individual or group for possessing it. This may be due to the fact that minimal

research has been conducted on stereotyping and its effects rather than on the

definite structure that produces exclusion from both social and economic life

(Parker & Aggleton, 2003).

Goffman (2009) and his "Social Stigma Theory" states that "society

established methods of categorizing persons and the complement of attributes to

be ordinary and natural for members of each of these categories"(p. 2). Goffman

explained about how visual is our first insight to any stranger and we, as humans,

continue on to, unconsciously, categorize the stranger. Goffman also wrote "while the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable kind- in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one." (Goffman, 2009 pp. 2-3).

Considering this study explores social workers' perception on HIV/AIDS and for the purpose of this research, stigma is defined as "a form of behaviors, thoughts, and feelings that express prejudice against people living with HIV, and can also be experienced by persons perceived to be living with HIV/AIDS" (NASTAD, 2001).

It can be said that the unconscious categorizing that produces stigma is a learned behavior. According to Bandura's (1971) Social Learning Theory, new behaviors are acquired with direct experience or direct observation. Most of the behaviors that people exhibit are learned either intentionally or unintentionally. Influence and example are a main source of learning through everyday life. Complex behaviors are influenced through modeling. Observational learning consists of two representational systems: image and verbal. During exposure to modeling, stimuli are produced, and through the process of sensory conditioning, enduring and retrievable images on the learned behavior is produced. The verbal portion of Observational Learning is the most effective. Actions are traversed by a model, retained and then later reproduced by verbal coding (Bandura, 1971).

Literature on HIV/ AIDS stigma has tied stigmatization with emotional feelings such as anger. Anger leads people to believe that PLWHA deserve the illness, avoidance, and support for public policies that threaten their rights (Parker & Aggleton, 2003).

<u>Brief History</u>

A wave of AIDS incidents rapidly surfaced back in 1980 and 1981. AIDS was primarily being diagnosed among gay, white men. Its unknown methods of transmission and absence of medical intervention made the "gay-immune disorder", as it was then referred to, a complicated enigma for society. As time progressed, AIDS was also diagnosed among IV-drug users, their sex partners, heterosexual women, and their children (Strug et al., 2002). In 1984, however, it was discovered that AIDS was a development of a human retrovirus by the name of human immunodeficiency virus (HIV) (Strug, et al., 2002). Later, the use of zidovudine (AZT) was implemented by 1986 to conquer the AIDS epidemic. AZT implementation resulted in the extension of life of some people, which, in turn, lifted hopes for those affected by the epidemic. Unfortunately, cases of AZT resistance rose due to factors such as the stage of the virus and the duration of AZT therapy (Strug et al.).

Between 1986 and 1990, the number of AIDS diagnoses increased in African- Americans and the number of women that tested positive for HIV in the U.S heightened by 600 percent. By this time, cases in heterosexual contact had surpassed cases involving infection through to drug use (Strug et al., 2002).

Furthermore, highly stigmatized populations, such as the incarcerated, prostitutes, and the homeless had been highly affected by the virus. Lastly, in 1996, the introduction to protease inhibitors (PIs) collaborated with AZT and other transcriptase inhibitors resulting in what we know today as HAART (highly active antiretroviral therapy), the HIV medical cocktail. This resulted in mortality reduction and improved the quality of life for many of infected individuals. This shifted the label of AIDS as being a terminal illness over to being a chronic illness. Regardless of medications, there is still no cure for HIV/AIDS. HIV/AIDS medications work on suppressing the virus and are only being consumed by one third of the infected Americans. HIV/AIDS continues to spread among the population and more commonly among African-American and Hispanics (Strug et al., 2002).

Stigma and AIDS

Previously, AIDS was believed to be a transmittable, deadly disease that was transmitted between individuals who were closely associated with each other, such as cultural groups, shared sexual orientation, drug users, and commercial sex workers (Tomaszewiski, 2012). The precarious practices lead society to label AIDS as a taboo disease, thus creating stigma among the general public. Stigmatization and hostility that existed within the government lead to a slow response of federal and state actions to address the societal problem (Tomaszewiski, 2012). Social workers, within the population, had also been exposed to the HIV/AIDS stigmas. At the time when AIDS was an

understudied, fatal disease, social workers were focusing on servicing AIDS

patients and their surrounding support with grieving, loss, and coping skills

Social workers would also aid in the preparedness of advance directives and

wills to ensure that their valuables were properly distributed among the patient's

loved ones (Strug et al., 2002). In the past 30 years, however, AIDS knowledge

has increased as well as government response. Nevertheless, HIV/AIDS stigma

still remains (Tomaszewiski, 2012).

The number of HIV/AIDS cases has increased within communities of

color, the poor, and the LGBT community; all of whom are already experiencing

discrimination for their life characteristics. These hurdles contribute to the already

existing struggles that the common HIV/AIDS population experiences. Fear of

judgment, on behalf of the service provider, discourages HIV patients to seek

help (Li, Comulada, Zunyou, Yingying, & Weiming, 2011).

Evidence from studies conducted around the world have found stigma in

multiple healthcare settings by health care providers against PLWHA (Rutledge,

Whyte, Abell, Brown & Cesnales, 2011). Studies show that the stigma of PLWHA

is not only a domestic issue but also a global problem that has to be addressed.

Stigma from health care and social service providers' affects the level of service

that is provided to PLWHA; the stigma of HIV creates barriers in efforts of

prevention and treatment (Earnshaw & Chaudoir, 2009). By creating barriers

health care and social service providers cannot provide adequate services to

PLWHA, therefore they are not provided with best quality of service to meet their medical, emotional, financial, and physical needs (Earnshaw & Chaudoir, 2009).

