Essay
Condoms and Healthcare professionals

Risk-behavior and attitudes towards condom use

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Abstract

Alarming S.T.I’s percentages and low condom use motivated this research. Healthcare professional’s risk-behavior and attitudes towards risk-behavior were reviewed. Three hypotheses, aimed to test whether healthcare professionals working with S.T.I’s should have a different attitude, knowledge and behavior to condom use compared to healthcare professionals that did not work with S.T.I’s. Ninety-five participants working at a hospital in middle-Sweden answered a questionnaire, based on the Swedish UNGKAB09 research. Mann-Whitney analyses showed no significant difference between the two groups on knowledge, attitude and behavior. A high percentage of steady relationships, high homogeneity between groups as well the same attitudes and intentions could have been a reliability problem. The collected data was however interesting as a base for further research.

Abstrakt

En alarmerande ökning av könssjukdomar samt låg kondomanvändning gav inspiration till denna undersökning. Risk-beteende och attityder till riskbeteende av vårdpersonal granskades. Arbetets tre hypoteser, syftade till att undersöka om huruvida vårdpersonal som arbetar med könssjukdomar har annorlunda attityder, kunskaper och beteenden gällande kondomanvändning gentemot vårdpersonal som inte arbetar med könssjukdomar. 95 undersökningsdeltagare från ett sjukhus i mellan-Sverige, besvarade en enkät baserad på den Svenska UNKAB09 undersökningen. Resultatet som analyserades med Mann-Whitney, visade ingen signifikant skillnad mellan de båda grupperna i fråga om kunskaper, attityder, intentioner eller beteende. Förfataren menar att det höga antalet fasta förhållanden, bland de väldigt homogena grupperna, kan ha utgjort eventuella reliabilitetsproblem. Data som samlades in kan ändå utgöra en bra bas till ytterligare undersökningar.
Condoms and sexually transmitted infections were not the latest novelty in the human society. Ancient cultures of India, China and Mesopotamia (3000 A.C) already recognized some infections as being sexually transmitted, especially infections as pubic lice, condylomata acuminata (genital warts) and gonorrhea. The treatment of S.T.I has been painful through most of the centuries (Dienst infectieziektenbestrijding, 2011). Humans have used many forms of sexual protection, like leather tubes, oiled silk paper, linen bandages and fish bladders, not all quite effective or pleasant (RFSU, 2011). It was likely in the mid-eighteenth century that a condom, made of sheep- or calf caecum was offered to the public (Dienst infectieziektenbestrijding, 2011). Condoms and S.T.I have been around for quite a while.

The UNGKAB09 research, named knowledge, attitude and sexual acts of the youth, (Tikkanen, Abolsson, & Forsberg, 2009), investigated the sexual experience and background of 15 278 adolescence and young adults between 15 and 29 years old, specified towards their attitudes knowledge and experience, like the use of contraceptives, sexual violence, sexual debut and alcohol and drug use of the youth in Sweden. The influence of religion and originality where also reviewed. This research gave a very clear view of behavior of the Swedish youth. The results were surprising. An extremely low percentage of adolescence and young adults used condoms as a protection for sexually transmitted infections in Sweden. An alarming fact there the increasing numbers of S.T.I, both with and without antibiotic resistance, have been worrying healthcare professionals (Svenska Smittskyddinstitutet, 2011). To use a condom could prevent most sexually transmitted infections (Hammerlund, Lundgren & Nyström, 2007; 2008). So why did not everybody used a condom, if was that easy to prevent contracting a S.T.I?

What was the underlying reason for this risk-taking behavior? An obvious answer might have been a lack of knowledge; maybe people did not know how to protect themselves, and by giving humans education they could obtain the knowledge to make the responsible choice of using a condom. The UNGKAB09 research (2009) came to the conclusion that the Swedish youths consider themselves to have satisfying knowledge concerning sexual transmitted infections. Research done in 2009 by De Rutgers Stichting confirmed that people had good knowledge about S.T.I’s. Nevertheless were percentages of people with sexually transmitted infections increasing and condom use remained relativity low (Kuyper, 2007; Soaaids, 2011; Svenska smittskyddinstitutet, 2006; Tikkanen, Abolsson & Forsberg, 2009). Adolescent’s knowledge was proved to be sufficient as a protection for sexual transmitted infections, but an attitude-change was required (Darj & Bondestam, 2003). Knowledge alone was not sufficient. Even though increased awareness and knowledge about health risks are important preconditions for self-directed change, information alone did not have a great influence on refractory health impairing habits. People still smoked, despite its acknowledged hazard for cancer, respiratory disorders, and heart disease and it did not change the sexually active into celibacy (Bandura, 1990).

