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Factors related to precautionary sex behaviors among Haitian college students.

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FACTORS RELATED TO
PRECAUTIONARY SEX BEHAVIORS
AMONG HAITIAN COLLEGE STUDENTS

A Thesis Presented
by
DANAE PEREZ

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
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Department of Psychology
FACTORS RELATED TO
PRECAUTIONARY SEX BEHAVIORS
AMONG HAITIAN COLLEGE STUDENTS

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CHAPTER 1
INTRODUCTION

Aside from normative developmental issues, currently, adolescents must deal with the risk of acquiring a sexually transmitted disease (STD), as well as acquired immune deficiency syndrome (AIDS). Acquisition of the human immune deficiency virus (HIV) is the gravest consequence of adolescents's sexual behavior because there is at present no cure for AIDS. Despite the growing number of programs designed to educate adolescents about healthy sexual behavior, an increasing number of adolescents are deciding to have sex before they are mature enough to understand the responsibilities and consequences of such a decision (Jaccard and Dittus, 1991). Consequently, the rates of acquisition of sexually transmitted diseases and AIDS continue to rise. Gonorrhea, syphilis, chlamydial cervicitis, and hospitalizations for pelvic inflammatory disease are highest among adolescents than in any other age group (Kipke, Futterman and Hein, 1990; Bell and Hein, 1984). It is estimated that 3 million teenagers will contract a sexually transmitted disease each year (Centers for Disease Control, 1989). Likewise, it is estimated that many young adults (20-29 years old) who currently have AIDS acquired the disease during their teenage years (Boyer and Kegeles, 1991). Cumulative AIDS cases increased by 53% among adolescents and young adults between the end of 1988 and the end of 1990 (Centers for Disease Control, 1989, 1991). Cumulative AIDS cases resulting from exposure to HIV through heterosexual contact increased from 16% in 1991 to 26% in 1992 among 13 to 19 year olds, stressing the need for prevention programs to address these issues in the heterosexual as well as the homosexual adolescent population (Centers for Disease Control, 1993).

Current prevention programs have focused on changing attitudes and behaviors that place adolescents at risk of AIDS. Despite the focus on education to increase knowledge about AIDS, abstinence, and condom use, adolescents continue to have sex at a younger age, with multiple and/or high-risk partners, and without the use of condoms.
According to Lawrence (1993), prevention efforts must contain developmentally appropriate and culturally relevant intervention strategies for their audiences. Furthermore, these efforts need to take into consideration the determinants of both risky and precautionary behavior and their interrelationships. Despite current attempts to address some of these issues, research efforts have been inadequate in identifying the factors that motivate adolescents to adopt precautionary sex behaviors. In addressing minority populations, research studies suggest that these adolescents are more at risk than their non-minority counterparts (Padilla and Baird, 1991, Lawrence, 1993). However, studies with minority adolescents have been limited as compared to those with non-minorities. Therefore, the purpose of this proposed research is to address the determinants of precautionary sex behavior in Haitian adolescents, a minority population which is increasing in numbers in the United States. Specifically, cognitive, behavioral, and affective factors that are associated with past condom use and intended condom use will be explored.

Factors Related to Sexual Activity

As the age of onset of sexual activity decreases for adolescents, sexual intercourse with a greater number of partners increases, placing adolescents at greater risk of coming in contact with someone who has AIDS or HIV (Jaccard and Dittus, 1991). Current research with adolescents suggests an increasing incidence of sexual activity (Jaccard and Dittus, 1991). The average age at which a teenager first has intercourse is sixteen and it is estimated that by the end of the teenage years, 70% of females and 80% of males have had sexual intercourse (Jaccard and Dittus, 1991). The number of sexually active youth range from almost 14% of 12 to 16 year olds to 44% of fifteen year olds, with males engaging in sex at earlier ages than females (Jaccard and Dittus, 1991, Faulkenberry et al., 1987). Sexually active adolescents are also engaging in frequent sexual encounters.
Among 12 to 16 year olds, 41.2% reported having sex between two to ten times and 41.2% reported having sex more than ten times in their lifetime (Jaccard and Dittus, 1991).

Researchers have attempted to identify factors that influence adolescents's decision to engage or not engage in sexual activity. Psychosocial reasons that have predicted initiation of sexual intercourse are enhancement of self and attainment of intimacy in the relationship (Jaccard and Dittus, 1991, Juhasz and Sonnenshein-Schneider, 1987). For females, intimacy considerations regarding sexual intercourse are most important, with emphasis on the relationship aspects of sexual activity. For males, self-enhancement through sexual intercourse is most important, with emphasis on sexual impulse gratification (Juhasz and Sonnenshein-Schneider, 1987). Factors which predict sexual abstinence are reliance on moral authority (such as parents, peers, church) for decision making and awareness of the consequences of childbearing (Juhasz and Sonnenshein-Schneider, 1987). Among female adolescents, factors such as fear of contracting STDs/AIDS, feeling of not being ready to have sex, and belief that sex goes against personal values, religion, or parental wishes influence their decision to remain sexually inactive (Leland and Barth, 1992).

Factors Related to Contraception Use

Despite adolescents willingness to engage in sexual activity at young ages and/or in frequent episodes, many fail to use contraception to prevent pregnancy and acquisition of STDs/AIDS. Not only do approximately 50% of all teens fail to use contraception at first intercourse, but many possess little or no knowledge about it (Jaccard and Dittus, 1991, Faulkenberry et al., 1987). A relationship has been found between the use of contraception during the first sexual incident and age and gender. The age of sexual initiation is positively related to use. The earlier adolescents experience coitus, the less likely they are to use contraception during the first sex incident (Melchert and Burnett, 1990, Faulkenberry et al., 1987). Gender also plays a role in use. Females are less likely
to use birth control during the first encounter (Leland and Barth, 1992). Contraception use among adolescents is also inconsistent during the initial months of sexual activity. Thirty seven percent of females and 56% of males reported having at least one occasion of intercourse without using contraception (Jaccard and Dittus, 1991). The number of adolescents reporting no use of contraception during sexual activity ranges from 13.5% of males and 21.8% of females, to 36% of delinquent adolescents (Leland and Barth, 1992, Melchert and Burnett, 1990). Even for adolescents who were involved in a pregnancy in the past, use of contraception remains unreliable (Melchert and Burnett, 1992).

Among adolescents that report using contraception, the most popular source used in their last sexual encounter are the condom for males and the pill for females (Leland and Barth, 1992). An explanation for this pattern of preferences is that each sex chooses a method within its own control and is unwilling to entrust the sexual partner with contraception (Lawrence, 1993). Despite the fact that some adolescents are using contraception, their methods of choice can be unreliable. Leland and Barth (1992) found that over half of adolescents reported using the withdrawal method, one tenth used douching, and one third used rhythm.

In an attempt to understand why adolescents fail to use contraception, researchers have examined adolescents's knowledge and knowledge sources. Inconsistent use of contraception has been found to be related to adolescents's lack of factual knowledge regarding pregnancy and contraception (Melchert and Burnett, 1990). Many adolescents lack information concerning the different types of contraceptives and their specific use. The following demonstrate some of the areas of knowledge deficits regarding condom use: effectiveness of latex condoms versus animal skin, proper way to hold a condom when removing, and effectiveness of condoms in protecting against STDs (Leland and Barth, 1992). This lack of contraceptive knowledge may be related to the change and quality of adolescents's sources of sexual information in the last decade. While many
adolescents still prefer parents as their ideal source of information (Handelsman et al., 1987, Sanders and Mullis, 1988) research suggests that parents are failing to be the primary providers of sexual information. Overall, friends are cited as the most important source of information about sex among adolescents (Davis and Harris, 1982, Rozema, 1986, Sanders and Mullis, 1988). It appears that this discrepancy may be due to a general decline in communication and quality of parent-child relationships among families (Fisher, 1988). Relationships between sex communication with parents and adolescents's sexual knowledge or sexual behavior have been inconsistent however, with some studies finding a relationship between communication with parents and sexual behavior and knowledge and others failing to find a relationship (Fisher, 1986, 1987, Moore et al., 1986, Jaccard and Dittus, 1991, and Handelsman et al., 1987). Fisher (1988) and Sanders and Mullis (1988) found such a relationship. In their sample, adolescents who do report speaking to parents about sex also report general communication with parents and similar sexual attitudes as parents.

Attitudes related to the use of contraception are another factor involved in contraception decision making among adolescents. The most common reasons adolescents report for not using contraception are that they feel uncomfortable obtaining it, have none available at the time they have sex, have not planned sex, and have a partner who resists using it (Leland and Barth, 1992). Attitudes about condom use have been examined among sexually active and inactive adolescents, as well as among consistent versus inconsistent condom users. Common attitudes shared by consistent condom users include the believes that condoms are effective in preventing HIV transmission and do not reduce sexual pleasure (Hingson et al., 1990, Pleck, Sonenstein, and Ku, 1990). Consistent users also share attitudes regarding the behaviors associated with using condoms. They are more likely to carry condoms with them, are not embarrassed if asked to use them, and are more likely to use them all the time (Hingson et al., 1990, Hernandez and Smith, 1990). Overall, those adolescents failing to
consistently use condoms are expressing more negative expected outcomes of condom use and higher perceived self-efficacy to perform safer sex (O'Leary et al., 1992). Although they are reporting higher self-efficacy to discuss sex history with a partner, the danger lies in that they believe that a partner's self-report of safe history is enough to confer protection against HIV infection (O'Leary et al., 1992). Among sexually active and inactive males, attitudes about condoms also differ. Sexually active as compared to sexually inactive males report lower perceived costs for condom use related to embarrassment about buying condoms, more facility in discussing them with partner, or putting them on in front of partner. However, they are more likely to perceive condoms as more costly in terms of reduction of pleasure (Pleck, Sonenstein, and Ku, 1990).

Factors Related to AIDS Risk Behaviors

With current HIV-positive diagnoses increasing for the adolescent population, recent research has focused on examining risk factors in adolescents's sexual behavior that place them in danger of contracting AIDS. One important factor studied is sexual behavior. Among tenth graders, 25% report high risk behaviors such as engaging in sex with one or more presumably higher risk partner without or inconsistently using a condom (Walter, Vaughan, and Cohall, 1991). Sexual history is also predictive of AIDS-risk behaviors among adolescents. For example, previous infection with a STD fails to lead to greater use of condoms. Rather, there is a greater likelihood of sexual activity and condomless sex among those with a STD history than among those without a history (Hernandez and Smith, 1990).

Researchers have identified a number of psychosocial risk factors in adolescents that are related to AIDS-risk behaviors. Adverse life circumstances (such as familial disruption, parental discord, economic hardship, and crime), low parental support (such as poor communication, increase conflict, lack of support, and inconsistent discipline, supervision, and expectations), psychological distress, poor self-esteem, use of any substance in the past year, and any academic problems in the past year (such as poor
grades, subject failures, absences, and suspensions) are related to adolescents's greater likelihood to engage in high risk sex behaviors (Water, Vaughan, and Cohall, 1991).

The relationship between social support and AIDS plays an important role in predicting safer sex behaviors. Social support entails a sense of attachment through relationships, social integration in friendships, self-affirmation from relationships, and relationships that provide assistance, guidance, and nurturance (Lawrence et al., 1994). Adolescents with less social support have been found to be less knowledgeable about AIDS, hold more negative attitudes about condoms, and have lower self-efficacy than those with high social support. This lack of social support is related to greater involvement in risk behaviors such as casual sex, sex with nonmonogamous partners, coercions into unwanted sex, and infection with STDs (Lawrence et al., 1994). Male adolescents with low social support have also reported engaging in a greater number of unprotected sexual activity, with a greater number of partners, and with less condom use than female adolescents (Lawrence et al., 1994).