Other literature focuses on attitudes and their correlation with misunderstandings and mis-education on modes of transmission and risks of infection According to Parker and Aggleton, (2003) in order to move past the barriers and current ways of thinking, critical reconstruction on discrimination and stigmatization is necessary to conceptualize them as processes that can only be dominated through education, and awareness. Stigma devalues individuals and places other groups into power, thus creating social inequality (Parker & Aggleton, 2003).

In the case of HIV/AIDS, whether true or false, people express their perceived ideations of the HIV/AIDS community and other people learn, take them on and believe what they have heard. Based on observational learning theory, people can visually acquire unjust treatment behaviors towards PLWHA.

Inequalities

Although inequalities have declined since the early years of the HIV/AIDS epidemic (Parker, 2002), inequalities persist. Inequalities experienced by HIV/AIDS individuals continue to persist as politically and socially problematic issues. In the more impoverished parts of the world, over 34 million people are receiving treatment for HIV, however, according to Smith (2013), it is estimated that over 7 million in the same locations of the world are not receiving care.

Disparities appear to exist in relation to poverty, limited access to medical care, ethnicity, and gender (Smith, 2013).

Health disparities and unequal access in the United States are areas of concern. In 2005, mortality rates of African-Americans infected with HIV/AIDS in the Unites States exceeded Whites by 29% (Rubin, Colen, &. Link, 2010). Braveman (2006) defines health inequality as the, "difference in which disadvantaged social groups, such as poor, racial ethnic minorities, women, or other groups who have persistently experiences social disadvantage or discrimination systematically have experienced worse health or greater health risk than the advantaged social group"(p.167). It is evident that HIV/AIDS has disproportionately impacted individuals and racial minorities. The lower socio-economic status of minorities correlates with limited access to health care, which results in increased mortality rates of minority individuals living with HIV/AIDS.

Unfortunately, individuals that have limited access to medical care are more likely to have a low socioeconomic status due to the fact they are unable to access the medical care that is needed for illness. Those who are more likely to experience prejudice and discrimination are those who lack access to resources (eg., money, knowledge, power, prestige, and social connections). They also will disproportionately profit from treatment (Rubin et al., 2010). People who have been diagnosed with HIV/AIDS; who have financial resources receive high quality health care and services compared to those who have limited health care and lack of financial resources. Although, treatment efficacy has reached new

heights with medical and treatment advances, theses disparities are below par and do not have a place in the 21st century (Smith, 2013). The disparities between socioeconomic status and care are not the only issues with HIV/AIDS, however there are race and gender inequalities that persist.

Researchers indicate there are higher rates of women contracting HIV/AIDS as opposed to men on an international level (Smith, 2013). In correlation to the disproportion of gender, race is disproportionate across different racial backgrounds; black men are diagnosed with HIV/AIDS at 7 times the rate of white men, and black women at twenty times the rate of white women (Center for Disease Control and Prevention, 2007). Among women, African Americans and Hispanics contribute to 80% of infection with a growing number of infections between girls, ages 13 to 19 (Miles, 2012. A study conducted a 33-year with data of individuals infected with HIV/AIDS in the years of 2001-2005. Findings indicated blacks were 13 percent of the population and accounted for 50.5 percent of all HIV/AID diagnoses. This was compared to Whites who were 72 percent of the population and accounted for 20.3 percent of all new HIV/AIDS diagnoses (Miles, 2012).

Poor Service

Disparities in service delivery of care received by PLWHA are determined by their location, sexuality, means of contraction, and the experience of health care providers (Reynolds, 2011). The demand for those with chronic HIV health services receives fearful or discriminatory attitudes of non-specialist health care

staff due to HIV-related stigma (Reynolds, 2011). Experts have emphasized that timely and adequate health care as well as social services are imperative to the quality of life of PLWHA (Motoya, Trevino, & Kreitz, 1999). Research indicates that patients who are infected with HIV/AIDS are aware of health care professional's stigma (Internalized stigma). These perceptions from health care professionals give less attention to the quality of service that are given to PLWHA. Most PLWHA experience internalized stigma which makes them feel shame regarding their diagnosis, therefore internalizing perception of stigma from health care provider's discrimination can most likely lead to a patient's desire to end treatment (Hasan et al., 2012). Results of studies have showed that internalized stigma might discourage PLHA from even seeking care (Hasan et al., 2012). Perceived discrimination affects the quality of treatment for patients that are diagnosed with HIV/AIDS (Schuster et al., 2005).

Service delivery is determined by how one contracted HIV/AIDS; findings report a difference in the level of care by health care workers who learn how an individual contracted HIV/AIDS. Men who identify as gay or bi-sexual and use intravenous drugs report poor services by doctors and nurses opposed to women who have contracted HIV/AIDS from being sex workers (Reidpath & Chan (2005). Service delivery is determined by the area in which one resides, poverty stricken areas are more likely to have limited resources for PLWHA, which causes individuals to receive inadequate services. However, urban areas are more likely to have resources and better services for PLWHA.

Unequal and inadequate service delivery for HIV/AIDS patients affects the patient's treatment (NASW, 2012). A research study was conducted to determine if HIV adults perceived discrimination in clinical health care settings. Findings indicated that patients can identify the stigmatized behavior and discrimination when receiving services from medical and social service providers (Schuster, et al., 2005). Patients reported that the perceptions' of stigma and discrimination from providers cause them to stop treatment, because they felt they were being judged and weren't provided the best service. Additionally, patients noticed that health care and service providers would stay distant from them patient when providing service, would not clarify questions, did not give direct eye contact, and/ or gave an "awkward" experience for the patients. The study signifies that unequal and inadequate services are detrimental to the patient's holistic wellbeing. Perceived discrimination in clinical settings discourages HIV-infected people from seeking health care, adhering to treatment regimens, or returning for follow-up (Schuster et al., 2005). The relationship between the service provider and patient with HIV/AIDS is beneficial and crucial during treatment unequal treatment will negatively impact PLWHA.

