

2018

# Assessing Condom Use among Navajo Men in the Southwest

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*Walden University*

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# Walden University

College of Health Sciences

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Terra Yabeny

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2017

Abstract

Assessing Condom Use among Navajo Men in the Southwest

by

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MPH, New Mexico State University, 2011

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Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Walden University

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## Abstract

The Navajo tribe reports extraordinarily high number of cases of sexually transmitted diseases (STDs), such as gonorrhea, chlamydia, and human immunodeficiency virus (HIV) among men who have sex with men (MSM) and heterosexual populations. The purpose of this qualitative study was to explore the cultural value of adil 'idli (self-respect) and how this cultural practice might influence health behaviors in sexual activity, condoms use, and acquiring of STDs among Navajo men. The Health Belief Model (HBM) was the theoretical foundation for providing a deeper understanding of the social, environmental, and cultural factors of condom use among Navajo men. Research questions focus on understanding whether condoms affected sexual activity, its protective role against STDs/HIV, and acceptability concerns pertaining to adil' idli (self-respect). A purposeful criterion-based sampling was used to select and interview 20 Navajo men ages 20 to 39 who lived in or near Shiprock, New Mexico and Gallup, New Mexico. I used a grounded approach and categorizing strategy to code and analyze the transcripts. Key findings revealed that the positive components of adil 'idli (self-respect) have influenced Navajo men to protect themselves by wearing condoms. Recommendations include identifying strategies to address condom errors and failures and to develop tactful approaches to promote correct condom use in order to decrease the rates of STDs and HIV among Navajo men. The positive social change implications include health professionals' use of findings to improve STD and condom use prevention behavior among Navajo men by integrating the cultural beliefs of adil 'idli (self-respect), specifically emphasizing the positive aspects of staying healthy in health messages.

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## Chapter 1: Introduction to the Study

### **Introduction**

The Navajo Nation in Arizona, New Mexico, and Utah is one of the 564 federally recognized Indian tribes. Although the Navajo tribe represents less than one percent of the American Indian population, in 2014, it reported more cases of STDs including chlamydia, gonorrhea, and HIV on the Navajo reservation than the Indian tribes in California, Oregon, and Oklahoma (Centers for Disease Control and Prevention [CDC] & Indian Health Service [IHS], 2014). At the end of 2011, CDC and IHS (2014) reported 1,344 cases of chlamydia and 165 cases of gonorrhea in Navajo adults aged 20-39 years. In 2011, the Navajo Area Indian Health Service reported that 39 Navajo adults aged 20-39 years have been diagnosed with HIV (Iralu, 2012). By the end of 2011, men who have sex with men (MSM) accounted for 41% of the new HIV cases on Navajo Nation (Iralu, 2012).

Generally, Navajo adults (ages 20 to 39 years old) experience higher rates of STDs than Navajo adolescents (ages 14 to 19 years) because of risky sexual behaviors such as unprotected sex, drug use, and having multiple sex partners (IHS, 2011). In addition, sexually active Navajo men show greater risk for STDs than women because men have limited STD/HIV screening and testing services. This difference for screening and testing is primarily because STD screening programs target women in IHS facilities (de Ravello, Shelby & Cheek, 2004). As a result, men are under-diagnosed for chlamydia and gonorrhea (IHS, 2014). It also appears that men do not seek or receive regular screening for sexual and reproductive health care, and have no STD screening

recommendations to support regularly screening in men (CDC & IHS, 2014). The high rates of STDs in Navajo adults illustrate unprotected sexual activity, inconsistent condom use, limited knowledge, unclear perception of risk, and a lack of awareness of HIV status (CDC & IHS, 2014; Taylor, Tulloch & de Ravello, 2010). In the absence of studies from the Navajo reservation, little is known about the prevalence of sexual-risk taking behaviors in Navajo men ages 20 to 39 years.

### **Background of the Problem**

Every year, the Indian Health Service spends over \$5 million dollars in treating sexually acquired STDs and HIV for all age groups among American Indians (IHS, 2011). The cost of treatment for an HIV infected individual is approximately \$25,000 dollars annually or \$600,000 dollars for lifetime treatment (CDC, 2013). In 2013, the Navajo Area health facilities provided treatment to 225 HIV/AIDS patients with 174 of the individuals being males and 50 being females (Iralu, 2014). Sexually transmitted disease infections can cause immediate and long-term complications for both men and women including infertility, cancer, chronic diseases, miscarriages, and ectopic pregnancy (Taylor et al., 2010). These figures for STD and HIV treatments emphasize the need for increased access to information about STDs, disease prevention methods, and research activities related to STD prevention and control in Navajo communities.

The CDC has long recommended condoms as one of the best tools for preventing the transmission of STDs, including HIV infection (CDC, 2009). In one recent study among American Indians in New York City, 73% of males reported no condom use during their last sexual intercourse (Simoni, Walters, Balsam & Meyers, 2006).

According to CDC and IHS (2014), sexual activity proves the main mode of STD and HIV transmission for adults in general. Several studies of American Indians and Alaskan Natives (AIAN) showed that adults engage in unprotected sexual behaviors and inconsistent condom use (Lapidus, Bertolli, McGowan & Sullivan, 2006; McIntosh & Eschiti, 2009; Simoni et al., 2006). Many studies suggests that sexually active adults who have multiple sex partners, use drugs or alcohol during sex, and have inconsistent condom use can increase their risk for STD and HIV infections (CDC & IHS, 2014; Nelson, Simoni, Pearson & Walters, 2011; Planned Parenthood Federation of America, 2011). Numerous studies of AIAN have sought to explain HIV risk behaviors among Gay and MSM populations (Nelson et al., 2011; Pearson, Walters, Simoni, Beltran et al., 2013; Simoni et al., 2006). The results of several studies show that AIAN MSM reported less overall drug use and fewer sex partners, but engaged in a significant amount of unprotected anal intercourse which placed them at risk for HIV. Few studies have explored cultural factors in relation to STD and HIV risk among heterosexual American Indian men. Furthermore, published reports on condom use behaviors regarding sexual activity among American Indian subgroups are scarce, though American Indians experience high levels of social and behavioral factors resulting in increased rates of STD and HIV (Lapidus et al., 2006; Nelson et al., 2011; Pearson et al., 2013).

The spread of chlamydia, gonorrhea, and HIV on tribal communities of the Navajo Nation demonstrate a significant threat to public health (Iralu, 2014). This study has added to a better understanding of cultural factors in relation to condom use, sexual-risk taking behaviors, and sexual activity among Navajo men. Additional research was

needed on sexual behaviors to spur greater efforts in STD/HIV prevention activities and control in tribal communities.

### **Problem Statement**

Since 1969, a number of syphilis and gonorrhea outbreaks occurred on the Navajo Nation, predominately among men who identify as gay or bisexual, MSM, and heterosexual populations. These outbreaks occurred in 1969, 1980, 1986, and the present years 2001-2013, which in turn led to the risk of contracting HIV as well as health disparities in reproductive cancers and infertility (Iralu, 2014). As a result of STD outbreaks, the numbers of HIV cases spiked over 400% from 1999 to 2013 among Navajo males (Iralu, 2014). In response to the epidemic, the Tribe's Division of Health took extraordinary steps to expand education programs and testing services in several venues such as tribal fairs, education settings, community gatherings, and correctional facilities. Additionally, the Navajo Division of Health developed a HIV/AIDS Code and Policy and the HIV testing policy and procedures to address HIV screening, the confidentiality of people living with HIV, and the stigma surrounding HIV status. Despite these efforts, Navajo Nation is still faced with rising infections, higher healthcare costs, and greater challenges in delivering culturally appropriate STD/HIV services.

### **Purpose of the Study**

The purpose of this qualitative study was to explore the cultural value of adil 'idli and how this cultural practice might influence health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. Although it is not clear whether adil 'idli (self-respect) is a major barrier to safer sex practices, it is clear that cultural taboos for

the most part prohibits the discussion of sex which enables sexual behaviors in such a way as to place Navajo's at high risk for STD/HIV transmission. This cultural practice also limits an individual's ability to speak openly about sex, sexuality, and contraceptive use. It was important to examine the relationship between cultural values and sexual behavior of Navajo men to help better inform prevention programming. To adequately serve Navajo men, STD and HIV organizations and health care facilities on Navajo Nation need to look beyond their demographic characteristics, such as age, gender, and income to understand these individuals, their perceptions, and experiences from their own perspective. For these reasons, it is important that education and prevention efforts fit the specific needs of the Navajo Indian tribe.

### **Research Questions**

1. What is the role of condoms in the Native culture among Navajo men?
2. What is the relationship between condom use, adil 'idli, and perceived susceptibility to STD/HIV among Navajo men?
3. What is the relationship between condom use, adil 'idli, and perceived severity of STD/HIV among Navajo men?
4. What is the relationship between the level of knowledge about STD/HIV and condom use among Navajo men?
5. What are reasons identified by Navajo men as barriers to condom use in sexual activity?

### **Theoretical and/or Conceptual Framework for the Study**

The Health Belief Model (HBM) is a theoretical framework that may lead to providing a deeper understanding of the social, environmental, and cultural factors on condom use in Navajo men. This model has been applied to a number of health behaviors such as condom use and the transmission of STDs. One study in Benin, West Africa, used the HBM to identify barriers to condom use among men and women aged 15 to 55 years old (Hounton, Carabin & Henderson, 2005). Another study in Nigeria used the HBM to predict self-reported condom use among the University students (Edem & Harvey, 1995). Since the HBM is used for understanding health behavior, it can be a good fit for condom use behaviors that focus on the sexual transmission of STDs and HIV. This model focuses on six major concepts which are: perceived susceptibility (e.g. a person perception of risk toward acquiring an illness); perceived severity (e.g. a person belief of how serious an illness is and its consequences); perceived benefits (e.g. a person belief that there is something that can be done to prevent the condition); perceived barriers (e.g. a person belief in the tangible costs of taking this action); cues to action (e.g. strategies to taking action); and self-efficacy (e.g. a person ability to take action). These six concepts are important in explaining the current, past, and intended use of condoms among Navajo men.

### **Nature of the Study**

The nature of this study was qualitative with a phenomenological approach. A qualitative research was ideal in exploring the way in which cultural values affect condom use behavior among Navajo males. As Creswell (2013) pointed out, qualitative research is appropriate for obtaining cultural specific information about the behaviors,



beliefs, emotions, values, and opinions of particular populations. In practice, it attempts to focus the investigation on the lived experiences of the subjects in order to understand their sexual behaviors, attitudes, and perceptions (Creswell, 2013). As Creswell (2013) noted, qualitative methods are effective in identifying intangible factors such as socioeconomic status, religion, social norms, religion, and ethnicity, which may not be readily apparent. An in-depth interview is particularly suited for obtaining data on the individual's perspectives, experiences, and personal history, especially when a sensitive topic is being explored such as condom use (Creswell, 2013). In addition, with qualitative methods, individuals have the opportunity to respond in greater detail and in their own words, rather than responding from fixed responses which quantitative methods do (Creswell, 2009). Generally, qualitative data are in forms of words, observations, or narrative data coming from a variety of sources. From this, data might be categorized or indexed for analysis. To do this, data was sorted into themes using abbreviated codes of letters, words or symbols for identifying patterns, themes, and attaching meaning to the data. Therefore, assessing the different themes and connections was important for interpreting the data.

### **Definitions**

*Adil 'idli-* a Navajo word meaning self-respect and value. It is a Navajo traditional teaching that can be used to describe individual concepts with which to frame sexuality (e.g., sexual self-esteem, sexual self-beliefs, and sexual self-efficacy).

*American Indian-* a person who is an enrolled member of a Native Indian tribe in all U.S. states except Alaska and Hawaii (Inter Tribal Council of Arizona, 2014).

*HIV*- a disease caused by a virus called human immunodeficiency virus (CDC, 2009).

*Indian Country*- tribal reservations located under the jurisdiction of the U.S. Government (Inter Tribal Council of Arizona, 2014).

*Indian Health Service (IHS)* - a federal funded agency of the U.S. Government that delivers health care services to American Indians as well as Alaska Natives (Inter Tribal Council of Arizona, 2014).

*Indian Reservation*- an area of land reserved for Native tribes to live on and use (Inter Tribal Council of Arizona, 2014).

*MSM*- men who have sex with men are male persons who have sexual intercourse with members of the same sex (CDC, 2009).

*Navajo*- a person that is a member of an American Indian tribe of New Mexico, Arizona, and Utah (Iralu, 2012).

*Navajo Nation*- an Indian reservation approximately 27,000 square miles that extends into the states of New Mexico, Arizona, and Utah (Iralu, 2012).

*Sexually Transmitted Diseases (STDs)* - a microorganism transmitted by sexual contact with an infected individual. Examples of some of the STDs are: HIV, hepatitis B, herpes, human papilloma virus, gonorrhea, chlamydia, and syphilis.

### **Assumptions**

An assumption within this study was that the willingness of Navajo men to participate might be difficult to obtain and the men might decline participation from the study.

Another assumption was that there would be enough participants to respond to the study

questions to legitimize the results. A third assumption was that the men would provide open and honest responses to all interview questions and are capable of understanding the questions in the In-depth interview. A final assumption was that my personal views and background experiences with STD/HIV would not influence data collection or analysis.

### **Scope and Delimitations**

The study focuses on the Navajo men's beliefs, behaviors, values, and emotions with condom use. This study did not cover the sexual activity or condom use behavior or STDs in Navajo women because men had the greatest risk for HIV and other STD infections. A further delimitation was that the results of the study might not be generalized to other Indian tribes due to data only representing the Navajo Indian tribe.

### **Limitations**

One of the limitations within this study was the location. The study was also limited to 20 Navajo men (ages 20 to 39 years) enrolled with the Navajo tribe and currently residing on the Navajo Nation. Another limitation of the study was the voluntary participation of Navajo men who might withdraw from the study at any time with no ramifications. Third, the interview response of participants was limited due to the recall of important information. Due to the qualitative design, the findings of the study are limited to Navajo men.

