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KNOWLEDGE AND ATTITUDES OF BLACK ELDERS REGARDING AIDS

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ABSTRACT

KNOWLEDGE AND ATTITUDES OF BLACK ELDERS REGARDING AIDS

by Deborah Summers-Collins

This study assessed the knowledge, attitudes, and beliefs of Black elders, participating in one organization's senior program regarding AIDS. The study also assessed the elders' willingness to function as AIDS educators. Face-to-face interviews, using a modified version of the AIDS Information Survey as an interview guide, were conducted at the site of the seniors' program. This group demonstrated a high awareness of the primary risk factors associated with HIV infection. A need for education clarifying the cause of AIDS, its incurability, and how it is and is not transmitted or prevented was evident. The vast majority expressed a willingness to function as AIDS educators within their circle of family and friends. Finally, this study also explored the feasibility of using the Black oral tradition as a culture specific educational tool which could be utilized by Black elders to educate their family and friends.

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TABLE OF CONTENTS

Chapter 1

INTRODUCTION

The human immunodeficiency virus (HIV) causes acquired immunodeficiency syndrome (AIDS) and AIDS related conditions (ARC) (Chaisson, 1987). HIV incapacitates the immune system, allowing ordinarily controllable opportunistic flora to flourish, ultimately killing the host. AIDS is incurable, and the proportion of persons infected who will ultimately develop AIDS is unknown. Estimates are that over 95% will develop AIDS within 10 years. The mean latency period between infection and development of AIDS varies according to the exposure category. In the case of transfusion-related infection, the mean latency period is approximately 24 months in children, aged 5 or less, and 8.23 years for persons between the ages of 5 and 59 (Curran et al., 1988). The mean latency period for homosexual/bisexual men is 11.8 years (Lemp et al., 1990).

The largest AIDS/HIV transmission group within the Black community is comprised of homo/bisexual, nonintravenous drug using men. The second highest transmission group for Blacks consists of male heterosexual intravenous drug users (IVDUs). Within any population, the best predictor of the total number of AIDS cases among women is the number of male, heterosexual IVDU cases (Blakeman & McCray, 1987). In one study, the Pearson product-moment coefficient of correlation between female cases and male heterosexual IVDU cases was .951 (Blakeman & McCray, 1987). The major route of transmission to children is perinatally, so any factor accounting for AIDS in women will also be responsible for AIDS in children. Black women of childbearing age and their children have been cited as one of the groups most often documented with diagnoses of HIV

infection or AIDS, usually attributable to exposure to intravenous drugs (Gayle, Selik, & Chu, 1990). Thus, AIDS/HIV infection within the Black community is a family concern which could have "domino effect" implications for the entire community unless the chain is broken.

The National Center for Nursing Research (NCNR, 1990) cited, as a high priority HIV research area, the exigency to "describe the influence of family dynamics and social, cultural, and geographic differences on the need for health-care services" (p. 6). In an effort to follow a research priority set for the profession, this study examined the influence of family dynamics and socio-cultural issues upon AIDS/HIV knowledge and education within the Black community.

Aged Blacks within the Black culture have traditionally been responsible for maintaining the health of their own families. Traditionally, they have fulfilled this responsibility by functioning as advisors, cultural leaders, and health providers. Due to this history, and because of the present ethnographic characteristics of the Black community, as well as the epidemiologic characteristics of AIDS/HIV infection in the Black community, this study assessed if Black elders could be instrumental in an educational endeavor to limit the spread of HIV infection within this community. The study also questioned whether Black elders are willing to function as community AIDS educators.

Problem

HIV disease is infecting and killing Blacks at an alarming rate, and there is no cure. Education regarding the origin, transmission, and prevention of HIV infection to produce behavioral changes is the only means of combating the disease, and public health education has not produced desired results in the Black community. Cultural factors may have influenced how people in the Black community interpreted AIDS information presented to them by health

professionals. Also, a more culture specific approach to HIV/AIDS education in the Black community might result in behavioral changes which would curtail the rate of HIV infection. One such culture specific approach could involve Black elders in the role of health educators.

Research Questions

This study sought information about the following questions:

1. What are the current knowledge and attitudes of Black elders regarding AIDS?

2. Do Black elders express a willingness to function as AIDS educators?

Definition of Terms

For this study, the following definitions apply:

1. Elderly Black Americans are persons of the Negro race, aged 65 years and older, with cultural origins emanating from Africa who most likely are the descendants of American slaves, and are citizens of the United States.

2. Acquired Immune Deficiency Syndrome (AIDS) "is a disabling or life-threatening illness caused by human immunodeficiency virus (HIV) and characterized by HIV encephalopathy, HIV wasting syndrome, or certain diseases due to immunodeficiency in a person with laboratory evidence for HIV infection or without certain other causes of immunodeficiency" (NCNR, 1990, p. 1).

3. Knowledge refers to the range of one's information or understanding of AIDS/HIV infection as measured by the modified version of the AIDS Information Survey (Appendix A).

4. Attitude refers to a feeling or emotion toward AIDS as measured by the modified version of the AIDS Information Survey.

5. Belief refers to a state or habit of mind in which one's trust or confidence is placed in one's knowledge of AIDS as measured by the modified version of the AIDS Information Survey.

Setting and Sample Population

The sample was composed of Black persons, both male and female, aged 65 and older, born in the United States who were active participants in one Black community in the western United States. Convenience sampling was utilized to obtain the subjects from a community group.

Research Design

The design of the study was exploratory. There was no randomization of participants, and no controls were placed on the knowledge base or attitudes of the participants. Age, race, and birth country were the only controlled variables. Each Black elder was interviewed using a guide based upon a modified version of DiClemente, Boyer, and Morales' (1988) AIDS Information Survey (Appendix B), which was designed to assess knowledge, attitudes, and beliefs about HIV infection. Permission to use and modify the AIDS Information Survey was obtained from the author (see Appendix C). The questionnaire also elicited information regarding demographics and family interactions. Participation was voluntary, and confidentiality was maintained. Data were summarized by frequency count, percentage of responses, and a summary of the respondents' answers.

The AIDS Information Survey is comprised of three subscales: (a) Knowledge Scale of AIDS, (b) Misconception Scale of Casual Contagion (MSCC), and (c) Scale of Perceived Susceptibility (SPS). Each item of each subscale has a point value of 1. The Knowledge Scale contains 28 items. Knowledge is measured by summing up the correct responses for each of the 28 items, yielding

a summary score. A score of 28 indicates a high level of AIDS knowledge, and a score of 0 indicates no knowledge of AIDS. The MSCC includes six items. The sum of all incorrect responses to those statements reflects the subject's inaccurate attribution of disease transmission by casual contact. A score of 6 on this scale implies that the respondent has no misconceptions regarding the spread of HIV via casual contact with an infected person. A score of 0 indicates that the respondent views HIV infection as easily transmissible during casual contact. The SPS is a composite of seven items of perceived risk. The SPS is not scored. In this study, attitudes and beliefs regarding AIDS were assessed via the MSCC on the SPS. Five additional items were included to assess subjects' attitudes and beliefs regarding personal and community AIDS eduction, willingness to discuss the topic of AIDS, and willingness to function as community AIDS educators.

