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ADAPTING AND PILOTING AN EVIDENCE-BASED HIV/AIDS AND TEEN PREGNANCY PREVENTION INTERVENTION FOR NATIVE AMERICAN TEENS

By

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A Dissertation submitted in partial fulfillment

of the requirements for the

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School of Community Health Sciences
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Abstract

Introduction: Native American youth are at disproportionate risk for HIV infection. Native Americans represent about 1.7% of the U.S. population, yet they rank fifth in HIV/AIDS diagnosis nationwide (U.S. Census, 2012; CDCd 2013). Native Americans with HIV/AIDS are more likely to be younger than non-Native Americans with the disease. There are limited evidence-based HIV/AIDS and teen pregnancy prevention interventions that have been developed, adapted, and/or evaluated for Native American teens. The purpose of this study was to adapt an existing evidence-based HIV/AIDS and teen pregnancy prevention intervention into a culturally responsive intervention curriculum for Native teens. **Methods:** There were three phases in this study: 1) Adaptation; 2) Implementation; and 3) Evaluation. The first phase of this study was to adapt the evidenced-based Becoming A Responsible Teen intervention with the assistance of a national advisory board. The recommendations were collected and compiled. The second phase of this study was implementing a pilot of the adapted curriculum for Native American teens aged 14-18 living within the Las Vegas, Nevada metropolitan area. The final phase involved a multi-level evaluation using mixed-methods approach: 1) a quantitative, pre-post, HIV knowledge survey; 2) end-of-session surveys that allowed for both quantitative and qualitative feedback on curriculum content and activities; 3) an end-of-intervention survey that gathered quantitative and qualitative feedback on the overall curriculum content and activities; and 4) a focus group to collect qualitative data about curriculum content and activities. **Results:** Based on the recommendations from the national advisory board tribal social structures, tribal stories, cultural teachings/philosophy, history, and tribal data were strategically incorporated into the curriculum. The adapted curriculum was

pilot tested with 14 participants who all completed the intervention. There was significant difference in the pre-survey (M=13.93, SD=3.08) and post-survey (M=17.14, SD=2.25), indicating that participant HIV knowledge scores, increased on average by 3 points.

The majority of the end-of-sessions and end-of-intervention survey Likert-scale responses among, all categories were rated good or very good. The focus group results indicated the adaptations helped participants to understand the link of cultural teachings to responsible-decision making. **Conclusion:** The findings support the premise that with a few carefully constructed, culturally appropriate adaptations, the adapted BART can be an appropriate HIV/AIDS intervention for Native American teens.

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I would like to acknowledge my Navajo ancestors who have survived tremendous odds so I can be here today. They are the true definition of strength and resilience. I would like to dedicate my dissertation to my grandfathers, Justin Lewis and Ralph Lee Sr. I would like to thank my maternal grandfather, Justin Lewis, my paternal grandfather, Ralph Lee Sr., and my uncles Chuck Lewis and Mando Joe for their love and support by conducting many ceremonies for me since I was an infant that involved numerous prayers and songs. I would have never achieved this goal without them. As my uncle stated when I graduated with my Bachelor's degree, "We did it!" I love and miss you all very much.

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Table of Contents

Abstract iii

Acknowledgements v

Table of Contents vi

List of Tables viii

Chapter 1: Introduction 1

Chapter 2: Cultural Framework 6

Native Discourse 6

"Two-Spirit" Sexual Orientation 12

Historical Trauma 13

Acculturation 18

Summary 20

Chapter 3: Literature Review 21

Sexually Transmitted Infections 21

Teen Pregnancy 28

Risk Factors Contributing to Risky Sex Behavior(s) 29

At-Risk Sexual Behavior(s) Among Natives 36

HIV and STI under-reporting among Natives. 39

Evidence-based HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions 40

Adapting HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions 44

Culturally Responsive Interventions 47

Native Culturally Responsive Prevention Interventions 48

HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions for Native Teens 57

The "Becoming A Responsible Teen" Evidence-Based Intervention 64

Conclusion 71

Chapter 4: Methods 73

Collaborators 73

Project Phases 75

Phase I-Adaptation 75

Phase II-Pilot Testing ... 81
Phase III-Mixed Methods Evaluation ... 86
Chapter 5: Results 98
Project Phases ... 98
Phase I-Adaptation ... 98
Phase II-Pilot Testing ... 120
Phase III – Mixed Methods Evaluation ... 123
Summary ... 183
Chapter 6: Discussion 185
Key Findings and Recommendations ... 186
Future Research ... 193
Conclusion ... 194
Appendix A ... 195
Appendix B ... 216
Appendix C ... 230
Appendix D ... 232
Appendix E ... 235
Appendix F ... 237
Appendix G ... 240
Appendix H ... 244
Appendix I ... 312
Appendix J ... 315
References 345
Curriculum Vitae 359

List of Tables

Table 1. American Indian/Alaska Natives with HIV/AIDS by Exposure Category (2001-2004) 39

Table 2. HHS Evidence-Based Teen Pregnancy Prevention Programs 196

Table 3. The 17 Characteristics of Effective Curriculum-Based Sex and STI/HIV Education Programs 43

Table 4. Native HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions 58

Table 5. BART Activities that Increase Knowledge to Abstain from Sex 68

Table 6. BART Activities that Increase Perceptions of Risk to Abstain from Sex 69

Table 7. BART Activities that Increase Skills to Abstain from Sex 70

Table 8. Summary of Evaluation 87

Table 9. Introductory Adaptations 104

Table 10. Past, Present, Future Session 107

Table 11. Relationships to Self & Others Session 109

Table 12. Options (Abstinence) Adaptations 201

Table 13. BART Session 1-Understanding HIV/AIDS Adaptations 203

Table 14. BART Session 2-Making Sexual Decisions & Understanding Your Values Adaptations 205

Table 15. BART Session 3-Developing and Using Condom Skills Adaptations 208

Table 16. BART Session 4-Learning Assertive Communication Skills Adaptations 210

Table 17. BART Session 5-Practicing Assertive Communication Skills Adaptations 211

Table 18. BART Session 6-Personalizing the Risks Adaptations 212

Table 19. BART Session 7-Spreading the Word Adaptations 213

Table 20. BART Session 8-Taking B.A.R.T. With You Adaptations 214

Table 21. Timeframe Changes for the BART Intervention 123

Table 22. Introduction Technical Evaluation 125

Table 23. Introduction (Please rate the activities) 126

Table 24. Introduction (As a Native teen, how well did you connect to these activities) 126

Table 25. Introduction Cultural Appropriateness 127

Table 26. Past, Present, Future Technical Evaluation 129

Table 27. Four Questions (Please rate the activities) 130

Table 28. Goals & Values (Please rate the activities) 130

Table 29. Four Questions (As a Native teen, how well did you "connect" to these activities) 131

Table 30. Goals & Values (As a Native teen, how well did you "connect" to these activities) 131

Table 31. Past, Present, Future Cultural Appropriateness 132

Table 32. Relationship to Self & Others Technical Evaluation 134

Table 33. Puberty is Ceremony (Please rate the activities) 135

Table 34. Activity 2-5 (Please rate the activities) 135

Table 35. Puberty is Ceremony (As a Native teen, how well did you "connect" to these activities) 136

Table 36. Activity 2-5 (As a Native teen, how well did you "connect" to these activities) 136

Table 37. Relationship to Self & Others Cultural Appropriateness 137

Table 38. Options Technical Evaluation 139

Table 39. Activity 1-4 (Please rate the activities) 139

Table 40. Activity 1-4 (As a Native teen, how well did you "connect" to these activities) 140

Table 41. Options Cultural Appropriateness 141

Table 42. BART Session 1 Technical Evaluations 143

Table 43. Activity 1-6 (Please rate the activities) 144

Table 43. Activity 1-6 (As a Native teen, how well did you "connect" to these activities) 144

Table 44. BART Session 1 Cultural Appropriateness 145

Table 45. BART Session 2 Technical Evaluations 147
Table 46. Activity 3-7 (Please rate the activities) 147
Table 47. Activity 3-7 (As a Native teen, how well did you "connect" to these activities) 148
Table 48. BART Session 2 Cultural Appropriateness 148
Table 49. BART Session 3 Technical Evaluations 150
Table 50. Activity 1-5 (Please rate the activities) 151
Table 51. Activity 1-5 (As a Native teen, how well did you "connect" to these activities) 151
Table 52. BART Session 3 Cultural Appropriateness 152
Table 53. BART Session 4 Technical Evaluations 154
Table 54. Activity 2-4 (Please rate the activities) 154
Table 55. Activity 2-4 (As a Native teen, how well did you "connect" to these activities) 154
Table 56. BART Session 4 Cultural Appropriateness 155
Table 57. BART Session 5 Technical Evaluations 157
Table 58. Activity 2-5 (Please rate the activities) 157
Table 59. Activity 2-5 (As a Native teen, how well did you "connect" to these activities) 158
Table 60. BART Session 5 Cultural Appropriateness 158
Table 61. BART Session 6 Technical Evaluations 160
Table 62. Activity 1-2 (Please rate the activities) 160
Table 63. Activity 1-2 (As a Native teen, how well did you "connect" to these activities) 161
Table 64. BART Session 6 Cultural Appropriateness 161
Table 65. BART Session 7 Technical Evaluations 163
Table 66. Activity 1-4 (Please rate the activities) 163
Table 67. Activity 1-4 (As a Native teen, how well did you "connect" to these activities) 164
Table 68. BART Session 7 Cultural Appropriateness 164

Table 69. BART Session 8 Technical Evaluations 166

Table 70. Activity 1-5 (Please rate the activities) 167

Table 71. Activity 1-5 (As a Native teen, how well did you “connect” to these activities)........ 167

Table 72. BART Session 8 Cultural Appropriateness... 168

Table 73. Intervention Cultural Appropriateness 170

Chapter 1: Introduction

Early sexual activity establishes multiple risks for adolescents, teenagers, and young adults. Early sexual risk behaviors have been linked to increased risk of human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and unintended pregnancies. The increasing rates of HIV, STIs, and unintended pregnancies among youth are primarily due to unprotected sexual activity, multiple sex partners, and substance abuse (CDC, 2004). In addition, gang involvement, truancy, criminal behavior, and early sexual initiation contribute to high-risk behaviors (Polacek et al., 2008).

In the U.S., the 2013 Youth Risk Behavior Surveillance System's (YRBSS) national overview of high school students illustrated that: 47% of students had sexual intercourse, 15% of students had sexual intercourse with four or more persons during their lifetime, 34% of students had sexual intercourse with at least one person during the 3 months prior to the survey (i.e., currently sexually active). Among the 34% of currently sexually active students, 22% had used alcohol or other drugs before last sexual intercourse (YRBSS, 2013). The prevalence of risky sex behavior(s) increased among students who reported using alcohol and/or cigarettes, and was highest among students who reported using marijuana, cocaine, or other illicit drugs (Shuper et al., 2010; Lowry et al., 1994).

In 2010, the high rates of HIV, STIs, and unintended pregnancy particularly affect young persons aged 13-24 years, men who have sex with men (MSM), and members of minority races and ethnicities (CDCa, 2013). As a result of risky sexual behaviors, about 9.5 million adolescents and young adults (ages 15-24) are diagnosed with sexually transmitted infections yearly (Forhan et al., 2009). It is estimated 4-in-10 sexually active adolescent females between the ages of 14

and 19 have an STI (OAH, 2013a). Forhan et al. (2009) study showed that among sexually active adolescent females, the most common STI is human papillomavirus, followed by chlamydia, trichomoniasis, and gonorrhea.

In 2010, young gay and bisexual men accounted for 19% of new HIV infections in the US and 72% of new HIV infections among persons aged 13–24 (CDCb, 2013). In 2010, 26% of young people aged 15-24 account for new HIV infections in U.S. (CDCb, 2013). Generally, HIV infects one out of every two persons between the ages of 15-24, which means five young people are infected every minute (Vernon, 2001). These statistics indicate that adolescents and young adults are engaging in risky sexual behaviors that put them at high-risk for contracting STIs and HIV.

In addition, as a result of engaging in early and often risky sexual behaviors, in 2013, a total of 273,105 babies were born to females aged 15-19 years, resulting for a live birthrate of 26.5 per 1,000 in this age group (CDCc, 2013). Black youth, Latino youth, Native American/Alaskan Native (Native) youth, and socioeconomically disadvantaged youth of any race/ethnicity experience the highest rates of teen pregnancy and childbirth (CDCc, 2013). Teen pregnancies and births have adverse consequences, especially when the mother is under the age of 18 years old. For example, females are less likely to complete high school and attend college, and are more likely to have large families and to be single parents, which result in significant social and economic costs (Hoffman, 2006, CDCc, 2013). The U.S. teen pregnancy and birth rates are substantially higher when compared to other western industrialized countries (CDCc, 2013).

More specifically, HIV, STIs, and teen pregnancy disproportionately impact Native Americans (Natives). They represent about 1.7% of the U.S. population and account for slightly less than 1% of all reported HIV/AIDS cases nationwide (U.S. Census 2012; Sileo & Sileo, 2008). In 2010, Natives rank fifth in estimated HIV infection rates with lower rates than Blacks, Hispanics

Native Hawaiians/Pacific Islanders, and people reporting multiple races, but have higher rates than Asians and Whites (CDCd, 2013). However, some tribal nations may have even higher HIV/AIDS rates that exceed the African American and Latino communities (Vernon & Jumper-Thurman, 2002). Natives who have HIV/AIDS are more likely to be younger than non-Native peoples because the majority of new infections occur among Native adolescents and young adults (Bertolli et al, 2004). Native teens had the third highest teen birth rate in 2012 in the U.S. among the five major racial/ethnic groups (www.thenationalcampaign, 2013). After considering these statistics, prevention efforts are needed to address the STIs, HIV, and teen pregnancy epidemic among tribal populations.

Evidence-based intervention programs are designed to delay first sexual intercourse or encourage practice of safe sex behaviors among adolescents and young adults as a strategy for reducing HIV, STIs, and unintended pregnancies. Evidence-based prevention programs are interventions that have met multiple standard criteria that demonstrate the intervention produced positive results (www.projectenhance.org, n.d.). According to the U.S. Department of Health and Human Services, Office of Adolescent Health, there are 35 evidence-based intervention programs that were found to be effective at preventing teen pregnancies and reducing STIs and HIV by reducing rates of sexual risk behaviors in August 2014 (OAHb, 2013).

Distinctively, an evidence-based HIV/AIDS prevention intervention, *Becoming A Responsible Teen* (BART), has been proven to be highly effective on this mission of reducing STIs, HIV, and teen pregnancy. BART was developed primarily for the African American teenage community, which is considered a high-risk minority population similar to the Native teen community. The BART intervention is designed for sessions to be held at community-based settings that are usually rooted in the social network and environment of the adolescents in the community, which would make it an ideal intervention to implement within the Native community to heighten cultural appropriateness (St. Lawrence, 1998). To thoroughly address the outcomes of risky sexual behaviors and prevention strategies in tribal communities the BART must be adapted to become culturally appropriate for Native adolescents and young adults.

Although there have been multiple evidence-based interventions to address such disparities, such as BART, limited culturally appropriate evidence-based interventions have been developed or adapted for Native youth. According to Castro, Barrera, and Martinez (2004) it was stated at a coalition meeting in a small traditional community in the Southwest, "Para que sirve la ciencia, si no nos ayuda?" This translated in English as, "What good is science, if it doesn't help us?" This statement reinforces that far too often studies with science-based approaches that are effective for mainstream populations are not tested or translated for use with minority populations.

Therefore, it is crucial to design or adapt culturally competent prevention programs that target Native youth. Current prevention interventions have minimal impact on tribal communities due to the contrary on cultural norms, knowledge levels, and behavior patterns.

Incorporating family structures, values, dynamics, socialization processes, and historical contexts are the etiological components of how to appropriately address high rates of HIV/AIDS, STIs, and teen pregnancy in tribal communities. These components are the heartbeat to create or adapt HIV/AIDS and teen pregnancy prevention interventions for Native youth.

The information in Chapter 2 includes a demographic background about Natives, including cultural beliefs and values, as well as their history and acculturation. Chapter 3 discusses the epidemiological assessment of varying STIs, HIV/AIDS, and teen pregnancy rates among all racial/ethnic groups in the U.S., and the associated risk factors. Also, this chapter will discuss the efforts to address the high rates of HIV/AIDS, STIs, and teen pregnancy evidence-based interventions, including adapting interventions, culturally relevant interventions, Native interventions, and BART intervention. Chapter 4 explains the mixed methods approach that was used to conduct this research study. Chapter 5 illustrates the results and Chapter 6 discusses key findings, recommendations, and the conclusion.

Chapter 2: Cultural Framework

Native Discourse

Native Americans and Alaskan Natives are Indigenous populations of the U.S. The cultural diversity among these groups is vast. The information in this chapter is intended to provide knowledge about the similarities and differences among Natives by specific topics.

Population. The U.S. Bureau of Indian Affairs legally defines a Native person as an individual who is an enrolled, registered member of a tribe or whose blood quantum is one fourth or more genealogically derived from Native American ancestry (1991). In 2010, Natives represent about 1.7 % of the U.S. population (US Census, 2012). Out of this percentage 0.9% identified as being Native alone and 0.7% identified as being Native in combination with one or more races, thus resulting in a total of 1.7% (US Census, 2012). The term Native(s) or tribes will refer to Native American peoples in this document. There are approximately 567 federally recognized tribes in the U.S. (Nakai et al., 2004). Though a small population, Natives are disproportionately disadvantaged in several areas, including education.

Educational status. Natives are less likely to possess a high school diploma or GED when compared with the mainstream population (Sarche & Spicer, 2008; Education Week, 2013). In 2010, the annual report released by Education Week (2013) reported that the national public high school graduation rate was 74.7%, while Natives had a graduation rate of 51.1% (Education Week, 2013). High-school graduation rates for Natives have declined from 54% in 2008 to 51% in 2010 (Graduation Week, 2013). Therefore, in 2010, Natives have the lowest graduation rate at 51% compared to Blacks at 62%, Hispanics at 68%, Whites at 80% and Asians at 81% (Graduation Week, 2013).

In 2003, Native students approximately comprise 1% out of the 28% postsecondary minority students in the U.S. (Snyder, Tan, & Hoffman, 2004). In 2003, Natives between the ages of 18 and 24 were less likely to be enrolled in a college or a university when compared to their White, Asian/Pacific Islanders, and Black counterparts (Freeman & Fox, 2005). More specifically, in 2003, 18% of Native American students between the ages of 18-24 are enrolled in college when compared with 42% of Whites, 60% Asian/Pacific Islanders, and 32% of African Americans (Shotton, Oosahwe, & Cintron, 2007). In 2000, Natives were less likely to earn a bachelor's or higher degree than their peers (Shotton et al., 2007; Freeman & Fox, 2005). Lower the educational attainment is often associated with lower socioeconomic status.

Socioeconomic status. According to the U.S. Census (2013), from 2007-2011, Natives had the highest poverty rate of any racial/ethnic group in the U.S., and according to the U.S. Commission on Civil Rights (2004) Natives have always had the highest poverty rate of any racial/ethnic group in the U.S. From 2007-2011, Natives had a poverty rate of 27% compared to the national average of 14.3% (U.S. Census, 2013). More specifically, Natives had poverty rates at 27.0%, Blacks at 25.8%, Hispanics at 23.2%, Native Hawaiians/Pacific Islanders at 17.6%, Asians at 11.7%, and Whites at 11.6% from 2007-2011 (U.S. Census, 2013). The Natives who live in Arizona, Maine, Minnesota, Montana, Nebraska, New Mexico, North Dakota, South Dakota, and Utah had poverty rates of about 30% or more, which all have tribal reservations within those states. The unemployment rate on some reservations can be as high as 75% (U.S Census, 2013; pslweb.org, 2013). In addition, over 14% of Native homes do not have electricity, which is 10 times the national average, and 20% of Native households lack running water (pslweb.org, 2013).

Lower income and educational levels are often associated with poor health status. In addition, lower socioeconomic status (SES) usually leads to an increased exposure to physical, environmental, and social environmental risks (LaVeist, 2005). It is crucial to recognize that the experience of poverty has adverse cumulative effects, especially in adulthood (Marmot & Wilkinson, 2006). These impoverished lifestyles can result in cardiovascular disease, respiratory disease, and some cancers late in life (Marmot & Wilkisnon, 2006). Poverty is also an important cofactor in relation to the risk for HIV infection due to limited access to HIV testing and treatment (Dennis, 2009). Generally, it is recognized that the higher the education, the higher the income, the better the health status, because it increases access to quality health care (U.S. Commission on Civil Rights, 2004).

Diversity. There are approximately 567 federally recognized tribes in the U.S., in addition to tribes only recognized at a state level and some seeking recognition at the state or federal level. It is important that tribal differences be taken into consideration, especially regarding the varying diversity of geography (Nakai et al., 2004). Approximately 60% of Natives do not live on tribal lands or reservations, yet they may frequently travel between urban areas and tribal lands for ceremonies, education, or employment opportunities (Kaufman et al., 2007). Natives who reside in urban areas are more transient than non-Natives, both within the same county and moving to a different county (Harvard Project, 2007). Also, the social structures within Native families and communities are dependent upon extended families, clans, affiliation, bands, and patriarchal or matriarchal structures and understanding their respective roles within their community (Nakai et al., 2004).

The members of this population may belong to one or more of the 566 federally

recognized tribes or Alaskan Native villages, all of whom are diverse in culture, language, traditions, and social structures. Abundant diversity exists among this population with a shared experience of colonization and systemic issues. Despite the many distinct differences, Natives share a universal worldview and have similar beliefs that are applied through tribal-specific song, ceremony, and cultural traditions (McNeil & Downer, 2006).

Worldview. The root of Native tradition and spirituality is the worldview of understanding and respecting the circle of life. For example, contrasting three major worldviews: A Western Judeo-Christian views God as exterior and in heaven above; an Eastern focuses internally and reaches within through meditation and other practices; and a Native view views people connected to the world, including nature and animals (Cunningham & Stanley, 2003). Within the Native worldview, the people, earth, air, water, and animals are all interconnected and all need to be in harmonious balance. Respect, obligation, and responsibility are granted to the circle of life to respect all entities with an obligation and responsibility to protect it (Cunningham & Stanley, 2003).

Culture. Generally, culture can be defined as “the sum of attitudes, behaviors, customs, and beliefs of a people; and it includes thoughts, styles of communication, ways of interacting, and views of roles and relationships” (Nakai et al., 2004, p. 1). In addition, culture is learned socially and adaptive (Scultz & Lavenda, 2013). Culture tells people about the world surrounding them and how they behave in it (Nakai et al., 2004). Native culture often is orally passed down from generation to generation via cultural stories, songs, and prayer. Generally, the more remote a tribe has been from colonizing influences, the more traditional it remained (Nakai et al., 2004). So the level of “traditionalism” varies amongst each tribe (Nakai et al., 2004).

Language. Language is a vital component of Native culture that guides worldviews and practices. Language simultaneously reflects culture because it is influenced and shaped by it. Jiang (2000) stated, "In the broadest sense, it is also the symbolic representation of a people, since it comprises their historical and cultural backgrounds, as well as their approach to life and their ways of living and thinking" (p. 328). Every language has meanings or carries meanings that are different because it is associated with a culture, which is more extensive than language (Jiang, 2000). Among Natives, language is culture and culture is language. Generations of accumulated knowledge transfer cultural values and help cultivate a person's self-awareness, identity, and interpersonal relationships because they are embedded in language (Nakai et al., 2004). Language is crucial to educate Natives using cultural stories to show them how to live in the world, how to behave, and how to survive (Nakai et al., 2004). Language is crucial to educate Natives about health and healing as well.

Health and well-being. Natives view health as multi-dimensional, believing a healthy embodiment consists of a simultaneous balance of the physical, mental, social, spiritual, and environmental elements. Natives have exercised this holistic philosophy of health for centuries, especially through their spiritual and cultural practices. For Natives spirituality is linked with culture that is linked with social structures and environmental conditions, which are ultimately linked to health and well-being (Nakai et al., 2004).

Most Native ceremonies are a treatment to help restore harmony to a tribal member's health. The healing process is enacted through ceremonies involving songs, rituals, prayers, and native herbs conducted by medicine men or women. These practitioners often specialize in specific ceremonial practices, just as Western doctors specialize in different specialties in

medicine. Ceremonies that are prescribed to the patient depend on the type and severity of the ailment.

In addition to ceremonies, Natives still have vast knowledge of illnesses and remedies that originate from their own environment, such as medicinal plants and mineral wraps. Often times the use of native herbs are intertwined with traditional ceremonies and healing songs (Nakai et al., 2004). For example, one of the oldest practices among Navajo people for personal healing and cleansing is the utilization of Native herbs. In the Navajo culture, native herbs and spirituality seem to be inseparable because Navajo herbalists link the profiles of individual plant species with important cultural associations (Joe, 2008).

To assist in describing health and healing, the Navajo people perceive the medicine men or women as Western societies perceive medical doctors, as healers. It takes medicine men or women years to learn the precise ceremonial procedures and songs, which are always orally taught. For example, the Navajo “Enemy Way” ceremony is a six day/five night ceremony for which a medicine man has to know over 400 songs. This healing ceremony often includes Navajo cultural history interwoven into the songs, and is often counseling-intensive for the patient. The patient will discuss problems in their personal, family, and community surroundings. To discuss such problems is considered “self-healing” and reinforces familial bonds. This practice of spiritual ceremonies and healing often includes native herbs.

Many Natives have found that the blending of traditional and Western medicine is important for health and wellbeing. A fundamental component of social structures found among most tribal communities is the sense of unity and responsibility for their communal health and well-being (Nakai et al., 2004). In many tribes, addressing sickness and wellness is

not only an individual issue but also a community issue (Nakai et al., 2004). Natives often have to blend their traditional culture with Western culture, which also includes self-identification, such as the lesbian, gay, bisexual, or transgender identities.

"Two-Spirit" Sexual Orientation

The term "two-spirit" is culturally appropriate for describing Native lesbian, gay, bisexual, or transgender identities that tie together the masculine and feminine qualities (Rowell, 1996). Two-spirit persons in many traditional Native cultures regularly assumed identities of the opposite sex (Sileo & Gooden, 2004). In some tribal communities two-spirit persons were and are revered as essential to the sacred web of life and society. They were or are perceived as unique because of their special qualities and characteristics, such as the gift of prophecy (Brown, 1997). The views regarding two-spirit people provides some insight on Native communities' worldview about acceptance of gay and lesbian identities because of their sacred status (Champagne, 1997).

Despite the sacred views of two-spirit persons, homophobia is a social factor that may increase HIV/AIDS and STIs within tribal communities. Discrimination towards gay and bisexual tribal members is pervasive among tribal communities (Vernon & Jumper-Thurman, 2002). This discrimination may result in participation in risky sexual behaviors. Additional risk factors include lack of information about risk, failure to seek medical treatment, and spreading the disease unknowingly (Vernon & Jumper-Thurman, 2002). Two-spirit persons may encounter culturally-based stigma, along with confidentially issues, that may limit opportunities for HIV education and HIV testing, especially among those who live on rural reservations (CDCd, 2013). Homophobia among two-spirit persons may also be the result of historical trauma.

Historical Trauma

The Historical Trauma Theory proposes the principle that populations who have been historically exposed to long-term, mass trauma have demonstrated a higher prevalence of disease(s) even several generations after the original trauma transpired (Sotero, 2006). Historical trauma is defined as the collective emotional and psychological damage both over the life span and across generations, resulting from a catastrophic history that occurred as a result of genocide and additional substantial mistreatments (www.sampsa.gov, n.d.). The Historical Trauma Theory integrates and is constructed upon three theoretical frameworks in social epidemiology: 1) Psychosocial Theory, which associates disease to both physical and psychological stress deriving from the social environment, 2) Political/Economic Theory, which acknowledges how the political, economic, and structural determinants of health and disease are associated by the practices of unjust power relations that result in class inequality, 3) Social/Ecological Systems Theory, which acknowledges the varying levels of interdependencies of present/past and life course factors of disease causality (Sotero, 2006). Sotero (2006, p.94-95) conceptualizes the four foundational conceptions that reinforce the Historical Trauma Theory:

1. Mass trauma is deliberately and systematically inflicted upon a target population by subjugating, dominant population
2. Trauma is not limited to a single catastrophic event, but continues over an extended period of time
3. Traumatic events reverberate throughout the population, creating a universal experience of trauma
4. The magnitude of the trauma experience derails the population from its natural, projected historical course resulting in a legacy of physical, psychological, social, and economic disparities that persists across generations

Historical trauma experienced by Natives. Historical traumas that Natives have been faced include but are not limited to is; genocide, removal from tribal lands, individuals who experienced concentration camp existence, forced sterilization of women, involuntary boarding school confinement, prejudice, racism, and other various social, psychological, and spiritual insults. Mainstream American institutions such as government agencies, schools, and churches have intentionally attempted to demolish Native foundations of family, clan, tribal structure, religious belief systems and practices, customs, and traditional life (Deloria, 1988). A strategic plan by White America to deal with the "Indian Problem" resulted in practices of extermination and racial genocide, as well as seizure of lands because tribes stood in the way of controlling the land and all the natural resources it entailed (Tlanusta & Pichette, 2000). Through warfare and infectious diseases the Native people's population had been reduced down to 10% of its original amount by the end of the eighteenth century (Oswalt, 1988). The period from the 1600s to 1840s was generally characterized by the phrase, "The only good Indian is a dead Indian" (Heinrich, Corbine, & Thomas, 1990). Millions of Native peoples were killed in the first 400 years following contact with Europeans as a result of being labeled as savages or being labeled less than human (Hirschfelder & Kreipe de Montano, 1993; Oswalt, 1998).

The period from the 1860s to the 1930s was characterized by the phrase, "Kill the Indian, but save the man" that reflected White America's dominant culture's assimilation policies (Heinrich et al., 1990). The extermination of Native peoples became more difficult to rationally justify so the popularity of policies created to eliminate Native peoples diminished. The areas where tribes were not killed through genocide the federal government then removed Natives from their original homelands to place them in lands that Whites had no use for or

reservations were created through treaties to keep Natives away from Whites (Tlanusta & Pichette, 2000). For example, in the 1830s the Cherokee, Chickasaw, Choctaw, and others were forcibly removed from eastern parts of the U.S. to Oklahoma which is known as the "Trail of Tears." These forced removals disrupted the tribes' cultures, traditions, values, and beliefs due to it being closely connected to their traditional homelands.

Within the same time period from 1860s to 1930s, White society turned towards education to assimilate Native youth early in their lives. Most treaty agreements had stipulations for Native youth to obtain an education by government-supported and church-run boarding schools. Therefore, some Native children were unwillingly removed from their homes at young ages and forced to attend boarding schools as far away from their homes as possible. Within the boarding schools Native children were not allowed to speak their native language or practice their cultural traditions. If children spoke their native language or practiced their cultural traditions, they were physical punished. Furthermore, the average age of children that were stolen from their homes were age 4 or 5 and usually spent a minimum of 8 continuous years away from their families and communities (Deloria, 1988; Herring, 1989, Sue & Sue, 1990). In 1978, the Indian Child Welfare Act of 1978 finally stopped the widespread use of boarding schools, but leaving about one half of the Native people alive today not being raised by parents or within their tribe because of these practices (Hagen, Skenandore, Scow, & Clay, 2012).

The Dawes Act of 1887 is another example of the policy of assimilation. The Dawes Act passed in 1887 granted Natives ownership of an allotment of land (Hirschfelder & Kreipe de Montano, 1993). The purpose of this policy was to force Natives to become accustom to the

social and economic structures of White America by disrupting the traditional Native practices of communal land sharing while freeing up surplus land that would be created in the process. This Act resulted in the sale of large regions of Native land that ultimately increased poverty levels. By 1934, Natives had lost about 90 million acres of land via government mishandling and mostly fraudulent sales transactions with Whites who wanted the land (Deloria, 1988).

There were certain legal prohibitions that hindered free exercises of Native religion practices in the 1890s that illustrate another form of cultural assimilation. Missionaries divided up the Native populations to decide which church denominations would control that geographical region. This collaboration between the government and churches either had Natives practice their religion covertly to avoid legal persecution or to lose their traditional/cultural practices by embracing Christianity (Hirschfelder & Kriepe de Montano, 1993).

In the 1950s, a federal program was implemented to Natives from their respective reservations to urban areas (Hirschfelder & Kriepe de Montano, 1993). Officially called the Voluntary Relocation Program, this program was created because jobs were scarce on the reservations. These Volunteers were given a one-way bus ticket, temporary low-cost housing, and new clothing (Deloria, 1988). However, many Natives were either unable to find employment or worked for low wages while being separated from extended family support, tribal communities, and their ceremonial life.

During the 1930s and early 1940s, many states implemented sterilization laws because the eugenics movement that advocated forced sterilization for individuals that were deemed “incompetent” (Lawrence, 2000). Due to the implementation and practice of sterilization,

Natives blamed the Indian Health Service (IHS) of sterilizing at least 25% of Native women who were between the ages of 15 and 44 in the 1970s (Lawrence, 2000). “The allegations included: failure to provide women with necessary information regarding sterilizations; use of coercion to get signatures on the consent forms; improper consent forms; and lack of an appropriate waiting period (at least seventy-two hours) between the signing of a consent form and the surgical procedure” (Lawrence, 2000, p. 400). It was not until 1924 that the U.S. government passed the Indian Citizenship Act that recognizes Natives as legal U.S. citizens and in 1978 that the U.S. government passed the American Indian Religious Freedom Act that granted Natives to freely exercise their traditional religious practices.

Cumulative intergenerational transmission of these historical traumas have led to adverse social climates, such as; low socioeconomic status, lack of education, and lack of access to quality healthcare, and poor health status. Narratives, observations, and preliminary evidence reports that historical trauma events are possibly related to poor mental health that tend to lead individuals to feel fear, guilt, shame, depression, anger, irritability, other post-traumatic stress symptoms, alcohol and substance abuse, and HIV risk (Duran & Walters, 2004; Dennis, 2009). Natives have lower health status when compared to other racial/ethnic populations in the U.S. (IHS, 2015). From 2007-2009, Natives had a life expectancy that is 4.2 years less than all U.S. racial/ethnic populations (IHS, 2015). Also, from 2007-2009, when compared to all U.S. racial/ethnic populations , Natives had higher rates of chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases (IHS, 2015). Although conditions and

policies have changed among Natives, historical dynamics influenced the varying levels of acculturation.

Acculturation

As a result of historical trauma among Natives, acculturation is an associated outcome that affects each tribal community on varied levels. Acculturation might be reflected upon the process of giving up one's traditional cultural values and behaviors while presuming the values and behaviors of the dominant social structure (Atkinson, Lowe, & Matthews, 1995). More specifically, acculturation has been defined as:

> "The cultural change that occurs when two or more cultures are in persistent contact. In this process, change may occur in each of the cultures in varying degrees…A particular kind of acculturation is assimilation, in which one culture changes significantly more than the other culture and, as a result, comes to resemble it. This process is often established deliberately through force to maintain control over conquered peoples, but it can occur voluntarily as well." (Garcia & Ahler, 1992, p.24)

Levels of acculturation has been linked with conflict resolution patterns, personality characteristics, and educational achievement (Atkinson et al., 1995; Suinn, Ahuna, & Khoo, 1992).

Due to different experiences with colonization among tribes and being that Natives are not a homogeneous population, they differ greatly in their level of acculturation. The following levels of acculturation have been identified for Natives:

> 1.*Traditional*: May of may not speak English, but generally speak and think in their native language; hold only traditional values and beliefs and practice only traditional tribal customs and methods of worship.
> 2. *Marginal:* May speak both the native language and English; may not, however, fully accept the cultural heritage and practices of their tribal group nor fully identify with mainstream cultural value and behaviors.
> 3. *Bicultural:* Generally accepted by dominant society and tribal society/nation; Simultaneously able to know, accept, and practice both mainstream values/behaviors and the traditional values and beliefs of their cultural heritage.

> 4. *Assimilated:* Accepted by dominant society; embrace only mainstream cultural values, behaviors, an expectations.
> 5. *Pantraditional:* Assimilated Natives who have made conscious choice to return to the "old ways." They are generally accepted by dominant society but seek to embrace previously lost traditional cultural values, beliefs, and practices of their Native tribal language. (LaFromboise, Trimble, & Mohatt, 1993, p.638).

These five levels of acculturation exhibit a continuum among which Natives may fall. For example, "marginal" Natives are the ones who are most likely to experience complications from cultural conflict (Garrett & Pichette, 2000). They may become conflicted between their birthright and the dominant society that results in losing touch with the former but not feeling comfortable in the latter, causing an identity crisis (Garrett & Pichette, 2000; Little Soldier, 1985). In comparison, the "bicultural" Natives are recognized as having less personal, social, and academic issues because of their capacity to effectively use greater range of social behavior and cultural communication that are appropriate in different dynamics and situations (LaFromboise & Rowe, 1983; Little Soldier, 1985).

The dichotomy between Native traditional values, beliefs, and modes of behavior and mainstream expectations can add stress to an already challenging identity formation processes (Garrett & Pichette, 2000). Research has acknowledged the importance of adolescence and early adulthood as a period of rapid changes occurring in physical, cognitive, and social growth (Byrde, 1972; Garrett & Pichette, 2000). Identity achievement indicates that an individual must measure their personal strengths and weaknesses to determine best practices of forming a sense of congruence with their self-concept (Muuss, 1988). Thus, answering questions as "Where did I come from? Who am I? What do I want to become?" The incapability to answer such questions results in identity confusion that is associated with alienation, isolation, and uncertainty (Garrett & Pichette, 2000).

Cultural values and the impacts of acculturation as an arbitrating factor in the process of identity development are vitally important for Natives (Deyhle, 1991; Garrett & Pichette, 2000). It has been proposed that in order for Natives to establish a healthy cultural identity they must find purpose through belonging, mastery, dependence, and generosity (Brendro, Brokenleg, & Van Bockern, 1990). The experiences of oppression and acculturation plays immense influence on self-identity, which also affects their social, emotional, intellectual, and spiritual well-being (Cummins, 1992). Therefore, acculturation is a huge factor when addressing HIV/AIDS prevention curriculum due to its impact on self-identity and self-esteem.

Summary

It is important that Native cultural differences and disparities be taken into consideration, especially regarding the diversity among tribes and historical trauma histories. Historical traumas can lead to factors that contribute to overall individual and population poor health status among Native peoples. It is important to recognize and address the long history of oppression because it grants the foundation of the extensive adverse impacts on Natives physically, psychologically, economically, and socially for generations. The history and impact of historical experiences must be acknowledged to effectively address health disparities among Natives.

Chapter 3: Literature Review

Teenagers and adolescents have been found to be at high risk for HIV/AIDS, sexually transmitted infections (STIs), and teen pregnancy based upon their sexual risk behavior(s) (Kotchick, Shaffer, & Forehand, 2001). While extensive evidence has been found in identifying prevention of risky sex behavior(s), limited HIV/AIDS, STIs, and teen pregnancy prevention interventions have been developed, adapted, and/or evaluated for Native teens. The need of cultural responsive interventions for Native teens should be consistent with tribal traditions, languages, and culture. This chapter will review literature associated with statistical data of sexually transmitted infections, HIV/AIDS, and teen pregnancy among all racial/ethnic populations. Second, factors contributing with sexual risk behavior(s) will be examined. Third, evidence-based interventions, including adapting, culturally relevant interventions, Native interventions, and the BART intervention will be discussed to identify the different constructs within varying interventions.

Sexually Transmitted Infections

Chlamydia. *C. trachomatis* infection is the most commonly reported STI in the U.S., and since 1994, has comprised the largest proportion of all STIs reported to the CDC (CDCe, 2013). Studies also demonstrate that the prevalence of chlamydial infections is particularly high among young women in the general U.S. population (Datta et al., 2012). Chlamydial infections in women are usually asymptomatic. However, untreated infections can result in pelvic inflammatory disease (PID), which may facilitate the transmission of HIV infection like other inflammatory STIs (CDCe, 2013; Fleming, 1999).

In 2013, a total of 1,401,906 chlamydial infections in the U.S. were reported to the Center for Disease Control (CDC) in the U.S. (CDCe, 2013). This case count averages to a rate of 446.6 cases per 100,000. Between 1993–2011, the rate of reported chlamydial infections increased from 178.0 to 453.4 cases per 100,000. Between 2011–2012, the national rate of reported cases remained constant at 453.4 to 453.3 cases per 100,000 (CDCe, 2013). During 2012–2013, the rate decreased 1.5% to 446.6 cases per 100,000. Counties in the U.S. with the highest rates of reported cases of chlamydia were located predominantly in the Southeast and West (CDCe, 2013). In 2013, 866 (27.6%) of 3,142 total counties in the U.S. had rates higher than 400.0 cases per 100,000 (CDCe, 2013).

The rates of reported cases of chlamydia were highest among teenagers and young adults aged 15–24 years. In 2013, the rate among 15–19 year olds was 1,852.1 cases per 100,000 and the rate among 20–24 year olds was 2,451.6 cases per 100,000 (CDCe, 2013).
In 2013, the case rates among females were 623.1 per 100,000 and 260.6-to-262.6 per 100,000 among males (CDCe, 2013). Among females, the highest age-specific rates of reported chlamydia in 2013 were among those aged 15–19 years (3,043.3 cases per 100,000 females) and 20–24 years (3,621.1 cases per 100,000 females) (CDCe, 2013). Within these age ranges, reported rates were highest among women aged 19 years (4,767.2 cases per 100,000 females) and aged 20 years (4,507.3 cases per 100,000 females) (CDCe, 2013). Age-specific rates among men, although significantly lower than the rates among women, were highest in those aged 20–24 years (1,325.6 cases per 100,000 males) (CDCe, 2013).

In 2013, the rates of reported chlamydia cases were highest among Black men and women (CDCe, 2013). The rate of chlamydia among Blacks (1,147.2 cases per 100,000) was 6.4

times the rate among Whites (180.3 cases per 100,000) (CDCe, 2013). The rate among Natives (697.9 cases per 100,000) was 3.9 times the rate among Whites. The rate among Hispanics (377.0 cases per 100,000) was 2.1 times the rate among Whites. The rate among Native Hawaiians/Other Pacific Islanders (633.3 cases per 100,000) was 3.5 times the rate among Whites. The rate among Asians (111.5 cases per 100,000) was lower than the rate among Whites (180.3 cases per 100,000) (CDCe, 2013). Chlamydia rates increased among all races and ethnicities between 2009-2012. During 2012–2013, rates decreased among Natives (5.0%), among Blacks (6.8%), and among Whites (0.8%), were stable among Hispanics, and increased 10.0% among Native Hawaiians/Other Pacific Islanders (CDCe, 2013).

Gonorrhea. *Neisseria gonorrhoeae* infection is the second most commonly reported sexually transmitted infection in the U.S. (CDCf, 2013). Like chlamydia, gonorrhea causes PID, which can facilitate the transmission of HIV infection (CDCf, 2013). In 2013, a total of 333,004 cases of gonorrhea were reported in the U.S., resulting at the rate of 106.1 cases per 100,000 (CDCf, 2013). The rate decreased 0.6% since 2012; however, the rate increased 8.2% overall during 2009–2013 (CDCf, 2013).

In addition, the overall gonorrhea rate decreased in the Northeast, Midwest, and South, but increased in the West (CDCf, 2013). During 2012–2013 in the West, the rate of gonorrhea cases increased among men (17.3%) and among women (11.8%) (CDCf, 2013). In comparison, the gonorrhea rate in the Midwest and the South increased among men (increased 0.6% in the Midwest, 2.4% in the South), but decreased among women (decreased 9.2% in the Midwest, 5.0% in the South) (CDCf, 2013). In the Northeast, the gonorrhea rate decreased among men (1.9%) and among women (13.2%) (CDCf, 2013). In 2013, the gonorrhea rate decreased among

women (102.4 cases per 100,000), but increased among men (109.5 cases per 100,000) (CDCf, 2013). As a result, 4.3% increase gonorrhea rate among men and 5.1% decrease gonorrhea rate among women occurred during 2012-2013, while during 2009-2013, the rate among men increased 20.3% and the rate among women decreased 2.0% (CDCf, 2013).

Statistics indicate the rate decreased among persons aged 15–19 years and 20–24 years, but increased among those aged 25 years or older (CDCf, 2013). Overall, persons aged 15–44 years accounted for 93.6% of reported gonorrhea cases in 2013. During 2012–2013, the gonorrhea rate decreased 11.6% among those aged 15–19 years, and decreased 1.9% among those aged 20–24 years (CDCf, 2013). However, the rates of reported gonorrhea cases were highest among adolescents and young adults. In 2013, the highest rates among women were observed among those aged 20–24 years (541.6 cases per 100,000) and 15–19 years (459.2 cases per 100,000). Among men, the rate was highest among those aged 20–24 years (459.4 cases per 100,000) (CDCf, 2013).

In 2013, the rate of reported gonorrhea cases remained highest among Blacks (426.6 cases per 100,000) (CDCf, 2013). The rate among Blacks was 12.4 times the rate among Whites (34.5 cases per 100,000 population). The gonorrhea rate among Natives (137.4 cases per 100,000) was 4.0 times that of Whites, the rate among Native Hawaiians/Other Pacific Islanders (94.0 cases per 100,000 population) was 2.7 times that of Whites, the rate among Hispanics (65.8 cases per 100,000 population) was 1.9 times that of Whites, and the rate among Asians (17.1 cases per 100,000 population) was 0.5 times that of Whites (CDCf, 2013). During 2009–2013, the gonorrhea rate increased among Natives (87.4%), Native Hawaiians/Other Pacific

Islanders (79.1%), Whites (54.4%), Hispanics (50.2%), and Asians (29.4%). During this same time period, the gonorrhea rate decreased 9.1% among Blacks (CDCf, 2013).

Syphillis. Syphilis is a genital ulcerative disease that can facilitate the transmission of HIV infection (CDCg, 2013). The syphilis rate increased annually during 2001-2009 prior to decreasing in 2010 and remaining constant during 2011, but the rate increased during 2012-2013 (CDCg, 2013). The syphilis cases in 2013 increased from 15,667 (5.0 cases per 100,000) in 2012 to 17,375 in 2013 (5.5 cases per 100,000), an increase of 10.9%. Since 2009 the syphilis rate in the West has increased annually, however, the South continues to have the largest proportion of syphilis cases. During 2012–2013, the rate of syphilis increased 24.2% in the Midwest (from 3.3 to 4.1 cases), 19.3% in the West (from 5.7 to 6.8 cases), 11.6% in the Northeast (from 4.3 to 4.8 cases), and 3.4% in the South (from 5.8 to 6.0 cases per 100,000) (CDCg, 2013).

In 2013, the rate of syphilis was highest among persons aged 20–24 years (16.1 cases per 100,000) and 25–29 years (15.6 cases per 100,000) (CDCg, 2013).The rate of syphilis increased 12.0% among men during 2012–2013 (from 9.2 to 10.3 cases per 100,000), while the rate among women remained unchanged (0.9 cases per 100,000 women) (CDCg, 2013). The rate of syphilis decreased among women aged 15–19 years and 45–54 years (from 2.3 to 1.9 and from 0.6 to 0.5 cases per 100,000, respectively) and the rate remained the same or increased for women of all other age groups. The rate of syphilis was highest among men 20–29 years, increasing 11.7% from 24.8 to 27.7 per 100,000 cases. Also, the rate increased among men 20–24 years by 14.8% (from 24.4 to 28.0 cases) and among men 25–29 years during 2012–2013. During 2008–2013, the rate has increased among men aged 20–24 years

by 60.1% (from 17.3 to 27.7 cases) and among men aged 25–29 years by 65.7% (from 16.9 to 28.0 cases) (CDCg, 2013).

In 2013, the rates of syphilis remained highest among Blacks (16.8 cases per 100,000 population). The rate among Blacks was 5.6 times the rate among Whites (3.0 cases per 100,000 population). The rate among Natives (4.6) was 1.5 times that of Whites, the rate among Native Hawaiians/Other Pacific Islanders (8.6) was 2.9 times that of Whites, the rate among Hispanics (6.3) was 2.1 times that of Whites, and the rate among Asians (2.5) was 0.8 times that of Whites.

During 2009–2013, the rate of syphilis increased 65.3% among Hispanics (from 3.9 to 6.5 cases per 100,000), 42.5% among non-Hispanic Whites (from 2.2 to 3.1 cases), 77.2% Natives (from 2.8 to 5.0 cases), 83.5% among Asians (from 1.4 to 2.7 cases), 102.3% among Native Hawaiians/Other Pacific Islanders (from 4.8 to 9.6 cases), and 113.8% among multi--race individuals (from 0.9 to 1.8 cases) (CDCg, 2013). The rate decreased 7.4% among non-Hispanic Blacks (from 18.7 to 17.3 cases per 100,000). Non-Hispanic Blacks, non-Hispanic Whites, and Hispanics comprised 95.0% of reported cases in 2009 and 92.3% of reported cases in 2013 (CDCg, 2013).

In 2013, the rates of syphilis among men were highest among non-Hispanic Black men (30.2 cases per 100,000 population), followed by Native Hawaiian/Other Pacific Islander (15.8 cases per 100,000), Hispanic (11.6 cases per 100,000), Native (7.1 cases per 100,000 population), non-Hispanic White (5.7 cases per 100,000), Asian (4.9 cases per 100,000) and multi-race men (3.4 cases per 100,000) (CDCg, 2013). Rates of syphilis among women were highest among non-Hispanic Black women (4.5 cases per 100,000), Native (2.1 cases per

100,000), Native Hawaiian/Other Pacific Islander (1.2 cases per 100,000), Hispanic (0.8 cases per 100,000), non-Hispanic White (0.3 cases per 100,000), multi-race (0.3 cases per 100,000 population) and Asian (0.2 cases per 100,000) women (CDCg, 2013).

HIV/AIDS. Acquisition of chlamydia, gonorrhea, and syphilis has been shown to facilitate HIV transmission at a 2 to 5 times more likely rate of infection (Vernon, 2001). An estimated 1.1 million people live with HIV in the U.S., with an estimated 20% of those are unaware of their HIV infection (CDCa, 2013). Approximately 50,000 Americans become infected with HIV each year (CDCa, 2013). In 2010, HIV was identified as the eleventh leading cause of death among Americans aged 15-24 years, and the seventh leading cause of death among the age group 25-44 years (Murphy, Zu, & Kochanek, 2012). Natives rank fifth in HIV/AIDS diagnosis after African Americans, Hispanics, Native Hawaiians/Pacific Islanders, and people reporting multiple races (CDCd, 2013). However, some tribes may have even higher HIV/AIDS rates that exceed the African American and Latino communities (Vernon & Jumper-Thurman, 2002).

