

National Native American Aids Prevention Center Needs Assessment: Focus Groups Series on Young Native Adults and Sexual Health

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Executive Summary

Purpose

In preliminary surveys, HIV Prevention programs throughout the country have indicated to the National Native American AIDS Prevention Center (NNAAPC) that they have little to no information about the specific needs of Native youth to help guide the development of well-rounded prevention programs. In order to provide these programs with technical assistance and capacity building services that are both culturally relevant and age appropriate, NNAAPC has subcontracted to The American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research, to conduct a needs assessment with Native Young Adults on sexual health.

Focus groups on the topic youth sexuality and sexual health were conducted for the needs assessment. The focus group participants were selected based on the following eligibility requirements: American Indian and Alaska Native female and male young adults aged 18-24. In some locations increasing the eligibility to age 30 was necessary. There were 37 participants with heritage in over 20 different tribes.

The ultimate goal of the needs assessment was to look for trends and patterns that are similar for all locations to serve as the starting point for the development of prevention curricula.

Key findings

- The average age when youth start dating was 12-13 or junior high school
- The majority reported the onset of sexual activity before graduating from high school.
- The participants discussed one major factor that explained why Native youth did or did not use drugs or alcohol – their environment.
- Most participants could not recall any Native youth that did not use drugs or alcohol.
- Violence was witnessed or experienced by the majority of participants.
- Some of the participants believed that violence was a part of every relationship.
- Participants that had seen adolescent couples fighting all reported that it happened when youth were drinking alcohol.
- Having positive role models was an important protective factor.
- Youth with families that participated in family outings and supported youth in after school activities did not use drugs and alcohol and they earned better grades.
- Economic development is critical to a community's health
- Urban Indians need support in raising their children and integrating into diverse communities
- The common reflection on their sex education experience was:
 - It was largely inadequate- most had sex education (biology, sexual development) in the 3rd grade with a second course in high school. The curricula never covered attitudes, beliefs, and values, complete reproductive health, body image, or gender roles.

Key Recommendations for a Native youth sex and sexuality education curriculum

Curricula Content should include:

- Values and emotions
- Communication skills
- Comprehensive reproductive knowledge
- Pregnancy prevention and family planning
- HIV and sexually transmitted disease and infections
- Identity issues
- Alcohol and Drug Prevention
- Violence Prevention

Curricula Delivery:

- Youth begin to explore sexuality in middle school. Curricula should prepare them before this age, with ongoing age-appropriate lessons through their school life. Starting early will lead to healthier relationships in adult life.
- Curricula should be school based with enhanced/supplemental non-school based activities (clubs, home, conferences).
- The primary educators/trainers should be anyone knowledgeable and willing to provide the information, such as, parents and teachers. They should NOT be athletic coaches.
- Curricula should be flexible enough to modify to fit the local communities' needs.

Recommendations for modifying the curricula:

- School based curricula must coordinate with home and community life, for example include parents in an evening class and utilize community members on an advisory board.
- The curricula should be flexible enough to modify to fit the local communities' needs.
- Explore definitions in the curricula and localize jargon for the community.
- If cultural rules state who or what is appropriate in a partner, i.e. clan rules, this should be a part of localized curricula.
- Educate parents on drug and alcohol use in their respective communities

Conclusion

Sexuality education is a lifelong process of acquiring information and forming attitudes, beliefs, and values. It includes sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles. This report provides recommendations for a well-rounded sexuality education program for Native Youth. It focuses on issues that are universal for Native youth, whether they live on a rural reservation, small town, or urban city.

Introduction

Purpose

In preliminary surveys, HIV Prevention programs throughout the country have indicated to the National Native American AIDS Prevention Center (NNAAPC) that they have little to no information about the specific needs of Native youth to help guide the development of well-rounded prevention programs. In order to provide these programs with technical assistance and capacity building services that are both culturally relevant and age appropriate, NNAAPC has subcontracted to The American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research, to conduct a needs assessment with Native Young Adults on sexual health.

This is a needs assessment, not a research study. The findings will be used for program planning. The information learned will serve as the background for a research proposal to develop, test, and evaluate a comprehensive Native youth reproductive health education program that includes HIV prevention. The target audience for this needs assessment is NNAAPC, the Centers for Disease Control and Prevention (CDC), tribal and urban communities, prevention programs, youth and HIV prevention programs.

Methods

Focus groups on the topic of youth sexuality and sexual health were conducted for the needs assessment. The focus group participants were selected based on the following eligibility requirements: American Indian and Alaska Native female and male young adults aged 18-24. In some locations increasing the eligibility to age 30 was necessary. There were 37 participants with heritage in over 20 different tribes.

Demographic Characteristics

The average age of focus group participants was 22.4. The average age ranged from a low of 19.1 in City#1 to a high of 28.6 in City #5.

The distribution of male and female participants varied between focus groups. While the focus group in City #3 was entirely female, only three in ten participants in City #4 were female. Overall, 35% of focus group participants were male and 65% were female.

Educational attainment was particularly high for participants in City #5, which is associated with age (four years older than others on average). On average, this particular group had a college degree or higher. While focus groups in Cities 2, 3, and 4 had an average educational attainment of a high school diploma or G.E.D., City #1 participants had some vocational or technical schooling. Overall, focus group participants had an average educational attainment of vocational or technical school.

Surprisingly, the 37 focus group participants had attended elementary and high schools in 11 various states throughout the country, although the focus groups were conducted in five cities in four states. The majority of participants had spent some time during these school years on a rural/reservation community AND in urban areas. These participants represent the circular migration pattern that many Native youth experience today.

Exhibits 1 through 5 below describe demographic characteristics and Tribal membership.

