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Perceptions of a culturally sensitive HIV/AIDS curriculum

Yolanda Vivian Mouton

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PERCEPTIONS OF A CULTURALLY SENSITIVE
HIV/AIDS CURRICULUM

A Project
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Education:
Health Education

by
Yolanda Vivian Mouton
December 2006
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Date
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ABSTRACT

HIV/AIDS is an epidemic in the United States (Centers for Disease Control and Prevention [CDC], 2006). The prevalence of the disease is higher among African-Americans than in other racial or ethnic populations (CDC, 2006; Satcher, 2006). Currently there is a concern for the increased incidence of HIV/AIDS among African-American women, elderly and youth (CDC, 2005). The focus of this study was to explore to what degree a culturally sensitive HIV/AIDS curriculum and materials were perceived as important by African-American students.

Students selected for this research were from San Bernardino, California, an area that represents a multiethnic population. Instruments used in this study included: the Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992), and an attitudinal questionnaire on HIV/AIDS. Frequency descriptions and bivariate correlations were conducted to analyze the data.

Two research questions framed the study: 1) Do African-American students perceive cultural sensitivity as an important aspect of HIV/AIDS education? and 2) Is there a correlation between African-American students’ ethnic identity, as measured by the Multigroup Ethnic Identity Measure (MEIM) and their perceptions of the need for
culturally sensitive HIV/AIDS education materials? Trends found in this study indicated African-Americans did not perceive cultural sensitivity as an important aspect of HIV/AIDS education, and correlations between the MEIM score of African-Americans and their perceptions of the need for culturally sensitive HIV/AIDS education materials were non-significant. Outcomes of this study suggest a more defined meaning of “cultural sensitivity” and “culturally sensitive” materials as it pertains to HIV/AIDS education.
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CHAPTER ONE
INTRODUCTION

Statement of the Problem

Communities of color, including African-American, Hispanic/Latino, Asian and Pacific Islander, and American-Indian/Alaska Native, are disproportionately affected by the HIV/AIDS epidemic (Centers for Disease Control and Prevention [CDC], 2004). In the 2000 census, African-Americans accounted for about 12.3% of the U.S. population, while constituting 40% of the AIDS cases since the beginning of the epidemic (CDC, 2005). HIV/AIDS is among the top three leading causes of death among African-American men, and in 2001 was the leading cause of death for African-American women aged 25-34 (CDC 2005).

The challenge to prevent HIV/AIDS is with changing the behaviors that lead to the contraction and spread of the disease. Transmission of HIV/AIDS is primarily through sexual behaviors and sharing needles with an infected person. There is no cure for HIV/AIDS, and the likelihood of developing a vaccine is unpredictable. According to the Academy for Educational Development (2002), HIV prevention has been demonstrated to be cost-effective by saving monies in the long-run rather than treating a lifetime case of HIV/AIDS. Primary prevention strategies include school and community-based sex education programs, and preventive counseling and screening for HIV/AIDS (Coyle et al., 2004; Kirby, 2001). These methods have demonstrated to be appropriate in reducing the risk of HIV, other STD infections, and unintended pregnancies among adolescents (Coyle et al., 2004; Kirby, 2001).

The Centers for Disease Control and Prevention aim to reduce barriers to early diagnosis of HIV infection and increase access to quality medical care, treatment, and prevention services (CDC, 2003). Funding the state and local health department to monitor the epidemic and carry out programs in their jurisdictions is also on the CDC agenda (CDC, 2003).
Significance

The focus of this study was to explore whether a popular HIV/AIDS prevention curriculum was perceived by African-American students to be culturally appropriate and likely to influence behaviors of African-American students in a positive direction. The outcome of this study demonstrated the need to make changes to HIV/AIDS education by promoting a more culturally appropriate approach for students. However, since the concept of race is socially constructed and may not be the best way to attribute risk (Pasick in Glanz, 1997), a race-based definition of cultural appropriateness is also called into question.

Research Questions

#1. Do African-American students perceive cultural sensitivity as an important aspect of effective HIV/AIDS education?

#2. Is there a correlation between African-American students' ethnic identity, as measured by the Multigroup Ethnic Identity Measure (MEIM) and their perceptions of the need for culturally sensitive HIV/AIDS education materials?
Limitations and Delimitations

Limitations

HIV/AIDS education and the concept of culture are both broad topics. This paper is limited to information and research specific to African-Americans, including research conducted in the San Bernardino Unified School District and the District's HIV/AIDS curriculum. The small convenience sample of students selected for this survey cannot be generalized to the entire African-American population. Students selected for the surveys were enrolled in summer school and may not be representative of the African-American student body in a typical school year.

In addition to limitations on generalizability, this study was limited to a descriptive analysis of comments from ninth and tenth-grade African-American students (although middle school students also received the curriculum in SBCUSD) without prospectively testing the impact of the curriculum which was reported elsewhere.

Delimitations

Because this was a study examining the relationship between students' perceptions of the importance of culturally sensitive HIV/AIDS education, this study did not consider the contribution of the following variables
on the curriculum's impact: age-appropriateness, students' gender, previous sexual history, students' overall academic ability, ethnicity of the instructor, instructor's fidelity in implementing the curriculum as written, or students' regard for the instructor.

Assumptions

The following assumption applies to this thesis:

1. The Multiethnic Identity Measure (MEIM) is a valid and reliable measure of students' identity.

2. The evaluation of Positive Prevention HIV/STD Curriculum (LaChausse, 2006) is a valid portrayal of its impact on all students.

Definitions of Terms

The following definitions apply in this thesis:

Cultural sensitivity. Refers to ethnic/cultural characteristics, experiences, norms, values, behavioral patterns, and beliefs of a target population as well as relevant historical environmental and social forces incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs (Resnicow et al., 1999 as cited in Bauer & Wayne, 2005).
Cultural competence. The capacity of individuals to exercise interpersonal sensitivity, and thus relates more to intervention materials and messages (Resnicow et al., 2000).

Ethnic Identity. (E.I.) refers to individuals identifying with and gravitating to their racial/ethnic pride, affinity for in-group culture (e.g., food, media, and language), attitudes toward majority culture, experiences, and attitudes regarding racism, intermarriage, and preserving one’s own culture (Resnicow & Ross, 1997; Thompson, 1992 in Cultural Sensitivity In Substance Use Prevention, 2000).