Statistics show that Blacks have the highest rate of HIV/AIDS representing approximately 14% of the U.S. population, yet account for almost half (44%) of all new HIV infections in 2010 (20,900) (CDCh, 2013). Black males represented almost one-third (31 %) of all new HIV infections in the U.S. in 2010 (14,700) and accounted for 70% of new HIV infections among Blacks. In addition, HIV incidence among Blacks was almost eight times higher than that of Whites (68.9 v. 8.7 per 100,000) (CDCh, 2013). By age, the largest percentage (38%) of new HIV infections among Black males in 2010 occurred in those aged 13–24 years, much higher than the percentage of new infections among Hispanic (25%) and White (16%) males that occurred in the same age group (CDCh, 2013). Hispanics represent

approximately 16% of the U.S. population, yet account for 21% of all new HIV infections in 2010 (9,800) (CDCh, 2013).

In 2010, Natives accounted for less than 1% (210) of the estimated 47,500 new HIV infections in the U.S. (CDCd, 2013). Men accounted for 76% (161) and women accounted for 24% (51) of the HIV diagnosis among Natives in 2011 (CDCd, 2013). In 2011, 75% (120) of the estimated 161 HIV diagnoses among Native men were attributed to MSM sexual contact and 63% (32) of the estimated 51 HIV diagnoses among Native women were attributed to heterosexual contact (CDCd, 2013). In 2011, an estimated 146 Natives were diagnosed with AIDS, which has been a relatively stable number since 2008 (CDCd, 2013). By the end of 2010, approximately 2,000 Natives with an AIDS diagnosis died in the U.S. and in 2010 HIV was the ninth leading cause of death among Native men and women aged 25-54 years (CDCd, 2013).

These levels of rising rates are concerning because Natives experience a faster time course from initial diagnosis of HIV infection to AIDS than any other racial group in the US (Kaufman et al, 2007; CDCd, 2013). In 2001, 48% of Natives diagnosed with HIV were diagnosed with AIDS within 12 months, compared with 40% for the general population (Kaufman et al., 2007). In addition, they experience one of the lowest survival rates after an AIDS diagnosis is determined (CDCd, 2013).

Teen Pregnancy

The U.S. has the highest teen pregnancy and birth rate compared to any other industrialized nation (CDCc, 2013). Nearly 750,000 teens become pregnant in the U.S. each year and 59% of these teen pregnancies end in birth while the remaining end in spontaneous or planned abortions (Guttmacher Institute, 2012). During the period 1991-2005, a decrease in the

rate of births among teens ages 15-19 occurred nationwide (Solomon-Fears, 2011). However, from 2005 to 2007 the teen birth rates increased for White, Black, and Native females aged 15-19 from (Solomon-Fears, 2011). More specifically, the teen birth rate among Native teens increased 12% from 2005 to 2007, which was more than twice the increase of any other racial/ethnic group (thenationalcampaign.org, 2009).

In 2012, Native youth have a higher birth rate than the national average (Hagen et al., 2012). In 2012, Hispanics had 43.9 births per 1,000 while Blacks had 43.9, Natives had 34.9, Whites had 20.5, and Asian/Pacific Islanders had 9.7 (www.thenationalcampaign.org, 2013). Thus, Natives have the third highest teen birth rate in the U.S. among the five major racial/ethnic groups. Further, 21% of Native teen females will become a mother before the age of 20 when respectively compared to 16% of females nationwide (thenationalcampaign.org, 2009). Native teen birth rates significantly differ from state to state. For example in 2006, birth rates for Native teens aged 15-19 ranged from 16 per 1,000 in New Jersey to 122 per 1,000 in Nebraska (thenationalcampaign.org, 2009). In one tribal community, 70% of the females were pregnant or had been pregnant before they graduated from high school (Wise Woman Gathering Place, 2002). In 2006, 90% of Native teens aged 15-19 who gave birth were unmarried teen moms (thenationalcampaign.org, 2009).

Risk Factors Contributing to Risky Sex Behavior(s)

The HIV/AIDS epidemic among Natives can be attributed to multiple factors that include economic and social factors, including high risk-behaviors, such as alcohol and substance abuse and risky sexual behaviors. It is has been stated that the root of these factors contributing to high HIV, STIs, and teen pregnancy rates largely stem from historical trauma (Saylors &

Daliparthy, 2005). It has been acknowledged that when an individual's racial/ethnic population has experienced historical trauma, and combined with individual trauma, such as being exposed to violence, it may lead to mental health effects, such as substance abuse issues (Saylors & Daliparthy, 2005). The National Institute on Drug Abuse reported an association of people in treatment for drug abuse with physical, sexual, or emotional abuse during childhood (Swan, 1998).

Research on the relationship with trauma, substance abuse, and mental health issues has a strong correlation with experiencing violence (Saylors & Daliparthy, 2005).

The experiences of violence and/or trauma may ultimately lead to low self-esteem, depression, and post-traumatic stress disorder, which may influence a person less likely to refuse unwanted sex, having more lifetime partners, being younger at first intercourse, and frequently using alcohol and substance abuse (Saylors & Daliparthy, 2005). While these experiences of trauma and/or violence may vary in tribal communities, the likelihood that many of the experiences exist in most tribes (Vernon & Jumper-Thurman, 2002). The identification of these experiences is vital to developing or adapting prevention and intervention efforts.

Cultural and social climate. Historical trauma, oppression, and racism have strongly influenced Native life (Nakai et al., 2004). For example, displacement, forced assimilation, genocide, sterilization, language and cultural suppression, and forced attendance of boarding schools have created continuous adverse effects within tribal communities. These experiences have contributed to feelings of internalized shame, depression, and hopelessness among Native persons (Nakai et al, 2004). Many health issues can be directly related to historical trauma in

direct and indirect forms, such as environmental, institutional, and interpersonal discrimination (Nakai et al., 2004).

Acculturation that resulted from historical trauma can accumulate adverse impacts overtime. Alcohol abuse within tribal communities has been explained as “a self-destructive act, often associated with depression as an outcome of internalized aggression, internalized oppression, and unresolved grief and trauma” (Brave Heart & DeBruyn, 1998, p. 69-70). A way of coping with cultural identity loss, especially for younger Native men and women, is alcohol and substance abuse.

Poverty. Poverty may contribute to the prevalence of HIV/AIDS (Farmer, Connors, & Simmons, 1996). HIV prevalence is disproportionately high in low SES communities, thus making Native communities more susceptible to be at risk for HIV (Farmer et al., 1996; Vernon & Jumper-Thurman, 2002). When poverty is rampant, limited access to HIV prevention education as well as lack of access to quality health care, housing, and proper medical treatment directly and indirectly increase the risk for HIV infection and affect the health of people living with HIV infection (Farmer et al., 1996; CDC, 2013). Natives have the highest poverty rates in the nation, have completed fewer years of education, are younger, less likely to be employed, and have lower rates of health insurance coverage (U.S. Census Bureau, 2013; CDCd, 2013). In addition, low SES has adverse social behavioral impacts by enhancing intimate partner violence that is related to HIV high-risk behaviors (Vernon & Jumper-Thurman, 2002). For instance, poverty keeps individuals at home, sometimes in violent and abusive conditions that are related to other high-risk sex behaviors (Roth & Fuller, 1998).

Alcohol and substance abuse. The leading risk factors for contracting HIV/AIDS, STIs, or becoming a teen parent among Native youth are sexual intercourse, alcohol use, and substance abuse (Vernon & Jumper-Thurman, 2002). Research indicates that by the age of 11 years old, nearly one third of all Natives have tried alcohol and that 78% of Natives have tried alcohol compared to 53% of the general population (Yabiku et al., 2007). One study found that 77% of Native participants reported they had issues with alcohol at some point in their lives and Native youth reported drug use and binge drinking (Baldwin & Rolf, 1996). Also, in the 2001, the Bureau of Indian Affairs (BIA) study found that 39% of high school students in BIA-funded high schools reported using alcohol or drugs before their last sexual experience compared to 26% of the high school students overall (www.thenationalcampaign.org, 2009).

Depression and substance abuse are common among Natives (Saylors & Daliparthy, 2005). Depression is the leading psychiatric diagnosis for Natives and is often associated with alcohol and substance abuse (Saylors & Daliparthy, 2005). The increased use of alcohol and substance abuse are a critical risk determinant to address because under these influences, condom use are often forgotten or ignored (Vernon & Jumper-Thurman, 2002).

Violence and trauma among Native youth. Natives are more likely to experience a range of violent and traumatic events that involve serious injury to self or witness threat or injury to others (Manson, Beals, Klein, & Croy, 2005). According to the National Crime Victimization Survey, between 1993 and 1998, Natives had the highest per-capita rate (119 victimizations per 1,000 among Natives age 12 or older) of violent victimization when compared to other races (Rennison, 2001). The rate of violent victimization between 1993-1998 determined that Natives experienced violent victimization 2 times that was experienced by Blacks, 2.5 times by Whites,

and 4.5 times than Asians (Rennison, 2001). The youth between the ages of 12-19 were more likely to be victims of both serious violent crimes and simple assault when compared to their non-Native peers (Rennison, 2001).

Native youth witness high rates of trauma among their friends and family, such as repeated loss due to traumatic deaths caused by injuries, accidents, suicides, homicides, and firearms. The witness of high rates of trauma among Native youth exceeds all U.S. races by at least two times (Sarche & Spicer, 2008). For example, one study reported that 50% of Native youth had experienced one traumatic event while 37% had experienced more than one (Vernon, 2001).

Suicide rates among Native youth are the highest out of any racial/ethnic group in the U.S.(CDC, 2015a). The 2005-2009 suicide rates among Natives aged 15-29 were substantially higher than non-Natives (CDC, 2015a). In 2013, suicide was the second leading cause of death among Natives aged 10-24 years (CDC, 2015b). In 2013, the suicide rate among Native adolescents and young adults between the ages of 15 to 34 (19.5 per 100,000) was 1.5 times higher than the national average for that age group (12.9 per 100,000) (CDC, 2015b). Native youth who are diagnosed with HIV are at high risk for suicide (Vernon, 2001).

Intimate partner violence exposure and child maltreatment are other experiences of violence and trauma that Native youth experience. Maltreatment types include physical abuse, sexual abuse, threatened abuse, parent use of drugs/alcohol, or safe relinquishment of a newborn (US HHS, 2013). Data is limited among Native youth and exposure to intimate partner violence in their homes, however, research suggests that exposure is high relative to their non-Native peers (Libby et al., 2004). Data indicate that 21.7 per 1,000 of Native youth were victims

of child maltreatment in 2001, compared with 20.1 per 1,000 among Black youth and 10.7 per 1000 among White youth (US HHS, 2002). In 2012, Native youth from Alaska were had the highest rates of maltreatment (44.7 per 1,000) of any racial/ethnic group (US HHS, 2013).

In 2012, of the youth who experienced sexual abuse, 26.3% were in the age group of 12-15 years and one-third (33.8%) were younger than 9 years (US HHS, 2013). A study of found that among Native youth, sexual abuse increases with age (Vernon, 2001). Childhood sexual abuse has been found to be linked to alcohol abuse (Saylors & Daliparthy, 2005). Childhood sexual abuse may be associated with a delayed onset of post-traumatic stress disorder in adulthood, which is associated with alcohol and substance abuse as the adult tries to suppress through self-medication (Saylors & Daliparthy, 2005). These experiences or exposure to traumatic events causes the youth to have higher rates of mental disorders, substance abuse, suicidal behavior, and behavioral/relationship problems that put them at greater risk for contracting HIV/AIDS, STIs, and teen pregnancy.

Assault, rape, and intimate partner violence. Native women experience the highest rates of assault, rape, and intimate partner violence (IPV) when compared to any racial/ethnic group (Saylors & Daliparthy, 2005). In 2007, a study found that Natives who had been a victim of rape or sexual assault had experience physical abuse as well (Saylors & Daliparthy, 2005). In 2008, a CDC study found that 39% of Native women identified as victims of IPV in their lifetime, a rate higher than any other race/ethnic group (MMWR, 2008).

In 2011, 27.5% of Native women were raped during their lifetime when compared to 21.2% of Black women, 20.5% of White women, and 13.6% of Hispanic women (Breiding et al., 2014). In 2011, an estimated 55% of Native women, 46.9% of White women, 38.2% of Black

women experienced sexual violence other than rape in their lifetimes (Breiding et al., 2014). In 2011, 26.6% of Hispanic men, 24.5% of Native men, 24.4% of Black men, and 22.2% of White men experienced sexual violence other than rape in their lifetimes (Breiding et al., 2014).

In 2011, 24.5% of Native women, 15.9% of White women, 14.2% of Hispanic, and 13.9% of Black women experienced stalking in their lifetimes. In 2011, an estimated 51.7% of Native women, 41.2% of Black women, 30.5 % of White women, 29.7% of Hispanic women, and 15.3% of Asian/Pacific Islander women experienced physical violence by an intimate partner during their lifetime (Breiding et al., 2014).

In 1998, 341 women were surveyed at an Indian Health Service hospital on the Navajo Nation about their experience with physical, sexual, and psychological violence. Of the surveyed women, 16.4% reported experiencing or being a victim of violence in the past 12 months, while 52.5% reported any type of violence in their lifetime (Fairchild, Fairchild, & Stoner, 1998). Of the 52.5%, 40.5% reported verbal, 41.9% reported physical, and 12.1% reported sexual abuse (Fairchild et al., 1998). In 1998, a study on intimate partner violence on the San Carlos Apache Reservation reported that 75% of female and 58% of male reported being victims of IPV at some point in their most recent relationship (Hamby & Skupien, 1998). Lastly, Native women are almost three times more likely to be killed by an intimate partner than Hispanics or Whites and have twice the prevalence rate of rape (Oetzel & Durran, 2004).

The social consequences of IPV are associated with lower physical health, lower mental health, and lower employment status (Brokaw et al, 2002; Hein & Bukszpan, 1999; Browne, Salomon, & Bassuk, 1999). A prominent consideration is a women’s exposure to emotional, physical, or sexual violence that makes her more susceptible to high-risk sex behavior or

substance abuse. These experiences with IPV have been associated with risky sexual behaviors that increase vulnerability to HIV. Condom use is a complex issue within sexual relationships, especially when it is linked to poverty, low self-esteem, desire to preserve a relationship, preventing abuse, rejection, and abandonment (Roth & Fuller, 1998). In general, women abused within the past three months were more likely to report fear of partner infidelity if they attempted condom negotiation, higher partner control of sex, and higher partner control of condom use than non-abused women (Raj, Silverman, & Amaro, 2004).

At-Risk Sexual Behavior(s) Among Natives

A study found risky sexual behaviors for Natives included sex at a young age, multiple sexual partners, partners who reported having very high numbers of other sexual partners (average of 29 partners), no condom use, and drug abuse (Bertolli et al., 2004).

Native teens and young adults risky sexual behavior(s). In 1994, 1997, and 2001 the BIA used the questionnaire from the Youth Risk Behavior Survey (YRBSS), which includes questions about sexual activity to conduct a national representative survey among high school students attending BIA funded high schools. In 2001, Native high school students attending BIA-funded schools were more likely to have had sex, compared to national rates of sexual experience from youth in the general population (www.thenationalcampaign.org, 2009).

This study found that 59% of BIA high school students reported having had sex compared to 46% of the national population. More specifically, 52% percent of Native teen girls in BIA high schools reporting having had sex when compared to 43% of all teen girls in high school; 66% of Native teen boys have had sex from BIA high schools when compared to 49% of all teen boys in high schools (www.thenationalcampaign.org, 2009). Condom use at last sexual

encounter was lower among teen girls from BIA schools (45%) when compared to all teen girls in high school (51%) while condom use at last sexual encounter among teen boys from BIA schools and boys in high school was the same (65% vs. 65%). Eight percent of students from BIA schools used birth control pills before the last time they had sex compared to 18% of all high school students (www.thenationalcampaign.org, 2009). Also, 24% of students that are enrolled in BIA schools reported having 4 or more partners compared to 14% of the national population. Eleven percent of students from BIA schools reported initiating in sex before the age of 13 compared with 7% of the national population (Everett-Jones, Anderson, Lowry, Conner, 2001). Further, a study found 10% of reservation-based Native between the ages of 15 and 24 years reported that their first intercourse was before the age of 14 years old when compared to 13.6% of non-reservation based females (Vernon, 2001).

In 2009, a study conducted by Child Trends about sex and contraceptive use between the ages of 18-26 found that Natives were more likely to report having had sex before age 16 when compared to their peers (44% vs. 34%). Within this study, Natives were less likely to use contraceptives and/or condoms than their peers. In 2009, Natives between the ages of 15-19 reported parallel levels of knowledge about reproductive health and contraception compared to their peers. Within this study Natives between the ages of 18-26 were less likely to use contraception during last sexual encounter when compared to their peers (59% vs. 69%) (Child Trends, 2009). For example, 63% of Natives between the ages of 18-26 used contraception during their first sexual experience when compared to 71% peers (Child Trends, 2009). Fifty-nine percent of Natives used a contraceptive during their last experiences when compared to 69% of their peers (Child Trends, 2009). In a study of 14,000 Native youth, 24% of

males and 44% of females did not use condoms (Aguilera & Plasencia, 2005). These high-risk sexual behaviors put Native youth at high-risk for contracting HIV/AIDS, STIs, and teen pregnancy.

A study of 333 Native young adults, 20-25 years of age, living on or within 20 miles of the Northern Plains reservation, Mitchell et al. (2002) found that most thought they could adequately protect themselves from HIV, but answered only half of the questions regarding HIV correctly (Mitchell et al., 2002). Participants as a group scored 67% on the sexual knowledge scale (Mitchell et al., 2002). In addition, exposures to education about sexual topics were minimal in the family and community environment, which makes it critical to construct and disseminate knowledge about HIV/AIDs, STIs, and teen pregnancy prevention efforts to Native youth. Mitchell et al. (2002) determined that a "broad base of culturally appropriate instruction, repeated over time, might be one way to improve knowledge to encourage healthy attitudes toward HIV and STDs" (p. 414).

High-risk behaviors and contracting HIV. High-risk behaviors among Natives that expose them to contracting HIV include both unprotected sex and injection drug use. Native women's main risk behaviors are injection drug use and sexual contact with HIV- positive and high-risk male partners. Native male risk behaviors include male-to-male sex, injection drug use, and a combination of injection drug use and heterosexual contact (CDC, 2005).

TABLE 3.1. American Indian/Alaska Natives with HIV/AIDS by Exposure Category (2001-2004)

EXPOSURE CATEGORY	FEMALE (N=223)	MALE (N=543)
Male-to-Male Sex (MSM)	NA	331 (61%)
Injection Drug Use (IDU)	65 (29%)	76 (14%)
MSM and IDU	NA	60% (11%)
Heterosexual Contact	154 (69%)	65 (12%)
Other	4 (2%)	5 (1%)

Adapted from: Center for Disease Control and Prevention, (2005). Trends in HIV/AIDS diagnosis-33 states, 2001-2004. MMWR 2005, 54: 1149-1153

HIV and STI Under-Reporting Among Natives

There are considerable data limitations regarding HIV/AIDS and STIs among Natives. HIV/AIDS and STIs statistics presented here could be higher than stated due to racial misclassification, underreporting, poor reporting from tribal health facilities to state agencies, coding errors, regional limitations on data collection, and the omission of data on Natives in urban areas (Vernon & Jumper-Thurman, 2002). In addition, states with large Native populations have not regularly conducted or reported HIV surveillance data to the CDC (Ravello, Tulloch, & Taylor, 2012). This may contribute to statistical error, and data are simply not available to describe the extent of HIV/AIDS and STIs within specific tribal communities and/or Native urban communities (Vernon & Jumper-Thurman, 2002). In many situations Natives are often misidentified as Asians, Caucasians, and Hispanics due to physical characteristics and Spanish surnames. For example, in Los Angeles, racial misclassification occurred among 56% of Natives with AIDS (Hu, Yu, and Frye, 2003). In comparison, in Alaska racial misclassification occurred only among 3% of Natives with HIV/AIDS (State of Alaska Health and Social Services, Section of Epidemiology, 2003). Misclassification plays a role in HIV/AIDS and STIs surveillance, especially among Natives living in urban areas, which is about 60% of the population (Kauffman et al., 2007).

Low HIV/AIDS diagnosis rates may reflect limited access to HIV testing sites. Participant is affected by confidentiality issues in small communities (Bertolli et al, 2004). Between 1997-2000 an estimated 58% of Natives in the Southwest reported they have never been tested for HIV when compared to Natives in the Northern Plains (46%), Alaska (48%), and the East (50%) (Denny, Holtzman, & Cobb, 2003). Inaccurate data and limited participation in HIV testing may create a misperception that the HIV/AIDS and STIs epidemic is not as prevalent in tribal communities, which could lead Native people to erroneously assume that they are at low-risk for HIV.

Evidence-based HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions

Evidence-based prevention programs meet a set of standard criteria that include: evaluation that demonstrate that the program produces the expected positive results, the results credited to the program itself rather than to other factors or events, evaluation peer-reviewed by experts in the field, and validation by a federal agency or respected research organization and inclusion in their list of effective programs (www.projectenhance.org, n.d.). An evidence-based program is an intervention with distinct goals, proven outcome results for a specific target population, a researched foundation, a definitive structure and timeframe, mandatory staffing skills, precise facility and equipment requirements, and program evaluation instruments to measure the program quality and health outcomes (www.projectenhance.org, n.d.).

Evidence-based interventions proved to be effective in targeted communities, such as low-and middle-income communities, rural and urban areas, among different racial/ethnic populations, and in school, clinics, and community settings. Evidence-based interventions were

and are evaluated multiple times and have exhibited continued effectiveness when implemented with fidelity by others in diverse communities (Hubbard, Giese, & Rainey, 1998; Jemmott, 2005; Jemmott, Jemmott, & Fong, 1998; Jemmott, Jemmott, Braverman, & Fong, 2005; Kirby, Barth, Leland, & Fetro, 1991; St. Lawrence, Crosby, Brasfield, O'Bannon, 2002; St. Lawrence et al., 1995; Zimmerman et al., 2008).

The U.S. Department of Health and Human Services (HHS), Office of Adolescent Health developed a list of program models that meet the criteria for HHS List of Evidence-Based Teen Pregnancy Prevention Programs. Table 3.2 (Appendix A) lists the following 35 evidence-based intervention programs in alphabetical order that met the effectiveness criteria in the HHS pregnancy prevention research review of more than 1,000 research studies (OAH, 2013b). These programs were found to be effective at preventing teen pregnancies or births and reducing STIs by reducing rates of associated sexual risk behaviors, such as increasing contraceptive use (OAH, 2013b).

The programs listed above have made a significant impact on reducing risky sexual behavior. For example, the *Becoming A Responsible Teen* (BART) intervention increased abstinence, reduced the number of sexual partners, increased condom use, and reduced unprotected sex (St. Lawrence et al., 1995). BART reduced the percent of sexually inexperienced youth who engaged in sexual activity during a 12-month period from 31% to 12%, a 63% reduction (St. Lawrence et al., 1995). Likewise, the *Safer Choices* intervention delayed the initiation of sex among Hispanic youth and increased both condom and contraceptive use among all boys and girls of all racial/ethnic backgrounds (Kirby et al., 2004). Also, *Safer Choices* reduced the mean number of unprotected sexual acts from 3.8 times to 2.4

times in a 3-month period, which is a 37% reduction (Coyle et al., 2001). *Making Proud Choices! A Safer Sex Approach to STD, Teen Pregnancy, and HIV/AIDS Prevention* reduced the percentage of youth who reported unprotected sex during the previous month from 10.8% to 5.4%, a 50% reduction (Jemmott et al., 1998). Also, the mean number of unprotected sexual acts during the previous month reduced from 0.5 to 0.2, a 67% reduction (Jemmott et al., 1998). Further, *Sistas, Informing, Healing, Living, Empowering* increased the consistent condom use by about 30% (DiClemente et al., 2004).

Characteristics of an effective HIV/AIDS, STIs, and teen pregnancy prevention intervention. Kirby and Laris (2009) conducted an in-depth evaluation study examining effective characteristics of HIV/AIDS, STIs, and teen pregnancy prevention interventions. This study found that majority of the effective programs incorporated most of the 17 characteristics and were more likely to elicit positive behavior change versus programs that did not incorporate these characteristics (Kirby & Laris, 2009). Kirby and Labis (2009) found that interventions that gave clear messages about positive behavior change and created logic models were found to be effective. The logic models consisted of specified health goals, behaviors they wanted to achieve, risk and protective factors that have positive impact on behavior change, and activities that would decrease risky sex behaviors (Kirby & Laris, 2009). Effective curriculum also incorporated multiple activities designed to improve each of the important risk or protective factors, such as role-playing exercises. In table 3.3, 17 characteristics that demonstrate curriculum effectiveness are described within program development, content, and implementation.

Table 3.3. The 17 Characteristics of Effective Curriculum-Based Sex and STI/HIV Education Programs

PROCESS OF DEVELOPING CURRICULUM	CONTENTS OF THE CURRICULUM ITSELF	PROCESS OF IMPLEMENTING THE CURRICULUM
1. Involved multiple people with different backgrounds in theory, research, and sex and STD/HIV education to develop the curriculum	**CURRICULUM OBJECTIVES AND GOALS** 6. Focused on clear health goals-the prevention of STD/HIV and/or pregnancy	14. Secured at least minimal support from appropriate authorities such as departments of health or education, school districts, or community organizations
2. Assessed relevant needs and assets of target group	7. Focused narrowly on specific behaviors leading to these health goals (e.g., abstaining from sex or using condoms or other contraceptives), gave clear messages about these behaviors, and addressed situations that might lead to them and how to avoid them	15. Selected educators with desired characteristics (whenever possible), trained them, and provided monitoring, supervision, and support
3. Used a logic model approach to develop the curriculum that specified the health goals, the behaviors affecting those health goals, the risk and protective factors affecting those behaviors, and the activities addressing those risk and protective factors	8. Addressed multiple sexual psychosocial risk and protective factors affecting sexual behavior (e.g., knowledge, perceived risks, values, attitudes, perceived norms, and self-efficacy)	16. If needed, implemented activities to recruit and retain youth and overcome barriers to their involvement (e.g., publicized the program, offered food, or obtained consent)
4. Designed activities consistent with community values and available resources (e.g., staff time, staff skills, facility space, supplies)	**ACTIVITIES AND TEACHING METHODOLOGIES** 9. Created a safe social environment for youth to participate	17. Implemented virtually all activities with reasonable fidelity
5. Pilot tested the program	10. Included multiple activities to change each of the targeted risk and protective factors	
	11. Employed instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information, and that were designed to change each group of risk and protective factors	
	12. Employed activities, instructional methods, and behavioral messages that were appropriate to the youths' culture, developmental age, and sexual experience	
	13. Covered topics in a logical sequence	

Kirby D & Laris BA. (2009). Effective curriculum-based sex and STD/HIV education programs for *Adolescents Child Development Perspectives, 3*, 21-29.

Adapting HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions

Since the HIV/AIDS epidemic began, behavioral scientists have produced research identifying HIV risk and protective factors across diverse communities and thus developed and tested primary prevention interventions designed to reduce risky sex behaviors. Translating an intervention from a highly controlled setting to a real-world setting presents some challenges. Communities of color consider interventions culturally inappropriate for their target population and communities (Miller, 2003). Empirical literature acknowledges that when adaptations are made to an intervention it may make the program as effective or even more effective to fit the target population, especially if the target population were different from those in the research trial (Solomon, Card, & Malow, 2006).

There is a consensus among the scientific community that behavioral interventions that are based on a theoretical framework and target a specific group can reduce risky sexual behaviors (Villarruel, Jemmott, & Jemmott, 2005). The process of identifying the influences of a specific cultural group and contextual variables, building on cultural protective factors, and integrating community perspectives are important for interventions that target minority communities. Solomon et al. (2006) states, "In particular, a large body of research in HIV prevention and related fields suggests that when an intervention is tailored to the linguistic needs, developmental level, and cultural background of its clients (including culturally specific risk issues, protective factors, and service delivery preferences), it is possible to enhance community support, client participation, and program satisfaction, outcomes, and institutionalization" (p.169). Academic researchers, service providers, and community partners have collaborated to develop research principles and procedures for adapting an HIV

prevention intervention, which are summarized below, and will be described in further detail (Solomon et al., 2006):

1. Know the target population and community context
2. Select the program that best matches the population and context
3. Retain fidelity to the "core program"
4. Systematically reduce mismatches between the program and the new context
5. Document the adaptation process and evaluate the process and outcomes of the adapted intervention as implemented

First, know the target population and community context, implies that a "Successful cultural adaptation of an empirically validated program requires an understanding of the HIV-related needs and assets of the target population and local community, including the cognitive, attitudinal, emotional, behavioral, and ecological factors that increase or decrease HIV risk" (Solomon et al., 2006, p. 170-171). This understanding promotes the framework of relevant, acceptable, and realistic program goals with regard to HIV risk and protective behaviors using HIV-related knowledge as mediators to reduce risky sexual behaviors or increase protective ones (Solomon et al., 2006). Also, a key component of adapting interventions is acknowledging how multiple cultural identities within the target population may be associated to sexual risk behaviors and prevention efforts.

Second, select the program that best matches the population and context implies to choose an intervention that best fits the new target population to minimize cost and associated adaptation challenges (Solomon et al., 2006). Third, retain fidelity to the original intervention's objectives helps improve success rates because the "empirical literature generally supports that the successful replication of an empirically validated intervention in a new site importantly depends on retaining fidelity to the 'core program' while permitting the flexibility to adapt noncore elements to the new population and context" (Solomon et al., 2006, p. 174). Fourth,

systematically reduce mismatches between the original program and the new context suggests adapting the intervention by reducing questionable adaptations while retaining fidelity to the core program (Solomon et al., 2006).

Last, document the adaptation process and evaluate the process and outcomes of an adapted intervention as implemented, suggest it is important to conduct process and outcome evaluations of the implemented intervention to determine the effectiveness of the adapted intervention in a new context. Solomon et al. (2006), stated, "Process evaluation, which includes documentation of what activities or services were implemented, how they were implemented, and with whom, compared to what was planned, can help shed light on the following: (a) what specific combinations of strategic activities and services did or did not lead to successful outcomes; (b) whether any negative outcome evaluation findings were the result of poor program theory, poor program implementation, or poor program attendance; and (c) how the intervention might be improved" (p.178).

In addition, according to research, a successful prevention program must: 1) be relevant to the developmental issues of its target groups, 2) address the values, beliefs, and attitudes of the target group within the contexts of their socio-cultural systems, and 3) promote relevant changes in health behavior of persons in their normal social action contexts (Oetting, 1992; Tarter, 1992, Baldwin & Rolf, 1996). Therefore, through research, HIV prevention researchers have successfully developed and tested numerous behavioral interventions in controlled efficacy trials, however, the need to adapt these interventions for culturally diverse populations is needed.

Culturally Responsive Interventions

The discipline of behavioral HIV prevention research has progressed significantly. Since the HIV/AIDS epidemic began, behavioral scientists have conducted an abundance of research identifying HIV risks and protective factors across diverse populations. Based on the accumulated information, researchers and their stakeholder partners have developed and tested many primary prevention interventions designed to reduce risky sex behaviors. Typically, these programs attempt to delay the initiation of sex, increase abstinence, reduce the number of sexual partners, or increase condom use. Among those, a limited number of these interventions have been shown to produce behavioral efficacy among groups, such as men who have sex with men, injection-drug users, young people, heterosexual men, heterosexual women, and certain racial/ethnic populations (Solomon et al., 2006).

It is crucial for culturally appropriate prevention interventions to be developed and/or adapted to promote responsible behaviors to reduce HIV/AIDS, STIs, and teen pregnancy. As an example, researchers have recognized that successful substance abuse programs address and incorporate aspects of the participants' culture and learning style(s) in their content and format (Hecht et al., 2003). Evidence-based behavioral intervention programs, such as BART, which has been developed for African American youth incorporates cultural and ethnic pride, have been shown to effectively reduce risks for contracting HIV or decreasing the spread of HIV infection among the target population. In addition, BART utilizes instructors from their respective communities and research has shown that minority youth positively respond to programs that have instructors from their own racial/ethnic group (Hecht et al., 2003).

Interventions that have been theoretically guided and culturally tailored to promote cognitive, social, and technical skills are associated with reducing risky sex behaviors (Solomon et al, 2006; Kelly & Kalichman, 2002). Specifically, cognitive and attitudinal factors that include inaccurate beliefs about risk, negative attitudes towards condoms, poor perceived self-efficacy for positive behavior change, poor risk reduction skills that facilitate correct condom use, sexual negotiation or assertiveness, relationship factors that produce safe sex patterns, and situational factors that address substance-use problems (Kelly & Kalichman, 202). Therefore, it is vital that programs are guided and tailored towards specific racial/ethnic populations, especially for Native youth.

Native Culturally Responsive Prevention Interventions

National leaders in Native education have recommended for increased content of ancestral traditions and knowledge within the learning process of Native youth (Demmert, McCArdle, Mele-McCarthy, & Leos, 2006). The need for more HIV/AIDS, STIs, and teen pregnancy prevention interventions culturally tailored for Native youth is essential due to the finite interventions designed for this target population. HIV/AIDS, STIs, and teen pregnancy prevention interventions should be created to include knowledge about family structures, values, dynamics, and socialization processes because current efforts are not effective in raising awareness about infection, transmission, and prevention due to contrary cultural norms (Sileo & Gooden, 2004). Culturally responsive HIV/AIDS, STIs, and teen pregnancy interventions designed for Natives should build upon diverse values, beliefs, traditions, and linguistic variations (Sileo & Gooden, 2004).

Foundational values and culture. Cultural responsiveness is dependent upon foundational values, relational skills and attitudes, and knowledge domains, which all grant professional understanding of other's lifestyles, communication, curriculum, and pedagogical needs (Hunt, Gooden, & Barkdull, 2001). "Foundational values include people's knowledge and appreciation of their own worldviews, cultures, and belief systems. They emphasize the inherent worth and dignity of all people, value diversity as a source of strength and empowerment, and honor others' rights to self-determination" (Sileo & Gooden, 2004, p.49). Foundational values recognize and accept strong social structures, family dynamics, support networks, interdependence, and attainment of common goals among Native communities (Sileo & Gooden, 2004). For example, Natives grandparents' role is to teach youth to be respectful, autonomous, loyal, and generous in a way that be The one consistent neglected and important component for an effective HIV/AIDS, STIs, and teen pregnancy prevention intervention is the role of culture (Nakai et al., 2004).

Culture can determine how people respond to medical education and intervention, therefore, it is important health professionals recognize and utilize cultural ideals when addressing health issues (Nakai et al., 2004). Research demonstrates that HIV/STD prevention is more effective when it promotes change by empowering individuals and community by utilizing strategies that include community norms, beliefs, and values (Nakai et al., 2004).Understanding these factors when working with communities and those developing prevention materials must understand both the traditional beliefs and the nature of transformations that have occurred, which makes HIV/STD work delicate (Nakai et al., 2004).

Relational skills and culture. Relational skills and attitudes incorporate humility, respect, and willingness to learn from others and consist of trust that is grounded in listening, communication, and conflict mediation skills (Hunt et al., 2001). Relational skills foster constructive alliances among people and acknowledge and accept differences in verbal and non-verbal communication (Hunt et al., 2001). Communication within Native cultures is taken seriously and with great respect. Traditional teaching commands silence among children; children are taught to avoid continuous eye contact because it is considered impolite (Sileo & Gooden, 2004). Natives often retain stoic facial expressions and use gestures to reinforce main ideas of a conversation (Sileo & Gooden). Natives also interpret silence as strength; therefore people speak with long pauses in conversations and speak in low-keyed, monotone voices (Sileo & Gooden, 2004). Finally, the conversational language may be metaphoric because the content of the message is more important than the emotional delivery (Sileo & Gooden, 2004).

Knowledge domains and culture. Knowledge domains are based in awareness with local systems, policies, and beliefs that affect intervention program design, implementation, and evaluation (Sileo & Gooden, 2004). Collaboration with tribal leaders, elders, and the community is needed to ensure that intervention programs address health risks, beliefs, and customs (Sileo & Gooden, 2004). Collaboration with the community allows access to knowledge of community norms and ideologies that guide program and strategy development (DePoy & Bulduc, 1997). Community norms may include cultural and spiritual philosophies about health and illness; spirituality and cultural morals related to sexual activity, two-spirit, alcohol and substance abuse, and contraception; language; and family and community resources (Miller Qualtere-Burcher, Lauber, Rockow, & Bauman, 1990). Not only should intervention programs be

culturally sensitive to rural and urban Native youth, but include sub-groups, such as two-spirit, women, and substance abusers (Maldanando 1999).

Program creators should engage tribal and community members to ensure culturally sensitive and appropriate programs that respect tribal knowledge, needs, histories, and personal and collective systems. Conducting observations, pilot studies, and ethnographic interviews is recommended to determine local culture and attitudes about sexuality, risk behaviors, and people's prior experiences with HIV/AIDS prevention (Sileo & Gooden, 2004). HIV/AIDS prevention programs fail to change high-risk sexual behaviors among two-spirit persons because of their lack of participation in program design and delivery (Rowell, 1996). Community members participating in developing and/or adapting HIV/AIDS, STIs, and teen pregnancy prevention curriculum should be empowered as a stakeholder who helps to minimize potential issues or concerns (National Commission on AIDS, 1994). Collectively, these components of understandings, attitudes, beliefs, and behaviors are the base for prevention programs to decrease risky sexual behaviors among tribal communities.

Holistic approaches. HIV/AIDS, STIs, and teen pregnancy prevention interventions for Natives needs understanding of and respect for cultural tribal customs and structures as the root for behavior change. Program developers must acknowledge that people's health beliefs may not be parallel with existing linear program models that are based upon Western social, medical, and scientific perspectives (DePoy & Bolduc, 1997; Rowell, 1996). Current intervention programs do not include holistic approaches that respect cultural, religious, spiritual, and psychosocial views. Sileo and Gooden (2004) state that "it is also important to prepare competent American Indian/Alaska Native health professionals who can combine state-of-the-

art medical treatment with traditional healing concepts and to provide services in the language of diverse tribal groups, as well as localized non-standard use of English, where appropriate" (p.52).

Culturally responsive prevention curriculum for Native youth should foster a socially, physically, emotionally, and spiritual balanced lifestyle. The involvement of these elements supports the integrity of cultural understandings and trust that learning is embedded in cultural beliefs, values, and practices (Sileo & Gooden, 2004). These curriculums should integrate examples from diverse Native perspectives to illustrate teachings about HIV/AIDS, STIs, and teen pregnancy prevention to help youth construct their knowledge and understandings. Program concepts promote cognitive and affective learning to apply the acquisition of skills, values, and behaviors that reduce HIV infection (Sileo & Gooden, 2004). Furthermore, the emphasis on self-respect and the commitment to family and the tribe are crucial to prevention strategies (Mangrum, Rush, & Sanabria, 1994).

Holistic approaches ultimately increase self-esteem among Native youth to assist in developing a positive identity and pride in themselves and their respective tribal affiliations as well as gain a deeper respect for cultural and spiritual beliefs (Sileo & Gooden, 2004). Traditional activities, such as sweat lodges and healing talking circles are recommended to provide mental, spiritual, and physical cleansing combined with unity and commitment to cultural values (Mangrum et al., 1994).

Social dynamics. Family is the core unit of Native cultures, accentuating interdependence, reciprocity, and obligation to care for one another (LaFromboise et al., 1993). Within this familial structure, Native children form strong relationships and attachments with not only their

biological family, but with aunts, uncles, cousins, and grandparents. In addition, relatives may include others who may be adopted into a family or family who part of their clanship system. Therefore, it is common for Native children to have multiple grandfathers, grandmothers, aunts, uncles, brothers, sisters, and cousins and treated as such regardless if blood related or not. This familial structure positively assists Native youth in their development by monitoring their behavior and ensuring family and community integration (Sarche & Spicer, 2008). These relationships also provide opportunities for the elders to pass on tribal stories, songs, and cultural practices that instill values to live by.

Native communities have incorporated spiritual elders, who are often times medicine men or women, in the attack against the spread of HIV/STD and believe the elder's support is a critical part of prevention and intervention (Nakai et al., 2004). It is significant to include intergenerational dialogues among elders, young adults, and youth to address cultural teachings, social matters, sexual orientation, HIV/AIDS transmission, and safe sex behaviors (DePoy & Bolduc, 1997). Elders are inherently respected for their age, wisdom, credibility, and status and viewed as role models who can share their cultural values, teachings, traditions, and experiences. They also promote active learning and participation by storytelling, song, and dance (Simpson, 2000). Elders can frame messages about reducing risky sex behaviors by incorporating how one's personal behaviors affect family and community. Programs must be grounded in reality of young peoples' daily lives and capitalize on communal responsibility in the framework of the communal unacceptability of risky sexual behaviors that is connected towards communal responsibility towards HIV/AIDS prevention (Sileo & Gooden, 2004).

Native youth have evidenced cognitive and social traits that emphasize social integration, working towards community support, and therefore, have global worldviews (Sileo & Gooden, 2004). Accordingly, they may prefer learning experiences from a large-scale descending into smaller, isolated sectors (Sileo & Gooden, 2004). This top-down approach enables youth to be actively involved in their learning style by considering subjective and social perceptions that are rooted in cultural values, experiences, and social interactions (Sileo & Gooden, 2004). For example, "talking circles" or small group discussions would be a beneficial method to promote safe sex practices and associated risky sex behaviors.

Historical trauma. Intervention programs should consider social and economic elements that impact tribal communities. Many tribes have experienced numerous traumas, such as poverty, substandard housing, poor nutrition, limited access to health services, poor health, and excessive alcohol and substance abuse (Rowell, 1996). Intervention programs should also consider intergenerational historical trauma and its adverse effects that placed a legacy of chronic depression (Rowell, 1996). Cunningham & Stanley (2003) stated,

> *"…evidence shows that the most effective programmes are those which acknowledge the devastating impact of removing people from their land, removing children from their families and their culture, and marginalizing people so that they cannot access any of the advantages of the dominant culture, such as education and employment, which would have enabled them to participate and control their own lives. This is evidence and the importance of the social determinants of health and how they have had an impact on generations of these populations-seen repeatedly in all colonized indigenous groups.*

We believe that sustainable solutions to indigenous health problems must address and acknowledge this history and the links these people have with nature" (p.404)

One way to combat intergenerational depression for youth is to teach them about reclaiming their cultural traditions and teachings. For that reason, many HIV/AIDS prevention programs integrate traditional healing and teaching methods (Mangrum et al., 1994). HIV/AIDS prevention programs should promote responsible sexual decision-making as an individual, spiritual, and communal responsibility. It should fuse a comprehensive, culturally competent alcohol and drug abuse session to mediate the high-risk of HIV/AIDS transmission and simultaneous use of drugs and alcohol (DePoy & Bulduc, 1997; Maldanado, 1999). Intervention programs that disregard these phenomena are shallow efforts and ill proactive solutions that do not address the root causes of sexual risk behaviors (Sileo & Gooden, 2004).

Instructional strategies. Native youth demonstrate social sensitivity to others when defining personal attitudes and beliefs (Sileo & Gooden, 2004). Informal teaching-learning methods where cultural knowledge and skills are innately relevant and work communally in performing tasks are educational opportunities that are consistent with their traditions and learning styles (DePoy & Boldoc, 1997). Strategies that foster observation, hands-on demonstrations, experiential experiences, and movement assist to facilitate learning (Nakai et al., 2004). Therefore, culturally appropriate participatory activities and projects are encouraged, such as sewing ribbon-shirts, dance outfits, and bead jewelry to help facilitate discussions. For example, DePoy and Bolduc (1997) recommend designing condom jewelry pins and earrings as an approach to discuss gender roles and cultural norms in efforts to promote condom use and responses to partners who resist condom use.

HIV/AIDS instructional strategies should include important Native topics that include history, cultures, languages, and arts and crafts. Understanding and utilizing Native languages in prevention and intervention efforts is important because many communities learn about health and healing through story- telling and language shapes the worldviews and teach communal responsibilities and obligations (Nakai et al., 2004). Each community has a form of appropriate language for discussing sex and related topics, which is based on cultural norms that must be incorporated into prevention materials (Nakai et al., 2004). These oral histories, song and dances, and ceremonial activities compliment prevention efforts as the youth acquire knowledge about cultural history and survival skills from their elders or cultural leaders (Sileo & Gooden, 2004).

Cultural phenomena and languages are vital because of varying acculturation levels affect Natives responses to Westernized delivery structures. Instructional strategies may also include legends, storytelling, and drama to personalize the impact of HIV/AIDS on the youth's lives and change their behaviors. For example, a play, *A Coyote Story*, relies on the Coyote to teach the youth about sexuality and living in harmony with the Creator, nature, and humanity by reinforcing traditional values and addressing simultaneous drug and alcohol use and unprotected sex (Sileo & Gooden, 2004). Also, a Native song was developed about an emotional experience of a community member who learned about his/her HIV seropositivity, which was then choreographed and performed for community members (Sileo & Gooden, 2004). Lastly, using a community-based center, providing a meal for the participants, and reimburse parents for gasoline expenses is recommended to enhance participation and retention (Sileo &Gooden, 2004).

HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions for Native Teens

Despite the abundance of studies on HIV/AIDS in the U.S., insufficient research has been conducted on HIV/AIDS, STIs, and teen pregnancy prevention interventions in tribal communities (Vernon & Jumper-Thurman, 2002). A limited availability of HIV/AIDS, STIs, and teen pregnancy prevention interventions are available that have been designed and/or specifically for Native teens. Most of these interventions have not been rigorously evaluated (www.thenationalcampaign.org, 2009). Minimal research on interventions and intervention results specific to Natives and HIV/AIDS, STIs, and teen pregnancy prevention has been published (Vernon & Jumper-Thurman, 2002). Table 3.4 summarizes some of the non-evidence-based prevention interventions that have been developed or adapted for Native youth due to the limited availability of Native evidence-based prevention interventions.

The *Live it!* is a sexuality education and teen pregnancy prevention intervention for Native youth, ages 11-18. The curriculum is culturally specific for Native youth designed to address the basic physiological and emotional development youth go through before, during and after adolescent, along with cultural, artistic, and self-reflective exercises. Also, different tribes can utilize the curriculum and the program seeks to reconnect youth with Native culture.

Table 3.4. Native HIV/AIDS, STIs, and Teen Pregnancy Prevention Interventions

Program Name	Program Description	Target Population	Program Setting	Program Duration
Live It!	Teen pregnancy prevention and sex education curriculum. Highlights strategies for parents to raise healthy families.	Native adolescents ages 11-18 and adults in their lives	In-school or community-based	10 sessions that last between 1 and 2 hours each
Gathering of Native Americans	HIV/AIDS and substance abuse prevention program	Native youth aged 9 to 22 that are: children of substance abusers, involved in juvenile justice system, members of low-income families, live in foster care, LGBT, involved with gangs, emotionally disturbed, or homeless	Community-based	Information not available
The Native American Prevention Project Against AIDS and Substance Abuse	HIV/AIDS, alcohol, and other drug abuse prevention program.	Native 8th and 9th graders	In-school	24-session: 12 for 8th graders and 12 for 9th graders
Circle of Life	HIV/AIDS Curriculum for K-6; HIV/AIDS and STD prevention curriculum for middle school	Natives youth K-6, Native 7th and 8th graders	In-school	~5 Modules
Native STAND: Students Together Against Negative Decisions	HIV/AIDS, STI, teen pregnancy prevention curriculum	Native high school students	In-school or community-based	29 session curriculum; 1.5 to 2 hours
Community-Based Abstinence Culture	Teen pregnancy prevention that teaches abstinence and healthy relationship development. Used a "Discovery Dating" curriculum	Eighth-grade students	Tribal schools or In-school	1 full academic year

The *Gathering of Native Americans* (GONA) is an HIV/AIDS and substance abuse capacity building program used throughout the country among Native populations. The intervention was based on incorporating traditional healing, cultural wellness education, and life-skills. When used among Native youth, the intervention connected culturally relevant substance abuse and HIV prevention education to Native youth aged 9 to 22 that are; children of substance abusers, involved in the juvenile justice system, members of low-income families, live in foster care, gay, lesbian, bisexual, transgender, involved with gangs, emotionally disturbed, or homeless (Aguilera & Plasencia, 2005). The GONA was built upon four core concepts: belonging, mastery, interdependence, and generosity addressing substance abuse, colonization, grief, loss, and historical trauma (Aguilera & Plasencia, 2005). While utilizing this curriculum, the Youth Services program found that of their 23 participants, 83% learned more about Native culture, 79% felt more connected to the Native community after participating, 55% felt their drug refusal skills improved, 79% felt they would be more involved in community activities, and 69% thought their communication skills improved as a result of the program (Aguilera & Plasencia, 2005). The GONA has been successfully used to help Native youth to learn and access tools, such as reconnecting to the Native community, which can ultimately reduce their HIV/AIDS risk and substance use.

The *Native American Prevention Project Against AIDS and Substance Abuse* (NAPPASA) is an in-school HIV/AIDS, alcohol, and other drug abuse prevention program for Native youth. The NAPPASA collaborated with schools throughout northern Arizona and western Washington to develop, implement, and evaluate culturally sensitive HIV/AIDS preventive interventions that are associated with alcohol and other drug abuse. The curriculum is composed of content and

procedures that aim to build knowledge and develop and practice new peer group norms for preventive communication and behavior in the context of Native health beliefs and values (Baldwin et al., 1996). The development of the NAPPASA curriculum involved five steps: 1) selective an integrative theoretical model of preventive intervention, 2) obtaining local input from youth and adults in the community, 3) integrating theory with local content and process input into testable intervention packages, 4) implementing field trials, and 5) conducting process and outcome evaluations (Baldwin et al., 1996). The use of a holistic paradigm of integrating the biological, social, cultural, and psychological was incorporated into the curriculum based on the communities' interest in creating a Native holistic approach to alcohol and other drugs and HIV/AIDS prevention programs.