### **Significance**

The study will add to an existing body of literature that describes the Navajo men's cultural views on condom use, sexuality, and beliefs about causes of STDs. It is also hoped that this study will provide existing programs with evidence to advance

STD/HIV prevention for those in Indian Country. The research study may also serve as a beginning point for prevention activities at the tribal level. This study may be beneficial to the Navajo Nation as this study may enhance the knowledge of tribal members about the sexual behaviors that pose risk to health outcomes. Furthermore, the output of this study may also be beneficial to tribal leaders, tribal health care providers, and non-tribal public health professionals as this study may provide cultural information that may assist providers in the development of prevention messages, intervention materials, and support the development of policies around STD/HIV. To the future researchers, this study may provide baseline information on the sexual risk-taking behaviors among Navajo men. The study also contributes to the STD/HIV prevention literature, where the prevalence of sexual-risk taking behaviors among American Indians has remained under-explored. Nonetheless, studies on sexual behavior, safer sex practices, and drug use are core areas of research in the field of STD/HIV, to which this study may be significant and change the way STD/HIV services is delivered in Indian Country.

### **Summary**

Although rates of STD infections are relatively low in Navajo Nation, it nonetheless indicates that STDs are not uncommon on Navajo reservations. More importantly, the rates of STDs on the Navajo Nation also show that Navajo's are not far behind the rest of the nation when it comes to the transmission of STDs. As STD infections increase in Navajo Nation, the chances for new infections also increase among those who live in reservations. For Navajo Nation to have more cases of STDs and HIV only means there are more Navajo people requiring health services and more Navajo

people capable of spreading the disease. Since Navajo men appear less likely than women to seek care from any health care facility, there could be an undercount in their reported rates of STDs. The study has sought to uncover the views, beliefs, and experiences Navajo men had towards condom use and the transmission of STDs.

This chapter will be followed by a literature review in Chapter 2. Then, Chapter 3 will follow with a description of methodology, an explanation for sampling strategies, identifying the participants, procedures for recruitment, data collection, and the protection of human subjects.

## Chapter 2: Literature Review

### **Introduction**

The purpose of this qualitative study was to explore the cultural value of adil 'idli and how this cultural practice might influence health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. In the Navajo Nation, STDs and HIV cause a growing concern, especially in light of challenges to accessing testing services and care in tribal communities. For Navajos, STDs and HIV represent a serious threat because of cultural values and taboos, and the risk factors that can increase STD/HIV transmission. Currently, the main mode of transmission for STDs and HIV is unprotected sexual intercourse between heterosexual couples (CDC & IHS, 2014; Iralu, 2014). Current 2014 IHS statistics revealed chlamydia, gonorrhea, and HIV account for the top leading causes of health disparities in adults aged 20-39 years (Iralu, 2014). The rates of STDs and HIV among Navajos fall highest among Navajo men aged 20-39 years old, followed by Navajo men aged 15-20 years old (Iralu, 2014). For Navajo men, aged 20-39, engaging in unsafe sexual behavior place them at increased risk for contracting STDs and HIV (CDC & IHS, 2014; Iralu, 2012; Iralu 2014). To date, minimal attention has been dedicated to understanding the sexual risk taking behaviors among Navajo men. In order to increase our understanding of the impacts of STDs/HIV on American Indians, this study has provided a detailed picture of Navajos and their participation in sexual-risk taking behaviors. This chapter will discuss current literature pertinent to the study purpose.

### **Literature Search Strategy**

An academic literature search was performed using two databases: Medline and Cinahl Plus. These databases were searched using two search words “American Indians,” and “condoms” as the key search terms for the root of all inquiries. Along with these search words, other words including “STDs,” “HIV,” “risk factors,” and “sexual risks” were used to refine the search. This refinement was performed by selecting studies that aim to reduce sex-related risk behaviors or incidence rates of STDs or HIV. A relevant study meets the following criteria:

- Published within the past 10 years (e.g., January 1, 2004)
- Research with American Indian populations
- Conducted inside the U.S.
- STD/HIV prevention focus
- Not drug treatment only
- Not biomedical only (e.g. vaccine trials)

In addition to the search of academic literature, a review of the gray literature was performed using the internet to identify available reports that focused on American Indian populations and STDs. The primary aim of the gray literature search was to identify reports and other documents that are unpublished, such as local health department reports, academic theses, and dissertations generated by researchers and practitioners in the field. The organizations identified (listed below) with extensive experience in STD prevention and related fields, and contributing relevant unpublished literatures to the gray literature include:

- Agency for Health Care Research and Quality
- Centers for Disease Control and Prevention
- Indian Health Service
- Inter-Tribal Council of Arizona, Inc.
- National Coalition of STD Directors
- Navajo Nation Social Hygiene Program
- Northwest Portland Area Indian Health Board

The main topics searched were STDs and American Indian men, condom use and American Indian men, sexual risk behaviors and American Indian men, HIV and American Indian men, and sexual behavior. A total of 46 items from the academic and gray literature were reviewed, of which 36 are included in this study.

### **Background of Navajo Nation**

The Navajo Nation covers 27,425 square miles of reservation land extending into the states of New Mexico, Arizona, and Utah. These tribal lands regulate as sovereign nations with their own government, laws, and jurisdictions. The Navajo Nation is comprised of about 110 tribal communities or chapters and includes 12 health care centers in the region. On the Navajo Nation, tribal lands are geographically isolated in which people have to travel 20 miles and greater to reach town and health care facilities. Further, roads servicing Navajo communities are primarily dirt roads and not paved.

As of 2010, the United States Census Bureau reported that there are 173,667 Navajo citizens residing on tribal lands of the Navajo Nation. Of the 173,667 Navajo populations, 49.1 % were males and 50.9% were females (Rural Institute of Arizona,



n.d.). Based on the 2010 United States Census Bureau, children under 18 years of age accounted for one third (30%) of the Navajo tribal population; 18 to 64 years of age accounted for 57%; and 65 years of age and older accounted for 10%. Among the Navajo population, 32% of all households have income of less than \$15,000; 28% of all households have income between \$15,000 and \$35,000; and 13% have income between \$50,000 and \$75,000 (Rural Institute of Arizona, n.d.). Approximately 44% of Navajo children under the age of 18 live in poverty, compared with 34% of Navajo adults aged 18 to 64 (Rural Institute of Arizona, n.d.).

Since 1977, the Navajo tribe has operated the Navajo Area Indian Health Service (NAIHS) and the Navajo Division of Health (NDOH), located in Window Rock, Arizona. The NDOH was established in 1977 to provide an array of preventive health services in the areas of substance abuse, nutrition, geriatrics, diabetes, and STD/HIV. On the Navajo Nation, the NAIHS is primarily responsible for providing health care services to Navajos through six hospitals, seven health centers, and fifteen health stations delivering inpatient care, outpatient contract, and preventive health.

Generally, the Navajo people live in a matriarchal society in which descent and inheritance is determined through the mother. In this culture the women is head of the family and typically own the bulk of resources and property, such as livestock. In Navajo society, women usually handle the domestic decisions while the men take the political leadership roles. Navajo women are the only ones who traditionally raise the children and the children always remain in the mother's care. In Navajo tradition, the mother is

the most important person in society (Health and Social Services Committee of the Navajo Nation Council, 1994).

Traditional Navajo learning is surrounded by the strength of cultural values, practices, and taboos. There are several cultural values, such as hozhoii (unity and harmony), adil 'idli (self-respect), and adaa 'ati hat'ii (seeking holistic protection) that dictate Navajo people behavior towards relationships, safe sex practices, and seeking health care. These traditional cultural values are essential to learning about sexuality, chemical dependency, and disease prevention. Adil' idli, a strong sense of individual protection and individual limits, is considered an important Navajo cultural value. However, adil 'idli is the prominent cultural value incorporated in STD/HIV education and the Navajo Nation HIV/AIDS Policy (Health and Social Services Committee of the Navajo Nation Council, 1994).

### **Factors of STD/HIV**

According to the National Coalition of STD Directors (2007), individuals who are sexually active increase their risk for contracting an STD. However, STDs pose a serious risk to certain populations and communities. In particular, STD rates tend to be higher among populations of men who have sex with men (MSM), women, youth, inmates, and communities of color (CDC, 2009). The communities of color who experience higher rates of STDs than Whites are African Americans, American Indians/Alaska Natives, and Hispanics (CDC, 2009). Nationally, American Indians have the second highest rates of chlamydia and gonorrhea than the rate reported among Whites (CDC, 2014). In 2011, the chlamydia rate among American Indians was 648.3 cases per 100,000 than the rate

for Whites, which was 159.0 cases per 100,000 (CDC & IHS, 2014). The 2011 gonorrhea rate among American Indians was 115.7 cases per 100,000 than the rate for Whites, which was 25.2 cases per 100,000 (CDC & IHS, 2014). For American Indian communities, socioeconomic factors, such as poverty, cultural beliefs and practices, substance abuse, discrimination, and access to health care all impact the likelihood of STD/HIV transmission (CDC, 2009). Such factors among American Indians may cause challenges to STD prevention due to their influence on willingness to seek care, access to and treatment of care, and cultural values regarding sex and sexuality (Native Communities STD/HIV Prevention Guidelines Task Force, 2004). In order to provide a comprehensive knowledge of the effects of STDs this review will first examine the social, economic, and behavioral factors that contribute to the spread of STDs.

### **Poverty**

According to CDC (2009), STD and HIV rates accelerate for individuals living at or below the poverty line. Similarly, the California Department of Public Health (2008) reported that low socioeconomic status and poverty causes high rates of STDs. For example, the California Department of Public Health (2008) found that in Alameda County the rates of chlamydia and gonorrhea infections increased as the poverty level of neighborhood increased. The California Department of Public Health also reported that chlamydia and gonorrhea infection rates were high in neighborhoods of Alameda County where 30% of households lived in poverty compared to neighborhoods where less than 10% of households lived in poverty.

In a study conducted to examine HIV infection among heterosexuals in 24 metropolitan statistical areas, CDC (2011) found results suggesting an association between HIV and socioeconomic status. The study consisted of 14,837 heterosexuals aged 18-50 years from U.S. urban areas in the regions of Northeast, South, Midwest, West, and Territories with high poverty rates and high AIDS prevalence. The study found that HIV infection was 2.8% higher among 7,426 of participants with an annual household income below \$9,999 compared with 1.4% among 3,490 of participants with an annual household income of \$10,000 to \$19,999, and 1.1% among 3,024 of participants with an annual household income of \$20,000 to \$49,999 compared with .5% among 649 of participants with an annual household income above \$50,000. The results of this study demonstrate HIV infection were higher among heterosexuals with lower socioeconomic status.

Research suggests that certain racial/ethnic groups become affected by higher rates of poverty. According to the United Census Bureau (2013), American Indians and Alaska Natives had the highest national poverty rate of 27.0% compared with African Americans (25.8%), Asians (14.7%), Hispanics (16.2%), and Whites (11.5%). In a study conducted to examine the relationship between poverty, race/ethnicity, and gonorrhea infections, Springer, Samuel, and Bolan (2010) found results suggesting socioeconomic status can affect infection rate among racial/ethnic groups. In a case analysis of 98,355 cases of gonorrhea reported in California from 2004 to 2006, researchers compared both poverty status and race/ethnicity groups in California. The racial/ethnic group to have the highest gonorrhea rates at poverty levels of <10%, 10%-19.99%, 20%-29.99%, and

$\geq 30\%$  is African Americans. In comparing the ethnic/racial groups, African Americans showed the highest poverty category ( $\geq 30\%$ ) for gonorrhea infections at 832.2 per 100,000 persons compared to 136.7 per 100,000 persons for Whites, 96.4 per 100,000 persons for Hispanics, and 45.2 per 100,000 persons for Asians. African Americans also demonstrated the highest gonorrhea infection rates per 100,000 population, and by poverty category in the lowest poverty category ( $< 10\%$ ) at 268.1 per 100,000 persons compared to 59.0 per 100,000 persons for Hispanics, 30.09 per 100,000 persons for Whites, and 21.1 per 100,000 persons for Asians. This study suggests that rates of gonorrhea infections were positively related to ethnic/racial groups living below poverty. These findings also imply that socioeconomic status plays the greatest predictor for an individual health status.

This section examined the relation between poverty, socioeconomic status, and three sexually transmitted diseases that have health disparities in rates of chlamydia, gonorrhea, and HIV. Specifically, this study sought to definitively describe the poverty levels of racial/ethnic groups affected by high rates of STDs and HIV. The information gathered from the literature will be used to address the gap in understanding the sexual behavior in Navajo men.

### **Alcohol and Illicit Drug Use**

The CDC (2014) found that alcohol and drug use does not cause STD/HIV infections; however, it can impair an individual's judgment which can contribute to the transmission of STDs. Evidence suggests that individuals who abuse alcohol or use drugs are likely to engage in unprotected sex when they are intoxicated or high on drugs.

Similarly, the National Coalition of STD Directors (2007) reported that alcohol and drug use have led to an increase in impulsivity and sexual arousal which can contribute to a decline in condom use. As Rural STD/HIV Prevention Work Group (2009) point out, the cycle of poverty, unemployment, and lack of education can also contribute to alcoholism and injection drug use.

Several studies have shown that American Indians use alcohol and drugs at younger ages, in higher quantities, and at higher rates than all other racial/ethnic groups (CDC, 2014; Lapidus et al., 2006; Marsiglia, Nieri & Stiffman, 2006; Simoni et al., 2006). Results of the 2013 National Survey on Drug Use and Health reported that the rate of binge alcohol use was higher among American Indians and Alaska Natives aged 12 and older (23.5%) than among African Americans 12 and older (20.1%) and Asians 12 and older (12.4%). The term binge alcohol use is used to describe five or more drinks within a couple of hours in one day in the last 30 days (Substance Abuse and Mental Health Administration, 2014). Among persons aged 12 and older in 2013, the rate of heavy alcohol use among American Indians and Alaska Natives was 5.8%, as compared to 4.5% for African Americans and 4.8% for Hispanics (Substance Abuse and Mental Health Administration, 2014). Heavy alcohol use, on the other hand, is described as having five or more drinks on the same occasion within five or more days in the last 30 days (Substance Abuse and Mental Health Administration, 2014). The National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Administration in 2013 reports that binge alcohol use was higher among persons aged 21 to 25 year old (43.3%) than those 26 to 29 year old (40%), 30 to 34 year old (35%), and

35 to 39 year old (29%). Furthermore, findings in the report showed higher rates of heavy alcohol use among persons aged 21 to 25 years old (13%) than those aged 26 to 29 years old (11%), 30 to 34 years old (10%), and 35 to 39 year olds (7%).

