

AN AIDS EDUCATION PROGRAM FOR MIGRANT WORKERS  
IN THE NORTHERN SHENANDOAH VALLEY  
UNDER AUSPICES OF SHENANDOAH COMMUNITY HEALTH CENTER  
Martinsburg, WV

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An AIDS education program was implemented by the staff of Shenandoah Community Health Center in Martinsburg, West Virginia. The purpose of the program was to provide information about AIDS transmission and prevention to Hispanic, Haitian, American Black, Jamaican, and other Caribbean migrant workers in the area. The program was initiated July 6, 1988 and continued for 15 weeks. Twenty-five camps were visited, with a total of 515 participants. Educational strategies included a short lecture, and the use of language-appropriate videos, and pamphlets. Pre and post tests were used to assess the level of knowledge, and attitudes/practices before and after implementation of the program. Of the 515 participants, 275 paired and completed pre and post tests were obtained. Findings indicated that for the most part, the knowledge level of participants increased after implementation of the educational intervention. Attitudes about personal risk of acquiring AIDS seemed to decrease after participation in the program, however intention to use condoms increased. Other attitudes about AIDS remained constant or were affected to a much lesser degree.

## INTRODUCTION

Since 1981 over 46,000 cases of acquired immune deficiency syndrome (AIDS) have been reported to Centers for Disease Control (CDC, 1987a). Projections through the year 1991 suggest that 250-300 thousand cases could be diagnosed by that time (Morgan, 1986). Given this projected course of the AIDS epidemic, and the absence of cure, educational efforts to reduce transmission of human immunodeficiency virus (HIV) infection have become a major thrust in public health and will continue to be a priority initiative in the next decade.

The American public has been deluged with information to help understand AIDS, to dispel myths about transmission, and to promote condom use. This has been accomplished through various forms of the media--television specials, condom ads, countless articles in popular magazines, columns in hometown newspapers, school programs, and most recently, an AIDS brochure prepared by CDC was mailed to every household in the country. Despite these colossal efforts to get the message about AIDS to everyone, major gaps in AIDS education exist in certain subgroups of the American population. The community of migrant agricultural laborers is one such subgroup which lives outside of the mainstream of American life, and by virtue of their mobile lifestyle, has had limited access to AIDS education. The purpose of this projects was to help bridge this gap by providing a culture-oriented health education program about AIDS to the migrant community in the

northern Shenandoah Valley.

Shenandoah Community Health Center (SCHC), located in Martinsburg, West Virginia provided the setting and staff for this project. SCHC is a primary health care center with a well-established migrant program, and a reputation for aggressive outreach. Between July and November 1987, some 2,500 migrant workers were registered by the clinic in its combined project area of West Virginia, northern Virginia, and Maryland. Although the population served is predominantly male (82%), approximately 10% of the migrants bring their families. And so pregnant women, children and adolescents are often included in the harvesting, and seek health care at the clinic and its satellites. On any given day it is not unusual to hear English, Spanish, and Haitian Creole spoken at the health center.

The following literature review will define the migrant community, and then address its relationship to health care, health education, and to AIDS.

## REVIEW OF LITERATURE

### The Migrant Community

By definition, a migrant worker: (a) is employed in agricultural labor, and (b) has a lifestyle characterized by constant mobility (Coles, 1971). The migrant farm labor system draws from some of the most economically underprivileged sectors of society. The east coast stream of migrants includes southern Blacks from Florida, Haitians,

Hispanic-Americans from the southwest, Jamaicans, Puerto Ricans, and aliens from Mexico (Trotter, 1984). For the migrant family, movement and travel is survival. Crop seasons dictate where and when the next move will be. Consequently, formal schooling is at best interrupted, and often forsaken entirely (Coles, 1971). While "on the season", migrants live in barracks-style housing located on farm camps. Cramped, substandard housing conditions, and occupational hazards contribute to the negative health status of the migrant worker. Problems with alcohol abuse, sexually transmitted diseases, and tuberculosis are among common health problems presented at migrant clinics (Trotter, 1984).

#### Migrants and Health Care

Since geographic relocation may occur several times during the year, health care often becomes fragmented and crisis-oriented, with health education taking a back seat to band-aid medical care. Migrant families frequently rely on folk remedies, magic-religious beliefs, and superstitions to handle their health problems (Coles, 1971). Since migrants place a premium on not losing a day's labor, they often do not seek help from health professionals until a condition is so debilitating he/she is no longer able to work.

