SPECIFICATION OF A MODEL FOR STUDY OF ATTITUDE TOWARDS GROUPS CARRYING HIV / AIDS

Cruz García Lirios
Academic Transdisciplinary Network

ABSTRACT

Within the framework of health policies, the psychological processes of identity and stigma are a binomial that tries to explain lifestyle evaluation processes related to vulnerable groups. Precisely, the objective of the present work is to establish the validity and reliability of an instrument that measured both dimensions in an attitude scale. A transversal and correlational study was carried out to establish the psychometric properties of the instrument with a non-probabilistic and intentional sample of 258 students of a public university. The results show both dimensions as preponderant factors attitude, but their inclusion in the construct was taken as part of a process of spontaneous activation; actions and risks that only a group or close to carriers of HIV/AIDS can carry out.

1. INTRODUCTION

The aim of the present work was to establish the reliability and validity of an instrument that measures attitudes towards groups close to HIV/AIDS carriers, since the theoretical and conceptual frameworks, as well as empirical ones, warn about the prevalence of identity and stigma as two determinants of differences between groups close to HIV/AIDS carriers and expectant, judgmental or stigmatizing groups of families and friends of HIV/AIDS carriers (Bautista, Delgado, García, Valdés, Hernández, Castro & Trujillo, 2016).

However, the psychology of health in general and the psychology of attitudes, as well as behavioral and health sciences such as nursing, social work or medicine have only built an instrument that measures attitudes to relate them to scales that measure beliefs, or knowledge, as well as inventories that measure behavior without considering sufficient reliability and validity criteria to carry out more complex analyzes such as linear models or structural models that allow a more detailed explanation of the relationships between cognitive and behavioral variables (García, Carreón, Sandoval, Bustos & Aguilar, 2016).

However, the literature continues to grow in terms of the one-dimensional measurement of attitudes towards HIV/AIDS carriers, towards the quality of the public health service, towards the performance of health professionals or towards those who stigmatize the disease and its carriers. Consider the attitudinal dimensions established in the specialized literature such as biomedical treatment, socio-emotional rehabilitation or family support as essential factors for an integral diagnosis of the context and the situation of those who carry the disease and those who care for them or interact with them (Carreón, Bustos, Hernández, Quintero & García, 2015).

Therefore, the instruments that measure attitudes toward HIV/AIDS do not specify factors and indicators when measuring general dimensions unrelated to specific decisions or actions such as the

Sense of Life Questionnaire (SLQ-25), Ontological Perception Scale. (OPS-18), Positive Affect Scale (PAS-21), Religious Attitude Scale (RAS-20) (Meneses, Avellar, Veloso, Nunes & Pinheiro, 2015).

It is necessary to carry out the psychological tests related to the consistency and convergence of more specific indicators with respect to the dimensions reported in the state of the question since: 1) The scales that measure general dimensions tend to establish a preponderant factor that limits the observation of specific dimensions and their relationships with other homologs; 2) General factors nullify the observation of trajectories of dependency or reflective relationships; 3) The observation of the internal consistency of scales and their construct or discriminant validity with a preponderant factor limit the construction of structural models that require specific factors and indicators (Lloret, Ferreses, Hernandez & Thomas, 2014).

The construction of an attitude scale suggests the revision of contextual, theoretical and empirical frameworks to specify their dimensions and the relationships with indicators, although the statistical parameters determine the consistency and convergence of latent and manifest variables (Krimberg, Saldanha & Neves, 2014).

2. PUBLIC HEALTH AND HIV / AIDS

The Human Immunodeficiency Virus (HIV) is a public health problem due to the process of incubation and development. The HIV cycle comprises a standard period of 10 years in which the infected continue to have risky lifestyles, since they do not change their behavior due to a symptom that compels them to self-care (Orcasita, Uribe and Valderrama, 2012).

The process of infection and reinfection is more likely, since since the plasmatic membrane and the CD4 receptor are infected, until the viral RNA is processed and the new viron is reconstructed, the diagnoses are not conclusive, and the spread of the virus proliferates in people with risk behaviors (Berenson, Paprocky, Fishman, Bhusman, El-Bassel & Downey, 2015).