Health promotion programs. Refers to the planning of interventions that are relevant and acceptable within the cultural framework of the population to be reached (Huff & Kline, 1999).

African-Americans and Blacks. The terms are used interchangeably and usually refer to American-born blacks only, excluding foreign-born blacks (Huff & Kline, 1999).
CHAPTER TWO
REVIEW OF THE LITERATURE

The AIDS Epidemic in the United States

The AIDS epidemic in the United States affects millions of people. "From the beginning of the epidemic in 1981 through 2003, an estimated 1.3-1.4 million people in this country have been infected with HIV/AIDS" (CDC, 2006). At the end of 2003, 1,039,000 to 1,185,000 persons in the U.S. were living with HIV/AIDS and 24-27% were undiagnosed/unaware of their HIV infection (CDC, 2005).

There are changes occurring in the HIV/AIDS epidemic. The most significant change is the populations most affected by the virus. In the beginning of the epidemic, men having sex with men (MSMs) and intravenous drug users (IDUs) were the highest risk group of contracting and spreading HIV. Currently the virus is spreading rapidly to ethnic minorities, women, and youth who engage in sexual-risk behaviors (CDC, 2006).

HIV/AIDS and African-Americans

HIV/AIDS is a health crisis for African-Americans, and disproportionately affects the health and well-being of this population (CDC, 2006; Satcher, 2006). HIV/AIDS is affecting African-American subgroups and communities at a
higher rate since the beginning of the epidemic (CDC, 2006).

The "new faces" of HIV infection are African-American subgroups such as African-American women, adolescents, and elderly (CDC, 2005). In 2001, HIV/AIDS was the leading cause of death for African-American women ages 25-34 (CDC, 2005). In 2003, 12% of persons diagnosed with HIV/AIDS were young people (people under the age of 25) (CDC, 2003). African-American youth of both genders account for 56% of HIV cases reported in the 13-24 age groups (CDC, 2002). The past years have also shown steady increases of HIV/AIDS infection among the elderly (Williams, 2003). Although epidemiological data are often reported by race or ethnicity, such reporting may blur the actual behavioral and socio-economic determinants of risk (Pasick in Glanz, 1997).

The primary modes HIV/AIDS transmission include the exchange of semen, blood and vaginal fluids during unprotected sexual intercourse with an HIV infected person, and sharing needles contaminated with HIV (CDC, 2005). Sexual behaviors that put individuals at risk include little or no use of condoms coupled with having multiple sex partners (Halpern et al., 2004). Drug users who share needles increase the risk of HIV infection.
Needle sharing is the direct drug-related route of HIV/AIDS transmission (Halpern et al., 2004).

The most common mode of HIV/AIDS transmission for African-Americans include MSMs infected with HIV, and slightly less common, injection drug use (Millett, Malebranche, Mason, & Spikes, 2005; CDC, 2006). African-American women are commonly infected by having sex with men who have HIV (CDC, 2004 in CDC; HIV/AIDS among African Americans, 2006). These women become infected by not knowing the sexual behaviors of the men they chose to have sex with (CDC, 2006). Contaminated injection drug use is a slightly less common mode of infection for African-American women (CDC, 2004 in CDC; HIV/AIDS among African Americans, 2006).

Socioeconomics

In addition to high-risk sexual behaviors, there are less obvious contributing factors associated with HIV/AIDS infection. Research suggests the social inequalities among many African-Americans and other racial or ethnic minorities include high unemployment, crime, violence, lack of education and poor health (Black AIDS Institute, 2005). According to the Black AIDS Institute (2005), these social disparities will increase the risk to practice
unsafe sexual behaviors such as trading sex for money and/or drugs, without using a condom, and failure to seek preventive counseling or screening for HIV. The African-Americans, who live in poor communities with high crime and violence, regard daily survival skills more important than practicing behaviors to reduce the risk of HIV/AIDS (Williams, 2003). These poor communities lack resources, access to health care and access to the infrastructure for health and other social services needed by the residents of the community (Williams, 2003).

The lack of education is directly related to high unemployment, and inevitable poverty. Low educational attainment results in the under-representation of African-Americans in the medical and public health professions (Williams, 2003). Their absence from these professions increases the barriers to adequate health care. Such barriers include the lack of communication between patient and provider, the unknown knowledge of the social influences affecting the health of African Americans, and distrust of medical prevention efforts (Williams, 2003). If African-Americans were represented more in these professions it may drastically change the health and well-being of this population because of the alleged cultural connection and empathetic approach to
addressing the health needs of the African-American population (Williams, 2003).

Adolescents are also burdened with social predictors related to HIV/AIDS, other STDS, and unintended pregnancies. The social predictors include low educational attainment, poverty, low attachment to school, and any older, individual role-model, and the lack of opportunities (Kirby, 2002; Santelli, Lowry, Brener, & Robin, 2000). "We know that young people who live in poverty, who have dropped out of school, and who are homeless are more likely to be forced to make decisions to put them at risk for transmission of the virus" (Reclaiming Our Future, 2005). In addition, McBride, Paikoff, and Holmbeck (2003) state that social predictors related to teen sexual risk behaviors include family structure and family conflict, suggesting the family plays a major role in adolescent development and decision-making. According to Ku (1993 in Santelli, Lowry, Brener, & Robin, 2000), family income was associated with sexual risk behaviors in adolescents, who are more likely to participate in high-risk sexual behavior when family income is higher. This contradicts the research conducted by Santelli, Lowry, Brener, and Robin (2000) that concludes that household income was not linearly related
to any sexual behaviors. According to Murry (1994), high-risk sexual behaviors include earlier coital initiation in adolescents of lower socio-economic status (SES). More research is warranted regarding how race and SES affect sexual behaviors in African-American adolescents. Yet as can be seen in the following sections, a number of health educators routinely advocate for culturally sensitive HIV/AIDS education without a more in-depth analysis of other more appropriate ways to assign risk (Bauer & Wayne, 2005; DeMarco & Norris, 2004; Garcia, 2006; Vinh-Thomas, 2003).

