

Native VOICES Project



Phase One Findings

August 2011

Native VOICES Project

In response to high rates of sexually transmitted diseases (STDs) and pregnancy among American Indian and Alaska Native youth, the Northwest Portland Area Indian Health Board (NPAIHB) and three project partners (one urban-based and two tribally-based) are working together to develop an evidence-based sexual health video for Native teens and young adults.

Over the course of three years, project staff will:

- adapt a CDC-recognized intervention, *Video Opportunities for Innovative Condom Education and Safer Sex (VOICES)*
- develop a new video-based intervention for youth called Native VOICES
- evaluate the effectiveness of Native VOICES as an STD/HIV prevention resource for Native teens and young adults 15-24 years old, and if shown to be effective
- disseminate the intervention across Indian Country

To adapt the *VOICES* intervention and make it more culturally-appropriate for Native youth, NPAIHB is working with project partners to hold youth talking circles, individual interviews, and community feedback sessions. Project staff are also seeking input from clinicians, health educators, and staff at AI/AN youth-serving organizations on the feasibility of the proposed intervention and ways to successfully integrate *Native VOICES* into the flow of clinical and social services.

Phase One

During the first phase of the project, NPAIHB and project staff organized four talking circles with NW Native youth (n=25), 10 individual interviews with clinical staff and staff at youth-serving organizations, and 5 individual interviews with youth who identified as LGBTQ (lesbian, gay, bisexual, transgendered, or queer) or two spirit.

The following report includes:

- Urban and tribally-based youths' beliefs about condom use and barriers to condom use in their communities
- Common questions and misconceptions about STDs and pregnancy expressed by youth
- Clinical and social service providers' expertise on developing a culturally-relevant and age-appropriate sexual health resource, and
- Other information relevant to those working with Native teens and young adults in the Pacific Northwest

To view a brief overview of the project, including phase two and three activities, please see Appendix A.

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Talking Circles with Youth

Four talking circles were held at partner sites in the summer of 2011. They included:

- 7 urban-based young men 15-19 years old
- 7 tribally-based young women 15-18 years old
- 4 urban-based young women 22-24 years old, and
- 7 tribally-based young men 15-18 years old

During the groups, participants provided insight on condom use among youth in their communities and identified several key factors that they believe increase young people's risk for STD infection and teen pregnancy. Asking additional questions about these and other topics brought up several questions by youth about sexual health, which the moderators recorded and responded to after the sessions. These questions, along with other relevant information that emerged during the groups, are included below.

Condom Use

When asked "do you think most people your age use condoms when they have sex?" the majority of participants felt that youth in their communities do not use condoms. However, if condom use was to occur, most felt it would be more likely to happen at the beginning of a relationship, during the first few sexual encounters, or with a short-term sexual partner. Participants explained that, in a long-term relationship, condoms were less likely to be used because partners "...just get lazy," or they are in love, and as a consequence feel that they no longer need to use condoms, despite concerns about pregnancy.

It should be noted that young men and women both expressed that they don't know how to bring up using protection with potential sexual partners, and that as a result, condoms and other forms of birth control are not typically discussed prior to sex with *either* long-term or short-term partners.

Youth Access to Condoms

Interestingly, participants' beliefs about low condom use among youth in their community had little to do with a lack of physical access to condoms. When asked where young people could go to get condoms, a common response was "everywhere." Urban-based youth reported that condoms were available at clinics, drugs stores, the school nurse's office, gas stations, Planned Parenthood, and at some local youth-serving organizations. Tribally-based youth spoke about the availability of free condoms at the tribal health clinic front desk, the gas station restroom, in local stores, and at times at the tribal health pharmacy counter.