Training for Social Workers

According to research, the social work profession remains an untapped resource within the community for addressing HIV/AIDS prevention and early detection (Wolf & Mitchell, 2002). Wolf and Michell conducted a study for preparing social worker to address HIV prevention and detection. It investigates

social workers knowledge and practices relation to HIV prevention, education, risk assessment, and case management. Licensed Clinical Social Workers (LCSW) and social workers were found to have knowledge of HIV; social workers that directly work with HIV/AIDS patients were more aware of prevention, early detection, and treatment. However those that did not work directly with HIV/AIDS clients were unable to fully give details on prevention and treatment. Early training in education is proven to be significant in the social work practice because a social worker is unaware if they will have a client with HIV/AIDS.

The importance of enhancing education about universal precautions will reduce stigma and reduce the fears of transmission amongst healthcare workers and social service providers (NASW, n.d). Social workers should to be trained thoroughly in providing services to the HIV/AIDS population. With the proper training and education social workers will gain information on intervention that will broaden the competency on PLWHA.

Education is beneficial for social workers and is necessary when providing services to PLWHA to achieve adequate care and service delivery. According to the NASW, HIV/AIDS Spectrum (n.d.), there are "necessary practice skills on mental health, substance use, trauma, end-of-life care, ethics, long-term health impact of HIV/AIDS, and medication adherence to enhance and promote culturally competent practice with individuals, families, and communities affected by HIV/AIDS" (NASW, n.d.). Particular trainings are needed that directly focus on PLWHA due to the vulnerability of the population. Educational trainings,

workshops, and conferences will improve service delivery for PLWHA, and confirm that they will receive adequate qualities of service (Jacobson et al., 2012).

Strug et al. (2002) argue that social workers will be challenged as their roles change in working with PLWHA. Roles as social workers will continue to change while providing services to PLWHA, improved medication and health has extended the lives of those infected with the disease. However, improved medication cannot prevent the spread of HIV/AIDS, it will require awareness and action to prevent the spread of HIV/AIDS to individuals with at-risk behaviors. Social workers will always play a role in secondary prevention by helping PLWHA manage medications, promote well-being and health through education and counseling (Wheeler, 2000). The literature of the early 2000's informs social workers of the roles that they will play in the future; as of the present date social workers work with the HIV/AIDS family as well as the patient. Instead of prior trainings in early 2000's that taught social workers to provide services to gay men, drug users, and to prepare for death, rather social workers are teaching PLWHA to prepare for life with HIV/AIDS, providing service to HIV/AIDS patients of all ages, counseling, teaching coping skills, providing services to families, and mental services.

As social workers challenges and roles continue to change as medical advances, social workers will have to attain more knowledge about PLWHA (Strug et al., 2002). NASW Spectrum Project encourages social workers to

participate in trainings, workshops, and educational presentations to prepare

social workers to provide services to PLWHA and to inform social worker of

current updates in treatment. The goal of the Spectrum program is provide social

workers with necessary HIV and mental health practice skills, as well as

substance abuse fields to enhance and promote culturally competent practice

with individuals, families, and communities affected by HIV/AIDS (NASW, n.d.).

The findings indicate that increased trainings for providers on HIV can contribute

to successful outcomes (Jacobson et al., 2012). Trainings for social workers will

be both beneficial for the client and the social worker. The social worker will be

competent in services that are needed for the client and the client will benefit

from the services provided from a social worker that is educated, trained, and

competent to provide adequate services.

Summary

There is a reasonable amount of literature on the stigmatization of the

HIV/AIDS population. Literature on HIV/AIDS history helps in the understanding

the reasons why PLWHA are stigmatized and discriminated against. Its

controversial mode of transmission has raised perplexed feelings among those

living without the illness. The literature explains that Social Learning Theory and

the Social Stigma are foundations by which stigma is established. The literature

emphasizes the inequalities within stigma and how race and socioeconomic

status can affect ones access to medical care. Literature suggests that

perceptiveness on stigma, the framework, and education, may help alleviate

stigma within medical professionals.

CHAPTER THREE

METHODS

Introduction

This project focuses on gathering data from professional social workers and exploring the presence of stigma towards PLWHA. This project determines if stigma affects service delivery from social workers towards PLWHA. The information was gathered through an anonymous, 31 item questionnaire that was distributed using Qualtrics, a random sample of social workers provided by NASW, and snowball sampling. Data from 60 participants was entered into the Statistical Package for the Social Sciences (SPSS) and was then analyzed using univariate and bivariate analyses. Univariate analysis include the reporting of percentages and frequencies while bivariate analysis include a non-directional t-test and a Pearson R product-moment correlation test.

Study Design

The purpose of this research project was to explore social workers' perceptions of the HIV/AIDS population, to determine the presence of stigma, and its possible effect on service delivery. The quantitative research design allowed us to evaluate the social workers' attitudes towards PLWHA and to observe if their attitudes impact service delivery toward PLWHA. An exploratory

design was suitable for this study because there are few to no studies on the relationships of social workers and HIV/AIDS clients.

For the purposes of this study, stigma was defined as "a form of behaviors, thoughts, and feelings that express prejudice against people living with HIV (PLWHA), and can also be experienced by persons perceived to be living with HIV/AIDS" (NASTAD, 2001). Service delivery was defined as including the following variables: assisting clients with social support, willingness to provide treatment, willingness to pursue mental health interventions, and willingness to establish rapport. The variables were measured using five-point, Likert- type scales, dichotomous response questions (yes, no), and ratio responses for demographic questions.

