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Rap about Clap: A Qualitative Study of American Indian Youth and STDs/STIs

Roe Bubar, Donna Rouner, Irene S. Vernon, Marilee Long, and Belinda C. Aungie

Nearly half of the 20 million new sexually transmitted infections a year are among young people ages 15 to 24 years old.[1] Youth of color are the most disproportionately affected, having a higher case rate than white youth.[2]

It is important that health professionals obtain the most current information about the sexual behaviors, knowledge, and perceptions of American Indian/Alaska Native (AI/AN) youth if they are to work toward reducing the rise of sexually transmitted diseases and sexually transmitted infections (STD/STIs) among them. Sexually transmitted diseases and sexually transmitted infections, including HIV/AIDS, affect youth and young adults in increasing numbers and continue to represent a serious health concern in tribal communities. Researchers Lori de Ravello, Scott Tulloch, and Melanie Taylor argue that STD rates among AI/AN youth are among the highest in the country.[3] In part, these rates, similar to other diseases found among people of color, are driven by a number of social determinants of health such as poverty, social discrimination, distrust of health care institutions, and unemployment.[4] AI/AN youth are at particular risk and are disproportionately impacted given historic underfunding of health care and the health care disparities experienced in tribal communities.[5] The STD/STI data in the literature that follows may reflect misreporting due to missing information, misclassification, and poor reporting systems for AI/AN.[6]

Roe Bubar is an associate professor in the Department of Ethnic Studies and the School of Social Work at Colorado State University. Donna Rouner's research has focused on communication audience processing, with a particular emphasis on health and social groups. A professor at Colorado State University, Irene S. Vernon is chair of the Ethnic Studies Department and the assistant to the dean of the College of Liberal Arts. Marilee Long is a professor in the Department of Journalism and Media Communication at Colorado State University and a professor in the Colorado School of Public Health. Belinda C. Aungie is from Eagle Butte, South Dakota, and is the health manager/disabilities manager of Cheyenne River Sioux Tribe Head Start Program.

Literature Review

Chlamydia

The most recent Indian Health Surveillance Report notes, "in 2011, reported rates of chlamydia, gonorrhea and primary and secondary syphilis (P&S) among AI/AN were 1.2 to 4.6 times higher than comparable rates for whites."[7] Chlamydia and gonorrhea represent the most notifiable diseases in the United States today. Both of these diseases are major causes of pelvic inflammatory disease, ectopic pregnancy, and infertility, and they also increase the risk of HIV/AIDs transmission. Centers for Disease Control and Prevention (CDC) data show AI/AN with the second highest rates of both chlamydia and gonorrhea, and the fourth highest rates for primary and secondary syphilis. In 2013 a total of 1,401,906 cases of chlamydia were reported, which represents the first time the overall rate for reported cases of chlamydia decreased.[8] The highest rate was among adolescents and young adults ages 15 to 24 years and among women, ages 20 to 24 years.[9] Surveillance data reports indicate that chlamydia case rates increased among AI/AN between 2008 and 2012 and decreased slightly in 2013. In 2013, the chlamydia rate among AI/AN was 697.9 cases per 100,000, which was approximately 4 times higher than the rate among whites.[10] This rate also represents a 23.9 percent increase for AI/AN from 2009 to 2013.[11]

Among AI/AN there are distinct gender differences in infection rates. The Indian Health Service (IHS) reported that in 2011 the chlamydia rate among AI/AN women (983.8/100,000) was 3.3 times higher than the rate among AI/AN men (296.9/100,000); the highest rates were reported among women ages 15 to 24.[12]

Gonorrhea

In 2013, a total of 333,004 cases of gonorrhea or 106.1 per 100,000 were reported in the United States, and for the first time since 2000 the rate of reported cases was higher among men (109.5 per 100,000 cases) than women (about 102.4 per 100,000 cases) between 2012 and 2013.[13] In 2012 the rate of gonorrhea among AI/ANs was the second highest at 124.9/100,000 or 4.0 times the rate among whites. Furthermore, similar to chlamydia gender rates, AI/AN women had higher numbers of STD/STIs (5.2 times the rate of white women) than their male counterparts (2.7 times the rate of white men).[14] Reported in 2011, young AI/AN women ages 20 to 24 had rates of gonorrhea at 668.6 per 100,000, and those ages 15 to 19 years had rates of 424.2 per 100,000, indicating at that time the need for attention.[15]