Could a change in people’s attitude create a more sensible behavior? Maybe more exposure to condoms would offer a solution. The complete lack of TV-advertising and
info commercials in Sweden concerning condom use has made the author wondering about the correlation to the low percentages in condom use in Sweden. Growing up in the mid-eighties in The Netherlands with all the great TV campaigns on condoms (in the beginning of 1987) as well in Germany (1987) and The United Kingdom (1986) has given a greater exposure to condoms, making the importance of condom use known to a large group of humans (de Rutgersstichting, 2011; Sandfort & de Vroome, 1998). According to the R.F.S.U (2011) the first and last big condom-campaign in Sweden took place at the end of the eighties. In these campaigns billboards where used (mostly in the big cities), but there was no T.V exposure. Frequent media exposure like in leaflets advertising promoted a strong cognitive and behavioral correlation in condom use (Abraham, Krahé, Dominic & Fritsche, 2002).

The Mere Exposure effect and it changing behavior has been proved in advertising (Baker, 1999; Nordhielm, 2002), in the area of improving exercise-frequency (Marcus, Selby, Niura & Rossi, 1992) and in eating, changing preference for eatable substances (Pliner, 1992). Mere exposure and specifically exposure to the negative effects of a behavior did not always work. Studies done in Porto Rico, China, Denmark, Northern Ireland and Australia showed that physicians and nurses, despite having a good knowledge and a positive attitude towards non-smokers, they still smoked. Although they were very aware of the consequence of smoking, they had a less favorable attitude toward smoking-prevention and stop-smoking programs (Clark, McCann, Rowe & Lazenbat, 2004; Grossman, Knox, McKenna, Slater, McCance, Bunting, Spiers & McElwwee, 2001; Jiang Ong, Tong, Yang, Nan, Gan & Hu, 2007; Nash & Jiménez, 1999; Secher, Sejr & Osler, 2002). The physicians and nurses were well aware of the risk and dangers of smoking, but kept on smoking, despite the mere exposure. Same findings were found with nurses and breast self-examination (Budden, 1998). However, in self-breast examination the subject norms were not negative, opposite to smoking and condom use. (Budden, 1998; Clark, McCann, Rowe & Lazenbat, 2004; Hammarlund, Ekenstam, Lundgren & Nyström, 2008).

Why did people engage in a risk-taking behavior anyway? A good question was to ask how high a risk should be before it is perceived as being a risk (Wijk, 2003). An individual could be exposed to a risk without being aware of it (Peterson & Lupton, 1996). Research showed that both experienced and inexperienced young people fail to identify their risk for contacting a S.T.I. Young women discard the fact that their own lifestyle could be a risk for contracting sexually transmitted infections (Hammarlund & Nyström, 2004). What is normal behavior varies between different societies and groups. A certain behavior could be considered being abnormal by one group, but perceived as normal by another (Wijk, 2003). (Young) man and women tried to build up their self-esteem according to the social standards of the group to which they belong. This might resulted in a balancing act where both man and women tried participating while shaping their sexual identity. At the same time, they tried to maintain their self-esteem and avoid getting a bad reputation. A great part of the subjective norms of a person were normally built in these years. (Hammarlund, Ekenstam, Lundgren & Nyström, 2008).

Research done on the sexual risk taking of adolescents in Sweden found that the reasons behind the increase of sexual transmitted infections were likely to be multidimensional, with social, cultural, economic, and epidemiologic factors all having an effect
So knowledge, self-efficacy, self-esteem, social and cultural influence all seemed to be the reasons for risk-taking behavior (Denison, 1996). These are all factors that lay the ground stones for behavior and attitudes. Research showed that in cross-sectional data waves, knowledge where greater among those with a high self-efficacy. In longitudinal data waves, knowledge-behavior correlations increased among those who increased their self-efficacy (Rimal, 2000).

Concerning the correlation between, healthcare professions and risk-behaving like smoking, we had to considerate the effect of nicotine-dependency. This physical chemical dependency drives a great part of behavior and had therefore a great impact on behavior (Sluyter, 2009). Even if sex could be addiction, only between 1 to 6 % of the population had a sex addiction (GGZ, 2011). We could presume that in a group of healthcare professionals the percentage of persons with a sex dependency controlling all factors of their behavior is very small.

So in relation to the healthcare professionals, if healthcare professionals where working with S.T.I.’s, they should know the consequences of having a S.T.I. The importance of using a condom to prevent a S.T.I., and practical how to use a condom should them a different behavior. Healthcare professionals not working with S.T.I.’s should have a different behavior towards condom use, for lacking the knowledge. Contact with several healthcare teachers confirmed that the actual education on the subject of S.T.I is for nurses and nurses-assistants were insufficient. Physicians and midwifes had the required knowledge (J. Belachew, personal communication, October 17, 2011, A-S. Lindqvist, Personal communication, October 13, 2011, M. Torati-Lindgren personal communication, October 17, 2011). Albarracín (2001) has in a meta-analysis on condom use found that attitudes can influence behavior. That is, people with better attitudes are more likely to form intentions to perform a particular action. People are more likely to use a condom if they have previously formed the corresponding intention (Albarracín, Johnson, Fishbein & Muellerleile 2001). This intention could be formed during the education of S.T.I to healthcare professionals. But since there is a poor ground of education for the most healthcare professionals, there should be a noticeable difference between healthcare professionals working with S.T.I.’s and healthcare professionals not working with S.T.I. Healthcare professionals working with S.T.I where subjected regularly to condoms and benefits of its use, therefore having a good knowledge about S.T.I and the consequence of risk behavior. Mere Exposure, experience, knowledge and risk-assessment about S.T.I and condom use gave a better attitude as it would give an altered behavior in relation to condom use.