Research Question

The research questionnaire was designed to explore stigma and the effects on the service being provided to the HIV/ AIDS population
The following hypotheses have been developed:
The research hypotheses for this study are as follows:

1. There is no relationship between stigma and service delivery.

2. There is no relationship between stigma and knowledge about HIV/AIDS risk.

3. There is no relationship between stigma and knowledge about contracting HIV/AIDS.

4. There is no relationship between stigma and general knowledge about HIV/AIDS.

Sampling

The targeted sample was of least 60 participants. With the help of the National Association of Social Workers (NASW), a list of registered social workers was obtained from San Bernardino County and Riverside County. A convenience sample was selected due to the large number of social worker participants needed. A snowball sample method was adopted later on in the data collection after the first method proved to be unsuccessful in gathering enough participants. Once utilizing the snowball sample method, we were able to gather exactly 60 responses. Participants who chose not to participate were not penalized, nor did they receive any benefits for completing the survey if they chose to participate.

Data Collection Instruments

A questionnaire composed of knowledge, attitudes, behavior scales, and demographic questions was derived from an existing questionnaire. The original questionnaire was composed of 142; however, some items were believed to be unfitting for this study and only 31 items out of the original inventory were utilized in this research. The questionnaire is composed of yes/no, five point Likert- type scales, and frequencies. Items on the questionnaire address knowledge on HIV

transmission and people's willingness to treat. This instrument has not been tested for validity and reliability. The NASW- California Chapter represents a large amount of social workers within the state; this provides a large sample pool and the anonymity of the questionnaire allows for sincere responses.

Procedures

The questionnaire was created online using Qualtrics. The link to the questionnaire will be provided on a postcard that will be sent via mail with use of the directory that will be provided by the NASW. Data was collected as participants complete the questionnaires. Data was only be accessible by the researchers with a password protected, online system. The data was extracted and placed into SPSS for analysis using univariate and bivariate analysis, percentages, frequencies, and t-tests. After research, analysis, and conclusions were drawn, the data gathered was destroyed.

Protection of Human Subjects

Individuals were studied for this research project; this was conducted by questioning participants via through self-administered online survey using Qualtrics. Researchers sent out postcard via United State Post Office to participants, that included a link from Qualtrics, and results received were not linked to any personally identifying information. Confidentiality and anonymity of individuals surveyed were protected. Prior to starting the questionnaire,

individuals were provided with the informed consent. Participants had the ability

to check a box on the questionnaire indicating that they agree or leave the box

unchecked to deny consent. If consent was denied participants were no longer

directed to continue the survey. Data collected was only accessible by the

researchers using a password protected, online system. Data gathered was

destroyed after conclusions were drawn.

Data Analysis

Quantitative procedures were used to conduct this research project. This

included a questionnaire that consists of eleven sections that will measure:

1. Clinical experience

2. Perceptions of risk

3. Perceptions about HIV/AIDS

4. Experience with people who have HIV/AIDS

5. Demographics of participants

Univariate analyses and bivariate analyses including a non-directional t-

test and Pearson R Product-Moment Correlation test were used for this study.

Univariate analyses were used to describe the demographics of our sample, i.e.,

the number of male and female respondents, age ranges, and types of social

workers (Licensed Clinical Social Worker, Associate Clinical Social Worker, or

Social Worker). Percentages about how many people had high levels of stigma

were reported. Bivariate analysis identified the relationship between the variables

of stigma (IV) and the following dependent variables (DV): assisting clients with social support, willingness to pursue mental health interventions, ability to experience empathy, ability to establish rapport, willingness to meet client needs, ability to discuss HIV/AIDS issues openly, ability/ willingness to learn about HIV/AIDS, willingness to provide treatment, and willingness to take additional training to learn more about serving the HIV/AIDS population using a Pearson R Product-Moment Correlation test.

The data was analyzed with the use of Statistical Package of Social Science (SPSS) to conduct the analyses. We then scored our survey to start calculating percentages and frequencies to explore social workers' level of stigma and see if there's a relationship between stigma and service delivery.

Summary

The evaluation of social workers' perceptions of HIV/AIDS and the effects on their quality of service with the HIV/AIDS population was conducted to examine the relationships between stigma and the level of service the PLWHA receive from social workers. Researchers maintained confidentiality and anonymity of participants; no harm was permitted for the research study. The study is a quantitative study in which a postcard with a link to the survey and be mailed to social workers who are members of the NASW. However, snowball was used after the failed number of participant in using the post card method.

Data was analyzed with the use SPSS to identify frequencies, percentages,

relationships between variables and differences between groups.

CHAPTER FOUR

RESULTS

Results

The sample (N = 60) was comprised of mostly females. The median age

was 34. Most of the sample included MSW students (N = 12). Forty percent of

the participants worked in mental health agencies while 35 percent work in Child

welfare agencies. Most of the participants had been in practice for two years

with the longest in practice for 29 years. Nearly 47 percent of the participants

were Caucasian and 33% were Hispanics. Over 28% of the participants were

married. Most of the participants were raised Catholic; however, in reporting

their current religious affiliation 23% reported identifying as Agnostic/Atheist (See

all Tables in Appendix A).

Table 2 presents responses to questions regarding the participants'

knowledge on the contraction of HIV/AIDS. These items were asked in with a

true/false option. The majority of the participants are aware that safe sex

practices such as using a condom can reduce the spread of HIV (98.3%). The

majority of the participnts are aware that high levels of promiscuity can increase

the chances of contracting HIV (95%).

Table 3 presents questions regarding social workers' perception on

HIV/AIDS risk. These questions were measured on a five point, Likert-type scale

(No Risk- Very High Risk). The majority of the participants believed that there is a

moderate risk in being bitten by a mosquito that has AIDS (M= 3.14); however, the current answer is no risk.

Table 4 presents the majority of the responses to questions regarding the participants' willingness to provide services to those living with HIV/AIDS. These questions were measured on a five point, Likert-type scale (Strongly Agree- Strongly Disagree). The majority of the participants strongly disagree with the statement, "Treating people with AIDS is unpleasant because they will always die" (M= 3.95). Below that, the majority of the participants do not feel it is difficult to care for HIV clients based on their uncertainty on how to pursue interventions (M= 3.37).