Certain IHS areas are impacted more severely than others; high gonorrhea rates are found in the IHS areas of Aberdeen, Alaska, Navajo, and Oklahoma City, with the Alaska area containing the highest rates.[16]

Syphilis

For many years, primary and secondary (P&S) syphilis rates decreased in the United States; however, in the twenty-first century, rates have increased among AI/ANs. In 2013, the rate of P&S syphilis among AI/ANs was higher (4.6 cases per 100,000)

than that among whites at 1.5 times the rate for whites.[17] Unlike previous findings of STDs/STIs related to gender differences among AI/ANs, in 2013, more P&S syphilis cases were diagnosed among men (7.1 cases per 100,000) than among women (2.1 cases per 100,000). The rates were highest for AI/AN men ages 20 to 24 and 25 to 29 (18.3 and 16.7 cases per 100,000) than AI/AN women ages 20 to 24 (9.0 cases per 100,000).[18]

HIV

Native youth are found to be at high risk for HIV given "their high levels of sexually transmitted infection (STIs), early age of first sexual activity and early onset of substance abuse."[19] When calculating HIV within the IHS areas between 2008 and 2010, HIV rates for AI/ANs were lower than the national average for all races/ethnicities (9.7 v. 19.5 per 100,000) but the "overlapping of high rates of STDs with HIV" were found in a number of IHS areas and raises great concern.[20]

Native Youth and STDs/STIs/HIV

The rise of STDs/STIs/HIV among AI/AN youth is concerning. The CDC notes that the increases may be due to "multiple barriers to accessing quality STD prevention services, including lack of health insurance or ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality"; the CDC adds that many interventions do not address important youth culture issues such as peer norms and how interventions for at-risk youth need to address "underlying aspects of the social and cultural conditions that affect sexual risk-taking behaviors."[21]

Although data should be viewed cautiously we also know that STDs are impacting youth most severely and that AI/AN youth are engaging in sex "at a substantially higher rate than youth of other races/ethnicities"; thus, to improve AI/AN youths' sexual health, there is a need for more information about them and their sexual health decision-making.[22] The purpose of this article is to provide much needed information on STD/STIs and AI/AN youth. This qualitative study is one of only a few to explore American Indian reservation-based youth in the following areas: knowledge of STDs/STIs, information- seeking behavior, media and/or interpersonal (dyad or small group) communication behavior for STDs/STIs, and their ideas of how to effectively reach other youth with STD/STI information.

Media Messaging

In health fields, HIV/AIDS and STDs/STIs have been studied extensively, while media research has concentrated primarily on HIV/AIDS communication, particularly research on news media, with some focus in persuasion studies[23] and interpersonal communication.[24] There is little available information and a dearth of empirical research on sexual health media messaging for youth, particularly AI/AN youth in tribal communities.[25] A 2005 study conducted in Canada examined the

portrayal of risk factors in mass media focusing on Canadian Natives and found that "the media may not be framing adequately enough the need for preventive information and effective interventions within Aboriginal communities to reduce peoples' misconceptions about HIV/AIDS risk"; this study also encouraged the use of interviews, focus groups, or surveys with the people themselves to accurately create messages. A second study conducted in 2005 reviewed print media on disease and health risks noting the need to culturally tailor prevention and treatment programs in order to increase awareness and access to accurate health information for First Nations and other ethnic communities.[26]