Scope and Limitations

This study was limited by the degree of truthfulness of the subjects' responses. The generalizability of the study was limited to Black elders interviewed in the study. The use of convenience sampling increased the chance of biased results. Due to the difficulty in accessing Black elders, it may not be possible to design a study to avoid these limitations. Consequently, the findings indicate the need for further research using larger, randomized samples and elders from diverse geographic locations.

Chapter 2

CONCEPTUAL FRAMEWORK AND RELATED LITERATURE

Conceptual Framework

Leininger's (1978) theory of transcultural nursing was the conceptual framework for this study. Transcultural nursing theory asserts that cultures determine the care which members want from health professionals. It is the professional caregiver's duty to incorporate cultural needs and desires when planning and implementing nursing care. When the nurse fails to incorporate cultural input, ineffective care occurs resulting in "unfavorable consequences to those served" (p. 34). During the early years of the AIDS/HIV epidemic, health care efforts focused on educating and changing the behaviors of the White, male homosexual community. The literature indicates that efforts were successful, but when the focus expanded to include minority groups, many health professionals unsuccessfully attempted to apply these same, unmodified methods and materials to minority cultures. The problem was that health professionals had failed to solicit and incorporate into their plan of care the culture specific needs and desires of the minorities whose behaviors they were trying to change.

Leininger's (1978) concept of "cultural imposition" applies to the behavior of these health professionals regarding AIDS/HIV eduction for minorities. Cultural imposition "is the tendency of an individual or cultural group to impose their beliefs, values, and patterns of behavior upon another culture for varied reasons" (Leininger, 1978, p. 490). The cultural imposition of health professionals resulted in the Black community mistakenly not perceiving itself as at risk for AIDS, and the spread of HIV infection continued unchecked.

This study was a limited culturalogic assessment of Black elderly persons in one community. A culturalogic nursing assessment is a systematic examination of individuals, groups, and communities regarding their cultural beliefs, values, and practices to determine explicit nursing needs and intervention practices within the cultural context of the people being evaluated (Leininger, 1978, p. 86). The short-term goal of this culturalogic assessment was to elicit and validate the AIDS knowledge of this group. The long-term result could be to use this information to develop and implement a culture specific AIDS teaching plan.

AIDS Literature

The incidence of AIDS among Blacks in America was reported as disproportionately high relative to the size of the Black population itself (Blakeman & McCray, 1987; Selik & Castro, 1988). Blakeman and McCray (1987) controlled for the influence of Haitian and Central African immigrants on Black American statistics and derived the same conclusion. Selik and Castro (1988), Blakeman and McCray (1987), and a national report on AIDS (Centers for Disease Control [CDC], 1986) identified intravenous drug use (IVDU) by heterosexuals and bisexuals as the primary route of HIV infection in the Black community. A byproduct of intravenous drug use is the risk of spreading AIDS to the heterosexual community because of the high seropositivity of IVDUs (Flaskerud, 1988; Hopkins, 1987; Selik & Castro, 1988). Seroprevalence determinations by race among IVDUs found that minority users were more likely to be seropositive. An explanation of why the difference occurred was not provided (Friedman & Sotheran, 1987).

HIV testing of 300,000 military recruits found that antibody seroprevalence rates were over four times higher for Black military recruit applicants and over seven times higher for Black potential blood donors in one city than for Whites

(CDC, 1986). After a positive diagnosis with AIDS, the mean survival time for Blacks in one study was 8 months, compared to 18 to 24 months for Whites (Friedman & Sotheran, 1987). A study of factors influencing survival rates revealed that IVDUs died sooner after diagnosis than did homosexuals. The racial/ethnic distribution of AIDS cases may reflect the racial/ethnic distribution of the populations at risk in high-prevalence areas, meaning that persons are at risk because of underlying behaviors, not because of their race or ethnicity (CDC, 1986).

Williams (1986) cites misconceptions among Blacks regarding the definition of AIDS, how it is spread, and who is at risk, as well as a lack of community response to the AIDS issue due to the stigma associated with drug use and homo/bisexuality as major problems. Cultural factors may also play a role, in that Black bisexuals do not consider themselves as gay and, therefore, may not benefit from educational programs targeted for homosexuals (CDC, 1986). Socioeconomically, the elevated rates of IVDU were related to high unemployment rates and inadequate education (Hopkins, 1987).

The knowledge that sex and IVDU are the principal routes of HIV infection, as well as the association of inadequate AIDS knowledge with feelings of increased susceptibility, was evident in all races and age groups (DiClemente, Boyer, & Morales, 1988; Flaskerud & Rush, 1989; Ross, 1988). Black adolescents (DiClemente et al., 1988) and Black adult women (Flaskerud & Rush 1989) demonstrated inaccurate and/or inadequate knowledge of HIV prevention measures and, consequently, were viewed as being at increased risk for HIV infection.

The relationship between age and AIDS knowledge was examined by some researchers. Flaskerud and Rush (1989) found that both younger and older Black

women, ages 27 to 69, had integrated AIDS knowledge into their traditional health belief system to equivalent degrees. Ross (1988) surveyed persons aged 16 to 70 and found that older persons had fewer personal concerns about AIDS.

Black Extended Family Literature

Research reports suggest that elderly Blacks are involved in two types of informal support networks (Mitchell & Register, 1984; Taylor, 1985; Taylor & Chatters, 1986). The first is the traditional extended family, comprised primarily of children and other blood relatives. The second is the modified extended family which, in addition to blood kin, includes friends and church members.

Involvement in these networks places Black elders in contact with the entire community. In addition, Black elders often take younger relatives into their homes to live, regardless of residential location (Mitchell & Register, 1984). They interact frequently with family, live in close residential proximity to immediate family, report extensive familial affective bonds, and derive a high degree of satisfaction from family life (Taylor, 1985). Finally, Black elders are much more likely to give advice about child rearing than are Whites, and because many Black children live in three-generation households, the role of Black elders as agents of socialization is maintained (Taylor, 1985). Therefore, Black elders are in a position to identify what teaching is required by assessing the knowledge deficits of the family members and friends they encounter and to implement primary, secondary, and tertiary preventative education as dictated by the situation.

Black Oral Tradition

Educating can involve "telling" to help define the problem and promote skill and understanding (Freeman & Heinrich, 1981, p. 111). The cultural reasons for this method are rooted in the oral tradition of Black American culture. The verbalized word was the principal communication form of the African, from whom

American slaves and, hence, the majority of today's Black Americans are descended (Levine, 1977, p. 157). American slaves used language to pass traditions from one generation to the next (Puckett, 1968, p. 13). Slaves placed great importance upon the spoken word because of their African heritage and because they were not "inducted into the literate world of their white masters" (Levine, 1977, p. 159). At the time of emancipation, about 93% of the adult Blacks in America were illiterate. In the 80 years after emancipation, that literacy figure was reversed, but many Blacks did not progress beyond the minimal ability to read and write due to discrimination in the nation's school system. The illiteracy figures for Blacks in 1920 were 23%, in 1910, 30%, in 1900, 44%, and in 1890, 56% (Levine, 1977, p. 156).