At all Native VOICES sites, youth reported a multitude of locations where condoms were available; however, when asked further, both tribal and urban-based young people commonly reported feeling uncomfortable being seen taking condoms when condom baskets were placed in public spaces, like clinic waiting rooms or at tribal health pharmacy counters. This made it challenging for youth to access condoms. In addition, young people were reluctant to ask teachers or nurses for condoms, because they feared others finding out that they were sexually active. Some young people reported stealing condoms from stores due to embarrassment or fear of being seen. To explain why some youth are too embarrassed to access condoms, one young woman said that young people "don't want to admit that

they are being sexually active because... because of their age, or because of their family members... having the community members see them and they would be passing it on to the family saying ‘oh, I seen your daughter or your son getting this and that.’”

To learn more about youth’s access to condoms, we will ask focus group participants the following questions during phase-two of this project:

“In talking with young people, several have mentioned that they are uncomfortable grabbing condoms at the health center or from a school nurse because they are afraid someone will see them and they don’t want to talk to anyone about needing condoms. Is this true here? If it was up to you, where would you put condoms to make sure that all young people who wanted them could easily pick them up?”

Youth’s Beliefs about the Pros and Cons of Condom Use

When asked about the positive and negative aspects of condom use, a variety of responses were provided:

Pros:

- You can have multiple partners
- You can prevent STDs and pregnancy
- A lot of young people know about them
- You can get them free
- They help men last longer
- They’re easy to use
- They’re good protection
- They come in different shapes, sizes, and flavors

Cons:

- They make sex not feel as good and “weird” (for both men and women)
- They break/rip/slip off
- Sometimes people don’t have time to put them on if they get caught up in the moment
- They ruin the moment/break the mood
- You don’t feel like using one when you are intoxicated
- Your sexual partner might not want to use one
- They are not 100% effective
- You don’t always have one when you need one
- Some people are scared to bring up protection with their sexual partner

Barriers to the Use of Condoms and Other Methods to Protect Against STDs and Pregnancy

By far, most young men and women agreed that condoms take away from the pleasure of sex and that is why young people choose not to use them. This was often expressed by youth at Native VOICES sites and seems to be a common reason young people use to explain low rates of condom use among youth in their communities.

Other common explanations for low rates of condom use include:

- impairment by drugs or alcohol
- a strong social stigma against youth carrying condoms around daily, to a party, or on a date
- the feeling that young people don't want to ruin the moment or potential for a sexual encounter to proceed
- a preference for "hidden" forms of birth control (like the shot or the birth control pill)
- the fact that some have had unprotected sex before without consequence, and
- young people often don't know how to bring up protection with a potential sexual partner

It should be noted that one significant factor affecting youth's decisions about safer sex is the context in which sexual encounters happen. Young people explained that for many people their age, sex happens at parties, where alcohol and at times drugs are significant factors influencing youth's decision not to use condoms and other forms of protection.

The research team also observed a general lack of knowledge among participants about different methods to prevent pregnancy and STDs, as well as a lack of knowledge about the potential consequences of acquiring certain STDs. In addition to the explanations offered by youth, this lack of knowledge could potentially explain, at least in part, why condom use was reportedly low in participating communities.

Lack of Knowledge, Misconceptions, and Common Questions

During the focus group, participants were asked to list the most common methods that young people in their community use to prevent STDs and pregnancy. Their responses included birth control pills, condoms, abstinence, the "shot," or IUDs. Additional questions around the use of these and other methods brought up several questions, which the group moderators recorded during the talking circles and responded to during post-group question and answer sessions. Some of these questions, along with misconceptions that emerged during the groups, are included below. For a complete listing, refer to Appendix B.

Questions asked of study team and/or other participants during the groups:

- Are the shot and the pill the same thing?
- How can people protect themselves during "butt sex" (anal sex)?
- Is HIV the one that turns into AIDS?
- What are female condoms?
- What is an IUD exactly?
- Do condoms prevent against all STDs?
- How much do condoms normally cost?
- How can you tell if someone has herpes?

Misconceptions that emerged during the focus groups:

- Brushing one's teeth is an effective way to reduce STD transmission after performing oral sex
- Two condoms are better than one
- Diaphragms can be used for STD prevention in addition to preventing pregnancy
- An IUD goes into your skin (like in your butt or under your arm)

- It is not possible to have protected sex when a woman receives oral sex
- The “T-shaped” (IUD) thing works to prevent pregnancy by blocking off a women’s tubes
- When someone has HIV they can never have sex again

Things to include in the Native VOICES Video, According to Youth

Youth provided a great deal of insight as to what information should be included in a successful sexual health video. They said:

Make sure to include...