#### Migrants and Health Education

In a report addressing the health and social needs of migrant workers nationwide (Farmworkers Justice Fund, 1986),

According to CDC, tuberculosis (TB) incidence is on the rise, most prominently in areas with high levels of HIV infection. This link between HIV infection and TB has prompted CDC to recommend considering HIV testing of all TB patients (CDC, 1987b). SCHC clinic statistics reflect a high incidence of positive TB reactors. For instance, in the combined project area served by SCHC in 1987, of the 392 PPD's administered, 180 (46%) were reactive. Four active cases of TB were confirmed, and 2 suspect cases were identified.

Among heterosexuals, non-intravenous drug users at sexually transmitted disease clinics make up a likely subpopulation in which to observe HIV infection (CDC, 1987a). Of the 1,007 serologies performed at SCHC on migrant workers in 1987, 128 (13%) were reactive. By comparison, only 7% of 292,185 serologies performed in the entire state of West Virginia in 1986 were reactive. Given these statistics and the fact that approximately 50% of the migrant workers registered by SCHC are males between the ages of 20 and 34, the likelihood of multiple sex partners and heterosexual transmission of infection is significant.

Although migrant workers are not classified as a group at high risk for becoming infected with AIDS, it is clear that certain cultural practices, health problems, and sexual behaviors warrant a comprehensive health education program to reduce risk.

Reaching the migrant community with information about

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the growing health problem of AIDS poses a special challenge since traditional public health methodologies are inappropriate for migrants who often have no television, little access to magazines, poor reading skills, no mailing address, and for whom cultural differences and language pose a barrier.

## METHODOLOGY

### The Sample

The sample for this project consisted of 275 migrant workers employed in the orchard industry of the combined project area served by SCHC. The 25 camps targeted included Mexicans (68.7%), Haitians (16.7%), American Blacks (6.5%), Jamaicans (4%), Bahamians (2%), and others (1.8%). Two hundred and fifty (90%) in the sample were male, and twenty-five (9%) were female. The majority of the participants were in the age range of 20-34 years.

### Procedure

The setting for the educational program varied according to the camp. For the most part, a multipurpose room located in the housing unit of the respective camps was used. Evening sessions were conducted to minimize lost hours of work by the participants.

Each educational session consisted of a twenty-minute informal lecture on AIDS which was done in the appropriate language.

The perception of personal risk of acquiring AIDS seemed to decrease after presentation of the educational program. Many of those who took the post-test pointed out that they are monogamous in their relationship, and they felt this decreased their personal risk considerably.

In response to the question "where would you go for help if you thought you had AIDS?" every one of the participants chose to go to a physician instead of a local healer or some other person in their community. Since it was clear that the clinic was conducting the educational program, the participants may have been offering an answer that they believed the clinic wanted to hear, instead of what they would actually do. Because of the strong possibility of this Hawthorne Effect, this data was not included in the result tables.

In addition, the question that had to do with AIDS being a punishment from God was worded in such a way that a double negative was created. This caused confusion and confounded the results.

SUMMARY

Blacks and Hispanics comprise approximately 90% of the east coast stream of migrant agricultural farmworkers. As of September, 1987, 10,388 Blacks and 5,883 Hispanics have been reported with AIDS nationally. In the absence of cure, health education has been recognized as the most effective way to control the spread of AIDS. A gap in health education

is evident in the migrant community, especially with regard to AIDS, other communicable and chronic disease, and occupational hazards.

Pregnant women in the migrant community are usually tied in with federal programs such as WIC and receive some nutrition and health education. Children of migrant workers are often included in school programs which address health issues during the harvest season. However, the vast majority of migrant workers are males who do not seek health care services until a condition interferes with their ability to work. Attempting to reach this group with information about AIDS is crucial, and challenges traditional public health methodologies. Language and cultural beliefs can present significant barriers to health education, and therefore need to be addressed.

Several research questions have been raised as a result of implementation of this project. The most striking involves further exploration of the relationship between knowledge and practices, or health beliefs and practices in the migrant community. The collection of ethnographic data regarding preventive health practices, and folk remedies used by migrants would be useful in designing future educational programs.

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### Procedure

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Each educational session consisted of a twenty-minute informal lecture on AIDS which was done in the appropriate language.

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Specific topics covered in each session included:

1. General information about AIDS--definition, incidence and prevalence especially among minority groups.
2. AIDS transmission-- risky behavior, how AIDS is and is not spread.
3. AIDS prevention--safe behavior to minimize risk of acquiring or transmitting AIDS, including condom demonstration.
4. AIDS testing-- who should get the test, what it will and will not tell you.
5. AIDS resources in the community for more information.