In relation to STDs, injection drug use is reported a high risk factor for the transmission of HIV (Knittel, Wren & Gore, 2010). Evidence shows that injecting drugs and the sharing of drug injection equipment and needles is an efficient way to transmit HIV into the blood (Knittel et al., 2010; Substance Abuse and Mental Health Service Administration, 2009). According to the Substance Abuse and Mental Health Service Administration (2009), the rate of injection drug use was higher in American Indians and Alaska Natives aged 12 and older (24%) than among Whites aged 12 and older (18%), Hispanics aged 12 and older (18%), and African Americans aged 12 and older (14%). Findings in the report showed that in 2009 the rate of injection drug use was higher among 18 to 25 (28%) than those aged 26 to 34 (26%) and among those aged 35 to 49 (19%). Data from the IHS (2014) report identifies unsurprisingly, that the mode of exposure to HIV among Navajo's was male-to-male sexual contact (37%), heterosexual contact (39%), injection drug use (5%) and male-to-male sexual contact, and injection drug use (3%). In fact, findings from the 2007 Urban Indian Health Commission report identified that one-third of patient care contracts with Indian Health Service in 2006 were related to substance abuse disorders among Urban Indians. These findings suggest that alcohol and drug use contribute to American Indians vulnerability to the transmission of STDs and HIV.

This section reviewed literature regarding the impact of alcohol and drug use among individuals who abuse alcohol or use drugs. Specifically, the findings of alcohol and drug use among American Indians provide evidence that alcohol and drug use can directly affect an individual's sexual behavior by heightening sexual risk-taking behaviors including condom use and unprotected sex. The information gathered from these studies will be used to address the gap in understanding the barriers to condom use related to sexual activity among Navajo men.

### **Culture**

Among American Indian people, there is a wide range of beliefs about illness, health, and healing. According to Thind, Goldsby, Dulin-Keita, and Baskin (2015), cultural beliefs are thoughts, ideas, and attitudes common to individuals who belong to the same culture. These cultural beliefs may present a conflict between a person's view of health, illness, and health care delivery. For a Navajo person, a well-balanced Indian must have equal development in four cultural values of life, work, social/human relations, and respect/reverence for growth (Marrone, 2007). When illness happens in a Navajo Indian life, a Navajo will use herbs, medicine man (diagnostician), prayers, songs, and ceremonies to heal the ailment. The essence of Navajo ceremonies is for the restoration and maintenance of social, physical, and spiritual harmony (Marrone, 2007).

Research shows that cultural beliefs affect health-related behaviors in sexual practices, screening utilization, and treatment-seeking behaviors (Fernandez, McCurdy, Arvey, Tyson, Morales-Campos et al., 2009; Thind, Goldsby, Dulin-Keita, & Baskin, 2015; Zhao, Esposito & Wang, 2010). In particular, Fernandez, McCurdy, Arvey, Tyson,



and Morales-Campos (2009) explored the Hispanic cultural beliefs towards sexuality, gender, and disease to understand the barriers of safer sex practices among men and women. It was found that Hispanic men and women were reluctant to use condoms as an STD prevention strategy against human papillomavirus (HPV) because they believed that marriage is based on trust and fidelity (Fernandez et al., 2009). This is a relevant point, because it provides factual information that Hispanic cultural beliefs towards sexuality, gender, and disease played a role in delaying HPV screening and treatment. The findings of this study support the fact that cultural beliefs can influence health behaviors toward safe sex practices in ethnic and racial minorities.

The concept of sex and sexuality and the beliefs about why and how STDs/HIV develops have many different interpretations among American Indian people. Research conducted by McIntosh and Eschiti (2009) found that American Indians who live in Oklahoma tend to underestimate their risk for HIV infection and also tend to believe HIV is an urban problem as well as a gay white man's disease. Likewise, Gilley (2006) established that each American Indian tribe has its own cultural taboos that surround the discussion of sex which can make it difficult to discuss STDs/HIV. For example, in the Navajo tribe, the open discussion about HIV is a taboo subject, something that can lead to "wishing" it upon the tribe (Marrone, 2007). Therefore, Navajo Indians are cautious about discussing disease and death for fear that they will precipitate illness, and rarely talk about it. To illustrate the importance of cultural beliefs with health, a study completed with families of an autistic child found Navajo Indian families to believe that autism is a punishment from God (Pitten, 2008). The results of the study also found

Navajo Indian families to believe that autism is due to parental missteps from witchcraft, adultery, and the mother viewing a dead animal while pregnant. As a result, Navajo Indian families of an autistic child are hesitant to seek professional treatment. This study suggests that cultural beliefs play a major role in treatment and utilizing health care.

In a study conducted to examine the association of cultural beliefs with STDs, HIV/AIDS, and pregnancy among Alaskan Native youth, Leston, Jessen, and Simons (2012), found results consistent with previous studies. The study consisted of 105 Alaskan Native youth ages 15 to 24 years from five communities in Alaska who participated in 21 focus groups. The authors found Alaskan youth to believe that sex should not be discussed and is a taboo subject. Also, Alaskan youth felt that the open discussion of sex can lead to negative consequences such as illness. Additionally, the authors found that youth experienced embarrassment, especially for discussing sexual health issues with a parent or health provider, for condom use, and for STD/HIV testing. It was reported that the Internet was the main platform for youth to receive general information about sexual health. The results of Leston, Jessen, and Simons (2012) study demonstrate that youth have attitudes and beliefs regarding sexual health which can affect access to sexual health information.

In a study conducted to examine the cultural impact of shame on Cherokee Indians in Oklahoma, Gilley (2006), found similar results to previous research focusing on cultural beliefs. The author found Cherokee Indians to believe that the public discussion of sex, condoms, and STDs to be an act of shame. It has been documented that the use of shame among Cherokee Indians does teach individuals how to act in an

appropriate way and how to be a member of a community. The author also reported that the use of shame does work against the Cherokee tribe in combatting the transmission of HIV because of beliefs about sexuality drawing shame. The study suggests that long held cultural beliefs about public discussion about sexuality has affected individual's decision to use condoms. As a result, American Indians continue to have the second highest rates of chlamydia, gonorrhea, and syphilis, and the fourth highest rate of new HIV infections for all races/ethnicities (CDC, 2014).

The literature reviewed thus far demonstrates that cultural beliefs can directly affect an individual's sexual behavior by minimizing the use of condoms. One avenue to broadening our understanding of the impact of cultural beliefs among Navajo's is to explore the cultural value of *adil 'idli*. The information gathered from studies on cultural beliefs will be used to help with understanding the relationship between condom use, *adil 'idli*, and perceived susceptibility to STD/HIV among Navajo men. In the next section, studies will be highlighted to provide additional information on how unequal access to and quality of care affects American Indians health outcomes.

### **Unequal Access to and Quality of Care**

American Indians face several challenges in accessing health care services, including the lack of fiscal resources, transportation, and the remoteness of tribal communities (IHS, 2011). According to a report of the California Department of Public Health (2008), American Indians were reported to have far worse health outcomes than any other racial or ethnic group. Health disparities experienced by American Indians are heart disease, obesity, diabetes, suicide, and unintentional injuries (Cobb, Espey & King,

2014). In 2011, American Indians were shown to have the poorest access to health care than Whites in the amount, quality, and timing of medical services received (Agency for Healthcare Research and Quality, 2012). Evidence suggests that alcohol use, drug abuse, addiction, and mental health disorders can complicate healthcare-seeking behaviors among American Indians with STDs and HIV (CDC, 2013; IHS, 2011; National Coalition of STD Directors, 2007). For example, in a Navajo Area Indian Health Service report which revealed that alcohol abuse affects HIV care for clinic follow-up and treatment.

In relation to STDs, public health professionals report that racism affects the health status of American Indians by making it difficult to obtain treatment or access prevention services (National Coalition of STD Directors, 2007). Researchers acknowledge that, racism has an impact on society by putting some individuals and communities at an unfair disadvantage or at an unfair advantage (California Department of Public Health, 2008; Marrone, 2007). It was reported that personally mediated racism can affect an individual's STD outcome through the delivery of inadequate care or in differences received in healthcare from health providers (California Department of Public Health, 2008). The California Department of Public Health (2008) defined personally mediated racism as individuals having different assumptions about the abilities as well as intents of others according to their race.

Research also shows that bias from a healthcare provider can lead to mistrust of the U.S. health care system (California Department of Public Health, 2008; National Coalition of STD Directors, 2007; Rural STD/HIV Prevention Work Group, 2009). As a

result, the mistrust in the health care system may keep American Indians from accessing prevention services or receiving adequate medical care, which may lead to worse disease outcomes. It can also prevent the complete disclosure of risk factors for sexual behaviors and a person's quality of care (California Department of Public Health, 2008). In addition, racism on health has been shown to increase a person's susceptibility to STD infection and transmission of HIV through the effects of stress on the immune function (California Department of Public Health, 2008; National Coalition of STD Directors, 2007; Rural STD/HIV Prevention Work Group, 2009). Thus, racism can impact the rates of STDs as well as poor health outcomes and unequal health care.

This section reviewed and discussed current literature pertinent to the study purpose. The information is essential because it provides insight into the STD/HIV epidemic among American Indians. The information gathered from the literature review will be used to help broaden our knowledge to Navajo men susceptibility to STD infection and HIV transmission.

### **Condom Usage**

The Planned Parenthood Federation of America (2011) established that condoms deliver the best method of protection against the transmission of STDs and HIV in sexually active people. In fact, the CDC has long promoted condom usage as a public health strategy in preventing STDs and HIV (CDC, 2009). In addition, the U.S. Public Health Service included in its Healthy People 2000 and 2020 objectives to increase condom usage among sexually active women and men for promoting health and disease prevention. A number of federal agencies including the CDC, National Coalition of STD

Directors, and the Planned Parenthood Federation of America have recommended condom usage for sexually active individuals who have multiple sex partners, who take part in risky sexual behavior, and whose primary partner is infected.

In a study designed to examine the uptake of sexual and reproductive health service of men, Kalmuss and Tatum (2007), found results suggesting that condom use is inconsistent in men. The study consisted of 3,611 men aged 20 to 44 who self-reported having oral, anal, or vaginal sex with a woman in their lifetime. The authors reported that 51% of men were not using a condom at last sexual intercourse with partner in the last four weeks. It was also reported that 42.2% of men were not using condoms at last sexual intercourse with two or more partners in the last 12 months.

In a pilot study to examine the condom-use behaviors of African American men ages 18 to 24 years old, Kennedy, Nolen, Applewhite, Pan, Shamblen, and Vanderhoff (2007), found similar results to that of previously mentioned studies. The study consisted of 136 young adults ranging in age from 18 to 24 years who had self-reported unprotected sexual intercourse, inconsistent condom use, and multiple sex partners in the past three to six months. Kennedy and colleagues (2007) found that 45% of young men were not using condoms in the last 30 days of sexual intercourse. It was reported that 25% of young men were not using condoms most of the time in the last three months of sexual intercourse. What the authors also found was that 32% of the young men were not intending to use condoms consistently in the next six months of sexual intercourse. This study suggests that males are not motivationally ready to consistently use condoms.

Generally, sexually active adults are at risk for acquiring STDs and HIV infections because they often engage in sexual risk-taking behaviors for STDs. These risky behaviors include multiple sex partners, unprotected sex, having sex intoxicated or high on drugs, and trading sex for drugs (National Coalition of STD Directors, 2007). In a study conducted to examine HIV risk behaviors in American Indians and Alaskan Native (AIAN) men, Pearson, Walters, Simoni, Beltran, and Nelson (2013), found results suggesting that efforts to improve condom use among AIAN men are needed. The study consisted of 174 American Indian and Alaskan Native men from Washington, California, Colorado, Oklahoma, Minnesota, and New York where each man had experienced same-sex sexual behavior. The authors reported that 51% of AIAN men reported 100% condom use with a man in the last 12 months. Pearson and colleagues (2013) also found that AIAN men had four or more sexual partners in their lifetime.

In an early study conducted to examine risk behaviors of HIV among American Indian men in New York City, Simoni, Walters, Balsam, and Meyers (2006), found results consistent with previous studies. The authors reported that 86% of the 51 American Indian men reported not using a condom the last time they had vaginal sex. They found that 51% of American Indian men had two or more sexual partners in the last 30 days. It was also reported that 46% of American Indian men had unsafe sex while high or drunk. This study suggests that American Indian men are inconsistent and infrequent users of protection.

Similarly, in a recent survey from the 2011 Navajo High School Youth Risk Resiliency, 28% of 14,948 Navajo adolescents' aged 14 to 18 years old reported they had

sexual intercourse during the last three months. It was reported that 11% of Navajo adolescents had sexual intercourse with four or more partners during their life. The 2011 Navajo High School Youth Risk Resiliency Survey also found that 58% of Navajo adolescents used a condom during last sexual intercourse in the past three months. The data supports the fact that much more preventive measure and work is needed to increase condom use among Navajo adolescents which places Navajo's at more risk for STD and HIV transmission. Also, the study suggests that adolescents are not far behind than adults in needing attention in sexual health and how to make sexual responsible decisions about their sexual health.

### **STD/HIV Testing Behaviors**

According to Tulloch (2010), the lack of STD information and the fear of discussing sex with partners and healthcare providers can prevent people from foregoing testing for STD/HIV. Other individual barriers to STD/HIV testing include no perceived risk of STD/HIV, no benefit of knowing STD/HIV status, the fear of learning HIV status, inadequate transportation, confidentiality concerns, and the lack of local availability of STD/HIV testing (Rural STD/HIV Prevention Work Group, 2009). As noted by the Native communities STD/HIV Prevention Guidelines Task Force (2004), the American Indians that live in rural areas become less likely to be tested for STD/HIV because of limited access to testing services in IHS and tribal health facilities. Because American Indians live in close-knit communities, they may be less likely to forgo STD/HIV testing due to encountering friends, relatives or acquaintances at the IHS, or tribal health



facilities. As a result, the uptake of STD and HIV testing becomes challenging to increase among men.