- Different methods to prevent STDs and pregnancy and their side effects
- The consequences of STD infections
- Images of STD infections that grab people’s attention
- Situations that are relatable to people on the reservation
- Young people snagging at powwows, meeting at basketball tournaments, and other events
- Information on drugs and alcohol
- How to talk to a sexual partner about protection
- That it’s alright to say “no” to sex anytime, even if you have had sex with that person before
- How women can maintain their sexual boundaries and “stand their ground” with a partner
- Information about sexual violence and how to know what constitutes sexual violence (like rape)
- A historical perspective on sexual health in Native communities
- Traditional teachings around sexual health
- Advice on teen pregnancy
- Statistics about the number of Native Americans in the community that have HIV
- Young Native actors
- Elders providing advice in the video
- Local resources
- How to access birth control locally

Make sure not to include...

- Horrible actors
- Anything that’s “old school”
- Someone talking at the camera, talking on and on

Don’t...

- Tell young people not to have sex
- Make it seem like everyone who has sex gets a disease, that’s a lie
- Have people saying “I use condoms...” or “I use IUDs” over and over. Do it once.

Interviews with LGBTQ/Two Spirit Youth

During the first phase of this study, project staff conducted four interviews in Portland, OR with self-identified LGBTQ (lesbian/gay/bi-sexual/transgendered/queer) or two spirit youth and one interview with a tribally-based young man who identified as gay. In an effort to include a diversity of perspectives in the Native VOICES video intervention, we will work with our project partners to recruit and interview additional LGBTQ/ two spirit youth during phase two of the project.

Like talking circle participants, LGBTQ youth were able to identify several basic methods used for preventing STDs and pregnancy, including condoms (both male and female), and dental dams or plastic wrap. In addition to these barrier methods, several youth mentioned additional types of risk reduction utilized by LGBTQ/two spirit youth, including no oral sex with hook-ups, no oral sex during menses, the use of medical gloves during manual stimulation of the vagina, dry humping, and mutual masturbation.

The altering of sexual practices to reduce risk was largely based on the longevity of LGBTQ/two spirit youth's sexual partnerships. As commonly expressed by talking circle participants, the majority of these youth felt that in long-term relationships, where both partner's "trusted" or "knew one another," protection (including condoms, gloves, dental dams, and the alteration of practices) was not likely to be used.

Additionally, hook-ups, one-night stands, and short-term sexual partnerships, although being perceived as higher-risk by youth, were at times not protected due to factors like alcohol or drug-use, feeling caught up in the moment, or the unexpectedness of an encounter with another LGBTQ/ two spirit youth.

Regarding her use of protection with other Native youth, one young woman in her early 20s said, "I've never used protection when I have had sex with other Native youth. I think most of the time it happens in spaces where we're not expecting it to happen, like we just ending up finding another...It's totally random... and so I usually don't bring anything with me because I just assume that nothing is going to happen."

LGBTQ/ Two Spirit Youth and Access to Condoms, Dental Dams, and Protective Gloves

Regarding access to condoms and other forms of protection, LGBTQ/ two spirit youth reported that *physically* accessing condoms was relatively easy and free at clinics, non-profit organizations, events for queer youth, and at gay clubs; however, youth seeking dental dams and gloves were harder pressed to find these forms of protection. Additionally, not all youth felt comfortable accessing condoms and lubricants from traditional "queer" spaces in urban centers, like LGBTQ student centers at their university, because they felt that these spaces do not adequately acknowledge Native cultural identity. Nor do they reflect, at times, how some Native youth express their sexual identity.