Findings from the NAPPASA study found that heavy illicit substance use and binge drinking norms were significant factors for increasing the risks of HIV transmission by engaging in risky sexual behaviors among teens in rural communities (Baldwin et al., 1996). Also, the lack of communication about sexuality across gender and between adolescents and adults was a key finding from the focus groups. Discussions about sexual activity, pregnancy, contraception, and sexually transmitted diseases were seldom. However, if these topics were discussed then the adolescents would prefer to speak with an older relative of the same gender. This information gathered about limited communication and communication preferences suggested that the curriculum should be conducted by a pair of instructors (one male and one female), and that role plays about HIV/AIDS prevention should be cautiously conducted to minimize embarrassment to the students. Further, the outcome results when compared with nonintervention groups found a significant number of the intervention participants remained in

or moved to the lower alcohol and other drug use risk category at both 9th and 10th grade follow-up. At baseline, among the nonusers, the normal developmental trend toward alcohol and other drug use was slowed and the intervention youths showed more likelihood of maintaining virginity and lower rates of risky sexual behavior when compared to nonvirgins. Among the older nonvirgin youths, the intervention groups were less likely to have had sex while intoxicated with alcohol or substance use and consistently showed an increase in their use of family, rules, laws, religion, traditional ways, and community protective influences to assist them to avoid health risk behaviors (healthycolumbiawillamette.org, 2002).

The *Circle of Life* (COL) are two curricula that have been developed for Native youth, which specifically are: “Circle of Life: HIV/AIDS Curriculum for K-6” and “Circle of Life: HIV/AIDS and STD Prevention Curriculum for Middle School.” The COL curriculum has a solid integration of health with culture, not simply health curricula with a segment on culture. Merging these two curricula is the Plains tribe medicine wheel, which is a symbol of a holistic paradigm utilized by many tribal communities. The developers adapted the medicine wheel to use as the foundational content for the curricula to engage tribal youth and incorporated skill-building games, activities, and stories that promote circumvention of risky behaviors (Kaufman et al., 2012).

Although the COL curriculum development utilized Western behavioral change theories, the core content stemmed from the medicine wheel that includes spiritual, emotional, physical, and mental well-being (Kaufman et al., 2012). “Indeed, the medicine wheel itself embodies a cultural theory of learning based on centuries of community epistemologies that form the foundation for cognitive and behavioral instruction” (Kaufman et al., 2012, p. 142). With

regards to the medicine wheel, all four components touching other symbolizes having harmony and balance to influence making healthy choices. The term, volition, is located at the center of the wheel to further emphasize maintaining balance among the wheel components for personal empowerment and enacting good decisions (Kaufman et al, 2012). The COL curriculum connects Native symbols, stories, and teachings to behavior with knowledge and ways of thinking. The cultural context was woven throughout the curriculum with emphasis on individual responsibility to self, family, and community (Kaufman et al., 2012).

When comparing the COL pre/post tests of the students showed significant increase in HIV/AIDS knowledge and increased understanding of healthy behaviors and avoiding risky behaviors. Within the K-6 students group, it was found that there was a significant reduction in students' fears about acquiring HIV and an increase in their acceptance of persons infected with HIV. The middle school COL curriculum delayed sexual activity within the 11-12 year olds. The teachers found that the curricula were age-appropriate, reflected health and personal behaviors, and were culturally appropriate to cultural issues. However, youth and facilitators recommended that the cultural content that is related to their own tribal history, traditions, and beliefs be increased (Kaufman et al., 2012).

Native STAND is adapted from *STAND-Students Together Against Negative Decisions-* a peer educator curriculum developed for youth in rural Georgia. The curriculum is comprehensive and skills-based, and includes STI, HIV, and teen pregnancy prevention, as well as drug and alcohol issues and dating violence. The curriculum was designed to honor tradition and culture that simultaneously meets 21st century Native youth where they are, walking between two different, but interconnected worlds. While Native STAND acknowledges that

Native youth face many of the same challenges as mainstream youth, it embraces the power of traditional teachings and cultural strengths that Native youth have within themselves and their communities.

The *Community-Based Abstinence Culture* (C-BAC) Program was a 5-year teen pregnancy prevention program developed to exhibit the effectiveness of abstinence education and healthy relationship development in reducing teen pregnancy in Native communities (Hagen et al., 2012). A healthy relationship program, based on Native teachings, tradition, and cultural norms, were delivered to eighth-graders for five continuous years. More specifically, the C-BAC program used the Discovery Dating curriculum, a core healthy relationship development curriculum along with abstinence, refusal skills, relevance of Native culture, and a future vision of careers. The program incorporated the social ecological approach by teaching and reinforcing messages with multiple layers; individuals, relationships, community, and society (Hagen et al., 2012). This study found that of those who reported that they were sexually active, the students who received the healthy relationship program (treatment group) reported higher condom use than the students who did not receive the healthy relationship program (comparison group) (Hagen et al, 2012).

The summary above of the limited availability of Native HIV, STIs, and teen pregnancy prevention interventions and the limited evaluation demand the need for more culturally tailored interventions to be developed and/or adapted. According to the Office of Adolescent Health, the interventions listed above were not evidence-based. The practice of adapting evidence-based interventions in culturally responsive contexts should be applied. The Becoming a Responsible teen intervention will be discussed.

The "Becoming A Responsible Teen" Evidence-Based Intervention

The curriculum that has been chosen to be adapted is titled "Becoming a Responsible Teen" (BART), which is an evidence-based and community-based HIV and teen pregnancy prevention curriculum that primarily targets African-American teenagers between the ages of 14-18. This curriculum was chosen because there are limited community-based HIV/AIDs and teen pregnancy prevention interventions for Native youth only and the time frame of this curriculum is feasible due to the short duration of the intervention. For instance, three out of the six Native HIV/AIDS and teen pregnancy prevention interventions are school-based interventions. Although the *Live It!* Native intervention can be conducted at a community-based center, it is designed for Native youth and their parents/caretakers. The *Gathering of Native Americans* intervention can also be conducted at a community-based center but are for Natives aged 9-22 years. This intervention is limited to children of substance abusers, involved in juvenile justice system, members of low-income families, live in foster care, LGBT, involved with gangs, emotionally disturbed, or homeless. Last, the *Native STAND* can be conducted at a community-based center but has 29 sessions, which is long in time duration. Further, most importantly, the BART intervention is designed for sessions to be held at community-based settings that are usually rooted in the social network and environment of the youth in the community (St. Lawrence, 1998). Language and values can be modified to fit the needs of the community, especially for Native youth and consists of eight 1.5 to 2 hour sessions that are conducted once a week.

The BART intervention has been identified by the Office of Adolescent Health as an effective evidence-based curriculum. St. Lawrence developed and based BART on Bandura's

Social Learning Theory and the three-factor conceptualization of AIDS-preventive behavior (St. Lawrence et al., 1995; Bandura, 1994; Fisher & Fisher, 1992). “Bandura’s Social Learning Theory emphasizes that learning is an interactional social process and that the social and physical environment help to form an individual’s behavior” (Butts & Hartman, 2002, p.165). BART acknowledges that all behaviors associated with HIV risk behaviors are a combination of interpersonal principles and experiences that occur within social interactions. Competence in decision-making, vulnerability to peers, and negotiation skills are all factors that are linked to the social interaction environment within the BART curriculum (Butts & Hartman, 2002). The Social Learning Theory stresses that learning stems from an interaction social process, therefore the social and physical environment assist to shape individual behaviors (Bandura, 1994). In addition, Bandura (1994) emphasizes that individual competence is attained from one’s orientation, modeling, and reinforcement of morals. Youth participation in active problem-solving scenarios, role-plays, and other experiential learning activities are primary practices that that enhances behavior change. More specifically, the BART curriculum was constructed utilizing the following four major components that stem from the Social Learning Theory and self-efficacy constructs: (1) Information is provided that increases adolescents’ knowledge and their awareness of risk; (2) Training is provided in the skills adolescents need to translate the information into action; (3) Adolescents are given opportunities to practice and receive corrective feedback, using skills in a safe environment with their peers before they face the challenges of using them in risky situations and; (4) Social support is provided for the desired behaviors, to help make them the norm in the youth’s social environment (St. Lawrence, 1995).

The three-factor conceptualization model, known as Information, Motivation, and Behavior (IMB) skills model, configure three fundamental determinants of AIDS risk reduction (Fisher & Fisher, 1992). More specifically IMB translates as, (I) Information on HIV/AIDS transmission and information on specific prevention methods, (M) Motivation to change risky behavior, and (B) Behavioral skills in practicing prevention acts. The IMB model could be utilized with any population by modifying the content to fit the particular population (Fisher & Fisher, 1992).

Encompassed in the IMB model is the Theory of Reasoned Action that indicates the individual's attitude towards performing the behavior and the individual's perception of how significant others regard the behavior (Fisher & Fisher, 1992). These must be present in order to motivate behavior change. The BART curriculum fosters participant behavior change by having the participants personalize their HIV risks and by helping participants learn from other individuals' behaviors and experiences (Fisher & Fisher, 1994).

Some of the unique features about this curriculum are that teens had an active role in curriculum development, was designed to be used with gender-specific groups (each group is facilitated by both a male and female at all times), and has been proved to be effective with sexually active and abstinent youth (St. Lawrence, 1995). This curriculum includes interactive group discussions and role-plays that have been created by teens; in turn teens learn to disseminate the learned information to their friends about HIV risks. According to the curriculum objectives and lessons, the youth who participate in the BART will be able to: (1) State accurate information about HIV and AIDS that includes means of transmission, prevention, and current community impact; (2) Clarify their own values about sexual decisions

and pressures and: (3) Demonstrate skills in correct condom use, assertive communication, refusal, information provision, self-management, problem-solving, and risk reduction (St. Lawrence, 1995). Below is an overview of the eight-session schedule of the BART curriculum:

Session 1: Understanding HIV and AIDS
•Introduces the program and addresses the key elements on HIV/AIDS
Session 2: Making Sexual Decisions and Understanding Your Values
•Focuses on HIV/AIDS related stereotypes and associates HIV with drug use
Session 3: Developing and Using Condom Skills
•Focuses on discussing proper condom use in preventing HIV/AIDS
Session 4: Learning Assertive Communication Skills
•Focuses on strengthening problem-solving and communication skills with potential partners
Session 5: Practicing Assertive Communication Skills
•This session enhances Session 4 by incorporating participants to practice utilizing their assertive communication skills by role-playing in cumbersome situations
Session 6: Personalizing the Risks
•Focuses on group discussions to probe feelings about peers and others living with HIV/AIDS
Session 7: Spreading the Word
•Focuses on reviewing the previous six sessions that prepare the participants to disseminate the learned information to their family and friends about HIV/AIDS
Session 8: Taking BART with you
•Participants communicate how the program has affected their lives

Table 3.5 shows the BART activities that increase knowledge of HIV, including definitions, transmission, testing, and prevention. Also, to help participants aware of situations that lead to unprotected sex and HIV and knowledge of how drugs and alcohol may influence sexual decision making. The knowledge learned will help participants abstain from oral, vaginal, or anal sex, to ultimately decrease HIV among African-American teens (ETR, 2011).

Table 3.5. BART Activities that Increase Knowledge to Abstain from Sex

Activities Designed to Change Risk & Protective Factors	**Risk & Protective Factors that Affect Sexual Behaviors**
Session 1: Understanding HIV/AIDS Activity 1:Share Personal Experiences Activity 2: Who is at Risk for HIV and Why? Activity 3: Introduction to HIV Terms Activity 4: Facts and Myths Activity 5: Deciding Your Risk Level Activity 6: Spreading the Word **Session 2: Making Sexual Decisions & Understanding Your Values** Activity 1: Definitions Review Activity 2: HIV Transmission Review Activity 3: AIDS and African Americans Activity 4: "HIV Feud" Activity 5; Video: Seriously Fresh Alternative Activity 5: Personalizing HIV Risks **Session 6: Personalizing the Risks** Activity 1: Meeting people with HIV Activity 2: Discussion and Debrief Alternative Activity: Video **Session 8:** Activity 1: Final Review of HIV Facts	Knowledge of HIV (Definitions, transmission, testing, and prevention)
Session 1: Understanding HIV & AIDS Activity 1: Share Personal Experiences **Session 5: Practicing Assertive Communication Skills** Activity 5: Assertive Communication Practice	Awareness of situations that lead to unprotected sex and HIV
Session 2: Making Sexual Decisions & Understanding Your Values Activity 6: Exploring Drug Risks for HIV	Knowledge of how drugs and alcohol use may influence sexual decision making

ETR Associates. (2011). *Becoming A Responsible Teen Logic Model*. Scotts Valley, CA: ETR.

Table. 3.6 show the BART activities that increase a participant's perception of risk of contracting HIV. The perceptions of risk will help participants to abstain from oral, vaginal, or anal sex, to ultimately decrease HIV among African-American teens (ETR, 2011).

Table 3.6. BART Activities that Increase Perceptions of Risk to Abstain from Sex

Activities Designed to Change Risk & Protective Factors	Risk & Protective Factors that Affect Sexual Behaviors
Session 1: Understanding HIV & AIDS Activity 1: Share Personal Experiences Activity 2: Who Is at Risk for HIV and Why? Activity 3: Introduction to HIV Terms Activity 4: Facts and Myths Activity 5: Deciding Your Level of Risk **Session 2: Making Sexual Decision & Understanding Your Values** Activity 2: HIV Transmission Review Activity 3: AIDS and African Americans Activity 4: "HIV Feud" Activity 5: Video: Seriously Fresh Alternative Activity 5: Personalizing HIV Risks **Session 6: Personalizing the Risks** Activity 1: Meeting People with HIV Activity 2: Discussion and Debrief Alternative Activity: Video **Session 8: Taking BART with You** Activity 1: Final Review of HIV Facts	Perception of chances of contracting HIV among African Americans

ETR Associates. (2011). *Becoming A Responsible Teen Logic Model*. Scotts Valley, CA: ETR.

Table 3.7 shows the BART activities that increase skills to abstain from oral, vaginal, or oral sex. The activities increase skills and self-efficacy to make decisions about what to do and not do sexually. The activities increase skills and self-efficacy to say "No" to sex, having unprotected sex, or to avoid having sex. The activities increase skills and self-efficacy to recognize, avoid, or get out of situations that might lead to sex. These learned skills give them tools to abstain from oral, vaginal, or anal sex, to ultimately decrease HIV among African-American teens (ETR, 2011).

Table 3.7. BART Activities that Increase Skills to Abstain from Sex

Activities Designed to Change Risk & Protective Factors	Risk & Protective Factors that Affect Sexual Behaviors
Session 1: Understanding HIV & AIDS Activity 1: Share Personal Experiences **Session 2: Making Sexual Decision & Understanding Your Values** Alternative Activity 5: Personalizing HIV Risks **Session 4: Learning Assertive Communication Skills** Activity 3: Problem-Solving Skills	Skill and self-efficacy to make a decision about what to do and what not to do sexually
Session 4: Learning Assertive Communication Skills Alternative Activity 2: Negotiating Safer Sex Activity 3: Problem-Solving Skills Activity 4: Different Communication Styles **Session 5: Practicing Assertive Communication Skills** Activity 1: Assertive Communication Review Activity 2: Assertive Communication Tips Activity 3: Ways to Say No Activity 4; Assertive Communication Demonstration Activity 5: Assertive communication Practice **Session 7: Spreading the Word** Activity 1: Assertive Communication in the Real World Activity 2: Getting Out of Risky Situations	Skill and self-efficacy to say NO to sex or unprotected sex or to avoid having sex
Session 5: Practicing Assertive Communication Skills Activity 5: Assertive Communication Practice **Session 7: Spreading the Word** Activity 1: Assertive Communication in the Real World Activity 2: Getting Out of Risky Situations	Skills and self-efficacy to recognize, avoid or get out of situations that might lead to sex

ETR Associates. (2011). *Becoming A Responsible Teen Logic Model*. Scotts Valley, CA: ETR.

The BART participants learn knowledge, perceptions of risk, values and attitudes, perception of peer norms, skills, emotions, communication with parents and other adults, communication with friends, connection to African-American culture, and intention to ultimately abstain from sex and use condoms correctly. St. Lawrence et al. (1995) found the original BART “HIV Knowledge” survey found there was difference in the pre-survey (M=17.4, SD=3.3) to post-survey (M=20.1, SD=3.1), which means the mean increased by 2.5 in test scores. The mean increase was 2.7, indicating that participating in the intervention increased HIV knowledge scores, on average, by approximately 3 points (St. Lawrence et al., 1995). This study found of the participants who were sexually abstinent prior to the intervention, 11.5%

were sexually active, compared with 31% of participants in the control groups. This indicated that BART had delayed the onset of intercourse by 63% (St. Lawrence et al., 1995). The participants who were sexually active prior to BART, 27% remained sexually active post one year, versus 42% of the control group (St. Lawrence et al., 1995). Participants who participated in the BART were more likely to stop having sex, use condoms, and were less likely to engage in unprotected vaginal or anal sex. BART reduced the rate of unprotected sex by 42% among participants (St. Lawrence et al., 1995).

Conclusion

Based on the statistical data, Native youth are considered at high risk for contracting HIV/AIDS, STIs, and becoming a teen parent. Numerous social factors contribute to the high rates of HIV/AIDS, STIs, and becoming a teen parent, such as poverty, alcohol and substance abuse, violence and trauma among Native youth, and IPV. Throughout the literature review, numerous scientific authors highlight Native youth are at greater risk when compared to peers for maltreatment, substance abuse, suicide, and violence. Despite the challenges, Native peoples are focusing on efforts to address adversities through cultural and culturally responsive intervention models (Spicer et al., 2001). At the core of these efforts are the ongoing incorporation of cultural beliefs and practices. Native youth are surrounded by strong kinship networks, learn and participate in cultural dynamics that contribute to a sense of belonging and identity, and learn tribal languages and stories (Sarche & Whiteshell, 2012). These protective factors should reflect the factors within culturally appropriate interventions. The BART will be adapted so the cultural values and the lens in which youth see their world will be integrated within the experience of learning safe-sex practices. The adaptations will recognize and respect

the diversity among tribal communities and allow the youth to develop a relationship between self and health that reflects their connectedness to self, family, community, and tribe.

Chapter 4: Methods

Native youth are at high risk for contracting HIV, STIs, and/or becoming a teen parent (CDCc, 2013; CDCd, 2013; thenationalcampaign.org, 2009). Underlying systemic issues that may contribute to Native youth being more susceptible to contracting HIV, STIs, and/or becoming a teen parent are high poverty rates, low high-school graduation rates, and limited access to resources (Education Week, 2013; U.S. Census, 2013; U.S. Commission on Civil Rights, 2003). In addition, insufficient research has been conducted on HIV/AIDS and teen pregnancy prevention intervention programs within tribal communities, nor has there been rigorous evaluation on the limited number of these intervention programs that do exist (Vernon & Jumper-Thurman, 2002; www.thenationalcampaign.org, 2009). The limited availability and research on HIV/AIDS and teen pregnancy prevention intervention programs within tribal communities have resulted in this research project. Based on the review of literature and information, the purpose of this project is to adapt the existing BART curriculum into a culturally competent HIV/AIDS, STIs, and teen pregnancy prevention intervention program for Native teens aged 14-18 years. This project will address the following research question.

Research question: What *content* changes are needed in order to adapt the BART curriculum to meet the needs of Native teens?

Collaborators

This project worked with several collaborators to implement project-related activities. This section describes the collaborators that contributed to this project.

Southern Nevada Teen Pregnancy Prevention Project. The Southern Nevada Teen Pregnancy Prevention Project (SN-TPPP) is currently funded by the Office of Adolescent Health (OAH) and is housed at the Center for Health Disparities Research at the University of Nevada Las Vegas (UNLV). The SN-TPPP targets African American youth ages 14 to 19 years by implementing the BART intervention in African American faith-based organizations in Southern Nevada. The SN-TPPP implements a modified version of the BART intervention. No adaptations were made to the content of BART. In acknowledging that abstinence is the most guaranteed way to prevent HIV/AIDS, STIs, and teen pregnancy, and that faith-based organizations would be more receptive to the project, an additional session on abstinence was developed by project staff. The abstinence session occurs prior to the start of the BART 1-8 sessions. The content and materials for the abstinence session have been reviewed and approved for medical accuracy and use by OAH. SN-TPPP has trained persons from the community to implement the BART intervention in faith-based organizations throughout Southern Nevada. For this project, SN-TPPP assisted in allocating project materials and provided trained BART instructors.

Las Vegas Paiute Clinic. The Las Vegas Paiute Clinic provides medical, dental, and mental health services to all urban Native Americans in Las Vegas metropolitan area. The former Family Therapist and former Youth Facilitator for the Native Nations youth group at the Las Vegas Paiute Clinic assisted with recruitment of participants for this project.

Las Vegas Indian Center. The Las Vegas Indian Center is a resource for employment, education, cultural enrichment, and community engagement for urban Natives residing in Las Vegas metropolitan area. The Las Vegas Indian Center assisted with recruitment of participants for this project.

Project Phases

The project focused on primarily on the curriculum adaptations and evaluation procedures. The adaptation process was and is a key procedural component on assisting to reduce the high rates of HIV/AIDS, STIs, and teen pregnancy prevention among Native youth by incorporating culturally appropriate content and activities. The project was divided into three phases: 1) adaptation; 2) pilot test implementation; and 3) evaluation. Each phase has distinct outcome objectives listed in each phase. Therefore, the methodology of each phase is explained separately and thoroughly in this section.

Phase I-Adaptation

Phase 1 was the adaptation of select content from the current BART intervention curriculum, primarily through the addition of culturally appropriate content to better meet the needs of Native youth. Phase 1 addressed a key component, which is the adaptation of the *content* of the BART curriculum. The *content* adaptation process involved the utilization of a national advisory committee, literature review, BART adaptation guidebook, and the researcher’s expertise.

The primary objective of Phase 1 was to utilize an advisory committee to help guide the adaptation of the BART curriculum. The advisors were asked to assist with curriculum adaptation by providing recommendations to ensure: A) the curriculum will be culturally relevant to the developmental issues of the Native population; B) the curriculum will address the cultural values, beliefs, and attitudes of the Native population within the contexts of their socio-cultural system, and; C) the curriculum will promote relevant changes in health behaviors

of persons in their normal cultural and socialization contexts. The specific steps applied to meet this objective are outlined below.

Recruitment of advisors. The adaptation of the BART curriculum included a national advisory board that assisted in recommending curriculum adaptations. A group of persons were recruited based on their personal, cultural, educational, and/or professional experiences in working in the fields of Native culture, sexual/reproductive health, curriculum adaptation, and/or program evaluation.

Thirteen persons were initially recruited in person or by email. Recruitment was continued by snowball sampling, in which a person who agreed to participate recommended, as needed, an appropriate colleague who could serve as a potential advisor. The thirteen persons that were initially asked and agreed to participate are listed below:

1. Jessica Leston, MPH (Tsimshian), STD/HIV Clinical Services Manager, Northwest Portland Area Indian Health board
2. Alexander White Tail Feather, MBA (Kashia Pomo), Executive Director, National Native American AIDS Prevention Center
3. Mattie Tomeo-Palmanteer, BSW (Confederated Tribes of Colville and Yakama Nation), Native VOICES Project Coordinator, Northwest Tribal Epidemiology Center, Northwest Portland Area Indian Health Board
4. Dawn Bruce (Moapa Band of Paiutes), Social Services Director, Moapa Tribe
5. Aisha Gilliam, Behavioral Scientist, Center for Disease Control Center for HIV/AIDS, Viral Hepatitis, STD, & TB Prevention
6. Gwenda Gorman, Director, Health and Human Services Inter Tribal Council of Arizona
7. Angela Gonzales, Ph.D (Hopi), Associate Professor of Development Sociology, Cornell University
8. Kyle Ethelbah, MPH (White Mountain Apache), Director of TRIO Programs, University of Utah

9. Dominic Nardini, MFT, Marriage & Family Therapist, Las Vegas Paiute Clinic
10. Philene Herrera, (Navajo), Health Program manager, Navajo Nation Health Education Program, Navajo Nation Department of Health
11. Lyle Harvey, (Navajo), Dine' Language Consultant, Bahozhoni Consulting
12. Dena Ned, Ph.D (Chickasaw), Associate Professor, College of Social Work, University of Utah
13. Jessica Danforth, (Ojibiwe), Executive Director, Native Youth Sexual Health Network

All of the invitees agreed either in-person or via email to assist with recommendations. As each person agreed, an email in September 2014 was sent with the introductory invitation letter that provided overall instructions, plus the abstinence and BART 1-5 sessions curriculum content. The remaining BART 6-8 sessions were emailed to all 15 persons on October 15, 2014. The final deadline for all persons to submit all adaptation recommendations was on December 15, 2014. Reminders and follow-up emails were conducted from October 15, 2014-December 15, 2014 to each person. Five of the 13 invited persons provided substantive recommendations; while the remaining 8 did not provide any recommendations.

Resources for advisors. Multiple documents were drafted to assist advisors in making the adaptation recommendations. Each document was emailed to the advisors. Each document is described below.

A. Introductory invitation for advisors

Introductory invitation letter (Appendix B) was drafted and emailed to the advisors in September 2014 once they agreed to participate. The invitation letter provided an overall introduction to the pilot project, as well as background on the BART intervention, including a brief summary of the BART research base, project history, theory, research design, and

evaluation so the advisors could get a concrete understanding about the intervention. Specified instructions for adaptations and deadlines of when the recommendations were due were also provided.

B. BART adaptation table guides

The adaptation guidebook, *The Adaptation Kit: Tools and Resources for Making Informed Adaptions to BART,* was used as a resource throughout the adaptation process for each of the BART 1-8 sessions (Rolleri et al., 2011). This guide helped advisors maintain fidelity to BART's core components within the scope of the BART 1-8 sessions only. The SN-TPPP created the abstinence session, which was an adaptation of the BART intervention. The abstinence session was also included in this project.

The adaptation kit is a step-by-step guide to the types of adaptations that are considered safe or unsafe for maintaining fidelity to the BART intervention. The BART adaptation kit includes 6 core elements to guide adaptations: (1) Determinant-Activity Matrix; (2) Behavior-Determinant-Intervention (BDI) Logic Model; (3) Core Components; (4) Green/Yellow/Red Light Adaptations; (5) Fidelity and Adaptation Monitoring Logs; and (6) Glossary. One of the 6 core elements was utilized, which was the green/yellow/red light adaptations because of the simple instructions.

Within the BART adaptation guidebook, the green light adaptations mean "Go for it"; the yellow light adaptations means "Proceed with caution and guidance"; and the red light adaptations means "Avoid". If the content or activity fell in the green light category, then it was considered "safe" to adapt. If the content or activity fell in the yellow light category, then it was still questionable and needed further examination or justification. If the content or activity fell

in the red light category, then it meant it cannot be adapted. The BART adaptation guide has an individual table guide for each activity in the BART sessions. For example, BART Session 1 has a total of 7 activities; therefore, there are 7 associated adaptation table guides. All of the BART session's 1-8 adaptation table guides were used to assist with recommendations.

C. Abstinence and BART curriculum content and attached the adaptation table guides

The SN-TPPP's abstinence and BART session's curriculum content were typed verbatim into an MS Word document. As stated previously, each of BART session's activities had an associated adaptation table guide. The adaptation table guides were included at the beginning of each session activity so the advisors could refer to the table for adaptations.

D. Guided questions and attached it to the abstinence and BART curriculum content

A series of questions were developed to query advisors about their recommendations for the intervention. Two open-ended and broad questions were developed and asked prior to the information for abstinence was presented. The questions, which focused on HIV/AIDS, STIs, and teen pregnancy prevention interventions for Native youth, are listed below:

1. What do you envision an HIV/AIDS and teen pregnancy prevention intervention curriculum for Native youth to look like? Why? Any references or materials you would include?
2. Are there other sessions that should be conducted prior to abstinence? If so, which ones and why?

Additional specific questions were then intertwined throughout the abstinence and BART curriculum that asked about specific activities and content. Two examples of specific questions are listed below:

1. On BART Session 2-Activity 5, there is a video titled "Seriously Fresh" that features African American experiences learning about and dealing with HIV. Do you know of a video that features Native American experiences learning about and dealing with HIV? If not, what would you recommend in place of this video?

2. On BART Session 2-Alternative Activity 5 titled "Personalizing HIV Risks", asks participants to write and talk about if they found out someone they know or if they individually found out they had HIV. Do you feel this activity is culturally appropriate? Why or Why Not? Do you recommend a different activity in substitute of this current activity? Please describe the recommended activity.

Adapt curriculum. The adaptation process was primarily conducted by utilizing the advisors' recommendations. Adaptations were also made by utilizing the literature review, conducting research on other intervention curriculums and/or other resources, and the researcher's expertise in the fields of sexual/reproductive health, culture, program evaluation, and program adaptation. In addition, this phase acknowledged maintaining fidelity to the BART by using the BART adaptation guidebook as a key reference.

The recommendations from the advisors were collected via email. Follow-up emails with reminders and/or follow-up questions about recommendations were conducted from October 2015-December 2015. No phone calls or in-person communication tactics were conducted because it was much easier to reach people via email.

The advisors submitted their recommendations by the end of December 2014. The advisors answered the specific questions and provided recommendations throughout the abstinence and BART sessions. The recommendations were then extracted and compiled by session in one document.

The development of the new sessions and the adaptations for the SN-TPPP's abstinence and BART sessions were conducted using multiple methods. First, the advisors made recommendations, some of which included content, materials, and/or activities. Second, a literature review was conducted to further identity intervention materials, content, or activities that were appropriate based upon recommendations. Third, research on other HIV/AIDS, STIs,

teen pregnancy, and alcohol/substance abuse prevention intervention programs, and other resources were conducted to utilize some of their curriculum content, materials, and/or activities, if appropriate. Fourth, based on the researcher's expertise, the researcher used all of the above to help adapt the intervention.

Phase II-Pilot Testing

Phase II involved the pilot testing of the adapted curriculum with Native teens at UNLV. The three community collaborators, SN-TPPP, Las Vegas Paiute Clinic, and Las Vegas Indian Center assisted with providing co-instructors and recruitment of Native teens.

Phase II had 3 objectives. **Objective 1** was to recruit 20 Native teens between the ages of 14-18 to participate in the pilot. **Objective 2** was to secure instructors to implement the intervention. Experienced male and female instructors (one of each gender) were recruited from the SN-TPPP pool of certified BART instructors. **Objective 3** was to pilot the adapted intervention with at least 10-15 Native teens between the ages of 14-18 in order to evaluate the adapted curriculum content and delivery for cultural appropriateness.

Objective 1: recruitment.

A. Participants

The target population for recruitment was Native males and females between the ages of 14-18 that are enrolled in an U.S. federally recognized tribe and that reside within the Las Vegas Metropolitan area. The inclusion criteria were that participants must be a registered member of any of the ~572 U.S. federally recognized tribes and between the ages of 14-18 years old. The exclusion criteria are if they are not a member of a U.S. federally recognized tribe and/or if they are outside of the mandated age range.

B. Participant recruitment

Recruitment involved multiple strategies. To assist with recruitment, the researcher collaborated with the Las Vegas Paiute Clinics' Native Nations Youth group and the Las Vegas Indian Center's Youth group. In addition, disseminating flyers and utilizing social media served as recruitment strategies. Specific details on the strategies are described below.

The Las Vegas Paiute Clinic

The former Family Therapist at the Las Vegas Paiute Clinic and the former facilitator of the Las Vegas Paiute Clinic's Native Nations Youth group assisted with recruitment. The former facilitator verbally recruited participants during his counseling sessions that he conducted with youth and/or their families at the Las Vegas Paiute Clinic. If they were interested, the facilitator gave the project's contact information to parents/guardians.

Las Vegas Indian Center

The Las Vegas Indian Center has a youth group focused on alcohol and substance abuse prevention. The youth group consists of approximately 150 youth aged 5-20. The project was announced during the youth group's Thursday night activities to parents, guardians, and youth aged 14-18 years. A sign-up sheet list was generated for interested participants.

Flyers

A flyer (Appendix C) was created to disseminate information about the project. A flyer was posted at the Las Vegas Paiute Clinic. The flyer had the project's contact information on it so the participant's parents/guardians could sign-up for the project. A list was generated from phone calls received by interested parents/guardians.

Social Media

The flyer was posted on Facebook, a social media site, to an open group called "Las Vegas Native." This group has about ~200 members that consist of Natives living in the Las Vegas metropolitan area. The purpose of this group is to provide local community members with tribal community information. Questions and inquiries were primarily answered via Facebook and a list was generated from interested parents/guardians via Facebook messages.

C. Protection of human subjects

All participants were required to complete a registration form (Appendix D), an UNLV assent to participate in research form (Appendix E), an UNLV informed consent (Appendix F), and an UNLV parent permission form (Appendix G) that each had to be signed by a legal parent/guardian (if under the age of 18 years old) before they were allowed to participate in the intervention. Two consent forms that were distributed, UNLV informed consent and UNLV parent permission form, consented that participants may either be audiotaped or videotaped for research purposes. In addition, participants were required to submit a copy of their tribal enrollment document (tribal card or Certificate of Indian Blood document). All surveys, questionnaires, and consent forms were approved by UNLV's Institutional Review Board. All information from this study was kept confidential by the researcher, co-instructors, and the focus group moderator. However, confidentiality could not be guaranteed among the participants, their family members, or guest speakers. Besides the registration and consent documentation, there were no written or oral materials that could link participants to this study. All documentations were stored at UNLV in a locked facility for five years after the

completion of the study. After five years of the study the documentation collected will be destroyed.

D. Attendance monitoring

To monitor the attendance, a co-instructor distributed a sign-in sheet for each day and participants had to sign the sheet at the beginning of each day. Participants' names on the attendance sheet were pre-populated by the researcher using the information that was provided on the program sign-up sheet during recruitment. A co-instructor ensured that the attendance sheet was completed each day. Attendance monitoring was used for retention measurements.

E. Participant incentives

Incentives were given to participants for recruitment and retention purposes. Each participant received a $75 incentive upon completion of the 2-day pilot directly after the completion of the surveys. If they participated in the focus group, they received an additional $25 directly after the completion of the interview. Breakfast and lunch was served each day. The parents/family of the participants were invited to join project instructors and participants from 8:30 am to 9:00 am each morning before instruction started to eat breakfast and/or ask questions about the intervention, if needed. Participants received a participant workbook (Appendix H) to keep after the intervention was completed.

Objective 2: formation of the instructor team.

The BART intervention requires two instructors (one male and one female) due to the condom demonstration activity. Two groups are separated into female and male groups during the condom demonstration activity so the instructors can conduct this activity with their own

respective gendered groups. Having one male and one female co-instructor is mandated by the BART intervention to adhere to fidelity.

Objective 3: pilot the adapted BART curriculum.

A. Pilot test

The adapted intervention plus additional sessions were piloted among the Native youth to evaluate: A) The degree to which the curriculum was culturally relevant to the developmental issues of the Native population; B) The degree to which the curriculum addressed the cultural values, beliefs, and attitudes of the Native population within the contexts of their socio-cultural system; and C) The degree to which the curriculum should promote relevant changes in health behaviors of persons in their normal cultural and socialization contexts. The intervention was held at the UNLV School of Community Health Sciences building on Saturday, February 21, 2015 from 9:00 am -5:30 pm and on Sunday, February 22, 2015 from 9:00 am -6:00 pm.

B. Time frame

The BART is recommended to be taught with the original eight 90-120 minute sessions delivered over 8 weeks. If needed, the BART can be condensed into 4 weeks by delivering two sessions per week with at least 48 hours apart. As stated previously, SN-TPPP implements a modified version of the BART curriculum, with the abstinence session preceding the BART sessions. The pilot also implemented the SN-TPPP's modified version of the BART intervention. Timeframe changes were implemented within the pilot to accommodate the specific project based on research objectives, retention, and resources. The pilot implemented the two new sessions prior to the abstinence and BART sessions. The pilot was conducted over two days at 8

hours per/day. Maintaining fidelity to the BART intervention timeframe is necessary. However, the purpose of this project is to review acceptability of the adapted content.

Phase III-Mixed Methods Evaluation

Phase III utilized mixed methods evaluation design to assist in evaluating the implementation. A mixed methods design allows for the simultaneous collection of both quantitative and qualitative data, a process for combining these data, and using the results to understand the research question (Creswell, 2003). The central principle is that the use of quantitative and qualitative approaches combined can deliver a better understanding of the research problem (Creswell & Plano Clark, 2007). The justification for mixing methods is that neither quantitative nor qualitative methods alone are sufficient to produce results desired for the study.

In this pilot, the HIV Knowledge survey and items from the end-of-session and end-of-intervention surveys provided quantitative data. Items from the end-of-session and end-of-intervention surveys as well as the focus group provided qualitative data. These evaluation methods combined produced a more complete analysis on evaluating the cultural appropriateness of the adapted intervention.

Four evaluations occurred in this phase. **Evaluation 1** was used to gather pre-intervention and post-intervention knowledge. **Evaluation** 2 gathered feedback on curriculum content and activities from participants in the intervention sessions. **Evaluation 3** distributed end-of-intervention surveys to gain feedback on curriculum content and activities. **Evaluation 4** was to conduct a focus group with 4-6 participants at the end of the program to collect qualitative data about curriculum content and activities.

Table 4.1. Summary of Evaluation

Evaluation	1.HIV Knowledge	2.Curriculum content/activities feedback	3.Verbal feedback from participants	4.Overall curriculum content/activities feedback
Data Type	Quantitative	Quantitative Qualitative	Qualitative	Quantitative Qualitative
Data Collection	Pre/Post surveys	End-of-session surveys	Audio recorded focus group	End-of-session surveys

In Table 4.1, a summary of the five evaluations are indicated. The evaluations consist of either quantitative or qualitative data, or both. There were various forms of data collection instruments, such as surveys, sign-in sheets, and an audio recorded focus group interview. These specific data collection procedures are outlined below.

Evaluation 1: HIV knowledge survey.

A. Process

The HIV Knowledge survey (Appendix I) measures the participant's knowledge of HIV, transmission, and clinical symptoms. This survey instrument was developed by the original BART creators and came with the BART intervention materials. Data for this study was collected using self-administered paper and pencil surveys. The survey has 20-items related to HIV knowledge that consists of true, false, and not sure questions. This survey was distributed before the start of the first session and distributed at the end of the last session of the intervention. The participants utilized their first and last names as their identifiers. The reason for this was to alleviate any coding errors that were previously noted as an issue with the SN-TPPP.

The co-instructors were to present to administer the surveys. For the distribution of the surveys before the start of the first intervention session, co-instructors asked every adult to

leave the room where the session was being held. The co-instructors explained to the participants:

1. To complete the pre-survey.
2. That the pre-surveys will not be graded, but merely implemented to determine what their HIV/AIDS knowledge currently is so it can be compared to their post-survey to measure their learning.
3. To write their full name at the top of the pre-survey.

Co-instructors then distributed the surveys to the participants and stayed in the room to answer questions that the participants had in regards to the survey. The participants gave their completed survey back to a co-instructor. Each survey was placed in a secured envelope for data entry and storage.

For the distribution of the survey at the end of the last intervention session, co-instructors ensured that no adults were in the room where the participants were meeting. The co-instructors then explained to the participants:

1. To complete the post-survey.
2. That the post-surveys will not be graded, but merely implemented to determine what their HIV/AIDS knowledge currently is so it can be compared to their pre-survey to measure their learning.
3. To write their full name at the top of the post-survey.

The staff person then distributed the survey to the participants and stayed in the room to answer questions that the participants may have in regards to the survey. The participants gave their completed survey back to a co-instructor. Each survey was placed in a secured envelope for data entry and storage.

B. Data entry and analysis

For statistical analysis, the paired t-test was used to calculate the statistical means, standard deviation, t-test, p-value, and confidence intervals. The paired t-test analysis was used because

it compares two population means where you have two samples, meaning it can be used for one group that measures the dependent variable twice to examine if the mean of the first measurement is different from the mean of the second (Daniels, 2005). The paired t-test calculates the difference within each before and after pair of measurements to determine whether the difference of the means is statistically significant (Daniels, 2005).

The pre-surveys were coded by giving all correct answers 1 point and giving all incorrect answers 0 points. Similarly, the post-surveys were coded by giving all correct answers 1 point and giving all incorrect answers 0 points. Each participant had their individual pre/post surveys coded and their individual points were tallied from each pre/post survey. The tallied score from each pre/post survey were inputted into SPSS and the paired t-test statistical analysis was conducted to determine the statistical data.

Evaluation 2: end-of-session surveys.

End-of-session surveys (Appendix J) were developed to collect feedback on each intervention session. There were a total of twelve end-of-session surveys distributed:

- Introduction
- Past, Present, Future
- Relationship to Self & Others
- Options
- BART Session 1-Understanding HIV/AIDS
- BART Session 2-Making sexual decisions & understanding your values
- BART Session 3-Developing & using condom skills
- BART Session 4-Learning assertive communication skills
- BART Session 5-Practicing assertive communication skills
- BART Session 6-Personalizing the risks
- BART Session 7-Spreading the word
- BART Session 8-Taking B.A.R.T. with you

The surveys were comprised of open-ended and Likert-scale questions. The questions were primarily focused on the participants' reactions relative to the sessions' value, usefulness, satisfaction, applicability, appropriateness, and relevance to culture and HIV/AIDS, STIs, and teen pregnancy prevention. Some questions were focus on the technical components of the program relative to the delivery, quality, organization, participation, and resources.

Each end-of-session survey has five components. ***Component 1*** asked participants to rate the technical content of each session using a Likert-scale (very poor, poor, fair, good, very good) on the following items: (1) Informational content; (2) Organization; (3) Easy to understand; (4) Interesting; (5) Involvement of your participations; and F) Workbook materials. ***Component 2*** incorporated two different subset of questions for the same activities: (A) Asked participants to rate the specific stated activities by using a Likert-scale (very poor, poor, fair, good, very good) to rate each of the activities; (B) Asked participants to rate how well they connected to the specific stated activities as a Native teen by using a Likert-scale (very poor, poor, fair, good, very good) to rate each of the activities. ***Component 3*** asked participants to rate the overall session's cultural appropriateness, the overall session's content cultural appropriateness, and the overall session's activities cultural appropriateness by using a Likert-scale (very poor, poor, fair, good, very good). ***Component 4*** asked participants each session how much percentage of the presented information was usable to them by using a percentage Likert-scale (0-20%, 21-40%, 41-60%, and 61-80%, 81-100%). ***Component 5*** consists of six open-ended questions about the session: (1) What do you think other Native teens would like most about this session; (2) How did the Native content help you connect to the activity?; (3) What was the single best thing about this session?; (4) What one thing would you change about this

session? Why?; (5) What would you like covered that wasn't covered today?; and (6) Are there any topics you feel should be added to this session?.

A. Process

Co-instructors distributed the end-of-session surveys to participants after each completed session. A 15-minute break was taken between each session so instructors could distribute the surveys to each participant. Participants used pencil/pen to complete the surveys Participants were asked not to write their names on the surveys. The completed surveys were returned to the instructors.

B. Data analysis

For ***Component 1*** the Likert-scale (very poor, poor, fair, good, very good) frequencies were calculated for each of the items: (1) Informational content; (2) Organization; (3) Easy to understand; (4) Interesting; (5) Involvement of your participations; and F) Workbook materials. For ***Component 2A*** the Likert-scale (very poor, poor, fair, good, very good) frequencies were calculated to determine how the participants rated each of the activities indicated for that session. For ***Component 2B*** the Likert-scale (very poor, fair, good, very good) frequencies were calculated to determine how well the participants connected to each of the activities indicated for that session. For ***Component 3*** the Likert-scale (very poor, poor, fair, good, very good) frequencies were calculated to determine how participants rated the overall session's overall cultural appropriateness, the overall session's content cultural appropriateness, and the overall session's cultural appropriateness. For ***Component 4*** the Likert-scale (0-20%, 21-40%, 41-60%, and 61-80%, 81-100%) frequencies were calculated to determine how much percentage of the information presented was usable to the participant. All of the frequency percentages are

presented in table format in Chapter 5. For ***Component 5*** the feedback was summarized and included in the results section for qualitative analysis. This component had six open-ended questions that were evaluated by summarizing the feedback and indicating it for each session in Chapter 6.

Evaluation 3: end-of-intervention surveys.

End-of-intervention surveys (Appendix J) were developed to collect feedback on the overall intervention. The surveys were developed to evaluate the overall intervention, including the content and activities. Therefore there are two separate components in this survey. ***Component 1*** asks participants to rate the overall intervention's cultural appropriateness, the overall intervention's content cultural appropriateness, and the overall intervention's activities cultural appropriateness by using a Likert-scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree). ***Component 2*** consists of six questions about the session: (1) Do you feel the content of this intervention were culturally appropriate? (If yes, why? If no, Why?); (2) Would you recommend this intervention to Native teens? (If yes, why? If no, why?); (3) Which of the following techniques helped you learn the best? (Circle all that apply-small group discussion, lecture, role playing, individual work, video examples, sharing by participants, Native cultural stories/teachings); (4) What were the weaknesses of this intervention?; (5) What were the strengths of this intervention?; and (6) My general comments and suggestions for improving this intervention are?.

A. Process

At the end of the final session this survey was distributed by co-instructors simultaneously with the HIV/AIDS Knowledge survey and end-of-session survey. Co-instructors collected the completed surveys. Participants were asked to not write their names on the surveys.

B. Data analysis

For ***Component 1*** the Likert-scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree) frequencies were calculated to determine how participants rated the overall intervention's overall cultural appropriateness, the overall intervention content cultural appropriateness, and the overall intervention's cultural appropriateness. The frequency percentages are presented in table format in Chapter 5. For ***Component 2*** the feedback was summarized and included in the results section for qualitative analysis. This component had six questions that were evaluated by summarizing the feedback and indicating it for each session in Chapter 6.

Evaluation 4: evaluation-focus group.

Based upon the end-of-session and end-of-intervention surveys a focus group was conducted to collect additional qualitative data for evaluation purposes. The ability to reunite the participants is desired in understanding any ambiguities from the original open ended questions asked after initial evaluation methods (Bloor, Frankland, Thomas, & Robson, 2001). The purpose of the focus group was to enhance the program evaluation by gaining deeper insights into what the participants liked or did not like about the intervention. Qualitative data is identifying descriptive input that can be separated into pieces to appropriately explain

phenomena (Creswell, 2002). Creswell (2000) further states that surveys cannot substantiate what a focus group does. Focus groups produce data that are communicated in the participants' own words and context, therefore, produce minimal fake responses (Stewart & Shamdasani, 2015).

A. Facilitation

The focus group facilitator is essential to guarantee that the group discussion goes efficiently (Stewart & Shamdasani, 2015). An effective focus group facilitator has functional individual and situational factors (Stewart & Shamdasani, 2015). These factors include personal characteristics (e.g., age, personality, racial/ethnic background), educational background, training, and amount of experience as a moderator. Therefore, the focus group facilitator should be experienced in group dynamics and interview skills (Stewart & Shamdasani, 2015). It has also been demonstrated that facilitators of the same race/ethnicity as the participants generally increase the willingness of participants to participate because participants tend to identify with and trust them (Stewart & Shamdasani, 2015). Based upon her personal and situational factors, the focus group facilitator was Dr. Carolee Dodge-Francis (Oneida tribe) who is an experienced qualitative researcher among tribal populations at UNLV. Dr. Dodge-Francis conducted the focus group, rather than the researcher, due to her professional experience and to reduce biased feedback from the participants regarding the intervention.

B. Focus group guide

A focus group guide (Appendix J) was developed that consisted of a series of twelve open-ended questions, including opening, introductory, transition, and key questions. In practice, most interview guides consist of about twelve or less questions (Stewart &

Shamdasani, 2015). The focus group guide was developed by the researcher under the guidance of Dr. Dodge-Francis. Skilled facilitators have a profound sense of what questions "work" and what questions may be challenging (Stewart & Shamdasani, 2015).

The focus group guide was based upon questions that referred to the intervention. Similar to the survey questions, the focus guide questions were primarily focused on the participants' reactions relative to the sessions' value, usefulness, satisfaction, applicability, appropriateness, and relevance to culture and HIV/AIDS, STIs, and teen pregnancy prevention. Some questions were focused on the technical components of the program relative to the delivery, quality, organization, participation, and resources. Discussion questions consisted of main research and leading questions. According to Stewart and Shamdasani (2015) the main research question(s) are focused on the discussion among issues that are directly related to the purpose of the session. The leading questions are focused on generating the discussion toward deeper meaning and often asking "Why?" (Stewart & Shamdasani, 2015).

It has been recommended that both the facilitator and the types of questions in the interview guide should be compatible with the participants who will be interviewed (Stewart & Shamdasani, 2015). The introductory questions were broad then followed on a continuum to more specific questions. The questions were phrased in simple language so the participants were able to easily understand.

C. Process

Convenience sampling was used to recruit participants from the intervention to be a member of the focus group. It is noted by author, Barbour (2014) the recommended focus group size for recruitment is between 6-8 participants. The focus group consisted of seven

participants, two males and five females between the ages of 14-18 years old. The focus group was conducted two days after the intervention on February 24, 2015. The focus group took place in the conference room at the Las Vegas Indian Center and lasted 75 minutes. It has been demonstrated that focus groups feel more comfortable when seated around a table (Stewart & Shamdasani, 2015). Therefore, the facilitator and the participants sat around a conference room table while conducting the session.

The focus group facilitator and the participants were the only persons in the room while the focus group was conducted. The focus group was audio-recorded using Sony digital voice recorder. The facilitator asked the participants to pick a "spirit animal" (e.g., eagle, duck, sheep) and write their animal on a name card. To ensure the protection of their privacy the participants were only called by their animal name during the interview.

D. Data analysis

The entire focus group discussion was transcribed verbatim by the researcher based on the audio recording. The method of analysis that was used is called the scissor-and-sort technique (Stewart & Shamdasani, 2015). The first step of this technique was to read through the transcript and identify the sections that were relevant to the research question. A categorization system for major themes was developed and material related to each topic was identified. The major themes and related topics were color-coded to mark the different themes within the text with colors. The researcher conducted multiple readings through the transcripts in order to acknowledge evolvement of themes. Once the coding process was complete, the color coded copy of the transcription was cut apart with scissors. Each piece of the coded

material was cut and sorted according to the themes. The themes were used as supporting data and were incorporated within the interpretative analysis (Stewart & Shamdasani, 2015).

Chapter 5: Results

Project Phases

This pilot test project occurred in 3 phases: 1) adaptation; 2) implementation; and 3) evaluation. The pilot test was conducted to address the research question: What *content* changes are needed in order to adapt the BART curriculum to meet the needs of Native teens? The results of this pilot project are separated into the three phases and are described below.

Phase I-Adaptation

Phase one was the adaptation of the BART intervention. The objective of Phase 1 was to utilize an advisory committee to help guide the adaptations of the BART intervention. In addition to the utilization of an advisory committee, a literature review, research on different interventions and/or resources, BART adaptation guidebook, and the researcher's expertise guided the adaptations that were made. In general, the adaptations made were primarily through the addition of culturally appropriate content in order to maintain fidelity to BART, versus removing content from the curriculum. This section explains: 1) Outcomes of the advisor recruitment and 2) BART recommendations and adaptations.