The aim of this essay is to get a greater insight in the behavior of healthcare professional concerning condom use, and to see if there is a difference between those with a greater work-related knowledge/attitude combined with the mere-exposure effect of condoms and healthcare professionals that are lesser exposed to S.T.I.’s.

Hypothesis1: Healthcare professionals working with S.T.I.’s, have a greater knowledge on S.T.I than healthcare professionals not working with S.T.I’s
Hypothesis 2: Healthcare professionals working with S.T.I’s have a more positive attitude towards the use of condoms in comparison to healthcare professionals not working with S.T.I’s.

Hypothesis 3: Healthcare professionals working with S.T.I’s have a different behavior in condom use in comparison to healthcare professionals not working with S.T.I’s.

Method

Participants:
Personal of several wards, specified 95 persons of the following professions: physicians, midwives, nurses and nurses-assistants were asked to participate. Forty of these participants where working on the S.T.I-wards, youth-S.T.I ward, the gynecological clinic and postnatal-ward (called group A). Age (\( \bar{x} = 45.59 \)), the youngest being 22 and the oldest 60, the amount of female participants 92.5 %, male 7.5 %. The professions where dived in: physicians 10 %, midwifes 19.8%, Nurses 15%, nurse’s aide 22.5% and 5 % of other. Of all the participants, 75.9% had a steady relation. The control group exists of another fifty-five persons working on a cardiovascular-ward, hematological-ward, gastrointestinal-ward, orthopedic-ward and cerebral-vascular /nephrological wards (called group B) In age (\( \bar{x} = 41.23 \)), the youngest was 19 and the oldest 60. The amount of female participants: 92.6 %, and male: 7.4 %. Their professions where divided into nurses: 59.3% and nurse’s aide: 37%. Of other profession there was 1.9 %. In this group 85% had a steady relation. The standard of normal distribution of gender was although not representative for a normal population, in correlation to the standard of normal distribution of gender in healthcare professions overall working in the Falu lasarett (P. Lindberg, personal communucation 12 october 2011).

Materials
The questionnaire was based on a model used in the UNGKAB09 research conducted in Sweden (Tikkanen, Abellson & Forsberg, 2009). Approval of the authors of the UNGKAB09 to use this questionnaire has been given. A pilot study was held to test the survey. The questions were reduced specifically to the subjects of knowledge, attitude, use of birth-control and condoms conform to TPB, from the original 63 of the UNGKAB09 survey to 23 questions in this research. Of these 23 questions 3 where on background information (age, gender and profession), 13 on knowledge (5 on Chlamydia and 8 on HIV), 10 questions on attitude, 1 on behavior and 1 on honesty. In relation knowledge, with questions like for instance: can you get HIV trough hugging? Or “Chlamydia is very contagious”. The answers possible where yes, no and I do not know. On behavior the question was: “Which kind of contraceptive do you use?” with
possible answers like: *a condom, an intrauterine device* and so on. On attitude there were questions, like “*using a condom is O.K., because I do not need to worry afterwards*” and “*condoms are arousing*”. The final question of the questionnaire, contained of 5 sub-questions how the participants perceived the survey in terms of honesty, importance, discomfort and so one. These questions made use of a so called Likert scale. The last of these sub-questions described the amount of honesty of the given answers by the participants. This gave a good base in judging the given answers.

All questions on knowledge concerning HIV as well questions on knowledge concerning Chlamydia where divided in a correct and incorrect given answer, giving a score of 1 for each correct answer per participant. All scores per question on Chlamydia and HIV were added, to a maximum score of 13 (out of 5 questions on knowledge on Chlamydia and out of 8 questions on knowledge on HIV). These score where labeled “Total Knowledge on S.T.I (\( \bar{x} = 12, \text{Md}= 8.0 \text{ and } \sigma= 1.422 \)). Chronbach \( \alpha \) tests resulted in: Total knowledge on S.T.I. = .264

Concerning the questions on attitudes, all the answers on positive attitude where given a score of 1 per given positive attitude. Of the 10 question on attitudes, a total of 5 where positive and 5 negative, given a total of 5 possible points, being called total positive attitude (\( \bar{x} = 1.86, \text{Md}= 1.5 \text{ and } \sigma= .968 \)). A Chronbach \( \alpha \) could not be conducted due to use of categories. One question on intention was added to the questionnaire, but was not used in the results because they did not fit in with the design of this essay. None of the variables had a normal distribution, so the choice for a non-parametric data scale was obvious.