Exhibit 1. Average Age of Focus Group Participants, by City, 2003

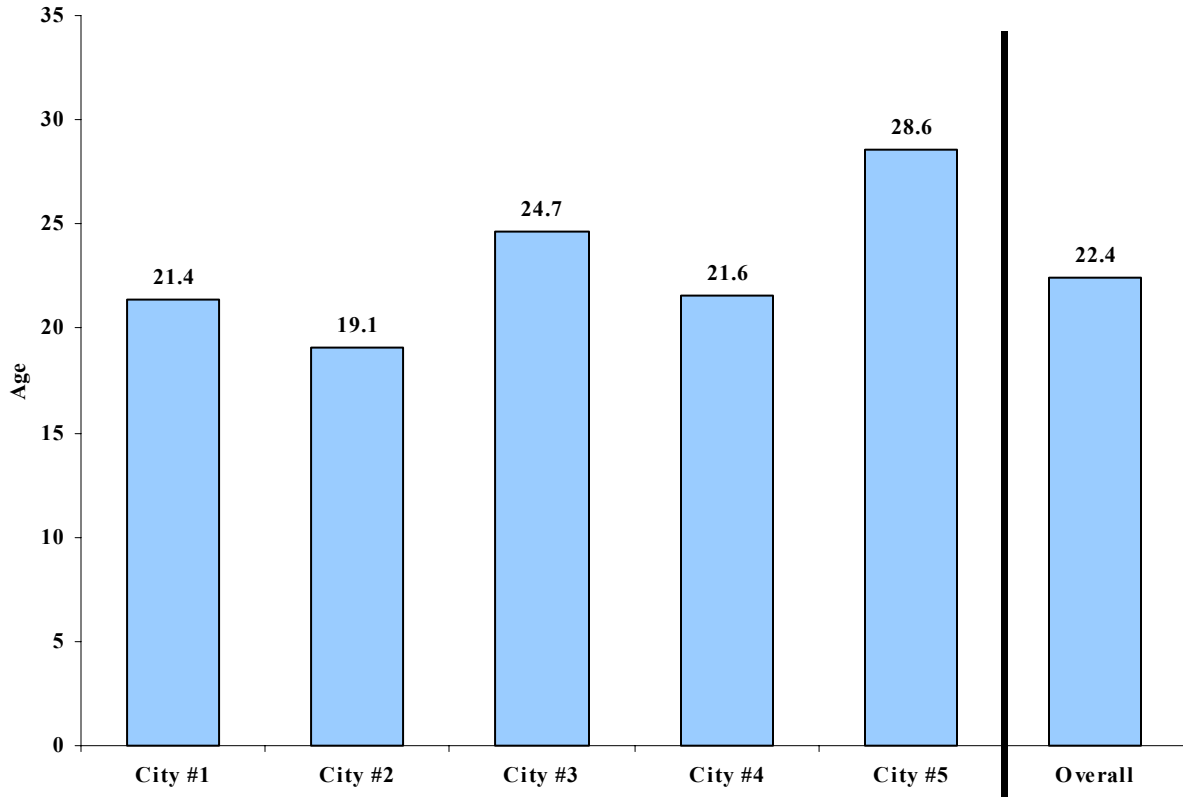


Exhibit 2. Gender Breakdown of Focus Group Participants, by City, 2003

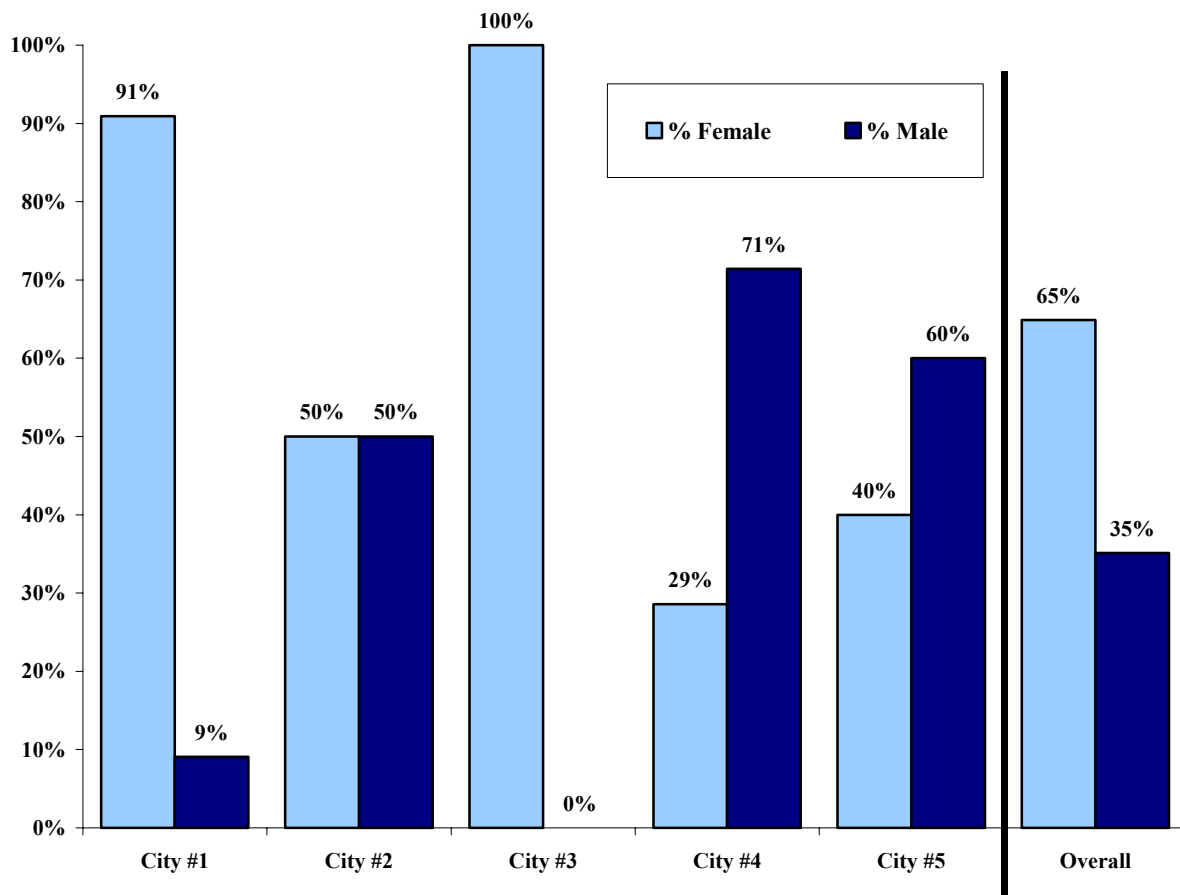


Exhibit 3. Average Educational Attainment of Focus Group Participants, by City, 2003

City	Average Educational Attainment
City #1	Vocational / Tech School
City #2	High School Diploma or G.E.D
City #3	High School Diploma or G.E.D
City #4	High School Diploma or G.E.D
City #5	College Degree or Higher
Overall	Vocational / Tech School

Exhibit 4. States in Which Focus Group Participants Attended Elementary, Junior High and High School, 2003