Research has found that the Internet has played a key role in STD/STI awareness.[27] In a 2007 study designed to develop pregnancy prevention in youth ages 15 to 25, participants told researchers they wanted interactive websites, chat rooms, message boards, and other places to post and read personal stories, surveys, and testimonials from role models, celebrities in particular.[28] Youth in the mainstream population use the Internet a great deal for many purposes, principally for entertainment reasons.[29] In general, they are less likely to use the Internet to seek health information than are adults. Relative to information seeking about STDs/STIs, youth have been found at times to mistrust the Internet, questioning the credibility of online content as well as the confidentiality of seeking the information.[30]

The use of other media sources for information, as well as the use of interpersonal sources, is also important. In the non-Native youth population, interpersonal sources are often cited as more used and more trustworthy than media sources.[31] Further, research has found that youth tend to hold little knowledge about sexual health, including low knowledge of STD/STI prevention, symptoms, and treatment.[32]

Methodology

This qualitative study is guided by interpretive theory that includes social constructionism. Social constructionism assumes that people create their social realities through individual and collective processes. Social constructionists "study what people at a particular time and place take as real, how they construct their views and actions, when different constructions arise, whose constructions become taken as definitive, and how that process ensues."[33] Multiple realities are considered, and researchers seek to understand how people construct and then act on their view of what is real.

There is also a growing body of literature supporting the fit between indigenous epistemologies and a constructivist paradigm.[34] Kovach argues that an interpretive qualitative "approach is by necessity, relational," noting that a relational worldview is of primary importance in indigenous epistemologies.[35] This methodological approach aligns well in working with AI/AN youth and the research questions posed for this study.

Community-based participatory research (CBPR) practices framed the groundwork and foundation for collaboration with tribal partners for this research. While this project was not a formal community-based participatory research project, researchers did collaborate with tribal partners to develop culturally relevant ways to understand

and consider sexual health issues within two distinct tribal community milieus. For example, researchers met with tribal members from key tribal committees to discuss youth and specific sexual health issues unique to youth from each of the tribal communities. Included in these discussions was consideration of the diversity among AI/AN youth residing in different areas of the same reservation. As a result, recruitment and representation of youth from different areas of the reservation were considered in the focus groups and later in the analysis. In addition, several of the researchers on this project have extensive experience working with tribal youth, tribal communities, and the communities involved in this study; they worked to incorporate a tribal-specific voice into the research project.

Salient in this project was the production of research where both researchers and tribal community professionals worked together, "sharing authority, responsibility, and credit for success."[36] Tribal community partners also assisted in critiquing and editing the focus group instrument, interpreting the focus group data, presentating the findings, and editing and approving this article. This project also incorporated tribal professionals' input on how the project could be a benefit to their community. For example, at the request of tribal health professionals, in the focus groups, the researchers explored how youth perceived tribal STD/STI initiatives; youth were queried about their reaction to existing collateral health messages produced within their communities, such as a poster designed on one of the reservations, another AI/AN-specific STD/STI prevention poster, brochures, and other STD/STI material.

The purpose of this research was to understand how AI/AN youth understand sexual health in their communities. The phenomenon under study was sexual health knowledge for AI/AN youth. The guiding research questions for this research asked the following: (1) what do AI/AN youth know about STDs/STIs? (2) what do Native youth report as the principal sources they use and trust for STD/STI information? and (3) what recommendations do AI/AN youth have for STD/STI messaging?

Methods

Qualitative data were collected from two Western reservation communities. Researchers, in consultation with tribal professionals partnering on this project, decided to use focus groups to explore areas of sexual health among AI/AN youth, particularly given how little research there is in this area.[37] The focus groups allowed the researchers to uncover beliefs, attitudes, and behaviors related to STDs/STIs. Data from focus groups are considered "socially constructed within the interaction of the group."[38] This particular method for data collection aligns well with a social constructivist methodology and allows for a modified talking circle format where, for example, youth are in a circle, taking turns sharing their experiences and perspectives on sexual health.[39] This method also promotes a deeper understanding of AI/AN youth perspective as well as learning about this topic in the social and cultural narrative milieu of youth participants.[40]

In the focus groups, researchers asked the following questions: (1) where do you think younger people would access information about sexually transmitted diseases/

infections and HIV/AIDS in your community; (2) what do you know about STDs/STIs; (3) tell me how you would seek information about sexually transmitted diseases/infections; (4) which STDs/STIs, if any, are of particular concern in your community or for which you are at particular risk; (5) are younger women/men/people in your community concerned about pregnancy prevention and STDs/STIs; (6) are you aware of any Native-specific messages, information, or media about STDs/STIs in your area; (7) tell me who you think is most at risk in your community for STDs/HIV/AIDS; and (8) tell me how else you would create STD/STI-specific information and get it out to younger women/men/people in your community.