Table 5 presents the responses to questions related to social workers' general knowledge on HIV/AIDS. These questions were measured on a five point, Likert-type scale (Strongly Agree- Strongly Disagree). The majority of the participants were fairly informed when it came to the effects that AIDS has on the brain (M= 2.65). On the other hand, the majority of the participants are not well informed about the time in which HIV appears on the body. The majority somewhat agreed with the statement, "Symptoms of HIV will usually appear within 12-24 hours after being infected" (M= 1.95).

Table 6 presents the findings on questions regarding social workers' perceptions of HIV/AIDS. These questions were measured on a five point, Likert-type scale (Strongly Agree- Strongly Disagree). The majority of the participants feel that AIDS is not getting much attention (M= 4.34) and if given a choice, they

would work with AIDS clients (M= 4.20). A majority of the participants felt strongly about not separating people living with HIV/AIDS from the general public (M= 4.5). On the other hand, a majority of the participants did not feel comfortable with their clients knowing that they service HIV/AIDS clients (M= 2.4).

The independent variable of the study, stigma, was comprised of the stigma variables and all these variables were added to calculate total score (Q9.6- Q9.8 & Q9.11). The minimum score obtained was 10, the maximum was 20. The average score was 16.69 (M = 16.69, Std. Dev. = 2.9). The comprised scores for the dependent variables, service delivery, risk, and general level of knowledge, were used to assess relationships with the independent variable, stigma.

A Pearson r product-moment correlation coefficient was conducted to assess the relationship between stigma and service delivery. The findings were statistically significant, r (58) = .57, p < .01, participating with a higher level of perceived stigma; and people living with HIV/AIDS were likely to provide ineffective service delivery than those with lower levels of perceived stigma against persons with HIV/AIDS.

Another Pearson correlation coefficient was conducted to see a relationship between stigma and risk. The findings were statistically significant, r(58) = -.35, p < .01, contributing with a higher level of perceived stigma; and people living with HIV/AIDS were likely to provide ineffective service delivery than those with lower level of perceived stigma against persons living with HIV/AIDS.

An additional Pearson correlation was conducted to evaluate the relationship between stigma and contracting. The findings implied that they are statistically significant , $r(58) = .44$, p < .01, participating with a higher level of perceived stigma; and people living with HIV/AIDS were likely to provide ineffective service delivery compared to those with a lower level of perceived stigma against those living with HIV/AIDS.

Finally, a Pearson correlation coefficient was conducted to examine the relationship between stigma and general knowledge of HIV/AIDS. The findings were statistically significant, $r(58) = .44$, p < .01, indicating with increased level of perceived stigma and persons living with HIV/AIDS were likely to provide inefficient service delivery than those with lower levels of perceived stigma against those living with HIV/AIDS.

CHAPTER FIVE

DISCUSSION

Introduction

The research conducted to explore social workers' perception on HIV/AIDS and their service delivery resulted in three significant findings: social workers are fairly comfortable with servicing people living with HIV/AIDS (PLWHA), social workers do not hold significant amounts of stigma towards PLWHA, and lastly, that there is a negative relationship between stigma and service delivery. All four of the hypothesis resulted in being unsupported. Previous research conducted on stigma- associated attitudes in 2012 support the findings of our study. Recommendations include further research on HIV/AIDS perceptions on the social work field, awareness on behalf of social workers on the needs of the HIV/AIDS population, and additional cultural competency trainings supported by social work policy.

Discussion

This study found that social workers in the study were willing to provide services to people living with HIV/AIDS. The majority of the participants did not feel that servicing people living with HIV/AIDS was unpleasant due of their high rate of mortality. In addition to that, the majority of the participants also reported

minimal difficulty in servicing PLWHA based on their uncertainty on how to pursue interventions.

These findings were consistent with previous research conducted on social workers' willingness to provide services. A previous study examined social workers' level of comfort of providing services to people living with AIDS. The results of this study found that social workers experienced feelings of compassion and sensitivity towards the needs of the AIDS client population. Further, factors such as background characteristics, knowledge about the disease, homophobia, and negative attitudes towards PLWHA were found associated with the social workers' comfort in servicing people living with AIDS (Wiener& Siegel, 1990).

The study revealed that the majority of the participants felt that AIDS was not getting too much attention from the mental health field, and if given a choice, they would work with AIDS clients. In addition, a fair amount of the participants felt strongly about not legally separating people living with HIV/AIDS from the general public.

There is minimal research on social workers and levels of HIV/AIDS-related stigma. Moreover, there is minimal research conducted on service provider HIV/AIDS-related stigma in the United States. Nevertheless, there are few international studies that measure HIV/AIDS related stigma on behalf of health care providers. Specifically, in 2009, a study conducted in China explored HIV/AIDS related stigma among health care providers from multiple health care

facilities (Wen, Wu, Lin, Li & Liang, 2009). Results showed that the majority of the providers demonstrated similarities between their personal views on HIV/AIDS and their attitudes towards HIV/AIDS when in a practice setting. Notably, the younger the healthcare providers were, the more likely they were to have higher liberal views about HIV/AIDS. Although the participants in that study were from the health care field rather than the social work field, they were both considered service providers and were actively in contact with the populations that they serve. The study conducted in China among medical professionals neither rejects or supports this study. Nevertheless, it is substantial to the research on stigma in the social service realm (Wen et al., 2009).

This study found that there was a negative relationship between participants' perception of stigma and service delivery. Participants with lower levels of stigma towards people living with HIV/AIDS were more likely to provide effective service delivery that those with higher levels of stigma. This is congruent to what a previous study found in 2007 (Padmore, McCann, Rutledge & Abell, 2007), which indicated that the providers whose roles were more likely to involve physical contact were more likely to engage in discriminatory behavior. More specifically, people with the ability to council, such as social service providers, reported higher levels of comfort and reduced discriminative behavior.