In a study conducted to examine the experiences of health care workers in providing HIV screening to American Indians, Reilley, Redd, Kittredge, Speakman, Bigbey, and Giberson (2009), found results suggesting that American Indians in Arizona are not frequently being tested for HIV and still remain unaware of their HIV status. The study consisted of 41 full-time and four part-time staff from Sells, Arizona and San Xavier, Arizona. The authors found that 39% of the health care workers felt that American Indian patients decline HIV testing because they did not perceive themselves to be at risk for HIV. Additionally, they found that 25% of the health care workers experienced patients with feelings of not wanting to know their HIV status. Confidentiality was also a frequent reason for declining an HIV test.

Similarly, in a study conducted by Cobb and Espey (2014), the researchers examined behavioral risk factors among American Indians and Alaskan Natives (AIAN) for morbidities and mortalities. The study consisted of 12,088 men and 18,785 women from six Indian Health Service regions located in the Northern Plains, Alaska, Southern Plains, Southwest, Pacific Coast, and East. The authors found that 50.7% of AIAN women were more likely to be tested for HIV compared with 42.9% of AIAN men. It was reported that 57% of AIAN men in the East were the only group to have been tested for HIV compared to 49.9% in Pacific Coast, 40.3% in Alaska, 38.7% in Northern Plains, 38.2% in Southern Plains, and 34.2% in Southwest. The authors also reported that AIAN men in the Southwest region were the only group less likely to be tested for HIV. This

study suggests that efforts to improve the uptake of HIV testing are needed among American Indians.

In an early study of HIV and testing services in 197 Black men who have sex with men (MSM), Mimiaga, Reisner, Bland, Skeer, Cranston, Isenberg, Vega, and Mayer (2009), found results consistent with previous studies. The authors only selected African American men aged 18 years and older from Massachusetts who self-reported having oral or anal sex with a man in the past 12 months. It was reported that 33% of Black MSM were not testing for HIV in the last two years. Additionally, the authors found that 60% of Black MSM were not testing for STDs in the last two years. They also found that Black MSM were not forgoing testing for STDs and HIV because they had no symptoms and they believed their partners were clean. This study suggests that men are unaware of their HIV status and do not routinely get tested for STDs and HIV.

Interestingly, de Ravello and colleagues (2004) found that men generally do not seek or receive regular care and, as a result they are not routinely screened for STDs or HIV. In fact, men are less likely to be screened annually for STDs, especially chlamydia in IHS and tribal health facilities. A result of this is that STD screening programs like chlamydia target primarily women (de Ravello, Shelby & Cheek, 2004). According to Park (2010), screening for STDs is not recommended for heterosexual men, however, screening is recommended for men with prior chlamydia and gonorrhea infections in the past 24 months. Not surprisingly, the 2010 STD screening guidelines from the CDC recommends more frequent screening among MSM with risk factors of multiple or anonymous sex partners, or having sex with illicit drug use (Park, 2010). Despite STD

screening guidelines that recommend no annual screening for heterosexual men, American Indian men continue to have high rates of STD infection. Thus, expanding STD screening services of sexually active men is needed as part of their routine health care since American Indians get tested at rates lower than other ethnic/racial population and engage in more unprotected sex.

### **Summary**

This literature review has revealed information regarding the impact of STDs/HIV among American Indians in general and American Indians in Navajo Nation. One avenue to broadening our understanding of the severity of STD/HIV among Navajo people was to explore the cultural value of Adil 'idli and how this cultural practice might influence health behaviors in sexual activity, condom use and acquiring of STDs among Navajo men. Specifically, this study sought to definitively describe the behavioral, social, and economic factors for STD/HIV acquisition. As a result, the ultimate goal was to provide Navajo men with empowering information to prevent the likelihood of contracting HIV or spreading other STDs. This chapter will follow with a description of methodology, an explanation for sampling strategies, identifying the participants, procedures for recruitment, data collection, and protection of human subjects.

## Chapter 3: Research Method

### **Introduction**

The purpose of this qualitative study was to explore the cultural value of adil 'idli and how this cultural practice might influence health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. The research design, role of the researcher, methodology, issues of trustworthiness, and the ethical treatment of participants will be outlined.

### **Qualitative Research**

This study utilized a qualitative design, which is a procedure for exploring a specific phenomenon in order to understand a research problem or topic more completely (Creswell, 2009; Morrissey & Higgs, 2006). The study was needed to explore the lived experiences of Navajo men in order to understand the essence of adil 'idli and how this cultural practice might influence health behaviors in sexual activity, condom use, and acquiring of STDs among Navajo men. In qualitative research, the researcher relies upon the individual's voice in obtaining their knowledge, attitudes, opinions, beliefs, and fears to provide a reason for behavior or action (Creswell, 2009; Morrissey & Higgs, 2006; Namageyo-Funa, Rimando, Brace, Christiana, Fowles et al. 2014). That is, qualitative researchers want to empower those who are studied to share their stories and to provide their perspectives in words or actions (Creswell, 2013; Namageyo-Funa et al. 2014). One advantage of qualitative research is that it presents a holistic or complex picture of the problem under study. This allows the researcher to identify the many factors or issues involved in a situation that is often missed by scientific enquiries (Morrissey & Higgs,

2006). At the other extreme, qualitative research ensures that the contexts of inquiry are natural and not contrived in which nothing is predefined (Creswell, 2013; Morrissey & Higgs, 2006). Qualitative researchers use the design of a qualitative study to obtain a detailed understanding of the issue which can only be established by having face to face interaction in their natural setting (Namageyo-Funa et al., 2014). Therefore, a qualitative research was simply a better fit for this research problem.

### **Methodology**

The study followed a phenomenological approach for its descriptive orientation. A phenomenological approach was appropriate for describing a common meaning of several individuals of a lived phenomenon (Creswell, 2013; Morrissey & Higgs, 2006). It primarily focuses on the individual's subjective experiences and interpretations of the world. In this case, the human experience was a phenomenon involving condom usage. The phenomenological approach allows the participants to give details of their state of mind, such as feelings, moods, and emotions (Morrissey & Higgs, 2006). Not only does a phenomenological approach provide valuable information but also a strong case for answering specific questions, such as the experience of using condoms. This phenomenological study was based on the following research questions:

1. What is the role of condoms in the Native culture among Navajo men?
2. What is the relationship between condom use, adil 'idli, and perceived susceptibility to STD/HIV among Navajo men?
3. What is the relationship between condom use, adil 'idli, and perceived severity of STD/HIV among Navajo men?

4. What is the relationship between the level of knowledge about STD/HIV and condom use among Navajo men?
5. What are reasons identified by Navajo men as barriers to condom use in sexual activity?

In phenomenological research, the appropriate methods for data collection include in-depth interviews, focus groups, storytelling, tape recording, and written anecdotes. This study used primarily interviews with 20 individuals who had all experienced the phenomenon. Qualitative interviewing is meant to fully understand someone's experiences or impressions, and to seek out the world views of research participants (Narui, Truong and McMickens, 2015). An advantage of using interviews is that it provides in- depth information and it allows the researcher to develop a relationship with the participant (Creswell, 2009; Narui et al, 2015). Interviewing was the sole method in this study and was used as part of a phenomenological study.

### **Role of the Researcher**

The role of the researcher in this study was to necessitate the identification of personal beliefs, behaviors, values, emotions, and biases at the outset of the study. I did have two roles as the observer and as the participant. As an observer-participant, I was present at, and involved in conducting one-on-one interviewing with the participants at the interview site. Through this, I gained insider views and subjective data. As the researcher, I could also record detailed field notes, conduct interviews, and gather relevant site documents that might be available at the setting as data.

In order to obtain a deeper understanding of the participant's experience of condom use, the interviews were conducted as an interpersonal encounter for this study. The importance of conducting the interviews was to elicit each participant's unique experience; therefore, it was relevant that I developed rapport with the participant. The use of social skills including empathy, warmth, attentiveness, humor, and consideration was essential for the development of trust and respect. Specifically, Gilley (2006) found that using an informal conversation with participants before conducting an interview can reduce anxiety levels and establish rapport with the participant. Thus, obtaining meaningful information from a respondent is easier if the researcher uses purposeful small talk to create a warm, thoughtful, and friendly environment (Gilley, 2006). Therefore much of the success of one-to-one interviewing was attributed to the researcher creating an open environment.

In one-to-one interviews, bias can stem from three sources including the researcher, the respondent, and the interview setting (Balan, Carballo-Diequez, Ventuneac, Remien, Dolezal et al., 2013; Vanable, Carey, Brown, Littlewood, Bostwick et al., 2012). For example, the researcher can misinterpret the response of participants or distort it while writing it down (Jacob & Furgerson, 2012; Vanable et al., 2012). That is, the researcher might unintentionally encourage certain responses through gestures or facial expressions. On the other hand, the respondent might not give his true opinion, or the respondent might avoid difficult questions, and answer questions depending on the respondent's mood (Balan et al, 2013; Creswell, 2013; Jacob & Furgerson, 2012). In an interview setting, the site can be good creating comfort or bad creating discomfort. This

interview site might also be open or in presence of friends or acquaintances, and the level of trust might be inadequate. In order to minimize interview bias, I had the knowledge, skills, and confidence to conduct one-to-one interviews. Therefore, rapport was established in the interview.

### **Target Population and Sample**

The target population in this study was sexually active Navajo males (ages 20 to 39 years) from the Navajo tribal communities in or near Shiprock, New Mexico and Gallup, New Mexico. According to East and colleagues (2007), sexually active is defined as having engaged in sexual acts that include oral sex, anal sex, or vaginal sex with a partner. As part of the study eligibility, individuals were eligible if they reported oral, anal, or vaginal sex with a woman in the past 12 months. In addition, the study was restricted to participants meeting the following criteria:

- aged 20 to 39 years old;
- male heterosexual;
- Navajo tribal member;
- resided in a community in or near Shiprock, New Mexico and Gallup, New Mexico;
- said they are sexually active in the past twelve months; and
- consented to participate in the study.

A participant was excluded under the following conditions:

- under 20 years of age or over 39 years of age;
- said they are homosexual;



- non-Navajo;
- did not reside in or near Shiprock, New Mexico and Gallup, New Mexico;
- no history of sexual activity in the past twelve months; and
- not willing to give consent to participate in the study.

### **Sample Size**

A purposive sample was used to select participants for this study. This approach was appropriate for accessing a particular subset of people, for example, the Navajo men that lived in or near Shiprock, New Mexico and Gallup, New Mexico. For this study, a purposive sample of 20 participants was needed to provide insight and understanding for the researcher. It is generally agreed that in phenomenological research consisting of in-depth interviews with participants can range from 5 to 25 individuals (Jacob & Furgerson, 2012; Namageyo-Funa et al., 2014; Narui et al, 2015). Several authors have suggested carrying out an in-depth interview with individuals until theoretical saturation is achieved (Morrissey & Higgs, 2006; Namageyo-Funa et al., 2014; Narui et al., 2015). With that in mind, sample size depended on theoretical saturation, the study's research question, resources, and time available.

### **Recruitment for Qualitative Interviews**

In this study, purposive sampling was used in the recruitment of participants based on the inclusion and exclusion criteria, such as age group, ethnic background, gender, geographic location, and history of condom use. Due to the sensitive nature of the topic, the recruitment of participants included posting flyers and collaborating with gatekeepers, such as health providers. Flyers were placed on notice boards at venues

frequented by target audience including Navajo Area Indian Health Service hospitals/clinics, Dine College, Substance Abuse Treatment Centers, Public Library, Drop-In Center, Work Force Development, Homeless Shelters, Tribal Detention Centers, and Casinos.

As Namageyo-Funa and colleagues (2014) suggest, the utilization of gatekeepers trusted by the target population can provide access to potential participants. They can inform potential participants about the study and encourage participants to enroll into the study. In this case, I worked one-on-one with the gatekeepers through the recruitment process to recruit participants one to three weeks in advance of interviews. Collaboration was established with tribal health programs including Navajo HIV Prevention Program, Navajo Health Education Program, Dine College HIV Program, Navajo Social Hygiene Program, Navajo Nation Work Force Development, and Navajo Community Health Representatives.

### **Contacting the Participants**

A week before the interviews, I contacted participants with a confirmation letter signed by the researcher. The confirmation letter provided travel directions to the interview site and my contact number. In addition to the letter confirming the date and time, I also contacted the participants by telephone, email, or texts as reminders the day before the interview.

### **Site Selection**

Interviews will work best when the participants are comfortable (Jacob & Furgerson, 2012). It was suggested by fellow colleagues from the Navajo Epidemiology

Program to conduct interviews in a familiar public setting to minimize distractions. I selected Shiprock Chapter House in Shiprock, New Mexico, as the center location that would be accessible to all participants. This location was checked for equipment including tables, chairs, lights, and electrical outlets for audio recording. I also checked the location for background noises and airflow. In my case, if participants had young children or lived a distance from the interview site, I provided baby-sitting or transportation services.

### **Participation Rate**

There are several ways to improve participation in a study. One of the ways to improve this study participation rate was to schedule the interviews at times that were convenient to the participants. Another way to improve participation rate was to provide monetary incentives (\$5 to \$50) for participants. As Namageyo-Funa (2014) point out, monetary incentives are viewed as a symbol that the researcher values the participant's perceptions and beliefs. With that in mind, each participant received a small incentive for his participation in the interview session.

### **Alternate Recruitment Plan**

For this study, consideration also needed to be given to recruitment issues during the recruitment process. These issues include slow recruitment and not being able to recruit participants within the expected time frame. To overcome these challenges, the researcher would recruit potential participants from another location in Chinle, Arizona. It is more acceptable to recruit from this location because Chinle, Arizona had the third most cases of STDs and HIV compared to Shiprock, New Mexico and Gallup, New

Mexico. This change in recruitment location would not affect the study's recruitment strategies, including the use of flyers and collaboration with gatekeepers.