State(s)	Number of Participants Who Attended Elementary School in the State	Number of Participants Who Attended Junior High or High School in the State
Arizona	9	9
California	8	8
Colorado	1	0
Massachusetts	1	1
Michigan	5	6
New Mexico	2	2
Ohio	1	0
Texas	1	1
Washington	8	8
More than one State*	1	1
Missing	0	1
Total	37	37

*Elementary School - Wisconsin and Illinois; Junior High/High School - Illinois and California

Exhibit 5. Tribal Heritage of Focus Group Participants, 2003

Tribal Heritage	Number of Participants
Apache, Quechaun	1
Assiniboine Fort Peck Tribe	1
Cherokee	1
Choctaw	1
Dakota Sioux, Navajo	2
Eastern Band Cherokee	1
Navajo	8
Navajo, Apache	1
Nisqually, Yakama	1
Northern Arapaho, Colville, Blackfeet, Flathead	1
Northern Cheyenne, Tlingit, Haida	1
Pima	1
San Carlos Apache, Arikara Mandan Hidatsa	1
Santee Sioux, Big Pine Paiute Reservation	1
Sault Tribe	5
Shoshone, Gros Ventre	3
Soo Tribe of Chippewa Indians	1
Tigua (Ysleta Del Sur)	1
Tlingit, Arikara	1
Wampanoag Aquinnak Assonnet Band Mashpee	1
Western Cherokee	1
Don't Know	2
Total	37

The focus groups were conducted in five communities nationwide. The goal was to hold focus groups in three urban and two rural/reservation communities. Locations were selected based on convenience, feasibility, and pre-existing relationships with NNAAPC or The American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research. For confidentiality reasons this report will refer to the communities as, Southwest, Northwest, Mideast and urban or rural. Exhibit 6 shows the original planned distribution of community participation and the actual results.

Exhibit 6. Geographic community participation (Goal/Results)

	Southwest	Northwest	Mideast	Southeast*
Urban	2/3	1/1	0/0	0/0
Rural	0/0	0/0	1/1	1/0

* We were not able to conduct the Southeast focus group due to two natural disasters.

Focus Group Methods

Methods for recruitment

The American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research established selection criteria with guidance from NNAAPC. The host organizations conducted recruitment through lists, nominations and flyers provided by the Center. Flyers were approved by the host community for cultural competency. Times and location of the focus group was selected by the host community to maximize participation.

Recruitment and Retention

Reminder calls were to be made one day before the focus group by NNAAPC. Refreshments and resources materials were provided (See Appendix A for an example). An honorarium of \$35.00 was provided to participants.

Focus Group Questioning Route

NNAAPC provided a comprehensive list of areas they would like to gather information. This list was grouped into the following public health domains by the American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research:

General information

- health issues
- dating and relationships

Community Risk Factors

- drug and alcohol use
- violence
- discrimination

Solutions

- solicit recommendations for sexuality and sex education, including teaching methods and role of parents and caregivers.

From this domain list, the American Indian and Alaska Native Research Program, UCLA Center for Health Policy Research, developed a focus group questioning route, which was reviewed, modified, and approved by NNAAPC. The questioning route was piloted at the first focus group. Some changes were made to the instrument.

Moderating

All focus groups were moderated by Ms. Satter (Umpqua/Klickitat of the Confederated Tribes of Grand Ronde), except one Southwest focus group which was moderated by Ms. Zubiarte, (Tigua Pueblo Ysleta del Sur). The assistant moderators were volunteers from the host organization, or a research assistant from the UCLA Center for Health Policy Research. Assistant moderators were offered a distance based training taught by Ms. Satter.

Analysis, Reporting

The analysis was notes-based, including data reduction and review, targeted proof-listening and editing to identify keywords, context, internal consistency, frequency, intensity, and specificity of the focus groups. The ultimate goal of this needs assessment was to look for trends and patterns that are similar for all locations to serve as the starting point for recommendations for the development of prevention curricula, etc.

Focus Group Discussion and Key Recommendations

1) When do Native youth start dating in this area or where you grew up? What are those relationships like? (define “dating” and “relationship” if different)

The participants discussed three levels of relationships: (a) pre-dating or kiddie dating, (b) dating, and (c) relationships. These are described in detail below and recommendations are presented at the end of this section.

Pre-dating/Kiddie-dating

Pre-dating, also called kiddie dating in some areas, was described as taking place in middle school. Boys and girls began showing interest in each other. For example, some children would take money for kissing.

A few participants reported knowing 5th and 6th graders who were sexually active, but these middle schoolers had no biological information of their own bodies or how to protect themselves from sexually transmitted disease or pregnancy.

“I started liking girls early...I had “dates,” like going to friends houses.”

“Kids in 4th/5th grade have boyfriends and girlfriends and they are already starting to kiss and stuff.”

Dating

The average age when youth start dating was 12-13 or junior high school. However, several participants reported delaying dating a few years. A few participants described the importance of extended family respecting nuclear family’s dating rules. In these cases the extended family fostered too lenient an environment; in each case this was regretted by the participant.

“When I was younger I grew up near my reservation and my extended family let me get away with more. My immediate family was strict.”

“I didn’t have that—couldn’t go anywhere. I was only allowed to see my boyfriend three times a week for 2 hours. I couldn’t go anywhere with him. My sisters had their fun, got pregnant, etc. and that made it more hard on me.”

Activities that defined dating were:

- Going out to movies, bowling
- Being away from parents
- Pre-relationship phase where you get to know each other
- Hang out and drink alcohol at houses of emancipated youth and of youth whose parents were at work
- Go to bars with loose drinking age controls for minors

- Some parents let their children’s girlfriend or boyfriend spend the night “then they know where they are”
- When you can touch your partner (e.g. hold hands, kiss)
- Dated quickly—one week with someone, next week someone different

“Dating in my community is not heard of because everyone knows each other or they are related. We only date at school.”

“In Navajo, clanships affect dating. You can’t date if you are from the same clan. So that limited who you could date. Parents would tell kids, no.”

Relationships

Relationships were described as a level of commitment, responsibility and connection beyond what was previously defined as dating. The majority reported the onset of sexual activity before graduating from high school. The average was reported around 10th to 11th grade.

Activities that defined relationships:

- A commitment (loyal and faithful)
- Go to someone’s house to meet parents
- Walk them home
- Kissing
- Sexual relationship

“Wasn’t like that for me, but for my sisters/brothers, once they started dating someone they thought it was ‘forever’. When I was home (12 years ago), commitment at such a young age limited promiscuity, but I think that has changed now, there is teen pregnancy and marrying within clan.”