Advisor recruitment. To assist with adaptations, thirteen persons agreed to participate as an advisor. Of the thirteen, five advisors made recommendations. Three of the five advisors who made recommendations made recommendations for eachsession. The five advisors who provided recommendations are listed below:

1. Mattie Tomeo-Palmanteer, BSW (Confederated Tribes of Colville and Yakama Nation), Native VOICES Project Coordinator, Northwest Tribal Epidemiology Center, Northwest Portland Area Indian Health Board

2. Kyle Ethelbah, MPH (White Mountain Apache), Director of TRIO Programs, University of Utah

3. Philene Herrera, (Navajo), Health Program manager, Navajo Nation Health Education Program, Navajo Nation Department of Health

4. Lyle Harvey, (Navajo), Dine' Language Consultant, Bahozhoni Consulting

5. Jessica Danforth, (Ojibiwe), Executive Director, Native Youth Sexual Health Network

BART recommendations. The recommendations were compiled and consistent recommendations were taken into highest priority when making the adaptations. Consistent recommendations were determined when two or more advisors used key terms or made recommendations for either one specific question and/or in general throughout the curriculum. The main recommendations that the advisors provided were considered to be the top priorities when adapting the BART intervention. The advisors recommended that these main themes should be incorporated before the abstinence and BART 1-8 sessions, which were:

- *I think it would be helpful to add culturally specific gender roles to this. Many tribes are matrilineal and matrilocal. This means the family lines go through the female. Athabascan peoples (Navajos and Apaches) still honor this connection to the sacred feminine through the Kinaaldaa and the Na'iiees – puberty ceremonies for the females.*

- *Native prevention gives students' holistic understanding of why their mind, body, and spirit are unique. How their elders and community went about their life socially, mentally, spiritually, and ceremonially. Through that there is a connection to understand their contribution and role/responsibility to their family and friends and above all their LIFE.*

- *In order to survive and participate successfully in mainstream culture, Native students must learn an extrinsic way to walk, talk, think and act, behaving as their innate Native self only when they are at home in their Native environment. This expectation places the burden of assimilation squarely on the shoulders of Native students and can be brutalizing to their identity, spirituality, and clarity.*

- *Nice to include the fact that the child is Native and that their mind, body, and spirit are important, not only to them but to their family, clan, community.*

Generally, it was recommended to include matrilineal/matrilocal tribal social structures within tribal communities with their associated tribal stories and cultural teachings. Also, it was recommended to include Native puberty ceremonies along with their connected cultural significance that relates to self-responsibility, cultural teachings, family, and community. Similarly, it was recommended to include Native philosophy and cultural teachings and how it relates to holistic worldviews, daily practices and understanding, and shared roles/responsibility between youth, family, and community. Last, the burden of colonization and historical trauma were recommended so participants can understand contributing factors of disparities within Native communities. Based upon these consistent recommendations, two new sessions were developed and implemented prior to the start of the abstinence session. The two new sessions that were developed and implemented were “Past, Present, Future” and “Relationship to Self & Others.”

The less consistent recommendations were taken into lowest priority and determined if one advisor made a recommendation on either one specific question and/or in general throughout the curriculum. Numerous recommendations that were recommended throughout the curriculum were not utilized due to the development and implementation of the two new sessions, which had already addressed those numerous recommendations. In addition, some recommendations were not utilized due to lack of feasibility either due to lack of resources and/or curriculum fidelity concerns. Also, majority of the specific recommendations were submitted for the abstinence and BART 1-5 sessions. BART 6-8 sessions had some recommendations, but not as significant as the abstinence and BART 1-5 sessions.

BART adaptations. Majority of the adaptations were conducted for BART 1-5 sessions while BART 6-8 sessions had minimal adaptations. There are twelve tables listed below that will demonstrate the adaptations that were completed for each session. The tables below provide: (1) BART intervention, which is the original BART content and the implementation procedures verbatim; (2) Adapted SN-TPPP BART, which are the adaptions the SN-TPP made to BART; (3) recommendations from advisors, which are the recommendations the advisors made to adapt the abstinence and BART sessions; (4) the content that was actually adapted and implemented for this pilot project.

A. Introduction

The title of the intervention was changed from "Becoming A Responsible Teen" to "Becoming A Responsible Native Teen" (BARNT) as part of the introductory adaptations. The BART curriculum conducts the introduction activity during BART 1-Session 1, whereas the SN-TPPP adapted BART conducts the activity during the abstinence session. For this pilot project, the introduction was conducted at the beginning of the first session, Past, Present, Future, which was a new session that was developed and implemented.

The name *ground rules* activity was changed to *agreements* activity. For this activity co-instructors state the intervention's foundational ground rules, clarify what they are, and ask participants to agree to abide by them throughout the intervention. The co-instructors ask the participants to contribute additional ground rules, if they wanted. An advisor recommended the name change because teens may be tired of hearing about ground rules from their school and home environments. The advisor thought this title would be more well-received by the participants.

An opening prayer and “smudge” was conducted by a community elder of the Sioux Nation. “Smudging” is a Native cleansing procedure that uses the smoke from the burning of certain herbs to cleanse the mind, body, and physical space(s). This cleansing rids the mind and body of negative energies to purify and promote health. The researcher thought this activity was culturally appropriate based on personal experiences of participating in cultural blessings to promote health and wellness. Per the literature review, the practice of Native ceremonies and healing often includes native herbs (Joe, 2008). In addition, the introductions were conducted in a “Talking Circle” format and included the participants’ tribal affiliations and clans. An important social structure of Natives is to properly identify themselves in a cultural context, so they could further connect with extended families, clans, tribal affiliations, bands, and patriarchal or matriarchal structures (Nakai et al., 2004).

There was a small activity incorporated into this session, which is called Descriptive Names activity. There were empowering descriptive names that were developed and placed in bag, so participants could “draw” a descriptive name out of the bag. Some examples of the descriptive names were: fabulous, wonderful, genius, spectacular, charming, etc… The participant would draw their descriptive name and write it on their name cards along with their name. For example, a name card would read “Fabulous Francine”, and the instructors would call them that throughout the intervention.

Last, Moola was not implemented for this pilot. The Moola is an incentive exercise that has been adapted for the SN-TPPP. Moola points are distributed in the form of one (1) ticket representing one (1) Moola point. Participants have the opportunity to earn Moola points for class participation and other positive actions in each session. Moola points are collected at the

end of each session and recorded. Moola points are accumulated throughout all the sessions and redeemed at the end of the project at graduation. The cumulative Moola points for each individual are posted at the end of the intervention so all participants can view their personal score. All participants who complete the program will have the opportunity to redeem their Moola points for gift cards and gifts with value ranging from $5-$50. The participant with the most Moola points gets to choose the first gift and/or gets the most expensive gift available, and so on. The participants were granted different incentives in lieu of Moola. Table 5.1 outlines the introductory adaptations that were recommended and made.

Table 5.1. Introductory Adaptations

BART	Adapted SN-TPPP BART	Recommended Adaptations	Adapted BARNT Content
-Introductions are conducted during BART Session 1- Activity 1	-Introductions are conducted during *Abstinence* session -Moola are implemented, which are incentives for increased participation -Comment or suggestion box included	-Utilize a "talking stick" for introduction -Use an engaging activity from the Native Wellness Institute (please refer to scanned copy of the "Switch"activity) -Use "agreements" vs. "groundrules" -Requesting a guest speaker to speak about personal experience about HIV -Ask about traditional community values & writing it on easel board -Write on paper, place in box, & draw paper for students to read and open discussion -If no personal story is available to discuss, I recommend a guest speaker or reading a story (Lisa Tiger's story & her experience with HIV and why youth should celebrate celibacy) -Story (http://virginislandsdailynews.com/news/aids-survivor-talks-about-positive-approach-to-condition-1.1070615)	-Changed name to "Becoming a Responsible Native Teen" -Conducted introductions during *Past, Present, Future* session (newly added session) -Changed term to "Agreements" instead of "Groundrules" -Invited Guest Elder/Spiritual person to do "Opening Prayer" & smudged -"Talking Circle" introductions -Introductions included: Tribal affiliation and Clans -There was no Moola implemented -Descriptive Names

B. Past, Present, and Future

The Past, Present, and Future session was a new 90-120 minute session that was developed and implemented for this pilot project. The objectives for this session are: 1) Participants will be challenged to think about "self-identity"; 2) Discuss their religious/cultural/spiritual values; 3) Discuss their family values; and 4) Discuss their goals and

purpose. These objectives incorporate foundational insights, thoughts and perspectives, as well as cultural values. The purpose of incorporating these objectives was to enhance protective factors against HIV/AIDS, STIs, and teen pregnancy using culturally appropriate curriculum.

This session had two modules of different activities. First, the 4 Questions activity had participants to think about four questions that relates to their past, present, and future. These questions enable participants to focus on self-identity by asking them to answer four questions within an Indigenous cultural, communal, tribal, and spiritual framework. The four questions are:

1. Who am I?
2. Where do I come from?
3. Why am I here?
4. Where am I going?

These questions intertwine self-identity with history by understanding terminology, facts, and tribal stories related to historical trauma, genocide, assimilation, and connecting them to their past, present, and future. These questions also connect the participants to their values, purpose, and future goals on an individual, familial, and community level. The question "Who am I?" discusses self-identity and self-concept from a Native context. The question "Where do I come from?" discusses colonization, historical trauma, and assimilation. The question "Why am I here?" discusses purpose and self-responsibility. The question "Where am I headed?" discusses goals, values, and responsibility to self, family, and community. Tribal stories from the Assiniboine, Kwakiutl, Lusieno, and Yakima tribes are incorporated into this activity to assist in answering the four questions that relates to past, present, and future.

The second activity, Goals and Values, reiterated participants to think about the four questions and how it relates to their personal goals, purpose, and self-identity. A "Rebel Music"

video, MTV production, was showed, which was about Native youth who are making a positive impact within tribal communities through music. This video reiterates the impact of goals, purpose, self-identity, which relate back to the 4 Questions activity. Also, the participants were divided into four groups to discuss the questions below:

1. Describe your religious/spiritual/racial/ethnic/cultural beliefs, traditions, and values.
2. Describe your family beliefs, traditions, and values.
3. How do your values impact your decisions?

Culturally relevant adapted interventions promote healthy behaviors that ultimately prevent disease(s) (Hecht et al., 2003). This session addressed numerous recommended adaptations, such as incorporating cultural stories/teachings and shared roles/responsibility between youth. The adaptations included content from advisors, research on videos from internet, research on various Native books that included tribal stories, and research on different interventions. Table 5.2 summarizes the new session that was developed.

5.2. Past, Present, Future Session

BART	Adapted SN-TPPP BART	Recommended Adaptations	Adapted Content: *Past, Present, Future*
-No are sessions conducted prior to BART Session 1	-No Session prior to abstinence session	-Holistic understanding -Extrinsic way to walk, talk, think, & act when in Native environment -Burden of assimilation -Values clarification (activity of family values & family experiences) -Cultural teachings -Shared role/responsibility between youth, family, & community	Developed and implemented new 90-120 minute session to discuss: -Self-Identity -Religious, cultural, spiritual values from a Native context -Discuss history: colonization, genocide, assimilation -Discuss family values -Discuss goals/purpose -Incorporated Native cultural stories/videos

C. Relationship to Self & Others

The Relationship to Self & Others session is a 90-120 minute session. The objectives for this session are: 1) Participants will get to know stories/teachings about tribal puberty ceremonies; 2) Participants will get to know traits about unhealthy/healthy relationships; and 3) Participants will get to know relationship to Mother Earth/Father Sky. These objectives were focused on relationships. Primarily, their relationship to themselves and how it transcends to other relationships. In reference to the literature review, the root of Native culture and spirituality is the worldview of understanding and practicing respect for the circle of life (Cunningham & Stanley, 2003). Within this worldview, the people are interconnected to themselves, other people, earth, air, water, and animals all need to be in harmonious balance. Therefore, respect, obligation, and responsibility are all granted to the circle of life (Cunningham & Stanley, 2003). This session incorporates the Native foundational worldviews

and cultural values that will enhance protective factors against HIV/AIDS, STIs, and teen pregnancy.

This session has a total of five activities: (1) Puberty is Ceremony; (2) Body Image; (3) Relationships; (4) Healthy Conflict; and (5) Relationship to Mother Earth and Father Sky. The Puberty is Ceremony activity had participants learn about female menstruation from a cultural context that incorporate female deities. This activity showed two videos about tribal puberty ceremonies, “Girls Rites of Passage” from the Apache tribe, and “Kinaldaa’ from the Navajo tribe. They also incorporated cultural stories about puberty from the Washo and Navajo tribe. The Body Image activity had participants learn about healthy and unhealthy body images. The Relationships activity enabled participants to examine characteristics of healthy and unhealthy relationships. The Healthy Conflict activity had participants examine healthy conflicts within a cultural context and incorporated a story from the Navajo tribe. The Relationship to Mother Earth and Father Sky activity enabled participants to examine their relationship to each by reading tribal cultural stories from the Navajo and Tewa Pueblo tribes.

All these activities addressed recommendations that include culturally specific gender roles (matrilineal/matrilocal), Native puberty ceremonies, holistic understanding, and cultural teachings. The adaptations comprised of content research on videos from internet, research on various Native books that included tribal stories, and research on different interventions. Table 5.3 summarizes the new session that was developed.

Table 5.3. Relationship to Self & Others Session

BART	Adapted SN-TPPP BART	Recommended Adaptations	Adapted Content: *Relationship to Self & Others*
-No are sessions conducted prior to BART Session 1	-No Session prior to *Abstinence* session	-Add culturally specific gender roles (Matrilineal/Matrilocal) -Native puberty ceremonies -Holistic understanding -Cultural teachings -Shared role/responsibility between youth, family, & community	Developed and implemented new 90-129 minute session to discuss: -Stories/teachings about Native Puberty Ceremonies -Traits of unhealthy/healthy relationships -Relationship to Mother Earth/Father Sky -Incorporated Native cultural stories/videos

D. Options (Abstinence)

As stated previously, the SN-TPPP implements a modified version of the BART intervention. Within the SN-TPPP, no adaptations were made to the content of BART, but an additional session, abstinence was developed and implemented. The abstinence session includes: (1) Defining abstinence and related terminology; (2) Discuss reasons to choose to be abstinence or postpone sex; (3) Game of how quickly HIV/STIs spread; and (4) Brainstorm alternatives to sex. The objective of this session is for participants to learn definitions of abstinence and sex and about the practice of abstinence.

Numerous recommendations were made by advisors within this session. Due to the development of the two new sessions, most of the recommendations were not utilized here as they were addressed in the new sessions. The session name, *abstinence,* was changed to *options*. According to the Native Youth Sexual Health Network (NYSHN), the term “abstinence” has a negative connotation to consider from a historical context. An advisor from the Native

Youth Sexual Health Network recommended that changing the session name was an important factor to take into account based upon the rationales stated below:

- *Abstinence – as you know this is a point of contention, not always meeting young people where they are at, reflecting their realities and lives, and often can come from shaming/blaming judgments of what they "should" and "shouldn't" do. We wonder instead of saying abstinence and framing in "absolutes" with lots of under and over-tones, to instead be about informed consent, options, awareness, education and information that speak to young people on their own terms and the multitude of realities and experiences they carry? This could include saying "no" to what we want, support for making decisions (especially when "choice" may not actually be present – considering the realities of violence, poverty, racism in healthcare services, etc) and saying yes to the things we do want, and more harm reduction supports free from stigma* (J. Danforth, personal communication, December 6, 2014).

- "Abstinence" also has different historical contexts to consider, particularly with the imposition of Christianity from colonization that specifically deemed sex/uality as "bad" and "evil". This is important to take into account for a curriculum for Native youth. If rites of passage and coming of age ceremonies, in addition to the restoration of Two Spirit and Indigenous LGBTQ teachings show us that we had/have practices and understandings of our bodies, relationships, and how they work – at what point did "abstinence" become forced? Or only about what we "don't" do from "moral" places as opposed to respecting self-determination and non-interference as standards of entire community or nation wellness? (J. Danforth, personal communication, December 6, 2014).

In reference to Table 5.4 (Appendix A), adaptations were made to Activities 2, 3 and 4. Statements and texts about Natives youth, sex, culture, language, and decision-making values was incorporated into the session verbiage. In Activity 2, the text "Relational, Cultural, and Ceremonial" was included as reasons why Native teens might abstain or postpone sexual activity. In Activity 3, no adaptations were made to the content/activities. In Activity 4, new text content was added to the student workbook about reasons to abstain or postpone sexual activity.

A new activity was implemented as an adaptation. A guest speaker, a tribal member of the Navajo Nation, is a pow-wow dance instructor at the Las Vegas Indian Center. She was

invited to speak about self-respect and conducted two culturally appropriate physical game activities, which were called “Sweep the teepee” and “Line up for cheese.” The activities used culturally appropriate terminology (e.g. teepee, owl dance) to describe different physical actions. Table 5.4 outlines the options adaptations that were recommended and made.

The remaining recommendations suggested incorporating females in the creations stories, Native puberty ceremonies, importance of language as part of their identity, spiritual discipline, self-identity related to culture, and different historical contexts. All of these recommendations were heavily incorporated in the Past, Present, Future and Relationship to Self & Others sessions and therefore were not incorporated into this session.

D. BART Session 1-Understanding HIV/AIDS

The objectives for this session are: 1) Explain how HIV/AIDS are affecting the Native community; 2) Show that they know how HIV is-and is not-transmitted; 3) Identify the levels of risk associated with a variety of behaviors; and 4) Recognize the important role they can play in helping stop HIV in their community. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. Six activities are in BART Session 1. The six activities are: (1) Introduction to B.A.R.T.; (2) Who is at risk for HIV and why?; (3) Introduction to HIV terms; (4) Facts & myths; (5) Deciding your risk level; and (6) Spreading the word.

As stated previously, under BART Session 1-Activity 1, “Getting to know each other”, was done at the beginning of BART Session 1-Activity 1. However, the SN-TPPP conducted this activity at the beginning of the abstinence session. BARNT conducted this session at the beginning of Past, Present, and Future session. As an adapted part of the BARNT activities (Refer to Introduction section, p. 103), an elder was invited to conduct an *Opening Prayer* and

"smudge." Also, the participants included their tribal affiliation/clans during Talking Circle introductions and the term *groundrules* were changed to *agreements*.

In reference to Table 5.5 (Appendix A), further adaptations were made to this session. All texts were changed from "African-American" to "Native" throughout the BARNT intervention. In Activity 2, based on recommendations and statistics were changed to reflect the general population for people aged 13-24 aged years and the Native population using the Center for Disease Control and Northwest Portland Area Indian Health Board epidemiological statistics. Additional information was added to explain why Natives are at higher risk for HIV infection from social determinants of health framework. Also, the whole activity of *Kwanzaa* was replaced with a Native *Medicine Wheel* for the strengths of prevention activity. The *Kwanzaa* is an activity that promotes cultural protective factors within the target population. The Medicine Wheel has been used for generations by Native tribes for health, healing, and well-being. The Medicine Wheel illustrates various cultural/spiritual metaphors to symbolize the cycles of life and natural elements for mental, physical, spiritual, social health, and environmental health. Activity 3 incorporated language about the increase use of meth and heroine on tribal lands when talking about how alcohol/drugs are a contributing risk factor to contracting HIV, STIs, or becoming pregnant.

As seen in Table 5.5, no adaptations were made to the content and activities for Activities 4-6 because the curriculum activities were concentrated on stating scientific facts about HIV/AIDS and transmission. Changing scientific facts about HIV/AIDS would compromise fidelity to the BART. Table 5.5 summarizes the adaptations that were recommended and made.

F. BART Session 2-Making sexual decisions & understanding your values

The objectives of this session are: 1) Explain that Natives are at high risk for HIV; 2) Explain how HIV is transmitted and how it can be prevented; 3) Examine their values regarding the decisions they make about activities that place them at risk for HIV; 4) Identify people they can talk to about safer sex and HIV; and 5) Share what they know about HIV with others. These objectives are from the BART intervention and due to fidelity issues, there are minimal adaptations. There are technically seven activities conducted in BART Session 2. However, an additional activity is included as an alternative activity in the event that there is not a video, “Seriously Fresh”, to show. For adaptation purposes all eight activities are included: (1) Definitions review; (2) Transmission review; (3) AIDS & African Americans; (4) HIV feud game; (5A) Video “Seriously Fresh”; (5B) Personalizing HIV risks (alternative activity); Exploring drug risks for HIV; (6) Exploring drug risks for HIV; and (7) Support systems.

In Activity 3, some of the terminology was changed to include tribal leaders, healers, and community members when questions were asked about the involvement of preventing HIV in our communities. In Activity 5A, the video was changed from the “Seriously Fresh” to “Native VOICES.” The “Seriously Fresh” was a video made for an African American audience by incorporating African American actors and culture. Likewise, the “Native VOICES” was made for a Native audience because it incorporated Native actors and culture. The “Native VOICES” video is a project to develop an evidence-based sexual health video for northwest tribes, which is a four-year grant from the Indian Health Service, issued through their Native American Research Centers for Health program (NARCH). The video provided by an advisor included accurate risk information, corrected misconceptions, and demonstrated culturally-specific strategies for

encouraging condom use and enhancing partner communication to reduce the incidence of HIV/STI and teen pregnancy.

In Activity 6, text about sexual abuse and drug-facilitated sexual assault definitions and the Native cultural implications were included. The definitions and the text that was utilized derived from the National Aboriginal Health Organization "Sexual Health Toolkit Part 2: Sexuality & Relationships" book that was developed for First Nations youth in Canada. The researcher thought it was important to include these definitions based on the literature review. It has been found that Native youth experience higher rates of violent and traumatic events (Manson et al., 2005). Also, Native females experience the highest rates of assault, rape, and IPV in the U.S. (Saylors & Daliparthy, 2005). Table 5.6 (Appendix A) provides a summary of these adaptations.

No adaptations were made to activities 1, 2, 4, 5B, and 7. In Activity 1, no adaptations were made because it was a review of HIV terminology from BART Session 1. In Activity 2, no adaptations were made because it was a review about HIV transmission from BART Session 1 and the recommendations made by advisors would have compromised fidelity to BART. In Activity 3, majority of the recommendations were utilized, however; due to time limitations, inviting tribal leaders/cultural experts to speak was not feasible. No recommendations were made for Activity 4, HIV feud game, therefore no adaptions were made. A summary of the adaptations are outlined in Table 5.6.

G. BART Session 3-Developing and using condom skills

The objectives for this session are: 1) Demonstrate correct condom application and removal skills; 2) Express confidence about using condoms effectively; 3) Identify condoms and

lubricants that can protect them from HIV if they are sexually active; and 4) Give an effective response if they encounter arguments against using condoms. These objectives are from the BART intervention and due to fidelity issues, they were not adapted. Five activities are in BART Session 3. The five activities are: (1) Using and developing skills; (2) Learning the facts about condoms; (3) Overcoming embarrassment about buying condoms; (4) Using condoms correctly; and (5) Countering barriers to using condoms.

As summarized in Table 5.7 (Appendix A), minimal adaptations were made to this session. In Activity 1, follow-up questions were asked about the “Native VOICES” video that was shown in BART Session 2. The video also included associated questions, which were developed by the NARCH program. Also, Native high school students and sexual activity statistics were included. The statistics derived from the literature review and the YRBSS. In Activity 3, a “Golden Girls” YouTube clip was included about overcoming embarrassment and buying condoms. This clip was recommended by an advisor to “loosen up” students.

No adaptations were made to Activities 2, 4, and 5. In Activity 2, the recommendations that were made were not used because the activity taught those recommendations within the activity. In Activity 4 and 5, no recommendations were made due to time limitations of inviting a family planning counselor and the researcher thought this was not feasible due to fidelity concerns of BART. Also, the recommendation of sharing the cultural message about how Navajos used to herd sheep to curb the release of the female eggs as a method of birth control was not utilized due to not having adequate information of the topic. In Activity 5, the recommendations were not made either by not having adequate information and some of the

recommendations were already addressed in other sessions. Table 5.7 outlines the adaptations that were recommended and made.

H. BART Session 4-Learning assertive communication skills

The objectives for this session are: 1) Identify barriers to talking with a partner about protection; 2) Use problem-solving skills to identify possible ways to talk to a partner; 3) Distinguish between assertive, aggressive, and passive communication styles; and 4) Learn to communicate effectively to protect their own health and the health of those they care about. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. There are technically four activities conducted in BART Session 4. However, an additional activity is included as an alternative activity in the event that there is not the video, “Are you with me?, to show. For adaptation purposes all five activities are included: (1) Correct condom use review; (2) Video “Are you with me?”; (3A) Negotiating safer sex (alternative activity); (3B) Problem solving skills; and 4) Different communication styles. Table 5.8 (Appendix A) summarizes the adaptations to this session.

No adaptations were made to BART Session 4. In Activity 1, no adaptations made were made because this activity is a review of condom use from BART Session 3. Some of the recommendations were not used because there was no access to obtain suggested materials, such as Ayn White curriculum, fish bone diagram, and communication models. Also, due to time limitations it was not possible to implement the alternate activity. The alternative activity, *Negotiating Safer Sex*, was highly recommended to be implemented as a mandatory activity. However, this recommendation will be considered for future pilots. A summary of the adaptations are outlined in table 5.8.

I. BART Session 5-Practicing assertive communication skills

The objectives for this session are: 1) Differentiate between passive, aggressive, and assertive communication; 2) Respond assertively in emotionally or sexually charged situations; 3) Practice assertive communication, negotiation, and refusal skills; and 4) Give feedback to others about their communication styles. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. Five activities are in BART Session 5. The five activities are: (1) Assertive communication review; (2) Participants learn practical tips for assertive communication; (3) Ways to say "No"; (4) Assertive communication roleplays; and (5) Assertive communication practice. See Table 5.9 for a summary of these adaptations.

No adaptations were made for BART Session 5. In Activity 1, no adaptations were made because this activity is a review of communication styles from BART Session 4. Also, some of the recommendations, such as including life goals, was addressed in the Past, Present, Future session. Also, including molestation or sexual exploits in this session was not feasible due to limited timeframe. Overall, most of the recommendations that were made have been addressed in the two new developed sessions and/or were addressed in this session and/or other BART sessions. A summary of the adaptations are outlined in table 5.9 (Appendix A).

J. BART Session 6-Personalizing the risks

These are the objectives for this session: 1) Explain that HIV is affecting their peers; 2) Show compassion for someone who has HIV; and 3) Acknowledge that they can get HIV if they engage in risky behaviors. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. There are technically two activities conducted in BART Session 6. However, an additional activity is included as an alternative activity in the event that there is a

guest speaker unavailable to do a presentation. For adaptation purposes all three activities are included: (1) Meeting people with HIV; (2) Video (alternative activity); and (3) Discussion and debrief.

The BART has 1-2 African American guest speakers who are HIV positive to speak to participants. There are no Native guest speakers who are HIV positive in the Las Vegas metropolitan area to invite as guest speakers for BARNT. The alternative activity was used in lieu of guest speakers. The video, the alternative activity, was a Native woman talking about her personal experiences of contracting HIV. Due to limited time, access to speakers, and fidelity concerns, a family/school counselor was not invited to speak to participants per recommended by an advisor. Activity 2 had no adaptations made to the content/activities because no recommendations were received from advisors. A summary of the adaptations are outlined in Table 5.10 (Appendix A).

K. BART Session 7-Spreading the word

The objectives for this session are: 1) Identify ways to get out of risky situations; and 2) Use effective communication strategies to talk with friends and family about HIV. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. Four activities are in BART Session 7. The four activities are: (1) Assertive communication in the real world; (2) Getting out of risky situations; (3) Spreading the word demonstration; and (4) Word practice.

As noted in Table 5.11 (Appendix A), no adaptations were made for BART Session 7. Activity 1 and 3 had no adaptations because the advisors did not make any recommendations for those activities. The remaining recommendations that were made for Activity 2 and 4 were

addressed for in the two new developed sessions and/or were addressed in this session and/or other BART sessions. A summary of the adaptations are outlined in Table 5.11.

L. BART Session 8-Taking B.A.R.T. with you

The objectives for this session are: 1) Demonstrate confidence that they can use the skills taught in B.A.R.T; and 2) Communicate accurate information about transmission of HIV. These objectives are from the BART intervention and due to fidelity issues, they are not adapted. Four activities are in BART Session 8. The original four activities are: (1) Final review of HIV facts; (2) What are you doing to protect yourself?; (3) What are you doing to educate others?; and (4) Graduation.

As indicated in Table 5.12 (Appendix A), a new activity was developed and implemented. This new activity is Activity 1, Sex and Traditional Stories. The Sex and Traditional Stories activity was derived from the Native Students Together Against Negative Decisions (STAND) intervention, which is a peer education curriculum for healthy decision making for Native youth. In this activity participants learn lessons about sex and responsible decision making through traditional stories. Six tribal stories are included in this activity: (1) Coyote Carelessness (Confederated Tribes of Warm Springs); (2) Coyote Dances with a Star (Cheyenne tribe); (3) Coyote and Mallard Duck (Nez Perce tribe); (4) Iktome and Ignorant Girl (Brule Sioux tribe); (5) Tolowin Woman and Butterfly Man (Maida tribe); and (6) The Woman Who Loved the Serpent Who Lived in a Lake (Passamaquoddy tribe).

Another new activity was developed and implemented, which was Activity 3, Self-reflection activity. This activity is based on and uses the four questions that was presented in the 4 questions activity in the Past, Present, Future session. Questions were asked in relation to

the previous four questions (e.g. Who am I?, Where do I come from?, Where am I going?, Why am I here?) that prompt participants to think about prevention and healthy decision making. Also, a tribal story, “Man in the Maze”, from the Tohono O’odham tribe was developed and implemented. The “Man in the Maze” story illustrates the journey of life and the choices to be made within it.

No recommendations were made for Activity 6. Activity 1 and 3 were implemented as an adaptation. The other recommendations were addressed previously in other sessions. Also, a formal Graduation activity was not conducted at the end of the pilot for timeframe purposes; however, a Closing Prayer was conducted by one of the participants with “smudging.” The Closing Prayer was an adaptation. The $75 incentive was presented to each participant after the prayer to conclude this pilot. A summary of the adaptations are outlined in Table 5.12.

Phase II-Pilot Testing

Phase II piloted the adapted intervention for Native teens. There were three Phase II objectives in the methods section, which were: 1) Recruit 20 Native teens between the ages of 14-18; 2) Form the instructor team; and 3) pilot the adapted curriculum with at least 10-15 participants. This section will discuss the outcomes of the Phase II objectives.

Participant recruitment and retention. Originally, 17 Native teens were recruited and signed-up to attend the intervention sessions. Over recruitment was conducted to ensure the pilot would have at least 10-15 participants complete the intervention. A total of 14 participants attended and completed the intervention. Among the participants six were males and eight were females.

A. Instructors

One male and one female co-instructor were hired for this project. In addition, the researcher served as a female co-instructor to teach the adapted content.

In total, there were two female co-instructors and one male co-instructor. The two co-instructors that were hired were recruited from the SN-TPPP pool of instructors based on his/her experience and availability. Each co-instructor had taught at least three BART intervention cycles for SN-TPPP. In alignment with SN-TPPP, the instructors:

- Were 21 years older or greater
- Possessed a high school diploma or equivalent
- Successfully passed the SN-TPPP background check
- Completed the BART and abstinence curriculum training
- Had previous experience in group instruction and facilitation, particularly with adolescents/youth
- Had the ability to create an atmosphere of trust and confidentiality
- Were familiar and comfortable with adolescent development concepts and general knowledge about STIs, HIV, and sexual risky behavior

In addition to the three co-instructors, this project invited two guest speakers to enhance the intervention for cultural appropriateness. As stated previously, a Sioux Tribal elder was invited to conduct the opening prayer, and a member of the Navajo Nation was invited to conduct a presentation and/or activity.

B. Pilot test

The BART intervention was originally developed for implementation to be held at a community-based center. The Las Vegas Indian Center and the Las Vegas Paiute Tribe Clinic were both asked if the intervention could be implemented at either of their sites; however, neither organizations had adequate resources to accommodate the intervention (i.e. internet access, staff). The UNLV School of Community Health Sciences was selected as the implementation site as it had appropriate space and support resources to accommodate the

pilot test. The pilot was conducted on Saturday, February 21, 2015 from 9:00-to-5:30 pm and on Sunday, February 22, 2015 from 9:00 am-to-6:00 pm.

C. Time frame

An adaption that was made was the timeframe implementation for this pilot. As stated previously, the BART is required to be taught with the original eight 90-120 minute sessions delivered over 8 weeks. If needed, the BART can be condensed into 4 weeks by delivering two sessions per week with at least 48 hours apart. The BART intervention time frame is mandated to allow participants time to practice the content taught in order to facilitate positive outcomes in behavioral changes.

As indicated in Table 5.13, the adapted SN-TPPP used to have an orientation session that introduced the intervention to parents/family of participants that occurred prior to the abstinence session. Therefore, the SN-TPPP had a total of 10 sessions over 10 weeks. However, the SN-TPPP eventually removed the orientation session and combined BART sessions 7 and 8 into one session. This resulted in the SN-TPPP implementing the abstinence and BART sessions 1-8 over 8 weeks.

For this pilot, the adapted intervention was implemented in a span of two days (weekend) at 8 hours per day, with two new 90-120 minute sessions that were developed. The pilot was shortened in duration due to limited resources and participant retention. Also, this project's principal priority was to examine the cultural appropriateness of the curriculum content and activities to ensure that the adaptations effectively taught Native teens HIV/AIDS, STIs, and teen pregnancy prevention information and preventative strategies.

Table 5.13.Timeframe Changes for the BART intervention

BART	Adapted SN-TPPP BART	Recommended Adaptations	Adapted for pilot
-Eight 90-120 minute sessions delivered over 8 weeks -If sessions condensed, then can do two sessions within 7 days with at least 48 hours apart	-9 to 10 Sessions that included "Orientation" and "Abstinence" that were delivered over 10 weeks -"Orientation " =60 minutes -"Abstinence"=120 minutes -8 Sessions that included "Abstinence" and combined BART Session 7 & 8 into one night that were delivered over 8 weeks	***NO RECOMMENDATIONS***	-Added two new 90-120 minute sessions -Whole intervention that included two new sessions, abstinence, and BART 1-8 Session were delivered over one weekend -Saturday: 8:30 am to 5:30 pm -Sunday: 9:00 am to 6:00 pm

Phase III – Mixed Methods Evaluation

Phase III utilized a mixed methods approach to assist in evaluation of the pilot implementation. Results from the four evaluation activities that were conducted in this phase are presented below.

Pre and Post HIV knowledge surveys. The "HIV Knowledge" survey was administered to measure the participant's knowledge of HIV, transmission, and clinical symptoms before and after the intervention. The survey is a 20-item survey that consists of true, false, and not sure questions. A paired sample t-test was conducted to compare HIV knowledge using pre and post surveys before and after the BARNT intervention. The range of scores of the pre-survey was between 8 and 18. The range of scores of the post-survey was between 13 and 20. There was significant difference in the pre-survey (M=13.93, SD=3.08) and post-survey (M=17.14, SD=2.25) conditions; t(13)=-4.166, p<0.0005 (two-tailed). The mean increase in test scores was 3.21 with

95% confidence interval ranging from -4.88 to -1.55. Specifically, these results indicate that participating in the intervention increased HIV knowledge scores, on average, by approximately 3 points.

End-of-session surveys. The end-of-session surveys were comprised of Likert-scale and open-ended questions. There are five components of the end-of-session survey. *Component 1* asked the participants to rate the technical aspects of the overall session by using a Likert-scale. *Component 2* incorporated two different questions for the same activities: (1) Asked the participants to rate the specific activities by using a Likert-scale; (2) Asked the participants to rate how well they connected to the specific activities as a Native teen by using a Likert-scale. *Component 3* asked participants to rate the overall session's culturally appropriateness, the overall session's content culturally appropriateness, and the overall session's activities culturally appropriateness by using a Likert-scale. *Component 4* asked participants how much percentage of the information in each session was usable to them by using a percentage Likert-scale. *Component 5* consists of six open-ended questions about the session. There end-of-session surveys were distributed at the end of the 12 sessions.

- Introduction
- Past, Present, Future
- Relationship to Self & Others
- Options (Abstinence)
- BART Session 1-Understanding HIV/AIDS
- BART Session 2-Making sexual decisions & understanding your values
- BART Session 3-Developing & using condom skills
- BART Session 4-Learning assertive communication skills
- BART Session 5-Practicing assertive communication skills
- BART Session 6-Personalizing the risks
- BART Session 7-Spreading the word
- BART Session 8-Taking B.A.R.T. with you

A. Introduction session results

There was one participant who attended Day 1 of the intervention late, therefore, missed this session and did not submit an end-of-session survey. In Table 5.14, the highest very good percentages were given to the session's *organization* and *easy to understand* categories, which meant the participants thought this session had great organization and the content was easy to understand. Overall, majority of the participants felt all these technical aspects were good or very good. However, in comparison to all the sessions, this session had the least total of good or very good ratings.

Table 5.14. Introduction Technical Evaluation

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	21% (n=3)	29% (n=4)	43% (n=6)
Organization	0%	0%	7% (n=1)	14% (n=2)	71% (n-10)
Easy to understand	0%	0%	7% (n=1)	36% (n=5)	50% (n=7)
Interesting	0%	0%	0%	50% (n=7)	43% (n=6)
Involvement of your participation	0%	0%	14% (n=2)	36% (n=5)	43% (n=6)
Workbook materials	0%	0%	0%	7% (n=1)	79% (n=11)

In Table 5.15 the highest very good percentages were given to the opening prayer and descriptive names activities. This indicated that the participants enjoyed those activities the most. Majority of the participants felt these activities were good or very good.

Table 5.15. Introduction (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Opening prayer	0%	0%	0%	7% (n=1)	86% (n=12)
"Talking Circle"	0%	0%	7% (n=1)	29% (n=4)	57% (n=8)
Agreements	0%	0%	21% (n=3)	14% (n=2)	57% (n=8)
Descriptive names	0%	0%	7% (n=1)	14% (n=2)	71% (n=10)

In Table 5.16, the activity that the participants connected the most to was the opening prayer activity. Majority of the participants indicated they connected to these activities as a Native teen, by selecting good or very good.

Table 5.16. Introduction (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Opening prayer	0%	0%	0%	14% (n=2)	71% (n=10)
"Talking Circle"	0%	0%	7% (n=1)	29% (n=4)	50% (n=7)
Agreements	0%	0%	21% (n=3)	14% (n=2)	50% (n=7)
Descriptive names	0%	0%	21% (n=3)	14% (n=2)	50% (n=7)

In Table 5.17, most participants agreed or strongly agreed that this overall session was culturally appropriate, including its content and activities.

Table 5.17. Introduction Cultural Appropriateness

	Strongly Agree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session was culturally appropriate	0%	0%	0%	57% (n=8)	36% (n=5)
Overall session content was culturally appropriate	0%	0%	7% (n=1)	43% (n=6)	43% (n=6)
Overall session activities were culturally appropriate	0%	0%	7% (n=1)	50% (n=7)	36% (n=5)

The last evaluation question asked how much percentage of the information presented in this session was usable to the participants. There were two participants who thought 0-20% of the information presented in this session was usable, four who thought 61-80% was usable, and seven who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, they stated they would like the aspect of meeting new people in a comfortable environment and to know that there are other teens they can talk with about related subject matters. The participants also stated the content would be relatable and interesting, specifically the opening prayer and talking circle. In addition, they liked the workbook materials. Last, they stated other Native teens would be interested to learn more about their body, how to take care of it, and how to prevent HIV/teen pregnancy.

When participants were asked how the Native content helped them connect to the activities, the participants stated that it helped them because it was specifically made for their culture. It helped them feel more connected to their self-identity, and it made them know more about their culture. Because of this, they felt more welcomed and comfortable. Also, they connected to the content/activities because they had lack of knowledge about the fact that there are high rates of HIV/AIDS within the Native population, which made them focus more. When participants were asked what the single best thing about this session was, they stated they enjoyed the opening prayer because it helped start the sessions on a positive note. They also enjoyed the talking circle because they got to know different things about their peers and where they come from.

When participants were asked what one thing they would change about this session was, most participants stated they would not change the session because the information and material were covered appropriately. However, some of the technical things they would change were; change the start time (no specific time indicated), provide more bagels, ensure cell phone use, and provide more comfortable chairs. When participants were asked if they would like something covered that was not covered in this session, and/or should be added, the participants stated there was nothing that was not covered in this session or anything that should be added because it was the opening session.

B. Past, Present, Future session results

As shown in Table 5.18, the informational content had the highest very good percentage, which meant the participants thought this session had great information. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.18. Past, Present, Future Technical Evaluation

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	21% (n=3)	79% (n=11)
Organization	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Easy to understand	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Interesting	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Involvement of your participation	0%	14% (n=2)	21% (n=3)	36% (n=5)	29% (n=4)
Workbook materials	0%	0%	0%	36% (n=5)	64% (n=9)

There were two modules of activities, therefore there will be two tables of "Please rate the activities." In Table 5.19, there was a 3-way tie between three activities that the participants rated very good, which were; education about colonization, Lusieno teaching, and Yakima story activities indicating that the participants enjoyed these activities. However, there was one participant that rated the education about colonization activity "poor." Overall, majority of the participants felt these activities were good or very good. It should be noted that in comparison to all the activities, the 4 questions itself activity had the lowest very good rating.

The Rebel Music video and goals and values activity both had very good percentages. This conveyed that the participants highly enjoyed both activities. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category, therefore, the goals & values activity was one of six activities within this category (Table 5.20).

Table 5.19. Four Questions (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
4 questions itself	0%	0%	14% (n=2)	43% (n=6)	43% (n=6)
Education about “colonization”	0%	7% (n=1)	0%	21% (n=3)	71% (n=10)
Assiniboine teaching	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Kwakiutl teaching	0%	0%	7% (n=1)	36% (n=5)	57% (n=8)
Lusieno teaching	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Yakima story	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)

Table 5.20. Goals & Values (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Rebel Music video	0%	0%	0%	21% (n=3)	79% (n=11)
Goals & Values activity	0%	0%	7% (n=1)	0%	93% (n=13)

There were two modules of activities, therefore there will be two tables of “As a Native teen, how well did you ‘connect’ to these activities.” As indicated in Table 5.21, the activity that the participants connected to the most was the education about colonization. Majority of the participants indicated they connected to these activities as a Native teen, by selecting good or very good.

The participants connected to the most to the goals and values activity, but the “Rebel Music” video was a close second. This indicated that majority of the participants connected to these activities. See Table 5.22.

Table 5.21. Four Questions (As a Native teen, how well did you "connect" to these activities)

	Very Poor	Poor	Fair	Good	Very Good
4 questions itself	0%	0%	14% (n=2)	36% (n=5)	43% (n=6)
Education about "colonization"	0%	0%	14% (n=2)	14% (n=2)	71% (n=10)
Assiniboine teaching	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Kwakiutl teaching	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Lusieno teaching	0%	0%	21% (n=3)	14% (n=2)	64% (n=9)
Yakima story	0%	0%	14% (n=2)	21% (n=3)	64% (n=9)

Table 5.22. Goals & Values (As a Native teen, how well did you "connect" to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Rebel Music video	0%	7% (n=1)	0%	21% (n=3)	71% (n=10)
Goals & Values activity	0%	0%	14% (n=2)	7% (n=1)	79% (n=11)

As indicated in Table 5.23, most participants agreed or strongly agreed that this overall session, including its content and activities, were culturally appropriate.

Table 5.23. Past, Present, Future Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session was culturally appropriate	0%	0%	0%	21% (n=3)	79% (n=11)
Overall session content was culturally appropriate	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Overall session activities were culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)

The last evaluation question asked how much percentage of the information presented in this session was usable to the participants. There was one participant who thought 21-40% of the information presented in this session was usable, two who thought 41-60% was usable, two who thought 61-80% was usable, and nine who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, participants stated they would like to learn about their culture and history. Specifically, they stated learning the information about Natives and the associated stories of historical oppression/trauma, and knowing how strong they are because of their history. They stated that these topics covered in this session were applicable to each one of them. They also stated the activities were inspiring because it taught them to stand up for themselves, such activities were; "Rebel Music" video, 7 Grandfathers teachings, and 4 Questions (if they were able to answer them themselves.) When participants were asked how the Native content

helped them connect to the activities, the participants stated: helping them to pay more attention because content was interesting and relatable, was easier for them to understand by showing and giving insight, helping them by showing how many Natives there are, and inspiring them to learn more about their tribes and/or helped them learn more about Native culture/tribes. When participants were asked what the single best thing about this session was, the participants stated they liked getting into groups and learning about their peers' tribes/culture/religion, hearing questions that were asked and answered, and the numerous tribal stories. They also liked the videos that showed Native resistance because it was inspiring.

When participants were asked what one thing they would change about this session, they stated they would like to discuss the music more and have more videos shown. Also, they stated that some of the participants should have been more participatory, they are shy and only responded if talked to directly. Last, they suggested they would want to be separated into four groups to discuss the 4 questions activity amongst themselves. When participants were asked what they would like covered that was not covered in this session, they stated: they would like to have included a discussion on how they could help their communities (specific details), include more stories of historical oppression, include statistics of how many Natives were harmed during historical traumas, and how the U.S. school systems lie about how Natives were treated. Last, they would like to have included content about how not knowing about your culture does not make you any less "Native" and ways to learn more and reconnect with their heritage(s). When participants were asked if there were any topics they felt should be added to this session, they stated: they wanted more about Native life stories and history included, how the school systems lie about how Natives were treated, how to handle situations

where people discriminate against them or their culture, and a topic about how Native culture/religion helps youth grow.

C. Relationships to Self & Others session results

In the evaluation session, participants had dispersed their technical ratings more evenly among all categories (Table 5.24). One participant did not give a response for the workbook materials category. The highest very good percentage was given to *informational content*, which meant they thought this session had great information. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.24. Relationship to Self & Others Technical Evaluation

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	14% (n=2)	21% (n=3)	64% (n=9)
Organization	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Easy to understand	0%	7% (n=1)	0%	57% (n=8)	36% (n=5)
Interesting	0%	0%	14% (n=2)	43% (n=6)	43% (n=6)
Involvement of your participation	0%	7% (n=1)	29% (n=4)	36% (n=5)	29% (n=4)
Workbook materials	0%	0%	7% (n=1)	29% (n=4)	57% (n=8)

There were two modules of activities, therefore there will be two "Please rate the activities" tables. In Table 5.25, all participants rated the activities as good or very good, which indicated they enjoyed the activities. The activity they enjoyed the most was the Navajo story about puberty.

In Table 5.26, the participants mostly enjoyed the relationship with Mother Earth/Father Sky: Tewa story activity. Majority of the participants felt these activities were good or very good.

Table 5.25. Puberty is Ceremony (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Washo teaching	0%	0%	0%	43% (n=6)	57% (n=8)
“Rites of Passage” Apache video	0%	0%	0%	21% (n=3)	79% (n=11)
Apache teaching	0%	0%	0%	36% (n=5)	64% (n=9)
Kinaldaa’ video	0%	0%	0%	21% (n=3)	79% (n=11)
Navajo story	0%	0%	0%	14% (n=2)	86% (n=12)
Navajo teaching	0%	0%	0%	36% (n=5)	64% (n=9)

Table 5.26. Activity 2-5 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
What is a healthy body image?	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Qualities of a healthy relationship	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Healthy conflict: Navajo story	0%	0%	7% (n=1)	36% (n=5)	57% (n=8)
Relationship with ME/FS: Navajo story	0%	0%	14% (n=2)	14% (n=2)	71% (n=10)
Relationship with ME/FS: Tewa story	0%	0%	7% (n=1)	36% (n=5)	57% (n=8)

There were two modules of activities, therefore there will be two “As a Native teen, how well did you ‘connect’ to these activities” tables. In Table 5.27, all the participants rated all of the activities good or very good, which indicated they connected to each activity. The activity that the participants connected the most to was the KInaldaa’ video. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category,

therefore, the Kindaldaa' video was one of three activities within this category that the participants highly connected to.

Table 5.27. Puberty is Ceremony (As a Native teen, how well did you "connect" to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Washo teaching	0%	0%	0%	50% (n-=7)	50% (n=7)
"Rites of Passage" Apache video	0%	0%	0%	21% (n=3)	79% (n=11)
Apache teaching	0%	0%	0%	36% (n=5)	64% (n=9)
Kinaldaa'video	0%	0%	0%	7% (n=1)	93% (n=13)
Navajo story	0%	0%	0%	14% (n=2)	86% (n=12)
Navajo teaching	0%	0%	0%	29% (n=4)	71% (n=10)

In Table 5.28, the participants connected the most to the Relationship with Mother Earth/Father Sky: Tewa story activity. Majority of the participants indicated they connected to these activities as a Native teen, by selecting good or very good.

Table 5.28. Activity 2-5 (As a Native teen, how well did you "connect" to these activities)

	Very Poor	Poor	Fair	Good	Very Good
What is a healthy body image?	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Qualities of a healthy relationship	0%	0%	7% (n=1)	43% (n=6)	50% (n=7)
Healthy conflict: Navajo story	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Relationship with ME/FS: Navajo story	0%	0%	14% (n=2)	21% (n=3)	64% (n=9)
Relationship with ME/FS: Tewa story	0%	0%	14% (n=2)	14% (n=2)	71% (n=10)

Overall, in Table 5.29, most participants agreed or strongly agreed this overall session, including its content and activities, were culturally appropriate.

Table 5.29. Relationship to Self & Others Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	7% (n=1)	43% (n=6)	50% (n=7)
Overall session content culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)
Overall session activities were culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)

The last evaluation question asked how much percentage of the information presented in this session was usable to the participants. There was one participant who thought 41-60% of the information presented in this session was usable, six who thought 61-80% was usable, and seven who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, they stated they would like learning about the different ways puberty is celebrated, learning the importance of traditional ceremonies, how puberty affects your life, and the importance of self-respect. However, one participant thought the substance of the content was appropriate, but not thoroughly taught. When participants were asked how the Native content helped them connect to the activities, they indicated the activities gave them

more knowledge of puberty, therefore, gave them more respect for puberty and a new definition of puberty as the start of your life as a woman. Also, the content explained more about the diversity of cultures, helped them to learn more about their own cultures, made them feel more comfortable and connected, and it made it more interesting. When participants were asked what the single best thing about this session was, they indicated they liked learning about the rites of passage stories/videos and about healthy body images.

When participants were asked what one thing would they change about this session, they stated they would like the instructor(s) to give deeper meanings of the content and to discuss the meaning of the stories. Also, they would like to talk more about body types and watch more videos. When participants were asked what they would like covered that was not covered in this session, they stated they would like to have learned about HIV and how to talk openly about sex. When participants were asked if there were any topics that should be added to this session, they felt that HIV and the impact of unhealthy relationship qualities should be added to this session.