In this way, the HIV cycle seems to show risky lifestyles that can be observed anywhere in the world and that could be associated with beliefs and attitudes around the bearers, as well as the groups to which they belong (Orcasita, Cuenca, Garrido, & Haderlein, 2018).

Thus, n is 30,1 Millo cases are adults, 16.8 million women and 1.5 million children. Sub-Saharan Africa has the highest number of carriers with 22 ' 900,000 while North Africa registers 470 thousand cases. In Latin America there are 1.5 thousand carriers and in Mexico only 200 thousand cases.

Both aspects, the infection process and the disproportionate increase in the regions seem to indicate that the problem has its origin in the risk behaviors themselves that being influenced by the identity of carriers and non-carriers make HIV a public health problem regarding stigma (Guerra & Gouveia, 2007).

In health sciences, groups close to the sick are known as social support and are a major factor in adherence to treatment, the main determinant of hospital health (Davis, Shell & King, 2012). In the case of groups close to HIV/AIDS carriers, not only are they associated with risk styles, but risk identities are attributed to them (Abbasi, Rafique, Aziz & Hussai, 2013).

Identity and stigma are two psychosocial processes that for the purposes of this work will be understood as attributions and biased choices in favor of a group belonging to another reference group (Cañizo & Salinas, 2010).

Both definitions underlie HIV / AIDS as a public health problem, which makes sense in a context; economic, political, social, welfare, symbolic, institutional, organizational, professional

In the construction of the instrument that measures attitudes toward HIV/AIDS contextual framework suggests that close groups carriers of the disease are responsible for their quality of life and subjective well without considering the emotional, physical or psychological wear supone such activity.

3. THEORY OF ATTITUDES TOWARDS HIV/AIDS

The theoretical and conceptual frameworks that explain attitudes towards HIV/AIDS are: 1) Theory of reasoned action, 2) Theory of Planned Behavior; 3) Theory of Spontaneous Processing, as well as its hegemonic factors, but general in the explanation of a specific action.

Attitudes, identity is a consequence of a deliberate, planned and systematic election (Summer, 2011). In this sense, there are three attitudinal theoretical frameworks that would explain the favoritism of the endogroup to the detriment of the exogroup known as ethnocentrism, although a conflict within the group of belonging would generate an altercentrism (Chacón, Barrantes, Comerfold & McCoy, 2014).

Theory of Reasoned Action (TAR) argue that identity and stigma are the result s of processing general information about a group belonging to the powers in contrast to a control group (Ferragut & Ortiz, 2013). In this conceptual model, beliefs process the surrounding information, but it is the attitudes that will determine the biased choice of a group (Uribe & Orcasita, 2011). These are categories in which the information is concentrated to carry out a specific action that enhances the endogroup and bypasses the outgroup (García & Rodríguez, 2014).

However, the resulting deliberate action, categorized as general information, does not always anticipate specific behaviors and will rather require perceived perceptions of control or behavioral controls (Jouen & Zielinski, 2013).

This is how the Theory of Planned Behavior (TCP) assumes that only the delimited information and its processing, both of beliefs and perceptions, will specify the information in such a way that they would anticipate specific behaviors (Klaus, Piñeres & Hincapie, 2010).

In this way, ART and TCP, identity and stigma are consequences of having processed deliberate, planned and systematic information concerning a group very close to an individual after having been contrasted with information relative to other groups far away from that same individual (Rodríguez, 2013).

Although attitudes have been considered as associations between evaluations made from group categories, the Spontaneous Processing Theory (TPE) argues that they are rather arbitrary, spontaneous or semiautomatic processes (Albacerrin & Wyer, 2011).

The TPE, unlike the TAR and the TCP that propose a deliberate, planned and systematic process, considers that this information is safeguarded in the long and short-term memory, as well as in its procedural phase (Mardones & Guzmán, 2011). In this way, the information is stored and is in a latency state that will be activated when some stimulus recovers it and associates with improvised behavior (Hughes & Barnes, 2011).