“Parents don’t know when kids are having a relationship, but they should because before you know it they are having kids and then their parents are raising them.”

“By 7th and 8th grade I knew kids that were pregnant.”

Miscellaneous Terms Used

- F.W.B. (friends with benefits) – two people who are sexual partners, but do not have a “relationship”
- Ball and Chain
- Your man
- Your fool
- Long tail
- Shorty
- Girl/boyfriend
- Sexual partner

Recommendations

- The curricula should be flexible enough to modify to fit the local communities' needs.
- Explore definitions in the curricula and localize jargon for the community. For example, most communities defined “dating” and “relationship” differently, this would be addressed in the modification process.
- Youth begin to explore sexuality in middle school. Curricula should prepare them before this age, with ongoing age-appropriate lessons through their school life. Starting early will lead to healthier relationships in adult life.
- School based curricula must coordinate with home and community life, for example include parents in an evening class and utilize community members on an advisory board.
- If cultural rules state who is appropriate in a partner, i.e. clan rules, this should be a part of localized curricula.
- Extended families should respect dating rules of the child's parents.

2) What age do Native youth start drinking, using drugs around here? (some, most, boys/girls, injection drugs)

Overall participants reported that alcohol and drugs use started early for them. The majority of participants started experimenting in junior high and high school. Participants felt that 11 years old was too late to start prevention messages. Most participants reported using alcohol and marijuana first and then moving on to other drugs.

The most common reason that youth began using alcohol and other drugs in high school was to “fit in” with each other and with older students. Also reported was that some youth used drugs because there were no alternative activities. Overall participants felt that drinking and drugs were normal daily events that affected their family and community.

According to most participants alcohol was easier to get a hold of than other drugs on their reservations or in their rural communities. Participants felt that access to other drugs was easier in the cities compared to reservations.

Most participants reported there was little use of injection drugs by Native youth or young adults. A few participants reported the use of injection drugs by some adolescent females involved in commercial sex work.¹

Slang

Common terms for some drugs are: crack, macke, sherm, wet, shrooms, liberty caps, e-bomb, ecstasy, blunts, glass, speed, meth, ‘G’ scrape a pipe, slanging (selling drugs)

¹ Commercial Sex Work - prostitution, applies to both female and male sex work. It can be opportunistic or full-time, for money or other forms of payment, such as drugs. The worker is a "commercial sex worker" or CSW. Some domestic treatment programs call this "survival sex."

“I grew up knowing about drugs and alcohol at an early age—I think Native kids know things earlier—because it is around all the time.”

“Because when you grow up in a certain family and it’s all around all the time...you see it in the fridge...it was real bad...a lot of people are dying. There’s suicide, too much drugs, shootings, health issues because of too much drugs and alcohol. It happens everyday.”

“I had plenty of info from my family. My friends and I used to say we weren’t gonna do it, but by high school we were all addicts. I grew up with speed all around me..I saw it all and I still fell into it.”

“It’s a vicious cycle—if you don’t know a lot about drugs and alcohol you are more susceptible. It leads you to them because you are not being educated. They kind of bleed together and fall into the same category and if you don’t know how things work then you [get caught up in the cycle].”

“It’s not clear cut...people just want to be liked—seem cool.”

“My first drink was at 7, my father would take me to local bars and play pool. He used to give me drinks and say, ‘Here go to sleep.’”

“When I was younger I used to go to store to buy it for my dad or other relatives.”

“I started smoking weed everyday at 14 until I was 18.”

Injection drug use... “I think it’s becoming a huge problem.” “It’s a yet.” (as in I haven’t tried it yet)”

“I started using narcotics when I was 14, I shot up for the first time.

“I think it depends a lot on your atmosphere, cuz you know I had cousins that come from broken homes and they would sneak beers, raid ash trays for roaches. I don’t know...the way I was brought up, my parents instilled manners; I didn’t really mess with anything until I was about 15 or so. But I know a lot of my cousins who were out at a young age.”

“People steal pain pills like oxycontin or vicodin from people who have prescriptions or they steal prescription pads from doctors.”

“It was different for me because I was a student athlete, but kids with money bought the good drugs, kids w/o money bought beer and marijuana...would steal for money to buy drugs. The clique you hung out with determined how you were viewed.”

“We have high rates of alcoholism, statistics are higher—it is something we are well-known for, ‘Oh there’s an Indian, there’s another drunk.’ I didn’t like being an Indian as a kid because of this.”

Recommendations

- Alcohol and drug prevention curriculum needs to be taught early to Native youth.
- Incorporate social opportunities and activities for students.
- Use role-playing as part of prevention curriculum.
- Include information about prescription drugs in prevention programs.
- Educate parents on drug and alcohol use in their respective communities.
- Ensure that curriculum is current by including local slang.

3) Think about Native youth you've known...friends or family members... who did NOT use drugs or alcohol...Why didn't they? (Prompt: What was it about them, their family, or their environment that didn't lead to drugs and alcohol?)

The participants only discussed one major factor that explained why Native youth did and did not use drugs or alcohol – their environment. Unfortunately, many of the participants could not recall any Native youth that did not use drugs or alcohol. These issues are described in detail below and recommendations are presented at the end of this section.

Environment

Most of the participants felt that a person's environment was the key factor in using or not using alcohol and drugs. Four subcategories of the environment were discussed at length: (a) general environment, (b) role modeling, (c) siblings and peers, and (d) social activities.

General environment

Several participants reported that urban settings provided better economic, educational, and social environments. The participants cautioned against parents isolating their children in urban environments, which led to rebellion in adolescence. They also discussed the high number of "very dysfunctional families" on reservations. Lastly, in some reservation communities the non-Indian professionals (e.g. doctors, teachers) thought that only the Indian adolescents used drugs and alcohol, not their own white children. This was not true and the concept of only the Native youth using alcohol and drugs, etc., was disturbing to the participants. A repeated theme throughout the focus groups was that the participants didn't think Native youth were any different from other racial and ethnic adolescents.

" 'Moving on' on the rez is more difficult because everyone around you drinks...A lack of economic development or educational opportunities makes it harder to move past drugs and alcohol. It is more difficult to say, 'I am not gonna do that, I am gonna be better than that.' "

[Regarding cousins growing up in an urban city.] *"Their whole life is centered in their living room. My aunt is scared. She is afraid they might get shot."*

Role models

Having positive role models was important to the participants. Some adolescents were able to see negative role models from a young age and learn from their mistakes. Others followed the negative role model's lifestyle but in young adulthood are taking steps to lead more healthy lives.