The next portion of the presentation involved showing a video, and then opening the floor to discussion and questions. A brief summary was given by the presenter to stress the most important points. The length of the entire educational program was approximately 50 minutes.

### Evaluation

Evaluation of the effectiveness of the educational program, and measure of the change in knowledge, attitudes, or practices of the participants as a result of the teaching was accomplished by means of a pre and post test (See Appendix).

The AIDS pre and post tests consisted of ten knowledge questions which focus on AIDS transmission and prevention. In addition, five questions were designed to target attitudes

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about AIDS, and two questions were designed to target practices. The format of the tests included a mixture of multiple choice and yes/no questions requiring that the participants circle the correct response. Validity and reliability of the tests were established by administering them to migrant volunteers before the start of the project, and by critique of the SCHC bilingual staff. Versions of the same tests were developed in Spanish and Creole as well as English, in anticipation of future programs. Due to the problem of illiteracy, and the nature of the questions, the pre and post tests were conducted by 1:1 interview when necessary.

#### RESULTS

Comparison of the pre and post-test scores obtained in the camps supports the idea that an increase in knowledge was achieved through educational efforts. Among Haitian participants, the results are more dramatically evident since 32% of those tested had no knowledge of AIDS prior to implementation of the program. See Table 1 for comparison of pre and post test scores of the five ethnic groups included.

Table 1

Comparison of Knowledge Scores by Ethnicity

<u>Ethnic Group</u>	<u>Average Pretest</u>	<u>Average Post-test</u>
Mexican	66.19%*	84.28%
Haitian	46.73%**	77.39%
American Black	82.77%	84.40%
Jamaican	72.72%	91.80%
Bahamian	88.3%	95.0%

\* 5% had a pretest score of 0

\*\*32% had a pretest score of 0

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Attitudes and practices elicited by pre and post testing in the camps are summarized in Tables 2-6. The importance of using a condom increased in all groups except Jamaicans. With regard to condom use and intention to use condoms, pre-tests indicated resistance to using condoms especially among Haitians and Bahamians. Post-testing indicated that 50% or more of the Haitians and Bahamians surveyed intended to use a condom always.

Pre-testing indicated that Mexicans and Haitians especially associated AIDS with being dirty. Even after implementation of the program, close to 40% of the Mexicans, and 50% of the Haitians maintained this belief.

Of all of those tested, only a small percentage maintained the belief that AIDS is a disease of white people after implementation of the program.

Perception of personal risk of acquiring AIDS decreased in all groups when pre and post-test responses were compared.

Table 2

## IMPORTANCE OF USING A CONDOM

ETHNIC GROUP	INDICATOR	PRE-TEST %	POST-TEST %
Mexican	Yes	87.6	94.3
	No	12.3	5.6
Haitian	Yes	72.0	95.3
	No	28.0	4.6
American Black	Yes	88.8	94.4
	No	11.1	5.5
Jamaican	Yes	54.5	100.0
	No	45.4	0
Bahamian	Yes	100.0	80.0
	No	0	20.0

Table 3

## CONDOM USE/INTENTION TO USE

ETHNIC GROUP	INDICATORS	PRE-TEST %	POST-TEST %
Mexican	Always	12.25	51.13
	Frequently	3.2	9.6
	Sometimes	30.32	25.56
	Never	54.19	13.63
Haitian	Always	4.3	61.9
	Frequently	0	2.3
	Sometimes	26.0	19.0
	Never	69.5	16.6
American Black	Always	21.4	53.3
	Frequently	21.4	0
	Sometimes	7.0	33.0
	Never	50.0	13.3
Jamaican	Always	11.0	70.0
	Frequently	11.0	20.0
	Sometimes	55.0	10.0
	Never	22.0	0
Bahamian	Always	16.6	50.0
	Frequently	0	0
	Sometimes	16.6	33.0
	Never	66.0	16.6

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one of the thirteen recommendations included developing culturally appropriate health education materials for farmworkers. Preventive health measures and information on sexually transmitted diseases were cited as topics pertinent to the migrant community.

Trotter (1988) points out that migrants have consistently shown interest in health education, especially information which would enhance self-care skills. In one study, 46% of the families surveyed indicated an interest in learning more about gonorrhea/syphilis (Trotter, 1984).

#### Migrants and AIDS

A look at the cumulative incidences of AIDS among Blacks and Hispanics in the United States shows that incidences in these two groups are over three times the rate for whites (CDC, 1986). Among women, Blacks and Hispanics accounted for 51% and 21% respectively of the 1,634 female patients identified in 1986. In addition, 90% of the children with perinatally acquired AIDS were black or Hispanic (CDC, 1986). Reasons for recurring racial disproportion have not yet been identified.