Adolescents and HIV/AIDS

Many adolescents practice high-risk sexual behaviors (CDC, 2005; Advocates for Youth, 2003; Dolijanac & Zimmerman, 1998). Such risk behaviors include early sexual initiation, and having multiple sex partners, coupled with drugs and alcohol use (CDC, 2005; Advocates for Youth, 2003). Studies conducted by Forehand et al., 2005, O'Donnell, 2003, and McBride, Paikoff, and Holmbeck, 2003, concluded that sexual risk behaviors in adolescents vary, and in their study found that African-American adolescents do engage in sex earlier when compared to their white counterparts. Additional sexual risk behaviors in
African-American adolescents include men having sex with men (MSMs) as well as having multiple sex partners (Halpern et al., 2004). The researchers suggest African-American adolescents are disproportionately at risk for negative health outcomes associated with early and unprotected sex, due to the lack of education associated with these risks and lack of access to care (Forehand et al., 2005; O'Donnell, 2003; McBride, Paikoff, & Holmbeck, 2003).

Other high-risk behaviors practiced by adolescents include using drugs and alcohol (Dolijanac & Zimmerman, 1998). The impact of drugs and alcohol use among adolescents increases the dangers of contracting and spreading HIV/AIDS regardless of ethnicity. Decision-making skills are often impaired while under the influence of drugs and alcohol. For adolescents in particular, the inability to make conscious decisions while under the influence perpetuates the risks for having sex without using a condom, or having sex with multiple partners (Dolijanac & Zimmerman, 1998; Goodenow, Netherland, & Szalacha, 2002).
Research on Effective HIV/AIDS Education Programs

Reducing the risk of individuals becoming infected with HIV includes implementing health education and health promotion programs. Effective HIV prevention is often bound to political and public controversy due to the very personal nature of drug use and sexual behaviors. However, some of these same personal behaviors have created a major public health epidemic such as HIV/AIDS.

In a national survey conducted by the Henry J. Kaiser Family Foundation (2003), 93% of Americans agree sex education should be taught in schools, and parents are generally content with the idea. There is little conflict within communities about teaching about sex-related topics; however there are differences on what approach is best, e.g., abstinence only or abstinence “plus” (Kaiser Foundation, 2003). According to the Kaiser survey, 36% of Americans believe young people should focus on how to make responsible decisions and not on abstaining from sexual intercourse only (Kaiser Foundation, 2003). Although sex education is approved by the majority of parents surveyed, 48% believe the biggest problems young people face is not sex-related problems, but instead the use of alcohol and other illegal drugs (Kaiser Foundation, 2003).
In a national survey of 1800 young people of various ethnic and racial subgroups, key findings revealed that young people are more concerned about sex and sexual health more than any other health issues in their lives (Kaiser Foundation, 2003). Young people are misinformed about the health risks of HIV/AIDS and other STDs, safe sex practices, and available testing sites for these diseases (Kaiser Foundation, 2003). Young people want to know more about how to use condoms, how to recognize the signs of STDs and HIV infections, and where to go for testing (Kaiser Foundation, 2003). They also want more instruction on how to communicate with partners about sensitive sexual concerns, and how to increase the comfort level of open dialogue about sexual health issues (Hoff, Greene, & Davis, 2003).

According to Kirby (2001), there are common characteristics of effective sex-education programs designed to reduce the risk of HIV infection. Effective programs place emphasis on clear norms about avoiding unprotected sex, recruit teachers or program leaders who believe in the program, are relatable to youth with leadership qualities, and include student involvement in voluntary or unpaid services (Kirby, 2001). Increasing knowledge, and changing attitudes and behaviors are also
goals of HIV/AIDS education. Behavior outcomes include postponing sex, decreasing the frequency of intercourse or the number of sex partners, and increasing effective contraception use.

According to Advocates for Youth (2005), an integrated approach to promoting sexual health includes information and services about STD, HIV, and pregnancy prevention. This integrated approach also incorporates sexual health information in youth development programs, youth-friendly health care providers, and offers health and social services under one roof that will link participants to needed services (Advocates for Youth, 2005). Such an approach works together with youth, parents, communities and government programs and offer benefits to both client and provider (Advocates for Youth, 2005).

School-based programs provide the greatest opportunity to reach a large majority of adolescents (Main et al., 1994). HIV/AIDS education among adolescents is important in combating the spread of infection. Over 87% of the nation's student population receives some sort of HIV education (CDC, 2004). According to Advocates for Youth (2005), there are at least eight effective
school-based sex education programs which impact at least two of the following behaviors:

- Postponing or delaying sexual initiation
- Reducing the frequency of sexual intercourse
- Reducing the number of sexual partners/increasing in monogamy
- Increasing in the use of effective methods of contraception and/or condoms
- Reducing the incidence of unprotected sex

Effective sex education programs are based on Social Cognitive Theory and/or the Health Belief Model. An example of such a program is Positive Prevention (American Red Cross, 2006). Positive Prevention is a theory-based HIV/STD prevention education curriculum for high school youth. Program evaluation identified (within-group and between-group) significant increases in positive attitudes towards abstaining from sexual intercourse, increases in self-efficacy to abstain from sex activity, and increases in self-efficacy to use condoms across both genders and all ethnic groups participating in the study (LaChausse, 2006). Positive Prevention emphasizes risk-recognition, internalization and social skills while limiting bio-medical information. The program elements are
consistent with the literature of effective prevention education for high school youth (LaChausse, 2006).

The Importance of Culture

There is an abundance of literature supporting the incorporation of culture in health promotion (DeMarco & Norris, 2004; Garcia, 2006; Huff & Kline, 1999; Resnicow et al., 2000; Wilson & Miller, 2003). According to Garcia (2006), the unequal distribution of disease and disability affecting racial and ethnic minorities is directly related to health promotion programs which ignore culture. Garcia (2006), also states that factors such as ethnic identity, culturally-based practices and socio-economic standing must be acknowledged in health promotion models.

Culture is mentioned by some researchers as an important construct of HIV education and prevention (DeMarco & Norris, 2004; Jemmott, Jemmott, and Fong, 1992) "Grounding HIV prevention in a target group’s culture makes the program understandable and more effective" (Wilson & Miller, 2003). "Commitment to attending to culture is guided by a desire to maximize the benefits of HIV prevention programs to people that have traditionally been underserved" (Wilson & Miller, 2003). For example, in the African-American population the women
are instrumental in disseminating health information and health practices to family members and members of the community (DeMarco & Norris, 2004). They use slang, song, and storytelling as a way to communicate information (DeMarco & Norris, 2004). This form of communication by African-Americans have existed from generation to generation and therefore should be included in HIV/AIDS education as a way to preserve the African-American culture, and maximize health promotion as indicated by Wilson and Miller (2003).