In the words of one participant, "Those [dental dams and gloves] are optional really. Even condoms, they're optional... for a lot of... queer Native youth, especially if we are acculturated into an urban society... I think we've been told a lot that being queer is a "white thing," and so we're not very educated, I've noticed, especially if you don't want to interact with the mainstream white community. So Native queer youth just kind of hold each other with misinformation, and for a lot of us... it [being

LGBTQ] is a practice, not an identity... And so we don't go to the spaces where those things are taught, or the education is given."

Misconceptions and Questions among LGBTQ/ Two Spirit Youth

As with talking circle participants, a number of questions and misconceptions arose during interviews, which were later addressed during a post-interview question and answer session. These questions, along with misconception that emerged during interviews with LGBTQ youth, are included below.

Questions asked of study team during the interview by LGBTQ/two spirit youth:

- How do you put on a condom the right way so it doesn't hurt?
- What are those condoms for lesbians that are like plastic wrap? How do they work?
- Can you get HIV through oral sex?

Misconceptions that emerged during the interviews with LGBTQ youth:

- Trusting your partner when they said they don't have a STD is a useful tool for risk reduction
- You don't need to use protection in a relationship, because you know and trust your partner
- Among women who have sex with women (WSW), the idea that when two female-bodied people are having sex there is no or little risk

Things to include in the Native VOICES Video, According to LGBTQ Youth

LGBTQ/ two spirit youth recommended including:

- Positive portrayals of multiple LGBTQ/ two spirit youth, who are involved in the community, tied to their culture and family, and who are valued by their community
- A bi-sexual person who is confident, assured in their sexuality, and is not "confused"
- Two spirit characters who express both positive feminine and masculine traits and who participate in both traditionally feminine and masculine activities (like beadwork and hunting)
- A description of the levels of risk by various sexual acts (e.g. manual stimulation vs. oral sex)
- A description of the different types of protection and how to use them effectively
- Resources (like testing locations, where to get dental dams, gloves, condoms, etc.)
- Information about the risks involved in oral sex and how to protect oneself during oral sex
- The common experience of isolation that is experienced by many LGBTQ/two spirit youth
- Images of STDs

Don't include...

- Romanticized Native imagery, like a shot of a red canyon, flute musicians, etc.
- A logo that has a feather, pottery, or a rainbow
- Any "heavy" seventh generation messaging
- The "practice abstinence" message. If it is included, it should be just a small portion of the video

Staff Perspectives

To ensure that the Native VOICES intervention is an appropriate sexual health resource, project staff conducted ten individual interviews with clinic staff and personnel at youth-serving organizations. Two youth programmatic staff and one counseling staff member provided input at our urban partner site. Additionally, five clinical staff, one counselor, and one school administrator provided useful information regarding the development of an intervention that could successfully fit within clinical and social services offered to youth within their tribal communities.

To elicit staff expertise on optimal intervention formats, the research team asked staff to listen to descriptions of both the current VOICES intervention and another intervention called *Safe in the City*. They were told that VOICES (*Video Opportunities for Innovative Condom Education and Safer Sex*) is a video-based HIV/STD intervention recognized by the CDC. The VOICES intervention is administered by a facilitator in a single session to a small group. In a private room, participants watch a short 15-20 minute video, where information about STDs is given, and condom use and negotiation skills are modeled. Then the facilitator conducts a small group skills-building session on overcoming barriers to condom use. During the session the facilitator also educates program participants about HIV/STD transmission, and informs them about the different types of condoms that are available and their various features. At the end of the 45-minute long session, participants are given self-selected condoms, identified to best meet their needs.

Likewise they were told that *Safe in the City* is an adapted VOICES video-based intervention. It is a 23-minute long HIV/STD looping video that has been used in STD clinic waiting rooms. *Safe in the City*, unlike VOICES, requires no counseling or small-group facilitation by staff. This intervention also requires just a single session, and the *Safe in the City* video, like the VOICES video, models condom negotiation skills between partners and demonstrates the outcomes that can occur when condoms are both used and not used.