This study targeted Black persons aged 65 and older, which means that they would have been born during or before the mid 1920's. Based on the literature review, this study predicted that many of these persons were socialized with, have assimilated, and practice the Black oral tradition to acculturate younger generations. It is also proposed that the Black oral tradition can be enlisted by AIDS literate Black elders to, in turn, educate other Blacks about AIDS and HIV infection.

Chapter 3

RESEARCH DESIGN AND METHODOLOGY

Sample and Setting

The design of this study was exploratory. The controlled variables were the age and ethnicity of the participants. The sampling criteria required that the subjects be African/Black Americans over the age of 65. Limited access to a pool of Black elders precluded randomization.

A letter was published in an organization's newspaper (Appendix D). The letter introduced the investigator, explained the purpose of the study, and asked interested persons to leave their names and phone numbers with the program director. The letter also identified the sampling criteria. In addition, the program director also spoke to program participants to recruit subjects.

Data Collection

Forty of the program's participants met the sampling criteria. Twelve persons were interested in the study. They received a thorough description and the consent of recruits was obtained (Appendix E).

Nine volunteers were recruited and interviewed to determine their knowledge, attitudes, and beliefs regarding AIDS. The interviewees ranged in age from 65 to 88 years. Eight were females and one was male. All identified the United States as their birth place and their ethnicity as Black/African American. All were involved with the organization's senior program, either as participants, volunteers, or staff.

Interviews lasted 15 to 30 minutes and were conducted at the site of the elder's program in a large, private, quiet, comfortable room which was familiar to the interviewees. The interviews were one-on-one and in person. Data were

collected over a 3-week period. The elder's program was located in a large urban city in northern California.

Instruments

The instrument used to measure knowledge and attitudes about HIV infection was a modified version of the AIDS Information Survey (DiClemente, Boyer, & Morales, 1988). DiClemente, Boyer, and Morales (1988) used the AIDS Information Survey to assess the AIDS knowledge, attitudes, and misconceptions of a multi-ethnic group of adolescents. The AIDS Information Survey is a self-report questionnaire and requires subjects to give "true," "false," and "I don't know" responses. It is composed of three sub-scales: a Knowledge Scale of AIDS, a Misconception Scale of Casual Contagion (MSCC), and a Scale of Perceived Susceptibility (SPS) (Appendix B). The internal consistency of the Knowledge Scale (alpha = 0.72), the MSCC (alpha = 0.75), and the SPS (alpha = 0.55) were reported as satisfactory (DiClemente et al., 1988).

The original questionnaire, as shown in Appendix B, consisted of 30 items. Four types of modifications were made. First, items numbered 3, 4, 11, 33, 38, and 40 appeared on the original questionnaire but were deleted from the modified survey. Items numbered 5, 8, 9, 12, 14, 16, 17, 19, 20, 22, 23, 25, 26, 30, 31, 34, and 36 of the original questionnaire were reworded to decrease their ambiguity. Items numbered 1, 29-33, and 38-51 were added to the modified survey to obtain demographic, family, and HIV/AIDS information not addressed in the original questionnaire. Finally, items numbered 28 and 31-37 of the original questionnaire were changed from the first person to the second person and the response choices from "true," "false," and "I don't know" to "yes," "no," and "I don't know." The tense and response changes made the questionnaire more

appropriate for the interviews. The preceding modifications may have resulted in a reduction in the validity and reliability of the instrument.

A copy of the modified questionnaire is shown in Appendix A. The investigator circled the respondent's reply to questions 1-41 on the questionnaire. The investigator also recorded explanatory information provided by the respondent. Questions 42 through 51 required the investigator to either circle the correct response or fill in the blank with the respondent's answer.

Discussion of Instrument Modifications

It was important to know how many participants had never heard of HIV/AIDS, so item 1 was added. If the participant had never heard of HIV/AIDS, the investigator would have skipped items 2 through 41 and completed items 42 through 51 only.

Items 2 through 26 comprised the Knowledge Scale in this study, as they did in the DiClemente et al. (1988) study. Items 27, 28, and 29 were also included in the Knowledge Scale for this study. The MSCC included items 4, 5, 7, 10, 14, and 19. The SPS originally only included items 34 through 37, which assessed perceived personal susceptibility. For this study, items 38 and 39 were added to assess how participants perceived the susceptibility of family and friends. Question 37 was removed from the SPS. It and question 40 (added for the current study) were used instead to assess if the respondent exhibited more fear toward a diagnosis of AIDS than toward any other disease diagnosis. Item 30 was added to assess attitudes toward more community education, item 41 was added to assess the need for more personal education regarding AIDS/HIV, and items 31 and 32 were added to assess participants' willingness to discuss the topic of AIDS with family and friends. Denial of the AIDS problem was assessed by item 33. Item 42 requested gender, race, age range, and birth country. Items 43

through 51 requested family information. A point value of 1 was given to each item assessing knowledge, perceived susceptibility, and misconceptions regarding casual contagion.

Data Analysis

Data were analyzed by frequency count, percentage of responses, and a summary of the respondents' answers. The respondents' scores on the Knowledge Scale and the Misconception Scale of Casual Contagion were also summarized.

The investigator obtained written permission from the executive director of the organization to collect, analyze, and interpret these data and use the results in a research paper (Appendix F). These results are described in Chapter 4.

Chapter 4

ANALYSIS AND INTERPRETATION OF DATA

Black elders were interviewed to determine their knowledge and attitudes regarding AIDS/HIV infection. These guided interviews also elicited information regarding family demographics and interaction patterns. The findings and analysis of those interviews are described in this chapter.

Description of the Sample Population

Nine Black elders, 8 females and 1 male, ages 65 to 88, were interviewed. All identified the United States as their place of birth and their race/ethnicity as Black American.

Survey Results

Knowledge Assessment

The data collection instrument was a 51-item interview schedule (Appendix A). The first question was asked to determine whether the respondent was aware of the existence of AIDS/HIV infection. The next 28 statements assessed the respondent's misconceptions regarding how HIV infection is spread. Questions 34 through 36 assessed the respondent's perceived personal susceptibility to HIV infection, while questions 38 and 39 assessed the respondent's perceptions of the susceptibility of family and friends to HIV disease. Fear of a diagnosis of AIDS as compared to other disease diagnoses was assessed by questions 37 and 40. The interviewee's willingness to discuss the topic of AIDS with family and friends was assessed by questions 31 and 32. Question 33 assessed for denial regarding the problem of HIV infection. Items 42 through 51 requested demographics and assessed family interaction patterns.

"Yes," "no," or "I don't know" responses were required by question 1 and questions 30 and 41. The reply options for questions 2 to 29 were "true," "false," or "I don't know." Each knowledge and attitude question was given a point value of 1. The knowledge score was calculated by summing the number of questions answered correctly. Incorrect and "I don't know" responses were totaled and subtracted from 28, the maximum achievable score on the Knowledge Scale.