Among certain Hispanic population, the common cultural practice of self-prescribing and administering injectible medication (especially vitamin B12) purchased in Mexico increases risk of transmitting AIDS when needles are shared or reused (National Migrant Referral Project, 1987).

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APPENDIX

CODE #: \_\_\_\_\_

POST-TEST

1. AIDS is a serious health problem because there is no cure.
 

Yes	No
-----	----
2. You can get AIDS from a dirty toilet seat.
 

Yes	No
-----	----
3. Only homosexual men get AIDS.
 

Yes	No
-----	----
4. A woman who is infected with AIDS can give the disease to her unborn baby.
 

Yes	No
-----	----
5. To protect yourself from getting AIDS, you should never share drug needles.
 

Yes	No
-----	----
6. It is possible to be infected with AIDS and still look and feel healthy.
 

Yes	No
-----	----
7. AIDS is often spread by hugging and kissing.
 

Yes	No
-----	----
8. People who have had other sexually transmitted diseases, or who have many sex partners, are more likely to get AIDS.
 

Yes	No
-----	----
9. Condoms (rubbers) prevent pregnancy, and prevent the spread of AIDS and other sexually transmitted diseases.
 

Yes	No
-----	----
10. There is a blood test to tell if you have been infected with the AIDS virus.
 

Yes	No
-----	----
11. It is important to use a condom every time you have sex.
 

Yes	No
-----	----
12. People with AIDS are dirty people who do not wash themselves every day.
 

Yes	No
-----	----
13. AIDS is a disease of white people.
 

Yes	No
-----	----
14. AIDS is a medical condition, and not a punishment from God.
 

Yes	No
-----	----
15. Do you consider yourself at risk for getting AIDS?
 

Yes	No
-----	----
16. I intend to use a condom:
 

1- Always
2- Frequently
3- Sometimes
4- Never
17. If you thought you had AIDS, who would you go to for help?
 

1	2	3	4	5
Doctor	Local Healer	Midwife	No One	Other _____
18. Having sex when you have been drinking increases your risk of getting AIDS, because you might forget to use a condom.
 

Yes	No
-----	----

PRE-TEST

1. AIDS can be cured if it is treated early. Yes  No
2. AIDS is spread by mosquitoes. Yes  No
3. Drug users who share needles when they shoot up can spread the AIDS virus. Yes  No
4. A woman can become infected with AIDS by having sex with a man who has AIDS. Yes  No
5. Not having sex is a good way to protect yourself from getting infected with AIDS. Yes  No
6. You can tell if a person has AIDS just by looking at them. Yes  No
7. You should avoid touching a person with AIDS because you might catch the disease that way. Yes  No
8. People with many sex partners are more likely to get AIDS than people who have only one partner. Yes  No
9. Condoms (rubbers) can help prevent the spread of AIDS. Yes  No
10. The AIDS virus is found in human blood and secretions. Yes  No
11. It is important to use a condom every time you have sex. Yes  No
12. People with AIDS are dirty people who do not wash themselves every day. Yes  No
13. AIDS is a disease of white people. Yes  No
14. AIDS is a punishment from God. Yes  No
15. Is it possible that AIDS could affect you or your family? Yes  No
16. I use condoms:   

1	2	3	4
Always	Frequently	Sometimes	Never
17. If you thought you had AIDS, who would you go to for help?  

1- Doctor	2- Local Healer	3- Midwife	4- No One
5- Other _____			
18. When I have sex, I have been drinking:  