Research on the impact of AIDS knowledge on adolescents's safer sex behaviors has been inconsistent. Contradictory findings may reflect the possible interaction knowledge may play with age. For example, AIDS knowledge was not related to AIDS-risk behavior of casual condomless sex nor to resistance to change sex behavior among a group with a mean age of 20 years (Winslow, Franzini, and Hwang, 1992). However, with a younger, sexually active sample of 13.2 years, AIDS knowledge was related to sex activity (Brown, DiClemente, and Beausoleil, 1992). Sexually active males and females possessed less knowledge than their sexually inactive peers on items such as: avoiding sexual intercourse prevents the spread of AIDS, and AIDS is not curable even if treated early (only males) (Brown, DiClemente, and Beausoleil, 1992). The importance of knowledge about safer sex behavior among younger adolescents is highlighted by their misconceptions that birth control pills provide some protection against HIV, it is possible to tell if a person is infected with HIV simply by looking at them, and AIDS cannot be
prevented through abstinence, condoms, or sex with an intravenous drug user. These students with less knowledge consequently report greater worry that they have been exposed to HIV (Durant et al., 1992).

In response to the AIDS crisis, media messages, school AIDS education programs, and community prevention programs have increased in numbers across the United States. Studies have been conducted to examine if greater AIDS awareness leads adolescents to make safer sex behavior changes. The variables leading to behavior change have not been simple to identify. The AIDS Risk Reduction Model (ARRM) has been proposed by Boyer and Kegeles (1991) for understanding the determinants of AIDS risk behavior change for adolescents. The AIDS Risk Reduction Model divides the process of behavior change into the following three stages, all of which must be attained for behavior change to occur: Identification and labeling of risky activities (Stage 1), Commitment to engaging in low risk behavior (Stage 2), and Enacting the commitment (Stage 3). Stage one involves the identification and labeling of risky activities. This requires knowledge about HIV transmission so that adolescents can recognize that they are at risk when engaging in unprotected sex. Adolescents must also feel personally susceptible to AIDS in order to realize that their risky behavior can lead to HIV infection. This personal awareness can be blocked by their cognitive development. Adolescents may not have reached the stage of formal operational thinking that allows them to realize that they are just as vulnerable as other people and are at risk of pregnancy and STDs/AIDS. Furthermore, early initiation of premarital sex is sometimes accompanied by feelings of anxiety and guilt and a lack of acceptance of one's sexuality, which subsequently hinder responsible practice of safe sex (Dembo and Lundell, 1979). The adolescents's peer group can also exert a great influence on their attitudes. If the peer group believes unprotected sex is not risky, adolescents are likely to hold the same belief. For example, the relationship between adolescents's perceived peer norms, defined as perceived AIDS-risk attitudes and behavior of one's peers, and their AIDS risk behaviors
has been studied. Teenagers who perceive that their peers have AIDS-risk attitudes and behaviors are more likely to engage in condomless casual sex themselves. They are also more resistant to changing their behavior and practice safe sex (Winslow, Franzini, and Hwang, 1992). Even is adolescents know they are engaging in unprotected sex that may place them at risk of AIDS, the influence of the peer group at this age can be profound. Heterosexual adolescents have very infrequently seen AIDS among their peers, and they use this peer group experience to think of themselves at low risk even when their knowledge about AIDS tells them they are not (Winslow, Franzini, and Hwang, 1992).

Stage two of the AIDS Risk Reduction Model involves a commitment to engaging in the low risk behavior. In order to make a decision to change their behavior, adolescents must be confident that the behavior can be altered and that the benefits outweigh the costs. In determining the latter, attitudes play a role in the adolescents's perceptions of events. If a female places more importance on her partner's wishes not to use a condom rather than on her belief in safe sex, the costs of using condoms are greater than the benefits. Perceived social norms can dictate how much value the adolescents will place on certain behavior. In order to make this commitment, adolescents must also possess self-efficacy or feel capable of doing the necessary behaviors, such as buying a condom, negotiating with a partner, etc. (Boyer and Kegeles, 1991).

The third stage of the ARRM involves actually enacting the commitment. Adolescents must be capable of overcoming financial, environmental, and psychological barriers to carry out their desired behavior. They must possess sexual communication abilities to express their concerns and wishes as well as negotiate and plan sex activity with their partners. They may also need to rely on help seeking from either formal (doctors) or informal (friends or family) sources as to what kind of contraception to use, how to obtain it, etc.. Finally, some degree of anxiety about AIDS is needed for an individual to make the commitment to change and follow through on it (Boyer and Kegeles, 1991). Cochran and Peplau (1991) examined cognitive factors as predictors of
behavior change in sexually-active teenagers with a median age of 19 years. Worry about contracting STDs, such as AIDS and herpes, was a predictor of risk behavior changes. The factor influencing level of worry for females was their previous sex history. For males, perception of greater personal vulnerability for contacting an STD infection and higher levels of homophobia predicted worry about acquiring an STD.

Minority Adolescents

Researchers have examined sexual behavior among minority adolescents and found them to be at greater risks of sexually transmitted diseases and AIDS than non-minority adolescents. Rates of gonorrheal infection for African-American male adolescents are 44 times higher than those for Anglo male adolescents; rates for African-American females are 16 times higher than those for Anglo females (Cates, 1990). Although syphilis has declined in occurrence among certain groups, it is increasing among African-American adolescents, particularly among females (Cox, 1992). Likewise, AIDS surveillance data (Centers for Disease Control, 1991) indicate that African-American and Hispanic male adolescents are over represented among those with AIDS.

Initiation of earlier sexual activity and/or lack of or inconsistent use of contraception among minority adolescents place them at greater risks of STDs and AIDS. Among African-American teenagers, the onset of sexual activity occurs earlier than among Anglo adolescents and is characterized by less commitment oriented relationships (Faulkenberry et al., 1987). Among African-American adolescents with a mean age of 15.3 years, 70% of the sample reported being sexually active, with an average age of 11.7 years at the time of their first intercourse experience (Lawrence, 1993). Although a smaller percentage of Hispanic adolescents are sexually active (Strunin, 1991) as compared to Anglo teens, Hispanic females are twice as likely as Anglos to become pregnant (Aneshensel et al., 1989). This is explained by the lack or inconsistent use of contraception among Hispanic teenagers. Among Mexican-Americans, 83% reported not
using birth control the last time they had sex and 61% reported no use at all (Padilla and Baird, 1991). Among minority teenagers engaging in unprotected sex, 73% of women and 51% of men reported not using condoms the last time they had sex (Goodman and Cohall, 1989).

Researchers have examined factors responsible for the initiation of sexual activity among minority adolescents. For example, 14-year-old, African-American, female adolescents report deciding to have sex once they felt the relationship with their partners was secure, and hence they would not be abandoned after sexual intimacy (Pete and DeSantis, 1990). Among African-American females, psychosocial variables that have predicted differences between sexual activity and inactivity are age, career motivation, and attitudes toward premarital sex. Sexually inactive, African-American females have been younger, more career motivated, and less approving of premarital sex (Keith et al., 1991). Family structure may also play a role in terms of the impact the presence of the father in the home can have on the sexual activity and contraception use of daughters (Keith et al., 1991). Almost forty-six percent of the sexually inactive subjects had fathers living at home, in contrast to 38.1% of the active noncontracepting subjects and 23.8% of the sexually contracepting subjects (Keith et al., 1991). Family relationships also affect initiation of sexual activity among African American females. Adolescents who lacked planned activities and supervision in the home, whose mothers were inconsistent in what they said their daughters could do and what they actually let them do, and who had ineffective authority figures initiated earlier sexual activity. Communication about sex was also limited between these adolescents and their mothers and friends, and the females reported discussing sex only with their boyfriends (Pete and DeSantis, 1990).

In examining lack or inconsistent use of contraception use among adolescents, knowledge concerning the use of contraception has been addressed. Even among adolescents that use contraceptives, there is still the risk that they are not doing so properly because they lack knowledge concerning use and effectiveness. Although the
rhythm method is a popular choice for birth control for Hispanic youth, they possess the least physiological information necessary to use the method when compared to African-Americans and Anglos (Moore and Frickson, 1985). When asked to identify contraceptive methods, a majority of African-American and Hispanic adolescents are only able to correctly identify the pill and the condom, and when asked to describe the way the methods work, only males demonstrate satisfactory knowledge regarding condom use (Scott et al., 1988). African-American and Hispanic females lack knowledge regarding the use of methods such as the pill, condom, and diaphragm (Scott et al., 1988).

The decision of minority adolescents to use contraception may be related to the attitudes they hold about its effectiveness. Overall, more African-American males and females are more likely to report at least one good thing about contraception as compared to Hispanic teens (Scott et al., 1988). The most common positive thing reported among African-American and Hispanic adolescents is that contraception prevents pregnancy. Among African-American adolescents, the next most common positive thing reported is that contraception prevents STDs and AIDS (Lawrence, 1993). However, the greatest misconception held by Hispanic and African-American adolescents is that contraceptive methods may bring harm to the individual, partner, or baby (Scott et al., 1988). African-American adolescents also report misconceptions about the reliability of methods and feelings of embarrassment (Lawrence, 1993).

Lawrence (1993) examined the predictors of condom use for African-American, sexually-active adolescents. Adolescents who used a condom for their first intercourse experience, who were in the earlier school grades, who held more positive attitudes about the effects of condoms on sexual experience, and who believed they retained self-control in sexual situations more often used condoms during sexual activity. This finding on earlier school grades is inconsistent with those found with non-minority adolescents (Melchert and Burnett, 1990). When specific attitude dimensions regarding condom use
were examined, gender differences emerged. African-American females endorsed more positive attitudes regarding the interpersonal impact of condom use (e.g., If partner suggested, I would respect him/her), effect of condoms on sexual experience (e.g., Condoms are not a hassle to use), relationship safety through use of condoms (e.g., A condom is necessary when you and your partner are monogamous), and global impact of condoms (e.g., Condoms protect against STDs) than did males. Females also perceived themselves to have greater self-control in sexual situations and to be at higher risk of STDs or AIDS during sexual activity than did males (Lawrence, 1993).

Adolescents from minority groups also fail to take responsibility to protect themselves from AIDS and STDs. AIDS knowledge has been an important variable studied in examining the reasons why these adolescents use condoms less frequently than Anglo adolescents. Misconceptions regarding transmission of HIV in the following areas were found among minority adolescents: HIV transmission through blood donation and casual contact and lack of HIV transmission through vaginal fluids and oral sex (Goodman and Cohall, 1989). Many African-American adolescents report the following believes: when people don't have other partners they don't need to practice safe sex, if the man pulls out before orgasm then intercourse is safe, all STDs can be cured, and people who have the AIDS virus quickly get sick (Lawrence, 1993).