Identity and stigma, from the point of view of TPE, are part of the arbitrary, spontaneous or semi-automatic process that characterizes attitudes (Solat, Velhal, Mahajan, Rao & Sharma, 2012). In that sense, it is noticed that the identity is a negative or positive attitude, for or against a group and the

stigma is a biased evaluation of this attitudinal and identity process, but that for some reason is latent and does not materialize as a behavior until a stimulus reactivates the discretion of the individual to categorize groups related to carriers of a disease such as HIV / AIDS (Becerra, Chunga, Palomino, Arévalo, Nivin, Portocarrero, Carbajal, Tomás, Caro, Astocaza, Torres, Carbajal, Pinto, Moras, Munayco & Gutiérrez, 2012).

According to the Theory of Spontaneous Processing, memory not only protects information concerning HIV / AIDS, risky styles and behaviors of vulnerable groups, but also such information is activated spontaneously or arbitrarily to carry out improvised behaviors that would explain self-care. In this sense, identity and stigma would be the result of information disseminated in the media, but they would indicate the emergence of a psychosocial process related to power or social influence around sexuality (Uribe, 2005).

From TAR, TCP and TPE it is possible to construct a theoretical framework in which both deliberate and spontaneous processes, planned with discretionary, systematic and semiautomatic coexist (Selesho & Modise, 2012). In this model, information does not flow from one side to another or is interconnected from one end to another but is in the whole cognitive structure of the individual evidencing the formation of a network (Villa, 2010).

In this sense, identity as stigma is not only correlated with attitudes, but also are structural nodes from which information is resignified to form new nodes; associations between categories and evaluations around information concerning the endogroup and outgroup (Méndez, Rojas & Moreno, 2012).

Therefore, in the construction of an instrument for measuring attitudes towards HIV/AIDS in general and attitudes towards groups close to HIV/AIDS carriers, it is necessary to consider: a) Reasoned, planned and spontaneous dimensions, b) Indicators related to aversion and propensity towards people who are distant or close to HIV/AIDS carriers.

4. STUDIES OF ATTITUDES TOWARDS HIV/AIDS

Psychological studies of attitudes, identity and stigma. They propose a cognitive network to explain the relationships among the groups and carriers of HIV/AIDS (Castillo & Chinchilla, 2011).

Psychosocial dimensions of years CERC groups with HIV/AIDS in the context of public health, about which information is generated lifestyles, risky behavior, violence and sexual exploitation.

The identity and stigma reported in the state of knowledge regarding groups close to carriers of VIH/AIDS: not only would be major factors in their study but would also be psychosocial effects of information related to lifestyles and risk behaviors, violence and sexual exploitation disseminated in the perceptions, beliefs, attitudes and discourses of groups with whom relatives and friends of HIV/AIDS carriers interact. In this sense, both identity and stigma are two representative and discursive nodes from which the information concerning public health risks is processed. That is, the information attributed to groups vulnerable to HIV/AIDS justifies and legitimizes the sexual division between those groups that deliberate, plan and systematize their sexual intercourse before groups that arbitrarily and improvably have sexual encounters.

Gender identity would be linked to stigma, as it is two information nodes that although they were influenced by media guide the formation of attitudes towards the choice and preference of a heterosexual group regarding a homosexual group. The identity is not only evaluated by the respondents but is also linked to associations that locate vulnerable groups in risk practices and sexual exploitation. The young people not only know their group belonging to the reference group in question

(family and friends of HIV/AIDS), but also warn a trend of attributes that makes them evaluate these groups as different from associating lifestyles and behaviors own risk of a sector vulnerable to sexual exploitation.

Identity and stigma are nodes attribution information concerning lifestyles and risk behaviors in an environment of sexual exploitation, but it is clear that both identity and stigma are components of a construct on attitudes towards related groups with carriers of HIV/AIDS. That is, identity and stigma are nodes where information is concentrated or generated, but its importance lies in observing the relationship between vulnerable, marginalized or excluded groups around HIV/AIDS carriers since these are part of a support social that determines the adherence to treatment.