**Procedure:**
The author visited several wards in the Falu Lasarett in Falun, Sweden and asked staff member permission to conduct a survey on birth-control. After receiving approval by the staff members of several wards of the hospital, the questionnaire has been conducted. The staff has been given a brief explanation before the questionnaire by the staff leader, either by an oral debriefing or an informative e-mail. The questionnaire was handed over accompanied by a covert letter and a sealable envelop. A sealed box containing a slot for returning the questionnaire was also provided with the questionnaire, its purpose giving a greater sensation of anonymity. The questionnaire and return box was placed on the wards in question for the duration of two week, after which the box containing the questionnaires was collected for processing.

All Boxes containing the filled-in questionnaires were collected after a 14 days waiting period. Each box was marked on the ward with A (wards related to S.T.I’s, gynecology and propagation) or B (Wards of different disciplines of the healthcare profession) when collected. All wards were thanked for their involvement. A Thank-you card was also send to all participating wards at a later date.

Following processing the surveys, all questionnaires with a self-proclaimed honesty of less than 4 where removed from the data (one survey in total), for ensuring a greater reliability. Level 4 was considered to be acceptable, because of the sensitive nature of the questions.). All participants declaring to be a student were added to their
corresponding profession, for example a nurse student would be added to the nurse’s profession, solely if the subject of the studies were known. In the question lack of condom use all answers stating “other” with explanation sterilized were added under “not able to have children.

**Analysis:**
Processing was done by using the SPSS program. Mann-Whitney analyze method was used. The effect-size was calculated.

**Results**

**Knowledge:**

*Knowledge:*
A Mann-Whitney test revealed no significant difference in total knowledge in S.T.I between Group A (healthcare professionals working with S.T.I’s) and Group B (healthcare professionals not working with S.T.I’s).

**Attitude:**

A Mann-Whitney test revealed no significant difference in positive attitude towards condoms between Group A (healthcare professionals working with S.T.I’s) and Group B (healthcare professionals not working with S.T.I’s).

**Behavior:**

A Mann-Whitney test revealed no significant difference in behavior concerning condom use between Group A (healthcare professionals working with S.T.I’s) and Group B (healthcare professionals working with S.T.I’s)

Of all participants only 10.4% used a condom the entire coitus. For percentage defined per group of healthcare professionals and their contraceptive use see figure 3 below.
The aim of this essay was to get a greater insight in the behavior of healthcare professionals concerning condom use, and to see if there is a difference between those with a greater work-related knowledge/attitude combined with the mere-exposure effect of condoms and healthcare professionals that are lesser exposed to S.T.I.’s.

Hypotheses 1: Healthcare professionals working with S.T.I’s, have a greater knowledge on S.T.I than healthcare professionals not working with S.T.I’s.

In order to accept this hypotheses, healthcare professionals working with S.T.I’s should have a greater knowledge on S.T.I and have a better score on the questions concerning Chlamydia and HIV, than healthcare professionals not working with S.T.I’s. The results showed no significant difference in knowledge and the could not be rejected. A difference was expected due to professional exposure to S.T.I., but the group of healthcare professionals not working with S.T.I had the same level of knowledge. This high rate of knowledge was rather surprising. In previous contact with teachers they were asked about the levels of quality and amount of received S.T.I. education of
nurses-assistants, nurses and physicians. They stated that only the physicians had a more acceptable level of qualitative education on the subject. (Belachew, 2011; Lindqvist, 2011; Torati-Lindgren, 2011). Maybe the exposure to HIV/ Aids campaigns has reached Sweden throughout the foreign TV-programs and TV-show’s, ore has the short exposure in the eighties been sufficient explaining the better knowledge on HIV/Aids. Recently Sweden has started a national campaign on Chlamydia, which might have had a good result. The importance of good knowledge of S.T.I and its risk were for healthcare professionals an important factor in giving good care and guidance to patients, as well to their own safety and protection in work related accidents. The author’s firsthand experiences with such accidents gave an indication of the importance of knowledge. This could have been a motivation on searching education and knowledge-enhancements outside school education. From another point of view however, these risk are mainly focused on HIV and Hepatitis, of which most healthcare professionals have been vaccinated for. This research has focused on merely HIV and Chlamydia, the most known forms of S.T.I, other forms of S.T.I, like pubic lice, condylomata acuminate (genital warts) and gonorrhea. It would not be reasonably to state that a good knowledge of HIV and Chlamydia is a good knowledge on S.T.I and therefore should an eventually rejection of the $H_0$ in this essay, only have been on the knowledge of HIV and Chlamydia, and should have been formulated as so.