Among immigrant and ethnic minority adolescents, the misconceptions about HIV transmission are even greater (Hingson et al., 1991, Scott et al., 1988). These adolescents are less likely to know HIV can be transmitted by sharing needles, heterosexual sex, sex between two men, and sex with someone who looks healthy (Hingson et al., 1991). They also know less about avoiding AIDS by abstinence, condoms, sex with noninfected persons, and not having sex with an IV drug user (Scott et al., 1988). Subsequently, they are more likely to report worrying about getting AIDS (Strunin, 1991). These findings can be explained by the fact that immigrant adolescents have fewer sources of information than non-immigrant adolescents. For example, fewer
immigrants talk to parents about AIDS, know where to obtain AIDS information, or know where they can be tested for HIV (Hingson et al., 1991). These adolescents are also more at risk because they are less likely to perceive their peers as practicing safer sex behavior through condom use (Hingson et al., 1991). This perception is important because recent immigrants "who want to 'fit in' with perceived U.S. social norms may be particularly vulnerable to pressure from other teens or adults to engage in unprotected sex" (p.1640). Other factors that may also affect their knowledge is their ability to understand HIV transmission facts in English, and their level of acculturation to the U.S. norms of health behavior (Strunin, 1991). Specific acculturation determinants related to increased knowledge are: experience with medical services that incorporated patient education and personalized care into treatment, early age of immigration to the U.S., low degree of encapsulation within an ethnic network, formal education of several years of secondary school, greater generational removal from immigrant status, previous experience with a particular disease in the immediate family, urban origin, and limited migration back and forth to mother country (Harwood, 1981).

Because of the greater likelihood for minority adolescents to come in contact with AIDS and STDs, it has become crucial to examine behavior changes in response to the AIDS epidemic. Almost forty percent of minority, high school students claim to have changed their behavior during the past six months because of concerns about AIDS (Hernandez and Smith, 1990). The most common change was an increase in condom use, followed by monogamy or reduction in number of sexual partners. Other less frequently reported behavior changes are a decrease in the frequency of sex, abstinence, and increase in number of questions asked before sex (Zimet et al., 1992, Hernandez and Smith, 1990). Despite these reported changes, behaviors have not always proven to be consistent. Some adolescents who claim to be currently abstinent report engaging in
sexual intercourse within the past week, and some who claim to be currently using
condoms report failing to use them the last time they had sex (Hernandez and Smith,
1990).

Complex relationships have emerged when examining the association between
behavior changes reported by minority adolescents and AIDS knowledge, beliefs, and
worry. Adolescents's HIV transmission knowledge, perceived AIDS risk, and level of
concern of getting AIDS are positively related to behavior change (Hernandez and Smith,
1990). However, when gender differences are examined these relationships have not
been as clear. Among African-American adolescents, males who report a decrease in the
frequency of sex have more AIDS knowledge and more accurate AIDS beliefs (Zimet et
al., 1992), while females who report a decrease in frequency have less knowledge and
less accurate beliefs. Females who indicate a decrease in the number of partners have
more knowledge than females with no decrease in partners. Less AIDS-related social
anxiety and greater AIDS-related vulnerability worries are related to male's reporting of
decrease in frequency of sex. The behavior change of increasing condom use is related
to greater worry about vulnerability to HIV for both sexes (Zimet et al., 1992).

Of the minority populations that have been studied, Hispanics and African-
Amercians have received the most attention. It is important to study other minorities
whose numbers are increasing in the United States' population and whose experiences
may differ from those of other minorities. Haitian adolescents are such a minority.
These adolescents are dealing not only with normative developmental issues of
adolescence, but also with conflicting norms, values, and messages from the Haitian and
American cultures. An additional issue for these adolescents is the stigma attached to
Haitians in the U.S. with respect to AIDS. This stigma was created when, in 1982, the
Centers for Disease Control inferred that Haitians in the United States were in some way
at risk for AIDS (Farmer and Kim, 1991). Although they were eventually removed form
the list of high risk groups, stereotypes continued to exist regarding the possible
origination of AIDS in Haiti and Haitians’ vulnerability to the disease. Another significant issue for Haitian adolescents is the many constraints their families face when coming to this country. According to Giles (1990), these constraints have a direct impact on children’s education. One such problem centers on the fact that Haitian parents are accustomed to school systems in Haiti that take a greater responsibility for children’s education. Parents do not expect to play the role that is required of American parents in educating their children. Haitian parent also remove themselves from their children’s educational process because of their limited English skills, lack of education, and time constraints due to their work schedules. Some fear involvement with the school system because of their illegal status in the United States. The experience of losing their parental authority in a new country can also explain their lack of involvement with their children’s education. It may therefore be the case that Haitian parents feel alienated from their children and unable to influence them in a new country. Children may then fail to receive important knowledge and attitudes not taught in schools. Knowledge regarding sexuality may be an important part of the educational process lacking for Haitian adolescents.

Based on the author’s knowledge, no studies have specifically looked at Haitian adolescents. Several studies have included Haitians and placed them in the African-American or Caribbean subgroups. It is crucial to determine if Haitian adolescents face the same risks of early sexual activity, STDs and AIDS as other minority adolescents. It is also important to examine preventive strategies for HIV transmission in this population, specifically the use of condoms during sexual intercourse.

The purpose of this research project was to examine the factors related to past and intended condom use among Haitian adolescents. The following hypotheses were examined:

Hypothesis 1- It was hypothesized that AIDS knowledge would be positively associated with rates of past and intended condom use. As the AIDS Risk Reduction Model
(ARRM) postulates, in order for adolescents to make behavior changes such as condom use they must possess sufficient HIV transmission knowledge to identify and label their behaviors as risky (Boyer and Kegeles, 1991). Researchers studying African-American and Hispanic adolescents have found a positive relationship between AIDS knowledge and behavior change (Hernandez and Smith, 1990).

**Hypothesis 2** - It was hypothesized that positive attitudes towards condoms would be positively associated with rates of past and intended condom use. The ARRM postulates that in order to make a decision about using condoms, adolescents's attitudes must reflect confidence that the benefits of using condoms outweigh the costs and that they are personally susceptible to AIDS (Boyer and Kegeles, 1991). Positive attitudes about condoms and the behaviors associated with their use have been positively related to consistent use (Lawrence, 1993, Hingson et al., 1990, Sonenstein and Ku, 1990, Hernandez and Smith, 1990), as well as positive attitudes regarding self-efficacy to use condoms (Pleck, Sonenstein, & Ku, 1990, O'Leary et al., 1992).

**Hypothesis 3** - It was hypothesized that sexual attitudes would be associated with rates of past and intended condom use. Specifically, scores which reflect permissive attitudes and attitudes regarding sex as a self-centered, physical activity will be negatively associated with rates of past and intended condom use because they reflect a lack of responsible sexual behavior and concern for the sex partner. Scores which reflect attitudes in favor of the sexual practices of birth control, sex education, and masturbation and attitudes about the positive interpersonal impact of sex will be positively associated with rates of past and intended condom use. The ARRM and subsequent research have highlighted the importance in adolescents's acceptance of their sexuality which leads to greater responsibility in practicing safe sex (Boyer and Kegeles, 1991, Pete and DeSantis, 1990).

**Hypothesis 4** - It was hypothesized that demographic variables would be related to past and intended condom use. Specifically, a high number of sex partners, past history of
pregnancy or STDs, low number of years spent in the United States, perception of peers not using condoms, early age of first intercourse experience, and a lack of behavior changes because of concerns about AIDS will be negatively associated with rates of past and intended condom use. Researchers have found these behaviors to be related to inconsistent use of contraception and condoms (Meleheert and Burnett, 1992, Hernandez and Smith, 1990, Strunin, 1991).

**Hypothesis 5**- It was hypothesized that the following variables would be predictive of rate of intended condom use: 1. past condom use, 2. AIDS knowledge, 3. condom attitudes in the following subscales: Interpersonal Impact, Effect on Sexual Experience, Self-Control, Global Attitude, Perceived Risk, Inhibition, Promiscuity, and Relationship Safety, 4. sex attitudes in the following subscales: Permissiveness, Sex Practices, Communion and Instrumentality and 5. the following demographic variables: number of sex partners, past history of pregnancy or STDs, number of years spent in the United States, perception of condom use in peers, age of first intercourse experience, and behavior changes because of concerns about AIDS. Since research findings have been inconsistent in determining predictor variables of intended condom use all of the above variables will be explored as possible predictors.
CHAPTER II

METHOD

Subjects

The subject pool for this study consisted of 26 Haitian college students from the University of Massachusetts at Amherst and Boston campuses. At the Amherst campus, students were recruited through the Haitian American Student Association (HASA) and the Psychology Department during the Spring semester, 1995. At the Boston campus, students were recruited during the Summer session, 1995.

The sample consisted of 11 males and 15 females. Subjects' ages ranged from 18-32 years; the mean age was 22.5 and the SD was 3.8. Four subjects were nontraditional college students in terms of age. Their ages ranged from 28-32 years. These four subjects were retained in the sample because their scores on measures did not appear significantly different from those of more traditional college students. Fifteen subjects (58%) were born in Haiti and the mean number of years they had lived in the United States was 11.2 and the SD was 7.3. The remaining 11 subjects (42%) were all born in the United States.

Materials

Demographic and Survey Information. A demographic questionnaire included questions about the subject's age, sex, religion, place of birth, and grade level (See Appendix B). Other questions assessed the number of years subjects lived in the United States, language fluency, parents's level of education, and language spoken most frequently at home. Open-ended questions asked subjects to give their definition of sexual intercourse and safe sex. Other questions addressed the sexual experience of the subjects, age of first intercourse, contraception use at first intercourse, number of sex partners, sources of sex information, and history of pregnancy and AIDS/STDs. More specific information about current sexual activity was obtained by asking subjects to report the frequency of sexual activity, contraception use, and behavior changes because
of concerns about AIDS in the last six months. The six month time frame has been found to be a reliable retrospective assessment period (Kauth, St. Lawrence, & Kelly, 1991).

**Condom Use.** The Condom Use Questionnaire (CUQ) was used to assess condom use (Sacco et al., 1991). The measure contains 25 items related to past condom use in the last two years and intended condom use (See Appendix C). The past condom use scale is divided into the CUQ-Past High Frequency subscale (CUQ-PHF), which depicts various circumstances in which a high frequency of subjects report having sex, and the CUQ-Past Moderate Frequency subscale (CUQ-PMF), which depicts various circumstances in which a moderate frequency of subjects report having sex. Subjects are asked to substitute each of the items described in the two subscales into the following sentence: "In the past two years, a condom was used when I engaged in sexual activity with." Subjects respond using a 7-point Likert scale ranging from "0% of the time" to "100% of the time." An eighth response option of "never had sex with anyone like this person," is also available. The intended condom use scale is divided into the CUQ-Intended High Frequency subscale (CUQ-IHF), which depicts various circumstances in which a high frequency of subjects report they would have sex, and the CUQ-Intended Moderate Frequency subscale (CUQ-IMF), which depicts various circumstances in which a moderate frequency of subjects report they would sex. Subjects are asked to substitute each of the items described in the two subscales into the following sentence: "In the future, do you intend to use a condom if you engage in sexual activity with _____?". Subjects respond using a 7-point Likert scale ranging from "never" to "always." An eighth option of "would not have sex" is available if subjects are certain they would never engage in sex under a particular situation described. The CUQ has been normed with mostly white, heterosexual college students. The internal consistency (alpha coefficient) was > .90 for each of the CUQ subscales. Test-retest reliability were all > .70, except for the CUQ-IMF (r = .62) and the intentions to keep condoms at home (r = .57) (Sacco et al., 1991).
Several modifications were conducted on the CUQ after consultation with its author. Scores in the CUQ-Past High Frequency subscale (CUQ-PHF) and the CUQ-Past Moderate Frequency subscale (CUQ-PMF) were combined into a single score for past condom use. The 7-point Likert scale was replaced by a 6-point scale ranging from “never had sex with this person” to “never used a condom when you had sex.” Scores in the CUQ-Intended High Frequency subscale (CUQ-IHF) and the CUQ-Intended Moderate Frequency Subscale (CUQ-IMF) were combined into a single score for intended condom use. The 7-point Likert scale was replaced by a 6-point scale ranging from “would never have sex with this person” to “would never use a condom.” Higher mean scores for the past and intended condom use subscales reflect greater precautionary sex behaviors such as abstinence or consistent condom use.