The results of this research have found that there is a significant negative relationship between stigma and service delivery. This outcome explains that as

the level of stigma increases, the level of service delivery decreases; thus making the first hypothesis unsupported.

The results of this research have found that there is a significant negative relationship between stigma and knowledge of HIV/AIDS risk. The outcome explains that as the level of stigma increases, the level of HIV/AIDS risk knowledge decreases. This outcome results in the second hypothesis being unsupported.

The results of this research have found that there is a significant negative relationship between stigma and knowledge of HIV/AIDS contraction. This outcome signifies that as the level of stigma increases, the level of knowledge for HIV/AIDS contraction modalities decreases. This results in the third hypothesis being unsupported.

The results of the research have found that there is a significant negative relationship between stigma and general knowledge of HIV/AIDS. The significance of this outcome explains that as the level of stigma increases, the level of general HIV/AIDS knowledge decreases. This results in the fourth hypothesis being unsupported.

The results of this study are backed by a previous study in which participants were tested for stigma-associated attitudes back in 2012 (Lifson, et al, 2012). In that study, 561 participants were randomly selected and participated in a survey that explored stigma- associated attitudes about people living with HIV/AIDS. The results revealed that more 80 percent of the participants held

negative perceptions about people living with HIV/AIDS. In addition to that, multivariate analysis revealed that there were significant relationships between stigma and lack of knowledge about prenatal transmission; stigma and knowledge about how HIV is not transmitted; stigma and lack of knowledge about HIV treatment (Lifson, et al, 2012).

Limitations

Limitations for this study include a small sample size and a narrow data collection time frame. Additional data collection time would have allowed for larger sample size and greater participant representation. The small sample size compromised the generalizability of the findings of this study. Another limitation includes the narrowing of the original 142 item questionnaire down to 31 items used; as a result, the validity and the reliability of the instrument used were compromised.

The most challenging limitation occurred in the attempt to gather sufficient participants for the study. Three hundred postcards containing the link to the survey were sent out to social workers registered with the National Association of Social Workers (NASW) via post office. The gathering of participants proved to be unsuccessful with a response rate lower than 15 percent. A Snowball Sample Method was then adapted to collect additional participants; as a result, the number of participants was compromised. Providing participants with convenient

access to the survey, such as via email) would have increased the sample number and allowed for more generalizability.

Implications for Future Research, Social Work Practice, and Policy

From the results of this study, we recommend that social workers work towards educating themselves about HIV/AIDS, PLWHA, and their needs. Social workers need to be competent in the resources that are needed for the PLWHA. Curriculum for student in the social work practices should include HIV/AIDS courses. Social workers should receive more trainings, webinars, and seminars regarding providing services to PLWHA. This will benefit in the decrease of stigma and improve the delivery of service. Social workers should be required to receive training on practice skills in HIV/AIDS and mental health. Also, social workers should be evaluated on their level of service provided to PWLHA to identify and improve services.

From results of the study, we recommend that policies are needed to advocate for PLWHA. Social work policies should require all social workers to obtain a set amount of HIV/AIDS trainings. Cultural competency is very important in social work policy, as social workers should be competent since they provide services to diverse populations with different diagnosis. Social workers need to advocate to for PLWHA to reduce health disparities, and participate in the prevention of HIV/AIDS.

It is recommended that future instruments used to explore social workers' perception of HIV/AIDS should be tested for reliability and validity to provide sound findings. It is also suggested that further research on social workers' perception of HIV/ AIDS acquire larger samples in order to provide accurate, generalizable results.

This study is an addition to the limited existing research on social workers' perception on people living with HIV/AIDS. The result of this research can be used towards advocacy towards increased AIDS education for social workers and for the promotion of an increase in cultural competency trainings.

Conclusion

This study was conducted to investigate social workers' perception on HIV/AIDS and their service delivery. Significant findings of the study conclude: social workers are fairly comfortable with servicing PLWHA; social workers do not hold significant amounts of stigma towards PLWHA; and a significant negative relationship between stigma and service delivery. Researchers suggest further research and examination of social workers' perception of PLWHA due to underrepresentation of social workers perceived stigma. Researchers also suggest that social workers should increase their knowledge about PLWHA, their needs, and cultural competency trainings supported by social work policy.

APPENDIX A

TABLES

Table 1: Demographics of the participants

Variables	N	Percentage	Mean	Std. Deviation
Gender	59			
Male	10	16.7		
Female	49	81.7		
Age	58	96.7	36.93	10.874
Ethnic Origin	60	100.0		
Hispanic	20	33.3		
Caucasian	28	46.7		
African American	6	10.0		
Asian	3	5.0		
Other	3	5.0		
Marital Status	60			
Married	24	40.0		
Married but separated	2	3.3		
Single, living with significant other	6	10.0		
Single, living alone	20	33.3		
Divorced	5	8.3		
Widowed	2	3.3		
Domestic Partnership	1	1.7		
Past Religion	56			
Atheist/Agnostic	7	23.3		
Catholic	17	16.7		

Protestant	16	25.0		
Fundamental Christian	7	13.3		
Other	9	15.0		
Present Religion	56			
Atheist/Agnostic	14	23.3		
Catholic	10	16.7		
Protestant	15	25.0		
Fundamental Christian	8	13.3		
Other	0	15.0		
Years of Clinical Experience	55	91.7	4.82	6.293