### **Data Collection**

In order to explore the phenomenon of condom use, I used a list of open-ended questions to elicit information from the participant. The use of open-ended questions in an interview would encourage the respondent to talk freely about condom use. Thus, the questions would begin with "What," "How," or "Why" to generate more thoughtful responses. For the purpose of this research, a set of questions were developed to serve as an interview protocol. The interview protocol was used as a guide to shape the order of questions by topic area. In addition, a script was included in the protocol so that I can introduce the interview, guide the questions, and conclude the interview in a consistent manner.

I pilot-tested the interview protocol with two key participants to assess that the questions were understandable and ordered sensible. The use of pilot-testers provided valuable feedback about how to improve the wording of each question and confirmed the length of an interview. At the end of pilot-testing, revisions were made according to the participant's feedback. Reliability and validity were confirmed during the pilot-testing.

### **Data Analysis**

The analysis process included summarizing the discussion immediately following the interviews so that important details were not forgotten. This approach to data analysis included writing down insights, observations, ideas, words, or phrases that can represent classification categories. Also, the audio tapes were transcribed immediately

after an interview had been conducted. The process of transcription involved making an exact word-for-word text version of the audio recordings.

After data had been transcribed, I organized transcripts into segments of text. Then, the segment of text were labeled and coded according to their meaning. One way to do this was through the continuous reading of data to identify any coding categories or themes. This process was undertaken by using NVivo to handle and manage qualitative data. After the categories or themes had been coded, results of the study analysis would be written up in a narrative form in chapter five.

### **Ethical Consideration**

In this study, I am obligated to respect the participant's rights, needs, values, and desires. To do this, I used a consent form to ensure the participants were aware of the risks and benefits of participating in the study. Consideration was also given to the participants in terms of cultural background and reading and education levels. Therefore, informed consent documents would be culturally and developmentally appropriate for the participants.

In addition to the protection and respect of participants, I abided by informed consent rules; maintained the fairness in selecting participants; respected Navajo culture; respected concerns of confidentiality and privacy; and ensured the safety of participants as the study was conducted. The following safeguards were used to protect the participant's rights:

- Protect both participant and tribal identity
- Comply with Navajo IRB clearance of publication

- Respect participant's rights, interests and choices in data collection methods, activities, and the reporting of data
- Honesty in reporting procedures, methods, data and results, and
- Sharing data, results, ideas, and tools with other people and organizations.

### **Summary**

Throughout this chapter, I presented comprehensive information regarding phenomenological research and how its approaches will direct the research process at every stage. An overall description was provided that described the participants and sample, recruitment, the protection of human subjects, and instrumentation. The following chapters will detail the results of the study along with recommendations. Chapter 4 will consist of the findings that derived from the interviews as it relates to the research question and theoretical framework. Chapter 5 includes an interpretation of the findings to the research questions. It will also provide an implication for social change and recommendations for future research.

## Chapter 4: Results

### Introduction

The purpose of this qualitative interview study was to explore the cultural value of adil 'idli (self-respect) and how this cultural practice might influence health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. A gap in the literature confirmed the need for additional studies to learn the experiences of the participants in using condoms (Gilley, 2006; Leston et al., 2012; Marrone, 2007; McIntosh & Eschiti, 2009). This phenomenological inquiry was guided by five research questions:

1. What is the role of condoms in the Native culture among Navajo men?
2. What is the relationship between condom use, adil 'idli, and perceived susceptibility to STD/HIV among Navajo men?
3. What is the relationship between condom use, adil 'idli, and perceived severity of STD/HIV among Navajo men?
4. What is the relationship between the level of knowledge about STD/HIV and condom use among Navajo men?
5. What are reasons identified by Navajo men as barriers to condom use in sexual activity?

Results of this study will assist tribal health officials with the development of prevention messages, intervention materials, and policies around STDs/HIV among Navajo men. In this chapter, the analyses of data collected during face-to-face interviews are presented.

The chapter also discusses the pilot study, demographics, data collection, and evidence of trustworthiness. The chapter concludes with a summary of main points.

### **Pilot Study**

Round one of the pilot study included the participation of five colleagues. Four of the colleagues were from the field of STD/HIV and one from the field of infectious diseases. A pilot study panel of six colleagues was contacted to secure participation for the pilot portion of this study via email and telephone. The group consisted of professional colleagues who hold a Masters or Bachelor degree and have more than five years of experience working with tribal communities. After obtaining their consent, the participants were invited to provide feedback on 25 open-ended questions. Each participant was given a cover letter and questionnaire that asked them to determine if the instrument was appropriate or too complicated. This included: checking the type and wording of questions; checking comprehension of questions; checking the ordering of questions; and the need to add questions for clarifications or cut questions. The interview guide included questions about condom awareness, knowledge about condoms and STD/HIV, and attitudes about condoms, sexual practices and STD/HIV. The guide also included probes to elicit details about condom usage and their thoughts about condoms.

The next step involved the editing process, amending the wording in the questions, the ordering of questions, and the adding of questions. One pilot participant suggested that question 1d, "Provide an example of a time in which you had learned about condoms?" come before 1b, "Can you tell me how you feel about condoms?" The pilot participant believed that it's important to have some knowledge about the men's



awareness of condoms before expressing their attitudes towards condoms. Another pilot participant suggested that question 2 c, “In what situations or with whom did you not use condoms?” be reworded to “In what situations or with whom (e.g. steady partner, casual partner) did you not use condoms?” He pointed out that question 2 c could be misinterpreted as asking for a specific name. It was also suggested to use the term STI (sexually transmitted infection) instead of STD to ensure the comprehension of questions about STD/HIV risk. A different pilot participant suggested that questions about STD/HIV risk come before questions about protection from STD/HIV. Following these suggestions, changes were made to the interview guide.

Round two of the pilot study included field testing the interview guide on two participants that met the study eligibility criteria. This stage was followed by reading the questions to testing participants and observing their reactions. The aim was to gather a sense of whether the participants comprehend the questions, if participants have difficulty with the wording of questions, and if participants have fatigue or discomfort with questions. One man showed confusion with the question, “Can you tell me how a person can get an STI?” He asked, “What is STI?” After being told the meaning of STI, he suggested that STD be the appropriate word to use. Before the next field test, corrections were made to the interview guide. Another man showed he understood the questions and was eager to answer. He said that the questions were understandable and felt no discomfort in answering the questions. For these participants, their responses were not used in the data analysis.

### **Demographics**

In this research study, a total of 20 Navajo men (aged 20-39 years) participated in the individual interviews. To participate, individuals were required to: (1) be 20 to 39 years old; (2) identify as male heterosexual; (3) be a Navajo tribal member; (4) reside in or near Farmington, NM and Gallup, NM; (5) report they were sexually active in the past twelve months; and (6) provide consent to participate in the study. All study participants were screened for eligibility prior to enrollment.

### **Data Collection**

Between May 2016 and July 2016, I used an institutional Review Board (IRB) approved flyer and placed it on notice boards at several locations such as laundry mats, grocery stores, restaurants, and gas stations. The flyers announced the study purpose, eligibility, compensation, and contact person. Those participants meeting the eligibility criteria were asked to provide a cell phone number to finalize their enrollment into the study. Twenty participants agreed to participate in the study, so I proceeded to schedule interviews within the next 24-72 hours. I used a Mead Five Star Planner to manage the interview schedules with participants. I conducted face-to-face interviews as the primary mode of data collection with the Navajo men in the study.

I had three participants request to reschedule their interviews and two participants request to change the times of their scheduled interviews because of illness, employment, and transportation. Prior to interviews, I made several attempts to contact scheduled participants by telephone and texts to confirm their participation. I also asked participants to notify me by telephone or text if they could not participate. This minimized no-shows. Ten participants were interviewed in Farmington, NM and ten

were interviewed in Gallup, NM. I did not experience any issues with recruitment or participants withdrawing from the study.

Data were collected through audio taped, face-to-face interviews conducted at Farmington Public Library and at Gallup Children's Library. I also collected data in the form of field notes about each interview as this provided key points to probe further. Before beginning the interviews, I introduced myself; introduced the study; explained how the data were going to be used; and provided an overview of the interview questions; consent process; and asked for participants' questions or concerns. I gave each participant a consent form and I went over the consent form with them line by line. Once the participant verbalized their understanding of the study I asked participants to sign the consent form. Each participant refused a signed copy of their consent form.

The original voices of the participants were maintained through electronic audio tape recording. To solicit rich data, I used an informal conversational strategy and an interview guide approach as recommended by Namageyo-Funn et al. (2014). I used the interview guide throughout each interview to ensure that the dialogue remained focused on condom use. If a question drew a blank stare, I would reframe the question to make it clearer and tie it to the participants' earlier comments. At the end of each interview, I would summarize key ideas and themes back to the participants to ensure I have a proper understanding of their meaning. At that point, participants were able to provide clarification of prior statements and additional information about their experiences. Each interview was 30 to 45 minutes long. Participants received \$15.00 cash at the end of the interview.

I captured the statements of participants on an Olympus WS-852 Digital Voice Recorder. Audio files were uploaded after each interview into O Transcribe software for transcription and saved in password protected computer. Data were transcribed word for word 72 hours after the interviews in Microsoft Word file formats into templates that were created to align with the questions on the interview guide. I then arranged the questions on the interview guide by research questions and imported into NVivo v.11 for analysis. Both the audio files and transcripts of participants were labeled with first two letters of last name, first two letters of first name, and date to protect participants' identity.

Initially, my study called for a sample of 20 Navajo men that live in or near Shiprock, NM and Gallup, NM. Fearing that I would be unable to gain Navajo IRB approval for the research site in Shiprock, NM, I opened up participation to Navajo men that live in or near Farmington, NM. As such, I decided to recruit participants from Farmington, NM instead of Shiprock, NM to avoid delays in proceeding with the study. I did negotiate with my Chair about the target sample and received approval to recruit participants from Farmington, NM. The data collection process commenced when I received permission on May 05, 2016 from Walden University IRB and my dissertation committee to proceed with the study. Table 1 shows the demographic characteristics of participants by pseudonyms.

Table 1

*Demographic characteristics of the study participants (N=20)*

Participant	Age	Occupation	Place of Residence
Joshua	39	Medical Services	Gallup, NM
Evan	26	Certified Nurse Asst.	Farmington, NM
Ethan	39	Unemployed	Gallup, NM
Tim	30	Self-employed	Gallup, NM
Andrew	21	Unemployed	Farmington, NM
George	30	Roofer	Farmington, NM
Justin	28	Unemployed	Farmington, NM
Lewis	35	Security Officer	Farmington, NM
Lloyd	37	Student	Farmington, NM
Cory	35	Pipe Fitter	Farmington, NM
Brian	30	Contractor	Farmington, NM
Richard	35	Industrial Mechanic	Farmington, NM
William	32	Unemployed	Gallup, NM
Robert	27	Unemployed	Gallup, NM
Bayler	21	Student	Gallup, NM
James	35	Auto Tech	Gallup, NM
Joseph	25	Auto Tech	Gallup, NM
Nicholas	24	Landscaping	Gallup, NM
Dustin	28	Unemployed	Farmington, NM
Trent	27	Unemployed	Farmington, NM

### **Data Analysis**

I analyzed the data in the following stages: (1) listened to the audio tapes prior to the transcription, (2) transcribed the audio tapes, (3) assigned codes to text segments, and

(4) categorized by coding and identifying common themes. During this stage of the analysis, I began with careful reading of the transcripts. Each transcript was read multiple times to identify themes and to understand the nature of the participants' experiences. Through the reading, I identified the portions of text that were meaningful and yielded rich knowledge to my topic of study.

Coding began with codes arising out of the transcripts as I read them. At this stage, grounded codes emerged from the transcripts as I put aside previous knowledge of the subject area and concentrated on finding new themes in the transcripts. I used a systematic approach to code transcripts, which included asking the following questions as I read the transcripts: (1) What is this saying? (2) What is happening? (3) What is trying to be conveyed? and (4) What do I see going on here? (Watt, 2007). In order to achieve this step, I scribbled on print transcripts and highlighted words in a sentence or paragraphs and added codes to text. Open coding was the grounded process used in creating codes in which every line is coded using the research questions as a guide. The types of codes that emerged from this process included conception, intimacy, infidelity, monogamy, pleasure, well-being, mistrust, arousal, pleasure, fear of STDs, disease progression, death sentence, casual sex, staying healthy, promiscuous, and scared. After hand coding, I imported data coding and organizing codes into a code list.

I ended up with 123 codes and then I arranged codes into a hierarchical coding, like a tree to refine the codes. NVivo v. 11 was helpful for key word searches, employing frequency counts, and to create diagrams to seek out the prevalence of themes. This involved grouping together the related codes under themes related to research questions.

What emerged from this process were five themes in terms of: (1) commitment to condom use; (2) perceived risk and vulnerability; (3) perceived severity; (4) knowledge; and (5) resistance to condom use.

### **Evidence of Trustworthiness**

In this study, several measures were taken to increase the trustworthiness of the qualitative data. First, I developed a series of inclusion and exclusion criteria for selecting study participants and used the criteria throughout the recruitment process. By defining clear participant's criteria, I was able to identify participants that were willing to share information essential to unraveling the complex and unique issue of condom use among Navajo men. The credibility of this study lies in setting clear criteria for selecting study participants and knowing that their characteristics are very directly related to the research questions.

Second, I developed a set of thoughtful, targeted, and unbiased interview questions. The questions were designed with prompts to elicit stories, feelings, and memories about the phenomenon being studied. A peer group review and feedback solicitation process further support credibility. The questions were given to five experts in the field of STD/HIV to ensure the following: questions aligned with the study purpose, questions are worded in a way they are most likely to be answered honestly, questions respond directly to study research questions, and questions produce data that will be used. This was done to avoid asking biased questions or just having an informal conversation. It was also part of the process of establishing credibility.

Third, data was collected in multiples. I conducted twenty interviews with individuals who met my inclusion/exclusion criteria on condom use using the same set of questions. This ensured a diversity of perspectives, reaching saturation, and validates that I haven't missed any major themes. The purpose of using multiple data sources was to provide comparison of data among and between participants and contributed to my understanding of the phenomenon. I also used cross checking for clarification of what was said with the men I interviewed and to check that aspects of lived experiences were clear. The credibility of this study is solidified through triangulation, which involved me asking the same interview questions of different study participants and using different methods to answer the research questions.