After hearing these descriptions the majority of staff felt that a VOICES-style, facilitator- led type of intervention was preferred for a number of reasons. Most importantly it could be better integrated into proposed or already existing programs/presentations for youth at tribal high schools, live-in youth residential facilities, Recreation Department activities (like basketball tournaments), and at other community events, conferences, and trainings. Furthermore, staff felt that interacting with a facilitator in a VOICES-style intervention would provide youth a better opportunity to ask questions and actively engage in the learning process.

Staff appreciated that a VOICES-style intervention would:

- offer a Native-specific and age- appropriate resource
- be more far reaching than talking with youth individually
- potentially encourage more youth to get tested
- provide staff with a formal curriculum for teaching about safer sex and encouraging condom use
- decrease the stigma associated with STDs
- offer a low-risk approach for opening up conversations about sex between patients and providers
- encourage partners to talk about safer sex and using protection
- reinforce messages about condom use already promoted by staff, and
- provide greater legitimacy for clinic staff to talk about safer sex, encourage condom use, and provide condoms at events attended by youth

Although the majority of staff interviewed favored a VOICES-style intervention, most clinic staff felt this facilitator-led intervention would be difficult to use in the clinic setting. One nurse explained, because the majority of clients seeking STD services are “walk in,” clients typically want to receive prompt medical services and then leave. Moreover she believed that there was neither the right space, nor the appropriate amount of time to incorporate a group-style, facilitator-led intervention into the flow of current STD clinical services.

Additionally, some tribal health clinic staff also questioned the acceptability of using the clinic waiting room to show a *Safe in the City*-style looping sexual health video, although this was not true of all clinicians. Clinic staff at one tribal site believed that a looping sexual health video could be played in the clinic waiting room, where patients were already exposed to videos focused on health topics like diabetes, hypertension, and other common conditions that affect Native people. These clinicians felt that providing sexual health information in a public space would help decrease the stigma associated with STDs. Moreover, they felt that this type of intervention (if implemented in the waiting room) would encourage patient-provider conversation and might serve as a motivating factor for those who were interested in receiving STD testing, but otherwise might be too embarrassed to broche the subject with their provider. Also, one tribally-based clinician expressed that this form of intervention might be a useful tool during the 20-minute education sessions she provides patients waiting for their HIV-test results.

Tribal and urban counseling staff also believed that providing this type of information in a looping video would be useful in a counseling setting. One counselor imagined using a *Safe in the City*-style intervention as a tool for educating clients while they waited for an appointment. Another counselor envisioned using this style of intervention between counseling sessions at both her organization’s in-patient and out-patient drug treatment facilities. Although both acknowledged its utility, they believe (as did other staff) that without a facilitator, youth would not necessarily stay engaged and watch the entire video. For this reason they concluded that a more interactive resource, like VOICES, would likely resonate better with youth in a group setting.

Optimal Intervention Duration According to Staff

Staff recommended - regardless of the type of intervention - that the video (or each topical video segment) be relatively short. Several staff members who work primarily with high school-aged youth felt that each video segment in a facilitator-led intervention should be no more than 7-8 minutes long. According to these staff, 7-8 minutes is optimal because it is a good duration for keeping teens engaged. After this period of time, they believed, it would be advantageous to have a reflection and group discussion period, so the facilitator could gauge youth comprehension of the materials, answer questions, and address any misconceptions.

Other staff members believed that 10-20 minute long video segments would work. They also recommended this “chunking” of information for similar reasons listed above.

The majority of staff felt that the optimal length of each intervention session, including the video and facilitator-led piece, should range anywhere from a half hour to a full hour, depending on how frequently the facilitator pauses the video to initiate group discussion, and the amount of time allocated for the session. Additionally, staff believed that the intervention should include multiple sessions, highlighting several topical areas in each session, although the number of proposed sessions varied.

Staff Recommendations for Making a Relevant Resource for Native Youth

Staff also provided many useful suggestions regarding how to adapt the current interventions to make them more applicable to youth in their communities. For a complete listing, refer to Appendix C.

Include...