D. Options (Abstinence) session results

This session is the SN-TPPP “Abstinence” session that got re-named “Options.” In Table 5.30, shows there was a 3-way tie between three categories that the participants rated very good, which were *informational content, interesting, and involvement of your participation*. This indicated they thought this session had great content, was interesting, and that they were participatory.

Table 5.30. Options Technical Evaluation

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	29% (n=4)	71% (n=10)
Organization	0%	0%	21% (n=3)	21% (n=3)	57% (n=8)
Easy to understand	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Interesting	0%	0%	0%	29% (n=4)	71% (n=10)
Involvement of your participation	0%	7%	7% (n=1)	21% (n=3)	71% (n=10)
Workbook materials	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)

As seen in Table 5.31, the activity the participants enjoyed the most was the preventing HIV game. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category, therefore, preventing HIV game activity was one of six activities within this category. In contrast, one participant rated the discussing reasons teens choose abstinence activity "poor." Overall, majority of the participants rated the activities good or very good.

Table 5.31. Activity 1-4 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Find a common language	0%	0%	0%	14% (n=2)	86% (n=12)
Definitions	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Discussing reasons teens choose abstinence	0%	7% (n=1)	0%	14% (n=2)	79% (n=11)
Preventing HIV game	0%	0%	7% (n=1)	0%	93% (n=13)
Brainstorming	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Kerribah	0%	0%	0%	14% (n=2)	86% (n=12)

Table 5.32, shows that the two activities that the participants equally connected to the most were the preventing HIV game and Kerribah. In comparison to the other sessions, there were few activities that were rated very good at 90%< within this category, therefore, both the preventing HIV game and Kerribah activities were two of three activities within this category that the participants highly connected to. Majority of the participants indicated they connected good or very good to the activities as a Native teen.

Table 5.32. Activity 1-4 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Find a common language	0%	0%	0%	14% (n=2)	86% (n=12)
Definitions	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Discussing reasons teens choose abstinence	0%	7% (n=1)	7% (n=1)	7% (n=1)	79% (n=11)
Preventing HIV game	0%	0%	7% (n=1)	0%	93% (n=13)
Brainstorming	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Kerribah	0%	0%	0%	7% (n=1)	93% (n=13)

As indicated in Table 5.33, all participants agreed or strongly agreed that this overall session, including its content and activities, were culturally appropriate.

Table 5.33. Options Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	14% (n=2)	50% (n=7)	36% (n=5)
Overall session content culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)
Overall session activities were culturally appropriate	0%	0%	7% (n=1)	43% (n=6)	50% (n=7)

The last evaluation question asked how much percentage of the information presented in this session was usable to the participants. There was one participant who thought 41-60% of the information presented in this session was usable, one who thought 61-80% was usable, and twelve who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, they stated they would like the preventing HIV game because this helped them understand that you can contract HIV by having unprotected sex and it made the session fun. Also, they stated that although this session was a serious topic, it was taught with humor and light heartedness. In addition, they stated that to learn that sex is not "bad", but there are healthful and unhealthful ways to approach sex. When participants were asked how the Native content helped them connect to the activities, the participants stated there was none to minimal Native content in this session. However, some participants stated that they better

understand the cultural reasons behind practicing abstinence, by using the information that was taught in the previous sessions and how it connected to this session. In addition, the content makes the conversation about sex less awkward by giving it the respect it deserves. When participants were asked what the single best thing about this session was, most participants stated the preventing HIV game, the participation among the participants, and the humor.

When participants were asked what one thing they would change about this session, most participants stated they would not change anything. However, a participant did not agree with a statement in this session that stated “Sex is better in a secure loving marriage relationship.” The participant thought this was more of an opinion versus a fact. Also, a participant stated the organization in this session could be improved by having some of the things that were taught in their workbooks. When participants were asked what would they liked covered that was not covered in this session, majority of the participants stated there was no recommendations. However, some participants did indicate they wanted some additional on the reasons why some teens want to have sex, to discuss other sexually transmitted infections, more information/clarification about the difference in sexual acts, and protection. When participants were asked if there were any topics that should be included in this session, majority of the participants stated there are no recommended additional topics. However, one participant indicated that a reassurance should be stated that it is okay if you choose to have sex. Also, another participant stated the topic of how to discuss your choice of practicing abstinence with your partner should be incorporated.

E. BART Session 1-Understanding HIV & AIDS session results

In Table 5.34, there was a 3-way tie between three categories that the participants rated very good, which were *informational content*, *interesting*, and *workbook materials*. This demonstrates that the participants thought the information was great, highly interesting, and the workbook materials connected well to the session. Overall, majority of the participants felt all these technical aspects were good or very good, with each category having 50%< very good response rate.

Table 5.34. BART Session 1 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	21% (n=3)	79% (n-11)
Organization	0%	0%	14% (n=2)	21% (n=3)	64% (n=9)
Easy to understand	0%	0%	7% (n=1)	7% (n=1)	71% (n=10)
Interesting	0%	0%	21% (n=3)	0%	79% (n=11)
Involvement of your participation	0%	7%	7% (n=1)	21% (n=3)	71% (n=10)
Workbook materials	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)

In Table 5.35, the highest very good percentages were given to the introduction to HIV terms and spread the word activities. This indicated that the participants enjoyed those activities the most. Majority of the participants felt these activities were good or very good, with each activity having 57%< very good response rate.

Table 5.35. Activity 1-6 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Share personal stories	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Who is at risk for HIV?	0%	0%	0%	29% (n=4)	71% (n=10)
Strengths for prevention	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Intro to HIV terms	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Facts & myths	0%	0%	14% (n=2)	7% (n=1)	71% (n=10)
Deciding your risk level	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Spread the word	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)

In Table 5.36, the activity that participants connected to the most was the facts & myths activity. Most of the participants indicated they connected to these activities by selecting good or very good.

Table 5.36. Activity 1-6 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Share personal stories	0%	0%	14% (n=2)	29% (n=4)	57% (n=8)
Who is at risk for HIV?	0%	0%	0%	29% (n=4)	71% (n=10)
Strengths for prevention	0%	0%	7% (n=1)	29% (n=4)	57% (n=8)
Intro to HIV terms	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Facts & myths	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Deciding your risk level	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Spread the word	0%	0%	0%	0%	36% (n=5)

In Table 5.37, majority of the participants of the participants agreed or strongly agreed the overall session was culturally appropriate, including the content and activities.

Table 5.37. BART Session 1 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	21% (n=3)	29% (n=4)	50% (n=7)
Overall session content culturally appropriate	0%	0%	14% (n=2)	36% (n=5)	50% (n=7)
Overall session activities were culturally appropriate	0%	0%	14% (n=2)	36% (n=5)	50% (n=7)

The last evaluation question asked how much percentage of the information presented in this session was usable to the participants. There was one participant who thought 61-80% of the information presented in this session was usable and thirteen participants who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, participants stated they would like the information they obtained, such as learning how to be protected when having sex and the information on HIV/AIDS. Also, they stated the enjoyment when playing the games (myth/fact sheet). When participants were asked how the Native content helped them connect to the activities, majority of the participants stated there was no or minimal Native content incorporated into this session.

However, a few stated that the Native statistics helped them understand that they have to be especially careful. When participants were asked what the single best thing about this session was, the participants stated the fact & myth game activity, and learning about HIV/AIDS, which enlightened them more about learning what spreads HIV/AIDS.

When participants were asked what one thing they would change about this session, majority of the participants stated they would not change anything. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was no further content that they would like covered. However one participant stated they would like to know the difference between HIV/AIDS and other STIs. Similarly, when participants were asked if there were any topics that should be added to this session, majority of the participants stated there are no further topics that should be added to this session.

I. BART Session 2-Making sexual decisions & understanding your values session results

In Table 5.38, *workbook materials* had the highest very good percentage, which meant the participants felt the workbook materials connected well to this session. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.38. BART Session 2 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	43% (n=6)	57% (n=8)
Organization	0%	0%	0%	36% (n=5)	64% (n=9)
Easy to understand	0%	0%	0%	29% (n=4)	64% (n=9)
Interesting	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Involvement of your participation	0%	7%	29% (n=4)	36% (n=5)	36% (n=5)
Workbook materials	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)

In Table 5.39, the participants rated the drugs/alcohol risks activity as the highest very good percentage, indicating they enjoyed that activity the most. However, 71%-86% of the participants rated each category "very good." This illustrates that the participants enjoyed each activity.

Table 5.39. Activity 3-7 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
AIDS & Natives	0%	0%	14% (n=2)	14% (n=2)	71% (n=10)
HIV feud game	0%	0%	14% (n=2)	14% (n=2)	71% (n=10)
Native voices video	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Drugs/alcohol risks	0%	0%	0%	14% (n=2)	86% (n=12)
Support systems	0%	0%	0%	14% (n=2)	79% (n=11)

In Table 5.40, the activities that the participants connected to the most were the Native Voices video and support systems activity. There was also a participant who gave a zero response for the HIV feud game. Overall, majority of the participants connected to the activities by selecting good or very good.

Table 5.40. Activity 3-7 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
AIDS & Natives	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
HIV feud game	0%	0%	14% (n=2)	14% (n=2)	64% (n=9)
Native voices video	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Drug/alcohol risks	0%	0%	0%	21% (n=3)	79% (n=11)
Support systems	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.41, 50%< of the participants strongly agreed the overall session, including content and activities, were culturally appropriate.

Table 5.41. BART Session 2 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Overall session content culturally appropriate	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Overall session activities were culturally appropriate	0%	0%	7% (n=1)	43% (n=6)	50% (n=7)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 41-60% of the information presented in this session was usable, three who thought 61-80% was usable, and ten who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, majority of the participants stated that they would enjoy the Native VOICES video because it was entertaining and funny. Also, they stated the content was interesting and helpful because they learned that every person can be at-risk for contracting HIV/AIDS and how to prevent HIV/AIDS in the real world context. When participants were asked how the Native content helped them connect to the activities, majority of the participants stated it made it relatable, by showing HIV/STIs are an epidemic on tribal reservations, and that Natives are being diagnosed with HIV/STIs. Also, the content demonstrated how easy it is to contract an STIs, gave them awareness for reasons to be safe and use condoms, and helped them better understand HIV. When participants were asked what the single best thing about this session was, majority of the participants indicated the Native VOICES video because it was interesting, relevant, and taught them not to be ashamed.

When participants were asked what one thing they would change about this session, every participant stated they would change nothing about this session. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was nothing further that needed to be covered. However, one participant stated to more thoroughly discuss HIV/AIDS and Natives. When participants were asked if there were any topics they felt should be added to this session, majority of the participants stated there should not be additional topics added to this session.

G. BART Session 3-Developing & using condom skills session results

In Table 5.42, there was a 4-way tie between the four categories that the participants rated very good, which were *informational content*, *easy to understand*, *involvement of your participation*, and *workbook materials*. This indicated that the participants thought the information presented was great, information was easy to understand, there was a high participatory rate, and the workbook materials connected well to this session. Each category had a 50%< very good rating, indicating majority of the participants felt these technical aspects were good or very good. However, one participant had a zero response for *easy to understand*.

Table 5.42. BART Session 3 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	14% (n=2)	86% (n=12)
Organization	0%	0%	0%	29% (n=4)	71% (n=10)
Easy to understand	0%	0%	0%	14% (n=2)	86% (n=12)
Interesting	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Involvement of your participation	0%	7%	0%	14% (n=2)	86% (n=12)
Workbook materials	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.43, the activity the thirteen participants enjoyed the most was learning about condom facts activity. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category, therefore, the learning about condom facts activity was one of six activities within this category. Also, each activity in this section had a 64%< very good rating, indicating that majority of the participants felt these activities were very good.

Table 5.43. Activity 1-5 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Discuss attitudes	0%	0%	0%	29% (n=4)	71% (n=10)
Learning condom facts	0%	0%	0%	7% (n=1)	93% (n=13)
Overcoming embarrassment	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Condom demos	0%	0%	0%	21% (n=3)	79% (n=11)
Encountering barriers	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)

In Table 5.44, there was a five-way between the five activities that the participants connected to the most. Seventy-nine percent of participants connected to discuss attitudes, learning condom facts, overcoming embarrassment, condom demos, and encountering barriers. Majority of the participants indicated they connected to the activities by selecting good or very good.

Table 5.44. Activity 1-5 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Discuss attitudes	0%	0%	0%	21% (n=3)	79% (n=11)
Learning condom facts	0%	0%	0%	21% (n=3)	79% (n=11)
Overcoming embarrassment	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Condom demos	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Encountering barriers	0%	0%	0%	21% (n=3)	79% (n=11)

In Table 5.45, 50%< of the participants strongly agreed the overall session was culturally appropriate, including the content and activities.

Table 5.45. BART Session 3 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	29% (n=4)	21% (n=3)	50% (n=7)
Overall session content culturally appropriate	0%	0%	29% (n=4)	21% (n=3)	50% (n=7)
Overall session activities were culturally appropriate	0%	0%	29% (n=4)	29% (n=5)	57% (n=5)

The last evaluation question asked how much percentage of the information presented in this session was usable. There was one participant who thought 61-80% of the information presented in this session was usable and thirteen participants who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, majority of the participants stated they would like the condom demonstrations the most. The condom demonstrations gave them an opportunity to learn how to protect themselves, so they could see how the condoms look and work, and it was fun. Also, the participants enjoyed the "Golden Girls" YouTube clip, which was included about overcoming embarrassment and buying condoms. When participants were asked how the Native content helped them connect to the activities, majority of the participants stated there was zero Native content in this session. However, they stated the information presented was

useful by learning condom use and how to prevent HIV/STIs for any person regardless of race/ethnicity. When participants were asked what the best single thing about this session was, majority of the participants stated they enjoyed the condom demonstrations due to: seeing the different types of condoms, learning how to properly use a condom, breaking stereotypes and attitudes towards condoms, and practicing with condoms. Also, they enjoyed the "Golden Girls" YouTube clip to help overcome embarrassment to obtain condoms.

When participants were asked what one thing they would change about this session, all fourteen participants stated they would change nothing about this session. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was no further content that they wanted covered. However, participants would like more information presented on how to use a female condom. When participants were asked are there any topics they want included in this session, majority of the participants stated no further content should be added to this session. However, some participants stated to input "how to" use a female condom and to add some Native content to this session.

H. BART Session 4-Learning assertive communication skills session results

In Table 5.46, there was a two-way tie between two categories that the participants rated very good, which were *involvement in your participation* and *workbook materials*. This indicated that the participants felt they were highly participatory and the workbook materials connected well to this session. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.46. BART Session 4 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	14% (n=2)	86% (n=12)
Organization	0%	0%	7% (n=7)	21% (n=3)	71% (n=10)
Easy to understand	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Interesting	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Involvement of your participation	0%	7%	0%	7% (n=1)	93% (n=13)
Workbook materials	0%	0%	7% (n=1)	0%	93% (n=3)

Table 5.47, the different communication activity had the highest very good rating, indicating that the participants enjoyed this activity the most. Overall, majority of the participants felt these activities were good or very good.

Table 5.47. Activity 2-4 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Are you with me? Video	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)
Problem solving skills	0%	0%	0%	21% (n=3)	79% (n=11)
Different communication	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.48, the participants connected the most to the different communication activity. Majority of the participants connected to these activities by selecting good or very good. Specifically 57%< of the participants selecting very good.

Table 5.48. Activity 2-4 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Are you with me? Video	0%	0%	21% (n=3)	21% (n=3)	57% (n=8)
Problem solving skills	0%	0%	0%	36% (n=5)	64% (n=9)
Different communication	0%	0%	0%	29% (n=4)	71% (n=10)

In Table 5.49, only 36% of participants rated the overall session cultural appropriateness and session content "very good." Majority of the participants agreed or strongly agreed that this overall session, including the content and activities, were culturally appropriate.

Table 5.49. BART Session 4 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	21% (n=3)	43% (n=6)	36% (n=5)
Overall session content culturally appropriate	0%	0%	29% (n=4)	36% (n=5)	36% (n=5)
Overall session activities were culturally appropriate	0%	0%	14% (n=2)	36% (n=5)	50% (n=7)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 41-60% of the information presented in this session was useful, one who thought 61-80% was useful, and twelve who thought 81-100% was useful.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, majority of the participants stated they would like the role plays because it helped them to prepare for real life experiences, it examined the role of peer pressure, and it was fun. Also, they enjoyed the Are you with me? video because it gave good examples of how to start conversations about practicing safe sex. When participants were asked how the Native

content helped them connect to the activities, majority of the participants stated there was no Native content. However, it was recommended that there should be a different video utilized for this session that included Native actors. When participants were asked what was the single best thing about this session was, majority of the participants indicated they enjoyed the role plays because it made them think of the different types of communication styles and gave them examples of how to be assertive when communication.

When participants were asked what one thing they would change about this session, majority stated there is nothing they would change. However, one participant stated to change the video because it was not believable the way the actors handled the situations. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was zero content that was not covered in this session. However, one participant suggested including some real life stories about partners telling their mate about condoms. When participants were asked if there were any topics that should be added to this session, majority of the participants stated there should not be additional content added to this session. However, one participant recommended including Native content and another participant recommended including situations on what to do if your partner refuses to cooperate with you.

I. BART Session 5-Practicing assertive communication skills session results

In Table 5.50, *involvement of your participation* had the highest very good percentage, indicating that the participants felt they were highly participatory. Majority of the participants felt all these technical aspects were good or very good. Also, it should be highlighted that 64%< of the participants thought all these technical aspects were very good.

Table 5.50. BART Session 5 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	14% (n=2)	86% (n=12)
Organization	0%	0%	0%	36% (n=5)	64% (n=9)
Easy to understand	0%	0%	0%	14% (n=2)	86% (n=12)
Interesting	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Involvement of your participation	0%	7%	0%	7% (n=1)	93% (n=13)
Workbook materials	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.51, the roleplays activity had the highest very good percentage, which indicated that the participants enjoyed this activity the most. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category, therefore, the roleplays activity was one of six activities within this category. Majority of the participants felt these activities were good or very good. Also, it should highlighted that 71%< of the participants indicated all these activities were very good.

Table 5.51. Activity 2-5 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive communication	0%	0%	0%	29% (n=4)	71% (n=10)
Ways to say "no"	0%	0%	0%	21% (n=3)	79% (n=11)
Roleplays	0%	0%	0%	7% (n=1)	93% (n=13)
Communication practice	0%	0%	0%	21% (n=3)	79% (n=11)

In Table 5.52, most of the participants connected the most the communication practice activity. All participants either selected good or very good when asked their connectedness to

the activities as a Native teen. It should be highlighted that 57%< of the participants indicated all these activities were very good.

Table 5.52. Activity 2-5 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive communication	0%	0%	0%	29% (n=4)	71% (n=10)
Ways to say "no"	0%	0%	0%	29% (n=4)	71% (n=10)
Roleplays	0%	0%	0%	43% (n=6)	57% (n=8)
Communication practice	0%	0%	0%	21% (n=3)	79% (n=11)

In Table 5.53, the participants equably chose: neither agree nor disagree, agree, or strongly agree. This indicated that participants felt this session was or was not culturally appropriate, or they agreed or strongly agreed it was.

Table 5.53. BART Session 5 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	21% (n=3)	43% (n=6)	36% (n=5)
Overall session content culturally appropriate	0%	0%	29% (n=4)	43% (n=6)	29% (n=4)
Overall session activities were culturally appropriate	0%	0%	29% (n=4)	36% (n=5)	36% (n=5)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 41-60% of the

information presented in this session was usable, twelve who thought 81-1005 was usable, and one who had a zero response.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, participants stated they would like the roleplays due to learning how to communicate in an assertive manner. When participants were asked how the Native content helped them connect to the activities, majority of the participants stated there was no Native content in this session. However, they stated they connected to information because it was relatable to everyone because HIV/AIDS affects everyone. When participants were asked what the single best thing about this session was, the participants stated the roleplays because it helped them prepare for real world scenarios.

When participants were asked what one thing they would change about this session, majority of the participants stated there was nothing they would change. However, it was recommended to include more discussion on ways to say "no" and add different real life stories so they have something to relate with. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was no content to be further covered. However, three different participants stated they would like to hear personal stories of saying "no", examples of how to break-up with a person, and include Native cultural contexts. When participants were asked are there any topics they felt should be added to this session, majority of the participants stated there were no further topics that they felt should be added to this session.

J. BART Session 6-Personalizing the risks session results

In Table 5.54, *informational content* had the highest very good percentage, indicating that participants enjoyed the session curriculum. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.54. BART Session 6 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	14% (n=2)	86% (n=12)
Organization	0%	0%	0%	29% (n=4)	71% (n=10)
Easy to understand	0%	0%	0%	21% (n=3)	79% (n=11)
Interesting	0%	0%	14% (n=2)	7% (n=1)	79% (n=11)
Involvement of your participation	0%	7%	21% (n=3)	14% (n=2)	64% (n=9)
Workbook materials	0%	0%	0%	29% (n=4)	71% (n=10)

In Table 5.55, meeting people with HIV activity had the highest very good percentage, which indicated that the participants enjoyed this activity the most. Majority of the participants either felt these activities were good or very good.

Table 5.55. Activity 1-2 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Meeting people with HIV	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Discussion	0%	0%	0%	36% (n=5)	64% (n=9)

In Table 5.56, participants connected most to the discussion activity, which is a follow-up discussion conducted after the meeting people with HIV activity. Majority of the participants indicated they connected to these activities as a Native teen, by selecting good or very good.

Table 5.56. Activity 1-2 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Meeting people with HIV	0%	0%	0%	21% (n=3)	79% (n=11)
Discussion	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.57, majority of the participants agreed or strongly agreed the overall session, including its content and activities, were culturally appropriate.

Table 5.57. BART Session 6 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	7% (n=1)	43% (n=6)	50% (n=7)
Overall session content culturally appropriate	0%	0%	0%	57% (n=8)	43% (n=6)
Overall session activities were culturally appropriate	0%	0%	7% (n=1)	36% (n=5)	57% (n=8)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 41-60% of the information presented in this session was usable, four participants who thought 61-80% was usable, and nine who thought 81-100% was usable.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, they stated they would like the videos about meeting people with HIV

because it illustrated Natives who are living with HIV. When participants were asked how the Native content helped them connect to the activities, they stated it helped them to understand that HIV is a problem in Indian Country and made it very personal. When participants were asked what the single best thing about this session was, majority of the participants stated the videos because it was eye-opening, but they also enjoyed the discussion afterwards.

When participants were asked what one thing they would change about this session, majority of the participants stated there was nothing they would change. However, some of the recommendations were to add more videos, add more discussion time, and have a guest speaker instead of a video. When participants were asked what they would like covered that was not covered in this session, majority of the participants stated there was no further content they wanted covered. However, few participants recommended including more information on where HIV/AIDS originated from and to include a guest speaker. Similarly, when participants were asked if there were any topics they felt should be added to this session, majority of the participants stated there are no further topics that should be added to this session. However, a few participants wanted more information on where HIV/AIDS originated from and the importance of different HIV viral strains.

K. BART Session 7-Spreading the word session results

In Table 5.58, participants rated the highest very good percentage to *workbook materials*. As a close second, there was a two-way tie between two categories that the participants rated very good, which were *informational content* and *interesting*. It should be highlighted that in examining the highest very good frequencies, this session was rated as having the best *informational content, interesting,* and *workbook materials* in comparison to all

the other sessions. This indicated that the participants thought this session had the best *informational content*, was the most *interesting*, and had the best *workbook materials* that connected best to the session curriculum in comparison to all the sessions. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.58. BART Session 7 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	7% (n=1)	93% (n=13)
Organization	0%	0%	0%	29% (n=4)	71% (n=10)
Easy to understand	0%	0%	0%	14% (n=2)	86% (n=12)
Interesting	0%	0%	7% (n=1)	0%	93% (n=13)
Involvement of your participation	0%	0%	0%	21% (n=3)	79% (n=11)
Workbook materials	0%	0%	0%	0%	100% (n=14)

In Table 5.59, getting out of risky situations activity had the highest very good rating, which means they enjoyed this activity the most. Majority of the participants felt these activities were good or very good.

Table 5.59. Activity 1-4 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive communication	0%	0%	0%	29% (n=4)	71% (n=10)
Getting out of risky situations	0%	0%	0%	14% (n=2)	86% (n=12)
Spreading the word	0%	0%	0%	29% (n=4)	71% (n=10)
Word practice	0%	0%	7% (n=1)	36% (n=5)	57% (n=8)

In Table 5.60, the participants connected the most to the spreading the word activity, although assertive communication, getting out of risky situations, and word practice were all a

close second. Majority of the participants indicated they connected to these activities, by selecting good or very good.

Table 5.60. Activity 1-4 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive communication	0%	0%	0%	36% (n=5)	64% (n=9)
Getting out of risky situations	0%	0%	0%	36% (n=5)	64% (n=9)
Spreading the word	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Word practice	0%	0%	7% (n=1)	29% (n=4)	64% (n=9)

In Table 5.61, only four participants rated the overall session cultural appropriateness very good and only three of participants rated overall session *activities* cultural appropriateness "very good." However, eight participants rated the overall session *content* cultural appropriateness "very good." This illustrated the participants did not strongly agree that this session was as culturally appropriate when compared to previous sessions.

Table 5.61. BART Session 7 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	36% (n=5)	36% (n=5)	29% (n=4)
Overall session content culturally appropriate	0%	0%	29% (n=4)	14% (n=2)	57% (n=8)
Overall session activities were culturally appropriate	0%	0%	29% (n=4)	50% (n=7)	21% (n=3)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 21-40% of the information presented in this session was useful and thirteen who thought 81-100% was useful.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, they stated they would like the getting out of risky situations activity. They said they would enjoy this activity because it utilizes roleplays to help participants practice their new skillsets they learned in the previous session (assertive communication) to get out of risky real-life situations. When participants were asked how the Native content helped them connect to the activities, majority of the participants stated there was no Native content, and therefore, could not connect on a Native dynamic. However, they did state the content can connect to anyone due to practicing skillsets. When participants were asked what the single best thing about this session was, they stated the roleplays, because they learned how to create their own responses effectively to get out of risky situations.

When participants were asked what one thing they would change about this session was, majority of the participants stated there was nothing they would change. However, it was recommended to split the participants into two groups for roleplays, so each group can practice the different roleplays. Also, to have instructors give more examples and put this session after BART Session 5. When participants were asked what they would like covered in this session that was not covered, participants stated there were no further topics they would like covered. Likewise, when participants were asked if there any topics they felt should be added to this session, participants stated there were no further topics they felt that should be added.

L. BART Session 8-Taking B.A.R.T. with you session results

In Table 5.62, *workbook materials* had the highest very good percentage, which meant they felt the workbook materials connected well with the session. Overall, majority of the participants felt all these technical aspects were good or very good.

Table 5.62. BART Session 8 Technical Evaluations

	Very Poor	Poor	Fair	Good	Very Good
Informational content	0%	0%	0%	14% (n=2)	86% (n=12)
Organization	0%	0%	0%	29% (n=4)	71% (n=10)
Easy to understand	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)
Interesting	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Involvement of your participation	0%	0%	7% (n=1)	7% (n=1)	79% (n=12)
Workbook materials	0%	0%	0%	7% (n=1)	93% (n=13)

In Table 5.63, there was a two-way tie between two activities that the participants rated very good, which were sex & traditional stories and the final review. In comparison to all the sessions, there were few activities that were rated very good at 90%< within this category, therefore, both the sex & traditional stories and final review activities were two of six activities within this category. This indicated that the participants enjoyed those activities the most. Overall, majority of the participants felt the activities good or very good.

Table 5.63. Activity 1-5 (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Sex & traditional stories	0%	0%	0%	7% (n=1)	93% (n=13)
Final review	0%	0%	7% (n=1)	0%	93% (n=13)
Self-reflection	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Man in the Maze story	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Reflections on protecting	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
What are you doing to protect yourself?	0%	0%	7% (n=1)	7% (n=1)	86% (n=12)

In Table 5.64 there was a three-way tie between three activities that the participants connected to the most, which were sex & traditional stories, final review, and what are you doing to protect yourself. Majority of the participants indicated they connected to the activities by selecting good or very good.

Table 5.64. Activity 1-5 (As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Sex & traditional stories	0%	0%	0%	14% (n=2)	86% (n=12)
Final review	0%	0%	0%	14% (n=2)	86% (n=12)
Self-reflection	0%	0%	7% (n=1)	21% (n=3)	71% (n=10)
Man in the Maze story	0%	0%	7% (n=1)	14% (n=2)	79% (n=11)
Reflections on protecting	0%	0%	0%	21% (n=3)	79% (n=11)
What are you doing to protect yourself?	0%	0%	0%	14% (n=2)	86% (n=12)

In Table 5.65, 50%-71% of the participants thought this session was culturally appropriate, including the activities and the content. This illustrated the participants strongly agreed this session was culturally appropriate.

Table 5.65. BART Session 8 Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall session culturally appropriate	0%	0%	0%	29% (n=4)	71% (n=10)
Overall session content culturally appropriate	0%	0%	0%	50% (n=7)	50% (n=7)
Overall session activities were culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)

The last evaluation question asked how much percentage of the information presented in this session was usable to participants. There was one participant who thought 21-40% of the information presented in this session was useful, one who thought 41-60% was useful, and twelve who thought 81-100% was useful.

Open-ended questions

When participants were asked what they think other Native teens would like most about this session, majority of the participants stated they would like the sex & traditional stories activity the most because it was interesting and how they are still applicable to modern-day situations. When participants were asked how the Native content helped them connect to

the activities, the participants stated it helped them because even within the Native tribal stories, risky sexual behaviors occurred. Also, it made a connection between morals/values/culture and why they are important when discussing self-protection. The stories helped the participants connect on a personal level, made them focused, and brought them together. When participants were asked what the single best thing about this session was, the participants stated it was the sex & traditional stories activity because it was fun and made it memorable.

When participants were asked what one thing they would change about this session, majority of the participants stated there was nothing they would change. When participants were asked what they would like covered that was not covered in this session, participants stated there was no further content to be covered. Likewise, when participants were asked if there any topics they felt should be added to this session, majority of the participants stated there were no further topics they felt that should be added, stating this session was perfect. However, one participant indicated they would like more traditional stories because they were unique and would like to learn about how Natives view “sex.

End-of-Intervention Survey Results. There were end-of-intervention surveys distributed at the end of the intervention that were a mix of quantitative and qualitative feedback to evaluate the overall intervention, including the content and activities. There are two separate components in this survey. *Component 1* asks participants to rate the overall intervention’s cultural appropriateness, the overall intervention’s content cultural appropriateness, and the overall intervention’s activities cultural appropriateness. *Component 2* consists of six questions about the session.

In Table 5.66, there were no participants who rated any of the overall cultural appropriateness, including content and activities as strongly disagree, disagree, or neither agree nor disagree. This indicated that all the participants either agreed or strongly agreed that the overall intervention, including content and activities, were culturally appropriate. Thirteen of fourteen participants strongly agreed that the overall intervention was culturally appropriate.

Table 5.66. Intervention Cultural Appropriateness

	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
Overall intervention culturally appropriate	0%	0%	0%	7% (n=1)	93% (n=13)
Overall intervention content culturally appropriate	0%	0%	0%	43% (n=6)	57% (n=8)
Overall intervention activities were culturally appropriate	0%	0%	0%	36% (n=5)	64% (n=9)

This survey asked what following techniques helped the participant learn the best (small group discussion, lecture, role playing, individual work, video examples, sharing by participants, and Native cultural stories/teachings). There were 4 participants who selected *individual work* as a technique that helped them learn best, 7 participants who selected *sharing by participants*, 9 who selected *lecture,* 12 who selected *small group discussion*, 12 who selected *Native cultural stories/teachings*, 13 who selected *role playing*, and 13 who selected *video examples*.

Therefore, majority of the participants learned best by small group discussions, content that included Native cultural stories/teachings, role playing, and watching videos.

Open-Ended Questions

When participants were asked if they felt the content of this intervention was culturally appropriate, all fourteen of the participants stated they felt it was. Majority of the participants felt this way because the content was relatable and informative due to having Native content, which automatically made them feel connected to the intervention. They enjoyed learning about Native history, Native statistics, Native stories, and understanding of values/traditional beliefs along with why it is important to them. Also, participants indicated through this, they learned how to prevent teenage pregnancy, STIs, and HIV/AIDS.

When participants were asked if they would recommend this intervention to Native teens, all fourteen participants stated they would recommend this intervention. They would recommend this intervention because it can educate other Natives about sex and prevention, which is ultimately eye opening and educational. One participant stated, "*I feel that most Native teens aren't aware of how serious STDs, like HIV, can be, and they view sex as such a simple thing when in reality it is extremely important and it is a big risk.*"

Also, they would recommend this because Native teens would feel comfortable with themselves while being among other Natives and learn about Native culture/history simultaneously.

When participants were asked what the weaknesses of the intervention were, participants indicated that there were lots of reading and lecture at times, which got boring. Also, one participant stated that the intervention did not have Native or HIV content in each

session, which they felt should have been incorporated. In addition, participants stated the organization could be improved. For example, the sessions could have gone more fluid with fewer breaks in between. Last, it was recommended to incorporate more Native statistics about STIs and teen pregnancy.

When participants were asked what the strengths of the intervention were, participants indicated that the overall intervention was powerful. More specifically, they indicated that learning about how to prevent HIV by role playing and learning how to use condoms. Also, they enjoyed the Native traditional stories, videos, and learning about Native history. When participants were asked what their general comments/feedback for improving the intervention were, the suggestions were: including more statistics, take less breaks, smoother transitions between lessons, have more group activities, have people take turns reading the book, implement more activities, and putting Native content in each session.

Focus Group Results. A focus group was conducted to gather additional qualitative information about the cultural appropriateness of the adapted intervention. Evidence-based interventions lack cultural relevance of beliefs, values, customs, traditions, and lifestyles among racial/ethnic populations, especially Natives (Castro, Barrera, & Holleran Steiker, 2010). Therefore, it has been supported by the scientific community that adapting evidence-based interventions for specific racial/ethnic populations in culturally appropriate contexts can help enhance interventions (Villarruel, Jemmott, & Jemmott, 2005; Castro et al., 2010). The focus group data analysis resulted in two major themes, which were cultural content and BART content.

Cultural content

The participants communicated multiple explanations of how the cultural content and activities improved learning two of the BART's original curriculum objectives. The two BART curriculum objectives the cultural content and activities helped enhance were stating HIV/AIDS and community impact and clarifying their own values about sexual decisions and pressures. The cultural content and activities helped participants link the use of Native teachings, stories, and philosophies to HIV/AIDS, STIs, and teen pregnancy prevention from a cultural context. Based upon the adaptations, the participants expressed themes of responsible decision-making, relationships, self-identity, historical trauma, and cultural content and activities.

Responsible decision-making

HIV/AIDS, STIs, and teen pregnancy prevention interventions for Natives need the supportive curriculum content that acknowledges and respects that cultural tribal customs and structures as core components to assist in positive behavioral change (DePoy&Bolduc, 1997). Participants indicated that the inclusiveness of Native cultural stories were beneficial during instruction because it either enhanced or gave them a new perspective on how to make responsible decisions. One participant discussed how the Native cultural stories helped shape her perspective on responsible decision-making. The participant stated,

> *"It actually gave a lot in my perspective because Native culture and their stories give a lot of metaphors or they give you a hint in that story, and when we read those stories…they actually gave us a hint in it too and what we should not or what we should do. We should be more careful and we should be wiser in what we do and in what we*

say and think. So that's what I thought of it because most Native culture and stories can give you something that you should learn."

In reference to the literature review, fostering socially, physically, emotionally, and spiritual balanced lifestyles were important to assist in teaching positive behaviors (Sileo & Gooden, 2004). The incorporation of these components support the respect of cultural understandings that are rooted in cultural beliefs, values, and practices (Sileo & Gooden, 2004). A medicine wheel was incorporated into the curriculum to recognize this core principal. The participants stated they enjoyed this activity because it conveyed health as holistic by an individual encompassing an emotional, mental, spiritual, and physical harmonious balance. For example, one participant stated,

"…there were activities where we use a medicine wheel and on each was emotional, mental, spiritual, then physical and how each aspect of that, when it's in balance, you are more balanced, and it showed how when you are align in yourself you feel good about yourself, then you're less likely to be around someone that's negative for you and that makes you make negative decisions."

These cultural holistic teachings ultimately increase self-esteem that assist in enhancing positive self-identity and self-pride (Sileo & Gooden). Participants talked about how making positive decisions can have a positive effect on cultural pride and one's association with their racia/ethnic group and culture. One participant mentioned, "…*when you're making positive decisions, you're breaking those negative stereotypes that are associated with your culture and you're redefining what your culture is…you're like advancing together.*" This statement

acknowledges that there is an incentive to make positive decisions that will enhance not only yourself, but your family and community as well.

Relationships

Relationships are a primary Native value (McNeil, 2006). “All Native values define the way in which relationships occur with other people, including the creation of life and what encompasses the universe” (McNeil, 2006, p.67). To clarify, McCormick (1994) describes relationship as interconnectedness, which transcends as the individual’s connection to the universe. The interconnectedness begins with relationship to self and extends to universe, including non-human relatives (e.g., plants, animals, earth). Native teens understood the importance of relationships on a macros level, beyond human interaction, as one participant stated, “*I think treating the earth right and being respectful towards the earth is really important*.”

The participants indicated that Native culture is the core because it teaches persons to be respectful to themselves, family, community, and the earth. Participants stated that Native culture increases self-respect and they acknowledge that it assists with positive decision-making. For example, a participant stated, “*… if you respect yourself, you’re not going to make bad decisions that are going to make you feel bad about yourself. Because if you care about yourself, you’re going to make the right decisions to stay healthy, to stay happy, and to try to do the best you can*.” From a relationship standpoint, participants indicated that you need to have a positive relationship with yourself because it impacts your decisions.

Family is a root element of Native cultures, emphasizing interdependence, reciprocity, and responsibility to take care of one another (Lamfromboise et al., 1993). It was indicated by participants that family is the most important thing. One participant stated,

> *"…to me and my family the most important thing is family. Without either parents or children what is there? There's just nothing. As all of here all have a family and the more that we get…the people that we know and the more people that we find out that's in our family, it's actually very informational and just knowing that there's family out there that will care about you and that's always there to help you out in case of emergencies.."*

Natives often have close extended relationships as part of their cultural and familial structures. The familial structure serves as protective factors (Sarche & Spicer, 2008) and provides opportunities for elders to pass on cultural teachings that instill cultural values. The participants indicated that respect and teachings from their elders are important. One participant stated, "…*even as a child we're always taught to respect our elders and I always think 'Is it just Native Americans that are taught that?' Because I know I've never seen anyone else like Hispanics or…I've never heard anyone talk like that or respect their elders*…" Participants indicated that teachings from their elders are important because they are wise from their life experiences, which are passed down from generation to generation.

Self-Identity

Many Natives have become acculturated on various levels. Many Native youth learn their traditional values, beliefs, communication, and behavioral mannerisms as their main frame of reference (Garrett & Pichette, 2000). In external environments (e.g. school, social settings), Native youth are often pressured to change their expectations or attitudes to reflect

the external environments (Sanders, 1987). Native youth may have challenging task of establishing a meaningful sense of personal identity. The inability to answer questions, such as "Where did I come from? Who am I? What do I want to become?" results in identity confusion (Erikson, 1968). Within the adaptations, there was an activity that asked: (1) Who are you?; (2) Where are you from?; (3) Why are you here?; and (4) Where are you going?. One participant stated,

> "*I think one thing it did to get us kind of thinking in those questions like who we came from, it brought a lot of cultural activities to make the connection and why they had those beliefs and morals so then it really made us think why we have our beliefs and morals and what we want to do to stick to those*..."

This activity brought their past, present, and future into a fluid framework by inter-connecting each aspect on an individual and social level.

It is important to acknowledge that Natives are often caught between two cultures, preserving Native tradition while adapting to contemporary lifestyles. The participants talked about their racial ambiguity among their peers, which relates to self-identity. They reflected on how the outside world perceives them by assuming they belong to a different racial/ethnic group. A participant stated,

> "…*usually when I meet new friends and usually right off the bat I can tell what kind of race they are because in my community, I live in a Mexican/African American community. So it's just really easy to tell what they are but then once it comes to me then they like want to know where I'm from and things about me, I say 'I'm Native American.' Sometimes they'll just like laugh or like 'you serious?' and I'm like 'Yeah.' And*

say 'Are you lying?' and its like 'No. I'm not lying. I can prove it to you.' And usually they just are like asking you questions about like where I live, how is everything? Sometimes it's like they'll try to make fun of it but then I'd right back at them with like their own culture and usually that's how I meet new friends and sometimes enemies I'm guessing."

Values among Native teens and young adults are often influenced by their unique contexts of their socio-cultural systems, which include both traditional and contemporary cultural values (Rushing & Stephens, 2012).A participant further indicated that Native families value all forms of education, "*I think education is an important value because there's two different types of education too. There's the traditional education and then there's the Western education that we all have to go through nowadays to get good jobs and keep ourselves with the times."* It is important to recognize that knowing both Western education and Native traditional education are important factors for Natives due to the dualities they live in.

Historical trauma

Native peoples have experienced historical trauma, oppression, and racism. Duran and Duran (1995) acknowledge the phenomena of cumulative trauma and the adverse effects Native communities suffer as a direct result of the genocidal consequences of colonization. Intervention programs should acknowledge intergenerational trauma that is present (Sileo & Gooden, 2004). The intervention incorporated history and stories of colonization. The participants were touched by this part of the curriculum. In reference to a story about the researcher's great-great grandmother who escaped the historical Navajo "Long Walk", one participant stated:

"I started crying during it because it was really emotional but it was about her grandmother like escaped a prison that she was held in, and she was forced to walk 100+ miles and she was pregnant during that. When she had to get home all by herself she escaped with her baby and her baby eventually passed because she couldn't even produce milk because she was so starved. It just reminded us that we are the seventh generation. It's time for us to better ourselves and to have good, healthy lives again and reclaim our heritage."

Rink et al. (2012) evaluated Native men ages 18-24 and the role of mental health associated with their intention to utilize birth control reported that young Native people do think about and are concerned with the histories of their communities. Young Native men who are experiencing emotional issues related to historical trauma may have challenges expressing their feelings on the topic and how it influences their contraceptive use (Rink et al., 2012). Interventions that neglect to incorporate historical trauma into the curriculum perpetuate poor proactive solutions that do not address some of the root causes of risky sexual behavior(s) (Sileo & Gooden, 2004).

Culturally specific content and activities

Culturally competent HIV/AIDS, STIs, and teen pregnancy prevention interventions for Natives should be built upon diverse values, beliefs, traditions, and linguistic variations, especially for urban Native teens (Sileo & Gooden, 2004). Numerous activities and content reflected diversity among tribal communities. An MTV video, Rebel Music, showing that details young Native musicians throughout the U.S. and Canada who were using their music to bring awareness of Native issues. They consistently talked about their self-identity and their

responsibility to help their communities. A participant stated, "*The video was really good because they showed how it is and how these problems are affecting communities, and the current events that are going on around the United States on different reservations*." The participants liked this video because it demonstrated from a young, successful, Native perspective the importance of self-identity and the responsibility to yourself and your community.

Participants stated they liked learning about the Native epidemiological statistics. The statistics made them realize that there are high rates of HIV/AIDS, STIs, and teen pregnancy within tribal communities, which they were unaware of. They were also unaware of the discrepancies of Native statistics that contribute to inaccurate statistical data among Natives. One participant stated, "..*the statistics, they explain how don't really know how much it's actually affecting the communities…*"

Participants stated they liked various content incorporated within the curriculum. They indicated the Native traditional stories that spoke of sex, sexuality, temptation, ignorance, and consequences of poor decision making from a cultural context. A participant stated, "*I think that Native traditional stories they told about sexuality made us realize that sex is sacred. It's a part of life and you shouldn't think it's bad because it's a good thing."* A participant followed by stating, "…*the stories reminded us that it's natural but in this day of age you have to take certain precautions and be safe*." The participants liked the cultural content and activities that were intertwined with the BART intervention.

Becoming A Responsible Teen

According to the BART curriculum objectives, the participants of BART will be able to state accurate HIV/AIDS information, clarify their own values about sexual decisions, and demonstrate skills in condom use, assertive communication, and problem-solving (St. Lawrence, 1995). The participants stated how the BART curriculum taught them technical skills to assist with HIV/AIDS, STIs, and teen pregnancy prevention.

Condom Use

The BART curriculum has been identified as an effective evidence-based intervention to address HIV/AIDS and teen pregnancy prevention among African-American teens between the ages of 14-18 (St. Lawrence, 1995). The BART intervention incorporates experiential learning activities that are practices focused to elicit behavior change. The participants acknowledged the condom demonstrations were helpful in teaching them preventative strategies. One participant stated, ""*It was helpful teaching us how to properly put on a condom. I think that it was good because a lot of people don't really know and they get STDs or they don't know lambskin condom will still give you STDs*." The participants learned a practical skillset to protect themselves.

Communication

The BART acknowledges that risky sexual behaviors are associated with interpersonal principles and social interactions. The BART's Social Learning Theory emphasizes that learning interaction processes are shaped by the social and physical environments (Bandura, 1994). Negotiation skills are a factor that is linked with social interaction environments (Butts & Hartman, 2002). Therefore, participants participate in problem-solving role-play scenarios by

learning effective communication methods. One participant stated, "*The way that you communicate with people ultimately like, they can influence the decision you make and like how you carry out some of your actions. So then that's really eye-opening because then if you notice like okay, maybe I don't talk clear with people, I don't get my point across and I'm not communicating clearly*."

By understanding and practicing effective communication methods, they understood how that can assist with letting others know their boundaries. The participants can confidently clarify their own values about sexual decisions and pressures. For example, a participant stated,

> *"I think the first thing I would want to stress is that they have to really think about their boundaries, or what we call the red, yellow, green lights of like what they want to do with the person and like that would be the first thing is to know what your boundaries are and the second thing is how to communicate those boundaries to another person and I think one thing that was really important was understanding like healthy relationships and healthy conflict because you know if you try to talk to someone and they're not respecting your boundaries then it's really better for you not to be with that person and so that kind of takes a lot of confusion out of someone's life. You know? It takes a lot drama out when they know that they don't have to put up with like that kind of behavior from someone and then the next thing I would definitely talk about is like how you have to be safe and how you have to think about stuff and it's not…you know if you're going to do something with someone like it shouldn't be awkward to bring up like using a condom you know? Like you know you have to follow your boundaries and that's like the most important thing."*

Consequences and facts

The BART provides information that increases the participants' knowledge and their awareness of risk. The participants got to learn accurate information about HIV/AIDS, including transmission, prevention, and consequential impact. The participants discussed the consequences of risky sexual behavior(s). One participant stated, "*They showed us more of like the consequences of why not to do it. Like with the whole AIDS thing, how much it would cost for like the treatment and how it's not actually getting rid of the disease. It's staying there. Or like how everything will change if that actually to you."* Also, they stated the BART intervention did an effective job of disseminating the facts about sex, poor choices, and the outcomes. One participant stated, "*They really didn't sugarcoat the truth at all. They gave you the hard facts about it. They told you the actual truth about it. Not like what they told us in health class. It was a lot different. It was more than I knew from health class too*."

Summary

The results stemmed from three different phases of this study. Within the first phase, the main recommendations from the advisors were to include tribal structures (matrilineal), cultural teachings (stories, philosophies), Native statistics, and histories of colonization. Within the second phase, the implementation was successful, having 14 participants who started and completed the intervention. Within the third phase, the HIV Knowledge surveys indicated that the participants HIV knowledge scores increased by 3 points when comparing the pre-surveys to the post-surveys. Overall, majority of the end-of-session and end-of-intervention surveys Likert-scale responses among all categories were rated good or very good. This demonstrated that the participants liked the adapted intervention, connected to the activities, and thought it

was overall culturally appropriate. The analysis of the qualitative transcripts revealed two major themes, adapted cultural content and original BART content. The participants indicated the native content helped them to understand the link of cultural teachings to responsible decision-making.

Chapter 6: Discussion

U.S. adolescents, teens, and young adults of all races/ethnicities engage in multiple sexual risk behaviors (Eaton et al., 2010; Everett Jones et al., 2011) and Native youth are disproportionately affected by high rates of STIs and teen pregnancy (Ravello, Tulloch, & Taylor, 2012). Despite numerous research studies on this topic there is a lack of research specific to HIV/AIDS, STIs, and teen pregnancy prevention interventions for Native peoples, rural or urban (Vernon & Jumper-Thurman, 2002). Of the six Native specific interventions discussed in the literature review, only one was an adapted evidence-based intervention (Ravello, Tulloch, & Taylor, 2012). The majority of the Native specific interventions are not considered evidence-based because they have not been rigorously evaluated (www.thenationalcampaign.org, 2009).

Based upon the limited availability of interventions for Native teens, the primary purpose of this research project was to adapt, pilot test, and evaluate the cultural relevance of an evidence-based HIV/AIDS prevention intervention. This project adapted the existing *Becoming A Responsible Teen* (BART) curriculum, implemented the pilot, and evaluated the effectiveness of the intervention content and overall project. The first phase was the adaptation of the BART curriculum for Native youth between the ages of 14-18 years, executed by recruiting a national advisory board of experts for adaptation recommendations. The second phase of this project - Implementation - pilot tested the adapted curriculum among a group of Native youth living in Las Vegas, NV. The final phase – Evaluation – examined the effectiveness of the curriculum and overall project. This research pilot project incorporated a systemic process of adapting, piloting, and evaluating the evidence-based intervention.

Key Findings and Recommendations

Adaptation. Falicov (2009) notes that cultural adaptations to evidence-based interventions are processes that must maintain fidelity to the core elements while adding cultural content to the intervention and/or approaches to engagement. In alignment with Falicov (2009), the adapted curriculum maintained fidelity to the core elements of BART while adding cultural content and practice to the intervention.

Experts further recommend collaboration with the community and tribal members to ensure the adaptations appropriately include Native philosophies, cultural morals and beliefs, customs, and histories (Sileo & Gooden, 2004; DePoy & Bulduc, 1997). A national advisory board was assembled to gain inter-tribal community perspectives for adaptation recommendations for the first phase of this pilot project. The main recommendations from the advisors were to include inter-tribal matrilineal/matrilocal tribal structures within their tribes, tribal stories, cultural teachings, and linguistics, relationships, and historical trauma. As a result, there were numerous cultural stories, cultural teachings, Native statistics, and history of colonization from different tribal nations incorporated into the adaptations. Three of the five advisors identified as tribes within the southwest region, which could have made recommendations biased to those specific tribal groups. Therefore, majority of the recommendations were not inclusive of all tribes within all region of the U.S. Although fifteen persons were asked to serve as advisors, only five advisors contributed recommendations. The advisors were emailed only with no verbal follow-up via in-person or telephone. Upon reflecting on the recruitment of advisors, a verbal follow-up should have been conducted, which might have helped with recruitment of advisors.