Fourth, a systematic process was used to analyze interviews. Data analysis involved repeated reading of transcripts in an effort to identify themes. Every effort was made to suspend my own preconceptions, beliefs, and values in order to focus on the participants experience so that the data analysis was a reflection of their ideas and values. Credibility was also achieved by faithfully presenting the words of the participants without changing the meaning or descriptions throughout the analysis. Also, notes made on the interview guides were used as supporting evidence that ensured the data was a reflection of participants experience and the analysis of emerging themes. In addition, the process of coding and refining the data was systematically carried out and maintained using NVivo v.11 software. The confirmability and dependability of this study lies in using NVivo software with open coding and analyzing data. Confirmability and dependability was achieved by documenting the data collection procedures and analysis



procedures for checking and rechecking the data throughout the study. I have maintained a research log on data collection, ethical conduct, data analysis, and insights into the topic area. The transferability of this study also lies in me generalizing the results to Navajo men.

Finally, approval to conduct the study was obtained from the Institute Review Board of Walden University. The protection of human subjects is required of all research conducted through Walden University. Each participant was over 18 years of age and was provided with an informed consent form, which they were asked to sign and date once they agreed to participate in the study. The form contained information about the study purpose and nature of the study and guaranteed the privacy and confidentiality of each participant. Participants were advised that they could withdraw at any time. Pseudonyms were used in reporting research to protect the anonymity of the participants.

## **Results**

### *Commitment to Condom Use*

Overall, this sample of Navajo men indicated that when they use condoms, it is mainly to prevent sexually transmitted disease (STD) and pregnancy (see Table 2). For example, Joseph stated, “I use condoms to, um, avoid you know of course STDs and I’m not quite ready and that or any kind of condition to have another baby.” And Brian remarked: “I use condoms to keep myself from getting any type of infection or getting myself sick.” Lloyd was particularly poignant stating that “I use condoms because I, um, feel safe and comfortable with them as opposed to catching a disease that they can’t cure and that will make me feel worse.”

High commitment to condom use was also described in intimate relationships associated with infidelity and mistrust within a partnership (see Table 2). As Ethan stated, “I use condoms because I don’t trust my partner, um, I can’t trust her because she’s been running off so many times you know drinking with strangers. I don’t know where she been and just not cool.” Robert stated that he got an STD from his wife who had cheated while he was in jail. He remarked: “When I freaking found out that my wife was STD positive and I just started using condoms after that. To this day I use condoms and I would use a condom no matter what.” Lloyd firmly believed that sexually active women are promiscuous and would deny any infection to their partner. He remarked, “I don’t have full trust in the opposite sex of what they may say and it may not be the whole truth and some are out there just to play games.”

Although condom use with sex partners is the norm, participants did describe condom use with sexual behavior in the context of *adil ‘idli* (self-respect). Being mindful of yourself emerged as a compelling reason for adopting *adil ‘idli* (self-respect) behavior among the men interviewed. The reason appeared to be that using condoms was related to sexual relations, intimacy, attraction, physical pleasure, and health. The men believed that condoms promoted well-being and maintaining a healthy lifestyle. These men also said that condoms are a way to keep themselves “clean” and it shows that you are being mindful of yourself by using condoms. As Evan said, “Um, I think it’s like if you use condoms you know you actually care for your body and who you’re with and you actually respecting the other person too if you use the condom you know cause you’re actually avoiding STDs or pregnancy because they probably don’t want it either so

you're respecting them and you respect yourself so respect others the way you want to be respected." Tim remarked: "Um that shows to take care of yourself you know and they say walk in beauty you know and that's a way to keep yourself clean from preventing from catching whatever is out there." And Andrew said, "Um, you go to take care of your health, you don't want to get no infections or diseases and try to take care of yourself as much as you can pretty much and condoms will do that pretty much it will help out a lot, you know for yourself as a guy, for females they carry it around too you know what I mean."

When questioned about their positive experiences with condoms, seven men reported that they are "STD free" (see Table 2). They feel clean and healthy. Joseph was particularly poignant, stating that "I don't have to take any medication or have to go to the hospital to get checked for, um, a sexually transmitted disease." As for Joshua, "Um, just, um, have good health and the things going on you know sexually not having an STD is the main reason." And Dustin remarked: "Not having a disease or anything like that not coming up with it, so yeah." Nicholas spoke about having sex with a female and how his friends had revealed that she had AIDS. He said, "I used a condom so it kept me safe and I got myself checked."

For seven men, their experience with condoms has also prevented pregnancies (see Table 2). All indicated that they were not ready for a child. For example, Trent said, "The good things, um, I'm not ready to be a father right now and like, um, I make smart decision like I'm just not ready right now I could be but later on I'm going to have to struggle and have to like do twice as more, I'm not ready I'm still young." Evan stated,

“I have no kids and STD free.” And Lewis said, “I don’t have kids all over the place.” As for Lloyd, “I don’t have a whole lot of kids.” For the most part, six men believed that their experience with condom use tended to evoke a feeling of being at ease (see Table 2). Brian said, “It made the experience more pleasurable and less nerve wrecking I guess.” Ethan stated, “Well it’s very less stressful to know that you used it (condoms) and it just takes a like a big old weight off your shoulder just that knowing I did.”

When asked about how they would feel if their wife/girlfriend or partner asked them to wear condoms, 13 men stated that they felt it was acceptable for their partner to insist on condom use (see Table 2). For these participants, they were very willing to wear condoms if their partner expressed not wanting to have children. For example, Cory said, “In a marriage situation you know I would find that you know if their wanting to hold back on kids that would be the only situation but for them to like constantly you know deny the condom or like use it either way you know it’s you know supposed to be mutual between husband and wife faithful, faithfulness and you know just being there for each other.” As for Ethan, “Uh, I think it is okay if for birth control to not have kids but if it’s where you know that she can’t have babies then that’s, um, a red light and saying that maybe she not supposed to be doing what she supposed to be doing.” Richard stated, “I feel the same way too it’s a good idea I mean reason being because if you want to have a child than it’s something you both talk about preparing for it, planning.”

For others, their experience with a wife/girlfriend or partner asking them to wear condoms was negative. Seven men reported that in this situation, they would assume that their partner was sexually involved with another person (see table 2). For example, Eric

said, “A red light and saying maybe she not supposed to be doing what she is supposed to be doing (infidelity).” And Dustin stated “It would make me feel like, um, she is saying something to me like she might be having something she is not sure about so.” Justin remarked: “If you have known her for a long time but there is also that thought of why do you want to use a condom all of a sudden out of nowhere and it will make me think like did you have sex with somebody else.” Joseph stated, “It would make me think twice you know that she was messing around and that she is afraid to give me something (STD).”

Table 2, shows condom use practices, including reasons to use condoms, positive experiences with condom use, and personal reaction to female partner introducing condoms.

Table 2

*Condom use practices by participants (N=20)*

Condom use	n (%)
<i>Reasons to use condoms</i>	
STDs/HIV	20 (100)
Pregnancy	20 (100)
Partner sexual infidelity	15 (75)
<i>Positive experiences with condoms</i>	
No STDs	7 (35)
No pregnancies	7 (35)
Other	6 (30)
<i>Reaction to partner introducing condoms</i>	
Positive	13 (65)
Negative	7 (35)

*Perceived Risk and Vulnerability*

When asked about concerns of STDs and HIV during the qualitative interviews, 15 men reported being very concerned about contracting STDs and HIV while five men had no concern at all (see Table 3). For these 15 men, they considered STDs to be a “gross” and “disgusting” disease. They also spoke of being fearful of STDs and specifically stated they did not want to be infected with STDs. For example, Andrew said, “I kind of feel worried and like I guess like something that I wouldn’t want to get just like I feel like kind of like kind of scares you, you know what I mean it does.” And Brian said, “I’ve never had it so I really don’t want to go through the experience I guess.” Furthermore, all participants spoke of HIV as a long-lasting and life-changing disease. For example, Evan stated, “HIV will slowly invade your body and break down your immune system and everything and your health.” Five men stated that HIV is a death sentence and incurable disease. For example, Justin stated, “It’s (HIV) something you shouldn’t have in your body and something you can live without and it kills people.” Cory said, “It’s (HIV) a fatal disease and a lot of people are so much into pleasuring themselves not thinking about the results after wards that it’s just killing a lot of people.”

Six men reported being worried about contracting STDs and HIV after they had engaged in unprotected sex with casual sex partners (see Table 3). As Evan said, “uh, because sometimes oh I had this one person and that I didn’t know that she was cheating so it kind of got me scared so you know there was a couple of times I didn’t use condoms with her so I didn’t know if she used condoms with the other person so but I got myself

checked and I was okay just like a little scared when you wait for the results.” And Andrew stated, “uh, just didn’t use it, I didn’t use a rubber.” As for Justin, “Because, uh, back when I was young I use to have sex with different partners and not use a condom.”

For four men, their experiences with friends or family members who contracted STDs/HIV increased their worries about contracting STDs and HIV (see Table 3). For example, Richard said, “One of my cousin brothers said he caught something from some girl so I guess his girlfriend was messing around and he caught genital warts from her or something like that.” George stated, “I just seen a friend go through that you know like I guess he thought he knew who he was with but at the end it turned out she had, um, hep C, the lady he was messing around with.” And Robert said, “I have friends (females) that are around me that caught that stuff (STDs) and it’s not like I have sex with them or anything but it worries me.” Nicholas openly admitted that he has a family member that is HIV positive.

When asked how often you use condoms, eleven men reported that they used condoms “most of the time,” five reported that they “never” used condoms, and four reported that they “always” used condoms (see Table 3). Of those who had reportedly used condoms “most of the time” and “always” used condoms had stated that they used condoms as a reaction to fear. Their motivation to use condoms was from the fear of getting infection rather than giving infection. For example, Andrew stated, “Um, to just stay safe and not to just stay safe and be healthy, I don’t want to get no infection like I said.” And Robert said, “Is to stay HIV negative and STD negative.” As for Ethan, “Uh, I don’t want to catch AIDS I don’t want to have any kind of STIs so it’s, uh, very

stressful and it can damage your body you know and I read about some of them you could go blind and stuff and I want to live for a long time so I don't plan on and the older I got the more I care." On the other hand, of those who had reportedly "never" used condoms had stated that they ceased condom use once their relationship became serious. These men perceived no STD risk from their female partners because they knew and trusted their partner. For example, Cory believed that condoms should be stopped once that commitment and trust is established within a relationship. Ethan stated, "I only have not used a condom when I was with the person for a long period of time and knowing that she didn't have any kind of disease." Dustin stated, "I did once because I trusted her so maybe I took it I felt comfortable around her so it was my own choice for what I did." As James, said, "I am involved with a girl right now a girlfriend so we have been together for a while so I don't use condoms with her and she is fixed (IUD) so she can't get pregnant and I can't get her pregnant."

When asked about how they would protect themselves against STDs and HIV, 13 men reported that they intend to use condoms, while five men reported that they intend to be abstinent, and four men reported that they were in monogamous relationships (see Table 3). For example, Joshua said, "For now just use condoms no matter what and if not I just refrain from having it (sex)." Justin said, "um, don't have sex with anybody that you do not know that you do not trust and always have sex with one person that I know that does not have any STDs or HIV." Cory remarked: "Abstinence and you know making sure that the person has the same belief as me you know being a religious man and you know wanting to have that faithful life." Table 3, shows perceived STD/HIV



related susceptibility, including concerns about contracting STDs/HIV, worrying about STDs/HIV, frequency of condom use, and STD/HIV prevention.

Table 3

*Perceived STD/HIV susceptibility for participants (N=20)*

<i>Susceptibility</i>	n (%)
Concerns about STDs/HIV	15 (75)
No Concerns about STDs/HIV	5 (25)
Worrying about STDs/HIV	
Had unprotected sex	6 (30)
Knows someone with STDs/HIV	4 (20)
No worrying about STDs/HIV	10 (50)
<i>Frequency of condom use</i>	
Most of the time	11 (55)
Never	5 (25)
Always	4 (20)
<i>STD/HIV Prevention</i>	
Condom use	13 (65)
Abstinence	5 (25)
Monogamy	4 (20)

*Perceived Severity*

The responses from study participants often reflected STDs to be a serious medical condition that can bring permanent damage to the reproductive organs. For example, Lewis remarked, “It’s (STD) something that gets you sick and it does things to your private areas also your body sick, um, it’s spread from an infected person and its

gross and, um, and it's around so." And Joseph said, "Sexually transmitted diseases it's just like, uh, it's not good for you it makes your body ill."

The men in this study are aware that men who have unprotected sex are vulnerable to STD and HIV infections. For example, George stated, "Having sex with a partner with no condom can get you an STD." Men are also aware that men who have unprotected vaginal, anal and oral sex are more likely to be at risk for HIV. For example, Andrew stated, "Um, by having sex I think anal sex and oral sex. And Robert said, "Without using condoms or with oral sex without a condom." Furthermore, two participants linked unprotected sex with contracting an STD infection. A comment from Dustin was: "Having sex with somebody that had it (STD) before." Lewis remarked: "From an infected person." For Tim, he connected the practice of sharing needle syringes to contracting HIV. For example, he stated, "HIV well it's all AIDS, and I heard you can catch from sexual intercourse you know sharing needles all that other stuff."

For the most part, men were aware that HIV is a life-long chronic illness. Participants also recognized that HIV is incurable and would require life-long treatment. For example, Joseph said, "I know it will kill you and take away your life and it's incurable and turns into AIDS." Lloyd said, "An incurable disease, messes with your immune system, can't heal properly, and bumps take longer to heal or something." William remarked: "HIV is a disease that attacks your body parts and affects your internal organs." Men typically said that HIV is a death sentence and they feel sadness for people living with HIV. As Tim said, "It makes me feel a little good that I don't have that (HIV) but a little sad for the ones who have it (HIV)."