"It's all in who you look up to."

“I grew up idolizing hustlers, like my uncles, who were in and out of jail...selling drugs...they had a lot of money, wore diamonds in their ear.”

“I saw alcohol abuse of my brother and dad. I am not gonna do that.”

Siblings and Peers

Several participants discussed wondering why within one family, some children used alcohol and drugs and others did not.

“I have a cousin. Some of us know him but he's a real cool square bear [I don't know how he is so cool without doing drugs?].”

“I have one brother who's into every drug and another sister who's clean. She is married and has a family. But they were brought up in the same neighborhood, went to the same schools. I don't know why he went that way. She got pregnant at 17 and stayed with the father. I don't know if that has anything to do with it, but she is more focused on school...she had to take care of her family.”

Social Activities

Participants stated that youth with families that participated in family outings and supported youth in after school activities did not use drugs and alcohol and they earned better grades.

“They had families and parents that picked them up and that took them to activities, like soccer.”

“If more of our youth had that...things would be different.”

All Native youth used drugs or alcohol

Unfortunately many of the participants could not recall any Native youth that did not use drugs or alcohol. It should be noted that this was unanimously reported in the Mideast and one community in the Southwest, possibly reflecting community specific issues. This needs assessment cannot state the extent of this issue precisely, but it would appear that somewhere between 30 and 50 percent of young Native adults cannot recall Native youth that did not use drugs or alcohol.

Recommendations

- Sexuality and sex education programs should incorporate social opportunities and activities for students
- Economic development is critical to a community's health
- Urban Indians need support in raising their children and integrating into diverse communities. Learning how to integrate into the larger community while retaining cultural heritage and identity may be of importance in some urban Indian communities.
- The curricula should provide safe tips for living in an at risk environment

4) How is alcohol and drug use related to sex? How does it change behaviors around sex?

According to participants, alcohol and drug lower your inhibitions and make you more likely to make decisions that you wouldn't if you were sober. In addition, participants felt that alcohol and drugs made people more confident gave you more "balls" to approach people and made you more receptive to flirtation. Overall, participants felt that "being high" enhanced how sex felt. Participants also expressed that people often felt regret or remorse for their actions the next day.

"If I do drugs, I'm willing to do a whole lot of stuff."

"Sober, drunk, blind, crippled or crazy—doesn't matter to me"

"Meth made me want sex all the time." (Reference to speed)

"Sober sex is not as good."

"You don't care what's going on...what is right there is what you are thinking about."

"Everyone drank, just depended on how much. I am not sure I see a relationship between sex and alcohol."

"Alcohol puts you in a position to be taken advantage of. You should have one person that is sober to watch over friends."

Recommendations

- Ensure that curriculum includes correlation of alcohol and drugs to sexual risk.
- Include harm reduction information for those that choose to use alcohol and drugs.
- Discuss issues related to use of alcohol and drugs with sex, such as:
 - Consent is void while under the influence.
 - It may lower inhibitions, but most drugs reduce pleasure (e.g. can cause erectile dysfunction).
 - Sex while under the influence is associated with decrease in intimacy.

5) What types of violence do the Native Youth here experience or witness? Particular groups? Conflict between groups? What about men and women (couples), especially Native youth?

The participants described five types of violence that Native youth experience or are exposed to either directly or indirectly: (a) gender violence, (b) gang violence, (c) alcohol related violence, (d) racial violence, and (e) family violence. Many of these types of violence overlap, especially gender and family. These issues are described in detail below and recommendations are presented at the end of this section.

"A lot of us see violence, it's not just Natives that fight, it's everyone all mixed together."

Gender violence²

Gender violence was witnessed or experienced by the majority of participants. In some communities the subject was not talked about in public or with youth. Participants reported their mothers and aunts acted as if it was “*normal to be beaten up - but they don't talk about it.*” In fact, some of the participants believed violence was a part of every relationship. Some participants thought verbal abuse was very common among adolescent couples.

“I've seen a lot of abuse from my dad to my mom. He broke her arm, gave black eyes, she had to have surgery. I vowed I would not be like my dad. I have kept that promise to myself.”

“Men in this area downgrade women and act vulgar.”

“I think that [abuse] goes along with every relationship you have ups and downs.”

“I think half of my friends are abusive towards their girlfriends. My best friend is abusive toward his and in front of their son—he neglects his son.”

“You would be surprised, you can push a women so far, she'll push back.”

Parental gender violence

Parental gender violence greatly impacted children in the home. Several youth that experienced violence in their homes reported they didn't trust people. Some males stated that they would never hit a woman because of the abuse they saw their mothers suffer. Still others found themselves being battered by their female partners. These partners took advantage of their promise to never hit a woman. Fist-fighting between high-schoolers was common in rural areas, and most often occurred over romantic jealousy on school property or on the way home from school.

“We know what goes down – parents drink and argue and then fight.”

“I know there's times when I push him [her boyfriend] to the limit.”

“My dad was abusive to my mom also. My girlfriend knew about my bad side and she didn't have limits.”

² Gender violence includes any act of force or coercion that gravely jeopardizes the life, body, psychological integrity or freedom of women in the service of perpetuating male power and control. Sexual coercion is the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behavior against her/his will.

Gang violence

Gang violence was experienced in urban and rural areas. Being affiliated with a gang was important to youth; becoming a member provided feelings of belonging. Additionally, gangs were able to “stand up” for themselves and their community against racism from the non-native community. Many participants stated that gang violence was decreasing in native communities. One community dealt with gang violence by increasing reliance on cultural identity. Television was thought to be importing “*thug culture*” on reservations.

“Young ages are ‘putting in work’”.

“On the rez it is happening due to a lot of racism and what happened to our people [historical violence].”

Once you get in[to a gang], your life’s in it...but now I am trying to change that. But finally now, I see its all bullshit! Violence is what I do, not on females—but on other people because of what I am in, but I am trying to change that. I am starting to see things in a different light. I am gonna go to college and gonna get out of the treatment center.”

“I don’t see it much because I am older, but cousins in rival gangs would be okay at family gatherings...it was weird to me.”

“Kids participate in gangs to get respect...making someone fear them in their minds equals respect.”

“Kids need to be taught difference between fear and respect.”

“MTV culture promotes it. They want to be part of the thug culture.”

Alcohol related violence

Participants that had seen adolescent couples fighting all reported that it happened when youth were drinking alcohol.

“People take things too personal or the wrong way and startin’ stuff.”