The knowledge scores ranged from 19 to 27. The 9 respondents either incorrectly answered or replied "I don't know" to 39 (15.5%) of the statements. Statements 5, 6, 11, 14, 15, 16, 20, 21, 22, 24, and 25 elicited correct responses from all of the respondents.

Statement 6 read, "All gay men have HIV infection," and statement 24 read, "All gay women have HIV infection." All of the respondents disagreed with these statements. Perhaps the respondents were aware that although the gay lifestyle had been implicated as a risk factor in the early years of the epidemic, recent research has cited unprotected sex as the true risk factor and not sexual orientation.

Statement 11, "AIDS is not at all serious, it is like having a cold," assessed the respondent's attitude toward the seriousness of the AIDS problem. The interviewees all felt that AIDS was an extremely serious condition. The goal of question 33 was similar to that of statement 11; it asked, "Do you feel that HIV infection is as big a problem as the media suggests?" It assessed for denial regarding the magnitude of the AIDS problem. All of the respondents replied "yes" to this question.

The Black elders demonstrated a high knowledge of primary AIDS/HIV risk factors, evidenced by the fact that 100% of the sample selected the correct responses to statements 15, 16, 20, and 21. These statements say that HIV can be

spread via sexual contact, perinatal transmission, needle sharing, and HIV infected blood.

Statement 13, "The cause of AIDS is unknown," was answered incorrectly by all of the respondents, even though statement 3, "AIDS is caused by a virus called HIV," was answered correctly by 88.8% of the respondents. Possibly, in statement 13, the respondents interpreted the phrase, "the cause," as meaning "the origin." The goal of statement 13 is to elicit the same information previously obtained in statement 3; therefore, its function is redundant. Thus, for purposes of clarification, statement 13 could be eliminated. A second alternative would be to reword statement 13 to read, "The virus that causes AIDS has not been identified," or "AIDS is caused by an unidentified virus." Either of these two alternatives would assist in decreasing or eliminating the ambiguity generated by this statement.

Statement 27 received the second highest number of incorrect responses in that four (44.4%) of the respondents felt that "AIDS can be cured if treated early." This is not true. Prophylactic treatment with AZT and aerosolized Pentamidine may delay the asymptomatic seropositive individual's progression along the HIV disease continuum to a diagnosis of AIDS, but a cure is not available (Woods, 1988). It is difficult to discern the dichotomy between the responses to this statement and statements 9 and 25. Statement 9 read, "AIDS can be cured," and eight (88.8%) of the respondents felt this was "false." Statement 25 read, "There is no cure for AIDS," and all of the respondents replied, "true." However, one respondent, upon hearing statement 27, realized that the statements were similar and commented, "I know I just caught myself in a lie," yet declined the opportunity to change either response. The phrase, "if treated early," may have been viewed as synonymous with the concept of early

intervention/detection which may, in turn, have been equated with the concept of prevention in the minds of many respondents. Another possible explanation is that perhaps for some, the verb, "can," used in statements 9 and 27, connotated that AIDS will be curable in the future versus now. The wording in statement 25 left no room for speculation on the part of the respondent. Statement 25 clearly referred to the present via the use of the verb, "is." The respondents seemed to understand this and provided the desired response. The results of these three questions suggest that the respondents need more education regarding prevention as the primary means of controlling the spread of AIDS and to clarify the distinction between the concepts of prevention and early intervention/detection as they relate to HIV infection.

Statement 4 received the third most incorrect responses. Statements 10, 12, and 29 tied for the fourth most often missed item. Each was missed by two (22.2%) of the respondents. In addition to being one of the fourth most frequently missed items, statement 12, "AIDS is caused by the same virus that causes gonorrhea," also elicited the highest number of "I don't know" responses, 33.3%. Most of the respondents may not have known that gonorrhea is caused by a bacterium (Neisseria gonorrhea) and not a virus (Phipps, Longs, & Woods, 1979). In addition, some respondents may not have known that different infecting agents cause different diseases and/or conditions.

Statement 12 was also the only statement that addressed a sexually transmitted disease (STD) other than HIV infection. If statement 12 responses are compared to the responses elicited in statement 27, one could make the case that the respondents may have transposed their knowledge of the STD, gonorrhea, onto their knowledge or lack of knowledge regarding the STD, AIDS. This could explain why 44.4% of the sample felt that the statement, "AIDS can be cured if

treated early," was true. Gonorrhea can be cured if treated early, but unfortunately AIDS cannot. Education comparing and contrasting AIDS with other STDs might clarify the cause of AIDs and the fact that, although many other STDs are curable, there is no cure for AIDS.

Two (22.2%) of the interviewees responded "true" to statement 29, "Bathing after intercourse will prevent HIV infection." Bathing after intercourse does not prevent HIV infection (Flaskerud, 1989). Information on how to prevent the spread of HIV infection is needed.

Statements 2, 8, 9, and 19 were each answered incorrectly by 11.1% of the respondents. One person disagreed with statement 2, "AIDS is a medical condition in which your body cannot fight off disease." A second person did not believe that statement 8, "Anybody can get infected by HIV," was a true statement. One respondent agreed with statement 9, which read, "AIDS can be cured."

Statement 12 was previously cited as the statement receiving most (33.3%) of the "I don't know" responses. Statements 7, 23, and 28 each received 22.2% of the "I don't know" responses. Finally, statements 3, 4, 17, 18, and 26 each received 11.1% of the "I don't know" responses.

Statement 3, "AIDS is caused by a virus called HIV," and statement 17, "Most people who get HIV infection usually go on to develop AIDS given enough time," assessed the respondent's understanding of the relationship between HIV and AIDS. The "I don't know" responses were indicative of confusion regarding how HIV and AIDs are related.

Statements 18 and 26 addressed the concept of prevention. Statement 18 read, "Using a condom during sex can lower the risk of getting infected with HIV." One respondent was not familiar with the word condom. Statement 26 read, "You

can avoid getting HIV infection by exercising regularly." The "I don't know" replies of the respondents may indicate that prevention messages delineating appropriate versus inappropriate behaviors are not reaching this population.

Misconception Scale of Casual Contagion

Statements 4, 5, 7, 10, 14, and 19 comprised the Misconception Scale of Casual Contagion (MSCC) (see Appendix A). This scale assessed the respondents' misconceptions regarding how HIV disease is spread. A point value of 1 was assigned to each of the six items. A maximum score of 6 points was possible. A score of 6 on this scale implied that the respondent had no misconceptions regarding the spread of HIV via casual contact with an infected person. A score of 0 indicated that the respondent viewed HIV infection as easily transmissible during casual contact. The respondents' scores ranged from 4 to 6 on the MSCC; five scored 6 points, and the remaining four scored 4 points. The results may indicate that the interviewees regarded HIV infection as hard to contract during the course of casual contact. Everyone answered statements 5 and 14 correctly. No one believed that HIV disease was spread simply by "being around someone with HIV infection" or "if you touched someone with HIV."