When questioned about the importance of male condoms, participants stated that condoms are for protection against STDs and HIV, a form of birth-control against pregnancy, and a method for practicing safe sex. For these participants, the male condom ranked the most important for preventing STDs and HIV, and the most effective way of preventing pregnancy. Evan said, “Um, it’s (condoms) used to prevent STDs and pregnancy.” The men viewed male condoms as a contraceptive that contributes positively to an intimate relationship. As James stated, “Condom is a must use or must have ,um, especially I think when you’re single going out and dating so it is a must because you never know what other people have.” They recognized and referred to the cultural value of *adil ‘idli* (self-respect) as that influences their behavior to always be mindful, always take care of yourself, and always be self-protective and understand limitations. For example, Joshua stated, “Well condom protects you against you know STDs or protection for having safer sexual behavior.”

### *Knowledge*

When asked if they had heard about STDs, 20 men said “yes.” For 19 men, the term STD typically meant “sexually transmitted disease.” However, Erik said, “Um, I think like, uh, herpes, chlamydia, HPV.” Four men also described the term STD as “dangerous,” “nasty,” or “gross” disease. For example, Andrew stated, “uh, it just brings up like an ugly picture like I don’t know it’s nasty like stay away from, stay as far as you can away from it pretty much, do everything you can not to get it.” And Lloyd said, “it mean it’s a dirty disease, um, anybody can get it if not careful and use soap and water everywhere you go.”

Among 14 men, chlamydia was most commonly recognized as an STD. Four men also named other STDs, such as gonorrhea, syphilis, herpes, and hepatitis. Only two men reported they had no knowledge about STDs. For example, Brian stated, “I don’t know it’s been such a long time since I’ve learned about this.” And Trent said, “There is a lot but I went to school and I read about this but I don’t know really all of it so, yeah, I guess I’m not aware of it.”

Nineteen men demonstrated their knowledge in relation to the symptoms of STD infection in men. These men described their own interpretation of what the symptoms might be, such as sores on or around the genitals, itchiness, weight loss, burning upon urination, and discharge from the genitals. However, three men believed it would be high blood pressure, black spots on the skin, red eyes, anal bleeding, and discoloration of the nails. About six men reported that they had no knowledge about STD symptoms in women. For example, George stated, “I’m not sure.” And Dustin said, “Um, I don’t know I never heard of signs.” As for Lloyd, “Um, I think they use a lot of cover up and its I don’t know what else to say about that.”

The two frequently reported locations for seeking STD treatment, included hospitals and clinics. Other locations that men discussed were medical center, nurse’s office, and school, STD center in Albuquerque, NM, Gallup Indian Medical Center, and Rehoboth McKinley Christian Health Care Services. However, three men reported that they had no knowledge of locations for seeking STD treatment. For example, George stated, “I have no idea.” And Lloyd said, “No clue, they got it, they got it.” As for Trent, “I don’t really know.”

*Resistance to Condom Use*

Men were consistent in describing the types of problems related to the resistance of condom use. Thirteen of the 20 participants reported experiencing discomfort problems with condom use (see Table 4). For six men, breakage was common. As Joseph stated, “they (condoms) break.” He suggested that an expensive brand of condom like Magnum is “better” and more comfortable. Nicholas said, “They sometimes rip.” He noted that he had to find the right brand of condom to avoid breakage. And Evan said, “There is a scare when it snaps.” He went on to note that certain brands of condoms cause discomfort and cause you to not “feel it” when the condom breaks. As for Andrew, “Some of them (condoms) are cheap, like you go to go to the store to get some good ones not the hospital, oh the hospital their pretty thick but there kind of like I don’t know just it’s not my style but I rather buy it you know what I mean I guess.” George also said, “A couple of them (condoms) tore.” He suggested that it’s important to have two or three condoms available for when the condom breaks.

Four participants also reported experiencing tightness with condom use (see Table 4). They believed that tight fitting condoms cause breakage and slippage during sex. William said, “The way it sleeves off the way everything comes off and all of a sudden you just continue after that.” He believed to have unintentionally impregnated someone that resulted from a broken condom. William stated, “I made twins that I love to this day and I never had regrets from it.” As for James, “Um, sometimes they (condoms) are not big enough or sometime they (condom) break too easy.” He believed this experience caused his past chlamydia infection. Robert said, “Well condoms are too small, yeah, for

reals and they're too thin and they break." He noted that Magnums are a bigger size brand and fit very comfortable.

Only three participants reported experiencing dryness with condom use (see Table 4). They believed that condoms break when the condom becomes dry. As Lloyd said, "They (condoms) break or fail and dry out." He suggested that reading the package was important because "not everything is what it says." And Richard remarked: "It (condoms) tends to dry out." He noted that adding lubrication to his condom was key to avoiding dryness.

When questioned about the availability of condoms, 14 participants reported that they did not have condoms on them when they needed them for sexual encounters (see Table 4). As Andrew noted, "Um, like the last moment kind of deal like you don't have, um, you know the situation comes up out of nowhere and you just don't have one you know what I mean." He also noted that his temptations and not having a condom available led to him having unprotected sex. George reported, "I just went along with it and I didn't use one." The comments of Ethan are worth noting: "I've learned to control like just not even do it (sex) as much as I want to you know and to tell myself that it's not going to happen (sex) so leave it alone." In addition three participants reported their past problems finding condoms. For example, Brian stated, "In the middle of the night at a party out in the boonies." He was very committed to using condoms: "I just waited until I found one (condom)." Richard said, "When you live way out in the reservation from you know where there is one store open and it closes at eight o'clock at night." He noted that sex had to wait. As James stated, "Late night, um, in the heat of the moment." He

noted that he would pass on the sex because of not having a condom available. Table 4, shows discomfort problems with condom use, including breakage, tightness, dryness, and lack of condom availability.

Table 4

*History of condom use problems reported by participants (N=20)*

Problems	n (%)
Condom broke	6 (30)
Tightness	4 (20)
Dryness	3 (15)
Had no condom problems	7 (35)
<i>Availability</i>	
Had no condom available for sex	14 (70)
Wanted condom but not available	3 (15)
Had no availability problem	3 (15)

The men in this study were committed to buying condoms. Eighteen of the 20 participants felt that they could comfortably get condoms from a grocery store or clinic. For example, Brian stated, “I’m comfortable with it, it don’t bother me at all.” And Lloyd said, “I feel comfortable with it, don’t feel ashamed.” William emphatically stated, “I feel nothing, not embarrassed and I can get condoms with no regrets about how I feel.” As Lewis stated, “I’m comfortable because I purchased some not too long ago but, um, it just depends on where you buy it (condom) if you get it like at a convenience store, yeah, it’s like you feel nervous I guess it’s if the line comes up but I don’t have no problem like if I’m at Wal-Mart or something.” Justin summarized the access issue

nicely by saying, “I would feel nothing at all and it’s easy to get and, uh, it’s just right there, go to the hospital, go to the store like every store sells it, 7 2 11, Conoco, there is no excuse for not being able to get one (condom).”

### **Summary**

This study provides multiple insights about condom use among Navajo men within Gallup and Shiprock, New Mexico. The study was conducted in hopes of understanding how Navajo men thought about condom use. Overall, the study did provide an understanding of how Navajo men perceive safer sex, concerns for STDs and HIV, beliefs about STDs and HIV, STD and HIV knowledge, and barriers to condom use. Thus, the findings supported that *adil ‘idli* (self-respect) is tied to ideas about disease, safer sex, and sexuality among the men in this study.

In Chapter 5, I will discuss the social implications of these findings, the limitations of this study, and future recommendations for continued research in the area of STDs and HIV behavior among Navajo men.



## Chapter 5: Discussion, Conclusions, and Recommendations

### **Introduction**

The purpose of this qualitative interview study was to explore the cultural value of adil 'idli (self-respect) and how this cultural practice might influence health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. The study was conducted to understand how Navajo men thought about condom use. This research study was guided by the Health Belief Model (HBM) to understand condom use behaviors within the population of focus. When applied to condom use behaviors, the HBM consists of four beliefs or behavior determinants: perceived susceptibility, perceived severity, perceived benefits, and perceived barriers. One significant finding in this study is that the positive components of adil 'idli (self-respect) have directed Navajo men to protect themselves by wearing condoms. The second finding is that fear beliefs held by Navajo men impacts the relationship between condom use, adil 'idli, and perceived susceptibility. Another finding is that Navajo men were concerned about STD/HIV infections that motivated their condom use with female partners. Lastly, Navajo men were not in the habit of carrying around condoms, and they lacked condom-carrying skills.

### **Interpretation of the Findings**

Research Question #1: What is the role of condoms in the Native culture among Navajo men?

One of the most consistent reasons for condom use among Navajo men was disease and pregnancy prevention. These two reasons, one related to their Navajo value

of adil 'idli (self-respect) and the other as to "well-being," motivated Navajo men to prioritize condom use. This study found that the aspects of adil 'idli (self-respect) are tied to the ideas about disease and health, which in turn has positively impacted men's attitudes and behaviors in sexual practices. Thind, Goldsby, Dulin-Keita, and Baskin (2015), cultural beliefs affect health related behaviors in sexual practices, screening utilization, and treatment-seeking behaviors. I found in my study that Navajo men had a strong desire to stay healthy and remain free of STDs/HIV transmission. The Navajo men in this study placed the responsibility of initiating condom use on themselves as a cultural obligation to stay healthy and to keep their bodies clean, pure, and protected. This responsibility came from the Navajo value of adil 'idli (self-respect), which teaches them to have respect, reverence, compassion, and sympathy for all things. The results of this study showed that the positive components of adil 'idli (self-respect) have directed Navajo men to protect themselves by wearing condoms. The findings of this study supported Thind, Goldsby, Dulin-Keita, and Baskin (2015) findings.

Fernandez, McCurdy, Arvey, Tyson, and Morales-Campos (2009) reported that Hispanic men and women were reluctant to use condoms as an STD prevention strategy against human papillomavirus because they believed marriage is based on trust and infidelity. However, Navajo men in this study were highly committed to using condoms as a protective device against STDs because they had steady partners that were sexually involved with another person. The men also felt the need to use condoms because of their own feelings of mistrust within a partnership and fearing the risk of STDs/HIV. Therefore, condom use was not a barrier for Navajo men to use in monogamous

relationships. The results of this study showed that attitudes and beliefs regarding safer sex practices were not influenced by minimizing the use of condoms in monogamous relationships.

Research Question #2: What is the relationship between condom use, adil 'idli, and perceived susceptibility to STD/HIV among Navajo men?

The results showed that fear beliefs held by Navajo men impacts the relationship between condom use, adil 'idli, and perceived susceptibility to STD/HIV. According to the HBM, a man's ability to use condoms is influenced by his beliefs that he is vulnerable toward acquiring an illness (Hounton, Carabin & Henderson, 2005). In my study, Navajo men held the belief that HIV was a death sentence, and they were frightened by this. They articulated how having HIV might be viewed negatively by their family and as an act of shame. The Navajo men also believed that STDs and HIV were "gross," "disgusting," "embarrassing," and they were concerned about the impact of a STD/HIV diagnosis on their health. Furthermore, men described how STDs and HIV could negatively affect how they see themselves, particularly as fathers and how having an illness interferes with the cultural ideal of adil 'idli (self-respect). The results here support Gilley (2006) where Cherokee Indians believed that the public discussion of sex, condoms, and STDs to be an act of shame. Additionally, Leston, Jessen, and Simons (2012) found that Alaskan Native youth ages 15 to 24 years old to believe that sex should not be discussed and STDs/HIV is a taboo subject.

The study found that Navajo men who held fear beliefs regarding STD/HIV were practicing safer sex by using condoms. Their condom use intentions and behaviors were

influenced in turn by personally knowing someone with an STD or HIV, the fear of disease, and for some, fear of infection from female partner. The results of this study showed that the attitudes and beliefs influencing condom use were consistent with the HBM. Furthermore, feelings of shame and fear that Navajo men experienced influenced positive condom attitudes by asserting safer sex practices within their relationships. However, this was not the case among five Navajo men who engaged in unprotected sex but only with steady partners. This is similar to the findings of Kalmuss and Tatum (2007) that condom use is inconsistent in men. The Kalmuss and Tatum study consisted of 3,611 men aged 20 to 44 who self-reported having oral, anal, or vaginal sex with a woman in their lifetime. Based upon the findings, the conclusion may be drawn that Navajo men have personal values for condom use and are aware of their vulnerability to STDs and HIV.

Research Question #3: What is the relationship between condom use, *adil 'idli*, and perceived severity of STD/HIV among Navajo men?

In regard to question three, the results showed that Navajo men were concerned about STD/HIV infections that motivated their condom use with female partners. According to the HBM, a man must have the belief that harm can be done by STDs/HIV infection in order to undertake condom use behaviors to protect one's health (Hounton, Carabin & Henderson, 2005). Likewise, I found in my study that Navajo men were concerned about the pain, disability, and illness that both men and women endure from STD/HIV infections. They worried about STD and HIV infections evolving into genital cancer and possibly death. Navajo men also had worries about erection problems

associated with STD infections and how this could interfere with sexual intercourse. Furthermore, men felt that if they had STD/HIV illness, they would feel violated of their manhood and cultural value of *adil 'idli* (self-respect), which jeopardizes their beliefs to always be mindful, always take care of yourself, be self-protecting, and understand limitations.

Simoni, Walters, Balsam, and Meyers (2006) reported that 86% of the 51 American Indian men reported not using a condom the last time they had vaginal sex. A previous study performed by Kennedy, Nolen, Applewhite, Pan, Shamblen, and Vanderhoff (2007) reported that 45% of 136 young adults aged 18 to 24 years were not using condoms in the last 30 days of sexual intercourse. My results contradict Simoni et al's findings, arguing that sixteen of the Navajo men in this study were using condoms within their relationships. I found that their judgements about safer sex and condom use were based on distrust and the fear of living with an STD or HIV-related disease. This led to Navajo men abstaining from unprotected sex and to consistently use condoms. According to the HBM, a man must hold the belief that there is something that can be done to prevent the condition (Hounton, Carabin & Henderson, 2005). I found in my study that Navajo men believed that wearing condoms, being celibate, and being in a monogamous relationship would protect them from STD and HIV infection, or creating a pregnancy. They also believed that being informed and aware about STDs and HIV would protect them from infection. The findings of this study were consistent with the HBM that beliefs and perceptions influence condom use. Basically, the results of this

study showed that concerns about STD and HIV infections impact the relationship between condom use, adil 'idli, and perceived severity of STD/HIV.

