

# Evidence-Based Interventions to Prevent HIV and STDs in Indian Country



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## *Evidence-Based Interventions*

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It has been recognized for some time that American Indians and Alaska Natives (AI/AN) are disproportionately impacted by high rates of HIV, HCV and sexually transmitted infections (STIs). Between 2010 and 2014, the number of AI/AN people diagnosed with HIV increased over 25%, to 9.5 cases per 100,000 for AI/ANs (Centers for Disease Control and Prevention, 2015). In 2015, the chlamydia rate for AI/AN was 709.1 cases per 100,000 population, 3.8 times the rate among Whites. On average, chlamydia rates were stable during 2011-2015. The gonorrhea rate increased by 71.3% among AI/AN from 2011-2015. In 2015 the gonorrhea rate was 192.8 cases per 100,000 population, which was 4.4 times the rate among Whites. In 2015, the P&S syphilis rate among AI/AN was 5.6 cases per 100,000 population, 1.4 times the rate among Whites.

To prevent HIV and STI transmission in the U.S., the Centers for Disease Control and Prevention compiled an online Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention, containing scientifically proven, cost-effective, targeted, scalable interventions. The interventions were proven effective through rigorous research that showed positive behavioral (e.g., use of condoms; reduction in number of partners) and/or health outcomes (e.g., reduction in the number of new STD infections).

The CDC's Compendium now includes 84 HIV risk reduction evidence-based behavioral interventions, 10 HIV medication adherence behavioral interventions, and 9 Best Practices for promoting linkage to and retention in HIV care:

[www.effectiveinterventions.org](http://www.effectiveinterventions.org)

Unfortunately, despite a persistent and growing need for culturally-relevant interventions, few interventions included in the Compendium were designed for or evaluated with AI/AN populations. This report includes a partial list of behavioral HIV/STI interventions that have been adapted or evaluated with AI/ANs.

Our goal is to share information about programs that are working in Indian Country, share adaptation processes and evaluation findings, promote collaboration between tribes and tribal organizations engaged in this work, and expand the reach and use of culturally-relevant HIV prevention programs in AI/AN communities.

# Rez Smart

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**Intervention:** Rez Smart, also known as Street Smart, is recognized by the CDC as evidence-based behavioral intervention to help youth practice safer sexual behaviors and reduce substance use.

The original intervention is conducted over a six- to eight-week period with 10-12 youth. The program consists of eight 1 ½- to 2-hour group sessions, one individual session, and one visit to a community-based organization resource. Each session has specific goals on HIV/AIDS, STDs, pregnancy prevention, coping and negotiation skills, personalized risk behaviors and reducing drug and alcohol use.

### Street Smart Core Elements

- Enhancing affective and cognitive awareness, expression, and control
- Teaching HIV/AIDS risk hierarchy and its personal application
- Identifying personal triggers, using peer support and small group skills-building sessions
- Building participant’s skills in problem solving, personal assertiveness, and HIV/AIDS harm reduction

Group members participate in scripted and non-scripted role plays, activities, and video production. Similarly, GPTCHB is working directly with the Cheyenne River Sioux Tribe to implement multiple cohorts of the group level intervention with AI youth who live on the reservation. Implementation will take place during the spring and summer of 2013. We are currently recruiting and training tribal members as intervention facilitators. Initial marketing for the intervention on the reservation has been very promising and we are expecting to surpass our recruitment goal of 71 youth and adults.

<b>Type/Level of Intervention</b>	Behavioral, group-level intervention.
<b>Adapted?</b>	Yes – For AI/AN youth and adults
<b>Evaluated with AI/AN?</b>	RCT with 71 AI/AN youth in 2014.
<b>Other Notes</b>	Evaluation findings will be available in 2014.

**Adaptation Process:** The adaptation process began with training in 2012 on the intervention as it was created. The project team and advisory board members then met to discuss areas of needed adaptation. Then multiple focus groups were held during 2013 on the reservation with tribal members (youth and adults) to discuss HIV attitudes, etc. in order to gauge additional areas of need and see if prevalent

behavioral determinants lined up with what the intervention was seeking to accomplish/change. The research team and advisory board members then met for a week during the summer of 2013 to review focus group data, re-review materials, and began re-writing sections of the curriculum to reflect the reality of being a Cheyenne River youth and adults on the reservation. Cultural elements were also included (like the 12 Lakota values) and are being woven into the intervention.

**Evaluation Methods and Findings:** We are planning on evaluating this research effort. Evaluation efforts to date have been formative in nature. We will be utilizing and outcomes-based evaluation framework – with no comparison group – with established measures. Evaluation will take place in 2014. Participants will be recruited from Cheyenne River Sioux Tribe consisting of approximately 71 AI/AN youth who have agreed to participate in the study.