Hypotheses 2: Healthcare professionals working with S.T.I’s have a more positive attitude towards the use of condoms in comparison to healthcare professionals not working with S.T.I’s

The healthcare professionals working with S.T.I’s should have had a more positive attitude towards condoms, based on for example the Mere–exposure effect. The results showed no significant difference in attitude and the Hypothesis could not be accepted. Opposite to the expectation and previous research done on risk-behavior like smoking and self-breast examination, where a more positive attitude was found in those that worked in prevention of risk-behavior (Budden, 1998; Secher, Sejr & Osler 2002) there was no difference in attitude. This is not either in line of the research done on mere-exposure and attitude on other risk-behavior. (Clark, McCann, Rowe & Lazenbat, 2004; Grossman, Knox, McKenna, Slater, McCance, Bunting, Spiers & McElwee, 2001; Jiang Ong, Tong, Yang, Nan, Gan & Hu, 2007; Nash & Jiménez, 1999; Secher-Sejr & Osler, 2002). The why of the attitude levels remains a question for the author, and could be a starting point for more research. Although the high positive attitude of both groups could not reject the $H_0$, it was, just as it was in knowledge, a very positive factor. It would be, on a general very interesting to see how the attitude would compare from other control-groups, like teachers or another hospital, to see is this positive attitude is restricted to healthcare professionals, or even limited to this hospital. The positive attitude did not change the behavior. If attitudes seem to come from the outcome of normative belief (Albarracín, Johnson, Fishbein & Muellerleile 2001), the low use of condoms could be explained that even if the attitude towards condoms was good, the believe that the outcome of their behavior would not be a great risk in contracting a S.T.I could explain the difference between attitude and behavior. This could be explained by the beliefs of the participants that having a steady partner and trust in the partner to tell if there would have been a risk for a S.T.I, again confirmed in the results, would form an attitude on not using a condom that was stronger than their positive
attitude towards condoms. In comparison to the smokers- research had the participants that did not use a condom still a favorable attitude towards condom use, of which was not the case in smoking. (McKenna, Slater, McCance, Bunting, Spiers & McElwee, 2001)

Hypothesis 3: Healthcare professionals working with S.T.I’s have a different behavior in condoms use in comparison to healthcare professionals healthcare professionals not working with S.T.I’s.

In need to accept this Hypothesis, healthcare professionals working with S.T.I’s should have been using condoms more frequently than healthcare professionals not working with S.T.I’s. The results showed no significant difference in behavior and the H₀ could not be rejected. The behavior of healthcare professionals was not quiet in keeping with their knowledge and attitude. They had high knowledge and a positive attitude, but did not use a condom. There could be many explanations for this gap. Most of the participants were in a steady relation, in which they felt trust to not use condoms as a contraceptive. The questions remained to be asked if a bigger percentage of single participants would have given a different result, and if those that had chosen to engage in the survey did so knowing that the lived in a steady relation and would not have given the “wrong” answer, namely having unprotected sex with several and/or unknown partners, not intending that single participants would always conduct this behavior. The hospital at which this survey was held maybe had a greater percentage of individuals living in a steady relation. The risk assessment of contracting a S.T.I is often linked to promiscuous behavior (Tikkanen, Abelsson, & Forsberg, 2009). As the participants where in a steady relation, the focus shifted from protection against S.T.I towards pregnancy-protection. The higher average age of the participants, with a fairly large percentage of women that where either sterile or in menopause, could have been a reliability problem. The insight on the levels of actual risk in contracting a S.T.I might have been low as well. A research conducted in a hospital in another part of the country could confirm or deny of this percentages being a reliability problem. The strong homogeneity of both groups could have been a reason for the not significant results. The ratio of physicians, nurses, midwifes and nurse-aides that worked in prevention and that did not use condoms is high, which is actually in consisted with the findings of McKenna et al. on the risk-behavior of smoking. (McKenna, Slater, McCance, Bunting, Spiers & McElwee, 2001)

How did the results of this essay compare to other studies done on the subject of health-risk and behavior? A fast amount of research has been done on risk-behavior and smoking among student-nurse. In this study those student-nurses that where smoking before the research period did not change their smoking behavior and attitude. (Secher-Sejr & Osler 2002). If all these facts had to do with the dependency on cigarettes remains to be asked. In comparison to other health risk-inducing behavior, the researchers took a look at nurses and breast self-examination (BSE). A group of Australian nurses cooperated in a survey on BSE. Most of the nurses did not practiced regular BSE and even fewer routinely to disciplines taught the procedure. Participants were found to be more likely to teach BSE if they performed monthly sessions of BSE. (Budden, 1998) These results could mean that healthcare professionals that regularly used condoms would be more at ease in teaching condom use, which was not the case
The participants working on wards related to S.T.I’s, gynecology and propagation did taught condom use in their occupation, but did not use a condom. However should be said that there was a very low percentage of the nurses that practiced BSE, just as the low percentage of condom use by the participants in this survey, which could be considered a parallel in results. To explain the non-existing difference in hypothesizes was probably that both the beliefs and attitudes were equal on both groups, which was apparent in the good knowledge of both groups on the subject of S.T.I’s and the positive attitude. On the meta-analysis of Albarracín (2001) the results of predictions to behavior was related to condom use, Based on the information received from the health-care educational staff this homogeneity should not have been as strong as it turned out to be. Even the higher mean age of the participants could have been of influence. As mentioned earlier, a further research with another group of professionals as variable, for example teachers, would be very interesting. Not only for the eventually difference between their behavior, as well the behavior in general in relation to contraceptive. Although all three hypotheses could not be proved, the falsification of these hypotheses gave a very positive outcome. The results pointed in a positive direction, with high knowledge and an open attitude.