Statement 4, "If you kiss someone with HIV infection, you will get the disease (AIDS)," revealed the most confusion regarding casual contagion. Three persons agreed that HIV infection could be passed from one person to another via kissing, five disagreed, and one did not know if this was true or not. Research indicates that the average kiss does not transmit HIV infection, although "deep kissing" or a kiss hard enough to break the skin and draw blood does have the potential to transmit HIV infection.

Two individuals responded, " I don't know," to statement 7, "The food you eat can give you HIV infection," but seven correctly disagreed with it. HIV disease is not spread in the food one eats (Lifson, 1988).

Statement 10, "HIV can be spread by using someone's personal belongings like a comb or hairbrush," is a false statement, but two interviewees thought it was true. Combs and hairbrushes are not usually exposed to blood or body fluids during normal usage and, therefore, do not spread HIV (Lifson, 1988).

Finally, one person responded affirmatively to statement 19, "You can get HIV shaking hands with someone who has it," but qualified this response by saying, "If someone goes to the restroom during her period, gets bloods on her hands, and then does not wash her hands thoroughly or at all, and I shake hands with that person not knowing that I have a cut, I could get infected." HIV could possibly be transmitted during a handshake under these circumstances, but research indicates that, in most case, HIV is not transmitted during a handshake (Lifson, 1988).

In summary, most respondents understood that HIV infection is not transmitted during casual contact. However, misconceptions regarding the casual contagion of HIV were evident and require correction through education.

Scale of Perceived Susceptibility

Questions 34 through 36 assessed the individual's perceptions regarding personal susceptibility to HIV infection. In response to question 34, "Are you afraid of getting HIV infection?," and question 35, "Are you worried about getting HIV infection?," seven interviewees were neither afraid nor worried about getting HIV infection. The remaining two were both afraid of and worried about getting infected. Many individuals commented that there was no need to be worried or afraid because, "I won't be doing anything to get infected." Question 36 revealed

that most (55.5%) interviewees believed that they were "less likely than most people to get HIV infection." However, three responded "no" and expressed the belief that their chances of getting HIV were the same as anyone else's. One person (11.1%) responded, "I don't know."

Questions 38 and 39 assessed the respondent's perceptions regarding the susceptibility of family and friends to HIV infection. Question 38 asked, "Are you worried that someone you know may become HIV infected or develop AIDS?"; five respondents denied that they were worried that someone they knew might develop AIDS, but four said, " yes." Question 39 asked, "Do you feel that your friends and family are less likely than most people to become HIV infected or develop AIDS?" Four respondents replied, "no," three said, "yes," and two responded, "I don't know."

To summarize, the elders did not perceive themselves as being very susceptible to HIV infection. Most viewed their family and friends as being more susceptible to HIV infection than they were. Most elders were more worried about the susceptibility of their family and friends to HIV infection than they were about themselves.

Questions 37 and 40 assessed if the respondent attached greater fear to a diagnosis of AIDS versus any other disease diagnosis. Question 37 asked, "Would you rather get any other disease than AIDS?" Five (55.5%) respondents answered, "yes," 33.3% said, "no," and 11.1% replied, "I don't know." Question 40 asked, "Would you prefer that your friends or family get any other disease than AIDS?" One respondent (11.1%) replied, "I don't know." The remaining eight were split; four said, "yes," and four said, "no." Questions 37 and 40 were described as "hard" to answer by the majority of the respondents. The difficulty was that many did not want either themselves or their family or friends to "get any

disease," and they also believed that other diseases "like cancer might be just as bad as AIDS."

The responses to questions 37 and 40 indicate that on a personal level, if given a choice, most respondents would prefer any other diagnosis over one of AIDS. The respondents were less certain regarding this disease preference for family and friends.

Attitude Toward HIV Education

Question 30 assessed the respondent's attitude toward additional HIV education in the Black community at large. It asked, "Do you feel that there is a need for more AIDS education in the Black community?" The response was a unanimous, "yes." Question 41 asked, "Would you like to know more about AIDS?" and assessed the respondent's personal desire for additional HIV education. A large majority (88.8%) of the respondents expressed a desire for more AIDS education. One person (11.1%) did not want to know more about AIDS. When the investigator told this respondent that knowing more about AIDS could enable the respondent to educate his children and grandchildren, the respondent replied that it was "the parents' responsibility to educate the grandchildren" and that his children were already informed.

In summary, the consensus was that the Black community, in general, would benefit from additional AIDS education. From a personal standpoint, some respondents felt that their existing knowledge base was sufficient, but most expressed a desire to learn more about AIDS.

Attitude Toward HIV Communication

Questions 31 and 32 assessed the respondent's attitudes toward discussing the topic of AIDS with his/her family and friends. Question 31 asked, "Have you ever discussed the subject of AIDS with someone in your family?" Six (66.6%) of

the sample responded, "yes," indicating that they had discussed the topic of AIDS with a family member. A third denied ever discussing the subject of AIDS with a family member. Question 32 asked, "Would you feel comfortable discussing the subject of AIDS with your friends or family?" Eight (88.8%) of the sample replied, "yes." Most went on to say that they would feel greater comfort talking about AIDS with family and friends if they knew more about it. One person said, "no," but went on to say, "I have discussed it, but I was uncomfortable because I didn't know enough to back up what I was saying," and "I didn't know if I believed what I was saying."

In summary, most of the respondents had discussed the topic of AIDS with a family member. All respondents, including those who had never discussed the topic of AIDS with family, expressed a willingness to do so. Many desired more HIV education to allow them to speak from a firm knowledge base.

Family Demographics and Contact Patterns

All of the respondents reported having children and grandchildren. Eight (88.8%) also reported having nieces and/or nephews. The number of children ranged from two to eight, and their age range was 20 years to 60 years. The majority (77.7%) of the respondents had children between the ages of 20 and 49. The number of grandchildren ranged from 3 to 30. Eight (88.8%) had grandchildren between the ages of 1 and 40. Seven (77.7%) of the respondents had pre-teen grandchildren, four (44.4%) had teenage grandchildren, and three 33.3%) had grandchildren who were in their twenties. Eight (88.8%) of the respondents had nieces and nephews. One person had none, and three (33.3%) had more than 10 each. The reported ages of the nieces and nephews were 2 to 56 years.

Four interviewees reported that they lived with one of their children. Two of those who lived with one child reported having daily contact with their nonresident children. Three respondents had had contact with their children a day or two ago, and two of these stated that they had daily contact with their children. Two respondents had had contact with their children a week or two ago, and one of these reported weekly contact between parent and child on a routine basis. Consequently, 44.4% of the sample reported daily contact with nonresident children, and 88.8% of the sample reported having contact with their children at least once within the last week.

Four respondents had had contact with their grandchildren "a day or two ago." Half of those making this response reported daily contact between grandparent and grandchildren. Three individuals reported weekly to biweekly contact with their grandchildren. One reported contact that occurred 1 month ago, and another one reported contact which had occurred 2 to 3 months ago.

Contact between the respondents and their nieces and nephews was divided. Three had had contact with their nieces/nephews "a day or two ago," and one had had contact "a week or two ago." The remaining four had not had any contact with their nieces or nephews for "more than 3 months."