**Great Plains Tribal Chairmen’s Health Board:** Established in 1986, the (GPTCHB) is an organization representing the 18 tribal communities in the four-state region of South Dakota, North Dakota, Nebraska and Iowa.

Through public health practices and the formation of tribal partnerships, we work to improve the health of the American Indian peoples we serve by providing public health support and health care advocacy.

Serving as a liaison between the Great Plains Tribes and the various Health and Human Services divisions including the Great Plains Area Indian Health Service, GPTCHB works to reduce public health disparities and improve the health and wellness of the American Indian peoples who are members of the 18 Great Plains tribal nations and communities.

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### **Great Plains Tribal Chairman Health Board**

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**Funding:** Rez Smart is supported by the NARCH and Indian Health Services.

## Circle of Life (COL)

**Intervention:** *Circle of Life* is a theory-based sexual risk reduction intervention for middle-school-aged American Indian/Alaska Native (AI/AN) youth. It teaches about making healthy decisions including preventing diseases like HIV/AIDS and preventing pregnancy. The original curriculum, known as *Circle of Life* (COL) was developed in the 1990's with extensive input from AI/AN educators, health providers, and community members. This classroom-based curriculum is grounded in AI/AN beliefs, symbols and concepts. In 2010, the Office of Minority Health, in partnership with Indian Health Services (IHS) and the Centers for American Indian and Alaska Native Health at the University of Colorado, updated, expanded and converted COL to a multimedia format (mCOL) specifically for young adolescents, 10-to-12-year-old AI/AN youth. mCOL teaches skills such as goal setting, decision making, and standing up to peer pressure. Prevention topics include how diseases are spread, health effects of HIV, AIDS, hepatitis and other sexually transmitted infections, and pregnancy prevention.

<b>Type/Level of Intervention</b>	Behavioral - The Medicine Wheel is the underlying theoretical model for the curriculum along with concepts from Social Cognitive Theory, Theory of Reasoned Action, and the Theory of Planned Behavior.
<b>Adapted?</b>	No. Already culturally-relevant.
<b>Evaluated with AI/AN?</b>	<p><b>COL</b> was evaluated in a cluster-randomized controlled trial where it was found effective in delaying the onset of sexual activity among young AI adolescents (11-13 years). (Kaufman, Whitesell, et al., 2014)</p> <p><b>mCOL</b> was evaluated in a group randomized trial with AI youth (10-12 yr old) and shown to be effective in respect to precursors to sexual behavior. For a description of the project, see Kaufman, Black, et al., 2014. (Findings are unpublished at this time).</p>
<b>To Access</b>	Access mCOL and accompanies training materials at: <a href="http://www.healthynativeyouth.org/curricula/multimedia-circle-of-life-mcol">http://www.healthynativeyouth.org/curricula/multimedia-circle-of-life-mcol</a>

**Implementation:** COL for middle school youth is divided into 5 modules, each with several units of activities and discussion. In total, the course is designed for about 30 hours of classroom instruction, ideally administered twice a week over a term. The curriculum also contains information on communicating with parents, involving the community, and integrating local resources into instruction. Materials required are low-tech, inexpensive, and readily available in most communities.

mCOL contains 7 chapters (about 20 minutes each) that use stories, narration, games, and videos to deliver sexual health information. Youth go through each online chapter independently. Optimally, each online chapter is supplemented by a 60 minute group lesson with games, discussion questions and hands on activities (lesson plans provided).

**Evaluation Methods and Findings:** COL was evaluated in a cluster-randomized controlled trial where it was found effective in delaying the onset of sexual activity among young AI adolescents (11-13 years) (Kaufman, Whitesell, et al., 2014).

mCOL was evaluated in a group randomized trial with 10- to 12-year-olds enrolled in Native Boys and Girls Clubs in the Northern Plains. Since sexual behavior is rare among this age group, the project was designed to assess change in precursors to sex. Compared to youth in the control group, youth who received mCOL scored significantly higher on HIV/STI knowledge questions at post-test and 9-month follow-up; self-efficacy to avoid peer pressure and resist sex were significantly higher at post-test; and self-perceived volition was significantly higher at 9-month follow-up. These modest effects on precursors to sexual behavior may lead to less risky sexual behavior in later years. A process evaluation found that mCOL was feasible to deliver and well-liked by youth and staff (published findings forthcoming).

### **Center for American Indians and Alaskan Natives Health University of Denver**

**Colorado:** The mission for the Centers for American Indian and Alaska Native Health (CAIANH) is to promote the health and well-being of American Indians and Alaska Natives, of all ages, by pursuing research, training, continuing education, technical assistance, and information dissemination within a biopsychosocial framework that recognizes the unique cultural contexts of this special population.