To summarize: The use of condoms has been low whilst the increase of S.T.I’s has been rising. To see if there would be a difference in knowledge, attitude and behavior caused by experience in working with nurses of S.T.I’s and condom use by healthcare professionals where they compared with those that worked in other disciplines of the Healthcare profession. No significant differences were found, although very interesting data was collected, on the usage of contraceptives, frequency of sexual intercourse, age and contraceptives and so one would be very usable for extended research. The current amount of knowledge, the attitudes, the intentions and the behavior of the participants where very positive. The high percentage of steady relationships of the participants, the equal amount of good knowledge which made the groups very homogenous and higher average age could all be reliability problems. When compared to research done in smoking as a risk-behavior among nurses, as well as breast self-examination, there are differences in attitude on condoms and smoking/BSE. The similarity of these studies lied in the low use of condoms and the low percentage of nurses that self-examined their breast, as in the Meta-analysis of Albarracín (2001) where their attitude neither contributed to more condom use. The equality in knowledge of the two groups, and same attitudes could explain the non-significant result of this essay, together with a probably stronger attitude towards other birth control use than the positive attitude towards condom use.

The collected data had from behavioral prospective very interesting information on the behavior of healthcare professionals, the relation of contraceptive to their age and the general use of contraceptives. This information could be of good use in further research.
References


Verontrustende cijfers en opvallende sekseverschillen *Soa Aids Magazine* 4.2.
Informationen om enkäten du nu ska besvara.

Detta är en enkät som ingår i en del av min C-uppsats i psykologi vid Högskolan Dalarna. Syftet med studien är att undersöka preventivmedelsanvändning hos män och kvinnor i åldersgruppen 18-65, alla verksamma inom hälsovården. Även om du inte är i en ”fertil” ålder ses dina svar som viktiga för undersökningen. Undersökningen kommer presenteras i form av en uppsats vid Högskolan Dalarna inom ämnet psykologi.

Frågorna kan upplevas som intima, men jag strävar efter en högt respektfull behandling av svaren. Enkäten är endast till för C-uppsatsen och kommer behandlas konfidentiellt. Svaren kommer alltså under inga som helst omständigheter användas vid andra sammanhang. Svaren kommer sammanställas tillsammans med de andra svaren och ingen enskild person ska kunna identifieras.

All medverkan är frivillig och du kan när som helst under undersökningen avbryta din medverkan, men för undersökningens kvalité önskar vi så hög svarsfrekvens som möjligt. Därför skulle vi uppskata om du tog dig tid för att svara på våra frågor.

Enkäten lämnar du i ett stängt kuvert i en plomberad låda som bara jag kommer att öppna. Alla svar i de insamlade lådorna kommer läggas ihop och jag kommer inte kunna urskilja från vilken avdelning svaren kommer ifrån. Detta för att uppnå en så hög sekretess som möjligt. Du är välkommen att ställa frågor om något är oklart.

Försök svara så ärligt som möjligt på frågorna och ringa endast in ett svarsalternativ om ingen annan information angetts. Insamling av lådorna görs två veckor efter utlämningsdatumet.

Tack så mycket för din hjälp!
Ytterligare upplysningar lämnas av nedanstående ansvariga:

Student: Esther Van Vliet,
Handledare: Christopher Paten FD. Vik. Universitetslektor
Survey:

Nu kommer först några allmänna frågor om dig.

1. Kön
   □ Man
   □ Kvinna

2. Din Ålder:

3. Vad är ditt yrke:
   □ Läkare
   □ Sjuksköterska
   □ Undersköterska
   □ Annan_______________________

Här följer några frågor om när du har sex tillsammans med någon annan.

4. När hade du senast sex tillsammans med någon annan?
   Om du inte minns exakt kan du uppskatta ungefär när det var.
   □ under de senaste två veckorna
   □ 2 till 4 veckor tillbaka
   □ 1 till 6 månader tillbaka
   □ 7 till 12 månader tillbaka
   □ mer än 12 månader tillbaka
   □ minns inte
   □ har aldrig haft sex med en annan.

5. När ni brukar ha samlag, Vilket/vilka skydd använder du/ni?
   [Av tekniska skäl ställs frågan till alla oberoende om man hade sex med någon av samma eller motsat kön.]