**Condom Attitudes.** The Condom Attitude Scale (CAS) is a 53-item measure assessing eight different aspects of condom attitudes (Sacco et al., 1991) (See Appendix D). The eight subscales consist of the following attitude factors: Interpersonal Impact (CAS-1) (e.g., if partner suggested, I would respect him/her), Effect on Sexual Experience (CAS-2) (e.g., condoms are a hassle to use), Self-Control (CAS-3) (e.g., I'm concerned about AIDS, but in the heat of the moment it wouldn't stop me from having sex without a condom), Global Attitude (CAS-4) (e.g., people who use condoms are wimps), Perceived Risk (CAS-5) (e.g., if I'm not careful, I could definitely catch AIDS), Inhibition (CAS-6) (e.g., I'd be embarrassed to buy condoms), Promiscuity (CAS-7) (e.g., people who carry condoms are just looking for sex), and Relationship Safety (CAS-8) (e.g., a condom is not necessary when you are with the same person for a long time) (Sacco et al., 1991). Subjects respond to each condom attitude item using a 5-point scale ranging from “strongly agree” to “strongly disagree.” Higher mean scores for each of the subscales reflect more positive attitudes toward condoms. The measure has been normed with white college students and African-Americans. Internal consistency reliability (coefficient alpha) for two studies are generally high and stable for all the subscales ($\alpha >$}
.73), except for the Global Attitude subscale ($\alpha = .79$ study 1, $\alpha = .62$ study 2). Test-retest reliability were also high for the subscales, except for the Global Attitude subscale ($r = .52$) (Sacco et al., 1991).

Sex Attitudes. The Sexual Attitudes Scale (SAS) is a 43-item scale measuring sexual attitudes (Hendrick & Hendrick, 1987). (See Appendix E). The scale is divided into four subscales measuring the following factors: Permissiveness (SAS-1) (attitudes about premarital sex and casual sex), Sexual Practices (SAS-2) (attitudes about birth control, sex education, and sex behavior), Communion (SAS-3) (attitudes about sex that focus on sharing, involvement, and idealism), and Instrumentality (SAS-4) (attitudes about utalitarian and genitaly focused sex). A 5-point scale ranging from "strongly agree" to "strongly disagree" is used. A lower mean score in the Permissiveness subscale reflects attitudes in favor of casual and premarital sex. A lower mean score in the Sexual Practices subscale reflects attitudes in favor of sex education, birth control, and masturbation. A lower mean score in the Communion subscale reflects attitudes about sex that focus on sharing, involvement, and idealism. A lower mean score in the Instrumentality subscale reflects attitudes in favor of utalitarian and genitaly focused sex. The measure has been normed with a population of Anglo, African-American, and Hispanic college students (Hendrick and Hendrick, 1987). Internal consistency reliability (coefficient alpha) for two studies are generally high and stable for all the subscales ($\alpha > .74$), except for the Sex Practices scale ($\alpha = .69$ study 1, $\alpha = .82$ study 2). Test-retest reliability ranged from a low of .66 for Instrumentality to a high of .88 for Permissiveness. The four subscales also show appropriate correlations with other measures of sex attitudes, demonstrating their criterion and concurrent validity (Hendrick and Hendrick, 1987).

AIDS Knowledge. Knowledge of AIDS-risk behaviors will be measured by the AIDS Risk Behavior Knowledge Test (Kelly et al., 1989) (See Appendix F). This true/false test contains 40 items measuring objective knowledge about AIDS such as
mode of transmission, misconceptions about AIDS, and safer sex behaviors. Scoring involves a summed total score based on the number of items answered correctly, so that higher scores reflect more knowledge about AIDS. Researchers report a K-R 20 reliability coefficient of .74, and a test-retest reliability coefficient of .84 (Kelly et al., 1990). The measure has normative data for homosexual men, and Anglo and African-American college students (Lawrence, 1993).

Procedure

Potential subjects were approached by the experimenter and asked to participate in a study designed to examine the sexual behaviors, attitudes, and knowledge of Haitian college students. Subjects at the University of Massachusetts, Amherst campus were administered the consent form (See Appendix A) and the questionnaire by the researcher and two undergraduate assistants at a psychology laboratory. Subjects at the University of Massachusetts, Boston campus were administered a consent form and questionnaire by the researcher at one of the academic buildings. These subjects took the questionnaires with them and returned them the same day to the researcher. Participation in the study lasted approximately one hour. Subjects received psychology credits or payment for their participation.
CHAPTER III
RESULTS

This study examined the factors related to past and intended condom use among Haitian college students. The following hypotheses were examined:

**Hypothesis 1** - It was hypothesized that AIDS knowledge in the AIDS Risk Behavior Knowledge Test would be positively associated with rates of past and intended condom use.

**Hypothesis 2** - It was hypothesized that attitudes towards condoms in the Condom Attitude Scale (CAS) would be positively associated with rates of past and intended condom use. Specifically, scores in each of the following subscales would be positively associated with rates of past and intended condom use: Interpersonal Impact (CAS-1), Effect on Sexual Experience (CAS-2), Self-Control (CAS-3), Global Attitude (CAS-4), Perceived Risk (CAS-5), Inhibition (CAS-6), Promiscuity (CAS-7), and Relationship Safety (CAS-8).

**Hypothesis 3** - It was hypothesized that sexual attitudes in the Sexual Attitudes Scale (SAS) would be associated with rates of past and intended condom use. Specifically, scores in each of the following subscales would be positively associated with rates of past and intended condom use: Permissiveness (SAS-1) and Instrumentality (SAS-4). Scores in each of the following subscales would be negatively associated with rates of pasts and intended condom use: Sex Practices (SAS-2) and Communion (SAS-3).

**Hypothesis 4** - It was hypothesized that demographic variables would be related to rates of past and intended condom use. Specifically, a high number of lifetime sex partners, past history of pregnancy or STDs, low number of years spent in the United States, perception of peers not using condoms, early age of first intercourse experience, and a lack of behavior changes because of concerns about AIDS would be associated with lower rates of past and intended condom use.
Hypothesis 5- It was hypothesized that the following variables would be predictive of rate of intended condom use: 1. past condom use, 2. AIDS knowledge, 3. condom attitudes in the following subscales: Interpersonal Impact (CAS-1), Effect on Sexual Experience (CAS-2), Self-Control (CAS-3), Global Attitude (CAS-4), Perceived Risk (CAS-5), Inhibition (CAS-6), Promiscuity (CAS-7), and Relationship Safety (CAS-8), 4. sex attitudes in the following subscales: Permissiveness (SAS-1), Sexual Practices (SAS-2), Communion (SAS-3), and Instrumentality (SAS-4) and 5. the following demographic variables: number of lifetime sex partners, past history of pregnancy or STDs, number of years spent in the United States, perception of condom use in peers, age of first intercourse experience, and behavior changes because of concerns about AIDS.

Demographic Characteristics

Subjects were distributed across undergraduate grade levels and one subject was a graduate student. Subjects reported a number of different religious orientations. The most frequent language spoken at home was Creole for 15 subjects (58%), English for 6 (23%), and Creole and English for 5 (19%). Twenty-two subjects (84.6%) were fluent in more than one language, 2 (7.7%) were most fluent in Creole, and 2 (7.7%) were most fluent in English. The majority of subjects’ fathers and mothers had attained less than a Bachelor’s degree. (See Table 1 for distribution of demographic characteristics by gender). No significant differences were found between males and females.
Table 1

Demographic Characteristics of Participants

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>23.4</td>
<td>21.9</td>
<td>22.5</td>
</tr>
<tr>
<td>Grade level</td>
<td></td>
<td></td>
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<tr>
<td>Freshman</td>
<td>3</td>
<td>3</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Sophomore</td>
<td>1</td>
<td>4</td>
<td>5 (19)</td>
</tr>
<tr>
<td>Junior</td>
<td>4</td>
<td>4</td>
<td>8 (31)</td>
</tr>
<tr>
<td>Senior</td>
<td>3</td>
<td>3</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Graduate</td>
<td>0</td>
<td>1</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Religious Preference</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>2</td>
<td>7</td>
<td>9 (37.5)</td>
</tr>
<tr>
<td>Christian</td>
<td>0</td>
<td>3</td>
<td>3 (12.5)</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>4</td>
<td>9 (37.5)</td>
</tr>
<tr>
<td>Atheist</td>
<td>2</td>
<td>1</td>
<td>3 (12.5)</td>
</tr>
<tr>
<td>Language spoken most at home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>English</td>
<td>2</td>
<td>4</td>
<td>6 (23)</td>
</tr>
<tr>
<td>Creole</td>
<td>7</td>
<td>8</td>
<td>15 (58)</td>
</tr>
<tr>
<td>English &amp; Creole</td>
<td>1</td>
<td>4</td>
<td>5 (19)</td>
</tr>
<tr>
<td>Language fluency</td>
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<td></td>
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<tr>
<td>English, French, &amp; Creole</td>
<td>7</td>
<td>5</td>
<td>12 (46)</td>
</tr>
<tr>
<td>English &amp; Creole</td>
<td>1</td>
<td>7</td>
<td>8 (31)</td>
</tr>
<tr>
<td>French &amp; English or Creole</td>
<td>1</td>
<td>1</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>English</td>
<td>0</td>
<td>2</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Creole</td>
<td>1</td>
<td>1</td>
<td>2 (7.7)</td>
</tr>
<tr>
<td>Father’s level of education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than Bachelor’s degree*</td>
<td>4</td>
<td>12</td>
<td>16 (67)</td>
</tr>
<tr>
<td>Bachelor’s or Master’s degree</td>
<td>6</td>
<td>2</td>
<td>8 (33)</td>
</tr>
<tr>
<td>Mother’s level of education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than Bachelor’s degree*</td>
<td>5</td>
<td>12</td>
<td>17 (68)</td>
</tr>
<tr>
<td>Bachelor’s or Master’s degree</td>
<td>6</td>
<td>2</td>
<td>8 (32)</td>
</tr>
</tbody>
</table>

* Less than Bachelor’s degree = high school or less, technical/vocational school, or some college
The majority of subjects were able to correctly define “safe sex” in terms of condom use or abstinence. Some subjects defined safe sex as the use of contraception to prevent pregnancy. Information on the sources of sex information was also obtained. Television/books was reported as the most common source of sex information (64%), followed by friends (60%), school (44%), and family (16%).

**Incidence of Sexual Behavior**

Eighty-five percent of subjects reported sexual activity, as defined by vaginal, oral, or anal sex. All the male subjects reported sexual activity, while 11 of the 15 female subjects (73%) reported sexual activity. With the exception of three females, all sexually-active subjects reported sexual activity within the last six months. All subjects reported engaging in vaginal intercourse, 72% in oral intercourse, and 23% in anal intercourse in the past six months. All subjects reported a heterosexual orientation, with the exception of a homosexual male and a bisexual, sexually-inactive female.

Sexually active subjects’ ages at the first incidence of sexual activity ranged from 7.5-22; the mean age was 15.8 and the SD was 3.4. The number of lifetime sex partners among the sexually active ranged from 1-60; the mode was 1 and 2. The mode is reported because of two extreme scores, 50 and 60 sex partners. The number of sex partners in the last six months ranged from 1-6; the mean number was 2.2 and the SD was 1.5. No gender differences were found for any of the variables.