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**Funding:** The Circle of Life project is supported by the Indian Health Service, Centers of Disease Control, DASH, and the Bureau of Indian Affairs.

### **Publications:**

Kaufman CE, Litchfield A, Schupman E, Mitchell CM. Circle of Life HIV/AIDS-prevention Intervention for American Indian and Alaska Native Youth. *American Indian and Alaska Native Mental Health Research* 2012; 19(1): 140-153.

<http://files.eric.ed.gov/fulltext/EJ970452.pdf>

Kaufman, C.E., Whitesell, N.R., Keane, E.M., et al. Effectiveness of Circle of Life, an HIV-preventive intervention for American Indian middle-school youth: A group-randomized trial in a Northern Plains tribe. *American Journal of Public Health*. 2014; 104(6):e106-e112.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4062020>

Kaufman CE, Black K, Keane EM, et al. Planning for a group-randomized trial with American Indian youth. *Journal of Adolescent Health*. 2014; 54(3 Suppl): S59-S63.

<http://www.ncbi.nlm.nih.gov/pubmed/24560078>

## Cognitive Processing Therapy

**Intervention:** *Cognitive Processing Therapy* (CPT) is an evidence-based intervention to address trauma related symptoms for post-traumatic stress disorder (PTSD), substance use and HIV/STI sexual risk behavior:

<http://www.thecommunityguide.org/violence/EffectivenessInterventionsReducePsychologicalHarmTraumaticEventsAmongChildrenAdolescentsSystematicReview.pdf>

CPT counseling includes 13 sessions with a counselor. Study assessment is at baseline, post intervention and 6 week follow-up.

The team carried out a 3-year project to culturally adapt and pilot the intervention with 56 American Indian (AI) women in a resource-limited rural area. Additionally, the team evaluated the feasibility, acceptability and treatment fidelity of delivering CPT via community health workers.

<b>Type/Level of Intervention</b>	Behavioral - Group-level, single-session counseling intervention.
<b>Adapted?</b>	Yes – 56 AI Women
<b>Evaluated with AI/AN?</b>	Yes. The study is in the final phase of recruitment and will end 7/31/2016. A six month follow-up is conducted, thus the study will close 12/31/2016. Finding will be available no later than 9/30/2017.
<b>Other Notes</b>	Trained local staff to deliver the intervention

**Adaptation Process:** The CPT manual was adapted over the course of one year. The team worked with a Yakama Nation (YN) community committee of 15 women, YN community leaders, and the YN Behavioral Health, Comprehensive Alcohol program, and Domestic violence program. We will continue to revise the manual as appropriate throughout the pilot phase of this study.

The process used to adapt the manual involved: forming a systematic review development team; developing a conceptual approach to organizing, grouping, and selecting interventions to evaluate; searching for and retrieving evidence; assessing the quality of and abstracting information from each study; assessing the quality of and drawing conclusions about the body of evidence of effectiveness; and translating the evidence of effectiveness into recommendations.

**Evaluation Methods and Findings:** We are conducting a randomized controlled trial with a 6 week follow-up of 56 American or Alaska Native women residing in or around the Yakama Nation. CPT counseling includes 13 sessions with a counselor. Study assessments took place at baseline, post intervention, and 6 week follow-up.

**Indigenous Wellness Research Institute National Center of Excellence University of Washington:** The Indigenous Wellness Research Institute—a National Institutes of Health designated Center of Excellence – collaborates with indigenous people in three areas: research, tribal capacity building and knowledge sharing. The Institute brings together community, tribal, academic and government resources, increasing its capacity to develop innovative, culture-centered and interdisciplinary social and behavioral research and education.

By developing partnerships with tribal organizations, the Institute ensures that research is responsive to the needs of regional indigenous communities. These relationships help build tribal research capacity and technology and create pipeline initiatives to encourage Indigenous youth to develop science and research skills in health disparities. The Institute is home to two research centers: one focused on indigenous health, and the other on indigenous child welfare and family wellness.

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**Funding:** NIDA

# Native VOICES

**Intervention:** *Video Opportunities for Innovative Condom Education and Safer Sex (VOICES)* is recognized by the CDC as an evidence-based, behavioral intervention to prevent HIV and STDs ([www.effectiveinterventions.org](http://www.effectiveinterventions.org)).

The original intervention includes two culturally-specific videos for African American and Latino men and women who visit STD clinics. Skills in condom use and negotiation are modeled in the videos then role-played and practiced by participants. At the end of the 45-minute session, participants are given self-selected condoms. Similarly, *Safe in the City* is a 23-minute HIV/STD looping video for STD clinic waiting rooms. *Safe in the City* requires no counseling or small-group facilitation. Both videos can be easily integrated into clinic flow, fit prevention education into a standard clinic visit or brief encounter, and do not require participants to return for multiple sessions.