In summary, the greatest degree of intergenerational contact occurred between the respondents and their children. The next highest level of intergenerational contact occurred between the respondents and their grandchildren., On average, the respondents interacted the least with their nieces and nephews.

Summary

This study was conducted in northern California. The sample consisted of 9 Black elders, 1 male and 8 females. All were between the ages of 65 and 88. All attended a community program for elders.

The findings indicate that this group is fairly knowledgeable about AIDS and acknowledges that it is an extremely serious problem. They demonstrated a high awareness of the primary risk factors associated with HIV infection. However, findings indicate a need for education clarifying the cause of AIDS, its incurability, and how it is and is not transmitted or prevented. The results also indicate that although the majority of the sample feel that they personally have little chance of becoming HIV infected, the disease still evokes some degree of fear. Most of the group perceived their family and friends as being more susceptible to HIV infection than they were, and this perception worried them. All felt that the Black community at large needed more AIDS education, but on a personal level, only one did not want to know more about AIDS. The findings also showed that all of the respondents had children and grandchildren, and that most had nieces and nephews. The respondents interacted most often with their children, followed by their grandchildren. Although some respondents interacted frequently with their nieces and nephews, on average, they interacted less often with nieces and nephews than with children and grandchildren.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS

An exploratory survey of Black elders was done to determine their knowledge and attitudes toward AIDS/HIV infection. This chapter presents the conclusions of this exploratory study. The elders' knowledge and attitudes pertaining to HIV risk factors and prevention behaviors will be discussed. Also discussed are the elders' attitudes regarding HIV eduction, their perceptions of personal and family susceptibility to HIV infection, their attitudes toward misconceptions regarding the casual contagion of HIV infection, their attitudes toward communicating the topic of AIDS with family and friends, and family demographics and contact patterns. Inferences are made and recommendation for future studies are offered.

Interviews were used to gather information. The sample population consisted of 9 Black elders who ranged in age from 65 to 88. Among the respondents, there were 8 females and 1 male.

The data collection instrument, an interview guide, consisted of: (a) a knowledge assessment containing 28 statements; (b) a 6-item attitude assessment of misconceptions regarding the casual contagion of HIV infection; (c) a 4-item attitude assessment of perceived susceptibility to HIV infection; (d) 2 items assessing relative fear of AIDS versus other diseases; (e) 1 item assessing for denial of AIDS as a problem; (f) 1 item assessing for awareness of the existence of AIDS; (g) 2 items assessing attitudes toward communicating on the topic of AIDS; and (h) 9 items assessing personal demographics, family demographics, and interaction patterns. Item 1 and items 30 through 41 could be answered, "yes," "no," or "I don't know." Items 2 through 29 could be answered, "true," "false," or "I

don't know." Items 42 through 51 required that the interviewer either circle the appropriate response or fill in the blank.

The investigator modified an existing instrument to make it appropriate for the needs of this study. The instrument was administered to 9 Black elders. The time required for administration was 15 to 30 minutes. Participation by the elders was voluntary, and confidentiality was assured. Written permission was obtained from the organization's executive director to collect the data on site and to use the data in a research report.

Major Findings

Information was gathered regarding the knowledge and attitudes of Black elders toward HIV infection, prevention, education, and communication. Information regarding personal demographics, family demographics, and contact patterns was also obtained. The findings indicate that this group is fairly knowledgeable about AIDS and acknowledges that it is an extremely serious problem. Findings showed that the respondents demonstrated a high awareness of the primary risk factors associated with HIV infection, but that they would benefit from more information regarding prevention. Findings also indicate a need for eduction clarifying the cause of AIDS, its incurability, and how it is and is not transmitted or prevented. Most persons from the sample believe that they personally have little chance of becoming HIV infected, but they still fear the disease. Most of the group perceived their family and friends as being more susceptible to HIV infection than they were, and this perception worried them. All felt that the Black community at large needed more AIDS education, but personally one did not want more AIDS education. The findings also showed that all of the respondents had children and grandchildren, and that most had nieces and nephews. They interacted most often with their children and grandchildren.

Some respondents interacted frequently with their nieces and nephews, but on average, they interacted less often with nieces and nephews than with children and grandchildren.

Scope and Limitations

Limitations to generalization are due to the small size of the sample, the lack of a random selection, the location of the organization (an urban city in northern California), the race/ethnicity of the respondents (Black/African American), and the age of the respondents (65 and older). The findings obtained from this study are not necessarily applicable to various populations of Black elders.

The investigator experienced difficulty accessing Black elders. This difficulty was explored with the program director who was familiar with both the program participants and the community at large. The discussion revealed that a number of factors may have contributed to recruitment problems. First, many elders did not feel that AIDS had had nor would have any direct impact on their lives. Second, AIDS was initially associated with the gay population, and many elders desire to distance themselves from that population. Finally, many elders did not believe that AIDS existed within the Black community to any significant degree. This belief may, in part, be due to the fact that Black leaders in the churches have not addressed the issue. Given the recruitment problems, randomization would have significantly reduced the population of respondents. Furthermore, random selection was not feasible for this study, because participation was purely voluntary.

Although the instrument was modified and untested, it proved to be time efficient, and responses were elicited with minimal difficulty. In addition, the modifications made the instrument more appropriate for this study, because it

covered all of the areas of interest to the investigator. Despite modifications aimed at decreasing the ambiguity and increasing the clarity of the instrument, some questions/statements may have still been misinterpreted by the respondents. The modifications may have also resulted in decreasing the instrument's validity and reliability.

Conclusions

The findings obtained from the knowledge and attitude assessments suggest that this sample group of Black elders possesses a good overall knowledge regarding HIV infection, prevention, and transmission. The findings also indicate that the respondents perceived themselves as being at low risk for HIV infection, but that they were, in most cases, uncertain of and worried about the risk that HIV infection may pose for their family and friends. In addition, the findings indicate an extremely positive attitude toward future HIV education on a community and a personal level. Finally, the findings indicate that the respondents are very active within the extended family network as evidenced by the frequent contacts among the respondents and their children, grandchildren, and other family members.

The Black oral tradition involves the use of the spoken word by one generation to pass social information on to successive generations. Because most of the respondents not only felt comfortable discussing the topic of AIDS with family and friends, and indeed had discussed it with at least one family member prior to the interview, one can infer that these respondents continue to practice the Black oral tradition. The fact that many also expressed the opinion that they would feel much more comfortable discussing the topic with family and friends if they knew more about it, allows one to infer that AIDS literate Black elders would, in turn, educate their family and friends regarding AIDS.

Recommendations

The following recommendations are made based upon the findings of this study:

1. HIV education classes, which either target specifically or include Black elders, should be initiated in the community. The classes should emphasize HIV transmission, prevention, and also the exposure and correction of misconceptions associated with HIV disease.

2. Enlarging the sample size, randomizing the sample, and using a diversity of geographic locations would help to validate the findings of this study.