Adapting interventions within a cultural context and structuring them within a conceptual framework can give communities a voice. Self-determination and sovereignty are important factors when working with tribal communities. The respect for their autonomy is a vital factor for them to determine their own health needs and wants. Every tribal community has their own set of values, cultures, interests, and viewpoints. That is why collaboration with community stakeholders is necessary when adapting interventions.

Within the adaptation process, it is important to acknowledge that cultural adaptations involve the processes of planning, organizing, researching, and collaborating with persons from the targeted population for whom the adaptations are being developed including an understanding of time in a tribal context. For example, Deloria (1994) described that Natives view time as “cyclical in nature”, whereas European time is more linear. When collaborating with Native people, the aspect of time is a state of process. Therefore, a researcher should allow more time for things to flow into existence, versus expecting immediate actions.

It is important to consider the geographical region when adapting and implementing an intervention. Natives are not a homogenous racial population, therefore have distinct languages, cultures, histories, traditions, and belief systems. The researcher should understand these diversities. For example, Las Vegas is an urban area that consists of different tribal affiliations throughout the United States. However, the researcher considered that majority of the participants tribal affiliations were originally from the southwest region; Nevada, Utah, Arizona. Therefore, majority of the adaptations were catered to the region of implementation.

It is also important to acknowledge that the cultural competence of the researcher and/or research team is important for ensuring cultural ethics and respect are practiced

throughout all phases. Possessing cultural competence also means acknowledging not to only adapt interventions using superficial aspects of the target population's culture (e.g., language, music, foods), but to involve changes based on deeper cultural, social, historical, environmental, and psychological factors.

Implementation. When an intervention is adapted to the socio-cultural systems, developmental levels, and cultural background of its participants, it is likely to enhance community support and participant retention (Solomon et al., 2006). Based on this research pilot project, community support was a fundamental factor for successful implementation. The urban Las Vegas Native community was vital in validating the need for an intervention, supporting the intervention, and assisting to disseminate the information about the intervention. This was reinforced by the participant recruitment because it was completed within a span of 4 hours once flyers and emails were publicized. Also, the researcher of this pilot project is Native and participates in numerous Native community events, which likely enhanced immediate participant recruitment.

The implementation timeframe of two days did not affect participant retention, although it was held on a weekend while school was in session. Participant retention was 100% with 14 participants who began and completed the intervention. Within the Native community, it is cultural appropriate practice for the researcher to strongly interact with the family of the participants to develop and/or foster trust with the participants, their family, and the Native community at large. Therefore, providing an opportunity to meet the participants' family is an important aspect to apply during implementation. Also, integrating guest speakers into the

intervention who know and practice different cultural actions (e.g., dance, song, prayer) can be beneficial to the participants, and overall intervention itself.

Evaluation. When an intervention is culturally appropriately adapted, it will likely enhance program satisfaction and outcomes (Solomon et al., 2006). Overall feedback from participants' on the cultural appropriateness of the intervention was constructive and positive.

The HIV Knowledge surveys indicated that the participants learned HIV knowledge about the disease symptoms, transmission methods, and prevention. The pre-survey range of scores was between 8 and 18 and the post-survey range of scores was between 13 and 20. The lowest score was 8 pre-intervention and the lowest score was 13 post-intervention. Likewise, the highest score post-intervention was 18 and the highest score post-intervention was 20. Overall, the participants improved their scores from pre-intervention to post-intervention by 3.21%. In comparison, St. Lawrence et al. (1995) found the participants in the original BART study increased their pre-intervention to post-intervention scores by 2.7%. These findings indicate that the BARNT was as or more effective in increasing knowledge HIV symptoms, transmission, and prevention when compared to the BART baseline study.

Within the end-of-session surveys, a Likert scale was used to evaluate the technical aspects of each session, how well the participants rated each activity, how well the participants connected to the activities, and if they thought the session was culturally appropriate, including the content and activities. Overall, majority of the Likert scale responses among all categories had frequency percentages of good or very good. This illustrated that the participants liked the adapted intervention, connected to the activities, and felt it was overall culturally appropriate.

The evaluation process would have been stronger if the adapted BART was contrasted with the original by having both a control group and an experimental group to validate that the adapted BART has equal/better outcomes than the original BART.

There were six activities the participants enjoyed the most throughout the intervention. Of the six activities, two of them were adaptations. The four activities that were not adaptations (i.e., original to BART), were highly interactive (preventing HIV game, learning condom facts, roleplays, and final review). The two activities that were adapted were not as highly interactive (goals & values and sex & traditional stories). This implied that the participants highly enjoyed the interactive activities. However, the goals & values activity incorporated many elements of Native culture and responsibility to self and others. The sex & traditional stories activity was an accumulation of different stories from different tribes that metaphorically explained risky behaviors in a cultural context.

There were three activities that the participants indicated they connected to the most as a Native teen. Of the three activities, two of them were adapted. The activity that was not adapted was the preventing HIV game. The activities that were adapted were the Kinaldaa' video and Kerribah. The Kinaldaa' video was a video about Navajo women and the associated ceremony they have when they reach womanhood. In reference to the end-of-session open-ended questions, the participants stated they felt connected to watching the Kinaldaa' video because they got to learn the importance of traditional ceremonies and it gave them a new perspective of starting your life as a Native woman. The Kerribah activities were an accumulation of various physical game activities that consists of Native terminology and

actions, such as “sweeping your teepee” or “owl dance.” The participants felt connected to this activity due to the cultural terminology and actions of the games.

Another component that was evaluated was for participants to evaluate three categories; overall session’s cultural appropriateness, content cultural appropriateness, and activity cultural appropriateness. The four sessions that participants rated the best in regards cultural appropriateness were: Past, Present, Future; Relationship to Self & Others; BART Session 2; and BART Session 8. Three of these sessions were newly developed and/or adapted. This illustrated that the participants felt three of the four sessions were the most culturally appropriate, including the activities and content. The three sessions that were developed and/or adapted incorporated plenty of Native culture, stories, videos, and history.

The purpose of the focus group was to determine what the participants liked and did not like regarding the cultural content and activities. The analysis of the qualitative data revealed several inter-related themes and insights onto data interpretation and intervention feedback. The focus group gave deeper insights of how the participants linked cultural activities and content to HIV/AIDS, STIs, and teen pregnancy prevention.

Participants consistently stated that the Native content/activities helped them connect to the intervention because it was specifically made for their culture, helped them feel more connected to their self-identity, and connected culture to making responsible decisions. The participants consistently stated they enjoyed the cultural stories/teachings that were dispersed throughout the intervention. The focus group assisted in validating that adapting an evidence-based intervention by incorporating Native content enhances the intervention for Native teens.

Intertwined within the adaptations were consistent teachings about the importance of maintaining a harmonious balance and its relationship to health:

> Native Americans believe that each individual chooses to make himself well or to make himself unwell. If one stays in harmony, keeps all tribal laws and the sacred laws, one's spirit will be so strong that negativity will be unable to affect it. Once harmony is broken, however, the spiritual self is weakened and one becomes vulnerable to physical illness, mental and/or emotional upsets, and the disharmony projected by others (Trimble, 2002, p. 54).

In addition, incorporating Native folk tales, storytelling, and legends assisted with personalizing insights on HIV/AIDS and how it relates to culture. With incorporating such content, it explained more about the diversity of Native cultures, helped participants learn more about their own cultures, which enabled them to have more self-pride and self-respect. Holistic approaches increase self-esteem and help youth to develop positive self-identity and self-pride. Also, they develop pride for their tribal affiliations and a deeper respect for spiritual beliefs. Native worldviews include all thoughts, feelings, and words that connect them to self, family, community, and the universe and a cultural adaptation must address them all.

The sample size for mixed methods research tends to be lower than solely quantitative research (Creswell & Plan Clark, 2007). The sample size for this pilot study was low for the quantitative analysis section of this study. Also, there was not adherence to the BART fidelity in terms of the time frame due to limited budget. Therefore, condensing the adapted intervention into one weekend may effect learning key practices on HIV/AIDS, STIs, and teen pregnancy prevention strategies. However, this project was not intended to measure behavioral change.

Although the intervention was implemented within a shortened, two day timeframe this did not affect participant retention. However, it did negatively affect the ebb and flow of the session implementations. Some of the session activities were rushed and did not give

participants the full time frame to engage or practice in certain activity exercises. The participants stated in the focus group that to improve the intervention, more time should be allowed during implementation. Also, due to the rushed timeframe, the participants stated that the intervention at times seemed unorganized. These findings support the premise that with a few carefully constructed, culturally appropriate adaptations, the adapted BART can be an appropriate HIV/AIDS intervention for Native teens.

Future Research

The lack of evidence-based prevention interventions for Native youth supports the need for further research to be conducted for peer review and practice. For this specific pilot study, it would be particularly interesting to compare the original BART to the adapted BART to evaluate the possible enhancements in the effectiveness of the adapted BART. A full field pilot should be conducted to thoroughly examine the differences.

Future prevention research should be conducted that focuses on developing evidence-based, culturally grounded interventions for Native youth, which may provide the foundation for Indigenous prevention science. An aspect to consider is rethinking what evidence means for Natives. Exploring Indigenous research methodologies in reference to HIV/AIDs, STIs, and teen pregnancy prevention is research that has not been remotely investigated.

Also, when considering future research, developing adaptive culturally adapted interventions would be an important avenue to investigate. For example, when knowing the levels of various acculturation or cultural differences between the targeted populations' subgroups, the adaptive intervention could offer different dosages of the intervention

components. This would be dependent upon the population with explicit decision rules for determining variations of adaptive dosages.

Conclusion

Native communities are progressively rejecting Western research frameworks and ideologies. Alternatively, they are reclaiming their right to be Natives, while revitalizing health and healing through cultural health promotion and utilizing Indigenous research methodologies. Therefore, it is imperative to develop and/or adapt and evaluate HIV/AIDS, STIs, and teen pregnancy prevention intervention programs for Native youth. Recognizing and understanding your target populations cognitive, attitudinal, emotional, behavioral, and ecological factors are vital determinants to decrease HIV risk is vital when adapting an intervention. This study contributed to the science of public health prevention in working with tribal communities to appropriately adapt and evaluate an evidence-based HIV/AIDS, STIs, and teen pregnancy prevention using cultural sensitive strategies. However, further pilot studies need to be conducted to thoroughly evaluate the adapted intervention.

Appendix A

Table 3.2. HHS Evidence-Based Teen Pregnancy Prevention Programs

Program Name	Program Description	Target Population	Program Setting	Program Duration
Aban Aya Youth Project	Reduce risky behaviors in an Afro-Centric format	AA children in 5th through 8th grades, Other ethnic students in middle school	Low-income metropolitan schools, Community-based organizations	4 year program; 16-21 lessons each year; 40-45 minute each lesson
Adult Identity Mentoring	Reduce sexual risk behaviors	AA youth; 7th grade students; at-risk youth ages 11-14 years	In-school, After school	12 sessions for 6 weeks
All4You!	Reduce sexual risk behaviors	High school students ages 14-18 or in grades 9-12	Schools	14 session program (about 26 hours total)
Assisting in Rehabilitating Kids	Increase abstinence, increase safer sex practices, and reduce sex behaviors in substance-dependent youth. Intervention is delivered in small groups after participants' initial detoxification in the drug treatment facilities.	Substance dependent adolescents. Average age is 16.	Residential drug treatment facilities	12 sessions; 90 minutes
Be Proud! Be Responsible!	Geared toward behavior modification and building knowledge, understanding, and a sense of responsibility regarding STD/HIV risk in vulnerable youth.	African-American male adolescents age 11-14. , Diverse youth populations age 13-18.	Local school outside of the regular school day. In-school classrooms , After school groups , Community-based organizations, Clinics	6 sessions; 60 minutes; 6 days 6-12 youth per group
Be Proud! Be Responsible! Be Protective!	Adaptation of Be Proud! Be Responsible! program targeting adolescent mothers or pregnant girls. Emphasizes role of maternal protectiveness in motivating adolescents to make healthy sexual decisions and decrease risky sexual behavior.	Pregnant and parenting females in grades 7-12	Schools	Eight, 60-minute modules

Becoming A Responsible Teen (BART)	HIV prevention curriculum based on ethnic pride	AA teens aged 14-18	After school, health clinic, community-based	Eight, 90-120 minute sessions
Children's Aid Society- Carrera Program	Uses holistic approach. Recruits boys and girls ages 11-12 years old and follows them through high school and beyond. Sees youth as "at promise" instead of "at-risk".	Predominantly AA and Latino adolescents. Disadvantaged youth. Ages 13-15 at baseline	After school	7 years
!Cuidate! (Take Care of Yourself)	Adaptation of Be Proud! Be Responsible! for Latino youth.	Latino youth ages 13 to 18 years old	Schools, after-school programs, community-based centers	Six 1-hour modules deliver over two days or more
Draw the Line/ Respect the Line	Comprehensive curriculum. Shows students how to set personal limits and meet challenges to those limits.	Grades 7 to 9 in some communities. Special needs (special education, bilingual)	School-based/ Classroom	19 classes. All classes are taught in sequence, 5 in 6th, 7 in 7th, and 7 in 8th
Families Talking Together	Parent-based intervention to reduce sexual risk behavior	Latino & AA ages 11-14 years	After school, health clinic, home-based	N/A
FOCUS: Preventing STIs and Unwanted Pregnancies in Youth Women	Curriculum-based intervention to educate youth people on issues such as responsible behavior, relationships, pregnancy and STD prevention.	Female Marine Corp recruits. Age 17 or older. *16 years or older	Marine recruit training *Class settings in clinics *Community-based *School/colleges	4 two-hour sessions
Health Improvement Projects for Teens (HIP Teens)	Sexual risk reduction intervention for low-income, urban, sexually active adolescent girls	Adolescent females ages 15-19 years	Community center, community-based, health clinic	Four 120 minute sessions
Heritage Keepers Abstinence Education	Classroom-based curriculum that teaches students the benefits of remaining abstinent until marriage	Middle-school and high-school students	Classroom	5 90-minute or 10 45-minute sessions
HORIZONS	Culturally tailored STD/HIV intervention for African American adolescent females	AA females age 15-21 Seeking reproductive health services	Urban clinics *Community-based clinical settings	Two group sessions over consecutive Saturdays, followed by a

	seeking sexual health services	from clinic. Engaged in vaginal intercourse in past 60 days, were single, were not pregnant or attempting to get pregnant		total of four 15-minute follow-up contacts every other month
It's Your Game: Keep it Real	Classroom and computer-based HIV/STI/pregnancy prevention	7th & 8th Grade Students	Classroom *Afterschool setting *Developer is working on a Native version	Twelve 50-minute sessions delivered in both 7th and 8th grade (24 sessions total)
Making a Difference	HIV/STI prevention curriculum	AA adolescents in 6th and 7th grade	Saturday program in middle schools	Eight 1-hour modules
Making Proud Choices!	HIV/STI prevention curriculum and information about puberty	AA youth ages 11-13 residing in urban areas	School-based on consecutive Saturdays *Clinics/community-based *In-school during school hours *After school	Eight 1-hour modules
Project IMAGE	Reduce STIs among ethnic minority adolescent women with a history of sexual or physical abuse and STIs	AA and Mexican adolescents 14-18 who have history of STIs, physical, or sexual abuse	Health clinic	3 or 4 sessions one week apart
Project TALC	Provides coping skills to parents living with HIV and their adolescent children	Parents living with HIV; Adolescents; Adolescents with a parent living with HIV	Community-based centers on Saturdays	24 sessions: 8 sessions with parents only/16 sessions with both parent and adolescent
Promoting Health Among Teens- Abstinence Only	HIV/STI prevention curriculum and information about puberty	AA youth ages 11-14	Urban schools on Saturdays	8 1-hour modules
Promoting Health Among Teens- Comprehensive Abstienece and Safer Sex Intervention	Comprehensive abstinence and safe sex intervention	AA students in 6th and 7th grade	Urban schools on Saturdays	12 modules delivered over 2 or 3 consecutive Saturdays for 8-12 hours
Raising Healthy	Incorporates school,	Elementary	School setting	School-year (9

Children	family, and individual programs to promote success	students *Middle school *High school		months)
Reducing the Risk	HIV/STI and pregnancy prevention curriculum	Youth ages 13-18 years old in 8th through 12th grades	In-School *Non-school settings	16 45-minute lessons taught in sequence
Respeto/Proteger	Young Latino parents with children who are at least 3 months of age. Parenting classes	Young Latino parents who are in a romantic relationship	Community and clinic settings	Six-session (12 hours)
Rikers Health Advocacy Program	HIV prevention among high-risk youth, drug users and youth in correctional facilities	Incarcerated inner-city teen males ages 16-19	Correctional facility setting	4 1-hour sessions; bi-weekly
Safer Choices	STI/HIV and teen pregnancy prevention	9th and 10th grades	In-School	11 lessons taught in 9th grade; 10 lessons taught in 10th grade
Safer Sex Intervention	Reduce the incidence of STIs and improve condom use among high-risk female adolescents	Adolescent females who sought treatment for cervicitis or pelvic inflammatory disease at a health clinic and were not pregnant at the time	Health clinic	30 to 50 minutes for the initial session and 10 to 30 minutes for each booster session
SiHLE-Sisters, Informing, Healing, Living, Empowering	Adaptation of the SISTA. Peer-led, group-level, social-skills training intervention designed to reduce sexual risk behaviors	Heterosexual AA female teenagers between the ages of 14-18 who have had sex	Local health department	Four sessions with 6 and 12 month follow-up sessions
Sexual Health and Adolescent Risk Prevention (SHARP)	Intervention is designed to reduce sexual risk behaviors among high-risk adolescents in juvenile detention	High-risk adolescents in juvenile detention facilities	Juvenile detention facilities	Single session (One 3-hour followed by a 1-hour)

	facilities			
Sisters Saving Sisters	Reduce risk of HIV/STIs	Sexually active AA and Latina female adolescents *Adolescent females of diverse races/ethnicities	Family-planning clinics Community-based organizations Schools	Four and half hours
STRIVE	Family-based intervention intended to reduce sexual risk behaviors, substance use	Homeless youth ages 12-17	Community center, community-based, home-based	Five sessions of 90 to 120 minutes for 5 weeks
Teen Health Project	HIV prevention	Adolescents aged from 12-17 years from housing developments in urban areas with high poverty, STIs, and drug use	Community-based low-income housing developments	Two THP workshops (3 hours each); Two follow-up sessions (90-120 minutes each), Parent education (90) minutes; THP Leadership Council (90 mi9nutes each, weekly for 6 months)
Teen Outreach Program	Youth development framework	High school grades 9-12; Disadvantaged and high-risk youth	In-school classrooms After school	9 months of programming; 25 sessions (minimum); 20+ hours community service
17 Days	HIV/STI prevention	Predominantly AA females ages 14-18 with previous sexual experience	Urban clinic-based health-care centers	Interactive; 45 minutes for full video

Office of Adolescent Health. (2013b). Evidence-based programs. Retrieved September 25, 2015, from: http://www.hhs.gov/ash/oah/oahinitiatives/teen pregnancy/db/programs.html

Table 5.4. Options (Abstinence) Adaptations

Activity 1: Defining Abstinence and Related Terminology			
BART	Adapted SN-TPPP BART	Recommended Adaptations	Adapted BARNT Content
-There are zero sessions conducted prior to BART Session 1	-Abstinence is a developed session by SN-TPPP -Abstinence is defined and related terminology	-Change the session name from "*Abstinence*" to "*Options*" -Incorporate the importance of females in the creation stories and teachings of the SW -Native puberty ceremonies -Abstinence is stressed by their cultural/religious connection to the ceremonies -Importance of language as part of their identity -Producing spiritual discipline to make healthy decisions -Importance of self-identity related to culture -Sex is a basic need that gives the Native teens sovereign mental expression of their physical understanding when they fully understand values of their Native philosophy -Reflecting the realities of Native teens lives (violence, poverty, racism) -Different historical contexts (imposition of Christianity from colonization that deemed sex/uality as negative) -Examine different world cultures of "virgin" -Define intercourse (anal, oral, vaginal, etc.) and "petting"	-Changed the session name from "*Abstinence*" to "*Options*" -Incorporated some statements made by an advisor -Incorporated texts about Native culture, language, and identity -Kerribah as a guest speaker
Activity 2: Discuss reasons to choose to be abstinence or postpone sex			
-No session prior to BART Session 1	-Discuss reasons to choose to be abstinent/postpone sex	-Cultural reasons to participate in ceremonies (Fire Dance, Ribbon Dance) -Female = Coming of Age ceremony -Male = Sweat lodge requirement	-Included "Relational and Cultural/Ceremonial" on reasons why teens might abstain or postpone sexual activity

Activity 3: Game of how quickly HIV/STIs spread			
-No session prior to BART Session 1	-Game of how quickly HIV/STIs spread	-Alternative Activity: Refreshment served and all but 1 training participant partook of the refreshments. Instructor said they all had HIV, the one person who did not eat did not have HIV	***NO CHANGES***
Activity 3: Brainstorm alternatives to sex			
-No session prior to BART Session 1	-Brainstorm alternatives to sex	-Give recommendations for those who are not involved with sports (band, guitar, club, etc.) -Recommend game “Straight Talk” that divides males/females -Recommend include “I think after he/she will leave, I don’t want to feel used” statement in Participant Book Insertion #2	-Added “After sex he/she will leave, I don’t want to feel used” to book insertion #3 (Alternatives to Sexual Activity) handout

Table 5.5. BART Session 1-Understanding HIV/AIDS Adaptations

BART	Adapted BART	Recommended Adaptations	Adapted Content
Activity 1: Introduction to B.A.R.T.			
-Get to know each other -Introduce BART -Set ground rules -Find a common language -Share personal experiences	-This int roduction occurs during *Abstinence* session	-Utilize a "talking stick" for introductions -Use an engaging activity from the Native Wellness Institute (please refer to scanned copy of the "Switch"activity) -Use "agreements" vs. "groundrules" -Requesting a guest speaker to speak about personal experience about HIV -Ask about traditional community values & writing it on easel board -Write on paper, place in box, & draw paper for students to read and open discussion -If no personal story is available to discuss, I recommend a guest speaker or reading a story (Lisa Tiger's story & her experience with HIV and why youth should celebrate delibacy) -Story (http://virginislandsdailynews.com/news/aids-survivor-talks-about-positive-approach-to-condition-1.1070615)	-Changed "African-American" to "Native" throughout curriculum -Conducted introductions during *Past, Present, Future* session (newly added session) -Changed term to "Agreements" instead of "Groundrules" -Invited Guest Elder/Spiritual person to do "Opening Prayer" with a smudge -"Talking Circle" introductions -Introductions included: Tribal affiliation and Clans
Activity 2: Who is at risk for HIV and why?			
-What are HIV & AIDS? -Who is at risk (AA statistics) -Strengths for prevention (Kwanzaa)	-No adapted content	-CDC: (http://www.cdc.gov/HIV/risk/racialEthnic/aian/index.html) -Coyote story, culture story with moral of story (inter-tribal) -Involve cultural instructor -See link from NPAIHB statistics related to new HIV infections: (http://www.npaihb.org/epicenter/project/reports) -Navajo Epidemiology Statistics -Statistics: (http://www.cdc.gov/HealthyYouth/yrbs/) - Research: (https://spr.confex.com/spr/spr2014/webprogram/Paper21441.html)	-Included general statistics on HIV/AIDS and STIs on persons aged 13-24 -Replaced HIV/AIDS statistics among Natives from AA -Replaced why Natives are at higher risk for HIV infection (social determinants of health) from AA -Replaced "Kwanzaa" with "Medicine Wheel" for strengths of prevention

Activity 3: Introduction to HIV terms			
-Define key HIV terms -Define HIV progression and incubation -Discuss you can/can't get HIV	-No adapted content	-Mention the increase use of meth & heroine on tribal lands -Any cultural story -No suggestions, great education taking place in this section!	-Included "crystal meth" into alcohol and other drugs
Activity 4: Facts & myths			
-Dispel myths about HIV	-No adapted content	-I would add the "H" in HIV stands for HUMAN (must be passed from human to human)	***NO CHANGES***
Activity 5: Deciding your risk level			
-Helps participants understand the degree of risk involved with particular behaviors	-No adapted content	-Will there be any mention that alcohol is a co-morbidity to acquisition and transmission of HIV? -Optional activity handout attached. "Personal Rules" activity	***NO CHANGES***
Activity 6: Spreading the word			
-Learning how they can use their new knowledge about HIV to influence others in a positive way	-No adapted content	***NO RECOMMENDATIONS***	***NO CHANGES***

Table 5.6. BART Session 2-Making Sexual Decisions & Understanding Your Values Adaptations

Activity 1: Definitions review			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-Review HIV terminology	-No adapted content	***NO RECOMMENDATIONS***	***NO CHANGES***
Activity 2: Transmission review			
-Review information about HIV transmission	-No adapted content	-Research is growing on the use of prophylactics for HIV prevention, specifically Truvada (http://www.nejm.org/doi/full/10.1056/NEJMoa1108524) -There should be a warning that some people can get allergic to latex -Putting on a condom is a skill -Maybe provide a handout brainstorming ideas about why people choose not to have sex (this question is currently being surveyed with AI/AN youth in our current Native VOICES evaluation)	***NO CHANGES***
Activity 3: AIDS & African Americans			
-Go over what the statistics mean among AA -Describes seriousness of HIV for AA -Encourages participants to take action to prevent HIV	-No adapted content	-Have dialogue about AI/AN HIV infection rates (not representative of true #) -Discuss what contributes to high rates (limited access to health care, IHS, etc) -Conversation about tribal efforts to address HIV (transient Natives) -Youth invite tribal leaders/traditional practitioners to tell stories of disease prevention in their tribe -Invite culture and language experts to share how Native communities responded to diseases/illness & explain the importance to maintain or restore balance - CDC: (http://www.cdc.gov/hiv/resources/factsheets/PDF/aian.pdf) -Resource: (http://www.nebraskapress.unl.edu/product/Killing-Us-Quietly,673494.aspx) -NNAACP curriculum (http://www.nnaapc.org/resources/toolkit/module_4/module43.html) -Sharing how Native youth can break the chain of infection -Understand nature and cause of disease - Resource	-Changed activity title to “AIDS & African Americans” to “AIDS & Native Americans” -Changed some terminology (i.e. tribal community, Natives) in text - Included tribal leaders and tribal healers when asked *“Who is involved in preventing HIV here in our community?”* -Had a dialogue about AI/AN HIV infection rates (not representative of true #) -Discussed what contributes to high rates (limited access to health care, IHS, etc)

		(http://www.cdc.gov/hiv/pdf/policies_strategy_nhas_native_americans.pdf) -Provide state statistical resources for Native youth to view -Stats: (http://aidsvu.org/local-statistics/)	-Replaced African American statistical data with relevant data
Activity 4: HIV feud game			
-Helps participants review risk levels for a variety of behaviors and activities	-No adapted content	***NO RECOMMENDATIONS***	***NO CHANGES***
Activity 5: Video "*Seriously Fresh*"			
-Watch & discuss video that features AA friends experience learning about & dealing with HIV	-No adapted content	-"Breaking the Silence, Strengthening the Spirit" film by Michael Covone (http://www.ak-pa.org/governance/boardmembers/_boardmember_pages/michael_covone.htm) -Ayn White video -*Native VOICES* (an evidence-based health video for Native teens) is currently in the process of being evaluated to be recognized by the CDC, contact to mail to you)	-Changed "*Seriously Fresh*" video to "*Native VOICES*" video -Incorporated associated questions from video
Activity 5: Personalizing HIV risks (Alternative activity)			
-Allows participants to complete an activity sheet that helps them think about how HIV could affect them personally	-No adapted content	-Ask how HIV has affected their tribal community and what they know about this	***NO CHANGES***
Activity 6: Exploring drug risks for HIV			
-Encourage participants to explore the link between drug/alcohol use and HIV	-No adapted content	-Mention snorting drugs can potentially increase HIV infection as this will tear membranes of the nose, and if sharing a straw or dollar bill those cells can be transferred (HIV less likely but HEP C is likely) -Site an annual EPI HIV report by NAIHS Infectious Disease Consultant -A handout will be scanned and attached	-Included text about sexual abuse & drug facilitated sexual assault definitions and the cultural implications
Activity 7: Support systems			

-Helps participants identify people they can turn to for info & confidential discussions about safer sex & HIV	-No content adapted	-Clergy, youth organization, school counselor, school nurses, medicine men -Provide online resources that allow youth greater privacy. I recommend WeRNative website "Ask Auntie" confidential question resource: https://www.youtube.com/user/Nativestand7#p/u http://www.wernative.org http://www.wernative.org/search.aspx?q=ask%20auntie http://greaterthan.org/campaign/empowered -Burn sweet grass cedar -Use quote: "You have one body-and nothing is more important than feeling confident in your own decisions and comfortable in your own skin. Embrace the awkward even if you're scared things can happen to you. If you have questions, there are lots of people here that care about you, and can help you find the answers."	***NO CHANGES***

Table 5.7. BART Session 3-Developing and Using Condom Skills Adaptations

Activity 1: Using and developing condom skills			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-Share questions and experiences about what they have learned thus far -Review "*Seriously Fresh*" video -Distribute AA high school students and sexual activity	-No adapted content	-Some Native students are shy, perhaps using a suggestion box	-Replaced "*Native VOICES*" video questions from "*Seriously Fresh*" video questions -Incorporated "Native American High School Students and Sexual Activity" statistics
Activity 2: Learning the facts about condoms			
-Learn about condoms -Learn about lubricants -Learn how to store condoms	-No content adapted	-Allergy to latex -Porous-lambskin?? (porous HIV could seep through or any STD germ) -How to store condoms	***NO CHANGES***
Activity 3: Overcoming embarrassment about buying condoms			
-Addressing embarrassment	-No content adapted	- I don't know about specific things for native youth, but this Golden Girls clip always opens the pathway to discussion: (http://youtu.be/6kOewRGhtx8) -Ask: It is a concern that in Native communities it may be a possibility of passing word of so-and-so purchased condoms?	-Included this "Golden Girls" clip (http://youtu.be/6kOewRGhtx8)
Activity 4: Using condoms correctly			
-Explain the steps for putting on a condom -Explain steps for removing a condom -Practice steps for condom use	-No content adapted	-Explain: What are the signs of an allergic reaction to the male/female body -Invite a guest: Family planning counselor -Cultural message: Share ancestors used to "herd" sheep to curb release of egg or as birth control (Navajo)	***NO CHANGES***
Activity 5: Countering barriers to using condoms			
-Understanding the barriers	-No content adapted	-Guest: Family planning counselor -Role play option: Male ("Come on baby, if you love me, you will let me love you. Ok, if	***NO CHANGES***

		you don't love me, I'll go see… or I'll go out with…" -Suggestion: refusal/just plain not ready and not willing -Compare/contrast levels of hormones between males (progesterone) & females (estrogen) -Explain why males have increased desire for sex on their mind, bodily reaction -Recall Male Puberty Ceremony/Female Ki'naalda Ceremony (About control of feelings, reaction vs. thinking of consequences)	

Table 5.8. BART Session 4-Learning Assertive Communication Skills Adaptations

<table>
<tr><th colspan="4">Activity 1: Correct condom use review</th></tr>
<tr><th>BART</th><th>Adapted BART</th><th>Recommended Adaptations</th><th>Adapted Content</th></tr>
<tr><td>-Review proper condom use</td><td>-No adapted content</td><td>-Negotiating

-No, great simple instructions!</td><td>*NO CHANGES*</td></tr>
<tr><th colspan="4">Activity 2: Video “Are you with me?”</th></tr>
<tr><td>-Watch video “Are you with me?”</td><td>-No adapted content</td><td>-Native VOICES is geared toward AI/AN youth

-Ayn White video</td><td>*NO CHANGES*</td></tr>
<tr><th colspan="4">Activity 2: Alternative activity (Negotiating safer sex)</th></tr>
<tr><td>-Demonstration on “Saying no to sex”

-Demonstration on “negotiating condom use”

-Practice negotiation skills handout</td><td>-No adapted content</td><td>-Ayn White curriculum
-Dine’ College Don Chee & Darlene Hunt

-This activity is great due to including two people having conversation about practicing safer sex

-This should be considered as a mandatory activity and not only an alternative activity because more skill application in communication

-Native youth have cultural communication norms of being quiet and not speaking up so this activity should be mandatory instead of an alternative</td><td>*NO CHANGES*</td></tr>
<tr><th colspan="4">Activity 3: Problem solving skills</th></tr>
<tr><td>-Introduce problem-solving skills

-Walk through the steps

-Reinforce the skills</td><td>-No adapted content</td><td>-Fish bone diagram (visual diagram for visual leaners)

-Consider a proactive response for the person who is using the six steps

-Determine a problem (My partner may go with my girlfriend’s worst enemy)</td><td>*NO CHANGES*</td></tr>
<tr><th colspan="4">Activity 4: Different communication styles</th></tr>
<tr><td>-Introduce different communication styles

-Demonstrate and discuss passive, aggressive, & assertive communication

-Roleplays</td><td>-No adapted content</td><td>-Communication model (sender=giving message; recipient=receives messages)

-Include meeting someone at a “49”

-Include decisions that have to be in a more spontaneous atmosphere

-Offer a challenge to each teen: “I challenge you to share a lesson with a sexually active friend.”

-See the STAND curriculum peer manual for additional Wrap-Up messages (http://www.ncsddc.org/what-we-do/health-disparities/native-stand-curriculum)</td><td>*NO CHANGES*</td></tr>
</table>

Table 5.9. BART Session 5-Practicing Assertive Communication Skills Adaptations

Activity 1: Assertive communication review			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-Review assertive, passive, and aggressive communication styles	-No adapted content	-Ask students: Explain/describe communication styles at religious/cultural events and song/ceremony among family/friends -Please see link and alienating message to prepare participants in advance on communication tactics (http://us.reachout.com/facts/factsheet/thinking-about-having-sex) -I didn't see much in the curriculum that address molestation or sexual exploits, which are conversations I have had on my reservation	***NO CHANGES***
Activity 2: Participants learn practical tips for assertive communication			
-Tips for more assertive communication	-No adapted content	-Is there anything about life goals? Thinking ahead 15 years (degree/graduate from a university, married, have children), family expectations, religious standards? -Please see link and snip on the following page: (http://www.wernative.org/SubTopicDetails.aspx?id=136&type=SexualHealth) -Benefits of journal writing	***NO CHANGES***
Activity 3: Ways to say "NO"			
-Explore options and develop an understanding of how to say NO assertively	-No adapted content	-Cultural story?	***NO CHANGES***
Activity 4: Assertive communication roleplays			
-Demonstration roleplays	-No adapted content	-Do youth still use the term "rubbers?" (I'm not sure that's still used in mainstream conversation) -Party scene mentioned previously -Add a section to prepare youth in advance if their partner is not willing to communicate -Resource: (http://www.wernative.org/SubTopicDetails.aspx?id=135&type=SexualHealth) -Role play is authentic	***NO CHANGES***
Activity 5: Assertive communication practice			
-Introduce roleplays	-No adapted content	-See Native VOICES Users Guide handout "Sensitive Questions" below.	***NO CHANGES***

Table 5.10. BART Session 6-Personalizing the Risks Adaptations

Activity 1: Meeting people with HIV			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-Meeting people with HIV	-No adapted content	-The standard fall backs in the southwest have been Lisa Tiger and Isadore Boni -You can show videos of positive people and their stories (http://www.thebody.com/content/66915/the-positive-project-first-person-stories-from-hiv.html) -Include family planning counselor -School counselor: if he becomes too intense offer suggestions to other people to talk to (e.g. clergy, traditional practitioner, grandparent) -Ayn White, Dine College	-Try to obtain a Native speaker
Activity 1: Alternative Activity (Video)			
-Watch a video if a guest speaker is unavailable	-No adapted content	***NO RECOMMENDATIONS***	-Used Alternative videos: Sharon, Native American living with AIDS (https://www.youtube.com/watch?v=8dOyeEmpn_U)
Activity 2: Discussion and debrief			
-Discuss & debrief on thoughts & feelings	-No adapted content	***NO RECOMMENDATIONS***	***NO CHANGES***

Table 5.11. BART Session 7-Spreading the Word Adaptations

Activity 1: Assertive communication in the real world			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-Review and reinforce the assertive technique communication	-No content adapted	***NO RECOMMENDATIONS***	***NO CHANGES***
Activity 2: Getting out of risky situations			
-Participants get specific about ways to get out of risky situations	-No adapted content	-Decide now, PRIOR, to attending the party, going on date, or be alone with your partner, decide now, you will not have sex (decide on the affirmative) -Is there anywhere in the lesson, “I’m not ready for a baby, I’m not ready to be a Mom/Dad” or “I have plans to get a college degree”? -Review the steps -“…..talk about safety….find out ahead of time” –I like that!	***NO CHANGES***
Activity 3: Spreading the word demonstration			
-Demonstrate ways to talk with family/friends about HIV	-No adapted content	***NO RECOMMENDATIONS***	***NO CHANGES***
Activity 4: Word practice			
-Practice passing along BART prevention messages in roleplays	-No adapted content	-Examples for life: Recommend sitting in circle with the Talking Stick - Remind the participants about their work: 2nd bullet “…You can ask the group to help you..” EXCELLENT!	***NO CHANGES***

5.12. BART Session 8-Taking B.A.R.T. With You Adaptations

Activity 1 (1): Sex and traditional stories			
BART	**Adapted BART**	**Recommended Adaptations**	**Adapted Content**
-BART Session 8-Activity 1 is " Final review of HIV facts"	-No adapted content	***NO RECOMMENDATIONS***	-This is BARNT Session 8-Activity 1 with "Sex & traditional stories" activity -Participants learn about responsible decision making in reference to sex through traditional stories
Activity 1 (2): Final review of HIV facts			
-This is BART Session 8-Activity 1 -Review basic facts about HIV/AIDS	-No content adapted	-Common myth in Indian Country/Navajo "Can I get HIV from toilet seat, sharing a towel with someone?" -Anywhere there is a reference to AA Change to AI/Alaskan Native -3rd bullet, p. 5: Navajo are being hit hard. In 2003, 300% increase in HIV NOTE: I'll double check with Dr. Iralu on year.	-Moved BART Session 8-Activity #1 to Activity #2
Activity 2: (3) Self-reflection			
-BART Session 8-Activity 3 is "What are you doing to protect yourself?"	-No adapted content	***NO RECOMMENDATIONS***	-This is BARNT Session 8-Activity 3 -Participants reflect on 4 questions from *Past, Present, Future* session -Read "Man in the Maze" tribal story
Activity 2 (4): What are you doing to protect yourself?			
-This is BART Session 8-Activity 2 -Reflect on BART	-No adapted content	-When reflecting on BART, suggest Talking Circle	-This is BARNT Session 8: Activity 4
Activity 3 (5): What are you doing now to educate others?			
-This is BART Session 8-Activity 3 -Participants learn from each other's experiences about educating others	-No adapted content	-In native communities we are often linked quite closer than we may know. This is why the clan system was put in place, to ensure we knew where we came from but to also ensure that we honored those lines by not crossing into them sexually. This is a good foundation to keep the communication lines built upon.	-This is BARNT Session 8-Activity 5
Activity 4 (6): Graduation			

-This is BART Session 8-Activity 4	-Distribute gift cards based on Moola tally	***NO RECOMMENDATIONS***	-One of the participants said a "Closing prayer" & smudged -There was no BART graduation -Gave out incentives

Appendix B

Hello ,

Ya'ta'hey, my name is Crystal Lee. I am originally from Teesto, Arizona (Navajo Nation) and an enrolled member of the Navajo Nation. I was born and raised on the Navajo Nation. My tribal clans are Tachii'nii (Red Running Into Water people), Tabaaha (Water's Edge people), Tsenjikini (Cliff Dwellers people), and Kin I ichii'nii (Red House people). Currently, I am pursuing my Ph.D in Public Health at the University of Nevada-Las Vegas.

This letter is respectfully requesting for you to serve on an Advisory Committee Board for my dissertation project. My dissertation project is aimed to address the epidemic of HIV/AIDS, sexually transmitted infections (STI's), and teen pregnancy in tribal communities. An HIV/AIDS, STI's, and teen pregnancy prevention intervention curriculum will be developed by adapting an evidence-based HIV/AIDS curriculum, *Becoming a Responsible Teen* (BART) for Native youth between the ages of 14-18 years. The purpose of project is to initiate the processes of adapting an evidence-based intervention curriculum, implementing the pilot at a Native community-based center, and evaluating the effectiveness of the intervention content and overall project.

The first phase of this project involves adapting an HIV/AIDS curriculum, *Becoming A Responsible Teen* (BART). This phase is vital due to the extremely limited amount of culturally appropriate HIV/AIDS, STI's, and teen pregnancy prevention curriculums that have been developed or adapted for Native youth nationwide. The adaptation phase will be executed by recruiting a national advisory board for persons that are experts in related fields to grant adaptation recommendations. The second phase of this project involves implementing a pilot at the Las Vegas Indian Center. The final phase involves evaluating the effectiveness of the curriculum and overall project. Upon completion of this pilot project any tribe in the U.S. will be able to utilize the adapted curriculum to implement in their communities.

Specifically, I am asking for you to be a part of the Phase One (adaptation) and the Phase Three (evaluation) processes. The objective for Phase One is to adapt the BART intervention by recruiting a maximum of twelve experts in the fields of Native culture, sexual/reproductive health, curriculum adaptation, or program evaluation to serve as an advisory committee member to assist with adaptions. The advisory committee members will assist with curriculum adaptation by providing recommendations to ensure:

A) The curriculum will be culturally relevant to the developmental issues of the Native population.

B) The curriculum will address the cultural values, beliefs, and attitudes of the Native population within the contexts of their socio-cultural system.

C)The curriculum will promote relevant changes in health behaviors of persons in their normal cultural and socialization contexts.

In addition, I am asking you to be part of one piece of the evaluation process. You will be invited to watch recorded videos of the adapted BART intervention to measure the quality of the implementation of the program delivery and participants' response to the adapted intervention using a 7-question likert-scale observation form.

As a Native doctoral student, I have encountered many challenges to be at this stage of my academic progress. I truly hope you will serve as an Advisory Committee Member for my project.

Sincerely,

M. Crystal Lee, MPH
(480) 518-6398
Crystal42lee@gmail.com

Dear Advisory Committee Member,

I would like to express deep gratitude that you are volunteering to assist with this project. Your recommendations will be used to adapt the BART intervention so it will be culturally appropriate for Native American (Native) youth. Your evaluation will assist on a continuum of adaptions that are needed to ensure this intervention is highly effective among Native youth between the ages of 14-18 years.

To reiterate, the purpose of project is to initiate the processes of adapting an evidence-based HIV/AIDS curriculum, implementing the pilot at a Native community-based center, and evaluating the effectiveness of the intervention content and overall project. The first phase of this project involves adapting the BART intervention. This phase is vital due to the extremely limited amount of culturally appropriate HIV/AIDS, teen pregnancy, and sexually transmitted infections prevention interventions that have been developed or adapted for Native youth nationwide. Upon completion of this pilot project any tribe in the U.S. will be able to utilize the adapted intervention to implement in their communities.

I have or will email you the "Abstinence" and BART Sessions 1-5 ASAP. I will email the remaining BART Sessions 6-8 on October 15, 2014. **The deadline for you to submit all adaptation recommendations is December 15th, 2014**. Please continue to read below for further instructions and considerations.

Ahe'hee' (Thank-you)

Crystal Lee, MPH
Crystal42lee@gmail.com
(480) 518-6398

CONSIDERATIONS BEFORE WE GET STARTED:

NOTE: The advisory committee will consist of people nationwide who are experts in the fields of Native culture, education, sexual/reproductive health, curriculum adaption, and/or program evaluation. Your recommendations will be acknowledged and noted in all academic and professional environments.

NOTE: The interventions will be broken down by each session. I will email each session to you so you may type your recommendations on your accord.

- Abstinence Session: (The "Abstinence" Session is **NOT** part of the BART intervention but it was created by the Southern Nevada Teen Pregnancy Prevention Project team)
- Session 1: Understanding HIV & AIDS
- Session 2: Making Sexual Decisions & Understanding Your Values
- Session 3: Developing & Using Condom Skills
- Session 4: Learning Assertive Communication Skills
- Session 5: Practicing Assertive Communication Skills
- Session 6: Personalizing the Risks
- Session 7: Spreading the Word
- Session 8: Taking B.A.R.T with You

NOTE: I will first mail out "Abstinence" and BART Sessions 1-5. I will then email out BART Sessions 6-8 on October 15, 2014. The deadline for you to submit all adaptation recommendations is **December 15th, 2014.**

NOTE: There will be a table under each BART Session Activity. The table below is an example. Please read.

****IMPORTANT****

The table below derives from the BART adaptation kit, which is a step-by-step guide to the types of adaptations that are considered safe or unsafe for maintaining fidelity to the BART intervention.

- **The green light adaptations means "Go for it"**
- **The yellow light adaptations means "Proceed with caution and guidance"**
- **The red light adaptations means "Avoid"**

Therefore, if the content/activity falls under the green light category then it is considered "safe" to adapt. If the content/activity falls under the yellow light category then it is still questionable and needs further examination or justification. If the content/activity falls under the red light category then it means it cannot be adapted. There will be a table for each BART activity.

PLEASE REFER TO THESE TABLES FOR ADAPTATION RECOMMENDATIONS.

Activity Title	Green	Yellow	Red
Activity 1: Intro to BART	Youth intro can be done in other ways, as long as youth have a chance to let others know their names, ages, schools and what they'd like to get out of the program. Some Youth prefer the term "group agreements" rather than "ground rules," can have a negative connotation.	None	There are 3 critical elements to Activity 1. All should be included for the following reasons: 1. Intros set the tone for group interaction, build trust, and encourage participation. 2. Setting ground rules or group agreements helps participants feel comfortable and safe when talking about HIV, sex and drugs in front of their peers. 3. Developing a common language for discussing sexuality also creates a comfort level for discussing HIV & protection.

NOTE: There will be questions that are written in bold and highlighted throughout each session to use as a guide for adapting the curriculum. Please respond to each question. You may respond to each question by typing under it.

NOTE: The handouts to each session will be located at the end of each session.

NOTE:

Definition:

Two Spirit: Term refers to Native American/Alaska Native Lesbian, Gay, Bisexual, Transgendered, Transsexual, Queer, Questioning (LGBTTQQ) individuals. It may have different meanings in different tribal communities.

NOTE: Below is the background of the BART intervention including the theory and the evidence of effectiveness that has been written verbatim from the BART intervention: St. Lawrence, JS. (1998). Becoming a responsible teen: An HIV risk reduction program for adolescents.Santa Cruz, CA: ETR Associates. This is for you to gain a better understanding of the BART intervention, if needed.

BART Intervention Background: Theory & Evidence of Effectiveness

St. Lawrence, JS. (1998). Becoming a responsible teen: An HIV risk reduction program for adolescents.Santa Cruz, CA: ETR Associates.

The Challenge

The biggest challenge is not to teach adolescents what to do to avoid HIV—it's to help them acquire the skills and self-confidence that will allow them to refuse a sexual invitation or to carry out safer-sex practices consistently if they choose to have sex. Even adults who are well informed about safer sex often make serious errors when they estimate the risks associated with their behaviors. The B.A.R.T. research team consistently found that people underestimated their own risk.

Many young people who enter steady relationships don't use protective measures, because they want to believe their partner is faithful and uninfected. Trying to judge risk based on what others say or how they appear is highly unreliable. Many infections don't have obvious symptoms, and past sexual behavior or drug use is often not discussed. Lacking accurate
knowledge about a partner's past, young people tend to make judgments based on physical appearance or social influences. Both can be deceptive.

This means that risk reduction programs need to do more than describe risky sexual practices and provide information; they also need to correct misperceptions that create a false sense of safety. Young people almost never set out to deliberately behave in a life-threatening way. Instead, they make a series of seemingly innocuous choices that eventually lead to a risky interaction. Effective self-protection requires good problem-solving skills so young people can deal with situations as they arise and anticipate consequences. It's easier to extricate oneself from a risky situation sooner rather than later.

To practice safer sex, youth must have both the skills and the self-efficacy beliefs that allow them to make sound choices, act on their personal values, and communicate honestly about sex and self-protection. The wish to protect themselves often comes into conflict with pressures, threats, enticements, desire for approval or peer acceptance, sexual feelings, fear of rejection and persona embarrassment. In particular, young people who have previously been coerced into sex m ay have a harder time believing they can protect themselves by refusing unwanted advances or negotiating safer sex.

The Theory Behind B.A.R.T.

Interventions that encourage people to practice healthier behaviors often rely heavily on persuasiveness. Many health messages try to promote change by creating fear, portraying the ravages of the disease or making dire predictions. It's true that teenagers need to know enough about the potential dangers to make sound choices, but they do not have to be scared senseless before they will act, any more than car owners need to witness a fatal accident before they will insure their vehicles.

What teenagers do need is sound information about how HIV is transmitted from one person to another, the motivation to act on that knowledge, a belief in themselves, and the conviction that they can successfully take self-protective action. In particular, they need the skills to act in their own best interests. The most effective health messages (1) instill the belief that teenagers have the ability to make good choices and then help them learn how to do so, and (2) make it clear that success requires persistence, so you th will not give up if they encounter difficulty. Changing behavior is rarely easy and often does not happen at the fist attempts.

Social learning theory and self-efficacy theory explain how people act in terms of (1) personal biological, emotional, and cognitive factors, (2) behavior, and (3) the environment. The B.A.R.T. curriculum includes 4 major components to reflect this:

- Information that increases adolescents' knowledge and their awareness of risk.
- Training in the skills adolescents need to translate the information into action.
- Opportunities to practice and receive corrective feedback, using the skills in a safe environment before they face the challenges of using them in risky situations.
- Social support for the desired behaviors, to help make them the norm in the social environment.

Programs need to shift from trying to scare teenagers into doing what's right and instead empower them with the tools they need to act on responsible choices.

Information

Our culture has always made it difficult for people to talk frankly about sex. As a result, most youth learn about sex from one another, from sources outside the home or school, and from the consequences of uninformed sexual experimentation. Some sectors of society actively try to maintain a veil of silence about sexuality, in the hope that withholding information will promote abstinence and the misbelief that providing information will stimulate indiscriminate sexuality.
B.A.R.T. is based on the knowledge that information and awareness are preconditions that set the stage for change. By themselves, however, they are not sufficient to change the behavior of most young people. Despite widespread knowledge about HIV, many adolescents continue in risky sexual or drug practices.