During evaluations participants demonstrated: 1) increased knowledge about the transmission of HIV/STD; 2) a more realistic assessment of their personal risk; 3) greater likelihood of getting condoms and intending to use them regularly; and 4) fewer repeat STD infections. A cost-effectiveness study in 2001 determined that these results warrant continued use of the intervention, given its efficiency and minimal cost.

<b>Type/Level of Intervention</b>	Behavioral - Group-level, single-session video-based intervention.
<b>Adapted?</b>	Yes – For AI/AN teens and young adults (15-24 years old) using a 2-year formative research process.
<b>Evaluated with AI/AN?</b>	Yes – National RCT with 900 AI/AN youth completed in 2014.
<b>To Access</b>	The Video and User’s Guide are Available at: <a href="http://www.healthynativeyouth.org/curricula/native-voices">http://www.healthynativeyouth.org/curricula/native-voices</a>

**Adaptation Process:** To maximize the cultural appropriateness of the Native VOICES video, Northwest Portland Area Indian Health Board staff and project partners conducted 8 focus groups with NW Native youth, 10 interviews with clinical staff and staff at youth-serving organizations, and 13 interviews with youth who identified as LGBTQ/TS (lesbian, gay, bisexual, transgendered, or queer, or two spirit) using community-based participatory research strategies.

**Evaluation Methods and Findings:** In 2014, the NPAIHB partnered with nine tribes across the U.S. to evaluate the effectiveness of the Native VOICES intervention. The sites included schools, youth centers, and tribal centers in Oregon, Minnesota, California, Mississippi, Montana, Arizona, Idaho, and Washington.

**The sites were randomized into one of three study arms:**

- Arm 1. Fact sheets alone (standard of care)
- Arm 2. Fact sheets plus the Native VOICES video (intervention)
- Arm 3. Fact sheets plus the Native VOICES video plus a facilitated discussion (intervention+)

Together, the sites recruited and consented nearly 800 AI/AN youth 15-24 years old to participate in the study. Youth who watched the video (n=443 respondents) expressed high levels of satisfaction with the Native VOICES intervention. Over 90% felt the video was culturally appropriate for AI/AN people. Over 75% found it to be entertaining or highly entertaining. And 86% felt the characters, scenes, and situations in the video were realistic. After watching the video, 78% of participants indicated that they were more likely to use condoms, 61% felt more likely to use dental dams, and 82% felt more likely to get tested for STDs/HIV. Statistically significant improvements in sexual health knowledge, attitude, intention, and self-efficacy occurred across all three study arms, many of which were retained 6 months later.

**Northwest Portland Area Indian Health Board:** The Northwest Portland Area Indian Health Board (NPAIHB) is a non-profit tribal advisory organization that serves the forty-three federally recognized tribes of Oregon, Washington, and Idaho. Each member tribe appoints a Delegate via tribal resolution, and meets quarterly to direct and oversee all activities of the NPAIHB.

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The *Northwest Tribal EpiCenter* is one of ten national Centers charged with collecting tribal health status data, evaluating data monitoring and delivery systems, and assisting tribes in identifying local priorities for healthcare delivery and health education. Since 1997, the *EpiCenter* has administered a number of successful health research and surveillance projects serving the Northwest Tribes.

**Funding:** Indian Health Service, Native American Research Centers for Health (NARCH) program.

# Positive Wellness

**Intervention:** Positive Wellness also known as (ARTAS) is recognized by the CDC as an evidence-based, Social Cognitive Theory intervention linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result ([www.effectiveinterventions.org](http://www.effectiveinterventions.org)).

The original intervention includes Anti-Retroviral Treatment and Access to Services (ARTAS) is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC).

<b>Type/Level of Intervention</b>	Behavioral , Single level intervention , Patient Navigation, Structural Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology.
<b>Adapted?</b>	Yes – For AI/AN with HIV/ADIS Within the first 6-12 months of diagnosis.
<b>Evaluated with AI/AN?</b>	No
<b>Implemented with AI/AN</b>	In progress
<b>Other Notes</b>	The project will begin April 2014.

**Adaptation Process:** NNAAPC adapted ARTAS 2012-2013. Adaptation began with two staff members going through the full training of facilitators training as it was originally created. Then a materials review and team meetings identified additional areas of potential adaptation. It is deemed that the original intervention was not culturally centered enough, nor were the materials complete enough to allow for uniform and easy implementation at the community level (among providers with little HIV experience or background). NNAAPC team rewrote the entire curriculum – facilitators guide and participant materials). NNAAPC then created a one day walk through for providers.