   A: Här kan du markera flera svarsalternativ.
   □ kondom som används under hela samlaget
   □ kondom, som sates på strax före utlösning
   □ p-piller
   □ spiral
   □ litar på avbrutet samlag
   □ litar på ”säker period”
   □ osäker, vet inte
   □ Inget
   □ annat_______________________

Fråga till dem som använder kondom.
**Vad var orsaken till att du/ni använder kondom?**

**B:** Här kan du markera flera svarsalternativ.
- □ det är en princip jag har
- □ för att undvika graviditet
- □ för att undvika en könssjukdom
- □ för att undvika HIV
- □ för att det är mer fräscht/hygieniskt
- □ för att undvika kladd
- □ för att öka lusten/känslan
- □ för att kunna ha sex längre/inte komma så fort
- □ för att göra inträngandet lättare
- □ min partner ville
- □ för att inte behöva vara orolig efteråt
- □ av omtanke om varandra
- □ vet inte
- □ annan orsak __________________

**Varför använder du/ni inte kondom?**

**C:** Här kan du markera flera svarsalternativ.
- □ hade ingen kondom till hands
- □ redan gravid/ville ha barn
- □ använde annat graviditetskydd (p-piller, spiral eller liknande)
- □ litade på ”säker period” eller avbrutet samlag
- □ min partner ville inte använda kondom
- □ jag var påverkad av alkohol/droger
- □ jag ville inte riskera att (killen skulle) tappa ståndet
- □ det kändes svårt att föreslå kondom
- □ jag tycker det är skönare utan
- □ jag är osäker på hur man sätter på en kondom
- □ det känns mer intimt utan kondom
- □ att inte använda kondom var ett gemensamt beslut
- □ det kändes mer spännande utan kondom
- □ det var lättare att få utlösning
- □ ville inte ha något avbrott/ville inte förstöra stämningen
- □ vi visste att ingen av oss hade en könssjukdom (testat oss, ny behandlade, inte haft sex förut)
- □ vet inte
- □ Jag/min partner kan inte få barn (mer).
- □ annan anledning ____________________

**Ifall ni inte använder något preventivmedel nu:**
6. Skulle du använda ett preventivmedel om du hade samlag:

A: Med ett nytt partner?

☐ ja ☐ nej ☐ kanske ☐ Vet inte

B: Med en annan partner utanför din nuvarande relation?

☐ ja ☐ nej ☐ kanske ☐ Vet inte

C: När Ert/din barnönskan är uppfylld?

☐ ja ☐ nej ☐ kanske ☐ Vet inte ☐ inte aktuellt

D: Vilken sorts preventivmedel skulle ni i så fall använda?

Här kan du markera flera svarsalternativ.

☐ kondom som används under hela samlaget
☐ kondom, som sates på strax före utlösning
☐ p-piller
☐ spiral
☐ litar på avbrutet samlag
☐ litar på ”säker period”
☐ osäker, vet inte
☐ Inget
☐ annat ________________________________

7. Hur allvarligt skulle det vara för dig att få följande könssjukdomar:

A: klamydia

☐ mycket allvarligt ☐ ganska allvarligt ☐ mindre allvarligt ☐ inte alls allvarligt ☐ vet inte

B: HIV

☐ mycket allvarligt ☐ ganska allvarligt ☐ mindre allvarligt ☐ inte alls allvarligt ☐ vet inte

C: könsherpes

☐ mycket allvarligt ☐ ganska allvarligt ☐ mindre allvarligt ☐ inte alls allvarligt ☐ vet inte

A: klamydia
☐ ingen risk
☐ liten risk
☐ medelstor risk
☐ stor risk
☐ mycket stor risk
☐ vet inte
☐ jag har det

B: HIV
☐ ingen risk
☐ liten risk
☐ medelstor risk
☐ stor risk
☐ mycket stor risk
☐ vet inte
☐ jag har det

Till dem som svarat ingen eller liten risk när det gäller klamydia.

C: Du har svarat att risken är liten eller ingen att du smittas av klamydia, beror det på att du:
Du kan välja flera alternativ.

☐ aldrig har sex
☐ har en fast partner
☐ litar på att partnern berättar om ev. smitta
☐ tycker dig kunna bedöma din partner
☐ du och din partner har testat er och vet att ni inte har klamydia
☐ alltid använder kondom
☐ alltid använder slickskydd
☐ klamydia verkar inte särskilt vanligt
☐ det har gått bra hittills
☐ annat ______________________________
Till dem som svarat ingen eller liten risk när det gäller HIV.

D: Du har svarat att risken är liten eller ingen att du smittas av HIV, beror det på att du:

Du kan välja flera alternativ.

☐ aldrig har sex
☐ har en fast partner
☐ litar på att partnern berättar om ev. smitta
☐ tycker dig kunna bedöma din partner
☐ du och din partner har testat er och vet att ni inte har HIV
☐ alltid använder kondom
☐ alltid använder slickskydd
☐ HIV verkar inte särskilt vanligt
☐ det har gått bra hittills
☐ annat ________________________________

9. Vet du vart du skall vända dig om du skulle vilja testa dig för könssjukdomar?
☐ ja
☐ nej

Nu kommer några frågor om dina kunskaper och atityder när det gäller sex och samlevnad.