“People drink at parties and it gets out of hand, people like to fight.”

“Most parties get broken up because of fights.”

Racial violence

Several participants described racial violence and discrimination. This subject deserved more time than available in this needs assessment. In one community Native students had been picked on by whites up to about ten years ago, however, the community was undergoing a demographic transition and now Native and white students were picking on new migrant African American youth.

Several of the participants of multi-racial heritage reported experiencing discrimination since an early age. Peers often misattributed their race. When they would affirm their American Indian heritage; the other children would say they were not. They reacted to this discrimination by fighting, or jumping, their accusers.

“I’ll throw down right now for my community and who I am.”

A few participants mentioned community level violence including civil unrest and demographic changes that led to racial violence and discrimination.

“Mardi gras a couple of years ago...it was off the hinges. I mean it was just so crackin’...I mean it couldn’t be any better. It was crazy...I thought I was in LA.”

[African American] families are here now because of the new prisons. [Families were relocating to the community from large urban populations to live near their imprisoned family members.]

Family violence

Family, parental, sibling and elder violence had been witnessed by most participants (see Gender violence above).

“I thought it was normal for you to see someone get angry and punch a hole in the wall.”

“Children witness violence and it affects them later in their relationships.”

“When you are young you see older siblings fighting with each other or you—you internalize it.”

Recommendations

- Schools are responsible for the safety of youth to and from school. Protocols should be put in place to ensure student safety.
- From an early age youth need to learn respect for the opposite sex/gender.
- Alternate solutions and responses (i.e. fighting) to symptoms of historical oppression (e.g. denial of another student’s race) must be taught.
- Parents and leaders must take responsibility to resolve racial conflict in communities. When left unaddressed youth try to solve problems without the necessary skills. Children should not feel they must take these issues on.
- Many communities need gender violence prevention programs, including domestic violence.
- Curricula must state violence is not a normal part of a relationship.
- Curricula must include prevention of violence including verbal abuse.
- Curricula must cover the impact of violence on children. It should describe the associations between experiencing or witnessing violence and the acceptance of high risk behaviors later in life.

6) What about sexual identity? Have you found that there is discrimination against gay or lesbian people? Are they welcome in this community?

Native and non-native gay, lesbian, and transgender people were discriminated to differing degrees in every community. One focus group was composed mostly of Christian participants. Their comments were more homophobic than other communities. In another community, men were reported to discriminate more than women. Violence and hate crimes were experienced in some communities. Only one person could recall a supportive school environment for gay and lesbian students. In two communities the magazine “Colors,” was mentioned as a resource. Its target is the gay community, however, this magazine provided not only reproductive health information, but also cultural guidance to the young adults. Not all participants were familiar with the terms bisexual or transgender. While we did not collect information on sexual orientation of the participants, several participants were openly gay or lesbian.

“Sometime Native guys are scolded for not being masculine enough.”

“If they’re gay, they can be shunned by their family.”

“[Gays are] made to feel not welcome and people make ‘fun’ of them.”

“Most gay and lesbian people move away from here.”

“The older you get the more accepting you are.”

“I have friends that are gay or bisexual or whatever...I think it depends on what group you hang with, if they don’t like them then you don’t like them.”

“On my reservation, to a certain extent there was discrimination.”

“In Texas there is prejudice and homophobia, most gays are openly out, but no violence, just some harassment and jokes.”

“I see more transgender people on the rez not so much out here [City #5].”

“I’m not God, it’s not for me to judge anyone.”

“I work at a bar and a friend of mine came to visit me and he was just sitting there having a diet coke and some guys came up and urinated on him [because he was gay].”

“The violence can come from siblings/parents. On my reservation community a kid was beaten by his brothers, then the father dressed him up in women’s clothes and made him go outside.”

“In [City #5], there is blatant homophobic attitudes, if you are gay you knew to hide it because of severe harassment even in elementary, middle school, and high school.”

“On my reservation, in high school there was a gay section of the cafeteria, no one

bothered them, not sure if would be the same now—it was more tolerated than accepted.”

“In my urban high school there were a lot of different kinds of people. I never heard of any violence.”

“ ‘Colors’ has native stories... I think the magazine has racy articles. But the July issue was on ‘transcenders’ [sic].”

7) What key concepts should be taught in sexuality education? What should they have taught you that they didn’t cover? (Prompt subjects if not discussed: Information, attitudes, values, insights, relationships and interpersonal skills, responsibility, cultural identity, health, sexual health and wellbeing, the role of colonial viewpoints on native sexual identity, gender issues and respect, disease?)

Prior to discussing this item, the moderator read the following definitions of sex education and sexuality education to the participants in order to spark discussion and provide a framework for brainstorming:

Sexuality – *encompasses not only anatomy, physiology, and biochemistry (what people sometimes think of as “sex”), but also gender roles, thoughts, feelings, and behaviors.*

Sexuality Education – *is a lifelong process of acquiring information and forming attitudes, beliefs, and values. It includes sexual development, reproductive health, interpersonal relationships, affection, intimacy, body image, and gender roles.*

Sexuality education addresses the biological, socio-cultural, psychological, and spiritual dimensions of sexuality from the cognitive domain (information); the affective domain (feelings, values, and attitudes); and the behavioral domain (communication and decision-making skills).³

The participants discussed many recommended concepts for sexuality and sex education. The concepts were: (a) values; (b) communication skills; (c) reproductive knowledge; (d) pregnancy prevention and family planning; (e) HIV and STD prevention; and (f) overall identity issues. In addition to these concepts, the participants provided excellent suggestions for teaching methods. These are described in detail below and recommendations are presented at the end of this section.

It is important to note is that the participants did not directly address spiritual or specifically cultural issues around sexuality. However, we believe these areas were important to the participants. Their age and communication skill level may have made it difficult to express these concepts directly. Additionally, extensive public health and psychology research demonstrates the importance of including cultural and spiritually grounded approaches to sexuality education.

³ National Guidelines Task Force, Guidelines for Comprehensive Sexuality Education , 2nd Edition, Kindergarten-12th grade (New York: Sexuality Information and Education Council of the United States, 1996) p. 3.

Values

In their experience, sex education training had only covered the biological aspects of sex. They wanted the curricula to also cover elements of a sexual relationship that go beyond the physical, such as, values and emotions. In particular they strongly recommended that sex should be taught as a normal part of a healthy life; it should never be taught as bad or “dirty”. Several participants also wanted the role of fathers to be taught including dead beat dads.

“Elders and parents should teach [sexuality] values, but the way things are now they aren’t doing it.”