Sample and Procedure

The study involved participants from two Western tribes and consisted of four focus groups of AI/AN youth, two in each tribal community with approximately eight participants in each group. Youth ranged in age from 14 to 21 years old. Tribal partners assisted in selecting participants from particular regions of the reservation, which informed specific issues that emerged in the data. Using cell phones, tribal youth also recruited friends to attend. The study received approval from Colorado State University's institutional review board, as well as the tribal community health board and tribal councils. The confidentiality of all participants and the identity of the tribal communities are kept confidential as requested by the tribes.

Focus groups were held at community-health facilities near the participants' schools and homes. Each participant received thirty-five dollars for participation and a gift packet, which included tokens of appreciation like snacks and pens, as well as good-quality condoms. One tribal health organization onsite provided additional gift bags that included health-care products for each participant. The focus groups were audiorecorded; participant permission was obtained prior to audiorecording.

We segmented youth into focus groups according to gender and tribal identification, thus creating groups that might lend comfort and understanding relative to sexual health risks. Focus groups also included participants who were similar in age and were from the same tribal community area, which increased the probability that group members would feel secure and likely generate more honest, open sharing of their feelings and views.[41]

This study's first author facilitated all of the focus groups. Roe Bubar has experience in tribal communities providing training, consultation, technical assistance, workshops, and research on health disparities and sexual violence; other authors assisted and took notes, in case of recorder malfunction. Tribal youth agreed that respecting one another's confidentiality was important; thus, when participants shared very personal details, the facilitator reminded all participants of the importance of the confidentiality of responses. Focus groups lasted on average between 1 and 2 hours.

Data Analysis

Qualitative methods were used to analyze focus group data. The analysis incorporated grounded theory methods of constant comparison. This approach complements

the theoretical framework of social constructivism, because the grounded theory approach seeks to understand how individuals perceive themselves within a particular context.[42]

Two of the study's authors initially coded the data.[43] The researchers read through the data multiple times. They began with a line-by-line coding analysis of comments, and they followed that with a more focused coding to determine patterns and trends in the data. This iterative process included using constant comparison methods representative of grounded theory.[44] Using this approach, the data were coded, discussed, separated into categories, and further discussed as to the distinctiveness and difference of the categories.

Data were analyzed according to each tribe first, with results combined where patterns were shared across communities. Researchers presented this initial data analysis to tribal community partners who then provided an additional layer of data analysis that included consideration of tribal-specific milieu. The narratives of tribal youth as participants and tribal professionals' knowledge as research partners remained at the center of the analysis.[45]

Findings

The focus group data provide insight into AI/AN youths' knowledge of STDs/STIs and their sources of sexual health information. Three emergent themes—information seeking and use behaviors, knowledge holding and misinformation, and problem-solving ideas—will be discussed. A few key differences were discovered across tribal communities and gender. However, more similarities across these communities led to the principal findings, which involved integrated data across the two communities.

Information Seeking and Use Behaviors

AI/AN youth reported that the Internet, pamphlets, posters, and interpersonal sources (friends, family, and school and clinic health professionals) were their primary sources of STD/STI information. When youth were discussing where they would seek information, participants said, "My best friend," "My Dad and I'd go to the clinic too," "Probably parents, school or friends," "School, clinics," "At the reservation clinic," "Health class, guidance office, nurse's office," and "Somebody that knows about it."

For AI/AN youth, the ability to access information without someone knowing was important, and a pamphlet or brochure was one area where media trust was evidenced; for example, participants reported, "I would probably go to the clinic and look at a brochure," "Yeah, there are a bunch of pamphlets where the midwife is," and, "Nurse's office in school and pamphlets."