10. Tänk dig att du träffar en ny sexpartner som säger att han/hon vill använda kondom vid vaginalt och/eller analt samlag, hur reagerar du då?

Här kan du markera flera svarsalternativ.

☐ jag tycker han/hon verkar vara omtänksam/ansvarsfull
☐ det får mig att tänka på könssjukdomar och känna obehag
☐ jag tycker kondomer kan vara upphetsande
☐ det skulle kännas som att han/hon kanske har en könssjukdom
☐ jag vill gärna använda kondom själv och tycker det är bra om han/hon föreslår det
☐ det skulle kännas som att han/hon tror att jag har en könssjukdom
☐ jag tycker kondomer är avtändande
☐ jag tycker det är bra eftersom jag då inte behöver oroa mig efteråt
☐ jag vill inte använda kondom och blir störd om han/hon föreslår det
☐ jag tycker att det är bra eftersom det blir enklare att ha sex med kondom
11. Sex och samlevnad kan man ha haft i flera olika ämnen i skolan. Vad av nedanstående stämmer för dig?

Tänk på hur det var både i grundskolan och på gymnasiet.

Jag fick lära mig om hur man skyddar sig mot oönskade graviditeter
☐ ja, men för lite  ☐ ja, tillräckligt  ☐ ja, för mycket  ☐ nej

Jag fick lära mig om kondomanvändning
☐ ja, men för lite  ☐ ja, tillräckligt  ☐ ja, för mycket  ☐ nej

Jag fick lära mig om HIV
☐ ja, men för lite  ☐ ja, tillräckligt  ☐ ja, för mycket  ☐ nej

Jag fick lära mig om andra könssjukdomar
☐ ja, men för lite  ☐ ja, tillräckligt  ☐ ja, för mycket  ☐ nej

Undervisningen gav mig kunskaper som jag sedan kunde använda för att för att ta hand om min egen sexuella hälsa
☐ ja, men för lite  ☐ ja, tillräckligt  ☐ ja, för mycket  ☐ nej

12. Vad vet du om följande när det gäller klamydia:

A: Klamydia är mycket smittsamt
☐ Stämmer  ☐ Stämmere inte  ☐ Vet inte

B: Man kan ha klamydia länge utan att märka det
☐ Stämmer  ☐ Stämmere inte  ☐ Vet inte

C: Om man har klamydia kan man smitta andra även om man själv inte har några symptom
☐ Stämmer  ☐ Stämmere inte  ☐ Vet inte

D: Om man använder kondom varje gång man har sex, minskar man risken att få klamydia
☐ Stämmer  ☐ Stämmere inte  ☐ Vet inte

E: Klamydiainfektion kan leda till att man inte kan få barn
☐ Stämmer  ☐ Stämmere inte  ☐ Vet inte
13. Vad vet du om följande:

A: Man kan få HIV om man kramar någon som är smittad
□ Stämmer □ Stämmer inte □ Vet inte

B: Man kan få HIV om man kysser någon som är smittad
□ Stämmer □ Stämmer inte □ Vet inte

C: Man kan få HIV genom at dricka ur samma glas/flaska som någon som är smittad
□ Stämmer □ Stämmer inte □ Vet inte

D: En person som ser frisk ut kan ha HIV
□ Stämmer □ Stämmer inte □ Vet inte

E: Om man använder kondom varje gång man har sex, minskar man risken at få HIV
□ Stämmer □ Stämmer inte □ Vet inte

F: Det finns inga människor i Sverige som har HIV
□ Stämmer □ Stämmer inte □ Vet inte

G: Risken för at bli smittad med en könssjukdom ökar ju fler man har sex med utan kondom
□ Stämmer □ Stämmer inte □ Vet inte

H: Det är viktigt at testa sig innan man går över till sex utan kondom med en ny partner
□ Stämmer □ Stämmer inte □ Vet inte

14. Vad tycker du at du behöver mer kunskap om?

Här kan du markera flera svarsalternativ.

□ säkrare sex
□ hur HIV smittar
□ hur andra könssjukdomar smittar
□ hur det är at leva med HIV
□ hur man talar om risker för könssjukdomar med en sexpartner
□ hur man undviker at kondomen går sönder
□ hur man undviker oönskade graviditeter
□ Inget
□ annat ________________________________
15. Hur var det för dig at svara på det här frågeformuläret?

<table>
<thead>
<tr>
<th>Frågorna var viktiga</th>
<th>Instämmer</th>
<th>Inte alls</th>
<th>Instämmer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frågorna var obehagliga</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frågorna var roliga at svara på</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Frågorna var svåra at svara på</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jag svarade upriktigt på frågorna</td>
<td></td>
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</tr>
</tbody>
</table>

Om du har synpunkter eller vill lämna ett meddelande:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Du har nu svarat på den sista frågan i enkäten och undersökningen är avslutad. Ett stort tack för den tid du har lagt ned!