- Humor to “break the ice” and teach about STDs in a de-stigmatizing way
- Age and culturally-appropriate actors, scenarios, and dialogue that reflect the experiences of Native youth
- Stories that reflect young people’s use of alcohol and how that effects their decision-making abilities
- Opportunities to pause the video to create a discussion, so youth stay engaged
- Portions of the curriculum that draw the messages “back home” so that youth can incorporate cultural elements into lessons in a meaningful way
- Idea that a healthy life is in balance spiritually, socially, emotionally/ mentally, and physically

Don’t...

- Include nudity or anything overly provocative or graphic
- Have bad actors, lighting, or sound
- Don’t downplay cultural elements by including token symbols of “Nativity” like feathers and pan-Native imagery... rather include opportunities for youth to learn about local traditional leaders and community-specific practices

Appendix A

Adaptations to the original VOICES intervention will be informed by three phases of talking circles (focus groups), key informant interviews, and CBPR feedback sessions. Project staff will also seek input (through individual interviews) from clinicians, health educators, and staff at youth-serving organizations on the usability and feasibility of the intervention, and ways to successfully integrate the intervention into the flow of clinical and social services.

When complete, the project will host “red carpet” showings of the video at partner sites. At each showing, participants will complete a short evaluation to assess the video’s quality, cultural appropriateness, and the relevance of modeled situations to the viewer’s own personal experiences. Additionally, each site will implement the adapted EBI in the intended intervention setting with AI/AN teens and young adults. A similar survey will be used to assess changes in key behavior-related sexual health indicators, including knowledge, attitudes, and intentions.

Following this project staff will disseminate the intervention and research findings to the NW tribes, national partners, and the scientific community.

Native VOICES Timeline Years 1-3:

Site	Year 1 Q-1	Year 1 Q-2	Year 1 Q-3	Year 1 Q-4	Year 2 Q-1	Year 2 Q-2	Year 2 Q-3	Year 2 Q-4	Year 3 Q-1	Year 3 Q-2	Year 3 Q-3	Year 3 Q-4
Portland, Oregon (Urban site)	Phase 1 Focus Groups - Males (15-19 yrs) - Females (20-24 yrs) Interview -3-4 staff		Phase 2 Focus Groups - Males (20-24 yrs) - Females (15-19 yrs) Interview -4-6 LGBTQ/TS		Phase 3 Focus Groups - Males (15-24 yrs) - Females (15-19 yrs)		Analysis, Adaptation		Red Carpet Showing 30-40 post-surveys		Implement Adapted EBI 30-40 post-surveys	
Washington (Peninsula/Coastal Tribe)	Phase 1 Focus Groups - Males (20-24 yrs) Interview -3-4 staff		Phase 2 Focus Groups - Males (15-19 yrs) Interview -4-6 LGBTQ/TS		Phase 3 Focus Groups - Females (15-24 yrs)		Analysis, Adaptation		Red Carpet Showing 30-40 post-surveys		Implement Adapted EBI 30-40 post-surveys	
Idaho (Rural/Plains Tribe)	Phase 1 Focus Groups - Females (15-19 yrs) Interview -3-4 staff		Phase 2 Focus Groups - Females (20-24 yrs) Interview 4-6 LGBTQ/TS		Phase 3 Focus Groups - Male and Females (20-24 yrs)		Analysis, Adaptation		Red Carpet Showing 30-40 post-surveys		Implement Adapted EBI 30-40 post-surveys	
Tribal Site Visits	Meeting Minutes		Meeting Minutes		Meeting Minutes		Meeting Minutes		Meeting Minutes		Meeting Minutes	
Alliance & NPAIHB Meetings	CBPR											

Appendix B

Youth Misconceptions and Common Questions that Arose During Focus Groups

Questions asked of study team and/or other participants during the groups:

- Is there “sperm killing” lube? How does it work?
- How does the shot work for birth control?
- Is anyone actually allergic to condoms?
- Is HIV the one that turns into AIDS?
- What are female condoms? How do they go in?
- Can female condoms break when you are having sex?
- What’s a hysterectomy?
- What’s a diaphragm?
- Is a diaphragm the same thing as the female condom?
- What is an IUD exactly?
- How much do condoms cost normally?
- What does it feel like to use a condom?
- What is oral sex? What does oral sex feel like?
- Doesn’t the shot ruin your bones?
- Are the shot and the pill the same thing?
- What about the little “T” thing (IUD)?
- Can you use rubber gloves to prevent STDs?!
- Do condoms prevent against all STDs?
- Which STDs can you get even if you use a condom?
- What is “depo” and how does it work?
- Is the shot 100% effective or can you still get a girl pregnant?
- How does an IUD work? (participants called it “the T shaped thing)
- When a girl uses an IUD, is it still possible to get her pregnant?
- How do you know if a girl is actually on the pill?
- Can you get herpes from sharing drinks?
- Can you get crabs from sex? What do they do once you’re infected, and are they for life?
- Can you get rid of crabs by shaving your pubic hair?
- Where are the condoms at the health center?
- How can people protect themselves from STDs during “butt sex” (anal sex)?
- Where did HIV originate from? Was it because people had sex with chimps?
- Do people who have HIV have sores?
- Can you get HIV from having unprotected sex even if the person you are having sex with doesn’t have HIV?
- When two people have HIV, can they have sex with one another without anything bad happening?
- To be treated for HIV/AIDS (using drugs) don’t you have to know the exact kind of HIV you have?
- So you said that there are different kinds of HIV. Are there also different types of herpes?
- How can you tell if a girl has herpes?
- Can two people with the same kind of herpes have sex?
- How long have STDs been around for?

Misconceptions that emerged during the focus group:

- Brushing one's teeth is an effective way to reduce STD transmission after performing oral sex on a sex partner
- The female condom doesn't prevent STDs
- Diaphragms can be used for STD prevention in addition to preventing pregnancy
- An IUD goes into your skin (like in your butt or under your arm)
- An IUD gets inserted into a woman's thing but doesn't go through the cervix
- People in long-term relationships don't need to use condoms
- You can use spermicide for protection during oral sex
- Two condoms are better than one
- "The shot" offers 100% protection against pregnancy
- Crabs aren't an STD
- There is no way to have safer sex when a woman is receiving oral sex
- Having sex with only one partner will protect you from getting an STD
- The "T-shaped" (IUD) thing works to prevent pregnancy by blocking off a women's tubes
- Women are given a shot of "depo" every 6 months
- Condoms break because they are stretchy
- When someone has HIV they can never have sex again

Appendix C

Complete Listing of Staff Recommendations for Adapting Current Interventions and Making a Relevant Resource for Youth

Include...

- Humor to talk about difficult subjects and teach about STDs in a de-stigmatizing way
- Age and culturally-appropriate actors, scenarios, and dialogue that reflect the actual experiences of Native youth
- Scenes that reflect youth's use of alcohol and how it effects their decision-making abilities
- Scenes that normalize healthy relationships and positive decision-making skills
- Real people talking about their experiences with HIV or herpes, the symptoms they experience, and how it has changed their lives
- Opportunities to pause the video to create a discussion, so youth stay engaged
- Information on how to make safer choices, different types of STDs, there symptom and potential health consequences, why we need to use condoms, how to use a condom the right way, and abstinence as an option
- Information about how to create personal rules for oneself regarding sexual behavior and enforce those rules with partners
- Traditional value of being disease free and that STDs are not a part of our tradition
- Respect for elders
- Hands-on activities
- "Worst case" scenarios of what can happen if one is infected by an STD
- Information about what happens during the testing process and what happens when you test positive for an STD (informing partners, etc.)
- Pictures of STDs
- The idea that homophobia is not a Native tradition
- A two spirit male character who is strong, successful, driven, and an integral part of the community
- A positive urban youth character who is active in the Native community, does the powwow circuit in the summer, someone who studies Native law, somebody who believes in participating in cultural activities, but also understands that we have to adapt to the modern world and continues to fight for the rights of Native people in a way that is positive and productive
- Portions of the curriculum that draw the messages "back home" so that youth can incorporate cultural elements into the lessons in a meaningful way and so youth learn where to access local/national resources
- Information about the balance and harmony Native people achieved with the environment, their healthy etc. before adapting non-Native ways (and becoming less balanced)
- Young female characters who demonstrate that they have the power to make their own decisions about condom use and enforce it within their own relationships and who say " I want to protect myself and I want to protect you"
- Information about how to create personal rules for oneself regarding sexual behavior and enforce those rules with partners (acknowledge that this might be especially difficult in relationships where partners are from the same tribal community and one partner is older)
- Idea that using condoms and talking about protection is sharing mutual respect for yourself and your partner(s)