The availability of brochures in public spaces provided males, in particular, with the opportunity to obtain trusted sexual health information in privacy. One participant noted, the "Jail gives out information, they will give information and shows what they look like [pamphlet]." Media trust was also present for the Internet, as other participants volunteered, "The Internet and then other things," and "In this community, in school, and Internet."

Tribal differences were also noted in the data; in one tribal community, participants discussed only a smaller number of media outlets they could access to get information, whereas in the other tribal community AI/AN youth mentioned a diversity of sources, including movies, magazines, and the Discovery Channel's program *MythBusters*: "I saw it on *MythBusters*, you can't get crabs from a toilet seat," "In a movie this guy was dancing with this girl and she walked about and he had one [pubic lice] on his eyebrow," and "I saw a magazine about how guys get genital warts."

Access to informed people (interpersonal sources), specifically health professionals, differed by gender. Male participants across both tribal communities acknowledged that females have regular check-ups and specific health reasons to frequent the clinic, noting, "We do not get tested like women; we do not go to the hospital for two to three years so they don't know if they have it," and, "Women get pregnant so they get tested," or, "They're the ones who go in and get treated." Use and access specifically to health professionals was an area of significant difference. Females are seen as having health-related reasons to access the clinic, and thus professionals, whereas males simply do not have a normalized pathway to go in to get checked. Female participants did not necessarily acknowledge this difference in discussing access to health care.

Participants also identified educational and health systems as major vehicles for prevention programming. In their critiques of health pamphlets, many participants noted that there was information not commonly available in pamphlets that they wanted access to, such as prevention, diagnosis, and treatment of STDs/STIs.

Young men and women conveyed the reluctance AI/AN youth experience when they contemplate going to the clinic: "They're too scared," "They won't tell anyone," "Yes, [people] gossip," and "They're embarrassed." Confidentiality can be a particularly challenging issue for those living in small tribal communities. As another participant shares, "It's all about embarrassment because the word travels fast." Particular clinics, staff, and agencies can become labeled as lacking trustworthiness or not maintaining confidentiality. As noted by this participant, "Yes, they try to figure out why you're there," or "And because they know people who work at the clinic." Lack of confidentiality is a concern for AI/AN youth accessing sexual health services in Indian Health Service clinics. One participant distinguished the downtown clinic from the IHS clinic saying, "The downtown clinic is more trustworthy."

Knowledge Holding and Misinformation

AI/AN youth were more informed about HIV/AIDS than any other STD/STI, and they were fairly informed about chlamydia with some gender differences found. Females were generally more informed about syphilis and gonorrhea, and somewhat more informed about HPV, compared to males. Female participants commenting on gonorrhea shared, "Gonorrhea you don't have to have symptoms," "I heard it hurts when you pee," and, "I heard you can get gonorrhea in the mouth." When referring to symptoms for chlamydia, female participants responded, "Burning or stinging," "It's down there; it hurts when you pee and stuff," and, "You can have no symptoms at all."

Males in one tribal community were relatively uninformed about other STDs/STIs (that is, HPV, genital herpes, and chlamydia), whereas males in the other tribal community demonstrated the most knowledge of any group—both male and female—on HPV, crabs, and genital herpes. This knowledgeable group of males was also quite informed about chlamydia, describing the symptoms as, "Probably discoloration of the urine; feels like razor blades, constant burning and pains in here" [pointing down]. This was the only group to properly refer to gonorrhea as "the clap"; others associated this slang term with chlamydia. However, these informed males also demonstrated misinformation specific to gonorrhea and hepatitis C. This group maintained that there was an STD called "bullhead clap" and provided descriptions that matched an Internet description of an urban STD legend. Participants made the following statements: "Bullhead clap is different [than clap]" and with regard to treatment for "bullhead clap," one participant added, "Bullhead clap, not gonorrhea. From what I know they stick a wire up your penis and stuff shoots out. Or they hit your penis with a hammer and other stuff goes all over."