Ten subjects (40%) reported having received a test for HIV/AIDS, and no subject reported having HIV/AIDS. Four subjects (15%) had a history of a STD and 7 subjects...
(28%) had a history of a pregnancy. Seven males (64%) and five females (45%) reported having changed their behavior because of concern about AIDS.

**Contraception Use**

Thirteen sexually-active subjects (59%) reported condom use in their first sexual activity. Five males (45%) and six females (75%) reported condom use less than 100% of the time in the last six months. (See Table 2 for distribution of sex behaviors of sexually active subjects by gender). Twenty-five percent of female subjects who did not report consistent condom use relied on the withdrawal method 100% of the time and 50% used condoms more than 50% of the time. Nine percent of male subjects who did not report consistent condom use relied on the partner’s use of the pill 100% of the time, 18% used condoms more than 50% of the time and 18% used condoms less than 50% of the time.

**AIDS Knowledge**

Subjects’ correct responses on the AIDS Risk Behavior Knowledge Test (Kelly, Lawrence, Hood, & Brasfield, 1990) ranged from 21-40, where 40 is a perfect score. The mean score was 31.96 and the SD was 5.8 (See Table 3 for scale means and standard deviations). To test hypothesis 1, correlational analyses were conducted to assess the association between AIDS knowledge and past and intended condom use. A significant positive relationship was found between AIDS knowledge and intended condom use at r = .56, p = .004. Hypothesis 1 was not supported regarding AIDS knowledge and past condom use (See Table 4 for correlations of AIDS knowledge with condom use). Gender differences in AIDS knowledge were not found.
<table>
<thead>
<tr>
<th></th>
<th>Males (%)</th>
<th>Females (%)</th>
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<tbody>
<tr>
<td>Sexually active</td>
<td>11 (100)</td>
<td>11 (73)</td>
</tr>
<tr>
<td>Mean age of first sexual activity</td>
<td>14.9</td>
<td>16.6</td>
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<tr>
<td>Condom use in first sexual activity</td>
<td>6 (55)</td>
<td>7 (64)</td>
</tr>
<tr>
<td>Mean lifetime sex partners</td>
<td>20.9*</td>
<td>5.2</td>
</tr>
<tr>
<td>History of pregnancy</td>
<td>3 (27)</td>
<td>4 (36)</td>
</tr>
<tr>
<td>History of STD</td>
<td>2 (18)</td>
<td>2 (18)</td>
</tr>
<tr>
<td>Sexually active last 6 months</td>
<td>11 (100)</td>
<td>8 (73)</td>
</tr>
<tr>
<td>Mean sex partners in last 6 months</td>
<td>1.7</td>
<td>2</td>
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<tr>
<td>Condom use in last 6 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% of the time</td>
<td>6 (55)</td>
<td>2 (25)</td>
</tr>
<tr>
<td>More than 50% of the time</td>
<td>2 (18)</td>
<td>4 (50)</td>
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<tr>
<td>50% of the time</td>
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<tr>
<td>Less than 50% of the time</td>
<td>2 (18)</td>
<td>2 (25)</td>
</tr>
<tr>
<td>Behavior change due to AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (64)</td>
<td>5 (45)</td>
</tr>
<tr>
<td>No</td>
<td>4 (36)</td>
<td>6 (55)</td>
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* Mean is inflated because of two extreme scores.
Table 3

Scale Means and Standard Deviations

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<thead>
<tr>
<th>Scales</th>
<th>Mean</th>
<th>SD</th>
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<tr>
<td>AIDS Risk Behavior Knowledge Test</td>
<td>31.96</td>
<td>5.8</td>
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<td><strong>Condom Attitude Scale (CAS)</strong></td>
<td></td>
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<tr>
<td>Interpersonal impact (CAS-1)</td>
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<td>.69</td>
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<td>Global attitude (CAS-4)</td>
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<td>.5</td>
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<tr>
<td>Perceived risk (CAS-5)</td>
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<td>.7</td>
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<tr>
<td>Inhibition (CAS-6)</td>
<td>4.34</td>
<td>.83</td>
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<tr>
<td>Promiscuity (CAS-7)</td>
<td>3.96</td>
<td>1.06</td>
</tr>
<tr>
<td>Relationship safety (CAS-8)</td>
<td>3.82</td>
<td>1.05</td>
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<td><strong>Sexual Attitudes Scale (SAS)</strong></td>
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<td>Permissiveness (SAS-1)</td>
<td>3.31</td>
<td>1.03</td>
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<tr>
<td>Sexual practices (SAS-2)</td>
<td>1.73</td>
<td>.67</td>
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<tr>
<td>Communion (SAS-3)</td>
<td>1.92</td>
<td>.69</td>
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<tr>
<td>Instrumentality (SAS-4)</td>
<td>2.9</td>
<td>1.1</td>
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Table 4
Correlations of Scales with Past and Intended Condom Use

<table>
<thead>
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<th>Scales</th>
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<th>Intended condom use</th>
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<tr>
<td>AIDS Risk Behavior Knowledge Test</td>
<td>.3</td>
<td>.56**</td>
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<td>.57**</td>
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<td>.17</td>
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<tr>
<td>Inhibition (CAS-6)</td>
<td>-.19</td>
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<td>Promiscuity (CAS-7)</td>
<td>.1</td>
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<td>Relationship safety (CAS-8)</td>
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<td>Sexual Attitudes Scale (SAS)</td>
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</tr>
<tr>
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<td>.44*</td>
<td>.66**</td>
</tr>
<tr>
<td>Sexual practices (SAS-2)</td>
<td>.27</td>
<td>.13</td>
</tr>
<tr>
<td>Communion (SAS-3)</td>
<td>.14</td>
<td>.2</td>
</tr>
<tr>
<td>Instrumentality (SAS-4)</td>
<td>.18</td>
<td>.54**</td>
</tr>
</tbody>
</table>

* p < .05    ** p < .01
Condom Attitudes

Mean scores on each of the eight subscales of the Condom Attitude Scale (Sacco et al., 1991) can range from 1 (negative condom attitudes) to 5 (positive condom attitudes). Subjects’ mean scores ranged from 3.68 to 4.44. (See Table 3 for CAS subscale means and standard deviations). Only the Self-Control subscale (CAS-3) was found to be significantly associated with condom use. A significant positive correlation was found between the Self-Control subscale and past condom use ($r = .42, p = .036$) and intended condom use ($r = .57, p = .003$). Hypothesis 2 was not supported for any of the other subscales (See Table 4 for correlations of CAS subscales with condom use). No gender differences were found in any of the subscales.

Sexual Attitudes

Mean scores on each of the four subscales of the Sexual Attitudes Scale (Hendrick & Hendrick, 1987) can range from 1 (high agreement) to 5 (low agreement). Subjects’ mean scores ranged from 1.7 to 3.3. (See Table 3 for SAS subscale means and standard deviations). As predicted, positive correlations were obtained between the Permissiveness subscale (SAS-1) and past condom use ($r = .44, p = .03$) and intended condom use ($r = .66, p = .0$) and the Instrumentality subscale (SAS-4) and intended condom use ($r = .54, p = .005$). Hypothesis 3 was not supported for the Sexual practices (SAS-2) and Communion (SAS-3) subscales (See Table 4 for correlations of SAS subscales with condom use). A gender difference was obtained in the Permissiveness subscale (SAS-1), where females reported less permissive attitudes than males. The respective means were 3.86 for females and 2.67 for males ($t = 3.39, p = .003$).
Demographic and Sex Characteristics

Hypothesis 4 was supported in part. Past condom use was positively associated with history of pregnancy ($r = .44$, $p = .03$) and history of STD ($r = .57$, $p = .003$) and was negatively associated with lifetime sex partners ($r = -.73$, $p = .000$). These findings suggest that those subjects less likely to use condoms in the past were more likely to have a history of pregnancy, a history of STD, and a greater number of lifetime sex partners.

No other significant associations were found between past and intended condom use and the following variables: years in U.S., peer condom use, behavior change because of AIDS concern, and age of first sex activity (See Table 5 for correlations of demographic and sex variables with condom use).

Table 5
Correlations of Sex Characteristics with Past and Intended Condom Use

<table>
<thead>
<tr>
<th></th>
<th>Past condom use</th>
<th>Intended condom use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years in U.S.</td>
<td>-.29</td>
<td>.02</td>
</tr>
<tr>
<td>Age of first sexual activity</td>
<td>.38</td>
<td>.28</td>
</tr>
<tr>
<td>Lifetime sex partners</td>
<td>-.73***</td>
<td>-.31</td>
</tr>
<tr>
<td>History of pregnancy</td>
<td>.44*</td>
<td>.26</td>
</tr>
<tr>
<td>History of STD</td>
<td>.57**</td>
<td>.28</td>
</tr>
<tr>
<td>Behavior change due to AIDS</td>
<td>.37</td>
<td>.22</td>
</tr>
<tr>
<td>Peer condom use</td>
<td>-.13</td>
<td>-.11</td>
</tr>
</tbody>
</table>

* $p < .05$  ** $p < .01$  *** $p < .001$
Regression Analysis

Due to the study's small sample size, the large number of variables hypothesized to be predictive of rate of intended condom use, and the high degree of intercorrelation among variables, the hypothesized regression analysis was not conducted. However, based on previous research findings, multiple regression analyses using forward selection were conducted using the following Condom Attitude Scale subscales as predictors and intended condom use as the criterion: Effect on Sexual Experience (CAS-2), Self-Control (CAS-3), Inhibition (CAS-6), and Relationship Safety (CAS-8). Previous research studies have found that these variables predict past condom use and intent to carry condoms and keep condoms at home in both Anglo and African-American populations (Lawrence, 1993, Sacco et al., 1991). While there is no published research on the association of sex attitudes and condom use, Sexual Attitude Scale subscales, Permissiveness (SAS-1) and Instrumentality (SAS-4) were also used as predictors of intended condom use. The expectation that these two SAS subscales would predict intended condom use is based on the belief that those adolescents who regard sex as a casual, self-gratifying behavior will lack the responsibility to use condoms in the future. Subscales were entered hierarchically based on their zero-order correlations with intended condom use (higher to lower). The scales were entered into the analysis in the following order: Permissiveness subscale (SAS-1), Self-Control subscale (CAS-3), Instrumentality subscale (SAS-4), Relationship Safety subscale (CAS-8), Effect on Sexual Experience subscale (CAS-2), and Inhibition subscale (CAS-6). The Permissiveness subscale (SAS-1) yielded a significant multiple R squared and accounted
for 41% of the variance in intended condom use (t = 4.1, p = .000). The Self-Control subscale (CAS-3) was then added to the equation and contributed 22% to the variance over the effect of the Permissiveness subscale (SAS-1) (t = 3.4, p = .003). Significance was not obtained in the remaining four subscales and together they contributed little to the variance over the effects of the Permissiveness (SAS-1) and Self-Control (CAS-1) subscales. The Permissiveness (SAS-1) and Self-Control (CAS-3) subscales accounted for 62% of the variability in intended condom use and the remaining four subscales together accounted for 7% of the variability in intended condom use (See Table 6 for multiple regression analysis).