Research Question #4: What is the relationship between the level of knowledge about STD/HIV and condom use among Navajo men?

The findings from this study revealed that education impacts the relationship between the level of knowledge about STDs/HIV and condom use. I found in my study that among Navajo men the term STD had different meanings but it's generally referred to as sexually transmitted disease and for some, a dangerous disease. Although STD had different meanings, STD was used to describe infections such as chlamydia, gonorrhea, syphilis, herpes, and hepatitis. However, Navajo men generally named chlamydia as an STD, with HIV being the least recognized STD.

I also found in my study that Navajo men had confusion about the symptoms of STDs, and they demonstrated uncertainty with identifying symptoms. I discovered that six men were incapable of naming one STD symptom. They openly admitted to not knowing symptoms and revealed that their lack of knowledge was because they had not learned about STDs in high school health class. This study also found that there were misconceptions about symptoms of STDs among three Navajo men. They assumed that symptoms could be high blood pressure, red eyes, and black spots on the skin, anal bleeding, and discoloration of the nails. Furthermore, one man linked the poor practice of hand hygiene to the transmission of STDs. These findings suggest that Navajo men have adequate knowledge to naming a few STDs but demonstrated little knowledge in relation to symptoms.

deRavello, Shelby, and Cheek (2004) found that men generally do not seek or receive regular care; as a result they are not routinely screened for STDs and HIV. Additionally, research conducted by Cobb and Espey (2014) examined behavioral risk factors among American Indians and Alaskan Natives for morbidities and mortalities. The results indicated that American Indian and Alaskan Native men in the Southwest region were the only group less likely to be tested for HIV. The results of this study showed that three men had no knowledge of locations for seeking STD testing and treatment services. This finding suggests that Navajo men have not been tested for STDs in their lifetime. This study also showed that Navajo men were limited in naming locations for STD testing and treatment services. They generally identified hospitals and clinics for seeking STD testing and treatment services. These findings suggest that Navajo men in Gallup, NM and Farmington, NM do not regularly get tested for STDs, or receive health care. The findings of this study supported de Ravello, Shelby, and Cheek findings.

Research Question #5: What are some reasons identified by Navajo men as barriers to condom use in sexual activity?

The findings from this study showed that Navajo men were committed to using condoms despite their problems with condom breakage, slippage, tightness, and dryness. According to the HBM, a man must hold the belief that perceived barriers to change can be overcome (Hounton, Carabin & Henderson, 2005). In my study, I found that Navajo men generally experienced breakage with condom use and that they had a preference in brand and size for condoms. Navajo men believed that an expensive brand of condom

like Magnum can provide comfort, pleasure, and climax. They felt that Magnum condoms prevented erection difficulties, tightness, breakage, and discomfort. I discovered that Navajo men were not in favor of the free condoms from Tribal STD/HIV prevention programs and the Indian Health Service because of problems with brand, fit, and breakage. They believed that condoms from the clinic were cheap, tight, and broke easily. Although Navajo men had a preference for certain brands of condoms, they had no issues with buying or asking for condoms in a grocery store or from a clinic. These findings suggest that Navajo men have developed personalized standards for using condoms including how well the condom fits. The results of this study showed that the attitude and beliefs influencing condom use were consistent with the HBM.

The results showed that Navajo men were not in the habit of carrying around condoms, and they lacked condom-carrying skills. I found in my study that Navajo men generally did not have condoms on them before sex occurred or when they actually needed condoms for sexual encounters. Navajo men admitted that at times they refused sex altogether because they had problems finding condoms, especially late at night. These findings suggest that Navajo men bear the responsibility for birth control and for initiating condom use for safer sex. The findings also suggest that the lack of condom availability before sex begins may hinder safer sex and condom use. Based upon the findings, the conclusion may be drawn that condom use is an essential practice among Navajo men although they experienced problems with breakage, fit, and availability.

### **Limitations of the Study**



The findings are limited by the use of qualitative self-reporting and lack of a representative sample. The sample was predominantly Navajo and comprised of male heterosexuals, aged 20 to 39 years old, residing in or near Farmington, NM and Gallup, NM. Therefore, the findings may not be generalizable to other American Indian tribes of men or women. It should also be noted that respondents may have exaggerated their responses to appear committed to condom use. There were no measures implemented in this study to test whether respondents answered the interview questions truthfully. These interview questions were personal and I do believe that the men answered to the best of their abilities.

### **Recommendations**

Further research is needed on condom use behaviors in Navajo men. This is recommended so that future studies would consider exploring condom use errors and problems since Navajo men reported a variety of problems that contributed to condom failure. These problems described were breakage, slippage, tightness, and dryness, which may lead to Navajo men acquiring an STD or HIV. My study only begins to address this neglected area of research. Therefore, intervention studies that explore racial and ethnic groups may uncover strategies for promoting correct condom use given that condoms are important means for preventing STDs and HIV.

Another very fundamental direction for future research is exploring the perspectives of Navajo women regarding condom use. Throughout this study, the research focused on Navajo men who are among the gender group with the highest rates of STDs. Therefore, it is essential to understand the attitudes, beliefs, values, and

opinions as well as cultural beliefs about safer sex among Navajo women. It would be beneficial for researchers to gather a detailed understanding of practical barriers to condom use among Navajo women. These researchers may find ways for improving condom use and strategies for negotiating condom use. This information could be used to promote safe and responsible sexual decision-making.

Research should also include building on current understanding of the cultural value of *adil 'idli* (self-respect) and how this cultural practice has influenced health behavior in sexual activity, condom use, and acquiring of STDs among Navajo men. It would also be helpful to use a quantitative study that could lend another important dimension to understanding STD/HIV safer sex behavior among Navajo men. Meanwhile, researchers must continue exploring Navajo men's perspectives regarding safer sex behaviors and include this information within persuasive messages that promote condom use among Navajo men.

### **Implications for Social Change**

The findings of this study offered a significant explanation of condom use behaviors in Navajo men. An important implication of the findings is that Navajo men are committed to using condoms despite their problems with condom use. They experienced problems with condom breakage, slippage, tightness, and dryness. Thus, these findings suggest that Navajo men have developed personalized standards for using condoms, even with condom brand and size. Using this information, health care practitioners or health educators can promote social change at the individual level by establishing behavioral interventions that are designed to promote correct condom use

and to refine condom use skills. This type of intervention may be an effective means of reducing STDs and HIV rates among Navajo men. Furthermore, health care practitioners and health educators should provide Navajo men with a wide selection of various brands and sizes of condoms and one to one instructions on how to avoid problems with condom use.

Another important finding of this study is that Navajo men have confusion about the symptoms of STDs and demonstrated uncertainty with identifying symptoms. These findings suggest that Navajo men have adequate knowledge to naming a few STDs but demonstrated little knowledge in relation to the symptoms. Using this information, health care practitioners or health educators can promote social change at the individual level by incorporating gender specific information into health education programs that incorporates education about STD/HIV, safer sex behaviors, and shared responsibility for contraception. Furthermore, because men had confusion about symptoms of STDs, there is a need to deliver accurate health messages to Navajo men through education and social marketing campaigns. Based on the study results, Navajo men believed that they had a cultural obligation to stay healthy, and to keep their body clean, pure, and protected. This responsibility came from their Navajo value of *adil 'idli* (self-respect), which motivated condom use. Therefore, messages around STDs and condom use should integrate the cultural beliefs of *adil 'idli* (self-respect), specifically emphasizing the positive aspects of staying healthy.

In this study, the implications for social change include a better understanding of sexual-risk taking behaviors, specifically condom use in Navajo men. Another

implication for positive social change includes knowledge useful for tribal leaders, tribal health care providers, non-tribal public health professionals and other researchers who are searching for direction in improving the sexual health of Navajo adults. Long-term results would include increased condom use practices, reduced number of STD/HIV infections, improved access to STD/HIV care, and increased implementation of culturally appropriate STD/HIV programs and interventions.

### **Significance of Study**

This study contributes to the literature by providing a clearer understanding of Navajo men's cultural views on condom use, sexuality, beliefs about causes of STDs, and STD/HIV prevention behaviors in Navajo men. The study is significant in concluding that Navajo men's cultural value of adil 'idli (self-respect) has directed Navajo men to protect themselves by wearing condoms. The study is also significant to tribal leaders, tribal health care providers, and non-tribal public health professionals in providing cultural information for the development of prevention messages, intervention materials, and the support in the development of policies around STD/HIV. Furthermore, the study provides baseline information on sexual risk-taking behaviors among Navajo men that tribal STD/HIV programs can use to advance prevention activities in Navajo Nation.

### **Dissemination of Research Findings**

The findings of this study will be presented at tribal health organization meetings and professional conferences such as the American Public Health Association Conference. The findings will be disseminated to the Navajo Health Education Program, Navajo HIV Prevention Program, Navajo Social Hygiene Program, and Navajo STD

Program. These tribal health professionals may use the data to develop STD/HIV prevention measures and strategies that lead to improved health and well-being for Navajo men. The results of the study could also be used to obtain funding to develop STD/HIV campaigns. In addition, I will ask the Navajo Health Education Program and Navajo HIV Prevention Program to feature the research findings in their newsletters and websites. The research findings will also be disseminated at the National Coalitions of STD Directors Annual Meeting and the Navajo IRB Research Conference. This will increase the likelihood of informing other health professionals about my research findings through oral presentations and poster sessions. Other researchers and STD/HIV program planners may use the data to develop simple interventions. Furthermore, the data will be published in research journals including the American Journal of Public Health, Culture, Health and Sexuality, and Sexually Transmitted Diseases.

### **Conclusion**

This study provided new empirical evidence to the literature on Navajo men's cultural views on condom use, sexuality, and beliefs about causes of STDs, where the prevalence of sexual-risk taking behaviors among Navajo men has never been researched. This information offered a broad array of Navajo men's beliefs, attitudes, and behavior patterns in relation to condom use but more significantly, the study provided an in-depth explanation of men's motivation to wear condoms and their negative experiences with condom use. I discovered that the reasons for condom use were centered on Navajo men's cultural value of *adil 'idli* (self-respect) and their cultural obligation to stay healthy. These positive concepts can be used to promote and encourage condom use. As

a result, STD and HIV rates would begin to decrease among Navajo men. The difficulties of condom use in sexual activity emerged in this study; thus, developing strategies and teaching skills for overcoming condom use errors and failures ought to be explored.

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## Appendix A: Informed Consent

### INFORMED CONSENT

You are invited to participate in a study about condom use and sexual practices among Navajo men. This study is being conducted by Terra E. Yabeny a doctoral candidate at Walden University. You were selected because you are heterosexual Navajo men at least 20 years of age. Please read this form and ask any questions you may have before acting on this invitation to be in the study.

#### **Background Information:**

The purpose of this study is to explore the cultural value of Adil 'idli and how this cultural practice can hamper personal beliefs regarding sexual practices, condom use and STDs for Navajo men.

#### **Procedures:**

If you agree to participate in this study, you will be asked to respond to a series of questions regarding condoms, condom use, attitudes and beliefs using condoms, sexual practices, protection from STDs, and STD/HIV knowledge.

#### **Voluntary Nature of the Study:**

Your participation in this study is strictly voluntary, and you may withdraw at any time you choose.

#### **Risks and Benefits of Participation:**

There are no foreseen risks to participation and all information you provide will be treated with strict confidence.

In the event you experience stress or anxiety during your participation in the study you may terminate your participation at any time. You may refuse to answer any questions you consider invasive or stressful.

#### **Confidentiality:**

The information that you provide while participating in this study will be kept confidential and you will not be individually identified with the information that you provide.



**Contacts and Questions:**

If you have any further questions, please contact Terra E. Yabeny at [terra.yabeny@waldenu.edu](mailto:terra.yabeny@waldenu.edu) or at 505-860-0247. Her faculty advisor is Dr. Jeanne L. Connors, and she may be contacted at [jeanne.connors@waldenu.edu](mailto:jeanne.connors@waldenu.edu). The research participant advocate at Walden University is Dr. Leilani Endicott, and she may be reached at 1-800-925-3368 x1210. She can be contacted concerning questions about participation in this study. Each participant will be provided with a copy of this consent form.

**Statement of Consent:**

I agree to participate in this study, I realize that my participation is strictly voluntary.

Printed name of Participant: \_\_\_\_\_

Participant Signature: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_

## Appendix B: Interview Questions

1. Question about Condoms
  - a. Could you tell me what condoms are used for? And why would a person not want to use a condom?
  - b. Can you tell me how you feel about condoms?
  - c. How do you see condoms contributing to Adil 'idli (self-respect)?
  - d. Provide an example of a time in which you had learned about condoms.
  - e. Could you tell me why you use condoms?
  
2. Questions about Sexual Practices
  - a. Can you tell me how often do you use condoms? (never, sometime, most of the time)
  - b. Who or what influences your decision to use a condom?
  - c. In what situations, or with whom, did you not use condoms?
  - d. Tell me about your positive experiences you've had with condoms?
  - e. What kind of disappointments have you had with condoms?
  - f. How do you feel about a woman suggesting to her husband/boyfriend or partner to use a condom?
  - g. How do you feel about a man suggesting to his wife/girlfriend or partner to use a condom?
  - h. Give me a time in which you had difficulty getting a condom.
  - i. How do you feel about buying or getting condoms?
  
3. Questions about Protection from STD/HIV
  - a. What do you do to protect yourself from sexually transmitted diseases and HIV?
  
4. Questions about STD/HIV Risk
  - a. What have you heard about HIV?
  - b. Aside from HIV, there are other diseases both men and women can get by having sex. Could you tell me some of the diseases you heard of?
  - c. Can you tell me how a person can get an STD?
  - d. Give me two examples of symptoms of a STD in a man? And what are the symptoms when a woman is infected with an STD?
  - e. Can you tell me how you feel about STDs? HIV?
  - f. Have you ever been concerned about getting an STD or HIV? If so, why? Or why not?
  - g. How do you feel about STDs? HIV?
  - h. Do you discuss sex, HIV, STDs and condoms with your partner? What do you say? What did your partner say?
  - i. What did your parents tell you about sex and STDs?
  - j. Where could a person obtain treatment for a sexually transmitted disease?