Skills Training and Practice

Social Learning Theory stresses that people learn by seeing others model the desired behaviors and values. B.A.R.T. includes modeling of the needed skills and values by group facilitators, as well as by the youth for one another. The modeling facilitators, as well as by the youth for one another. The modeling that takes place among the participants is especially important. The impact of modeled behavior is greater when the models are similar to the participants in age, race, gender and status. Thus, having youth role play for

one another ensures that they learn from people similar to themselves. In addition, people learn modeled skills when the situations and problems are similar to events in their daily lives.

Proficiency in using any new skill requires practice. After teenagers gain knowledge and learn skills, they need opportunities to practice those skills. In the B.A.R.T. program, teenagers firs practice using the skills in simulated situation where they don't have to worry about making mistakes. Following the role plays, they receive constructive feedback about their use of the skills and continue to practice until they can use them proficiently. This is why the curriculum emphasizes repeated practice.

Benefits from these role play practices go beyond skill improvement. In the course of practicing the skills, the teenagers also gain in self-efficacy and learn to believe in themselves. This is an important aspect of the skill practice: if adolescents are not fully convinced that they can handle a situation, self-doubt will undermine their use of the skills.

Social Support

Adolescents change their behavior when they understand the information, acquire the skills to protect themselves, believe in their ability to use those skills, and are motivated to do so. However, their individual behavior takes place within a network of social influences. These social influences can either help or undermine their efforts.

Social Cognitive Theory recognizes that social norms influence behavior in two ways: through social sanctions and through self-sanctions. Actions that violate social norms often bring censure or other punishing consequences, while behavior that conforms to what others want is approved and rewarded. In this way, social norms become external standards for conduct. Among adolescents, the norms of their peers are usually stronger than societal norms. As increasing numbers of adolescents become B.A.R.T. "graduates."" they alter the social norms in their community to favor safety and discourage risk taking. Such social influences from peers have greater impact and sustaining power than pressure from outsiders.

History and Research Design of the B.A.R.T. Program

B.A.R.T. is one of a series of Research-to-Classroom programs funded by the Centers for Disease Control and Prevention, Division of Adolescent School Health. It was developed in Jackson, Mississippi, by Dr. Janet St. Lawrence, Jackson State University, in cooperation with the Jackson-Hinds Comprehensive Health Center, under a grant from the National Institute of Mental Health.

Research Based on B.A.R.T.

The project Director began by conducting several studies to provide information for the curriculum:

- One study examined gender difference in knowledge, attitudes and sexual behavior to see whether there were differences that needed to be considered in preparing the curriculum. The results indicated important differences between boys and girls and

led to the decision to offer the program to gender-specific groups. Males knew less about HIV, had more sexual partners, held less favorable attitudes about using condoms, and expressed less confidence in their ability to make healthy choices. Females were already positively predisposed toward using condoms but needed more training in communication skills to persuade their partners to use condoms or to refuse pressure to engage in unprotected sex.

- Another study assessed whether providing youth with condoms would promote increases in sexual behavior. The results showed that adolescents who used condoms beginning with their first sexual experience remained at lower risk than their peers.

In order to establish a baseline of risk behaviors already present among adolescents, the Project Director assisted the Mississippi Department of Education in conducting a statewide survey of youth risk behaviors. That survey indicated that 72.6% of Mississippi high school students were already sexually active and that 50% initiated sexual activity before age 15. The survey also provided a baseline of teenage sexual behavior in the state where the program would be delivered and confirmed the need for an effective risk-reduction intervention.

Statistics provided by the Mississippi State Department of Health indicated that a high percentage of adolescents were diagnosed with sexually transmitted diseases and that Mississippi had the highest rates of STD in the nation. In addition, the state had double the national average of people under age 24 who had been diagnosed with AIDS. Over the following years, the program staff continued to compare B.A.R.T. participants with the baseline state figures from the statewide survey to ensure that the program did not increase sexual activity among its participants or otherwise harm the youth who participated.

Project History

For the initial intervention, B.A.R.T.'s Project Director, Dr. Janet St. Lawrence, approached Jackson Hind's Comprehensive Health Center, a trusted community-based organization with a long history of providing trusted community-based organization with a long history of providing services to African-American adolescents in the community.

Once the Center agreed to help develop the program, adults who worked with high-risk youth were invited to serve on a Community Advisory Committee. This committee reviewed the curriculum and evaluation measures and provided oversight for the years B.A.R.T. was provided to ensure that the values of the community were represented by the program. Funding for the project came from a grant from the National Institute of Mental Health.

A Teen Advisory Panel was recruited to help develop the program. The Advisory Panel helped review the measures that would be used to evaluate the program and drafted the role play scripts. Scenarios were chosen only if 75% of the youth agreed that they had been in a similar situation and had found it hard to handle.

Applicants for the co-leader positions were interviewed separately by both the Community Advisory Committee and the Teen Advisory Panel members. Once hired, staff received intensive training from the Project Director and a training coordinator. They first observed the training coordinator leading groups, then gradually assumed the session leadership.

Youth participants were recruited at Jackson-Hinds, with the Center's support. Staff talked to the youth individually and, because this was a research project, obtained their verbal and written informed consent as well as parental permission.

Intervention
African-American adolescents, separated by gender attended 8 weekly sessions of a sexually explicit education program (B.A.R.T.) that included behavior-skills training. In addition to receiving information about HIV and prevention of infection, the youth participated in activities to build skills in correct condom use, assertive communication, refusal, information provision, self-management, and problem solving and risk recognition.

Group sizes ranged from 5 to 15, and sessions lasted from 90 minutes to 2 hours each. After the final session, participants "graduated" from the program and received a certificate and a T-shirt with the project logo. After the final session, the Project Director wrote to the parents to thank them for allowing project staff to work with their sons and daughters.

Fourteen sets of sessions were conducted over 3 years in Jackson, Mississippi, a southern urban area of 400,000 in a comprehensive community health center that serves predominately low-income minority residents.

Research Design
Two hundred forty-six adolescents were randomly assigned to either a control condition or the experimental intervention (B.A.R.T.). The control condition consisted of a single, 2-hour education session that provided information about HIV, including prevention and its impact on the local community. The first session of B.A.R.T. was identical to the control condition. In B.A.R.T., however, interactive discussions were interspersed with games, activities, skill building and problem solving.

Participants completed questionnaires before, immediately after and at 6-month intervals for 1 year after the intervention. Participation remained high and 91.5% of the original 246 participants completed the 12-month follow-up assessments. Measures included HIV risk, sexual behaviors, self-efficacy, attitude toward condoms and HIV knowledge.

Evaluation and Evidence of B.A.R.T.'s Effectiveness
People are often concerned that giving adolescents sexually explicit material may cause them to misinterpret such information and training as encouraging, or at least condoning, sexual activity. The evaluation of B.A.R.T. provides some interesting data on that issue, as well as showing, the effectiveness of the program.

In general, the young people in the B.A.R.T. program reduced their number of sexual partners, decreased unprotected sexual activity, and increased their use of condoms to a

greater degree than the youth who received education only, although neither program increased sexual activity, and both programs produced some reductions. One year later, however, there were marked differences.

Of the youth who participated in B.A.R.T. who were sexually abstinent prior to the intervention, only 11.5% were sexually active one year later, compared with 31% of participants in the control groups. Thus, the B.A.R.T. program delayed the onset of sexual activity to a greater extent than information unaccompanied by skills training.

Among those who were sexually active prior to the intervention, only 27% of the B.A.R.T. group remained so after one year, versus 42% of the control group. In comparison to their behavior before the intervention, and in comparison with those in the control group, youth who participated in B.A.R.T were more likely to discontinue having sex or to use condoms and less likely to engage in unprotected vaginal or anal intercourse.

Despite the fact that both groups received the same basic information component, the B.A.R.T. group scored higher on the HIV knowledge test than the control group and maintained that lead across the 12-month follow-up period. Moreover, youth from the B.A.R.T. group were more skillful than those in the control group in handling pressures to engage in unprotected sex and in providing information to peers.

The graphs that follow illustrate some of the research findings. A more complete report can be found in the 1995 article, "Cognitive-Behavioral Intervention to Reduce African American Adolescents' Risk for HIV Infection"; J. St. Lawrence, T. Brasfield, K. Jefferson, E. Alleyne, R. O'Bannon and A. Shirley; Journal of Consulting and Clinical Psychology 63:221-237.

Number of Sex Partners

Figure 1 shows the number of sex partners reported by boys. Although both groups showed a decline immediately after their respective programs, only the B.A.R.T. participants continued to reduce the number of partners over the following year.

Figure 2 shows the number of partners reported by girls in each group. Girls in the B.A.R.T. program reduced their number of sexual partners immediately after the program ended, and these numbers remained lower throughout the following year. In contrast, girls who received education only did not reduce the number of reported partners, and one year later these numbers continued to increase. This increase is consistent with other evidence that shows that as teenagers get older, they typically increase their sexual activity, and is in marked contrast with the stable partner reductions by the girls in the B.A.R.T. program. The girls who received the more explicit B.A.R.T. program had fewer partners after the intervention.

Protected Intercourse

Figures 3 and 4 illustrate the number of condom-protected intercourse occasions reported by the sexually active boys and girls. Figure 3 show that the boys in the education-only program discontinued using condoms to a greater extent than boys in the B.A.R.T. program. The latter group increased their frequency of condom use during sexual activity.

The girls show a similar pattern in Figure 4. Girls who receive the education-only program decreased condom use, while the girls who participated in B.A.R.T. increased condom use, maintained the increase and continued to increase use over the following year. Thus, the B.A.R.T. participants who remained sexually active protected themselves to a greater extent than youth who had not received the skills training.

Unprotected Intercourse

Changes were also apparent in the number of unprotected vaginal intercourse occasions reported from the two groups. Boys from both groups (Figure 5) had lower numbers of these occasions after their respective programs, but the boys who participated in the B.A.R.T. had markedly lower numbers, and a year later their numbers still remained somewhat lower.

Girls showed even greater changes in the number of occasions of unprotected vaginal intercourse (Figure 6). Girls in the education-only program increased their numbers over the following years, while B.A.R.T.-trained girls maintained much lower numbers for a full year after the program.

Percentage of Condom Use

Figures 7 and 8 illustrate the percentage of intercourse occasions when condoms were used. Immediately after the intervention the boys in the B.A.R.T. program greatly increased condom use to over 90% of all intercourse occasions. Six months later, they were gradually decreasing condom use, although their condom use was still considerable higher than the education-only participants, who decreased their condom use over time (Figure 7). After a full year, the two groups were comparable. Clearly the B.A.R.T. program increased condom use for boys, but the intervention's effects gradually lessened as time went by.

A different pattern emerged for the girls (Figure 8). Girls in the B.A.R.T. program increased their condom use and used condoms at a higher rate throughout the following year than the girls who received education only. Condom use among the latter group lessened throughout the year after the program ended.

Summary of Effectiveness

Both males and females benefited more from the skills training in B.A.R.T. than from the education-only program, although the effects were somewhat different for each gender.

- The boys were already engaging in higher rates of sexual activity before the program began, but boys who participated in B.A.R.T. lowered their rates of unprotected vaginal, oral and anal intercourse to a greater degree than the boys who received education only.

- Girls in both groups rated much lower than boys on all sexual behaviors before the interventions, but the girls who received education only increased their frequencies of all unprotected sexual activities over the year following the intervention. By contrast, the girls who received the skills training in B.A.R.T. stayed at stable and lower levels of unprotected vaginal intercourse and stopped engaging in unprotected anal intercourse entirely.

Sexually active boys and girls in the B.A.R.T. program increased their use of condoms after participating, although the boys gradually reduced their condom use over the following year. By contrast, boys and girl in the education-only program steadily reduced their use of condoms as time went by, consistent with national surveys that show steadily decreasing rates of condom use by adolescents over time.

These results indicate that brief, education-only programs are not a futile exercise, although clearly they are not as beneficial as a more sustained and intensive skills-training approach. It is also clear that the more explicit B.A.R.T. intervention did not promote increased sexual activity or accelerate the onset of sexual activity among abstinent youth. Instead, B.A.R.T. lowered risky behavior among the youth who were sexually active and delayed the onset of sexual activity by youth who were abstinent.

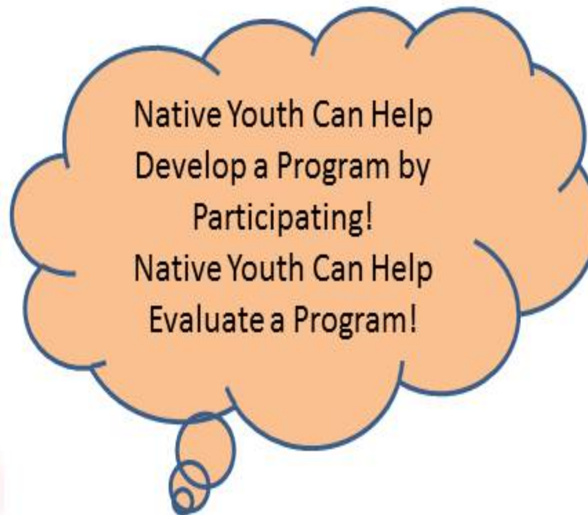
Appendix C

NATHivE

"Becoming A Responsible Native Teen"

This "Research Study" is for Native Youth 14-18 Years Old to Assist in Evaluating an HIV/AIDS & Teen Pregnancy Prevention Curriculum While Learning Useful Knowledge and Skills!

WHEN: February 21st and February 22nd, 2015
TIME: 9:00 am to 5:30 pm
WHO: Native American youth ages 14-18
WHERE: UNLV (4505 S. Maryland Parkway BHS Bldg.)
CONTACT: Crystal Lee: (702) 895-4617 or Dr. Michelle Chino: (702) 895-2649



Appendix D

Registration/Consent Form

Site: ___________________________________

<table>
<tr><td colspan="7">Participant Information Please Print and Fill In Completely
Date:</td></tr>
<tr><td colspan="2">Name: (Last, First, MI)</td><td colspan="2">Complete Mailing Address:</td><td>Date of birth:</td><td>Phone: ( )</td><td>E-mail address:</td></tr>
<tr><td>Age:
□ 14
□ 15
□ 16
□ 17
□ 18
□ 19</td><td colspan="2" rowspan="2">Grade:
□ 6
□ 7
□ 8
□ 9
□10
□11
□12

□ GED program
□ Technical/vocational training
□ College
□ Not currently in school</td><td rowspan="2">Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown/unreported

Race:
□ Black
□ White
□ American Indian or Alaska Native
□ Hawaiian or Pacific Islander
□ Other
□ More than one race
□ Unknown/unreported</td><td colspan="2" rowspan="2">Language spoken at home:

□ English
□ Spanish
□ Chinese
□ Other (Please specify)
________________________________</td><td>Have you participated in a pregnancy prevention program?
□ Yes □ No

If yes, list______________________
________________________________</td></tr>
<tr><td>Gender:
□ Male

□ Female</td><td>Do you have any food allergies?
□ Yes (Please specify)
____
□ No</td></tr>
<tr><td colspan="7">Parent/Guardian Information</td></tr>
<tr><td>Name:</td><td colspan="2">Complete Mailing Address:</td><td>Phone: ( )</td><td colspan="2">E-mail address:</td><td></td></tr>
<tr><td colspan="7">Emergency Contact Information</td></tr>
<tr><td colspan="3">Name:</td><td>Phone: ( )</td><td colspan="3">Relationship to youth:</td></tr>
</table>

Please read each of the agreement terms below and *place your initials* beside each box indicating you have read the statement, understand it, and agree to it. Please sign the form in the space at the end of the page.

{ } I understand that the Becoming a Responsible Native Teen (BARNT) is a Sexual Health Workshop for youth, and give my child permission to attend all sessions.

{ } I understand that trained professionals will be teaching the course to youth participants separated into groups by gender when applicable, and that a staff person associated with the intervention will always be present.

{ } I understand that specific methods to keep safe from diseases and pregnancy, proper condom skills will be discussed and a demonstration of their use will occur.

{ } I understand that a discussion of **abstinence**- the 100% way to prevent pregnancy will be held during the intervention.

{ } I understand that my child is required to participate in all sessions of BART- **beginning on Saturday, February 21st thru Sunday, February 22nd, 2015 from 9:00 am to 5:30 pm** and I will make sure he/she is ready and present.

{ } There is an anonymous question, and a referral and resource process explained to all youth participants at the beginning of each session, and available each day. A resource board with referrals is placed in the classroom along with a comment box. The questions are reviewed and responded to by an Instructor to the class.

{ } I know that videos, still photos, and possibly audio recordings may occur during the program and I give full permission for my child to participate in these activities.

{ } I know that my child (or his/her parent) can decline to participate in any and all aspects of the intervention without punishment of any kind, simply by letting an Instructor know immediately before, during, or after any workshop session. However, he/she will not be compensated the $75.00 stipend.

{ } I understand that data collected as a part of the SN-TPPP may be used for research. No identifying information of participant will ever be used or reported. All reported results will be done for an entire group.

{ } I have initialed each of the statements and signed this form indicating my full consent for my youth to participate in all aspects of BART.

Participant Signature **Date**

Parent/Guardian Signature **Date**

Appendix E

ASSENT TO PARTICIPATE IN RESEARCH

Adapting an Evidence-Based HIV/AIDS and Teen Pregnancy Prevention Program for Native American Youth

1. My name is Murlynn Crystal Lee.

2. We are asking you to take part in a research study because we are trying to learn more about whether or not you think this HIV/AIDS and teen pregnancy prevention intervention we have changed is culturally appropriate for Native youth 14-18 years old.

3. If you agree to be in this study, you will be asked to attend intervention sessions held on Saturday, February 21st and Sunday, February 22nd, 2015 from 9 to 5:30 pm. This intervention will include Native cultural content and activities. You will be asked to fill out end-of-session questionnaires, HIV Knowledge pre/post survey, end-of-intervention questionnaire, and/or participate in a focus group after the intervention is over.

4. You may feel uncomfortable at times participating in the project due to the topics related to HIV and teen pregnancy prevention that are discussed.

5. You will receive a $75.00 stipend to attend the full 2-day intervention sessions. You will receive additional $25 compensation for participating in a 1.5 hour focus group after the intervention is completed.

6. Please talk this over with your parents before you decide whether or not to participate. We will also ask your parents to give their permission for you to take part in this study. But even if your parents say "yes" you can still decide not to do this.

7. If you don't want to be in this study, you don't have to participate. Remember, being in this study is up to you and no one will be upset if you don't want to participate or even if you change your mind later and want to stop.

8. You can ask any questions that you have about the study. If you have a question later that you didn't think of now, you can call me at [480.518.6398] or ask me next time. You may call me at any time to ask questions. If I have not answered your questions or you do not feel comfortable talking to me about your question, you or your parent can call the UNLV Office of Research Integrity – Human Subjects at 702-895-2794 or toll free at 877-895-2794.

9. Signing your name at the bottom means that you agree to be in this study. You and your parents will be given a copy of this form after you have signed it.

______________________________ ____________________
Print your name Date

____
Sign your name

Appendix F

INFORMED CONSENT

School of Community Health Sciences

TITLE OF STUDY: Adapting an Evidence-Based HIV/AIDS and Teen Pregnancy Prevention Program for Native American Youth

INVESTIGATOR(S): Murlynn Crystal Lee, MPH

For questions or concerns about the study, you may contact M. Crystal Lee at **(480) 518-6398.**

For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted, contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794 or via email at IRB@unlv.edu.**

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to address the epidemic of HIV/AIDS and teen pregnancy in tribal communities in Southern Nevada, a HIV/AIDS and teen pregnancy prevention intervention curriculum will be developed by adapting an evidence-based HIV/AIDS curriculum, *Becoming a Responsible Teen* (BART) for Native youth between the ages of 14-18 years. The purpose of project is to initiate the processes of adapting an evidence-based HIV/AIDS curriculum, implementing the pilot at a Native community-based center, and evaluating the effectiveness of the intervention content and overall project. The first phase of this project involves adapting an HIV/AIDS curriculum, *Becoming A Responsible Teen* (BART).

Participants

You are being asked to participate in the study because you fit this criteria: he/she is between the ages of 14-18 years and is an enrolled member of a federally recognized Native American tribe.

Procedures

If you volunteer to participate in this study, you will be asked to do the following: attend the intervention sessions held on Saturday, February 21st and Sunday, February 22nd, 2015 from 9 am to 5:30 pm. This intervention will include Native cultural content and activities. You will be asked to fill out end-of-session questionnaires, HIV Knowledge pre/survey, end-of-intervention questionnaire, and/or participate in a focus group after the intervention is over.

Benefits of Participation

There *may* be direct benefits to your child as a participant in this project. However, we hope to learn the effectiveness of adapting an evidence-based prevention program (BART) so it is

culturally appropriate for Native teens and implementing the pilot to thoroughly evaluate the intervention content from a Native youth lens. Also, by reducing the Southern Nevada teen pregnancy and birth rate; as well as reduce the rate of new HIV infections associated with sexual outcome behaviors among Native American youth ages 14-18.

Risks of Participation
There are risks involved in all research studies. This study may include only minimal risks. The risks associated with participating in this project include feeling uncomfortable about the nature of the topic.

Cost /Compensation
There *will not* be financial cost to you to participate in this study. The study will take a total of 17 hours at 8.5 hours each day , which will be held on Saturday, February 21st, and Sunday, February 22nd. Your child *will* be compensated for their time.

Confidentiality
All information gathered in this study will be kept as confidential as possible. No reference will be made in written or oral materials that could link you to this study. All records will be stored in a locked facility at UNLV until August 2015 after completion of the study. After the storage time the information gathered will be destroyed in accordance with state of the art techniques at the time.

Voluntary Participation
Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with UNLV. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Participant Consent:
I have read the above information and agree to participate in this study. I have been able to ask questions about the research study. I am at least 18 years of age. A copy of this form has been given to me.

____ ____________________
Signature of Participant Date

____
Participant Name (Please Print)
I agree to be audio or video taped for the purpose of this research study.

____ ____________________
Signature of Participant Date

____
Participant

Appendix G

PARENT PERMISSION FORM

School of Community Health Sciences

TITLE OF STUDY: Adapting an Evidence-Based HIV/AIDS and Teen Pregnancy Prevention Program for Native American Youth

INVESTIGATOR(S): Murlynn Crystal Lee

CONTACT PHONE NUMBER: cell (480) 518-6398

Purpose of the Study

Your child is invited to participate in a research study. The purpose of this study is to address the epidemic of HIV/AIDS and teen pregnancy in tribal communities in Southern Nevada, a HIV/AIDS and teen pregnancy prevention intervention curriculum will be developed by adapting an evidence-based HIV/AIDS curriculum, *Becoming a Responsible Teen* (BART) for Native youth between the ages of 14-18 years. The purpose of project is to initiate the processes of adapting an evidence-based HIV/AIDS curriculum, implementing the pilot at a Native community-based center, and evaluating the effectiveness of the intervention content and overall project. The first phase of this project involves adapting an HIV/AIDS curriculum, *Becoming A Responsible Teen* (BART).

Participants

Your child is being asked to participate in the study because he/she is between the ages of 14-18 years and is an enrolled member of a federally recognized Native American tribe.

Procedures

If you allow your child to volunteer to participate in this study, your child will be asked to do the following: attend the intervention sessions held on Saturday, February 21st and Sunday, February 22nd, 2015 from 9 am to 5:30 pm. This intervention will include Native cultural content and activities. Your child will be asked to fill out end-of-session questionnaires, HIV Knowledge pre/post survey, end-of-intervention questionnaire, and/or participate in a focus group after the intervention is over.

Benefits of Participation

There *may* be direct benefits to your child as a participant in this project. However, we hope to learn the effectiveness of adapting an evidence-based prevention program (BART) so it is

culturally appropriate for Native teens and implementing the pilot to thoroughly evaluate the intervention content from a Native youth lens. Also, by reducing the Southern Nevada teen pregnancy and birth rate; as well as reduce the rate of new HIV infections associated with sexual outcome behaviors among Native American youth ages 14-18.

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There are risks involved in all research studies. This study may include only minimal risks. The risks associated with participating in this project include feeling uncomfortable about the nature of the topic.

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There *will not* be financial cost to you to participate in this study. The study will take a total of 17 hours at 8.5 hours each day , which will be held on Saturday, February 21st, and Sunday, February 22nd. Your child *will* be compensated for their time.

Contact Information
If you or your child have any questions or concerns about the study, you may contact M. Crystal Lee at **(480) 518-6398.** For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact **the UNLV Office of Research Integrity – Human Subjects at 702-895-2794, toll free at 877-895-2794, or via email at IRB@unlv.edu.**

Voluntary Participation
Your child's participation in this study is voluntary. Your child may refuse to participate in this study or in any part of this study. Your child may withdraw at any time without prejudice to your relations with the university. You or your child is encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality
All information gathered in this study will be kept completely confidential. No reference will be made in written or oral materials that could link your child to this study. All records will be stored in a locked facility at UNLV for until August 2015 after completion of the study. After the storage time the information gathered will be destroyed in accordance with state of the art techniques at the time.

Participant Consent:
I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

_______________________________________ ______________________

Signature of Parent Child's Name (Please print)

_______________________________________ ______________________

Parent Name (Please Print) Date

Participant Note: Please do not sign this document if the Approval Stamp is missing or is expired.

I agree to be audio or video taped for the purpose of this research study.

____ ____________________

Signature of Participant Date

____

Participant Name (Please Print)

Appendix H

PARTICIPANT WORKBOOK

RESOURCE DIRECTORY

Information Hotlines

CDC-National Prevention Information Network - 1-800-458-5231
8am-8pm ET Mon-Fri **www.cdcnpin.org/**
The US reference and referral service for information on IV/AIDS, viral hepatitis, sexually transmitted diseases and tuberculosis

STI Resource Center Hotline – 1-800-227-8922
9am-6pm ET Mon-Fri www.ashastd.org/
Information and referrals about sexually transmitted diseases.

Planned Parenthood National Hotline – 1-800-230-PLAN (7526)
Available 24 hours a day. Counseling for STDs, pregnancy and other sexual health issues Sponsored by Planned Parenthood Federation of America.

GLBT National Help Center and Hotline -1-888-842-4564
4pm-12am ET Mon-Fri, 12pm-5pm Sat, www.ginh.ord/index2.html
Free and confidential telephone and internet peer-counseling, information, and local resources for gay, lesbian, bisexual, transgender, and questioning individuals.

AIDSinfo – 1-800-448-0440
Mon-Fri 12pm-5pm ET www.aidsinfo.hih.gov/
Access to federally approved HIV/AIDS medical practice guidelines, HIV treatment and prevention clinical trials and other research information.

Emergency Contraception Hotline
1-888-NOTLATE (668-2528)
Pre-recorded information, in English and Spanish, about emergency contraception sponsored by the Reproductive Health Technologies Project. For information about providers of emergency contraception visit: www.not-2-late.com

National Domestic Violence Hotline
1-800-799-SAFE (7233) or 1-800-787-3224
Available 24 hours a day, every day, in English and Spanish; victims and anyone calling on their behalf can provide crisis intervention, safety planning, and information and referrals to agencies in all 50 states, Puerto Rico and US Virgin Islands.

LOCAL RESOURCES

Southern Nevada Health District-Sexual Health Clinic
400 Shadow Ln. Suite 106 Las Vegas, Nevada 89106
(702) 759-0702 www.southernnevadahealthdistrict.org/std-clinic/services.php EMAIL at STDClinic@snhdmail.org
Monday – Friday between 8AM and 4PM. First come first served. Arrive before 3:30 for testing. The fee is $30. No person is turned away if they cannot pay.

Southern Nevada Health District
330 S. Valley View Las Vegas, Nevada 89107
702-759-1000
www.southernnevadahealthdistrict.org

The Center (LBGTQ)
401 S. Maryland Parkway Las Vegas, NV 89101
702-733-9800
HIV Testing/STD Screenings/Hepatitis A & B Vaccines on select days
Monday – Friday 10:30-12:30 and 1:30 – 5:00PM: Saturday – 10AM-3:00PM

Aid for AIDS of Nevada (AFAN)
Services and Education for HIV/AIDS – free condoms
1120 Almond Tree Lane, Suite 207 Las Vegas, Nevada 89104
702-382-2326
www.afanlv.org

Community Counseling Center
Offers counseling services for substance abuse and mental health – free condoms
714 E. Sahara Suite 101 Las Vegas, Nevada 89104
702-369-8700

INTERESTING/INFORMATIVE – WEBSITES

AIDS.GOV – Provides information to the general public about HIV/AIDS education, resources and social media tools.

Native Youth Sexual Health Network: www.nativeyouthsexualhealth.com

National Native American AIDS Prevention Center: http://www.nnaapc.org/

The Well Project – www.thewellproject.org/en_US/ - is dedicated to women and girls living with HIV

The Bacchus Network – www.bacchusnetwork.org/index.html

BECOMING A RESPONSIBLE NATIVE TEEN

PAST, PRESENT, FUTURE

DEFINITIONS

Self-Concept: is the accumulation of knowledge about the self, such as beliefs regarding personality traits, physical characteristics, abilities, values, goals, and roles.

Genocide: is the deliberate killing of a large group of people, especially those of a particular ethnic group or nation.

Historical Trauma: is the collective emotional and psychological injury both over the life span and across generations, resulting from a tragic history of genocide.

Assimilation/Acculturation: Acculturation might be reflected upon the process of giving up one's traditional cultural values and behaviors while presuming the values and behaviors of the dominant social structure (Atkinson, Lowe, & Matthews, 1995).

- In order to survive and participate successfully in mainstream culture. Native youth must learn an extrinsic way to walk, talk, think and act, behaving as their innate Native self only when they are at home in their Native environment. This expectation places the burden of assimilation squarely on the shoulders of Native youth and can be brutalizing to their identity, spiruality, and clarity. –Lyle Harvey, Dine' Institute

NATIVE STORIES - Past, Present, and Future

Assiniboine Tribe

"…Our Indian religion, the Great spirit; we're thankful that we're on this Mother Earth. That's the first thing when we wake up in the morning, is to be thankful to the Great Spirit for the Mother Earth; how we live, what it produces, what keeps everything alive. I know my old father-died about twenty years ago, almost a hundred years old-he never neglected his thanks early in the morning when he'd be out and the sun came up, shining-that's the eye of the Great Spirit…No matter what he's doing, certain times, he looked up, just before it got into the middle of here in the sky-that's the throne of the Great Spirit. When the sun got about there, noon, he stopped, just for a few seconds, gave thanks for the Great Spirit and asked to be blessed. Then again when the sun was going down, he watched that until it got out of sight. Those are the things I always think are wonderful when we're talking about our Indian life." –Joshua

Navajo Tribe

"My grandfather was a great man. He said, educate yourself but we will help you. We will tell you which rattlesnake has poison, and where it is safe to walk. You will get soreness if you walk in poison ivy. Don't walk near a cliff for a devil might push you over. Don't throw a rock at a woman; don't be afraid of animals they do not dislike you. Be spiritual. Don't play cards because you might lose your property. Know things in nature are like a person. Talk to tornadoes; talk to the thunder. They are your friends and they will protect you." –Navajo Man

Kwakiutl Tribe

"A Kwakiutl mother desired that her infant girl become an industrious woman. So, when a girl is born by her mother it is washed by the midwife who takes care of the woman who has given birth. After she has washed her, she wraps her in warm covers. Now the mother of the child takes a little mountain goat wool and she takes a narrow strip of cotton cloth. Then she prays to it…As soon as she stops praying she wraps the narrow strip of cotton cloth around the four strips of wool…She puts them into a small basket in which the clothes of her child are. Now she waits for the naval cord of her child to come off. As soon as it is off she ties it around the right hand of her child. Now it stays on her hand, and until the time when the child is nine months old it will not be taken off. As soon as the child is nine months old her mother takes the remains of the wool and she takes the four strings and wraps around them the cotton cloth that has been washed, around the four strings of wool. Then she ties it around the right hand of her child and she also takes one piece of wool and cuts it up so that it is like flour. She puts a little water with it so that it becomes pasty. Then she prays to it finely cut wool and says, "O, supernatural power of the Supernatural-One-of-the-Rocks, go on, look at what I am doing to you, for I pray you to take mercy on my child and, please, let her be successful in getting property and let nothing evil happen to her when she goes up the mountain picking all kinds of berries; and, please protect her, Supernatural One," says she as she puts her first finger into what is like milk, the wool mixed with water, and she puts it on the tongue of the child. Four

times she does so. When she has finished she suckles her child. Now for four days she does this in the morning, then she stops after this. Now this woman who has been treated grows up and she really gets much when she picks all kinds of berries on the berry picking places on the mountains of Knights Inlet and therefore she has many berry cakes and crabapples and Viburnum. She is rich in property, for the woman is industrious. That is the end (Boas, 1968: 283-284) (Beck, 1984, p. 201-202)."

Luiseno Tribe

"I'm not going to be influenced, or no one is going to influence my soul, unless I'm the one who's going to. I'm the only one who's responsible for that soul, if I don't do the right thing here, I'm at fault, not him, not the church, not that mountain over there or the sun. This is the way they teach Indian religion. No one is going to influence you, no one is going to bring you to your grave, but yourself (Morey, 1970, p.27) (Beck, 1984, p. 64)." –Statement from a Luiseno elder

Yakima Tribe

Alex Saluskin, Yakima man, explains how among his young people a young person would be assigned to a tutor-an expert to be his/her teacher. These tutors were responsible for preparing a young man for his "vision quest" or spirit quest: In our tribal custom, which was handed down to my grandfather…each of his children were assigned to a tutor, like he had been by his grandparents, so that each child, each of his descendants should be trained by an expert…it was not a parent that was undertaking the teaching of the young boy or girl, it was an elder related either to grandpa, or grandma….These experts were proficient in hunting and everything for survivial, as well as teaching the blessing of the Great Creator. I was assigned to my uncle…so he and his wife had undertaken to bring me under their wing for a season…My grandfather came and asked my father if I would make a trip with them to the mountains where they hunt for deer, as well as mountain sheep, and gather huckleberries. They caught salmon from the spawning beds there ane dried them for their provisions while they were staying in the mountains. Naturally, they depended on their livelihood on what they could catch and kill, as well as catch small fish from the streams.

When we began, first I was to learn how to control my horse, which was given to me with a complete outfit, as well as a gun. Then we came to the first camp. Early in the morning my uncle stated to assume his responsibilities, got me out of bed, and he says, "Nephew, let's hurry down the creek. It's my duty now to train you, to equip you with the wisdom and knowledge that I had acquired. First of all, we're going to go down to this swift stream and we will disturb the old lady." (We referred to the stream as an old lady.) "We'll disturb her and the old lady will rub you down and soothe up your sore muscles and give you an endurance for the rest of the day." I knew I had to do the things that I was told. We went down and we stripped off and jumped into this swift water, very cold, we stayed in the water until my body was numb. We came up and pranced around, jumped up and down to get our circulation going. We put on our clothes and by the time we got back to the camp, the breakfast was ready.

Again, we were taught how to care for the horses and how to handle them. As we traveled, the same processes were conducted until we reached our destination. AS soon as we reached our destination, I was told that the sweat house and the hot rocks which was prepared for the sweat house were blessings taught and handed down from the Great Spirit. This hot steam caused by pouring cold water on the rocks would cleanse you and purify your scent, so the wild animals wouldn't detect you. You would have the scent the same as the fir bough and reeds that grow in the mountains. So naturally I had to believe that this was the case. I followed through this system and we had to do this every morning about three o'clock while we were in the mountains. At the end of our trip, I was wiry; I could walk, probably for days and weeks if I had to. I had gone through my course of training for survival. I learned every herb, root, berries and how to take care of them. This kind uncle of mine and his wife took time to explain these things step by step. They didn't leave one thing untold and it was shown physically to me, then asked me if I could do it (More, 1970: 43-45).

The children were taken from their parents after they became about six-seven-eight, up to thirteen years old. They were sent out for a spirit quest. They looked for the power in the wilderness and fasted for a minimum of three days and nights and a maximum of five days and nights. During the hardship, fighting for survival out in the wilderness, without anything to eat, no tools to gain energy, competing with the wild animals and dark cold nights, the little fellows got down and prayed, asked the Great Spirit to help them to survive the ordeal. During the course of the training, some of these people were blessed and they carried the blessing on and handed it down to their children, and also later on they would become tutors to teach the same thing that the Indian must follow

Saluskin discusses the significance of the quest and says that not only is it on of the most events in the person's life who undertakes it, it is also a preparation for teaching and being someone else's tutor later in life. So we see that this educational process of learning sacred ways involves not only many relatives of different ages, but future generations as well. (Beck, 1984, p. 57).

St*ories attributed to: Beck PV, Walters AL, & Franciso N. (1977). The Sacred: Ways of knowledge, sources of life. Tsaile, AZ: Navajo Community College Press.*

SELF-IDENTITY ACTIVITY

1. **Who am I?**

2. **Where do I come from?**

3. **Why am I here?**

4. **Where am I headed?**

Activity/terminology accredited to: Lyle J. Harvey at Institute for Dine' Culture, Philosophy, and Government

GOALS & VALUES ACTIVITY

1. Describe your religious/spiritual/racial/ethnic/cultural beliefs, traditions, and values.

2. Describe your family beliefs, traditions, and values.

3. How do these values indicated on the "The Seven Grandfathers" worksheet relate to your community? How do they differ?

4. How do values impact your decisions?

BECOMING A RESPONSIBLE NATIVE TEEN

RELATIONSHIP TO SELF & OTHERS

NATIVE “PUBERTY” CEREMONIES

Washo Tribe

The Washo people expected a young woman to “be active and not lazy” during her “girl’s dance” which is what they called the girl’s ceremony.“If she behaved properly during the dance and the four days preceding it, she would be hard working, energetic, self-effacing, able to withstand hunger, generous, and able to endure discomfort all her life. The view at that time of her first menses a girl was malleable and that her entire life would be shaped by the way she behaved at this time was widespread.” (Downs, 1966, p.24)

Apache Tribe

“The puberty ceremony may be interpreted as isolating symbolically four critical life-objectives towards which all Apache girls on the threshold of adulthood should aspire. These are physical strength, an even temperament, prosperity, and a sound, healthy-age. To understand why these particular life objectives are emphasized…consider their relation to other aspects of Western Apache culture, powers, the role of women in native economy, the conduct of interpersonal relationships, and the natural environment.…the puberty ceremonial not only defines longevity as a life-objective but also helps the girl attain it.” (Basso, 1970: 68)

Navajo Tribe

Kinaalda of Changing Woman

It was long time ago the Changing Woman had her Kinaldaa. She made herself become Kinaalda. She naturally became one. This happened after the creation of the Earth People. The ceremony was started so women would be able to have children and the human race would be able to multiply. To do this, women had to have relations with men. The Kinaalda was created to make it holy and effective, as the Holy People wanted it to be. They called many meetings to discuss how they should do this ceremony.

In the beginning, there was fog at the top of Blanca Peak. After four days, the fog covered everything down to the base. Coyote, of course, went there to find out what was happening. When he went running over there, he saw a baby floating on the lake which was at the top of Blanca Peak. He wanted to pick up the baby and bring it back, but he was not able to. So he came back and reported it to Hashch’ehooghan (Hogan God). Hashch’ehooghan went over there and could not get it either. Then Talking God went there, got the baby out of the lake and brought it to the top of Gobernador Knob.

The one who was picked up as a new baby was Esdzaanadleehe (Changing Woman). She was taken home to be raised. In four days she grew up and became Kinaalda. When this happened, they decided to have a ceremony for her.

At this time, the Holy People were living on the earth. They came to her ceremony, and many of them sang songs for her. They did this so that she would be holy and so she could have children who would be

human beings with enough sense to think of themselves and a language with which to understand each other.

The first Kinaalda took place at the rim of the Emergence Place in the First Woman's home. The first time that changing Woman had it, they used the original Chief Hogan songs. The second time, they used the Hogan Songs which belonged to Talking God.

The first ceremony took place at Ch'ool'I'I (Gobernador Knob); this is a place that is now on the Jicarilla Apache Reservation. When Changing Woman became Kinaalda, Salt Woman, who was the First White Shell Woman, gave her her own name, "White Shell Woman." She dressed in white shell clothes. Changing Woman also painted with white shell; that is why she called "White Shell Woman."

The Kinaalda started when White Shell Woman first menstruated. It is still done the same way today. At her first ceremony, White Shell Woman ran around the turquoise that was in the east. That is why the Kinaalda today wears turquoise. During her second ceremony, she started from the west, where there was white shell. The second menstruation was connected with white shell.

Nine days after that, Changing Woman gave birth to Naaghee' neezghani (Monster Slayer) and ToBajishchini' (Born for Water) twin boys. These two were put on earth so that all the monsters which were eating the human beings would be killed. They rid the earth of all these monsters; that is why they were called Holy People. As soon as they had done this, their mother, Changing Woman, who was then living at Governador Knob, left and went to her home in the west, where she lives today.

After she moved to her home in the west, she created the Navajo People. When she had done this, she told these human beings to go to their original home, which was the Navajo country. Before they left she said, "After this, all the girls born to you will have periods at certain times when they become women. When the time comes you must set a day and fix the girl up to be Kinaalda; you must have these songs sung and do whatever else needs to be done at that time. After this period, a girl is a woman and will start having children." (Frisbie, 1967; 11-12)

With most tribes, an important prerequisite to the rite is that the young woman undergoing the ceremony should be pure. She should not have experienced sexual relations. This is what most tribes preferred

Today, with both the Navajo and Apache, the rite continues for four days. There is socializing, feasting and participation in events of the ceremony. For the girl there is instruction; her body is pressed and molded that she might be beautiful and healthy, in the likeness of Changing Woman or White Painted Woman. Navajo version by Frank Mitchell (Origins of Menstruation).

<u>Navajo Tribe</u>

"Today, the Navajo woman folk teach their girls to observe the same instruction and teaching
Which was handed down to them by Holy People, so they might grow up into a wholesome,
Normal, mature maid (womanhood). Each girl when she becomes of age, in every family, is supposed to have this ceremony done. If it is not done, the girl may not know the value of
Womanhood and take the role lightly. (H. Denetsosis Interview, 1976)

St*ories attributed to: Beck PV, Walters AL, & Franciso N. (1977). The Sacred: Ways of knowledge, sources of life. Tsaile, AZ: Navajo Community College Press.*

BODY IMAGE

What is a "healthy" body image?

- You feel comfortable with your body
- You feel good and comfortable about the way you look
- You have feelings of strength, attractiveness, and control without trying to have an unrealistic "perfect" body

What is an "unhealthy" body image?

- You're not happy with the way you look
- You may not see yourselves the way you look to other people
- You may feel self conscious or awkward
- You may be ashamed of your bodies

Having an "unhealthy" body image may have negative consequences

- May try to lose or gain weight in unhealthy ways
- It makes it difficult to talk about sex with partners and if you can't talk about sex, it is hard to set boundaries
- It enhances your risk of contracting HIV/AIDS, STI's, and unplanned pregnancy
- Stereotyping
- Low self-esteem
- Suicide

Definitions/text accredited to: Sexual Health Toolkit: Sexuality and Relationships. (2011) National Aboriginal Health Organization

QUALITIES OF RELATIONSHIPS

Qualities of a healthy relationship

The following qualities of healthy relationships apply to romantic relationships but also apply to relationships we have with friends and family.

SAFETY: Both people are safe to express their thoughts and feelings. There is no fear of the other person.

RESPECT: Both people value the others' opinions and each is viewed as an equal. Decisions are made together. You support each other in bad times and in good times.

TRUST: Each person is requested as an individual with unique qualities. You encourage each other to have friends and activities outside of the relationship. It is natural to feel jealous sometimes, but how you react to those feelings is what is important.

COMMUNICATION: Includes verbal and non-verbal communication as well as listening skills and the ability to resolve conflicts in ways that are satisfying to both people. Communication can increase trust, openness, and closeness.

ENJOYMENT: Both people have fun and enjoy the relationship.

FAIRNESS: Both people are willing to compromise and accept change.

Qualities of an unhealthy relationship

- Does your partner get angry when you have other plans, or won't drop everything for him/her?
- Does your partner criticize the way you look or dress or make you feel bad about yourself?
- Does your partner ask you to stop doing something you like or ask you to stop talking to other girls/boys/women/men?
- Does one of you make the decisions or set up all the rules for your relationship?
- Do you hide things because you're worried they may upset your partner?
- Are you afraid to say "no" to sexual activities or sex?
- Do you know that your partner was abusive in a previous relationship?

- Has your partner ever threatened you, or grabbed, pushed, or hit you?

This is not a complete list of warning signs. Any behavior that is controlling, separates you from friends and family, or results in physical or sexual harm is NOT okay.

REMEMBER:

- Victims of abuse or drug-facilitated assault are NEVER at fault.
- Women are more often assaulted by their partners than strangers.
- A jealous partner is not showing his/her love but is being possessive or controlling.
- Abuse isn't just physical. Emotional abuse, such as name calling, has health effects too – like lowering self-esteem.

Navajo Tribe

Monster Slayer (The Twin Brother of Born-for-Water, sons of Changing Woman and the Sun), made preparation for the inhabitants of this earth. He killed all the monsters, everything that would prey on the people. When he thought he had got rid of all the monsters that would be deadly to the people, that would devour the people, he thought he had finished his role and he was coming back to his home on that little mesa that is the cradle of our origin.

Then he met someone and asked him, "I thought I killed all the enemies of the people. Are you still alive, or where did I dodge you?" then he found out this was Poverty. "No, grandchild, I don't want to be killed," Said Poverty. "If you kill me, then it will be the end of humanity, because you will have no knowledge of the needs, the necessity of one another, and the urge to do things for yourself and others. I should be here, and it will help you to develop compassion for one another. There will be need, there will be necessity, there will be the urgency to do things for yourself and for those around you because you are a human and you have certain needs. Your moccasins will wear away and there is a necessity that you get new moccasins. It develops your mind that you have to acquire and look for those things you need and others need. If you kill me, you will be like the rest of the animal world, without compassion for your fellow man and concern for yourself. You, as a human, should retain me. But I'm not the only one. There are four of us all in this category." The first one that he met, he didn't kill-he didn't kill Poverty. He didn't kill the need. He saw that man needed poverty to be humble and to be concerned with the needs of others as well as himself.

He met another one-as the first one stated, there were four of them. He met the second person, The Sun God boy says, "I thought I killed all the monsters that would be killing the humanity on this earth, but I notice that you're still alive." The answer came that he didn't want to be killed because "I have a definite purpose to live and to stay with you." He found that it was Hunger. "Because I must have a place in your life to bother your stomach. When your stomach becomes empty, you will feel that you're hungry and you will think, develop your mind about how to get food. You will become industrious and stop being lazy. You will go out and look for game or into the fields to get the crop. I have a definite purpose to live with your people. Without me, you will be lazy and couldn't develop the qualities of mind and strength you should have for the world." So that's the second person he let go. Hunger was not killed. The Spirit of Hunger was not destroyed. It was left purposely to remain with us to make us work.

Then he went ahead and he met the third person. He asked him the same question. "I thought I had killed all the enemies of humanity. Are you still around here? How was it I missed you?" He found that it was fatigue. Every night we should go to sleep. It's a must if we are not to forget the world of the spirit. We have to have the sleep to be in good health. "If you kill me," said Fatigue, "You will never rest. You have to have your sleep each night to replenish both your physical and spiritual strength. Without sleep man would forget the spirit and be aware of only the physical world. If you kill me, that will be the end. Your eyes will dry up. You won't get the necessary rest to continue your life." So he didn't kill him. He let him abide with humanity. But there is an extreme to that thing, too. If you do nothing but sleep and sleep, you'll die of poverty. You'll be lazy and die of want. It is part of the life necessity to sleep, but if you continue to do nothing but sleep, you'll fall into the hands of hunger which forces you to work. He let Fatigue go because it was necessary that he be retained as a help to humanity.

He went on again and met the fourth person. He told him the same thing, "I thought I had killed all the enemies of humanity, and here you are. "You're still alive." He found it was Body Lice. He wanted to kill him, but the Body Lice also has a purpose. Without lice, people wouldn't bother to keep clean. When people come together to come each other's hair, it's kind of a leisure period for them. Those periods, they'll be talking about something that happened with the community. It serves a purpose that they have the time to visit. Body Lice forces people to make an effort to keep clean and to be sociable. So he wasn't killed either. Body Lice he let go, to abide with humanity. Four of those, as a group, were given freedom to operate in their sphere. By viewing this legend, we know that it definitely has purpose. It is a problem-how to combat the needs in a person's life, how to think of others, what to wear, what to eat. Is he tired? Does he need that rest? Does he need that cleanliness? To my knowledge, it is those things that are an aid to humans to force us to think, to act. I think it was well that they were spared otherwise our efforts for the needs of the human race would have dried up. –Navajo

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RELATIONSHIP TO MOTHER EARTH &FATHER SKY

Navajo Tribe

Corn Pollen and why it's considered sacred: "This is symbolic thinking. Just imagine this corn pollen. We use this as an offering. Maybe the Great Spirit doesn't need it, but for us it's just the thing. We know we should try to offer what little we have, the pollen which is needed for all vegetation. One plant communicates with another by pollination. Even the worms, even those little ants down there, know this. Pollination is the sign of the growing of the harvest crop or anything that needs pollination; then the fruit comes following that." –Navajo People

Tewa Pueblo Tribe

One summer a few years ago a man who was, like me a Tewa Pueblo Indian, and I undertook a journey…We were driving to the country of the Utes in southwestern Colorado to share in the blessings of their Sun Dance. My companion had never in his life been in that part of Colorado before. As the massive outcropping that is known today as Chimney Rock loomed larger and larger beyond the road ahead, he became very alert. Pointing to it, he said, "There is Fire Mountain! It is just as the old people spoke of it." As he recognized distinct features of the place, he proceeded to unfold tale after tale of events in the early life of our people which took place at Fire Mountain and in the surrounding country. Every prominent feature along the road began to live for him, and as he spoke of that remembered place, we, each of us, began to realize that we were tracing a portion of the ancient journey which began beneath a lake somewhere in this southwestern corner of Colorado, who knows how many thousands of years ago, and a journey which, as long as there are Tewa to tell of it, shall always end again at this lake of emergence.