From the review of the reporter findings in the literature consulted it is possible to notice that the groups close to HIV/AIDS carriers seem to have a greater influence in decision making only if the carrier considers that the relationship with this group is significant and high commitment, or if aversion and propensity h to cia these groups is defined and there is no ambivalence, then the attitude will be guided by indicators present rather than the past or the future as in the case of attachment or detachment of an interpersonal relationship.

In short, the contextual, theoretical and empirical relationships used in the literature regarding the relationships to be observed in the attitudes of close groups carrying HIV/AIDS suggest significant differences between groups that are distant or close to sick people. That is, a greater distancing from the phenomenon suggests a negative attitude towards family and friends of the terminally ill. This is the case of social work professionals who carry out procedures or administrative monitoring of cases.

In contrast, a greater proximity to cases such as the case of conflict mediation indicates a greater concern not only for the health and wellbeing of the carrier of the disease but also suggests an identification with the relatives of the sick.

Therefore, the instrument to be constructed must consider: 1) The context of the quality of public medical services; 2) The theory of attitudes in deliberate, planned and systematic processes, but also spontaneous, heuristic and improvised processes; 3) The findings regarding low correlations between factors and indicators.

What are the dimensions of attitudes towards groups close to HIV/AIDS carriers considering the identity of the group and the stigma towards that group by future health professionals?

Null hypothesis: there will be significant differences between the dimensions of identity and stigma established in the contextual, theoretical and empirical review with respect to the dimensions observed in the study.

Alternative hypothesis: There will be no significant differences between the dimensions of identity and stigma reviewed in the contextual, theoretical and empirical framework with respect to the observed relationships between factors and indicators of the study with public health practitioners.

5. METHOD

An exploratory, cross-sectional and correlational study was carried out. A non-probabilistic selection was made of 258 students from a public university in the State of Mexico. The criterion of choice was to have sufficient knowledge of HIV / AIDS and to have interacted with carriers, their relatives or friends.

Sex. 49% of the respondents were women ($M = 339.45$ dollars of monthly income and $DE = 21.37$ dollars), 48% were men ($M = 384.58$ dollars and $DE = 19.36$ dollars) and 3% I do not answer.

Age. 51% are between 22 and 29 years old (*M* = 326.38 dollars monthly income and *DE* = 21.25), 37% are between 18 and 22 years old (*M* = 273.29 and *DE* = 18.0), 9% are less than 18 years old (*M* = 220.13 and *SD* = 10.6), 3% did not answer.

Group. 63% declared that they did not belong to any group (*M* = 257, 27 dollars of monthly income and *DE* = 19.08), 34% indicated that if they belonged to a particular group (*M* = 345, 24 and *DE* = 17.20), 3% did not answer.

Preferences. 82% indicated that it is preferably heterosexual (*M* = 259.40 dollars of monthlyincome and *DE* = 37.29), 15% declared homosexual (*M* = 301.27 and *DE* = 18.79), 3% I do not answer.

Intercourse. 71% said they had sex with people of different sex before age 18 (*M* = 241.28 dollars monthly income and *DE* = 17.29), 20% have not had sex (*M* = 215.01 and *SD* = 18.20), 6% reported having sex with people of the same sex (*M* = 253.48 and *SD* = 15.08).

Sources. 71% said they heard about HIV/AIDS on television (*M* = 267.28 dollars monthly income and *SD* = 17.68), 20% said they found out at school (*M* = 283.49 and *DE* = 18.39), 6% stated that they did not know what consisted of sexually transmitted disease (*M* = 254.71 and *SD* = 18.29).

The García Attitudes toward HIV/AIDS Scale (2013) was used, which includes 26 statements about negative or positive, favorable or unfavorable dispositions towards groups close to HIV/AIDS carriers and their lifestyles, risk behaviors and vulnerability to sexual exploitation. Each statement includes four response options ranging from 0 = "not likely" to 3 = very likely. The dimension of identity measures attitudes towards a group close to HIV / AIDS carriers in comparison to groups that are considered distant and reach a reliability (alpha = 0,718) higher than the minimum indispensable. The stigma dimension measures attitudes towards life styles and risk behaviors, as well as the vulnerability to sexual exploitation associated with groups close to HIV/AIDS carriers with respect to distant groups reaching a reliability (alpha = 0.702). Higher than required the general scale had an internal consistency (alpha = 0.780) higher than the identity and stigma subscales.