- Middle school youth in the plots because they are also having sex, getting STDs and getting pregnant
- Show a young people turning to respected adults in the community for advice (like coaches, counselors, teachers, or a dorm advisor)
- Shorter video clips related to specific focus areas, like STDs, healthy relationships, how to talk to your partner, or the testing process, so a facilitator could pause the video and narrow in on one or two key messages per clip
- Multi-racial Native actors, non-Native actors, and multi-racial relationships
- The concept that some young women actually want to get pregnant and address the issue of STDs and positive decision-making within that context
- Information on positive decision-making skill development
- Address the fact that among many youth condom use is not a priority
- Include tactics facilitators can use to address joking and embarrassment and tips for encouraging all youth to participate
- Positive messaging and positive examples of desired behavior
- Idea that a healthy life is in balance and that a healthy person tends to their spiritual, social, mental, and physical health
- Partners modeling how to talk about safer sex and protection
- Regional/ local STD statistics (not broken down by race)
- Scenes that normalize testing and reinforce the messages that “everyone is at risk for infection” and “we all need to get tested”
- Information about what happens during the testing process and what happens when you test positive for an STD (informing partners, etc.)
- The issue of confidentiality at clinics and patient rights
- Idea that “...what you do is going to affect your whole family too... It affects future generations...”
- Show a partner calling another partner to tell them that they just tested positive for an STD , like in the Safe in the City video (It showed responsibility and it was good to see that the person was appreciative of the information and did not judge or ostracize their former partner)
- The condom cartoon in Safe in the City
- Idea that you can't tell if someone has an STD by looking at them, you have to both get tested
- How to put on an condom
- Talk about the different types of sex (vaginal, oral, and anal)
- Talk about different kinds of lubricants
- Snagging at powwows
- An introduction on why the topic is important, to help anyone who might be offended better understand why we need to discuss sex, STDs, and protecting oneself
- An auntie or other non-parental immediate family member who youth can confide in and receive advice from
- An elder talking in the beginning of the video about STDs and the 7th generation (include the message: “protect yourself, protect the future of our people”), introduce facts about Native people and STDs, and then start the main plot line of the video... end with “it is in your hands, you can change these statistics, protect yourselves and our people.”
- Information on what constitutes sexual violence, what young people's rights are, and what the potential repercussions are for committing sexual violence
- A guide for engaging youth in advertising the intervention

- Acceptance by adult characters that young people are sexual beings and that sex is normal
- Moon house (place where mother and newborn go after birth, they stay for a certain amount of time away from the rest of the community, and people come to the moon house to teach the mother how to care for her child)

Don't...

- Include nudity or anything overly provocative or graphic (youth will lose focus)
- Make a slow-moving video that's bland
- Forget that youth attention span is often shorter than the adult attention span (try to make the video attention grabbing and interesting)
- Promote casual sex among youth
- Just focus on information about preventing STDs and teen pregnancy, rather include characters that demonstrate general positive decision-making skills in different aspects of their lives (address specific "irresponsible outcomes" that result from "irresponsible behavior" as well as "responsible outcomes" that result from "responsible behavior")
- Show two men kissing, however you can allude to a same-sex intimate relationship
- Have bad actors, lighting, or sound
- Downplay cultural elements, by including token symbols of "Nativeness" like feathers and pan-Native imagery... rather include opportunities for youth to learn about traditional leaders and practices within their specific community