African-American women are plagued with "the down-low" phenomenon. This is reported as the main reason for the increase of HIV infection among them (Millett, Malebranche, Mason, & Spikes, 2005). A recent study shows young African-American men are the driving force of new HIV infection among gay and bisexual men (Black AIDS Institute, 2005). Bisexual men and MSM/W (men who have sex with men and women) who do not disclose their bisexual activities to their female partner increase the risk of HIV/AIDS for African-American females. However, studies conducted by Millett, Malebranche, Mason, and Spikes (2005), concluded "having sex with a bisexual man is not the only HIV risk factor for heterosexual black women," and the behaviors regarding the larger population of
heterosexual African-American men, who practice high sexual-risk behaviors, require more attention and further research.

In the African-American culture the church is the cornerstone of the community (Agate et al., 2005). "Churches and other faith-based organizations are an essential part of the black neighborhood. They are often located in areas with large concentrations of people hardest hit by HIV and can play an important role in guiding the minority community" (Agate et al., 2005). Many African-American churches are trying to address the AIDS epidemic in a culturally acceptable manner by setting and defining values and norms for community members, and providing reliable information and support regarding HIV/AIDS (Smith, Simmons & Mayer, 2005). Unfortunately, many African-American churches are stretched for funds to implement a comprehensive approach to HIV/AIDS prevention (Smith, Simmons, & Mayer, 2005).

Some of the different beliefs and attitudes African-Americans have about how HIV/AIDS is contracted have caused a slow or negative response to using condoms while engaging sex (Bogart & Bird, 2005; Williams, 2003). For example the perception of AIDS as being a "gay" person disease or admitting to promiscuous behaviors makes
HIV/AIDS prevention very challenging in the African-American population (CDC, 2006). The denial of HIV/AIDS among African-Americans is also enabling the spread of the disease within this population (CDC, 2006).

Ethnic Identity

For adolescents, the development of ethnic identity is a complex process as they cope with a variety of life's situations. For instance, it is particularly complicated for adolescents to have self-identity and to integrate ethnicity or race into one's self-concept or self-image (Guanipa-Ho & Guanipa, 1998). Ethnic identity is related to the sense of belonging to an ethnic group, and the part of one's thinking, perceptions, feelings and behavior that is due to ethnic group membership (Rotheran & Phinney, 1987 as cited in Guanipa-Ho & Guanipa, 1998). The formation of ethnic identity involves the interaction of contextual and developmental factors and cannot be separated from the culture(s) which build and structure it (Guanipa-Ho & Guanipa, 1998).

Ethnic Identity and HIV/AIDS Education

The call for cultural sensitivity in HIV education suggests there are characteristics among males, females, ethnic and socioeconomic groups that are unique. According
to Flora and Thoresen (1988), each group differs in values, attitudes, skills and information levels related to sexual behaviors. The researchers suggest programs must consider the type of language, reading level, and normative beliefs about sex and HIV/AIDS. Research suggests interventions are most effective when they build on understanding psychosocial factors, practice behaviors particular to ethnic groups, use language familiar to participants, congruent with participants' cultural values and lifestyles and delivered by nonjudgmental persons at ease with sexual topics (DeMarco & Norris, 2004).

HIV prevention and education is moving towards an appeal to behavior patterns of ethnic minorities, particularly the African-American population. The infusion of culturally sensitive materials is driven by client demands, health disparities, and the disproportionate effects of HIV/AIDS in this population (Williams, 2003; Robenstine, 1995). If behavior change is to occur, health messages must be meaningful and relevant to the intended population (Kreuter & Holt, 2001; Norris, 2004). Therefore, HIV/AIDS prevention programs are encouraged to focus more on the role of culture in its delivery in order to help decrease the disparity of the disease among racial groups (Vinh-Thomas, 2003).
According to Vinh-Thomas, Bunch, and Card (2003), less work has been done on the role of cultural competence in the delivery of HIV/AIDS prevention programs aimed at minorities. Jemmott's study (1992) of 157 African-American male adolescents was conducted to determine the effects of a small group intervention of risk behaviors, and to increase condom use among African American boys. Both African-American men and women led the sessions. Materials were allegedly more culturally and developmentally appropriate to reinforce learning and encourage active participation. Behavior findings of adolescents who participated in the intervention reported more use of condoms and fewer sex partners, as opposed to adolescents in the comparison group.

A study conducted by Wilson and Miller (2003) found that culturally-grounded programs are effective at increasing certain HIV protective behaviors and attitudes. Their study was designed to test if materials related to culture were more effective than programs that were not designed with a specific ethnic group in mind, but the study could not address if the programs were successful due to the inclusion of culture. With facilitation in small group discussions, including themes of cultural concepts, activities and messages, the evaluation focused
on how the program appealed to the intended population (visually and audibly). According to the findings, matching facilitators with participants did help to increase knowledge, but did not reduce risk behaviors. In addition, women who recognized cultural themes were more likely to be tested for HIV. African-American hosted videos rated higher than white hosted videos. However, no other differences appeared between the groups who received standard treatment and those who received treatment with a cultural theme. The authors do not suggest ignoring cultural practices. They understand the significance of integrating cultural concepts into content rather than relying exclusively on presentation for intervention. They do, however, suggest more research is warranted on how to integrate cultural concepts into educational content.

Cultural sensitivity is a widely used concept in public health e.g., any health intervention should be tailored to the social and cultural characteristics of the intended population (Resnicow et al., 2000). Achieving this “tailoring” and its impact on outcomes has not been adequately described or empirically examined (Resnicow et al., 2000), and the research literature is mixed on the outcome of such approaches. The purpose of this thesis was to investigate African-American students’ own opinions
about whether an interactive and normative HIV/AIDS and
STD prevention curriculum not tailored to the
African-American students was perceived as adequately
culturally-sensitive, and whether tailoring has
implications (in their view) for increased effectiveness
among their peers.
CHAPTER THREE
DESIGN AND METHODOLOGY

Subjects
A convenience sample of 121 students attending summer school at Arroyo Valley High School in the San Bernardino Unified School District, San Bernardino, California was used for this study. Arroyo Valley High School was selected for its multiethnic population, its implementation of the HIV/AIDS curriculum Positive Prevention, and its non-involvement in the district’s outcome study on Positive Prevention. The survey sample included adolescents between the ages of 13-18 enrolled in summer school, as suggested by the school’s administrator. The sample consisted of 57 male and 64 female students. The percentages of ethnic groups in the sample were: White (0%), African Americans (15.9%), Latino/Hispanic (72%), Asian (3.7%), Native American (.9%) and multi-racial (7.5%) (See Table 1 in Appendix B).