“Traditional values are being lost, just like manners are being lost. I want that in the curricula, not just “sex ed.”

“There is not a lot shared about traditional ways or spirituality in this community.”

“A lot of kids don’t know how to deal with emotions—kids don’t know how to deal with feelings.”

“My kids don’t know their traditions, we have to travel back home, but I think that is important....maybe that is the best solution [to pregnancy prevention].”

“It’s hard to be both urban and traditional, it’s like you are in two different worlds. You can go back home, but can’t bring it back...it’s hard to incorporate.”

Communication skills

Participants discussed at length recommendations around values (see above). They also provided specific subtopics for communications skills, such as communicating with the opposite sex, peer pressure and refusal skills.

“In high school urged to get on the pill by friends and teachers. But boyfriends won’t use condoms if they know their girlfriend is on the pill.”

“Girls need to know when a guy is just trying to ‘game ‘em down’.”

Reproductive knowledge

Reproductive knowledge was requested. Many of the participants described not having enough information on the anatomy of sex. They called this “how sex works”. In particular they mentioned embarrassing body functions (which they would not describe); that vaginal sex is not the only form in which people express their sexuality, it could also include anal and oral sex; and issues of penis size and impotence. They wanted the curricula to teach that oral sex is sex, as many youth do not know this.

“When I actually started having sex mistakes got made because I didn’t understand how things worked. I didn’t understand about the occurrence (act of sex)... because I only learned about my body.”

“You watched Melrose place and saw everyone having sex, but actually you don’t know how it works. I never talked to parents of friends...you don’t tell how stuff happens...its like, ‘Oh we had sex, or we did whatever.’ For me I thought it was just that two people laid on top of each other.”

“Oral sex should be explained. I thought it was phone sex [laughter].”

“All it takes is one time. If I had known how sex leads to pregnancy I wouldn’t have had a child at 15.”

“Boys need to be educated, how to use condoms correctly, accept responsibility and respect partners.”

“There is a lot more that can be learned, than what we learned.”

“They teach that there is only one type of way it happen, it’s not just penis into vagina—it can be anal or oral sex.”

Pregnancy prevention and family planning

Participants recommended that pregnancy prevention be included in the curricula. Some also believed sharing information on how to plan a family was important. It became apparent that in some communities the men and women, although adults, still did not have access to complete reproductive health information and technology. For example, many did not know about emergency contraception, such as, abortion or the “morning after pill.”

Participants thought it was important to include messages that said it was “Okay to wait.” To be clear, they were not recommending abstinence messages, but that knowing you can wait until you feel ready is fine. Lastly, they did have an interest in learning about insurance and publicly funded programs for reproductive health care.

“Important to talk about teenage pregnancy. You don’t realize how hard it is to have a baby. You need to be studying, or you want to sleep, but have the baby to take care of.”

“Some people are just not ready for sex. Its cool to wait.”

“Teens avoid birth control because they think they have to tell their parents first.”

“School should distribute birth control, its embarrassing to go to store to buy them.”

HIV/STIs

HIV and sexually transmitted disease and infections were recommended topics. Some participants had learned about these issues too late.

“I only learned about HIV prevention in jail.”

“I didn’t know about Hepatitis C risk and intravenous drug use until jail.”

“Use condoms – be safe.”

“It would be more effective if they show how people do things in everyday life (that have STD’s). What’s it like, the pills or shots.”

Identity issues

The participants spoke of overall identity issues, including gay and lesbian identity.

“Mixed race American Indians need to know they are not alone.”

“I was not taught that it is okay to be gay or lesbian, but that’s important. My brother had to keep it on the DL [down low] growing up. Now he is proud and I am proud of him being gay.”

Teaching methods

The majority of the discussants contributed great ideas on the actual teaching methods and approaches they had experienced or recommended. The most critical issue is who should be the primary teachers. The participants also discussed “how” to teach sexuality education. Again, the topic of never teaching that sex is “dirty” or wrong was emphasized. The majority of participants talked about school based curricula, some mentioned that this could be supplemented with other activities. They recommended education begin in middle school with continuous yearly age-appropriate training.

“It was taught in junior high and elementary, but only if parents gave permission. I was never allowed to go—asked my parents, but they said no—never did learn.”

“Schools have taught poor self image. This is not a good teaching method. If you have sex you should not feel bad about yourself. Used self image against them.”

“Maybe we need to teach early because who knows what happens when were not around.”

The sections below provide details on who should and should not be the primary teachers, and a list is provided of the “how” to provide the information.

Who should teach

The most common and widespread topic was that coaches should NOT teach sexuality education. Other than that, the participants wanted anyone knowledgeable and willing to provide the information, such as, parents and teachers. A few of the participants, in particular those who had been in jail or treatment, recommended peer education programs.

“Their friends, same age or just a little bit older would be great.”

“Our health class in the freshman and sophomore year was taught by a white volleyball coach who was really uncomfortable. That made it awkward. I was turned off and didn’t listen. No one participated.”

“I was very uncomfortable in sex ed class taught by my coach, especially if on sports team...you got singled out. Coach made masculine/feminine comments for example to the football team, ‘this is what makes you a man’ and to the girls things like, ‘this is your place.’ ”

“In my high school we had husband and wife teachers that taught class, it was like having parents teach it. They taught it as if we were adults. That was good.”

Recommendations

The sex and sexuality education curricula should include/cover:

- Values and emotions (e.g. responsibility and respect).
 - sex should be taught as a normal part of a healthy life; it should never be taught as bad or “dirty”.
 - the role of fathers, including dead beat dads.
- Communication skills (e.g. communicating with the opposite sex, peer pressure, refusal skills).
- Comprehensive reproductive knowledge
 - anatomy and physiology (“how sex works”).
 - issues of penis size and impotence.
 - vaginal sex is not the only form in which people express their sexuality, it could also include anal and oral sex
- Pregnancy prevention and family planning
 - birth control methods
 - how to plan a family
 - it is “Okay to wait.”
 - health insurance (public and private) for reproductive health care.
- HIV and sexually transmitted disease and infections
- Identity issues

Curricula Delivery

- Youth begin to explore sexuality in middle school. Curricula should prepare them before this age, with ongoing age-appropriate lessons through their school life. Starting early will lead to healthy relationships in adult life.
- Curricula should be school based with enhanced/supplemental non-school based activities (clubs, home, conferences).
- The primary educators/trainers should be:
 - anyone knowledgeable and willing to provide the information, such as, parents and teachers.
 - and should not be athletic coaches.
- Involve parents in learning process.