Table 6

Multiple Regression Analysis Model: Predictors of Intended Condom Use

<table>
<thead>
<tr>
<th>Variable</th>
<th>Coefficient</th>
<th>STD Error</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
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<td>.56</td>
<td>3.2</td>
<td>.006</td>
</tr>
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<td>Permissiveness (SAS-1)</td>
<td>.49</td>
<td>.14</td>
<td>3.52</td>
<td>.003</td>
</tr>
<tr>
<td>Self-Control (CAS-3)</td>
<td>.27</td>
<td>.12</td>
<td>2.32</td>
<td>.034</td>
</tr>
<tr>
<td>Instrumentality (SAS-4)</td>
<td>.14</td>
<td>.07</td>
<td>1.92</td>
<td>.073</td>
</tr>
<tr>
<td>Relationship Safety (CAS-8)</td>
<td>-.06</td>
<td>.11</td>
<td>-.56</td>
<td>.585</td>
</tr>
<tr>
<td>Effect on Sex Exp. (CAS-2)</td>
<td>-.19</td>
<td>.11</td>
<td>-1.7</td>
<td>.108</td>
</tr>
<tr>
<td>Inhibition (CAS-6)</td>
<td>.08</td>
<td>.15</td>
<td>.54</td>
<td>.599</td>
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</tbody>
</table>
CHAPTER IV

DISCUSSION AND CONCLUSION

The purpose of this study was to examine the sexual behaviors, knowledge, and attitudes of Haitian college students, a minority population that has received little attention in research on adolescent sexuality. Specifically, the study’s goal was to identify condom use behaviors as a preventive measure in the transmission of AIDS/STDs. The incidence of sexual activity among female Haitians (73%) in this sample was found to be consistent with the reported incidence for Anglo female college students (Murstein and Mercy, 1994). The number of sexually active Haitian males (100%) is greater than the reported incidence for Anglo male college students (Murstein and Mercy, 1994). Although the difference between the number of sexually active Haitian males and females was not statistically significant, there was a greater number of sexually active Haitian males than females. A greater sample size may have yielded statistical significance. Differences in sexual activity between the sexes may be expected in cultures such as the Haitian, where religious and moral values dictate the sex behavior of females. While it may be acceptable for Haitian males to have sexual relations before marriage, females are expected to remain virgins until marriage. It may be possible that the sexually inactive females (N = 4) in the sample were adhering to such standards.

Subjects’ mean age at the initiation of sexual activity (15.8 years) was closer to that reported for Anglo adolescents than for African-Americans (Winslow, Franzini and Hwang, 1992, Wilson et al., 1994). Although all the Haitian males were sexually active, they wait longer to initiate sex as compared to other minority groups. Perhaps religious
and cultural values also affect Haitian males’ decision to engage in sex at a later age than African-American males. Although Haitian males did not wait for marriage to be sexually active, they may wait for a monogamous or loving relationship to initiate sex. The similarity in the age of initiation of sex among males and females warrants exploration. Those females who decided to become sexually active at the same age as males may have been less influenced by Haitian values regarding female sexuality. Their attitudes might have been influenced by the American culture which allows greater freedom in women’s sexual behavior. Future research should explore these issues.

The number of Haitians who reported condom use the first time they had sex (59%) was higher than that reported among younger Anglo adolescents (Jaccard and Dittus, 1991). This percentage among Haitians is consistent with that reported among older Anglo adolescents, since older adolescents tend to use condoms more frequently the first time they have sex than younger ones (Melchert and Burnett, 1990). The number of consistent condom users in the past 6 months (42%) was higher than those reported for Anglo college students (Murstein and Mercy, 1994). This difference may be explained by the higher mean age of the Haitian sample (22.5 years). Forty-five percent of males and 75% of females reported condom use less than 100% of the time when they engaged in sex in the last six months. The high number of inconsistent condom users among Haitian females cannot be explained by previous research findings that females substitute the use of condoms for the pill after the initiation of sex activity (Leland and Barth, 1992). None of the Haitian females that were inconsistent condom users relied on the pill or other forms of birth control.
The reasons that Haitian females failed to use condoms are similar to those reported by Anglo, Hispanic, and African-American adolescents (O’Leary et al., 1992, Leland and Barth, 1992). Some Haitian females failed to use condoms because they were involved in monogamous, trusting relationships and did not feel the need to protect themselves from AIDS/STDs. As one female stated, “We were with each other for a long time, so we thought we knew each other enough (not to practice safe sex).” Some females also failed to use condoms when they allowed the male partner to decide against their use. For example, one female stated that she did not use condoms because “it didn’t feel good with condom to him,” while another stated that she trusted “them (partners) to let it be known if we should use one.”

Factors Related to Condom Use

It was hypothesized that AIDS knowledge, condom attitudes, sex attitudes, and demographic variables would be related to Haitian students’ condom use in the past two years and in the future. AIDS knowledge, as measured by the AIDS Risk Behavior Knowledge Test, was found to be positively associated with Haitian subjects’ intent to use condoms in the future. Hence, those subjects who possessed greater AIDS knowledge were also more likely to report the intention to use condoms in the future. This finding supports previous research that found that greater AIDS knowledge is related to minority adolescents’ reports of safe-sex behavior changes such as condom use (Hernandez and Smith, 1990). The lack of a significant relationship between Haitian adolescents’ past condom use and AIDS knowledge, however, indicates that greater AIDS awareness is not related to greater condom use or abstinence. Previous research
has found that despite knowledge about AIDS transmission and prevention, adolescents fail to use condoms (Winslow, Franzini, and Hwang, 1992). Because Haitians have been stereotyped as HIV carriers, it might be expected that they should be more aware of the risk of AIDS and, hence, practice safer sex. However, among Haitian college students, as with other groups, the intention to use condoms is independent from their actual behavior. Not only is their AIDS knowledge not greater than that of Anglo and African-American college students, it is also not related to their condom use (Kelly, Lawrence, and Brasfield, 1989).

The hypothesis that condom attitudes would be positively related to rate of past and intended condom use was only supported in one of the eight subscales of the Condom Attitudes Scale, the Self-Control subscale (CAS-3). This subscale measures attitudes toward self-control in sexual opportunities when a condom is not available and there is risk of acquiring AIDS/STDs, little knowledge about partner’s sex history, or impaired judgment due to drug use. Those Haitian students whose attitudes reflected poor self-control were less likely to have used condoms in the past and less likely to report intent to use condoms in the future. Although Haitian subjects reported positive condom/abstinence attitudes in the other CAS subscales, these attitudes were not related to condom use. Future research should further explore these findings in the Haitian population utilizing larger samples.

Attitudes regarding sexual intercourse were also examined for their role in the prevention of AIDS/STDs. Although there is limited research on the effects of sex attitudes on condom use, the AIDS Risk Reduction Model (Boyer & Kegeles, 1991)
postulates that adolescents who engage in premarital sex may have feelings of guilt and anxiety and a lack of acceptance of their sexuality which hinder the responsible practice of safe sex. It was therefore hypothesized that values regarding sex would be related to rate of past and intended condom use. Two of the four subscales of the Sexual Attitudes Scale were found to be related to condom use. The Permissiveness subscale (SAS-1) was found to be related to past and intended condom use. Specifically, Haitian students who endorsed premarital, polygamous, casual sex were less likely to report condom use in the past or intent to use condoms in the future. The significant association found between the Instrumentality subscale (SAS-4) and intended condom use further showed that adolescents who viewed sex as a self-centered, physical act were less likely to use condoms in the future. Permissive and instrumental attitudes may reflect an immature view of sex among Haitian students. It is possible that these views are the product of Haitian’s sex education, where the family plays a small or nonexistent role in educating children about sex. The most common sources of sex information for Haitian college students (television, books, school, and friends) may not be the most appropriate sources for the acquisition of sex information. Because of the Haitian culture’s conservative sexual views, parents do not communicate with children about sex nor help to foster the development of mature, sexual adults. Therefore, Haitian college students who engaged in sex may lack the sexual maturity to understand the consequences and responsibilities of their actions, as evidenced by their condom use behaviors.

The relationships between condom use and permissive and instrumental attitudes suggest that Haitian adolescents’ who view sex as a self-gratifying activity in the absence
of a relationship are less likely to use condoms and are therefore placing themselves in greater risk of AIDS/STDs. Sex under such casual circumstances can frequently be unplanned, thereby decreasing the chance of condom use. Furthermore, the risk of AIDS/STDs increases in situations where the partner is not known, there is sex with more than one partner, or there is a lack of emphasis on communication between the partners. It is crucial that future research explore the role of these attitudes in safe-sex behavior.

The nonsignificant relationship found between condom use and the Sexual Practices subscale (SAS-2) supports previous research findings. It was found that attitudes in favor of birth control and sex education were not related to past or intended condom use. Research has found that female adolescents more frequently use contraceptive methods such as the pill to prevent pregnancies than condoms to prevent AIDS/STDs (Leland and Barth, 1992). Haitian students also appear to have separate attitudes regarding birth control and condom use. While they may believe that they should protect themselves from an unwanted pregnancy, they may not believe they are in danger of AIDS/STDs.

The number of lifetime sex partners and history of pregnancy and STD were also related to past condom use among Haitians. Those adolescents who had a greater number of sex partners, and a history of pregnancy and STD were less likely to have used condoms in the past. These findings are consistent with past research with other populations. However, number of years subjects lived in the United States, perception of peer condom use, and behavior change because of concerns about AIDS were not related to condom use. No differences were found between Haitian-born and American-born
subjects on any variable in this sample. Those Haitians who emigrated to the U.S. may have acculturated to such a degree that they have become indistinguishable from those born in the U.S. Peer condom use may have failed to play a role in subjects' condom use because older college students may not be as influenced by the behavior of peers as younger adolescents.

Predictors of Intent to Use Condoms

Regression analysis revealed that the best predictors of intended condom use were the Self-Control subscale (CAS-3) and the Permissiveness subscale (CAS-1). Attitudes that endorsed lack of self-control in circumstances where a condom was not available and favored casual, noncommitted relationships were predictors of lower rates of intent to use condoms in the future. The Self-Control subscale (CAS-3) along with the Effect on Sexual Experience (CAS-2) and Global Attitude (CAS-3) subscales were found to be predictors of condom use in a younger African-American sample (Lawrence, 1993). Perhaps among older Haitian college students, condom use occurs despite some negative attitudes about the effects of condoms on the sexual experience. Furthermore, although global attitudes reflect knowledge about condom use, these attitudes may be independent from the actual behavior of condom use.

Analysis of the role of self-control attitudes within the context of the AIDS Risk Reduction Model (ARRM) can provide information about the process of behavior change among Haitians. The decision making process of whether or not to have sex in situations where condoms are unavailable/discouraged and there is risk of AIDS/STDs may be part of the commitment building stage of the ARRM. At this second stage, adolescents are
struggling with the costs and benefits of condom use in order to establish a commitment to engage in low risk behavior. Although they have progressed through stage 1 and realized they are susceptible to AIDS if they engage in unprotected sex, they have yet to establish set guidelines for their behavior. Haitian students who reported low self-control attitudes when condoms were unavailable perceived greater costs in condom use. Their inconsistent, sexual guidelines may therefore impair their ability to use condoms in the future.

The finding that the Permissive subscale (SAS-1) was a significant predictor of intent to use condoms questions the behavior change theory of the AIDS Risk Reduction Model as well as research that has ignored or failed to find a relationship between precautionary behavior and general sex values. It makes intuitive sense that conservative attitudes opposed to premarital, polygamous, casual sex will be related to the safe sex behaviors of consistent condom use and abstinence. This finding supports the idea that mature, moral values can predict responsible sexual behavior among Haitian students.