Table 2: HIV/AIDS Contraction Questions

Item	Frequency *(f)*	Percentage (%)
7.1 I believe you can get HIV from donating blood.		
True	10	16.7
False	50	43.3
7.2 I believe that if you sit on the same toilet seat as someone w/AIDS you can get the disease		
True	4	6.8
False	55	93.2
7.3 Receiving a transfusion, w/ blood infected by HIV virus is a way to get the disease		
True	57	95
False	3	5
7.7 If you French kiss someone w/ HIV. You will get the disease		
True	8	13.3
False	52	86.7
7.8 I believe that if a person w/ AIDS is bitten by a mosquito it is possible to get AIDS of that same insect bites you		
True	20	33.3
False	40	66.7
7.9 Using a condom during sexual intercourse can reduce the spread of HIV infections		
True	59	98.3
False	1	1.7
7.10 You can increase the chance of getting HIV by having sexual intercourse w/ many different people		
True	57	95
False	3	5

Table 3: Risk Questions

Item	Mean	Std. Deviation
6.1 Risk of becoming infected with HIV if I do not treat AIDS infected clients	1.41	.673
6.2 Risk of being infected w/ HIV if I do not treat HIV-infected clients	1.66	.734
6.3 Interacting w/ a coworker living w/ HIV	1.59	.673
6.6 Being bitten by a person who has AIDS	3.14	1.191

Table 4: Service Delivery Questions

Item	Mean	Std. Deviation
9.1 I feel confident in managing the social supports needs of persons w/ HIV infection	2.40	1.028
9.3 I am comfortable w/ the degree of emotional involvement I have w/ HIV infect clients	3.37	1.104
9.4 I enjoy the relationship I established w/ AIDS clients	2.43	.963
9.5 Treating people w/ AIDS is unpleasant because they will always die	2.18	.965
9.5 Treating people w/ AIDS is unpleasant because they will always die	3.95	1.111

Table 5: General knowledge questions

Item	Mean	Std. Deviation
7.4 AIDS is a disease that destroys the body's natural immunity against infection	1.05	.220
7.5 AIDS is cause by a virus	1.08	.279
7.6 Symptoms of HIV will usually appear within 12-24 hrs after being infected	1.95	.220
9.9 I think that a person can be infected by HIV and not have AIDS	1.62	1.043
9.10 AIDS can damage the brain	2.65	1.246

Table 6: Stigma questions

Item	Mean	Std. Deviation
9.6 I think AIDS is getting too much attention from the mental health field	4.34	.958
9.7 If you have a choice, I will not work w/ AIDS clients	4.20	1.005
9.8 I would be comfortable if my other clients knew I was servicing people w/ infections	2.40	1.265
9.11 People w/ AIDS should be legally separated to protect the public health	4.47	1.120

Table 7: Relationship between independent variable stigma and dependent variables: device delivery, risk, contracting, and general

Variables	*Stigma*	*r*	*p*
Service Delivery		.572	*P <.01*
Risk		-.353	*P <.01*
Contracting		.438	*P <.01*
General		.400	*P <.01*

All tables created by Elsa Rodriguez and O'Shonda Renee McDowell, 2014

APPENDIX B

INFORMED CONSENT

College of Social and Behavioral Sciences
School of Social Work

Informed Consent

The study in which you are being asked to participate is designed to explore social workers' perception on HIV/AIDS and its effects on service delivery. This study is being conducted by MSW Students, Elsa Rodriguez and O'Shonda McDowell. This study has been approved by the School of Social Work Sub Committee of the ~~International~~ Review Board, California State University, San Bernardino. *Institutional*

Purpose: The Purpose of this study is to explore social workers' perceptions on HIV/AIDS and the effect on their service delivery.

Description: Areas in the questionnaire aim to explore experience, perceptions of risk, beliefs about contracting HIV /AIDS.

Participation: Your participation in this study is voluntary. Refusal to participate will not result in any penalty. There is no penalty for withdrawing from the study if you choose to exit the questionnaire at any point.

Confidentiality: This study is completely confidential. Although your mailing address was provided for the purpose of delivering the hyperlink to the questionnaire, there is no knowledge of your identity post-delivery. The same hyperlink was provided to all participants and there is no personal record on the individuals that participated.

Risks: There are not foreseeable risks to the participants.

Benefits: There will not be any direct benefits to the participants.

Duration: The estimated time to complete the questionnaire is 10 minutes.

Contact: If you have any questions regarding the research or your rights as a participant, please contact Janet C. Chang at **(909)537-5184 or jchang@bsusb.edu.**

Results: The results for this study will be located at the CSUSB Library after December 2014.

By clicking on the confirm button below, I am agreeing to participate in your study and have read and understand the consent document and agree to participate in your study.

909.537.5501
5500 UNIVERSITY PARKWAY, SAN BERNARDINO, CA 92407-2393

The California State University · Bakersfield · Channel Islands · Chico · Dominguez Hills · East Bay · Fresno · Fullerton · Humboldt · Long Beach · Los Angeles
Maritime Academy · Monterey Bay · Northridge · Pomona · Sacramento · San Bernardino · San Diego · San Francisco · San Jose · San Luis Obispo · San Marcos · Sonoma · Stanislaus

REFERENCES

Bandura, A. (1971). Social learning theory. New York: General Learning Press.

Braveman, P. (2006). Health disparities and health equity: Concepts and

measurement. *Annual Review of Public Health, 27,* 167-194.

Center for Disease Control and Prevention (2007). *HIV/AIDS surveillance report:*

Cases of HIV and AIDS in the United States and department areas.

Retrieved from

http://www.cdc.gov/HIV/pdf/statistics_2007_HIV_Surveillance_Report_vol

_19.pdf

Earnshaw, V., & Chaudoir, S. (2009). From conceptualizing to measuring HIV

stigma: A review of HIV stigma mechanism measures. *AIDS and*

Behavior, *13*(6), 1160- 1177.

Goffman, E. (2009). *Stigma notes on the management of spoiled identity*. (pp. 1-

2). New York, NY: Simon and Shuster.