**Evaluation Methods and Findings:** NNAAPC did train providers in 4 different reservation-based communities on the intervention in hopes that they would implement it. NNAAPC has submitted an NIH grant to try to evaluate the feasibility of implementing Positive Wellness in urban Native and reservation communities. Should funded be received, the project will begin April, 2014.

The implementation has NNAAPC only evaluated the trainings that we provided to providers during 2013. As we have not implemented the intervention to date, there has been no evaluation

**The National Native American AIDS Prevention Center:** NNAAPC serve Native communities to plan, develop and manage HIV/AIDS prevention, intervention, care and treatment programs. Indigenous communities free of HIV where health, wellness and balance are celebrated and helps organizations that eliminate HIV/AIDS and confront related health and social determinants that negatively impact American Indian, Alaska Native, Native Hawaiian and Indigenous peoples . NNAAPC seeks to achieve its mission and vision through: advocacy and policy development, culturally appropriate research, creating culturally specific educational materials and training opportunities, technical and capacity building assistance and networking and resource exploration.

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**Funding:** The Positive Wellness project is supported by the Indian Health Service, and through the National Indian Health Board.

# Becoming a Responsible Teen (BART)

**Intervention:** Becoming a Responsible Teen (BART) is recognized by the CDC as an evidence-based behavioral intervention to increase information and skills to make sound choices, Increase abstinence and eliminate or reduce sex risk behaviors. <http://www.cdc.gov/hiv/prevention/research/compendium/rr/bart.html>

The original intervention includes a group-level, education and behavior skills training intervention designed to reduce risky sexual behaviors and improve safer sex skills among African American adolescents. The 8 intervention sessions, delivered to groups of 5-15 youth, provide information on HIV and related risk behaviors and the importance of abstinence and risk reduction. The sessions were designed to help participants clarify their own values and teach technical, social, and cognitive skills. Through discussions, games, videos, presentations, demonstrations, role plays, and practice, adolescents learn problem solving, decision-making, communication, condom negotiation, behavioral self-management, and condom use skills. The participants also have a discussion with local, HIV-positive youth to promote risk recognition and improve their perception of vulnerability. In addition, the intervention encourages participants to share the information they learn with their friends and family and to provide support for their peers to reduce risky behaviors.

The following components were added for AIAN community: Added 3 Adult Preparations, names and scenarios revised to reflect AIAN culture; AIAN talking circle, AI/AN digital stories, updated videos replaced original African American video, and discussion questions.

During evaluations participants demonstrated: Local evaluation findings indicated positive changes specific to knowledge.

<b>Type/Level of Intervention</b>	Behavioral - Group-level based intervention , Information Motivation Behavior (IMB) Model, and Social Learning Theory
<b>Adapted?</b>	Yes – For AI/AN teens and young adults mean (15-years old)2012
<b>Evaluated with AI/AN?</b>	Ongoing – National RCT with 100 AI/AN youth 2012-2013
<b>Other Notes</b>	September of 2014 national performance measures will be collected.

**Adaptation Process:** The adaptation process took place in 2012, CRIHB staff worked with an AIAN Consultant (Barbara Aragon) to develop an AI/AN framework to augment the original BART curriculum at 7 sites. The following components were added:

- Added 3 Adult Preparation Subjects (APS): adolescent development, healthy life skills and parent-child communication and 1 birth control option/STI prevention session for a total of a 12 session curriculum
- Names and scenarios revised to reflect AIAN culture throughout curriculum
- AIAN talking circle added following each session to provide an opportunity for reflections/questions
- AIAN digital stories and updated videos replaced original African American video
- Discussion questions developed to accompany video components
- AIAN quotes to close the session and transition to talking circle

**Evaluation Methods and Findings:** Local evaluation (pre/post surveys) were collected during 2012-2013 (Year 1 of implementation), findings indicated positive changes specific to knowledge. Additionally, national performance measures will be collected at our seven sites beginning in November 2013 (entry surveys) and September 2014 (exit surveys). Our seven sub-contracting sites have implemented the American Indian Adaptation of Becoming a Responsible Teen (BART) curriculum with nearly 100 AIAN youth in California in the past year; site instructors indicate that the project is useful and well-received by youth participants. Overall the project has proven to be worthwhile and effective with youth. 1 more year of the study is being conducted.

**California Rural Indian Health Board:** The California Rural Indian Health Board, Inc., (CRIHB) was formed in 1969 to enable the provision of health care to member Tribes in California. It is devoted to the needs and interests of the Indians of rural California and is a network of Tribal Health Programs which are controlled and sanctioned by Indian people and their Tribal Governments.

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**Funding:** The Becoming a Responsible Teen (BART) project is funded by the Administration for Children and Families.