It is important to note limitations of this study. The sample size may have been too small and the statistical power too low to detect all possible relationships between variables. Due to the small number of nonsexually active subjects, between-group comparisons with the sexually active subjects were not conducted. Furthermore, although the study consisted of college students, the mean age was higher than expected due to four subjects who were in their late twenties and early thirties. Subjects might
have also responded differently depending on whether they received credit or payment for their participation, or completed the questionnaire in the presence of the researcher or alone.

Despite these limitations, this study is the first to examine those factors that motivate Haitians to adopt precautionary sex behaviors. Haitians' sexual behaviors, attitudes, and knowledge in this sample were found to be most similar to those of Anglo adolescents. Although Haitian college students tended to use condoms more consistently than adolescents from other groups, a great number was still at risk of AIDS/STDs. Self-control condom attitudes were found to be related to condom use behavior and to predict intent to use condoms. This study further addressed the role of sexual attitudes in condom use behavior, which had not been previously examined in the literature. Sexual attitudes that reflected permissive and instrumental views of sex were found to be associated with condom use, while permissive attitudes were found to predict intent to use condoms. Finally, the findings and questions generated in this study can contribute to the development of culturally-sensitive intervention strategies that address the prevention of AIDS and sexually transmitted diseases in Haitian young adults.
APPENDIX A

CONSENT FORM

As a Haitian student at the University of Massachusetts, you are invited to participate in a study that will look at the sexual behaviors, knowledge, and attitudes of Haitian college students. The study is being conducted by Danae Perez, a graduate student in the Clinical Psychology Program at the University.

If you decide to participate in this study you will be asked to complete a questionnaire. All your answers will be kept confidential and anonymous. If you have any questions concerning the procedures at any time during the study, you may contact the researcher at 545-4381. Risks in this study are minimal since you will be responding to questions which only the researcher will see. You also have the freedom to withdraw consent at any time and discontinue participation in the study. Your participation will be greatly appreciated.

Your signature indicates that you agree to all of the above conditions.

________________________________________
SIGNATURE

________________________________________
DATE
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY:

1. Age: _____

2. Male _____ Female _____

3. Current grade:
   - Freshman _____
   - Sophomore _____
   - Junior _____
   - Senior _____
   - Graduate _____

4. Religion:
   - Roman Catholic _____ Protestant _____
   - Other (Please specify)____________________

5. Place of Birth:
   - Haiti _____ U.S. _____ Other (Please specify)____________________

6. How many years have you lived in the U.S.? _____

7. In which language(s) are you fluent?
   - English _____
   - French _____
   - Creole _____
   - Other (Please specify)____________________

8. Which language is spoken most at home? (Choose only one)
   - English_____  French_____  Creole_____  Other (Please specify)____________________

9. Do you have family in Haiti with whom you keep in contact?
   - Yes _____  No _____
10. Father's level of education:
   - Less than High School
   - Some High School
   - Graduated High School or GED
   - Technical or Vocational

11. Mother's level of education:
   - Less than High School
   - Some High School
   - Graduated High School or GED
   - Technical or Vocational

12. Please write your father's occupation

13. Please write your mother's occupation

14. Please write your definition of "sexual intercourse" in the space provided.

15. Please write your definition of "safe sex" in the space provided.

16. How often do you practice safe sex?
   - All the time
   - Most of the time
   - Some of the time
   - Hardly ever
   - Never
   - Not sexually active

17. Please describe how you have practiced safe sex.
18. Please write the reason(s) why you have not practiced safe sex.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

19. Please indicate your sexual orientation:
   Heterosexual ______
   Bisexual ______
   Homosexual ______

IN THE FOLLOWING QUESTIONS, THE TERM "SEXUAL ACTIVITY" WILL ONLY REFER TO VAGINAL, ORAL, AND ANAL SEX.

20. Are you or have you ever been sexually active?
   Yes ______  No ______ (If "no" please skip to question 26)

21. How old were you when you first became sexually active? _____________

22. Did you and your partner use any form of contraception the first time you engaged in sexual activity?
   Yes ______  No ______  Don't Remember ______

23. What type of contraception did you or your partner use during first sexual activity? (Indicate more than one if applicable)
   Condom ______  Withdrawal ______
   Pill ______  Rhythm Method ______
   Diaphragm ______  Sponge ______
   Spermicide ______  Other (Please Specify) ______

24. How many sexual partners have you had? _____________

25. Have you ever been pregnant or gotten someone pregnant?
   Yes ______  No ______
   How old were you? ______

26. Have you ever had a sexually transmitted disease (STD)?
   Yes ______  No ______
   How old were you? ______
27. If yes, please indicate which one(s):
   Herpes ____  Crabs ____
   Chlamydia ____  Gonorrhea ____
   Syphilis ____  Genital Warts ____
   Other (Please specify) ________________________

28. Have you ever been tested for HIV (the virus that causes AIDS)?
   Yes ____  No ____

29. Are you infected with the HIV virus?
   Yes ____  No ____

30. Do you know someone who is infected with the HIV virus or has AIDS?
   Yes ____  No ____  Not sure ____

31. What is your most common source of sexual information?
   School ____  Friends ____
   T.V. and Books ____  Family ____
   Church ____  Other (Please specify) ________________________

32. What is your most important/valuable source of sexual information?
   School ____  Friends ____
   T.V. and Books ____  Family ____
   Church ____  Other (Please specify) ________________________

If you have never engaged in sexual activity please skip to question 38

33. During the past six months, how often did you engage in the following:
   More than 10 times  Between 9 & 3 times  Once or twice  Never
   Vaginal intercourse ____  ____  ____  ____

34. During the past six months, how often did you engage in the following:
   More than 10 times  Between 9 & 3 times  Once or twice  Never
   Anal intercourse ____  ____  ____  ____

35. During the past six months, how often did you engage in the following:
   More than 10 times  Between 9 & 3 times  Once or twice  Never
   Oral intercourse ____  ____  ____  ____
36. In the past **six months**, how often did you and your partner(s) use any of the following forms of contraception during sexual activity?

<table>
<thead>
<tr>
<th></th>
<th>100% of the time</th>
<th>More than 50% of the time</th>
<th>50% of the time</th>
<th>Less than 50% of the time</th>
<th>0% of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condom</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pill</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragm</td>
<td></td>
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</tr>
<tr>
<td>Spermicide</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Withdrawal</td>
<td></td>
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<tr>
<td>Rhythm</td>
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<td>Sponge</td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

35. How many sexual partners have you had in the previous **six months**?

36. Would you say that you have changed your sexual behavior because of concerns about AIDS?

   Yes   No

37. If you responded "Yes" to the previous question, please indicate in what way(s) you changed your behavior in the space provided.

   ______________________________________
   ______________________________________

38. How often do you think your peers use condoms when they are sexually active?

   All of the time  
   Most of the time  
   Some of the time  
   Hardly ever  
   Never

39. Please rate your ability to understand AIDS/HIV facts in English.

   Very good  
   Somewhat good  
   Neither good nor poor  
   Somewhat poor  
   Very poor
APPENDIX C

CONDOM USE SCALE

The following set of questions ask whether you have used a condom in various situations. You will be presented with a number of statements that you are to mentally substitute into the following sentence:

"In the past two years, a condom was used when I engaged in sexual activity with ________ ."

After mentally substituting each of the following 12 items into the sentence, indicate how often you used a condom by circling the appropriate number.

0 = Never had sex with this person
1 = Used a condom all the time when you had sex
2 = Used a condom more than half the time when you had sex
3 = Used a condom half the time when you had sex
4 = Used a condom less than half the time when you had sex
5 = Never used a condom when you had sex

1. Someone you were quite attracted to, but whose sexual history you didn't know.

2. Someone you were attracted to and whose sexual history you didn't know, and you were intoxicated.

3. Someone you just met, and who you believed had 1 to 3 sexual partners in the last year.

4. Someone you knew for a pretty long time and were attracted to, but you didn't know their sexual history.

5. Someone you were in a romantic relationship with, even though you didn't know their sexual history.

6. Someone who had many sexual partners, and who you had already had sex with recently without using a condom.

7. Someone who you loved, even though he or she had many sexual partners.

8. Someone you were sexually attracted to, but who had many sexual partners, and you were intoxicated.
0 = Never had sex with this person
1 = Used a condom all the time when you had sex
2 = Used a condom more than half the time when you had sex
3 = Used a condom half the time when you had sex
4 = Used a condom less than half the time when you had sex
5 = Never used a condom when you had sex

9. Someone you were beginning to feel attracted to, and who had 4-7 sexual partners in the previous year.  
   0 1 2 3 4 5

10. Someone you liked a lot, but didn't know very well, and who said they didn't have AIDS.  
    0 1 2 3 4 5

11. Someone you believed had eight or more sexual partners in the previous year, and you found sexually attractive  
    0 1 2 3 4 5

12. Someone you believed had four to seven sexual partners in the previous year  
    0 1 2 3 4 5

The next set of questions ask whether you think you would use a condom in various situations. You will be presented with a number of statements that you are to mentally substitute into the following sentence:

"In the future, do you intend to use a condom if you engage in sexual activity with __________."

After mentally substituting each of the following 13 items into the sentence, indicate how often you would use a condom by circling the appropriate number.

0 = Would not have sex with this person
1 = Would always use a condom
2 = Would most of the time use a condom
3 = Would sometimes use a condom
4 = Would hardly ever use a condom
5 = Would never use a condom

1. Someone you've known for a pretty long time and are attracted to, but you don't know their sexual history.  
   0 1 2 3 4 5

2. Someone you are in a romantic relationship with, but you don't know their sexual history.  
   0 1 2 3 4 5
0 = Would not have sex with this person
1 = Would always use a condom
2 = Would most of the time use a condom
3 = Would sometimes use a condom
4 = Would hardly ever use a condom
5 = Would never use a condom

3. Someone who you love, even though he or she has had many sexual partners.
   0 1 2 3 4 5

4. Someone you are quite attracted to, but whose sexual history you don't know.
   0 1 2 3 4 5

5. Someone you are attracted to and whose sexual history you don't know, and you are intoxicated.
   0 1 2 3 4 5

6. Someone you like, but who has had a blood transfusion before they checked blood for AIDS.
   0 1 2 3 4 5

7. Someone you just met, and who you believe has had 1 to 3 sexual partners in the last year.
   0 1 2 3 4 5

8. Someone you are sexually attracted to, but who has had many sexual partners in the last year
   0 1 2 3 4 5

9. Someone you just met and find attractive, and who had a test for AIDS 6 months ago that was negative (that is, the test indicated that the person has not been exposed to the AIDS virus.
   0 1 2 3 4 5

10. Someone you are beginning to feel attracted to and who has had 4-7 sexual partners in the last year
    0 1 2 3 4 5

11. Someone you believe has had eight or more sexual partners in the last year and you find sexually attractive
    0 1 2 3 4 5

12. Someone who has had many sexual partners, and who you have already had sex with recently without using a condom.
    0 1 2 3 4 5

13. Someone you like a lot but don't know very well, and who says they don't have AIDS.
    0 1 2 3 4 5
APPENDIX D

CONDOM ATTITUDE SCALE

Please read the following statements carefully and indicate how much you agree or disagree using the scale below. Please answer according to how you actually feel, not how you should feel or would like to feel. Thank you.