So it was that by the time we neared the town of Pagosa Springs, it was no longer July 1963, but another time, a time in and out of time. This place is called Warm Sands in Tewa, for there are sands which are kept warm by the hot springs which gave birth to the town; sands which by themselves are said to be able to melt snow and moderate the mid-winter cold; sands for the obtaining of which our religious men in other times made winter pilgrimages. My companion and I, both silent, recalled ancestors who were among those religious men. He wanted to stop, to gather some of the warm sand from the nearby springs, as did I. When he came to the sands, he knelt before the land, then he ran the sand through his fingers. And then he wept. He had never been there, but then he had never really left. He remembered his own grandfather and the other grandfathers who had preceded him here. He had never journeyed here, but it was as if he had come home (Ortiz, 1973: 89-90) (Beck, 1984, 78).

Stories attributed to: Beck PV, Walters AL, & Franciso N. (1977). The Sacred: Ways of knowledge, sources of life. Tsaile, AZ: Navajo Community College Press.

BECOMING A RESPONSIBLE NATIVE TEEN

OPTIONS

Abstinence can mean different things to different people. For some, it means having no physical contact with other people. For others, it could mean having limited contact, allowing some activities, but not sexual intercourse.

Abstinence is often referred to as being 100% safe: Meaning that it completely eliminates the risk of a sexually transmitted disease or unplanned pregnancy. This is only true if the definition includes eliminating any intimate sexual behavior involving skin to genital, genital to genital or body fluid to genital contact. Pregnancy can occur without intercourse if sperm is ejaculated near the entrance of the vagina or on an area that comes into contact with the vagina. Sexually transmitted infections such as herpes and genital warts can be passed through skin-to-skin genital contact.

For BART purposes…our definition of **Sex is:**

- Vaginal intercourse (penis to vagina sex),
- Oral sex (mouth to penis or mouth to vagina, mouth to anus),
- Anal intercourse (penis to anus sex), and:
- Genital to genital contact (vagina to vagina, penis to penis, vagina to penis)

For BART purposes……**Abstinence is:**

- avoiding vaginal intercourse (penis to vagina sex),
- avoiding oral sex (mouth to penis or mouth to vagina, mouth to anus),
- avoiding anal intercourse (penis to anus sex), and:
- avoiding genital contact (vagina to vagina, penis to penis, vagina to penis.

ALTERNATIVES TO SEXUAL ACTIVITY

These Are Alternatives to Sexual Activity

- Take a walk together
- Talk about your feelings
- Eat dinner by candlelight
- Read a book and discuss it
- Be best friends

These are alternatives to engaging in sexual activities. Now, please add to this list below:

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

REASONS TO WAIT FOR SEX

1. To avoid STDs.
2. I'd rather say no to my boyfriend than 'Yes, I am pregnant' to my parents.
3. I don't want to feel guilty.
4. I don't want the reputation of being someone people date and expect to have SEX.
5. I would disappoint my parents.
6. I might lose respect for the other person, he or she might lose respect for me, and I might lose respect for myself.
7. Sex is better in a secure, loving marriage relationship.
8. The thought of having an abortion scares me to death.
9. Sex gets in the way of real intimate communication.
10. Sexual relationships are a lot harder to break up even when you know you should.
11. I am afraid it may ruin a good relationship rather than make it better.
12. There are better ways to get someone to like you.
13. You won't have to worry about birth control side effects.
14. I'm not emotionally ready for that intense of a relationship.
15. I could become scared of my partner.
16. I don't want to hurt someone I really care about.
17. Sex could become the main focus of the relationship, like an addiction. At that point it is no longer a meaningful relationship, but we are using each other to satisfy sexual desires.
18. You begin to compare sexual experiences, leading to lots of disappointments.
19. I don't want to make myself vulnerable to being used or abused sexually.
20. If I am hurt too many times, I might miss out on something great because I'm so afraid of being hurt again.
21. I like my freedom too much. Sexual relationships are binding.
22. I'm only sixteen.
23. I am proud of my virginity, and I want to stay that way.
24. Building a relationship in other ways is more important.

25. I don't want to risk becoming someone's sex object.
26. I want my first experience to be a good one with someone who won't laugh at me, reject me, or tell lies about me, and who I know will always be there tomorrow.
27. It's possible to enjoy ourselves without getting sexually intimate.
28. Why rush into something that could be lousy or mediocre now, when it could be great later?
29. I don't want sex to lose meaning and value so that I feel 'sexually bankrupt'.
30. I am afraid that at this age it might not meet my expectations, and I will be disappointed.
31. I don't want to risk ending a relationship by our hating each other because of it.
32. I might find it painful and the other person rough and uncaring.
33. I don't want the boy to brag about scoring with me.
34. It's the safest way not to become pregnant.
35. You may feel invaded, and you can't take it back after it's happened.
36. You may have to grow up too fast and too soon.
37. Sex may become the only thing that keeps the relationship together.
38. You may have sex too early to really enjoy or understand it.
39. You lose the chance to experience the 'first time' with someone who really cares for you.
40. I want my most intimate physical relationship to be with the one I marry.
41. Sex brings feelings of jealousy, envy, and possessiveness. Every relationship changes.
42. After sex he/she will leave, I don't want to feel used.

REVIEW

Definition of Abstinence:

- Avoiding vaginal intercourse (penis to vagina)
- Avoiding oral sex (mouth to penis or vagina or mouth to anus)
- Avoiding anal intercourse (penis to anus)
- Avoiding genital contact (any direct touching of a partner's penis or vagina)

Abstinence is the only 100% effective way to prevent unwanted pregnancy and Sexually Transmitted Infections/Diseases (STIs/STDs).

Definition of Sex:

- Vaginal sex (penis to vagina)
- Oral sex (mouth to penis, mouth to vagina, mouth to anus)
- Anal sex (penis to anus)
- Genital to genital contact (vagina to vagina, penis to penis, vagina to penis)

A responsible decision is a decision that:

- Promotes Health, Promotes Safety, Follows Laws, Shows Respect For Self & Others, Follows the guidelines of kinship (parents, grandparents, family) and shows good judgment

Reasons why teens may postpone sexual activity:

- **Personal** – personal values or religious/moral beliefs, not ready yet, guilt, fear, disappointment
- **Medical** – pregnancy, have STD/STI or HIV/AIDS and do not want to spread, protection/health reasons etc.
- **Relational** – haven't met the right person, want to strengthen a relationship before having sex, partner does not want to use protection Promotes Health, Promotes Safety, Follows Laws, Shows Respect For Others, Follows the guidelines of kinship (parents, grandparents, family) and shows good judgment
- **Cultural/Ceremonial:** To undergo a puberty ceremony the woman must be a "virgin" in most tribes or participate in dances/ceremonies

BECOMING A RESPONSIBLE NATIVE TEEN

BART SESSION #1 UNDERSTANDING HIV & AIDS

DEFINING HIV & AIDS

HIV and AIDS

- Human Immunodeficiency Virus (HIV)
- HIV is transmitted person to person
- HIV attacks and infects cells in the immune system that help the body fight infections
- Acquired Immune Deficiency Syndrome (AIDS)
- AIDS is the state when HIV has damaged the immune system and the body can no longer fight infections and cancers
- These infections cause extreme illness and even death

HIV TRANSMISSION:

These are the BODILY FLUIDS through which HIV can be transmitted:

- Semen
- Pre-ejaculatory fluid (Pre-cum)
- Vaginal fluid
- Blood
- Breast milk

These are the BEHAVIORS associated with transmission of HIV:

- Oral sex
- Vaginal sex
- Anal sex
- Sharing needles (drugs, tattoos, body piercings)
- Alcohol and other drugs
- Pregnancy, childbirth or breast milk

YOUNG PEOPLE (HIV/AIDS, ETC.)

The STIs, HIV, and unintended pregnancies epidemic particularly affects young persons aged 13-24 years and members of minority races and ethnicities (CDCa, 2013).

- 9.5 million adolescents and young adults (ages 15-24) are diagnosed with STIs yearly (Gonorrhea, Chlamydia, Syphilis, HPV, etc)
- It is estimated 4-in-10 sexually active adolescent females between the ages of 14 and 19 have an STI
- 26% of young people aged 15-24 account for new HIV infections in U.S.
- Generally, HIV infects one out of every two persons between the ages of 15-24, which means five young people are infected every minute

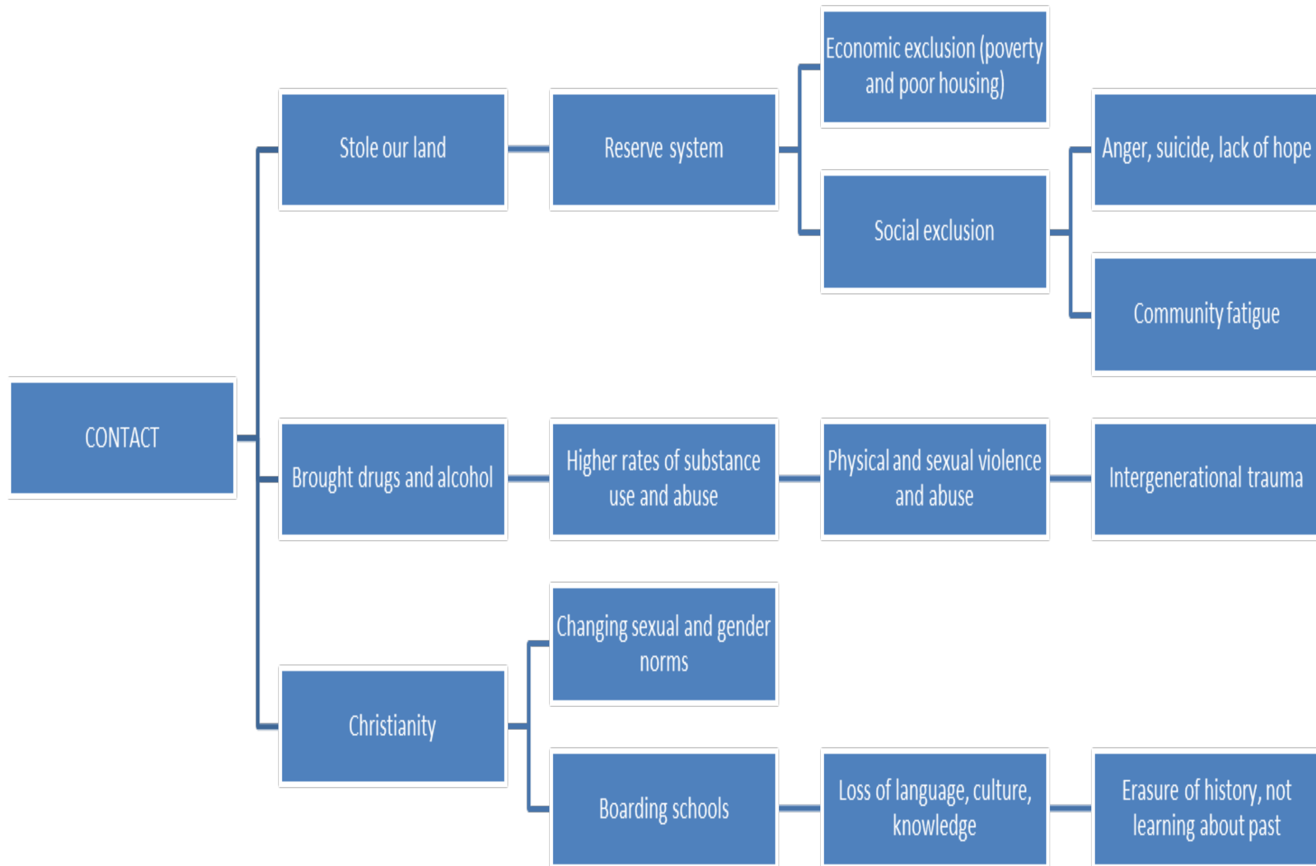
The Youth Risk Behavior Surveillance System's (YRBSS) 2013 National Overview of high school students illustrated that:

- 47% of students had sexual intercourse
- 15% of students had sexual intercourse with four or more persons during their lifetime
- 34% of students had sexual intercourse with at least one person during the 3 months prior to the survey (i.e., currently sexually active)
- Among the 34% of currently sexually active students, 22% had used alcohol or other drugs before last sexual intercourse

NATIVES AND HIV/AIDS

- In 2010, Natives accounted for less than 1% (210) of the estimated 47,500 new HIV infections in the U.S. (CDCd, 2013)
- Native men accounted for 76% (161) and Native women accounted for 24% (51) of the HIV diagnosis in 2011 (CDCd, 2013)
- In 2011, an estimated 146 Natives were diagnosed with AIDS, (CDCd, 2013)
- By the end of 2010, approximately 2,000 Natives with an AIDS diagnosis died in the U.S.
- In 2010 HIV was the ninth leading cause of death among Native men and women aged 25-54 years (CDCd, 2013)
- These levels of rising rates are concerning because Natives experience a faster time course from initial diagnosis of HIV infection to AIDS than any other racial group in the US (Kaufman et al, 2007; CDCd, 2013)
- In 2001, 48% of AI/ANs diagnosed with HIV were subsequently diagnosed with AIDS within 12 months, compared with 40% for the general population" (Kaufman et al, 2007, p. 769)
- In addition, they experience one of the lowest survival rates after an AIDS diagnosis is determined (CDCd, 2013)

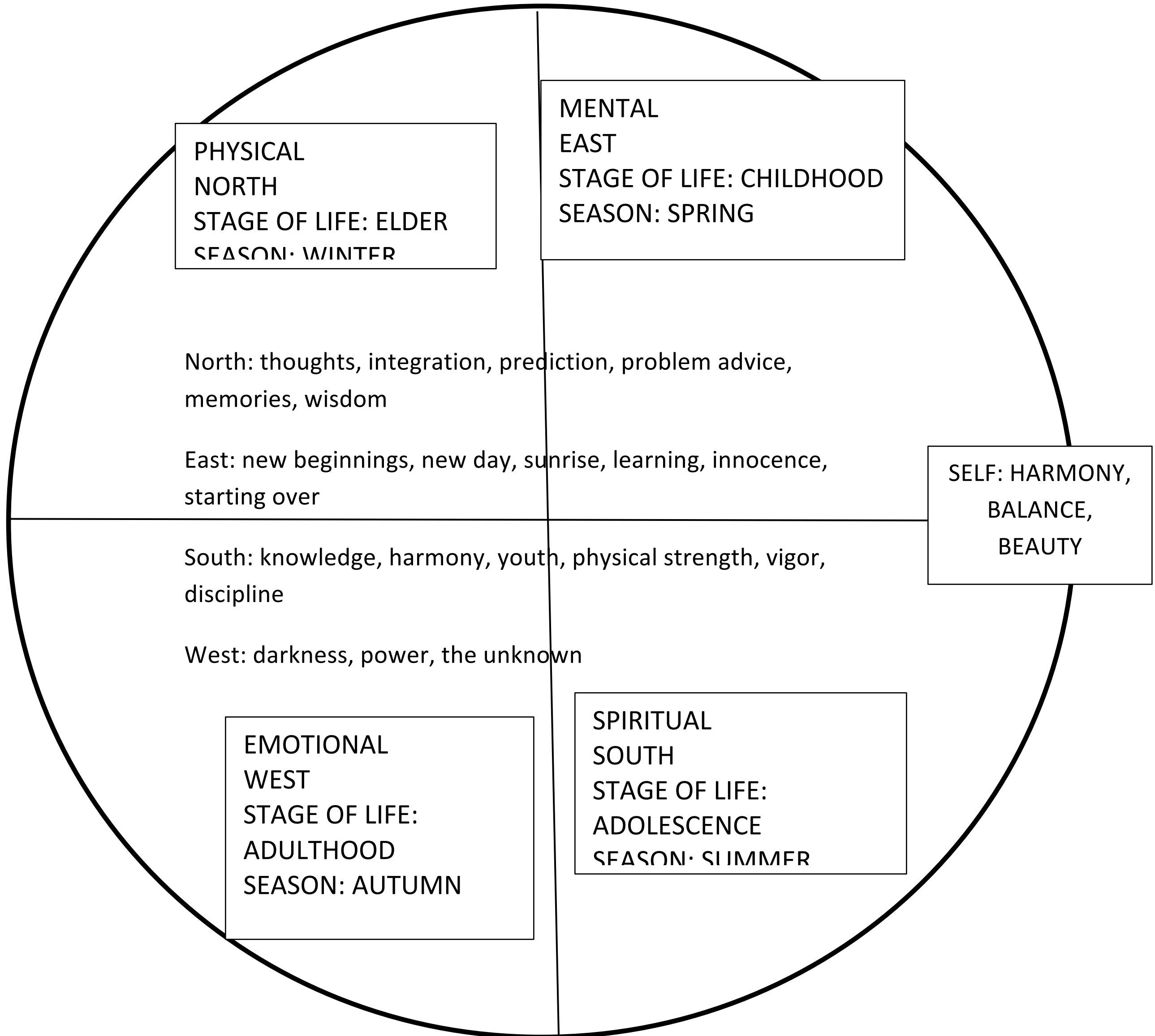
HOW DOES OUR PAST INFLUENCE OUR PRESENT?



Flicker, S. et al. (2012) Talking Action! Art and Aboriginal Youth Leadership for HIV Prevention Toronto, ON.

MEDICINE WHEEL

- North: thoughts, integration, prediction, problem solving, imagaination, analysis, organization, advice, memories, wisdom
- East: new beginnings, new day, sunrise, learning, innocence, starting over
- South: knowledge, harmony, youth, physical strength, vigor, discipline
- West: darkness, power, the unknown, dreams, prayers, meditation, perseverance, maturity, understanding (NATIVE STAND curriculum).



DEFINITIONS ACTIVITY/REVIEW

HIV

- The letters H.I.V. stand for Human Immunodeficiency Virus.
- HIV can infect people who engage in the behaviors that allow the virus to be transmitted from one person to another.
- The virus attacks and infects cells in the immune system that help the body resist infections.
- HIV enters the immune system cells, takes over and uses the cells to manufacture more HIV. Gradually HIV kills the immune system cells.
- As the body loses immune cells, it becomes open to attack by infections and cancers that a healthy body is able to fight off.

AIDS

- The letters A.I.D.S. stand for Acquired Immune Deficiency Syndrome.
- AIDS is the stage when HIV has damaged the immune system so much that the body can no longer resist infections and cancers.
- These infections and cancers can make people who have AIDS very sick.

Antibodies

- Antibodies are substances in the blood that protect people against viruses such as colds, flu and measles.
- With most viruses, the body eventually destroys the virus and cures itself. HIV is an unusual virus because it destroys the immune system cells that help make antibodies.
- The body still tries to fight back. It takes the body from 2 weeks to 6 months after being infected with HIV to produce enough antibodies to show up on a test.
- Tests to determine whether a person has HIV look for these antibodies.

ELISA

- ELISA stands for Enzyme-Linked Immunosorbent Assay. It is a type of test called enzyme immunoassay, or EIA.
- An ELISA test is a very sensitive test that detects antibodies to HIV.
- This test can be used on a blood or oral fluids sample.
- Because the ELISA test is so sensitive and may detect other antibodies, another test is used to confirm results.

DEFINITIONS CONTINUED:

Western Blot Test

- This test is used to check the accuracy of the ELISA test when 2 or more ELISAs have detected HIV antibodies.
- It is very accurate. A positive Western blot means that HIV antibodies are present.
- Positive results on both tests indicate that a person has HIV
- Neither test detects the virus itself. Instead, the tests detect antibodies in the blood.
- The health department or a doctor can perform both tests by drawing a small blood or oral fluids sample.
- Test results are usually available in 2 to 4 weeks.

Rapid testing

- A rapid test can be used to detect HIV antibodies. Results are available in a few minutes.
- The rapid test can be used on a blood or oral fluids sample.
- As with other HIV tests, positive results must be tested a second time. Results of the second test can take up to 2 weeks.

Anonymous testing

- At some test sites, a person can get tested for HI antibodies without giving his or her name. The test site assigns a random identification number, so test results are not linked to a name. The person gives the number to get the results.
- Total numbers of positive results, but no names, may be reported to the state health department.

Confidential testing

- This means the person getting tested gives his or her name to the testing site. Test results are linked to the person's name.
- Only a few people specified by state confidentiality laws or through a signed permission, will know who has positive test results.
- Positive tests, with both names and results, may be reported to the state health department.

DEFINITIONS CONTINUED:

Home testing

- A home test kit can be purchased over the counter. It involves submitting a dried blood sample by mail to a laboratory.
- People can call a toll-free number for results, posttest counseling, and medical referrals if necessary.

Treatment

- New treatments for HIV are being developed, tested and approved all the time. Treatment plans usually involve taking several different kinds of medications at the same time.
- There are 3 main types of medicines. Each has different treatment goals:
    - ❖ Some drugs slow the increase of HV in the body after a person is infected. These drugs don't kill HIV, but they help protect the immune system and increase the person's chances of staying healthy for a longer time. Many of these drugs have been approved by the government.
    - ❖ Some drugs may make the immune system stronger. These drugs may also control the spread of HIV, but many of them are still being tested, so no one really knows how well they might work.
    - ❖ Some drugs prevent or treat other infections and diseases that people get because HIV has affected their immune system's ability to fight off disease. People with HIV are more likely to get sick when the immune system becomes weak. These drugs help slow or stop these "opportunistic infections".
- Many of the drugs used to treat HIV have side effects that can make the person feel sick.
- HIV medicines can be complicated to take. People may need to eat certain foods or at certain times to help the medicine work. The different medicines have to be taken several times a day and it's very important not to miss a dose. If a person misses doses, the medicine may stop working because HIV becomes "resistant" to it.
- HIV medicines are expensive.
- Treatment is not a cure. Medicines can help people stay healthy longer, but they can't change the ultimate outcome.

HIV PROGRESSION

Window Period

T(1)	T(2)	T(3)
Acute Stage Lasts up to 6 months: Average of 3 months	**Clinical Latency** Lasts up to 20 yrs: Average of 10 yrs	**AIDS** Opportunistic Infections

Acute Stage (Time 1) **–** The time when a person becomes infected with HIV. This stage can last up to six months, but is most commonly three months. Some people may experience an episode of flu like symptoms (worst Flu Ever) once infected. Not everyone experiences illness.

Window Period – Is between the time a person first is infected with HIV (T1) and the time when an HIV test can detect antibodies (T2). This window period can last 2 weeks to six months long. During the window period, even before a person knows they are infected, people can transmit HIV to others.

Clinical Latency (Time 2) – The time when antibodies have developed (a test will show a positive result) and before the HIV infected person develops AIDS. This stage can last as long as 20 years, but the average period is 10 years.

Opportunistic Infections – Infections that occur due to a weakened immune system from having HIV/AIDS. Infections can be a common cold, flu, Pneumonia or cancer. These are more common during the AIDS stage. Opportunistic infections are usually the cause of death, not AIDS.

CREATING YOUR OWN PRIVATE TRAFFIC LIGHT

RISKY BEHAVIORS I WON'T DO:

RED

BEHAVIORS WITH SOME RISK I MIGHT DO:

YELLOW

BEHAVIORS I'D BE WILLING TO DO THAT WON'T PUT ME AT RISK:

GREEN

BECOMING A RESPONSIBLE NATIVE TEEN

BART SESSION #2 MAKING SEXUAL DECISIONS & UNDERSTANDING YOUR VALUES

DRUGS, ALCOHOL & HIV

- Types of drugs include injection drugs, getting high on crack or other drugs and getting drunk.

- Injection drug use and sharing works puts a person at high risk for HIV.

- Blood can be left on the needle and infect the next user.

- Smoking crack can transmit HIV if people share a crack pipe and have open or bleeding sores on the lips.

- All drug and alcohol users lose inhibitions and impairs judgment, which can lead people to take risks they wouldn't normally take.

- Use of alcohol or other drugs weakens the immune system causing a person who drinks or uses drugs to get sick more often than people who don't use drugs or alcohol.

- For a person with HIV, alcohol or other drug use can weaken an already damaged immune system, which can increase the progression of HIV.

- Sexual abuse is any incident where force is intentionally applied to a person without their consent and sexual activity is involved. Many instances of sexual abuse and sexual assault involve alcohol (WHO, 2006).

- Drug facilitated assault involves substances, like drugs and alcohol. These substances may be used willingly by the victim or may be given to a victim without consent. **Sexual activity that occurs when one person is unable to give consent to the activity is assault even if the victim was willingly using drugs or was drinking.**

UNDERSTANDING EACH OTHER

Name someone you can talk to about safer sex. ____

Does this person understand your feelings and help you? ________________________________

How reliable is this person's information? ____

Name someone you can talk to about drugs. ____

Does this person understand your feelings and help you? _________________________________

How reliable is this person's information? ____

Name someone you can talk to about safer sex and drugs. ________________________________

Does this person understand your feelings and help you? _________________________________

How reliable is this person's information? ____

BECOMING A RESPONSIBLE NATIVE TEEN

BART SESSION #3 DEVELOPING & USING CONDOM SKILLS

CONDOMS AND LUBRICATION

Condom Types:		Protects Against:
I.	Latex	HIV/AIDS, STIs, Pregnancy
	Polyurethane	HIV/AIDS, STIs, Pregnancy
	Polyisoprene	HIV/AIDS, STIs, Pregnancy
	Lambskin	Pregnancy only (DO NOT USE)
II.	Colored	
	Colored and Flavored	
III.	Small, Medium, Large, (Magnum)	
IV.	Non-lubricated	
	Lubricated	
	Lubricated w/spermicide	

Lubrication Types

Water-based
Oil-based (DO NOT USE WITH CONDOMS)

How to store Condoms

- Store in a cool place free of sharp objects
- Jacket pocket or purse without sharp objects ok
- Heat causes breakdown
- Do not leave in car
- No wallets or back pockets

Extra Points of Advice:

- Only use one condom----do not double bag/use two at once
- Use a new condom for each sexual act (especially when switching from anal sex to vaginal sex or vice versa. This can cause major infections)

HOW TO PUT ON A CONDOM

1. Check expiration date.
2. Check for punctures/holes by squeezing package to make sure it is full of air.
3. Check if condom is latex, polyurethane or polyisoprene.
4. Open package from top corner to top corner (across). Be careful to not rip, tear or poke the condom with fingernails.
5. Remove condom carefully by pushing condom up through opening with thumb and first finger. Grab with first finger and thumb of other hand.
6. Pinch the tip with thumb and first finger to keep air out.
7. Hold the condom against the tip of the penis while it is hard.
8. Carefully roll the condom over the penis to the base being sure to leave room for a reservoir.
9. Use a water-based lubricant or spermicidal.

HOW TO TAKE OFF A CONDOM

1. After ejaculation, hold the condom rim around the base of the penis.
2. Pull out the penis while it is still hard, making sure to keep hold of the condom rim so no semen spills out.
3. Remove the condom from the penis.
4. Throw the condom in the trash. DO NOT flush the condom.

BART SESSION #4 LEARNING ASSERTIVE COMMUNICATION SKILLS

SCENARIOS

Directions: Read the situations below, then answer the questions for each part.

What Can I Do To Be Safe: - Abstinence

You and your partner have been going together for a while and care for each other very much. You haven't had sex yet, but have talked about it a little. There's going to be a party at a friend's house this weekend where you can be alone. Your partner hints about having sex at the party. You don't want to have sex. What can you do to stay abstinent?

Give one reason for not wanting to have sex.

____

____

____

Describe two things you could say or do before going to the party to avoid being pressured to have sex.

____

____

____

Describe two things you could say or do at the party to avoid having sex.

____

____

____

Describe two things you could say or do after the party to avoid having sex.

____

____

____

SCENARIOS CONTINUED:

What Can I do To Stay Safe? – Condom Use

You and your partner have been going together for a while and care for each other very much. You haven't had sex yet, but have talked about it a little. There's going to be a party at a friend's house this weekend and you can be alone. Your partner hints about having sex at the party. You don't want to have unsafe sex. What can you do to make sure you use a condom if you decide to have sex?

Give one reason for not wanting to have a sex without a condom.

____

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____

Describe two things you could say or do before going to the party to avoid being pressured into having unprotected sex.

____

____

____

Describe two things you could say or do before going to the party to avoid being pressured into having unprotected sex.

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____

____

Describe two things you could say or do after the party to keep your relationship going and always use condoms when you have sex.

____

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____

PROBLEM SOLVING SKILLS

1. **Determine the problem.**

2. **Identify your goal…what you want to happen.**

3. **Brainstorm potential solutions**

4. **Examine a solution.**

5. **Pick a solution and try it.**

6. **Evaluate what worked and try again if necessary.**

PROBLEM SOLVING SKILLS

1. **Determine The Problem. –** Who is responsible for deciding when the time is right, or whether to practice safe sex? Answer: Both have the right and responsibility to protect own health. It is your decision to act or not to act. Abstinence is the 100% safe choice **and** it is a choice you can make.

2. **Identify Goal –** Certain situations make it difficult to think clearly. It is sometimes difficult to know what we want in the heat of passion, anger or hurt. Think back to your Traffic Light Handout 1.6. Focus on goal of staying safe – Communicate to partner.

3. **Brainstorm Potential Solutions –** Be creative. Congratulate one another for making an effort to find a solution.

4. **Examine Solutions –** Is it what you want to do? Will it create more problems for you? How might others react? How will it make you feel? How will it work long term? Will more problems arise?

5. **Pick a solution and try it –** Which approach seems the best one to try first? If you try one solution and it doesn't work, you can still try other options.

6. **Evaluate What Works And Try Again –** How well did this work? What would I do differently in the future? Even if it doesn't work out the way you wanted, you can still learn from the situation.

Problem solving skills can help you to stay safe in the future:

- Comfort level and skill change with each situation.
- It is difficult discussing the right time for sex; talking about using a condom, talking about either with a new partner.
- Easy to think "it won't happen to me".
- Safe sex is your responsibility…Practice! (how to communicate with your partner)

COMMUNICATION SYTLES

Passive Communication

- Poor eye contact, soft voice, hesitant speech
- Don’t get message across
- Don’t get what you want
- Not understood
- Feel and get used
- May do something you don’t want to do

Aggressive Communication

- Loud, lots of hand/body movement
- Punishing
- Demanding
- Threatening
- Yelling, name calling, hostile
- Creates anger, humiliation, feelings of shame and regret

Assertive Communication

- Direct eye contact, speaks clearly, stands ground
- Telling like it is: How you feel, what you want without being threatening
- Direct and honest
- Me Style
- Takes Practice
- Self-Awareness

BART SESSION #5 PRACTICING ASSERTIVE COMMUNICATION SKILLS

ASSERTIVE COMMUNICATION TIPS

1. **Say in your own words what you think the other person wants.**

2. **Use "I" messages to express what you believe, value and wants.**

3. **Be specific about what you will and will not do, and stick to it.**

4. **Clearly communicate your bottom line.**

5. **Suggest specific alternatives.**

6. **Be ready to say NO firmly and repeatedly if you have to.**

WAYS TO SAY NO!

There are many ways to say NO when you're faced with a risky situation or feeling pressured.

Some ideas to try:

Offer an alternative. Say "I *don't want to do that;"* instead, let's ______________________.

Pretend you didn't hear it.

Say, "*I feel uncomfortable."*

Say *NO* firmly---and mean it.

Say *NO* over and over again, until the other person gets the message.

Change the subject.

Make a joke.

Act shocked.

Give a reason. For example, say, *"That's not healthy, so I won't do it."*

Reverse the pressure. Say, *"I can't believe you'd ask me to do that."*

Walk away.

Add your own ideas below:

____

____

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____

ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY A

Situation: It's Friday night, and you and some of your friends are invited to a wild party. When you get to the house, you see that primos (marijuana cigarettes laced with cocaine) are being passed around. Your friend takes a hit, then passes it to you.

Friend: *Come on.* This is *some good stuff*!

Response:

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____

____

Friend: Take a hit!

Response:

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____

Friend: It's mostly *weed.* Try it!

Response:

____

____

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ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY B

Situation: You just got home with your girlfriend or boyfriend. You're sitting in the car kissing and things get out of hand. Before you even realize it, you're in the back seat. Your partner is really worked up and wants to have sex.

Boyfriend/Girlfriend: I need you baby.

Response:

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____

Friend: Let's do it.

Response:

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Friend: Sweetheart, I can make it real good for you.

Response:

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ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY C

Situation: You're at a party pretty late. Someone is supposed to arrive with some serious drugs soon. Your partner wants to stay.

Partner: Come on, the best is yet to come.

Response:

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Partner: Don't wreck our good time. It's been a great night together and its only going to get better.

Response:

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Partner: I can't believe you won't at least try this stuff!

Response:

____

____

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ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY D

Situation: You're out one night, when this really fine girl/guy walks up to you. She/he says, "I've been watching you since you walked in and would love to get to know you getter." She/he suggests that the two of you leave and go home together.

Girl/Guy: *Come on, baby, I'm gonna make you feel the earth move*.

Response:

____

____

____

Girl/Guy: *You're not scared of a real woman/man, are you?*

Response:

____

____

____

Girl/Guy: *Baby, you can handle it.*

Response:

____

____

____

ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY E

Situation: You and your partner are alone, and have been leading up to sex for a couple of weeks. Even though you've talked about condoms, you want to do something safer. You need to persuade your partner to have sex in a way that won't have any risks.

Partner: *Come on, baby, I want the real thing. I don't want to fool around.*

Response:

____

____

____

Partner: *Have you been leading me on just to knock me down?*

Response:

____

____

____

Partner: *I thought we understood each other.*

Response:

____

____

____

ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY F

Situation: You and the person you've been dating are really getting serious. You're talking one day, and you want to ask how he/she feels about using condoms. When you bring up the subject, your date isn't interested.

Date: A rubber just takes the *feeling away.*

Response:

____

____

____

Date: *We don't need them because what we've got is special.*

Response:

____

____

____

Date: *Don't you trust me, baby?*

Response:

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____

____

ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY G

Situation: You're spending the night at a friend's house, and the two of you are just talking. Somehow you end up on the subject of sex, and your friend says, "I don't use condoms." When you suggest it would be a good idea, your friend doesn't want to hear it.

Friend: *I know my baby's clean.*

Response:

____

____

____

Friend: *Me and my baby don't mess around on each other.*

Response:

____

____

____

Friend: *After all the time we've been together, I haven't caught anything.*

Response:

____

____

____

ASSERTIVE COMMUNICATION ROLE PLAYS

ROLE PLAY H

Situation: You're alone with your boyfriend/girlfriend and the two of you are really turned on. You reach in your pocket and take out a condom. When your partner sees it, he/she isn't happy.

Partner: *I don't want to use a rubber.*

Response:

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____

____

Partner: *If you cared, you'd trust me.*

Response:

____

____

____

Partner: *Baby, don't dis me like that.*

Response:

____

____

____

BECOMING A RESPONSIBLE NATIVE TEEN

BART SESSION #6 PERSONALIZING THE RISKS

NOTES: SPEAKER SESSION

BECOMING A RESPONSIBLE NATIVE TEEN

BART SESSION #7 SPREADING THE WORD

KNOW WHEN IT'S TIME TO GET OUT!

Walk away, say no and self-talk

Opportunities to leave:

- Before you are in a situation with pressure to have sex
- When sexual activity seems likely but before sex is initiated
- After you have explained your limits but partner doesn't want to go along

Self-Talk

- Messages you say to yourself - what you say to yourself contributes to how you feel
- Negative beliefs about abilities or appearances, self-talk is defeating
- Positive beliefs can influence how you talk to yourself and feel about yourself
- Pay attention to what you tell yourself
- Positive thoughts/mantras are key to success

10 STEPS TO PUT GOOD INTENTIONS INTO PRACTICE

1. **Make up your mind** about what you will and won't do ahead of time. Decide what your red, yellow and green lights are. Stick to them.
2. **Daydream safely**. When you think about sex, imagine using a latex condom.
3. **Before you have sex with anyone, talk about safety**. If the other person doesn't share your views, find out ahead of time. Make sure others know you care about protecting your own health and theirs. For girls, especially: Before being alone with a partner, think about the risks. Don't get into a two-person-only situation until you feel sure you'll be safe.
4. **Keep condoms around** at home and with you in your jacket or purse. They won't get used unless you have them near when you need them.
5. **Be prepared to say NO**. IN the heat of the moment, sometimes you hust have to say NO, to your partner and to yourself. Be able to stick to it. Remember, sometimes it's better to leave.
6. **Practice in your mind** what you'll say if a partner wants to do something that's riskier than you want. Practice ways to suggest being safe—and ways to insist if you need to. Be ready to leave if necessary.
7. **Avoid alcohol and other drugs**. If your judgment is blurred from alcohol or drugs, don't have sex. Staying safe is easier when your head is clear.
8. **Show that you care for yourself and the other person**. Love is great! But you still need to stay safe. Sticking with being safe doesn't mean you don't love or trust your partner.
9. **If you make a mistake, learn from it**. Think about what caused the problem For example:
    - Drinking can create a problem for you by blurring your judgment**.**
    - *Wanting to please* could make it hard to say NO.
    - *Feeling lonely or unloved* can put you under pressure to go past your limits.

    Plan says to handle these things the next time so that you won't repeat a past mistake.

10. **Praise yourself and your partner** for staying safe. This helps you both feel good. It makes safety the norm. You'll both have peace of mind.

SPREAD THE WORD. POSITIVE MESSAGES FOR EDUCATING YOUR FRIENDS

- "Be careful," or "Stay safe" doesn't give a clear message. Give examples, such as "Use a latex condom every time"; "If you're going to have sex, don't let someone else's body fluids get into your body"; or "Say NO if you don't want to have sex."
- **Don't preach.** Instead, use yourself as a positive example.
- **Use I statements.** Start with "I always…" "Now I….," or other "I" phrases, rather than saying, "You should…" The person you're talking to will think, "If he/she can do this, I can, too, and it's OK."
- **Offer tips about how to be safe.** Tell your friends to be specific with partners about what they will and won't do. Share some of the steps you practice. For example:
    - "If I have too much to drink, I don't have sex. I want to be clearheaded and safe."
    - "If someone wants to sex me up without a condom, I say 'No. Let's do something safe instead."
    - "I keep condoms everywhere so they're always around. I even practiced how to use them."
    - "I won't have sex with anyone without making sure she/he knows how to stay safe."

- **Stress all the good things about staying safe.** Teens who take good care of themselves feel more at peace and worry less. When you care about others you feel better about yourself.

SPREAD THE WORD ROLE PLAYS

Role Play A

Situation: You and a friend are watching a television show that features a gay man with HIV.

Friend: *I'm glad that will never happen to me!*

Response:

____

____

____

Role Play B

Situation: On a Friday night, you and a friend go to a club downtown. Your friend spots someone attractive and starts to go over to that person.

Friend: *See you later; that's what I came here for!*

Response: ____

____

____

____

Role Play C

Situation: A friend is telling you about his or her new boyfriend/girlfriend. Your friend doesn't spell it out, but you know they're having sex. Your friend has made fun of people who use condoms. You want to bring up the subject in a way that will not be a turn-off. You have to start the discussion.

Response: ____

____

____

____

____

BART SESSION #8 TAKING B.A.R.T. WITH YOU

REVIEW - BART SESSIONS 1 THOURGH 8 AND GRADUATION

NOTES:

Appendix I

BART Student Knowledge Test

1. Student Code:

2. Most people who have HIV look sick.
   True False Not Sure

3. A person can get HIV during oral sex.
   True False Not sure

4. A person can get HIV in one sexual contact.
   True False Not sure

5. A shower after sex reduces the risk of getting HIV.
   True False Not sure

6. When people have only one sex partner, they don't need to protected themselves from HIV.
   True False Not sure

7. Proper use of latex condoms helps to protect people from HIV.
   True False Not sure

8. People who have HIV quickly get sick.
   True False Not sure

9. By having just one sex partner at a time, people can protect themselves from HIV.
   True False Not sure

10. HIV doesn't go through unbroken skin.
    True False Not sure

11. Semen (cum) can carry HIV.
    True False Not sure

12. A person must have a lot of different sex partners to be at risk for HIV.

True False Not sure

13. People who have HIV feel quite sick.
    True False Not sure

14. A person can get HIV if she shares a needle for ear piercing with someone infected with HIV.
    True False Not sure

15. People who practice withdrawl during sex won't get HIV.
    True False Not sure

16. A negative result on the HIV test can happen even if somebody has HIV.
    True False Not sure

17. Breast milk can carry HIV.
    True False Not sure

18. Most people who have HIV know they have it.
    True False Not sure

19. No cases of AIDS was ever caused by kissing on the cheek.
    True False Not sure

20. All STD's can be cured.
    True False Not sure

21. Infection with other STD's can put a person at higher risk for getting HIV during sex.
    True False Not sure

Citation: ETR Associates. 2010 B.A.R.T. Student Knowledge Survey, modified from original source (St. Lawrence, 1993. See key for full citation) Revised 9/27/10 Scotts Valley, CA ETR Associated. All Rights Reserved.

Appendix J

"Introduction" End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Opening Prayer	1	2	3	4	5
Talking Circle	1	2	3	4	5
Agreements	1	2	3	4	5
Descriptive Names	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Opening Prayer	1	2	3	4	5
Talking Circle	1	2	3	4	5
Agreements	1	2	3	4	5
Descriptive Names	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“Past, Present, and Future” End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

Activity 1: “4 Questions” (Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
4 Questions Itself	1	2	3	4	5
Education about “colonization”	1	2	3	4	5
Assiniboine teaching	1	2	3	4	5
Kwakiutl teaching	1	2	3	4	5
Lusieno teaching	1	2	3	4	5
Yakima story	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 1: “4 Questions” (As a Native teen, how well did you “connect” to these activities)

	Very Poor	Poor	Fair	Good	Very Good
4 Questions Itself	1	2	3	4	5
Education about “colonization”	1	2	3	4	5
Assiniboine teaching	1	2	3	4	5
Kwakiutl teaching	1	2	3	4	5
Lusieno teaching	1	2	3	4	5
Yakima story	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 2: “Goals & Values” (Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Rebel Music video	1	2	3	4	5
Goals & Values activity	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 2: “Goals & Values” (As a Native teen, how well did you “connect” to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Rebel Music video	1	2	3	4	5
Goals & Values activity	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree   Disagree   Neither Agree Nor Disagree   Agree   Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree   Disagree   Neither Agree Nor Disagree   Agree   Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree   Disagree   Neither Agree Nor Disagree   Agree   Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%   21-40%   41-60%   61-80%   81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“Relationship to Self & Others” Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

Activity 1: “Puberty is Ceremony” (Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Washo teaching	1	2	3	4	5
“Rites of Passage” – Apache video	1	2	3	4	5
“Kinaldaa” video	1	2	3	4	5
Navajo story (Changing Woman)	1	2	3	4	5
Navajo teaching	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 1: “Puberty is Ceremony” (As a Native teen, how well did you “connect” to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Washo teaching	1	2	3	4	5
“Rites of Passage” – Apache video	1	2	3	4	5
“Kinaldaa” video	1	2	3	4	5
Navajo story (Changing Woman)	1	2	3	4	5
Navajo teaching	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 2, 3, 4, and 5 (Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
What is a healthy body image?	1	2	3	4	5
Qualities of a healthy relationship	1	2	3	4	5
Healthy Conflict: Navajo story	1	2	3	4	5
Relationship to ME & FS: Navajo teaching	1	2	3	4	5
Relationship to ME & FS: Tewa Pueblo story	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 2, 3, 4, and 5 (As a Native teen, how well did you "connect" to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
What is a healthy body image?	1	2	3	4	5
Qualities of a healthy relationship	1	2	3	4	5
Healthy Conflict: Navajo story	1	2	3	4	5
Relationship to ME & FS: Navajo teaching	1	2	3	4	5
Relationship to ME & FS: Tewa Pueblo story	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20% | 21-40% | 41-60% | 61-80% | 81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“Options” End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

Activity 1: (Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Find a common language	1	2	3	4	5
Definitions	1	2	3	4	5
Choices of abstinence	1	2	3	4	5
Preventing HIV game	1	2	3	4	5
Brainstroming	1	2	3	4	5
Kerribah	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

Activity 1: (As a Native teen, how well did you connect to these activities)					
Find a common language	Very Poor	Poor	Fair	Good	Very Good
Definitions	1	2	3	4	5
Discussing	1	2	3	4	5
Preventing HIV game	1	2	3	4	5
Brainstroming	1	2	3	4	5
Kerribah	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session activities were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“BART Session 1” End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Share personal exp.	1	2	3	4	5
Who is at risk for HIV?	1	2	3	4	5
Medicine Wheel	1	2	3	4	5
Deciding Your Risk Level	1	2	3	4	5
Spread the Word	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Share personal exp.	1	2	3	4	5
Who is at risk for HIV?	1	2	3	4	5
Medicine Wheel	1	2	3	4	5
Deciding Your Risk Level	1	2	3	4	5
Spread the Word	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

"BART Session 2" End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)

	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
AIDS & Natives	1	2	3	4	5
HIV Feud game	1	2	3	4	5
Native Voices video	1	2	3	4	5
Drug/Alcohol Risks	1	2	3	4	5
Support Systems	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
AIDS & Natives	1	2	3	4	5
HIV Feud game	1	2	3	4	5
Native Voices video	1	2	3	4	5
Drug/Alcohol Risks	1	2	3	4	5
Support Systems	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

"BART Session 3" End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Discuss attitudes	1	2	3	4	5
Learning condom facts	1	2	3	4	5
Overcoming embarrassment	1	2	3	4	5
Condom demonstrations	1	2	3	4	5
Encountering barriers	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Discuss attitudes	1	2	3	4	5
Learning condom facts	1	2	3	4	5
Overcoming embarrassment	1	2	3	4	5
Condom demonstrations	1	2	3	4	5
Encountering barriers	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“BART Session 4” End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Are you with me? Video	1	2	3	4	5
Problem solving skills	1	2	3	4	5
Different communication	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Are you with me? Video	1	2	3	4	5
Problem solving skills	1	2	3	4	5
Different communication	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree Disagree Neither Agree Nor Disagree Agree Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree Disagree Neither Agree Nor Disagree Agree Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

<u>"BART Session 5" End of Session Questionnaire</u>

Please rate the session content on the following items: (Circle one for each item)

	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive com. Tips	1	2	3	4	5
Ways to say "NO"	1	2	3	4	5
Assertive comm. Roleplays	1	2	3	4	5
Assertive comm. practice	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)

	Very Poor	Poor	Fair	Good	Very Good
Assertive com. Tips	1	2	3	4	5
Ways to say "NO"	1	2	3	4	5
Assertive comm. Roleplays	1	2	3	4	5
Assertive comm. practice	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree | Disagree | Neither Agree Nor Disagree | Agree | Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20% | 21-40% | 41-60% | 61-80% | 81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

"BART Session 6" End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Meeting people with HIV	1	2	3	4	5
Discussion and debrief	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Meeting people with HIV	1	2	3	4	5
Discussion and debrief	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

"BART Session 7" End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Assertive comm. in real world	1	2	3	4	5
Getting out of HIV risky situations	1	2	3	4	5
Spreading the word	1	2	3	4	5
Word practice	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Assertive comm. in real world	1	2	3	4	5
Getting out of HIV risky situations	1	2	3	4	5
Spreading the word	1	2	3	4	5
Word practice	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

“BART Session 8” End of Session Questionnaire

Please rate the session content on the following items: (Circle one for each item)					
	Very Poor	Poor	Fair	Good	Very Good
Informational Content	1	2	3	4	5
Organization	1	2	3	4	5
Easy to Understand	1	2	3	4	5
Interesting	1	2	3	4	5
Involvement of your participation	1	2	3	4	5
Workbook materials	1	2	3	4	5

(Please rate the activities)					
	Very Poor	Poor	Fair	Good	Very Good
Sex & traditional stories	1	2	3	4	5
Final review	1	2	3	4	5
Self-reflection (4 ?’s)	1	2	3	4	5
Man in the Maze story	1	2	3	4	5
Reflections on protecting yourself	1	2	3	4	5
What are you doing to protect yourself?	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

(As a Native teen, how well did you connect to these activities)					
	Very Poor	Poor	Fair	Good	Very Good
Sex & traditional stories	1	2	3	4	5
Final review	1	2	3	4	5
Self-reflection (4 ?’s)	1	2	3	4	5
Man in the Maze story	1	2	3	4	5
Reflections on protecting yourself	1	2	3	4	5
What are you doing to protect yourself?	1	2	3	4	5
	1	2	3	4	5
	1	2	3	4	5

As a Native youth, the overall session was **culturally appropriate** (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **content** was culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall session **activities** were culturally appropriate (Circle One)

Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Of the information presented today, how much is usable to you? (Check One)

0-20%	21-40%	41-60%	61-80%	81-100%

As a Native teen, what do you think other Native teens would like most about this session?

How did the Native content help you connect to the activity?

Did the Native content help you connect to the activity?

What was the single best thing about this session?

What one thing would you change about this session? Why?

What would you like covered that wasn't covered today?

Are there any topics you feel should be added to this session?

End of Intervention Questionnaire (Participant)

As a Native youth, the overall intervention was **culturally appropriate**. (Circle One)

Strongly Agree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native youth, the overall intervention **content** was culturally appropriate.

Strongly Agree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

As a Native you, the overall intervention **activities** were culturally appropriate.

Strongly Agree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree

Do you feel the content of this intervention were culturally appropriate?

a. Yes, why?

b. No, why?

Would you recommend this intervention to Native teens?

a. Yes, Why?

b. No, Why?

Which of the following techniques helped you learn the best? (Circle all that apply)

a. Small group discussion
b. Lecture
c. Role playing
d. Individual work
e. Video examples
f. Sharing by paricipants
h. Native cultural stories/teachings

What were the weaknesses of this intervention?

What were the strengths of this intervention?

My general comments and suggestions for improving this intervention are:

Focus Group Guide

Opening Question (Round Robin)
Tell us the name that you would like to be called and how long you have lived in this community.

Introductory Questions

1. Do you believe that the choices teens make today can impact them in their adult lives?
- If yes, why? If no, why not?

2. What do you think are the beliefs, attitudes, and/or social norms that influence teens to make a bad decision?

Transition Questions

3. Do you believe that this NATHiVE intervention addressed some beliefs, attitudes, and/or social norms you mentioned to help lower Native teens become at risk for unintended pregnancy, sexually transmitted infections, or even HIV?
- If yes, why? If no, why not?

Key Questions

4. What are some of the strengths of the NATHiVE intervention?

5. What are some of the weaknesses of the NATHivE intervention?

6. Do you think the Native cultural content (pictures, stories, games) were culturally appropriate?
- If yes, why? If no, why not?

7. Do you think some sessions should be added to this intervention?
- If yes, what and why? If not, why?

8. Would you change anything about the NATHiVE intervention?
- If yes, what and why? If not, why?

9. What are some of the influences in your families or community that can help teens make positive health choices?

10. What are some of the influences culturally that can help teens make positive health choices?
11. What values are most important to families in this community?

Closing Question

12. What else might make this intervention more appealing to the teens in this community?

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