1	2	3	4
Always	Frequently	Sometimes	Never

## Tes Avan Nou Koze

- |   |          |         |        |             |
|---|----------|---------|--------|-------------|
| 1. Moun kab geri si SIDA-a trete byen.  | Wi       | Non     |        |             |
| 2. Se moustik ki bannou SIDA-a.   | Wi       | Non     |        |             |
| 3. Moun Ri nan drog epitou ki sevi ak menm zegwi pou yo pike kab baye viris SIDA-a tou.   | Wi       | Non     |        |             |
| 4. Youn fanm kab vinenfekte ak SIDA le li fe lanmou ak youn nonm ki genyen li.            | Wi       | Non     |        |             |
| 5. Sel jan pou-ou pata pran enfeksyon SIDA se pou-ou pata fe lanmou.                      | Wi       | Non     |        |             |
| 6. Depi ou gade youn moun, ou ka konnen si li gen SIDA.                                   | Wi       | Non     |        |             |
| 7. Se pou-ou pa manyen moun ki gen SIDA si ou pa vle atrap maladi-a.                      | Wi       | Non     |        |             |
| 8. Moun ki fe lanmou ak plizie lot kab atrap SIDA pli fasil ke saki genyen youn sel moun. | Wi       | Non     |        |             |
| 9. Kapot(kaoutchou)kab ede rete SIDA-a.   | Wi       | Non     |        |             |
| 10. Viris(jem) SIDA-a nan san moun ak nan tout dlo moun rann.                             | Wi       | Non     |        |             |
| 11. Se pou-ou toujou sevi ak kapot le ou apfe lanmou.                                     | Wi       | Non     |        |             |
| 12. Moun ak SIDA se moun malprop ki pa propte ko yo toulejou.                             | Wi       | Non     |        |             |
| 13. SIDA-a se maladi Blan.  | Wi       | Non     |        |             |
| 14. SIDA-a se pinisyon bondye.  | Wi       | Non     |        |             |
| 15. SIDA-a kab byen tonbe sou-ou ou sinon sou fanmi ou.                                   | Wi       | Non     |        |             |
| 16. Mwen sevi ak kapot:   | 1        | 2       | 3      | 4           |
|   | tout tan | souvan  | pafwa  | janmen      |
| 17. Si ou ta kwe ke ou ta gen SIDA, ki moun ou ta val jwen pou ede ou?                    |          |         |        |             |
|   | 1.       | 2.      | 3.     | 4.          |
|   | Docte    | Houngan | Sajfam | Peson moun  |
|   |          |         |        | 5. Lot moun |
| 18. Le mwen fe lanmou se le mwen bwe:   | 1        | 2       | 3      | 4           |
|   | tout tan | souvan  | pafwa  | janmen      |

Non \_\_\_\_\_ Kan-an \_\_\_\_\_ Code \_\_\_\_\_

Post-Test(Apre Koze)

- |   |    |     |
|---|----|-----|
| 1. SIDA-a se youn gro problem pse pa genyen gerizon pou li.   | Wi | Non |
| 2. Ou kab pran SIDA le ou chita sou youn wate sal.  | Wi | Non |
| 3. Se gason-fanm selman ki kab gen SIDA.  | Wi | Non |
| 4. Youn fanm ki gen jem SIDA-a kab bye pitit nan vant li-a jem maladi-a.  | Wi | Non |
| 5. Pou proteje tet ou, ou pa doue janm sevi ak zegi dwog lot moun sevi.   | Wi | Non |
| 6. Le youn moun gen jem SIDA-a, li tou jou paret malad, epitou, li santi li malad.  | Wi | Non |
| 7. Byen souvan, jem SIDA-a pwopaje le moun kroke ousinon le yap bo.   | Wi | Non |
| 8. Moun ki gen lot malad ke yo pran le yap fe lanmou, ousinon moun ki fe lanmou ak anpil moun, moun sa yo pli fasilman gen SIDA.                    | Wi | Non |
| 9. Kapot(kaoutchou) anpeche fanm vini ansent, li anpeche mikwob SIDA-a pwopaje epitou li anpeche moun gen lot maladi yo kab atrap le yap fe lanmou. | Wi | Non |
| 10. Genyen youn tes san ki kab di si youn moun gen jem SIDA-a.  | Wi | Non |
| 11. Fok moun sevi ak kapot chak fwa yap fe lanmou.  | Wi | Non |
| 12. Moun ak SIDA se moun malpwop ki pa pwopte ko yo chak jou.   | Wi | Non |
| 13. SIDA se maladi Blan.  | Wi | Non |
| 14. SIDA se youn maladi, se pa youn pinisyon.   | Wi | Non |
| 15. Eske ou panse ke ou riske gen SIDA?   | Wi | Non |
| 16. Mwen gen li de sevi ak kapot:   |    |     |
| 1.Tout tan  |    |     |
| 2.Pafwa   |    |     |
| 3.Souvan  |    |     |
| 4.Janmen  |    |     |
| 17. Si ou ta kwe ke ou gen SIDA, ki moun ou ta vale jwen?   |    |     |
| 1                      2                      3                      4                      5   |    |     |
| Docte              Houngan              Sajfam              Pason moun              Lot moun  |    |     |
| 18. Si ou fe lanmou le ou bwe, ou riske genyen SIDA-a, paske ou kab bliye mete kapot-la.  | Wi | Non |