# Be Proud! Be Responsible! - Adaptation

**Intervention:** *Be Proud! Be Responsible!* is recognized by the CDC an Evidence Based intervention as a promising practice, behavioral intervention to prevent risky sexual behaviors that put adolescents at risk of HIV and STDs  
<http://www.cdc.gov/hiv/prevention/research/compendium/rr/beproud.html>

The original intervention, "*Be Proud! Be Responsible!*" is a small group skills building and motivational intervention to increase knowledge of AIDS and sexually transmitted diseases (STDs) and to reduce positive attitudes and intentions toward risky sexual behaviors among African-American male adolescents. The intervention consists of one 5-hour session delivered to groups of 5-6 males. The intervention includes facts about HIV/AIDS and risks associated with intravenous drug use and sex behaviors; clarifies myths about HIV; and helps adolescents realize their vulnerability to AIDS and STDs. Videos, games, exercises, and other culturally and developmentally appropriate materials are used to reinforce learning and build a sense of pride and responsibility in reducing HIV risk. Adolescents also engage in role-playing situations to practice implementing abstinence and other safer sex practices, including practicing condom use skills.

Each module incorporates a theme that encourages the participants to be proud of themselves and their community, to behave responsibly for the sake of themselves and their community, and to consider their goals for the future and how unhealthy behavior might impede those goals. The curriculum involves group discussions, videos, games, brainstorming, experiential exercises, and skill-building activities. Participants in the program work in groups of six to eight and are led by a trained facilitator" (Promising Practices Network, 2013).  
<http://www.promisingpractices.net/program.asp?programid=30>

<b>Type/Level of Intervention</b>	Behavioral: based on Social Cognitive Theory ,Theory of Reasoned Action, and Theory of Planned Behavior
<b>Adapted?</b>	Yes – For 115 AI/AN teens 12 to 20 years old
<b>Evaluated with AI /AN?</b>	We are part of a national evaluation being conducted by the Office on Women’s Health.
<b>Implemented with AI /AN</b>	Ongoing and continually adding additional modules for 7 years.

**Adaptation Process:** The adapted curriculum has been implemented at Riverside Indian School for the past seven years. 115 American Indian/Alaska Native (AI/AN) adolescent girls ages 12-20 years who participated in Believing In Native Girls (BLING), Updated and added modules included in 2010, 115 participants completed baseline surveys to identify risk and protective factors. Initial findings are discussed regarding a variety of topics, including demographics and general characteristics, academic engagement, home neighborhood characteristics and safety, experience with and perceptions of gang involvement, problem-solving skills, self-esteem, and depression, sexual experiences and risk-taking behaviors, substance abuse, and dating violence.

115 American Indian/Alaska Native (AI/AN) adolescent girls ages 12-20 years who participated in Believing In Native Girls (BLING), a juvenile delinquency and HIV intervention at an AI/AN residential boarding school.

**Background:** In response to the high levels of HIV and juvenile delinquency among young girls, in 2008-2009 the Office on Women's Health (OWH) initiated a competitive call for proposals for the HIV/AIDS Prevention Education Services for Female Youth at Greater Risk for Juvenile Delinquency Project. Each site provided evidence-based programming across multiple sessions; however, specific program curricula varied, based upon the cultural needs of the respective minority groups.

**Riverside Indian School:** Riverside Indian School is a boarding school for nearly 800 Native American students. The school provides a learning atmosphere for Native American student. The Riverside campus covers more than 135 acres and is located in the Anadarko Basin of southwestern Oklahoma. The social life at Riverside is more than just classroom; students enjoy outdoor basketball, skating, movies, and weekend picnics among the local parks.

The school's mission is to create and maintain a safe, positive learning environment to ensure the holistic development of each student and staff member through cultural, spiritual, physical, technological, and academic experiences.

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**Funding:** The Be Proud! Be Responsible! Project is supported by the Indian Health Services and Office of Women's Health.

## *¡Cuidate!*

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**Intervention:** *¡Cuidate!* A Culturally Based HIV Sexual Risk Reduction Intervention for Youth is recognized by the CDC as an evidence-based, behavioral intervention to prevent HIV and STDs.

<http://www.cdc.gov/hiv/prevention/research/rep/packages/cuidate.html>

The original intervention theme of this culturally-based program designed to reduce HIV sexual risk among Latino youth. The *¡Cuidate!* program incorporates cultural beliefs that are common among Latino subgroups and associated with sexual risk behavior. The goals of *¡Cuidate!* are to: 1) influence attitudes, behavioral and normative beliefs, and self-efficacy regarding HIV risk-reduction behaviors, specifically abstinence and correct condom use, by incorporating the theme of *¡Cuidate!*—taking care of oneself and one’s partner, family and community; 2) highlight cultural values that support safer sex practices, and reframe cultural values that are perceived as barriers to safer sex; and 3) emphasize how cultural values influence attitudes and beliefs in ways that affect HIV risk-associated sexual behavior.