1 = Strongly agree
2 = Somewhat agree
3 = Neutral- neither agree nor disagree
4 = Somewhat disagree
5 = Strongly disagree

1. If my partner suggested using a condom, I would feel grateful.  1 2 3 4 5
2. I'd only use a condom if one was available.  1 2 3 4 5
3. People who use condoms are "wimps" (afraid).  1 2 3 4 5
4. Condoms reduce the spontaneity of sex.  1 2 3 4 5
5. Using a condom takes the "wonder" (amazement) out of sex.  1 2 3 4 5
6. I am concerned about catching AIDS or some other sexually transmitted disease.  1 2 3 4 5
7. A condom should be used when one's partner is a woman who has had sex with a bisexual male.  1 2 3 4 5
8. A condom is not necessary when you and your partner are monogamous (only have sex with each other)  1 2 3 4 5
9. A condom should be used when you don't know your partner too well:  1 2 3 4 5
10. Condoms are messy.  1 2 3 4 5
11. I dislike condoms because they decrease sensitivity during intercourse.  1 2 3 4 5
12. If a condom is not handy, I'll have intercourse anyway.  1 2 3 4 5
13. A condom should be used when you have anal sex.  1 2 3 4 5
14. I'm concerned about catching AIDS (or other sexually transmitted diseases), so I'd be careful and play it safe even in the heat of the moment.

15. A condom is not necessary when you know enough about the person to trust his/her word about his/her past.

16. I'd be embarrassed to buy condoms.

17. A condom is not necessary when you plan to marry a person.

18. Using condoms would show my partner I cared about his/her welfare.

19. Condoms are a hassle to use.

20. A condom is not necessary when you're pretty sure the other person doesn't have a sexually transmitted disease.

21. If I'm not careful, I could catch a sexually transmitted disease.

22. People who use condoms are understanding.

23. I wouldn't use a condom if my partner insisted against using one.

24. I probably wouldn't use a condom if I was drunk or "high".

25. People who carry condoms would have sex with anyone.


27. I wouldn't mind if my partner brought up the topic of using a condom.

28. I'm concerned about catching AIDS (or other sexually transmitted diseases), but there might be some situations where I wouldn't be as careful as I ought to be.

29. I'm too old-fashioned to buy or carry a condom.
1= Strongly agree  
2= Somewhat agree  
3= Neutral- neither agree nor disagree  
4= Somewhat disagree  
5= Strongly disagree  

30. People who use condoms sleep around a lot.  
31. If I'm not careful, I could definitely catch AIDS.  
32. If my partner suggested using a condom, I would respect his/her concern.  
33. A condom should be used when the other person is promiscuous. *(has sex with more than one partner)*  
34. Condoms are disgusting.  
35. Condoms take away the pleasure of sex.  
36. If my partner suggested using a condom, I would respect him or her.  
37. I'm concerned about catching AIDS, but in the heat of the moment it probably wouldn't stop me from having intercourse without a condom.  
38. I think people worry too much about catching AIDS.  
39. Condoms are clean.  
40. Other people should respect my desire to use a condom.  
41. I am not inhibited about buying condoms.  
42. People who use condoms are considerate.  
43. I'm concerned about catching a sexually transmitted disease, but in the heat of the moment it probably wouldn't stop me from having intercourse without a condom.  
44. If I engage in sexual intercourse without the use of a condom, I could definitely catch AIDS.  
45. I worry that I could catch a sexually transmitted disease.
1= Strongly agree
2= Somewhat agree
3= Neutral- neither agree nor disagree
4= Somewhat disagree
5= Strongly disagree

46. Using condoms interrupts the pleasure of sex.  
1 2 3 4 5

47. If my partner suggested using a condom, I would feel relieved.  
1 2 3 4 5

48. I wouldn't keep condoms at home because someone (e.g., my parents, roommate, friends) might find out I was having sex.  
1 2 3 4 5

49. People who carry condoms are just looking for sex.  
1 2 3 4 5

50. A condom is **not necessary** when you are with the same person for a long time.  
1 2 3 4 5

51. I **wouldn't use** a condom if I had a strong sexual craving for a person, even if I knew little about their sexual history.  
1 2 3 4 5

52. If my partner suggested using a condom, I would feel good towards him or her.  
1 2 3 4 5

53. If my partner suggested using a condom, I would think he/she was only being cautious.  
1 2 3 4 5

54. Using condoms takes the time out of foreplay.  
1 2 3 4 5

55. Condoms protect against sexually transmitted diseases.  
1 2 3 4 5

56. People who insist on using a condom are moral.  
1 2 3 4 5

57. If I engage in sexual activity without the use of a condom, I could definitely catch a sexually transmitted disease.  
1 2 3 4 5
Listed below are several statements that reflect different attitudes about sex. For each statement circle the number that indicates how much you agree or disagree with that statement. Some of the items refer to a specific sexual relationship, while others refer to general attitudes and beliefs about sex. Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never had a sexual relationship, answer in terms of what you think your responses would most likely be. For each statement:

1 = Strongly agree with the statement
2 = Moderately agree with the statement
3 = Neutral - neither agree or disagree
4 = Moderately disagree with the statement
5 = Strongly disagree with the statement

1. I do not need to be committed to a person to have sex with him/her.  
2. Casual sex is acceptable.  
3. I would like to have sex with many partners.  
4. One-night stands are sometimes very enjoyable.  
5. It is okay to have ongoing sexual relationships with more than one person at a time.  
6. It is okay to manipulate someone into having sex as long as no future promises are made.  
7. Sex as a simple exchange of favors is okay if both people agree to it.  
8. The best sex is with no strings (no responsibilities) attached.  
9. Life would have fewer problems if people could have sex more freely.  
10. It is possible to enjoy sex with a person and not like that person very much.  
11. Sex is more fun with someone you don't love.  
12. It is all right to pressure someone into having sex.  
13. Extensive premarital sexual experience is fine.
1 = Strongly agree with the statement  
2 = Moderately agree with the statement  
3 = Neutral - neither agree or disagree  
4 = Moderately disagree with the statement  
5 = Strongly disagree with the statement  

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<thead>
<tr>
<th></th>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>14.</td>
<td>Extramarital affairs are all right as long as one's partner doesn't know about them.</td>
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<td>15.</td>
<td>Sex for its own sake is perfectly all right.</td>
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<td>16.</td>
<td>I would feel comfortable having intercourse with my partner in the presence of other people.</td>
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<td>17.</td>
<td>Prostitution is acceptable.</td>
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<td>18.</td>
<td>It is okay for sex to be just good physical release.</td>
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<td>19.</td>
<td>Sex without love is meaningless.</td>
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<td>20.</td>
<td>People should at least be friends before they have sex together.</td>
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<td>21.</td>
<td>In order for sex to be good, it must also be meaningful.</td>
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<td>22.</td>
<td>Birth control is part of responsible sexuality.</td>
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<td>23.</td>
<td>A woman should share responsibility for birth control.</td>
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<td>25.</td>
<td>Sex education is important for young people.</td>
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<td>26.</td>
<td>Using &quot;sex toys&quot; during lovemaking is acceptable.</td>
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<td>27.</td>
<td>Masturbation is all right.</td>
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<td>28.</td>
<td>Masturbating one's partner during intercourse can increase the pleasure of sex.</td>
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<td>29.</td>
<td>Sex gets better as a relationship progresses.</td>
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<td>30.</td>
<td>Sex is the closest form of communication between two people.</td>
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<td>31.</td>
<td>A sexual encounter between two people deeply in love is the ultimate human interaction.</td>
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</tbody>
</table>
1 = Strongly agree with the statement  
2 = Moderately agree with the statement  
3 = Neutral - neither agree or disagree  
4 = Moderately disagree with the statement  
5 = Strongly disagree with the statement

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>Rating</th>
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<tbody>
<tr>
<td>32.</td>
<td>Orgasm (climax) is the greatest experience in the world.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>33.</td>
<td>At its best, sex seems to be the merging of two souls.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>34.</td>
<td>Sex is a very important part of life.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>35.</td>
<td>Sex is usually an intensive, almost overwhelming experience.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>36.</td>
<td>During sexual intercourse, intense awareness of the partner is the best frame of mind.</td>
<td>1 2 3 4 5</td>
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<tr>
<td>37.</td>
<td>Sex is fundamentally good.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>38.</td>
<td>Sex is best when you let yourself go and focus on your own pleasure.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>39.</td>
<td>Sex is primarily the taking of pleasure from another person.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>40.</td>
<td>The main purpose of sex is to enjoy oneself.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>41.</td>
<td>Sex is primarily physical.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>42.</td>
<td>Sex is primarily a bodily function, like eating.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>43.</td>
<td>Sex is mostly a game between males and females.</td>
<td>1 2 3 4 5</td>
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</tbody>
</table>
APPENDIX F

AIDS RISK BEHAVIOR KNOWLEDGE TEST

This is a true/false test. Please do not skip any questions. Because this is a test, some of the statements are true and accurate, while others are false and inaccurate.

Please circle T for True and F for False.

1. Most people who transmit the AIDS virus look unhealthy. T F
2. Anal intercourse is high risk for transmitting the AIDS virus. T F
3. Oral intercourse carries risk for AIDS virus transmission. T F
4. A person can be exposed to the AIDS virus in one sexual contact. T F
5. Keeping in good physical condition is the best way to prevent exposure to the AIDS virus. T F
6. It is unwise to touch a person with AIDS. T F
7. Condoms make intercourse completely safe. T F
8. Showering after sex greatly reduces the transmission of AIDS. T F
9. When people become sexually exclusive with one another, they no longer need to follow "safe sex" guidelines. T F
10. Oral sex is safe it the partners "don't swallow". T F
11. Most people who have been exposed to the AIDS virus quickly show symptoms of serious illness. T F
12. By reducing the number of different sexual partners, you are effectively protected from AIDS. T F
13. The AIDS virus does not penetrate unbroken skin. T F
14. Female-to-male transmission of AIDS has not been documented. T F
15. Sharing toothbrushes and razors can transmit the AIDS virus. T F
16. Pre-ejaculatory fluids carry the AIDS virus. T F
17. Intravenous drug users are at risk for AIDS when they share needles. T F
18. A person must have many different sexual partners to be at risk for AIDS. T F
19. People carrying the AIDS virus generally feel quite ill. T F
20. Vaginal intercourse carries high risk for AIDS virus transmission. T F
21. Withdrawal immediately before orgasm makes intercourse safe. T F
22. Persons who are exclusively heterosexual are not at risk for AIDS T F
23. Healthy persons in AIDS risk groups should not donate blood. T F
24. Sharing kitchen utensils or a bathroom with a person with AIDS poses no risk. T F
25. Intravenous drug users become exposed to the AIDS virus because the virus is often contained in heroin, amphetamines, and the injected drugs. T F
26. A wholesome diet and plenty of sleep will keep a person from becoming exposed to the AIDS virus. T F
27. A cure of AIDS is expected within the next two years. T F
28. It is more important to take precautions against AIDS in large cities than in small cities. T F
29. A negative result on the AIDS virus antibody test can occur even for people who carry the virus. T F
30. A positive result on the AIDS virus antibody test can occur even for people who do not carry the virus. T F
31. Coughing does not spread AIDS. T F
32. Only receptive (passive) anal intercourse transmits AIDS. T F
33. Most present cases of AIDS are due to blood transfusions that took place before 1984. T F
34. Most persons exposed to the AIDS virus know they are exposed. T F
35. A great deal is now known about how the AIDS virus is transmitted. T F
36. Donating blood carries no AIDS risk for the donor. T  F

37. No cases of AIDS have ever been linked to social (dry) kissing. T  F

38. Mutual masturbation and body rubbing are low in risk unless the partners have cuts or scratches. T  F

39. People who become exposed to the AIDS virus through needle-sharing can transmit the virus to others during sexual activities. T  F

40. The AIDS virus can be transmitted by mosquitoes or cockroaches. T  F
REFERENCES


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