The original instrument was adjusted to the university setting considering the findings reported in the state of knowledge and the public health context. Students were surveyed in the lobby of medical services and sexual orientation with prior informed consent and warning that the results of the study would not affect their academic status. The data was processed in the SPSS version 20 and AMOS version 4.0.

Centric tendency measures and dispersion measures were estimated for the descriptive data of the instrument and alpha coefficients for reliability, as well as exploratory factor analysis values of principal components with varimax rotation, adequacy and sphericity. Values higher than 0.70 were considered as evidence of internal consistency and KMO values higher than 0,600 were assumed as evidence of adequacy with significant levels lower than 0.05 were considered a case of sphericity. Factor weights greater than 0.300 were assumed as evidence of construct validity.

6. RESULTS

The values above 0.70 for the overall scale (alpha, 785) and for the items that were measured by two subscales relative identity (alpha, 780) and stigma (alpha, 787) as Preponderant factors are the attitude towards HIV/AIDS: which was established with factor weights greater than 0.300, which explained 43% and 57% of the total variance.

Bootstrap = 0.000; K = 1,304; KMO = 0.721; BARTLETT [χ^2 = 18.33 (18gl) p = 0.000], F 1 = Attitude to the identity of nearby groups with HIV/AIDS (43% of the total variance explained), F2 = Attitude to stigma of groups close to carriers of HIV/AIDS (57% of the variance explained).

Internal consistency and construct validity indicate that the instrument can be replicated in other contexts with other samples, but the latter must be university students since the selection of the sample was not probabilistic.

Once the two factors were established, the trajectories of dependency relationships between the two factors and their indicators were compared with the Pearson correlation test and covariance tests.

It is possible to observe a low correlation between the factors, which suggests a common and hegemonic factor, but a high covariance that implies the inclusion of a third factor not included in the study. A structural model was estimated to establish the preponderant factor or the two-dimensional aspect of attitudes towards groups close to HIV/AIDS carriers.

The adjustment and residual parameters $\lceil X^2 = 342.12$ (56gl) p =, 009; CFI =, 990; GFI =, 0997; RMSEA =, 009$\rfloor$ suggest the non-rejection of the null hypothesis regarding the adjustment of the dimensions of identity and stigma established in the literature review with respect to the relationships between these factors observed in the present work.

7. DISCUSSION

The present study has established the validity and reliability of an instrument that measures the attitude toward identity and stigma of groups close to HIV/AIDS carriers, although the type of non-experimental study, the type of non-probabilistic sampling and the type of Non-confirmatory analysis limits the results to the research scenario.

The internal consistency of the instrument and the two subscales reached values higher than those reported by García (2013), but lower than other instruments that measured attitudes towards HIV/AIDS as dimensions of the quality of life and the subjective well-being of Villegas, Rosas y García (2018) where they reported alpha reliability values higher than 800.

Carreón, Hernández, Bustos and García (2018) proposed a more specific instrument that measured the work commitment of health professionals with respect to their preventive and social care functions, finding a high commitment for those who had low incomes in relation to who own the financial resources for their private attention.

In the present work, the dimension of stigma includes the dimensions established in the labor commitment, but the alpha values of internal consistency seem to suggest a social desirability that concerns public servants and health professionals even in their own career choice, academic performance and work practice (García, Bustos & Carreón, 2017).

Therefore, it is necessary to apply a scale of social desirability to investigate the academic and formative bias with which health professionals carry out their performance.

8. CONCLUSION

The objective of the present work was to establish the reliability and validity of an instrument that measures the attitude towards groups close to HIV/AIDS carriers, but the type of non-experimental study, the type of non-probabilistic sampling and the type of exploratory analysis limited the results to the context of the investigation, suggesting the application of an instrument of social desirability.

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