Concluding Statement

Traditionally, within the Black culture, aged Blacks have been viewed as honored elders and have functioned in the capacity of advisors and cultural leaders (Leininger, 1978, p. 331). Black elders have also been responsible for maintaining the health of their families, functioning in the capacity of health care providers, and as functioning health seekers (p. 331). Consequently, the successful implementation of an education plan would be enhanced by identifying the needs of the Black community with respect to AIDS, education of the Black elderly using a culture specific plan of care, and enlisting them to function in their traditional roles of community advisors, cultural leaders, and most of all, health care providers to disseminate this information throughout their community. This cultural approach would not only allow Black elders to care for their community as they always have; it would also allow them to ultimately care for themselves. Hopefully, this study was a step in that direction.

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APPENDIX A

Aids Information Survey: Modified Version

AIDS Information Survey: Modified Version.

STATEMENT/QUESTION

Please respond Yes (Y), No (N), or Don't Know (DK) to the following question.

1.	Have you ever heard of AIDS?	Y	N	DK

Please respond True (T), False (F), or Don't Know (DK) to the following statements:

2.	AIDS is a medical condition in which your body cannot fight off disease.	T	F	DK
3.	AIDS is caused by a virus called HIV.	T	F	DK
4.	If you kiss someone with HIV infection, you will get the disease (AIDS).	T	F	DK
		T	F	DK
5.	If you touch someone with HIV you will get infected.	T	F	DK
6.	All gay men have HIV infection	T	F	DK
7.	The food you eat can give you HIV infection.	T	F	DK
8.	Anybody can get infected by HIV.	T	F	DK
9.	AIDS can be cured.	T	F	DK
10.	HIV can be spread by using someone's personal belongings like a comb or hairbrush.	T	F	DK
11.	AIDS is not at all serious; is like having a cold.	T	F	DK
12.	AIDS is caused by the same virus that causes gonorrhea.	T	F	DK

PLEASE CONTINUE NEXT PAGE

13.	The cause of AIDS is unknown.	T	F	DK
14.	Just being around someone with HIV infection can give you the disease.	T	F	DK
15.	Having sex with someone who has HIV infection can give you the disease.	T	F	DK
16.	If a pregnant woman has HIV there is a chance it may harm her unborn baby.	T	F	DK
17.	Most people who get HIV infection usually go on to develop AIDS given enough time.	T	F	DK
18.	Using a condom during sex can lower the risk of getting infected with HIV.	T	F	DK
19.	You can get HIV shaking hands with someone who has it.	T	F	DK
20.	Receiving a blood transfusion with infected blood can give a person HIV infection.	T	F	DK
21.	You can get HIV infection by sharing a needle with a drug user who has the virus.	T	F	DK
22.	AIDS is a life-threatening disease.	T	F	DK
23.	People with AIDS usually have lost of other diseases as a result of HIV infection.	T	F	DK
24.	All gay women have HIV infection.	T	F	DK
25.	There is no cure for AIDS.	T	F	DK

PLEASE CONTINUE NEXT PAGE

26.	You can avoid getting HIV infection by exercising regularly.	T	F	DK
27.	AIDS can be cured if treated early.	T	F	DK
28.	There is a vaccination you can get to prevent getting HIV infection.	T	F	DK
29.	Bathing after intercourse will prevent HIV infection.	T	F	DK

Please respond Yes (Y), No (N), or Don't Know (DK) to the following questions:

30.	Do you feel that there is a need for more AIDS education in the Black community?	Y	N	DK
31.	Have you ever discussed the subject of AIDS with someone in your family?	Y	N	DK
32.	Would you feel comfortable discussing the subject of HIV with your family and/or friends?	Y	N	DK
33.	Do you feel that HIV infection is as big a problem as the media suggests?	Y	N	DK
34.	Are you afraid of getting HIV infection?	Y	N	DK
35.	Are you worried about getting HIV infection?	Y	N	DK
36.	Do you feel that you are less likely than most people to get HIV infection?	Y	N	DK
37.	Would you rather get any other disease than AIDS?	Y	N	DK

PLEASE CONTINUE NEXT PAGE

38.	Are you worried that someone you know may become HIV infected or develop AIDS?	Y	N	DK
39.	Do you feel that your friends and family are less likely than most people to become HIV infected or develop AIDS?	Y	N	DK
40.	Would you prefer that your friends or family get any other disease but AIDS?	Y	N	DK
41.	Would you like to know more about AIDS?	Y	N	DK

42. Please indicate which response is appropriate for you:

Sex: Male Female

Race: Black White Hispanic Asian

Native American

Age: 65-69 70-74 75-79 80-84 85-89

90-94 95-99 >99

Born: United States _____ Other _____

43. Do you have any children? Yes No

44. If yes, how many? _____ What are their ages? _____

45. Do you have any grandchildren? Yes No

46. If yes, how many? _____ What are their ages? _____

47. Do you have any nieces or nephews? Yes No

48. If yes, how many? Nieces _____ Nephews _____
What are their ages? _____

PLEASE CONTINUE NEXT PAGE

49. When did you last see or have contact with your children?

    a. I live with them.

    b. A day to two ago.

    c. A week or two ago.

    d. A month ago.

    e. 2 to 3 months ago.

    f. More than 3 months ago.

50. When did you last see or have contact with your grandchildren?

    a. I live with them.

    b. A day or two ago.

    c. A week or two ago.

    d. A month ago.

    e. 2 to 3 months ago.

    f. More than 3 months ago.

51. When did you last see or have contact with your nieces/nephews?

    a. I live with them.

    b. A day to two ago.

    c. A week or two ago.

    d. A month ago.

    e. 2 to 3 months ago.

    f. More than 3 months ago.

THANK YOU FOR YOUR COOPERATION!

APPENDIX B

Aids Information Survey

AIDS Information Survey

HIGH SCHOOL SURVEY OF KNOWLEDGE AND OPINIONS ABOUT AIDS

We are conducting a survey to learn about students' knowledge, attitudes, and beliefs about AIDS. This is not a test. We are interested in your opinions regarding the cause, transmission, treatment, and prevention of AIDS. Please take a few moments to complete the questions that follow. Remember, that we are only interested in your opinions and all your answers are completely anonymous. Thank you for your cooperation.

1. What is your gender?

   A. Male
   B. Female

2. What is your age? _____

3. What is your ethnic background?

   A. Caucasian (White)
   B. Black
   C. Asian
   D. Hispanic (e.g., Mexican, Latino)
   E. Other _____

5. How long have you lived in the Bay Area?

   A. Less than 1 year
   B. 1-3 years
   C. 4-6 years
   D. 7-9 years
   E. 10 or more years

(AIDS Information Survey, a questionnaire designed to assess knowledge, attitudes, and beliefs regarding AIDS/HIV.)

Note. From "Minorities and AIDS: Knowledge, attitudes and misconceptions among Black and Latino adolescents" by DiClemente, R. J., Boyer, C. B., & Morales, E. S. (1988). American Journal of Public Health, 78(1), 55-57.

Please read the statements below and circle T if you feel the statement is TRUE or F if you feel the statement is FALSE. If you don't know whether the statement is true or false, please circle DK (DON'T KNOW).