Females from this same community of informed males showed misinformation on hepatitis C and gonorrhea, and also referred to chlamydia as "clap." Some of these female participants also believed that genital warts were herpes. When referring to HPV, one participant said, "It's like a cold sore but it's on your genitals." In this same group, some participants thought it was possible to catch pubic lice off a toilet seat, which prompted a long discussion that included misinformation regarding contracting hepatitis C from drinking out of someone's water bottle; as stated by one participant, "And you can get it [hepatitis C] by drinking out of somebody's water bottle." During the discussion on pubic lice one youth said, "Can't you get them [pubic lice] on your eyebrows also?"

Overall participants were more knowledgeable about types of STDs/STIs and less informed about specific symptoms and treatment. This lack is also where tribal youth themselves indicated that they needed more information: "I think instead of [knowing about how many] cases, how about the symptoms"; "We need information on treatment"; and "Because that's what people are looking for and you're afraid to ask."

Problem-Solving Ideas for Youth STD/STI Messaging

Problem-solving ideas for media messaging reflected tribal knowledge, stories, and AI/AN lifeways, particularly as a way to maintain sexual health. Females offered traditional messages as most appealing for problem solving, noting that messages about women as sacred and staying with one partner offered protection and safety. For example, some of their suggestions for effective messages were: "traditional messages about how people stayed safe"; "women as sacred"; "reflecting on traditional stories"; and, "if one woman stayed with the same man, you might not get it [STDs/STIs]." Suggestions also included how traditionally women were knowledgeable—"How women took care of their babies." In one tribal community, females agreed and discussed together how at the center of any media campaign should be traditional stories and traditional ways of honoring women and intimate relationships.

Across tribal groups, males tended to be more focused on solutions. Males suggested the use of larger tribal community gatherings where community members could speak openly about sexual health, thus making information readily available while discouraging naysayer tribal members from attending: "do a feed, have a speaker"; "big gathering and have people come and talk"; "have a dance and give out condoms to everyone who came to it"; and "give out condoms at powwows." They also suggested using tribal radio or specific programming on public television. Males from both tribal communities tended to offer diverse and creative STD messages for other youth including the quote selected for the title of this research article, "rap about clap," and a suggestion for a condom campaign that included, "don't be silly, wrap that willy."

As another way to discuss successful sexual health media campaigns, two AI/AN-specific posters with culturally specific graphics and information were also introduced for input from the youth. One was a local tribal poster that identified locations in the tribal community where various STDs had been documented; the other AI/AN-specific STD poster presented a pan-Native way of understanding protection. Both posters generated a lot of discussion and engagement by focus group participants and provided a more culturally relevant way to discuss sexual health. As these participants shared, "I like the poster," and "They look like it's a party." This latter comment makes reference to a culturally and tribally specific way to embrace condom use illustrated on one of the posters. This poster also provoked some of the more detailed and specific discussions or questions posed by the youth.

Participants voiced strongly that they needed to be the ones to deliver the sexual health messaging to their peers and to younger youth, middle-school youth ages eleven to thirteen. AI/AN youth thought it was important to talk with youth who were much younger than they, since this is when they believed youth in their community are at risk for unprotected sex. As one participant considered, "I'd go to the middle schools around 12 years old," while another youth added, "I think that's when people should be talking about it because that's when they start having sex," and "talk them into getting checked." Others thought a link to the school's website where youth could provide the health messaging for other youth saying, "a link to the school's website," "a lot of people would listen to it more," "it would be a lot of help," and "if teenagers could talk about it."

Limitations

Most notably, this is a sample from two similarly situated Western tribal communities, which may not be representative of other tribal communities throughout the country. In addition, focus-group participants may not be representative of their larger reservation communities.