Instrumentation and Data Collection
Parents and adolescents received informed consent forms. Signatures were required to participate in the study. Students who completed the HIV/AIDS education curriculum while enrolled in 9th grade Science courses
completed the survey. Approval of surveys, forms and procedures was obtained from the Institutional Review Board of California State University, San Bernardino. The consent form contained a brief description of the study. Since this study involves adolescents, parental consent was required. Confidentiality issues were discussed and the identities of the subjects were not disclosed. The parental consent form explained the study's goals, procedures, risks and benefits. Only students who returned the consent forms were allowed to complete the survey.

The distribution of 300 informed consent forms resulted in the return of 140 checked forms. One hundred and twenty-one student surveys were returned, 15 surveys had missing data and were reflected in the final data analysis. The participants and their parents were briefed on the study. The students participating in the study were given the surveys, and had the instructions read to them. The parents of the participants received a written explanation of the research.

Two separate measures were combined to form the 26-item student instrument used in this study. The student survey is located in Appendix A. The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992), was used for questions 5-19. Written permission for use of the study
was not required. The Multigroup Ethnic Identity Measure (MEIM) is reported as consistently showing good reliability to assess racial identity across a wide range of ethnic groups and ages (Phinney, 1992). The second instrument included an attitudinal questionnaire devised by the researcher on HIV/AIDS education received by the students. The measure had several items rated on a scale including an opportunity for students’ comments.

Surveys were completed July 10-12, 2006 under the direction of the classroom teacher (See Appendix A). Completed surveys were not shown to anyone else, and collected by the researcher on July 13, 2006. Surveys were reviewed by the researcher, faculty advisors assisting the research, and committee members. All data was stored off-site and destroyed upon completion of the study.

Data Treatment Procedures
The Statistical Package for the Social Sciences (SPSS), a comprehensive statistical software package, was used to explore, analyze and display data. Analysis of general frequencies of all responses, frequencies by ethnicity, a combined Multigroup Ethnic Identity Measure (MEIM) score, as well as a correlation between Multigroup Ethnic Identity Measure (MEIM) scores among
African-Americans and their perception of the importance of culturally sensitive HIV/AIDS materials, were conducted (See Appendix B).

For demographic questions #1-4, frequencies of all responses were determined. Questions #5-19 were analyzed via frequencies by ethnicity. A combined Multigroup Ethnic Identity Measure (MEIM) (average) score was also created by the researcher. Multigroup Ethnic Identity Measure (MEIM) can best be thought of as comprising two factors: ethnic identity search; and affirmation, belonging, and commitment. The two factors are as follows: ethnic identity search (items 5, 6, 8, 12, and 14); affirmation, belonging and commitment, (items 7, 9, 10, 11, 13, 15, and 16). The preferred scoring for Multigroup Ethnic Identity Measure (MEIM) is to use the mean of the items scored. The range of scores is from 1 to 4.

Frequency of responses for each question, average Multigroup Ethnic Identity Measure (MEIM) scores (including subcategories), and correlations between students' MEIM scores and their perceptions regarding curriculum appropriateness and effectiveness were determined. Written student comments are reported.
CHAPTER FOUR
FINDINGS

Baseline characteristics of all respondents are represented by ethnicity, gender, age and grade levels (See Table 1). The majority of students were Hispanic (74.1%). There were 57 males and 64 females. The average age of students was 16 years old, and the average grade level was 11th. African-American students accounted for (14.7%) of the total number of respondents (N = 121).

The Multigroup Ethnic Identity Measure (MEIM) (Phinney, 1992) is a scale for use with adolescents and young adults from diverse groups. The Multigroup Ethnic Identity Measure (MEIM) indicates the strength of ethnic orientation, and includes two subscales: Ethnic Identity Search (EIS); and Affirmation, Belonging and Commitment (ABC). EIS represents developmental and cognitive components, and ABC represents the affective component. To determine MEIM, the items scored (questions 5-16), which are rated on a scale of 1-4 (low to high) were averaged. As seen in Table 3, the average scores for African-Americans were: 3.25 (MEIM), 2.93 (EIS) and 3.48 (ABC). By comparison, the average scores for Hispanics were: 2.94 (MEIM), 2.62 (EIS), and 3.18 (ABC). The
averages for all students were: 2.99 (MEIM), 2.68 (EIS), and 3.29 (ABC). Thus the African-American students' scores indicate stronger ethnic identity in all categories including subscales, as compared to the Hispanic population, and the overall participants of the study.

The Findings for Research Questions

#1. Do African-American Students' Perceive Cultural Sensitivity as an Important Aspect of HIV/AIDS Education?

Of the total N = 121, 14.7% were Black/African-Americans. The frequency of student responses by response category was used to answer the first research question, based on survey items #21, 23, 24, and 26.

Item #21. Do you feel like the information was helpful to students of your own race/ethnicity? Cumulative percentages for African-American students were: 22.2% of African American students felt the information was not helpful, 11.1% were not sure, 61.1% felt the information was helpful, and 5.6% didn't know (See Table 2).

Item #23. If the HIV/AIDS lessons were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS
and STDs? Cumulative percentages for African-American students were: 27.8% said no, 22.2% said not sure, 50% of said yes (See Table 2).

Item #24. Do you feel like these learning activities were helpful to students of your own race/ethnicity? Cumulative percentages for African-American students were: 11.8% said no, 35.53 were not sure, 41.2% said yes, and 11.8% didn’t know (See Table 2).

Item #26. If the HIV/AIDS learning activities were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STDs? Cumulative percentages for African-American students were: 26.7% said no, 26.7% were not sure, and 46.7% said yes (See Table 2).