The program consists of six 1-hour modules delivered over the course of at least 2 days to groups of 6 to 10 youth. HIV/AIDS knowledge (i.e., transmission and prevention), condom negotiation, refusal of sex, and correct condom use skills are taught to participants through the use of interactive games, group discussion, role-plays, video, music, and mini-lectures. The program was originally tested in schools and delivered by trained adult facilitators, but it can be delivered in a variety of settings (e.g., community centers, agency field offices, schools) by a variety of agency employees (e.g., health educator, counselor, health care provider).

The *¡Cuidate!* program tested among youth were less likely to report sexual intercourse, multiple partners, days of unprotected sexual intercourse, and more likely to report using condoms consistently. All effects continued 12 months after the program ended, although the majority of youth were sexually inactive, youth in the *¡Cuidate!* program reported greater intentions to use condoms and contraceptives than youth in a health-promotion program.

<b>Type/Level of Intervention</b>	Behavioral - Group-level, two day module-session intervention <i>on Social Cognitive Theory, Theory of Reasoned Action and Theory of Planned Behavior.</i>
<b>Adapted?</b>	Yes – For AI/AN teens and young adults (13-18 years old)
<b>Implemented with AI/AN</b>	Yes- 3 Native American community sites were used

**Adaptation Process:** To maximize the cultural appropriateness of ¡Cuidate! used 15 students at each site. The students who participated in the pilot as well the community advisory panel for each site also participated in focus groups to make recommendations for the curriculum. Each site developed their own logo, named the curriculum, cultural values, and created five minuet prevention video that is embedded into the program. One site had a person create two songs that all sites are using. Additional material has also been included to address sexuality, sexual orientation, gender identity, and several other types of barrier methods including FC2-the female condom and dental dams.

**Evaluation Methods and Findings:** The ¡Cuidate! adapted intervention has been evaluated with approximately 45 teens and young adults (13-18 years old) living in the U.S. Participants were be recruited from 3 tribal and urban sites (including: tribes, tribal high schools and, and Native youth-serving programs) who have agreed to participate in the study.

**About the Albuquerque Area Indian Health Board:** AAIHB is a nonprofit organization, 100 percent Indian-owned and operated, serving tribal communities in New Mexico and southern Colorado. We provide specialized health services including clinical Audiology and HIV/AIDS prevention education, as well as advocacy, training, innovative capacity building programs and technical assistance. *The Albuquerque Area Indian Health Board, Inc. advocates on behalf of American Indians through the delivery of quality health care services, which honor spiritual and cultural values*

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**Funding:** ¡Cuidate! Is funded by the Indian Health Services, and the NARCH program

# Draw the Line Respect the Line

**Intervention:** *Draw the Line/Respect the Line* is a 3-year evidence-based curriculum that promotes abstinence by providing students in grades 6, 7 and 8 with the knowledge and skills to prevent HIV, other STD and pregnancy. Using an interactive approach, the program shows students how to set personal limits and meet challenges to those limits. Lessons also include the importance of respecting others’ personal limits.

Great Plains Tribal Chairmen’s Health Board in partnership with three tribal communities in the Northern Plains have piloted and complete the second dose of the intervention, approximately nineteen hours with grades six, seventh, and eighth in the second school based programs in the spring of 2013. The DTL/RTL is embedded in PE or health classes. Facilitators trained to deliver the curriculum provide the instructions and record delivery of lessons in fidelity logs after each lesson. The school based programs had almost all students in each grade participate with only two to three abstaining. Retention and completion levels were also outstanding with low attrition rates.

The community-based program struggles with recruitment, retention and attrition. None of the participants completed the community-based program. The next dose of the intervention will be in the spring of 2014 including the pre and post measurement survey.

<b>Type/Level of Intervention</b>	<i>Draw the Line/Respect the Line</i> is based on several social psychological theories, particularly Social Inoculation Theory and Social Cognitive Theory.
<b>Adapted?</b>	Yes – For AI/AN 6-8 grade in two school based programs in the Spring 2013
<b>Evaluated with AI/AN?</b>	No-but is on the HHS list

**Adaptation Process:** Each site staff person was trained to identify changes that were acceptable by the creators of the DTL/RTL. The sites established Tribal Advisory Groups to review each lesson identifying and suggesting changes that would be appropriate for the community. The adaptations were put into the report and submitted to Cardea, Incorporated (who was retained by GPTCHB) to provide technical assistance in implementing the DTL/RTL with fidelity and to provide ongoing training, skill building and to conduct fidelity observation and facilitator feedback. All adaptations were acceptable with all the core elements remaining intact.