Discussion

This study suggests that basic health information and health care for prevention, detection, and treatment of STDs/STIs is limited for tribal youth in our study. While some American Indian youth are knowledgeable about particular STDs/STIs, others

hold misinformation about sexual health, which creates a barrier for detection and treatment. First Nations youth in Canada have also indicated a lack of good sexual health education, and they have stressed the importance of involving youth in the development and delivery of sexual health information because they might be able to relate better to "people of their own age and ethnicities."[46] Alaska Natives and rural youth also indicated they wanted to know more about STDs and HIV. They too had limited access and resources, and indicated that health-seeking may be limited by "the belief that people 'don't talk about it' (sex)."[47] Cultural taboos around sexuality are one of several factors that can hinder effective HIV/AIDS and STDs prevention.[48]

AI/AN youth in this study believe it is important to reach out and educate younger tribal members about sexual health. The ability of AI/AN youth to discuss sexual health openly, honestly, and authentically holds great promise for effective youth message design targeting in sexual health prevention efforts.

Interest in and use of the Internet appeared somewhat low among AI/AN youth, which could be due to access issues and privacy concerns. Access to the Internet for sexual-health information may be a particular barrier for lower-income families and patchy cell phone coverage can also be a challenge particularly in remote areas of rural reservations. Public access to computers may not provide the level of privacy needed for youth to seek sexual health information. Further, hegemonic content and the lack of American Indian youth-targeted information might lead to the youth judging the Internet as less important than other media sources. Given how Internet use for health information and patient behavior is found to be important in empowering patients, it is concerning that Internet use for American Indian youth is somewhat lower than for non-American Indians.[49] If the computers that are readily available to reservation-based youth are public in nature, it becomes difficult for youth to maintain their privacy when they access information about sexual health on the Internet. In general the use of other media for sexual health information—magazines and television programs such as *MythBusters*—was similar to how non-American Indian youth access information sources.[50]

In general, this study's participants reported they did not trust media information. They indicated they did not find tribal-specific information available beyond one poster developed in one of their communities to promote STD/STI awareness. It is important to note that all participants reported being aware of and seeing this poster in their community, which suggests the importance of customizing information culturally, as well as localizing information. The other prevention poster introduced in this study, although developed for a different tribal community, was still well received. It suggests that strong, culturally appropriate graphics and tribally specific messaging may be important in communication campaign designs, given the appealing visuals and tribal information evident on the critiqued poster. Participants were also clear that the information they needed and wanted was prevention, detection, and treatment, none of which was readily available. AI/AN specific messaging was available in both communities involved in this study with respect to HIV/AIDS prevention. Thus it wasn't surprising that participants were more knowledgeable about HIV/AIDS than they were about other STDs/STIs.

Most AI/AN males did not seek sexual health information, examinations, or advice from health and medical professionals within their communities. In some instances they may not perceive a need to seek or receive sexual health information and advice. Most males stated they would seek treatment if necessary, such as if they suspected they had an STD/STI. However, AI/AN youth did not trust that their identities would remain confidential if they went to a clinic for sexual health treatment. Confidentiality has been an ongoing concern of AI/ANs and health professionals who work in HIV/AIDS prevention; it is both a risk factor and a barrier to care and education.[51]

Implications

The following implications should be considered preliminary. First, AI/AN youth may respond positively to interpersonal examples that model social scripts for talking to partners, putting on condoms, going to a clinic, and getting tested for STDs/STIs, because each of these involve interpersonal communication. Second, use of traditional tribal messages that honor women may also provide material for promising prevention campaigns. Third, creation of clinic programs or campaigns that identify American Indian males for screening and treatment could provide a promising vehicle to access needed clinic services. Fourth, barriers to confidentiality for clinic services and computer access should be explored to promote health access to clinics and the Internet.

Additionally, media and interpersonal health campaigns that include youth ideas and development are important, particularly if they involve youth. Social media campaigns that include a combination of interpersonal and mediated communication could be particularly effective since the use of cell phones, texting, and social networking is increasing. This method may be particularly effective in addressing larger-scale prevention messaging for AI/AN youth. Finally, additional formative and community-based participatory research on sexual health, sexual violence, and STD/STI prevention among AI/AN youth is important if we are to keep youth safe and healthy.

Notes

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