Over 60% of African-American students felt the HIV/AIDS lessons were helpful as indicated by item #21. When asked if the HIV/AIDS lessons were changed to be more helpful to young people of their race/ethnicity, 50% of African-American students said yes, as indicated by item #23. Less than half of African-American students felt the learning activities were helpful to their race (item #24); but if the activities were changed to be more helpful, more students believed young people of their race/ethnicity would take fewer risks regarding HIV/AIDS.
and STD, but still less than 50%. This information suggests the actual activities are not of particular importance to the students (or that they do not recall the activities).

The survey also provided an opportunity for students to write suggestions as requested by item #22, Tell how HIV/AIDS and STD information could be more helpful to students of your own race/ethnicity. The students' suggestions were: "Spend time on each ethnic group and tell them the statistics of their race," and "What races are more at risk for something, and how to keep them protected." These suggestions indicate students are cognizant of their culture and are interested in factual statistical information as it pertains to their race. A couple of students responded by asking "Why is this question about race important?" A question such as this one may indicate that some students may respond negatively to being reminded about race-based data. More research is needed on learning activities that have a cultural appeal however, since merely reporting negative data about health status may be objectionable.

#2. Is there a correlation between African-American students' ethnic identity, as measured by the Multigroup Ethnic Identity Measure (MEIM) and their
perceptions of the need for culturally sensitive HIV/AIDS education materials?

According to the Multigroup Ethnic Identity Measure (MEIM) and subscale scores, there is a strong ethnic identity among African-Americans (See Table 3 in Appendix B).

A bivariate analysis was used to identify any correlation between ethnic identity and perceptions of the need for culturally sensitive HIV/AIDS education materials. The Multigroup Ethnic Identity Measure (MEIM) responses along with EIS and ABC subscales were the three variables used with items #21, 23, 24, and 26 to detect any correlations. Although ethnic identity is high among African Americans, the current results indicate a mild but non-significant correlation between MEIM, EIS, and ABC and the perceptions by African-Americans of the need for more culturally sensitive HIV/AIDS curriculum (See Tables 4).

The largest population represented in this study was Hispanics/Latinos (74.1%). A separate correlation analysis was conducted to see if the perception of the need for culturally sensitive materials existed in this population. As seen in Table 5, there is a significant correlation between EIS and item #21. An interpretation of this finding may be that respondents, who are seekers of ethnic

34
identity, do not feel the (generic, ethnicity-free) information is helpful to students of their own race/ethnicity. This finding suggests a secondary role of HIV/AIDS education, i.e., to assist in the establishment of cultural identity for those students who are in the midst of cultural formation (identity seeking). A recommendation is to continue more research on ethnic identity and culturally sensitive HIV/AIDS education information for Hispanics/Latinos.

Discussion

The results for question #1 Do African-American Students’ Perceive Culture as an Important Aspect of HIV/AIDS Education?, indicate that the African-American students surveyed for this project do not perceive culture as an important aspect of HIV/AIDS education. Although not an important aspect of HIV/AIDS education, culture can serve as a gatekeeper to the learning activities that will help emphasize social skills to help reduce the risks taken by African-Americans. Preliminary findings from this small study may challenge the notion of so-called culturally sensitive approaches popularly recommended in the health education literature of DeMarco and Norris (2004), Kreuter and Holt (2001) and Norris (2004). These
authors suggested that HIV/AIDS education is most effective when interventions are built on understanding psychosocial factors particular to ethnic groups, use language familiar to participants, cultural values and lifestyles, and have health messages meaningful and relevant to the intended population. My current findings are, however, consistent with Kirby (2001), who suggests effective programs place emphasis on clear norms about avoiding unprotected sex, as does Advocates for Youth (2003), which reported that effective HIV/AIDS education should be based upon sound social learning theory.

Limitations to consider include the small sample size of African-American students, limitations of the descriptive study design, and the overall recall of social desirability biases involved in self-report measures. These may all have been threats to both internal and external validity. Another limitation to consider is the lack of research information related to culturally sensitive HIV/AIDS education curricula.

The results for question #2 *Is there a correlation between African-Americans' ethnic identity and their perceptions of the need for culturally sensitive HIV/AIDS education materials?* indicate the Multigroup Ethnic Identity Measure (MEIM) score is not a factor in HIV/AIDS
education for African-American students in this study. The higher ethnic identity score did not correlate with African-Americans' perception of culturally sensitive materials as an important aspect in HIV/AIDS education (See Tables 4). More research is needed on ethnic identity and its role in health promotion.

Since there is very little literature in support of these findings, it does suggest further research is warranted in defining the necessity and attributes of culturally sensitive HIV/AIDS education curriculum and approaches. For example, does cultural competence lie in the curriculum or lie in the instructors' abilities, a combination of both, or expanding the definition of culture that acknowledges a youth culture or the impact of socio-economic status.
CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

Conclusion

The effects of HIV/AIDS continue to devastate people of color, particularly African-Americans. According to research, African-Americans have the highest rates of HIV/AIDS infection despite prevention and intervention strategies that are designed to increase knowledge, and change attitudes and behaviors associated with the disease. The literature on HIV/AIDS prevention suggests that culturally sensitive education and materials are presumably more effective in reducing the risk of HIV, other STDs and unintended pregnancies among high-risk populations. However, more research is warranted on how to integrate cultural concepts into educational content (Wilson & Miller, 2003).

Young people between 13-24 years of age make up 12% of the American population infected with HIV/AIDS (CDC, 2006). School-based programs provide the greatest opportunity to reach a large majority of adolescents (Main et al., 1994). HIV/AIDS education in the school setting has proven to be effective; however, African-American
youth still contribute two-thirds of new AIDS cases in this age group (Satcher, 2006).

The focus of this study was to explore whether culturally appropriate curricula and materials for HIV/AIDS education were perceived important by African-American students.

This study's findings were unable to identify a correlation between African-American students' ethnic identity, and their perceptions of cultural sensitivity as an important aspect of HIV/AIDS education. The variables analyzed did not indicate the current culture-free HIV/AIDS curriculum used by students at Arroyo Valley High School in San Bernardino, California was of concern to the African-American population surveyed. Most students had moderate regard for the curriculum. The African-American students in this study thought the information and learning activities were helpful to their ethnicity, and they did not feel strongly that if the information and learning activities were changed to be more culturally sensitive, that young people of their ethnicity would take fewer risks regarding HIV/AIDS and STDs. The results indicate more research is needed on the relationship between what constitutes culturally sensitive curricula and its implementation in HIV/AIDS education. Further
research in this area is necessary to determine the mediating factors which could prevent the continued rise of HIV/AIDS in the African-American population.