Hasan, M., Nath, S., Khan, N., Akram, O., Gomes, T., & Rashid, S.F. (2012).

Internalized HIV/AIDS-related stigma in a sample of HIV-positive people in

Bangladesh. *Journal of Health, Population, and Nutrition*, *30*(1), 22-30.

International Federation of Social Workers (2012). *Statement of Ethical*

Principles. Retrieved from http://ifsw.org/policies

Jacobson, K., Wong, A., Espinoza, L., Ryu, J., Chacko, R., & Gates, J.D. (2012). Developing the HIV workforce: A case study of a training model for inexperienced HIV providers. *Journal of Health Care for the Poor and Underserved, 23*(4), 1502-1511.

Li, L., Comulada, S. W., Zunyou, W., Yingying, D., & Weiming, Z. (2011). Provider's HIV-related avoidance attitude and patient satisfaction. *Health Expectations, 16*, 105-112. doi: 10.1111/j.1369- 7625.2011.00705.x

Miles, T. (2012). *Minority HIV Rates, Inequality, and the Politics of AIDS Funding.* n.p.: ProQuest, UMI Dissertations Publishing.

National Association of Social Work (n.d). *Nasw HIV/AIDS spectrum: Mental health training and education of social worker project.* Retrieved from http://www.naswdc.org/practice/HIV_AIDS/

National Association of Social Work (2002). *HIV/AIDS stigma: Making the connection to discrimination and prejudice.* Retrieved from www.socialworkers.org/practice/HIVAIDS/AIDS_Day2002.pdf

National Association of Social Work (2008). *Code of ethics of the national association of social worker.* Retrieved from https://www.socialworkers.org/pubs/code/code.asp

Padmore, J., McCann, T., Rutledge, E., & Abell, N. (2007). Examining HIV/AIDS provider stigma: Assessing regional concerns in the islands of the Eastern Caribbean. *AIDS Care, 19*, 242-247.

Parker, R. (2002). The global HIV/AIDS pandemic, structural inequalities, and the politics of international health. *American Journal of Public Health*, *92*(3), 343- 346.

Parker, R., & Aggleton, P. (2003). HIV and AIDS- related stigma and discrimination: A conceptual framework and implications for action. *Social Science & Medicine*, *57*, 13-24.

Portillo, C., Holzemer, W., & Chou, F. (2007). HIV symptoms. *Annual Review of Nursing Research*, *25*, 259.

Reidpath, D., & Chan, K. (2005). A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care*, *17*(4), 425-432.

Reynolds, L. (2011). HIV as a chronic disease: Considerations for service planning in resource-poor settings. *Globalization and Health*, *7*(1), 35.

Rubin, M., Colen, C., & Link, B. (2010). Examination of inequalities in HIV/AIDS mortality in the united states from a fundamental cause perspective. *American Journal of Public Health, 100* (6), 1053-1059.

Rutledge, S., Whyte, J., Abell, N., Brown, K., & Cesnales, N. (2011). Measuring stigma among health care and social service providers: The HIV/AIDS provider stigma inventory. *AIDS Patient Care and Standards*, *25*(11), 673-682.

Schuster, M., Collins, R., Cunningham, W., Morton, S., Zierler, S. Wong, M., ...

 Kanouse, D.E. (2005). Perceived discrimination in clinical care in a

 nationally representative sample of HIV-infected adults receiving health

 care. *Journal of General Internal Medicine*, *20*(9), 807-813.

Sikkema, K., Watt, M., Drabkin, A., Meade, C., Hansen, N., & Pence, B.W.

 (2010). Mental health treatment to reduce HIV transmission risk behavior:

 A positive prevention model. *AIDS and Behavior*, *14*(2), 252-262.

Smith, M. (2013). The end of HIV? The cure demands social change (social

 inequality). *Harvard International Review*, *34*(4), 6-7.

Strug, D., Grube, B., & Beckerman, N. (2002). Challenges and changing roles in

 HIV/AIDS social work: Implications for training and education. *Social Work

 in Health Care*, *35*(4), 1-19.

Tomaszewiski, E. P. (2012). Understanding HIV/AIDS stigma and discrimination.

 Retrieved from http://www.socialworkers.org

Wen, Y., Wu, Z., Lin, C., Li, L., & Liang, L. (2009). Individual attitudes and

 perceived social norms: Reports on HIV/AIDS-related stigma among

 service providers in China. *International Journal of Psychology*, *44*, 443-

 450.

Wheeler, D. P. (2000). HIV/AIDS prevention. In V. J. Lynch (ed.), HIV/AIDS at

 year 2000: A sourcebook for social workers (pp. 188-196). Boston: Allyn

 and Bacon.

Wiener, L., & Siegel, K. (1990). Social workers' comfort in providing services to

      AIDS patients. *Social Work*, *35*, 18-25. Retrieved May 5, 2014, from

      http://sw.oxfordjournals.org/content/35/1/18.full.pdf+html

Wolf, M., & Mitchell, C. (2002). Preparing social workers to address HIV/AIDS

      prevention and detection: Implications for professional training and

      education. *Journal of Community Health*, *27*(3), 165-180. Retrieved from

      http://www.naswdc.org/practice/HIV_AIDS/

RESPONSIBILITIES

Title Pages- Elsa Rodriguez

Abstract- O'Shonda McDowell

Acknowledgements- Elsa Rodriguez

Chapter One- Elsa Rodriguez & O'Shonda McDowell

Chapter Two- Elsa Rodriguez & O'Shonda McDowell

Chapter Three- Elsa Rodriguez & O'Shonda McDowell

Chapter Four - Elsa Rodriguez & O'Shonda McDowell

Chapter Five- Elsa Rodriguez

References- Elsa Rodriguez & O'Shonda McDowell

Appendix A- O'Shonda McDowell