**Evaluation Methods and Findings:** GPTCHB is working with Sanford Research, an external evaluator. This spring will be the first year in which data from all three sites will be collected using the pre/post measures. A one page program result summary was created to disseminate to the tribal community, school administrators, and other tribal key stakeholders. The data belongs to each other the funders and the community.

Our seven sub-contracting sites have implemented the American Indian Adaptation of Becoming a Responsible Teen (BART) curriculum with nearly 100 AIAN youth in California in the past year; site instructors indicate that the project is useful and well-received by youth participants. Overall the project has proven to be worthwhile and effective with youth. 1 more year of the study is being conducted.

**Great Plains Tribal Health Board:** “So That the People May Live” or “Hecel Oyate Kin Nipi Kte”

Established in 1986, the Great Plains Tribal Chairmen’s Health Board (GPTCHB) is an organization representing the 18 tribal communities in the four-state region of South Dakota, North Dakota, Nebraska and Iowa.

Through public health practices and the formation of tribal partnerships, we work to improve the health of the American Indian peoples we serve by providing public health support and health care advocacy.

Serving as a liaison between the Great Plains Tribes and the various Health and Human Services divisions including the Great Plains Area Indian Health Service, GPTCHB works to reduce public health disparities and improve the health and wellness of the American Indian peoples who are members of the 18 Great Plains tribal nations and communities.

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## Safety Counts for Native Communities

**Intervention:** Safety Counts for Native Communities also known as (Safety Counts) is recognized by the CDC as an evidence-based, STDs Cognitive-Behavioral Intervention to Reduce HIV/Hepatitis Risks among Drug Users Who Are Not in Drug Treatment ([www.effectiveinterventions.org](http://www.effectiveinterventions.org)).

The original Safety Counts Safety Counts is an HIV prevention intervention for out-of-treatment active injection and non-injection drug users aimed at reducing both high-risk drug use and sexual behaviors. It is a behaviorally focused, seven-session intervention, which includes both structured and unstructured psycho-educational activities in group and individual settings.

*SAFETY COUNTS* allows clients to define their own risk reduction goals and provides supportive reinforcement for their risk reduction efforts. The specific objectives of the *SAFETY COUNTS* intervention are to:

- Introduce methods of reducing HIV and viral hepatitis risk to drug-using clients.
- Assist clients in receiving counseling and testing for HIV and hepatitis.
- Motivate and help clients to choose and commit to specific behavioral goals to reduce their risk of transmitting HIV and hepatitis.
- Assist clients in defining concrete steps toward achieving their personal risk reduction goals.
- Provide social support and problem solving in individual and group settings to assist.

NANAPC did not implement the intervention nor are there any plans to implement it. NNAAPC provided three trainings on the adapted intervention to different communities 2009-2010, but do not know how implementation went.

<b>Type/Level of Intervention</b>	Behavioral – Single -level, single-session based intervention
<b>Adapted?</b>	Yes– AI/AN persons living with and at high risk for HIV infection 2009-2010
<b>Evaluated with AI /AN?</b>	No
<b>Implemented with AI /AN</b>	No
<b>Other Notes</b>	There are no plans to evaluate or implement Safety Counts for Native Communities.

**Adaptation Process:** The intervention was adapted in 2008-2009. It started with an IDU advisory group of Native people who had experience and expertise working with Native IDU or was former IDU themselves. We reviewed materials and selected Street Smart for adaptation and then explored areas of needed adaptation. NNAAPC staff and one IDU advisory group member then received training on the original intervention as it was originally created. Internal reviews and re-writes were undertaken by NNAAPC staff and were completed in 2009. Prayer, affirmations, and cultural elements that embodied Native worldviews were added to the curriculum – while maintaining the original structure of group sessions, individual sessions and social functions.

**Evaluation Methods and Findings:** Intervention was adapted in 2008-2009. NNAAPC did not implement the intervention nor are there any plans to implement it. NNAAPC provided three trainings on the adapted intervention to different communities 2009-2010, but do not know how implementation went. The adaptation was for Reduce HIV/Hepatitis Risks among Drug Users Who Are Not in Drug Treatment off all ages within the Cheyenne River Sioux Tribe.

**About The National Native American AIDS Prevention Center:** NNAAPC serve Native communities to plan, develop and manage HIV/AIDS prevention, intervention, care and treatment programs. Indigenous communities free of HIV where health, wellness and balance are celebrated and helps organizations that eliminate HIV/AIDS and confront related health and social determinants that negatively impact American Indian, Alaska Native, Native Hawaiian and Indigenous peoples . NNAAPC seeks to achieve its mission and vision through: advocacy and policy development, culturally appropriate research, creating culturally specific educational materials and training opportunities, technical and capacity building assistance and networking and resource exploration.

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