Recommendations for Future Research

The results of this study indicate that the definition of "cultural sensitivity" and "culturally sensitive materials" need further defining and examining. This study also did not show a correlation between the strength of cultural identity and preference for culturally sensitive HIV/AIDS education by African-Americans. Further research should include a larger sample population and a comparison across groups to increase the ability to generalize the results. This research should also include questions regarding other potentially culturally-sensitive curriculum approaches, such as the perceived cultural appropriateness of teaching assertive communication skills, expecting student engagement in interactive (including cross-gender) learning activities, challenging culturally-based gender roles and scripts, and highlighting race-based data.

The current findings have practical implications for the development of HIV/AIDS education intended to have an
appeal to any high-risk, ethnic minority youth, leading them to take fewer risks regarding HIV/AIDS and STDs.

In conclusion, as the rates of HIV/AIDS increase among African-Americans, health promotion programs and professionals are encouraged to increase best practices to help prevent the cause and spread of this disease. Although cultural sensitivity has been implied as an important aspect in prevention, the concept of culturally sensitive materials must be well defined in order to be effective. Culturally sensitive materials may have the effect of strengthening ethnic identity, which in itself may also create greater resilience among the students. Based on these findings, using ethnically-defined HIV/AIDS materials as a guarantor of curriculum effectiveness may be as misleading as using socially-constructed race identifiers as a proxy to determine health status and health behaviors.
APPENDIX A

SURVEY, CONSENT FORM, DIRECTIONS
ETHNICITY AND AIDS EDUCATION

STUDENT SURVEY

Directions: Please answer the following questions, and return the survey to your teacher.

1. What is your gender? Circle: Male Female
2. How old are you? Circle: 14 15 16 17 18
3. What is your current grade level in school? Circle: 9th 10th 11th 12th
4. Please fill in: In terms of ethnic group, I consider myself to be ______________
For the following questions, use the numbers below to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th>(4) Strongly agree</th>
<th>(3) Agree</th>
<th>(2) Disagree</th>
<th>(1) Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I am active in organizations or social groups that include mostly members of my own ethnic group.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I have a clear sense of my ethnic background and what it means for me.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. I think a lot about how my life will be affected by my ethnic group membership.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I am happy that I am a member of the group I belong to.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I have a strong sense of belonging to my own ethnic group.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. I understand pretty well what my ethnic group membership means to me.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I have a lot of pride in my ethnic group.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I participate in cultural practices of my own group, such as special food, music, or customs.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I feel a strong attachment towards my own ethnic group.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. I feel good about my cultural or ethnic background.</td>
<td>4 3 2 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
17. My ethnicity is: (circle one)
   (1) Asian or Asian American, including Chinese, Japanese, and others
   (2) Black or African American
   (3) Hispanic or Latino, including Mexican American, Central American, and others
   (4) White, Caucasian, Anglo, European American; not Hispanic
   (5) American Indian/Native American
   (6) Mixed; Parents are from two different groups
   (7) Other (write in): ________________________________________

18. My father's ethnicity is (use numbers above) ______

19. My mother's ethnicity is (use numbers above) ______

20. Do you remember receiving HIV/AIDS education in your 9th grade science class?
   Yes  No  Don't remember

21. The HIV/AIDS lessons contained information on HIV/AIDS and STDs. Did you feel like this information was helpful to students of your own race/ethnicity?
   Yes  No  Not sure  Don't remember

22. Please tell us how information on HIV/AIDS and STDs could be more helpful to students of your own race/ethnicity?

23. If the HIV/AIDS lessons were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STD's?
   Yes  No  Not sure

   Explain your answer…

24. The HIV/AIDS unit contained a variety of student learning activities focusing on HIV/AIDS and STDs. Did you feel like these learning activities were helpful to students of your own race/ethnicity?
   Yes  No  Not sure  Don't remember

25. Please tell us how student learning activities focusing on HIV/AIDS and STDs could be more helpful to students of your own race/ethnicity?
26. If the HIV/AIDS student learning activities were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STD’s?
Yes  No  Not sure

Explain your answer...

Thank you for completing this survey.

Please return it to your teacher.
Perceptions of a Culturally Sensitive HIV/AIDS Curriculum
Researcher: Ms. Yolanda Mouton
Written Consent Form/Parental Informed Consent & Permission

Dear Parent/Guardian,

My name is Ms. Yolanda Mouton. I am a graduate student attending California State University, San Bernardino. Soon I will be conducting a survey of 9th grade students, under the supervision of Dr. Kim Clark, Professor of Health/Human Ecology. The Institutional Review Board at California State University, San Bernardino, and the District’s research office has approved the content and procedures in this study, including questions contained in the questionnaire.

This is to request that your son/daughter be allowed to participate in a survey to investigate the need to adapt high school HIV/AIDS education materials for various cultures. In this study your child will be asked to complete a written survey about their cultural identity, age and gender. They will also be asked how they felt about their HIV/AIDS unit of study. The survey will be conducted in one class period and should take about 20 to 30 minutes to complete. All of the responses will be held in the strictest of confidence. Your child’s name or student ID# will not be gathered or reported with their responses and data collected from the survey will be anonymous. All data will be reported in group form only. You may receive the group results of this study upon completion, July 31, 2006 at Arroyo Valley High School, San Bernardino CA. If you wish, you may review the survey prior to distribution at AVHS on July 13, 2006 from 11:30 a.m.-12:30 p.m.

Your child’s participation in this study is totally voluntary. Your child is free not to answer any questions and withdraw at any time during this study without penalty. The benefits of this study might include making changes to HIV/AIDS education to make it more culturally appropriate. The risks in this study are minimal; for example, students may have some difficulty remembering the topics they studied regarding HIV/AIDS, or they may feel uncomfortable about HIV/AIDS. If so students are to contact their school counselor.

If you have any further questions or concerns about this study, please feel free to contact Yolanda Mouton or Dr. Clark at (909) 537-5323.