How to provide the information

- Ensure that the teaching materials are not too old and utilize a spectrum of multi-media materials (posters, tapes, pamphlets).
- Ensure resource telephone numbers and websites are provided.
- Maintain control over the classroom behavior
- Demonstrate condom use
- Use graphic details
- Use a question and answer box to allow anonymity
- Brush up on slang
- Use incentives to encourage participation
- The majority of participants felt separating boys and girls is not good
- Non-school based locations (clubs, home, conferences)

“Maybe they should do it though Native American clubs—like at someone’s house and have a parent volunteer. They should split up the boys and girls and have talk about what is going on with sex.”

“Had class in high school for ½ a semester, but I didn’t take it until my senior year and by then I already new stuff...everything...well not everything, but it seemed pointless then.”

“Sex ed class was not taken seriously.... “Oooh, private parts.” For example, we had to watch a breast exam video and the boys were “excited”.

“They should have a reception for parents to teach them what to teach us—so we won’t be confused like they were.”

“Parents have to teach kids—our parents probably didn’t have that. They got nothin’ from their parents so we didn’t get nothin’.”

“The main thing is responsibility—to take care of yourself for the future, not just live the moment...just have sex or whatever. You could do it if you are a responsible person or if not you shouldn’t be messing around with it.”

“It boils down to self respect...this is your role socially, family...everyone influences you, but you make decisions. Self respect and holistic health lead to good decisions.”

Summary of Recommendations

This section describes the recommendations for sex and sexuality education (a) curricula content, (b) curricula delivery, (c) how to modify the curricula for a local community, and (d) other issues.

Curricula content:

- Values and emotions (e.g. responsibility and respect).
 - sex should be taught as a normal part of a healthy life; it should never be taught as bad or “dirty”.
 - from an early age children need to learn respect for the opposite sex/gender.
 - the role of fathers, including dead beat dads.
- Communication skills (e.g. communicating with the opposite sex, peer pressure, refusal skills).
- Comprehensive reproductive knowledge
 - anatomy and physiology (“how sex works”).
 - issues of penis size and impotence.
- Vaginal sex is not the only form in which people express their sexuality, it could also include anal and oral sex
- Pregnancy prevention and family planning
 - birth control methods
 - how to plan a family
 - it is “Okay to wait.”
 - health insurance (public and private) for reproductive health care.
 - ensure resource telephone numbers and websites are provided.
- HIV and sexually transmitted disease and infections
- Identity issues
- Alcohol and Drug Prevention
 - the correlation of alcohol and drugs to sexual risk
 - provide safe tips for living in an at risk environment
 - information about prescription drugs in prevention programs
 - include safety tips (don’t drink and drive) for those that choose to use alcohol and drugs
 - issues related to use of alcohol and drugs with sex, such as:
 - Consent is void while under the influence
 - It may lower inhibitions, but most drugs reduce pleasure (e.g. can cause erectile dysfunction)
 - decrease in intimacy
- Violence Prevention
 - violence is not a normal part of a relationship.
 - the impact of violence on children. It should describe the associations between experiencing or witnessing violence and the acceptance of high risk behaviors later in life.
 - prevention of violence including verbal abuse.
 - alternate solutions and responses (i.e. fighting) to symptoms of historical oppression (e.g. denial of another student’s race) must be taught.

Curricula Delivery

- Youth begin to explore sexuality in middle school. Curricula should prepare them before this age, with ongoing age-appropriate lessons through their school life. Starting early will lead to healthy relationships in adult life.
- Curricula should be school based with enhanced/supplemental non-school based activities (clubs, home, conferences).
- The primary educators/trainers should be:
 - anyone knowledgeable and willing to provide the information, such as, parents and teachers.
 - and should not be athletic coaches.
- Incorporate social opportunities and activities for students.
- Maintain control over the classroom behavior.
- Sexuality and sex education programs should incorporate social opportunities and activities for students.
- Ensure that the teaching materials are not too old and utilize a spectrum of multi-media materials (posters, tapes, pamphlets).
- Demonstrate condom use.
- Use graphic details.
- Use a question and answer box to allow anonymity.
- Use role-playing as part of prevention curriculum.
- Use incentives to encourage participation.
- Do not separate boys and girls.

Recommendations for modifying the curricula for your local community

- School based curricula must coordinate with home and community life, for example include parents in an evening class and utilize community members on an advisory board.
- The curricula should be flexible enough to modify to the local communities' needs.
- Explore definitions in the curricula and localize jargon for the community.
- If cultural rules state who is appropriate in a partner, i.e. clan rules, this should be a part of localized curricula.
- Educate parents on drug and alcohol use in their respective communities

Other

- Extended families should respect dating rules of the child's parents.
- Schools are responsible for the safety of children from school to home. Protocols should be put in place to ensure student safety.
- Parents and leaders must take responsibility to resolve racial conflict in communities. When left unaddressed youth try to solve problems without the necessary skills. Children should not feel they must take these issues on.
- Many communities need gender violence prevention programs, including domestic violence.
- Economic development is critical to a community's health
- Urban Indians need support in raising their children and integrating into diverse communities. Learning how to integrate into the larger community while retaining cultural heritage and identity may be of importance in some urban Indian communities.

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Appendix A: Resources



UCLA Center for Health Policy Research American Indian, Alaska Native Research Program

Sexuality Health Resource Guide

Sexuality Information and Education Council of the United States (SIECUS)

is a national, nonprofit organization which affirms that sexuality is a natural and healthy part of living. Incorporated in 1964, SIECUS develops, collects, and disseminates information, promotes comprehensive education about sexuality, and advocates the right of individuals to make responsible sexual choices. www.siecus.org

The Population Council

is an international, nonprofit institution that conducts research on three fronts: biomedical, social science, and public health. This research—and the information it produces—helps change the way people think about problems related to reproductive health and population growth. The Council's research makes a difference in people's lives. www.popcouncil.org

American Association for Health Education

<http://www.aahperd.org/aahe/template.cfm>

American School Health Association

<http://www.ashaweb.org/>

American Social Health Association

<http://www.ashastd.org/>

CDC National AIDS Clearinghouse

<http://www.cdc.gov/hiv/dhap.htm>

ETR Associates

<http://www.etr.org/>

National AIDS Hotline

800-344-7432

<http://www.ashastd.org/nah/>

Planned Parenthood Federation of America

<http://www.plannedparenthood.org/index.html>

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