		TRUE	FALSE	DON'T KNOW
1.	AIDS is a medical condition in which your body cannot fight off disease.	T	F	DK
2.	AIDS is caused by a virus.	T	F	DK
3.	AIDS is a condition you are born with.	T	F	DK
4.	Stress causes AIDS.	T	F	DK
5.	If you kiss someone with AIDS, you will get the disease.	T	F	DK
6.	If you touch someone with AIDS you can get AIDS.	T	F	DK
7.	All gay men have AIDS.	T	F	DK
8.	What you eat can give you AIDS.	T	F	DK
9.	Anybody can get AIDS.	T	F	DK
10.	AIDS can be cured.	T	F	DK
11.	Women are more likely to get AIDS during their period.	T	F	DK
12.	AIDS can be spread by using someone's personal belongings like a comb or toothbrush.	T	F	DK
13.	AIDS is not at all serious; it's like having a cold.	T	F	DK
14.	AIDS is caused by the same virus that causes VD.	T	F	DK
15.	The cause of AIDS is unknown.	T	F	DK

CONTINUE ON THE NEXT PAGE

16.	Just being around someone with AIDS can give you the disease.	T	F	DK
17.	Having sex with someone who has AIDS is one way of getting it.	T	F	DK
18.	If a pregnant woman has AIDS there is a chance it may harm her unborn baby.	T	F	DK
19.	Most people who get AIDS usually die from the disease.	T	F	DK
20.	Using a condom during sex can lower the risk of getting AIDS.	T	F	DK
21.	You can get AIDS by shaking hands with someone who has it.	T	F	DK
22.	Receiving a blood transfusion with infected blood can give a persons AIDS.	T	F	DK
23.	You can get AIDS by sharing a needle with a drug user who has the disease.	T	F	DK
24.	AIDS is a life threatening disease.	T	F	DK
25.	People with AIDS usually have lots of other diseases as a result of AIDS.	T	F	DK
26.	All gay women have AIDS.	T	F	DK
27.	There is no cure for AIDS.	T	F	DK
28.	I can avoid getting AIDS by exercising regularly.	T	F	DK
29.	AIDS can be cured if treated early.	T	F	DK
30.	A new vaccine has recently been developed for the treatment of AIDS.	T	F	DK

CONTINUE ON NEXT PAGE

31.	AIDS is not as big a problem as the media suggests.	T	F	DK
32.	I am afraid of getting AIDS.	T	F	DK
33.	Living in the Bay Area increases my chances of getting AIDS.	T	F	DK
34.	I am not worried about getting AIDS.	T	F	DK
35.	I am not the kind of person who is likely to get AIDS.	T	F	DK
36.	I am less likely than most to get AIDS.	T	F	DK
37.	I'd rather get any other disease than AIDS.	T	F	DK
38.	I've heard enough about AIDS and I don't want to hear any more about it.	T	F	DK
39.	It is important that students learn about AIDS in Family Life Education classes.	T	F	DK
40.	I have had instruction about AIDS in my school curriculum.	T	F	DK

THANK YOU FOR YOUR COOPERATION!

APPENDIX C

Letter of Permission

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO

SANTA BARBARA • SANTA CRUZ

Department of Epidemiology
and International Health

SAN FRANCISCO, CALIFORNIA 94143-0560

Dear Ms. Collins:

I am flattered by your interest in using the AIS in your research. By all means, please feel free to use it.

If I can be of further assistance please do not hesitate to contact me directly at 415-937-8617.

Sincerely:

Joseph J. Clemente, PhD

APPENDIX D

Letter to Program Director

April 23, 1990

To: Mrs. S. L.

From: Deborah Jean Summers-Collins

Re: Request for Volunteers

Dear Mrs. L.:

I was given permission to proceed with my study by the San Jose State Human Subjects Institutional Review Board on April 18, 1990. I have prepared the following statement requesting volunteers from your program participants:

Hello:

My name is Deborah Summers-Collins. I am a graduate student at San Jose State University. I am currently writing my thesis, which is required to obtain the Master of Science in Nursing degree. The purpose of my thesis is to obtain information about the knowledge and attitudes of Black elders regarding AIDS risk factors and prevention behaviors. My goal is to interview 8 to 10 persons aged 65 and over. The interviews will be confidential and done on a one-on-one basis for your convenience.

If you are a Black person, aged 65 or over, and interested in being interviewed, please give your name and phone number to Mrs. L. Your participation will be greatly appreciated.

Sincerely,

Deborah Summers-Collins

Mrs. L., thank you very much for allowing me to recruit from your clients.

APPENDIX E

Consent Form

AGREEMENT TO PARTICIPATE IN RESEARCH
SAN JOSE STATE UNIVERSITY

RESPONSIBLE INVESTIGATOR: Deborah Summers-Collins

TITLE OF PROTOCOL: KNOWLEDGE AND ATTITUDES OF BLACK ELDERS REGARDING AIDS RISK FACTORS AND PREVENTION BEHAVIORS

I have been asked to participate in research study investigating the knowledge, attitudes, and beliefs of Black elders regarding AIDS risk factors and prevention behaviors. The results of this study should further the understanding of knowledge, attitudes, and beliefs of Black elders regarding AIDS risk factors and prevention behaviors.

I understand that:

(1) I will be asked to participate in an in person interview lasting about an hour at _____ .

(2) The possible risks of this study are embarrassment and psychological discomfort.

(3) This study will not provide any discernible benefits to me.

(4) There are no alternative procedures or treatments being withheld.

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

(6) I will not be compensated for participating in this study.

(7) Any questions about my participation in this study will be answered by Deborah Summers-Collins at (408) _____. Complaints about procedures may be presented to Virgil Parsons: Department Chair for Nursing at (408) 924-3130. For questions or complaints about research subjects' rights, or in the event of research-related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies & Research) at (408) 924-2480.

(8) My consent is given voluntarily without being coerced; I may refuse to participate in this study or in any part of this study, and I may withdraw at any time, without prejudice to my relations with SJSU or with the Santa Clara Valley _____.

AGREEMENT TO PARTICIPATE IN RESEARCH
SAN JOSE STATE UNIVERSITY
(Cont.)

(9) You may refuse to participate in this study. Your refusal will not in any way affect your right to receive services from the Santa Clara Valley _____ .

(10) I have received a copy of this consent form for my file. I have made a decision whether or not to participate. My signature indicates that I have read or that I have been read the information provided above and that I have decided to participate.

_____ _____
Date Subject's Signature

_____
Investigator's Signature

APPENDIX F

Letter from Executive Director

Valley
Urban League, Inc.

753 North Ninth Street, #131
San Jose, CA 95112
Telephone (408) 971-0117

February 15, 1990

Ms. Deborah Summers-Collins

San Jose, CA 95138

Dear Ms. Summers-Collins:

This letter confirms our conversation of November, 1990, at which time I indicated that the Valley Urban League will permit you to come into our organization, to survey those senior citizens who participate in our Senior Services Programs.

All I ask, is that you schedule your time with Mrs. , Project Director. At your convenience, I will introduce you to the Santa Clara Valley Urban League and it's services and to Mrs. Logan.

We look forward to your involvement in the Urban League.

Sincerely,

D J. H
Executive Director
/ll