Thank you for your cooperation in this study, please sign and return this consent form to your child’s teacher no later than July 17, 2006.

☐ Yes, my son/daughter __________________________ has permission to participate in this survey.

☐ No, my son/daughter __________________________ does not have permission to participate in this survey.

Parent/Guardian

Signature ________________________ Date ____________
Dear Teacher,

Thank you for agreeing to distribute and collect the attached surveys. The purpose of this survey is to determine the students’ perception of the district’s HIV/AIDS curriculum and its relevance to cultural sensitivity. I ask that you take the time to follow the instructions in the order given below.

**Instructions:**

- Please distribute and collect Parent Informed Consent (permission slips) prior to administering the survey.
- On the day of the survey, pass out the Child Assent Forms that are attached. Please tell the students not to write on their papers until asked to do so. Read the Child Assent Form out loud to the class. Please make sure the students are following along as you read the letter. After you have read the form out loud to the class, ask the students if they have any questions. Once all questions have been answered, have students place a check in the box where it says yes if they agree to take the survey, or have them place a check in the box where it says no if they do not want to participate in the survey. Remind students there is NO penalty for not participating in the survey.
- Please collect and count the Child Assent Forms. There should be one form collected for each student that is present in your class.
- The alternate assignment for any student wishing not to participate in the survey is to read quietly or work on ______________________ as directed by the teacher until the last survey is collected.
- **Prior to distributing the survey, it is important that you have received a signed parent permission letter from each participant.**
- Before you begin passing out the survey, inform students they are not to write their names anywhere on the survey. Also inform students this survey will be done in class and will take 20-30 minutes to complete.
- Pass out the surveys, read the instructions to the students. Remind students not to write their names or student I.D. on the survey, or not to discuss any items on the survey with others. Also remind students not to start answering any question until told to do so.

**Read These Instructions to the Student:**

"Please read and answer each question as truthfully as possible. When you are completed please fold your survey and place it in the envelope provided and seal the envelope to your teacher and begin working on the alternate assignment. Your teacher will collect all sealed surveys and return them to Yolanda Mouton".

Thank the students for completing the survey.

I will make arrangements to pick up the envelopes from you. Thank you for your cooperation with this survey. Yolanda Mouton
APPENDIX B

TABLES
TABLES

Table 1. Ethnicity, Gender, Age & Grade Level

N = 121

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian American</td>
<td>3.4</td>
</tr>
<tr>
<td>Black/African American</td>
<td>14.7</td>
</tr>
<tr>
<td>Hispanic/Latino/Mexican</td>
<td>74.1</td>
</tr>
<tr>
<td>Native American/Indian</td>
<td>1.7</td>
</tr>
<tr>
<td>Mixed</td>
<td>5.2</td>
</tr>
<tr>
<td>Other</td>
<td>.9</td>
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</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th># of Students</th>
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<tbody>
<tr>
<td>Males</td>
<td>57</td>
</tr>
<tr>
<td>Females</td>
<td>64</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th># of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
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<td>14</td>
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<tr>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>18</td>
<td>2</td>
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</table>

<table>
<thead>
<tr>
<th>Current Grade Level</th>
<th># of Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>9th</td>
<td>25</td>
</tr>
<tr>
<td>10th</td>
<td>16</td>
</tr>
<tr>
<td>11th</td>
<td>58</td>
</tr>
<tr>
<td>12th</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 2. Frequency of African American responses

<table>
<thead>
<tr>
<th>Item</th>
<th>Frequency</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>#21 Do you feel like the information was helpful to students of your own race/ethnicity?</td>
<td>No: 22.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure: 11.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 61.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 5.6</td>
<td></td>
</tr>
<tr>
<td>#23 If the HIV/AIDS lessons were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STDs?</td>
<td>No: 27.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure: 22.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 50.0</td>
<td></td>
</tr>
<tr>
<td>#24 Do you feel like these learning activities were helpful to students of your own race/ethnicity?</td>
<td>No: 11.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure: 35.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 41.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t know: 11.8</td>
<td></td>
</tr>
<tr>
<td>#26 If the HIV/AIDS student learning activities were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STDs?</td>
<td>No: 26.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not sure: 26.7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes: 46.7</td>
<td></td>
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</table>
Table 3. African American MEIM, ABC, EIS Average Score

<table>
<thead>
<tr>
<th>Respondent</th>
<th>MEIM</th>
<th>EIS</th>
<th>ABC</th>
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<tr>
<td>1</td>
<td>3.67</td>
<td>3.60</td>
<td>3.71</td>
</tr>
<tr>
<td>2</td>
<td>3.58</td>
<td>3.20</td>
<td>3.86</td>
</tr>
<tr>
<td>3</td>
<td>3.08</td>
<td>2.40</td>
<td>3.57</td>
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<td>4</td>
<td>3.58</td>
<td>3.60</td>
<td>3.57</td>
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<td>5</td>
<td>3.25</td>
<td>3.00</td>
<td>3.43</td>
</tr>
<tr>
<td>6</td>
<td>3.08</td>
<td>3.20</td>
<td>3.00</td>
</tr>
<tr>
<td>7</td>
<td>3.75</td>
<td>3.40</td>
<td>4.00</td>
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<td>8</td>
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<td>17</td>
<td>2.75</td>
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</tr>
<tr>
<td>18</td>
<td>3.50</td>
<td>3.00</td>
<td>3.86</td>
</tr>
</tbody>
</table>

MEAN SCORE 3.25 2.93 3.48
Table 4. African American Correlations

<table>
<thead>
<tr>
<th></th>
<th>MEIM</th>
<th>MEIM</th>
<th>MEIM</th>
<th>MEIM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Do you feel like the information was helpful to students of your own race/ethnicity?</td>
<td>If the HIV/AIDS lessons were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STDs?</td>
<td>Do you feel like these learning activities were helpful to students of your own race/ethnicity?</td>
<td>If the HIV/AIDS student learning activities were changed to be more helpful, do you think that young people of your race/ethnicity would take fewer risks regarding HIV/AIDS and STDs?</td>
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Table 5. Hispanic Correlation Subscale EIS and item #21

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<td>r = -.246*</td>
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<td>P = .025</td>
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*Correlation is significant at the 0.05 level (2-tailed).
REFERENCES


